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Troubling Legislative Agendas: Leveraging Women's Health Against Women's Reproductive Rights

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Beyond any doubt, women's reproductive healthcare is in serious jeopardy domestically and abroad due to federal and state policies promulgated by lawmakers in the United States. Shortly after taking office, President Donald Trump issued an executive order reinstating and expanding the "Mexico City Policy," which literally silences medical providers abroad from speaking about certain reproductive healthcare options, including abortion, for women and girls in nations receiving U.S.AID funds.¹ Activists refer to the Mexico City Policy as the "Global Gag Rule" because, in addition to prohibiting nongovernmental organizations from utilizing U.S. funds for voluntary abortion services, it prevents organizations from using their own funds to provide advice or information both on a public and private basis.

Equally, in 2017, Congress enacted legislation essentially permitting states to discriminate against medical providers that perform abortions. The president immediately signed that legislation into law, which now places Title X reproductive health services in jeopardy for poor men and women in the United States. According to the new law, states can choose whether to ban organizations that perform abortion services from reimbursement for providing services unrelated to abortion. Because Title X specifically supports reproductive health services for indigent Americans, those most likely to suffer will be America's poorest women, girls, and men who rely on these providers. Those hardest hit will surely be in rural communities already suffering from other social and economic conditions. For most poor people in the United States, the only health providers nearby who accept Title X funding also provide abortions. If states bar these providers from reimbursement for providing contraceptive and other reproductive health services, such as HIV

* This issue brief is drawn from Michele Goodwin & Meigan Thompson, *In The Shadow of the Court: Strategic Federalism and Reproductive Rights*, 18 GEO. J. GENDER & L. 333 (2017) and Michele Goodwin, *Whole Woman's Health v. Hellerstedt: The Empirical Case Against Trap Laws*, __ MED. L. REV. __ (forthcoming 2017). ©Michele Goodwin

¹ The Mexico City Policy, otherwise known as the "Global Gag Rule" or "Global Gag Order," was originally launched by President Ronald Reagan at the Second United Nations International Conference on Population in Mexico City, in August of 1984. Policy Statement of the United States of America At the United Nations International Conference on Population, 2d Sess., Mexico City, Mexico (Aug. 6–13, 1984), http://www.uib.no/sites/w3.uib.no/files/attachments/mexico_city_policy_1984.pdf.

screenings, testing for sexually transmitted diseases, and cancer screenings, where will Americans living in poverty go?

However, it would be a mistake to read this policymaking as confined to the federal government and congressional legislating. To the contrary, a virtual renaissance against women's reproductive health privacy and autonomy is taking shape throughout the United States with the enactment of more antiabortion and contraception laws in recent years than in the collective forty years prior. These measures, commonly referred to as "targeted regulations of abortion providers" (TRAP) laws, include a myriad of restrictions on abortion, forcing women to wait 24, 48, and even 72 hours, not counting weekends, between medical visits to terminate a pregnancy. Some states require counseling at crisis pregnancy centers that purposefully mislead pregnant women with false claims that abortions cause cancer and mental illness. Some states even force women to receive unnecessary and intrusive vaginal ultrasounds and to hear a script produced by the state and read by the doctors as a condition of terminating pregnancies.

These laws occupy a troubling space in American reproductive healthcare. However, lawmakers erroneously justify these types of mandates as bundles of informed consent processes that supposedly benefit women. In reality, these laws cause substantial and undue burdens on women's reproductive healthcare access and interfere with fundamental reproductive healthcare rights. Yet, lawmakers view each enactment of these laws as a victory and persist in their problematic enactment of bills that impose constraints on women and providers of abortion services. For example, despite the Supreme Court striking down two Texas TRAP law provisions in *Whole Woman's Health v. Hellerstedt* in 2016,² including one related to ambulatory surgical centers, in 2017 Minnesota legislators sponsored legislation similar to that already ruled unconstitutional by the Court.

Lawmakers erroneously claim that laws restricting abortion and contraceptive access further women's health. Nothing could be further from the truth. In the United States, a woman is fourteen times more likely to die from pregnancy and childbirth than from obtaining a legal abortion.³ Being pregnant is far more dangerous than not being in that condition. The harms are even greater for African American women, who are 3.5 times more likely than their white counterparts to die during pregnancy and childbirth.⁴ Stunning data from the Central Intelligence Agency confirms the dire status of pregnancy in the United States: women are less likely to die during pregnancy in Bosnia than in the United States.⁵

² 136 S. Ct. 2292 (2016).

³ See Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 OBSTETRICS & GYNECOLOGY 215, 216 (2012).

⁴ *Pregnancy Mortality Surveillance System*, CDC, <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html> (last visited July 10, 2017); Mary Beth Flanders-Stepans, *Alarming Racial Differences in Maternal Mortality*, 9 J. PERINATAL EDUC., 50–51 (2000) (noting the disparity in maternal death rates between Black and white women at 2-6 times greater).

⁵ *World Factbook: Maternal Mortality Rate*, CIA, <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2223rank.html> (last visited July 10, 2017).

