ALLIANCE DEFENDING FREEDOM
FOR FAITH. FOR JUSTICE.

September 11, 2022

Miguel A. Cardona
Secretary of Education
U.S. Department of Education
VIA REGULATIONS.GOV

RE: Nondiscrimination on the Basis of Sex in Education Programs or Activities Receiving Federal Financial Assistance
Docket ID ED-2021-OCR-0166

The Rule Jeopardizes Unborn Human Life, Mandates Life-Altering and Dangerous Medical Treatments, And Coerces Healthcare Professionals To Violate Their Consciences.

Dear Secretary Cardona,

Fifty years ago, Congress acted to protect equal opportunity for women by passing Title IX. Now, by radically rewriting federal law, the Biden administration is threatening the advancements that women have long fought to achieve in education and athletics. Along with denying women a fair and level playing field in sports, this new rule seeks to impose widespread harms, including threatening the health of adults and children, denying free speech on campus, trampling parental rights, violating religious liberty, and endangering unborn human life.

Alliance Defending Freedom (ADF) submits these comments on the Notice of Proposed Rulemaking (NPRM) on Title IX of the Education Amendments of 1972, Docket ID ED-2021-OCR-0166. ADF is an alliance-building legal organization that advocates for the right of all people to freely live out their faith. It pursues its mission through litigation, training, strategy, and funding. Since its launch in 1994, ADF has handled many legal matters involving Title IX, the First Amendment, athletic fairness, student privacy, and other legal principles addressed by the Notice of Proposed Rulemaking.

ADF strongly opposes any effort to redefine sex in federal regulations inconsistent with the text of Title IX itself, or otherwise to impair the First Amendment, due process, or parental rights. ADF thus urges the Department of Education to withdraw and abandon the NPRM.

These comments focus on the negative impact of the proposed rule on the sanctity of human life and on health care services related to sex and gender. The proposed rule will harm unborn human life and women by imposing broad abortion

mandates, and it will harm children and adults who struggle with their sex by coercing doctors to perform dangerous and life-altering medical procedures on patients.

I. The proposed rule threatens unborn human life and it threatens women's access to obstetrical and gynecological care.

20 U.S.C. § 1688 requires Title IX to be neutral with respect to forcing Title IX recipients to pay for or provide abortion: "Nothing in this chapter shall be construed to require or prohibit any person, or public or private entity, to provide or pay for any benefit or service, including the use of facilities, related to an abortion." But Section 106.40(b)(5) reverses that, requiring that a recipient

> treat "pregnancy, childbirth, false pregnancy, termination of pregnancy, and recovery" in the "same manner and under the same policies as any other temporary disability with respect to any medical or hospital benefit, service, plan or policy which such recipient administers, operates, offers, or participates in with respect to students admitted to the recipient's educational program or activity."

This proposed regulation purports to create an abortion mandate. And that mandate poses several issues that must be addressed.

A. An abortion mandate will harm pro-life activities.

The proposed rule purports to impose a broad abortion mandate. "Termination of pregnancy" and discrimination based on pregnancy termination are not adequately defined in the regulations. ADF is concerned that the federal government will, as it has indicated, give this vague provision an expansive understanding, with many far-reaching effects not addressed in the proposed rule or considered in their costs and benefits. And given the Department's maximalist position on abortion, its vagueness is likely to be an opportunity for courts and bureaucrats to impose broad abortion mandates on schools across the country, including campus health centers and medical schools.

If termination of pregnancy, i.e., abortion, is given equal status to pregnancy and childbearing, it necessarily requires acceptance of abortion as morally equivalent to pregnancy and childbirth. This would have major ramifications for pro-life states, schools, school employees, and students across the country, both in conduct and speech.

The Department must examine and quantify the impact on pro-life schools, pro-life speech, pro-life organizations, pro-life events, pro-life speakers, and others who promote, adopt, and administer pro-life policies. How will this impact sex education in public schools? How will it affect medical schools and teaching hospitals? Is it discrimination to notify parents about their minor child receiving abortion as a

termination of pregnancy? Must schools prohibit pro-life activities? What impact will the addition of in loco parentis to the definition of the term "parental status" have on parental notification laws? Would it allow someone other than a child's parents to agree to an abortion or be the only person notified? What is the impact of laws allowing minors to be able to make medical decisions? Would pro-life activities be considered harassment based on termination of pregnancy? Would the proposed rule restrict education or instruction on abortion in medical or moral contexts that are not "pro-abortion"? How will the Department ensure that there is no chilling effect? The rule mentions supportive measures like leaves of absence to obtain termination of pregnancy: could this be construed to encompass travel to other states to obtain an abortion?

The Department should consider omitting termination of pregnancy nondiscrimination from this rulemaking, which is an approach that would comport with the statute. This vague definition leaves far too much discretion in the hands of an activist court or bureaucrat. It gives no notice, let alone the clear notice required by Title IX. At the same time, the Department should consider adding an explicit carve-out for abortion and abortion-related services in obedience to the abortion neutrality clause found in the Title IX statute.

B. The Department should reconsider its legal rationale for any abortion mandate preempting state laws.

In its landmark *Dobbs* decision, the Supreme Court overruled *Roe v. Wade* and *Planned Parenthood of Southeastern Pennsylvania v. Casey*.[1] The Supreme Court expressly returned the right to prohibit elective abortion to the people and their elected representatives. Since the decision was released on June 24, 2022, several states have passed laws offering nearly total protection to unborn children. Some are in effect, and others are enjoined because of ongoing legal battles.

The Department thus must address this provision's preemptive effect upon pro-life state laws. Has the Department considered the intervening U.S. Supreme Court decision in *Dobbs*? Or the major questions doctrine from *West Virginia v. EPA*? *Dobbs* teaches that the question of abortion is a matter to be addressed by the legislative branches of government. And the major questions doctrine suggests that Congress would not bury an abortion mandate in Title IX, to be pulled out by bureaucrats fifty years after passage just because *Roe v. Wade* was overruled. This is particularly true in light of Title IX's abortion neutrality clause.

The Department has not considered these questions in a way that gives a rationale subject to public comment. The Department must explain how purportedly preemptive regulations will be applied in light of this new legal context—explanations that are clearly and intentionally lacking in the proposed rule.

