

April 1, 2024

**EO 12866 Meeting
“Unaccompanied Children Program Foundational Rule”
RIN: 0970-AC93**

**Rachel N. Morrison
HHS Accountability Project
Ethics & Public Policy Center**

Thank you for the opportunity¹ to provide comments on OIRA’s review of the Department of Health and Human Services (HHS) Administration for Children and Families’ (ACF) proposed rule, “Unaccompanied Children Program Foundational Rule.”²

My name is Rachel Morrison, and I’m an attorney and fellow at the Ethics and Public Policy Center, where I direct the HHS Accountability Project. I am also a former attorney at the Equal Employment Opportunity Commission. I, along with my EPPC colleague and fellow attorney Mary Rice Hasson—the Kate O’Beirne Senior Fellow and co-founder of EPPC’s Person and Identity Project (an initiative that equips parents and faith-based institutions to counter gender ideology and promote the truth of the human person)—submitted a public comment on this rulemaking.³

While this rule relates “to the key aspects of the placement, care, and services provided to unaccompanied children” by the Office of Refugee Resettlement (ORR),⁴ my comments will focus on two aspects of the rule: (1) certain considerations required for making placements; and (2) the facilitation of “medical services requiring heightened ORR involvement” for unaccompanied children, which ACF says include abortion and which likely also include medical “gender transitions.”

Today, I will discuss nine points of particular interest for OIRA.

¹ As OMB cancelled a previous EO 12866 meeting it scheduled with EPPC on another rule, I am glad you are willing to hear EPPC input on this rule. See Rachel N. Morrison, *Biden and Becerra Kill Democratic Norms in Rush to Fund Big Abortion*, National Review, Oct. 8, 2021, <https://www.nationalreview.com/bench-memos/biden-and-becerra-kill-democratic-norms-in-rush-to-fund-big-abortion/>.

² 88 Fed. Reg. 68908 (Oct. 4, 2023), available at <https://www.federalregister.gov/documents/2023/10/04/2023-21168/unaccompanied-children-program-foundational-rule>.

³ EPPC, EPPC Comment on HHS Proposed Rule “Unaccompanied Children Program Foundational Rule,” RIN: 0970-AC93 (Dec. 4, 2023), <https://eppc.org/wp-content/uploads/2023/12/EPPC-Comment-on-UC-Program-Proposed-Rule-1.pdf>.

⁴ 88 Fed. Reg. at 68908.

I. ACF must clarify its placement considerations, especially whether it is adopting a similar standard to its proposed foster care rule.

- **“Best interest.”** Under proposed 45 CFR § 410.1103(a), ACF dictates that “ORR shall place each unaccompanied child in the least restrictive setting that is in the best interest of the child and appropriate to the unaccompanied child’s age and individualized needs,” provided that the setting is “consistent with the interest in,” among other things, “protecting the unaccompanied child’s well-being.”⁵
- An unaccompanied child’s “best interest” is determined considering an “inexhaustive list of factors,” which include the child’s “identity,” “individualized needs,” and “expressed interests, in accordance with the unaccompanied child’s age and maturity.”⁶
- I ask ACF to clarify the following:
 - Will “best interest” of a child be interpreted under this rule similar to how ACF has proposed in the foster care context, where an unaccompanied child’s asserted LGBTQI+ identity must be affirmed for a placement to be “appropriate” and in the child’s “best interest”?
 - I do not believe it would be legal or good policy for ACF to do so, either here or in the foster care context. But if ACF does intend to do so, ACF must reopen this rule for public comment with that proposal clearly identified for the public’s input. To do otherwise would be arbitrary and capricious and not a logical outgrowth of the proposed rule.
 - Does ACF believe that it is in the best interest of the child to place a pregnant girl or LGBTQI+-identifying child in states that have more permissive abortion and gender transition laws? Less permissive abortion and gender transition laws? To what extent do state laws on abortion and gender transition factor into the “best interest of the child,” if at all?
 - Would the availability of medical services for abortion and gender transitions trump placing an unaccompanied child with family or kin who are located in a state where such services are not available or legal?
- **“LGBTQI+ Status.”** According to proposed 45 CFR § 410.1103(b)(7) and § 410.1210(c)(3), an unaccompanied child’s “LGBTQI+ status” (defined as “lesbian, gay, bisexual, transgender, queer or questioning, and intersex” status⁷) is a relevant factor in placement considerations.⁸

⁵ *Id.* at 68983.

⁶ *Id.* at 68978.

⁷ *Id.* at 68980.

⁸ *Id.* at 68983, 68988.

- I ask ACF to clarify the following.
 - How does ACF purport to ascertain a child’s “LGBTQI+ status,” including whether a child’s purported “LGBTQI+ status” is a self-determined label, a label applied by providers, or a label applied to the child by unnamed others, such as the child’s parents, guardian, sponsor, or another adult with caregiving responsibilities?
 - At what age a child might be labeled according to “LGBTQI+ status”—As a toddler? At age 5, 10, or 15?
 - Is a child’s “LGBTQI+ status” determined by “assessment, evaluations, or reports of the child”? If so, what are those assessments, who conducts them, and by what criteria is “LGBTQI+ status” accorded to a child? Given that “[s]exual fluidity (change over time in one or more dimension of sexual orientation: attraction, identity, and behavior) is a common experience for youth, with greater fluidity among adolescents than young adults, and among sexual minority compared with heterosexual individuals,”⁹ the designation of an unaccompanied child as having “LGBTQI+ status” at a given point may quickly become outdated, inaccurate, or no longer applicable.
 - How should a child’s LGBTQI+ status should impact a placement? For starters, ACF fails to identify what the “individualized” or “special needs” of a child accorded “LGBTQI+ status might be or how those needs might differ from the needs of other unaccompanied children.
 - However, in another proposed rule that was published only a few days before this rule, ACF proposed that a “safe and appropriate” placement for “LGBTQI+ children” in foster care means that the provider must affirm the child’s LGBTQI+ identity; to do otherwise is considered “abuse.”¹⁰ Does ACF intend to adopt the same standard here?
 - As explained in EPPC’s comment to ACF’s foster care proposed rule:

Underlying ACF’s proposal are two incorrect and harmful assumptions. First, the proposal assumes that *only* “affirmation” of a child’s asserted LGBTQI+ identity is “safe and appropriate”; and conversely, “non-affirmation” of a child’s sexual desires or behaviors, and self-proclaimed “gender” is unsafe and abusive.

