



Summer 2022

Abortion Rights and Disability Equality: A New Constitutional Battleground

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Recommended Citation

Allison M. Whelan and Michele Goodwin, *Abortion Rights and Disability Equality: A New Constitutional Battleground*, 79 Wash. & Lee L. Rev. 965 (2022).

Available at: <https://scholarlycommons.law.wlu.edu/wlulr/vol79/iss3/4>

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Abortion Rights and Disability Equality: A New Constitutional Battleground

Allison M. Whelan* & Michele Goodwin**

Abstract

*Abortion rights and access are under siege in the United States. Even while current state-level attacks take on a newly aggressive scale and scope—emboldened by the United States Supreme Court’s June 2022 decision in *Dobbs v. Jackson Women’s Health Organization* to overturn *Roe v. Wade* and *Planned Parenthood of Southeastern Pennsylvania v. Casey*—the legal landscape emerging in the wake of *Dobbs* is decades in the making. In this Article, we analyze the pre- and post-*Roe* landscapes, explaining that after the Supreme Court recognized a right to abortion in *Roe* in 1973, anti-abortionists sought to dismantle that right, first thread by thread and now whole cloth. As we explain, these concerted efforts impose unique and uniquely burdensome harms on those living at the intersections of historically marginalized and vulnerable identities, including persons of color, low-income populations, persons with disabilities, and individuals in LGBTQ+ communities. This Article examines the deeply troubling—and now successful—efforts to dismantle *Roe* and the legal attacks on reproductive freedom. It foreshadows continuing legal efforts to*

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gut abortion rights and new battlefronts related to disability justice and LGBTQ+ equality emerging from the same efforts. Focusing on persons with disabilities, this Article argues that the political movement to deny abortion rights will eviscerate gains made toward disability justice, as well as many other social justice gains such as LGBTQ+ equality.

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INTRODUCTION

In the wake of contemporary threats to reproductive freedom, advocacy organizations are turning to social movement frameworks long articulated and adopted by Black women. For centuries, Black women urged a more nuanced and capacious understanding of discrimination that accounts for the unique ways in which racism, sexism, disability, and ageism produce unequal and immoral treatments under and guided by law.¹ In

1. See, e.g., BELL HOOKS, *AIN'T I A WOMAN: BLACK WOMEN AND FEMINISM* (1981); Serena Mayeri, *Intersectionality and Title VII: A Brief (Pre-)History*, 95 B.U. L. REV. 713, 719 (2015) (noting that Pauli Murray anticipated Kimberlé Crenshaw's theory of intersectionality); Pauli Murray & Mary O. Eastwood, *Jane Crow and the Law: Sex Discrimination and Title VII*, 34 GEO. WASH. L.

her iconic nineteenth century memoir, Harriet Jacobs prevailed upon readers to understand the unique ways in which racial subordination and sexual violence toxically combined to threaten the safety of even young Black girls from the sexual predations of white families that held Black children in bondage.²

Poignantly, Jacobs illumed a world in which three generations of Black women suffered under the vile conditions of enslavement shaped by overlapping and distinct horrors, and framed by their differences in age, disability, and other vulnerabilities.³ Most importantly, the memoir illustrated conditions universally experienced by Black women, highlighted as well by Sojourner Truth,⁴ Harriet Tubman,⁵ Frederick Douglass,⁶ and W.E.B. Du Bois.⁷

REV. 232, 243 (1965) (“[I]t is exceedingly difficult to determine whether a Negro woman is being discriminated against because of race or sex.”); Jennifer C. Nash, *‘Home Truths’ on Intersectionality*, 23 YALE J.L. & FEMINISM 445, 450 (2011) (describing how Sojourner Truth, Ida B. Wells, and Anna Julia Cooper “labored to show how race and gender cooperate to marginalize black women”); Pauli Murray, Memorandum in Support of Retaining the Amendment to H.R. 7152, Title VII (Equal Opportunity) to Prohibit Discrimination in Employment Because of Sex (Apr. 14, 1964) (on file with Schlesinger Libr., Radcliff Inst. for Advanced Stud., Harv. Univ.) (“[Sex and race] discrimination are so closely intertwined [sic] and so similar that Negro women are uniquely qualified to affirm their interrelatedness.”).

2. See generally HARRIET JACOBS, INCIDENTS IN THE LIFE OF A SLAVE GIRL. WRITTEN BY HERSELF (Maria L. Child ed. 1861).

3. See generally *id.*

4. See *Compare the Two Speeches*, THE SOJOURNER TRUTH PROJECT, <https://perma.cc/MKX4-FEX7>.

5. See BENJAMIN DREW, A NORTH-SIDE VIEW OF SLAVERY: THE REFUGEE OR THE NARRATIVES OF FUGITIVE SLAVES IN CANADA RELATED BY THEMSELVES WITH AN ACCOUNT OF THE HISTORY AND CONDITION OF THE COLORED POPULATION OF UPPER CANADA 30 (1856) (“I had two sisters carried away in a chain-gang,—one of them left two children . . . I think slavery is the next thing to hell.” (quoting Harriet Tubman)).

6. See FREDERICK DOUGLASS, WHAT TO THE SLAVE, IS THE FOURTH OF JULY? (1852) (“The crack you heard, was the sound of the slave-whip; the scream you heard, was from the woman you saw with the babe. Her speed had faltered under the weight of her child and her chains! That gash on her shoulder tells her to move on.”); see also PHILIP S. FONER, FREDERICK DOUGLASS: SELECTED SPEECHES AND WRITINGS 188–206 (1999).

7. See W.E.B. DU BOIS, BLACK RECONSTRUCTION IN AMERICA 1860–1880, 11 (1935) (describing slavery as the “deliberate commercial breeding and sale

Building on this robust literary and historical legacy, in the late twentieth century, Professor Kimberlé Crenshaw urged a deeper and more meaningful understanding of the unique harms experienced by Black women at the intersections of race and sex. From this, the important term “intersectionality” was introduced in 1989 to describe how race and sex intersect to shape the experiences of Black women.⁸ Increasingly, scholars understand the value and importance of this framework and how its application extends well beyond race and sex, fundamentally reshaping how scholars think about some of society’s most pressing social and legal concerns.

That is, intersectionality “expose[s] how single-axis thinking undermines legal thinking, disciplinary knowledge production, and struggles for social justice.”⁹ Critically, the framework “helps explain the realities of people who have multiple identities in which they experience oppression, and how they not only contend with the harms of each of those separate identities . . . but also experience compounded and unique harms at the particular intersections of those identities.”¹⁰

This Article builds from that important conceptual framework grounded in centuries of thought on Black women’s status in society to examine the deeply troubling—and now successful—efforts to dismantle *Roe v. Wade*¹¹ and legal attacks on reproductive freedom. It foreshadows continuing legal efforts to gut abortion rights and new battlefronts related to disability justice and LGBTQ+¹² equality emerging from the same

of human labor for profit”); see also W.E.B. DU BOIS, *THE SOULS OF BLACK FOLKS* 5, 135 (W.W. NORTON & Co. 1999) (1903).

8. See Kimberlé Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, 1989 U. CHI. LEGAL F. 139, 141–50 (1989).

9. Sumi Cho et al., *Toward a Field of Intersectionality Studies: Theory, Applications, and Praxis*, 38 SIGNS 785, 787 (2013).

10. NIKITA MHATRE, NAT’L P’SHP FOR WOMEN & FAMILIES, AUTISTIC SELF ADVOC. NETWORK, ACCESS, AUTONOMY, AND DIGNITY: ABORTION CARE FOR PEOPLE WITH DISABILITIES 3 (2021), <https://perma.cc/P2AA-K698> (PDF).

11. 410 U.S. 113 (1973), *overruled by* *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228 (2022).

12. This Article’s use of the acronym “LGBTQ+” should be read broadly. “LGBTQ+” includes but is not limited to lesbian, gay, bisexual, transgender,

efforts.¹³ It argues that the political tides to deny abortion rights will eviscerate gains made toward disability justice.¹⁴ As we argue, reproductive rights, the policing of reproductive bodies and identities, bodily autonomy, and freedom of “choice” cannot be fully understood without appreciating peoples’ lived experiences and the spectrum of subordination that redounds on the lives of vulnerable people. As such, the “choice” framework proves hollow and unsatisfactory to meet the challenges and demands of the current legal landscape. For this reason, we adopt and advocate for a reproductive justice lens.¹⁵

We make several key observations. First, despite the promise that *Roe* held for reproductive freedom, the choice framework set forth by *Roe* operated in a more illusory than real manner for many pregnant persons,¹⁶ such as persons with physical disabilities, who are the focus of this Article.¹⁷ In other words, *Roe* was never a “north star” for reproductive freedom, but rather an important and landmark decision to dismantle criminal laws targeting physicians that assisted patients in the termination of pregnancies. Sadly, *Roe* could not withstand nor stem the tide of Hyde-era amendments and legislation to distance poor persons from the promise of reproductive

and queer people, including nonbinary, gender-nonconforming, genderqueer, and questioning individuals.

13. See *infra* Part I. This Article concentrates on disability justice, while subsequent work will focus on LGBTQ+ equality.

14. See *infra* Part III.

15. Reproductive justice, which builds from intersectionality and recognizes reproductive rights as human rights, represents a pivotal issue of the twenty-first century. See International Conference on Population and Development, *Programme of Action*, ¶¶ 7.1–7.26, U.N. Doc. A/CONF.171/13 (Sept. 13, 1994) (“Reproductive rights embrace certain human rights, [including the] right to make decisions concerning reproduction free of discrimination, coercion and violence.”). See *generally* U.N. POPULATION FUND ET AL., *REPRODUCTIVE RIGHTS ARE HUMAN RIGHTS: A HANDBOOK FOR NATIONAL HUMAN RIGHTS INSTITUTIONS* (2014), <https://perma.cc/86H5-RD2P>.

16. Abortion is often framed as a “women’s” issue, but transgender, nonbinary, and gender-nonconforming people may also become pregnant and need abortions. Whenever possible, this Article uses gender-neutral language. The term “woman” or “women” may be used, particularly where the sources use that terminology.

17. See *generally* Dorothy Roberts, *Reproductive Justice, Not Just Rights*, *DISSENT MAG.*, Fall 2015, <https://perma.cc/G63E-6QSV>.

freedom.¹⁸ Nor did advocates of the choice framework expand their vision to include economically disadvantaged persons too poor to access reproductive health services, including abortion.

Second, we note that state and federal regulation of reproduction can inhibit, or even eliminate, the ability of many women, girls, or persons with the capacity for pregnancy to exercise choice. This is glaring and apparent in the contemporary landscape and milieu, but such conditions preexisted the most recent battles illustrated by *Dobbs v. Jackson Women's Health Organization*.¹⁹ Third, a person's ability to exercise choice is further informed and influenced by their race, class, disability status, and/or sexual orientation. For example, a century ago, eugenics and political platforms related to procreative "fitness" influenced and shaped state legislation and ultimately Supreme Court jurisprudence.²⁰

Our contribution to this valuable Symposium²¹ emerges at a time of a chilling legal storm. Despite earlier warnings, the dismantling of abortion rights with a proliferation of anti-abortion laws at the state level can no longer be ignored or pushed aside.²² The Supreme Court's decision to hear *Dobbs*, *Whole Woman's Health v. Jackson*,²³ and *United States v. Texas*²⁴ during the Court's 2021 term raised fears amongst advocates for reproductive rights, health, and justice that the Court would overturn *Roe v. Wade* and *Planned Parenthood v. Casey*.²⁵ These fears now materialize with the Supreme Court's decision in *Dobbs* to overturn *Roe* and *Casey*.

18. See *infra* notes 120–122 and accompanying text.

19. 142 S. Ct. 2228 (2022); see *infra* notes 23–28 and accompanying text.