[1] *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2288.

Furthermore, many protections such as the Church Amendments also depend on the definition of a "lawful abortion," making it critical for the government explain what it learned from the ruling in *Dobbs* before analyzing or defining the scope of any exemptions.

The Department must provide specific examples of how it could require access to abortion. It should then put these situations up for a supplemental comment period. Any failure to do so renders the proposed rule hopelessly vague and procedurally improper. If a judge or federal bureaucrat deems failure to provide access to abortion as discriminatory, then colleges and universities could be required to provide abortions. Campus health offices could become dispensaries for abortion poison pills. And more.

C. An abortion mandate will harm States' ability to protect unborn life, especially at on-campus medical centers.

Of these concerns, the likelihood of conflict with pro-life laws is most squarely raised by the effect of the proposed rule upon on-campus medical center. Namely, does a Title IX recipient, such as a college or university, violate Section 106.40(b)(5) if: (1) the college or university's student health center provides certain medical services such as obstetrical and gynecological care or hormonal contraception, but (2) the student health center does not prescribe chemical abortion[2] or refer for surgical abortions when (3) the college or university is in a state that limits elective abortion?

Under 20 U.S.C. § 1688, a Title IX recipient that is a college or university should not be found to violate Section 106.40(b)(5) if that recipient's student health center does not provide chemical abortion or referrals for surgical abortion. But Section 106.40(b)(5) requires Title IX recipients to treat "termination of pregnancy" in the "same manner" as "any other temporary disability with respect to any medical or hospital benefit, service, plan or policy which such recipient administers, operates, offers, or participates in." It is therefore unclear whether a Title IX recipient might be violating Section 106.40(b)(5) if the recipient's student health center offers certain obstetrical and gynecological care and/or contraception, but not abortion.

States' ability to prohibit elective abortion adds an additional layer of confusion to Section 106.40(b)(5).

To illustrate, Alabama is currently enforcing Ala. Code Ann. § 26-23H-4, which makes it unlawful for any person to perform an abortion unless a licensed physician determines that an abortion is necessary in order to prevent a serious health risk to

[2] The term "chemical abortion" used throughout refers to the abortion-inducing drug regimen mifepristone and misoprostol, which together are often prescribed to terminate a pregnancy. *See* https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information.

the mother. Auburn University in Auburn, Alabama, is a public university and Title IX recipient.

Auburn operates a Medical Clinic that provides "routine gynecological care, breast exams, counseling and prescribing of birth control, pregnancy testing, and diagnosis and treatment of STDs" to students.[3] Because Auburn offers certain medical services as described in Section 106.40(b)(5), but does not indicate that it offers similar services for "termination of pregnancy," (such as providing prescriptions for chemical abortions or referrals for abortions), is Auburn University violating Section 106.40(b)(5)? Even when the state of Alabama prohibits elective abortion under Ala. Code Ann. § 26-23H-4?

Auburn is not the only Title IX recipient where potential violation of Section 106.40(b)(5) is a possibility. The following chart illustrates that application of Section 106.40(b)(5) poses serious problems for Title IX recipients across the country, especially in states that now enforce pro-life laws that protect unborn children following the Supreme Court's ruling in *Dobbs*.

State limiting or seeking to limit abortion	**Title IX Recipient Example**	**Medical services offered relating to Section 106.40(b)(5)**
Alabama	University of Alabama	Routine annual exams, pelvic exams, breast exams, pap smears, contraception, treatment of STDs, pregnancy testing, and counseling.[4]
Arizona	University of Arizona	Pap testing, STI screening and treatment, pelvic/vaginal exams, pregnancy testing, birth control, colposcopy, treatment of genital warts, abnormal bleeding, breast concerns, emergency contraception (Plan B and Ella), hormone therapy.[5]

[3] https://cws.auburn.edu/aumc/pm/Services#acuteCare.
[4] https://cchs.ua.edu/shc/services/.
[5] https://www.health.arizona.edu/womens-health.

Arkansas	University of Arkansas	GYN annual exams, contraception, emergency contraception prescriptions, vaginal infection assessment and treatment, UTI assessment and treatment, pregnancy testing, STI testing, HPV vaccination, and provides referrals for mammograms, infertility treatment, prenatal care, nutritional counseling, and more.[6]
Florida	Florida State University	Annual exams, pregnancy testing and referrals, emergency contraception prescriptions, STD testing and treatment, UTI testing and treatment, counseling and educational information on contraceptive options and breast health.[7]
Georgia	University of Georgia	Annual wellness exams, including pap smears, contraception prescriptions, emergency contraception, UTI testing and treatment, pregnancy testing, STD testing, treatment for other gynecological issues.[8]
Idaho	Boise State University	Contraception, testing and treatment for STIs,

[6] https://health.uark.edu/medical-health/gynclinic.php.
[7] https://uhs.fsu.edu/health-care/clinical-services/womens-clinic.
[8] https://healthcenter.uga.edu/services/gynecology-clinic/.

		pregnancy tests, and HPV vaccines.[9]
Indiana	Purdue University	Well-women exams, treatment of STIs, emergency contraception counseling and prescriptions.[10]
Iowa	Iowa State University	Pelvic, breast, testicular exams, pap screening, prescriptions for birth control, pregnancy testing, testing and treatment of STIs, care for menstrual concerns, evaluation and treatment of vaginal infections and urinary tract infections, Plan B emergency contraception.[11]
Kentucky	University of Kentucky	Preventive screenings and care for reproductive and sexual health concerns, pregnancy testing, birth control prescriptions.[12]
Louisiana	Louisiana State University	Women's wellness class, annual exams, contraceptive counseling and placement, evaluation of menstrual irregularities, pregnancy testing and counseling, treatment and testing of STIs, ultrasounds.[13]

[9] https://www.boisestate.edu/healthservices/sexual-health/.
[10] https://www.purdue.edu/push/Medical/index.html.
[11] https://health.iastate.edu/services/womens-health/.
[12] https://ukhealthcare.uky.edu/university-health-service/student-health/services/gyn-gu.
[13] https://www.lsu.edu/shc/medical/gynecology.php.

