2024

Confusion, Chaos, and Conflict in U.S. Law and Health Care after Dobbs

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ILCEA
Revue de l'Institut des langues et cultures d'Europe, Amérique, Afrique, Asie et Australie

55 | 2024
Le droit à l'avortement au Royaume-Uni et en Amérique du Nord : échelles, frontières et inégalités

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Electronic version
URL: https://journals.openedition.org/ilcea/20060
DOI: 10.4000/11pre
ISSN: 2101-0609

Publisher
UGA Éditions/Université Grenoble Alpes

Printed version
ISBN: 978-2-37747-492-9
ISSN: 1639-6073

Electronic reference
Nicole Huberfeld, "Confusion, Chaos, and Conflict in U.S. Law and Health Care after *Dobbs*", *ILCEA* [Online], 55 | 2024, Online since 26 May 2024, connection on 29 May 2024. URL: http://journals.openedition.org/ilcea/20060 ; DOI: https://doi.org/10.4000/11pre

Confusion, Chaos, and Conflict in U.S. Law and Health Care after *Dobbs*

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Acknowledgements
Edward R. Utley, Professor of Health Law, Boston University School of Law and School of Public Health; Co-Director, BU Program on Reproductive Justice. Thanks always DJT and SRHT.

1 The U.S. Supreme Court declared more than seven times in the 2022 decision *Dobbs v. Jackson Women's Health Organization* that *Roe v. Wade* should be overturned to "return the issue of abortion to the people's elected representatives".[1] The Court's majority opinion asserted this would free the judiciary of a role in abortion debates, but the reversal of constitutional protection for access to abortion unleashed confusion, chaos, and conflict across the U.S. Indeed, the Supreme Court already has granted petitions for certiorari in two new abortion-related cases during the 2023 Term. *Dobbs* has many implications, and this essay considers one that is underexplored: the impact of the Court's elevation of federalism in "returning" abortion to the "people's elected representatives" on health care more broadly.

2 Without federal constitutional or statutory baseline rules, the conflicts between state laws will grow. Federalism doctrine accounts for and even encourages the vertical tensions between state and federal law. However, after *Dobbs*, state laws vary to a degree not often seen in U.S. history, causing conflicts that traditional federalism theory and doctrine do not often address. These state law differences exceed the usual variability that U.S. federalism tolerates. The confusion caused by the rapidly changing legal landscape impacts the medical care people of reproductive age can access across the U.S., not just in abortion-restrictive states. As such, the division of power and responsibility between national government and states that federalism theory traditionally values must also be studied for conflicts between states.

3 This paper documents the rapidly changing development of laws regulating reproductive care to investigate how *Dobbs* caused confusion for health care providers across the U.S., which impacts health care for all patients and especially those with reproductive capacity. This background helps to contextualize the increasing contradictions among state laws, which have grown with each state legislative session and each judicial opinion. These intractable conflicts have no clear path to resolution. They also illustrate how health inequities deepen when health care is left in the hands of state governments without national rules. This essay draws on legal, medical, and public health research, all of which are necessary for understanding the far-reaching impact of *Dobbs*. The essay considers how the emphasis on vertical division in federalism theory, which promotes sub-government variation, does not answer questions about new barriers to states' recognition of each other's laws. The consequences are broader than the Supreme Court and advocates may have anticipated, as federalism and inter-state cooperation are foundational elements of governance for abortion but also health care more generally in the U.S.

1. State laws before and after *Dobbs*

4 U.S. media is permeated with news about health care providers afraid of practicing evidence-based medicine and the patients harmed by their fear of criminal prosecution and loss of medical licensure because *Dobbs* unleashed so many new and inconsistent laws (Grossman et al., 2023; Goodman, 2023; Simmons-Duffin, 2022). Yet, states had significant authority to regulate abortion in the era of *Roe v. Wade*. The difference now is that no federal constitutional baseline, and few federal statutes, prevent states from taking the most extreme policy positions.

1.1. Reproductive rights history

5 To offer context, this part briefly summarizes the fifty-year history of abortion rights in the U.S. In 1973, the U.S. Supreme Court held in *Roe v. Wade* that a "right of privacy" grounded in the U.S. Constitution's Fourteenth Amendment Due Process Clause protected a "woman's decision whether or not to terminate a pregnancy".[2] *Roe* also sanctioned state authority to regulate access to abortion before the gestational age where life is possible outside the uterus ("viability") to protect "maternal health" and "maintain medical standards," and state interest in "potential life" could be advanced by restricting abortion after viability so long as exceptions for protecting the patient's life and health existed.[3] *Roe* built on prior decisions establishing a right of privacy and involved two distinct ideas: the privacy of the physician-patient relationship recognized at common law and constitutionalized in cases like *Griswold v. Connecticut*,[4] and the privacy of the home protected by the Fourth Amendment and the Fourteenth Amendment.[5] Both remain important facets of right to privacy and are implicated in other intimate matters such as the right to marry,[6] procreate,[7] use contraceptives,[8] raise children,[9] and consent to medical treatment[10]—longstanding Supreme Court-recognized fundamental rights.

6 Years of anti-abortion advocacy tested the boundaries of *Roe* and resulted in the Court's 1992 decision in *Planned Parenthood v. Casey* (Ziegler, 2020), which affirmed constitutional protection for access to abortion but as a "liberty interest" rather than a

privacy right,[11] and which declined to overrule *Roe*.[12] While states could not place a "substantial obstacle" in the path of people seeking abortions, *Casey* allowed more restrictions than *Roe*, so long as states did not impose an "undue burden" on those seeking abortions.[13] *Casey* allowed the state to require 24 hour waiting periods, scripted information delivered by a physician, medical record requirements, and parental consent—a blueprint that other states soon followed (Ziegler, 2020).

7 Neither *Roe* nor *Casey* required states to facilitate access to abortions. Between *Roe* and *Casey*, the Court upheld Congress's restriction of federal Medicaid payment for abortion only to save the life or health of a pregnant person (or in cases of rape or incest).[14] Notably, federal courts have not found the Fourteenth Amendment's Equal Protection Clause, which protects against sex-based discrimination, to be a source of constitutional protection for abortion (Siegel, 1992).

8 As a result of *Roe* and *Casey* continuing to allow states to regulate access to abortion, from 1973–2022, a patchwork of laws grew, with abortion protections and restrictions varying from state to state. Yet, constitutional rights protected access to abortion before viability, and the life and health of pregnant people after viability, and this guided federal courts navigating litigation over state laws designed to test the boundaries of *Roe* and *Casey* (Ziegler, 2020).

