Author: Brietta Clark
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Chapter 16 Reproduction and Birth, Section III, Abortion

- **These Notes & Questions should follow the *Dobbs v. Jackson Women's Health Organization* case excerpt in the E-supplement you provide to students.**

NOTES AND QUESTIONS FOLLOWING DOBBS V. JACKSON WOMEN'S HEALTH ORGANIZATION

1. *The New Supreme Court*. At the time that the Ninth edition of the case book was published, the Supreme Court had granted certiorari on the *Dobbs* case, but the case had not yet been decided. Many predicted that the significant change in the makeup of the Supreme Court brought about during the Trump administration signaled the impending demise of the federal constitutional right to abortion—three justices were appointed by former President Trump, who promised to appoint justices that would overrule *Roe v. Wade*. This prediction came true. Those three new justices—Justices Gorsuch, Kavanaugh, and Barrett—joined Justices Thomas and Alito in overruling *Roe* and *Casey*. Justices Breyer, Sotomayor, and Kagan dissented. And, as explained further in the notes below, Chief Justice Roberts authored a separate opinion concurring in the judgment only, because he thought the Court went too far.

2. *Legal Questions in* Dobbs. The excerpted opinion above highlights the two main questions considered by the Court with respect to whether *Roe* and *Casey* should be overruled. First, both the majority and dissent revisited the question of whether the federal Constitution protects the right to abortion. Then, the Court considered whether the principles of stare decisis weighed against overruling such a longstanding precedent, even if some believe it was wrongly decided. The majority and dissent didn't just come to very different conclusions in answering these questions; they also took very different methodological approaches to each. Reflect on your initial impressions of the opinion: What differences did you notice in their approaches to these questions? Which approach did you find more persuasive and why?

3. *Theories of a Constitutional Right to Abortion, Rejected in* Dobbs:

   a. *Liberty*. The majority opinion begins by noting various constitutional provisions that have been identified as possible sources for an implicit right to abortion, but it focused its analysis on the right to liberty, which is expressly protected by the Fourteenth Amendment's Due Process Clause.

   Substantive due process as a source of implicit fundamental rights has been contested and the subject of intense disagreements among the justices for years. At one extreme, Justice Thomas has consistently rejected outright any notion of a substantive due process right that is the source of implicit fundamental rights—a position he repeated in his concurring opinion in *Dobbs* (omitted from the above excerpt). See, 142 S.Ct. 2228, 2300 (J. Thomas, concurring in the opinion) ("I write separately to emphasize a second, more fundamental reason why there is no abortion guarantee lurking in the Due Process Clause. . . . . [T]he Due Process Clause at most guarantees *process*. It does not, as the Court's substantive due process cases suppose, 'forbi[d] the government to infringe certain 'fundamental' liberty interests *at all*, no matter what process is provided.'"). More commonly, however, disagreement among the justices has turned on what should count among such implicit fundamental rights. To determine this, the Court has long framed the relevant legal question as whether the particular activity is one that is "deeply rooted in [our] history and tradition' and whether it is essential to our Nation's 'scheme of ordered liberty.'" In *Dobbs*, both the majority and dissent revisit this question for abortion.

   The majority focused on what the adopters of the Fourteenth Amendment would have understood as protected within the liberty right at that time, specifically based on

historical practices that criminalized abortion. Indeed, the majority spent a great many pages (most of which are omitted from the above excerpt) recounting these historical practices, as support for its "inescapable conclusion . . . that a right to abortion is not deeply rooted in the Nation's history and traditions." The dissent criticized this approach, calling the majority's approach a "pinched view" of the constitution that would "freeze for all time the original view of what [the right to liberty and equality] guarantee" and that had been consistently rejected by the Supreme Court prior to *Dobbs*.

In defending the constitutional right to abortion recognized in *Roe* and *Casey*, the dissent re-traced the reasoning of early cases viewing abortion as connected to a series of other rights, which are also not expressly mentioned in the Constitution but have long been recognized as encompassed in a broad right of privacy. This includes the right to bodily integrity and autonomy, which have been recognized as supporting a right to refuse unwanted medical intervention. (This is discussed further in Chapter 19.) It also includes the freedom to make basic decisions about marriage, family and whether to have children, used to support the right to access contraception to prevent or control the timing of pregnancy. (This is discussed further at Section IV of this chapter.) The majority rejected this view of abortion as an integral part of a broader entrenched right of privacy grounded in ordered liberty, distinguishing abortion from these other rights based on the fact that it involves the termination of life.

b. *Equality*. In Section II.A.1 of the opinion, the dissent briefly considered and rejected an alternative theory for treating abortion bans as implicating a constitutionally recognized interest—that a state ban on abortion implicates the Equal Protection Clause of the Fourteenth Amendment because it is a sex-based classification that uniquely disadvantages women. The majority suggested that such a law should not get heightened scrutiny, absent proof of invidious discrimination. It then pointed to precedent holding that abortion regulation does not constitute such discrimination.

By contrast, the dissent's theory of liberty is intertwined with deep concerns about gender equality. First, it criticized the majority's narrow definition of liberty on equality grounds, cautioning that "[w]hen the majority says that we must read our foundational charter as viewed at the time of ratification . . . , it consigns women to second-class citizenship." The dissent also highlights how the inability of women to be able to prevent or control the timing of pregnancy has profoundly adverse effects on women's ability to organize their personal and professional lives on an equal footing with men. Finally, the dissent emphasizes how liberty and equality interests are inextricably linked when it writes: "Throughout our history, the sphere of protected liberty has expanded, bringing individuals formerly excluded. In that way, the constitutional values of liberty and equality go hand in hand; they do not inhabit the hermetically sealed containers the majority portrays."

Were you more persuaded by the majority or dissent's view of the relevance of equal protection guarantees? For those who agree with the dissent, there is a growing awareness of the fact that pregnancy is not only experienced by cisgender women, but also by transmen and nonbinary individuals. Does this complicate your belief that abortion restrictions implicate equal protection? Or does the historic marginalization and sex-stereotyping of each of these groups remain relevant for viewing this through an equality lens?

4. *Stare Decisis.* In addition to the question of whether the Constitution protects a right to abortion, the Court considered whether the principle of stare decisis counseled against overturning Supreme Court precedent, even if current justices disagree with the Court's earlier reasoning and decision. The Court considered several factors in its stare decisis analysis: *nature of the Court's error, quality of the Court's reasoning, workability, effect on other areas of law*, and *reliance interests*. Much of the discussion of the first two factors echoed the justices' disagreement as to the foundational

constitutional question. But their disagreements on the workability and reliance factors helped to tease out the more practical legal, health, and socio-economic implications of eroding the constitutional protections that have long constrained state bans and other regulations impeding abortion access. Both of which are explored further in the notes below.

5. *Quality of Reasoning & The Viability Line.* A significant aspect of the majority's discussion of the quality of reasoning was grounded in its criticism of the "viability" line established in *Roe* and reaffirmed by *Casey*, which prohibited pre-viability abortion bans. See Section III.B. of the majority opinion. In Chief Justice Roberts' concurring opinion, he agrees with the majority's decision to discard the viability line, but says he would not have gone as far as eliminating the abortion right in this case:

> I would take a more measured course. I agree with the Court that the viability line established by Roe and Casey should be discarded under a straightforward stare decisis analysis. That line never made any sense. Our abortion precedents describe the right at issue as a woman's right to choose to terminate her pregnancy. That right should therefore extend far enough to ensure a reasonable opportunity to choose, but need not extend any further—certainly not all the way to viability. Mississippi's law allows a woman three months to obtain an abortion, well beyond the point at which it is considered "late" to discover a pregnancy. . . . I see no sound basis for questioning the adequacy of that opportunity.
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> But that is all I would say, out of adherence to a simple yet fundamental principle of judicial restraint: If it is not necessary to decide more to dispose of a case, then it is necessary *not* to decide more. . . . Surely we should adhere closely to principles of judicial restraint here, where the broader path the Court chooses entails repudiating a constitutional right we have not only previously recognized, but also expressly reaffirmed applying the doctrine of stare decisis. The Court's opinion is thoughtful and thorough, but those virtues cannot compensate for the fact that its dramatic and consequential ruling is unnecessary to decide the case before us.
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> 142 S.Ct. at 2310 (2022) (emphasis in original).