Michigan	University of Michigan	Routine gynecological exams, contraception, testing and treatment of vaginal infections and STIs, routine immunizations.[14]
Mississippi	University of Mississippi	Annual gynecological exams and counseling, treatment for menstrual irregularity, testing and treatment for STDs, information on birth control, pregnancy testing, counseling, and referrals.[15]
Missouri	University of Missouri	Contraception, IUDs, STI testing and treatment, medication for HIV prevention, male sexual dysfunction, general sexual health issues.[16]
North Dakota	University of North Dakota	Contraceptive counseling, IUD, STD screening, pregnancy testing, pap tests.[17]
Ohio	Ohio State University	Annual exams, breast exams, pelvic exams and pap smears, pregnancy testing, testing and treatment of STIs, contraceptive counseling and prescriptions, emergency contraception.[18]

[14] https://uhs.umich.edu/gyn-sexual-health.
[15] https://healthcenter.olemiss.edu/services-2/.
[16] https://wellbeing.missouri.edu/medical-care-services/sexual-health-services/.
[17] https://und.edu/student-life/student-health/medical-services.html.
[18] https://shs.osu.edu//services/gynecologic-services.

Oklahoma	University of Oklahoma	Annual exams, pap tests, breast exams, contraceptive counseling, IUD insertion, testing and treatment for STDs, pre-conception counseling and planning, referral services for pregnancy.[19]
South Carolina	University of South Carolina	Annual exams, contraception, HPV vaccinations, pap tests, pelvic exams, pregnancy testing and counseling, STI testing, UTI testing.[20]
South Dakota	South Dakota State University	Contraception, STI screening, pregnancy testing, pap smears.[21]
Tennessee	University of Tennessee	Annual exams, pap smears, pregnancy testing, birth control, testing and treatment of STIs.[22]
Texas	University of Texas	Annual exams, contraception prescriptions, emergency contraception, STI testing and treatment, care for menstrual concerns, pregnancy testing and referrals, breast health assessments, treatment and

[19] https://www.ou.edu/healthservices/medical-services/sexualhealth.
[20] https://sc.edu/about/offices_and_divisions/health_services/medical-services/womens-health/index.php.
[21] https://www.sdstate.edu/health-wellness/health-clinic-services.
[22] https://studenthealth.utk.edu/womens-health-clinic/.

		testing for vaginal infections and UTIs.[23]
Utah	University of Utah	Well exams, pap smears, contraceptive prescriptions, emergency contraception, acute care for gynecological problems, STD screening, diagnosis, and treatment, pre-conception counseling, pregnancy testing and counseling, HPV vaccination.[24]
West Virginia	West Virginia University	Pap smears, birth control/contraception, pregnancy testing, vaccinations, and more.[25]
Wyoming	University of Wyoming	Gynecological exams, birth control counseling and prescriptions, STI treatment and testing, evaluation, and treatment of abnormal pap smears.[26]

D. An abortion mandate will harm healthcare and imperil conscience rights.

In addition, Section 1557 of the Patient Protection and Affordable Care Act incorporates Title IX. The Department thus must address whether this definition of pregnancy and related conditions will be incorporated into Section 1557, and if so, whether Title IX's abortion neutrality and religious exemption be incorporated as well. Will doctors be forced to provide abortion? Will insurers and employer health plans be forced to cover abortion? If not, why not? What are the costs of requiring that

[23] https://www.healthyhorns.utexas.edu/womenshealth.html.
[24] https://studenthealth.utah.edu/services/womens-health.php.
[25] https://wvumedicine.org/ruby-memorial-hospital/services/wvu-specialty-clinics/student-health/.
[26] http://www.uwyo.edu/shser/Services.html.

Title IX entities provide abortions? The Department would need to quantify those costs at a granular level, something the proposed rule fails to consider or attempt. The Department must also consider the myriad of conscience protection laws and religious freedom laws that apply in that context, something that this proposed rule also fails to do.

One of the freedoms Americans have cherished most is the freedom to live according to their faith and conscience, free from government coercion. Unfortunately, nurses, doctors, and health care providers have faced discrimination and even have lost their jobs because of their commitment to saving life. The government has a duty to respect and enforce federal conscience and religious freedom protections for pro-life healthcare providers, not to enact new abortion mandates that trample on these rights.

ADF also defends the rights of pro-life healthcare professionals in court. Forcing doctors and nurses to end life is the opposite of good healthcare or good government. When the government has not protected conscience right and religious freedom, ADF has gone to court to do so. Avoiding coerced participation in abortion is vital, as many doctors and nurses told HHS in formal comments in 2018 on the HHS conscience rule.

> "After 28 years of working as a critical care and emergency room nurse, I never imagined my employer would force me to choose between taking the life of an unborn child and losing my job. But 11 other nurses and I were ordered to assist in abortion even though it violated our religious convictions and contradicted our calling as a medical professional to protect life. Both New Jersey and federal law prohibited this discrimination. But those laws are only as effective as the willingness of government officials to enforce them." — *Fe Esperanza Racpan Vinoya, Danquah v. University of Medicine and Dentistry of New Jersey*

> "My faith in God and the Catholic Church's teachings about the value of all human life inspired my career in nursing and encouraged me to never harm or intentionally take the life of an innocent person. I'll never forget the day my supervisor ignored the law and forced me to participate in an abortion. I still have nightmares about that day." — *Cathy DeCarlo, Cenzon-DeCarlo v. The Mount Sinai Hospital*

> "I never dreamed that my desire to serve women and their families would prevent me from joining the medical profession, but it almost did. I applied for a nurse-midwife position at a federally-funded center that provides health care to poor, underserved women in Florida. But I was shocked when the center refused to consider my application because I was a member of a pro-life medical association and was committed to saving lives not ending them. . . . Diversity among health providers,

including religious and moral diversity, helps ensure women have more options available to them in finding a medical professional who shares and supports their values." — *Sara Hellwege, Hellwege v. Tampa Family Health Centers*

"The pregnancy care center I help lead informs pregnant moms about all their options—parenting, placing a child for adoption, and abortion. We offer hope, encouragement, and practical support. But the state of California tried to force us to speak a message we didn't believe, refer for free abortions, and turn our walls into a billboard for the abortion industry. Thankfully, the Supreme Court ruled that the government can't force us to speak a message that contradicts the very core of who we are and why we exist . . . ." — *Heidi Matzke, National Institute of Family and Life Advocates v. Becerra*

E. The Department should select pro-life alternative policies.

The Department should consider and adopt one of several pro-life alternative policies.

