

# BACKGROUND

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## Proposed Obamacare Gender Identity Mandate Threatens Freedom of Conscience and the Independence of Physicians

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### Abstract

*New proposed regulations from the Office for Civil Rights in the Department of Health and Human Services would create serious conflicts of conscience for many organizations, hospitals, physicians, and other individuals involved in health care. The proposed regulations create special privileges based on gender identity that would lead to unreasonable and costly litigation for physicians, hospitals, insurers, and others involved in health care. They effectively would require controversial procedures, such as “sex-reassignment” surgery, that respected medical professionals argue have not been proven to be effective in treating serious mental health conditions. Every individual should be treated with dignity and respect, especially when he or she is in need of medical care. However, the proposed regulations would interfere with the doctor-patient relationship, threaten freedom of conscience, and advance bad public policy.*

Proposed new health care regulations threaten the religious liberty, freedom of conscience, and independent medical judgment of health care professionals. On September 8, the Office for Civil Rights (OCR) in the Department of Health and Human Services (HHS) published a notice of proposed rulemaking that would implement certain nondiscrimination provisions of the Patient Protection and Affordable Care Act (ACA or Obamacare).

The proposed regulations would create serious conflicts of conscience for many organizations, hospitals, physicians, and other individuals involved in health care. By prohibiting differential treatment on the basis of “gender identity” in health services, these regulations propose to penalize medical professionals and health care

### KEY POINTS

- New proposed regulations under Obamacare redefine prohibitions on “sex” discrimination in health care programs to include “sex stereotyping,” “gender identity,” and “termination of pregnancy.”
- The regulations could open health care professionals and insurers to extensive liability if they decline to participate in or pay for “gender transition” treatments or “sex change” operations.
- The regulations could even threaten freedom of conscience and the independence of health care professionals and organizations that—as a matter of faith, moral conviction, or professional medical judgment—believe maleness and femaleness are biological realities to be respected and affirmed, not altered or treated as diseases.
- The regulations could even threaten the freedom of conscience concerning abortion.
- They are another striking example of regulatory overreach under Obamacare and further justify its repeal.

This paper, in its entirety, can be found at <http://report.heritage.org/bg3089>

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organizations that, as a matter of faith, moral conviction, or professional medical judgment, believe that maleness and femaleness are biological realities to be respected and affirmed, not altered or treated as diseases.

The proposed regulations create special privileges based on gender identity that will lead to unreasonable and costly litigation for physicians, hospitals, insurers, and others involved in health care. They effectively require controversial procedures, such as “sex-reassignment” surgery, that respected medical professionals argue have not been proven to be effective in treating serious mental health conditions. Rather than respect the diversity of opinions on sensitive and controversial health care issues, the proposed regulations endorse and enforce one side of the debate and trample on the freedom of conscience of many in the medical community.

Every individual should be treated with dignity and respect, especially when he or she is in need of medical care. Most physicians, nurses, other health care professionals, and health care organizations joined the field of medicine precisely because they believe in the inherent dignity and value of every human life and have a strong desire to heal and help individuals achieve their full potential. However, the proposed regulations would interfere with the doctor-patient relationship and would advance bad public policy. They represent another striking example of regulatory overreach under Obamacare and provide further justification for its repeal.<sup>1</sup>

### **Redefining “Sex” to Include Gender Identity and Possibly Sexual Orientation**

Section 1557 of the Affordable Care Act states:

[A]n individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et

seq.), or section 794 of title 29, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title 1 (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection.<sup>2</sup>

Section 1557 guarantees that no individual can be denied benefits in a health program that is either federally run or federally funded because of their membership in well-established categories of civil rights law, including race, color, national origin, sex, age, or disability.<sup>3</sup> As passed by Congress, Section 1557 of the ACA does not create special privileges for new classes of people or require insurers and physicians to cover or provide specific procedures or treatments. The Office for Civil Rights, however, interprets Section 1557 as if it does.

