Protecting Health after *Dobbs*

by Brietta R. Clark

In *Dobbs v. Jackson Women's Health Organization*,[1] the Supreme Court eliminated the long-standing federal constitutional right to abortion first recognized in *Roe v. Wade*[2] and later affirmed in *Planned Parenthood of Southeastern Pa. v. Casey*.[3] Discussions about abortion rights tend to emphasize protection for reproductive choice. But a related yet distinctly important interest also shaped abortion protection in *Roe* and *Casey*: the preservation of health.

This focus on health is important for a few reasons. For one, it can deepen understanding of the protection lost in *Dobbs*, which includes the apparent erasure of women's health as a check on government power to regulate and control reproduction. It also connects this erasure to the emergence of increasingly restrictive and punitive abortion bans, which are causing providers to deny or delay care necessary to prevent serious and wide-ranging harms to both pregnant and nonpregnant patients.

Finally, the health focus taken here underscores the limited impact of regulatory attempts to blunt these effects, partially due to Congress's own history of exceptionalizing abortion in ways that devalue health. This, in turn, reveals the need for a more comprehensive and enduring approach to protect the health of women, trans men, and other patients who, because of their capacity for pregnancy, are targeted for reproductive regulation and control.

Dobbs's Erasure of Health

Concern for women's health was an essential component of the abortion right established in *Roe*. Roe's prohibition of pre-viability bans and its limits on other forms of regulation were partly based on the safety of early-stage abortions as compared to pregnancy. The role of health was even more explicit in how the Supreme Court dealt with post-viability bans via *Roe*: they were allowed but were subject to an exception permitting abortion when necessary to preserve the woman's life or health. *Casey* relaxed constitutional scrutiny for some regulation but maintained the pre-viability ban and the health exception requirement for post-viability bans. Crucially, health was broadly construed. This provided important protection for decisions that depend on uncertain risk assessments by physicians and patient-specific sensitivity to risk—factors that support deference to physician judgment and patient autonomy generally.

By contrast, the *Dobbs* majority virtually ignored the health implications of forcing a woman to carry a pregnancy to term. This was true throughout its opinion, but the ultimate holding cemented this erasure. Finding no constitutional right to abortion, the majority held that abortion regulation would be subject only to the lowest level of scrutiny, requiring that a law be upheld if there is a rational basis on which the legislature *could have thought* it would serve legitimate state interests. After declaring health regulations to be presumptively valid, the majority listed several government interests satisfying this standard, including the preservation of life at *all* stages of development, potentially allowing government usurpation of health care decision-making from the moment of fertilization. Missing was any discussion of the health risks at stake or the need for a constitutionally required health exception.

Dobbs has thus opened the door for increasingly restrictive and punitive pre-viability bans. Although bans vary by state and the law is in flux,[4] three characteristics make it likely that a pre-viability ban will cause harm. First, bans are applying much earlier in pregnancy. Twelve states ban abortion at fertilization, before one can even know of a pregnancy. Second, exceptions are narrower. While all states have an exception for life endangerment, none have *general* health exceptions. *Physical* health exceptions tend not to apply until a risk has progressed to the point of being deemed an "emergency" or sufficiently "serious"—terms that may not be clearly defined. And none of these allow exceptions for physical risks, like suicide, resulting from *mental* health problems. Fewer than ten states specify exceptions for lethal fetal anomaly, and only four for rape or incest. Third, some laws are extremely punitive and may make providers uncharacteristically vulnerable to prosecution. Bans framing violations as murder or homicide are likely to rely on severe criminal penalties. And such bans have triggered concerns that providers could be arrested for merely performing an abortion and then have the burden of proving that a statutory exception applies.[5]

Such bans are having a chilling effect on provider willingness to deliver care.[6] Women with viable pregnancies

that pose serious health risks are being denied timely abortion care because of legal uncertainty about when pregnancy becomes dangerous enough to meet the exception, and providers lament that this uncertainty forces them to violate their ethical and professional duties of care. Physicians are taught to intervene before patients get sick because the progression of disease or illness generally happens on a continuum and is unpredictable. Pregnancy has become safer over time but is still much more dangerous than abortion, and certain groups, especially Black, American Indian, and Alaska Native women, are at disproportionately greater risk for pregnancy-related mortality and morbidity. Pregnancy always implicates health, but not always in predictable ways.

These bans are harming women even where fetal life isn't at stake. Abortion care is being delayed for women with ectopic pregnancies, which are never viable and can become fatal without prompt treatment, and for women experiencing a spontaneous but incomplete miscarriage, which can lead to serious complications.[7] Without a clear exception for nonviable pregnancies, some providers (or their institutions) believe that they must wait until complications develop in order to avoid criminal liability. Nonpregnant patients are also being denied access to medication for conditions as varied as cancer, autoimmune disease, and arthritis if the medication can also induce abortion.[8] Medication is being denied because of the possibility of interference with future pregnancy.