Indeed, the United States leads all developed nations in maternal and infant mortality.⁶ In fact, a recent study published in the *Journal of Obstetrics and Gynecology* found that, rather than meeting international goals to decrease maternal mortality, “[t]he estimated maternal mortality rate (per 100,000 live births) for 48 states and Washington, DC (excluding California and Texas, analyzed separately) increased by 26.6%, from 18.8 in 2000 to 23.8 in 2014.”⁷ While “California showed a declining trend,” the rate of deaths in Texas “had a sudden increase in 2011–2012”.

Actually, Texas is ranked as the most dangerous place among developed nations for pregnant women, due to extremely high rates of maternal mortality.⁸ The pregnancy death rate in Texas doubled within a two year period, from the already high rate of 18.6 in 2010 to over 37 in 2012, placing it well beyond rates in developed and even many developing nations. The data is similarly stark in Mississippi, Louisiana, and other states that have reduced abortion access to one clinic in the state.⁹ As the medical evidence shows, restrictions on reproductive healthcare in some instances is a death sentence for American women. Sadly, given that more than half of the pregnancies in the United States are unintended, legislative attacks on reproductive healthcare access for some women will become a matter of life or death. For many other women, unwanted and unintended children may result in poverty and other medical and social hardships.

This Issue Brief provides a cursory update on *Whole Woman’s Health v. Hellerstedt*,¹⁰ the most recent development in the Court’s abortion jurisprudence, and situates that case within the broader framework of legislation and jurisprudence on reproductive healthcare access, from the landmark *Roe v. Wade*,¹¹ which recognized a constitutional right to terminate a pregnancy, to the more recent *Planned Parenthood v. Casey*,¹² which established the undue burden standard that is now used to evaluate restrictions on that right. It draws from prior scholarship to highlight why healthcare advocates correctly perceive TRAP legislation as an attack on women, because such laws directly undermine women’s health and safety, while chipping away and truncating their constitutional rights.

⁶ *Id.*

⁷ Marian F. MacDorman, et al, *Is the United States Maternal Mortality Rate Increasing? Disentangling Trends from Measurement Issues*, 128 *OBSTETRICS & GYNECOLOGY* 447 (2016).

⁸ *Id.*; Sophie Novack, *Texas’ Maternal Mortality Rate: Worst in Developed World, Shrugged off By Lawmakers*, *TEX. OBSERVER* (June 5, 2017), <https://www.texasobserver.org/texas-worst-maternal-mortality-rate-developed-world-lawmakers-priorities/>; Katha Pollitt, *The Story Behind the Maternal Mortality Rate in Texas Is Even Sadder Than We Realize*, *NATION* (Sept. 8, 2016), <https://www.thenation.com/article/the-story-behind-the-maternal-mortality-rate-in-texas-is-even-sadder-than-we-realize/>.

⁹ For example, data reveals and increase, rather than decrease, in maternal mortality. JUANITA GRAHAM, *MISS. STATE DEP’T HEALTH, PREGNANCY-RELATED MATERNAL MORTALITY, MISSISSIPPI, 2011-2012*, <http://msdh.ms.gov/msdhsite/static/resources/5631.pdf>.

¹⁰ 136 S. Ct. 2292 (2016).

¹¹ 410 U.S. 113 (1973).

¹² 505 U.S. 833 (1992).

I. Texas House Bill 2 and the Legislative Landscape

Whole Woman's Health concerned the constitutionality of two new Texas Health and Safety Codes that were created by the controversial H.B. 2.¹³ Section 171.0031, or the “admitting-privileges requirement,” mandated “[a] physician performing or inducing an abortion must, on the date the abortion is performed or induced, have active admitting privileges at a hospital that is located not further than 30 miles from the location at which the abortion is performed or induced.”¹⁴ The second provision, related to Texas Health and Safety Code section 245.010, required that, at a minimum, “an abortion facility must be equivalent to the minimum standards adopted under Section 243.010 for ambulatory surgical centers.”¹⁵

The Texas legislature enacted H.B. 2 on July 18, 2013, in the wake of political chaos that included impassioned floor speeches by proponents and opponents, late night legislating, pro-choice protestors descending in droves at the capitol building, and a robust filibuster by state Senator Wendy Davis. The protests, including Davis’s filibuster and clamorous chants to disrupt the roll-call vote, resulted in broad news coverage throughout the United States. According to Davis, “[t]he fight for the future of Texas [was] just beginning.”¹⁶

In the end, however, abortion rights activists suffered a painful defeat while anti-abortion activists proudly proclaimed the newly enacted H.B. 2 to be one of the most restrictive measures to regulate abortion access in the United States.¹⁷ As described above, H.B. 2 required physicians to obtain admitting privileges at local hospitals within a 30 mile radius of the abortion clinic. The law also banned abortions at twenty weeks or later, except in cases of severe fetal abnormality and maternal health endangerment. H.B. 2 prohibited the use of abortion-by-medication, except as permitted by the Food and Drug Administration (FDA). Finally, the law required all abortion facilities to comply with ambulatory surgical center requirements. That is, Texas legislators mandated that all abortion facilities operating in their state acquire all the equipment necessary to resemble and function as emergency surgical centers—even if not medically necessary.

