

SEEKING COMMON GROUND IN THE ABORTION REGULATION DEBATE

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INTRODUCTION

Texas State Senator Wendy Davis drew national attention in June 2013 when she staged one of the longer filibusters in United States history—nearly eleven hours—in an effort to prevent a vote on pending legislation that would “ban[] abortions after 20 weeks of pregnancy in Texas, severely limit[] access to medication-induced abortions and regulate[] first-trimester abortion clinics as ambulatory surgical centers.”¹ Repeatedly during her filibuster, Davis asked her colleagues to describe the ways in which the legislation would achieve its stated purpose of increasing women’s safety.² In particular, she questioned how the requirement that “clinics be regulated in the same way as ambulatory surgical centers” would increase women’s safety when not all Texas abortion clinics provide surgical abortions.³ Davis received no response.⁴

The fervor currently surrounding abortion legislation in the United States, and, specifically, the requirement that abortion clinics be held to ambulatory surgical center standards, form the topic of this Note. The strongest criticism of these regulations is that they are motivated by legisla-

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1 Laura Bassett, *Wendy Davis, Texas Democrat, Fights Abortion Bill with 13-Hour Filibuster*, HUFFINGTON POST (June 25, 2013, 5:28 PM), http://www.huffingtonpost.com/2013/06/25/wendy-davis-filibuster_n_3498699.html; see also Jon Henley, *Wendy Davis and the Lengthy History of the Filibuster*, THE GUARDIAN (June 26, 2013, 12:43 PM), <http://www.theguardian.com/world/2013/jun/26/wendy-davis-lengthy-history-filibuster> (“Senator Wendy Davis’s courageous—and successful—10 hour 45 minute bid to block a law that would have radically restricted access to abortion in Texas by talking was a wonder to behold.”); Andy McSmith, *Wendy Davis’ 10-hour Speech Propels Her into the Filibuster Super League. She’s in Varied Company*, THE INDEPENDENT (June 26, 2013), <http://www.independent.co.uk/voices/comment/wendy-davis-10hour-speech-propels-her-into-the-filibuster-super-league-shes-in-varied-company-8674365.html> (“Davis’ speech blocking an anti-abortion bill is a historical achievement.”).

2 Bassett, *supra* note 1.

3 *Id.*

4 *Id.*

tors' efforts to close clinics, rather than to ensure maternal health and safety.⁵ As of November 4, 2014, the Guttmacher Institute⁶ identified facility regulations in twenty-five states that “go beyond what is necessary to ensure patients' safety.”⁷ In more than half those states, the regulations apply to all abortion clinics equally, those in which surgical abortions are performed and those in which no surgical abortions are performed (clinics providing only medication-induced abortions).⁸

This Note argues that requiring abortion clinics to adhere to the same standards as ambulatory surgical centers is unconstitutional, at least in the context of those clinics that provide only medication abortion, because it unduly burdens a woman's right to choose whether to obtain an abortion. Although there may be a rational basis to require abortion clinics offering surgical abortion procedures to meet surgical facility standards, no such basis attends the imposition of those requirements on clinics that provide non-surgical services. Given the number of clinics that continue to close in the face of this new regulatory legislation—which significantly reduces access to abortion services, increases their cost, and makes them logistically more difficult to procure due to increased geographic travel—it is arguable that even requiring surgical abortion clinics to meet ambulatory surgical center standards will result in an undue burden.

At the same time, however, state legislators have a valid interest in ensuring that abortion procedures are conducted in a safe manner. Although abortion clinics currently are subject to regulatory oversight outside the realm of state-specific statutes, the requirements currently in place govern the privacy of patients' health records,⁹ laboratory testing practices,¹⁰ and

5 See generally, e.g., Rachel Benson Gold & Elizabeth Nash, *TRAP Laws Gain Political Traction While Abortion Clinics—and the Women They Serve—Pay the Price*, GUTTMACHER POL'Y REV., Spring 2013, at 7, 8–9, 12 (describing the basic content of TRAP laws, highlighting examples in certain states, and emphasizing clinic closure as one major impetus for their enactment).

6 The Guttmacher Institute is a nonprofit organization dedicated to researching, advancing, and promoting “sexual and reproductive health worldwide.” GUTTMACHER INST., <http://www.guttmacher.org> (last visited Nov. 21, 2014). Its research is cited by pro-choice and pro-life organizations alike. See, e.g., *Abortion Myths*, TEXAS RIGHT TO LIFE, <http://www.texasrighttolife.com/about/145/Abortion-Myths> (last visited Nov. 21, 2014); *Guttmacher Institute: Facts on American Teens' Sexual and Reproductive Health*, NARAL PRO-CHOICE TEXAS, <http://www.prochoicetexas.org/what-is-choice/sex-education/facts-on-american-teens.shtml> (last visited Nov. 21, 2014).

7 GUTTMACHER INST., STATE POLICIES IN BRIEF AS OF NOVEMBER 4, 2014: TARGETED REGULATION OF ABORTION PROVIDERS (2014) [hereinafter STATE POLICIES IN BRIEF], http://www.guttmacher.org/statecenter/spibs/spib_TRAP.pdf.

8 *Id.* (“16 states' regulations apply to sites where medication abortion is provided, even if surgical abortion procedures are not.”).

9 *Health Information Privacy*, HHS, <http://www.hhs.gov/ocr/privacy/> (last visited Nov. 21, 2014).

10 See *Clinical Laboratory Improvement Amendments (CLIA)*, FDA, <http://www.fda.gov/medicaldevices/deviceregulationandguidance/ivdregulatoryassistance/ucm124105.htm> (last visited Nov. 21, 2014).

workplace health and safety,¹¹ but do not address directly the regulation of surgical procedures.¹²

In light of the constitutional problems embedded in current state efforts to regulate abortion clinic facilities and the shortcomings of federal regulatory efforts, it may be time to entertain a different approach to abortion clinic regulation. Part I presents the legal framework and standards currently governing abortion legislation. Part II utilizes this foundation to evaluate current problems in state regulatory practices, spotlighting two pieces of recent state legislation that seek to impose ambulatory surgical center standards on all abortion clinic facilities within their borders. Lastly, Part III introduces and outlines an alternate means of regulation—accreditation—that offers common ground in the abortion debate by serving everyone’s interest in providing safe, accessible medical services to women.

I. WHO REGULATES ABORTION CLINICS?

The federal and state governments concurrently regulate abortion practices and the facilities in which those practices take place. This Part introduces the legal framework for abortion regulation, presenting the basic premise of the undue burden standard and the preference for as-applied challenges—rather than facial challenges—to abortion legislation.

A. *Recent State Regulations of Abortion Clinic Facilities*

Recently, multiple states enacted laws restricting the facilities in which physicians perform abortions to hospitals and clinics that meet the standards of ambulatory surgical centers. These pieces of state legislation require abortion clinics to obtain state health department licenses, meet heightened administrative and facility standards, and mandate hospitalization for abortions performed after a threshold date in the second trimester.¹³ The pro-choice movement dubbed such regulations “TRAP” laws—Targeted Regulation of Abortion Providers—on grounds that the laws single out “doctors who provide abortions, and impose on them requirements that are different and more burdensome than those imposed on other medical practices.”¹⁴ Under these regulations, private physicians’ offices that do not offer abortion services are not required to obtain the same state licenses,¹⁵ and those facility

11 *OSHA Law & Regulations*, U.S. DEP’T OF LABOR, <http://www.osha.gov/law-regs.html> (last visited Nov. 21, 2014).

12 *See infra* Section I.A.

13 *Targeted Regulation of Abortion Providers (TRAP)*, CTR. FOR REPROD. RIGHTS (Mar. 5, 2009), <http://reproductiverights.org/en/project/targeted-regulation-of-abortion-providers-trap> (describing the basic content of TRAP laws).

14 *Id.*

15 Amalia W. Jorns, Note, *Challenging Warrantless Inspections of Abortion Providers: A New Constitutional Strategy*, 105 COLUM. L. REV. 1563, 1568 (2005).

regulations imposed on abortion providers are “not imposed on other medical facilities.”¹⁶

Although many disagree with these new regulatory measures, the Supreme Court has been quite clear that states have the power to regulate abortion practices in light of the legitimate governmental interests in maternal safety and the promotion of life. In *Planned Parenthood of Southeastern Pennsylvania v. Casey*,¹⁷ the Supreme Court restored to the states much of the regulatory power they lost under *Roe v. Wade*¹⁸ by replacing the trimester framework with an “undue burden standard.”¹⁹ The *Casey* Court described this standard as “shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.”²⁰ Accordingly, a statute whose purpose is not to “inform the woman’s free choice, [but] . . . hinder it”²¹ will be held invalid, as will a statute that furthers one of the state’s legitimate interests but “has the effect of placing a substantial obstacle in the path of a woman’s choice.”²² This new standard lowered the level of protection that *Roe* initially secured: post-*Casey*, the courts will uphold any state regulatory measure that does not pose a “substantial obstacle” to a woman’s decision to obtain an abortion.²³ In designing regulatory measures in furtherance of the legitimate interest in maternal health, the state may consider both the physical and psychological consequences of having an abortion and legislate accordingly.²⁴ As such, the majority of discussion today centers on whether the state regulation imposes a “substantial obstacle” on a woman’s ability to obtain an abortion.²⁵

16 Ania O. Wlodek, Note, *Legal Does Not Mean Rational: The Practicality of Treating First-Trimester Abortion Clinics the Same as Hospitals*, 18 WM. & MARY J. WOMEN & L. 395, 407 (2012) (citing *Greenville Women’s Clinic v. Bryant*, 66 F. Supp. 2d 691, 742 (D.S.C. 1999), *rev’d*, 222 F.3d 157 (4th Cir. 2000)) (finding that state regulations in question specifically targeted abortion providers); *see id.* at 406–07.

17 505 U.S. 833 (1992).

18 410 U.S. 113 (1973).

19 *Casey*, 505 U.S. at 873, 876 (joint opinion of O’Connor, Kennedy, and Souter, JJ.) (rejecting the trimester framework set forth in *Roe v. Wade* on grounds that it undervalued the state’s legitimate interest in potential life).

20 *Id.* at 877.

21 *Id.*

22 *Id.*

23 Christopher Mirakian, *Gonzales v. Carhart: A New Paradigm for Abortion Legislation*, 77 UMKC L. REV. 197, 209–10 (2008).

24 Jared H. Jones, Annotation, *Women’s Reproductive Rights Concerning Abortion, and Governmental Regulation Thereof—Supreme Court Cases*, 20 A.L.R. FED. 2d 1, § 8 (2007) (“[F]actors regarding the mother’s health not only include those related [to] physical well-being, but also psychological considerations, amongst others.”).

25 The *Casey* Court made clear that “regulations which do no more than create a structural mechanism by which the State, or the parent or guardian of a minor, may express profound respect for the life of the unborn are permitted, if they are not a substantial obstacle to the woman’s exercise of the right to choose.” *Casey*, 505 U.S. at 877 (joint opinion of O’Connor, Kennedy, and Souter, JJ.). Further, “[u]nless it . . . [places a sub-

This regulatory power extends to the facilities in which abortions are performed. In *Simopoulos v. Virginia*,²⁶ the Court held that Virginia's requirement that "second-trimester abortions be performed in licensed clinics is not an unreasonable means of furthering the State's compelling interest in 'protecting the woman's own health and safety.'"²⁷ Though this decision came down prior to *Casey*, *Casey* did not overrule *Simopoulos*. To the contrary, the *Casey* Court specifically included *Simopoulos* in a string citation of cases supporting its conclusion that "only where state regulation imposes an undue burden on a woman's ability to make this decision [to obtain an abortion] does the power of the State reach into the heart of the liberty protected by the Due Process Clause."²⁸

Recognizing the states' ability to regulate abortion clinic facilities, the question becomes whether the new requirement that abortion clinics satisfy the facility standards for ambulatory surgical centers is in furtherance of the legitimate interest in maternal safety and, if so, whether such regulations impose an undue burden on a woman's ability to seek an abortion. As of November 4, 2014, twenty-three states required abortion clinics to meet the facility standards for ambulatory surgical centers.²⁹ Ambulatory surgical centers are clinical facilities that provide same-day outpatient surgical care.³⁰ Although each state dictates additional requirements, at a minimum, every ambulatory surgical center must have "at least one dedicated operating room and the equipment needed to perform surgery."³¹ Given that most ambulatory surgical centers provide care to patients covered by Medicare, they generally are subject to federal governance and must comply with standards established by Medicare itself,³² which include regulations on "facility design [and] patient care."³³ In addition, the centers must comply with state-specific regulations and the Health Insurance Portability and Accountability Act (HIPAA).³⁴

stantial obstacle] on her right of choice, a state measure designed to persuade her to choose childbirth over abortion will be upheld if reasonably related to that goal." *Id.* at 878.

26 462 U.S. 506 (1983).

27 *Id.* at 519 (quoting *Roe v. Wade*, 410 U.S. 113, 150 (1973)).

28 *Casey*, 505 U.S. at 874 (joint opinion of O'Connor, Kennedy, and Souter, JJ.).

29 STATE POLICIES IN BRIEF, *supra* note 7 ("23 states require facilities where abortion services are provided to meet standards intended for ambulatory surgical centers."). Two additional states—Kansas and Texas—also have this requirement, but their laws are "temporarily enjoined pending a final decision in the courts." *Id.*

30 See *What Is an ASC?*, AMBULATORY SURGERY CTR. ASS'N, <http://www.ascassociation.org/ASCA/AboutUs/WhatIsanASC> (last visited Nov. 21, 2014).

31 *Id.* (detailing the generic requirements of ambulatory surgical centers under its description of "What ASCs Are Not").

32 See *Federal Regulations*, AMBULATORY SURGERY CTR. ASS'N, <http://www.ascassociation.org/FederalRegulations/Overview/> (last visited Nov. 21, 2014).

