Abortion Surveillance

Anya E.R. Prince[*]

I. INTRODUCTION 606
II. TRACKING ABORTION & PUBLIC HEALTH 610
A. CDC Abortion Surveillance 610
B. The True Count 611
III. STATE ABORTION TRACKING LEGISLATION 614
A. Legislating Abortion Surveillance 614
B. Recent Legislative Trends 616
1. State Participation in Abortion Reporting 616
2. Increased Reporting of Abortion Complications 619
3. Incidental Data Collection 623
IV. BALANCING PRIVACY AND PUBLIC HEALTH 627
A. Privacy and Public Health Imperatives 627
B. Privacy Risks 629
V. SHORING UP PRIVACY IN ABORTION SURVEILLANCE 632
A. Government collection of information 633
1. Purpose to promote public health 633
2. Reporting requirements tailored to this purpose 636
B. Confidentiality of Information Collected 639
1. Aggregate Reporting 639
2. Limited Public Access 640
3. Insulation from use in investigations/prosecutions 642
4. Protections for providers 644

---

[*] Professor & Joseph F. Rosenfield Fellow in Law, University of Iowa College of Law; Thank you to the many people who provided feedback on drafts of this paper, including the faculty of Iowa Law and Cornell Law and the members of the Reproductive Rights/Reproductive Justice workshop group. Thank you in particular to Jolynn Dellinger and Laura Lindberg for helpful comments and to Lauren Stubbs for research assistance.

5. Reexamine any reporting requirements..... 645
C. Illinois as a Case Example..... 645

I. INTRODUCTION

Data are powerful. They can be used to sway public opinion and provide the necessary findings to research the impacts of legal and policy changes.[1] The impact and leveraging of data is especially poignant in reproductive health and policy.[2] Following *Roe v. Wade*, public health tracking of abortion incidence helped to prove the safety and effectiveness of abortion procedures.[3] Now, in the wake of *Dobbs v. Jackson Women's Health Organization,* abortion-related data is once again in the spotlight, as advocates both for and against abortion seek to paint a picture of how abortion policy is impacting public health and access to pregnancy termination.[4]

Assessing the number of abortions is a particularly salient and fraught task.[5] Most states have historically collected statistics as part of national public health abortion surveillance.[6] This nation-wide system of data collection has been integral to public health research on reproductive health. But counting abortions following *Dobbs*, has become an increasingly contested project. For example, recent reporting from several abortion-restrictive states claims that there were zero or just a handful of abortions performed within the states in 2023—the latest year for which such official reports are available.[7] Researchers, policymakers, and activists on both side of the abortion debate acknowledge that these numbers are incorrect.[8] The statistics fail to take into account telehealth or self-managed abortion or abortions that are occurring in the state which providers may be fearful to

---

[1] Shiva Darian et al., *Competing Imaginaries and Partisan Divides in the Data Rhetoric of Advocacy Organizations*, 7 PROC. ACM HUM. COMPUT. INTERACT. 259:1 (2023) (discussing how advocacy organizations leverage data to shape public opinion).

[2] *See, e.g.*, Sherry L. Pagoto et al., *The Next Infodemic: Abortion Misinformation*, 25 J. MED. INTERNET RSCH. e42582 (2023).

[3] *See infra* Section II.A.

[4] *See, e.g.*, Pam Belluck & Emma G. Fitzsimmons, *Abortion Data Wars: States and Cities Debate How Much Information to Collect*, N.Y. TIMES (Apr. 23, 2024), https://www.nytimes.com/2024/04/23/health/abortion-patient-data-privacy.html (on file with author).

[5] *Id.*

[6] *See infra* Section II.A.

[7] Sarah Varney, *Some Red States Report Zero Abortions. Doctors and Researchers Say It's Not True*, NPR (Feb. 13, 2025), https://www.npr.org/sections/shots-health-news/2025/02/13/nx-s1-5293523/abortion-data-states-bans [https://perma.cc/BV2Z-3363].

[8] *Id.*

report.[9] Yet, the state reports carry a veneer of officiality that impacts how people view the issue.[10]

Abortion data are also extremely personal. Public health abortion surveillance programs reach into private provider-patient relationships to collect information. Although the data collected and publicly reported generally do not include patient names, there remain privacy risks for both patients and providers alike.[11] In general, the United States privacy regime recognizes that this privacy infringement can be justified when the data is used to meet public health goals.[12] Yet, in a time of severe abortion restrictions across states and increases in criminalization of those who are pregnant[13] any potential for tracking abortion raises alarm bells. There is a fear that records of abortions could open patients and providers to investigation, harassment, and legal or criminal liabilities.[14]

This is all the more a concern when abortion data are increasingly being politicized and manipulated.[15] For example, data collection is an integral aspect of Project 2025, the Heritage Foundation's conservative roadmap for the second Trump presidency.[16] The document recommends that states should be required to report to the Centers for Disease Control and Prevention (CDC) abortions that take place within the state or risk losing federal Medicaid funding for family planning services.[17] However, the document goes on further noting that statistics should be separated by category: "spontaneous miscarriage; treatments that incidentally result in the death of a child (such as chemotherapy); stillbirths; and induced abortion," highlighting that all pregnancy loss would be monitored and tracked under

---

[9] *Id.*

[10] *Id.*

[11] *See infra* Section IV.B.

[12] *See infra* Section III.A. One of the challenges of politicization of abortion tracking, of course, is that all sides use language regarding the goals of public health, even when proposing changes that would problematically increase surveillance and sew distrust regarding abortion data. *See* HERITAGE FOUND., MANDATE FOR LEADERSHIP: THE CONSERVATIVE PROMISE 455 (Paul Dans & Steven Groves eds., 2024) [Hereinafter "THE CONSERVATIVE PROMISE"] (stating that "[a]ccurate and reliable statistical data about abortion, abortion survivors, and abortion-related maternal deaths are essential to timely, reliable public health and policy analysis.").

[13] WENDY A. BACH & MADALYN K. WASILCZUK, PREGNANCY AS A CRIME: A PRELIMINARY REPORT ON THE FIRST YEAR AFTER DOBBS, PREGNANCY JUSTICE (Sept. 2024) (identifying 210 prosecutions related to pregnancy, pregnancy loss, or birth in the year following Dobbs—the most in a single year since the organization began tracking in 1973).

[14] *See infra* Section IV.A.

[15] Pagoto et al., *supra* note 2 (discussing dis- and mis- information surrounding abortion following the reversal of *Roe v. Wade*); *see also* Belluck & Fitzsimmons, *supra* note 4.

[16] THE CONSERVATIVE PROMISE, *supra* note 12.

[17] *Id.* at 455–56.

Project 2025's vision.[18] Indeed, Jessica Valenti of Abortion, Every Day, argues that "[d]ata collection has become one of the fastest-growing anti-abortion strategies since *Roe* was overturned."[19]

Data are a powerful tool to mold public opinion and, depending on how data are packaged and presented, can be used by opposing groups to advocate for their particular positions.[20] Given this, both reproductive rights and anti-abortion organizations and policymakers have sought to control the post-*Dobbs* narrative about abortion—who is having abortions, how safe the procedures are, and what the impacts are of bans on abortion.[21] For example, one manifestation of these efforts has been reporting on increases in maternal mortality and morbidity following *Dobbs*[22] and subsequent responses from anti-abortion states to limit the collection and dissemination of data that report on maternal mortality post-*Dobbs*.[23]

Specific to abortion tracking, there have been two concurrent trends that point to a problematic data future.[24] First, there is a concerted effort across the nation to increase reporting on abortion complications, despite decades of evidence proving the safety of abortion procedures and medications.[25] Legislation increasing complications reporting is concentrated in abortion-restrictive states. Second, concerns of politicization and weaponization of abortion data have led several abortion-supportive states to consider a halt of their public health surveillance programs.[26] Just recently, the Guttmacher

---

[18] *Id.* at 455.

[19] Jessica Valenti, *Project 2025 & Abortion*, ABORTION, EVERY DAY (July 30, 2024), https://jessica.substack.com/p/project-2025-abortion-explainer [https://perma.cc/7RRX-JV9F].

[20] Darian et al., *supra* note 1 (discussing how advocacy organizations leverage data to shape public opinion).

[21] Pagoto et al., *supra* note 2 (discussing dis- and mis- information surrounding abortion following the reversal of *Roe v. Wade*); *see also* Belluck & Fitzsimmons, *supra* note 4.

[22] Lizzie Presser et al., *Texas Banned Abortion. Then Sepsis Rates Soared.*, PROPUBLICA (Feb. 20, 2025), https://www.propublica.org/article/texas-abortion-ban-sepsis-maternal-mortality-analysis [https://perma.cc/FD5R-XQU3]; Melody Schreiber, *'One Death is Too Many': Abortion Bans Usher in US Maternal Mortality Crisis*, GUARDIAN (Sept. 25, 2024), https://www.theguardian.com/world/2024/sep/25/abortion-bans-healthcare-maternal-mortality [https://perma.cc/FL8V-2GQZ].

[23] Eleanor Klibanoff, *Texas' Maternal Mortality Committee Faces Backlash for Not Reviewing Deaths from First Two Years Post-*Dobbs, TEX. TRIBUNE (Dec. 6, 2024), https://www.texastribune.org/2024/12/06/texas-maternal-mortality-committee-deaths/ [https://perma.cc/Y39T-NX5E]; Anna Claire Vollers, *Maternal Death Reviews Get Political as State Officials Intrude*, STATELINE (Jan. 15, 2025), https://stateline.org/2025/01/15/maternal-death-reviews-get-political-as-state-officials-intrude/ [https://perma.cc/H2ZQ-PSZU].

[24] *See infra* Section III.B.

[25] *See infra* Section III.B.2.

[26] *See infra* Section III.B.1.

Institute, a leading abortion research and policy non-profit, took the position that states should end their mandated abortion reporting or, at the very least, reform their current systems.[27] Taken together, these trends lay the groundwork for a data mirage that seemingly shows that abortion incidence are decreasing while complications from abortion procedures and medication are increasing.[28] These incomplete data can then be further politicized to advocate for increasingly draconian restrictions on legal abortions.

What should be done about the tensions between public health goals, privacy, and politicization of abortion data? Have abortion statistics been so politicized that state governments should no longer have a role in surveilling abortion rates? Do privacy risks of a post-*Dobbs* world outweigh any public health benefit of tracking abortion? While the competing interests of privacy and public health are difficult to balance, especially in a politicized environment, this article argues that states should continue to surveil abortion rates but should shore up privacy protections of the information. This recommendation comes with an acknowledgement of the on-the-ground practical, but unfortunate, reality that states where the most privacy is needed due to extreme abortion restrictions are the least likely to limit tracking or increase privacy of the data in any way. To the extent that there is an opportunity to eliminate abortion surveillance in an abortion-restrictive state, this option should be seriously considered.