The OCR’s proposed regulations redefine discrimination on the basis of “sex” to include “sex stereotyping,” “gender identity,” and “termination of pregnancy,” among other things.<sup>4</sup> Specifically, the proposed regulations consider “discrimination” based on sex stereotypes to include “expectations that gender can only be constructed within two distinct opposite and disconnected forms (masculinity and femininity), and that gender cannot be constructed outside of this gender construct (individuals who identify as neither, both, or as a combination of male and female genders).”<sup>5</sup>

Additionally, the OCR notes that, “as a matter of policy, we support banning discrimination in health programs and activities not only on the bases identified previously, but also on the basis of sexual ori-

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1. Nina Owcharenko and Edmund F. Haislmaier, “*King v. Burwell*: An Opportunity for Congress and the States to Clear Away Obamacare’s Failed Policies,” Heritage Foundation *Issue Brief* No. 4360, February 27, 2015, <http://www.heritage.org/research/reports/2015/02/king-v-burwell-an-opportunity-for-congress-and-the-states-to-clear-away-obamacares-failed-policies>.

2. 42 U.S. Code § 18116 (a) (November 18, 2015).

3. *Federal Register*, Vol. 80, No. 173 (September 8, 2015), p. 54218.

4. *Ibid.*

5. *Ibid.*

entation.” The OCR requests comment “on the best way of ensuring that this rule includes the most robust set of protections supported by the courts on an ongoing basis.”

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The OCR considers any explicit or categorical exclusions of coverage for gender transition treatment as “unlawful on its face.”<sup>6</sup> Although the OCR claims that the proposed regulations would not “affirmatively require”<sup>7</sup> coverage of such treatment, this claim is undercut by the OCR’s more concrete statements on the matter:

In evaluating whether it is discriminatory to deny or limit a request for coverage of a particular service for an individual seeking the service as part of transition related care, OCR will start by inquiring whether and to what extent coverage is available when the same service is not related to gender transition. If, for example, a health plan or State Medicaid agency denies a claim for coverage of a hysterectomy that a patient’s provider says is medically necessary to treat gender dysphoria, OCR will evaluate the extent of the plan’s coverage of hysterectomies under other circumstances.<sup>8</sup>

A provider specializing in gynecological services that previously declined to provide a medically necessary hysterectomy for a transgender man would

have to revise its policy to perform the procedure on transgender individuals in the same manner it provides the procedure for other individuals.<sup>9</sup>

Under these guidelines, if a covered physician administers treatments or perform surgeries that *can* further gender transitions, that physician *must* provide them for gender transitions on the same terms, and insurance must cover it, regardless of the independent medical judgment of the physician.<sup>10</sup> Furthermore, the OCR has proposed no religious accommodation or exemption to its gender identity mandate or any other aspect of its proposed regulations.

Thus, the regulations propose to force many physicians, hospitals, and other health care providers to participate in sex-reassignment surgeries and treatments, even if it violates their religious beliefs or their best medical judgment. Moreover, because they apply so broadly, the regulations propose to also force employers, individuals, and taxpayers to fund coverage for such procedures even if doing so conflicts with their sincere beliefs.

### Scope and Impact of the Proposed Regulations

The proposed regulations would apply to any “health programs or activities any part of which receives Federal financial assistance administered by HHS” as well as any health programs or activities administered by HHS or those established under Title I of the ACA, including federally facilitated and state-based insurance exchanges.<sup>11</sup>

This includes any “hospital, health clinic, group health plan, health insurance issuer, physician’s practice, community health center, nursing facility, residential or community-based treatment facility, or other similar entity” that receives HHS funds.<sup>12</sup>

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6. Any “covered entity shall not,” among other things, “[c]ategorically or automatically exclude from coverage, or limit coverage for, all health services related to gender transition” or “[o]therwise deny or limit coverage, or deny a claim, for specific health services related to gender transition if such denial or limitation results in discrimination against a transgender individual.” *Ibid.*, pp. 54190 and 54220.

7. *Ibid.*, p. 54190.

8. *Ibid.*

9. *Ibid.*, p. 54204.

10. According to the OCR, “if a provider is not accepting new patients, the provider does not have to accept a new patient request from a transgender person.” *Ibid.*, p. 54205. However, all existing patients must be treated in a “nondiscriminatory” manner, and it is unclear if a physician could stop taking new patients *in response* to the regulations or if the OCR would consider that illegal discrimination as well.

