

UC Irvine
UC Irvine Law Review

Title

Whole Woman's Health v. Hellerstedt and the Future of Abortion Regulation

Permalink

<https://escholarship.org/uc/item/6np4h1j3>

Journal

UC Irvine Law Review , 7(3)

ISSN

2327-4514

Author

Robertson, John A

Publication Date

2017-12-01

Whole Woman's Health v. Hellerstedt and the Future of Abortion Regulation

John A. Robertson*

Abortion opponents in many states have succeeded in passing alleged health-related restrictions that reduce the availability of abortion while providing little actual health benefit. Their validity depends on how courts interpret the undue burden test of Planned Parenthood of Southeastern Pennsylvania v. Casey: does a rational basis suffice or may judges assess the actual benefits of the law in light of the burdens it imposes on access to abortion?

In Whole Woman's Health v. Hellerstedt, the most important abortion case since Casey, the Supreme Court opted for a benefits/burdens balancing approach. A Texas statute, requiring abortion facilities to meet the standards of ambulatory surgical centers and providers to have admitting privileges in nearby hospitals, was facially invalid because it did little to protect health while making access to abortion more difficult for many women.

The decision is a major setback for abortion foes as long as the Roe-Casey framework of abortion rights holds. It will invalidate most targeted regulation of abortion providers, and have implications in other areas, such as for laws banning abortion after twenty weeks. This Article analyzes the reasoning of the case, assesses whether its conclusions are justified, and shows its importance for other types of

* John A. Robertson (1943–2017) held the Vinson and Elkins Chair at The University of Texas School of Law. He graduated from Dartmouth University and Harvard Law School. John was the author of landmark books in bioethics and reproductive health, including CHILDREN OF CHOICE. He began his law teaching career in 1973 at the University of Wisconsin Law School before joining the University of Texas law faculty in 1980. He was a leading bioethicist, probing important questions for law, medicine, and society. He was widely recognized as one of the most important voices in law and medicine in the United States. Professor Robertson was a longtime participant and contributor to the Baby Markets Roundtable Series. He found community among the scholars in the Series and mentored many junior scholars. This article marks his final contribution to the Series. It is published posthumously.

—Professor Michele Goodwin, Chancellor's Professor, Founder Baby Markets Roundtable Series.

abortion regulation until there is a seismic shift in the makeup of the Supreme Court.

I. <i>Planned Parenthood v. Casey</i> and the Background of <i>Hellerstedt</i>	625
II. When Is a Burden “Undue?”	628
III. Undue Burden: Admitting Privileges Requirement.....	632
A. Does the Hospital Admitting Privileges Requirement Advance Health?	632
B. Burden on Access	633
IV. Undue Burden—Surgical Center Requirement.....	635
A. Do ASC Standards for Abortion Clinics Promote Health?.....	635
B. The Burdens of the ASC Requirement	636
V. Facial Attack: Severability and Large Fraction.....	638
VI. The Opinions of Justice Ginsburg and Justice Thomas.....	640
A. Justice Ginsburg’s Concurrence	640
B. Justice Thomas’s Dissent	641
VII. Future Issues: the Impact of <i>Hellerstedt</i>	643
A. Health, Licensure, and Informed Consent Restrictions.....	644
B. Respect for Fetal Life and Dignity Strategies	646
1. Twenty-Week Ban on Abortion	646
2. A Ban on Fetal Dismemberment	647
3. Disposition of Fetal Remains.....	648
4. No Discrimination Among Fetuses	650
Conclusion.....	651

Abortion has been a never-ending battleground in American law and politics since *Roe v. Wade* in 1973. The election of President Trump in 2016 has only intensified the strife, as it gives new hope to those who fight to see *Roe* overturned. With abortion opponents successful in many state legislatures, pro-choice advocates have depended on the courts for protection.¹ As legal doctrine and restriction strategies have evolved, however, the willingness of courts to protect abortion rights outside of the core right has varied. A few circuit courts of appeal have been protective on those issues. Several others have found controversial restrictions that do not aim directly at reversing *Roe* to be valid.²

Since *Planned Parenthood of Southeastern Pennsylvania v. Casey*,³ which in 1992 reaffirmed the core right to terminate pregnancy up until viability, the Supreme

1. See generally *Gonzales v. Carhart*, 550 U.S. 124 (2007); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992); *Webster v. Reprod. Health Servs.*, 492 U.S. 490 (1989).

2. See, e.g., *infra* note 13.

3. *Casey*, 505 U.S. 833.

Court has seldom intervened.⁴ Yet in 2016 in *Whole Woman's Health v. Hellerstedt*,⁵ the Court decided the most important abortion case since *Casey*. *Hellerstedt* gave substance to the undue burden test of *Casey*, and in doing so, handed a major setback to the antichoice movement. To understand its doctrinal significance and implications, one must begin with *Casey*.

Before addressing the provenance and importance of *Hellerstedt*, one must recognize that its precedential power depends on how long the *Roe* and *Casey* framework for abortion rights survives. With the Trump presidency, new justices appointed to the Court are likely to be pro-life, committed to some form of originalism, and likely opposed to abortion rights. However, it will take some time to reverse *Roe v. Wade*. With President Trump's first appointee, Justice Neil Gorsuch, replacing Justice Scalia, there remains a 5-4 majority for the basic abortion right and for the *Hellerstedt* interpretation of *Casey*'s undue burden test. Justice Kennedy is eighty years old and Justice Ginsburg is eighty-four years old. If either retires during President Trump's tenure, a justice with views similar to Gorsuch/Scalia is likely to be appointed, which would in theory give the Court a majority of justices ill-disposed to abortion rights.

Even then, that reversal would not occur overnight. A case challenging a twenty-week limit on abortion could move the viability restriction earlier without necessarily overturning a right to abortion before twenty weeks.⁶ A more direct attack on *Roe* would arise if a state passed a law that banned almost all abortions. Even then, it might require a circuit split to land on the Court's docket. If it does, the new justices will have to ignore *stare decisis* to overturn the case, and then also decide how much power over abortion to return to government.⁷ The ultimate fate of *Hellerstedt* will thus depend on the speed at which justices retire, the views of new members, their willingness to reach out to eviscerate *Roe* and *Casey*, and how they go about unraveling those decisions. Until then, *Hellerstedt* is likely to remain an important limit on health and fetal protection legislation.

I. PLANNED PARENTHOOD V. CASEY AND THE BACKGROUND OF HELLERSTEDT

After President Reagan made four appointments to the Court in the 1980s and early 1990s, many expected *Casey* to be the death knell for *Roe v. Wade*'s constitutional right to abortion.⁸ In *Casey*, however, three of the four Republican

4. The main exception has been partial birth abortion. After striking down a state ban in *Stenberg v. Carhart*, 530 U.S. 914 (2000), the Court upheld a federal ban on partial birth abortion in *Gonzales*, 550 U.S. at 168.

5. *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016).

6. Such a decision would not redefine viability, but rather find a new basis—such as sentence—as a limit. *See infra* notes 9–14 and accompanying text.

7. For example, whether exceptions for the life and health of the mother must be recognized.

8. Many thought that *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989), prefigured this demise. *See* John A. Robertson, *The Future of Early Abortions*, 75 A.B.A. J. 72, 74 (1989). Chief Justice Rehnquist's plurality opinion asserted that the right to abortion was a "liberty interest protected by the Due Process clause" subject to restriction by any laws that would permissibly further a rational

appointees, Justices Sandra Day O'Connor, David Souter, and Anthony Kennedy, found an intermediate position that upheld the core right of *Roe*—a right to terminate a pregnancy up until viability—but demolished its rigid trimester regulatory framework.⁹ In place of trimesters, it fashioned the “undue burden” test—is the purpose or effect of a restriction to place a substantial obstacle on access to abortion—without further specification.¹⁰ Under this test, *Casey* upheld regulations that *City of Akron v. Akron Reproductive Center*¹¹ and other cases had invalidated on the basis of *Roe*. Now, states could show “respect” for prenatal life and ensure the “autonomy” of pregnant woman through waiting periods and mandated information about the gestational stage of the fetus and alternatives to abortion.

Inspired by *Casey*, the antiabortion movement adopted strategies to limit abortion as much as they could within the confines of *Casey*. One approach was to implement the informed consent and waiting periods that case had blessed. At least twenty states enacted twenty-four- to forty-eight-hour waiting periods and a menu of risks of abortion (some of which were highly questionable).¹² Later several states adopted mandatory ultrasound laws, most of which were held valid under *Casey* and the First Amendment.¹³

state interest such as protecting potential life. *Webster*, 492 U.S. at 520. He noted that this would require the court to “modify and narrow *Roe* and succeeding cases.” *Id.* at 521. Justice Scalia wrote a concurring opinion that argued that the Court ought to have overturned *Roe*, rather than attempting to uphold both *Roe* and the laws at issue and agreed with Justice Blackmun’s assertion that the approach of the plurality would make *Roe* a dead letter. *Id.* at 532.

9. Their three votes, together with those of Justices Stevens and Blackmun, constituted a majority for the core rights of *Roe*. *Casey*, 505 U.S. at 843–44. Antonin Scalia, the fourth Republican appointee, joined the other three dissenters. *Id.* at 844.

10. The precise language is: “An undue burden exists, and therefore a provision of law is invalid, if its purpose or effect is to place substantial obstacles in the path of a woman seeking an abortion before the fetus attains viability.” *Casey*, 505 U.S. at 837. However, some guidance follows from its statement four sentences later that “unnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right.” *Id.*

11. Justice O’Connor in her dissent first outlined the undue burden test later recognized in *Casey*. See *City of Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 453 (1983) (O’Connor, J., White, J., & Rehnquist, J., dissenting).

12. See Cynthia R. Daniels et al., *Informed or Misinformed Consent? Abortion Policy in the United States*, 41 J. HEALTH POL. POL’Y & L. 181 (2016) (discussing findings of a comprehensive study of state informed consent materials, including finding that approximately one-third of statements were medically inaccurate).

13. Ultrasound laws posed special problems. While ultrasound images provided truthful information, laws requiring patients who refused to view them to hear the doctor’s description of fetal parts and fetal heartbeat seemed to be coercive. Yet several courts of appeal upheld them. See, e.g., *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570 (5th Cir. 2012). The exception was the Fourth Circuit, which invalidated the North Carolina ultrasound law on the ground that state interest—protecting fetal life, protecting pregnant women’s psychological health, and ensuring the choice is well informed—is outweighed by the physician’s right to free speech. See *Stuart v. Camnitz*, 774 F.3d 238, 250 (4th Cir. 2014).