The agency should consider providing broad exemptions on the face of the rule for scientific, medical, conscientious, or religious objections to its mandates. This includes grandfathering existing categories of healthcare; exempting religious institutions; and crafting privacy exemptions for single-sex facilities and programs.

The rule should state that it does not preempt state or local laws including state heath laws, malpractice suits, child abuse law, and abortion laws. In particular, the Department should clarify that the rule does not preempt any state or local laws restricting abortion or gender interventions, especially post-*Dobbs*.

So that regulated entities and individuals have recourse short of litigation, the department should consider creating an explicit and prompt new mechanism for requests for conscience and religious exemptions from its many mandates, including binding letters of assurance of exemption that preclude public or private suits against the regulated entity. This avenue should not foreclose the ability of a regulated entity or individual to immediately seek judicial relief, rather than avail itself of this process.

The Department should also consider not defining what constitutes discrimination in terms of the provision or coverage of any specific procedures, such as gender identity or termination of pregnancy, given the changing nature of medical science. This includes avoiding mandating coverage for abortion, for gender interventions, or situationally for any reproductive services (like infertility treatments, IVF, gestational surrogacy, or contraceptives) contrary to a provider's belief that sexuality and marriage is reserved for the union of one man and one woman and to the belief that each child deserves a mother and a father.

The Department likewise should expressly exclude children under 18 from any mandates concerning termination of pregnancy procedures

F. The Department should consider alternatives that promote the health of mothers and their unborn children without promoting abortion or redefining sex.

ADF believes that federal policy should support pregnant women and mothers, and should accommodate pregnancy and breastfeeding within the educational context. No woman should be pressured to abort her child or leave the educational environment because of pregnancy or childbirth. But even the inclusion of these provisions in the proposed rulemaking must be justified under textualist approaches that respect the Department's statutory and constitutional limits. Breastfeeding and lactation is biologically sex-based, and so it should be justified under principles different from the inclusion of gender identity, sexual orientation, and abortion in the proposed rule. The Department should also consider other alternatives in this area, such as requiring changing tables in men's and women's restrooms.

Finally, the Department should reconsider its definitional textual additions pertaining to abortion. The Department's notice proposes to add new sections that impact the definition of sex discrimination:

- the Department proposes in section 106.10 to define sex discrimination to include discrimination based on sex stereotypes, sex characteristics, pregnancy or related conditions, sexual orientation, and gender identity;[27]

- the Department proposes in section 106.31(a)(2) to clarify that even where Title IX permits sex-separation, a recipient cannot carry out that different treatment in a way that discriminates on the basis of sex by subjecting a person to more than *de minimis* harm. A policy or practice that prevents a person from participating in an education program or activity consistent with their gender identity subjects a person to more than *de minimis* harm.[28]

Not only does this redefinition of sex deviate from past agency statements[29] (as the Department admits) and lack any basis in federal law or Supreme Court opinion, but this collective redefinition of sex in Title IX will hurt students, faculty, and schools alike. For the reasons detailed below, Alliance Defending Freedom opposes the addition of sections 106.10 and 106.31(a)(2) to the Title IX regulations.

The Department thus should consider using the biological definition of sex, which does not address gender identity or sexual orientation. It must explain why

[27] NPRM at 519.
[28] NPRM at 529.
[29] NPRM at 7-8.

that definition cannot be retained. And it must consider the many harms that will follow from its proposed redefinition.

II. The redefinition of "sex discrimination" to include gender identity unlawfully coerces health care providers to perform or refer for life-altering procedures related to gender identity.

The Title IX rule affects the practice of health care at many educational institutions.[30] By changing the meaning of "sex" to include gender identity, the NPRM will have negative effects on healthcare by coercing the performance of dangerous and life-altering medical procedures; crushing free speech; and ignoring conscience protections for medical providers. These negative impacts should cause the Department to reconsider and withdraw the Rule.

A. Coercing the performance and promotion of life altering procedures related to gender identity is unjustified.

The government should promote the common good and dignity of all people, while upholding the constitutional freedoms of all Americans. Doctors, patients, and families deserve no less. The government thus should not force doctors to offer or participate in abortions or in gender transition procedures, which go against doctors' deeply held medical and ethical convictions—especially when it involves children and adolescents—and which are controversial and dangerous.

The proposed rule fails to grapple with its import for these serious medical questions—even though Title IX could end up setting a new medical standard of care by virtue of its effects on medicine in educational settings. Title IX applies to many educational healthcare settings, such as on-campus medical centers, teaching hospitals, and nurses' offices.

Likewise, Section 1557 of the Patient Protection and Affordable Care Act incorporates Title IX. The Department thus must address if this definition of sex will be incorporated into Section 1557, and if so, what conscience protections and religious freedom protections will be in place. The proposed rule does not even attempt to address this crucial issue of the impact on the practice of medicine, let alone quantify its costs and identify its benefits. This omission is fatal to the proposed rule.

The Department thus must explain whether the federal government can compel medical doctors to perform gender-transition surgeries, prescribe gender-transition drugs, and speak and write about patients according to gender identity,

[30] *See, e.g.,* https://www2.ed.gov/about/offices/list/ocr/docs/investigations/more/15186901-a.pdf (Department of Education letter setting forth OCR determination in investigation of Michigan State University for actions of Dr. Lawrence Nassar).

rather than biological reality—regardless of doctors' medical judgment or conscientious objections.

This concern is not speculative. The U.S. Department of Health and Human Services (HHS) has re-interpreted Section 1557 of the Affordable Care Act (ACA), which prohibits sex discrimination, to require doctors to perform such interventions by prohibiting discrimination on the basis of gender identity. Under the government's overreaching interpretation, doctors now face an untenable choice: either act against their medical judgment and deeply held convictions by performing controversial and often medically dangerous gender interventions, or succumb to huge financial penalties, lose participation in Medicaid and other federal funding, and, as a practical matter, lose the ability to practice medicine in virtually any setting. HHS has also imposed a gender identity mandate through its overarching grants regulation, 45 C.F.R. § 75.300, which partly overlaps and partly surpasses the Section 1557 mandate in many health contexts.