Federal Action to Protect Health

Federal regulators are trying to prevent these harmful effects, but their power is limited. Regulatory action is subject to reversal by a new administration. In addition, regulators are subject to existing limits in the law, and there is no general right to care in the United States. Instead, there is a patchwork of laws that create narrow duties of care, including laws that have exceptionalized abortion in ways that devalue health.

Consider the Emergency Medical Treatment and Labor Act,[9] the federal law requiring emergency departments to provide stabilizing care for emergency conditions. The U.S. Department of Health and Human Services (HHS) has issued guidance explaining that EMTALA may require abortion care in certain cases and that state laws banning abortion care required by EMTALA should be preempted.[10] But this still raises the question of how severe the risk must be for a patient to qualify for EMTALA protection. Moreover, federal conscience protections allow providers and institutions to refuse to perform abortions, without specifying how those entities should ensure that patients can otherwise access care. Indeed, abortion-restrictive states are pointing to these conscience protections to try to undermine HHS's EMTALA guidance.

HHS has also suggested that denials of care may implicate sex- and disability-discrimination prohibitions.[11] Yet the federal government has consistently carved out some abortion care from antidiscrimination and other health laws. Consider Title VII of the 1964 Civil Rights Act,[12] which prohibits sex discrimination in employment, including employee-benefit plans. It was amended by the Pregnancy Discrimination Act to clarify that exclusions based on pregnancy, childbirth, and related conditions constitute sex discrimination; but it included a caveat that employers could not be required to cover abortion, except in cases of life endangerment or where medical complications arise. Similar risk-based line drawing has occurred in legislation banning Medicaid and other federal funding from being used to cover abortion. Although government could not ban most abortions directly under *Roe*, subsequent cases allowed government to erect resource barriers to care that are contingent on severity of risk.

Other examples abound. Indeed, as consequential as *Dobbs* is, it reflects the culmination of a longer erosion of health protection in abortion regulation broadly—a problem that only legislation can correct. Such legislation has already been proposed. The Women's Health Protection Act[13] would restore the prohibition on pre-viability bans and the requirement that any ban have a broad health exception that respects provider judgment. And it would go further in centering health: abortion restrictions would be allowed only if they were the least-restrictive means of significantly advancing patient health or safety. The Equal Access to Abortion Coverage in Health Insurance Act[14] would restore abortion coverage for people enrolled in Medicaid and other federal programs, facilitating access to care before a risk becomes too serious. Together, these bills reflect the kind of comprehensive and enduring approach needed to protect the health of those targeted for government regulation because of their capacity for pregnancy.

1. Dobbs, 142 S. Ct. 2228 (2022).
2. Roe, 410 U.S. 113 (1973).
3. Casey, 505 U.S. 833 (1992).
4. Guttmacher Institute, "State Bans on Abortion throughout Pregnancy," rev. October 6, 2022, at https://www.guttmacher.org.
5. See, for example, Idaho Code § 18-622(2)-(3) (2022).
6. J. Winter, "The Dobbs Decision Has Unleashed Legal Chaos for Doctors and Patients," *New Yorker*, July 2, 2022.
7. P. Belluck, "They Had Miscarriages, and New Abortion Law Obstructed Treatment," *New York Times*, July 17, 2022.
8. K. Shepherd and F. S. Sellers, "Abortion Bans Complicate Access to Drugs for Cancer, Arthritis, Even Ulcers," *Washington Post,* August 8, 2022.
9. EMTALA, 42 U.S.C. 1395dd.
10. Department of Health and Human Services, Centers for Medicare & Medicaid Services, "Reinforcement of EMTALA Obligations Specific to Patients Who Are Pregnant or Are Experiencing Pregnancy Loss," July 11, 2022, https://www.cms.gov/files/document/qso-22-22-hospitals.pdf.
11. "Guidance to Nation's Retail Pharmacies: Obligations under Federal Civil Rights Laws to Ensure Access to Comprehensive Reproductive Health Care Services," Department of Health and Human Services, Office for Civil Rights, last reviewed July 14, 2022, https://www.hhs.gov/civil-rights/for-individuals/special-topics/reproductive-healthcare/pharmacies-guidance/index.html#:~:text=9%20As%20recipients%20of%20federal,of%20federal%20civil%20rights%20laws.
12. Title VII, 42 U.S.C. 2000e.
13. Women's Health Protection Act, H.R. 3755, 117th Cong. (2021).
14. Equal Access to Abortion Coverage in Health Insurance Act, S. 1021, 117th Cong. (2021).

DOI: 10.1002/hast.1441