According to the Texas Policy Evaluation Project, within months of the law’s enactment, the number of abortion clinics in Texas dramatically declined by 56%; from 41 licensed clinics to 18.¹⁸

¹³ Act of Jul. 18, 2013, ch. 1 (HB 2), §§ 1–12, 2013 Tex. Sess. Law Serv. 4795–802 (West) (codified at TEX. HEALTH & SAFETY CODE ANN. §§ 171.0031, 171.041–.048, 171.061–.064) (amending TEX. HEALTH & SAFETY CODE ANN. §§ 245.010–.011, 164.052, 164.055) [hereinafter H.B. 2]

¹⁴ TEX. HEALTH & SAFETY CODE ANN. § 171.0031(a) (West 2015).

¹⁵ TEX. HEALTH & SAFETY CODE ANN. § 245.010(a).

¹⁶ Morgan Smith et al., *Abortion Bill Finally Bound for Perry's Desk*, TEX. TRIB. (July 13, 2013, 12:17 AM), <http://www.texastribune.org/2013/07/13/texas-abortion-regulations-debate-nears-climax/>.

¹⁷ Becca Aaronson, *House Approves Abortion Restrictions*, TEX. TRIB. (July 10, 2013, 11:23 AM), <http://www.texastribune.org/2013/07/10/take-two-house-debates-proposed-abortion-regulation/>; Manny Fernandez, *Abortion Restrictions Become Law in Texas, but Opponents Will Press Fight*, N.Y. TIMES (July 18, 2013), <http://www.nytimes.com/2013/07/19/us/perry-signs-texas-abortion-restrictions-into-law.html>; Jordan Smith, *Updated: Senate Passes House Bill 2: Rejected Amendments, Dramatic Speeches, and Finally a Vote*, AUSTIN CHRON. (July 12, 2013, 11:48 PM), <http://www.austinchronicle.com/daily/news/2013-07-12/senate-considers-house-bill-2/>.

¹⁸ See TEX. POLICY EVALUATION PROJECT, ACCESS TO ABORTION CARE IN THE WAKE OF HB2, <http://www.utexas.edu/cola/txpep/files/pdf/AbortionAccessafterHB2.pdf>; see also Manny Fernandez & Erik Eckholm, *Court Upholds Texas Limits on Abortions*, N.Y. TIMES (June 9, 2015),

The number of legal abortions in Texas also declined,¹⁹ due to the reduced number of clinics in the state. Wait periods for an abortion increased by nearly three weeks,²⁰ also attributable to fewer clinics legally permitted to operate in Texas. Longer wait periods produced serious barriers and harsh consequences, particularly for poor women, because H.B. 2 also enacted a ban on abortions after 20 weeks. Many women reported that the Texas restrictions placed an undue burden on their constitutionally-protected right to an abortion by constructing significant, insurmountable barriers to access.²¹ One such example could be found in the Rio Grande of Texas, where only one abortion clinic operated. With its closure, the nearest clinic to perform abortion services would have been 230 miles away, a 12 hour roundtrip car ride.²² In this context, researchers recorded a dramatic uptick in the number of women who sought to self-induce abortions. They estimated that between 100,000 to as many as a quarter of a million women in Texas attempted self-induced abortions.²³

H.B. 2, and the movement that swept the legislation into existence, bore the signs of a larger trend, emblematic of strategic legal and policy efforts to systemically erode reproductive healthcare rights. H.B. 2 was typical of legislation emerging in 2013, in that it substantively and strategically burdened women's reproductive healthcare rights. Lawmakers in 35 states proposed over 300 abortion rights restrictions in 2013.²⁴ Seventy of those restrictions were enacted.²⁵ The laws emanated from 22 states²⁶ and represented the second highest number of reproductive rights restrictions passed in one

<https://www.nytimes.com/2015/06/10/us/court-upholds-texas-law-criticized-as-blocking-access-to-abortions.html>; *Fewer Abortion Clinics in Texas*, N.Y. TIMES (June 10, 2015),

<http://www.nytimes.com/interactive/2014/08/04/us/shrinking-number-of-abortion-clinics-in-texas.html>.

¹⁹ See TEX. POLICY EVALUATION PROJECT, ABORTION WAIT TIMES IN TEXAS: THE SHRINKING CAPACITY OF FACILITIES AND THE POTENTIAL IMPACT OF CLOSING NON-ASC CLINICS, (Oct. 5, 2015),

http://sites.utexas.edu/txpep/files/2016/01/Abortion_Wait_Time_Brief.pdf (finding six months after the first three provisions of H.B. 2 were enforced, the number of abortions performed in Texas fell by 13% compared to the same six-month period one year earlier).

²⁰ Stephen Young, *Texas Women Face Long Abortion Waits in HB2's Wake*, DALL. OBSERVER (Oct. 6, 2015, 4:00 AM), <http://www.dallasobserver.com/news/texas-women-face-long-abortion-waits-in-hb2s-wake-7658610>; Mark Reagan, *HB2 Increasing Wait Times for Women Seeking Abortion Services*, SAN ANTONIO CURRENT (Oct. 6, 2015, 8:06 AM), <http://www.sacurrent.com/Blogs/archives/2015/10/06/hb2-increasing-wait-times-for-women-seeking-abortion-services>.