Consider Chief Justice Roberts' explanation for his attempt to craft a less extreme result. Does he suggest a *more workable* alternative to the viability framework that avoids a complete repudiation of the constitutional right previously identified by *Roe* and *Casey*? Chief Justice Roberts seemed comfortable with the line drawn by Mississippi at 15 weeks (pre-viability), in part, he explained, because he believes this gives women enough time to discover and terminate their pregnancy. But if this standard is based on an assumption about one's ability to discover and terminate pregnancy within a certain time period, doesn't this implicate factors that differ based on a patient's individualized circumstances—circumstances that may undermine this assumption, such as youth, lack of access to care, and other health conditions? How does this compare to the factors that Justice Alito flags as creating uncertainty or lack of clarity under the viability framework?

The majority characterizes the U.S. as an outlier for drawing the line at viability, noting that a number of other countries allow bans earlier, after 15 weeks or so. Yet most countries permitting abortion tend to have broad exceptions permitting abortion to preserve a woman's life *or health*. See CENTER FOR REPRODUCTIVE RIGHTS, THE WORLD'S ABORTION LAWS, *Abortion Law and Policy Guide, Health Exceptions*, at https://reproductiverights.org/maps/worlds-abortion-laws/law-and-policy-guide-health-exceptions/. Such a broad *health* exception provides greater flexibility to account for those circumstances beyond patients' control that may make it difficult or impossible for them to identify the need for an abortion prior to the 15-week mark. The role of health-related exceptions after *Dobbs* is explored further in Note 9.b. below.

6. *Workability & The Undue Burden Test.* A key focus of the majority's workability analysis was its criticism of the undue burden test, especially the legal disputes arising when state regulations other than outright abortion bans are challenged in court. See Section III.C. of the majority opinion. As *Casey* (Section III.A.) and *Whole Woman's Health* (Section III.B.) demonstrate, the undue burden test has been used by courts to distinguish regulations seeking to discourage abortion through efforts

like mandatory disclosures that shape the information patients are given in their decision-making process, from laws that create substantial obstacles to abortion such as spousal consent requirements or the targeting of abortion providers with unusual and unnecessary requirements that threaten the supply of abortion services. The majority points to the plethora of state regulations that have been challenged under this standard, and the resulting splits this has created among lower federal courts. (Examples of these challenges are discussed in the Notes and Questions after Casey, at Section III.B. of Chapter 16).

The dissent counters by characterizing such questions as no more remarkable than the types of questions that courts face every day in a variety of areas. Reflect on the other cases you've read in Section III of this Chapter, or other cases you've read in law school, whether focused on common law, statutory interpretation, or other areas of constitutional law. Who has the more persuasive argument about how the undue burden test compares with other general standards that courts are asked to interpret—the majority or dissent? The dissent also counters the majority's workability critique by predicting that *Dobbs* will also generate a whole host of new fraught and difficult legal questions about abortion regulation that federal courts will be forced to confront (and which have indeed already emerged as of late Summer 2022). See Notes 10 & following below for a brief survey of these emerging legal questions.

7. *Reliance.* At one level, the majority and dissent disagreed about what should count as reliance for purposes of a stare decisis analysis. The majority asserts the absence of "traditional" or "concrete" reliance interests, while characterizing the reliance interests discussed by the dissent and relied on by *Casey* as "indirect" and "intangible." See Section III.E. of the majority opinion. The majority also claims that this form of reliance "depends on an empirical question that is hard for anyone … to assess, namely the effect of the abortion right on society and in particular on the lives of women." Reread the dissent's discussion of these interests. Do you agree with these characterizations of these reliance interests as "intangible"? Why or why not? As the dissent's discussion illustrates, there is available data relevant to understanding both the potential health consequences of being denied an abortion, as well as the socioeconomic consequences of unplanned pregnancy. (As in the case of the majority opinion, most of the citations were omitted from the dissenting opinion for streamlining purposes). Why do you think the majority decided not to engage with this data, even if it would ultimately reach the same conclusion? The issue of when and how certain data should be used to help inform jurisprudence, constitutional or otherwise, is an ongoing subject of debate more broadly. But this has had particular significance in the area of civil rights and constitutional law. See, e.g., Rachel F. Moran, *What Counts as Knowledge: A Reflection on Race, Social Science, and the Law*, 44 L. & SOC'Y REV. 515 (2010); Kathleen E. Hull, *The Role of Social Science Expertise in Same-Sex Marriage Litigation*, 13 ANN. REV. L. & SOC. SCI. 471 (2017). Social science data has been viewed as crucial to educating courts on the nature and severity of harms from government actions that infringe on important liberty and equality interests, as well as enabling courts to scrutinize the government's purported justifications for such infringements.

8. *The Rational Basis Standard.* In Section VI of the majority opinion, Justice Alito explains that in the event that state abortion regulations, including bans, are challenged on federal constitutional grounds, such laws will now only be subject to the lowest form of scrutiny under the rational basis test. Under this test a law "must be sustained if there is a rational basis on which the legislature *could have thought* that it would serve legitimate state interests." (emphasis added). This standard has effectively shielded state laws from scrutiny of either the government's purported interests for a law or whether the means chosen by the government is *in fact* rationally related to those interests. Importantly, Alito lists a broad range of government interests that satisfy this standard in the case of an abortion ban, including the preservation of life at *all* stages of development, potentially allowing government control of health care decisionmaking from the moment of fertilization.

What the *Dobbs* majority opinion doesn't do, however, is discuss whether there are *any* outer limits to this tremendous deference given to government's power to ban certain types of health care in the name of protecting fetal health; that is, whether there are any circumstances under which a ban may be clearly viewed as an irrational means for achieving the relevant state interest. For example,

should an abortion ban be constitutionally required to have an exception where the fetus suffers from a condition that has been determined to be fatal? The Mississippi law challenged in *Dobbs* did contain an exception in the case of severe fetal abnormality, but as discussed further below, not all previability bans that have emerged since *Dobbs* have such an exception. Would banning abortion under these circumstances qualify as a rational means for protecting fetal life?

Under the *Roe* and *Casey* frameworks, an abortion ban was constitutionally required to have an exception allowing abortion to preserve the pregnant person's life or health. What does the *Dobbs* majority say about the relevance of these interests under a rational basis test? Should it matter if the government also lists "maternal health" as one of its purposes for banning abortion, as in the case of the Mississippi law at issue in *Dobbs*? The Mississippi ban contained an exception for "medical emergencies," but the majority opinion contains no discussion of what kind of health threats this exception would cover or how it compares to the health exception required under *Roe* & *Casey*. What if one could offer data demonstrating that a law's exception was so narrow that women were suffering serious health harms from delays or denials of care? Does the majority offer any clues as to how closely it would scrutinize such a challenge? Would/should a court consider such data after *Dobbs*?

9. *Abortion Bans after* Dobbs. Abortion law is in tremendous flux in the wake of *Dobbs*. Almost immediately in the wake of *Dobbs*, many pre-viability abortion bans have begun to take effect: some bans were *newly enacted* in the wake of *Dobbs*; some are *newly effective* trigger laws—laws that were clearly unconstitutional under *Roe* but enacted by states in anticipation of *Roe's* overruling and written to take effect upon that occurrence; some states even have pre-*Roe* bans on the books whose effect is unclear; and in some states, there may be a combination of these different types of laws, creating confusion where the different laws seem inconsistent. Indeed, because state laws are evolving so quickly there has been tremendous legal uncertainty about exactly what is banned or permitted in many states. See, e.g., Jessica Winter, *The Dobbs Decision Has Unleashed Legal Chaos for Doctors and Patients*, The New Yorker (Jul. 2, 2022). This note, and the following ones, attempt to provide an overview of emerging state abortion trends and their implications, recognizing, however, that this landscape is evolving quickly and should continue to be monitored.