A second strategy was to ban “partial birth” abortions (intact dilation and extraction (D&E)).¹⁴ Unknown until the 1990s, and rarely used even in late second trimester cases, abortion opponents abhorred the intact D&E technique. The legs and torso of the fetus were removed whole from the woman and then its skull was crushed in the birth canal to ease removal.¹⁵ The Court struck down state bans on partial birth abortion in 2000 in *Stenberg v. Carhart* because those laws were so broadly written that they also banned some standard second trimester D&Es, and had no exception for the life or health of the woman.¹⁶ In 2002, Congress enacted a more carefully drafted ban, including specific findings of fact that asserted that no life or health exception was ever needed.¹⁷ The Court upheld the new law in *Gonzales v. Carhart*, finding that Congress had cured earlier drafting woes and had not imposed an undue burden because other alternatives were available and no health exception was needed.¹⁸ Even though the Court noted that doctors disagreed about whether there was ever a medical need for the procedure, the Court recognized the legislature’s discretion to resolve disputed medical and scientific matters was sufficient to withstand facial attack by those doctors in favor of the technique.¹⁹

A third strategy focused on alleged “common sense” measures²⁰ to regulate abortion clinics for health and safety. Although the vast majority of abortions, which occur in the first trimester, are in already regulated clinics and are overwhelmingly safe, these laws targeted the credentials, staffing, and operation of abortion facilities in the name of protecting the health and safety of women. Such Targeted Regulation of Abortion Provider (“TRAP”) laws made it more difficult for many clinics to

14. A ban on partial birth abortion was arguably consistent with *Casey*’s reaffirmation of *Roe* because it prohibited only one abortion technique when others were available.

15. See *Stenberg*, 530 U.S. at 927.

16. 530 U.S. 914. Justice Kennedy dissented on the ground that the legislature should have discretion to assess medical evidence. *Id.* at 956 (Kennedy, J., dissenting). This point became a key factor in his opinion in *Gonzales*, 550 U.S. at 165, upholding a federal ban on intact dilation and evacuation.

17. See Partial-Birth Abortion Ban Act of 2003, 18 U.S.C. § 1531 (2003).

18. *Gonzales*, 550 U.S. at 164 (noting that “an injection that kills the fetus” in utero enables a doctor to perform intact D&E on a dead fetus and thus avoid the statute’s prohibition of delivery of “a living fetus”).

19. *Id.* While as-applied attacks were still possible, it would be extremely difficult for a woman faced with a need for a late second trimester abortion, which usually becomes known just before the procedure is needed, to have the time or money to muster the legal resources for one. See *id.* at 189–90 (Ginsburg, J., dissenting).

20. Abortion opponents viewed the Texas restrictions as “common sense safety standards regularly followed by facilities that perform invasive outpatient surgeries and requiring doctors who perform abortions to have admitting privileges at a nearby hospital.” Elizabeth Slattery & Roger Severino, *Supreme Court Puts Abortion Industry Profits over Women’s Safety*, THE DAILY SIGNAL (June 27, 2016), <http://dailysignal.com/2016/06/27/supreme-court-strikes-down-commonsense-abortion-clinic-safety-standards/> [https://perma.cc/7VHU-PXML]. To disallow them would prevent “state legislators [from making] common sense judgments about how to regulate the abortion industry . . .” See *id.* Of course, whether they qualified as “common sense” depended on how much they actually improved health in light of the burdens they imposed on access.

operate, and in some states reduced greatly the number of abortion clinics and women's access.²¹

Texas, like twenty-five other states, adopted a TRAP law in its 2013 House Bill 2 (H.B. 2).²² Among its provisions were requirements that doctors performing abortions have admitting privileges in a hospital within thirty miles and that abortion clinics meet the standards for ambulatory surgical centers (ASCs). In September 2013, several Texas abortion providers obtained a declaratory judgment that the admitting privilege requirement of H.B. 2 was facially unconstitutional.²³ On appeal, the Fifth Circuit reversed the decision in significant part.²⁴ Justice Scalia subsequently refused the plaintiff's application to vacate before the Supreme Court.²⁵ Although Justice Breyer wrote the majority opinion, as in *Casey* and *Gonzales*, Justice Kennedy's vote was key.

One week after the Fifth Circuit's decision in *Abbott I*, many of the same providers filed a new complaint that facially attacked the ASC requirement. That complaint also made an as-applied attack against the admitting privilege requirement upheld in *Abbott I* against the McAllen and El Paso clinics.²⁶ The District Court granted an injunction on both claims. The Fifth Circuit reversed *Lakey* on the ASC claim,²⁷ but this time the Supreme Court issued a stay and accepted the plaintiffs' petition for certiorari.²⁸ The Supreme Court reviewed as a whole the Fifth Circuit decisions in both *Abbott I* and *Lakey*. On June 27, 2016, the Supreme Court issued the decision of the court in *Whole Woman's Health v. Hellerstedt*.²⁹

II. WHEN IS A BURDEN "UNDUE?"

The key issue in *Hellerstedt* was whether *Casey*'s undue burden test, adopted for health restrictions on abortion, allowed courts to weigh the importance of the health goals of the law versus its burdens on women.³⁰ District courts and courts of appeals had developed two positions on these questions. One was that balancing burdens and benefits was essential to determine whether the burden imposed by

21. See *Targeted Regulation of Abortion Providers*, GUTTMACHER INST., <https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers> [https://perma.cc/HZU8-LQKV] (last visited on Feb. 1, 2017).

22. H.B. 2, 83rd Leg., 2nd C.S., Ch. 1 (Tex. 2013) (West). Final passage of the law was delayed by Senator Wendy Davis' twenty-four-hour filibuster against the law. See Manny Fernandez, *Filibuster in Texas Senate Tries to Halt Abortion Bill*, N.Y. TIMES (June 25, 2013), <http://nyti.ms/1OsGHaO>.

23. See *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 951 F. Supp. 2d 891 (W.D. Tex. 2013), *rev'd in part*, 748 F.3d 583 (5th Cir. 2014).

24. *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott (Abbott I)*, 748 F.3d 583 (5th Cir. 2014).

25. *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 134 S. Ct. 506 (2013).

26. See *Whole Woman's Health v. Lakey*, 46 F. Supp. 3d 673 (W.D. Tex. 2014).

27. *Whole Woman's Health v. Cole*, 790 F.3d 563 (5th Cir. 2015) (per curiam), *modified*, 790 F.3d 598 (5th Cir. 2015), *rev'd*, *Hellerstedt*, 136 S. Ct. 2292.

28. See *Hellerstedt*, 136 S. Ct. 2292.

29. *Id.*

30. See *id.* at 2300.

the regulation was “undue.”³¹ The opposite view was that as long as no substantial impact on access occurred, a rational basis for the legislature would suffice.³²

The Fifth Circuit had adopted this highly deferential rational basis approach in its *Hellerstedt* opinion.³³ Under this approach, a law is constitutional if it does not have the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion and “is reasonably related to (or designed to further) a legitimate state interest.”³⁴ If there was medical uncertainty about the issue, its “resolution [is for] legislatures, not the courts.”³⁵ The opposite view, used by the district court in *Hellerstedt* and district courts in Illinois, Alabama, and Arizona,³⁶ allowed courts to assess the importance of the health interest in light of the burdens imposed on access to determine whether they were “undue.” In doing so, they could also review legislative findings to determine whether they provided factual support for the state’s health goal.

The Supreme Court resolved the question in favor of petitioners by citing language in *Roe*, *Casey*, and *Gonzales* that it perceived as permitting such assessments.³⁷ It quoted *Roe*’s recognition that the “[s]tate has a legitimate interest in seeing to it that abortion . . . is performed under circumstances that insure maximum safety for the patient.”³⁸ It then used *Casey* to say that “a statute which, while furthering [a] valid state interest, has the effect of placing a substantial obstacle in the path of a woman’s choice cannot be considered a permissible means of serving its legitimate ends.”³⁹ It noted that “[u]necessary health regulations that have

31. *Id.* at 2303.

32. Courts may have adopted this approach because of a statement in *Gonzales v. Carhart* that “[w]here it has a rational basis to act, and it does not impose an undue burden, the State may use its regulatory power to bar certain procedures and substitute others, all in furtherance of its legitimate interests in regulating the medical profession in order to promote respect for life, including the life of the unborn.” 550 U.S. at 158. However, this statement refers to medical procedures and not provider and clinic regulations.

33. *Cole*, 790 F.3d at 567.

34. *Id.* at 572.

35. *Id.* at 587. (citing *Gonzales*, 550 U.S. at 163).

36. *Planned Parenthood of Wis., Inc. v. Van Hollen*, 94 F. Supp. 3d 949, 953 (W.D. Wis. 2015), *aff’d sub nom.* *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908 (7th Cir. 2015); *Planned Parenthood Se., Inc. v. Strange*, 33 F. Supp. 3d 1330, 1378 (M.D. Ala. 2014). *Planned Parenthood Ariz., Inc. v. Humble*, 753 F.3d 905 (9th Cir. 2014), used a similar approach in enjoining a state ban on medication abortions.

37. The Court reached this question only after finding that the petitioners’ claim was not barred by res judicata. It found Justice Alito’s dissent on this point “simply wrong.” *Hellerstedt*, 136 S. Ct. at 2306. In addition to its own analysis, the Court also cited an amicus brief by Michael Dorf and professors in civil procedure from Cornell Law School, New York University Law School, Columbia Law School, University of Chicago Law School, and Duke University Law School. *See id.* at 2309; *see also* Brief for Constitutional Law Scholars Bhagwat et al. as Amici Curiae Supporting Petitioner, *Cole*, 790 F.3d 563 (No. 15-274).

38. *Hellerstedt*, 136 S. Ct. at 2309. *Roe v. Wade*, 410 U.S. 113, 163 (1973), also stated that “a State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health.” The question of how strict the “reasonably relates” requirement scrutiny is that lies at the heart of *Hellerstedt*.