33 *Id.* The Center for Medicare & Medicaid Services (CMS) must certify and provide ongoing oversight and compliance checks of those facilities for which federal funds are used for the reimbursement of medical procedures. *Id.*

34 *Id.*

Indeed, prior to this new legislation, all non-hospital clinics providing abortion services were and continue to be subject to the regulations imposed by HIPAA, the Clinic Laboratory Improvement Amendments (CLIA), the Occupational Safety and Health Administration (OSHA), and state and local building and fire codes.³⁵ HIPAA regulations govern the privacy of patients' health records and provide a mechanism for dealing with breaches of that privacy.³⁶ CLIA regulations cover laboratory-testing practices "on specimens derived from humans for the purpose of providing information for the diagnosis, prevention, treatment of disease, or impairment of, or assessment of health."³⁷ Finally, OSHA holds employers in all industries accountable to "workplace health and safety standards,"³⁸ as established and promulgated by agency and state-approved plans.³⁹

Aside from these federal regulations, many abortion clinics also are subject to "evidence-based standards," such as those the National Abortion Federation (NAF) and International Planned Parenthood Federation (Planned Parenthood) provide.⁴⁰ These guidelines, updated annually, offer a basis for "ongoing quality assurance . . . [with respect to] infection prevention; use of antibiotics, analgesia and sedation; and treatment of complications."⁴¹ They also require "equipment and medication be available on-site to handle emergencies," and that transport procedures be in place in the event of an emergency.⁴² All clinics that are members of NAF are required to comply with the guidelines, which is enforced by NAF's Clinic Services Department.⁴³ Similarly, failure to comply with Planned Parenthood's Manual of Medical Standards, which includes clinic facility and administrative requirements, can

35 *The TRAP: Targeted Regulation of Abortion Providers*, NAT'L ABORTION FED'N, available at http://prochoice.org/wp-content/uploads/trap_laws.pdf (last visited Nov. 21, 2014).

36 *Health Information Privacy*, *supra* note 9.

37 *Clinical Laboratory Improvement Amendments (CLIA)*, CTRS. FOR MEDICARE & MEDICAID SERVS. 1 (July 2014), <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CLIABrochure.pdf>.

38 *OSHA Law & Regulations*, *supra* note 11.

39 *See Interlinked Information on State Plan Standards and Directives*, U.S. DEP'T OF LABOR, https://www.osha.gov/dcsp/osp/std_fpc.html (last visited Nov. 21, 2014).

40 Gold & Nash, *supra* note 5, at 8.

41 *Id.*

42 *Id.*

43 *2014 Clinical Policy Guidelines*, NAT'L ABORTION FED'N, <http://prochoice.org/education-and-advocacy/2014-clinical-policy-guidelines/> (last visited Nov. 21, 2014). Currently, more than 400 clinics nationwide are members of NAF. *Id.* Membership benefits include group medical malpractice insurance, violence and security support, eligibility to purchase supplies and pharmaceuticals at reduced cost, training, and technical publications, as well as referrals from the NAF hotline. *NAF Membership*, NAT'L ABORTION FED'N, <http://prochoice.org/health-care-professionals/naf-membership/> (last visited Nov. 21, 2014). Currently, only four states—Wyoming, Missouri, Alaska, and Hawaii—do not have NAF-affiliated clinics. *Find a Provider*, NAT'L ABORTION FED'N, <http://prochoice.org/think-youre-pregnant/find-a-provider/> (last visited Nov. 21, 2014).

result in clinics being stripped of their Planned Parenthood affiliation.⁴⁴ However, independent clinics unaffiliated with either of these larger organizations are not subject to such guidelines.⁴⁵

Accordingly, although it is true that abortion clinics are subject to some regulatory oversight, the regulations currently in place do not address surgical procedures directly. HIPAA and CLIA regulations do not mandate that all clinic facility standards match those of ambulatory surgical centers. The evidence-based standards that NAF and Planned Parenthood promulgate do not govern all clinics, only those with affiliation, and do not have the force of law. Moreover, since the Hyde Amendment prohibits the use of federal funds to obtain an abortion,⁴⁶ abortion clinics would not be required to meet the facility design requirements specified by the Center for Medicare & Medicaid Services if they provide no other services for which Medicare or Medicaid funds might be used in reimbursement.⁴⁷

B. Challenging Current Abortion Regulations

Plaintiffs may bring facial or as-applied challenges against abortion statutes, but the Supreme Court now prefers the latter. The difference between the challenges is substantial. As Professor Michael Dorf explains: “If a court holds a statute unconstitutional on its face, the state may not enforce it under any circumstances, unless an appropriate court narrows its application; in contrast, when a court holds a statute unconstitutional as applied to particular facts, the state may enforce the statute in different circumstances.”⁴⁸ Although *Casey* itself was a facial challenge, the Supreme Court since has

44 See Katharine Mieszkowski, *Planned Parenthood Clinics Are Stripped of Affiliation After Complaints*, N.Y. TIMES, Aug. 28, 2010, <http://www.nytimes.com/2010/08/29/us/29bcpar.html> (reporting on local clinic in San Francisco bay area stripped of Planned Parenthood affiliation for allegedly failing to comply with parent corporation’s administrative standards).

45 See Samuel W. Calhoun, *Stopping Philadelphia Abortion Provider Kermit Gosnell and Preventing Others Like Him: An Outcome That Both Pro-Lifers and Pro-Choicers Should Support*, 57 VILL. L. REV. 1, 13–14 (2012) (noting that Planned Parenthood and NAF regulations do not govern independent clinics, to which Planned Parenthood and NAF clinics refer patients for abortion services they do not offer themselves).

46 Congress enacted Medicaid in 1965 to provide funds for the medical care of low-income persons through a cost-splitting arrangement between the federal and state governments. See JON O. SHIMABUKURO, CONG. RESEARCH SERV., RL33467, ABORTION: JUDICIAL HISTORY AND LEGISLATIVE RESPONSE 11 (2014). Although the arrangement did not initially cover reimbursement for abortion, the Nixon administration made this possible following the Supreme Court’s decision in *Roe. Id.* This coverage ended in 1976 when Congressman Henry Hyde, a Republican representative from Illinois, successfully submitted a Medicaid budget provision that foreclosed the application of Medicaid funds to those women seeking an abortion for any reason other than absolute medical necessity. See Dorothy E. McBride, *Abortion in the United States* 48 (2008) (noting that Medicaid “is required to pay for ‘medically necessary’ procedures”).

47 See *supra* note 33 and accompanying text.

48 Michael C. Dorf, *Facial Challenges to State and Federal Statutes*, 46 STAN. L. REV. 235, 236 (1994).

signaled that it is more appropriate for petitioners to bring as-applied challenges against abortion legislation. This trend began in the appellate courts and reached fruition in *Gonzales v. Carhart*.⁴⁹ Although facial challenges remain available to plaintiffs, the standard governing such challenges is now unclear. Looking forward, those seeking to bring challenges against recent state regulations of abortion clinic facilities likely will advance as-applied challenges.

The federal courts of appeals currently apply differing facial challenge standards in the context of abortion legislation. In *Greenville Women's Clinic v. Commissioner*,⁵⁰ the Fourth Circuit upheld provisions of a South Carolina law that imposed a variety of restrictions on abortion clinics, including requirements that clergy members be on call, physicians obtain admitting privileges at local hospitals or that clinics sign transfer agreements with local hospitals, and clinics "review, copy, and retain abortion patients' medical records without protecting any personally identifying information in those records from public disclosure."⁵¹ In making its determination, the Fourth Circuit looked to the facial challenge standard set forth in *United States v. Salerno*,⁵² which stated that "facial challenges can succeed outside the First Amendment only when a statute has no valid applications."⁵³ Consequently, the Fourth Circuit refused to overturn the state statutory scheme for being facially unconstitutional unless "no set of circumstances exist[ed] under which the Act would be valid."⁵⁴

However, two years prior, the Third Circuit in *Planned Parenthood of Central New Jersey v. Farmer*⁵⁵ explained that *Casey* "muted the *Salerno* requirement in the abortion context by stating that a statute regulating abortion is facially invalid if 'in a large fraction of the cases in which [the statute] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion.'⁵⁶ In deciding *Tucson Woman's Clinic v. Eden*,⁵⁷ the Ninth Circuit came to the same conclusion: *Salerno* applied to all facial challenges *except* those

49 550 U.S. 124 (2007).

50 317 F.3d 357 (4th Cir. 2002), *cert. denied*, 538 U.S. 1008 (2003). For the "odyssey" of this case's procedural history, see Emma L. Brackett, Comment, "*Trapped*": *Greenville Women's Clinic v. Commissioner, South Carolina Department of Health & Environmental Control and the Proliferation of Targeted Regulation of Abortion Providers*, 34 Sw. U. L. REV. 511, 518-24, 518 n.67 (2005).

51 Brackett, *supra* note 50, at 521.

52 481 U.S. 739, 745, 755 (1987) (holding the Bail Reform Act of 1984 valid under both the Due Process Clause of the Fifth Amendment and Excessive Bail Clause of the Eighth Amendment because petitioners failed to meet the heavy burden of a facial challenge, which requires "establish[ing] that no set of circumstances exists under which the Act would be valid").

53 Richard H. Fallon, Jr., *As-Applied and Facial Challenges and Third-Party Standing*, 113 HARV. L. REV. 1321, 1322 (2000) (citing *Salerno*, 481 U.S. at 745).

54 Brackett, *supra* note 50, at 520 (quoting *Salerno*, 481 U.S. at 745).

55 220 F.3d 127 (3d Cir. 2000).

56 *Id.* at 142 (alteration in original) (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 895 (1992) (majority opinion)).

57 379 F.3d 531 (9th Cir. 2004).

brought against abortion laws.⁵⁸ As such, both the Third and Ninth Circuits determined that, in the context of abortion, *Salerno* does not apply; instead, plaintiffs need only show that the challenged legislation would create an undue burden in a large fraction of cases, rather than in all cases. More recently, in both October 2013 and October 2014, the Fifth Circuit drew attention to the ambiguity surrounding the application of *Salerno* to abortion legislation. In both cases the court declined to state whether it would follow the *Salerno* “no set of circumstances” standard or the *Casey* “large fraction” standard, as it found that even under the latter, the legislation at issue did not constitute an undue burden.⁵⁹

Justices Scalia and Thomas repeatedly have drawn attention to the need to clarify the standard governing facial challenges to abortion statutes.⁶⁰ In *Gonzales v. Carhart* the Supreme Court made clear that where there is medical uncertainty as to the necessity of a procedure or potential risks involved therein, all pre-enforcement challenges to abortion legislation should be brought as-applied, because “[i]n an as-applied challenge the nature of the medical risk can be better quantified and balanced than in a facial attack.”⁶¹ The Court acknowledged that the burden facing plaintiffs bringing facial challenges “in the specific context of abortion statutes has been a subject of some question,”⁶² but declined to provide clarification. Accordingly, the Court did not foreclose facial challenges, but the extent of the plaintiffs’ burden—specifically, the applicability of *Salerno* in the abortion context—remains unclear and the Court signaled a clear preference for as-applied challenges. In light of such ambiguity, those preparing arguments against abortion legislation may be better served in framing the challenge on an as-applied basis.

58 *Id.* at 538–39 (“In *United States v. Salerno*, the Supreme Court held that one facially challenging a statute ‘must establish that no set of circumstances exists under which the Act would be valid. . . . [W]e have not recognized an ‘overbreadth’ doctrine outside the limited context of the First Amendment.’ In *Planned Parenthood v. Casey*, however, the Court held that an abortion law is unconstitutional on its face if ‘in a large fraction of the cases in which [the law] is relevant, it will operate as a substantial obstacle to a woman’s choice to undergo an abortion.’ With respect to plaintiffs’ undue burden claim, we follow the *Casey* standard. With respect to other facial constitutional challenges, we generally follow the *Salerno* standard.” (alterations in original) (citations omitted) (quoting *Salerno*, 481 U.S. at 745, and *Casey*, 505 U.S. at 895)).

59 See *Whole Woman’s Health v. Lakey*, No. 14-50928, 2014 WL 4930907, at *6–7 (5th Cir. Oct. 2, 2014), *vacated in part*, No. 14A365, 2014 WL 5148719 (U.S. Oct. 14, 2014); *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 734 F.3d 406, 414 (5th Cir. 2013).

60 See *Janklow v. Planned Parenthood*, 517 U.S. 1174, 1178 (1996) (Scalia & Thomas, JJ., dissenting) (arguing for a grant of certiorari as the question of *Salerno*’s applicability in the abortion context “virtually cries out for our review”); see also Dorf, *supra* note 48, at 261 (arguing that the *Salerno* standard should not apply in the context of abortion legislation).

61 550 U.S. 124, 167 (2007).

62 *Id.*

II. PROBLEMS ATTENDING CURRENT REGULATORY PRACTICES

In light of the potential for surgical procedures to go awry, state legislators have a legitimate interest in ensuring that abortion clinics offer safe procedures with adequate protections.⁶³ The states do not have an affirmative duty to provide abortion clinics, but they are legally obligated to avoid enacting legislation that imposes an undue burden on a woman's decision to obtain an abortion. At the same time, it is a natural extension of the jurisprudence behind *Casey* to insist that state regulations seeking to ensure maternal safety not have the practical effect of precluding the choice to have an abortion by eliminating all or nearly all abortion service providers from a geographic area.⁶⁴

Although state regulation of abortion clinics is fairly commonplace today, in the past two years representatives in several states introduced pieces of legislation that will have the practical effect of shuttering many abortion clinics across the nation, leaving some states with no or very few clinics relative to the size of their female populations. In 2013, several abortion clinics brought suit over recently enacted laws requiring their physicians to obtain admitting privileges at hospitals located in close proximity to the abortion clinic.⁶⁵ These suits were resolved in the clinics' favor, allowing them to

63 Those in favor of stricter clinic facility regulations often cite the unsafe practices of abortion provider Kermit Gosnell. See, e.g., *Doctor Kermit Gosnell Found Guilty of Murdering Infants in Late-Term Abortions*, FOX NEWS (May 13, 2013), <http://www.foxnews.com/us/2013/05/13/jury-split-on-2-counts-in-trial-abortion-doctor-kermit-gosnell/>; Jon Hurdle, *Doctor Starts His Life Term in Grisly Abortion Clinic Case*, N.Y. TIMES, May 15, 2013, <http://www.nytimes.com/2013/05/16/us/kermit-gosnell-abortion-doctor-gets-life-term.html>. It is, of course, critical to remember that Gosnell's conduct was criminal, and clinic facility regulations are not aimed at addressing physicians' criminal behavior, but rather ensuring that the facilities with which women are met are safe.