9 The Court overturned *Roe* and *Casey* on 24 June 2022. This reversal of a nearly 50-year constitutional protection occurred after Justice Ruth Bader Ginsburg, a lifelong advocate for sex equality, died in September 2020, allowing Republican President Donald Trump to appoint his third Supreme Court justice. With Amy Coney Barrett's appointment, the balance of the Court shifted, allowing Mississippi to argue that its 15-week, pre-viability limit on abortion was constitutional, and that *Roe* and *Casey* should be overturned. The *Dobbs* majority agreed, relying on a "history and tradition" test to decide whether a right that is not explicit in the Constitution is protected—the Court held the right of privacy continues to exist but does not protect abortion. This "history and tradition" test provides little guidance to lower federal courts, and it is already being tested in other contexts, such as a Second Amendment firearm regulation case[15] (also now subject to a "history and tradition" analysis[16]).

10 *Dobbs* held states must have a "legitimate" goal for laws regulating abortion, and the laws must have a "rational basis" for achieving that goal.[17] The *Dobbs* majority expressed that other rights are not disturbed because they do not involve fetal life. However, the erosion of one right that is interwoven with others within longstanding constitutional doctrine causes instability. As the dissent wrote, if the 50-year liberty interest that protected abortion could be eroded, then "no one should be confident that this majority is done with its work".[18] After *Dobbs*, the legal landscape is much more complex, so the rapidly changing situation with state regulation of abortion is discussed next.

1.2. Restrictive state laws

11 Each state with restrictive abortion laws has similarities and differences to other restrictive states, which is true for both pre- and post-*Dobbs* laws. Though the line of viability was a common feature of all kinds of state laws, other restrictions existed in each state that tried to limit the protections *Roe* and *Casey* afforded pregnant people. State legislators commonly relied on model laws generated by advocacy organizations

like Americans United for Life but also learned from each other's attempts at eroding *Roe* (Ziegler, 2020). For example, states have used statutes developed in other states, such as Texas's novel abortion whistleblower law ("SB 8"), which was adopted later by Oklahoma and Idaho.[19] Likewise, states followed each other's models for "trigger laws", enacted to wait on the books unenforceable yet ready to ban abortion on the day the Court overturned *Roe*.

12 Even though states already had "fetal heartbeat" laws limiting abortion access after 6 to 15 weeks, "trigger laws" resulted in limits on abortion access changing right after *Dobbs*, as thirteen states could make abortion a crime immediately. Abortion restriction laws include 6-week, 12-week, 15-week, 18-week, and 22-week limits based on the "last known menstrual period" ("LMP") (Center for Reproductive Rights, 2024). In the pre-*Dobbs* landscape, these were deemed "restrictive" laws because they limit abortion at a point before viability. However, in the post-*Dobbs* era, even the word restrictive may have different interpretations. Banning abortion at 0 week is very different from 12 weeks and makes a state like North Carolina and its 12-week limit[20] appear closer to protective than restrictive. In this new context, North Carolina has become a destination for people traveling to access abortion (Guttmacher, 2024). Likewise, a 15-week ban seems less restrictive than a 0-week or 6-week ban, because a majority of abortions occur within 15 weeks.

13 States that enacted such restrictions before *Dobbs*, like Mississippi, were testing *Roe*. Now, they will also test each other because people are traveling to less-restrictive and protective states to obtain care (Guttmacher, 2024). A bit more detail helps for understanding the growing complexities. As noted above, abortion limitations have a timing range, but exceptions to these time limits vary too. Among total bans (or 0-week bans), all states have exceptions allowing abortion to prevent the death of the pregnant person, but most exceptions exclude mental health threats, including Alabama, Arkansas, Florida, Kentucky, Louisiana, Montana, North Carolina, North Dakota, Oklahoma, South Carolina, Tennessee, Texas, and West Virginia (Felix, Sobel & Salganicoff, 2023). Some states have both life and health exceptions, such as Georgia and North Dakota (Felix, Sobel & Salganicoff, 2023). Some states allow preserving life and health and include exceptions for rape or incest; however, some have limited rape exceptions by requiring a police report for the exception to apply, such as Florida.[21] Some states also limit abortion for fetal anomalies (Guttmacher, 2023). Many states limit private and/or public health insurance coverage for abortions (Huberfeld, 2013). And, other *Roe*-era restrictions also remain on the books, for example, those modeled after Pennsylvania's law approved in *Casey* and targeted regulation of abortion provider ("TRAP") laws, which require abortion providers to adhere to medically unnecessary state regulations such as special building requirements for clinics, extra inspections and higher fees for licensure, and requiring abortions to occur in settings such as hospitals for no medically-based reason (Center for Reproductive Rights, 2024). In some states, multiple gestational age bans sit on the books, such as Arizona,[22] and though the most limiting law may be understood as the applicable standard, these conflicting and overlapping intra-state standards confuse providers and patients (Felix, Sobel & Salganicoff, 2023).

14 States' 2023 legislative sessions continued more of these restrictions, but also new kinds of restrictive models began to emerge. For example, Florida's legislature prohibited abortions after 6 weeks of pregnancy with exceptions in cases of rape and

incest until 15 weeks of pregnancy, but only if victims can provide a police report, restraining order, or other legal documentation.[23] A law in Idaho banned "trafficking" minors to obtain an abortion, meaning helping them to cross state lines to access abortion care; others have used this trafficking ban model.[24] Utah ended licensure for abortion clinics, which would force reliance on hospitals.[25] Wyoming legislators introduced a bill declaring abortion is "not health care" but rather "the intentional termination of the life of an unborn baby" to try to bypass the state's constitution.[26] This law in Wyoming, and similar laws in other states, also proposed to protect fetal life. New types of laws are emerging, indicating that the post-*Dobbs* legal chaos is just beginning.

15 States historically have regulated medicine under their "police power" to protect public health, safety, and welfare, so the U.S. has always had variation in health care regulation. Before *Dobbs*, state law differences were not irreconcilable, and they had federal rules to which they must adhere. For example, viability was the only enforceable limitation related to gestational age, because of *Roe* and *Casey*. Thinking of health care more generally, a person qualified to be licensed as a physician in Texas would also be qualified for licensure in Massachusetts, because each state tends to look for the same qualifying factors, and then the state licensure is accepted by the federal government for becoming a participating provider in federal programs like Medicare. Further, outlawing a specific medical procedure has been quite rare, leading to coining the phrase "abortion exceptionalism" (Metzger, 2007; Vandewalker, 2012; Corbin, 2014; Borgmann, 2014; Greenhouse & Siegel, 2015; Joffe & Schroeder, 2021; Serpico, 2021; Fox & Cole, 2021; Donley, 2022; Sepper, 2023). The bottom line is that new conflicts between states' laws jeopardize historical reliance on state cooperation to achieve health care regulation across state lines. It is also worth noting that restrictive states are not just outlawing abortion, but also their officials threaten to cross state lines to enforce their laws (Romo, 2022). This makes understanding the trends in protective laws necessary too.