²¹ *Id.*

²² *About Us*, WHOLE WOMAN'S HEALTH, <http://wholewomanshealth.com/about-us.html> (last visited Dec. 1, 2015).

²³ See TEX. POLICY EVALUATION PROJECT, KNOWLEDGE, OPINION AND EXPERIENCE RELATED TO ABORTION SELF-INDUCTION IN TEXAS (Nov. 17, 2015), <http://liberalarts.utexas.edu/txpep/files/pdf/TxPEP-Research-Brief-KnowledgeOpinionExperience.pdf>; TEX. POLICY EVALUATION PROJECT, TEXAS WOMEN'S EXPERIENCES ATTEMPTING SELF-INDUCED ABORTION IN TEXAS (Nov. 17, 2015), <http://liberalarts.utexas.edu/txpep/files/pdf/TxPEP-Research-Brief-WomensExperiences.pdf>.

²⁴ *States Where They Think We're Dumb: Abortion Access Under Attack in 2013*, ACLU, <https://www.aclu.org/maps/states-where-they-think-were-stupid-abortion-access-under-attack-2013> (last updated Aug. 5, 2013).

²⁵ Elizabeth Nash et al., *Laws Affecting Reproductive Health and Rights: 2013 State Policy Review*, GUTTMACHER INST., <http://www.guttmacher.org/statecenter/updates/2013/statetrends42013.html> (last visited July 19, 2014); see, e.g., ARK. CODE ANN. § 20-16-1405 (West 2016) (prohibiting abortion after 20 weeks unless there is a risk of death or serious injury to the pregnant woman); N.D. CENT. CODE § 14-02.1-05.3 (West 2016) (prohibits abortion after 20 weeks except in the case of a medical emergency.); ALA. CODE § 26-23E-9 (West 2016) (requiring abortion or reproductive health centers be classified as ambulatory health care occupancy); MISS. CODE ANN. § 41-41-107 (West 2016) (making it unlawful for any person other than a physician to administer an abortion-inducing drug).

²⁶ Those 22 states were: Alabama, Arkansas, Indiana, Iowa, Kansas, Louisiana, Maryland, Michigan, Missouri, Mississippi, Montana, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas, Virginia, and Wisconsin.

legislative session.²⁷ According to the National Women’s Law Center, “[n]o year from 1985 through 2010 saw more than 40 new abortion restrictions; however, every year since 2011 has topped that number.”²⁸ In fact, more anti-abortion legislation was enacted between 2010 and 2014 than in every other year since *Roe v. Wade* combined.

II. Whole Woman’s Health and the Impact of TRAP Laws

The litigation following Texas’s passage of H.B. 2 highlighted not only the devastating impacts on reproductive healthcare access for women in Texas, but also exposed how federalism is now a powerful tool in undermining abortion rights. After successful litigation at the District Court level, challengers of the law suffered a terrible defeat in the Fifth Circuit, where the abortion regulation provisions were upheld under the less scrutinizing rational basis standard.²⁹ In November 2015, the Supreme Court granted certiorari in *Whole Woman’s Health*, taking up only two provisions of the law—the ambulatory surgical center and admitting privileges provisions—and vacating the Fifth Circuit Court of Appeals ruling, essentially restoring the original District Court injunctions.

In a 5–3 decision, the Supreme Court struck down the provisions in question. The Court specifically observed that “prior to the enactment of H.B. 2, there were more than 40 licensed abortion facilities in Texas,” and that number “dropped by almost half leading up to and in the wake of enforcement of the admitting-privileges requirement that went into effect in late-October 2013.”³⁰ Quoting directly from the District Court opinion and writing for the majority, Justice Breyer cautioned:

- “If the surgical-center provision were allowed to take effect, the number of abortion facilities, after September 1, 2014, would be reduced further, so that ‘only seven facilities and a potential eighth will exist in Texas.’”³¹
- The state’s claim “that these seven or eight providers could meet the demand of the entire state stretches credulity.”³²
- And, the “two requirements erect a particularly high barrier for poor, rural, or disadvantaged women.”³³

One critical aspect of the *Whole Woman’s Health* decision was that the Court dispelled the notion that the Texas law actually served pregnant patients’ interests. The Court chipped away at the notion that laws such as H.B. 2 safeguard women’s health while not constraining abortion rights.

²⁷ 2013 *State Level Abortion Restrictions: An Extreme Overreach into Women’s Reproductive Health Care*, NAT’L WOMEN’S LAW CTR., http://www.nwlc.org/sites/default/files/pdfs/2013_state_legislation_factsheet_1-27-14.pdf (last visited Jan. 28, 2014).

²⁸ Heather D. Boonstra & Elizabeth Nash, *A Surge of State Abortion Restrictions Puts Providers—and the Women They Serve—in the Crosshairs*, 17 GUTTMACHER POL’Y REV. 9, 9 (2014), <https://www.guttmacher.org/sites/default/files/pdfs/pubs/gpr/17/1/gpr170109.pdf> (explaining that states enacted 92 abortion restrictions in 2011, 43 restrictions in 2012, and 70 restrictions in 2014).

²⁹ *Whole Woman’s Health v. Cole*, 790 F. 3d 587 (2015).

³⁰ *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2301 (2016).

³¹ *Id.*

³² *Id.* at 2302.