⁹ Katz-Wise SL, Perry NS, Nelson KM, Gordon AR, Ybarra ML. Sexual Fluidity in Identity and Behavior Among Cisgender Youth: Findings from the Longitudinal Growing up with Media Study. *J Pediatr.* 2023 Jun; 257:113355. doi: 10.1016/j.jpeds.2023.01.020. Epub 2023 Feb 22. PMID: 36822509; PMCID: PMC10293031.

¹⁰ 88 Fed. Reg. 66752 (Sept. 28, 2023), available at <https://www.federalregister.gov/documents/2023/09/28/2023-21274/safe-and-appropriate-foster-care-placement-requirements-for-titles-iv-e-and-iv-b>; see also Rachel N. Morrison, *Non-Affirmation of Child’s “LGBTQI+” Identity Is Abuse Under Proposed Foster Care Rule*, FedSoc Blog, Nov. 19, 2023, <https://fedsoc.org/commentary/fedsoc-blog/non-affirmation-of-child-s-lgbtqi-identity-is-abuse-under-proposed-foster-care-rule>.

Second, the proposal assumes that any foster care provider that holds traditional beliefs about marriage, sexuality, and gender—including but not limited to faith-based foster care providers with differing convictions about how best to love LGBTQI+ identifying children—is unable to provide LGBTQI+ children with a safe and loving home.

As detailed [in our comment], these assumptions are incorrect, harmful, and contradicted by the best social science. Furthermore, ACF fails to acknowledge or take into account the proposed rule’s profound ramifications. If it is legally established that not affirming a child’s asserted LGBTQI+ identity in any given moment constitutes “mistreatment” or “abuse,” this standard could have massive consequences for families seeking to adopt, biological parents of children both in and out of foster care, and individuals who work with children. Indeed, that appears to be the very intent.¹¹

- **“Gender.”** According to proposed 45 CFR § 410.1501(a) and (f), care providers are required to maintain and report data on unaccompanied children that includes the child’s “gender,” an undefined term that does not appear to include “LGBTQI+ status (since “gender” and “LGBTQI+ status” are listed as separate factors in 45 CFR § 410.1103(b)(6) and (b)(7)), as well as “information gathered from assessments, evaluations, or reports of the child.”
- The rule also directs ORR to consider an unaccompanied child’s “gender” for a placement under proposed 45 CFR § 410.1103(b)(6)¹²; no reference is made to consideration of a child’s “sex.” “Gender” is not defined. While the term historically was used synonymously with “sex” to refer to whether a person is biologically male or female, it appears the term “gender” here refers to a child’s subjective identity, which may not align with the child’s biological sex.
- I ask that ACF replace “gender” with “sex,” or, at a minimum, add “sex” as a factor. If gender is retained as a factor, I ask that ACF define “gender” because it is a term that is ambiguous.
- Defining “gender” is especially important because under proposed 45 CFR § 410.1501, care provider facilities are required to report the “gender” of an unaccompanied child, and proposed 45 CFR § 410.1401(f), a care provider facilitating transporting an unaccompanied child “shall assign at least one transport staff of the same gender as the

¹¹ EPPC Scholars Comment Opposing HHS Proposed Rule “Safe and Appropriate Foster Care Placement Requirements for Titles IV-E and IV-B,” RIN 0970-AD03 (Nov. 27, 2023), <https://eppc.org/wp-content/uploads/2023/11/EPPC-Comment-Opposing-HHS-Foster-Care-Proposed-Rule.pdf> (citing Nathanael Blake, *The Biden Administration Is Scheming To Take Your Kids Away*, Federalist, Nov. 27, 2023, <https://thefederalist.com/2023/11/27/the-biden-administration-is-scheming-to-take-your-kids-away/>).

¹² 88 Fed. Reg. at 68983.

child being transported to the greatest extent possible under the circumstances.”¹³ Does this mean that male transport staff shall accompany male children and female transport staff female children? Or does this mean that a male transport staff who identifies as a woman is able to transport a female child who identifies as a girl? What about an unaccompanied child who identifies as nonbinary or gender fluid or an uncommon gender from the over 100 identified genders (and counting)¹⁴? Unless “gender” is defined, how will ORR make appropriate determinations for which transport staff is best qualified to accompany the child? Will ORR have to inquire about a child’s and ORR staff’s “gender identity” to comply with this requirement?

II. ACF must clarify how it will facilitate abortions and which abortions it will facilitate.

- In addition to factors for placement considerations, ACF proposes that under 45 CFR § 410.1307, “ORR shall ensure that all unaccompanied children in ORR custody will be provided with routine medical and dental care; access to medical services requiring heightened ORR involvement, consistent with paragraph (c) of this section; family planning services; and emergency healthcare services.”¹⁵ “Medical services requiring heightened ORR involvement” means: “(1) Significant surgical or medical procedures; (2) Abortions; and (3) Medical services necessary to address threats to the life of or serious jeopardy to the health of an unaccompanied child.”¹⁶ The rule expressly (and correctly) excludes abortion from the definition of “family planning services.”¹⁷
- Under paragraph (c), if ORR determines an unaccompanied child requires medical care or the child “reasonably requests” such care, the child must be placed with a provider that is able to care for the child and “is in a location where the relevant medical services are accessible.”¹⁸ If such a placement is not immediately available, or a medical need or reasonable request subsequently arises, then ORR shall, if possible, transfer the child to a provider that can accommodate the child’s medical needs.¹⁹
- Paragraph (c) also requires ORR to provide an unaccompanied child with transportation to access medical services, including across state lines if necessary, to ensure the child can access medical specialists, “care that may be geographically limited,” and medical services requiring heightened ORR involvement.²⁰ The travel requirement applies

¹³ *Id.* at 68997.