39. *Hellerstedt*, 136 S. Ct. at 2309 (quoting *Casey*, 505 U.S. at 877).

the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right.”⁴⁰ Based on these statements, the Court of Appeals’s allegiance to the rational basis view was incorrect because “[t]he rule announced in *Casey* . . . requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer.”⁴¹ It followed then that the Court of Appeals was wrong in equating “the judicial review applicable to the regulation of a constitutionally protected personal liberty with the less strict review applicable where, for example, economic legislation is at issue.”⁴² As a result, “[t]he Court of Appeals’ approach simply does not match the standard that this Court laid out in *Casey*, which asks courts to consider whether any burden imposed on abortion access is ‘undue.’”⁴³

The Court also found that courts may review whether the facts developed in challenges to legislation were sufficient to sustain the law.⁴⁴ It cited *Casey*’s use of the factual findings of the district court and research-based submission of amici to find that the prevalence of spousal abuse was so great that a spousal notice requirement for abortion erected an undue burden on access.⁴⁵ It also cited *Gonzales*’s recognition that the “Court retains an independent constitutional duty to review factual findings where constitutional rights are at stake.”⁴⁶ When district court findings contradict legislative findings, “[u]ncritical deference to Congress’ factual findings . . . is inappropriate.”⁴⁷

Although H.B. 2 itself did not make factual findings, the Court inferred that the legislation had sought to further the constitutionally acceptable objective of protecting a woman’s health.⁴⁸ Given the Court’s view that its cases did not leave questions of medical uncertainty wholly to the legislature, the district court had acted properly in determining whether the law actually advanced those objectives. In doing so, the district court (and now the majority) was not simply substituting its own judgment for that of the legislature, as Justice Thomas argued in dissent, but applying a more hands-on standard of review.⁴⁹ Having considered evidence in the

40. *Id.* (quoting *Casey*, 505 U.S. at 878).

41. *Id.*

42. *Id.* It cited *Williamson v. Lee Optical of Okla., Inc.*, 348 U.S. 483 (1955), as an example of the deferential approach to economic regulation.

43. *Hellerstedt*, 136 S. Ct. at 2310.

44. *See id.*

45. *Id.* (citing *Casey*, 505 U.S. at 888–94).

46. In *Gonzales*, however, the legislature was entitled to decide differences of medical opinion as it chose because there were alternative ways to terminate the pregnancy. 550 U.S. at 163.

47. *Hellerstedt*, 136 S. Ct. at 2310 (quoting *Gonzales*, 550 U.S. at 166).

48. *Id.*

49. *See id.* at 2324–25. Of course whenever a court finds insufficient evidence to support legislative impingement of a constitutional right, it is replacing the legislative judgment with its own. But in *Hellerstedt*, the legislature had adopted and the Fifth Circuit upheld the law on a mere rational basis, without examining whether the presumed health benefit actually existed. The different judgment of the District and then Supreme Court was based on applying a different standard of review to the facts developed at trial. The Court left open the question of how in closer cases the balancing should be done, i.e., would a preponderance of benefits outweigh the burden on access, or must the state have

record, the district court then weighed the asserted benefits against the burdens, as the Court now found that *Casey* instructed. As a result, the Court held that in doing so, “[t]he [d]istrict [c]ourt applied the correct legal standard.”⁵⁰

The Court’s closer scrutiny of the state’s health interest under the undue burden test in light of the access burdens on women is more consistent with the role of courts in constitutional litigation than a highly deferential, hands-off review.⁵¹ If *Casey* were read to mean that a rational basis and no substantial obstacle would sustain abortion-restrictive legislation, regulation that could not meet any closer scrutiny would invariably survive. The idea that some regulations were “unnecessary” and thus created an “undue burden” because they contributed so little to actual health made sense. If there was no actual benefit, then more than de minimis burdens, even if not a substantial obstacle, would be “undue.” To hold otherwise would remove most judicial scrutiny of legislation in the abortion area and impair the dignity, not only of women, but of law itself.⁵² While a low level of scrutiny may be tolerable with economic, social, and commercial matters, it robs fundamental rights, such as autonomy in choosing not to procreate, of the greater “momentum [of] respect”⁵³ which they deserve.

It bears mentioning that a similar balancing approach has been adopted in cases involving *indirect* burdens on voting rights. Instead of having to meet strict scrutiny, the Court in *Anderson v. Celebrezze*⁵⁴ and *Burdick v. Takushi*⁵⁵ upheld voting restrictions that did not “unreasonably” burden the right to vote in light of the state’s “important regulatory interests.”⁵⁶ Such a standard requires courts to balance

to meet a higher standard for showing that the health benefits outweighed the burden on access? Would this be a form of intermediate scrutiny? I am indebted to Lynn Blais for this point.

50. *Id.* at 2310.

51. Simply determining whether there was a rational basis for legislation had been the basis for Justice Rehnquist’s dissent in *Roe*, 410 U.S. at 171. He reiterated it in subsequent cases. *See, e.g., Webster*, 492 U.S. at 490.

52. Linda Greenhouse & Reva Siegel, *Casey and the Clinic Closings: When “Protecting Health” Obstructs Choice*, 125 YALE L.J. 1428, 1480 (2016). Their full statement on this point is:

We have frequently referred here to women’s dignity as a value that *Casey* sought to protect. At this crucial juncture in the never-ending abortion controversy, we suggest that courts must also be attentive to another claim to dignity: the dignity of law itself. If the decision announced nearly a generation ago under an intense public spotlight can be so easily manipulated and evaded, among the betrayed will be not only the women of America, but the understanding that *Casey* affirmed: that constitutional law matters, and matters especially in those precincts where we most deeply disagree.

Id. at 1480.

53. Recall Justice White’s statement in *Griswold v. Connecticut*, that “[s]urely the right invoked in this case, to be free of regulation of the intimacies of the marriage relationship, ‘come[s] to this Court with a momentum for respect lacking when appeal is made to liberties which derive merely from shifting economic arrangements.” 381 U.S. 479, 502–03 (1965) (White, J., concurring) (quoting *Kovacs v. Cooper*, 336 U.S. 77, 95 (1949)).

54. 460 U.S. 780, 806 (1983) (third-party presidential ballot requirements burdens voters’ freedom of choice and freedom of expression unquestionably outweigh the State’s interest in imposing a March deadline).

55. 504 U.S. 428, 441 (1992) (write-in votes in presidential election may be prohibited).

56. *Burdick*, 504 U.S. at 434.

the importance of the state's regulatory interest in light of the burdens imposed, as *Hellerstedt* has interpreted *Casey*'s "undue burden" test to require. The Fourth Circuit applied this approach in striking down North Carolina's voter identification requirements in *N.C. Conference of NAACP v. McCrory*, on the ground in part that the law provided "inapt remedies . . . for [voter fraud] problems . . . that did not exist."⁵⁷ *Hellerstedt*'s balancing approach to abortion restrictions both reflects voting right cases and may influence them in turn.

III. UNDUE BURDEN: ADMITTING PRIVILEGES REQUIREMENT

Having established that the undue burden test permits judicial inquiry into the importance of the state's health interest, the Court then turned to the district court's evaluation of the evidence, first for the admitting privileges requirement, and then for the surgical center standards.⁵⁸ For each requirement, the court analyzed the evidence showing whether or not there was a health benefit, and then to what extent the requirement placed a substantial obstacle to access to abortion.⁵⁹ This approach was fact-intensive, based on evidence in the record and several amici briefs from medical and hospital professionals. The dissents questioned several of the majority's conclusions, but those arguments were not sufficient to disturb the Court's conclusion that the district court's findings were adequate to uphold a facial attack on H.B. 2.⁶⁰

A. Does the Hospital Admitting Privileges Requirement Advance Health?

With regard to the admitting privileges requirement, the Court first noted that before H.B. 2 Texas already had a law that required abortion providers to "have admitting privileges or have a working arrangement with a physician(s) who has admitting privileges at a local hospital in order to ensure the necessary back up for medical complications."⁶¹ The new law required that providers themselves have admitting privileges at a hospital within thirty miles of the clinic, but the district court found that this mandate served no real health need and made abortion access more difficult, thus imposing an "undue" burden on a woman's right to abortion.⁶²

57. *N.C. State Conference of NAACP v. McCrory*, 831 F.3d 204, 214 (4th Cir. 2016), *rev'g and remanding* 182 F. Supp. 3d 320 (M.D.N.C.).

58. *Hellerstedt*, 136 S. Ct. at 2310, 2314.

59. By focusing on the actuality of the health benefit and degree of burden, the majority decided the case on the effects, not the purpose, prong of the undue burden case. However, purpose had been argued in the courts below and in the Supreme Court on the theory that a law that added so little to health must have been adopted for the purpose of stopping abortion. Rather than get into the entanglements of purpose analysis, the Court simply avoided the question. *See Palmer v. Thompson*, 403 U.S. 217 (1971); *see also* Priscilla J. Smith, *If the Purpose Fits: The Two Functions of Casey's Purpose Inquiry*, 71 WASH. & LEE L. REV. 1135, 1136 (2014).

60. *See Hellerstedt*, 136 S. Ct. at 2321–53 (Thomas, J., and Alito, J., dissenting).

61. *Hellerstedt*, 136 S. Ct. at 2310.

62. *Id.* at 2310–11 (citing TEX. HEALTH & SAFETY CODE ANN. § 171.0031(a) (West 2015)).

The majority in *Hellerstedt* upheld the district court's finding that there were no actual health benefits from the law.⁶³ First, abortion in Texas was "extremely safe with particularly low rates of serious complications and virtually no deaths occurring on account of the procedure."⁶⁴ Serious complications requiring hospital admission were less than one-quarter of one percent of abortions. Other complications rarely required hospital admission, much less immediate transfer to a hospital from an outpatient clinic, and if they do occur, the quality of care that the patient receives is not affected by whether the abortion provider has admitting privileges at the hospital.⁶⁵

Second, expert testimony showed that when complications occur, they occur in the days after the abortion and not on the spot at the clinic.⁶⁶ This is especially true for medication abortions, which occur after the patient has taken a medication in the clinic and has left the facility. In cases in which complications occur, patients are likely to seek medical attention at a hospital near their home. In short, the Court found nothing in the record evidence to show that the new law advanced Texas's legitimate interest in protecting health.