General trends. In anticipation of *Dobbs*, thirteen states passed laws that would trigger pre-viability abortion bans immediately upon *Roe* or *Casey* being overruled, or soon thereafter, and many other states have enacted or considered pre-viability abortion bans since the *Dobbs*. By contrast, some states have responded by amending their laws to reaffirm or even strengthen protections to abortion. As Justice Alito emphasized in *Dobbs*, the Court's holding now leaves it up to states to decide whether and how much to protect abortion access. Of course, this state-by-state approach assumes the absence of federal legislation that would either create new *federal protections* for abortion access by codifying *Roe*- or *Casey*-like protections (such as the proposed legislation described in Note 13 below) or create new *federal restrictions* on abortion access that could limit how protective states could be (such as a bill recently introduced by Senator Lindsey Graham for a nationwide ban on abortions at 15 weeks).

For up-to-date tracking of all state actions in response to *Dobbs*, see GUTTMACHER INSTITUTE, ABORTION POLICY IN THE ABSENCE OF ROE, at https://www.guttmacher.org/state-policy/explore/abortion-policy-absence-roe (Nov. 1, 2022 update).

The most dramatic changes in the landscape of health care access and regulation are occurring in states that are seizing on *Dobbs* to impose increasingly restrictive abortion bans. For this reason, this note highlights the key characteristics of these bans that seem to be creating the most significant impediments to abortion care, even where fetal life is not at stake, as well as generating significant new regulatory conflicts and uncertainties for health care providers. *Dobbs* notwithstanding, these bans are the subject of numerous legal challenges that may affect their status, which is fleshed out further in the notes below.

Key Characteristics of the Abortion Bans Emerging after Dobbs. Among states focused on restricting abortion, several factors are key for understanding the scope and impact of these laws: the timing of the ban; the types of exceptions allowed (or not); who may be targeted; and the nature and

severity of punishment for a violation. The following highlights are based on the Nov. 1, 2022, update by the GUTTMACHER INSTITUTE, STATE BANS ABORTION THROUGHOUT PREGNANCY, at https://www.guttmacher.org/state-policy/explore/state-policies-later-abortions.

a. *Timing of Bans*. State bans are often tied to gestational age, based on last menstrual period (LMP) (pregnancy is calculated from the beginning of the most recent menstrual period). As of November 1, nine states ban abortion at 22 weeks LMP, two ban abortion at 20 and 18 weeks, respectively, two at 15 weeks LMP, one at 6 weeks LMP, and twelve states have laws banning abortion at conception. Instead of using gestational age, some states ban abortion once fetal cardiac activity has been detected, which can happen at around 6 weeks. See Julie Carr Smyth, *Abortion Landscape Under State "Heartbeat" Laws*, AP News (Jun. 29, 2022). A ban at conception would create a near total ban on abortion (and potentially ban some forms of contraception), while a ban at 6 weeks LMP practically achieves the same effect, as many women do not even know that they are pregnant at this point. Do you think Chief Justice Roberts would have been willing to uphold such a ban? In some states, these more restrictive bans may be on the books but not yet in effect.

b. *Scope of Exceptions*. All state bans allow an exception where needed to save the life of the pregnant patient, but this is much narrower than the health exception previously required under *Roe* & *Casey*. Among states with pre-viability bans, none have general health exceptions. At most, they have exceptions for physical health, the exact contours of which have led to some confusion because of the qualifying language used to narrow the scope of the exception to severity of risk. For example, some laws allow exceptions to prevent *serious injury* and others tie the exception to a *medical emergency*. Mental health risks tend not to be considered a basis for an exception, even where there is evidence of suicidality or other physical consequences of the mental distress or illness that will be exacerbated by pregnancy. See, e.g., Idaho Code § 18-622(3)(a)(ii) (2022) ("No abortion shall be deemed necessary to prevent the death of the pregnant woman because the physician believes that the woman may or will take action to harm herself."). Fewer than ten states specify exceptions for lethal fetal anomaly, and only four have exceptions for rape or incest.

The narrowing of exceptions emerging after *Dobbs* necessarily means that women and other pregnant patients will be forced by the state to undergo greater health risks related to pregnancy, risks which are often preventable with early abortion care. Prior to *Dobbs*, a patient with a viable pregnancy who needed to grapple with the emergence of a medical risk to the fetus and/or the patient had the right to make the decision about whether to terminate the pregnancy based on a number of factors: the relevant medical risks (the magnitude of risks, the likelihood that such risks would increase or become life-threatening at a later point in time, and the risks of any treatment alternatives); the patient's individualized sensitivity or vulnerability to those risks; and the patient's own personal values and ethics. After *Dobbs*, states appear to have a great deal more power to override physician and patient judgment about the safest and most appropriate way to address and minimize such risks.

c. *Who May Be Targeted*. The most explicit regulatory targets of abortion laws have been physicians and health care entities that provide abortion care, and many of the initial legal challenges being brought to emerging bans are by health providers. But abortion bans may be written broadly enough to be used to punish others as well, especially the pregnant women or other patients seeking abortion care, and the family, friends, and even employers providing support or resources to facilitate abortion access.

(i) *Criminalization of Pregnant Patients.* Some abortion bans contain language that frames the legally banned conduct as the murder or killing of an unborn human. And laws being enacted or considered that define legal personhood as beginning at conception, implicitly create the possibility that traditional criminal prohibitions on killing would now be applied to anyone involved in bringing about an abortion. See Elizabeth Dias, *Inside the Extreme Effort to Punish Women for Abortion*, N.Y. TIMES (Jul. 1, 2022) (contrasting

"abortion abolitionists" who want to "criminalize abortion from conception as homicide, and hold women who have the procedure responsible — a position that in some states could make those women eligible for the death penalty," with the "anti-abortion mainstream, which opposes criminalizing women and focuses on prosecuting providers.") In either case, where the law does not have a provision expressly exempting pregnant patients from prosecution, pregnant patients are vulnerable to prosecution.

Indeed, even before *Dobbs*, there were examples of state and local prosecutors (sometimes in defiance of state law), attempting to punish women for pregnancy loss. This might occur, for example, where a person attempts a self-managed medication abortion in violation of state abortion laws that strictly regulate how and when a medication abortion can be performed. See GUTTMACHER INSTITUTE, Prosecuting Women for Self-Inducing Abortion: Counterproductive and Lacking Compassion, at https://www.guttmacher.org/gpr/2015/09/prosecuting-women-self-inducing-abortion-counterproductive-and-lacking-compassion (Sep. 22, 2015). But some women have been criminalized even for *unintended pregnancy loss*. Certain women, especially the poor and racial/ethnic minorities, have long been targeted for prosecution based on pregnancy losses, such as a miscarriage or stillbirth, based on the suspicion of health care workers and/or law enforcement officials that the women engaged in behavior that could have caused or contributed to the loss. Such prosecutions have occurred even where a causal link between the patient's behavior and the pregnancy loss could not be proven. See id. This is discussed more fully in Section VI of this Chapter, Decision-making During Pregnancy. Consider how such losses are likely to be viewed in a state with restrictive abortion bans: Will women experiencing a miscarriage or stillbirth be suspected of trying to self-induce termination? What effect might this have women's willingness to seek care for problems that arise during pregnancy? Reconsider these questions once you read Notes 4-7 in Section VI, explaining the role that healthcare workers have played in the criminalization of women for pregnancy loss.