¹⁴ See, e.g., *How Many Genders Are There? Gender Identity List*, Sexual Diversity (updated May 22, 2023), <https://www.sexualdiversity.org/edu/1111.php>.

¹⁵ 88 Fed. Reg. at 68993.

¹⁶ *Id.* at 68980.

¹⁷ *Id.* at 68979.

¹⁸ *Id.* at 68946.

¹⁹ *Id.*

²⁰ *Id.*

“regardless of whether Federal appropriations law prevents ORR from paying for the medical care itself.”²¹

- If ACF continues its policy to provide abortions for unaccompanied children (which it shouldn't), then we ask ACF to clarify the following questions:
 - In ORR's view, is it always in the best interest of a pregnant unaccompanied child to receive an abortion? If not, how does it determine whether abortion is in the unaccompanied child's best interest?
 - Will ORR encourage or promote abortion in any way?
 - Until what point in pregnancy will ORR facilitate access to abortion for an unaccompanied child? Will ORR facilitate access to abortion at 40-weeks gestation? What about 30 weeks or 22 weeks or 15 weeks?
 - Will ORR consider the viability of the unborn child if born prematurely?
 - Will ORR facilitate an abortion of an unborn child that has a heartbeat? What about if the unborn child can feel pain?
 - Will ORR consider whether, instead of abortion, the unborn child can be delivered prematurely (either vaginally or via cesarian section) and have a chance to survive outside the womb?
 - Will ORR provide an unaccompanied child access to abortion for *any* reason? Will ORR facilitate abortion access if an unaccompanied child wants an abortion because her unborn child is diagnosed with a disability, such as Down syndrome? What about if it is a sex-selective abortion?
 - Will an unaccompanied child who is the victim of sexual assault receive counseling for her trauma *prior* to receiving an abortion?
 - Will a pregnant unaccompanied child receive options counseling? Will such counseling be provided by an abortion provider?
 - How will ORR ensure that an unaccompanied child is not pressured or coerced into receiving an abortion? Will she be informed that her immigration or refugee status is not dependent on whether she obtains an abortion? Will she be informed that she may have an easy path to citizenship if she has a child born in the United States who is an American citizen?
 - Will a pregnant unaccompanied child be given an ultrasound and have the option to see her unborn child prior to an abortion?

²¹ *Id.* at 68994.

- Will a pregnant unaccompanied child be provided support if she continues her pregnancy and gives birth? Will she be informed about pregnancy centers and other resources that can provide material assistance?

III. ACF’s facilitation of abortion is contrary to law.

A. The Hyde Amendment does not permit funding for abortion travel.

- The rule explains that ORR will continue to permit an unaccompanied child access to abortion “consistent with limitations on the use of Federal funds for abortions which are regularly included in HHS’ annual appropriations, commonly referred to as the ‘Hyde Amendment.’”²² “Consistent with current policy” and a post-*Dobbs* memo by the Department of Justice Office of Legal Counsel titled “Application of the Hyde Amendment to the Provision of Transportation for Women Seeking Abortions,” the proposed rule states that ORR will facilitate access to abortion “regardless of whether the Federal Government may pay for the abortion under the Hyde Amendment.”²³
- The Hyde Amendment is a longstanding appropriations provision with bipartisan support (at least until recently) that restricts federal health dollars from paying for abortion. Originally passed in 1976, the text of the Hyde Amendment, named after sponsor Rep. Henry Hyde (R-Ill.), has changed some over the years. The current text states, “none of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion.”²⁴ The Amendment covers all abortions except when the pregnancy was a result of rape or incest or where a mother “suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.”²⁵ In such cases, the federal government is permitted *but not mandated* to pay for those procedures.
- Notably, the constitutionality of the Hyde Amendment was upheld, even under the now defunct *Roe* regime, by the Supreme Court in the 1980 case *Harris v. McRae*.²⁶ In his brief defending the Hyde Amendment before the Court, Rep. Hyde explained that “the Hyde Amendment withholds governmental support for abortion decisions.”²⁷

²² *Id.* at 68946.

²³ *Id.* (citing Department of Justice, Office of Legal Counsel, Application of the Hyde Amendment to the Provision of Transportation for Women Seeking Abortions (Sept. 27, 2022), <https://www.justice.gov/d9/2022-11/2022-09-27-hyde-amendment-application-to-hhs-transportation.pdf>).

²⁴ Consolidated Appropriations Act, 2022, Pub. L. No. 117-103, div. K, 136 Stat. 49, 580.

²⁵ *Id.*, div. H, §§ 506–07, 136 Stat. at 496.

²⁶ 448 U.S. 297 (1980).

²⁷ Reply Brief of Intervening Defendants-Appellees James L. Buckley, Jess A. Helms, Henry J. Hyde, and Isabella Pernicone in Support of Appellant Harris, *Harris v. McRae*, 448 U.S. 297 (1980), available at <https://aul.org/wp-content/uploads/2019/03/1980-Harris-v.-McRae-Reply-Brief.pdf>.