1.3. Protective state laws

16 Abortion-protective states also have diverse and layered laws. Like restrictive states, different gestational age limits exist. Most protective states permit or protect access up to the point of viability but define it differently, with some drawing a line at 24 weeks (Massachusetts, Nevada, New Hampshire), others at 22 weeks (Iowa, Kansas, Ohio, Wisconsin), and others relying on the concept of viability without setting a number (California, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Michigan, Montana, Rhode Island, and Washington) (Kaiser Family Foundation, 2024). Also, protective states have various exceptions for abortions after viability, though the most common approach reflects the *Roe* and *Casey* framework, to include exceptions protecting the life or health of the pregnant patient, and for rape or incest (Felix, Sobel & Salganicoff, 2023). In addition, protective states have a variety of other laws applying to abortion, with many having at least some of the restrictions that were common under *Roe* and *Casey*.

17 Nevertheless, states have been enacting laws to become proactively protective of providers and patients. For example, some states require insurers to cover legal health care in the state (Massachusetts), and seventeen, either by statute or judicial decision

cover Medicaid patients' abortions with state funds, including Alaska, California, Connecticut, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, Vermont. Some states' laws require private insurance to cover abortion care, such as California, Illinois, Maine, New York, Oregon, and Washington (Center for Reproductive Rights, 2024). Novel "interstate shield laws" are meant to deflect abortion-restrictive states' prosecutorial actions against health care providers and anyone else who helps in abortion care (Cohen, Donley, Rebouché & Aubrun, 2023). Shield laws commonly prohibit a state medical board from penalizing licensees, prohibit cooperation with other states' criminal investigations, and prevent extraditing physicians who act legally under state law to states where that care is illegal. Relatedly, state laws protecting abortion access to the point of viability have the effect of protecting providers and patients within those states, even without shield laws.

18 The 2023 state legislative session showed new trends for protective laws. For example, Hawaii and Illinois eliminated the rule that only physicians can provide abortions. Illinois prohibited higher charges for out-of-network care if a patient's in-network provider objects to performing an abortion. Maryland enacted a data privacy law with extra protection for reproductive care medical records. Minnesota codified a right to access abortion, which already was protected under a 1995 state supreme court decision, and other states considered such "*Roe* codifying" laws. New Hampshire removed penalties imposed on doctors who provide abortions after 24 weeks (Center for Reproductive Rights, 2024).

19 Shield laws are especially interesting because they protect health care providers' medical judgment, which is rooted in their training to provide the evidence-based care indicated in a given medical situation. Shield laws also have the effect of encouraging inter-state travel, which data shows has been increasing after *Dobbs*, with one report observing protective states that border a number of restrictive states have greater travel increases, such as Colorado, Florida, Illinois, New Mexico, and Ohio (Forouzan, Friedrich-Karnik & Maddow-Zimet, 2023). States have authority to enact and enforce laws within their borders, but states cannot reach across borders to enforce their own laws in another jurisdiction. Historically, constitutional provisions such as the Full Faith and Credit Clause (requiring states to recognize other states' laws),[27] Extradition Clause (return criminals fleeing across state lines),[28] and Privileges and Immunities Clause (citizens of one state are treated equally in other states to prevent discriminating against out-of-state citizens),[29] as well as informal norms of cooperation, led states to help enforce each other's laws (Delaney & Mason, 2022). This cooperation facilitated smoothing differences among the assortment of health care laws across the U.S.

20 However, shield laws work against the norm of cooperation, instead reinforcing the barriers that states have erected to ban abortion or protect access. Because shield laws prevent extradition, limit use of state resources to aid abortion-restrictive states, protect licensure and confidentiality, limit the reach of other states' judgments against providers licensed in the shield state, and in Massachusetts facilitate telehealth for patients in restrictive states, states have firm and irreconcilable conflicts between their abortion laws. A shield state cannot protect a physician who travels to treat patients in an abortion-ban state, or maybe even who travels through one (Cohen, Donley, Rebouché & Aubrun, 2023). Notably, and perhaps in response to shield laws, prosecutors in Alabama and Texas are seeking medical records from protective states

to discover whether patients have traveled to seek care that is unlawful in their home states.

21 This is not the first time states have dissonant policies; but, in the abortion context, the stakes for the individuals caught between conflicting state laws are unusually high, because the differences between protective and restrictive states' laws are irresoluble. A crime in one state is protected lawful behavior in another. That crime could be a felony that leads to loss of licensure and civil liability in some states, but it is treated as necessary medical care by others.

1.4. Additional variability

22 Adding to the chaos, in both protective and restrictive states, state supreme courts have interpreted state constitutions to protect access to abortion care. For example, health care choice provisions adopted as anti-Patient Protection and Affordable Care Act (ACA) maneuvers, trying to limit the ACA's universal health insurance coverage, are general enough to encompass access to abortion (Thomas, 2023). Litigation is proceeding under several theories: privacy; equal protection; liberty or autonomy, depending on the language of the state's constitution; life; and protection for free exercise of religion or against establishment of religion (Center for Reproductive Rights, 2024). State courts have protected access to abortion under each of these theories, but not in every instance. For example, the Supreme Court of South Carolina rejected arguments that the state constitution protects abortion—but only after an election changed the balance of the court, which had previously protected access as an aspect of privacy.[30] More recently, the Alabama Supreme Court held that frozen embryos created for in vitro fertilization are considered "minor children" under the state constitution and laws protecting fetal life.[31]

23 In both protective and restrictive states, ballot initiatives have put abortion policy questions to voters, and the consistent votes to protect access to abortion in the 2022 and 2023 elections suggest this democratic process will continue to play an important role in the 2024 election and beyond. For example, in 2023, abortion was on the ballot in Ohio, considered a conservative state, yet more than 56% of voters approved "Issue 1", which created "an individual right to one's own reproductive medical treatment, including but not limited to abortion" and protects individuals who assist people seeking reproductive care. Similarly, in 2022, Kansas voters rejected a proposed constitutional amendment that would have declared no right to abortion, as did Kentucky voters. In California, Michigan, and Vermont, voters approved constitutional amendments protecting reproductive autonomy, including abortion and contraception. Conversely, in Montana, where the law prohibits post-viability abortions (after 24 weeks), a ballot initiative failed that would have created criminal penalties if doctors did not try to save a fetus "born alive" after an abortion. In 2024, Maryland and New York have ballot initiatives to protect access to abortion, and Florida voters are working on a similar referendum (Huberfeld & McClain, 2023).