20. See generally, e.g., *Buck v. Bell*, 274 U.S. 200 (1927) (upholding a Virginia law authorizing the Commonwealth's right to forcibly sterilize a person deemed unfit to procreate).

21. This paper was presented at the invitation of the *W&L Law Review* at the 2021–2022 *Lara D. Gass Symposium* at Washington and Lee University School of Law.

22. See, e.g., Michele Goodwin, *Fetal Protection Laws: Moral Panic and the New Constitutional Battlefield*, 102 CAL. L. REV. 781, 781 (2014).

23. 142 S. Ct. 522 (2021).

24. 142 S. Ct. 416 (2021) (mem.).

25. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992), overruled by *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228 (2022).

The laws at issue in these cases were some of the most restrictive in the nation at that time. The Mississippi law considered in *Dobbs* bans abortions at fifteen weeks' gestation and contains no exception for rape or incest²⁶—exceptions that were once a rare source of agreement.²⁷ The Texas law, Senate Bill 8 (“SB 8”), goes much further, banning abortions upon detection of a fetal heartbeat, typically around six weeks' gestation, when many do not yet know they are pregnant.²⁸ Like the Mississippi law, it contains no exceptions for rape or incest.²⁹ Unlike most other state abortion laws, which are enforced by state officials, SB 8 provides a civil cause of action against those who aid and abet an individual seeking to terminate a pregnancy after six weeks, awarding plaintiffs at least \$10,000 for each successful judgment.³⁰ Essentially, the law deputizes ordinary citizens as “bounty hunters,” legalizing a form of vigilantism and harassment of patients, doctors, nurses, and anyone else providing aid and support to a pregnant person considering an abortion.³¹ Notably, it pulls from the archives of American slavery, where such laws made “fugitives” of individuals who sought bodily autonomy and freedom.³² In *Whole Woman's Health v. Jackson*, the Supreme Court ruled that the lawsuit brought by Texas abortion providers against a group of state medical licensing officials could proceed, and returned the case to the conservative U.S. Court of Appeals for the Fifth Circuit.³³ The Fifth Circuit then sent the case to the

26. MISS. CODE § 41-41-191 (2018).

27. Michele Goodwin & Mary Ziegler, *Whatever Happened to the Exceptions for Rape and Incest?*, THE ATL. (Nov. 29, 2021), <https://perma.cc/S5X5-GRT8>.

28. TEX. HEALTH & SAFETY CODE § 171.204 (2021).

29. *See generally id.* §§ 171.001–171.212.

30. *Id.*

31. *See Whole Woman's Health v. Jackson*, 142 S. Ct. 522 (2021) (Sotomayor, J., concurring in part and dissenting in part); Robert L. Tsai & Mary Ziegler, *The New Abortion Vigilantism*, N.Y. REV. (Sept. 23, 2021), <https://perma.cc/UTC5-2Z88> (PDF).

32. *See, e.g.*, Fugitive Slave Act of 1850, ch. 60, 9 Stat. 462; Fugitive Slave Act of 1793, ch. 7, § 3, 1 Stat. 302.

33. *Whole Woman's Health*, 142 S. Ct. at 539. The Court ruled that the abortion providers could not proceed against state court judges, clerks, the state attorney general, and an anti-abortion activist whom the providers

Texas Supreme Court for further interpretation.³⁴ On March 11, 2022, the Texas Supreme Court effectively dealt the final blow to the legal challenges against the law, ruling that medical licensing officials did not have any power to enforce the law and thus could not be sued.³⁵ The law remains in effect as of this writing. And now, post-*Roe*, numerous states have enacted abortion bans, many of which are subject to ongoing legal challenges.³⁶

Unsurprisingly, other states quickly proposed copycat bills to SB 8, sometimes exceeding the level of civil liberty and civil rights infringements found in the Texas law.³⁷ In Ohio, for example, a bill with a citizen enforcement provision was introduced that would ban *all* abortions, at any time, except to prevent the death of the pregnant person.³⁸ On March 14, 2022, Idaho became the first state to pass abortion legislation modeled after SB 8.³⁹

believed would be likely to sue them under SB 8. *See generally id.* The Court also issued a brief, unsigned order dismissing the Biden Administration's challenge to the Texas law as "improvidently granted," a decision that does not resolve the case on the merits. *United States v. Texas*, 142 S. Ct. 522 (2021) (mem.).

34. *Whole Woman's Health v. Jackson*, 23 F.4th 380, 389 (5th Cir. 2022).

35. *See* Kate Zernike & Adam Liptak, *Texas Supreme Court Shuts Down Final Challenge to Abortion Law*, N.Y. TIMES (Mar. 11, 2022), <https://perma.cc/4D5Q-M9GK>.

36. *See Tracking the States Where Abortion Is Now Banned*, N.Y. TIMES, <https://perma.cc/GZS6-L9YG> (last updated Sept. 9, 2022, 8:15 AM) (providing maps and a chart which are updated periodically and describe the current status of abortion laws in the states); *see also* Tierney Sneed & Veronica Stracqualursi, *Abortion Is Banned or Severely Limited in a Number of States. Here's Where Things Stand*, CNN, <https://perma.cc/ZMN9-EPXB> (last updated Sept. 8, 2022, 4:00 PM). On August 5, 2022, the Governor of Indiana signed the first post-*Roe* abortion ban. Mitch Smith & Julie Bosman, *Indiana Governor Signs First Post-Roe Abortion Ban, With Limited Exceptions*, N.Y. TIMES (Aug. 5, 2022), <https://perma.cc/R2M6-QE8V>.

37. *See, e.g.*, Katie Kindelan, *Abortion Bill Similar to Texas' Controversial Ban Introduced in Florida*, ABC NEWS (Sept. 23, 2021), <https://perma.cc/JMM2-LB6U>; *Oklahoma Senate Approves Texas-Style Anti-Abortion Law Allowing Private Lawsuits*, NBCDFW (Mar. 11, 2022), <https://perma.cc/BU5Q-4X6Y>.

38. H.B. 480, 134th Gen. Assemb., Reg. Sess. (Ohio 2021) (codified in scattered sections of OHIO REV. CODE ch. 2919).

39. IDAHO CODE §§ 18-8801 to 18-8808 (2022). Like SB 8, the law bans abortions once a fetal heartbeat is detected. *Id.* It provides a civil cause of

Despite *Roe*, *Casey*, and the now-defunct guarantees of the Court's decisions in *Whole Woman's Health v. Hellerstedt*⁴⁰ and *June Medical Services L.L.C. v. Russo*,⁴¹ which struck down abortion restrictions in Texas and Louisiana, respectively, states continued to erect significant barriers to reproductive autonomy. Advocates for these increasingly broad and severe restrictions gambled on the premise that sufficient votes existed on the Supreme Court to overturn *Roe* or otherwise significantly curtail the right to abortion.⁴² Given the Supreme Court's decision in *Dobbs*, those gambles were worth it for opponents of abortion.

This Article proceeds in three parts. Part I situates the current debate on abortion rights, clarifying their status in the wake of *Dobbs*.⁴³ It then addresses current legal challenges and hurdles to abortion rights and access at the state and federal levels, making clear that those interested in advancing reproductive justice must mobilize and campaign for reproductive rights rather than wait for legislatures to initiate legal change.⁴⁴ Part II unpacks the intersectionality of these issues by exploring the impact of these laws on persons with

action against any medical professional who “knowingly or recklessly attempted, performed, or induced the abortion in violation of” the law to the person on whom an abortion is performed or attempted to be performed, as well as the father, grandparent, sibling, aunt, or uncle of the “preborn child.” *Id.* § 18-8807(1)(a). Unlike SB 8, the law includes exceptions for “medical emergencies” as well as rape and incest. *Id.* § 18-8804(1). On April 12, 2022, Oklahoma Governor Keven Stitt signed a bill into law that makes it a felony to perform an abortion at any time during pregnancy, except to save the life of the pregnant person. Sean Murphy, *Oklahoma Governor Signs Bill to Make Abortion Illegal*, AP (Apr. 12, 2022), <https://perma.cc/D67R-CVBV>. This law does not, however, contain a civil enforcement mechanism like SB 8. OKLA. STAT. tit. 63, § 1-731.3 (2022).

40. 579 U.S. 582 (2016), *abrogated by* *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228 (2022).

41. 140 S. Ct. 2103 (2020), *abrogated by* *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228 (2022).

42. See Amy Howe, *Majority of Court Appears Poised to Roll Back Abortion Rights*, SCOTUSBLOG (Dec. 1, 2021), <https://perma.cc/EGJ5-JTHP>; Mary Ziegler, *The End of Roe Is Coming, and It Is Coming Soon*, N.Y. TIMES (Dec. 1, 2021), <https://perma.cc/9SB7-XY3N>.

43. See *infra* Part I.

44. See *infra* Part I.

physical disabilities.⁴⁵ Part III offers a normative account, arguing that communities at the intersections must embrace their commonalities and differences, and come together to build intersectional coalitions to further the reproductive justice discourse and to advance common goals of bodily autonomy, self-determination, and equality.⁴⁶

I. ABORTION RIGHTS IN THE UNITED STATES

In Part I, we situate the debate over abortion rights in the United States by providing a brief overview of the U.S. Supreme Court's jurisprudence in *Roe*, *Casey*, and *Dobbs*. While the general concepts undergirding *Roe* and *Casey* may be perceived as well understood, professors and pundits in both law school and popular discourse misread and misrepresent the core holdings in these cases. As to the former, law professors frequently teach that *Roe* established reproductive rights for women. While not inaccurate, a more nuanced reading illuminates the Court striking down criminal laws that banned physicians from performing abortions rather than recognizing women's abilities to govern their own bodies without consulting medical providers. A more rigorous reading of *Roe* avoids this faulty intellectual shortcut and reveals other important holdings in *Roe*, such as rejecting fetal personhood and recognizing reproductive freedom as a fundamental right. Equally, the abridged reading of *Casey* ignores the important acknowledgment that domestic violence impedes and threatens reproductive freedom.⁴⁷ Further, laws that establish rights in third parties vis-à-vis a woman's pregnancy undermine reproductive freedom and cannot stand.

We first offer a clearer reading of *Roe* and *Casey* and then clarify the current status of abortion rights in the United States in light of *Dobbs*, addressing present challenges at the state and federal levels.

45. See *infra* Part II.

46. See *infra* Part III.

47. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 887–98 (1992).

A. *Jurisprudential Foundations: Roe and Casey*

The Supreme Court decided the landmark abortion case *Roe v. Wade* in 1973, striking down several Texas laws that criminalized abortion except when necessary to save the life of the mother.⁴⁸ The Court invalidated these laws on the ground that the constitutional right to privacy encompasses the decision to obtain an abortion, although that right is not unqualified.⁴⁹ *Roe* established a three-part framework in which a woman's right to abortion and the state's right to protect potential life shift. According to Justice Blackmun, the author of the Court's decision, a woman's right to abortion is strongest during the first trimester, when the state may not regulate abortion and the decision is left to the woman and her healthcare provider.⁵⁰ During the second trimester, the state may promote its interest in the woman's health by regulating abortion in ways that reasonably relate to preserving and protecting maternal health.⁵¹ Post-viability, the state may promote its interest in potential human life by regulating or even proscribing abortion except when necessary to preserve the life or health of the mother.⁵²

In *Casey*, the Court reaffirmed *Roe* but abandoned the trimester framework and the strict scrutiny standard, replacing it with a more permissive "undue burden" standard.⁵³ Restrictions that placed an undue burden on a person seeking an abortion were unconstitutional.⁵⁴ Under *Casey*, a state regulation imposed an undue burden when it "has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus."⁵⁵ Viewed through the lens of reproductive freedom, both cases were imperfect even if important to the liberation of women's abilities to govern their pregnancies.