B. The Department's view of sex in science and medicine will harm children and adults.

Any medical mandate from Title IX or Section 1557 based on a legally and factually faulty view of the meaning of "sex" will harm children and adults.

When it comes to the science, the Department is just wrong that sex and biology are separate from gender.[31] Human sexuality is an objective biological binary trait: "XY" and "XX" are genetic markers of sex—not genetic markers of a disordered body. The norm for human design is to be conceived either male or female with the purpose being the reproduction and flourishing of our species. This principle is self-evident. Children who identify as "feeling like the opposite sex" or "somewhere in between" do not comprise a third sex. They remain biological boys or biological girls. Normalizing the myth of innate gender fluidity thus will cause psychological trauma to youth who are not confused about their gender identity.

Disorders of sex development (DSD), commonly referred to as intersex conditions, do not demonstrate otherwise. Disorders of sex development are maladies in which normal sexual differentiation and function are disrupted. Some argue that disorders of sex development demonstrate the existence of more than two sexes. But disorders of sex development do not represent additional reproductive organs, gonads, or gametes. Thus, by definition, disorders of sex development do not constitute additional sexes.

[31] The medical science supporting these facts is laid forth in medical declarations in a pending ADF case. *See* Declaration of Quentin Van Meter, M.D., A*merican College of Pediatricians v. Becerra*, No. 1:21-cv-00195, ECF Bo. 15-1 (E.D. Tenn. Nov. 10, 2021).

Human sex is a binary, not a spectrum, and disorders of sex development are rare congenital disorders affecting 0.02% of the population in which either genitalia are ambiguous in appearance, or an individual's sexual appearance fails to match what would be expected given the person's sex chromosomes. Reflecting the unfortunate nature of these conditions, all disorders of sex development are linked to impaired fertility.

Teaching children to question their biology and gender is untested and unscientific. Young children and developing adolescents struggling with their sex characteristics should receive counseling, not medical experimentation. Up to 98% of children who struggle with their sex desist and will accept their sex by adulthood.[32] But the long-term effects of puberty blockers and cross-sex hormones have not been rigorously studied.[33] No drugs have been approved by the Food and Drug Administration (FDA) to treat gender dysphoria. But puberty blockers and cross-sex hormones combined will sterilize many youth and cause them to develop serious chronic illnesses such as diabetes, heart disease, stroke and cancers that they otherwise would have never experienced. And, after sex-reassignment surgery, people who identify as transgender are nearly 20 times more likely to die from suicide than the general population.[34]

In no other area of science would these types of surgeries, procedures, and interventions move forward without the research to support them. There is a lack of high-quality scientific data for common gender identity interventions, such as the general lack of randomized prospective trial design, a small sample size, recruitment bias, short study duration, high subject dropout rates, and reliance on opinion. There

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[32] Michael K Laidlaw, et al., "Letter to the Editor: 'Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline', " The Journal of Clinical Endocrinology & Metabolism, 104, no. 3 (March, 2019): 686–687, https://academic.oup.com/ jcem/article-abstract/104/3/686/5198654?redirectedFrom=fulltext ("Children with GD will outgrow this condition in 61-98% of cases by adulthood.").

[33] Paul W. Hruz, et al., "Growing Pains: Problems with Puberty Suppression in Treating Gender Dysphoria," New Atlantis, Spring 2017, https:// www.thenewatlantis.com/publications/growing-pains, ("Whether puberty suppression is safe and effective when used for gender dysphoria remains unclear and unsupported by rigorous scientific evidence."); See also: Johanna Olson-Kennedy, et al., "Health considerations for gender non-conforming children and transgender adolescents," UCSF Center of Excellence for Transgender Health, accessed on February 21, 2019, https://transcare.ucsf.edu/guidelines/youth, ("While clinically becoming increasingly common, the impact of GnRH analogues administered to transgender youth in early puberty and <12 years of age has not been published.").

[34] A long-term study conducted in Sweden followed 324 transgender-identified people who had undergone sex reassignment surgery and found that after surgery, these adults were nearly 5 times more likely to attempt suicide and nearly 20 times more likely to commit suicide than the general population. As a result, "Persons with transsexualism, after sex reassignment, have considerably higher risks for mortality, suicidal behaviour, and psychiatric morbidity than the general population. Cecilia Dhejne, et al., "Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden," PLoS One 6, no. 2 (2011): e16885, https://doi.org/10.1371/journal.pone.0016885.

are serious deficits in understanding the cause of this condition or in understanding the reasons for the marked increase in people presenting for medical care. Under the established principles of evidence-based medicine, providers should exercise a high degree of caution before accepting gender-transition medical interventions as a preferred treatment approach. It is thus recommended to give continued consideration and rigorous investigation of alternate approaches to alleviating suffering in people with gender dysphoria, especially further investigation of the phenomenon of adolescent girls with no prior expression of gender dysphoria presenting as having a transgendered identity in social networks (aka rapid onset gender dysphoria).[35]

For this reason, the United Kingdom, Sweden, and Finland have taken steps to limit these interventions in youth. Sweden's Karolinska University Hospital restricted its use of the Dutch Protocol (medical interventions in response to transgender identification) to children over 16 years old stating it is "potentially fraught with extensive and irreversible adverse consequences such as cardiovascular disease, osteoporosis, infertility, increased cancer risk, and thrombosis."[36] World-renowned child psychiatrist Dr. Christopher Gillberg has referred to this as "possibly one of the greatest scandals in medical history." His neuropsychiatry research group at Gothenburg University has called for "an immediate moratorium on the use of puberty blocker drugs because of their unknown long-term effects."[37]

C. The Rule would illegally coerce health care providers' medical care and speech.

A gender identity mandate in healthcare, even in educational settings only, likely would require providers to participate in a litany of objectionable practices.

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[35] Paul W. Hruz, Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria, 87 Linacre Quarterly 34, 34-42 (Sept. 20, 2019), https://doi.org/10.1177/0024363919873762.