- Ironically, President Biden was once a stalwart supporter of the Hyde Amendment and consistently voted in support of appropriation bills containing it. In a 1994 letter to a concerned constituent who requested, “Please don’t force me to pay for abortions against my conscience,” Biden replied, “I agree with you.” He explained, “those of us who are opposed to abortions should not be compelled to pay for them.”²⁸ Apparently, out of political expediency, Biden flipped his position during his 2020 presidential campaign,²⁹ and as president, he has doubled down on his support of federally-facilitated and taxpayer-funded abortion with an emphasis on abortion-related travel.³⁰
- The Office for Legal Counsel in Biden’s Department of Justice issued an opinion on September 27, 2022, agreeing with Biden HHS’s view that the Hyde Amendment would permit appropriated funds to be used for providing transportation for women seeking abortions in circumstances in which HHS has the requisite statutory authority and appropriations to provide transportation, including with respect to abortions not excepted from the Hyde Amendment’s coverage.³¹ According to OLC, the Hyde Amendment is “best read to prohibit only direct expenses for the procedure itself and not indirect expenses, such as those for transportation to and from the medical facility where the procedure is performed.”³²
- OLC is wrong. Its post-*Dobbs* opinion is political, not legal. The distinction OLC attempts to draw between direct and indirect funding of abortion is unpersuasive.
- The best reading of the Hyde Amendment is that federal funding of expenses to obtain abortion, including for travel, is not permitted. As I, along with my EPPC colleague Natalie Dodson wrote for *The Hill*:

²⁸ Letter from Joseph R. Biden, Jr., United States Senator, to Michael Gregg (April 7, 1994), *available at* <https://www.documentcloud.org/documents/6127592-biden94letter.html>.

²⁹ See Katie Glueck, *Joe Biden Denounces Hyde Amendment, Reversing his Positions*, NY Times (June 6, 2019), <https://www.nytimes.com/2019/06/06/us/politics/joe-biden-hyde-amendment.html>.

³⁰ See, e.g., OMB, Availability of Sick Leave for Travel to Access Medical Care, <https://www.opm.gov/policy-data-oversight/pay-leave/leave-administration/fact-sheets/sick-leave-faqs.pdf>; HHS, Secretary’s Report: Health Care Under Attack: An Action Plan to Protect and Strengthen Reproductive Care (Aug. 2022), <https://www.hhs.gov/sites/default/files/hhs-report-reproductive-health.pdf>; Press Release, Department of Veterans Affairs, VA will offer abortion counseling and—in certain cases—abortions to pregnant Veterans and VA beneficiaries (Sept. 2, 2022, 11:00 AM), <https://news.va.gov/press-room/va-will-offer-abortion-counseling-and-in-certain-cases-abortions-to-pregnant-veterans-and-va-beneficiaries/> (announcing interim final rule allowing VA to provide access to abortion counseling and abortions to Veterans and VA beneficiaries); Department of Justice, Office of Legal Counsel, Authority of the Department of Defense to Use Appropriations for Travel by Service Members and Dependents to Obtain Abortions (Oct. 3, 2022), <https://www.justice.gov/olc/file/1545696/download>; Rachel N. Morrison, *The Biden Administration’s Post-Dobbs, Post-Roe Response*, FedSoc Blog, July 13, 2022, <https://fedsoc.org/commentary/fedsoc-blog/the-biden-administration-s-post-dobbs-post-roe-response>.

³¹ Department of Justice, Office of Legal Counsel, Application of the Hyde Amendment to the Provision of Transportation for Women Seeking Abortions, at 1 (Sept. 27, 2022), <https://www.justice.gov/d9/2022-11/2022-09-27-hyde-amendment-application-to-hhs-transportation.pdf>.

³² *Id.* at 2.

Despite the text of Hyde prohibiting federal funding “for any abortion,” the Biden administration conveniently decided post-*Dobbs* that this prohibition does not include expenses for travel to receive an abortion.

If this is true, taxpayers could be required to pay for not only abortion travel but also abortion counseling and a host of other abortion-related expenses, as long it is not the medical procedure itself. Like Planned Parenthood’s infamous 3 percent abortion calculation, abortion expenses could be itemized so that federal funding is restricted only for the final act of inserting the abortion instrument into a woman’s uterus or handing a woman abortion pills.

This is like saying a school cut funding for basketball (“no school funds shall pay for any basketball”), but then turning around and saying it could still pay for the team’s uniforms, practice space, coaches or, for that matter, bus ride for the team to play a basketball game across state lines. Paying for the basketball team’s uniforms, practice space, coaches and bus ride to a basketball game is effectively paying for basketball. Likewise, paying for travel to receive an abortion is effectively paying for abortion.

There would be no abortion but for the travel, and no travel costs but for abortion. Thus, travel for abortion is an abortion expense and funding for abortion.

Nevertheless, the once-respected Office of Legal Counsel (OLC) in the Department of Justice (DOJ), likely at the bidding of the White House, rubberstamped the Biden administration’s interpretation of Hyde as not prohibiting federal funding for travel to obtain abortion.

The Biden administration’s novel interpretation of the Hyde Amendment post-*Dobbs* is politically expedient and highly suspect. If the Hyde Amendment allows for abortion travel funding as the OLC opinion and the Biden administration suggests, it is surprising other pro-abortion rights Democratic administrations failed to recognize and capitalize on this giant loophole.³³

B. Unaccompanied children do not have a federal right to abortion.

- Even if the federal government is not prohibited from paying for certain limited abortions under Hyde, Hyde does not create any obligation for it do so. Unaccompanied children do not have a right to abortion. Indeed, there is no federal constitutional or statutory right to abortion. In *Dobbs v. Jackson Women’s Health Organization*, the Supreme Court overruled *Roe v. Wade* and returned “the issue of abortion to the people’s elected representatives.”³⁴ Congress, the people’s elected representatives at the federal level, has

³³ Rachel N. Morrison & Natalie Dodson, *Should Taxpayers Pay for Abortion Travel?*, The Hill (Dec. 24, 2022, 3:00 PM), <https://thehill.com/opinion/healthcare/3749245-should-taxpayers-pay-for-abortion-travel/> (internal citations omitted).

³⁴ 142 S. Ct. 2228, 2243 (2022).

not created a statutory right to abortion for citizens, much less unaccompanied children. It is inappropriate for ACF, unelected government bureaucrats, to say otherwise.