To defend this argument, Section II discusses the history of tracking abortions for public health surveillance and explains the gaps and challenges of these efforts. Section III lays out the regulatory and statutory framework that allows for public health reporting of private medical information and highlights several recent legislative proposals regarding abortion reporting since the *Dobbs* decision, including decisions whether to track, reporting of abortion complications, and incidental collection. Section IV imagines a problematic reality if abortion-supportive states limit abortion tracking while abortion-restrictive states increase reporting requirements for abortion complications. It also considers the likely on the ground privacy risks of abortion surveillance data. Given the current relatively low individual privacy risk in comparison to the public health benefits of access to aggregate data, Section V provides recommendations to bolster the privacy of abortion tracking to maintain a balance between public health goals and essential reproductive privacy.

---

[27] Kelly Baden & Joerg Dreweke, *With Risks to Patients and Providers Growing, States Should Revisit Abortion Reporting Requirements*, GUTTMACHER INST. (Mar. 12, 2025), https://www.guttmacher.org/2025/03/risks-patients-and-providers-growing-states-should-revisit-abortion-reporting-requirements [https://perma.cc/2S6E-2MYV].

[28] *See infra* Section IV.A.

II. TRACKING ABORTION & PUBLIC HEALTH

For decades prior to *Dobbs* abortions across the United States have been tracked in various ways—and for good reason. Reliable and accurate data on abortions can help researchers evaluate who are obtaining abortions, barriers to access, and the potential health impacts of abortion.

A. CDC Abortion Surveillance

Abortion tracking at the federal level began as early as 1969, when the CDC began to compile data voluntarily provided by the states.[29] This tracking coincided with the increasing prevalence of legal abortions and the decreasing criminalization of abortion leading up to *Roe v. Wade* in 1973.[30] "Because of the inevitable controversy that would surround this issue, public health leaders needed to obtain accurate and complete information on the epidemiology of women choosing this procedure, as well as on the morbidity and mortality occurring during the transition from predominantly illegally induced to mostly legally induced abortions."[31]

This 'Abortion Surveillance', as it is called by the CDC[32], allows assessment of trends in rates of abortions, characteristics of those seeking abortion, and method utilized.[33] The CDC gathers abortion data via the U.S. Standard Report of Induced Termination of Pregnancy, which requests information such as the facility name, patient demographics (i.e. race, ethnicity, age, and marital status), and patient zip code.[34] Forty-eight states and territories have participated in the reporting in recent years.[35] Tracking

---

[29] *CDC's Abortion Surveillance System FAQs*, CDC (May 15, 2024), https://www.cdc.gov/reproductive-health/data-statistics/abortion-surveillance-system.html [https://perma.cc/88VQ-2Y5U].

[30] Willard Cates et al., *Abortion Surveillance at CDC: Creating Public Health Light Out of Political Heat*, 19 AMER. J. PREV. MED. 12, 12 (2000).

[31] *Id.*

[32] In the public health context, 'surveillance' is a word with positive connotation, indicating the tracking of a disease for important health goals. However, the term is likely to raise alarm bells amongst the lay public who think about surveillance differently in the context of reproductive rights and criminal investigations. *See* Jill Wieber Lens, *Counting Stillbirths*, 56 UC DAVIS L. REV. 525, 582 (2022).

[33] KATHERINE KORTSMIT ET AL., CDC, ABORTION SURVEILLANCE – UNITED STATES, 2021 4 (2023), http://dx.doi.org/10.15585/mmwr.ss7209a1 [https://perma.cc/ZCZ2-K9VX].

[34] U.S. DEP'T OF HEALTH AND HUMAN SERVICES, HANDBOOK ON THE REPORTING OF INDUCED TERMINATION OF PREGNANCY app. at 15 (1988), https://www.cdc.gov/nchs/data/misc/hb_itop.pdf [https://perma.cc/GQ9V-U58A].

[35] California, Maryland, New Hampshire, and New Jersey do not provide data to the CDC, but the District of Columbia and New York City do, leading to 48 reporting entities. KORTSMIT ET AL., *supra* note 33.

over time has provided insights that abortions are generally occurring at earlier gestational ages and have shifted from hospital facilities to free-standing clinics to telehealth abortions.[36] It also provides evidence of the safety of abortion. For example, between 2013–2020, 0.45 legal induced abortions resulted in death per 100,000 procedures.[37] Public tracking of abortion in the days post-*Roe* was also vital in understanding the public health benefits of increasing access to safe, legal abortion, as the early CDC data showed a dramatic reduction in mortality from abortion as individuals shifted from accessing illegal abortion to legal abortion.[38]

B. The True Count

Although the CDC has tracked abortion statistics now for decades, pinpointing the actual total number of abortions in the United States is extremely difficult, and increasingly so.[39] There are several reasons for this difficulty.

First, the CDC abortion surveillance is voluntary—there is no federal law that requires abortion reporting.[40] Thus, the CDC data is incomplete. Several states, California, Maryland, New Hampshire, and New Jersey[41], have historically not tracked and reported abortion data to the agency.[42] Thus,

---

[36] Cates et al., *supra* note 30, at 13 (finding that women seeking abortions "did so at progressively earlier gestational ages" and that in 1973 most abortions were performed in a hospital, but by the mid-1990s, more than 90% of procedures were done in free-standing clinics); Rachel K. Jones & Amy Friedrich-Karnik, *Medication Abortions Accounted for 60% of All US Abortions in 2023 – An Increase from 53% in 2020*, GUTTMACHER INST. (Mar. 2024), https://www.guttmacher.org/2024/03/medication-abortion-accounted-63-all-us-abortions-2023-increase-53-2020 [https://perma.cc/6BDY-W4Z2].

[37] KORTSMIT ET AL., *supra* note 33. The low rates of complications (morbidity) of abortion procedures are, in part, due to improvements in methods identified from early tracking of the safety of various types of procedures used. Cates et al., *supra* note 30, at 14 (highlighting the shift from for pregnancies post 13-weeks gestation, the dilation and evacuation (D&E) was safer than a previously more commonly used intrauterine instillation procedure).

[38] Cates et al., *supra* note 30, at 15.

[39] J. Jackson Hill, *A Call for Better Abortion Data: Common Ground Amid* Dobbs *and the Abortion Debate*, 55 LOY. U. CHI. L.J. 175, 177 (2023).

[40] Jeorg Dreweke, *Abortion Reporting: Promoting Public Health, Not Politics*, 18 GUTTMACHER POLICY REV. 40, 41 (2015); Hill, *supra* note 39, at 178; *but see infra* Section III.B.1. (discussing recent proposals to create mandated reporting at the federal level).

[41] New Jersey had reported abortion data as recently as 2020, but did not report any data in 2021 or 2022, the latest years of CDC data. STEPHANIE RAMER ET AL., CDC, ABORTION SURVEILLANCE – UNITED STATES, 2022 (2024), https://www.cdc.gov/mmwr/volumes/73/ss/ss7307a1.htm [https://perma.cc/WP9X-CZWD]. Reporting of abortions by health care providers in New Jersey is voluntary, so that could impact the data to be subsequently reported to the CDC. It is not immediately clear why New Jersey stopped reporting in 2021.

[42] Hill, *supra* note 39, at 178. California and Maryland do not have any reporting, whereas New

even as the numbers of abortions in these states is expected to increase as neighboring states restrict the procedures, the statistics of this shift will not be readily known from CDC data.[43] Additionally, in the states that do provide reports to the CDC, reported data is variable and has missing values.[44]

Given the known gaps in the CDC reporting, many turn to the Guttmacher Institute.[45] The Guttmacher Institute arguably has more comprehensive data on abortions than the CDC because it collects data directly from abortion facilities across all 50 states.[46] The Guttmacher Institute undertakes an Abortion Provider Census every three years, where it sends surveys and conducts follow-ups with health facilities providing abortion care.[47] When there is non-response, the Guttmacher researchers estimate the number of abortions from other data sources, including, historically, the CDC surveillance data.[48] Since the *Dobbs* decision, the Guttmacher Institute has also implemented a Monthly Abortion Provision Study that uses sampling data to generate statistical models of the number of abortions each month.[49] #WeCount is another effort by the Society of Family Planning that conducts a monthly survey of abortion providers to track trends in abortions.[50] By focusing on providers rather than facilities, #WeCount claims to be "the only effort that reports the total number of

Hampshire has voluntary reporting by providers, but does not pass on that information to the CDC. Dreweke, *supra* note 40, at 42; *but see infra* Section III.B.1. (discussing Michigan's recent decision to also stop their abortion surveillance program).

[43] *See, e.g.*, Kristen Hwang, *California Fails to Collect Basic Abortion Data – Even as it Invites an Out-of-State Influx,* CALMATTERS (June 27, 2022, 2:02 PM), https://www.kpbs.org/news/local/2022/06/27/california-fails-collect-basic-abortion-data-invites-out-of-state-influx [https://perma.cc/YKG2-QX7Z] (discussing California's lack of abortion reporting).

[44] RAMER ET AL., *supra* note 41 (noting that, "[t]he reporting of abortion data to CDC is voluntary, and many reporting areas have developed their own data collection forms and might not collect or provide all the information requested by CDC.").

[45] There are significant differences in the number of abortions estimated between the two sources. For example, in 2020, the estimates had counting differences of over 300,000 abortions and the CDC reporting decreasing rates of abortions whereas the Guttmacher Institute reported increasing rates of abortion. Hill, *supra* note 39, at 196–97.

[46] Dreweke, *supra* note 40, at 43 (noting that the Guttmacher data is "routinely recognized as the most reliable."); Rachel K. Jones et al., *Abortion Incidence and Service Availability in the United States, 2020*, 54 PERSP. ON SEXUAL & REPROD. HEALTH 128, 129–30 (2022).

[47] Jones et al., *supra* note 46. This survey data is additionally supplemented by data from state health departments.

[48] *Id.* This is a strategy that is distinct from the CDC, which does not estimate gaps in data. Hill, *supra* note 39, at 198.

[49] *Monthly Abortion Provision Study: US Abortion Data Dashboard*, GUTTMACHER INST., https://www.guttmacher.org/monthly-abortion-provision-study#methodology [https://perma.cc/98KN-Q7KV].

[50] SOC'Y OF FAM. PLAN., #WECOUNT REPORT 25 (Oct. 22, 2024). As with the Guttmacher Institute, #WeCount also imputes data (19%) when it is missing from abortion providers.

abortions provided via telehealth by state and month."[51]

Second, the 'true' number of abortions in the country is becoming increasingly difficult to track, largely due to self-managed abortions. Self-managed abortions are pregnancy terminations occurring outside the healthcare system.[52] As states restrict abortion following *Dobbs*, those who are pregnant may increasingly turn to self-managed options, such as ordering abortion pills from overseas distributors.[53] As rates of these extra-legal methods rise, it will be increasingly difficult to accurately measure how many abortions occur.[54]

Third, the politicization and stigmatization of abortion also add to the difficulties of accurately counting abortions through other commonly used research methodologies. For example, many researchers studying healthcare utilization turn to billing claims; however, these data are limited for abortion services due to the prohibition on spending federal dollars, including Medicaid funding, on abortions.[55] Similarly, historically there has not been extensive prescription data on abortion because FDA regulations required

---

[51] *Id.* at 26.