Third, hospital credentialing placed "a substantial obstacle in the path of a woman's choice" without a corresponding health benefit.⁶⁷ The Court found that it was often impossible for abortion doctors to receive hospital credentials⁶⁸ for reasons other than their medical competence. It noted that privileges were granted on the basis of the applicant's number of admissions per year, and did not operate as a second check on the credentials or skill of abortion providers, as the state had asserted below.⁶⁹ With abortions yielding so few complications, doctors performing them would not be able to meet minimum admission requirements. The amicus brief of the American College of Obstetrics and Gynecology confirmed that hospital privileges were not granted on ability or qualifications, but admission numbers, and thus did not serve "any relevant credentialing function" for abortion providers who rarely sought hospital admission for their patients.⁷⁰

B. Burden on Access

The Court also agreed with the district court that the admitting privileges requirement caused clinics to close, without a corresponding health benefit. After this provision went into effect on September 1, 2015, the number of abortion facilities dropped from forty to about twenty. The record contained sufficient

63. *Id.* at 2311.

64. *Id.*

65. *Id.*

66. *Id.*

67. At oral argument Texas admitted that there was nothing in the record that of even a single case in which "the new requirement would have helped even one woman obtain better treatment." *Id.* at 2311–12.

68. *Id.* at 2312.

69. *Id.* at 2312 (citation omitted).

70. *Id.* at 2313.

evidence that the privileges requirement led to the closure of about half of Texas clinics.⁷¹ These closures meant fewer doctors, longer waiting times, and increased crowding. With fewer clinics, the number of women of reproductive age living more than 150 miles from a clinic increased from 86,000 to 400,000, and those more than 200 miles away increased from 10,000 to 290,000.⁷² While the Court, citing *Casey*, found that increased driving times do not always constitute an undue burden,⁷³ they could not be ignored. Taken together with the scheduling and delay burdens that the closings brought about and the virtual absence of any health benefits, the district court's undue burden analysis was correct.

Justice Alito's counter-argument in dissent was evidentiary. He argued that some clinics may have closed for other reasons, such as physician retirement, so all closures should not be counted as a burden created by the law.⁷⁴ But the Court rejected this speculation because so many clinic closures occurred around the time the admitting privileges requirement took effect. Whether other evidence not presented at trial or credited by the district court might have shown that some clinics closed for unrelated reasons did not provide a sufficient ground to disturb the district court's finding on that issue.

Justice Alito also suggested that the hospital privileges requirement may have forced unsafe facilities to shut down, pointing to the Kermit Gosnell scandal in Pennsylvania.⁷⁵ Gosnell was convicted of first degree murder of a child who was born alive after an abortion procedure and manslaughter by omission of an abortion patient, who died after a procedure. He also was accused of permitting unlicensed and indifferent workers to practice unsupervised and to work in dirty facilities with unsanitary instruments.⁷⁶ The Court agreed that Gosnell's conduct was deplorable, but did not find that an extra layer of regulation would have affected his behavior.⁷⁷ Preexisting Texas law already contained detailed regulations covering abortion facilities, including a requirement that facilities be inspected at least annually. It found nothing in the record to suggest that H.B. 2 would be more effective than preexisting Texas law at deterring wrongdoers like Gosnell from criminal behavior. Thus, there was little health benefit from the admitting privilege requirement and a substantial burden on access.⁷⁸

71. *Id.*

72. *Id.*

73. The *Casey* plurality in upholding the Pennsylvania twenty-four-hour waiting period had accepted the District Court finding that some women had to drive 150 miles each way and stay overnight to satisfy that requirement. *Id.* (citing *Casey*, 505 U.S. at 833).

74. *Id.* at 2344.

75. *Id.* at 2313.

76. *Id.*

77. *Id.*

78. *Id.*

IV. UNDUE BURDEN—SURGICAL CENTER REQUIREMENT

The Court applied a similar fact-intensive analysis to the ambulatory surgical center (ASC) standards requirement.⁷⁹ It found that the ASC standards did little to protect health, and that the regulation limited access to abortion.⁸⁰

A. Do ASC Standards for Abortion Clinics Promote Health?

As with admitting privileges, the Court noted that Texas law already heavily regulated abortion clinics with requirements for recordkeeping, reporting, quality assurance, staffing, infection control, environmental protection, and anesthesia standards.⁸¹ These regulations were policed by random and announced annual inspections and could be enforced with administrative, civil and criminal penalties, and injunctions. H.B. 2 added additional detailed requirements relating to the size of the nursing staff, building dimensions, surgical suites, preoperative holding and postoperative recovery rooms, corridors of wider width, and piping and plumbing requirements. All were costly to add and appeared to improve safety marginally, if at all, for most abortion patients.⁸²

The Court found “considerable evidence in the record supporting the [d]istrict [c]ourt’s findings indicating that . . . statutory provision requiring all abortion facilities to meet all surgical-center standards does not benefit patients and is not necessary.”⁸³ The risks were not lowered for patients who underwent abortions in ambulatory surgery centers as compared to nonsurgical facilities. As the district court put it, women “will not obtain better care or experience more frequent positive outcomes at an ambulatory surgical center as compared to a previously licensed facility.”⁸⁴ The Court found this conclusion well supported both by record evidence and amici briefs. For example, the requirement that even medical abortions occur in a surgical center provides no benefit since complications, if any, almost always arise after the patient has left the facility.

The record also showed substantial discrimination between what was required of abortion clinics and other settings in which higher risk procedures occur. Abortions in abortion facilities are not only safe, but also safer than the numerous outpatient procedures that are not subject to the surgical center requirement. Nationwide childbirth is fourteen times more likely to result in death, but Texas allows a midwife to oversee childbirth in the patient’s own home.⁸⁵ Colonoscopy,

79. *See id.* at 2314–15.

80. *Id.* at 2321.

81. *Id.* at 2314.

82. *Id.* at 2314–15.

83. *Id.* at 2315.

84. *Id.* (citing *Lakey*, 46 F. Supp. 3d at 684).

85. The Court also noted that death from abortion has occurred only once in every 120,000–140,000 abortions, or one every two years. *Hellerstedt*, 136 S. Ct. at 2313. By contrast, 148 women in Texas died from pregnancy-related causes in 2012, up from seventy-two deaths in 2011. Maternal deaths in developed countries are roughly twelve per 100,000 live births. In Texas, the number was 35.8 deaths

which typically occurs outside of a hospital or surgery center, has a mortality rate ten times higher than that of abortion, while liposuction, another typical outpatient procedure, is twenty-eight times more dangerous than abortion.⁸⁶ Medical procedures after miscarriage often involve a procedure equivalent to that involved in a nonmedical abortion, but they often take place outside of a hospital or surgery center. The Court found that this regulatory disparity was not based on differences that are reasonably related to protecting women's health, the ostensible purpose of the law.⁸⁷

Moreover, many of the requirements are inappropriate as applied to surgical abortions, such as requiring scrub facilities, one-way traffic patterns throughout the facility, and special pre-op and post-op waiting areas. Nor are filtration and humidity requirements that aim to reduce infection when doctors penetrate the skin applicable to abortions, which typically involve either the administration of medicines or procedures performed through the natural opening of the birth canal, which is itself not sterile.⁸⁸ Similarly, emergency provisions for deeply sedated patients are not relevant to abortion, which typically does not involve general anesthesia or deep sedation.⁸⁹

The upshot of the record evidence was to provide ample support for the district court's conclusion that "[m]any of the building standards mandated by the [A]ct and its implementing rules have such a tangential relationship to patient safety in the context of abortion as to be nearly arbitrary."⁹⁰ In short, the surgery center requirement "will not [provide] better care or . . . more positive outcomes."⁹¹ Therefore, "[t]he record evidence thus supports the ultimate legal conclusion that the surgical-center requirement is not necessary."⁹²

B. *The Burdens of the ASC Requirement*

At the same time, the Court concluded that the record provided adequate evidentiary support for the conclusion that the surgical center requirement placed a substantial obstacle in the path of a woman seeking an abortion.⁹³ The parties stipulated that the requirement would reduce the number of abortion facilities to seven or eight, located in Houston, Austin, Dallas, Fort Worth, and San Antonio.

per 100,000 live births in Texas in 2014 (400,000 live births annually). Brittney Martin, *Pregnancy-Related Deaths in State Double*, AUSTIN AM.-STATESMAN, Aug. 22, 2016, at B1.

86. *Hellerstedt*, 136 S. Ct. at 2314.

87. Although Texas partly waives or grandfathers the surgical center requirements for about two-thirds of the facilities to which the new surgical center standards apply, it never waived any of the new requirements or grandfathered any facilities that perform abortions. *Id.* at 2298–99.

88. Two critics of *Hellerstedt* commented that, "In other words, the court is claiming a woman's body is already unsanitary to a certain degree so no need to increase the cleanliness of the abortion environment and abortion instruments." SLATTERY & SEVERINO, *supra* note 20.

89. *Hellerstedt*, 136 S. Ct. at 2316.

90. *Id.* (citing *Lakey*, 46 F. Supp. 3d at 684).

91. *Id.* at 2315.

92. *Id.* at 2316.

93. *Id.*

The district court found that those seven or eight facilities could not meet the demand of the entire state.⁹⁴ Yet the Fifth Circuit Court of Appeals found that this finding was “clearly erroneous” because it rested on the “ipse dixit of one expert,” and because there was no evidence that the current surgical centers for abortion were operating at full capacity.⁹⁵

The Court, however, found adequate support for the district court’s finding.⁹⁶ That expert said that as a result of the surgical center requirements, those seven clinics would have to increase their capacity from 14,000 abortions per year to 60,000–70,000—a five factor increase.⁹⁷ The district court found that the expert could offer his opinion if it were based on sufficient facts or data and reliable principles and methods.⁹⁸ Since the expert had participated in research and review of studies and existing data, the district court determined that he met the *Daubert* standards for an expert witness.⁹⁹ The Supreme Court agreed.¹⁰⁰

In addition, the Court relied on common sense, using as an example that if a store, apartment, or train served 200 customers a week, it was unlikely to be able to suddenly shift and serve 1000.¹⁰¹ Justice Alito’s dissent took issue with this conclusion, arguing that many places operate below capacity and could simply hire more providers to satisfy new demand.¹⁰² The Court noted, however, that medical facilities are well known for their waiting times and that it defied common sense to conclude that they could easily accommodate five times the number of patients.¹⁰³ Because petitioners had satisfied their burden, the obligation was on Texas, if it could, to present evidence rebutting the district court. Texas admitted on oral argument that it had presented no such evidence.¹⁰⁴

More fundamentally, the Court found that in the face of no threat to women’s health from the prior regulatory approach, the new requirements would not improve women’s health and instead might harm it.¹⁰⁵ As Justice Breyer noted for the majority:

Texas seeks to force women to travel long distances to get abortions in crammed-to-capacity superfacilities. Patients seeking those services are less

94. *Id.*

95. *Id.* (citing *Cole*, 790 F.3d at 590).