³³ *Id.*

A. Admitting Privileges

Citing an amicus brief from the Society of Hospital Medicine, the Court noted the “undisputed” fact that “hospitals often condition admitting privileges on reaching a certain number of admissions per year.”³⁴ As such:

[I]t would be difficult for doctors regularly performing abortions at the El Paso clinic to obtain admitting privileges at nearby hospitals because “[d]uring the past 10 years, over 17,000 abortion procedures were performed at the El Paso clinic [and n]ot a single one of those patients had to be transferred to a hospital for emergency treatment, much less admitted to the hospital.”³⁵

Writing for the majority, Justice Breyer explained that “[i]n a word, doctors would be unable to maintain admitting privileges or obtain those privileges for the future, because the fact that abortions are so safe meant that providers were unlikely to have any patients to admit.”³⁶ Moreover, amicus briefs filed by Medical Staff Professionals and the American College of Obstetricians and Gynecologists (ACOG) clarifying that “admitting privileges . . . have nothing to do with the ability to perform medical procedures”³⁷ provided a persuasive factual foundation for the Court. In the latter brief, ACOG specifically related that “some academic hospitals will only allow medical staff membership for clinicians who also accept faculty appointments.”³⁸

Justice Breyer took special note of a particular gynecologist with nearly 40 years of practice experience who, despite experience in delivering over 15,000 babies, was yet unable to obtain hospital admitting privileges at the seven hospitals within a 30 mile radius of his office. The Court cited a letter from one of the nearby hospitals that explained the refusal to provide the doctor admitting privileges was “not based on clinical competence considerations.”³⁹ To that end, the Court concluded that “[t]he admitting privileges requirement does not serve any relevant credentialing function.” Instead, the law resulted in numerous clinic closures throughout the state of Texas and placed inordinate, unjustifiable burdens on pregnant women.

For example, after H.B. 2’s enactment, the number of women living more than 150 miles from a clinic providing abortion services increased from about 86,000 to 400,000. In addition, the number of women residing in a “county more than 200 miles from a provider” increased from 10,000 to 290,000.⁴⁰ The Court concluded that, when taken together, increased distance to a provider (which is not dispositive of an undue burden) and other factors that resulted in the dramatic number of clinic closures constituted an undue burden on the right to abortion and thus did not meet the constitutional threshold laid out in *Casey*.

³⁴ *Id.* (citation omitted).

³⁵ *Id.* at 2312.

³⁶ *Id.*

³⁷ *Id.*

³⁸ *Id.*

³⁹ *Id.* at 2313.

⁴⁰ *Id.*

It is worth taking note of the dissenting Justices' response to the majority analysis on this point. The dissenting Justices conjectured that while some clinics possibly closed because of the conditions imposed by the enactment of H.B. 2, other clinics may have ceased operation under the purpose and intent of the law to weed out bad actors, and therefore "force unsafe facilities to shut down."⁴¹ Notably, the Justices' speculations were not rooted in any evidence—and none was proffered by the state to support such a conclusion.

B. Surgical-Center Requirements

The second issue the Court turned to was whether H.B. 2's surgical-center requirement violated the constitutional standards set forth in *Casey*. Prior to the enactment of H.B. 2, "Texas . . . required abortion facilities to meet a host of health and safety requirements."⁴² Specifically, Justice Breyer noted that Texas law already required clinics that perform abortions to develop, complete, and maintain: environmental and physical requirements; annual reporting; infection control; record keeping; patients' rights standards; quality assurance mechanisms; disclosure requirements; and anesthesia standards among others.⁴³ Moreover, clinics performing abortions in Texas are subject to random and unannounced inspections as a means of monitoring compliance with nearly a dozen separate standards. In fact, the Texas Administrative Code, Title 25, § 139.33 and Texas Health & Safety Code Annotated § 245.011 impose criminal penalties for failure to comply with the aforementioned regulations and for violating reporting guidelines.

As the Court observed, the state's new ambulatory surgical-center mandate added "detailed specifications relating to the size of the nursing staff, building dimensions, and other building requirements" to the already extensive requirements the state of Texas imposed on abortion providers prior to H.B. 2.⁴⁴ The requirements included a full surgical suite "with an operating room that has 'a clear floor area of at least 240 square feet,'" as well as preoperative rooms and postoperative recovery suites, with specified traffic patterns, wall arrangements, shelving arrangements, specific types of ventilation, heating, and air conditioning among other requirements. Again siding with the District Court, the Court found the new stipulations did not benefit patients nor promote any greater safety and that, "risks are not appreciably lowered for patients who undergo abortions at ambulatory surgical centers as compared to nonsurgical-center facilities."⁴⁵ In other words, women were no better off receiving an abortion at an ambulatory care facility than at a previously licensed facility. In addition, the new law offered "no benefit when complications arise in the context of an abortion produced through medication."⁴⁶

Perhaps even more compelling to the Court was important evidence that legal abortions performed at clinics prior to the enactment of H.B. 2 were safe. As Justice Breyer wrote, "[t]he record also

⁴¹ *Id.* at 2343.

⁴² *Id.* at 2314.