11. *Ibid.*, p. 54173.

12. *Ibid.*, p. 54216.

The proposed regulations would therefore apply to:

- Approximately 133,000 health care facilities;
- “[A]lmost all practicing physicians in the United States...because they accept some form of Federal remuneration or reimbursement”;
- All state Medicaid programs; and
- All private insurers that receive any type of federal financial assistance or whose products are purchased with the help of a federal subsidy on an Obamacare exchange. Such insurers must make *all* of their health insurance products comply with the proposed regulations.<sup>13</sup>

Because the federal government now subsidizes and manages such a large part of the medical insurance market, the proposed regulations would make it nearly impossible for private employers and individuals to find a health plan that does not cover gender transition treatments and procedures. It would also make it nearly impossible for medical professionals to work free from these regulations.

The Office for Civil Rights proposes to enforce Section 1557 by conducting compliance reviews and investigating complaints. If it concludes that a covered entity has violated Section 1557, the entity may be stripped of its federal funding. Additionally, the OCR interprets “enforcement mechanisms” to include private rights of action, meaning individuals who feel that they have been discriminated against based on their gender identity may sue for damages in federal court.<sup>14</sup>

## Reasonable Judgments About Biology Are Not “Discriminatory”

Many people reasonably believe that maleness and femaleness are objective, biological realities that are integral to who we are as human beings. On the basis of religious teachings, moral reasoning, scientific evidence, and medical experience, many have strong grounds to hold that one’s sex is an immutable characteristic that should be respected, not rejected or treated as a disease.<sup>15</sup> Accordingly, many involved in providing medical care and those enrolled in health insurance plans have serious objections to participating in or paying for sex-reassignment surgeries or gender transitions. Yet the regulations would label these kinds of reasonable beliefs as “discriminatory” and seek to forbid them from being followed in the coverage or provision of health care services.

Gender identity and sexual orientation, unlike race or sex, are changeable, self-reported, and entirely self-defined characteristics. Government should not grant special privileges on such bases when legal recognition of a group as a “protected class” is, with few exceptions, reserved for groups with objectively identifiable immutable characteristics.<sup>16</sup>

The OCR nevertheless argues that Section 1557’s uncontroversial bar on “sex discrimination” should be redefined controversially to cover gender identity and possibly sexual orientation.<sup>17</sup> But differential treatment based on actions related to gender identity or sexual orientation does not constitute “sex” discrimination under a plain reading of Section 1557, and no evidence indicates that Congress departed from the common, objective definition of sex when drafting Section 1557. Absent clear congressional authorization, the OCR is not justified in replacing

13. *Ibid.*, pp. 54174–54175 and 54195.

14. *Ibid.*, p. 54192.

15. Ryan T. Anderson, “Sexual Orientation and Gender Identity (SOGI) Laws Threaten Freedom,” Heritage Foundation *Backgrounder* No. 3082, November 30, 2015, <http://www.heritage.org/research/reports/2015/11/sexual-orientation-and-gender-identity-sogi-laws-threaten-freedom>; Ryan T. Anderson, “Sexual Orientation and Gender Identity Are Not Like Race: Why ENDA Is Bad Policy,” The Witherspoon Institute, *Public Discourse*, March 18, 2015, <http://www.thepublicdiscourse.com/2015/03/14649/> (accessed October 27, 2015); John Finnis, “Law, Morality, and ‘Sexual Orientation,’” in *Human Rights and Common Good: The Collected Essays of John Finnis*, Vol. 3 (New York: Oxford University Press, 2011), pp. 335–336.

16. Anderson, “Sexual Orientation and Gender Identity (SOGI) Laws Threaten Freedom”; Ryan T. Anderson, “ENDA Threatens Fundamental Civil Liberties,” Heritage Foundation *Backgrounder* No. 2857, November 1, 2013, <http://www.heritage.org/research/reports/2013/11/enda-threatens-fundamental-civil-liberties>; and Anderson, “Sexual Orientation and Gender Identity Are Not Like Race.”