64 There can be no legitimate state interest in promoting fetal life after a woman decides to have an abortion. Accordingly, the validity of an abortion clinic facility regulation hinges on the state's interest in maternal safety. See Calhoun, *supra* note 45, at 12 ("[O]nce a woman in a clinic has decided to proceed with an abortion, the chance to save the fetus's life has been lost."). One exception to this generalization that Calhoun does not address is in the area of palliative care for infants who survive an attempted abortion. Whether these infants have the same rights as those born naturally, rather than from a failed abortion, is a complex topic that extends beyond the scope of this Note. However, if infants do have such rights, the state might reasonably regulate abortion clinic facilities in such a way as to further its legitimate interest in fetal life, per palliative care requirements.

65 See, e.g., *Planned Parenthood of Wis., Inc. v. Van Hollen*, No. 13-cv-465-wmc, 2013 WL 3989238 (W.D. Wis. Aug. 2, 2013) (finding in favor of plaintiffs, abortion service providers in Wisconsin, and enjoining state law mandating physicians requiring abortion services obtain admitting privileges at hospital within 30 miles of the abortion clinic), *aff'd*, 738 F.3d 786 (7th Cir. 2013), *cert. denied*, 134 S. Ct. 2841 (2014); *Jackson Women's Health Org. v. Carrier*, 940 F. Supp. 2d 416 (S.D. Miss. 2013) (finding in favor of the plaintiff, the last women's health clinic in Mississippi, and enjoining a state law requiring all physicians associated with abortion clinics to obtain admitting and staff privileges at a local hospital and board certification in obstetrics and gynecology), *aff'd as modified*, 760 F.3d 448 (5th Cir. 2014) (modifying the award of a preliminary injunction only by recognizing that the

obtain preliminary injunctions and remain open in the face of statutory schemes that would otherwise force them to close.⁶⁶

At least two cases from this year also indicate the potential for clinic closures to factor in judicial determinations of whether a state regulation constitutes an undue burden on a woman's ability to choose whether to obtain an abortion. On August 4, 2014, an Alabama district court judge determined that a state law requiring doctors who perform abortions to obtain admitting privileges at a local hospital imposed an undue burden specifically because the legislation had the effect of forcing three of the state's five abortion clinics to close.⁶⁷ Similarly, on August 29, 2014, a Texas district court held that the state requirement that abortion clinics meet ambulatory surgical center standards was unconstitutional because it would have the effect of leaving operational only seven or eight abortion clinics in the state.⁶⁸

State waived its argument that the law's implementation would not force clinics to close, and that the court could not factor into its undue burden analysis the availability of abortion services in neighboring states); *Planned Parenthood Se., Inc. v. Bentley*, 951 F. Supp. 2d 1280 (M.D. Ala. 2013) (finding in favor of plaintiffs, abortion facility operators, and enjoining state law requiring all physicians performing abortions at state-licensed clinics to obtain staff privileges at hospital within close proximity of the clinic).

66 See *supra* note 65 and accompanying text.

67 *Planned Parenthood Se., Inc. v. Strange*, No. 2:13cv405-MHT, 2014 WL 3809403, at *1 (M.D. Ala. Aug. 4, 2014) ("In order to give 'real substance to the woman's liberty,' while at the same time fully honoring the State's ability to pursue, in good faith, its own acknowledged legitimate interests, this court concludes that it must hold that this requirement is unconstitutional. The evidence compellingly demonstrates that the requirement would have the striking result of closing three of Alabama's five abortion clinics, clinics which perform only early abortions, long before viability. Indeed, the court is convinced that, if this requirement would not, in the face of all the evidence in the record, constitute an impermissible undue burden, then almost no regulation, short of those imposing an outright prohibition on abortion, would." (citation omitted) (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 869 (1992) (joint opinion of O'Connor, Kennedy, and Souter, JJ.))). Importantly, Judge Myron H. Thompson noted that although there technically existed five clinics in Alabama at the time he wrote the opinion, there could be "as few as three clinics in operation," with at least one clinic seeking relocation to a new building "in order to comply with recently enacted architectural requirements for abortion clinics." *Id.* at *49 n.2.

68 *Whole Woman's Health v. Lakey*, No. 1:14-CV-284-LY, 2014 U.S. Dist. LEXIS 124500, at *12, 32–33 (W.D. Tex. Aug. 29, 2014); see also Eric Eckholm & Manny Fernandez, *Judge Rejects State Stricture on Abortions*, N.Y. TIMES, Aug. 29, 2014, <http://www.nytimes.com/2014/08/30/us/politics/federal-judge-strikes-down-restrictive-texas-abortion-law.html> ("The closings would have left Texas, the second-biggest state by population and by size, with seven or eight abortion clinics, all in major cities like Houston and Dallas. Women in El Paso in West Texas and in the Rio Grande Valley in the south would have lived more than 150 miles—a distance ruled constitutional by a federal appeals court—from the closest clinic in the state, in San Antonio."). Plaintiffs challenged the ambulatory surgical center requirement both facially and specifically as it applied to those clinics providing only medication abortions. *Whole Woman's Health*, 2014 U.S. Dist. LEXIS 124500, at *5. Judge Yeakel ruled that the ambulatory surgical center requirement was facially uncon-

Requiring clinics to meet hospital standards in order to obtain state licensure is strikingly similar to the requirement that certain abortions be performed in hospitals. Although *City of Akron*⁶⁹ made clear that any state law mandating second-trimester abortions occur in hospitals would not be upheld under *Roe*, it is not clear whether the same would be true under *Casey*.⁷⁰ These building requirements—namely that the facilities meet the higher standard required of ambulatory surgical centers—have had the effect of closing abortion clinics nationwide. Adherence to state ambulatory surgical center standards would require many clinics to increase the size of their procedure rooms and corridor widths, or to relocate to be within closer proximity of a hospital.⁷¹ Since the trend of TRAP laws began, approximately fifty-eight clinics in twenty-four different states have either closed or stopped providing abortion services.⁷²

Perversely, clinic closures resulting from legislation premised on an interest in maternal health ultimately may reduce women's overall safety in undergoing abortion procedures. The reality of human nature dictates that although state legislation likely will reduce access to legal abortions, it will not affect the desire to obtain an abortion. Women who do not have access to clinics due to either cost or geography, yet remain resolute in their decision to obtain an abortion, may be forced to turn to abortion providers who offer services illegally and most likely through more dangerous methods. Indeed, current estimates place the risk of death from an illegal abortion at approximately seventy times the risk of death from a legal abortion.⁷³ After *Roe*, the correlation between increased access to safe abortion procedures in clinics and overall maternal health became starkly evident, as "there was a ninety-four percent decline in the number of deaths"⁷⁴ occurring from abortion. Importantly, as the district court recently recognized in *Planned Parenthood Southeast, Inc. v. Bentley*, just because "a woman has some conceivable opportunity to exercise her right does not mean that a substantial obsta-

stitutional and enjoined its enforcement. *Id.* at *6, *36. This case is discussed at greater length in Section II.A.

69 *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416 (1983).

70 *Id.* at 433 (striking down the portion of an Ohio statute that required all second-trimester abortions to be performed in a hospital). The query today, under *Casey*, would be whether a hospitalization requirement for second-trimester abortions constitutes an undue burden on a woman's decision whether to obtain an abortion.

71 STATE POLICIES IN BRIEF, *supra* note 7, at 1 (listing several of the most common requirements attending state legislation requiring abortion clinics adhere to ambulatory surgical center standards). The Guttmacher Institute reports that of the twenty-three states currently requiring abortion clinics' facilities to meet the structural standards of surgical centers, twelve states specify the minimum size of procedure rooms and width of corridors, eleven states require the clinic to be within a certain distance of a hospital, and eight states require abortion clinics to have a transfer agreement with a local hospital. *Id.* at 2.

72 Esmé E. Deprez, *Abortion Clinics Close at Record Pace After States Tighten Rules*, BLOOMBERG (Sept. 3, 2013, 8:52 AM), <http://www.bloomberg.com/news/2013-09-03/abortion-clinics-close-at-record-pace-after-states-tighten-rules.html>.

73 Wlodek, *supra* note 16, at 420.

74 *Id.* at 421.

cle to the exercise of that right is not imposed.”⁷⁵ Severe impediments, such as insurmountable cost or great geographic distance, are precisely the kinds of burdens that might force women to seek dangerous alternatives.

To illustrate this problem, this Part will look specifically at legislation enacted in Indiana and Texas in 2013 and evaluate whether these types of regulations impose an undue burden on a woman’s decision to obtain an abortion. Although the Supreme Court initially suggested that legislation concerning a woman’s decision to obtain an abortion would be subject to strict scrutiny review,⁷⁶ the Court indicated a change in its level of deference to the legislature when deciding *Gonzales v. Carhart*: “Where [government] has a rational basis to act, and it does not impose an undue burden, the State may use its regulatory power . . . in furtherance of its legitimate interests in regulating the medical profession in order to promote respect for human life, including life of the unborn.”⁷⁷ The Court’s adoption of rational basis language suggests it may grant greater deference to state legislators’ decisions to require abortion clinics to meet ambulatory surgical center standards. Still, a statute must both have a rational basis and avoid imposing an undue burden in order to be found constitutional. Even under a more deferential standard, a statute that imposes an undue burden on a woman’s decision to obtain an abortion will be held unconstitutional—even if it has a rational basis.

This Part addresses the undue burden and rational basis elements in turn, and concludes with a discussion of additional problems some clinics encounter even after meeting the ambulatory surgical center standard.

A. *Does the Ambulatory Surgical Center Requirement Create an Undue Burden?*

Legislation that seeks to regulate abortion clinic facility standards is recognizably new territory. This type of legislation imposes a direct burden on clinics, but an indirect burden on women. The indirect nature of a burden on the decision to obtain an abortion, however, is not grounds for dismissing a challenge to abortion legislation. To the contrary, the fact that an undue burden is indirect rather than direct has not kept courts from striking down legislation in the past. For example, the Nebraska statute at issue in *Stenberg v. Carhart* criminalized the act of late-term abortions, thereby imposing an indirect burden on the woman’s decision by eliminating access to professionals legally authorized to perform certain surgical abortion procedures.⁷⁸ Yet, the Supreme Court found the Nebraska statute’s vagueness to constitute an

75 *Planned Parenthood Se., Inc. v. Bentley*, 951 F. Supp. 2d 1280, 1286 (M.D. Ala. 2013).

76 *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 871 (1992) (joint opinion of O’Connor, Kennedy, and Souter, JJ.).

77 *Mirakian*, *supra* note 23, at 213 (alteration in original) (quoting *Gonzales v. Carhart*, 550 U.S. 124, 158 (2007)).

78 *See* 530 U.S. 914 (2000).

undue burden.⁷⁹ Similarly, in *Sojourner T v. Edwards*,⁸⁰ the Fifth Circuit found unconstitutional the Louisiana Abortion Act, which criminalized the provision of abortion services except in extremely limited circumstances.⁸¹ No criminal liability attached to the woman undergoing an abortion, and yet the Fifth Circuit did not hesitate to find the statute imposed an undue burden under *Casey*.⁸²

Certainly, some indirect burdens on choice have been upheld in the past, such as parental consent provisions for minors⁸³ and the elimination of certain late-term abortion procedures.⁸⁴ However, given the realities of clinic closures and the consequent elimination of access to abortion procedures for substantial geographic expanses, the burden the ambulatory surgical center standard requirement places on a woman's decision to obtain an abortion differs significantly from those indirect burdens in that it may entirely preclude the *option* of abortion. In contrast, the Court found the parental consent requirement constitutional only when accompanied by a judicial bypass option,⁸⁵ and the Partial-Birth Abortion Ban Act constitutional in light of its narrow language, which permitted continued access to the most commonly used abortion procedure.⁸⁶ The Court did not perceive these indirect burdens to foreclose abortion access—but the ambulatory surgical center requirement potentially does just that.

79 *Id.* at 938–39, 945–46 (holding unconstitutional a Nebraska statute whose language encompassed not only “dilation and extraction” surgical abortion procedures but also potentially all “dilation and evacuation” procedures as well).

80 974 F.2d 27 (5th Cir. 1992).

81 *Id.* at 29–31.

82 *Id.*

83 The Supreme Court upheld parental consent and notification provisions under *Roe v. Wade* in its decisions in *Bellotti v. Baird*, 443 U.S. 622, 643 (1979) (upholding the constitutionality of parental consent provisions provided such provision is accompanied by an alternate procedure authorizing abortion), *Ohio v. Akron Ctr. for Reprod. Health*, 497 U.S. 502, 510–11 (1990) (holding that any judicial bypass option that satisfied the criteria for a parental consent provision also would satisfy the criteria for a parental notification provision), and *Hodgson v. Minnesota*, 497 U.S. 417, 456 (1990) (upholding the constitutionality of parental notification provisions accompanied by an optional judicial bypass). In *Casey*, the Supreme Court reaffirmed the constitutionality of parental notification provisions accompanied by an optional judicial bypass. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 899 (1992) (joint opinion of O'Connor, Kennedy, and Souter, JJ.).

84 The Supreme Court upheld the Partial-Birth Abortion Ban Act of 2003 in *Gonzales v. Carhart*, 550 U.S. 124 (2007), rendering it illegal for doctors to knowingly perform late-term dilation and extraction procedures in light of perceived inhumanity. Criminalization of this procedure, however, did not foreclose a woman from undergoing an abortion by another procedural method, nor did it penalize doctors who perform the procedure in absence of the requisite *mens rea*. See *Partial-Birth Abortion Ban Act of 2003*, Pub. L. No. 108-105, 117 Stat. 1201 (codified as amended at 18 U.S.C. § 1531 (2012)).