[36] Cummings DM, Swedish Hospital No Longer Gives Puberty Blockers or Sex Hormones to Children," Lifesite News (May 6, 2021), available at https://www.lifesitenews.com/news/swedishhospital-no-longer-gives-puberty-blockers-sex-hormones-tochildren; Karolinska University Hospital Dutch Protocol Policy, https://segm.org/sites/default/files/Karolinska%20_Policy_Statement_English.pdf (last accessed Oct. 6, 2021) (concluding that from April 1, 2021 onwards, "hormonal treatments (i.e., puberty blocking and cross-sex hormones) will not be initiated in gender dysphoric patients under the age of 16").

[37] Jonathan Van Maren, World-renowned child psychiatrist calls trans treatments "possibly one of the greatest scandals in medical history," The Bridgehead (Sept. 25, 2019), https://thebridgehead.ca/2019/09/25/world-renowned-child-psychiatrist-calls-trans-treatmentspossibly-one-of-the-greatest-scandals-in-medical-history/ ("Professor Gillberg's neuropsychiatry group at Sweden's Gothenburg University — which has research hubs in Britain, France and Japan— has called for an immediate moratorium on the use of puberty blocker drugs because of their unknown long-term effects.") (citing The Australian, https://www.theaustralian.com.au/nation/doctors-back-inquiry-on-kids-trans-care/news-story/6f352bc99da430b194620a2605e8a50d).

Many providers have medical, ethical, or religious objections to the following activities and speech that a gender identity mandate in medicine would require:

a. Prescribing puberty blockers off-label from the FDA-approved indication to treat gender dysphoria and initiate or further transition in adults and children;

b. Prescribing hormone therapies off-label from the FDA-approved indication to treat gender dysphoria in all adults and children;

c. Providing other continuing interventions to further transitions ongoing in both adults and minors;

d. Performing hysterectomies or mastectomies on healthy women who believe themselves to be men;

e. Removing the non-diseased ovaries of healthy women who believe themselves to be men;

f. Removing the testicles of healthy men who believe themselves to be women;

g. Performing a process called "de-gloving" to remove the skin of a man's penis and use it to create a faux vaginal opening;

h. Remove vaginal tissue from women to facilitate the creation of a faux or cosmetic penis;

i. Performing or participating in any combination of the above mutilating cosmetic procedures, or similar surgeries,[38]

j. Offering to perform, provide, or prescribe any and all such interventions, procedures, services, or drugs;

k. Referring patients for any and all such interventions, procedures, services, or drugs;

l. Ending or modifying existing policies, procedures, and practices of healthcare providers to not offer to perform or prescribe these procedures, drugs, and interventions;

[38] Similar objectionable surgeries include orchiectomy and penectomy (removal of testicles and penis); clitoroplasty, labiaplasty, and vaginoplasty (creation of a clitoris, labia, and vagina); vulvectomy and vaginectomy (removal of vulva and vagina); and metoidioplasty and phalloplasty (creation of penis).

m. Saying, against the medical and moral judgment of healthcare providers, that these gender intervention procedures are the standard of care, are safe, are beneficial, are not experimental, or should otherwise be recommended;

n. Treating patients according to gender identity and not sex;

o. Expressing views on gender interventions that are contrary to a medical provider's professional and moral beliefs;

p. Saying that sex or gender is nonbinary or on a spectrum;

q. Using language affirming any self-professed gender identity;

r. Using patients' preferred pronouns according to gender identity, rather than using no pronouns or using pronouns based on biological sex;

s. Creating medical records and coding patients and services according to gender identity and not biological sex;

t. Providing the government assurances of compliance, providing compliance reports, and posting notices of compliance in prominent physical locations, if the 2016 ACA Rule's interpretation of the term sex governs these documents;

u. Refraining from expressing medical, ethical, or religious views, options, and opinions to patients when those views disagree with gender identity theory or transitions; and

v. Allowing patients to access single-sex programs and facilities, such as mental health therapy groups, breastfeeding support groups, post-partum support groups, educational sessions, changing areas, restrooms, communal showers, and other single-sex programs and spaces, by gender identity and not by biological sex.

D. The Rule's health care coercion concerning gender identity lacks statutory authority.

Federal statutes do not support the imposition of these gender identity mandates in medicine. Section 1557 of the Affordable Care Act (ACA), 42 U.S.C. § 18116, states in paragraph (a) that:

> Except as otherwise provided for in this title (or an amendment made by this title), an 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 (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.

None of the anti-discrimination statutes mentioned in Section 1557 prohibit discrimination on account of gender identity. Among the statutes cited in Section 1557, the only one that prohibits discrimination on the basis of sex is Title IX of the Education Amendments of 1972 (Title IX). Many provisions in the ACA show that Congress understood "sex" to mean the biological binary of male and female, and not to encompass the concept of gender identity.[39] For example, the ACA requires the provision of "information to women and health care providers on those areas in which differences between men and women exist."[40] Likewise, language throughout Title IX reflects that Congress understood "sex" as a biological binary and not as including gender identity.[41]

E. The Rule's coercion in health care would violate, free speech, religious exercise, and other constitutional rights.

Any rule that mandates the provision of healthcare based on false notions of the meaning of "sex" as set forth above violates the Administrative Procedure Act, and is also a violation of the Religious Freedom Restoration Act, 42 U.S.C. § 2000bb-1, the First Amendment's Free Speech and Free Exercise of Religion Clauses, and other constitutional doctrines, on the following grounds.

- Any gender identity mandate exceeds the authority of Section 1557, the Affordable Care Act, and Title IX of the Education Amendments of 1972, as amended, all of which limit discrimination on the basis of sex and do not encompass discrimination on the basis of gender identity.

- Any gender identity mandate exceeds the authority of Title IX, as incorporated into Section 1557, which does not apply where it would violate the religious tenets of an organization.

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[39] *See, e.g.*, 124 Stat. at 261, 334, 343, 551, 577, 650, 670, 785, 809, 873, 890, 966.
[40] *Id*. at 536–37.
[41] *See, e.g.*, 20 U.S.C. §§ 1681(a)(2); 1681(a)(8), 1686.

- Any Section 1557 gender identity mandate is contrary to the ACA's provision that "[n]othing in this Act shall be construed to have any effect on Federal laws regarding (i) conscience protection."[42]

- *Bostock v. Clayton County*[43] did not interpret the ACA or Title IX, and does not require the Section 1557 gender identity mandate.