24 Only a snapshot of these rapid developments is possible, as legislation, litigation, and ballot initiatives are ongoing. Furthermore, vertical conflicts between state and federal laws are proliferating, leading to the two abortion-related cases before the Court in the spring of 2024. In *Idaho v. U.S.*, the Court will consider Medicare, the federal public health insurance program for people age 65 and older, which has a provision called

"EMTALA" (Emergency Medical Treatment and Labor Act) that requires hospitals paid by Medicare to treat all emergency medical conditions, or stabilize and transfer to an appropriate hospital, regardless of the patient's ability to pay—nearly all hospitals are Medicare providers.[32] The Biden administration notified hospitals after *Dobbs* that, under EMTALA, provider should continue to follow standards of care that indicate abortion is the proper course of action for a medical emergency or risk federal penalties. The Supreme Court granted Idaho's emergency petition on 5 January 2024 to decide the conflict between Idaho's zero-week ban and EMTALA.[33] In a second case, the Court will consider federal regulation of mifepristone; Food and Drug Administration (FDA) protocols for obtaining mifepristone conflict with some restrictive states' laws that outlaw abortion or impose extra access requirements on medication abortion. The Court was asked to hear questions regarding the FDA's power to change mifepristone's protocols,[34] and whether federal regulations preempt contradictory state laws, which could determine access to medication abortion—but oral arguments sounded like the Court may decide this case based on the challengers' lack of standing to sue. The EMTALA decision could have broader implications, because a decision favoring Idaho would allow states to carve out other politically-disfavored treatments from a longstanding, universal emergency care protection.

25 The purpose of charting the high level of inter-state conflicts that exist and will continue to evolve is to show how challenging access to health care is without a federal constitutional or statutory baseline. Such conflicts are causing real-world problems for patients and health care providers alike.

2. Impediments to health care after *Dobbs*

26 The practice of medicine, medical training, and patients' health are beginning to experience changes reflecting *Dobbs*' constitutional reversal. State restrictions on abortion access, and inter-state conflicts, impose direct prohibitions on care, but providers' fear and misunderstanding of the law also impact access to care. These phenomena are documented in medical and public health literature, and indicate that inequality is deepening for people of reproductive age living in restrictive states.

27 Before *Dobbs*, obstetrician/gynecologists and others who provide reproductive care became scarce in many places, especially rural areas and states in the deep South and central Midwest. These "maternity care deserts" exist where prenatal, pregnancy, delivery, and post-partum care, in addition to abortion, are difficult to access (Sonenberg & Mason, 2023). Pregnancy outcomes are worse in maternity care deserts, including higher maternal and infant mortality and more pre-term and low-birthweight births. States in the South and Midwest also were more likely to have restrictive abortion regulations enacted before *Dobbs*, as *Casey*'s undue burden standard allowed more deference to state rules. Relatedly, public health research shows that maternal mortality, pre-term birth, teen birth, and infant mortality are higher in abortion-restrictive states (Declercq, Barnard-Mayers, Zephyrin & Johnson, 2022).

28 Public health as a field seeks to reduce risk of illness, injury, and death, making reproductive care a public health issue. The U.S. has high rates of unplanned pregnancies (Bearak et al., 2022) and the highest maternal mortality among wealthy nations (Munira, Gumas & Williams, 2022), and the risk of maternal mortality is higher if a patient is Black (Fleszar et al., 2023). A public health approach includes strategies

for safe pregnancy, childbirth, and healthy children and childrearing in the circumstances of a person's choosing, including abortion. Yet, at the time *Dobbs* was decided, these goals were already difficult to achieve in many states, especially states that have not expanded Medicaid eligibility under the ACA, which allowed low-income adults (earning up to 138% of the federal poverty level, about $20,000 U.S.D.) to enroll in Medicaid. States without Medicaid expansion have higher uninsurance rates, less access to medical care, populations that are sicker, and tend to limit social programs (Solomon, 2021). Combined with changes occurring in medicine, people of reproductive age living in abortion-restrictive states that limit public health programs face many barriers to health.

29 ANSIRH researchers, who published the famous *Turnaway Study* documenting negative health outcomes for people denied abortions, issued a preliminary report in May 2023 that shows state abortion restrictions stopped doctors from providing medical care consistent with the standard of care after *Dobbs* (Grossman et al., 2023). Doctors conveyed uncertainty about the law, which led to inaction or delayed action, and patients then experienced negative outcomes. The report includes the experiences of only 50 doctors, but their stories are detailed, involve health care providers of all kinds across many specialties, and are consistent with other evidence that doctors working in restrictive states face legal barriers and have deep confusion about the law (Surana, 2023). For example, providers in emergency medicine report that the hospitals in which they work are unable to provide clear legal or medical guidance because exceptions to abortion bans are written in nonscientific language that does not correlate to medical standards (Balch, 2023). A group of twenty women sued Texas on these grounds, asserting harm occurred during their pregnancies because Texas's abortion ban has exceptions that are too vague to protect patients.[35]

30 In 2023, the American Academy of Medical Colleges published the first post-*Dobbs* physician residency data (Orgera, Mahmood & Grover, 2023). Residency applications were due months after the Court issued *Dobbs*, yet data shows shifts in the workforce are starting. Medical students applied for residencies in greater numbers in abortion-protective states and avoided the zero-week ban states, and the specialties most affected by *Dobbs*—emergency medicine, obstetrics/gynecology, internal medicine, family medicine, and pediatrics—experienced a slight drop in applications, with the largest decrease in obstetrics/gynecology applicants occurring in zero-week ban states such as Idaho (minus 10.5%) and the smallest decrease in abortion-protective states such as Massachusetts (minus 5.3%) (Orgera, Mahmood & Grover, 2023). The researchers hypothesized that desire to finish physician training could outweigh choosing residency in a state based on its abortion laws. Even so, in the specialties of obstetrics/gynecology and emergency medicine, medical school graduates chose to train in abortion-protective states and avoid abortion restrictive states (Orgera, Mahmood & Grover, 2023). Only one placement cycle has occurred since *Dobbs*, so this is a developing issue.

31 Wider effects on access to care are emerging. In the U.S., hospitals are a community anchor, providing economic stability in addition to medical care. For years, hospitals have been closing, especially in rural areas (Cecil G. Sheps Center, 2024). When a hospital does not close, management often must choose departments to close, and obstetrics units in sparsely-populated areas are expensive to maintain (Hung, Kozhimannil, Casey & Moscovice, 2016). Hospital and obstetrics unit closures

contribute to maternity care deserts (Sonenberg & Mason, 2023). Concurrently, health care providers who treat patients of reproductive age are experiencing elevated moral distress (Chen, Gordon, Chervenak & Coverdale, 2024), and physician burnout was already high from the trauma of the COVID-19 pandemic (Riedel, Kreh, Kulcar, Lieber & Juen, 2022). ANSIRH researchers documented how providers' uncertainty about the law causes delay and inaction, but also showed that distress results when the medical standard of care is clear and action is legally restricted—for example, doctors helping a patient who ended up in intensive care after her abortion was delayed were weeping while discussing the case (Grossman et al., 2023). Other studies show negative patient outcomes cause harm to patients but also to providers' mental health (Mengesha, Zite & Steinauer, 2022). Researchers predict these trends will worsen as providers choose to live and work in states that do not ban abortion, causing greater inequity in health care access (Grover, 2023).