85 See *supra* note 83 and accompanying text.

86 The Supreme Court recognized the dilation and evacuation procedure as the “most commonly used” abortion procedure, in comparison to the less frequently utilized dilation and extraction procedure. *Stenberg v. Carhart*, 530 U.S. 914, 945 (2000).

The requirement that an abortion clinic meet the standards of an ambulatory surgical center in order to remain operational could impose an undue burden on a woman's decision to obtain an abortion in two ways. First, legislation that does not differentiate between facilities that provide only medication abortions, versus those that provide both medical and surgical (or only surgical) abortions, likely would constitute an undue burden in light of the effective elimination of abortion access in large geographic swaths and the cost attendant to seeking abortion services in other states. Second, legislation that requires abortion clinics to meet ambulatory surgical center standards within one year of enactment likely will constitute an undue burden for similar reasons, as such time constraints will cause a large number of clinic closures given the impossibility of raising the requisite funds and completing the mandated renovations in the time allocated. Both overbroad legislation and fast-track timetables for clinic renovations are likely to result in a dramatic number of clinic closures, and thus are likely to constitute an undue burden on a woman's decision to obtain an abortion.

As of November 4, 2014, twenty-three states had laws in place requiring that abortion facility structural standards be equivalent to those of surgical centers and seventeen states applied regulations to abortion clinics that provided medication abortion irrespective of whether they offered surgical abortion services.⁸⁷ Indiana is one state with legislation in place that fails to make the key distinction between abortion clinics that provide surgical procedures and those that do not. In April 2013, Indiana enacted Senate Bill 371, which mandates that all abortion facilities, regardless of the type of abortion services provided, maintain "separate procedure, recovery and scrub rooms like surgical centers."⁸⁸ It does this by "[a]mend[ing] the definition of 'abortion clinic'" to "include facilities that provide abortion inducing drugs."⁸⁹ Planned Parenthood of Indiana and Kentucky (PPINK) filed suit in late August 2013 challenging this provision.⁹⁰

87 STATE POLICIES IN BRIEF, *supra* note 7. The exceptions to these statements are Michigan and Missouri, which impose surgical center standards only on facilities whose primary service is abortion. Michigan fails to distinguish facilities whose primary service is medication abortion only. As of November 10, 2014, court orders temporarily enjoined the laws in Indiana, Kansas, and Texas. *Id.*

88 REUTERS, *Indiana: State Sued over Abortion-Clinic Rules*, N.Y. TIMES, Aug. 22, 2013, <http://www.nytimes.com/2013/08/23/us/indiana-state-sued-over-abortion-clinic-rules.html> (describing Indiana's legislative efforts to regulate abortion clinics under the same standards as surgical centers, regardless of the type of abortion services made available at the clinic).

89 S.B. 371, 118th Gen. Assemb., 1st Reg. Sess. (Ind. 2013).

90 Ashley Balcerzak, *Planned Parenthood Sues Indiana over 'Unconstitutional' Abortion Law*, HUFFINGTON POST (Aug. 23, 2013, 2:27 PM), http://www.huffingtonpost.com/2013/08/23/planned-parenthood-indiana-abortion-law_n_3805436.html; accord REUTERS, *supra* note 88. Given the breadth of the legislation, it is possible it will not pass even rational basis review as the surgical requirements are being applied to facilities that do not perform surgeries. There is arguably no rational relation between increased maternal safety during nonsurgical procedures and the imposition of surgical center standards on abortion clinics performing only nonsurgical procedures. See *infra* Section II.B.

The Supreme Court encountered overbroad language with analogous effect in *Stenberg v. Carhart*,⁹¹ in which it struck down a Nebraska statute, the language of which encompassed not only the more specific “dilation and extraction” (D&X) surgical abortion procedure, but also potentially all “dilation and evacuation” (D&E) procedures,⁹² effectively rendering surgical abortion illegal. Legislation that fails to distinguish between medical and surgical abortion providers, and demands that both meet ambulatory surgical center standards, effectively creates the same undue burden of eliminated access to abortion services. If, however, some clinics in the state remain able to meet the ambulatory surgical center requirements, it is possible that an undue burden challenge will fail. The extent to which federal courts will take cost and geography into account when making undue burden judgments remains unclear and will largely depend on whether the Supreme Court adopts the approaches of the Eighth and Ninth Circuits, taking into account these practical factors, or adheres to the Fourth Circuit’s rejection of such factors serving as the basis of an undue burden. In the event that the Court is willing to take into account more pragmatic factors, it seems likely that legislation imposing a uniform requirement that all abortion clinics—regardless of the nature and type of procedure performed—meet ambulatory surgical center standards will not survive constitutional scrutiny.

Cost and geographic concerns are more acute in some states than others. For instance, in Texas, availability of clinics may greatly affect a woman’s decision to obtain an abortion in light of the state’s substantial geography. On July 18, 2013, Texas Governor Rick Perry signed into law House Bill 2, which amends the State Health and Safety Code as follows: “On and after September 1, 2014, the minimum standards for an abortion facility must be equivalent to the minimum standards adopted under Section 243.010 for ambulatory surgical centers.”⁹³

Different groups of clinics brought two separate lawsuits challenging particular provisions of House Bill 2. First, on September 27, 2013 a consortium of reproductive rights groups—the Center for Reproductive Rights, Planned Parenthood Federation of America, American Civil Liberties Union, and American Civil Liberties Union of Texas—filed suit against Texas Attorney General Greg Abbott on behalf of several women’s health and abortion providers.⁹⁴ Although House Bill 2 contained four comprehensive restrictions on abortion access, these plaintiffs challenged only the requirements that physicians obtain admitting privileges at local hospitals and that medication abortions follow the FDA-approved label use (as opposed to the widely

91 *Stenberg*, 530 U.S. 914.

92 *Id.* at 938–39, 945–46.

93 H.B. 2, 83d Leg., 2d Spec. Sess. (Tex. 2013).

94 *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 951 F. Supp. 2d 891, 891 (W.D. Tex. 2013), *rev’d in part*, 748 F.3d 583 (5th Cir. 2014); *accord* Jordan Smith, *Abortion Rights Lawsuit Filed Against State of Texas*, AUSTIN CHRON., Oct. 4, 2013, <http://www.austinchronicle.com/news/2013-10-04/abortion-rights-lawsuit-filed-against-state-of-texas/>.

used, off-label use).⁹⁵ Analysts estimate that the “expensive updates to [clinic] facilities” that House Bill 2 requires “would force 90 percent of the state’s clinics to close their doors . . . leav[ing] just five abortions clinics in the entire Lone Star State.”⁹⁶ More than forty clinics provided abortion services in Texas prior to the enactment of House Bill 2; by late October 2013, approximately half of those clinics closed in response to new requirements under House Bill 2.⁹⁷ On October 28, 2013, the Western District of Texas issued a permanent injunction against the admitting privileges requirement,⁹⁸ but upheld the medication abortion provision.⁹⁹ The Fifth Circuit subsequently reversed the district court’s injunction on grounds that the State of Texas likely would succeed on the merits in proving the provision’s

95 *Abbott*, 951 F. Supp. 2d at 895–96; accord Smith, *supra* note 94; Andrew Harris & David Montgomery, *Texas Abortion Laws Will Close Clinics, Witness Testifies*, BLOOMBERG (Oct. 22, 2013, 12:01 AM), <http://www.bloomberg.com/news/2013-10-21/texas-abortion-restrictions-tested-at-trial-in-austin.html>.

96 Tara Culp-Ressler, *What the Mainstream Media Misses About Texas’ Ongoing Abortion Battle*, THINKPROGRESS (Jul. 3, 2013, 2:25 PM), <http://thinkprogress.org/health/2013/07/03/2253921/texas-ongoing-abortion-battle/>; see also Laura Bassett, *Anti-Abortion Laws Take Dramatic Toll on Clinics Nationwide*, HUFFINGTON POST (Aug. 26, 2013, 7:30 AM), http://www.huffingtonpost.com/2013/08/26/abortion-clinic-closures_n_3804529.html (discussing abortion clinic closures nationwide and showing a map of the percentage changes in abortion clinic numbers between 2010 and 2013).

97 *Whole Woman’s Health v. Lakey*, No. 1:14-CV-284-LY, 2014 U.S. Dist. LEXIS 124500, at *13 (W.D. Tex. Aug. 29, 2014).

98 The Western District of Texas emphasized the two-step analytical process, under *Casey*, with which a court must engage: (1) whether there is a rational basis between the regulation and the legitimate state interest, and (2) whether such restriction places an undue burden on the decision to obtain an abortion, taking into account the “real purpose” behind the regulation. *Abbott*, 951 F. Supp. 2d at 898–99. The court struck down the admitting privileges requirement due to the State’s failure to prove there existed a rational basis for the regulation. *Id.* at 899–900 (holding, under the undue burden standard, that “[a] lack of admitting privileges on the part of an abortion provider is of no consequence when a patient presents at a hospital emergency room. By law, no hospital can refuse to provide emergency care.”). Further, even if the State provided a rational basis, the law would still fail on grounds that it created an undue burden by forcing many clinics to close. *Id.* at 900 (“By requiring abortion providers to have hospital admitting privileges, the evidence is that there will be abortion clinics that will close. The record reflects that 24 counties in the Rio Grande Valley would be left with no abortion provider because those providers do not have admitting privileges and are unlikely to get them.”).

99 The court determined that the undue burden threshold was not met in the challenge to the requirement that medication abortion be performed only in conformity with FDA approval, despite widespread off-label use that the court found to be a “safe and effective procedure.” *Id.* at 906; accord *id.* at 907 (“At some point, the totality of incidental effects may become an undue burden. However, the record before the court, when viewed through the prism of the Supreme Court’s controlling precedent, establishes that threshold has not been met.”). The court noted, however, that the states may not restrict abortions deemed necessary by a physician in order to preserve the life of the mother, and therefore, the medication abortion provision of House Bill 2 does not apply to physicians who deem an abortion necessary for that reason. *Id.* at 908–09.

constitutionality.¹⁰⁰ The Fifth Circuit specifically noted that the anticipated closure of clinics failing to meet the physician admitting requirement did not constitute an undue burden, despite some patients' anticipated increased travel of nearly 150 miles.¹⁰¹ The Supreme Court denied an emergency application to block the law from going into effect.¹⁰²

In a second lawsuit, a separate group of plaintiffs challenged House Bill 2's hospital admitting privileges requirement as applied to particular clinics, and brought a facial challenge against the ambulatory surgical center requirement. Despite the Fifth Circuit's reversal in the first lawsuit, the potential closure of multiple abortion clinics across Texas led district court Judge Lee Yeakel to rule on August 29, 2014 that House Bill 2's ambulatory surgical center requirement imposed an undue burden on a woman's decision to obtain an abortion.¹⁰³ In reaching this decision, the court took particular note of the geographic burden placed on women in Texas seeking an abortion: "[A]fter September 1, 2014, approximately 2 million women will live further than 50 miles [from an abortion clinic], 1.3 million further than 100 miles, 900,000 further than 150 miles, and 750,000 further than 200 miles."¹⁰⁴ Even assuming the remaining seven or eight clinics in the state could accommodate all those requesting their services, Judge Yeakel explained, the ambulatory surgical center requirement still constituted an undue burden because the reduced number of clinics, in combination with pragmatic factors attending access, created a "*de facto* barrier" to obtaining an abortion for a substantial portion of those women who might otherwise seek one.¹⁰⁵ Judge Yeakel highlighted several potential impediments to clinic access: "lack of availability of child care, unreliability of transportation, unavailability of appointments at abortion facilities, unavailability of time off from work, immigration status and inability to pass border checkpoints, poverty level, the time and expense involved in traveling long distances, and other, inarticulable psychological obstacles."¹⁰⁶ Even if increased travel up to 150 miles might not alone constitute an undue burden, the court reasoned that increased travel *plus* unique travel concerns rises to the level of an undue burden on the decision to obtain an abortion.¹⁰⁷

100 748 F.3d 583, 605 (5th Cir. 2014).

101 *Id.* at 597–98.

102 134 S. Ct. 506 (2013); see Carolyn Jones, *Texas' Anti-Abortion Law Lands at Supreme Court*, TEXAS OBSERVER (Nov. 4, 2013, 12:44 PM), <http://www.texasobserver.org/fifth-circuit-unblocks-texas-abortion-law-clinics-expected-close/>; Adam Liptak, *Justices Reject Bid to Block Texas Law on Abortions*, N.Y. TIMES, Nov. 19, 2013, <http://www.nytimes.com/2013/11/20/us/supreme-court-rejects-bid-to-block-texas-abortion-law.html>.

103 *Whole Woman's Health v. Lakey*, No. 1:14-CV-284-LY, 2014 U.S. Dist. LEXIS 124500 (W.D. Tex. Aug. 29, 2014).

104 *Id.* at *15.

105 *Id.* at *19.

106 *Id.*

107 See *id.* at *18–19 ("The State argues that the Fifth Circuit has established a *de facto* 'safe harbor' of 150 miles and that no abortion regulation that increases travel distance alone could act as an undue burden on the right to previability abortion. But here, the

On an emergency appeal, the Fifth Circuit reversed the district court's ruling.¹⁰⁸ After acknowledging the ambiguity surrounding the proper facial challenge standard for abortion legislation, the Fifth Circuit found that the lower court failed to apply either the *Salerno* "no set of circumstances" or the *Casey* "large fraction" standard.¹⁰⁹ Instead, the district court inappropriately focused on the increased number of women of reproductive age in Texas who would need to drive further to reach a clinic, and then employed a balancing test in which it weighed the severity of the burden against the legitimate state interests.¹¹⁰ If the district court had applied the "large fraction" standard, the Fifth Circuit explained, it would have needed to determine how many women *seeking abortions* would need to drive more than 150 miles to access a clinic, rather than look to the number of women in general.¹¹¹ Even assuming, *arguendo*, both that 150 miles provided a relevant cutoff for the analysis and that all 900,000 women living in excess of 150 miles from a clinic did seek an abortion, the Fifth Circuit still found the "large fraction" standard unsatisfied; an affected population of 900,000 out of 5.4 million women of reproductive age meant only 16.7% of the population faced an undue burden.¹¹² The Fifth Circuit found additional practical factors affecting clinic access—child care, transportation, work conflicts, etc.—irrelevant to the analysis, as it read *Casey* to require that the law itself cause the undue burden if it is to be held unconstitutional.¹¹³ Under this rationale, the court indicated, extralegislativ factors have no place in the undue burden calculation. Consequently, the Fifth Circuit upheld the ambulatory surgical center requirement on grounds that the State had shown a likelihood of success that the requirement was facially valid.¹¹⁴

The Supreme Court subsequently halted House Bill 2 from taking effect pending the Fifth Circuit's final ruling on the law's constitutionality.¹¹⁵

record conclusively establishes that increased travel distances *combine* with practical concerns unique to every woman. These factors combine with increased travel distances to establish a *de facto* barrier to obtaining an abortion for a large number of Texas women of reproductive age who *might* choose to seek a legal abortion." (citations omitted)).