17. See *Federal Register*, pp. 54176–54177.

the commonsense understanding of sex as a permanent reality grounded in biology with *its* view that sex is something merely “assigned at birth” and that a person’s gender may actually be “neither, both, or a combination of male and female,” regardless of biology, and based solely on one’s subjective “internal sense of gender.”<sup>18</sup>

Under the OCR’s radical redefinition of “sex,” a person or covered entity that in conscience and good faith declines to participate in “gender transition” treatments could face unwarranted litigation and liability.<sup>19</sup> Because decisions about medical procedures, treatments, and insurance coverage made in line with reasonable medical, moral, and religious beliefs about biology and the best interests of the patient are nothing like invidious sex discrimination, they should not be treated by the federal government as such.

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### **The Unsettled Question of Proper Treatment of Gender Dysphoria**

Serious concerns raised by respected physicians about the propriety of sex-reassignment operations should give HHS and the OCR pause before forcing individuals, physicians, hospitals, and insurers to participate in or cover such procedures. There are a variety of reasonable medical opinions about the best treatment for gender dysphoria—a deep-seated desire to appear and be treated as a member of the opposite sex. Permanently altering, resecting, or amputating well-functioning organs of the human body is a controversial form of treatment. The federal government should not take sides in these debates through unac-

countable agency action and then coercively impose that judgment on all medical professionals.

Paul McHugh, MD, University Distinguished Service Professor of Psychiatry at the Johns Hopkins University School of Medicine and former Psychiatrist-in-Chief at Johns Hopkins University Hospital, has written extensively about the serious medical and psychological questions surrounding sex-reassignment surgery. When Dr. McHugh arrived at Johns Hopkins in the 1970s, the hospital had become one of the leading centers for sex-reassignment surgery in the country. Yet few follow-up studies were being conducted with patients receiving sex-reassignment operations as treatment for gender identity disorder (now called gender dysphoria in the *Diagnostic and Statistical Manual of Mental Disorders*). McHugh encouraged Jon Meyer, who was a colleague, psychiatrist, and psychoanalyst, to conduct research on the psychological well-being of patients after sex-reassignment surgery to see if the procedure led to any improvements. The results, as McHugh describes them, left much to be desired:

[Meyer] found that most of the patients he tracked down some years after their surgery were contented with what they had done and that only a few regretted it. But in every other respect, they were little changed in their psychological condition. They had much the same problems with relationships, work, and emotions as before. The hope that they would emerge now from their emotional difficulties to flourish psychologically had not been fulfilled. We saw the results as demonstrating that just as these men enjoyed cross-dressing as women before the operation so they enjoyed cross-living after it. But they were no better in their psychological integration or any easier to live with.<sup>20</sup>

Seeing little to no positive impact on the psychological health of transgender adults, McHugh could not justify continuing to surgically alter or remove healthy and fully functioning organs at the patients’ requests. McHugh concluded that Johns Hopkins’s

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18. *Ibid.*, pp. 54174 and 51477.

19. *Ibid.*, p. 54220.

20. Paul R. McHugh, “Surgical Sex,” *First Things*, November 2004, <http://www.firstthings.com/article/2004/11/surgical-sex> (accessed October 27, 2015).

practice of sex-reassignment surgeries, instead of helping patients, “was fundamentally cooperating with a mental illness” and the hospital stopped prescribing and performing the procedure.<sup>21</sup>

Concurring with the observations made at Johns Hopkins, a 2011 long-term study of individuals who underwent sex-reassignment surgery documented sustained mental hardships of transgender individuals. Conducted over a 30-year period in Sweden, the study found that 10 years to 30 years after sex-reassignment surgery “the most striking result was the high mortality rate,” due in significant part to post-operative transgender individuals having suicide rates nearly 20 times higher than their peers.<sup>22</sup>

McHugh addressed the question of proper treatment in the context of civil rights:

[P]olicy makers and the media are doing no favors either to the public or the transgendered by treating their confusions as a right in need of defending rather than as a mental disorder that deserves understanding, treatment and prevention.