[52] *See generally* Yvonne Lindgren, *When Patients are their own Doctors: Roe v. Wade in an Era of Self-Managed Care*, 107 CORNELL L. REV. 151 (2022); In addition to self-managed abortions, an increasing number of abortions are provided via telehealth—many occurring with the provider and patient in different states. *See, e.g.*, Sareen Habeshian, *Abortions up Nationally, Largely Due to Telehealth*, AXIOS (Oct. 22, 2024), https://www.axios.com/2024/10/22/abortions-us-2024-telehealth-report (on file with author). These telehealth abortions are occurring within the healthcare setting, so they are more likely to be counted than self-managed abortions, but the differing avenues for accessing abortions complicate abortion tracking.

[53] Claire Cain Miller & Margot Sanger-Katz, *The (Incomplete) Revolution in Counting Abortions*, N.Y. TIMES (Dec. 8, 2022), https://www.nytimes.com/2022/12/08/upshot/abortion-roe-dobbs-drugs.html (on file with author)

[54] *See, e.g.*, Abigail R.A. Aiken et al., *Requests for Self-Managed Medication Abortion Provided Using Online Telemedicine in 30 States Before and After the* Dobbs v. Jackson Women's Health Organization *Decision*, 328 JAMA 1768 (2022) (analyzing anonymous requests for medication from the nonprofit Aid Access, but not tracking the number of requests filled or number of medical abortions completed); *see* SOC'Y OF FAM. PLAN., #WECOUNT REPORT 27 (Oct. 22, 2024) (noting that while they measure abortion medication provided by telehealth, they can't capture abortions happening outside the healthcare setting and do not have data on whether the medications were actually ingested); Aieken et al., *Safety and Effectiveness of Self-Managed Medication Abortion Provided using Online Telemedicine in the United States: A Population Based Study,* 10 THE LANCET 1, 4 (2022) (finding that, in one study, 88% of individuals who were mailed medication abortion from Aid Access used the medications). In addition to accurately measuring the count of abortions, changes in how individuals receive abortion care will necessitate changing how related outcomes, such as abortion access, are measured. Tracy A. Weitz & Jenny O'Donnell, *The Challenges in Measurement for Abortion Access and Use in Research Post*-Dobbs, 33 WOMEN'S HEALTH ISSUES 323, 323–24 (2023) (noting that traditional measures, such as distance to an abortion provider, are not adequate measures of access in an era of telehealth and self-managed abortions).

[55] Weitz & O'Donnell, *supra* note 54, at 324.

mifepristone to be dispensed in-person, directly to the patient.[56] Population surveys are an additional mainstay for researchers. However, studies have identified significant underreporting of abortion rates by individuals filling out the questionnaires, in part due to the stigma associated with abortion.[57] It is likely that the increasing legal restrictions and criminalization of abortion will exacerbate these levels of underreporting in population surveys and surveys of organizations who assist with abortions or abortion access.[58]

Despite the challenges of identifying the true rate of abortions, there is also promise in how much data is collected. Some argue that because of efforts like the CDC and Guttmacher, we know more about abortions than any other medical operation.[59] Thus, overall, efforts to count abortions have provided important data for public health and policy researchers, although there are limitations and improvements that could be made in the reporting.[60]

III. STATE ABORTION TRACKING LEGISLATION

Governmental abortion tracking is governed by statute, is done without patient consent and, most likely, without patient knowledge. This section highlights the statutory and regulatory frameworks that allow for information sharing of private medical procedures and discusses recent trends regarding state tracking systems.

A. Legislating Abortion Surveillance

Although public health surveillance of disease and medical conditions is commonplace today, it is important to remember the baseline—that healthcare is a private relationship between a physician and their patient and

---

[56] *Id.* These rigid regulations were recently eased, allowing for telehealth prescriptions of abortion medications. *Information About Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation*, FDA (Mar. 23. 2023), https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/information-about-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation [https://perma.cc/PFB7-G42S].

[57] Laura Lindberg et al., *Abortion Reporting in the United Sates: An Assessment of Three National Fertility Surveys*, 57 DEMOGRAPHY 899, 901, 918 (2020) (noting that abortion stigma leads to underreporting of abortions in surveys of individuals and finding that participants in prominent surveys reported only 30–40% of estimated rates of abortion).

[58] Weitz & O'Donnell, *supra* note 54, at 325 (explaining that "[t]he challenge of collecting abortion data via population-level surveys is made even more difficult by the reality that many people will now be asked to report on activity that may be criminalized in the state in which they live.").

[59] Dreweke, *supra* note 40, at 46.

[60] *See, e.g.*, SOC'Y OF FAM. PLAN., #WECOUNT REPORT 29 (Oct. 22, 2024) (noting that abortion counts alone miss complex details, such as delays in care and whether/how policy is impacting their decisions and whether their pregnancy outcomes align with their preferences).

government intrusion into this relationship imposes upon this privacy.[61] Thus, one level of invasion into personal informational privacy is the very act where the government gathers medical information without consent.[62] The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule reflects this normative baseline. HIPAA begins with the premise that all health information collected within the healthcare setting must be kept confidential.[63] It then delineates specific categories when health information can be shared without patient authorization,[64] including for public health activities that have been authorized by law.[65]

To this end, each state that participates in abortion surveillance has its own legislation or regulation specifying what data should be collected and how confidentiality will be protected.[66] According to the Guttmacher Institute, forty-six states and the District of Columbia have laws that require abortion providers to report to the state.[67] Abortion surveillance generally begins with hospitals, clinics, and physicians submitting individual level, but deidentified[68], reports to a designated agency, often the state public health department or vital statistics agency.[69] The information collected often

---

[61] Wendy K. Mariner, *Mission Creep: Public Health Surveillance and Medical Privacy*, 87 B.U. L. REV. 347, 375–76 (2007) (noting common law and statutory requirements of privacy and confidentiality between and physician and patient).

[62] *Id.* at 388.

[63] 45 C.F.R. § 164.502(a) (2025) ("A covered entity or business associate may not use or disclose protected health information, except as permitted or required by this subpart . . .").

[64] 45 C.F.R. § 164.512 (2025).

[65] 45 C.F.R. § 164.512(b)(1)(i) (2025).

[66] *See, e.g.*, Rebekah Saul, *Abortion Reporting in the United States: An Examination of the Federal-State Partnership*, 30 FAM. PLAN. PERSPECTIVES 244 (1998) (discussing abortion reporting laws by jurisdiction).

[67] *Abortion Reporting Requirements*, GUTTMACHER INST. (Sept. 1, 2023), https://www.guttmacher.org/state-policy/explore/abortion-reporting-requirements [https://perma.cc/3WZG-9KUM] [hereinafter GUTTMACHER Abortion Reporting Requirements]. For a detailed breakdown of these reporting requirements, see Temple University Center for Public Health Law Research, *Abortion Reporting Requirements*, LAWATLAS (Nov. 1, 2022), LawAtlas.org/datasets/abortion-reporting-requirements [https://perma.cc/AYY8-8ZH9] [hereinafter LAWATLAS Abortion Reporting Requirements]. The jurisdictions without state-level reporting requirements are California, Maryland, Michigan, and New Jersey. GUTTMACHER Abortion Reporting Requirements, *supra* note 67.

[68] This paper uses the term deidentified to refer to reports that do not include patient names. *See, e.g.*, Lea Kissner, *Deidentification versus Anonymization*, IAPP (June 18, 2019), https://iapp.org/news/a/de-identification-vs-anonymization [https://perma.cc/S7BK-RU36]. Many of the abortion reporting laws require that no identifying information be included in abortion reports. *See* LAWATLAS Abortion Reporting Requirements, *supra* note 67.

[69] Dreweke, *supra* note 40, at 42; *see also Abortion Reporting*, ELEC. FRONTIER FOUND., https://www.eff.org/issues/abortion-reporting?language=en [https://perma.cc/TS7M-4X8M] (noting that abortion reports go to either the public health agency or vital statistics department). Several states collect aggregate reports, as opposed to individual-level reports,

mirrors the CDC's template, the U.S. Standard Report of Induced Termination of Pregnancy[70], although there is some variability in what data points are collected in each state.[71] The state agencies then report the aggregate data, without the individual level reports, to the CDC[72] and sometimes on their own state websites.[73]

B. Recent Legislative Trends

Abortion surveillance laws existed well before the *Dobbs* decision, but changes to these systems have continued to be proposed in recent years. This section highlights three types of state abortion surveillance legislation that have been proposed or passed in the years since *Dobbs*—laws regarding state participation in CDC abortion reporting, statutes that increase reporting of abortion complications, and laws that govern abortions and incidentally increase tracking through paperwork requirements. These laws are by no means unique to the post-*Dobbs* era. They follow trends that have been in place for years. However, post-*Dobbs* legislation implicating abortion reporting or increasing the tracking of abortions must be reviewed in a new light given the increased risks to providers and patients when sensitive data is collected and shared.

1. State Participation in Abortion Reporting

The *Dobbs* decision has renewed debates about whether states should mandate abortion reporting and participate in the CDC surveillance at all. For example, at the very end of the legislative session in 2024, New Hampshire Republicans introduced legislation that would mandate abortion reporting in the state.[74] As discussed, New Hampshire is one of three states that has not historically provide abortion statistics to the CDC surveillance. The bill would have required abortion providers to report the date and place of the abortion performed, the age of the pregnant individual, their state of residence, the abortion method used, including whether any prescriptions were written, and the gestational age at the time of the abortion.[75] This

---

from providers. Stanley K. Henshaw, *Birth and Abortion Data*, WELFARE REFORM ACAD. 53 (June 2001).

[70] Dreweke, *supra* note 40, at 42.

[71] Saul, *supra* note 66; *see also* GUTTMACHER Abortion Reporting Requirements, *supra* note 67.

[72] Dreweke, *supra* note 40, at 42.

[73] *See, e.g.*, *Abortion Statistics: Induced Pregnancy Terminations in Illinois by Year*, ILL. DEP'T OF PUB. HEALTH, https://dph.illinois.gov/data-statistics/vital-statistics/abortion-statistics.html ://perma.cc/8EEX-W57M].

[74] S.B. 461, Reg. Sess. (N.H. 2024).