96. *Id.* at 2316.

97. *Id.*

98. *Id.*

99. *Id.* at 2317 (citing *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579 (1993)). This is true even if the expert had been previously wrong in one of his predictions about the effect of passage of H.B. 2.

100. *Id.* at 2317.

101. *Id.*

102. *Id.* at 2347.

103. *Id.* at 2317.

104. *Id.* Texas noted that the increased capacity of a new Planned Parenthood facility in Houston was not typical of other clinics. Abortions were only one of the services provided there, so that the total cost of the new facility was not indicative of how easily a clinic could meet requirements. *Id.* at 2318.

105. *Id.* at 2311–12.

likely to get the kind of individualized attention, serious conversation, and emotional support that doctors at less taxed facilities may have offered Surgical centers attempting to accommodate sudden, vastly increased demand . . . may find that quality of care declines.¹⁰⁶

With the cost of meeting the surgical-center standards so high—from \$1 million per facility with adequate space to \$3 million (depending on whether new land must be purchased), capacity would not easily increase to accommodate the needs of Texas women.¹⁰⁷ The Court thus agreed with the district court that the surgical-center requirement, like the admitting privileges requirement, provides few, if any, health benefits for women, poses a substantial obstacle to women seeking abortions, and thus constitutes an “undue burden” on their right to do so.¹⁰⁸

V. FACIAL ATTACK: SEVERABILITY AND LARGE FRACTION

The Court also dealt with two additional arguments made by Texas and found neither persuasive.¹⁰⁹ One was severability and the other was the number of women affected to warrant facial review. H.B. 2 had a very broad severability clause that applied to “every provision, section, subsection, sentence, clause, phrase or word in this Act.”¹¹⁰ Texas argued that even if some of the surgical-center provisions were invalid, others were not, and thus only the most burdensome ones should be struck down.

The Court rejected this claim for a more narrowly tailored remedy, noting that “a severability clause is an aid merely; not an inexorable command.”¹¹¹ Further, its prior cases had “never required us to proceed application by conceivable application when confronted with a facially unconstitutional statutory provision.”¹¹² Strictly enforcing such a severability clause would impose on courts the duty to pick out the individual applications that were invalid, thus substituting judicial for legislative governance, and allow a legislature to insulate unconstitutional statutes from facial attack. Moreover, the costs would be high for courts and litigants, who would have to specify which of many provisions were valid and which were not, whenever a single application of a law might be valid. Texas’s attempt to broadly draft a requirement to sever “applications,” the Court concluded, “does not require us to proceed in piecemeal fashion when we have found the statutory provisions at issue facially unconstitutional.”¹¹³

106. *Id.*

107. *Id.* at 2318.

108. *Id.*

109. The state’s third argument relied on *Simopoulos v. Virginia*, 462 U.S. 506 (1983), in which the Court upheld a law requiring second trimester abortions be performed in a hospital. The *Hellerstedt* Court distinguished it on the ground that it involved second trimester abortions, and not all abortions as H.B. 2 did. *Id.* at 2320.

110. *Id.* at 2318 (citing H.B. 2, 83rd Leg., 2d Spec. Sess. (Tex. 2013)).

111. *Id.* at 2319 (citing *Reno v. ACLU*, 521 U.S. 844 (1997)).

112. *Id.*

113. *Id.*

Texas's second argument was that a facial attack was not appropriate because the women affected by these laws are not a "large fraction" of Texas women of reproductive age, which Texas read *Casey* to require.¹¹⁴ The State spent much time arguing that *Casey* required as a denominator the number of women of reproductive age in Texas, and the numerator those women who lived more than 150 miles from an abortion facility that met H.B. 2 standards.¹¹⁵ Concluding that H.B. 2 would be a substantial burden only for seventeen percent of Texas women of reproductive age, it found that this was not "a large fraction" and thus not suitable for a facial attack.¹¹⁶

The Court answered by clarifying that *Casey* used "large fraction" to refer to the situations in which the provision at issue directly impacts women, a class narrower than all women, pregnant women, or even the class of women seeking abortions identified by the state. It found that the "relevant denominator is 'those women for whom the provision is an actual rather than an irrelevant restriction.'"¹¹⁷ In *Casey*, where the Court struck down Pennsylvania's spousal notification requirement, that provision was a substantial obstacle to only one percent of married women, but the *Casey* plurality upheld a facial invalidation of the entire provision. In *Hellerstedt*, the number of women burdened was even higher.¹¹⁸

One may puzzle over this conclusion in *Casey*, since it seems tautological—the actual number affected defines both numerator and denominator. If any women are burdened by a provision, then the provision may be challenged in a facial attack because of the actual effect on a few. In addition, this conclusion seems inconsistent with the plurality's conclusion about the burdens of a twenty-four-hour waiting period in *Casey*. Although some women would have to travel more than 150 miles each way, the Court in *Casey* found that this burden did not support facial invalidation of the waiting period provision, presumably because it would not prevent those women from obtaining an abortion. Yet a similar large impact on a few women from spousal notification was enough for facial invalidation of that provision.

Casey finessed the problem by saying that "[a] particular burden is not an undue burden," suggesting that long travel time was not an undue burden even

114. *Id.* at 2320.

115. Texas included in the denominator women within 150 miles of the facility in McAllen, which had been found adequate on an as-applied basis. Even though there was no abortion facility that met H.B. 2 requirements, the state did argue that El Paso women should not be included because they were twelve miles away from a clinic in New Mexico. Ironically, that clinic would not have met H.B. 2 requirements and was in another state. *See Jackson Women's Health Org. v. Currier*, 760 F.3d 448, 458–59 (5th Cir. 2014), *cert. denied*, 136 S. Ct. 2536 (2016) (holding availability of abortion in a contiguous state should not count in determining the burden on women).

116. Brief in Opposition at 10, *Cole*, 790 F.3d 563 (No. 15–274).

117. *Hellerstedt*, 136 S. Ct. at 2320.

118. According to Texas, 17% of women of reproductive age (200,000 women) would have to drive more than 150 miles each way to have an abortion, which it argued was not a "large fraction." *See* Brief for Respondents at 45, 48, *Hellerstedt*, 136 S. Ct. 2292 (No. 15–274).

though spousal notification was.¹¹⁹ If so, the difference was that the one percent of women for whom spousal notification was a substantial obstacle were burdened by a law that served no valid purpose, while the waiting period law did serve the valid purpose of informing women about the fetus and alternatives to abortion.

That reasoning, however, still does not explain why the surgical center and admitting privileges requirements, which would be a substantial obstacle for seventeen percent of women according to the state, would invalidate those requirements for the rest of Texas women for whom it would not be a substantial obstacle. One might infer that it is because those provisions serve no valid health purpose, and thus they are invalid for all women, even if they directly burden a smaller percentage. In not providing a more complete explanation, the Court might have intended to give lower courts the authority to entertain facial attacks on abortion statutes even if very few women are actually burdened, which was apparently the situation before *Gonzales*.¹²⁰

VI. THE OPINIONS OF JUSTICE GINSBURG AND JUSTICE THOMAS

There were three other opinions in the case: a concurrence by Justice Ginsburg and dissents by both Justices Thomas and Alito. Justice Alito argued that the Court is wrong, as Justice Thomas describes it, because its reasoning “creates an abortion exception to ordinary rules of res judicata, ignores compelling evidence that Texas’ law imposes no unconstitutional burden, and disregards basic principles of severability doctrine.”¹²¹ Because I have addressed Justice Alito’s evidentiary and severability objections in previous discussion, I focus on Justice Ginsburg’s concurrence and Justice Thomas’s dissent.¹²²

A. Justice Ginsburg’s Concurrence

Justice Ginsburg’s sharp summary of the flaws of H.B. 2 adds no new argument, but deserves mention because it emphasizes the discriminatory aspect of the law and its impact on women. It is also a masterpiece of brevity.¹²³ She finds claims that H.B. 2 will protect the health of women who experience complications from abortion are simply not credible, for “[i]n truth, complications from an abortion are both rare and rarely dangerous.”¹²⁴ And procedures far more dangerous than abortion are not subjected to the same two restrictions. Given those

119. *Casey*, 505 U.S. at 887.

120. *See Carhart*, 550 U.S. at 163. This arguable inconsistency/ambiguity does not escape Justice Alito’s eye in his dissent.

121. *Hellerstedt*, 136 S. Ct. at 2321 (Thomas, J., dissenting).

122. I have not discussed Justice Alito’s dissenting arguments on preclusion because they do not affect regulation of abortion generally. *See supra* note 34.

123. She also relies extensively on amicus briefs to support her claims, especially those of the American College of Obstetricians and Gynecologists, Social Science Researchers, American Civil Liberties Union, and Ten Pennsylvania Abortion Providers. *See Hellerstedt*, 136 S. Ct. at 2320–21 (Ginsburg, J., concurring).

124. *Id.* at 2320 (quoting *Schimmel*, 806 F.3d at 912).

realities, “it is beyond rational belief that H.B. 2 could genuinely protect the health of women, and certain that the law ‘would simply make it more difficult for them to obtain abortions.’”¹²⁵ “When a State severely limits access to safe and legal procedures, women in desperate circumstances may resort to unlicensed rogue practitioners . . . at great risk to their health and safety.”¹²⁶ As long as the Court adheres to *Roe v. Wade* and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, TRAP laws like H.B. 2 “that ‘do little or nothing for health, but rather strew impediments to abortion’ . . . cannot survive judicial inspection.”¹²⁷

B. Justice Thomas's Dissent

In dissenting, Justice Thomas writes both on general questions of substantive due process lawmaking and more specific ones about the majority's transformation of “undue burden” into “strict scrutiny.”¹²⁸ To him, neither is sound constitutional interpretation and neither gives guidance to courts that will have to apply the Court's holding in the future. His attack on the majority begins with an argument against the permissive tradition of allowing third-party standing in abortion cases.¹²⁹ However, since that attack is more general than his resistance to the interest-balancing under the undue burden test, I focus only on the latter arguments.