48. *See generally* *Roe v. Wade*, 410 U.S. 113 (1973).

49. *Id.* at 152–55.

50. *Id.* at 163.

51. *Id.*

52. *Id.* at 163–64.

53. *Casey*, 505 U.S. at 876.

54. *Id.* at 877.

55. *Id.*

In *Roe*, the Court determined that abortion was a woman's choice in consultation with her doctor.⁵⁶ In other words, even in the early 1970s, the Court stopped short of ruling that women possessed the basic moral and intellectual capacities to independently govern their bodies when it relates to pregnancy. Further, even while the decision established a right associated with abortion, it liberated male doctors in the performance of the procedure. At that time in American medicine, doctors were overwhelmingly male, including obstetricians and gynecologists.⁵⁷ Thus, as much as *Roe* served the interests of women, it also liberated male doctors to expand their practices without threat of state surveillance, hostility, and arrests. Therefore, doctors could not be charged with assault or even murder in the termination of a pregnancy and the death of a fetus.

By contrast, twenty years later in *Casey*, the Court centered its decision on women rather than their physicians. Notably, not only had women's rights taken deeper root within American law and jurisprudence, but Justice Sandra Day O'Connor had integrated the Court the decade prior.⁵⁸ In the twenty-year gap between *Roe* and *Casey*, myriad sex-discriminatory laws that constrained women's ability to live equal lives to men fell away, expanding opportunities in education, employment, and civil life that were previously foreclosed to women. Importantly, fastening the abortion right to women rather than women in consultation with their physicians was more than symbolic, it was a substantive and overdue recognition of the legal and moral capacities of women to independently govern their reproductive health. Even so, a sharper reading of *Casey* also sets the stage for more clearly understanding that the genesis of targeted regulations of abortion providers (TRAP) laws began

56. See *Roe*, 410 U.S. at 167.

57. See Phillip R. Kletke et al., *The Growing Proportion of Female Physicians: Implications for the US Physician Supply*, 80 AM. J. PUB. HEALTH 300, 301 (1990) (reporting that in 1970, only 7.1% of active physicians in the United States were female); *Physician Statistics Summary (1970–1999)*, PINNACLE HEALTH GRP. (Dec. 31, 1999), <https://perma.cc/N79X-DRXM>.

58. See Charles D. Kelso & R. Randall Kelso, *Sandra Day O'Connor: A Justice Who Has Made a Difference in Constitutional Law*, 32 MCGEORGE L. REV. 915, 917 (2001).

with *Casey*, albeit likely not predicted by the Justices at the time. That is, while the Court shifted states' attention away from women consulting with their physicians to terminate a pregnancy, it did not abandon its historic patterns of paternalism in association with women's liberty interests.

In *Casey*, the Court reasoned that states could enact laws that furthered their interest in determining that women were fully informed in their decision-making to terminate a pregnancy.⁵⁹ As such, states could impose waiting periods and other constraints that would not obstruct the right to terminate a pregnancy (that is, not impose an "undue burden"), but rather which would ensure informed consent.⁶⁰ Thirty years later, such provisions would serve as a blueprint for dismantling *Roe* and undermining *Casey*. For decades, *Roe* and *Casey* provided the foundation for the Supreme Court's extensive abortion jurisprudence, including myriad cases addressing federal and state abortion laws and regulations, along with other cases addressing broader reproductive rights such as access to contraception.

B. Ongoing Legal Challenges to Abortion Rights at the State and Federal Levels

Despite *Roe*, *Casey*, and other Supreme Court decisions reaffirming the right to an abortion, state and federal laws and regulations frequently infringed on this right. It was well understood that the Court's current 6-3 conservative majority placed abortion rights at great risk. Indeed, on one hand, the Court gutted almost fifty years of precedent when it overturned *Roe* and *Casey* in *Dobbs*. On the other hand, if one considers the too frequently overlooked Supreme Court jurisprudence in *Skinner v. Oklahoma*,⁶¹ which articulated a human and civil right to individual reproductive decision-making, the Court eviscerated eighty years of stare decisis in its *Dobbs* decision.⁶² This Part examines common restrictions at the state and federal

59. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 878 (1992).

60. *Id.*

61. 316 U.S. 535 (1942).

62. *See id.* at 562–63.

levels, providing a descriptive account of the ongoing legal challenges and hurdles to abortion rights in the United States.

1. State Restrictions

Today, states are the primary abortion battleground in the United States.⁶³ Emboldened by the Supreme Court's strengthening conservative majority, 2021 marked the first time that states enacted more than one hundred abortion restrictions in a single year.⁶⁴ Notably, however, the fierce push to curtail abortion rights began a decade prior, if not before. Between 2011 and 2013, more abortion restrictions were enacted than the previous decade combined.⁶⁵ That period marked a backlash against the Obama Administration and the Affordable Care Act, which furthered contraceptive access; the mainstreaming of evangelism and its influence in politics; and the rise of tensions within the Republican Party.⁶⁶ Ultimately, a movement transpired that more clearly aligned with anti-abortion sentiment than ever before, particularly considering that five of the seven *Roe* Justices who voted to strike down laws criminalizing abortion were appointed by Republican Presidents.⁶⁷

63. See generally ELIZABETH NASH, GUTTMACHER INST., THE DANGER AHEAD: EARLY INDICATORS SHOW STATES WILL BE THE MAIN ABORTION BATTLEGROUND IN 2021 (2021), <https://perma.cc/9Y6J-GTD2>.

64. ELIZABETH NASH, GUTTMACHER INST., FOR THE FIRST TIME EVER, U.S. STATES ENACTED MORE THAN 100 ABORTION RESTRICTIONS IN A SINGLE YEAR (2021), <https://perma.cc/GN23-D23T>. As of April 8, 2022, at least sixteen states had “attempted to ban abortion before viability but were stopped by court order.” GUTTMACHER INST., STATE BANS ON ABORTION THROUGHOUT PREGNANCY (2022), <https://perma.cc/A42F-NW42>. Of these, three attempted to ban abortion throughout pregnancy and eight attempted to ban abortion around six weeks based on the presence of fetal heartbeat. *Id.*

65. According to the Guttmacher Institute, states passed 205 abortion restrictions from 2011 to 2013, compared to 189 from 2001 to 2010. Heather D. Boonstra & Elizabeth Nash, *A Surge of State Abortion Restrictions Puts Providers—and the Women They Serve—in the Crosshairs*, 17 GUTTMACHER POL'Y REV. 9, 10 (2014).

66. See Jillian Weinberger, *How We Got Here: Roe v. Wade From 1973 to Today*, VOX (May 6, 2022), <https://perma.cc/CE6V-BHHW>.

67. See *id.* (“The anti-abortion movement has also focused on building a pipeline of judicial nominees through organizations like the Federalist Society.”).

Increasingly, states designed laws to challenge *Roe* and the constitutional right to abortion directly, such as through “trigger laws,” which were designed to take effect automatically or through quick state action if the Supreme Court overturned *Roe*—as it has now done in *Dobbs*.⁶⁸ States also enacted—and continue to enact—laws that slowly chip away at abortion rights or make abortion more difficult to access.⁶⁹ These include TRAP laws, mandatory counseling and waiting periods, restrictions on medication abortion, and insurance restrictions.⁷⁰

TRAP laws represent an important part of the anti-abortion movement. By design, the laws shut down abortion providers by imposing costly and burdensome regulations, such as facility requirements and hospital relationship/admitting privilege requirements.⁷¹ Proponents of TRAP laws suggest that these laws protect and promote a pregnant person’s health while still retaining their ability to “choose” an abortion.⁷² In reality, these laws manifest little connection to safety and greatly inhibit the ability to exercise choice, particularly for persons whose identities include intersections of race, sex, disability, or LGBTQ+ statuses.⁷³ The American Medical Association (AMA), the American College of Obstetricians and Gynecologists (ACOG), and other medical groups oppose these laws because they have the opposite effect by blocking access to safe abortions.⁷⁴ Further, when these laws result in clinic closures,

68. See GUTTMACHER INST., ABORTION POLICY IN THE ABSENCE OF *ROE* (2022), <https://perma.cc/9CWN-KCBA> (“[Thirteen] states have post-*Roe* laws to ban all or nearly all abortions that would be triggered if *Roe* were overturned.”).

69. See Weinberger, *supra* note 66.

70. See *Types of State Attacks on Abortion*, PLANNED PARENTHOOD, <https://perma.cc/N3X8-ZY5P>.

71. See *What Are TRAP Laws?*, PLANNED PARENTHOOD, <https://perma.cc/P8ST-RSZD>.

72. For example, Marjorie Dannenfelser of the Susan B. Anthony List, an anti-abortion group, described the Supreme Court’s decision in *Hellerstedt*, which struck down TRAP laws, as “anti-woman” and “anti-health-of-women.” *Reaction to Supreme Court Ruling Striking Down Abortion Restrictions in Texas*, NPR (June 28, 2016), <https://perma.cc/JRF7-F8RH>.

73. See *infra* Part II.

74. See, e.g., Brief of American College of Obstetricians & Gynecologists et al. as Amici Curiae Supporting Petitioners at 21–25, June Med. Servs. L.L.C. v. Russo, 140 S. Ct. 2103 (2020) (No. 18-1323); Am. Coll. of Obstetricians

they inhibit access to essential non-abortion healthcare services, such as contraception, cancer screenings, prenatal care, gender-affirming care, and more.⁷⁵

For example, the Supreme Court struck down two TRAP laws in *Whole Woman's Health v. Hellerstedt* and *June Medical Services L.L.C. v. Russo*. In *Hellerstedt*, the Court reaffirmed *Casey* and struck down two Texas TRAP laws.⁷⁶ One required abortion providers to obtain admitting privileges at local hospitals located within thirty miles of their clinic.⁷⁷ The other contained surgical facility standards and required abortion facilities to satisfy minimum safety standards applicable to ambulatory surgical centers, such as those relating to the size of the nursing staff, building dimensions, and other building requirements.⁷⁸ The Court struck down both, explaining that neither actually promoted patient health and safety but rather imposed an undue burden on a woman's right to seek a pre-viability abortion.⁷⁹ The Court reached its conclusion by assessing whether the laws' benefits outweighed their burdens to determine whether they imposed an undue burden.⁸⁰

Four years later in *June Medical*, the Court struck down a similar Louisiana admitting privileges requirement.⁸¹ Four Justices voted to uphold *Hellerstedt* and the undue burden standard.⁸² Chief Justice Roberts concurred in the judgment,

& Gynecologists, Comm. on Health Care for Underserved Women, *ACOG Committee Opinion No. 815: Increasing Access to Abortion*, 136 *OBSTETRICS & GYNECOLOGY* e107 (2020).

75. See, e.g., PLANNED PARENTHOOD, PLANNED PARENTHOOD 2019–2020 ANNUAL REPORT 35 (2020), <https://perma.cc/8XAQ-AJSB> (PDF); Kate Sosin, *Advocates Fear Texas Abortion Ban Could Impact LGBTQ+ Health Care*, THE 19TH (Sept. 2, 2021), <https://perma.cc/5PGY-H5MC> (listing hormone replacement therapy, surgery referrals, puberty blockers for teens, and testing and treatment for HIV and STDs as other services provided by Planned Parenthood).

76. See *Whole Woman's Health v. Hellerstedt*, 579 U.S. 582, 591 (2016).

77. *Id.* at 610.

78. *Id.* at 590, 615.

79. *Id.* at 590.