[75] *Id.* § 2.

information would be reported to the state Department of Health and Human Services and published annually.[76] The partisan bill passed the Senate with only Republican support, but did not gain any traction in the House. The New Hampshire Senate Democrats did not support the bill because there was not clarity in the level of detail regarding the location of abortion providers, opening them up to potential harassment, and there wasn't detail in how gestational age would be measured.[77] Proponents were worried that the bill would be read to require that gestational age be assessed via an ultrasound, adding a potentially unnecessary and invasive procedure to the process.[78] Abortion advocates in the state highlighted the lack of trust regarding the true purposes of any reporting law. For example, a Planned Parenthood representative noted, "We are always willing to work with lawmakers who want to collect abortion statistics for legitimate epidemiological purposes, however, Planned Parenthood of Northern New England was not asked for any input on this amendment, nor was there a public hearing . . . ."[79]

In Michigan in 2024, state legislators opted to end their decades long reporting of abortion incidence.[80] The changes to the reporting requirements were part of a broader abortion rights legislation that also did away with the state's existing laws, known as TRAP laws, that targeted abortion providers and enforced excessive requirements unrelated to public health, such as onerous licensing requirements for abortion clinics.[81] Some likewise viewed the state reporting mandate as burdensome administrative requirements that

---

[76] *Id.* § 3.

[77] Todd Bookman, *Abortion Data Collection Bill Latest Flare up over Reproductive Rights in NH*, N.H. PUBLIC RADIO (Apr. 18, 2024), https://www.nhpr.org/nh-news/2024-04-18/abortion-data-collection-bill-latest-flare-up-over-reproductive-rights-in-nh [https://perma.cc/QW8X-DSC8]; *see also* Annmarie Timmins, *NH Bill Would Require State to Collect Abortion Statistics*, SEACOASTONLINE (Apr. 5, 2024), https://www.seacoastonline.com/story/news/2024/04/05/nh-bill-abortion-statistics/73204146007/ [https://perma.cc/CV2C-KGLW] (noting that it was unclear whether the location of the provider would be reported as their specific practice location or their city/county).

[78] Bookman, *supra* note 77. This concern is not far-fetched, as other abortion reporting legislation has proposed to require that an ultrasound be completed to assess gestational age. S.B. 20, § 91-21.93(b)(6) (N.C. 2023) (enacted). Transvaginal, as opposed to abdominal, ultrasound is more accurate early in pregnancy, so there are concerns that these bills would require the more invasive transvaginal ultrasound.

[79] Timmins, *supra* note 77 (quoting the vice president of public affairs for Planned Parenthood of Northern New England).

[80] Robin Erb, *How Many Abortions in? The State Can't Say Under New Law*, MICH. HEALTH WATCH BRIDGE MICH. (June 11, 2024), https://www.bridgemi.com/michigan-health-watch/how-many-abortions-michigan-state-cant-say-under-new-law [https://perma.cc/V73W-9QSE].

[81] H.B. 4949, 102nd Leg., (Mich. 2023). TRAP laws are Targeted Restrictions on Abortion Providers (TRAP), which were meant to impose burdensome regulations on abortion providers in order to limit their ability to provide services.

are not similarly imposed on other medical procedures, such as colonoscopies.[82] The reporting law in Michigan required providers to report details such as the patient's age, race, pregnancy history, and marital status, their city and county, the facility and provider who performed the abortion, the method of abortion, how it was paid for, and whether there were any immediate complications.[83]

Proponents on both sides of the abortion debate expressed surprise at the reversal of state mandated reporting of abortion numbers.[84] Those against abortion argued that the loss of reporting is concerning, particularly because rates of complications will become unknown.[85] Abortion providers made clear that they would continue to track many details regarding abortions they perform for their own internal information and to provide to other organizations, such as the Guttmacher Institute.[86] However, some public health researchers are concerned with losing important state and federal data for several reasons. For example, government collected data can be seen as official and potentially more persuasive, especially within a state context. Additionally, the Guttmacher reporting does not include some important demographic variables, such as race and ethnicity—essential datapoints for understanding health disparities. Thus, decreased state collection could impact robust data overall if more states follow the path of Michigan. This would be especially pronounced if abortion-protective states become more likely not to report statistics, just as they are performing increased numbers of abortions due to individuals traveling from restrictive states to access care.[87]

The recent legislative activity of New Hampshire and Michigan foreshadow that states may increasingly debate the merits of abortion surveillance regimes in their jurisdictions. Indeed, there were calls for a similar bill to be introduced in the 2025 Arizona legislative session that would stop abortion reporting in the state.[88]

---

[82] Erb, *supra* note 80; *see also Senate Democrats Expand Reproductive Healthcare Through Passage of Reproductive Health Act*, MICH. SENATE DEMOCRATS (Oct. 19, 2023), https://senatedems.com/chang/2023/10/19/reproductive-health-act [https://perma.cc/Y96K-9GWM].

[83] PUB. HEALTH CODE ACT 368 OF 1978 § 333.283 (Mich. 1978).

[84] Erb, *supra* note 80.

[85] *Id.*; *see infra* Section III.B.2. (discussing increasing anti-abortion focus on tracking abortion complications).

[86] Erb, *supra* note 80. Some invasive patient details however, such as marital status, will no longer need to be collected by the health care facilities. *Id.*

[87] *See infra* Section IV.A. for a discussion on the potential impacts to the data landscape if widespread data collection practices shift.

[88] Associated Press, *Arizona Governor Calls for Repeal of State Law Requiring Annual Abortion Report*, GUARDIAN (Dec. 18, 2024), https://www.theguardian.com/us-news/2024/dec/19/arizona-

However, under the second Trump Administration, states may no longer meaningfully be able to make the choice of whether or not to report abortion statistics. Project 2025 advocates for the passage of a law that would condition federal Medicaid dollars for family planning services on reporting certain abortion statistics to the CDC.[89] This recommendation is modeled after a Congressional bill, introduced in 2023, that would have established a federal mandatory reporting system for abortion statistics.[90] The bill proposes a list of mandatory variables and gives the CDC the power to add voluntary variables and to recategorize variables as mandatory over time.[91] Mandatory variables included in the bill are: maternal age, race, ethnicity, race by ethnicity, marital status, and residence (county and state), as well as history of previous pregnancies (including number of live births, abortions, and miscarriages), gestational age, abortion method used, and "whether the child survived the abortion."[92] Notably, the bill would have also required the ability for cross-tabulation of multiple variables, meaning that each variable could not be reported in the aggregate—instead there would need to be some level of de-identified individual level reporting.[93] Although, under the bill, the statistics would be reported to the CDC in aggregate form overall, cross-tabulation can threaten the privacy of people in categories with small numbers of people.[94] If a version of this bill passed, states would have to report statistics to the CDC or risk losing precious Medicaid dollars. California, a state that currently does not report abortion statistics to the CDC, estimates that this would lead to a $300 million decrease in Medicaid funding per year.[95]

2. Increased Reporting of Abortion Complications

Many recent proposed legislative changes to abortion reporting have involved increased requirements regarding the reporting of abortion complications. Since 2022, the Guttmacher Institute has identified seventeen

---

governor-calls-for-repeal-of-state-law-requiring-annual-abortion-report [https://perma.cc/5XYT-2E3K].

[89] THE CONSERVATIVE PROMISE, *supra* note 12, at 456.

[90] Ensuring Accurate and Complete Abortion Data Reporting Act of 2023, S. 15, 118th Cong. (2023). A similar companion bill was introduced in the House as well. Ensuring Accurate and Complete Abortion Data Reporting Act of 2023, . H.R. 632, 118th Cong. (2023).

[91] Ensuring Accurate and Complete Abortion Data Reporting Act of 2023, S. 15, 118th Cong. § 317W(a)(2), (a)(4) (2023).

[92] *Id.* § 317W(b).

[93] *Id.* § 317W(a)(3).

[94] *See infra* Section IV.B.

[95] Monique O. Madan, *The Price Tag on Project 2025's Abortion Plan: $300 Million Cut to Medi-Cal*, CALMATTERS (Nov. 26, 2024), https://calmatters.org/politics/2024/11/project-2025-abortion-california-cost/ [https://perma.cc/UTP5-WBV5].

state bills proposed across the country that would alter rules regarding reporting of complications, two of which were passed.[96] This section discusses this state-level legislation regarding complications, although there have also been recent proposals that would increase abortion complication reporting at the federal level.[97]

For example, Montana's new 2024 bill adds specific reporting requirements for providers who prescribe medication abortion, including reporting adverse side effects.[98] In 2022 the Kentucky legislature passed a law, over Governor Andy Beshear's veto, that added much more complex abortion reporting requirements.[99] The act adds nineteen categories of reporting requirements, ranging from information about the provider, to the location (zip code) of the patient, to the reason for the abortion, to whether the fetus was viable, to any complications, and to whether insurance was billed for the procedure.[100] The new law also requires reporting requirements related to medication abortion, which the bill calls 'abortion-inducing drugs', and any complications.[101] Specifically the bill states that

> [a]ny physician, qualified physician, associated physician, or other healthcare provider who diagnoses or knowingly treats a patient, either contemporaneously to or at any time after a drug-induced abortion, for a complication or adverse event . . . shall make a report of the complication or adverse event to the cabinet . . . .[102]

An additional section requires hospitals, healthcare facilities, or individual physicians to file written reports when a patient has a complication that is believed to be "a primary or secondary result of an abortion."[103] These extensive reports are to be compiled by the state and reported to the public in the aggregate.[104] Furthermore, the reports required by the law are public records and explicitly available to state law enforcement and child protective

---

[96] Guttmacher Institute, *State Legislation Tracker*, https://www.guttmacher.org/state-legislation-tracker [https://perma.cc/VZ2W-CGKE] (last visited Mar. 1, 2025).

[97] *See, e.g.*, THE CONSERVATIVE PROMISE, *supra* note 12, at 459 (proposing updates to the Food and Drug Administration (FDA) Adverse Events Reporting System to increase reporting of complications from medication abortion).

[98] H.B. 786, 68th Leg., § 7(b) (Mont. 2024).

[99] H.B. 3, Reg. Sess. (Ky. 2022).

[100] *Id.* § 4.

[101] *Id.* § 9.

[102] *Id.* § 9(3).

[103] *Id.* § 25.