108 See *Whole Woman's Health v. Lakey*, 769 F.3d 285, 296 (5th Cir. 2014) (finding House Bill 2's hospital admitting privileges requirement and the ambulatory surgical center requirement constitutional).

109 *Id.* at 296.

110 *Id.* at 296–97.

111 See *id.* at 298.

112 *Id.*

113 *Id.* at 299. The court also deemed irrelevant the law's incidental effect of increasing the cost to obtain an abortion. *Id.* at 300 ("[A]s the Supreme Court recognized in *Carhart*, and we observed in *Abbott I*, '[t]he fact that a law which serves a valid purpose, one not designed to strike at the right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it.'" (alteration in original) (quoting *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 734 F.3d 406, 413 (5th Cir. 2013))).

114 *Id.* at 293–94, 300.

115 See *Whole Woman's Health v. Lakey*, No. 14A365, 2014 WL 5148719, at *1 (U.S. Oct. 14, 2014).

Although the Court provided no analysis for its order, lawyers arguing on behalf of the affected clinics “had said that clinics closed as a result probably would not reopen,”¹¹⁶ which may have influenced the Court’s decision, given the threat of irreparable harm. Justices Scalia, Alito, and Thomas dissented, stating they would deny the application in full.¹¹⁷ Returning the case for full constitutional evaluation will give the Fifth Circuit an opportunity to explain further what factors should be included in the undue burden calculation.

Clinic closures resulting from the impossibility of meeting ambulatory surgical center standards in the dictated timeline also could constitute an undue burden on a woman’s decision to obtain an abortion. The costs of transforming a clinic to meet ambulatory surgical center standards are substantial. Experts testifying in the recent Texas district court decision estimated the cost of renovating an existing clinic would likely exceed \$1.5 million, and the cost of building an entirely new clinic would be in excess of \$3 million.¹¹⁸ Those figures may be understated. Bloomberg News reported that most clinics will not be able to afford the cost of transforming their facilities to meet the new standards.¹¹⁹ For independent clinics that operate at narrow profit margins, or often at a loss, the concept of building a single “new surgical center with four operating rooms . . . [for] \$6 million to \$8 million”¹²⁰ is unfathomable.¹²¹ More importantly, saving and/or raising the necessary funds to upgrade building facilities in the required timeline likely will be impossible for many clinics. For others, cost is irrelevant because the abortion clinic’s facilities are rented, thereby entirely precluding the option of remodeling to meet regulatory requirements.¹²²

116 Lyle Denniston, *Court Blocks Abortion Limits in Texas*, SCOTUSBLOG (Oct. 14, 2014, 7:08 PM), <http://www.scotusblog.com/2014/10/court-blocks-abortion-limits-in-texas/>; accord ASSOCIATED PRESS, *Supreme Court Blocks Parts of Texas Abortion Law*, FOX NEWS (Oct. 14, 2014), <http://www.foxnews.com/politics/2014/10/14/supreme-court-blocks-parts-texas-abortion-law/>; Robert Barnes, *Supreme Court Blocks Texas Abortion Law*, WASH. POST, Oct. 14, 2014, http://www.washingtonpost.com/politics/courts_law/supreme-court-blocks-texas-abortion-law/2014/10/14/a3c51252-53ad-11e4-892e-602188e70e9c_story.html; Adam Liptak, *Supreme Court Allows Texas Abortion Clinics to Stay Open*, N.Y. TIMES, Oct. 14, 2014, <http://www.nytimes.com/2014/10/15/us/supreme-court-allows-texas-abortion-clinics-to-stay-open.html>.

117 *Whole Woman’s Health*, 2014 WL 5148719, at *1.

118 *Whole Woman’s Health v. Lakey*, No. 1:14-CV-284-LY, 2014 U.S. Dist. LEXIS 124500, at *16–17 (W.D. Tex. Aug. 29, 2014); see also Tara Culp-Ressler, *Court Ruling Devastates Texas’ Abortion Clinic Infrastructure*, THINKPROGRESS (Oct. 3, 2014, 11:02 AM), <http://thinkprogress.org/health/2014/10/03/3575477/court-ruling-texas-asc/>.

119 See Esmé E. Deprez & David Miltenberg, *Texas Abortion Clinics Need Million-Dollar Fixes to Stay Open*, BLOOMBERG (Jul. 15, 2013, 12:01 AM), <http://www.bloomberg.com/news/2013-07-15/texas-abortion-clinics-need-million-dollar-fixes-to-stay-open.html>.

120 *Id.*

121 Lower estimates place renovations at only \$2 million, but this is likely still too large a figure for independent clinics, unaffiliated with larger entities like Planned Parenthood, to afford. See Wlodek, *supra* note 16, at 415.

122 *Id.*

The Indiana and Texas laws dictate that all abortion clinics in the respective states meet the ambulatory surgical center requirement within an established and aggressive timetable. Texas's legislation allowed only thirteen months for clinics to raise the necessary funds, hire engineers and builders, and perform the requisite facility changes in order to remain open to the public.¹²³ Even more aggressively, Indiana's legislation allowed only nine months to finance, complete all physical renovations, and meet ambulatory surgical center standards.¹²⁴

The aggressive and perhaps unrealistic timelines these statutes impose are likely to reduce the number of clinics available to perform abortions in such proportions as to create an undue burden on women desiring to obtain an abortion. In this regard, the travel requirements will be more onerous and the cost associated with that travel will increase the overall expenditure necessary to obtain an abortion. Nevertheless, it remains unclear whether courts will consistently consider availability and cost when evaluating the burden such legislation imposes.

B. Is There a Rational Basis?

Whether the states have a rational basis for requiring that abortion clinics meet the same facility standards as ambulatory surgical centers largely depends on the type of abortion being performed at the clinic. Importantly, not all abortion clinics offer both medication and surgical abortion procedures. Indeed, the imposition of ambulatory surgical center standards on abortion clinics that provide surgical procedures likely will be held to be rational, but that same logical inference is missing with respect to clinics that perform abortions through nonsurgical procedures. Accordingly, even if the Supreme Court adopts the most deferential standard of review, the imposition of an ambulatory surgical center requirement on clinics performing only nonsurgical abortions may be invalidated because there is likely no rational relation between increased patient safety during nonsurgical procedures and the imposition of surgical center standards on clinics.

Ambulatory surgical centers provide a wide range of services for patients that do not require overnight hospital stays. According to the National Survey of Ambulatory Surgery (NSAS), the five most utilized services performed at ambulatory surgical centers are endoscopy of the large intestine, endoscopy of the small intestine, extraction of lens, injection of agent into spinal canal, and insertion of prosthetic lens.¹²⁵ Additional available services at ambulatory surgical centers include operation on muscle, tendon, fascia, and bursa; tonsillectomy with or without adenoidectomy; adenoidectomy with or

123 See H.B. 2, 83d Leg., 2d Spec. Sess. (Tex. 2013).

124 See S.B. 371, 118th Gen. Assemb., 1st Reg. Sess. (Ind. 2013).

125 Karen A. Cullen et al., *Ambulatory Surgery in the United States, 2006*, NAT'L HEALTH STATISTICS REPORTS 1 (Sept. 4, 2009), <http://www.cdc.gov/nchs/data/nhsr/nhsr011.pdf>.

without tonsillectomy; injections of prophylactic substances; and endoscopic polypectomy.¹²⁶

The risks attending these procedures generally are not extreme. Tonsillectomy and adenoidectomy procedures involve the surgical removal of either the tonsils or adenoid glands, and recovery is complete in seven to fourteen days.¹²⁷ The risks associated with these surgeries are not life threatening, and include bleeding, infection, or injury to the soft palate.¹²⁸ Similarly, endoscopy of the upper intestine carries with it minimal risks, including bleeding (sometimes requiring a blood transfusion), infection, or “tearing of the gastrointestinal tract” (occurring in “an estimated 3 to 5 of every 10,000 diagnostic upper endoscopies”).¹²⁹ Endoscopy of the lower intestine carries the same risks of bleeding, infection, or potential perforation.¹³⁰

Other, more invasive surgeries also take place at ambulatory surgical centers. These include a variety of different plastic surgeries, including liposuction; biopsies of lymph nodes, breast tissue, liver, muscle, and temporal arteries; urological services; gynecological services, including dilation and curettage; ear, nose, and throat surgeries; and orthopedic surgeries.¹³¹ The risks associated with these surgeries are generally much higher than the less invasive procedures. Potential complications with liposuction, for example, include infection, embolism, puncture wounds in organs, seroma (pooling of serum where tissue was removed), swelling, skin necrosis, burns, fluid imbalance, toxicity from anesthesia, or even death (3 in every 100,000 cases).¹³² In many ways, surgical abortion appears to have the same characteristics as the

126 *Id.* at 6. This is not intended to be an exhaustive list. See *infra* note 131 and accompanying text.

127 *Adenoid Removal*, MEDLINE PLUS, <http://www.nlm.nih.gov/medlineplus/ency/article/003011.htm> (last visited Nov. 21, 2014); *Tonsillectomy*, MEDLINE PLUS, <http://www.nlm.nih.gov/medlineplus/ency/article/003013.htm> (last visited Nov. 21, 2014).

128 *Tonsillectomy*, *supra* note 127; *Adenoid Removal*, *supra* note 127.

129 *Upper Endoscopy: Risks*, MAYO CLINIC (Aug. 29, 2012), <http://www.mayoclinic.com/health/endoscopy/MY00138/DSECTION=risks>.

130 G. Jechart & H. Messmann, *Indications and Techniques for Lower Intestinal Endoscopy*, PUBMED, <http://www.ncbi.nlm.nih.gov/pubmed/18790432> (last visited Nov. 21, 2014).

131 *Abbott Northwestern Hospital: Ambulatory Surgery Center*, ALLINA HEALTH, <http://www.allinahealth.org/ahs/anw.nsf/page/amburctr> (last visited Nov. 21, 2014). The ambulatory surgical center at the Abbott Northwestern Hospital performs the following surgeries: abdominoplasty; breast augmentation; chin augmentation; dermabrasion; liposuction; melanoma excision; skin grafts; varicose vein ligation; biopsies of lymph nodes, breast tissue, liver, muscle, temporary artery; hernia repairs; wound debridement; porta cath removal; cystoscopy; bladder biopsy; needle biopsy of prostate; adult circumcision; vasectomy; colposcopy; dilation and curettage (D&C); tubal dye studies; hysteroscopy; vaginal biopsies; nasal cautery; septoplasty; rhinoplasty; closed reduction nasal fracture; joint manipulations; bunion removal; close reductions; hardware removal; and cyst excisions. *Id.* (listing available procedures under expandable sections in center of page).

132 *What Are the Risks or Complications?*, FOOD & DRUG ADMIN., <http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/SurgeryandLifeSupport/Liposuction/ucm256139.htm> (last visited Nov. 21, 2014) (discussing the risks and complications associated with liposuction).

less risk-laden surgical procedures. An aspiration surgical abortion, performed during the first six to sixteen weeks of pregnancy, involves administration of a local anesthetic to the cervix, the placement of rods inside the cervix to induce dilation, and the insertion of a cannula into the uterus to “suction out the fetus and placenta.”¹³³ This surgery appears very similar in nature to the adenoidectomy procedure, in which the surgeon inserts a small tool to keep the patient’s mouth open, removes the glands using a curette (small cutting device), and then relies on electrocautery, coblation, or other absorbent material to control the bleeding.¹³⁴ The aspiration abortion surgery takes very little time, and recovery time is only a few hours.¹³⁵ The other type of surgical abortion is dilation and evacuation (D&E), which occurs when the pregnancy is more than sixteen weeks in progress.¹³⁶ The procedure involves the placement of rods inside the cervix, often one day in advance, to induce dilation.¹³⁷ The physician then administers a numbing agent to the cervix, utilizes additional rods or tenaculum to induce further dilation, and makes a series of passes with a cannula and curette to remove fetal tissue from the uterus.¹³⁸ General anesthesia is used on occasion with the D&E procedure.¹³⁹ The procedure concludes with “a final suctioning to make sure the contents are completely removed.”¹⁴⁰ The D&E procedure takes approximately twice as long as the aspiration abortion, generally lasting fifteen to thirty minutes,¹⁴¹ but recovery time remains minimal.¹⁴²

Both the aspiration and D&E procedures incur several potential risks. By choosing to undergo a surgical abortion, the patient risks “damage to the womb or cervix; uterine perforation (accidentally putting a hole in the uterus with one of the instruments used); excessive bleeding; infection of the uterus or fallopian tubes; scarring of the inside of the uterus; [or] reaction to the

133 *Surgical Abortion Procedures: Aspiration*, AM. PREGNANCY ASS’N, <http://americanpregnancy.org/unplannedpregnancy/surgicalabortions.html> (last updated Feb. 2014). This procedure is also known as a “suction aspiration, suction curettage, or vacuum aspiration.” *Id.* (emphasis omitted).

134 *Adenoid Removal*, *supra* note 127.

135 Surgical abortion performed using the aspiration method takes approximately 10–15 minutes to complete, with recovery lasting a few hours. *Surgical Abortion Procedures: Aspiration*, *supra* note 133.