3. Federalism, fragmentation, and future interventions

32 Federalism is a feature of the government written into the U.S. Constitution but is not unique to the U.S. Many nations have federalism structures, including Canada, Germany, Brazil, India, and others (Forum of Federations, 2023), but the U.S. tolerates more variability in health care. Other nations have health care systems with national rules that are less fragmented than the U.S., typically providing universal coverage or health care, and have signed and ratified treaties protecting a right to health (International Covenant on Economic, Social, and Cultural Rights, Art. 12, 1966). Most nations also have ended abortion bans, which follows human rights principles established in Article 6 of the International Covenant on Civil and Political Rights (ICCPR): "Every human being has the inherent right to life" (ICCPR, 1966). The ICCPR builds on Article 1 of the Universal Declaration of Human Rights, "All human beings are born free and equal in dignity and rights" (UDHR, 1948). The Human Rights Committee published General Comment 36, which declares the right to life "should not be interpreted narrowly", includes "safe, legal, and effective access to abortion", and States parties should not enact criminal measures regarding pregnancy and abortion (General Comment 36, § 3, § 8, 2019).

33 Human rights principles highlight how the *Dobbs* decision empowering states to enforce zero-week abortion bans is an outlier. States banning abortion have enacted laws that jeopardize the life and health of pregnant persons, which controverts Article 6 and General Comment 36 (UN Office of the High Commissioner, 2023). As global health researchers have documented, mortality due to childbirth is higher than abortion, and abortions occur whether legal or not, but injury and death from abortion are more likely where it is illegal (Bearak et al., 2020). In other words, it is predictable that pregnant people will be harmed by zero-week bans. The risk is compounded given that many of the states that ban abortion have not expanded Medicaid eligibility (Solomon, 2021; Declercq, Barnard-Mayers, Zephyrin & Johnson, 2022). These states reject an approach common to other nations, universal insurance coverage, leaving millions of people uninsured and causing residents of these states to have less access to preventive medicine and other health care, resulting in worse health outcomes. These factors existed before *Dobbs*, but they are aggravated now and underscore the UN's conclusion that such state laws violate Article 6.

34 A global federalism comparison also arose during the COVID-19 pandemic, when certain attributes of U.S. federalism made it harder for the nation to effectively address the public health emergency, especially when states refused to implement federally-recommended containment measures or accept federal financial relief (Huberfeld, 2023; Joffe & Schroeder, 2021; Huberfeld, Gordon & Jones, 2022). The problems surfacing after *Dobbs* are similar but also have key differences: no federal statute or policy addresses the situation comprehensively, and more than ever, people are traveling across state lines to seek care if they can afford to do so. These factors increase the likelihood that legal conflicts will arise between states, with no clear path to resolution given that federal constitutional guardrails do not exist at this time.

35 The U.S. has an emerging horizontal federalism problem. Extraterritorial application of state laws is an unsettled area of the law (Cohen, Donley & Rebouché, 2023). Interstate shield laws facilitate providers' sense that they can safely care for patients in their home state if it is a protective state ("State A"), but shield laws cannot provide certainty for doctors and patients in State A regarding whether a restrictive state ("State Z") has power to prosecute them when they leave State A (Cohen, Donley, Rebouché & Aubrun, 2023). This State A/Z conflict is the kind that requires federal intervention, not only ad hoc judicial interventions. State abortion lawmaking is generating the same kinds of variability that contribute to enduring health inequity from state to state, and it is spilling over into other politically-charged topics such as gender affirming care (Romo, 2022).

36 Horizontal federalism requires studying the ways that states relate to each other given that they exist within a federal union. Federalism theory tends to focus on vertical relationships—federal-state, or state-local—and usually names four values that justify vertically-divided government: state autonomy, diversity, policy experimentation, and fostering competition for voters, features that are political in nature (Young, 2004). Scholars have explored less whether these values are meaningful for horizontal federalism, with an influential account arguing that conflicts between states can be "harness[ed]" to improve democratic outcomes (Gerken & Holtzblatt, 2014: 66). This account is unconvincing in light of the irreconcilable conflicts between states after *Dobbs*, which appear to reflect the will of the people when ballot initiatives arise, but politicians in abortion ban states are attempting to make ballot initiatives harder to achieve too (Carter & Clapman, 2024).

37 Abortion is a crime in States Z and protected in States A. Physicians can lose their license to practice medicine in States Z, and are protected from licensure loss in States A. This situation is more like the distance between slave and free states before the Civil War than the run-of-the-mine differences that state regulation of health care usually incurs. The Court often calls states "sovereign", yet sovereign power only exists within states' borders. So, states must rely on federal judges and Congress, as well as each other, for stability and cooperation to implement laws that reach into or outside of their borders (Delaney & Mason, 2022). Scholars who study horizontal federalism argue that politics will resolve most inter-state disputes and that judges are not the only answer (Gerken & Holtzblatt, 2014). The high-conflict horizontal federalism arising after *Dobbs* will need both paths to find stability in the chaos.

38 Though returning abortion to "the people's elected representatives" implied state lawmakers, Congress also is comprised of "the people's elected representatives". Congress has power under the Commerce Clause to regulate abortion as health care

that people seek in inter-state commerce. The Court upheld such regulation in the past, for example, in *Gonzales v. Carhart*, the Court upheld the federal Partial-Birth Abortion Ban Act of 2003, which criminalized the intact dilation and extraction procedure physicians used for safety reasons when performing later-in pregnancy abortions, as an exercise of Congress's commerce power.[36] In *Harris v. McRae*, the Court held Congress could attach the Hyde Amendment to Medicaid funding, restricting payment for abortions as an exercise of the spending power.[37] In *Rust v. Sullivan*, the Court held the federal government could exercise its spending power to fund family planning grants but also prohibit abortion as a form of family planning.[38] These acts involved limitations on abortion, which speaks to the policy, not the power. Congress has power to protect access to care, as it did with the Freedom of Access to Clinic Entrances Act of 1994, which prohibits protestors from blocking clinics.[39] Arguably, the commerce power would be even more straightforward in the wake of *Dobbs*, given the increasing number of people crossing state borders to obtain reproductive care.

39 Historically, federal law in the domain of health law tends to be stabilizing, creating regulatory baselines that protect access to care (Gluck & Huberfeld, 2018). Federal lawmakers provide consistency after states have generated different policies that indicate where pitfalls lie, understood to be one of the values of vertical federalism—that Congress can learn from state mistakes (Gerken & Holtzblatt, 2014). States are making abortion policy pitfalls clear, quite quickly, after *Dobbs*. Whether Congress will follow its own history of providing level-setting for the nation, and the lead of other nations, by acting to protect access to care and improve equity, remains to be seen.