- To the extent that ACF believes unaccompanied children are entitled to abortions, we ask that ACF explain its reasoning.
- Is it ACF's position that the *Garza* settlement still applies? *Garza* was issued pre-*Dobbs* when there was a constitutional right to abortion under *Roe*. As such, *Dobbs* undermines the court's reasoning in *Garza*, and statements about an unaccompanied child's right to abortion or ORR's obligation to facilitate abortion do not survive post-*Dobbs*.

IV. ACF's rule must consider the harms of abortion.

- ACF assumes without justification that if an unaccompanied minor is pregnant, abortion is in her best interests, especially in tragic cases of sexual assault. But the answer to violence is not more violence. Abortion is not a neutral. Those who experience sexual assault should receive counseling and support, not abortion. For those unaccompanied children, ORR should not add the trauma of abortion to the sexual trauma they experienced.
- As ORR Director Scott Llyod explained in December 2017 when he denied a request for an abortion for an unaccompanied girl who was sexually assaulted:

Sexual assault is among the gravest offenses in the catalogue of offenses man can commit against his fellow man, or in this case, a teenaged young woman. Every compassionate society, including our own, seeks to provide protection against such brutality, to prosecute it vigorously, and to provide aid and comfort to its victims. The UAC program has no prosecutorial authority, but is very strong both in protecting UACs from rape and also providing comfort to those who have the tragic misfortune of experiencing such an offense against their person and their dignity.

Over and above the trauma of the assault itself, a pregnancy that results from a rape is itself a continuous reminder of the attack. Women who experience pregnancy from rape must wrestle with the phenomenon of being the mother of a child whose other parent brutally terrorized and did violence to her. Certainly, it is understandable that a woman who is pregnant from the vile actions of a criminal would want to terminate her pregnancy. I do not, and am in no position to, judge anyone who has taken such an action or supported another in doing so.

But I cannot authorize our program to participate in the abortion requested here, even in this most difficult case. Here, where the pregnancy is advanced to such a late stage, we have in stark relief the reality that abortion entails, as Dr. Harris candidly admitted, violence that has the ultimate destruction of another human being as its goal.

Even supposing it was possible to justify abortion in this context, abortion does not here cure the reality that she is the victim of an assault. It also carries with it significant risk of further complicating the matter. It is possible, and perhaps likely, that this young woman would go on to experience an abortion as an additional trauma on top of the trauma she experiences as a result of her sexual assault. Although formal research on this matter appears to be sparse, those who have worked with women who have experienced abortion have compiled a catalogue of anecdotal evidence, impossible to ignore, that shows that many women go on to experience it as a devastating trauma, even in the instance of rape. If the young woman was to go on to regret her abortion and experience it as a trauma, ORR will have had a hand in causing that trauma, and I am unwilling to put this young woman or ORR in that position.

I am mindful that abortion is offered by some as a solution to a rape. In fact, some would suggest that, by declining to assist in the abortion we are in some way engaging in a form of violence against the mother, as in the notion that ORR is forcing her to carry her pregnancy to term.

I disagree. Implicit here are the dubious notions that it is possible to cure violence with further violence, and that the destruction of an unborn child's life can in some instances be acceptable as a means to an end. To decline to assist in an abortion here is to decline to participate in violence against an innocent life. She remains pregnant, but this is not the intent of our actions. Moral and criminal responsibility for the pregnancy lies with the attacker, and no one else.

Others might suggest that abortion is justified as a form of self-defense in this instance, but this gets it wrong again. The child—the one who is destroyed—is not an aggressor. The aggressor, again, was the rapist.

At bottom, this is a question of what is in the interest of the young woman and her child. How could abortion be in their best interest where other options are available, and where the child might even survive outside the womb at this stage of pregnancy? Here there is no medical reason for abortion, it will not undo or erase the memory of the violence committed against her, and it may further traumatize her. I conclude it is not her interest.

Regarding any further legal questions, I defer to the various attorneys representing our position in this and related litigation that this is a legally permissible path. There is nothing in the law or in the Constitution that requires this program to participate in providing abortion for UAC, and the Department of Justice has argued that ORR does not impose an undue burden by declining to authorize abortions that are not medically indicated.³⁵

³⁵ Scott Llyod, Director, Office of Refugee Resettlement, Note to File (Dec. 17, 2017) (copy on file with author).

- Director Llyod concluded:

The Office of Refugee Resettlement serves a large number of persons who have experienced some sort of violence. Refuge is the basis of our name and is at the core of what we provide, and we provide this to all the minors in our care, including their unborn children, every day. In this request, we are being asked to participate in killing a human being in our care. I cannot direct the program to proceed in this manner. We cannot be a place of refuge while we are at the same time a place of violence. We have to choose, and we ought to choose protect life rather than to destroy it.³⁶

V. ACF should clarify whether ORR must facilitate medical gender transitions.

- I ask ACF to clarify whether medical gender transitions are covered under the definition of “medical services requirement heightened ORR involvement.” “Medical services requiring heightened ORR involvement” means: “(1) Significant surgical or medical procedures; (2) Abortions; and (3) Medical services necessary to address threats to the life of or serious jeopardy to the health of an unaccompanied child.”³⁷
- Though the proposed rule does not take a clear position on the issue, I anticipate that under the proposed rule, “medical services requiring heightened ORR involvement” includes “gender transitions” of unaccompanied children under definitions (1) and (3). Puberty blockers, cross-sex hormones, double mastectomies, and genital surgeries are fairly characterized as “significant surgical or medical procedures.” The Biden administration has called such medical interventions “life-saving”³⁸ and “crucial [to a child’s] overall health and well-being,”³⁹ which would seem to qualify medical gender transitions as “medical services necessary to address threats to the life of or serious jeopardy to the health of an unaccompanied child.”
- This interpretation would be consistent with the proposed rule’s direction that ORR consider an unaccompanied child’s “LGBTQI+ status” and identity for placements, as well as actions by the Biden administration and HHS to promote so-called “gender affirming care” for children.⁴⁰
- If ACF does intend to do provide gender transitions to unaccompanied children, ACF must reopen this rule for public comment with that proposal clearly identified for the

³⁶ *Id.*

³⁷ *Id.* at 68980.