⁴³ *Id.* at 2314 (citing TEX. ADMIN. CODE, tit. 25, §§ 139.4, 139.5, 139.55, 139.58; §§ 139.43, 139.46; § 139.48; § 139.49; § 139.50; § 139.59); *see also* TEX. ADMIN. CODE §§ 139.23, 139.31; TEX. HEALTH & SAFETY CODE ANN. § 245.006(a) (West 2010)).

⁴⁴ *Whole Woman's Health*, 136 S. Ct. 2292 (2016).

⁴⁵ *Id.* at 2315 (citation omitted).

⁴⁶ *Id.* at 2315.

contains evidence indicating that abortions taking place in an abortion facility are safe—indeed, safer than numerous procedures that take place outside hospitals and to which Texas does not apply its surgical-center requirements.”⁴⁷ To emphasize this point, the Court noted that a colonoscopy, which takes place outside of a surgical center and hospital setting, “has a mortality rate 10 times higher than an abortion,” and liposuction (also performed outside of a surgical center and hospital) has a mortality rate that “is 28 times higher than the mortality rate for abortion.”⁴⁸

Justice Breyer concluded that:

The upshot . . . [of this] record evidence, along with the absence of any evidence to the contrary, provides ample support for the District Court’s conclusion that “[m]any of the building standards mandated by the act and its implementing rules have such a tangential relationship to patient safety in the context of abortion as to be nearly arbitrary.”⁴⁹

According to Justice Breyer, “we conclude that neither of these provisions confers medical benefits sufficient to justify the burdens upon access that each imposes”⁵⁰ on women in Texas. Simply put, by placing substantial obstacles in a woman’s path to a legal abortion, the state of Texas created an undue burden on abortion access, in violation of the Constitution.

III. The Problem with *Whole Woman’s Health*

Abortion rights activists heralded the Supreme Court’s 5–3 decision that H.B. 2’s admitting privileges provision and the surgical center requirements substantially interfered in a woman’s ability to seek a previability abortion. Activists and scholars view the case as a substantial victory and reframing of the abortion debate. On the one hand, they are right. Substantively, *Whole Woman’s Health* upholds the legacy of *Roe v. Wade* and protects the constitutionality of abortion rights.⁵¹ Linguistically, not once in the case does the Court mention the word fetus in contestation with a woman’s right to end a pregnancy. Moreover, the case was a landmark for women, because the Court actually focused on the burdens experienced by women; thus, moving away from treating pregnant women as third parties in their reproductive health.⁵² So, what is wrong with the case?

While *Whole Woman’s Health* represented a judicial victory for those who seek to safeguard and preserve abortion rights, the case nevertheless further rooted the primacy of the Supreme Court’s flawed framework in *Planned Parenthood v. Casey*.⁵³ In that decision, the Court rejected *Roe*’s trimester doctrine as “rigid,” and expanded the State’s interest in potential life to include the entire period throughout a woman’s pregnancy.⁵⁴ Unlike Justice Blackmun’s opinion in *Roe*, Justice Kennedy’s

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ *Id.* at 2316.

⁵⁰ *Id.* at 2300.

⁵¹ *Id.* at 2321.

⁵² *See id.* at 2313, 2317–18.

⁵³ 505 U.S. 833 (1992).

⁵⁴ *Id.* at 872–73, 876.

plurality opinion in *Casey* neglected to focus on the unique nature of an unintended and unwanted pregnancy in a woman's life. Justice Blackmun explained in *Roe* that an unwanted pregnancy imposed a range of financial, physical, social, and even psychological hardships on women.⁵⁵ Furthermore, Justice Blackmun emphasized the social stigmas and shaming that often resulted from unwed pregnancies.⁵⁶

In *Roe*, Justice Blackmun explained, a state's imposition of motherhood onto women who would not otherwise determine that for themselves is a severe injury.⁵⁷ Blackmun wrote: "Maternity, or additional offspring, may force upon the woman a distressful life and future," burdened by potentially imminent psychological trauma.⁵⁸ The Court stated that "there is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically, and otherwise to care for it."⁵⁹

Justice Blackmun reflected on the fact that anti-abortion laws actually fit within strategic lawmaking of a "relatively recent vintage."⁶⁰ For example, "those laws, generally proscribing abortion or its attempt at any time during pregnancy except when necessary to preserve the pregnant woman's life, are not of ancient or even of common-law origin,"⁶¹ he wrote. Rather, as he described, the laws derived from "statutory changes, effected, for the most part, in the latter half of the 19th century,"⁶² when Anthony Comstock launched his notorious anti-vice campaigns against contraception, abortion, naked images—even in medical books—and vice generally, which ultimately resulted in federal bans on contraception and 24 states enacting similar prohibitions on contraception and abortion.⁶³

But in *Casey*, Justice Kennedy sidestepped analysis focusing on pregnant women and the potential detriments caused by pregnancy. Instead, the Court established that states have a "profound interest" in potential life.⁶⁴ As such, the Court found that States could take actions to ensure that pregnant women made "informed" choices related to their pregnancies.⁶⁵ Moreover, the Court emphasized that laws designed to influence pregnant women's decisions to choose childbirth over abortion would not be invalidated.⁶⁶ Instead, prior to viability, only laws that placed "substantial

⁵⁵ *Roe v. Wade*, 410 U.S. 113, 153 (1973).