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Claiming that this is [a] civil-rights matter and encouraging surgical intervention is in reality to collaborate with and promote a mental disorder.<sup>23</sup>

The proposed regulations make no mention of the professionals who argue that there are serious medical and psychological concerns surrounding sex-reassignment surgery and gender-transition treatments.<sup>24</sup>

The Office for Civil Rights’ proposed regulations will have serious effects on the practice of medicine, freedom of conscience, and choice in health care coverage. Yet both the preamble and the proposed

regulations appear to operate on the presumption that the question of sex-reassignment surgery is settled when respected physicians and researchers believe it is not the proper treatment for gender dysphoria. Whether or not one agrees with Dr. McHugh and other medical professionals’ concerns about such procedures, they should retain the freedom to practice medicine according to their best judgments without governmental penalty.

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### Forcing Physicians to Act Against Their Medical Judgment and Insurance to Pay for It

The proposed regulations would disregard reasonable medical decisions and instead open medical professionals to extensive litigation and potential liability if they decline to participate in a transgender individual’s demands for a “sex change.”

As stated earlier, the Office for Civil Rights explains how a hypothetical gynecologist’s office would be required to change its policy under the proposed regulations to “provide a medically necessary hysterectomy for a transgender man...in the same manner it provides the procedure for other individuals.”<sup>25</sup> What constitutes a “medically necessary” procedure is not defined in the proposed regulations.

However, in a preceding section of the preamble, the Office for Civil Rights suggests that health insurance plans could be forced to cover procedures

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21. Ibid.

22. Cecilia Dhejne et al., “Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden,” *PLOS ONE*, Vol. 6, No. 2 (February 2011), <http://www.plosone.org/article/fetchObject.action?uri=info:doi/10.1371/journal.pone.0016885&representation=PDF> (accessed October 27, 2015).

23. Paul McHugh, “Transgender Surgery Isn’t the Solution,” *The Wall Street Journal*, June 12, 2014, <http://www.wsj.com/articles/paul-mchugh-transgender-surgery-isnt-the-solution-1402615120> (accessed October 27, 2015).

24. *Federal Register*, Vol. 80, No. 173 (September 8, 2015), pp. 54189–54190. Indeed, the only medical evidence cited in the preamble to the proposed regulations is a citation to an HHS Departmental Appeals Board decision to invalidate Medicare’s previous exclusion of sex-reassignment coverage, which in turn cites the opinion of only one medical group that advances transgender surgeries.

25. Ibid., p. 54204.

involved in sex-reassignment surgeries provided at least one medical professional deems the procedure “medically necessary” to treat gender dysphoria. The OCR explains:

If, for example, a health plan or State Medicaid agency denies a claim for coverage of a hysterectomy that a patient’s provider says is medically necessary to treat gender dysphoria, OCR will evaluate the extent of the plan’s coverage of hysterectomies under other circumstances. OCR will also carefully scrutinize whether the covered entity’s explanation for the denial or limitation of coverage for transition-related care is legitimate and not a pretext for discrimination.<sup>26</sup>

Without further clarification, the proposed regulations could force gynecologists who perform hysterectomies for some purposes, such as to treat uterine or ovarian cancer, to perform the surgery for sex-reassignment purposes as long as the patient has a referral from a psychologist. Gynecologists who decline to perform hysterectomies in such cases because of conscientious objections or because they judge them medically inappropriate could nevertheless face litigation under the proposed regulations, as would insurers that decline to pay for the procedures. Similarly, physicians or insurers who regularly prescribe or cover hormones for some purposes, such as to treat conditions associated with aging in men and women, could face liability under the proposed regulations if they refuse to provide or pay for such hormones for gender-transition reasons.

The full impact of the proposed regulations on the judgments of medical professionals is unclear. For instance, could psychologists or counselors who recommend, in their best medical judgment, that patients with gender dysphoria *affirm*, rather than reject, their sex be liable for supposed “discrimination” under the proposed regulations? Similarly, may an endocrinologist recommend that patients with gender dysphoria try hormone treatments that reinforce instead of counteract their sex without being subject to a lawsuit

under the regulations? At the very least, the lack of clarity would likely invite expensive litigation on these and similar questions, and the proposed regulations would subordinate professional medical judgments to the rulings of OCR bureaucrats or federal judges.