³⁸ Press Statement, HHS, Statement by HHS Secretary Xavier Becerra Reaffirming HHS Support and Protection for LGBTQI+ Children and Youth (Mar. 2, 2022), <https://www.hhs.gov/about/news/2022/03/02/statement-hhs-secretary-xavier-becerra-reaffirming-hhs-support-and-protection-for-lgbtqi-children-and-youth.html>.

³⁹ Office of Population Affairs, HHS, Gender-Affirming Care and Young People (Aug. 2023), <https://opa.hhs.gov/sites/default/files/2023-08/gender-affirming-care-young-people.pdf>.

⁴⁰ See generally Rachel N. Morrison, *Gender Identity Policy Under the Biden Administration*, 23 Fed. Soc’y Rev. 85 (2022), available at <https://ssrn.com/abstract=4104566> (documenting Biden’s gender identity policies in employment, health care, education and athletics, with a focus on children’s interests, among others).

public's input. To do otherwise would be arbitrary and capricious and not a logical outgrowth of the proposed rule.

- If “medical services requiring heightened ORR involvement” includes medical gender transitions, I ask ACF to answer the following questions:
 - Will ORR be permitted or mandated to provide an unaccompanied child puberty blockers? If so, on what basis? Does the child need a diagnosis of “gender dysphoria”? A history of childhood identity or body-related distress? Or can the child access puberty blockers simply by self-identifying as “transgender” and requesting them? Starting at what age?
 - Will ORR be permitted or mandated to provide an unaccompanied child cross-sex hormones? If so, on what basis? Does the child need a diagnosis of “gender dysphoria”? A history of childhood identity or body-related distress? Or can the child access cross-sex hormones simply by self-identifying as “transgender” and requesting them? Starting at what age?
 - Will ORR be permitted or mandated to provide an unaccompanied female child a double mastectomy for transitioning purposes? If so, on what basis? Does the child need a diagnosis of “gender dysphoria”? A history of childhood identity or body-related distress? Or can the unaccompanied child access a double mastectomy simply by self-identifying as “transgender” and requesting one? Starting at what age?
 - Will ORR be permitted or mandated to provide an unaccompanied child genital surgery for transitioning purposes? If so, on what basis? Does the child need a diagnosis of “gender dysphoria”? A history of childhood identity or body-related distress? Or can the child access genital surgery simply by self-identifying as “transgender” and requesting it? Starting at what age?
 - Even WPATH advises that mental health screening is necessary before a patient should be approved for “hormonal or surgical treatments [for] gender dysphoria.”⁴¹ Will ORR require unaccompanied children in federal custody to undergo a psychological assessment and receive counseling sessions prior to undergoing any medical interventions for a gender transition? If so, how many sessions? Will a child be screened for mental health conditions, including but not limited to trauma associated with being an unaccompanied child? Will ORR provide access to “exploratory” therapy rather than one-size-fits-all, “gender affirmative” therapy that claims “gender transition” is the only solution to identity or body-related distress?

⁴¹ Timothy F. Murphy, Ph.D., *Should Mental Health Screening and Psychotherapy Be Required Prior to Body Modification for Gender Expression?*, AMA Journal of Ethics (Nov. 2016), <https://journalofethics.ama-assn.org/article/should-mental-health-screening-and-psychotherapy-be-required-prior-body-modification-gender/2016-11>.

- Will a child’s biological parents be consulted in a timely fashion, and their consent obtained *before* ORR facilitates any medical interventions for transitioning?
- In ACF’s view, can a child provide informed consent for medical interventions for gender transitions? At what age? How will ORR ensure that an unaccompanied child, who may have experienced trauma and who may be diagnosed with one or more mental health conditions, understands and is able to give informed consent to the risks associated with medical interventions for gender transition?
- How will ORR ensure that a child, who may or may not speak English, understands and is able to give informed consent to the risks associated with medical interventions for gender transition?
- How will ORR ensure that a child does not feel coerced or pressured or believe that they must undergo medical interventions to remain in the country?
- Who will pay for an unaccompanied child’s gender transition medical bills? Will taxpayers be responsible? How much will it cost ORR to facilitate such medical interventions? How many children does ACF estimate will seek medical interventions for gender transitions? All these costs and more must be calculated by ACF.

VI. ACF must consider the harms of medical gender transitions.

- The rule, with its implicit support for the medical gender transition of minors, appears as yet another example of “dangerous groupthink” likely to result in “patient harm”—harms that must be considered by ACF in promulgating its rule.
- HHS continues to assert, despite growing evidence to the contrary, that medical and surgical “transition” procedures “improv[e] the mental health and overall wellbeing of gender-diverse children and adolescents.”⁴² This position is not only an outlier but increasingly indefensible.
- Four Scandinavian countries, to date, and the United Kingdom, have repudiated the American “affirmation” model that subjects vulnerable minors to harmful medical and surgical transition procedures that lack supportive, long-term, quality evidence. Health authorities in Finland, Sweden, and the UK each commissioned substantive evidence reviews to assess the risks and benefits of medical and surgical “transition” interventions in minors; all three countries determined that the evidence base supporting such interventions is of low or very low quality (an unreliable basis for making clinical decisions), while the harms of those interventions (which include heightened cardiovascular risks, impaired fertility, impaired sexual function, decreased mental health, and unknown long-term risks to bones and the brain) were serious and often

⁴² Office of Population Affairs, HHS, Gender-Affirming Care and Young People (Aug. 2023), <https://opa.hhs.gov/sites/default/files/2023-08/gender-affirming-care-young-people.pdf>.