136 *Surgical Abortion Procedures: Dilation & Evacuation (D&E)*, AM. PREGNANCY ASS’N, <http://americanpregnancy.org/unplannedpregnancy/surgicalabortions.html> (last updated Feb. 2014).

137 *Id.*

138 *Id.*

139 Warren M. Hern, *Second-Trimester Surgical Abortion*, in 6 GYNECOLOGY AND OBSTETRICS ch. 125 (John J. Sciarra ed., rev. ed. 2002), available at <http://www.drhern.com/pdfs/secondsurg.pdf>.

140 *Surgical Abortion Procedures: Dilation & Evacuation (D&E)*, *supra* note 136.

141 *Id.*

142 See *Abortion—Surgical*, MEDLINE PLUS, <http://www.nlm.nih.gov/medlineplus/ency/article/002912.htm> (last updated Nov. 21, 2012) (noting that the recovery period is “a few hours”).

medicines or anesthesia, such as trouble breathing.”¹⁴³ However, these risks are recognized to “rarely occur.”¹⁴⁴ Death occurs in 0.0006% of all legal surgical abortions,¹⁴⁵ with the greatest likelihood attending second-trimester abortion, since risk correlates with the length of the pregnancy.¹⁴⁶

The courts likely will conclude that state legislators have a rational basis for believing similar surgical procedures should be performed in equivalently equipped facilities, particularly in light of the state’s legitimate interest in ensuring maternal health. Surgical abortion procedures utilize some of the same tools and parallel techniques as other procedures currently performed in ambulatory surgical centers. Further, the risks attending surgical abortion, either by aspiration or D&E, echo those presented in some of the less risky procedures currently subject to ambulatory service facility requirements. It also is perhaps a logical extension of *Mazurek v. Armstrong*¹⁴⁷ to argue that if states have wide latitude to regulate who may perform an abortion, the state likely also retains authority to dictate the requirements for the facilities in which abortions are performed.¹⁴⁸ The strength of the state’s interest in

143 *Id.*

144 *Id.*

145 See Geneva Pittman, *Abortion Safer than Giving Birth: Study*, REUTERS (Jan 23, 2012, 5:16 PM), <http://www.reuters.com/article/2012/01/23/us-abortion-idUSTRE80M2BS20120123> (noting that “between 1998 and 2005, one woman died during childbirth for every 11,000 or so babies born” while only “one woman of every 167,000 . . . died from a legal abortion”).

146 The “rare, [although] possible[,] complications” resulting from second-trimester surgical abortions include “a blood clot in the uterus that can cause pain or require a repeat aspiration; infection, which is generally easily identified and treated; a tear in the cervix that can be easily repaired with suture; perforation; retained pregnancy tissue requiring repeat aspiration; and excessive bleeding requiring a transfusion.” *Surgical Abortion (Second Trimester)*, UCSF MED. CTR., http://www.ucsfhealth.org/treatments/surgical_abortion_second_trimester/ (last visited Nov. 21, 2014). Second-trimester abortions are necessarily surgical, as the FDA only approved medication abortion for abortions that occur within forty-nine days of fertilization. *Mifeprex (Mifepristone) Information*, FOOD & DRUG ADMIN., <http://www.fda.gov/drugs/drugsafety/postmarketdrugsafetyinformationforpatientsandproviders/ucm111323.htm> (last updated July 19, 2011). While it is true that there have been several deaths reported in connection with the use of mifepristone and misoprostol, FDA investigations could not determine a causal link between the use of the drugs and the sepsis that resulted in the deaths. While noting these deaths on its disclosure page, the FDA states plainly that it “do[es] not know whether using mifepristone and misoprostol caused these deaths.” *Id.*; see also Heather D. Boonstra, *Medication Abortion Restrictions Burden Women and Providers—and Threaten U.S. Trend Toward Very Early Abortion*, GUTTMACHER POL’Y REV., Winter 2013, at 18, available at <http://www.guttmacher.org/pubs/gpr/16/1/gpr160118.html> (noting the lack of a causal link between medication abortion drugs and the deaths).

147 520 U.S. 968 (1997).

148 In *Mazurek*, the Supreme Court upheld a Montana statute that restricted the performance of abortions to licensed physicians on grounds that the plaintiffs “had [neither] established any likelihood of prevailing on their claim that the law imposed an ‘undue burden’ within the meaning of *Planned Parenthood of Southeastern Pa. v. Casey*,” *id.* at 970, nor provided any evidence that the Montana legislature had the “improper legislative pur-

ensuring maternal health, in combination with the similarity between surgical abortions and other surgical procedures currently performed at ambulatory surgical centers, creates a strong case that there is a rational basis for state legislation requiring surgical abortions take place in facilities that meet ambulatory surgical center standards.

At the same time, however, the lack of similarities between surgical procedures and medication-induced abortion make readily apparent the lack of a rational basis for imposing ambulatory surgical center standards on clinics not providing surgical abortion services. Medication-induced abortion requires no anesthesia, no invasion of the body cavity, and no in-clinic stays. Rather, the procedure requires dispensing two medications, and a follow-up appointment.¹⁴⁹ The patient takes the “abortion pill” (mifepristone) while at the clinic, and is then sent home with a second pill (misoprostol) to be taken twenty-four to forty-eight hours later.¹⁵⁰ The second pill causes cramps and heavy bleeding as the uterine lining breaks down and the pregnancy terminates.¹⁵¹ There is no official recovery time; most women’s bleeding lasts four or five hours, although for some the abortion takes up to a few days to complete.¹⁵² A follow-up appointment is necessary to ensure the abortion was successful and there are no recognized complications.¹⁵³ In light of the fact that women who obtain medication to induce abortion do not stay in the clinic while the abortion occurs, the imposition of surgical center standards on these clinics would not further maternal safety, and therefore such legislation likely would fail even rational basis analysis.

C. *Inability to Obtain State Licenses Even Upon Meeting Requirements*

Beyond the question of whether ambulatory surgical center standards should apply to abortion clinics, there remains concern that abortion clinics will not be able to obtain the requisite state licenses even upon meeting those standards. Importantly, the *Simopoulos* Court based its decision on the premise that there was “no reason to doubt that an adequately equipped clinic could, upon proper application, obtain an outpatient hospital license permit-

pose” of intending to “interfere with the constitutionally protected right to abortion.” *Id.* at 972. The Court found the fact that “an antiabortion group” drafted the legislation “[said] nothing significant about the legislature’s purpose in passing it.” *Id.* at 973. The Court concluded that even though there was no evidence suggesting a physician may perform the procedure more safely than a non-physician, the states retain “‘broad latitude to decide that particular functions may be performed only by licensed professionals, *even if an objective assessment might suggest that those same tasks could be performed by others.*’” *Id.* (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 885 (1992)).

149 See *The Abortion Pill*, PLANNED PARENTHOOD, <http://www.plannedparenthood.org/health-topics/abortion/abortion-pill-medication-abortion-4354.asp> (last visited Nov. 21, 2014).

150 *Id.*

151 *Id.*

152 *Id.*

153 *Id.*

ting the performance of second-trimester abortions.”¹⁵⁴ Contrary to this assumption, some states became quite restrictive in granting licenses to clinics that provide abortion services.

Such was the case in Mississippi in 2004. In *Jackson Women’s Health Organization v. Amy*,¹⁵⁵ an abortion clinic sought injunctive relief from an amendment to Mississippi state law that would require both first-trimester and second-trimester abortions to be performed in a licensed hospital or ambulatory surgical facility.¹⁵⁶ The clinic sought injunctive relief because the amendment would bar it from performing abortions from weeks thirteen through fifteen, despite having performed such abortions for many years and meeting the requisite criteria to be designated an ambulatory surgical facility.¹⁵⁷ The court granted the injunctive relief, noting that “it appears from the record that plaintiff does meet all the substantive standards for licensure . . . and yet the State has made it plain that this plaintiff cannot obtain the necessary license for reasons wholly unrelated to any . . . legitimate motivation by the State.”¹⁵⁸ The court pointed out that the Mississippi State Department of Health required the clinic to seek certification as an ambulatory surgical center prior to applying for licensure, but since the clinic only performed surgical abortions, it would fail the criteria to receive certification and therefore would not receive a license.¹⁵⁹ Therefore, the court explained, the plaintiff’s specific specialty in surgical abortions rendered it ineligible for state licensure, and prohibited it from performing second-trimester abortions under the amendment.¹⁶⁰ The abortion clinic did not challenge the ability of the State to regulate the health standards of facilities in which second-trimester abortions are performed, but rather sought injunctive relief on grounds that Mississippi applied its statute so as to bar performance of early second-trimester abortions for reasons unrelated to the legitimate state interest in maternal health.¹⁶¹

These pragmatic concerns echo those present in the Eighth Circuit’s opinion in *Planned Parenthood of Minnesota/South Dakota v. Rounds*, decided just one month earlier.¹⁶² There, the Eighth Circuit held that a South Dakota statute requiring all abortions after twelve weeks to be performed in a hospital imposed an undue burden because there was no hospital in the state available to perform abortions.¹⁶³ In the absence of a Supreme Court ruling,

154 *Simopoulos v. Virginia*, 462 U.S. 506, 518–19 (1983).

155 330 F. Supp. 2d 820 (S.D. Miss. 2004).

156 *Id.* at 822.

157 Despite meeting the substantive requirements, the clinic had not been able to obtain official licensure as an ambulatory surgical center. *Id.* at 822, 824–25.

158 *Id.* at 824.

159 *Id.*

160 *Id.* at 825 n.4.

161 *Id.* at 823.

162 372 F.3d 969 (8th Cir. 2004).

163 *Id.* at 972 (“The plaintiffs’ complaint itself alleges that in South Dakota, abortions are virtually unavailable in hospitals. There is only one hospital—Sioux Valley Hospital—that has reported to the State that abortions have been performed at their facilities. Sioux

however, the circuits will remain unguided and divided on the proper role practical factors play in the *Casey* analysis.

Clinics in Ohio also faced difficulty obtaining the requisite state licensure despite meeting the substantive facility requirements. A recent state law bans public hospitals—those in receipt of local government funds¹⁶⁴—from signing formal transfer agreements with local clinics, even though those clinics are required by state law to obtain such agreements in order to receive state licensure.¹⁶⁵ Although it is still debated whether the formal agreements themselves are necessary—given that clinic facilities are generally able to handle complications and hospitals must accept emergency patients for treatment—the new Ohio law will likely force several of the state’s remaining clinics to close “because they cannot find willing partners.”¹⁶⁶ As of late-August 2014, four of Ohio’s thirteen clinics ceased operations due to their inability to procure a transfer agreement with a local hospital.¹⁶⁷

III. WHO SHOULD REGULATE ABORTION?

In light of the legal framework in place, and the practical reality that many state regulations have the effect of closing abortion clinics, it is unclear that the current division of power between the federal and state governments is the ideal solution. Although there are many benefits to leaving abortion regulation largely in the hands of the states, there are also significant detriments, including the risk of disparate levels of access nationwide and the potential that clinics in one state will prove safer than those in another state, rendering some women subject to greater medical risks simply due to the state in which they live. This Part evaluates the benefits and detriments

Valley Hospital will allow abortions only under very limited circumstances, *i.e.*, when the woman’s life or health would be significantly endangered by continuing the pregnancy, or when the fetus appears to have serious and uncorrectable medical conditions or genetic disorder. Plaintiffs’ first and second amended complaints contain the same allegations. These pleadings also allege that Planned Parenthood’s Sioux Falls clinic is the only outpatient clinic providing abortions in the state of South Dakota. The first and second amended complaints allege that a South Dakota woman who is unable to secure an abortion at Planned Parenthood must travel long distances out of state to obtain such medical care. These two allegations taken together must mean that there is no hospital that performs abortions in South Dakota.” (citations omitted) (internal quotation marks omitted)).

164 *Public Hospitals Decline Swiftly*, WASH. TIMES, Aug. 16, 2005, <http://www.washington-times.com/news/2005/aug/16/20050816-102614-7824r/>.

165 Erik Eckholm, *With New Abortion Restrictions, Ohio Walks a Narrow Legal Line*, N.Y. TIMES, Oct. 9, 2013, <http://www.nytimes.com/2013/10/10/us/with-new-abortion-restrictions-ohio-walks-fine-line.html>.

166 *Id.*

167 Cheryl Wetzstein, *New Ohio Abortion Rules Close Decades-Old Clinic*, WASH. TIMES, Aug. 21, 2014, <http://www.washingtontimes.com/news/2014/aug/21/cincinnati-areas-last-abortion-clinic-closes-suppo/>; see also Laura Bassett, *Cincinnati Abortion Clinic Closes, Leaving Access ‘Severely Endangered’ in Region*, HUFFINGTON POST (Aug. 20, 2014, 3:12 PM), http://www.huffingtonpost.com/2014/08/20/ohio-abortion-clinic-closing_n_5695376.html.

attending federal and state regulation of abortion, and ultimately offers a third option for readers' consideration: regulation by accreditation.

A. *Congress Versus the States*

Congressional efforts to regulate abortion since 1973 suggest Congress could quell the current debate surrounding abortion clinic facility standards through legislation.¹⁶⁸ Perhaps the best evidence to support this approach is the existence and continued viability of the Partial-Birth Abortion Ban Act of 2003. Importantly, though, Justice Thomas's concurrence in *Gonzales* makes clear that the Court was not asked to address whether the Act is a valid regulation under Congress's commerce power.¹⁶⁹ Accordingly, although there is a potential constitutional challenge to federal legislation in this arena, where the federal government has acted, it has done so with success.