⁵⁶ *Id.*

⁵⁷ *Id.* at 153.

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ *Id.* at 129.

⁶¹ *Id.*

⁶² *Id.*

⁶³ *The Pill, People & Events: Anthony Comstock's "Chastity" Laws*, PBS,

http://www.pbs.org/wgbh/amex/pill/peopleevents/e_comstock.html (last visited Oct. 16, 2016) ("The driving force behind the original anti-birth control statutes was a New Yorker named Anthony Comstock [who as] a devout Christian . . . was offended by explicit advertisements for birth control devices . . . soon identified the contraceptive industry as one of his targets.>").

⁶⁴ *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 878 (1992).

⁶⁵ *Id.*

⁶⁶ *Id.*

obstacles” in the path of a woman seeking an abortion would be struck down.⁶⁷ And, while the Court did not define a substantial obstacle, by its ruling it made clear that parental notification, a 24 hour waiting period, and measures to secure “informed consent” were not so odious as to violate this constitutional right.⁶⁸

The *Casey* framework rests on perpetuating the misleading medical notion that abortions are likely psychologically regrettable and potentially unsafe to such a degree that women (even after weeks of pregnancy) would benefit from states mandating 24 hours or more for women to ponder their decisions.⁶⁹ In other words, a woman could come to regret her decision *if she did not wait 24 hours*. In reaching that conclusion, the Court granted far too much character to a state’s conception of a woman’s pregnancy, coloring it with stigma and shame that *Roe* sought to relieve.⁷⁰ As such, *Casey* not only perpetuated the notion that abortions are risky (the very premise of women *needing* a wait period), despite evidence to the contrary, but also the belief that women are uninformed decision-makers even in matters as important as their health.⁷¹

Casey reified the stereotype that women lack the capacity to make informed decisions about terminating their pregnancies *without* involvement by the state.⁷² Indeed, the extent to which the Court overturned *Akron I*⁷³ and *Thornburgh*,⁷⁴ both of which insist that an informed consent law cannot be used solely to deter a woman from making the decision to terminate a pregnancy, bears examination, because the Court granted states license to literally and figuratively reframe abortion and to create their own narratives, which presently in many states include inaccuracies and mistruths associating abortions with breast cancer, sterility, severe infections, medical complications, and psychoses.⁷⁵ The Court states imposing information requirements does not interfere with a constitutional right to privacy, because the privacy right exists between a woman and her doctor.⁷⁶

Problematically, the Court’s flawed jurisprudence in *Casey*, and thus the broader domain of abortion law, grants states power to construct the types of proxies for constitutional obstructionism and discrimination as carried out by Texas. Thus, the weakness in *Whole Woman’s Health* was the Court’s failure to engage in a third wave of abortion jurisprudence that builds on a reproductive justice framework. This type of framework would take into account an evolved understanding of women’s autonomy right and social, mental, and cultural capacities. A third wave abortion jurisprudence would build on the empirical record so robustly taken up by Justice Blackmun in *Roe*, demonstrating the entrenched nature of sex discrimination in society that results in added discrimination and stigma

⁶⁷ *Id.*

⁶⁸ *Id.* at 886–87, 895.

⁶⁹ *Id.* at 882.

⁷⁰ *See id.* at 882.

⁷¹ *See id.* at 882–85.

⁷² *See id.*

⁷³ 462 U.S. 416, 444 (1983).

⁷⁴ 476 U.S. 747, 762 (1986).

⁷⁵ *See* Chinué Turner Richardson & Elizabeth Nash, *Misinformed Consent: The Medical Accuracy of State-Developed Abortion Counseling Materials*, 9 GUTTMACER POL’Y REV. 6 (2006), https://www.guttmacher.org/sites/default/files/article_files/gpr090406.pdf.

⁷⁶ *Casey*, 505 U.S. at 883.

across employment and pay against women who bear children. Such an analysis would include considering how race and class barriers and discrimination continue to uniquely and disparately harm pregnant women and inhibit them from pursuing the futures they imagine for themselves. In fact, a third wave jurisprudence would finally begin to unpack a sturdy sex equality framework within the space of reproductive health.

IV. Conclusion

What accounts for TRAP lawmaking? Some commentators and scholars point to conservative values surreptitiously influencing legislatures or pressure from the “alt-right” in the political and legislative processes.⁷⁷ Professor Caitlin Borgmann explains that “[v]iewed in this light, abortion restrictions are transformed into measures that promote women’s health and well-being and that protect women from the exploitation and deception of abortion providers.” Some scholars argue that anti-abortion efforts reflect religious fundamentalism creeping into the legislative space.⁷⁸ Still others maintain that implicit and explicit bias explains anti-choice lawmaking; they argue men simply do a poor job legislating on behalf of women.⁷⁹ Reva Siegel brilliantly describes this type of legislating as resting “on traditional assumptions about women’s natural obligations or instrumental uses as mothers.”