### **The Harm to Religious Liberty and Freedom of Conscience**

In the preamble to the proposed regulations, the OCR acknowledges that its recommended nondiscrimination rule may conflict with religious beliefs. Although the OCR says the regulations will not displace the federal Religious Freedom Restoration Act or laws and regulations protecting people from having to perform, pay for, or refer for abortion against their will, it provides no guidance as to how the proposed regulations would be limited, if at all, by those laws and regulations. Moreover, the new regulations propose no moral or religious accommodation whatsoever, and it is unlikely that a religious exemption, even if proposed at some later date, would adequately protect the freedom of conscience of physicians, insurers, employers, health care providers, and taxpayers given the breadth of the proposed rule.<sup>27</sup>

The practical impact of the proposed regulations would spread across the field of health care and to employers and taxpayers generally:

- **Physicians.** Doctors, gynecologists, psychologists, and counselors, among others, could be forced to participate directly in treatments or procedures in violation of their moral or religious beliefs.
- **Hospitals, health clinics, nursing homes, and other health care organizations.** The impact on many health care entities would be twofold. Like physicians, they could be forced to participate directly in procedures in violation of their moral or religious beliefs. They would also be forced to pay for coverage of the same procedures in their own employee health plans.<sup>28</sup> The proposed regulations could require health care

26. *Ibid.*, p. 54190.

27. The OCR asks for comment “on whether the regulation should include any specific exemptions” and, if so, whether any should track the exemption process for certain religious institutions found in Title IX regulations. *Ibid.*, p. 54173.

28. The proposed regulation lists specific covered entities that would be required to ensure their own employee health benefits program abide by the proposed nondiscrimination policy. *Ibid.*, p. 54220.

organizations to open their bathrooms, locker rooms, and shower facilities to everyone regardless of sex or to provide “comparable” facilities, regardless of an organization’s religious beliefs on the matter.<sup>29</sup>

- **Employers and individuals purchasing health insurance.** As discussed above, the proposed regulations require private insurers that receive any enrollee subsidy on an Obamacare exchange or any other type of federal financial assistance to make all of their health insurance products comport with the gender identity mandate. That means, in practice, that private employers and individuals would find it nearly impossible to avoid paying for coverage of sex-reassignment surgeries and treatments through their insurance plans contrary to their religious belief or moral convictions.
- **Taxpayers.** Because the proposed regulations would apply to all insurance plans receiving taxpayer-funded subsidies on Obamacare exchanges and to all state Medicaid plans, which are funded with both state and federal tax dollars, the proposed regulations would make American taxpayers complicit in funding coverage of controversial surgeries and treatments.

### Proposed Regulations May Violate Conscience Concerning Abortion

In addition to the preceding concerns, the proposed regulations may threaten the freedom of conscience of physicians, health care entities, and individuals who have religious or moral objections to abortion. For nearly four decades, the federal government has prohibited

discrimination against individuals and health care providers who do not wish to pay for, cover, or perform abortions. However, the proposed regulations would prohibit discrimination in health care “on the basis of sex” further defined to include discrimination on the basis of “termination of pregnancy,” i.e., abortion.<sup>30</sup>

In the preamble to the proposed regulations, the Office for Civil Rights cites existing conscience protections for individuals, physicians, and other health care entities, yet those conscience laws are not explicitly applied in the text of the proposed regulations, and it is unclear how the regulations would interact with those existing policies. It is also unclear what “discrimination” based on termination of pregnancy would look like in practice. Would it prevent any differential treatment of a woman who has had an abortion, is seeking one, or both? Would the regulations prohibit pro-life obstetricians from declining to refer patients for abortions, or would the proposed regulations require coverage and provision of abortions, as with sex-reassignment surgeries? Because of this extreme ambiguity, the proposed regulations risk serious conflict with long-standing and widely accepted law and policies protecting conscience.<sup>31</sup>

### Yet Another Example of Regulatory Overreach Under Obamacare

Section 1557 of the Affordable Care Act is meant to extend *existing* protections against discrimination in federal programs to health care or health insurance programs that receive federal funds or are run by the federal government. The health care law does not create special privileges, new protected classes, or new rights to particular procedures. The proposed regulations are therefore unnecessary and

29. The preamble to the proposed regulations notes, “HHS does not propose to prohibit separate toilet, locker room, and shower facilities where comparable facilities are provided to individuals, regardless of sex.” *Ibid.*, p. 54181. Presumably, if a covered entity fails to provide such “comparable facilities,” regardless of sex, it could be found in violation of the proposed regulations. Notably, the OCR makes no estimate of the cost to covered entities for ensuring compliance with the proposed regulations in this respect.