[104] *Id.* § 13(2).

services.[105]

More recently, the Missouri legislature has introduced a state constitutional amendment that would repeal the recently passed ballot measure providing a fundamental right to reproductive freedom enshrined in the state constitution.[106] In addition to retracting the citizen-approved initiative, the proposal would add abortion and abortion complication reporting requirements to the state constitution.[107]

These examples increasing abortion complications reporting are part of a broader trend that began well before the *Dobbs* decision. Many of the bills mirror a model law developed by Americans United for Life, an anti-abortion activist organization that produces model legislation and policy. The organization has been rallying against "inaccurate abortion statistics" for years, arguing that evidence showing the safety of abortion is not reliable given the gaps in state and federal abortion reporting.[108] Thus, since at least 2015, the organization has advocated for passage of its model law, the Abortion Reporting Act.[109] Unsurprisingly, the model law focuses on reporting abortion complications in order to fabricate data that would bolster the organization's claims that abortion is unsafe.[110]

There are several major problems, however, with attempting to utilize state systems to increase reporting of abortion complications. First, and most importantly, reliable scientific evidence continues to show that abortions are incredibly safe.[111]

> Today, the available evidence on abortion's health effects is quite robust. There is a great deal of related scientific

---

[105] H.B. 3, Reg. Sess. § 13(3) (Ky. 2022).

[106] H.R.J. Res. 31, 103 Gen. Assemb. (Mo. 2023).

[107] *Id.*

[108] John M. Thorp Jr. & Clarke D. Forsythe, *Inaccurate Abortion Statistics*, THE WASH. TIMES (Mar. 26, 2015), https://www.washingtontimes.com/news/2015/mar/26/john-thorp-clark-forsythe-inaccurate-abortion-stat [https://perma.cc/7WNE-TXWS].

[109] *Id.*

[110] AMERICANS UNITED FOR LIFE, ABORTION REPORTING ACT: MODEL LEGISLATION & POLICY GUIDE 3 (2018) [hereinafter AMERICANS UNITED FOR LIFE] (noting that "[a] comprehensive state reporting system—one that specifically emphasizes reporting on complications—is the only way to [safeguard maternal health]"); *see also* Nicole Knight, *As Abortion Reporting is Politicized, Wyoming Abortion Providers Ignore State Law*, REWIRE NEWS GRP. (Mar. 16, 2018, 2:32 PM), https://rewirenewsgroup.com/2018/03/16/abortion-reporting-politicized-wyoming-abortion-providers-ignore-state-law [https://perma.cc/X4Q8-LFQR] (quoting a representative from the Guttmacher Institute explaining that anti-abortion activists are seeking to increase complications reporting to build a false evidence base that abortion is dangerous).

[111] *See generally* COMM. ON REPRODUCTIVE HEALTH SERVICES, THE NAT'L ACADEMIES PRESS, THE SAFETY AND QUALITY OF ABORTION CARE IN THE UNITED STATES (2018).

> research, including well-designed randomized controlled trials, systematic reviews, and epidemiological studies examining the relative safety of abortion methods… The clinical evidence clearly shows that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective.[112]

Thus, while some complications will inevitably occur, it is impossible to vastly increase reporting of complications that are not occurring without fabricating data. As Planned Parenthood argued in a 9th Circuit case challenging Idaho's version of the abortion reporting bill, "[t]he uncontested evidence below showed that the Act cannot and will not generate usable or reliable data, its purported goal."[113]

Second, a public health surveillance system is not designed to capture the nuanced and detailed information regarding abortion complications that do occur.[114] Third, the model law and associated state legislation are written in ways that will likely lead to overreporting of complications.[115] For example, the Kentucky law discussed above has eight sections that contain reporting requirements, four of which include requirements to report complications.[116] These multiple layers of complex reporting make it more likely for a single event to be overcounted. Additionally, the laws require a wide variety of providers, including hospitals, facilities, or individual physicians to file a report when treating an individual for a complication. This increases the risk that multiple providers or multiple facilities will report the same complication for the same individual.[117] One version of the bill, which has been passed into law in Texas, requires the state to ensure that an event isn't double counted.[118] However, the statute also requires that all reports are stripped of any names

---

[112] *Id.* at 11.

[113] Brief for Plaintiff-Appellant at 12, 25, Planned Parenthood of the Great Northwest and the Hawaiian Islands v. Lawrence Wasden (No. 18-35926), 2018 WL 6606011 (9th Cir. Dec. 7, 2018) (noting further that the reporting cannot be used for reliable research and instead will "be useless and unusable for evidence-based scientific research.").

[114] Hill, *supra* note 39, at 218 (arguing that "[a] national abortion reporting surveillance system lacks the capabilities to capture [abortion complications] consistently or accurately.").

[115] Jessica Valenti, *Texas is Fabricating Abortion Data*, ABORTION, EVERY DAY (May 4, 2023), https://jessica.substack.com/p/texas-is-fabricating-abortion-data [https://perma.cc/797U-M7AN] (discussing a similar state law in Texas that will likely lead to extensive overcounting of abortion complications, in part because of the extremely broad way that complication has been defined in the laws).

[116] H.B. 3, Reg. Sess. (Ky. 2022).

[117] Brief for Plaintiff-Appellant at 11, Planned Parenthood of the Great Northwest and the Hawaiian Islands v. Wasden (No. 18-35926), 2018 WL 6606011 (9th Cir. Dec. 7, 2018).

[118] Women's Right to Know Act, Tex. Health and Safety Code §171.006(i) (2017).

and identifying information.[119] Therefore, it may be impossible for double counting of a complication to be readily identified in the reporting. The risk of overreporting is also increased because the laws do not include a time limitation within which the complication must occur in order to trigger reporting.[120]

What's more, the bills provide for strict penalties on providers who fail to meet reporting requirements.[121] For example, the Montana bill states that it is unprofessional conduct for a physician to fail to file a report and threatens providers with a suspension of their license of up to 1 year if they fail to comply.[122] These hefty consequences of failing to comply with the law will increase the number of providers likely to submit complications, further increasing the risk of overcounting.[123]

3. Incidental Data Collection

Several legislative efforts post-*Dobbs* have not focused explicitly on abortion reporting and surveillance but could themselves lead to increased tracking of abortions due to paperwork requirements added to the bill. For example, the Kentucky bill discussed above also adds lengthy consent requirements for medication abortion and requires both the patient and physician to sign a consent form and submit it to the Cabinet for Health and Family Services.[124] While these forms ostensibly ensure that those obtaining medication abortion have received consent information required under the law, they also create a paper trail of the patients and providers who have been involved in the process and it is not immediately clear how the Cabinet will protect the identity of patients when aggregating the reports for the public or providing access to reports via public records.[125]

In another example, a 2024 bill introduced in Illinois proposed to set rules related to the disposition of fetal tissue. As with the reporting of

---

[119] *Id.* §171.006(e).

[120] *See* Brief for Plaintiff-Appellant at 12, 25, Planned Parenthood of the Great Northwest and the Hawaiian Islands v. Wasden (No. 18-35926), 2018 WL 6606011 (9th Cir. Dec. 7, 2018) (noting that Idaho's version of the law has no time limitation leading to a requirement that providers report complications years after the abortion occurred).

[121] AMERICANS UNITED FOR LIFE, *supra* note 110, at 11 (proposing § 7(c)).

[122] H.B. 786, 68th Leg., §7(b) (Mont. 2024).

[123] The design of the bill also provides "medical and scientific credibility" to the evidence of complications since it is coming from providers. Valenti, *supra* note 115.

[124] H.B. 3, Reg. Sess. § 8(2) (Ky. 2022).

[125] For example, the bill states that "[s]tatistical information that may reveal the identity of a pregnant person obtaining or seeking to obtain a drug-induced abortion shall not be maintained by the cabinet . . .", H.B. 3, Reg. Sess. § 13(5) (Ky, 2022), but also requires signed informed consent forms to be submitted to the cabinet. *Id.* § 8(2).

abortion complications, the Americans United for Life has developed a model law related to fetal tissue disposal, leading to several states with similar laws. According to LawAtlas, as of November 2022, ten states had laws creating requirements regarding the disposal of aborted fetal tissue through burial or cremation, and half of these laws include a requirement that the patient must sign a consent form signifying a decision about disposition.[126] The proposed Illinois bill has a similar requirement.[127] The bill states that the consent form should be kept in the patient's file and an aggregate report regarding fetal tissue disposition be filed with the Department of Public Health.[128] However, by requiring the patient to sign the consent form, there is one more piece of paper that exists linking a patient's name to the incidence of abortion.

Similarly, in May 2024, the Louisiana legislature passed a first-of-its-kind law that defined mifepristone and misoprostol, the two drugs utilized in medication abortion, as Schedule IV controlled substances.[129] Adding abortion pills to the list of controlled substances creates criminal penalties for those who possess the medications without a valid prescription, although the act includes an exception for a pregnant woman to carry medication for her own consumption.[130] To be clear, there is no medical indication that these drugs should be labelled as controlled substances because they are not linked to the potential for dependence and abuse.[131] And, while the Food and Drug Administration (FDA) at times placed heightened restrictions on the medications, they were never labelled as controlled substances at the federal level, nor was there any indication that they should be.[132]

Furthermore, Louisiana already has one of the most restrictive laws in

---

[126] LAWATLAS Abortion Reporting Requirements, *supra* note 67.

[127] Dignity for Aborted Children Act, 103rd General Assembly, State of Illinois S.B. 1640 (2023), § 10(a).

[128] Dignity for Aborted Children Act, 103rd General Assembly, State of Illinois S.B. 1640 (2023), § 10(b), § 20.

[129] Louisiana State Legislature S.B. 276 Reg. Sess. (2024), §964; A suit has been brought challenging this law under state constitutional claims. *Birthmark Doula Collective LLC v. State of Louisiana,* 19th Judicial District Court (2024).

[130] Louisiana State Legislature S.B. 276 Reg. Sess. (2024), §969. The criminal penalties include fines of up to $5000 and imprisonment between one to five years. *Id.* Other state law has heightened penalties for distributing or possession with the intent to distribute the medication. [RA]

[131] Maryann Mazer-Amirshahi et al., *ACMT Position Statement: Mifepristone and Misoprostol are Not "Controlled Dangerous Substances,"* AMER. COL. MED. TOXICOLOGY (Sept. 30, 2024).

[132] Greer Donley, *Medication Abortion Exceptionalism*, 107 CORNELL L. REV. 627, 639 (2022) (citing Lars Noah, *A Miscarriage in the Drug Approval Process?: Mifepristone Embroils the FDA in Abortion Politics*, 36 WAKE FOREST L. REV. 571, 584 (2001)).

the country, banning abortion in nearly all circumstances,[133] and the bill is not meant to limit healthcare providers from legally prescribing the medication for uses unrelated to abortion, such as to treat postpartum hemorrhage or incomplete miscarriage.[134] However, in effect, the law creates barriers for the provision of mifepristone and misoprostol, even outside the context of abortion.[135] Most notably for purposes of this essay, labelling abortion pills as controlled substances triggers the Prescription Monitoring Program, which requires pharmacists and those dispensing the controlled substances to report data on prescriptions. Reporting requirements include information about the pharmacy, the patient, dates the prescription was written and filled, and the diagnosis associated with the prescription.[136] This information is subsequently available to regulatory agencies, such as the State Board of Medical Examiners, and law enforcement.[137] Reporting is allowed without the patient's authorization.[138]

Louisiana was the first state to introduce legislation that places abortion medication on a controlled substances list; however, it is possible that other states could follow.[139] Indeed, a bill has already been introduced in the Texas

---

[133] R.S., § 14.87 (La. 2017). There are very limited exceptions such as for ectopic pregnancies and to prevent the death of the mother. *Id.* § 14.87.1(b).