80. See *id.* at 608–23.

81. See *June Med. Servs. L.L.C. v. Russo*, 140 S. Ct. 2103, 2113 (2020).

82. *Id.* at 2112.

but would have struck down the law under *stare decisis*.⁸³ He voiced disagreement with the undue burden standard used by the plurality.⁸⁴ Many commentators overlooked the fact that the Chief Justice would have dispensed with the rigorous empirical analysis started in *Casey* and continued most assertively in *Whole Woman's Health*. Instead of balancing benefits against burdens, Chief Justice Roberts would have considered first whether an abortion restriction has a legitimate purpose and is reasonably related to that purpose.⁸⁵ Given the Court's current makeup, these two decisions almost certainly would be decided differently today.⁸⁶

As described earlier, the legacy of *Casey* includes upholding *Roe*, yet it also set the stage for mandatory counseling and post-counseling waiting periods, ranging from eighteen to seventy-two hours, which make accessing abortion needlessly difficult.⁸⁷ States claim these requirements are necessary to ensure patients make informed choices.⁸⁸ In *Casey*, the Supreme Court held that Pennsylvania's twenty-four-hour waiting period did not impose an undue burden on the right to an abortion.⁸⁹ The counseling requirements, however, are duplicative and not medically necessary, as every state already requires that patients provide informed consent prior to receiving medical treatment.⁹⁰ Even worse, the laws often mandate the provision

83. Although concurring with the judgment in this case, Chief Justice Roberts, who dissented in *Hellerstedt*, revoiced his opinion that he “continue[d] to believe that [*Hellerstedt*] was wrongly decided.” *Id.* at 2133 (Roberts, C.J., concurring).

84. *Id.*

85. *Id.* at 2138–39.

86. See Michael Scherer et al., *A 49-Year Crusade: Inside the Movement to Overturn Roe v. Wade*, WASH. POST. (May 7, 2022), <https://perma.cc/T8JG-GG69>.

87. See *Counseling and Waiting Periods for Abortion*, GUTTMACHER INST. (Aug. 1, 2022), <https://perma.cc/HXU5-UPDM>.

88. *Id.*

89. See *generally* *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992).

90. Generally, informed consent requires that (i) the patient has the capacity/competence to make decisions about their care, (ii) the patient's decision is voluntary, and (iii) the patient is provided sufficient, accurate information, such as benefits, risks, costs, and alternatives. *Informed Consent*,

of irrelevant, misleading, or scientifically unsupported information.⁹¹ Mandatory waiting periods are particularly problematic when the initial counseling must be done in person, thus requiring patients to make two potentially lengthy trips to obtain an abortion.⁹²

As further discussed in Part II, multiple trips impose significant, sometimes prohibitive burdens for certain patient populations, such as persons with low incomes or travel-limiting disabilities and those who live in “abortion deserts,” residing at least one hundred miles away from the nearest abortion facility.⁹³ As with many state abortion restrictions, evidence suggests that mandatory waiting periods are unnecessary, generally do not influence a patient’s decision, and can harm a patient’s physical and mental health.⁹⁴ Nevertheless, states

Code of Medical Ethics Opinion 2.1.1, AM. MED. ASS’N, <https://perma.cc/DTX6-DMFV>.

91. See generally *Counseling and Waiting Periods for Abortion*, *supra* note 87. Texas, for example, requires patients to be informed of a possible link between abortion and breast cancer. TEX. HEALTH & SAFETY CODE ANN. § 171.012(a)(1)(B)(iii). Other states require similar disclosures. See, e.g., KAN. STAT. ANN. § 65-6709(a)(3); MISS. CODE ANN. 41-41-33(1)(a)(ii). ACOG, the American Cancer Society, and other medical associations have all stated that the best available evidence shows no causal link between abortion and breast cancer. See, e.g., AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMM. ON GYNECOLOGIC PRACTICE, ACOG COMM. OPINION NO. 434: INDUCED ABORTION AND BREAST CANCER RISK 1 (2009), <https://perma.cc/5ZXQ-93R8> (PDF) (reaffirmed 2019) (“Early studies of the relationship between prior induced abortion and breast cancer risk were methodologically flawed.”).

92. *Counseling and Waiting Periods for Abortion*, *supra* note 87.

93. See Sarah Fowler, *Can Mississippi’s Last Abortion Clinic Survive?*, POLITICO (May 26, 2021), <https://perma.cc/B8ML-ASLP>; Elizabeth Nash et al., *Impact of Texas’ Abortion Ban: A 14-Fold Increase in Driving Distance to Get an Abortion*, GUTTMACHER INST. (Aug. 4, 2021), <https://perma.cc/VG6V-R47G> (last updated Sept. 15, 2021) (noting that after SB 8 went into effect, pregnant persons in Texas had to travel an average of 247 miles one way to get to the nearest abortion provider); Claudia Stagoff-Belfort, *Abortion Deserts: Inequitable Access Amidst COVID-19*, (Jan. 18, 2021), <https://perma.cc/S7DA-MUEN> (noting that at the time of the article’s publication in January 2021, at least six states—including North Dakota, Missouri, Mississippi, Kentucky, and West Virginia—had only one abortion facility, meaning that many residents in the South and Midwest live in “abortion deserts”).

94. See GUTTMACHER INST., WAITING PERIODS FOR ABORTION (2020), <https://perma.cc/BF46-EVKX>; see also *infra* Part II.

continue to impose such requirements.⁹⁵ The imposition of extra and unnecessary requirements for abortion illustrate abortion exceptionalism, which refers to the tendency of courts and legislatures to subject abortion to unique and unduly burdensome rules.⁹⁶

States increasingly impose restrictions on medication abortion that extend beyond the requirements for the drugs imposed by the U.S. Food and Drug Administration (FDA).⁹⁷ Specifically, as of August 2022, twenty-nine states require clinicians who administer medication abortion to be physicians;⁹⁸ two states prohibit the use of medication abortion starting at a specific point in pregnancy, with one banning it earlier than the FDA-approved indication of ten weeks' gestation;⁹⁹ and nineteen states require the clinician providing a medication abortion to be physically present when the medication is administered, thereby prohibiting the use of

95. See *Counseling and Waiting Periods for Abortion*, *supra* note 87.

96. See, e.g., Caitlin E. Borgmann, *Abortion Exceptionalism and Undue Burden Preemption*, 71 WASH. & LEE L. REV. 1047, 1048 n.2 (2014). Mandatory waiting periods, which are almost never required for other medical procedures, provide another example of abortion exceptionalism. *Id.* One other medical service requiring mandatory waiting periods, also in reproductive healthcare, is Medicaid-funded sterilization procedures. 42 C.F.R. § 50.203. Individuals generally must give informed consent 30 days prior to the procedure. *Id.* This policy was enacted in response to coercive sterilization practices—particularly on women of color and those with mental illnesses—and aims to achieve a delicate balance between recognizing this deeply troubling history on the one hand and over-paternalistic policies that impede access to sterilization on the other. See Sonya Borrero et al., *Medicaid Policy on Sterilization—Anachronistic or Still Relevant?*, 370 N. ENGL. J. MED. 102, 102 (2014). Physician-assisted suicide also generally requires a waiting period. See, e.g., ORE. REV. STAT. ANN. § 127.850(1) (2021) (requiring a fifteen-day waiting period between initial oral request and writing of a prescription and forty-eight hours between written request and writing of prescription); WASH. REV. CODE § 70.245.110 (2008) (same).

97. See *infra* notes 128–135 and accompanying text.

98. *Medication Abortion*, GUTTMACHER INST. (Aug. 1, 2022), <https://perma.cc/W668-WYAS>.

99. An Oklahoma law prohibited medication abortion after forty-nine days' gestation, but that law was permanently enjoined by court order. See *Okla. Coal. for Reprod. Just. v. Cline*, 441 P.3d 1145, 1156 (Okla. 2019) (noting that the forty-nine day gestational period unduly burdened women seeking abortions because there was “much less time to discover the pregnancy, and to decide whether to terminate it”).

telemedicine to prescribe medication abortions.¹⁰⁰ Moreover, in states implementing or considering abortion bans after *Dobbs*, these bans encompass both medical and surgical abortions. These laws are uniquely harmful for persons for whom travel is impossible or burdensome, whether due to economic constraints, geographic location, physical disability, or other constraints.¹⁰¹

100. *Medication Abortion*, *supra* note 98. For example, Texas SB 4 prohibits use of medication abortion after forty-nine days' gestation (lower than the FDA-approved seventy days' gestation), requires that a physician physically examine the pregnant person, requires the prescribing healthcare provider to be a physician, and prohibits the use of mail pharmacies to dispense medication abortion to the patient. TEX. HEALTH & SAFETY CODE § 171.006 (2021).

101. AidAccess, an international organization, stated it will continue to send medication abortion to patients via mail, including in states that ban the practice. *See* Kelly Wiley, *Texas Lawmakers Tried to Halt Online Abortion Pill Sales. Providers Say They Won't Stop*, KXAN, <https://perma.cc/NB5D-URLH> (last updated Nov. 5, 2021). Because AidAccess is an international organization, it believes it cannot be sued by anyone in these states. *Id.* Further, because it takes time to ship the medication internationally, AidAccess will now allow nonpregnant persons to order the pills in advance. *Id.*; *see also* Olga Khazan, *The Abortion Backup Plan No One is Talking About*, THE ATL., <https://perma.cc/7VL2-L574> (last updated Oct. 15, 2021). Notwithstanding these intentions, this is a legal gray area, and conservative states are likely to try to increase enforcement of their medication abortion laws. According to one report, around two dozen people have been prosecuted for self-managing an abortion since 2000. Khazan, *supra*; *see also* Nicole Fallert, *Self-Managed Abortions Could be Legally Riskier After Texas's Six-Week Law, Advocates Say*, BUZZFEED NEWS (Sept. 16, 2021), <https://perma.cc/96ZZ-5WMQ> (arguing that “people of color who already experience disproportionate rates of criminalization” are at a higher risk of being prosecuted for self-induced abortions). At least a few states explicitly prohibit self-induced abortions. Nevada law, for example, provides:

A woman who takes or uses, or submits to the use of, any drug, medicine or substance, or any instrument or other means, with the intent to terminate her pregnancy after the 24th week of pregnancy, unless the same is performed upon herself upon the advice of a physician acting pursuant to the provisions of NRS 442.250, and thereby causes the death of the child of the pregnancy, commits manslaughter and shall be punished for a category B felony by imprisonment in the state prison for a minimum term of not less than 1 year and a maximum term of not more than 10 years, and may be further punished by a fine of not more than \$10,000.

NEV. REV. STAT. ANN. § 200.220 (2013); *see also* OKLA. STAT. ANN. § 1-733 (2014) (prohibiting self-induced abortion except under the supervision of a licensed physician). A similar law in South Carolina states:

States also restrict access to abortion by limiting insurance coverage. This includes banning or limiting coverage provided by (i) all private insurance plans, (ii) plans offered through health insurance exchanges, or (iii) plans offered to public employees.¹⁰² These restrictions, combined with those imposed by the federal Hyde Amendment,¹⁰³ may render the cost of an abortion prohibitive, or delay necessary care while the pregnant person raises the necessary funds.¹⁰⁴ Problematically, delaying abortion only increases the costs, as later-term abortions are more expensive.¹⁰⁵ Further, by the time a girl, woman, or person with the capacity for pregnancy obtains sufficient funds, they may be beyond their state's gestational limit for an abortion.¹⁰⁶ As a result, they must either carry the pregnancy to term or overcome the additional time and cost required to obtain an out-of-state abortion.¹⁰⁷

For adolescents, parental consent or notification requirements further restrict access to abortion.¹⁰⁸ Most states

Except as otherwise permitted by this chapter, any woman who solicits of any person or otherwise procures any drug, medicine, prescription or substance and administers it to herself or who submits to any operation or procedure or who uses or employs any device or instrument or other means with intent to produce an abortion, unless it is necessary to preserve her life, shall be deemed guilty of a misdemeanor and, upon conviction, shall be punished by imprisonment for a term of not more than two years or fined not more than one thousand dollars, or both.

S.C. CODE ANN. § 44-41-80(b) (2021).