4. Conclusion

40 *Dobbs* has escalated the conflict that exists among states, and between states and the federal government, increasing risk for all people of reproductive age, especially already-vulnerable populations. Traditional federalism values like state sovereignty cannot resolve this quandary, because inter-state cooperation is foundational for health care governance and public health in the U.S. Prior periods of heightened inter-state conflict have required more than judicial decisions and indicate that Congress will need to act to quell the chaos through a bill like the Women's Health Protection Act.[40] This bill would protect all kinds of reproductive care and prevent states from enacting the kinds of regulations that whittled away at the right of privacy as protected by *Roe* and *Casey*. While state constitutions sometimes protect abortion access, and voter referenda on 2024 ballots in Florida, Maryland, New York are likely to do the same, the entire nation is facing a crisis jeopardizing the health of reproductive-age people. The upcoming presidential election, as well as the Supreme Court's two abortion-related cases, will continue to put these issues front and center.

BIBLIOGRAPHY

Balch Bridget (2023), "What Doctors Should Know about Emergency Abortions in States with Bans", *AAMC News*, 26 September: <www.aamc.org/news/what-doctors-should-know-about-emergency-abortions-states-bans> (14 March 14 2024).

Bearak Jonathan Marc, Popinchalk Anna, Beavin Cynthia, Ganatra Bela, Moller Ann-Beth, Tunçalp Özge & Alkema Leontine (2022), "Country-Specific Estimates of Unintended Pregnancy and Abortion Incidence: A Global Comparative Analysis of Levels in 2015–2019", *BMJ Global Health*: <https://gh.bmj.com/content/bmjgh/7/3/e007151.full.pdf> (16 March 2024).

Bearak Jonathan, Popinchalk Anna, Ganatra Bela, Moller Ann-Beth, Tunçalp Özge, Beavin Cynthia, Kwok Lorraine & Alkema Leontine (2020), "Unintended Pregnancy and Abortion by Income, Region, and the Legal Status of Abortion: Estimates from a Comprehensive Model for 1990–2019", *The Lancet Global Health*, *8*(9), e1152–e1161, <http://dx.doi.org/10.1016/S2214-109X(20)30315-6>.

Carter Sara & Clapman Alice (2024), "Politicians Take Aim at Ballot Initiatives", *Brennen Center for Justice*: <www.brennancenter.org/our-work/research-reports/politicians-take-aim-ballot-initiatives> (16 March 2024).

Cecil G. Sheps Center for Health Services Research (2024), "191 Rural Hospital Closures and Conversions since January 2005", *Sheps Center*: <www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/> (16 March 2024).

Centers for Clinical Standards and Quality (2022), "Memorandum Regarding Reinforcement of EMTALA Obligations Specific to Patients Who Are Pregnant or Experiencing Pregnancy Loss", *Center for Medicare and Medicaid Services*, U.S. Department of Health and Human Services: <www.cms.gov/files/document/qso-21-22-hospital-revised.pdf> (14 March 2024).

Center for Reproductive Rights, "After *Roe* Fell: Abortion Laws by State", *Center for Reproductive Rights*: <https://reproductiverights.org/maps/abortion-laws-by-state/> (16 March 2024).

Center for Reproductive Rights, "State Constitutions and Abortion Rights", *Center for Reproductive Rights*: <https://reproductiverights.org/maps/state-constitutions-and-abortion-rights/> (16 March 2024).

Chen Rebecca, Gordon Mollie, Chervenak Frank, Coverdale John (2024), "Addressing Moral Distress after *Dobbs v. Jackson Women's Health Organization*: A Professional Virtues-Based Approach", *Academic Medicine*, *99*(1), 12–15, <http://dx.doi.org/10.1097/ACM.0000000000005476>.

Cohen David S., Donley Greer & Rebouché Rachel (2023), "The New Abortion Battleground", *Columbia Law Review*, *123*(1).

Cohen David S., Donley Greer, Rebouché Rachel & Aubrun Isabelle (2023), "Understanding Shield Laws", *Journal of Law, Medicine & Ethics*, *51*(3), 584–591.

Corbin Caroline Mala (2014), "Abortion Distortion", *Washington & Lee Law Review*, *71*(2), 1175–1210.

Declercq Eugene, Barnard-Mayers Ruby, Zephyrin Laurie C. & Johnson Kay (2022), "The U.S. Maternal Health Divide: The Limited Maternal Health Services and Worse Outcomes of States Proposing New Abortion Restrictions", *The Commonwealth Fund*: <www.commonwealthfund.org/

publications/issue-briefs/2022/dec/us-maternal-health-divide-limited-services-worse-outcomes> (16 March 2024).

Delaney Erin F. & Mason Ruth (2022), "Solidarity Federalism", *Notre Dame Law Review*, *98*(2), 617–669.

Donley Greer (2022), "Medication Abortion Exceptionalism", *Cornell Law Review*, *107*, 627–704.

Felix Mabel, Sobel Laurie & Salganicoff Alina (2023), "A Review of Exceptions in State Abortion Bans: Implications for the Provision of Abortion Services", *Kaiser Family Foundation*: <www.kff.org/womens-health-policy/issue-brief/a-review-of-exceptions-in-state-abortions-bans-implications-for-the-provision-of-abortion-services/> (14 March 2024).

Fleszar Laura G., Bryant Allison S., Johnson Catherine O., Blacker Brigette B., Aravkin Aleksandr [...] Roth Gregory A. (2023), "Trends in State-Level Maternal Mortality by Racial and Ethnic Group in the United States", *Journal of the American Medical Association*, *330*(1), 52–61, <http://dx.doi.org/10.1001/jama.2023.9043>.

Forouzan Kimya, Friedrich-Karnik Amy & Maddow-Zimet Isaac (2023), "The High Toll of US Abortion Bans: Nearly One in Five Patients Now Traveling Out of State for Abortion Care", *Guttmacher*: <www.guttmacher.org/2023/12/high-toll-us-abortion-bans-nearly-one-five-patients-now-traveling-out-state-abortion-care> (12 April 2024).

Forum of Federations, The Global Network on Federalism and Devolved Governance: <https://forumfed.org/> (14 March 2024).

Fox Dov & Cole Erin (2021), "The Supreme Court's Abortion Exceptionalism-Judicial Deference, Medical Science, and Mifepristone Access", *New England Journal of Medicine*, *384*(24), e94, <http://dx.doi.org/10.1056/NEJMp2104461>.

Gerken Heather K. & Holtzblatt Ari (2014), "The Political Safeguards of Horizontal Federalism", *Michigan Law Review*, *113*(1), 57–120.

Goodman J. David (2023), "Abortion Ruling Keeps Texas Doctors Afraid of Prosecution", *New York Times*, <www.nytimes.com/2023/12/13/us/texas-abortion-doctor-prosecution.html> (12 April 2024).

Greenhouse Linda & Siegel Reva B. (2015), "Casey and the Clinic Closings: When Protecting Health Obstructs Choice", *Yale Law Journal*, *125*, 1428–1480.