irreversible.⁴³ In response, these countries have prioritized psychotherapeutic interventions as the first line of treatment for youth identity- or body-related distress, and limited medical interventions in minors to research settings. Norway and Denmark have similarly—and sharply—changed course.⁴⁴ Norway’s medical directors recently concluded that puberty blockers and cross-sex hormones are experimental treatments for children and their use should be limited to clinical trials.⁴⁵

- Most recently, the use of pubertal suppression and hormonal interventions in gender-distressed minors has come under fire in the Netherlands, the very country that *launched* the destructive practice of puberty suppression and medical interventions in minors. In a series of critiques, Dutch medical professionals, ethicists, legal experts, and journalists have urged a re-evaluation of the Netherlands’ approach to medicalized “gender transitions” for minors.⁴⁶ The Dutch criticisms echo the concerns raised across the international community: the original Dutch research failed to adequately assess the adverse effects of these experimental interventions; the long-term consequences of the medicalized protocol remain unknown, particularly as patient demographics have shifted; potential adverse effects on the brain have never been adequately investigated, even though concerns were raised years earlier; the interventions have serious and often irreversible effects on fertility and sexual function, along with other significant health consequences (including heightened cardio-vascular risks); and the early reported benefits to mental health have not been replicated.⁴⁷
- The international outcry over medicalized interventions in minors has had little impact, to date, on the American medical establishment. Backed by the Biden administration, the American gender industry has refused to acknowledge the harms of “gender transition” interventions. Last fall, the leading Finnish gender expert, Dr. Riittakerttu Kaltiala, publicly rebuked the American gender industry, saying:

I have been particularly concerned about American medical societies, who as a group continue to assert that children know their “authentic” selves, and a child who declares a transgender identity should be affirmed and started on treatment... Medical organizations are supposed to transcend politics in favor of upholding standards that protect patients. However, in the U.S. these groups—including the American Academy of Pediatrics—have been actively hostile to the message my colleagues and I are urging....

⁴³ For a summary of the research, see Block J. Gender dysphoria in young people is rising—and so is professional disagreement *BMJ* 2023; 380 p382 doi:10.1136/bmj.p382.

⁴⁴ *Denmark Joins the List of Countries That Have Sharply Restricted Youth Gender Transitions*, Society for Evidence-Based Gender Medicine, Aug. 17, 2023, <https://segm.org/Denmark-sharply-restricts-youth-gender-transitions>.

⁴⁵ See Bernard Lane, *Tighten Up: New Proposal Would End Routine Paediatric Transition in Norway*, Gender Clinic News (Mar. 1, 2024), <https://www.genderclinicnews.com/p/tighten-up>.

⁴⁶ *The 2023 Dutch Debate over Youth Transitions*, Soc’y for Evidence-based Gender Med. (Nov. 19, 2023), <https://segm.org/Dutch-protocol-debate-Netherlands>.

⁴⁷ *Id.*

I am also disturbed by how gender clinicians routinely warn American parents that there is an enormously elevated risk of suicide if they stand in the way of their child’s transition. Any young person’s death is a tragedy, but careful research shows that suicide is very rare. It is dishonest and extremely unethical to pressure parents into approving gender medicalization by exaggerating the risk of suicide.

- This year the Endocrine Society of the U.S. reiterated its endorsement of hormonal gender transition for young people...[But] “[e]very systematic review of evidence to date, including one published in the *Journal of the Endocrine Society*, has found the evidence for mental health benefits of hormonal interventions for minors to be of low or very low certainty.” Medicine, unfortunately, is not immune to dangerous groupthink that results in patient harm.⁴⁸
- HHS in other contexts has relied on the World Professional Organization for Transgender Health (WPATH) “Standards of Care” (which WPATH calls standards of care but acknowledges are merely guidelines).⁴⁹ WPATH is relied on as an authority by American medical groups, including the American Academy of Pediatrics and the Endocrine Society. On March 5, 2024, Environmental Progress released leaked documents called the “WPATH Files.”⁵⁰ These documents reveal that despite public assertions about the benefits of medical “gender transition” interventions, WPATH members privately acknowledge harms of such interventions, including potential risks of bone and brain health, sexual dysfunction, and cancer. The documents further reveal that the members acknowledge that children are unable to provide informed consent, and many have serious psychiatric issues that are left untreated.

VII. ACF must address the federalism implications of its rule.

- ACF claims there are not “sufficient federalism implications” to warrant a federalism impact statement under Executive Order 13132.⁵¹ However, many states have laws

⁴⁸ Riittakerttu Kaltiala, *Gender-affirming care is dangerous. I know, because I helped pioneer it*, Free Press (Oct. 23, 2023), <https://www.thefp.com/p/gender-affirming-care-dangerous-finland-doctor>.

⁴⁹ See, e.g., HHS, Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47824, 47834 n.139, 47867-68 nn.416-17, 423 (Aug. 4, 2022) (proposed rule expected to be finalized soon).

⁵⁰ Mia Hughes, Environmental Progress, *The WPATH Files: Pseudoscientific Surgical and Hormonal Experiments on Children, Adolescents, and Vulnerable Adults* (Mar. 5, 2024), available at <https://static1.squarespace.com/static/56a45d683b0be33df885def6/t/65e64b9e5cbd756da9fbbdfa/1709591479160/Final+WPATH+Report.pdf>.

⁵¹ 88 Fed. Reg. at 68976. Cf. 88 Fed. Reg. 66752, 66764 (Sept. 28, 2023), available at <https://www.federalregister.gov/documents/2023/09/28/2023-21274/safe-and-appropriate-foster-care-placement-requirements-for-titles-iv-e-and-iv-b> (explaining ACF’s foster care proposed rule “has sufficient federalism implications that warrants the preparation of a federalism summary impact statement”).

prohibiting certain abortions or medical gender transition services for minors.⁵² These state laws may conflict with ORR’s obligation under the proposed rule to provide medical services requiring heightened ORR involvement to unaccompanied children.