[134] S.B. 276, Reg. Sess. § 6–7 (La. 2024) (noting that healthcare professionals and pharmacists may prescribe and fill prescriptions as allowed by law). *See also* R.S. 14:87.9(C)(6) (La. 2017).

[135] Outside the context of data collection, the law also creates problematic barriers to timely care. For example, these medications are commonly administered on an emergency basis if an individual is hemorrhaging post-birth. However, under the controlled substances rules, the medications can no longer be stored freely on emergency hemorrhage carts but now must be stored in locked cabinets. Michael Harrington & Ralph L. Abraham, *Louisiana Department of Health Memorandum and Guidance Re: Act 246 of the 2024 Louisiana Regular Legislative Session*, STATE OF LA. DEP'T. OF HEALTH (Sept. 6, 2024) (providing healthcare professionals with guidance on how to comply with the new law). This greatly increases concerns of delay in providing emergency medical treatment to women post-labor. *See, e.g.*, Rosemary Westwood, *A New Louisiana Law Will Re-Classify Misoprostol as a Dangerous Controlled Substance*, NPR (Sept. 27, 2024, 6:00 PM), https://www.npr.org/2024/09/27/nx-s1-5118339/a-new-louisiana-law-will-re-classify-misoprostol-as-a-dangerous-controlled-substance [https://perma.cc/JG7Z-MYER] (interviewing a doctor that noted that a delay of seconds unlocking medications can have an impact on a hemorrhaging patient).

[136] BAMBOO HEALTH, DATA SUBMISSION GUIDE FOR DISPENSERS: LOUISIANA PRESCRIPTION MONITORING PROGRAM app. A (Mar. 2024), https://www.pharmacy.la.gov/assets/docs/PMP/Support_Guides/LA-Data-Submission-Dispenser-Guide_v3.2_2024.03.pdf [https://perma.cc/RM3G-RH4K].

[137] LA. BD. OF PHARMACY, PRESCRIPTION MONITORING PROGRAM (PMP) (Apr. 2009), https://www.pharmacy.la.gov/assets/docs/PMP/PMP-GeneralInformation.pdf [https://perma.cc/6XT9-DT2G].

[138] 45 C.F.R. § 164.512 (a) & (d) (2025).

[139] *See* Mazer-Amirshahi et al., *supra* note 131 (noting that Louisiana is first of its kind, but that similar legislation could appear in other states).

legislature to mirror Louisiana's restrictions.[140] To the extent that more states follow suit, this increases state tracking of prescriptions of mifepristone and misoprostol. Given the vast information sharing that occurs related to prescription drugs, increased surveillance of abortion medication for use in criminal and civil investigations is a great risk.[141]

In states like Louisiana where it is already illegal to prescribe these medications for abortion, the effect is greater state surveillance of those experiencing pregnancy complications and loss, since, absent abortion, the medications are most likely to be prescribed in miscarriage management. The Louisiana bill "effectively [creates] a database of prescriptions for every woman who is prescribed mifepristone and misoprostol, regardless of the reason, truly monitoring women and their pregnancies."[142] Additionally, it is greater tracking of the providers who regularly prescribe abortion medications, placing them at greater risk of scrutiny.[143]

While these three examples highlight recent bills that increase the tracking of abortion seemingly incidental to the main crux of the law, there are many examples of existing state laws that have similar requirements, such as the five states with existing regulations regarding fetal remains. Current state laws that require collection of forms and reports, especially those that include identifying information of patients or providers, must now be viewed under a new lens in the post-*Dobbs* era.

Additionally, it is important to note that certain vulnerable communities in our society were already subject to increased government surveillance and lack of privacy. Post-*Dobbs*, these existing surveillance systems are more likely

---

[140] H.B. 1339, 89th Leg. Sess. (Tex. 2024); *see also* Eleanor Klibanoff, *Texas Bill Would Reclassify Abortion Drugs as Controlled Substances*, TEX. TRIBUNE (Nov. 25, 2024), www.texastribune.org/2024/11/25/abortion-texas-pills-controlled-substance [https://perma.cc/7CCE-3ZG4].

[141] *See generally* Jennifer D. Oliva, *Expecting Medication Surveillance*, 93 FORDHAM L. REV. 509 (2024).

[142] Kaia Hubbard, *Louisiana House Approves Bill to Classify Abortion Pills as Controlled Substances*, CBS NEWS (May 22, 2024, 1:17 PM), https://www.cbsnews.com/news/louisiana-house-approves-bill-classify-abortion-pills-controlled-substances [https://perma.cc/2NWE-W44C] (quoting reproductive health law attorney Ellie Schilling).

[143] Since the State Board of Medical Examiners, the state agency which licenses healthcare providers, has access to the Prescription Monitoring Program, they could theoretically look for providers who prescribe greater levels of mifepristone and misoprostol under suspicion that they are prescribing the medications for illegal abortions. Increased scrutiny of healthcare providers who conduct legal abortions by state medical boards has precedence, as in the case of Dr. Caitlin Bernard, an Indiana doctor who was reprimanded by the state medical board after speaking publicly about performing an abortion for a 10-year-old rape victim from Ohio. Nicki Brown & Melissa Alonso, *Indiana Medical Board Reprimands Doctor Who Publicly Discussed Providing Abortion Services to 10-Year-Old Ohio Rape Victim*, CNN (May 26, 2023, 11:29 PM), https://www.cnn.com/2023/05/26/us/dr-caitlin-bernard-indiana-medical-board-hearing/index.html [https://perma.cc/7TLQ-4YAY].

to identify individuals seeking abortions. For example, women who are on probation or parole following a criminal sentence must often ask their probation or parole officer for permission to leave the state.[144] Thus, access to abortion for many women on probation and parole living in a state with abortion restrictions is dependent on receiving permission from an officer.[145] The Prison Policy Initiative estimates that 82% of women on probation and 85% of women on parole live in a state with travel restrictions for those under supervision and that has abortion restrictions that may necessitate going out of state to receive care.[146] In some instances, those with electronic monitoring may not be able to see a doctor or go to a pharmacy for a prescription without permission—permission that has not always been granted.[147] Similar barriers and lack of privacy to make reproductive decisions is likely to impact other vulnerable communities, such as those in custody[148], or those in poor[149] or immigrant communities.[150] These barriers and increased tracking of abortions in vulnerable communities is more likely to impact Black and Brown communities, who are already more likely to be targets of criminalization for pregnancy outcomes.[151]

IV. BALANCING PRIVACY AND PUBLIC HEALTH

A. Privacy and Public Health Imperatives

The second Trump administration increases both the privacy concerns and public health imperatives of abortion surveillance. On the one hand, it is widely expected that the presidential administration will bring in greater restrictions on abortion and increased criminalization and investigation of

---

144 Wendy Sawyer, *Two Years After the End of* Roe v. Wade*, Most Women on Probation and Parole Have to Ask Permission to Travel for Abortion Care*, PRISON POL'Y INITIATIVE (June 18, 2024), https://www.prisonpolicy.org/blog/2024/06/18/dobbs [https://perma.cc/427L-X3AN].

145 *Id.*

146 *Id.*

147 *Id.*

148 *See generally* Allison Herr, *Abortion Access for Women in Custody in the Wake of* Dobbs v. Jackson Women's Health, 49 AMER. J. L. & MED. 471 (2023) (discussing the difficulty incarcerated women face in accessing abortions).

149 *See generally* KHIARA M. BRIDGES, THE POVERTY OF PRIVACY RIGHTS (2017).

150 Michele Goodwin & Erwin Chemerinsky, *Pregnancy, Poverty, and the State*, 127 YALE L. J. 1270, 1285–86(2018) (detailing the lack of reproductive privacy and choice for individuals with custody of the Office of Refugee Resettlement); *see also New Details About Trump-Era Efforts to Block Pregnant Minors in Immigration Detention from Accessing Abortions*, AM. OVERSIGHT (May 6, 2021), https://americanoversight.org/new-details-about-trump-era-efforts-to-block-pregnant-minors-in-immigration-detention-from-accessing-abortions [https://perma.cc/FCZ3-ZVB4].

151 BACH & WASILCZUK, *supra* note 13, at 10–11.

patients and providers alike. With this reality, the privacy of reproductive health information is essential due to the worry that abortion surveillance data could be used to identify patients and providers for targeted criminal or civil investigations or harassment.[152] Thus, some wonder, as was legislated in Michigan, whether it is worth collecting abortion statistics at the state level. As the Governor of Arizona stated in her call to end abortion reporting, "[t]he government has no place in surveilling Arizonans' medical decision-making or tracking their health history. Starting a family is a sensitive and personal experience for a woman and her loved ones; there should be no room for government surveillance and publication of that decision."

Yet increased restrictions and criminalization of pregnancy outcomes also intensifies the need for meaningful and accurate public health research to help understand the health consequences of the new policies. The proposed and enacted legislation described in Section III paints a potential worrisome future of abortion data. If abortion-protective states, like Michigan, begin to limit the reporting of abortions out of privacy concerns for patients and providers, there will be a decrease in accurate information about the numbers of abortions occurring in the states, just at the time when these numbers are expected to increase due to people traveling to receive care from restrictive states. Simultaneously, if abortion-restrictive states, like Kentucky, increasingly require reporting of complications of abortions there will likely be rises in reported complications in these states at the same time as the overall numbers of abortions in the state will decrease because of the need to travel out of state to receive legal care.

An increase in reported complications could arise for several reasons. First, as mentioned above, the complication reporting bills are written in ways that are likely to lead to overcounting.[153] Second, it is tragically foreseeable that abortion restrictions themselves will lead to increased complications.[154] While abortion overall is safe and effective, it is known that the rates of complications, while still low, increase for procedures completed at later gestational ages.[155] Thus, as state abortion restrictions lead to delayed care due to out-of-state travel, it is appallingly likely that more individuals will experience complications, which could be reported (multiple times over) if the complication occurs back in their home state with expansive

---

[152] *See, e.g.*, Jolynn Dellinger & Stephanie Pell, *Bodies of Evidence: The Criminalization of Abortion and Surveillance of Women in a Post-Dobbs World*, 19 DUKE J. CONST. L. & PUB. POL'Y 1 (2024).

[153] *See supra* Section III.B.2.

[154] *See* Valenti, *supra* note 115.