(ii) *Punishing Those Who Help Pregnant Patients*. Finally, some laws ban the "aiding and abetting" or "facilitation" of abortion, raising concerns that such laws could be used to cast a wide criminal net that ensnares family, friends, employers, and non-physician care workers providing economic, informational, or other social support for the person getting an abortion. Consider this recent example of some Texas lawmakers threatening a the lawyers of a prominent law firm with potential criminal liability and disbarment for announcing that its health benefits plan would include financial support for employees that must go out of state to seek legal abortion care:

> It has come to our attention that Sidley Austin has decided to reimburse the travel costs of employees who leave Texas to murder their unborn children. It also appears that Sidley has been complicit in illegal abortions that were performed in Texas before and after the Supreme Court's ruling in Dobbs v. Jackson Women's Health Organization [ ]. We are writing to inform you of the consequences that you and your colleagues will face for these actions.
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> Abortion is a felony criminal offense in Texas unless the mother's life is in danger. See West's Texas Civil Statutes, article 4512.1 (1974) (attached). The law of Texas also imposes felony criminal liability on any person who "furnishes the means for procuring an abortion knowing the purpose intended." West's Texas Civil Statutes, article 4512.2 (1974). This has been the law of Texas since 1925, and Texas did not repeal these criminal prohibitions in response to Roe v. Wade, 410 U.S. 113 (1973). These criminal prohibitions extend to drug-induced abortions if any part of the drug regimen is ingested in Texas, even if the drugs were dispensed by an out-of-state abortionist. To the extent that Sidley is facilitating abortions performed in violation of article 4512.1, it is exposing itself and each of its partners to felony criminal prosecution and disbarment.

Letter from Texas Freedom Caucus to Sidley Austin LLP, July 7, 2022, at https://www.freedomfortexas.com/uploads/blog/3b118c262155759454e423f6600e2196709787a8.pdf. In anticipation of *Dobbs* and since the decision was issued, numerous companies in states with restrictive abortion bans have made similar promises, often as part of a broader plan to fund out-of-state travel when necessary for any kind of health care—not only abortions. See Emma Goldberg, *These Companies Will Cover Travel Expenses for Employee Abortions*, N.Y. Times (Aug. 19, 2022). Whether such promises become realities, however, will depend, in part, on how aggressively states go after these companies, and in part, whether companies can successfully argue that interfering with employers' ability to ensure employees' access to legal health care violates some other protected federal or state interest. (See Notes 10-14 below).

d. *Enforcement*. As the above letter from Texas lawmakers demonstrates, abortion bans may be enforced through severe criminal penalties. In particular, bans framing violations of abortion law as a form of "murder" or "homicide" are likely to rely on severe criminal penalties, such as one Louisiana law that punishes violations up to 15 years in prison depending on when the abortion was performed. In addition, as explained in the main text at Section III.C. at note 4 on the Future of Abortion Jurisprudence Note, Texas created a novel form of civil liability even before *Dobbs*, that allowed private citizens to sue anyone who aided and abetted an abortion in violation of the law (excluding the pregnant person)—civil liability that remains a significant deterrent in addition to the almost total criminal abortion ban in Texas that went into effect after *Dobbs*.

Although the nature of the legal sanctions attached to abortion regulations has not gotten as much attention as concerns about timing and exceptions, this is indeed an important characteristic of the law that can have a powerful chilling effect on providers that results in the denial or delay of abortion care. In fact, we are already seeing these effects unfolding in certain states. This is happening either because confusing terminology in the statute makes it unclear exactly when abortion care would be considered to fall within an exception, or because the ever-expanding threat of liability and punishment is causing health care institutions to erect new layers of prior review of such decisions that delays care. Bans that are increasingly broad because they apply earlier in pregnancy, and have much narrower exceptions, not only limits the circumstances under which abortion can be provided, but also seems to shift the burden to the provider to prove that an exception applies. Indeed, at least one law seems to be written in a way that exposes providers to arrest and prosecution based on the mere fact of providing an abortion, and then shifts the legal burden to the provider to assert an affirmative defense proving that the abortion fell within a permitted exception. See Idaho Code § 18-622(3) (2022). The Texas Freedom Caucus Letter, *supra*, illustrates some lawmakers' hopes and expectations that such liability will discourage employers and others from helping women get abortion services, even women seeking abortion from states where it is legal.

Notably, as soon as the draft opinion of *Dobbs* was leaked, some prosecutors began making pronouncements that they would use their discretion to not enforce these newly restrictive bans. That said, prosecutorial discretion is just that—discretionary authority that varies based on the identity of people in charge of the prosecutor's office. On its own, it cannot eradicate the legal vulnerability of providers, pregnant patients, and others under these laws, nor are these pronouncements providing the legal certainty providers need to feel comfortable providing care. See Winter, *The Dobbs Decision Has Unleashed Legal Chaos for Doctors and Patients*, supra.

10. *Legal Challenges to Abortion Bans after* Dobbs. While *Dobbs* removed federal constitutional protection for abortion under the theory that abortion is a fundamental right, this did not put legal controversy related to abortion laws to rest. Quite the contrary, a whole host of new legal questions have arisen about whether there are other state or federal constraints on how states ban or otherwise regulate abortion after *Dobbs*. In *The New Abortion Battleground*, 123 Columbia Law Review (forthcoming 2023), Professors Cohen, Donley, and Rebouché previewed the likely

interjurisdictional conflicts (federal-state conflicts, as well as interstate conflicts) that would unfold as a result of the elimination of a federal constitutional right to abortion. And their predictions are being borne out, as states race to enact increasingly restrictive abortion bans and to test the limits of how aggressively they can use their power to stamp out abortion among their citizens whether at home or out-of-state. Some consequences of these trends are already materializing: (1) increased health risks for pregnant persons, some by statutory design (as in the case of laws that only provide exceptions for life endangerment or in emergencies) and some potentially unintended (due to vague or inconsistent statutory language); (2) provider uncertainty about what conduct is banned and the chilling effect caused by fears of prosecution; and (3) states and other localities using the threat of severe criminal penalties and expanded civil liability to discourage help for pregnant persons seeking abortion care, even beyond state borders. *Dobbs* notwithstanding, the design and effect of these restrictive bans are viewed as implicating a number of other state and federal interests, and they are being challenged just as quickly as they are being enacted. The following notes highlight key examples of the various legal questions or disputes arising, which are evolving rapidly and should be monitored for on-going developments.

11. *State Constitutional Protections for Abortion.* As discussed in the notes following *Roe* and *Casey* in Chapter 16, state constitutions have provided an important source of independent protection for abortion access, grounded in state constitutional guarantees of privacy, liberty, and/or equality guarantees. For example, California's state supreme court interpreted its state constitution as protecting abortion as a part of the right of privacy, even before the U.S. Supreme Court's holding in *Roe v. Wade*. Moreover, California's constitution has been interpreted as providing more robust protection for abortion funding than the U.S. constitution. See Note 6 after *Roe*. But this is not only true for states whose executives and legislatures have historically been viewed as supportive of abortion access. In some states where lawmakers have recently enacted (or are attempting to restore pre-*Roe* restrictive abortion bans), opponents of such bans are bringing challenges based on state constitutional protections for abortion, with mixed success so far.

For example, in *Planned Parenthood of Southwest and Central Florida v. State*, 2022 WL 2436704 (Jul. 5, 2022), a Florida circuit court initially issued a temporary injunction of a recently enacted 15-week abortion ban, on the grounds that it likely violated the explicit right to privacy added to Florida's state constitution in 1980. The court pointed to decisions by the Florida Supreme Court soon thereafter, interpreting this privacy right as implicated by a woman's right to determine whether or not to terminate her pregnancy and as protecting this right to terminate pregnancy until viability. According to the court, the 15-week ban was presumptively unconstitutional unless the state could show that the law satisfied a compelling state interest through the least restrictive means. This recognizes a state constitutional limit on abortion bans that is essentially the equivalent of the standard established in *Roe* and *Casey*, and that would restore the earlier balance struck by the Supreme Court for protecting fetal life and women's health and reproductive choice. Id. 1-2. Although the trial court initially temporarily enjoined the law because it found that the plaintiffs demonstrated a likelihood of success on the merits, an automatic stay of the trial court order went into effect based a state procedural rule that automatically imposes a stay when a trial court order is appealed. *Planned Parenthood of Southwest and Central Florida*, 2022 WL 2680000 (Jul. 12, 2022). Litigation of this matter is on-going and should be watched closely.