30. *Ibid.*, p. 54216.

31. Specifically, the Church Amendments prevent the government from forcing any individual or entity receiving certain federal dollars to “perform or assist in the performance of any sterilization procedure or abortion” or make its facilities available for such procedures if doing so would violate religious or moral beliefs about abortion. 42 U.S. Code § 300a-7 *et seq.* Likewise, the Weldon Amendment, attached to every HHS appropriations bill since fiscal year 2004, prohibits any government receiving certain federal dollars from discriminating against health care entities (including health insurance plans) because it “does not provide, pay for, provide coverage of, or refer for abortions.” For example, see the Consolidated Appropriations Act, 2010, Public Law No. 111-117. Even the ACA prohibits qualified health plans offered on state and federal exchanges from “discriminat[ing] against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions.” Public Law 111-148 as amended by Public Law 111-152. See also U.S. Department of Health and Human Services, “Overview of Federal Statutory Health Care Provider Conscience Protections,” <http://www.hhs.gov/ocr/civilrights/faq/providerconsciencefaq.html> (accessed October 27, 2015).



outside the proper scope of agency rulemaking. The OCR has nevertheless proposed another regulatory scheme under Obamacare that will inject Washington bureaucrats into intimate medical decisions without adequate justification.

Medical professionals should remain free to operate according to their best medical judgments. No American should be forced to violate his or her moral and religious beliefs, especially in morally fraught issues in health care. Individuals, employers, and all Americans should be able to choose health care and health insurance that best fits the needs of their families and respects their beliefs. Likewise, the federal government should not force taxpayers to subsidize medically and ethically controversial procedures. Yet the proposed gender identity mandate would violate all of these principles.

This is not the first time, nor likely to be the last, that federal agencies have used the power given to them under Obamacare to promulgate rules that trample on the conscience rights of Americans. Just a few weeks after this proposed rule was published, the Supreme Court agreed to hear numerous cases challenging a different Obamacare regulation that

forces religious nonprofits to provide coverage of abortion-inducing drugs and devices, contraception, and sterilization in their employee health plans—under threat of heavy fines.<sup>32</sup> By centralizing control of health care decisions in the hands of unaccountable bureaucrats and forcing individual citizens to obtain government-approved insurance, the sweeping health care law poses an unprecedented and profound threat to the liberty of Americans.

To truly protect individual liberty, freedom of conscience, and fully respect the medical independence of physicians, Obamacare must be repealed. Patient-centered health care reform that puts decision making back in the hands of individuals, families, and physicians would lower costs, increase access, and respect the freedom of conscience of both consumers and medical providers.<sup>33</sup>

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32. Elizabeth Slattery and Sarah Torre, “Supreme Court Will Hear Obamacare Abortion-Inducing Drugs Case. Why That’s Important for Religious Freedom,” *The Daily Signal*, November 6, 2015, <http://dailysignal.com/2015/11/06/supreme-court-will-hear-obamacare-abortion-inducing-drugs-case-why-thats-important-for-religious-freedom/>.

33. Robert E. Moffitt, Jennifer A. Marshall, and Grace Smith, “Patient’s Freedom of Conscience: The Case for Values-Driven Health Plans,” Heritage Foundation *Backgrounder* No. 1933, May 15, 2006, <http://www.heritage.org/research/reports/2006/05/patients-freedom-of-conscience-the-case-for-values-driven-health-plans>, and Edmund Haislmaier et al., “A Fresh Start on Health Care Reform,” Heritage Foundation *Backgrounder* No. 2970, October 30, 2014, <http://www.heritage.org/research/reports/2014/10/a-fresh-start-for-health-care-reform>.