- Any Section 1557 gender identity mandate is contrary to Section 1554 of the ACA,[44] specifically: parts (1)–(2) and (6) because it pressures providers out of federally funded health programs and the practice of healthcare; parts (3)–(4) because it requires providers to speak in affirmance of gender identity and refrain from speaking in accordance with a patient's biological sex and related medical needs; part (5) because it requires providers to deprive patients of informed consent by preventing them from warning patients of the dangers of gender transition interventions; and also part (5) because it forces providers to violate their ethical and conscientious standards as healthcare professionals.

- Any Section 1557 gender identity mandate violates 42 U.S.C. § 300a-7(d) because it compels providers, within health service programs funded by HHS, to provide gender identity procedures, interventions, and information, including sterilizations, in violation of their religious beliefs and moral convictions.

- Any Section 1557 gender identity mandate violates the Medicare statute's restriction that it may only pay for items and services that are "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,"[45] and it removes the authority of states to declare that gender transition interventions are not covered under Medicaid and Medicaid Expansion CHIP programs, in violation of 42 U.S.C. § 1396d(r)(5).

- Any Section 1557 gender identity mandate is contrary to the Religious Freedom Restoration Act, because it substantially burdens the exercise of religion by religious providers and is not the least restrictive means of advancing a compelling government interest.

Any gender identity mandate on healthcare, in educational settings or via Section 1557, also would raise free-speech and religious-freedom problems for providers, such having to offer and refer for gender interventions; the use of pronouns; medical screening questions; medical coding and record keeping; referrals; policies

[42] 42 U.S.C. § 18023(c)(2); see Executive Order 13535, Enforcement and Implementation of Abortion Restrictions in [ACA], 75 Fed. Reg. 15599 (Mar. 29, 2010).
[43] 140 S. Ct. 1731 (2020),
[44] 42 U.S.C. § 18114.
[45] 42 U.S.C. § 1395y(a)(1)(A).

governing speech and information at their medical practices; assurances of compliance with Section 1557; and mandatory notices of compliance with Section 1557.

In the past, many providers have conveyed medical views and concerns, in appropriate and patient-sensitive ways, to their patients and their families in the context of their clinical practice, but under any gender identity mandate, the government might consider this speech to harassment, indicative of a hostile environment, or discrimination on the basis of gender identity. It would prevent conversations between providers and their patients, and would constitute a credible threat of government prosecution over those conversations. It would chill a health care professional of ordinary firmness (1) from engaging in full and frank conversations on alternatives to gender procedures and interventions; (2) from using proper descriptions of sex in coding and medical records according to biological sex; and (3) from the spoken and written use of biologically correct pronouns. It would prohibit providers from engaging in speech that affirms a policy that healthcare is based on biological sex, and that patients are treated based on what their biological sex is. At the same time any mandate requires speech saying the opposite. Providers wish to keep using their best medical, ethical, and religious judgments in speaking and giving information to patients, but a gender identity mandate does not allow this.

The proposed rule, as applied to healthcare, would also conflict with the Religious Freedom Restoration Act and the First Amendment's Free Exercise Clause. It would substantially burden the exercise of religion and would not be the least restrictive means of advancing a compelling government interest. The government has no legitimate interest in coercing doctors to perform abortions or dangerous gender interventions. The government's mandates contain statutory and discretionary limits and exemptions, undermining any claim of a general applicability or a compelling interest, let alone a narrowly tailored interest.

F. The Rule would violate statutory conscience protections.

The proposed rule also conflicts with statutory conscience protections.

- The Church Amendments protect in various ways the conscience rights of individuals who object to abortion or sterilization procedures.

- Federally funded programs may not require an "individual to perform or assist in the performance of any sterilization procedure or abortion if his performance or assistance in the performance of such procedure or abortion would be contrary to his religious beliefs or moral convictions."[46]

- "No individual shall be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part

[46] 42 U.S.C. § 300a-7(b).

under a program administered by the Secretary of Health and Human Services if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions."[47]

- The ACA states that "nothing in this title (or any amendment made by this title), shall be construed to require a qualified health plan to provide [abortion coverage] as part of its essential health benefits for any plan year."[48]

- Section 245 of the Public Health Service Act, prohibits the federal government and any state or local government receiving federal financial assistance from discriminating against any healthcare entity because the entity refuses to perform abortions, provide referrals for abortions, or to make arrangements for such abortions.[49]

- Under the Weldon Amendment, which has been readopted or incorporated by reference in every HHS appropriations act since 2005, no funds may be made available under an HHS appropriations act to a government entity that discriminates against an institution or individual physician or healthcare professional because the entity or individual "does not provide, pay for, provide coverage of, or refer for abortions."[50]

ADF represents medical providers in court raising these claims against HHS. The American College of Pediatricians, the Catholic Medical Association, and an OB-GYN doctor who specializes in caring for adolescents have filed suit in federal court to challenge the HHS gender identity mandates requiring doctors to perform gender transition procedures on any patient, including a child, if the procedure violates a doctor's medical judgment or religious beliefs.[51]

Three courts have already recognized that the Section 1557 mandate is illegal and enjoined it in favor of plaintiffs in those cases.[52]

ADF represents the Christian Employers Alliance in one of these victories. The Alliance is challenging two Biden administration mandates that force religious nonprofit and for-profit employers to pay for or perform gender transition surgeries,

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[47] 42 U.S.C. § 300a-7(d).
[48] 42 U.S.C. § 18023; *see also id*. §§ 280h-5(a)(3)(C), 280h-5(f)(1)(B).
[49] 42 U.S.C. § 238(n).
[50] Weldon Amendment, Consolidated Appropriations Act, 2009, Pub. L. No. 111-117, 123 Stat 3034.
[51] ADF, American College of Pediatricians v. Becerra, https://adflegal.org/case/american-college-pediatricians-v-becerra; *see American College of Pediatricians v. Becerra*, No. 1:21-cv-00195 (E.D. Tenn.).
[52] *Franciscan Alliance, Inc. v. Becerra*, No. 7:16-cv-00108-O, 2021 WL 3492338 (N.D. Tex. Aug. 9, 2021), as amended (Aug. 16, 2021); *Religious Sisters of Mercy v. Azar*, 513 F. Supp. 3d 1113, 1139 (D.N.D. 2021); *Christian Emps. All. v. United States Equal Opportunity Comm'n*, No. 1:21-CV-195, 2022 WL 1573689 (D.N.D. May 16, 2022).

procedures, counseling, and treatments in violation of their religious beliefs.[53] "No government agency ought to be in the business of evaluating the sincerity of another's religious beliefs," the court wrote in its order. The court continues:

> HHS Guidance encourages a parent to file a complaint if a medical provider refuses to gender transition their child, of any age, including an infant. The thought that a newborn child could be surgically altered to change gender is the result of the Biden HHS Notification and HHS Guidance that brands a medical professional's refusal to do so as discrimination. Indeed, the HHS Guidance specifically invites the public to file complaints for acting in a manner the Alliance says is consistent with their sincerely held religious beliefs.