Justice Thomas chiefly objects to the majority's “reimagin[ing] the undue-burden standard used to assess the constitutionality of abortion restrictions.”¹³⁰ He states that *Casey* instructed courts to “look to whether a law substantially impedes women's access to abortion, and whether it is reasonably related to legitimate state interests.”¹³¹ Although he is fundamentally opposed to the Court's abortion jurisprudence, taking *Casey* as the baseline, he finds that the Court rewrites the standard in three ways.

First, Justice Thomas claims that the majority's acceptance of a standard comparing the burdens imposed on abortion access together with the benefits those laws confer, creates a “free-form balancing test . . . contrary to *Casey*.”¹³² However, his two supporting examples are not convincing. True, *Casey* had found that certain recordkeeping provisions served valid interests in research and public health without balancing burdens and benefits. But because the evidence showed that there was a public health benefit and no burden, there was nothing to balance. Similarly, Justice Thomas's claim that that *Casey*'s invalidation of spousal notice

125. *Id.* at 2321 (quoting *Schimmel*, 806 F.3d at 910). This statement suggests that the legislative purpose was itself invalid, but she says nothing more about a purpose analysis.

126. *Id.*

127. *Id.* (quoting *Schimmel*, 806 F.3d at 921).

128. *Id.* at 2324–30 (Thomas, J., dissenting).

129. *Id.* at 2321; *Singleton v. Wulff*, 428 U.S. 106 (1976) (holding a physician may assert the right of women patients against government interference with the abortion decision).

130. *Id.* at 2323.

131. *Id.* Here he quotes language from *Casey* relating to promoting life of unborn, not regulation of health. He also omits the “unnecessary language” of *Casey*.

132. *Id.* at 2324.

without balancing supports his position is also not persuasive. The evidence showed a significant burden for the one percent of women directly affected but no legitimate benefit to balance against the burden on those women who were burdened.¹³³

Second, Justice Thomas cites to *Mazurek v. Armstrong*¹³⁴ as a post-*Casey* case, which upheld a law requiring that only doctors, not qualified nurse practitioners, perform abortions even though there were no evidence of health benefits from the law. Indeed, the Court said in that case the state had broad latitude to decide that particular functions may be performed only by licensed professionals, “*even if an objective assessment might suggest that those same tasks could be performed by others.*”¹³⁵ Justice Thomas is correct that no direct balancing occurred in *Mazurek*, but the Court confronted a record in which the licensing requirement did not create a substantial burden because women still had access to abortion. Again, there was nothing to balance. Going forward, courts may have to reconsider licensing laws if they provided little benefit and burdened women.¹³⁶

Third, Justice Thomas argues that the Court has changed its position in *Casey*, reiterated in *Gonzales*, that legislatures, not courts, have the authority to resolve questions of medical uncertainty as long as there is a rational basis for their action. He writes that *Casey*’s invalidation of the spousal notice law was not to the contrary because disputed evidence about the impact of that law was not a medical dispute.¹³⁷

In Justice Thomas’s view these deviations from prior cases “will surely mystify lower courts for years to come” since the majority simply highlights certain facts in the record that seem significant to them in establishing an undue burden.¹³⁸ Justice Thomas laments that the Court appears to be imposing a strict scrutiny test for abortion, requiring the most compelling justification for any restriction, thus ruling out even minor, previously valid regulation of abortion.¹³⁹ Moreover, he is disturbed because, by second guessing medical evidence and making its own assessment of whether a law or regulation achieves an actual benefit, the “majority reappoints this Court as ‘the country’s ex officio medical board with powers to disapprove medical and operative practices and standards throughout the United States.’”¹⁴⁰ He also worries about the burden imposed on states by making them guess how strong or compelling their health interests must be to pass muster.¹⁴¹

133. This was the point of the searing language presumably written by Justice O’Connor in *Casey* about how women are no longer the property of their husbands. See *Casey*, 505 U.S. at 833.

134. See *Mazurek v. Armstrong*, 520 U.S. 968 (1997) (per curiam).

135. *Id.* at 973 (quoting *Casey*, 505 U.S. at 885); see also *Gonzales*, 550 U.S. at 164 (citing *Mazurek*, 520 U.S. at 973).

136. See *infra* note 92 and accompanying text.

137. Nor was *Gonzales*’ invalidation of Congress’s finding that there was never a medical necessity because there was in fact a debate within the medical community (which was left to the legislature to decide).

138. *Hellerstedt*, 136 S. Ct. at 2326.

139. *Id.* at 2326 (Thomas, J., dissenting).

140. *Id.* (quoting *Gonzales*, 550 U.S. at 164).

141. *Id.*

If reproductive choice is not a fundamental right and can be regulated if there is a rational basis for legislative action, Justice Thomas's position makes sense. But the Court in *Hellerstedt* is taking the abortion right seriously, which means subjecting it to more than rational basis scrutiny if a law burdens access to abortion. *Hellerstedt*'s view of "undue burden," however, is not necessarily equivalent to strict scrutiny, even if modest restrictions may have to be justified. A more confined decision rule for undue burden may be desirable, but there are limits to how one would specify in advance the fact-based comparison of actual benefits and burdens that determine when an "undue burden" exists.¹⁴² As in other litigation, it is unavoidable that judges will make inferences from record evidence within the constraints given to them and decide accordingly.¹⁴³

Some laws, like record-keeping for public health and research purposes, are easily sustained because they impose slight or no burden and provide benefit. Others, like licensing laws, long believed proper, may have to be rethought in terms of their burdens and benefits.¹⁴⁴ Nor is the fear of the courts becoming ex officio medical boards based likely to be realized. The courts would step in only where evidence of health benefit has highly questionable factual support. In short, Justice Thomas's objections are to the post-*Griswold*¹⁴⁵ structure of fundamental reproductive rights in general and the closer scrutiny that that status entails.

VII. FUTURE ISSUES: THE IMPACT OF *HELLERSTEDT*

Whole Woman's Health v. Hellerstedt is a major setback for the antichoice movement. It will most likely invalidate most TRAP laws, which usually only marginally advance health while making it more difficult for women to access abortion. *Hellerstedt*, however, will not stop the antichoice movement from pressing its fight against abortion in other areas, even before President Trump makes two appointments to the Court. It now controls many state legislatures, and more legislation in areas left open by *Hellerstedt* may be expected.

Of course, the future of abortion regulation after *Hellerstedt* will be affected by the makeup of the Court. As noted earlier, Justice Gorsuch, who replaced Justice Scalia, alone will not shift the balance. Assuming that Justice Ginsberg, Breyer,

142. See generally Mitchell N. Berman, *Constitutional Decision Rules*, 90 VA. L. REV. 1 (2004) (discussing how many Supreme Court decisions concern fashioning decision rules for implementing constitutional principles).

143. Mark Tushnet makes the same point more insightfully. He states that: [R]ule-guided judgments were not in principle different from clinical ones (or, to put the latter in terms more congenial to lawyers, from all-things-considered judgments) A clinical judgment was just the result of an accumulation of rule-guided judgments that could be teased out through careful analysis, and the judgments reached in a system of complex rules could never be fully justified by any identifiable subset of rules.

Mark Tushnet, *Jan Deutsch: An Appreciation*, BALKINIZATION (Aug. 20, 2016, 12:21 PM), <https://balkin.blogspot.com/2016/08/jan-deutsch-appreciation.html> [<https://perma.cc/TXJ9-3ZFB>].

144. See *infra* note 91 and accompanying text.

145. See *Hellerstedt*, 136 S. Ct. at 2324 (Thomas, J., dissenting) (stating "fundamental[] oppos[ition]" to the Supreme Court's abortion jurisprudence and criticizing the transformation of the undue burden test into a strict scrutiny equivalent).

Kagan, and Sotomayor remain for the foreseeable future, the power of *Hellerstedt* will depend on Justice Kennedy remaining on the Court.¹⁴⁶ Having joined the *Casey* plurality that upheld the core right of *Roe* to abortion up until viability, he is likely to maintain that commitment in situations that directly impair that right, as he did in *Hellerstedt*. His vote in *Gonzales* to uphold the federal ban on partial birth abortion is not inconsistent with this commitment, since that case involved only one particular rare technique, and did not prevent women from getting abortions by other means, including causing fetal demise in utero.¹⁴⁷ Although the *Gonzales* opinion was highly deferential to state resolution of medical and scientific uncertainty, he left room for an as-applied attack if the technique was needed to protect a woman's health.¹⁴⁸ Assuming his continued presence on the Court, the reliability of Justice Kennedy's vote in future cases will thus depend on the type of regulation at issue. The important questions for him are: does the regulation improve information exchange, does it advance respect for prenatal life, is there an actual health benefit, and is there a substantial effect on access to abortion and its impact on women seeking abortion.

A. Health, Licensure, and Informed Consent Restrictions

If *Hellerstedt*'s doctrine is taken seriously in future disputes, the case will make it harder to restrict abortion both health-related and fetal-protection regulation. Regulations that purport to protect women's health and autonomy will have to follow *Hellerstedt* and provide real benefit if they substantially limit access to abortion. But close questions may still arise.

For example, what if a state has a valid health justification for a regulation that closes the only clinic in the state, which could occur in Mississippi?¹⁴⁹ Should health take priority over access or vice versa? The answer should turn on the requirement's contribution to women's health. A state, for example, should be able to close the only clinic in the state if it were as derelict as the Gosnell clinic. That case, however, is easy—one could show serious danger to women's health and life that would be comparable or even greater than the risk of childbirth. But the question is harder if

146. *Hellerstedt*, 136 S. Ct. at 2292. There has been speculation in the press that the appointment of Justice Gorsuch, who had clerked for Justice Kennedy, will reassure him that future Trump appointees will be of high quality, and thus might lead him to retire sooner than he otherwise would. If he did, that would be a major blow to abortion rights.

147. “[I]n some circumstances, it appears likely an injection that kills the fetus is an alternative under the Act that allows the doctor to perform the procedure.” *Gonzales*, 550 U.S. at 164. Still, he did include paternalistic language about the regret that women would feel if they later learned the details of the intact dilation and evacuation that they had had. *Gonzales*, 550 U.S. at 159–60. One would have thought that informing them of those details before the procedure, rather than banning it altogether, would have been more protective of women's interests.