[155] COMM. ON REPRODUCTIVE HEALTH SERVS., THE NAT'L ACADEMIES PRESS, THE SAFETY AND QUALITY OF ABORTION CARE IN THE UNITED STATES 10 (2018) (noting that serious complications are rare, but that the risk for them increases the further along in pregnancy one is).

complication reporting requirements.[156]

These two trends in concert would create a data mirage which could be interpreted, inaccurately, as showing the dangers of abortion, as opposed to the dangers of abortion bans: data that could be further politicized and weaponized to justify even more draconian restrictions on reproductive health care. Although more accurate data could continue to be collected by non-governmental groups,[157] the state and CDC data carry with it the veneer of officiality and will likely be cited by reporters even if many states are no longer participating in the surveillance. Properly and accurately tracking abortions serves important epidemiological and public health goals. Yet, efforts to politicize data collection and reporting threaten trust in these essential research aims and thwart the ability to conduct essential research. For example, without accurate public health data on abortions, it will be impossible to calculate rates of pregnancy, including unintended and teen pregnancies.[158] It would also be impossible to accurately assess the impacts of public policy, from abortion restrictions to efforts to lower rates of unintended pregnancies to understanding health disparities in reproductive outcomes.[159]

B. Privacy Risks

The post-*Dobbs* reality of increasing threats of criminalization for providers and pregnant individuals across the country cause many to question the merits of any collection of sensitive data with the new on-the-ground reality.[160] Given competing tensions between privacy and public health, it is important to take seriously the considerations to end state data collection of abortion statistics. It is well known that there are flaws in current abortion reporting through the CDC, and these inaccuracies could continue to increase given changes in abortion methods and incomplete data.[161] Yet the federal and state abortion surveillance still fills important gaps that non-profit

---

[156] Valenti, *supra* note 115.

[157] *See, e.g.*, Baden & Dreweke, *supra* note 27 (calling for alternative ways to collect abortion data beyond state programs).

[158] Dreweke, *supra* note 40.

[159] *Id.*; The *Dobbs* decision is sadly expected to increase health disparities because Black and low-income individuals are most likely to have even greater difficulties accessing abortion post-*Dobbs*. Losing the ability to effectively track these policy impacts makes it impossible to fully understand the population-level impacts of state restrictions post-*Dobbs*. Weitz & O'Donnell, *supra* note 54, at 324.

[160] *See, e.g.*, David S. Cohen et al., *The New Abortion Battleground*, 123 COLUM. L. REV. 1, 51 (2023) (arguing that reporting requirements, "continue to serve the purpose of collecting abortion data, but that purpose must be balanced against the risk of extraterritorial punishment.").

[161] *See supra* Section II.A.

abortion surveillance does not provide, such as demographic statistics and an air of governmental legitimacy.[162]

The difficult question is whether to prioritize the privacy imperative or the public health imperative post-*Dobbs*. If reporting abortion statistics would lead to increases in pregnancy-related prosecutions or investigation of patients and providers, the trade-off may not be worth it.[163] However, it is important to consider the on-the-ground risks—risks that will be variable depending on the state, what information is collected and shared, and who may be seeking the information. When thinking about the privacy of the information, it is important to consider both individual reports that have been deidentified and the aggregate statistical reports. Historically, the statistical reports have always been available to the public and have not included any identifiable data. However, in recent years, there has been increased attention on public access to the underlying data as well. Aggregate statistical data naturally carries fewer privacy risks than individual level reports. However, individual level reports would also provide more granular information for public health reporting, thus balancing privacy against public health goals remains challenging.[164]

The most worrisome potential use of abortion surveillance data would be for identification of patients or providers to target for criminal or civil investigations. This could come in the form of law enforcement or a medical licensure board attempting to identify individuals who have sought or provided abortions that are unallowed in the state. Very broadly speaking then, the most concerning use of abortion surveillance data would come from access and use by actors within a restrictive-abortion state. This could be attempts for these states to use their own state abortion surveillance data or gain access to another state's abortion surveillance data. Privacy risks could also come from private organizations or citizens attempting to gather information about patients and providers.[165] These attempts could come in the form of public access requests or discovery requests via civil lawsuits and

---

[162] This air of governmental legitimacy is a double-edged sword. On the one hand, government data could help local public health researchers to argue for needed policy changes based on the state's own tracking data. On the other, as politicization of abortion tracking increases inaccuracies in the system, the air of government legitimacy could obscure the misinformation being baked into the reporting statistics.

[163] *See, e.g.*, Baden & Dreweke, *supra* note 27 (arguing that "[t]he enactment of abortion reporting requirements for purely political reasons and their increasing weaponization against patients and providers are clear indications that the harms of this mandatory data collection now outweigh its benefits.").

[164] *Abortion Reporting*, *supra* note 69 (admitting that "[i]t's not clear what more could be done to de-identify state abortion-report data, while still enabling it to generate what are considered necessary public health statistics.").

[165] *See, e.g.*, Voices for Life, Inc. v. Ind. Dep't of Health, Case No. 49D02-2405-MI-019876 at 5 (Ind. Super. Ct. Aug. 22, 2024).

could come from actors both within states and out of states.[166]

Given these threats, the question is whether, on balance, it is better to stop tracking abortions overall. This article argues that, although the privacy concerns of abortion surveillance are important and real, at this point in time there is still more that can be done to shore up privacy of abortion surveillance data to continue to facilitate essential public health research. Indeed, there is some argument that this approach will also help to protect privacy of reproductive data within the medical records as the availability of aggregate reports could weaken legal arguments for the need to access individualized medical records.[167]

This balancing of competing interests comes with several practical assumptions and caveats. First, given the increasing polarization of abortion policy, including discussions of abortion reporting[168], it seems unlikely that abortion tracking would be suspended in abortion-restrictive states.[169] However, if there are political opportunities to limit tracking or shore up privacy protections in states most likely to use the data to prosecute patients and providers, these opportunities should be taken.[170] Second, relatedly, the states most likely to successfully enact a pause on tracking abortion statistics would likely be those with policies supportive of abortions and thus those where there is the lowest risk of prosecutions and investigations. It is also most likely that these are states where stronger privacy protections of abortion surveillance data can pass in the state legislature. However, if increased privacy cannot be ensured, there are greater arguments for the need for limiting state collection of abortion data. Third, as will be discussed further below, a key privacy need in this area is the ability to prevent out-of-state actors from accessing abortion data for prosecution or investigation.[171] Insulating requests for health information across state lines for use in state

---

166 Such efforts are especially worrisome in states that have developed civil bounty hunter style laws. *See, e.g.*, Anya E.R. Prince, *Reproductive Health Surveillance*, 64 B.C. L. REV. 1077, 1118–20 (2023) (discussing state laws creating bounty systems for enforcing abortion restrictions).

167 Carmel Shachar & Carleen Zubrzycki, *Informational Privacy after Dobbs*, 75 ALA. L. REV. 1 (2023).

168 The votes in Michigan and New Hampshire, for example, discussed above fell along party lines with Democrats voting against reporting and Republicans voting for reporting.

169 *See, e.g.*, Bud Foster, *Democrats Plan to Introduce Bill to End Abortion Data Collecting,* 13 NEWS (Dec. 19, 2024), https://www.kold.com/2024/12/20/democrats-plan-introduce-bill-end-abortion-data-collecting [https://perma.cc/PNC4-NF9A] (noting that it will be "quite a heft" to pass the Arizona bill stopping abortion tracking "with the GOP strengthening its hold on the state legislature this session.")

170 In this way, this paper's arguments and the policy position of the Guttmacher Institute are aligned. States that will weaponize data and restrict abortions should not be collecting statistics under the guise of public health. *See* Baden & Dreweke, *supra* note 27.

171 *See infra* Section V.B.3.

investigations is a complex, uncertain, and rapidly growing area of law.[172] To the extent that future developments in this area of law make it more difficult to protect sensitive health information, reconsideration of abortion surveillance systems may be warranted. Finally, this recommended balance between public health research and privacy rests on the unfortunate reality that there are many potential sources of information that can be used to identify abortion patients and providers.[173] Aggregate data and deidentified individual abortion reports, especially those that do not disclose names of providers, could potentially be used for identification, but they are likely not the most readily and easily accessible source for this purpose. Thus, with additional privacy protections in place, public health surveillance data may be relatively insulated from unwanted surveillance. To the extent that this begins to change and there is an increase of successful requests to access abortion surveillance data in states that have shored up privacy protections of abortion data, a reexamination of public health tracking of abortions could again be warranted.

V. SHORING UP PRIVACY IN ABORTION SURVEILLANCE

This section explores key principles and concrete recommendations that can be incorporated into abortion surveillance laws. Incorporating these protections would help to strengthen the privacy and confidentiality of abortion surveillance data, while still allowing for important public health research. Ideally, these are norms that should be essential to respect privacy and public health ethics across the nation. However, at a minimum they should be policies that states without severe abortion restrictions should consider before jumping immediately to ending abortion reporting overall.

Balancing between privacy and public health goals in public health surveillance programs is not without precedence. Another common public health surveillance program across the US is the creation of state cancer registries.[174] As these cancer registries developed, concerns about privacy of the collected information grew.[175] Thus, robust confidentiality guidelines were recommended to provide practical mechanisms for ensuring privacy.[176]

---

[172] *Id.*

[173] Prince, *supra* note 166, at 1077.

[174] Robert H. McLaughlin et al., *Are Cancer Registries Unconstitutional*, 70 SOC. SCI. & MED. 1295, 1295 (2010) (noting that all 50 states have cancer surveillance programs).

[175] *Id.* (giving examples of when privacy was prioritized over public health, such as Veterans Affairs hospitals withdrawing from public health reporting).

[176] *See, e.g.*, Int'l Assoc. of Cancer Registries & Int'l Agency for Rsch. on Cancer, *Guidelines on Confidentiality for Population-Based Cancer Registration*, 6 ASIAN PACIFIC J. CANCER PREVENTION 87 (2004); *see also* M.P. Coleman et al., *Confidentiality in the Cancer Registry*, 66 BR. J. CANCER 1138 (1992) (noting that cancer registry statutes should "provide both a statement of principles underlying confidentiality in the cancer registry, and a practical mechanism for ensuring that

This section pulls on examples from cancer surveillance programs to illustrate how privacy in abortion surveillance can be further strengthened, in ways that exist within other essential health care contexts.

The section concludes by highlighting two states that have taken steps to improve the privacy of their abortion surveillance practices post-*Dobbs*, without jettisoning the public health data collection completely.