102. *Regulating Insurance Coverage of Abortion*, GUTTMACHER INST. (Aug. 1, 2022), <https://perma.cc/4YW6-KNTH>. Some states have exceptions, such as in cases of life endangerment, rape, or incest. Michele Goodwin & Mary Ziegler, *Whatever Happened to the Exceptions for Rape and Incest?*, THE ATL. (Nov. 29, 2021), <https://perma.cc/B9LJ-8X3F>.

103. *See infra* notes 119–122.

104. *See* Sara C.M. Roberts et al., *Estimating the Proportion of Medicaid-Eligible Pregnant Women in Louisiana Who Do Not Get Abortions When Medicaid Does Not Cover Abortion*, 19 BMC WOMEN'S HEALTH (2019); *see also* Alina Salganicoff et al., *The Hyde Amendment and Coverage for Abortion Services*, KAISER FAM. FOUND. (Mar. 5, 2021), <https://perma.cc/4EJE-QMFS>.

105. Salganicoff et al., *supra* note 104.

106. *Id.*

107. *Id.*

108. *See Parental Involvement in Minors' Abortions*, GUTTMACHER INST., (Aug. 1, 2022), <https://perma.cc/J3X9-8D23>.

include a judicial bypass procedure that allows minors to obtain court approval for an abortion without their parents' knowledge or consent,¹⁰⁹ but these procedures delay care and are onerous for an adolescent to navigate.¹¹⁰ Further, a judge may deny the request.¹¹¹ Instead of protecting minors, research reveals that these requirements cause "humiliation, shame, stigma, and sometimes trauma."¹¹² Prior to *Dobbs*, the Supreme Court upheld parental consent and notification requirements on numerous occasions, including in *Casey*.¹¹³ Now that *Casey* has been overturned, adolescents' access to abortion and their ability to seek a judicial bypass hang in the balance.

"Conscience laws" provide states with an indirect means to restrict abortion access.¹¹⁴ These laws allow certain healthcare providers and institutions to refuse to provide abortion services.¹¹⁵ As of August 2022, forty-six states allow individual healthcare providers to refuse to provide abortion services, and forty-four states allow certain health care institutions to refuse

109. *Id.*

110. *See, e.g.*, Lauren J. Ralph, *Reasons for and Logistical Burdens of Judicial Bypass for Abortion in Illinois*, 68 J. ADOLESCENT HEALTH 71 (2021); "The Only People It Really Affects Are the People It Hurts": *The Human Rights Consequences of Parental Notice of Abortion in Illinois*, HUM. RTS. WATCH (Mar. 11, 2021), <https://perma.cc/3MVW-U34Q>.

111. Justice Marshall concurred in part in *Hodgson v. Minnesota* to reiterate his concerns about judicial bypass procedures, stating that a "judge's refusal to authorize an abortion effectively constitutes an absolute veto." *Hodgson v. Minnesota*, 497 U.S. 417, 473–75 (1990) (Marshall, J., concurring in part); *see also* Amanda Jean Stevenson et al., *Denials of Judicial Bypass Petitions for Abortion in Texas Before and After the 2016 Bypass Process Change: 2001–2018*, 110 AM. J. PUB. HEALTH 351 (2020).

112. Francie Diep, *Here's What It's Like to Argue Before a Judge That You Should Be Able to Get an Abortion Without Telling Your Parents*, PAC. STANDARD (Sept. 14, 2018), <https://perma.cc/CQB5-6MVA>; *see also* Stevenson et al., *supra* note 111, at 351.

113. *See, e.g.*, Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 899 (1992) ("Our cases establish, and we reaffirm today, that a State may require a minor seeking an abortion to obtain the consent of a parent or guardian, provided that there is an adequate judicial bypass procedure.").

114. *See* CONG. RSCH. SERV., RL34703, THE HISTORY AND EFFECT OF ABORTION CONSCIENCE CLAUSE LAWS 1 (2010).

115. *See Refusing to Provide Health Services*, GUTTMACHER INST. (Aug. 1, 2022), <https://perma.cc/7HWB-8CQF>.

to provide abortion services.¹¹⁶ Essentially, these laws “provide[] the means and legal protection to individuals and institutions (professing sincerely held religious beliefs) to refuse to provide, assist, or otherwise facilitate” abortion services.¹¹⁷

Notwithstanding *Roe* and *Casey*, this Part makes clear that prior to *Dobbs*, states used many direct and indirect mechanisms to restrict abortion, often with the Supreme Court’s blessing. As the number and severity of restrictions mounted, their cumulative effect often rendered abortion out of reach for many pregnant persons.¹¹⁸

The Supreme Court’s decision in *Dobbs* to overturn *Roe* and *Casey* returned complete control over abortion regulations to the states. States are now free to enact ever more stringent restrictions, as well as outright bans, on abortion. Anti-abortion legislatures are taking advantage of this opening, leaving the federal government, patients, providers, and advocates scrambling to ensure patients can access abortion—a necessary and sometimes lifesaving medical service.

2. Federal Laws and Regulations

Federal laws and agency regulations play an important yet often overlooked role in the right and access to abortion, including constraints on the right.¹¹⁹ The Hyde Amendment

116. *Id.*

117. Michele Goodwin & Allison M. Whelan, *Constitutional Exceptionalism*, 2016 U. ILL. L. REV. 1287, 1312 (2016).

118. BENJAMIN P. BROWN ET AL., ASSOCIATION OF HIGHLY RESTRICTIVE STATE ABORTION POLICIES WITH ABORTION RATES, 2000–2014, 7 (2020), <https://perma.cc/85JC-U6CY> (PDF).

119. This Article focuses on the United States, but U.S. laws and policies also impact abortion access internationally. For example, the Mexico City Policy (“the Policy”), often referred to as the “global gag rule,” has been instated by every Republican President since Ronald Reagan, whereas the Clinton, Obama, and Biden administrations all rescinded the Policy. *See generally* Zara Ahmed, *The Unprecedented Expansion of the Global Gag Rule: Trampling Rights, Health and Free Speech*, 23 GUTTMACHER POLY REV. 13 (2020), <https://perma.cc/WZU7-NRBV> (PDF). To receive U.S. governmental global family planning funding under the original Policy, foreign non-governmental organizations were required to certify that they would not “perform or actively promote abortion as a method of family planning” using funds from any source (including non-U.S. funds). White House Off. of Pol’y Dev., *U.S. Policy Statement for the International Conference on Population*, 10

represents one of the most well-known federal impediments to abortion. First adopted in 1976, the Hyde Amendment prohibits the use of federal funds for abortion except in cases of rape, incest, or if the pregnancy is determined to endanger the pregnant person's life.¹²⁰ The law dramatically limits abortion coverage for millions who receive coverage or care through federal programs, including Medicaid enrollees, federal employees, military personnel and veterans, Native Americans, and Peace Corps volunteers. The Hyde Amendment disproportionately impacts populations historically marginalized by the healthcare system, including low-income populations, communities of color, immigrants, young people, and LGBTQ+ persons.¹²¹ Problematically, unintended pregnancies are highest amongst some of these populations, including low-income populations, individuals aged eighteen to twenty-four, and persons of color.¹²²

In 2021, President Biden's budget proposal for Fiscal Year 2022 did not include the Hyde Amendment.¹²³ This was the first time in nearly thirty years that a President proposed a budget without the Hyde Amendment.¹²⁴ Legislators in favor of its removal, however, reluctantly reintroduced Hyde to strike a

POP. & DEV. REV. 574, 575 (1984). The Trump Administration expanded the Policy so that it applied to most U.S. bilateral global health assistance, including funding for HIV under the President's Emergency Plan for AIDS Relief and other programs addressing issues such as maternal and child health, malaria, and nutrition. *The Mexico City Policy: An Explainer*, KAISER FAM. FOUND. (Jan 28, 2021), <https://perma.cc/2FG9-S5WK>. The Trump Administration also sought to further tighten restrictions to reach other areas of U.S. development assistance beyond global health and other non-U.S. funding streams. *Id.*

120. Pub. L. No. 94-439, 90 Stat. 1418 (1976). The Supreme Court upheld the Hyde Amendment in *Harris v. McRae*. See generally 448 U.S. 297 (1980).

121. See Press Release, Rosa DeLauro, U.S. Rep., U.S. House of Reps., Health Appropriations Subcommittee Examine Hyde Amendment's Impact on Women's Rights and Economic Security (Dec. 8, 2020), <https://perma.cc/E6R2-RLQ8>.

122. GUTTMACHER INST., UNINTENDED PREGNANCIES IN THE UNITED STATES 1 (2019), <https://perma.cc/C98Q-SW2L> (PDF).

123. OMB, EXEC. OFF. OF THE PRESIDENT, BUDGET OF THE UNITED STATES GOVERNMENT, FISCAL YEAR 2022 (2022), <https://perma.cc/22KL-NLR2> (PDF).

124. Susan Rinkunas, *Joe Biden Stakes Out Position Against Discriminatory Abortion Rule*, THE GUARDIAN (May 28, 2021), <https://perma.cc/8JS2-VLK5>.

legislative deal and appease conservative lawmakers during negotiations over the 2022 spending bill.¹²⁵ In his 2023 budget proposal, President Biden again did not include the Hyde Amendment.¹²⁶ Expectedly, Republicans threaten to push back, articulating strong opposition to the legislation without the Hyde Amendment.¹²⁷ At the time of this writing, it remains unclear whether President Biden's second attempt will be successful.

The Hyde Amendment's ramifications are significant. That said, focusing on the Hyde Amendment and state-level abortion restrictions overlooks the important role of federal agency regulations and agency-level harms to reproductive rights. The history of the FDA's regulation of medication abortion provides a salient example. In 2000, the FDA approved mifepristone in a regimen with misoprostol for the termination of intrauterine pregnancy.¹²⁸ Mifepristone is currently approved for use through seventy days' gestation.¹²⁹

Mifepristone, however, remains subject to certain restrictions. Currently, mifepristone is available only through a restricted program called a Risk Evaluation and Mitigation Strategy (REMS).¹³⁰ On December 16, 2021, the FDA relaxed some of the REMS requirements.¹³¹ Importantly, the Agency removed the requirement that mifepristone be dispensed only in certain healthcare settings (clinics, medical offices, and hospitals).¹³² As a result, the medication can now be dispensed

125. Alexandra Martinez, *Biden's Proposed Budget Left Out the Hyde Amendment, and Advocates Hope It Stays That Way*, PRISM (Apr. 6, 2022), <https://perma.cc/FNG9-WBV5>.

126. *Id.*

127. Aris Folley, *House Negotiators Advance Final Appropriations Bill*, THE HILL (July 1, 2022), <https://perma.cc/V4C2-ZD89>.

128. FDA, MIFEPREX PRESCRIBING INFORMATION 1, (2019), <https://perma.cc/KAW5-9YA8> (PDF).

129. *Id.*

130. 21 U.S.C. § 355-1; *see also Risk Evaluation and Mitigation Strategies*, FDA. (Aug. 8, 2019), <https://perma.cc/S3KT-5T27>.

131. Letter from Patrizia A. Cavazzoni, Dir., Ctr. for Drug Evaluation & Res., to Graham Chelius, Soc'y of Fam. Planning, Cal. Acad. of Fam. Physicians (Dec. 16, 2021), <https://perma.cc/X4KX-EVU7> (PDF).

132. *Questions & Answers on Mifeprex*, FDA (Dec. 16, 2021), <https://perma.cc/RP62-F67P>. This FDA action makes permanent the Biden

through certified pharmacies and through the mail.¹³³ This represents a significant improvement from the prior prohibition on the use of local and mail pharmacies and increases the accessibility of medication abortion, particularly for persons living in rural areas, low-income populations, persons with disabilities, and others for whom travel is difficult.