148. See *Gonzales*, 550 U.S. at 167–69.

149. See Jonathan Will, *Whole Woman's Health—Some Preliminary Thoughts on Benefits, Purposes, and Fetal Status*, BILL OF HEALTH (June 29, 2016), <http://blogs.harvard.edu/billofhealth/2016/06/29/whole-womans-health-some-preliminary-thoughts-on-benefits-purposes-and-fetal-status/> [https://perma.cc/MF9D-NPEK].

the health benefit is less but still substantial. Must the state allow even a substandard abortion facility to exist, when access is available through acceptable facilities across a state line?¹⁵⁰

Challenges to licensing laws that require only physicians to perform abortions can also be close under *Hellerstedt*'s emphasis on real medical benefit. For example, *Mazurek v. Armstrong* upheld a Montana ban on a physician assistant performing first trimester abortions even though she was qualified, in part because there the petitioners did not argue that the law burdened access.¹⁵¹ The Court simply relied on the language in *Roe* and *Casey* that stated states may require only licensed doctors to perform abortions.¹⁵² But after *Hellerstedt* such bans may be challenged if physicians are not available to meet abortion needs and physician assistants or nurse practitioners are adequately trained and supervised.¹⁵³

Similarly, restrictions on use of telemedicine for prescribing abortion drugs to women in rural areas, which some states have enacted, may also be subjected to scrutiny in light of *Hellerstedt*.¹⁵⁴ Such restrictions could apply both to prescriptions by doctors and by nurse practitioners and physician assistants. If a state permits a doctor generally to treat and prescribe by telemedicine, under *Hellerstedt*, a ban on prescribing medication abortions should not stand. A similar result should follow for nurse practitioners and physician assistants who are permitted to treat and prescribe remotely except for medication abortions. Such cases should turn on whether telemedicine restrictions provide an actual health benefit without imposing a substantial obstacle to access.

Hellerstedt dealt with health restrictions on abortion, but its emphasis on actual facts could support new challenges to informed consent and waiting period laws. *Casey* was very lenient with states that wanted to impose a waiting period, and has been used as authority for states to extend their laws from twenty-four- to forty-eight- or seventy-two-hour waiting periods.¹⁵⁵ A new challenge to waiting periods might be successful if data shows how burdensome such requirements are for women in rural areas with long driving distances, overnight stays, and low income. Women in those circumstances might argue that less restrictive rules, such as

150. See *Currier*, 760 F.3d at 457–58.

151. *Mazurek*, 520 U.S. at 968.

152. *Id.* at 973–74.

153. See Ian Lovett, *California Expands Availability of Abortions*, N.Y. TIMES (Oct. 9, 2013), <http://www.nytimes.com/2013/10/10/us/california-expands-availability-of-abortions.html>; Auren Weinberg, *Ensure Practice Staff Works to the Top of Their License*, PHYSICIAN'S PRACTICE (Apr. 28, 2016), <http://www.physicianspractice.com/articles/ensure-practice-staff-works-top-their-license> [<https://perma.cc/Y7TY-LZL9>] (arguing that having non-MD providers practice to “the top of their license” would reflect the movement in health policy to a more efficient and quality/outcome approach).

154. See *Planned Parenthood of the Heartland, Inc. v. Iowa Bd. of Med.*, 865 N.W.2d 252, 253 (Iowa 2015); E. Ray Dorsey & Eric Topol, *State of Telehealth*, NEW ENG. J. MED. 154, 155 (2016).

155. See ALA. CODE § 26–623A–4 (2014) (forty-eight hours); N.C. GEN. STAT. ANN. § 90–21.82 (West 2015) (seventy-two hours); UTAH CODE ANN. § 76–67–305 (West 2016) (72 hours); see also *Planned Parenthood Minn., N.D., S.D. v. Daugarrd*, 799 F. Supp. 2d 1048 (D.S.D. 2011) (issuing a temporary injunction against the seventy-two-hour waiting period in South Dakota).

informed consent by Skype or other means, should be as effective in informing women as face-to-face meeting with the provider.

Finally, *Hellerstedt* has also breathed new life into the viability of facial attacks on abortion laws. *Gonzales* had landed a hard punch against abortion rights with its apparent rejection of facial attacks when as-applied challenges by affected individuals could be brought.¹⁵⁶ *Hellerstedt*, however, upheld a facial challenge to H.B. 2 even when the total number of women affected overall was small because the burden for that small number had no medical justification. *Hellerstedt* thus appears to have restored facial challenges to the role that they had prior to *Gonzales* status.¹⁵⁷

B. Respect for Fetal Life and Dignity Strategies

With *Hellerstedt* having given abortion rights proponents a victory in the battle over health-related abortion curbs, abortion opponents going forward are likely to focus attention on respect for potential life and the dignity of fetuses prior to viability, which *Casey* and *Gonzales* had permitted. Several new kinds of abortion limitation are being sought under this rubric, but all are likely to fail unless *Roe*'s core right to terminate pre-viable pregnancy is altered.

1. Twenty-Week Ban on Abortion

The most significant new effort, already adopted in fifteen states, is the movement toward a twenty-week ban on abortion based on claims of fetal pain. At present, twenty-weeks is two-to-four weeks prior to most medical assessments about viability (the ability to survive outside of the womb). A twenty-week ban would thus be constitutionally acceptable only if viability were no longer the cutoff line for abortion—a decision that only the Supreme Court can make.¹⁵⁸ Proponents of the twenty-week ban argue that ability to feel pain—an indication of the humanity of the fetus—should substitute for viability. Yet this view has little medical or scientific support¹⁵⁹ of when sentience is highly contested. Most scientists and physicians knowledgeable about the issues believe that pain sensitivity arises only at twenty-four to twenty-six weeks or later, because only then are cortical networks and neural receptors fully developed.¹⁶⁰

156. *Carhart*, 550 U.S. at 167–69.

157. *Id.* at 187–89 (Ginsburg, J., dissenting).

158. *See McCormack v. Herzog*, 788 F.3d 1017, 1029 (9th Cir. 2015); *Isaacson v. Horne*, 716 F.3d 1213, 1222–25 (9th Cir. 2013). A North Dakota law banning abortion whenever a heartbeat was detectable was struck down on similar grounds—it conflicted with Supreme Court precedents protecting the right to abortion before viability. *See MKB Mgmt. Corp. v. Stenehjem*, 795 F.3d 768, 773 (8th Cir. 2016).

159. *See* John Robertson, *Abortion and Technology: Sonograms, Fetal Pain, Viability, and Early Prenatal Diagnosis*, 14 U. PENN. J. CONST. L. 327, 365 (2011) [hereinafter Robertson, *Abortion and Technology*]; *see also* John Robertson, *Science Disputes in Abortion Law*, 93 TEX. L. REV. 1849 (2015) [hereinafter Robertson, *Science Disputes in Abortion Law*].

160. *See* Robertson, *Abortion and Technology*, *supra* note 159, at 365–66.

States that have adopted the twenty-week ban have relied on the opinion of a small group of neuroscientists and doctors who believe otherwise, akin to giving credence to a few scientists who question climate change science.¹⁶¹ They rely on language in *Gonzales* that purports to limit judicial review of contested scientific findings, thereby allowing legislative-backed minorities to carry the day on fetal pain.¹⁶² However, if courts may make their own independent assessment of medical and scientific claims, as *Hellerstedt* teaches, courts could find no scientific basis for the twenty-week ban, which substantially impacts women in that situation. Even if the Court allowed sentience, not viability, to define the cutoff point, under *Gonzales* the fetus could still be killed in utero prior to removal or expulsion from the body.¹⁶³

2. *A Ban on Fetal Dismemberment*

A second fetal protective strategy now touted by abortion opponents is to ban dilation and evacuation abortions that lead to the dismemberment and piecemeal removal of fetal parts on the ground that this procedure is an affront to human dignity.¹⁶⁴ This strategy appears based on the concerns that Justice Kennedy's *Gonzales* opinion cited in upholding the federal partial-birth abortion law. The cosponsor of such a law in Arkansas called dilation and evacuation a "gruesome, barbaric procedure" and "one that no civilized society should embrace."¹⁶⁵

In that case, however, the crushing the skull of the fetus occurred after partial removal from the uterus, thus blurring the line between abortion and birth. The proposed laws, however, ban in utero procedures on fetuses that are not yet in the birth canal, which avoids the blurring that concerned Justice Kennedy.¹⁶⁶ Moreover, such laws would render illegal the most common method of second-trimester abortion, thus imposing a substantial obstacle to abortion access. The state of Alabama argued in a challenge to such a law that a standard D&E could occur if the abortionist first caused fetal demise, citing injection of potassium chloride or digoxin into the fetus or transection of its umbilical cord as ways to achieve that end. The plaintiffs' experts, however, testified that achieving fetal demise in those ways was far beyond the capabilities of doctors in abortion clinics, and would increase the burdens on women undergoing those abortions. The district court agreed, even with the gain in human dignity so questionable, and issued a preliminary injunction against the law. Presumably the proponents of such laws

161. *See id.* at 365–67.

162. *See Gonzales*, 550 U.S. at 163–64.

163. *See id.* A concurring judge in *Isaacson* reached the same conclusion. *Isaacson*, 716 F.3d at 1231–32.

164. *See* Katia Desrouleaux, *Banning Partial-Birth Abortion at All Costs—Gonzales v. Carhart: Three Decades of Supreme Court Precedent "Down the Drain,"* 35 S.U. L. REV. 543, 548 (2008) (describing the D&E process).

165. Kelly Weill, *New Law Lets Dads Veto Abortions*, THE DAILY BEAST (Feb. 2, 2017, 9:00 PM), <http://www.thedailybeast.com/articles/2017/02/02/new-law-lets-dads-veto-abortions.html> [<https://perma.cc/2MXQ-LH9R>] (quoting Arkansas Rep. Andy Mayberry).

166. *Gonzales*, 550 U.S. at 157–60.

would allow termination of pregnancy only by medication or induction of a very early preterm birth, which might lengthen the abortion process and thus deter some women from choosing it. Moreover, the gain in human dignity is questionable if the terminated fetus will emerge stillborn or die very shortly thereafter.¹⁶⁷

3. *Disposition of Fetal Remains*

A third strategy for demonstrating respect for fetuses—requiring that they be cremated or buried after abortion, not merely flushed or incinerated as other medical waste—has already foundered in Indiana and Texas. Under *Hellerstedt*, it is likely to do so in others as well.