- If a potential conflict arises between the regulations and state law, the proposed rule directs ORR to “review the circumstances to determine how to ensure that it is able to meet its statutory responsibilities.”⁵³ Notably, “if a State law or license, registration, certification, or other requirement conflicts with an ORR employee’s duties within the scope of their ORR employment, the ORR employee is required to abide by their Federal duties.”⁵⁴ This language is reminiscent of the Biden administration’s position that the Department of Veterans Affairs (VA) rule on abortion benefits allows VA staff to provide or facilitate abortions otherwise unlawful under state law.⁵⁵
- I ask ACF to clarify the federalism implications of its proposal in its final rule.
 - In ACF’s view, will this rule preempt state laws?
 - Is it ACF’s position that ORR may facilitate abortion and medical gender transitions contrary to state law?
 - Will ORR employees or contractors be able to perform abortions or medical gender transitions that are unlawful under state law, similar to what the VA claimed under its abortion benefits rule?

VIII. ACF must clarify religious freedom and conscience protections for ORR staff.

- The preamble of the proposed rule repeats four times, without elaboration, that ORR operates its Unaccompanied Child Program “in compliance with the requirements of the Religious Freedom Restoration Act and other applicable Federal conscience protections, as well as all other applicable Federal civil rights laws and applicable HHS regulations.”⁵⁶
- I applaud ACF for recognizing that ORR must operate its program in compliance with federal laws protecting religious belief and conscience. However, this statement, without more, is insufficient provide adequate assurances and protection.
- I ask ACF to elaborate on how it will operate its program, especially if it requires ORR to provide unaccompanied children with abortions and medical gender transitions, in

⁵² See *Interactive Map: US Abortion Policies and Access After Roe*, Guttmacher Inst. (current as of Nov. 29, 2023), <https://states.guttmacher.org/policies/>; *Bans on Best Practice Medical Care for Transgender Youth*, Movement Advancement Project (current as of Nov. 29, 2023), https://www.lgbtmap.org/equality-maps/healthcare_youth_medical_care_bans.

⁵³ 88 Fed. Reg. at 68937.

⁵⁴ *Id.*

⁵⁵ See Rachel N. Morrison, *Department of Veterans Affairs Rule Doubles Down on Abortion*, FedSoc Blog (Mar. 13, 2024), <https://fedsoc.org/commentary/fedsoc-blog/department-of-veterans-affairs-rule-doubles-down-on-abortion>.

⁵⁶ 88 Fed. Reg. at 68938, 68944, 68946, 68957.

compliance with RFRA and federal conscience protections. These protections will be especially important for providers and ORR staff who cannot facilitate abortions and medical gender transitions in accord with their religious beliefs or moral convictions.

- In its final rule, I ask ACF clarify the following: How will ORR staff be notified of their religious freedom and conscience rights? How can staff request a religious exemption under RFRA, religious accommodation under Title VII, or protection under the conscience protection laws? Will any ORR staff be forced to help facilitate an abortion or sterilizing gender transition intervention contrary to their religious beliefs or moral convictions?
 - I ask that ORR answer these logistical questions in its final rule before staff have to resort to litigation to receive adequate protections, such as the case for VA employees under the VA’s interim final rule on abortion benefits.⁵⁷
- Finally, the text of the proposed regulations fails to mention religious freedom and conscience protections. I ask that in its final rule ACF add reference to those protections in the text of the regulations themselves, including specific references to RFRA and federal conscience protection laws.

IX. ACF’s rule undermines family well-being; ACF must conduct a family policymaking assessment.

- ACF must conduct a Family Policymaking Assessment. Section 654(c) of The Treasury and General Government Appropriations Act of 1999,⁵⁸ requires Federal agencies to issue a Family Policymaking Assessment for any rule that may affect family well-being:
 - (c) Family policymaking assessment.—Before implementing policies and regulations that may affect family well-being, each agency shall assess such actions with respect to whether—
 - (1) the action strengthens or erodes the stability or safety of the family and, particularly, the marital commitment;
 - (2) the action strengthens or erodes the authority and rights of parents in the education, nurture, and supervision of their children;
 - (3) the action helps the family perform its functions, or substitutes governmental activity for the function;
 - (4) the action increases or decreases disposable income or poverty of families and children;
 - (5) the proposed benefits of the action justify the financial impact on the family;
 - (6) the action may be carried out by State or local government or by the family; and
 - (7) the action establishes an implicit or explicit policy concerning the relationship

⁵⁷ See *Texas Nurse Practitioner Wins Religious Accommodation Process for All VA Employees*, First Liberty (July 28, 2023), <https://firstliberty.org/news/nurse-practitioner-wins-religious-accommodation/>.

⁵⁸ Pub. L. 105-277, 118 Stat. 814.

between the behavior and personal responsibility of youth, and the norms of society.

- ACF says its proposal “will not have a negative impact on family well-being,” which is defined as whether the policy “strengthens or erodes family stability and the authority and rights of parents in the education, nurture, and supervision of their children; helps the family perform its functions; and increases or decreases disposable income.”⁵⁹
- This is incorrect. Facilitating the killing of an unborn child via abortion destroys the family by eliminating the bond between parent and child. Further, as detailed above, medical gender transitions are harmful, come with risks and result in complications, and lead to a lifetime of medical care—all of which require medical and other expenses which will decrease disposable income.
- To the extent ORR facilitates abortions or medical gender transitions of an unaccompanied child without parental consent, it erodes family stability, as well as the authority and rights of parents in the supervision of their children. And as such, ACF must conduct a family policymaking assessment.

Conclusion

I urge OIRA to ensure that the statutory and regulatory process is upheld, and that ACF’s rule has sufficient legal and economic analysis that reflects its obligations under the Constitution, the Administrative Procedure Act, federal laws protecting religious liberty, and all other relevant legal authority.

⁵⁹ 88 Fed. Reg. at 68977.