1. Does the Commerce Power Cover Abortion?

Is Congress authorized to regulate abortion services under the Commerce Clause? The answer seems to be "yes." Congressional regulatory power under the Commerce Clause remains expansive. Consider the decisions of the Supreme Court in four major building blocks of modern Commerce Clause jurisprudence—*United States v. Lopez*,¹⁷⁰ *United States v. Morrison*,¹⁷¹ *Gonzales v. Raich*,¹⁷² and *National Federation of Independent Business*

168 Shortly after *Roe*, Congress began actively seeking to regulate abortion practices in the form of (unsuccessful) constitutional amendments and federal statutes. SHIMABUKURO, *supra* note 46, at 10 (noting that while, prior to *Roe*, "relatively few bills involving abortion were introduced in either the House or the Senate . . . more than 1,000 separate legislative proposals have been introduced" since 1973). Congress never codified the *Roe* decision, despite fervent legislative efforts during the 102nd, 103rd, and 110th Congresses, nor did it succeed in passing a constitutional amendment reversing *Roe*. *Id.*; see also McBRIDE, *supra* note 46, at 182 (providing the text of the proposed Freedom of Choice Act of 1993, an ultimately unsuccessful attempt "to put the guarantees of *Roe* into law through Congressional action"). Congress's greatest achievements in federal regulation of abortion are arguably the successful passage and continued vitality of the Freedom of Access to Clinic Entrances Act of 1994, Pub. L. No. 103-259, 108 Stat. 694 (codified as amended at 18 U.S.C. § 248 (2012)), and the Partial-Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, 117 Stat. 1206 (codified as amended at 18 U.S.C. § 1531 (2012)).

169 550 U.S. 124, 169 (2007) (Thomas, J., concurring) ("[W]hether the Partial-Birth Abortion Ban Act of 2003 constitutes a permissible exercise of Congress' power under the Commerce Clause is not before the Court. The parties did not raise or brief that issue; it is outside the question presented; and the lower courts did not address it.").

170 514 U.S. 549, 561 (1995) (holding unconstitutional the Gun-Free School Zones Act, on grounds that Congress cannot regulate noneconomic activities under the Commerce Clause).

171 529 U.S. 598, 617 (2000) (holding that the civil remedy provision of the Violence Against Women Act is not a valid exercise of the Commerce Power, because Congress cannot "regulate noneconomic, violent criminal conduct based solely on that conduct's aggregate effect on interstate commerce").

172 545 U.S. 1, 17 (2005) (holding constitutional the Controlled Substances Act because Congress's commerce power extends to cover those purely local activities for

v. Sebelius (NFIB),¹⁷³ which effectively tethered regulations of purely intrastate activity to a series of line-drawing exercises. Today, it is understood that Congress may regulate any one of three categories: channels of interstate commerce, instrumentalities of interstate commerce, and those local activities having a substantial relation to interstate commerce.¹⁷⁴ For this last category, the broadest of the three, the Court specifically asks whether the regulation “substantially affects interstate commerce.”¹⁷⁵ In addition, per *Lopez* and *Morrison*, the regulation must be “economic” in nature.¹⁷⁶ Lastly, per *NFIB*, it must govern “activity,” as opposed to “inactivity.”¹⁷⁷

Abortion likely may be regulated by Congress as either an instrumentality of interstate commerce or as a local activity having a substantial effect on interstate commerce. Numerous unsuccessful challenges to the Freedom of Access to Clinic Entrances Act of 1994¹⁷⁸ (FACE) suggest that abortion itself is the type of activity subject to Commerce Clause regulation as a local activity that has a substantial effect on interstate commerce.¹⁷⁹ Those circuits upholding the constitutionality of FACE¹⁸⁰ did so on grounds that the regulated activity—protesting outside clinic facilities—had a substantial effect on

which Congress has a rational basis for believing is part of a “class of activities” that, in the aggregate, will have a substantial effect on interstate commerce).

173 132 S. Ct. 2566, 2586; *accord id.* at 2585–91 (2012) (noting that the Patient Protection and Affordable Care Act of 2010 was not a valid exercise of Congress’s commerce power because Congress may not regulate inactivity, and the failure to purchase health insurance, creating the cost-shifting problem that the individual mandate seeks to correct, is inactivity).

174 See Laura J. Tepich, Note, *Gonzales v. Carhart: The Partial Termination of the Right to Choose*, 63 U. MIAMI L. REV. 339, 346 (2008) (citing *Lopez*, 514 U.S. at 558–59).

175 *Id.* (quoting *Lopez*, 514 U.S. at 559) (internal quotation marks omitted).

176 See *supra* notes 170–71.

177 See *supra* note 173 and accompanying parenthetical text.

178 18 U.S.C. § 248 (2012).

179 Tepich, *supra* note 174, at 354 (quoting Jordan Goldberg, Note, *The Commerce Clause and Federal Abortion Law: Why Progressives Might Be Tempted to Embrace Federalism*, 75 FORDHAM L. REV. 301, 327 (2006)).

180 The First Circuit has not yet addressed this issue. The Second, Third, Fourth, Fifth, Sixth, Seventh, Eighth, Eleventh, and D.C. Circuits upheld FACE as a valid exercise of Congress’s Commerce Clause power. *United States v. Bird*, 401 F.3d 633, 634 (5th Cir. 2005); *Norton v. Ashcroft*, 298 F.3d 547, 559 (6th Cir. 2002); *United States v. Gregg*, 226 F.3d 253, 256 (3d Cir. 2000); *United States v. Weslin*, 156 F.3d 292, 294 (2d Cir. 1998); *Hoffman v. Hunt*, 126 F.3d 575, 589 (4th Cir. 1997); *Terry v. Reno*, 101 F.3d 1412, 1413–14 (D.C. Cir. 1996); *United States v. Dinwiddie*, 76 F.3d 913, 920–21 (8th Cir. 1996); *United States v. Wilson*, 73 F.3d 675, 688 (7th Cir. 1995); *Cheffer v. Reno*, 55 F.3d 1517, 1520–21 (11th Cir. 1995).

District Courts in the Ninth and Tenth Circuits also upheld FACE as a valid exercise of the Commerce Clause power. *Planned Parenthood of the Columbia/Willamette, Inc. v. Am. Coal. of Life Activists*, 945 F. Supp. 1355, 1375 (D. Or. 1996); *United States v. Lucero*, 895 F. Supp. 1421, 1423 (D. Kan. 1995); *United States v. White*, 893 F. Supp. 1423, 1434 (C.D. Cal. 1995); *Riely v. Reno*, 860 F. Supp. 693, 708 (D. Ariz. 1994); *Council for Life Coal. v. Reno*, 856 F. Supp. 1422, 1431 (S.D. Cal. 1994).

interstate commerce.¹⁸¹ FACE also withstood challenges after *Lopez* and *Morrison*, asserting that the regulated activity was not economic in nature. The circuit courts held that “the fact that the activity [of protesting] was aimed at preventing or threatening commerce made the statute sufficiently related to ‘economic activity’ to fall within Congress’s power.”¹⁸² Inherent in these rulings is the concept that abortion constitutes “economic activity.”¹⁸³ This is a logical conclusion. The act of an abortion is necessarily economic, as it is a service procured for a fee. Planned Parenthood places the cost of a medication-induced abortion at approximately \$300 to \$800,¹⁸⁴ with higher costs attending surgical abortions.¹⁸⁵ Further, it readily satisfies the “activity” requirement, as those who purchase the service (with the exception of minors whose parents pay for abortion services on their behalf) must physically participate in the procedure; there is no ‘abstention’ quality to procuring an abortion. Those women who never become pregnant, or who become pregnant and choose not to obtain an abortion, never interact with the abortion “market,” and therefore do not detract from the designation of abortion as an “activity.”

It is also possible that Congress has authority to regulate abortion under its power to regulate the channels of interstate commerce. This argument is supported by the Court’s more recent decision in *Raich*. There, the Supreme Court upheld the Controlled Substances Act,¹⁸⁶ which classified marijuana as a controlled substance and thereby criminalized even local, noncommercial consumption for medicinal purpose. The Court reasoned that Congress has the power “to regulate purely local activities that are part of an economic ‘class of activities’ that have a substantial effect on interstate commerce.”¹⁸⁷ Accordingly, as Jordan Goldberg hypothesizes, Congress could determine that the “provision of abortions in one state[] [is] part of a class of economic activities that have a substantial effect on interstate commerce when aggregated.”¹⁸⁸

181 Tepich, *supra* note 174, at 353 (quoting Goldberg, *supra* note 179, at 334).

182 *Id.* (quoting Goldberg, *supra* note 179, at 334) (internal quotation marks omitted).

183 The Seventh and Eleventh Circuits specifically stated that the provision of reproductive health services is an economic activity. *Wilson*, 73 F.3d at 683; *Cheffer*, 55 F.3d at 1520–21. Even Judge Weiss, dissenting in the Third Circuit’s ruling that FACE was a proper exercise of the Commerce Clause, “conceded that abortion services are commercial.” Goldberg, *supra* note 179, at 342 (discussing *Gregg*, 226 F.3d at 268 (Weiss, J., dissenting)).

184 *The Abortion Pill*, *supra* note 149.

185 *In-Clinic Abortion Procedures*, PLANNED PARENTHOOD, <http://www.plannedparenthood.org/health-topics/abortion/in-clinic-abortion-procedures-4359.asp> (last visited Nov. 21, 2014); see also *Surgical Abortion Fees*, AFFILIATED MED. SERVS., <http://www.affiliatedmedical-services.com/en/surgical-abortion/fees> (last visited Nov. 21, 2014) (identifying the cost of a surgical abortion, beginning at six to twelve weeks, and progressing week by week thereafter).

186 *Gonzales v. Raich*, 545 U.S. 1, 10 (2005).

187 *Id.* at 17.

188 Goldberg, *supra* note 179, at 335.

Accordingly, federal legislation that created a uniform standard for clinic facilities, based on a close nexus between the facility regulations and legitimate maternal health concerns, most likely would constitute a valid exercise of the Commerce Power because it would be in furtherance of ensuring access, in all states, to the abortion market.¹⁸⁹ Furthermore, given that abortion access dictates the number of persons born in the country each year, thereby affecting population needs and workforce growth, it seems highly likely that the Court would find a rational basis exists for such legislation.

2. Is Congress the Best Gatekeeper?

Practical realities create substantial skepticism of the viability of congressional regulation of abortion facility standards. Federal regulation of this kind could eliminate the needless closure of clinics that provide abortion services while simultaneously ensuring that those clinics meet uniform standards of health and safety. The potential for such federal legislation, however, is *de minimis*. Congress, as currently populated, is not likely to be able to reach accord on such a politically charged issue. Moreover, any legislation put in place would be inherently unstable, as every new party majority might easily overrule it. Lastly, leaving to Congress so contentious a topic as abortion may politicize the issue to the point that women's health is no longer the controlling concern.

The alternative path of leaving abortion regulation to the states initially seems better for a number of reasons. Most importantly, perhaps, abortion is a topic on which few agree. Even when we divide opinion into roughly two camps—those who favor a right to choose versus those who do not—there still exist factions within the two classifications. In the absence of widespread agreement, state governments are the ideal tinkers, and state experimentation should perhaps be recognized as a critical prerequisite to uniform federal regulation. Moreover, leaving abortion regulation to the states ensures a closer nexus between the state-citizens' preferences concerning abortion practices and the actual laws in force, as opposed to the distance that inevitably develops at a federal level, where many different state populations' preferences must be considered in the creation of uniformly applicable legislation.

At the same time, though, states already have spent millions of dollars litigating abortion-related restrictions. Despite economies still suffering from

189 The general public is likely long-familiar with the concept of an "abortion market." Specifically, "abortion industry" is the phrase most utilized in the media, often as a pejorative, to describe collectively those physicians and clinics that provide abortion services. See, e.g., Ryan Bomberger, *The Abortion Industry Puts the Con in Control*, LIFE NEWS.COM (Oct. 17, 2013, 3:02 PM), <http://www.lifenews.com/2013/10/17/the-abortion-industry-puts-the-con-in-population-control/> (describing the abortion industry as a population control tool); Matthew Clark, *Media's Abortion Distortion Plays into Abortion Industry's Deception*, AM. CTR. FOR LAW & JUSTICE, <http://aclj.org/media-abortion-distortion-plays-abortion-industry-deception> (last visited Nov. 21, 2014) (describing Planned Parenthood as the leader of the abortion industry).

the recession, many states are engaging in legal battles costing hundreds of thousands of dollars.¹⁹⁰ This litigation crowds court dockets and spends the valuable tax dollars of all state citizens, irrespective of their interest in or preferred outcome of the debate. For example, Kansas “spent \$769,000 defending its abortion limits between January 2011 and June of [2013], and the total sum will almost certainly top \$1 million, as the attorney general has requested \$500,000 more.”¹⁹¹ Such expenditures also often result in budget cuts elsewhere, including in education, the arts, environmental protections, and hunger-reduction projects for the elderly.¹⁹² Part of the impetus for defending current abortion laws so vigorously may be the desire to reach the Supreme Court, which the state hopes will seize the opportunity to overturn *Roe* and *Casey*. Christopher Mirakian dubbed this tactic the “Alabama Plan”¹⁹³ in light of Alabama Senator Hank Erwin’s cavalier statements that the purpose of proposing a state statute criminalizing all abortions would be that its enactment could generate the litigation necessary for the Supreme Court to revert to its pre-1973 abortion jurisprudence.¹⁹⁴ However, in light of the Supreme Court’s resolute adherence to *Roe* in *Casey*, it is highly unlikely this path will prove fruitful. In the meantime, it ties up valuable state resources and hurts the citizens of that state by reducing or eliminating funding in other areas.

B. Finding a Neutral Zone: Accreditation

As Dawn Johnson eloquently wrote in 2009, “[c]ommon ground’ instead of ‘compromise’ is a useful way of conceptualizing the organizing principle that should guide constructive efforts to bridge the abortion divide.”¹⁹⁵ Johnson envisioned this approach through a “broader agenda that empowers individuals both to prevent unwanted pregnancy and to choose wanted childbearing through a range of government-supported programs for women and families.”¹⁹⁶ However, in recognizing that the need for abortion will never disappear, this Note suggests an alternate scheme that remains engaged in the debate surrounding facility standards, rather than relying exclusively on sexual health education and contraception.

190 Bryce Covert, *Five States Spending Thousands to Defend Abortion Laws That Could Use the Money Elsewhere*, THINKPROGRESS (Aug. 29, 2013, 3:35 PM), <http://thinkprogress.org/economy/2013/08/29/2552381/states-spending-thousands-defend-abortion-laws-money/>.