Grossman Daniel, Joffe Carole, Kaller Shelly, Kimport Katrina, Kinsey Elizabeth, Lerma Klaira, Morris Natalie & White Kari (2023), "Care Post-*Roe*: Documenting Cases of Poor-Quality Care Since the *Dobbs* Decision", Advancing New Standards in Reproductive Health (ANSIRH) & Population Research Center and Texas Policy Evaluation Project, University of Texas at Austin: <www.ansirh.org/sites/default/files/2023-05/Care%20Post-Roe%20Preliminary%20Findings.pdf> (14 March 2024).

Grover Atul (2023), "A Physician Crisis in the Rural US May Be about to Get Worse", *Journal of the American Medical Association*, *330*(1), 21–22, <http://dx.doi.org/10.1001/jama.2023.7138>.

Guttmacher Institute (2023), "Abortion Bans in Cases of Sex or Race Selection or Genetic Anomaly", Guttmacher Institute: <www.guttmacher.org/state-policy/explore/abortion-bans-cases-sex-or-race-selection-or-genetic-anomaly> (12 April 2024).

Guttmacher Institute (2024), "Monthly Abortion Provision Study", Guttmacher Institute: <www.guttmacher.org/monthly-abortion-provision-study> (16 March 2024).

GLUCK Abbe R. & HUBERFELD Nicole (2018), "What Is Federalism in Healthcare For?", *Stanford Law Review*, *70*, 1689–1803.

HIGH COMMISSIONER FOR HUMAN RIGHTS (2023), "United States: Abortion Bans Put Millions of Women and Girls at Risk, UN Experts Say", *United Nations Office of the High Commissioner for Human Rights*: <www.ohchr.org/en/press-releases/2023/06/united-states-abortion-bans-put-millions-women-and-girls-risk-un-experts-say> (14 March 2024).

HUBERFELD Nicole (2013), "With Liberty and Access for Some: The ACA's Disconnect for Women's Health", *Fordham Urban Law Journal*, *40*(4), 1357–1393.

HUBERFELD Nicole (2023), "High Stakes, Bad Odds: Health Laws and the Revived Federalism Revolution", *U.C. Davis Law Review*, *57*, 977–1058.

HUBERFELD Nicole, GORDON Sarah H. & JONES David K. (2022), "American Public Health Federalism and the Response to the COVID-19 Pandemic", V. Molinari & P. A. Beylier (dir.), *COVID-19 in Europe and North America: Policy Responses and Multi-Level Governance*, Berlin: DeGruyter.

HUBERFELD Nicole & MCCLAIN Linda C. (2023), "Abortion Rights Victories Show This Issue Is Unlikely to Fade in 2024 Elections – 3 Things to Know", *The Conversation*: <https://theconversation.com/abortion-rights-victories-show-this-issue-is-unlikely-to-fade-in-2024-elections-3-things-to-know-217249> (12 April 2024).

HUNG Peiyin, KOZHIMANNIL Katy B., CASEY Michelle M. & MOSCOVICE Ira S. (2016), "Why Are Obstetric Units in Rural Hospitals Closing Their Doors?", *Health Services Research*, *51*(4), 1546–1560, <http://dx.doi.org/10.1111/1475-6773.12441>.

HUMAN RIGHTS COMMITTEE (2018), "General Comment No. 36 on Article 6: Right to Life, § 3, U.N. Doc. CCPR/C/GC/36", *United Nations Office of the High Commissioner for Human Rights*: <www.ohchr.org/en/calls-for-input/general-comment-no-36-article-6-right-life> (14 March 2024).

International Covenant on Civil and Political Rights, opened for signature 16 December 1966 (entered into force 23 March 1976).

International Covenant on Economic, Social, and Cultural Rights, opened for signature 16 December 1966 (entered into force 3 January 1976).

JOFFE Carole & SCHROEDER Rosalyn (2021), "COVID-19, Health Care, and Abortion Exceptionalism in the United States", *Perspectives on Sexual and Reproductive Health*, *53*(1–2), 5–12, <http://dx.doi.org/10.1363/psrh.12182>.

KAISER FAMILY FOUNDATION, "Abortion Gestational Limits and Exceptions" (2024), *Kaiser Family Foundation*: <www.kff.org/womens-health-policy/state-indicator/gestational-limit-abortions/?currentTimeframe=0&sortModel=%7B"colId":"Location","sort":"asc"%7D> (12 April 2024).

MENGESHA Biftu, ZITE Nikki & STEINAUER Jody (2022), "Implications of the *Dobbs* Decision for Medical Education: Inadequate Training and Moral Distress", *Journal of the American Medical Association*, *328*(17), 1697–1698, <http://dx.doi.org/10.1001/jama.2022.19544>.

METZGER Gillian E. (2007), "Abortion, Equality, and Administrative Regulation", *Emory Law Journal*, *56*, 865–906.

MUNIRA Z. Gunja, GUMAS Evan D. & WILLIAMS II Reginald D. (2022), "The U.S. Maternal Mortality Crisis Continues to Worsen: An International Comparison", *Commonwealth Fund*: <www.commonwealthfund.org/blog/2022/us-maternal-mortality-crisis-continues-worsen-international-comparison> (16 March 2024).

ORGERA Kendal, MAHMOOD Hasan & GROVER Atul (2023), "Training Location Preferences of U.S. Medical School Graduates Post *Dobbs v. Jackson Women's Health Organization* Decision", *AAMC Research Institute*: <www.aamcresearchinstitute.org/our-work/data-snapshot/training-location-preferences-us-medical-school-graduates-post-dobbs-v-jackson-women-s-health> (14 March 2024).

RIEDEL Priya-Lena, KREH Alexander, KULCAR Vanessa, LIEBER Angela & JUEN Barbara (2022), "A Scoping Review of Moral Stressors, Moral Distress and Moral Injury in Healthcare Workers during COVID-19", *International Journal of Environmental Research and Public Health*, *19*(3), 1666, <http://dx.doi.org/10.3390/ijerph19031666>.

ROMO Vanessa (2022), "Can States Limit Abortion and Gender-Affirming Treatments Outside Their Borders?", *NPR*: <www.npr.org/2022/03/15/1086114214/missouri-idaho-abortion-gender-affirming-treatments> (12 April 2024).

SEPPER Elizabeth (2023), "Abortion Exceptionalism after Dobbs", *Journal of Law, Medicine & Ethics*, *51*(3), 612–617.

SIEGEL Reva B. (1992), "Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection", *Stanford Law Review*, *44*(2), 261–381.

SERPICO Jaclyn J. (2021), "Abortion Exceptionalism and the Mifepristone REMS", *Contraception*, *104*(1), 8–11, <http://dx.doi.org/10.1016/j.contraception.2021.03.031>.

SIMMONS-DUFFIN Selena (2022), "Doctors Who Want to Defy Abortion Laws Say It's Too Risky", *NPR*: <www.npr.org/sections/health-shots/2022/11/23/1137756183/doctors-who-want-to-defy-abortion-laws-say-its-too-risky> (12 April 2024).