In Ohio, health care providers attempted a similar challenge in order to get an emergency stay of a 2019 trigger law banning abortion at 6 weeks. Providers argued that the ban implicates "the Ohio constitution's substantive due process protections [which] extend to 'matters involving a right to privacy, procreation, bodily autonomy, and freedom of choice in health care decision making'." State ex rel Preterm-Cleveland v. Yost, Case No. 2022-0803 (Filed Jun. 29, 2022). Providers also grounded their challenge in state constitutional equality protections as well. Id. The State Supreme Court denied the providers motion for an emergency stay without any discussion of the merits. See State ex rel Preterm-Cleveland v. Yost, Case No. 2022-0803, 07/01/2022 Case Announcements #2, 2022-Ohio-2317.

It's difficult to predict whether state constitutions will provide protection for abortion access (and if so, how much), in part, because litigation in still in the early stages. More importantly, though, the

questions about the scope of state constitutional protection will be shaped by emerging political battles to amend state constitutions, to either take away or strengthen constitutional protections for abortion. For example, as this supplement is being finalized Kansas has gotten a great deal of attention because voters decisively rejected a constitutional amendment that would have given the state legislature greater power to restrict abortion access. This occurred during a primary election, which would typically have a very low turnout by Democratic voters—those previously assumed to be ones who would vote against such an amendment. Instead, two things happened that were deemed important: a significant number of Democratic voters turned out specifically to vote against this amendment, and many Republican voters played a significant role in its defeat. Despite Kansas voting overwhelmingly for former President Trump in both the 2016 and 2020 elections (especially in light of Trump's promises to appoint justices who would overturn *Roe v. Wade*), a significant percentage of people in liberal and conservative regions voted against removing such protection from the state constitution. Many see this as signaling a state constitutional battle over abortion rights that may be more nuanced than lawmakers were anticipating solely based on voters' political affiliations or support for certain candidates. See Mitch Smith, Lauren Fox, & Elizabeth Dias, *In Kansas, Support for Abortion Rights Didn't Just Come from the Usual Places*, N.Y. TIMES (Aug. 3, 2022), at https://www.nytimes.com/2022/08/03/us/kansas-abortion-amendment.html. This is especially likely as people become increasingly aware of the adverse health consequences of more restrictive bans. As of this writing, several more states are expected to have abortion-related amendments on the ballot for the upcoming November elections, some aimed to restrict abortion rights and some to strengthen abortion rights.

12. *Statutory Confusion, Unintended Harms, & Legal Challenges Based on Vagueness.* Much of the discussion in anticipation of *Dobbs* focused on just how far states could go in banning abortion—both in terms of how early in pregnancy abortions could be banned and what kind of exceptions for the pregnant person's health, if any, would be required. But what if the laws as written are so vague, confusing, and/or severely punitive that they create a chilling effect that causes providers to delay or deny services that were likely not intended to be banned, resulting in serious health consequences including increased risk of death? Does the rational basis test shield even these laws from any meaningful constitutional scrutiny? Or is there some other basis for challenging laws having such effects? These are not hypothetical questions, as there are already reports from patients and providers of such consequences of the newly emerging bans in the wake of *Dobbs*, as well as legal challenges based on these concerns. Consider the following recent reports from patients and providers:

- *Patients with non-viable pregnancies.* Medications that can induce abortion are used to manage certain types of pregnancy loss, and the complications that can result. For example, medication may be needed to a treat spontaneous miscarriage in early pregnancy, to facilitate the passing of the miscarriage and prevent infection and other health complications. Such medication is also used to treat ectopic pregnancies, a condition in which the pregnancy is never viable, and which can become fatal for the pregnant patient if the pregnancy is not terminated right away. Since new bans have come into effect, patients with non-viable pregnancies report being denied care or forced to wait longer for medically necessary abortion-related treatment. These delays not only prolong patients' pain and distress, but also increases patients' risk of serious health complications. See Pam Belluck, *They Had Miscarriages, and New Abortion Law Obstructed Treatment*, N.Y. Times (Jul. 17, 2022).

- *Non-pregnant patients.* Methotrexate and misoprostol are medications that may induce abortion, but are also prescribed to treat other health conditions, such as cancer, autoimmune diseases, arthritis or stomach ulcers. In states with very restrictive abortion bans, patients are reporting having trouble accessing this medication for non-pregnancy related conditions. Some women report being abruptly cut off because of provider fears of prosecution in the event the patient eventually becomes pregnant while taking the medication. In one case, a 46-year-old patient's rheumatologist reportedly gave her an ultimatum: she had to go on birth control (despite her age and history of infertility), if she wanted him to continue to prescribe methotrexate—the only medication that had

successfully relieved her disabling pain from rheumatoid arthritis for many years. She ultimately opted for a sterilization. See Katie Shepherd & Frances Stead Sellers, *Abortion Bans Complicate Access to Drugs for Cancer, Arthritis, Even Ulcers*, Wash. Post (Aug. 8, 2022).

- *Patients experiencing pregnancy-related complications.* Providers are calling attention to the confusion and legal uncertainty created by new bans, specifically as to whether and when a pregnancy becomes dangerous enough to meet the requisite legal exception. They are highlighting the potential consequences of such laws, as not only impeding providers' ability to satisfy their usual ethical and legal duties to provide timely medical care, but also as creating serious risks to a patient's health or life due to delayed care. This confusion occurs despite exceptions in the law for medical emergencies or to save the life of the pregnancy patient, as explained by an OB-GYN:

  > [Dr. Nisha Verma explained that] it's been unclear to physicians how to interpret medical emergency exceptions and discern when it's legally permissible to intervene. She pointed to a type of high blood pressure called pulmonary hypertension that she said is fatal in pregnant people 50% of the time, as well as cases where a pregnant person's water breaks before the fetus is viable outside the uterus. / "What we're taught to do is intervene before they get sick, but these laws are telling us we have to wait until it's an emergency," Verma said. / But what constitutes an emergency isn't at all clear because they generally happen on a continuum, where a patient seems fine one minute and is crashing the next, she noted. / "What I need to do as a doctor is to intervene earlier in that continuum to keep that person safe and healthy, but the laws are making it really unclear about whether I can do that," she added.

  Britain Eakin, *AMA President Says Doctors Facing Uncertainty Post Dobbs*, LAW360.COM (Jul. 19, 2022).

So far, there has been at least one successful challenge to the implementation of a restrictive abortion ban based on claims that the law was so lacking in clarity that it should be found void for vagueness. This doctrine, arising out of both federal and state constitutional due process protections, can be used to invalidate a statute that fails to give ordinary citizens clear notice of the conduct that is prohibited and punishable. Providers in Louisiana alleged that inconsistencies in the various state laws regulating abortions generated confusion about what conduct was banned or permitted, and the severity of penalties that would apply. They sought an injunction on the grounds that such lack of clarity would jeopardize pregnant patients' health and cause irreparable harm. A Louisiana district court agreed and issued an order temporarily enjoining enforcement based on evidence of "constitutional ambiguity" in the criminal abortion bans and thus a failure to provide "[c]onstitutional notice for lawful implementation and for full and immediate enforcement" of such laws. June Medical Services v. Landry, 2022 WL 3093100 (Jul. 26, 2022). Three days later, the judgment was suspended pending appeal. June Medical Service, 2022 WL 3093015 (Jul. 29, 2022). This is yet another example of how quickly the abortion landscape is shifting post-*Dobbs*.