191 *Id.* Idaho, South Dakota, North Dakota, and Arkansas have similar spending records defending abortion laws during the last ten to fifteen years. *Id.*

192 *Id.* (noting, as one example, that Kansas defunded the Kansas Arts Commission, cut education spending, and eliminated an environmental protection program aimed at clean water, all while pursuing expensive litigation in defense of its abortion laws).

193 Mirakian, *supra* note 23, at 219.

194 *Id.*

195 Dawn Johnson, “TRAP”ing *Roe* in Indiana and a Common-Ground Alternative, 118 YALE L.J. 1356, 1389 (2009).

196 *Id.*

An independent accreditation agency might be the most viable means of finding common ground in the abortion debate. Currently, there exists an independent, not-for-profit organization, the Joint Commission, which offers accreditation and certification services to a range of more than 20,000 health organizations.¹⁹⁷ Although the Joint Commission already offers accreditation to ambulatory surgical centers, the ambiguity surrounding whether all abortion clinics should have to meet ambulatory surgical center standards makes it inappropriate to immediately subject abortion clinics to those accreditation requirements. However, the Joint Commission is well situated to establish a new set of facility standards to address surgical and medication abortions, respectively.

Irrespective of whether a new accreditation agency or an existing one fills this role, it is necessary to flesh out what an abortion clinic accreditation agency would do and how it could further women's health. In theory, the relationship between an accreditation agency and abortion clinics would function in a fashion that parallels the relationship between the American Bar Association (ABA) and American law schools.

1. An Example: The ABA

The ABA is a voluntary organization recognized by the United States Department of Education under Title 34, Chapter VI, § 602 of the Code of Federal Regulations as "the national agency for the accreditation of programs leading to the J.D. degree in the United States."¹⁹⁸ The ABA is a large organization, with specific sub-sections that perform specialty functions. The Section of Legal Education and Admissions to the Bar is the group within the ABA that sets the official accreditation standards and deals with the process of accreditation.¹⁹⁹ The Code of Federal Regulation mandates that this Section and the Council that approves all accreditations be legally separate from the ABA itself.²⁰⁰ The Section itself is divided into three sub-committees: the Accreditation Committee, Standards Review Committee, and Data Policy & Collections Committee.²⁰¹

The ABA Standards and Rules of Procedure for Approval of Law Schools (ABA Standards) govern every accredited law school's organization and administration; program of legal education; faculty qualifications, size, instructional roles, responsibilities, and professional environment; admis-

197 *About the Joint Commission*, JOINT COMM'N, http://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx (last visited Nov. 21, 2014).

198 *The Law School Accreditation Process*, ABA SECTION OF LEGAL EDUC. & ADMISSIONS TO THE BAR 3 (Aug. 2013), http://www.americanbar.org/content/dam/aba/publications/misc/legal_education/2013_revised_accreditation_brochure_web.authcheckdam.pdf (citing 34 C.F.R. § 602 (1988)).

199 *About Us*, ABA SECTION OF LEGAL EDUC. & ADMISSIONS TO THE BAR, http://www.americanbar.org/groups/legal_education/about_us.html (last visited Nov. 21, 2014).

200 *The Law School Accreditation Process*, *supra* note 198, at 3.

201 *Id.* at 4.

sions; student services; library and information resources; and facilities.²⁰² The process of ABA accreditation is quite involved. A school must first apply for provisional approval after at least one year's operation.²⁰³ The ABA then engages in a fact-finding site visit,²⁰⁴ after which it submits a report to an Accreditation Committee, which holds a hearing and allows representatives from the school to prove how the school satisfies all the ABA Standards.²⁰⁵ The Committee then makes a recommendation to the Council regarding whether the school should obtain provisional approval status, based on whether it determines the school is in "substantial compliance with each of the [ABA] Standards."²⁰⁶ A school obtains full approval once it has had provisional approval for at least three years and demonstrates full—not simply substantial—compliance with the ABA Standards.²⁰⁷ While in a state of provisional approval, law schools are subject to close scrutiny and will receive site visits from members at three different times during the provisional status, "in years two, four, and five after provisional approval," which result in reports that the Accreditation Committee reviews.²⁰⁸ These reports create open communication between the school and the ABA, allowing the Accreditation Committee to cite needed corrections and raise any concerns it may have, and for the school to address such concerns by making any necessary corrections.²⁰⁹

Even once a school obtains accreditation, it is subject to subsequent Committee oversight. The school will undergo another "full site evaluation in the third year after full approval, and then a full sabbatical site evaluation every seven years."²¹⁰ In addition, each law school must submit an Annual Questionnaire, which allows the ABA to collect data "regarding curriculum, faculty, facilities, fiscal and administrative capacity, technology resources, student profiles, bar passage rates, and student placement data."²¹¹ In this way, the ABA ensures compliance with its Standards while avoiding micromanagement. Despite these lengthy processes, law schools are incentivized to obtain ABA-accreditation because all United States jurisdictions now permit graduates of ABA-accredited schools to sit for their bar exams.²¹²

202 *Standards*, ABA SECTION OF LEGAL EDUC. & ADMISSIONS TO THE BAR, http://www.americanbar.org/groups/legal_education/resources/standards.html (last visited Nov. 21, 2014).

203 *The Law School Accreditation Process*, *supra* note 198, at 5.

204 All site evaluation visits are performed by a Site Team, which reports back to the Accreditation Committee, and are specifically governed by a set of guidelines and rules. For details, see *id.* at 10.

205 *Id.* at 6.

206 *Id.* (internal quotation marks omitted).

207 *Id.* at 7.

208 *Id.*

209 *See id.*

210 *Id.* at 8.

211 *Id.*

212 *Frequently Asked Questions*, ABA SECTION OF LEGAL EDUC. & ADMISSIONS TO THE BAR, http://www.americanbar.org/groups/legal_education/resources/fre

2. Devising an Accreditation Agency for Abortion Providers

An accreditation agency promulgating the standards to which abortion providers are held would be required to respond, at minimum, to five critical tasks: (i) obtaining congressional approval, (ii) establishing a process for accreditation, (iii) forming an unbiased accreditation committee, (iv) setting the criteria governing accreditation, and (v) providing incentives for accreditation. The following sections seek to outline what such an agency might look like, including its structure, division of tasks, and the ways in which such an organization would further women's health.²¹³

3. Establishing a Structure

Ideally, the accreditation agency would be an independent, not-for-profit organization that has congressional approval to offer accreditation services to abortion clinics. Congress itself should determine whether authorization should be included in the Code of Federal Regulations, or if authorization should depend on reevaluation on an established schedule. For example, authorization could be contingent on a proven track record of ensuring that accredited abortion clinics comply with the agency's standards. Other independent, not-for-profit agencies already exist in such a relationship with Congress.²¹⁴

The agency itself might conceivably consist of a National Council, as well as fifty State Councils, under each of which operate two sub-committees: an Accreditation Committee and a Compliance Committee. The State Councils could be responsible for managing the two sub-committees, as well as investigating allegations of noncompliance and imposing sanctions for actual noncompliance. Each Accreditation Committee could be tasked with responsibility for the process of provisional approval, and each Compliance Committee could handle grants of full approval and ensure continuing compliance. The National Council could be tasked with setting the standards

quently_asked_questions.html (last visited Nov. 21, 2014) ("In many states, a person may not sit for the bar examination unless that person holds a J.D. degree from an ABA-approved law school.").

213 This Note conceives of an accreditation agency that governs "abortion clinics" generally, but which would take into consideration the procedures performed at a clinic when specifying facility requirements. It is unclear how Congress might define this term. This is an important caveat in light of recent legislation that does not distinguish between abortion clinics that provide surgical abortions and those that provide only medication abortions. See *supra* Section II.A; *infra* subsection III.B.5.

214 For example, SoundExchange is the only independent, not-for-profit agency that Congress authorized to administer statutory licenses and collect royalties on behalf of sound recording copyright holders, pursuant to 17 U.S.C. §§ 112, 114 (2012). *Licensing 101*, SOUND EXCHANGE, <http://www.soundexchange.com/service-provider/licensing-101/> (last visited Nov. 21, 2014). "The Copyright Royalty Board selects the Collective for each term at the applicable proceeding. SoundExchange is currently the only authorized Collective, through 2015." Email from Alex Reed, Senior Specialist, Licensee Relations, SoundExchange, Inc., to author (Oct. 31, 2013, 8:45 AM) (on file with author).

that abortion clinic facilities must meet, handling all appeals from State Council sanction decisions, and communicating directly with Congress.

An ideal National Council would be composed of qualified and reputable physicians who appreciate the respective risks attendant to medical and surgical abortion. The objective would be to formulate regulations premised on furthering women's health and safety—entirely separate from any political agendas. By utilizing qualified physicians to address health concerns, the resulting regulations are likely to be appropriate in scope and include requirements that will ensure safe procedures and safeguards in the event of a complication.

The composition of State Councils should mirror that of the National Council, a panel of reputable physicians. This neutrality and emphasis on medical expertise would be particularly critical in these higher-level oversight positions, which set the tone of the agency. The National Council, itself filled with medical experts, could select the State Council members. In turn, the State Council members could select those to serve on its Accreditation and Compliance Committees. The number of people on the State Council, Accreditation Committee, and Compliance Committee would likely vary in response to the number of clinics in each state, which would dictate the extent of personnel required for proper oversight.

4. Establishing a Process for Accreditation

Although it is true that law schools and medical facilities are quite different, the intricate ABA accreditation process provides a promising framework for a theoretical abortion clinic accreditation process. Importantly, ABA accreditation bifurcates the approval process into two distinct steps: provisional approval, during which the greatest amount of scrutiny occurs, and full approval, during which continued, but less frequent, oversight takes place.

Recognizing that the ABA does not have to deal with medical safety interests, the ABA provisional approval step requires three adjustments to fit the context of an abortion clinic accreditation agency. First, the abortion clinic accreditation process should likely begin *ex ante*, prior to receipt of any patients, rather than following the ABA *ex post* model, waiting until after at least one year of operation. In addition, the ABA model should likely be revised to only allow an abortion clinic to receive provisional approval if in full compliance with the accreditation standards, not merely substantial compliance. Lastly, in light of the fact that these two prior changes shift the burden onto the abortion clinic, the accreditation agency could be made to bear the burden of proving a clinic is *not* in compliance with the standards, rather than demanding the clinic also bear the burden of proving compliance. This arrangement strikes a balance of burdens between the two parties without compromising patient safety.

The remainder of the provisional approval process for the ABA maps well onto a theoretical abortion clinic accreditation agency's potential process. After receipt of an application for provisional approval, the Accredita-

tion Committee could assign a representative to perform a fact-finding site visit, after which the representative would then submit a report to the Accreditation Committee. The Committee would need to convene regularly to review applications and make decisions. In order to match the abortion clinic's interest in efficient Committee deliberation, the Committee should also have the discretion to amend the procedure's timeline in order to ensure it accounts for the demand for clinic oversight. Upon receipt of provisional approval, the abortion clinic would be permitted to open its doors to patients.

Also similar to the ABA accreditation process, abortion clinics would still be subject to substantial oversight during the time they have provisional approval. Accreditation Committee members would perhaps perform annual site visits, slightly more frequent than the ABA process but at scheduled times, thereby eliminating the concept of warrantless searches.²¹⁵ This again strikes a balance, furthering women's health by ensuring facilities are meeting the established standards, while simultaneously guaranteeing that oversight is not performed in a manner akin to harassment.

Even once a clinic obtains official accreditation, it could remain subject to subsequent Compliance Committee oversight and undergo site-evaluations at a scheduled time and date. At any time, however, patients should be able to file noncompliance complaints with the State Council, which could, at its discretion, launch an investigation of the clinic to ensure full compliance with the agency's standards. The State Council would also have the power of imposing sanctions on noncompliant clinics, up to and including revocation of accreditation. However, all State Council decisions would be subject to appeal to the National Council.

5. Setting the Criteria Governing Accreditation

As a preliminary move in setting the standards to which abortion clinics will be held, the National Council should bifurcate the standards into those that govern clinics performing surgical *and* nonsurgical abortions, and those governing clinics that only provide nonsurgical abortions. This division is critical in light of over-breadth challenges already undergoing judicial review today.²¹⁶ This separation alone will go far in ensuring facility standards are closely tied to the interest in promoting women's health.

The National Council should look to the NAF and Planned Parenthood guidelines to see what facility and training requirements those national federations require their clinics to possess. Simultaneously, the Council should look to current state guidelines for comparison and debate as to whether those regulations are sufficiently tightly connected to an interest in women's health to satisfy all parties.

²¹⁵ See generally Jorns, *supra* note 15 (discussing TRAP laws that allow for effectively warrantless searches of abortion clinic facilities).

²¹⁶ For a discussion of the lawsuit filed by Planned Parenthood of Indiana and Kentucky, see *supra* Section II.A.

Although this Note focused its efforts on ensuring that facility regulations promoted by an accreditation agency would be closely tied to the legitimate interest in women's health, it is possible that standards for other aspects of clinic regulation—qualification requirements for those performing abortions and general staff training, for example—could be developed by the National Council. Once the infrastructure of an accreditation agency is in place, it may prove to be the ideal method of regulating abortion clinics in all aspects, ensuring uniformity and good faith in the regulations it puts in place.

Relatedly, providing an incentive for abortion clinic accreditation is unnecessary if accreditation replaces individual state regulatory schemes. All abortion clinics will need to be accredited in order to open their doors to patients. Importantly, replacing individual state regulation with an accreditation agency would make certain that all abortion clinics performing the same procedures would be held to and meet the same standards, while simultaneously protecting abortion clinics nationwide from certain state regulations aimed at effecting closure rather than ensuring women's safety.

CONCLUSION

It is unlikely that a topic as polarizing as abortion can be addressed through legislation alone. However, growing fractures in abortion jurisprudence, particularly with respect to the role of practical considerations like cost and geography, may indicate a new means of regulation is preferable to the current regime. Accreditation by an independent, nonprofit entity offers a novel approach to ensuring a close nexus between abortion facility regulations and women's health, as well as guaranteeing uniformity in the quality of services women receive across the entire United States.