That said, the FDA retained certain requirements, including one that requires prescribers to be certified with the program,¹³⁴ and *added* a requirement that pharmacies dispensing the drug also be certified.¹³⁵ Further, the decision in *Dobbs* opens the door to complete bans on medication abortion. Thus, while the FDA's decision to allow the use of local and mail pharmacies represents an important step toward access, the fight for broader and equal access to medication abortion remains unwon, particularly at the state level.

The Title X Family Planning Program (the "Program") is another example of how federal agency regulation can either restrict or promote access to reproductive healthcare. The Office of Population Affairs (OPA) in the Department of Health and Human Services (HHS) administers Title X, which provides a broad range of services including contraception education, wellness exams, testing for sexually transmitted infections, breast and cervical cancer screenings, and other preventative healthcare services.¹³⁶ Title X funds cannot "be used in programs where abortion is a method of family planning."¹³⁷ From 2000 to

Administration's decision to exercise enforcement discretion against the in-person dispensing requirement during the COVID-19 public health emergency. See Letter from Janet Woodcock, Acting Cmm'r of Food & Drugs, FDA, to Maureen G. Phipps, Chief Exec. Off., Am. Coll. of Obstetricians & Gynecologists, & William Grobman, Pres., Soc'y for Maternal-Fetal Med. (Apr. 12, 2021), <https://perma.cc/77LE-ZQRT> (PDF).

133. *Questions & Answers on Mifeprex*, *supra* note 132.

134. This requirement limits the number of providers able to prescribe the drug, and often means that a patient cannot receive a prescription from their primary care provider. See Carrie N. Baker, *FDA Lifts Some Abortion Pill Restrictions, Leaves Others in Place: "Ignores the Science and Smacks of Political Interference"*, MS. MAG. (Dec. 17, 2021), <https://perma.cc/2PG6-KL4B>.

135. See *Questions & Answers on Mifeprex*, *supra* note 132.

136. OFF. POPULATION AFFS., HHS, TITLE X FAMILY PLANNING PROGRAM, <https://perma.cc/ZD5V-8PQP> (PDF).

137. 42 U.S.C. § 300a-6.

2019, agency regulations interpreted that provision narrowly and did not prohibit referrals for abortion.¹³⁸ But on March 5, 2019, HHS published a Final Rule prohibiting healthcare providers from referring Title X patients for abortions, along with other limitations on provider-patient communications.¹³⁹

The Final Rule also required Title X clinics that provide abortion services to physically and financially separate non-abortion services from abortion services.¹⁴⁰ The Final Rule degraded the quality of services available through Title X clinics and caused many clinics to leave the Program. The OPA's Title X Family Planning Annual Report for 2020 documented the impact of the Trump Administration's Final Rule and the COVID-19 pandemic on the number of clients served by Title X clinics and the number of Title X grantees and clinic sites.¹⁴¹ The OPA found that from 2018 to 2020, the number of clients served fell from 3.9 million to 1.5 million.¹⁴² The OPA estimated that the Trump Administration's Final Rule accounted for nearly two-thirds of this reduction, while the COVID-19 pandemic accounted for about one-third.¹⁴³ The Program also experienced a net decrease of more than 1,000 service sites, and all Planned Parenthood affiliates and several state health departments withdrew from the Program.¹⁴⁴ Further, the Final Rule resulted in no Title X-funded services in six states (Hawaii, Maine, Oregon, Utah, Vermont, and Washington), and substantially reduced services in six others (Alaska, Connecticut, Massachusetts, Minnesota, New Hampshire, and New York).¹⁴⁵

Fortunately, the Biden Administration released a new Final Rule in October 2021 to strengthen Title X.¹⁴⁶ The Trump Administration's Final Rule, although no longer in effect,

138. See *Comparison of 2000 and 2019 Title X Regulations*, OFF. POPULATION AFFS., HHS, <https://perma.cc/LFT7-3Q9U>.

139. See 84 Fed. Reg. 7714, 7760 (Mar. 4, 2019).

140. *Id.* at 7715.

141. See generally OFF. POPULATION AFFS., HHS, FAMILY PLANNING ANNUAL REPORT: 2020 NATIONAL SUMMARY (Sept. 2021), <https://perma.cc/7MVF-YKW7> (PDF).

142. *Id.* at D-5.

143. *Id.* at ES-5–6.

144. *Id.* at ES-5.

145. *Id.*

146. 86 Fed. Reg. 56144 (Oct. 7, 2021).

nonetheless represents a prime example of the important role that agency regulations play in access to abortion as well as many other essential, non-abortion reproductive health services. Compared to laws, regulations are typically faster and easier to enact or change and often receive less publicity. Yet they are extremely influential and provide a key means by which an administration can impose its antiabortion views. Moreover, because regulations and interpretations of regulations often change when a new President takes office, access to reproductive healthcare can change frequently, with potentially devastating consequences.

II. ABORTION ACCESS FOR PERSONS WITH DISABILITIES

The scope and severity of anti-abortion laws and regulations frequently change with transitions in federal and state political leadership. Recent years have been particularly devastating for reproductive rights, with the 2022 decision in *Dobbs* representing a pivotal turning point in the right and ability to access abortion. These threats, many of which are now reality, are even more alarming for people with intersecting vulnerable statuses who are acutely and uniquely harmed by anti-abortion laws.¹⁴⁷ In other words, identity significantly shapes the ability to exercise choice. Even while there is greater attention paid to how race, sex, and class continue to manifest within the reproductive rights discourse,¹⁴⁸ far less attention is

147. Although this Part focuses on pregnant persons with physical disabilities, many other groups are disproportionately affected by restrictive abortion laws and policies. Others include those living in rural areas, adolescents, the LGBTQ+ community, immigrants and noncitizens, and victims of domestic violence and sexual assault.

148. The disproportionate impacts of—and the connections between—race and class have been noted and described by Supreme Court Justices, scholars, and others. *See, e.g.*, *Food & Drug Admin. v. Am. Coll. of Obstetricians & Gynecologists*, 141 S. Ct. 578, 582 (mem.) (2021) (Sotomayor, J., dissenting) (noting the impact of abortion restrictions on poor women and women of color); *June Med. Servs. L.L.C. v. Russo*, 140 S. Ct. 2103, 2130 (2020) (“[T]he burdens of this increased travel would fall disproportionately on poor women, who are least able to absorb them.”); *Webster v. Reproductive Health Servs.*, 492 U.S. 490, 557–58 (1989) (Blackmun, J., concurring and dissenting in part) (suggesting that dismantling *Roe* would result in the deaths or injury of “many women, especially poor and minority women”); *Harris v. McRae*, 448 U.S. 297, 343 (1980) (Marshall, J., dissenting) (“The class burdened by the

given to individuals with physical disabilities. In this Part, we unpack the important, yet often underdiscussed, intersection between pregnancy and physical disability. In doing so, this Article acknowledges that although the dynamics and experiences of each group and individual are unique, the ultimate consequences of anti-abortion laws are often similar—they inhibit access to abortion and render choice illusory. As discussed further in Part III, leveraging these similarities and building bridges between the intersections, while still providing space for individual voices, will strengthen the fight for reproductive justice for *all* instead of a few.¹⁴⁹

A disability rights perspective remained largely absent from the fight for reproductive rights until the reproductive justice movement took shape, which centered it as core to achieving full reproductive equality.¹⁵⁰ Still, much of the discourse involving disability justice continues to focus on persons with mental disabilities and mental illnesses, influenced in large part by the Supreme Court's infamous 1927 decision in *Buck v. Bell*.¹⁵¹ In *Buck*, which upheld a Virginia law authorizing the sterilization of "mental defectives," Justice Holmes notoriously stated that "[t]hree generations of imbeciles

Hyde Amendment consists of indigent women, a substantial proportion of whom are members of minority races."); REPRODUCTIVE RIGHTS AND JUSTICE STORIES 1 (Melissa Murray et al. eds., 2019) ("The framework of reproductive justice highlights the intersecting relations of race, class, sexuality, and sex that shape the regulation of reproduction."); Jill E. Adams & Jessica Arons, *A Travesty of Justice: Revisiting Harris v. McRae*, 21 WM. & MARY J. WOMEN & L. 5, 50–51 (2014) ("[T]he Hyde Amendment affects large numbers of women who live at the intersection of various lines of subordination, including race, gender, and class."); Melissa Murray, *Race-ing Roe: Reproductive Justice, Racial Justice, and the Battle for Roe v. Wade*, 134 HARV. L. REV. 2025, 2046, 2048, 2051 (2021).

149. See *infra* Part III.

150. Murray, *supra* note 148, at 2059. The relative absence may stem, in part, from the problematic perception that women with disabilities are "asexual" and not involved in romantic or intimate relationships. See Vanessa Volz, *A Matter of Choice: Women with Disabilities, Sterilization, and Reproductive Autonomy in the Twenty-First Century*, 27 WOMEN'S RTS. L. REP. 203, 211 (2006).

151. 274 U.S. 200 (1927).

are enough.”¹⁵² Despite wide criticism, *Buck* has never been overruled.

Much work remains to advance the reproductive health and rights of persons with mental disabilities. Indeed, a recent report from the National Women’s Law Center found that thirty-one states and the District of Columbia permit forced permanent sterilization.¹⁵³ Seventeen of these states allow the permanent surgical sterilization of children with disabilities.¹⁵⁴

A broader look at the academic and lay discourse about abortion reveals that too often it lacks a thoughtful and thorough discussion about the impact of abortion restrictions on persons with *physical* disabilities, particularly those who also identify with other vulnerable and politically marginalized groups. Historically in the United States, the political and cultural norms have been to diminish the autonomy of and take bodily control away from people of color and vulnerable groups,¹⁵⁵ and persons with physical disabilities are no exception. In this urgent moment of attention to historic patterns of racial discrimination that emanate from the vestiges of slavery and Jim Crow, retrenchment of systemic sex discrimination, and clear work yet unfinished with regard to LGBTQ+ discrimination, we argue that individuals with disabilities must be centered in pathways forward, particularly as discrimination may be compounded in their lives.

In the context of reproduction, and abortion particularly, discussions about physical disability often focus on birth defects. Indeed, physical disability, much like race and mental disability, is “intertwined in the history of eugenics [and] linked in contemporary discourses about abortion rights,” such as those about disability-based abortion bans, which prohibit abortions

152. *Id.* at 205, 207.

153. NAT’L WOMEN’S LAW CTR., FORCED STERILIZATION OF DISABLED PEOPLE IN THE UNITED STATES 18–19 (2021), <https://perma.cc/8U4W-AYF6> (PDF). As noted in the report, these laws affect primarily persons with developmental and intellectual disabilities, as well as people with disabilities related to mental health. *Id.* at 31.

154. *Id.* at 34.

155. *See, e.g., Bell*, 274 U.S. 200; Mhatre, *supra* note 10, at 4–5.

based on the diagnosis of a fetal disability or impairment.¹⁵⁶ This problematic history creates tensions that abortion opponents frequently and unfairly exploit. Claiming to care about antidiscrimination, they hone in on disability-based abortion bans to “win over ambivalent voters and legislators who are concerned about disability discrimination” and to “dampen the enthusiasm of those angry about abortion restrictions.”¹⁵⁷ Abortion opponents claim that abortions based on fetal disability are “the height of prejudice,”¹⁵⁸ whereas abortion rights advocates generally emphasize how abortion can prevent newborn suffering and provide options to pregnant persons faced with devastating fetal diagnoses.¹⁵⁹

Similar to discussions about race, these narratives exploit divisions between advocates for reproductive rights and disability rights, inhibiting successful collective advocacy.¹⁶⁰ And yet, abortion opponents’ expressed concerns about equality and antidiscrimination fall flat, as they tend to simultaneously and hypocritically turn a blind eye to the discriminatory effects of other anti-abortion laws they promote, which harm the very people they claim to serve.¹⁶¹ Opponents of abortion focus on hypothetical disabled fetuses at the expense of those who

156. Murray, *supra* note 148, at 2060. “Disability-based bans” are also encompassed in terms like “reason bans” and “trait-selection bans,” which include banning abortion for reasons such as sex or race selection. *See generally id.* (trait-selection laws/bans); Mary Ziegler, *The Disability Politics of Abortion*, 2017 UTAH L. REV. 587 (2017) (disability-based bans) [hereinafter Ziegler, *Disability Politics*]; Mhatre, *supra* note 10 (reason bans); *see also* Kendall Ciesemier, Opinion, *Leave My Disability Out of Your Anti-Abortion Propaganda*, N.Y. TIMES (July 31, 2022), <https://perma.cc/Z6WU-ZAEF>.