It is important to note that this is a more limited type of protection from the state constitutional challenge described in the prior note. A challenge based on void for vagueness or constitutionally defective notice does not establish substantive due process rights that limit how far states can go in restricting abortion; rather, it focuses on the clarity of the law, something lawmakers can easily fix. But consider whether such a challenge may still ultimately have a substantive impact on the law. If this kind of challenge can shine a light on deficiencies in the law that create unintended harms, might this ultimately lead to a more deliberative and transparent political process—one in which members of the public who are concerned about these harms can implore political leaders to take a more thoughtful and careful approach to crafting abortion laws in ways that better protect pregnant patients' health?

13. *Conflict with Federal Duties to Treat & Other Legal Obligations*. Since the leak of the *Dobbs* opinion, there has been a lot of speculation about whether Congress would enact federal legislation to try to counteract new abortion restrictions after *Dobbs*. Two bills have been passed in the House to protect abortion access: the Women's Health Protection Act of 2022 (H.R. 8296), would restore many of the protections established in *Roe* and *Casey*, and would allow abortion restrictions only if they were the least-restrictive means of significantly advancing patient health or safety; and the Ensuring Women's Right to Reproductive Freedom Act of 2022 (H.R. 8297) would prohibit interference with the provision of abortion care across state lines. But their fate is uncertain as of this writing.

In the meantime, however, an emerging set of challenges to restrictive state abortion bans is coming from federal regulators concerned that certain state bans (and the means used to enforce the bans) may impede or undermine existing federal laws governing various aspects of health care. Federal regulators have begun identifying federal laws, which they believe preempt state abortion bans that create a conflict, based on the Supremacy Clause of the U.S. Constitution.

a. *EMTALA*.

The most prominent example of this type of conflict is occurring in the context of EMTALA—the federal law requiring Medicare-participating hospital emergency departments and physicians to provide stabilizing treatment for patients experiencing a medical emergency. See Ch. 6, III. Recall the various types of health harms that can and are resulting from the new wave of restrictive abortion bans, discussed in the notes above. In some cases, this may be the result of intentional line-drawing, such as a ban that only has a narrow exception to save the life of the pregnant woman, which necessarily prevents timely abortion care to address serious health risks that may evolve slowly or unevenly over the course of a pregnancy. In other cases, confusing and apparently inconsistent statutory provisions (along with the ratcheting up of provider penalties) may have the unintended effect of preventing timely abortion care to address serious health risks, even in the case of non-viable pregnancies. Both scenarios have significant implications for emergency care providers.

In a recent update to its EMTALA guidance in the wake of *Dobbs*, CMS made clear that "Emergency medical conditions involving pregnant patients may include, but are not limited to, ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features." Perhaps most importantly, CMS highlighted the following:

> ***If a physician believes that a pregnant patient*** *presenting at an emergency department is experiencing an emergency medical condition as defined by EMTALA, and that abortion is the stabilizing treatment necessary to resolve that condition, the physician* ***must*** *provide that treatment. When a state law prohibits abortion and does not include an exception for the life and health of the pregnant person — or draws the exception more narrowly than EMTALA's emergency medical condition definition —* ***that state law is preempted****.*

Centers for Medicare & Medicaid Services, Memo to State Survey Agency Directors: Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss (QSO-21-22-Hospitals UPDATED JULY 2022) (Jul. 11, 2022), at https://www.cms.gov/files/document/qso-22-22-hospitals.pdf (emphasis in original).

Consider the two scenarios identified by CMS that could create a conflict in which EMTALA should be understood to preempt a state abortion ban. One seems to reflect an obvious direct conflict: where the state ban's exception is narrower than the EMTALA's emergency medical definition. But take a closer look at the alternative basis for CMS claiming preemption in the first part of that sentence—if a state law fails to include an exception for the life *and health* of the pregnant person. Would the scope of a "health" exception be considered coterminous with "medical emergency" under EMTALA, or is it broader than that? How might this affect the success

of a claim of preemption based on the lack of a health exception? Certainly, the *health exception* required under *Roe* and *Casey* seemed to be broader than what would qualify as having reached the point of an "emergency." But can you discern a clear distinction between an exception necessary for "health" versus "life" versus a "medical emergency"? The guidance summarizes EMTALA's definition of medical emergency as follows:

> An [emergency medical condition] includes medical conditions with acute symptoms of sufficient severity that, in the absence of immediate medical attention, could place the health of a person (including pregnant patients) in serious jeopardy, or result in a serious impairment or dysfunction of bodily functions or any bodily organ. Further, an emergency medical condition exists if the patient may not have enough time for a safe transfer to another facility, or if the transfer might pose a threat to the safety of the person.

Questions about whether EMTALA preempts state abortion bans, and if so, to what extent, will certainly play out in the courts. Indeed, two lawsuits are already under way. In one, the federal government has filed suit to prevent a near-total ban from taking effect in Idaho. Asserting preemption, the government explains how the ban could prevent providers from complying with their EMTALA obligations:

> . . . Under the Idaho law, once effective, any state or local prosecutor can subject a physician to indictment, arrest, and prosecution merely by showing that an abortion has been performed, without regard to the circumstances. The law then puts the burden on the physician to prove an "affirmative defense" at trial. Idaho Code § 18-622(3) (2022). Nothing protects a physician from arrest or criminal prosecution under Idaho's law, and a physician who provides an abortion in Idaho can avoid criminal liability only by establishing that "the abortion was necessary to prevent the death of the pregnant woman" or that, before performing the abortion, the pregnant patient (or, in some circumstances, their parent or guardian) reported an "act of rape or incest" against the patient to a specified agency and provided a copy of the report to the physician. Id. Beyond care necessary to prevent death, the law provides no defense whatsoever when the health of the pregnant patient is at stake. And, even in dire situations that might qualify for the Idaho law's limited "necessary to prevent the death of the pregnant woman" affirmative defense, some providers could withhold care based on a well-founded fear of criminal prosecution.
>
> . . . Idaho's abortion law will therefore prevent doctors from performing abortions even when a doctor determines that abortion is the medically necessary treatment to prevent severe risk to the patient's health and even in cases where denial of care will likely result in death for the pregnant patient. To the extent Idaho's law prohibits doctors from providing medically necessary treatment, including abortions, that EMTALA requires as emergency medical care, Idaho's new abortion law directly conflicts with EMTALA. See 42 U.S.C. § 1395dd(f) (EMTALA preempts State laws "to the extent that the requirement directly conflicts with a requirement of this section"). To the extent Idaho's law renders compliance with EMTALA impossible or stands as an obstacle to the accomplishment of federal statutes and objectives, EMTALA preempts the Idaho law under the Supremacy Clause of the United States Constitution.

In late August, the federal district court decided to temporarily enjoin the Idaho ban while the parties fully litigate the issue, but only to the extent that the ban conflicts with providers' duties under EMTALA. The court found that there were scenarios in which stabilizing abortion care required under EMTALA would violate the state ban because EMTALA requires care necessary to prevent the immediate deterioration of health, as well as to preserve life. In addition, even where EMTALA required care overlapping with that allowed under the state ban, physicians would nonetheless face a conflict because providing such care would automatically render physicians vulnerable to state prosecution, even if the physician could ultimately prove an affirmative defense. For these reasons, it found the federal government was likely to succeed on the merits of its conflict preemption claim. U.S. v. Idaho, Memorandum and Order, Case No. 1:22-cv-00329-BLW (Aug. 24, 2022).