SOLOMON Judith (2021), "Closing the Coverage Gap Would Improve Black Maternal Health", *Center for Budget and Policy Priorities*: <www.cbpp.org/research/health/closing-the-coverage-gap-would-improve-black-maternal-health> (14 March 2024).

SONENBERG Andrea & MASON Diana J. (2023), "Maternity Care Deserts in the US", *JAMA Health Forum*, *4*(1), e225541, <http://dx.doi.org/10.1001/jamahealthforum.2022.5541>.

SURANA Kavitha (2023), "Doctors Warned Her Pregnancy Could Kill Her. Then Tennessee Outlawed Abortion", *ProPublica*, 14 March: <www.propublica.org/article/tennessee-abortion-ban-doctors-ectopic-pregnancy> (10 April 2024).

THOMAS Tracy (2023), "Protecting Abortion with State Health Care Freedom of Choice", *Journal of Law, Medicine & Ethics*, *51*(3), 601–605.

Universal Declaration of Human Rights (10 December 1948).

VANDEWALKER Ian (2012), "Abortion and Informed Consent: How Biased Counseling Laws Mandate Violations of Medical Ethics", *Michigan Journal of Gender & Law*, *19*(1), 1–70.

YOUNG Ernest A. (2004), "The Rehnquist Court's Two Federalisms", *Texas Law Review*, *83*(1), 1–165.

ZIEGLER Mary (2020), *Abortion and the Law in America: Roe v. Wade to the Present*, United Kingdom: Cambridge University Press.

NOTES

1. Dobbs v. Jackson Women's Health Organization, 597 U.S. 215 (2022), at 232, 256, 259, 292 (twice), 302 (Justice Alito's majority opinion "return[ing]" the issue of abortion to "the people's

representatives"); id. at 338, 339, 341, 345, 346, 347 (Kavanaugh, J., concurring) ("question of abortion [is] for the people and their elected representatives").

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

3. Roe v. Wade, 410 U.S. at 154, 155.

4. Griswold v. Connecticut, 381 U.S. 479 (1965).

5. Roe v. Wade, 410 U.S. at 152.

6. Loving v. Virginia, 388 U.S. 1 (1967); Zablocki v. Redhail, 434 U.S. 374 (1978); Obergefell v. Hodges, 576 U.S. 644 (2015).

7. Skinner v. Oklahoma, 316 U.S. 535 (1942).

8. Griswold v. Connecticut, 381 U.S. 479 (1965); Eisenstadt v. Baird, 405 U.S. 438 (1972).

9. Meyer v. Nebraska, 262 U.S. 390 (1923); Pierce v. Society of Sisters, 268 U.S. 510 (1925).

10. Cruzan v. Missouri Department of Health, 497 U.S. 261 (1990).

11. Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 846–847 (1992).

12. Casey, 505 U.S. at 861.

13. Casey at 874, seriatim.

14. Harris v. McRae, 448 U.S. 297 (1980).

15. United States v. Rahimi, Docket No. 22-915 (7 Nov. 2023 oral argument).

16. New York State Rifle & Pistol Association Inc. v. Bruen, 597 U.S. (2022).

17. Dobbs, 597 U.S. at 301.

18. Dobbs, 597 U.S. at 359, 363 (Breyer, Sotomayor, Kagan, J.J., dissenting).

19. Tex. Health & Safety Code Ann. §§ 171.204–171.209 (West Cum. Supp. 2021).

20. N.C. Gen. Stat. § 90–21.81B(2) (2023).

21. West's F.S.A. § 390.0111 (2023).

22. Planned Parenthood Arizona v. Mayes, – P.3d –, 2024 WL 1517392 (Az. Supreme Ct., 2024).

23. Fla. Stat. Ann. Ch. 390 (2023).

24. Idaho House Bill No. 242 (2023).

25. Utah Code 26B-2-204 (2023).

26. Life Is a Human Right Act, Wyoming HB0152 (2024).

27. U.S. Const. Art. IV sec. 1.

28. U.S. Const. Art. IV Sec. 2 cl. 2.

29. U.S. Const. Art. IV sec. 2 cl. 1.

30. Planned Parenthood South Atlantic v. South Carolina, 892 S.E.2d 121 (2023).

31. LePage v. Center for Reproductive Medicine, 2024 WL 656591 (16 February 2024).

32. 42 U.S.C. § 1395dd.

33. Idaho v. United States, Docket No. 23A470 (oral arguments 24 April 2024).

34. Food and Drug Administration v. Alliance for Hippocratic Medicine, Docket No. 23-235 (oral arguments 26 March 2024).

35. Zurawski v. Texas, Case Number 23-0629 (TX Supreme Court Oral Arguments November 2023).

36. Gonzales v. Carhart, 550 U.S. 124 (2007).

37. Harris v. McRae, 448 U.S. 297 (1980).

38. Rust v. Sullivan, 500 U.S. 173 (1991).

39. 18 U.S.C. § 248 (1994).

40. S. 701 & H.R. 12, 118th Congress (2023–2024).

ABSTRACTS

The U.S. Supreme Court's *Dobbs* decision caused a proliferation of contradictory state laws and judicial decisions that are producing confusion for health care providers, which in turn limits access to care for all patients of reproductive age. This paper documents the rapidly changing legal landscape to investigate and contextualize the significance of these inter-state conflicts and illustrate how inequities deepen when health care is left in the hands of state governments without national law to provide guardrails. Drawing on interdisciplinary scholarship, including legal, medical, and public health research, this essay considers how traditional federalism theory, which encourages sub-government variation, does not provide clear solutions to state law barriers to inter-state cooperation within a federal union, which has been essential to regulating health care in the U.S.

L'arrêt *Dobbs* de la Cour suprême des États-Unis a entraîné une prolifération de lois étatiques et de décisions judiciaires contradictoires qui sèment la confusion chez les prestataires de soins de santé, ce qui limite l'accès aux soins pour tous les patients en âge de procréer. Cet article documente l'évolution rapide du paysage juridique afin d'étudier et de contextualiser l'importance de ces conflits interétatiques et d'illustrer comment les inégalités s'aggravent lorsque les soins de santé sont laissés aux mains des gouvernements des États sans que la législation nationale ne serve de garde-fou. S'appuyant sur une recherche interdisciplinaire, notamment dans les domaines du droit, de la médecine et de la santé publique, cet article examine comment la théorie traditionnelle du fédéralisme, qui encourage la variation sous-gouvernementale, n'apporte pas de solutions claires aux obstacles que pose le droit des États à la coopération interétatique au sein d'une union fédérale, qui a été essentielle pour réglementer les soins de santé aux États-Unis.

INDEX

Mots-clés: Roe, Casey, Dobbs, avortement, droits reproductifs, soins de santé, fédéralisme, droit constitutionnel
Keywords: Roe, Casey, Dobbs, abortion, reproductive rights, health care, federalism, constitutional law

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