157. Ziegler, *Disability Politics*, *supra* note 156, at 621.

158. National Right to Life (@nrlc), TWITTER (Sept. 27, 2019, 3:00 PM), <https://perma.cc/L2Y5-TEUZ>.

159. *See Personal Stories: How Bans on Abortion Later in Pregnancy Hurt People*, PLANNED PARENTHOOD, <https://perma.cc/3B6T-HW8R>; *see also* Murray, *supra* note 148, at 2060–62. *See generally* Ziegler, *Disability Politics*, *supra* note 156.

160. For an account of the role of race in the abortion debate, see Murray, *supra* note 148, at 2031–62.

161. *See* Mhatre, *supra* note 10, at 11; *see also* Ziegler, *Disability Politics*, *supra* note 156; Ciesemier, *supra* note 156 (“Despite the fact that abortion opponents would champion my disabled ‘life’ in my mom’s womb, the laws they’ve levied across the country now put my life and that of other disabled and chronically ill people in danger . . .”).

actually bear the brunt of anti-abortion laws: pregnant persons with disabilities, who become a mere afterthought, collateral damage in the war against reproductive justice.

The complicated history between reproductive rights and disability rights must be acknowledged and confronted, but it does not warrant stripping pregnant persons of the right to control their bodies.¹⁶² Indeed, eugenics and anti-abortion policies produce similar consequences: they diminish the dignity, autonomy, and worth of marginalized populations. To elevate the voices of pregnant persons with disabilities, it is critical to examine abortion restrictions with a sharper eye toward the harms imposed on pregnant persons with physical disabilities.

Laws that require medically unnecessary clinic trips, prohibit the use of telemedicine, or prohibit the use of local retail or mail pharmacies to obtain medication abortion create significant and sometimes insurmountable barriers for persons with disabilities for whom travel may be physically or logistically difficult. Our society remains woefully far from achieving equal accessibility, despite laws prohibiting discrimination against persons with disabilities.¹⁶³ Persons with disabilities may be reliant on others for transportation, such as

162. See Ciesemier, *supra* note 156 (“What chronically ill and disabled people need is autonomy to make the health care choices right for them. It’s what we all deserve.”).

163. The experience of Senator Tammy Duckworth during the January 6, 2021, attack on the U.S. Capitol illuminates our country’s failures to make society accessible. Senator Duckworth, an Iraq War veteran who uses a wheelchair due to a battle injury, barricaded herself in her office instead of sheltering with the other Senators because she feared the Senate’s inaccessibility would hinder her escape if the Senators needed to move. Warren Rojas & Kayla Epstein, *Sen. Tammy Duckworth Sheltered on Her Own on January 6 Because Evacuating the Senate Would Have Been Nearly Impossible for a Wheelchair User*, BUS. INSIDER (Oct. 27, 2021), <https://perma.cc/445Z-26D7>. In another tragic example, Engracia Figueroa, a disability rights activist, died due to complications from injuries sustained after United Airlines broke her custom wheelchair. Blithe Riley, *Hand in Hand Grieves the Loss of Engracia Figueroa*, HAND IN HAND (Nov. 3, 2021), <https://perma.cc/QH5B-LFAC>. While battling with United to get a replacement, she had to use a loaner chair that caused pressure sores and other health problems. *Id.* A pressure sore became infected, and the infection reached her hip bone, requiring emergency services. *Id.* Figueroa passed away on October 31, 2021. *Id.*

public transport, paratransit, family, or friends. Finding an accessible clinic and coordinating transportation to that clinic can take time. By the time a pregnant person with a disability can do so, they may fall outside their state's gestational limit for abortion, requiring additional time and out-of-state travel to obtain an abortion, if they can at all. Further, depending on the location of the nearest accessible abortion facility, public transportation may be unavailable and paying for a cab or ride share may be cost-prohibitive or not disability-friendly. And importantly, the abortion decision is incredibly personal and private. Structuring or restricting abortion access in a way that requires a pregnant person to rely on others for unnecessary and potentially lengthy travel is thus problematic. In fact, for victims of intimate partner violence, this could be dangerous or even fatal.¹⁶⁴

Most persons with disabilities can safely carry pregnancies to term, but some may face a higher risk of complications, rendering pregnancy dangerous or even life-threatening.¹⁶⁵ In fact, pregnancy represents a dangerous time for disabled and nondisabled persons alike in the United States, which has the highest maternal mortality rate among developed countries.¹⁶⁶ This issue is all the more tragic and urgent for persons with disabilities and Black women who, regardless of disability status, are more likely to suffer or die from pregnancy-related

164. See Lysaundra Campbell, *The Hidden Link Between Domestic Violence and Abortion*, REWIRE NEWS GRP. (Oct. 19, 2019), <https://perma.cc/33B9-WG25> (“Financially burdensome and medically unnecessary requirements—like making multiple trips or traveling long distances—makes obtaining abortion care difficult for those whose daily tasks, bank accounts, and access to friends and family may be controlled by an abusive partner.”); see also *infra* notes 174–176 and accompanying text.

165. See JESSICA L. GLEASON ET AL., RISK OF ADVERSE OUTCOMES IN PREGNANT WOMEN WITH DISABILITIES 1 (2021), <https://perma.cc/8X2F-NNFV>; Vill. Univ. Coll. of Nursing, *Pregnancy in Women with Disabilities*, NAT'L LEAGUE FOR NURSING (2017), <https://perma.cc/GL4X-T4ZV>; Meena Venkataramanan, *Their Medications Cause Pregnancy Issues. Post-Roe, That Could be Dangerous*, WASH. POST (July 25, 2022), <https://perma.cc/MR8P-C979>.

166. See Roni Caryn Rabin, *Maternal Deaths Rose During the First Year of the Pandemic*, N.Y. TIMES (Feb. 23, 2022), <https://perma.cc/34GF-2F8X>.

complications.¹⁶⁷ These risks make timely access to reproductive healthcare, including abortion, an important part of mitigating risks for these groups. Yet, the states most hostile to reproductive rights have some of the highest rates of maternal morbidity and mortality.¹⁶⁸

Further, restrictions that increase the financial cost of abortion are particularly problematic for persons with disabilities, who have a higher risk of economic insecurity due in large part to systemic discrimination, exclusion from the workforce, expensive healthcare, and a broken—if not altogether absent—social safety net.¹⁶⁹ In 2019, for example, only one in four persons with disabilities ages sixteen and over were employed.¹⁷⁰ People of color with disabilities fare worse and are more likely to be unemployed and live in poverty than white people with disabilities.¹⁷¹ The COVID-19 pandemic

167. See Mhatre, *supra* note 10, at 6; GLEASON ET AL., *supra* note 165, at 1. The most recently available U.S. maternal mortality rate for 2020 was 23.8 maternal deaths per 100,000 live births, higher than the 2019 rate of 20.1. DONNA L. HOYERT, NAT'L CTR. FOR HEALTH STATS., MATERNAL MORTALITY RATES IN THE UNITED STATES, 2020, 3 (2022), <https://perma.cc/LL2J-W2YF> (PDF). This translated to 861 maternal deaths in 2020. *Id.* The maternal mortality rate for non-Hispanic Black women (55.3) was 2.9 times the rate for non-Hispanic white women (19.1) and 3 times the rate for Hispanic women (18.2). *Id.* at 1.

168. See SURGO VENTURES, GETTING HYPERLOCAL TO IMPROVE OUTCOMES & ACHIEVE RACIAL EQUITY IN MATERNAL HEALTH: THE US MATERNAL VULNERABILITY INDEX 11 (Aug. 21, 2021), <https://perma.cc/S6MJ-U5UH> (PDF); Sema Sgaier & Jordan Downey, Opinion, *What We See in the Shameful Trends in U.S. Maternal Health*, N.Y. TIMES (Nov. 17, 2021), <https://perma.cc/8J3K-XSBR>.

169. See Mhatre, *supra* note 10, at 7. Abortion restrictions can increase the costs of abortion in many ways. *Id.* Requiring unnecessary clinic visits means additional, potentially unpaid, time off from work and increases the costs of transportation and childcare. *Id.* Further, abortion-related insurance restrictions increase the cost of the procedure itself. *Id.*

170. *Selected Economic Characteristics for the Civilian Noninstitutionalized Population by Disability Status*, U.S. CENSUS BUREAU, <https://perma.cc/5PTS-RLKL>.

171. See *Employment Status of the Civilian Noninstitutionalized Population by Disability Status and Selected Characteristics, 2020 Annual Averages*, U.S. BUREAU OF LABOR STATISTICS (Feb. 24, 2021), <https://perma.cc/Y6LB-PLP3>; NANETTE GOODMAN ET AL., NAT'L DISABILITY INST., FINANCIAL INEQUALITY: DISABILITY, RACE, AND POVERTY IN AMERICA 12 (2019), <https://perma.cc/J36S-NL85> (PDF).

exacerbated these disparities, as people with disabilities were more likely to become unemployed during the pandemic.¹⁷² Further, because people with disabilities, especially those of color, often rely on Medicaid, they are more likely to encounter a lack of insurance coverage for abortion due to the Hyde Amendment and other laws and policies restricting use of public funds for abortions.¹⁷³ As a result, they may have to pay for an abortion out of pocket, potentially forgoing other life necessities such as medication or food.

Finally, persons with disabilities are more likely to be victims of intimate partner violence and violent crimes like rape and sexual assault.¹⁷⁴ Persons with disabilities make up approximately 12% of the population, but 26.5% of rape/sexual assault victims.¹⁷⁵ When sexual assault results in pregnancy, the victim may need access to abortion. Laws that eliminate exceptions for rape and incest are thus particularly troubling and inhumane. These laws amplify the harms of sexual assault, reviolating the victim's bodily autonomy and exposing them to further indignity and trauma. Timely and confidential access to abortion and other healthcare services are imperative for victims of sexual assault or interpersonal violence. Moreover, because persons with disabilities may have to rely on others for transportation, it may be extremely difficult to access abortion without their abuser's knowledge. Restrictions that require

172. Press Release, Kessler Found., nTIDE May 2020 Special Report: Workers with Disabilities in the COVID Economy (May 20, 2020), <https://perma.cc/Y9EB-3C8A>.

173. See *supra* notes 102–105, 120–122 and accompanying text; see also Mhatre, *supra* note 10, at 9–10.

174. See ERIKA HARRELL, DOJ, BUREAU OF JUST. STATS., CRIME AGAINST PERSONS WITH DISABILITIES (Nov. 2021), <https://perma.cc/B329-KDGL> (PDF) (“In 2019, the rate of violent victimization against persons with disabilities was nearly four times the rate for persons without disabilities.”); *Sexual Violence and Intimate Partner Violence Among People with Disabilities*, CDC, <https://perma.cc/YCL2-4GNA>; see also, e.g., Kendall Ciesemier, Opinion, *Misusing Words Like ‘Groomer’ Isn’t Just Wrong. It’s Dangerous.*, N.Y. TIMES (May 31, 2022), <https://perma.cc/WC9C-LPDN> (“In my case, a medical professional used my reliance on health care, as a child with a life-threatening illness, to take advantage of me, stripping away any remnant of bodily autonomy I had left.”).