In a separate suit, Texas government officials filed suit challenging this most recent EMTALA guidance. Texas v. Becerra, No. 5:22-cv-00185-H, Complaint, filed 7/14/22. Texas officials characterized HHS's guidance as essentially creating an "abortion mandate" under EMTALA, which they want declared unlawful on a number of grounds. One is based on a provision in the Social Security Act that states: "Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided. . . . " 42 USC 1395. Texas asserts that the guidance is effectively mandating a specific type of care in violation of this limit. Relatedly, Texas argues that the HHS guidance requiring abortion care reflects federal interference or usurpation of areas of health regulation within the domain of state governance in violation of the Tenth Amendment. Pointing to *Dobbs*, Texas emphasizes that this now includes states' rights to ban abortion. Notably, Texas also pointed to federal laws that would seem to be inconsistent with an abortion mandate, namely the Hyde Amendment's funding restrictions on certain types of abortions, and the Weldon Amendment's prohibition on discrimination against those individuals or entities that refuse to provide or pay for abortion. Specifically, Texas alleged that HHS's interpretation would effectively coerce federal funding recipients into providing abortions in violation of these laws. Finally, Texas alleged that the guidance would effect a substantive change which requires HHS to follow the notice and comment procedures under the Administrative Procedure Act (APA). In this case, a district court found for Texas and preliminary enjoined application of the EMTALA guidance against the plaintiffs. The court found the guidance was unauthorized by the text of EMTALA and violated the APA's procedural requirements. Texas v. Becerra, 22-cv-00185, US District Court, Northern District of Texas (Lubbock).

b. Conflict with Other Federal Health Laws

Although EMTALA is an important focus of preemption litigation at the moment, it only applies in the emergency setting. Recent executive orders and HHS pronouncements suggest potential conflicts between restrictive state abortion bans and other federal laws—laws that may protect abortion care beyond the emergency setting and/or other health and privacy interests infringed upon as a result of abortion restrictions.

One example of this is in HHS's updated guidance on antidiscrimination obligations. See, e.g., U.S. DHHS, Office of Civil Rights, Guidance to Nation's Retail Pharmacies: Obligation under Federal Civil Rights Laws to Ensure Access to Comprehensive Reproductive Health Care Services (content last reviewed Jul. 14, 2022). In this guidance, HHS reminds pharmacies that as recipients of federal financial assistance, including Medicare and Medicaid payments, they are prohibited from discriminating on the basis of race, color, national origin, sex, age, and disability in their programs. It emphasizes federal civil rights law that prohibits pregnancy discrimination as a form of sex discrimination, which includes discrimination based on current pregnancy, past pregnancy, potential or intended pregnancy, and medical conditions related to pregnancy or childbirth. And it lists several examples of denials of care, similar to the patient reports described in Note 12, which would implicate laws that prohibit pregnancy or disability discrimination. For example, it explains that refusing to fill a prescription for misoprostol prescribed to treat an ectopic pregnancy may constitute sex discrimination, while refusing to fill a prescription for methotrexate to treat rheumatoid arthritis may constitute disability discrimination.

The federal government's authority to regulate drug safety may be another potential source of protection. As noted above, these more restrictive bans, especially bans at conception and 6-weeks LMP, are impeding patients' access to safe and effective treatment for a wide range of health conditions. In response, there is a growing call for the FDA to use its authority to argue that state bans that deny patients access to drugs found safe and effective by the FDA, creates a direct conflict with federal drug safety laws and thus should be preempted. Such an approach raises questions about whether and under what circumstances a state may prohibit sale of an FDA-approved drug. See Lars Noah, *State Affronts to Federal Primacy in the Licensure of Pharmaceutical Products*, 2016 Mich. St. L. Rev. 1 (arguing that such a question does not have an easy answer).

Finally, increasingly aggressive attempts by states to ban abortion have raised serious concerns about expanding state surveillance of women's reproductive care. Can the state force medical providers and health care organizations to disclose otherwise confidential medical information for purposes of determining whether a pregnancy was terminated and when? Can state officials compel employers to provide information about employees' request for funding to cover abortion services or travel out of state, as threatened by Texas lawmakers in the above letter? Can state officials access and/or use health data that people may be storing in pregnancy tracking apps, sharing on social media apps believed to be "private," or housed within other electronic sources, to prosecute pregnant patients and the people who help them? In response to these concerns, federal regulators are issuing updated guidance on, or signaling a new focus on, the sharing of reproductive health information in various contexts. See, e.g., Statement by Acting Associate Director, FTC Division of Privacy & Identity Protection, Location, health, and other sensitive information: FTC committed to fully enforcing the law against illegal use and sharing of highly sensitive data (Jul. 11, 2022); OCR DHHS, HIPAA Privacy Rule and Disclosures of Information Relating to Reproductive Health Care (content last reviewed Jun. 29, 2022). Of course, as with other federal attempts to protect abortion access in the face of restrictive abortion bans after *Dobbs*, these efforts will certainly be subject to legal challenge by the states.

14. *Interstate Conflicts: Expanding the Reach of Abortion Bans Beyond State Borders*. The bottom-line of the *Dobbs* opinion, according to the majority, is that the question of whether to ban or protect abortion will be returned to the states. Yet state borders are permeable, and many women have had to look beyond their own state's borders to secure abortion care.

Even before *Dobbs*, many people lived in states where it was difficult to access abortion because of increasingly burdensome regulations and funding restrictions, which dwindled the supply of qualified health care professionals and facilities. These patients often had to travel to neighboring states that were more protective of abortion access to get care. At the same time, scientific and technological developments have made it easier and safer for many patients to access abortion services from outside the state, without even having to leave. Specifically, the availability and safety of abortion medication to treat pregnancy up to about 10 weeks, coupled with the increasing availability of telehealth options for visits with health care providers, has led to a growing number of women engaging in "self-managed abortions" that look very different from the limited and dangerous options women had pre-*Roe*. Not only do these developments make it easier for women to circumvent certain abortion bans, they are more difficult for states to monitor.

Some states are already attempting, or have signaled their intent, to use their power to try to prevent women from securing abortion services from out of state. One way to do this is by criminalizing any assistance for the person who needs to travel out of state for care, as a means of depriving her of essential resources she would need to access care. The Texas letter excerpted in Note 9 above is an example of this approach. It threatened criminal liability and professional discipline against the Texas employer for funding *out-of-state travel*, without regard to the fact that the services women would be seeking would be legal in those states. Indeed, based on a recent complaint filed against Texas officials, there is serious concern about Texas officials using its abortion ban to penalize not only financial assistance, but also logistical support (such as providing transportation) and informational assistance (such as providing women out-of-state health care referrals).

In late August, a number of nonprofit organizations and a medical provider brought a constitutional challenge to Texas officials' ability to penalize such a wide swath of conduct. Among the claims brought, plaintiffs alleged that the punishment of informational assistance would infringe the right to free speech, and that criminalizing assistance to those seeking abortion out of state more generally infringed on the federal constitutional right to travel. See Fund Texas Choice v. Paxton, Complaint, No. 1:22-cv-859 (U.S. Dist. Ct. W. Dist. Tx) filed 8/23/22. At least one of the justices in the *Dobbs* majority seemed to open the door to some limits on state bans based on the right to travel. See 142 S.Ct. at 2309 (*J. Kavanaugh concurring in the opinion and judgment*, ("[M]ay a State bar a resident of that State from traveling to another State to obtain an abortion? In my view, the answer is based on the constitutional right to interstate travel.") This statement suggests a constitutional limit on states' ability to punish women for traveling out of state for abortion care based on the right to

travel. But will this right be viewed as constraining state attempts to impede cross border access to abortion care short of a direct travel ban on the patients in need of care? What about legal action to discourage assistance by others?

Concerns have also been raised about whether abortion-restrictive states can target out-of-state health care professionals who provide abortion care to their residents, despite the fact that abortion is legal in the provider's state. Can abortion-restrictive states reach across state lines to go after these providers for criminal prosecution, civil liability, or disciplinary action, on the theory that they are participants or co-conspirators of murder or some other criminal act? Does the answer to this depend on whether the abortion care was entirely carried out in the state where that abortion is legal? For example, if a patient obtains the drugs for a two-part medication abortion regimen in the state where abortion is legal, but then takes the second drug back in her home state where the abortion would be illegal, did the health care provider violate the law of the patient's home state? What if the professional also provides a follow-up consultation with the patient via telehealth?