"Beyond the religious implications, the Biden HHS Notification and resulting HHS Guidance frustrate the proper care of gender dysphoria, where even among adults who experience the condition, a diagnosis occurs following the considered involvement of medical professionals…," the court added. "By branding the consideration as 'discrimination,' the HHS prohibits the medical profession from evaluating what is best for the patient in what is certainly a complex mental health question."[54]

The proposed rule must expressly engage this important question of its effect on the regulation of medicine, especially on medicine in educational settings; must expressly address the effect on Section 1557; and must expressly address the above bases why any mandate would be unlawful.

G. The Rule would be arbitrary and capricious for not avoiding these legal violations.

The Department must consider these policy questions about the proper standard of care. As it is, the proposed rule is arbitrary and capricious on the following grounds:

- For failing to adequately consider that in medical practice, sex is a biological reality, and there is an evolving state of medical knowledge concerning gender transition interventions that the federal government should not circumvent by rulemaking.

- For failing to adequately consider that it requires providers to treat patients by providing objectionable practices.

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[53] ADF, Christian Employers Alliance v. EEOC, https://adflegal.org/case/christian-employers-alliance-v-equal-employment-opportunity-commission.
[54] *Christian Emps. All. v. EEOC*, No. 1:21-CV-195, 2022 WL 1573689 (D.N.D. May 16, 2022).

- For relying on facts and studies only from one side of the issue, and for ignoring experts who point out that there is not enough evidence to require the provision of gender transition procedures.

- For ignoring the impact on doctors and medical associations with medical, ethical, conscientious, and religious objections to it, or their reliance interests in not being subject to such a mandate.

- For ignoring the harm to patients, either in general, or to those patients who want to continue receiving care from objecting providers.

- For failing to consider alternative policies that respect the interests of doctors and medical associations with medical, ethical, conscientious, and religious objections to the mandate.

- For relying on the erroneous legal view that Section 1557, Title IX, and *Bostock* require Section 1557 to be interpreted to prohibit gender identity discrimination.

In particular, the Department must consider that sex matters in medicine. Medicine relies on biology, and rewriting the definitions of "male" and "female" in the context of medicine is anti-science, unlawful, and dangerous. A few years ago, the *New England Journal of Medicine* reported that a patient who was rushed to the hospital with hours of abdominal pain was identified in medical records as male. Since the patient had been on high blood pressure medication and recently stopped, the nurse classified the patient as a non-emergency. Unfortunately, the patient was not a male, despite the medical records, but claimed a male gender identity, and in fact was pregnant and in labor. Tragically, because the nurse was operating from inaccurate information, the baby did not survive.[55]

The medical profession has long respected the biological differences between men and women, as well as boys and girls. Women's and men's bodies are not the same; they react differently to different medications, they are at greater risks for different types of cancer, and, of course, only women are capable of being pregnant.

Making doctors act as if patients are a different sex creates inaccurate, dangerous, and potentially lethal situations for patients of all ages. Doctors should not be forced to perform experimental, often-dangerous procedures on anyone — especially on minors. Doctors should be free to diagnose and treat each person consistent with their expertise. In nearly all cases, gender dysphoria is resolved in children with no intervention. Doctors should not be forced to experiment unnecessarily on children.

[55] 85 Fed. Reg. at 37,188.

In short, the government has no authority to interfere with what doctors can and cannot say about and concerning the debated topic of gender identity in the context of the patient-physician relationship. Families have a right to know certain facts regarding documented harms associated with gender interventions as well as the permanence of a decision to follow through with a gender transition.

H. The Rule must consider alternative approaches in health care.

Finally, the Department should consider several other healthcare-related alternatives.

The agency should consider and say whether its proposed provisions on gender identity and sex stereotyping protect against healthcare discrimination against detransitioners, i.e., persons who seek to desist from identifying with a gender opposite their biological sex, often after undergoing medical interventions to support that identity. Education and healthcare discrimination against detransitioners is rampant. "When these young adults transitioned, they received affirmation from doctors, mental health practitioners, and the trans and queer community. After transitioning back, they report feeling abandoned by the surgeons and hormone providers that irrevocably altered their bodies and the therapists who refuse to take responsibility for the dangers of 'gender affirming' care."[56] The Department should expressly consider whether to clarify that it is sex discrimination for educators and providers to withdraw support and their best health efforts from a student or patient when the student or patient states that they regret gender interventions and now wishes to be affirmed in their sex.

The Department likewise should expressly exclude children under 18 from any mandates concerning gender transition procedures. The Department should provide a safe harbor for rigorous gatekeeping procedures before gender interventions and HHS should recognize the validity of various forms of treatment for gender dysphoria, such as watchful waiting, treatment for other mental health issues, and counseling—rather than mandating early or unquestioning gender interventions.

The Department should provide that the proposed rule neither displaces requirements for parental informed consent for minors' medical treatments nor precludes giving parents full information about their child's healthcare nor prevents parents from selecting a healthcare provider or medical chaperone of the sex of their choice for their child, especially for sensitive medical exams or inpatient care.

[56] Ginny Gentles, Detransitioners and Parents vs. Gender Ideology (March 30, 2022), https://www.iwf.org/2022/03/30/detransitioners-and-parents-vs-gender-ideology%EF%BF%BC/.

It also should provide express carve-outs for women's private spaces and programs in health care facilities, including hospital wards, breastfeeding programs, post-partum support groups, lactation programs, breast cancer groups, and other areas.

Thank you for your consideration of these important concerns.

Denise Harle
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Director of the Center for Life
Alliance Defending Freedom