175. HARRELL, *supra* note 174, at 4.

multiple, medically unnecessary, trips to a healthcare facility exacerbate these risks.¹⁷⁶

Persons with disabilities, particularly those living at the intersections of other identities such as persons of color with disabilities or transgender persons with disabilities, undeniably experience the harms of abortion restrictions in uniquely burdensome ways. The disproportionate harms experienced by pregnancy-capable people with disabilities discussed in this Part expose the devastating consequences of the ongoing and strengthening attack on abortion rights in the United States. At the same time, it illuminates commonalities between the experiences of people with multiple vulnerable statuses that can be used to forge strong alliances in the fight for reproductive justice. The need for action is clear, and the time is now to forge intersectional coalitions.

III. REIMAGINED ADVOCACY: INTERSECTIONAL COALITION BUILDING TO ADVANCE ABORTION RIGHTS AND AMPLIFY DISABILITY JUSTICE

In an enlightening essay published in the *New York Times*, Kendall Ciesemier offers a poignant first-person account of living with a disability and being pro-choice.¹⁷⁷ She explains, “[t]wo liver transplants and countless other lifesaving interventions later,” as a twenty-nine-year-old woman, “it’s clear that I will not have the same freedom to make choices about my own body that my mother had.”¹⁷⁸ She argues, “[a]bortion opponents like to use disabled fetuses as pawns to support their politics” and she acknowledges that even sometimes she is moved by those arguments, because the human value of “disabled people is often overlooked or ignored.”¹⁷⁹ That said, she concludes, “I know this inner conflict is manufactured and sold to me, not of me.”¹⁸⁰

176. Domestic violence concerns were emphasized by the Supreme Court in striking down a spousal notification requirement in *Casey*. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 887–98 (1992).

177. Ciesemier, *supra* note 156.

178. *Id.*

179. *Id.*

180. *Id.*

In reality, abortion restrictions wreak havoc on the lives of all those needing abortion care, with acute consequences for pregnant persons living at the intersections of historically marginalized and vulnerable identities. According to Ciesemer, abortion opponents too frequently forget that “pregnancy can endanger disabled people,” and “[r]emoving abortion access is not protecting our lives; it is putting them in danger.”¹⁸¹

Indeed, the voices of girls, women, and pregnancy-capable persons with disabilities too often remain unheard, muted, or fragmented in the discourse. More troublingly, abortion opponents may appropriate their voices and use them in selective, misleading, and divisive ways that fail to appreciate the complicated and nuanced history of reproductive regulation.¹⁸² This strategy drives divisions between those otherwise united by a common goal: the realization of human rights that advance bodily autonomy, self-determination, equality, and inclusion.¹⁸³

Why is this so? If restrictive abortion laws and regulations harm the interests of all persons capable of becoming pregnant, if all historically marginalized persons experience uniquely burdensome harms, and if all are united by the common goal of reproductive justice, what inhibits broad and effective coalition building?

Part of the answer lies in a failure to appreciate that reproductive justice and reproductive choice mean different things for different people and groups. Indeed, there is a long history of social movements sidelining or silencing the concerns

181. *Id.*

182. *See supra* notes 157–161 and accompanying text.

183. Claims of racial, disability, socioeconomic, and LGBTQ+ discrimination and injustice have informed efforts to both expand and restrict abortion rights. *See, e.g.*, J.C. WILKE, ABORTION AND SLAVERY: HISTORY REPEATS (1984); Murray, *supra* note 148, at 2062–72; Mary Ziegler, *Bad Effects: The Misuses of History in Box v. Planned Parenthood*, 105 CORNELL L. REV. ONLINE 165, 165–66 (2020); Ziegler, *Disability Politics*, *supra* note 156, 588–90; Gregory Angelo, *If You’re Gay, You Should Choose Life*, WASH. EXAM’R (Jan. 17, 2019), <https://perma.cc/WV2Z-YL7D> (“If being gay is not a choice, gay people should be mindful of the likelihood that if it ever becomes possible for prenatal testing to identify whether a child is heterosexual or homosexual, the incentive to abort gay babies will become a reality.”); Valerie Ploumpis, *Abortion Rights are LGBTQ Rights*, THE HILL (June 14, 2019), <https://perma.cc/3UNH-FXZG>.

of politically marginalized groups in order to advance the movement's broader goals, such as movements that have largely centered on the political advancement and civil liberties concerns of white women.¹⁸⁴ For example, scholars' rigorous critiques of "white feminism" for essentializing and universalizing *white* women's experience as if it represents *all* women's experience persuasively demonstrate how this brand of feminism over time has ignored race, class, sexual identity, and other experiences to the neglect and detriment of all women.¹⁸⁵ For example, Margaret Sanger, who founded the American Birth Control League, which later became the Planned Parenthood Federation of America, linked the birth control movement to eugenics to appeal to wealthy white men and women—a wider audience than the poor women she served—and to "emphasize contraception not only as conducive to women's health and autonomy, but also as a means of promoting the national welfare."¹⁸⁶

Rather than advocating for change separately in a piecemeal fashion, or worse, in a manner that sows division among groups of women and other stakeholders, we urge a social

184. The women's suffrage movement provides one salient example. See, e.g., Joan Marie Johnson, "Not as a Favor, Not as a Privilege, But as a Right": *Woman Suffragists, Race, Rights, and the Nineteenth Amendment*, 42 W. NEW ENG. L. REV. 385, 394–96 (2020) (noting that anti-Black racism infected the women's suffrage movement); Margaret E. Johnson, *Lessons Learned from the Suffrage Movement*, 2 MD. BAR J. 115, 117 (2020) ("Specifically, at times the suffrage movement leaders prioritized white women's voting rights over non-white women's voting rights in order to appease racist chapters within their own organizations."); Tracy Thomas, *Reclaiming the Long History of the "Irrelevant" Nineteenth Amendment*, 105 MINN. L. REV. 2623, 2645–46 (2021) (describing how after Reconstruction, the women's suffrage movement "affirmatively engaged in racist politics").

185. See CHELA SANDOVAL, *METHODOLOGY OF THE OPPRESSED* 45–52 (Sandra Buckley et al. eds., 2000) (describing the work of feminists of color that identified how white feminists dismissed concerns and experiences of women of color, creating a "single-issue" feminism that falsely universalized white women's experience as all women's experience). See generally Angela P. Harris, *Race and Essentialism in Feminist Legal Theory*, 42 STAN. L. REV. 581 (1990).

186. Murray, *supra* note 148, at 2039; see also DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY* 65–112 (discussing how the reproductive rights movement was marked by racism and eugenics); Dorothy Roberts & Sujatha Jesudason, *Movement Intersectionality: The Case of Race, Gender, Disability, and Genetic Technologies*, 10 DU BOIS REV. 321, 321 (2013).

movement-oriented reframing of the reproductive health, rights, and justice movement and agenda. First, as an initial matter, we recognize that law has its limits and courts, while important to protecting the rule of law, too frequently fail. Second, a movement to merely restore *Roe*-level protections ultimately disservices people at the margins, including those who experience socioeconomic constraints, people living in rural areas, and individuals with mobility disabilities. Such vulnerabilities hold at bay the right to terminate a pregnancy. Simply restoring *Roe* would also fail to account for the myriad ways in which racial injustice, LGBTQ+ discrimination, and hardships targeted at individuals with disabilities too frequently compound marginalization and vulnerability.

In other words, we posit that the new social movement agenda should engage intersectional coalition-building. As such, all communities affected by reproductive injustice can find solidarity and work together to build coalitions that incorporate and accept different identities and needs while still pursuing common goals. Importantly, effective intersectional coalition-building demands that individual experiences not get lost. Rather, it requires the *amplification* of voices that on their own lack a platform and go unheard. At its core, intersectional coalition-building is about utilizing commonalities to support collective action while understanding and making space for the unique experiences of individuals with different identities. There exists no universal “woman” or “pregnant person” experience, and coalitions seeking to advance abortion rights must avoid both essentialism and sacrificing one group’s interests to further the interests of another. Coalitions must also recognize that some groups in the coalition experience different or greater harms than others.¹⁸⁷

Protecting reproductive freedom is a concern that anchors across race, sex, LGBTQ+ identity, and disability status. Yet, historic patterns of oppression, as well as divestment or exclusion from the political process, have traditionally sidelined the interests of groups with marginalized status.¹⁸⁸

187. It is undeniable, for example, that a low-income, Black, transgender man with a disability will experience more obstacles in accessing an abortion than a white, financially stable, nondisabled lesbian.

188. See *supra* Part II.

However, intersectional advocacy in social movements might hold promise for advancing reproductive health, rights, and justice. Simply put, where separate voices are muted and silenced, collective intersectional advocacy can offer an effective means of articulating overlapping group concerns. Such movements also have the potential to reshape political agendas and influence elections, simply by the scale of numbers. More individuals within a coalition may produce a greater number of voters to support the cause of a candidate committed to reproductive justice. An intersectional approach to coalition-building provides the basis for reconceptualizing the fight for abortion rights as a movement for all persons capable of becoming pregnant.

The recognition of common experiences—from the entrenched and ongoing history of discrimination and abuse to the current disproportionate harms imposed by abortion restrictions—provides a fundamental starting point for building bridges between the intersections. For example, Part II makes clear that women and pregnancy-capable people with physical disabilities are more likely to live in poverty and rely on Medicaid, and therefore face economic constraints and insurance coverage restrictions for abortions.¹⁸⁹ Thus, all will benefit from the elimination of state and federal restrictions on the use of government funds for abortions. Similarly, removing requirements that result in medically unnecessary trips to healthcare facilities and allowing broader use of telemedicine, local retail pharmacies, and mail pharmacies for medication abortion will significantly improve access to early abortion care for Americans with disabilities who frequently experience unique hurdles caused by travel and financial constraints, as well as privacy and safety concerns. That said, not all individuals experience the same type or magnitude of harm. Thus, although ultimate goals may remain common, achieving those goals may require different approaches for different identities. This fact reinforces the importance of ensuring that the voices of each individual and each group remain heard. Effective and inclusive coalitions require trade-offs, as members must be willing to advance or even prioritize outcomes that have little to no direct or immediate impact on their lives.

189. See *supra* Part II.

CONCLUSION

There is a fraught irony revealed by reproductive freedom advocates who live with disabilities. The Supreme Court's decision in *Dobbs* denies them the constitutional and reproductive liberty that their mothers had two generations ago. For them, and all persons affected by *Dobbs*, the fight for reproductive health, rights, and justice remains long and unwon. Ongoing and devastating attacks on abortion rights and access at the state and federal levels prove its fragility and the need for continual, ever-stronger advocacy. The Supreme Court's decision in *Dobbs* is not the end. On the contrary, it is just the beginning, requiring new and innovative approaches to reproductive justice advocacy. While the constitutional right to abortion has been eviscerated, leading many states to ban or further restrict access to abortion, abortion remains legal in some states and thus theoretically accessible. But as exposed by this Article, it is realistically accessible only to women and pregnancy-capable persons with the resources, support, and ability to travel. Post-*Roe*, women and pregnancy-capable persons with physical disabilities face even greater and increasingly insurmountable barriers to affordable and accessible abortion care.

Intersectional coalition-building that brings together a multi-dimensional group of individuals with different experiences—yet common goals—provides an important weapon in the fight to advance reproductive freedom, bodily autonomy, self-determination, equality, and inclusion. This Article exposes that although coalition-based, interdependent, and interwoven advocacy is not without challenges, with work and dedication those challenges can be overcome to build a stronger movement that ensures all voices are heard and that the rights of all are secured. Reproductive justice will not be attained until it is attained for all.