Some abortion-protective states have already begun taking proactive steps to protect providers in their states, and the out-of-state patients they serve, from punitive actions. For example, in the wake of *Dobbs*, California lawmakers passed a series of laws protecting providers and patients, such as laws prohibiting California officials from cooperating with records requests and other requests for assistance in investigations or other adverse legal actions against providers or patients involved in legal abortion care provided in California. For example, California Health & Safety Code § 123467.5 provides:

> (a) A law of another state that authorizes a person to bring a civil action against a person or entity that does any of the following is contrary to the public policy of this state:
> (1) Receives or seeks an abortion.
> (2) Performs or induces an abortion.
> (3) Knowingly engages in conduct that aids or abets the performance or inducement of an abortion.
> (4) Attempts or intends to engage in the conduct described in paragraphs (1) to (3), inclusive.
>
> (b) The state shall not do either of the following:
> (1) Apply a law described in subdivision (a) to a case or controversy heard in state court.
> (2) Enforce or satisfy a civil judgment received through an adjudication under a law described in subdivision (a).

Some abortion opponents have already raised questions about the legality of such legislation, signaling the likelihood that interstate conflicts that will eventually end up in the courts.

15. *Invisible Patients: Taking the Freedom of Movement for Granted.* Much of the focus on how to preserve abortion access for residents in abortion restrictive states has centered around legal questions about cross border activity: whether existing law protects those who need to travel to states where abortion is legal, and the role of law in the face increased access medication abortion by mail for those living in states with restrictive bans. But this focus makes important presumptions about the freedom of movement, access to electronic resources, and a basic level of privacy and ability to communicate freely that does not apply to everyone. Certain groups of women, transmen, and nonbinary pregnant patients have been invisible in much of the conversation around protecting abortion access after *Dobbs.* This includes groups who have no freedom of movement because they are in carceral settings, like jails, prisons, or immigration detention centers. And pregnancy and abortion care is important for these groups, as research shows that around 50,000 pregnant women likely enter jails or prisons each year. Even pre-*Dobbs*, care in such facilities had been uneven, with practical barriers undermining the access supposedly guaranteed by law. Carly Graf, *Policies to Roll Back Abortion Rights will Hit Incarcerated People Really Hard,* Kaiser Health News (Aug. 22, 2022).

These barriers can also apply to those who may be under other forms of state or federal

surveillance and control, such as those on probation, parole, or pretrial or hearing release, which includes a growing number of undocumented immigrants. Despite being technically free from incarceration, the people who fall into these categories lack the basic privacy rights and freedom of movement that are crucial for accessing cross border health care. Professor Weisburd explains the effect of abortion bans on these groups:

> On any given day, millions of women on probation, parole and pretrial release are subject to myriad forms of state surveillance and control. Thousands of women wear GPS-equipped ankle monitors that track their location 24/7. This surveillance also often entails warrantless searches of cellphones, including of text messages, social media and web browsing history. Some ankle monitors also include two-way audio functions that allow supervising agents to listen in on any conversations. This surveillance allows government officials to monitor, listen and read all communication, including with doctors, pharmacists and others.
>
> Women on court supervision or monitors are often not permitted to leave their homes or change their schedules without prior permission. A trip to the doctor, a prenatal appointment or a pharmacy depends on the approval of a government official, which may not be timely or may never come. Women on court supervision are also almost always prevented from leaving the state. Any unapproved trip out of the house, or state, can result in more jail or prison time. For women on court supervision in states with abortion bans, accessing abortions without government detection is not possible.

Opinion, Women in Prison and Under Court Surveillance Will Suffer Under New Abortion Bans, L.A. Times (July 5, 2022, 10:44 AM).

16. *Implications of* Dobbs *for Other Constitutional Rights Relating to Reproduction and Birth*. The majority and dissent's disagreement on the question of abortion reveals a more fundamental disagreement over proper constitutional analysis—a disagreement that could have significant implications for other implicit constitutional rights that we touch upon in the remaining sections of this Chapter on Reproduction and Birth. The dissent pointed to the fact that the majority's approach—which relies heavily on how the adopters of the Fourteenth Amendment would have understood the meaning of liberty at that time—renders vulnerable many other implicit rights that we have long held constitutionally protected. Although the majority counsels against reading too much into the opinion in terms of how it may affect other rights, the dissenting justices are not the only ones anticipating the further elimination of rights. In a separate concurrence omitted from the above excerpt, Justice Thomas implores the Court to "reconsider all of this Court's substantive due process precedents, including *Griswold*, *Lawrence*, and *Obergefell*." 142 S.Ct. at 2301. As the majority relies heavily on the fact that abortion was not recognized as a constitutional right in the 19th Century, consider the other rights we have today that were not recognized as constitutional rights at that time:

a. *Access to Contraception*. Given historical practices banning contraception, will the majority use the same *Dobbs* reasoning to overrule *Griswold* and the other cases affirming a right to access contraception? Even if the majority is unwilling to go that far, might it uphold a state ban on contraception that acts (or that some claim has the potential to act) after fertilization, in states recognizing life from the moment of conception? Would an asserted state belief that the termination of life is involved, regardless of medical evidence to the contrary, be enough for the majority to be willing to carve out certain forms of contraception from an otherwise protected constitutional right? What other legal interests might be implicated. In the HHS guidance to pharmacists, supra Note 13, HHS specifically noted that the refusal to dispense emergency contraception to treat sexual assault, as well as the refusal to dispense certain forms of contraception believed to prevent pregnancy after fertilization, could implicate federal prohibitions on sex discrimination. Revisit these questions after you read Section IV, Contraception, of this Chapter.

b. *Protection Against Forced Sterilization.* In Section V of this Chapter, you'll learn about early Supreme Court precedent holding that the constitution permitted government-based sterilizations under state eugenics statutes. Although this precedent that has not been officially overturned, subsequent cases, including the *Skinner* case mentioned by the dissent, have recognized that forced sterilization infringes a constitutionally protected liberty interest. This recognition has effectively meant the end of state eugenics programs and significantly curtailed, though not eliminated entirely, other forms of involuntary sterilization in this country. Like abortion and contraception, the right against forced sterilization is an implicit one that has evolved over time. Is this right in danger under *Dobbs*' reasoning?

c. *Refusal of Unwanted Treatment During Pregnancy.* The dissent mentions the right to bodily integrity and autonomy, which has allowed people to refuse unwanted medical treatment under certain conditions. But as you'll see in Section VI on Decision-Making During Pregnancy, there is disagreement about the extent to which these privacy rights, along with the right to make decisions concerning procreation, protect patient decision-making during pregnancy. Some courts have used these rights to prevent or limit forced medical interventions, while others allowed such interventions in the name of protecting fetal health. Consider what, if anything, the *Dobbs* case might suggest about how courts can weigh apparently competing interests against a patient's wishes going forward? See also Ch. 19.

d. *Same-Sex Marriage & Family Formation.* In Section VII, we cover Assisted Reproductive Technology (ART), and an important aspect of this has to do with how parentage laws can either facilitate and protect family formation through ART on the one hand, or create uncertainty that impedes its utility for non-traditional couples on the other. As you'll see, constitutional developments protecting same sex intimacy and marriage have been crucial for shaping modern parentage legal reforms and have led courts to strike down state laws that interfere with the recognition of parentage by same sex couples using ART. To the extent *Dobbs*' reasoning suggests that same sex marriage protections may also be in jeopardy, this could disrupt existing legal protections for other aspects of family formation.

e. *Access to ART & the Legal Status of Embryos.* The Supreme Court has never recognized a constitutionally protected right to use a particular form ART. And now some question whether *Dobbs* has opened the door for states to ban or significantly curtail the creation, use, and disposition of embryos in ways that may further limit or prevent access to ART. Some abortion opponents also oppose ART, and their views of life beginning at fertilization shape their concerns about how embryos are created and used, especially those not able to be implanted. Interestingly, such concerns have received considerably less political attention than abortion, and ART has remained relatively unregulated as compared to other reproductive care. Yet, as noted above, abortion opposition in some states is catalyzing legislative efforts to legally recognize life or personhood from the moment of fertilization. Will such states feel emboldened to start regulating ART much more aggressively or even enact bans on certain ART practices?