Despite the meaningful victory represented in *Whole Woman’s Health v. Hellerstedt*, the Court evaluated only two questions related to the legislation and did not address the broader plethora of laws described above, that prevail against women in states like Missouri, Mississippi, North Dakota, South Dakota, and Wyoming where only one abortion clinic remains.⁸⁰ Indeed, it would be a mistake to read *Whole Woman’s Health* as representing a fundamental change to abortion access on

⁷⁷ See, e.g., Caitlin E. Borgmann, *The Meaning of “Life”: Belief and Reason in the Abortion Debate*, 18 COLUM. J. GENDER & L. 551, 558–63 (2009) (noting, “[t]he conservative portrayal of fetuses as persons pervades public discourse about abortion “now results in “the embryo or fetus treated as a legal person in many contexts outside abortion”); Hannah Fingerhut, *On Abortion, Persistent Divides Between—and Within—the Two Parties*, PEW RES. CTR. (April 8, 2016), <http://www.pewresearch.org/fact-tank/2016/04/08/on-abortion-persistent-divides-between-and-within-the-two-parties-2/>.

⁷⁸ See, e.g., Diane di Mauro & Carole Joffe, *The Religious Right and the Reshaping of Sexual Policy: An Examination of Reproductive Rights and Sexuality Education*, 4 SEXUALITY RES. & SOC. POLY 67, 73 (2007) (noting that “[t]he Religious Right has [so]skillfully capitalized on the power of ultrasounds” that the result has included shifts in legislation and millions diverted to pregnancy crisis centers); Karen F.B. Gray, *An Establishment Clause Analysis of Webster v. Reproductive Health Services*, 24 GA. L. REV. 399, 418 (1990) (arguing that government enacted abortion statutes reflect pressure from the groups aligned with religiously motivated, anti-abortion beliefs.”); *Issue Ranks Lower on the Agenda: Support for Abortion Slips*, PEW RES. CTR. 1, 21–23 (2009), <http://www.pewforum.org/files/2009/10/abortion091.pdf> (explaining “[r]eligious beliefs hold much stronger sway over those who oppose abortion than over those on the pro-choice side of the abortion issue.”).

⁷⁹ CATHARINE A. MACKINNON, *WOMEN’S LIVES, MEN’S LAWS* 143 (2005) (arguing that the criminalization of abortion is an equal protection issue, because: “pregnancy can be experienced only by women, and because of the unequal social predicates and consequences pregnancy has for women, any forced pregnancy will always deprive and hurt members of one sex only on the basis of gender.”); Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 366 (1992) (“[R]egulators may adopt particular means for protecting unborn life because stereotypical assumptions about the maternal role lead them to underestimate the impact of fetal-protective regulation on women.”).

⁸⁰ Esme Depres, *U.S. Abortion Rights Fights*, BLOOMBERG NEWS (July 7, 2016), <https://www.bloomberg.com/quicktake/abortion-and-the-decline-of-clinics>.

the ground level, because the conditions in many states continue to so significantly burden and stigmatize that right, particularly for poor women.

Moreover, given federal proscriptions on taxpayer dollars aiding pregnant women who seek abortion under the Hyde Amendment framework,⁸¹ TRAP legislation uniquely and fundamentally harms poor women. Unequivocally, TRAP laws do not provide a legitimate basis for denying abortion access and importantly, they actually place women's health in danger. Ironically, the solution may be a return to the principles of *Roe v. Wade*, where the Court actually considered the life circumstances of women.

In *Roe*, the Court ruled that a right to terminate a pregnancy is rooted in the right of privacy, “whether it be founded in the Fourteenth Amendment’s concept of personal liberty and restrictions upon state action, as we feel it is, or, as the District Court determined, in the Ninth Amendment’s reservation of rights to the people.”⁸² This privacy right, according to the Court, “is broad enough to encompass a woman’s decision whether or not to terminate her pregnancy.”⁸³

Clearly, *Roe* did not resolve women’s inequality. However, the Court made an important intervention in the advancement of women’s reproductive health. Sadly, forty years later, women’s reproductive healthcare autonomy and privacy are under direct threat, notwithstanding *Whole Woman’s Health*.

About the Author

Michele Goodwin is a Chancellor’s Professor of Law at UC Irvine with appointments also in the Department Gender & Sexuality Studies, Department of Criminology, Law, & Society, Program in Public Health, and Center for Psychology and Law. She is the founder and director of the Center for Biotechnology and Global Health Policy at UC Irvine School of Law and its internationally acclaimed Reproductive Justice Initiative. Her publications include five books and over 70 articles and book chapters on law’s regulation of the human body, including civil and criminal regulation of pregnancy and reproduction, reproductive technologies, human trafficking (for organs, sex, and marriage), and tissue and organ transplantation. Her most recent book, *Policing the Womb*, is a timely, socially and politically relevant book that expands the public policy dialogue on reproductive privacy and autonomy beyond the traditional terrain of abortion debates to offer a nuanced contemporary account of pregnancy and birthing in the United States.

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⁸¹ *Harris v. McRae*, 448 U.S. 297 (1980) (establishing that even in instances where maternal health is threatened, the government does not place an “obstacle in the path of a woman who chooses to terminate her pregnancy, but rather, by means of unequal subsidization of abortion and other medical services, encourages alternative activity deemed in the public interest.”). *Id.* at 315.

⁸² *Roe v. Wade*, 410 U.S. 113, 153 (1973).

⁸³ *Id.*

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