The Indiana case arose from a law signed in 2016 by Indiana Governor Mike Pence, which was preliminarily enjoined by a district court just before taking effect.¹⁶⁸ Even though the court found that the law did not infringe a fundamental right, it did find that the opponents of the law were likely to succeed on the merits because the state's interest in treating "fetal remains with 'the same' dignity as human remains" is not rationally related to a legitimate governmental interest.¹⁶⁹ The state interest was not legitimate even under a lenient rational basis standard because the Supreme Court has held that for Fourteenth Amendment purposes the fetus is not a person, thus treating its remains with the same dignity and respect given human remains has no constitutional basis.¹⁷⁰

The judge found that while Indiana's formulations of its interest "are not premised on a fetus being *the same* as a person, they are premised on the related principle that fetal tissue is entitled to a more respectful, dignified, or humane disposition because it, like human remains, in some sense represents life."¹⁷¹ Yet the State cited no legal authority that recognizes this premise as a legitimate interest. Nor did the court find that the protection of potential life recognized as legitimate in *Casey* and *Gonzales* apply, because fetal remains have no potential for human life. Those interests are legitimate only during stages of pregnancy when there is a potential life, not after the pregnancy has been terminated.¹⁷²

The Texas case arose when its Health and Human Services Commission (TSHS) issued a similar regulation four days after *Hellerstedt* to "affirm the value

167. Those concerns might also be minimized by in utero killing of the second-trimester fetus prior to dismemberment, as *Gonzales* permitted to avoid the ban on partial birth abortion. *See id.*

168. *See* Planned Parenthood of Indiana and Kentucky, Inc. v. Comm's, Indiana Dep't of Health, 194 F. Supp. 3d 818, 822 (S.D. Ind. 2016).

169. *Id.* at 832.

170. *See id.*

171. *Id.* at 832.

172. *See id.* at 833. Even if the state had some power to symbolize respect for fetal remains, there would still be the question of undue burden. Complying with the Indiana law would cost between \$36,000 and \$63,000 a year including an additional \$5,000–\$9,000 upfront cost to purchase a crypt at a cemetery and to periodically open close the crypt to deposit cremains. *Id.* at 825. The impact of the additional cost on access to abortion might constitute an undue burden.

and dignity of all life.”¹⁷³ A federal district court issued a preliminary injunction against that rule on January 27, 2016.¹⁷⁴ The regulation prohibited the previously accepted method of incineration and deposition in a sanitary landfill, and now required only interment or cremation with interment as a permissible means of disposing of fetal remains.

The district court found that there was evidence showing that the stated interest “is a pretext for its true purpose, restricting abortion.”¹⁷⁵ Even if that were not its purpose, the Court was not persuaded that its alleged interest in “protecting the dignity of the unborn” was a legitimate one. While the Supreme Court has acknowledged that the State has an “important and legitimate interest in protecting the potentiality of human life[.]”¹⁷⁶ the Court found “that the Amendments do not further such a legitimate state interest . . . [because] they regulate activities after a miscarriage, ectopic pregnancy, or abortion—activities when there is no potential life to respect.”¹⁷⁷

Alternatively, even assuming that “protecting the dignity of the unborn” is a legitimate state interest, the Court applied the *Hellerstedt* balancing test and found that the “burdens on abortion access substantially outweigh the benefits.”¹⁷⁸ Assessing the benefits, the Department of State Health Services (DSHS) undercut the strength of the asserted benefit by recommending that “healthcare providers place fetal tissue in a single container, commingle fetal tissue from various procedures together, and freeze the tissue until disposal can be secured . . .”¹⁷⁹ DSHS was not able to explain how this better protects the dignity of the unborn, nor why fetal tissue must be treated differently at home than in a doctor’s office.

Turning to the burdens imposed by the DSHS rule, the Court found that restricting disposal of fetal tissue consistent with the disposal of human remains will impose burdens on abortion access. DSHS’s “back of the envelope” estimate that the ash from all abortions could be buried for one time for only \$300 per year ignored the reality of the 280,000 square miles that comprised the State and the 5.4 million women of reproductive age living there. The plaintiffs showed that the costs would be considerably greater because of transportation and administrative costs and vendor availability. The Amendments would also pose significant logistical

173. Asher Price, *Proposed Rules: Bury or Cremate Fetal Remains*, AUSTIN AM. STATESMAN, July 8, 2016, at A1.

174. *Whole Woman’s Health v. Hellerstedt*, 231 F. Supp. 3d 218 (W.D. Tex. 2017).

175. *Id.* at 229.

176. *Casey*, 505 U.S. at 846.

177. *Hellerstedt*, 231 F. Supp. 3d at 229. The Court also noted that the State appeared “to be inferentially establishing the beginning of human life at conception, potentially undermining the constitutional protection afforded to personal beliefs and central to the liberty protected by the Fourteenth Amendment.” *Id.*

178. *See id.* at 230.

179. *See id.*

challenges for healthcare providers in terms of sorting procedure, storage, transportation, and ultimate disposal.¹⁸⁰

Finally, there was only one funeral provider licensed and willing to bury fetal remains available for the entire state of Texas, and that provider had no experience with fetal tissue.¹⁸¹ Nor had they experienced the controversy that might arise once it became known that that funeral home was in the fetal burial business. An offer from the Catholic Bishops of Texas to bury all fetal remains at no charge in a Catholic cemetery foundered because that organization had not obtained the required permits for doing so, and if they had, the likelihood that women of other faiths might object to burial in a Catholic cemetery would block that alternative.

While the Indiana and Texas decisions involve preliminary injunctions that have not yet been reviewed on appeal, they show the roadblocks that statutes will encounter in imposing such requirement. The question of whether a legitimate interest in potential life exists when the fetus is dead will be difficult to overcome. Even if it is legitimate, the benefits of fetal disposal law will still have to overcome *Hellerstedt's* requirement that those benefits outweigh the burdens on access which they create.

4. No Discrimination Among Fetuses

Bans on abortion for particular reasons are a fourth area of fetal protection that also lacks traction, even before *Hellerstedt*. States have passed laws banning abortion decisions on account of the sex, race, or mental status of fetuses.¹⁸² These laws purport to extend discrimination that would be illegal once the child was born to fetuses prior to birth. Such laws call into question whether states may limit abortions based on particular characteristics of fetuses or on the motivation of women.

A good example of such efforts is Indiana's 2016 law that would outlaw abortions on the basis of "the fetus's race, color, national origin, ancestry, sex, or diagnosis or potential diagnosis of the fetus having Down syndrome or any other disability."¹⁸³ The district court granted a preliminary injunction against the law's implementation because it violated the right recognized in *Roe* and *Casey* to

180. *Id.* There was also evidence that the burial requirements could cause women grief and shame, possible discouraging them from obtaining abortion and miscarriage management from a medical facility. *Id.* at 230–31.

181. The owner of that home had testified that he expected health care providers to "individually wrap the fetal tissue in cloth and tape so he could transport the tissue, up to twenty-five units at a time, on a stretcher." *Id.* at 231.

182. See also Pub. L. No. 213-2016 (codified as amended in scattered sections of IND. CODE ANN. § 16). See generally ARIZ. REV. STAT. ANN. §13–3603.02 (2011). For an overview of states with those restrictions please see *Abortion Bans in Cases of Sex or Race Selection or Genetic Anomaly*, GUTTMACHER INST. (Jan. 1, 2017), <https://www.guttmacher.org/state-policy/explore/abortion-bans-cases-sex-or-race-selection-or-genetic-anomaly> [<https://perma.cc/RZQ2-7TBL>].

183. H. 1337, 119th Gen. Assemb., 2d Reg. Sess. (Ind. 2016). The term disability did not include "a lethal fetal anomaly." *Id.* Note that such laws would prevent a woman infected with the Zika virus, which causes microcephaloy in offspring, to terminate pregnancy.

terminate pregnancy prior to viability. This right is categorical and does not depend on the genetic or other characteristics of the fetus or a woman's motivation in choosing an abortion. To hold otherwise would require the district court to recognize an exception, which has never existed, not to mention the Hydra-headed implementation problems that would arise in assessing the importance of the various situations that lead women to terminate pregnancy.

Nor do technological advances that allow earlier and more accurate diagnosis of Down syndrome or other disabilities and more abortions for those reasons change the situation. As the district court said, while "the [s]tate's interest in protecting and even promoting potential life is a legitimate one, the Supreme Court has already weighed this interest . . ." ¹⁸⁴ Because this is the central holding of *Roe* and *Casey*, technological advances in prenatal screening and diagnosis that increase the number of abortions cannot override it. ¹⁸⁵ On the other hand, laws mandating provision of information, for example, about life with a Down syndrome child would be acceptable, as long as the woman's right to abort is still respected. ¹⁸⁶

CONCLUSION

In sum, *Hellerstedt* has drastically reoriented the terms of the abortion debate and has shrunk the field of play for opponents within the confines of *Roe* and *Casey*. Pretextual or ill-considered health restrictions will not stand, and precedents about licensure and waiting periods may now have to be rethought. While licensure, informed consent, and nonfunding laws may survive, abortion opponents are increasingly relegated to measures that attack the right to abort before viability. But that avenue is foreclosed until *Roe* and *Casey* are modified.

As long as the current politics of abortion remain, opponents will continue to fight hard to limit abortion with direct restrictions, even while greater access to contraception and sex education may be more successful in lowering abortion rates. A future Court different in makeup may change the law of abortion. Until then, the parameters of litigation post-*Hellerstedt* should remain for some time.

184. *Planned Parenthood of Indiana and Kentucky, Inc.*, 194 F. Supp. 3d at 828. The State also advanced a "binary choice" interpretation of *Roe* and *Casey* that viewed a woman as either choosing to have an abortion or not. If she chooses not to, she would not be able to change her mind on a discriminatory basis. The court found this argument equally unpersuasive. *Id.* at 828–29.

185. See John Robertson, *Abortion and Technology*, *supra* note 159, at 370–79, for a discussion of noninvasive prenatal diagnosis that could occur on the basis of a blood test alone. Nor could the tests on which such earlier prenatal diagnosis occur be banned. *See id.* at 372; *see also* Jaimie S. King, *And Genetic Testing for All . . . The Coming Revolution in Non-Invasive Prenatal Genetic Testing*, 42 RUTGERS L.J. 599 (2011).

186. John Robertson, *Abortion and Technology*, *supra* note 159, at 381.