A. Government collection of information

In her discussion of government collection of medical information, Wendy Mariner notes that there are two stages of potential infringements on privacy—the collection of the information and the confidentiality of the information collected.[177] "Discussions of mandatory reporting laws often proceed directly to the second question, skipping over the first."[178] Therefore, it is important to keep in mind that government collection of abortion data, in and of itself, is an infringement on privacy. With this in mind, abortion reporting should incorporate two basic requirements: the purpose of data collection should be to promote public health and, relatedly, the specific reporting elements should be narrowly tailored to meet this goal.[179]

1. Purpose to promote public health

Public health surveillance has always carried a worry of government intrusion, but, in general, tailored public health activities are viewed as ethical because of their promotion of the public good.[180] Surveillance first began in the context of contagious diseases, but that scope has broadened to tracking of genetic conditions in newborns, cancer, and chronic diseases.[181] This expansion of scope has come with an expansion of the purpose for collection: the original goal of tracking was to contain disease outbreaks, but

these principles are observed.").

[177] Wendy K. Mariner, *Reconsidering Constitutional Protection for Health Information Privacy*, 18 UNIV. PA. J. CONST. L. 975, 983 (2016).

[178] *Id.*

[179] These recommendations mirror conditions that have been recommended to ensure ethical public health activities. *See generally* James F. Childress et al., *Public Health Ethics: Mapping the Terrain*, 30 J. L. MED. & ETHICS 170 (2002) (arguing for five conditions that justify public health activities to override other values, such as privacy: effectiveness, proportionality, necessity, least infringement, and public justification). And mirror general privacy recommendations related to Fair Information Practice Principles and the principle of 'purpose specification and use limitation. *Fair Information Practice Principles (FIPPS)*, FED. PRIV. COUNCIL, https://www.fpc.gov/resources/fipps [https://perma.cc/TDF6-A6AN].

[180] Childress et al., *supra* note 179 (noting the end-oriented and consequentialist ethics framing of public health activities).

[181] Mariner, *supra* note 177, at 352–54.

the purpose today has stretched to include research, analysis, and budgeting.[182] In the context of abortion surveillance, state laws often mention an additional governmental goal of ensuring compliance with regulations.[183] But this mission creep, from public health goals to enforcement goals, threatens personal autonomy and privacy.[184] "The greatest resistance to abortion reporting laws has arisen where states used them as a mechanism to restrict abortion rather than a means to study public health."[185]

When the Supreme Court has been presented with questions regarding the legitimacy of reporting requirements, they have focused on the public health purpose for government collection. For example, in *Planned Parenthood of Central Missouri v. Danforth,* the Supreme Court held that "[r]ecordkeeping and reporting requirements that are reasonably directed to the preservation of maternal health and that properly respect a patient's confidentiality and privacy are permissible."[186] The Supreme Court further defended reporting requirements aimed at promoting health in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.[187] "The collection of information with respect to actual patients is a vital element of medical research, and so it cannot be said that the requirements serve no purpose other than to make abortions more difficult."[188] However, the Supreme Court has indicated that a broad scope of information collected and the availability of that information to others

---

[182] *Id.* at 350.

[183] Dreweke, *supra* note 40, at 40 (explaining that states are "exploiting reporting requirements that exist for public health purposes to create a legal and political tool to monitor compliance with state abortion restrictions aimed at impeding access to care and deterring women from seeking abortion services."); *See e.g.*, IND. CODE § 16-34-2-5(a); *see also Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 79 (1976) (discussing a Missouri law "the purpose and function of which shall be the preservation of maternal health and life by adding to the sum of medical knowledge through the compilation of relevant maternal health and life data and to monitor all abortions performed to assure that they are done only under and in accordance with the provisions of the law." (citing H.B. 1211, 103rd Gen. Assemb. (Mo. 2025))).

[184] Indeed, Wendy Mariner argues that even the shift from disease tracking to research is a threat to privacy. Wendy K. Mariner, *Mission Creep: Public Health Surveillance and Medical Privacy*, 87 B.U. L. REV. 347 (2007). For example, utilizing personally-identifiable public health surveillance data for research purposes is a way of circumventing the need to obtain informed consent from large numbers of individuals. *Id.* at 350–51. Thus, using public health surveillance data for research, "poses a challenge to the principles of liberty and privacy that underpin one's individual autonomy to decide whether to participate in research or to accept medical care." *Id.* at 351. In the context of abortion surveillance, most reporting laws state that patient names should not be included in the initial report. This deidentified information is allowed to be collected for research purposes without patient authorization.

[185] Hill, *supra* note 39, at 226.

[186] Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 80 (1976) (noting too that the stated compliance goal of the law "fades somewhat into insignificance" given the holdings of the court).

[187] Planned Parenthood of Southeastern Pennsylvania. v. Casey, 505 U.S. 833, 900–01 (1992).

[188] *Id.*

beyond public health officers, especially the public, can render the purpose of a reporting collection beyond public health and therefore impermissible.[189] These cases were decided prior to *Dobbs*, so the Constitutional analysis regarding decisional privacy and the burdens these requirements place on access to abortion would be altered, however they still provide insight into policy arguments regarding the balance between informational privacy and data collection.

Thus, the Supreme Court has recognized the importance of abortion tracking for public health and research purposes. However, as mentioned, some state laws also include monitoring compliance with the law as a purpose of any reporting requirements. Yet, ensuring compliance with existing laws is only tenuously related to public health.[190] Thus, given the balance between respecting the informational privacy of patients and the legitimacy of governmental intrusion into the patient/provider relationship, information collected within the abortion surveillance system should only be collected for the purpose of public health goals, such as research.[191]

The cancer surveillance system provides a model for this.[192] Many of the state laws that establish the reporting systems expressly state that they are for public health and research purposes.[193] Some states actualize this purpose by barring all uses of registry data except those specifically delineated. For example, Arkansas states that "[i]nformation accumulated and maintained in the Cancer Registry of Arkansas shall not be divulged except for statistical information that does not identify individuals and for purposes of research by a qualified researcher."[194] Arizona states that "information collected on individuals by the surveillance system that can identify an individual is confidential and may be used only pursuant to this section" and a violation

---

[189] Thornburgh v. Am. Coll. of Obstetricians and Gynecologists, 476 U.S. 747, 766–67 (1986).

[190] Tucson Woman's Clinic v. Eden, 379 F.3d 531, 552 (9th Cir. 2004); *see also* Dreweke, *supra* note 40, at 44–45 (arguing that it is important for states to ensure compliance with their laws, but that they should not use an existing public health tool to do so).

[191] *See* Lens, *supra* note 32, at 583 (noting that it is unethical to share public health surveillance data for non-public health reasons unless there are "extreme and compelling circumstances" (citing Charles M. Heilig & Patricia Sweeney, *Ethics in Public Health Surveillance*, *in* PRINCIPLES & PRAC. OF PUB. HEALTH SURVEILLANCE (2010)).

[192] For example, international guidelines for promoting confidentiality for population-based cancer registration recommends that "[t]he purposes for which data collected by the cancer registry are to be used should be clearly defined[.]" Int'l Assoc. of Cancer Registries & Int'l Agency for Rsch. on Cancer, *Guidelines on Confidentiality for Population-Based Cancer Registration*, 6 ASIAN PACIFIC J. CANCER PREVENTION 87, 89 (2004).

[193] McLaughlin et al., *supra* note 174, at 1297 (listing statutory language describing the purpose of a cancer registry); A full listing of state cancer registry laws and regulations is compiled by the North American Association of Central Cancer Registries. https://apps.naaccr.org/cfd-portal/public/cari/state-laws-and-regulations [https://perma.cc/86L7-YRUP].

[194] ARK. CODE §20-15-203(a).

of this confidentiality carries risk of a misdemeanor.[195] Thus, abortion surveillance statutes could be altered to bar all uses of the collected data other than for public health research and statistical reporting.

2. Reporting requirements tailored to this purpose

It should go without saying that public health research relies on reliable and accurate data. Indeed, this argument is echoed by advocates on both sides of the abortion debate.[196] However, as discussed above, increased reporting requirements, particularly surrounding complications data, are likely to lead to overcounting of medical problems following an abortion.[197] Thus, it is important to interrogate whether the reporting is designed in a way that it will provide information that is usable to public health agencies to conduct thorough and accurate research. The politicization of reporting requirements threatens this very most basic standard. However, without this basic standard, state reporting requirements are imposing upon the privacy of the patient/provider relationship without a legitimate public health reason for doing so.

Excessive reporting requirements that are unmoored from public health goals also create distrust within the system that leads to lack of compliance[198] and feelings of invasions of privacy.[199] If providers view reporting requirements as intruding upon their relationships with patients, without an underlying legitimate public health goal, they may feel compelled not to report in order to protect the patient's privacy.[200] This potential to create

---

[195] ARIZ. CODE §36-133(F).

[196] *See, e.g.*, AMERICANS UNITED FOR LIFE, *supra* note 110, at 4–5 (citing both *Danforth* and *Casey* to illustrate their model law's ties to public health, despite the model act likely increasing the inaccuracy of abortion data); CHARLES A. DONOVAN & REBECCA GONZALES, CHARLOTTE LOZIER INST., ABORTION REPORTING: TOWARD A BETTER NATIONAL STANDARD 1 (Aug. 2016) (arguing that "abortion policy must be grounded on the most accurate, comprehensive and up-to-date statistical information and health data."); Hill, *supra* note 39, at 180 (noting that "good abortion data is critical to sound and relevant policymaking.").

[197] *See supra* Section III.B.2.

[198] *See* Nicole Knight, *As Abortion Reporting is Politicized, Wyoming Abortion Providers Ignore State Law*, REWIRE NEWS GRP. (Mar. 16, 2018, 2:32 PM), https://rewirenewsgroup.com/2018/03/16/abortion-reporting-politicized-wyoming-abortion-providers-ignore-state-law [https://perma.cc/J4VF-3GYB].

[199] *See, e.g.*, Bud Foster, *Democrats Plan to Introduce Bill to End Abortion Data Collecting,* 13 NEWS (Dec. 19, 2024), https://www.kold.com/2024/12/20/democrats-plan-introduce-bill-end-abortion-data-collecting [https://perma.cc/4W4C-NUJ3] (noting that proponents of stopping abortion reporting feel that the information collected is too invasive).

[200] This could begin to occur even with the threat of steep penalties for noncompliance. *See* Valenti, *supra* note 115 (reporting on one provider, 'Sue', who has opted not to comply with Texas' reporting requirements so as not to be complicit in creating inaccurate and misleading data).

systematic gaps further threatens the accuracy of abortion data because the providers may fail to report all categories of abortion data, not just those seen as overburdensome. However, the providers may still be reporting statistics to trusted organizations such as the Guttmacher Institute.[201]

It is important to question, not just whether the overall reporting requirements meet the goals of improving public health, but also whether each individual reporting element is related to public health and appropriate for the state to collect. "Governmental public health reporting systems must be limited to collecting basic incidence and demographic data for legitimate public health purposes."[202] Even if general reporting meets public health goals, the scope of the questions can go beyond this legitimate government interest.[203] For example, in Thornburgh v. American College of Obstetricians and Gynecologists, the Supreme Court believed that the Pennsylvania reports at issue in the case fell outside the range of public health because they asked for extraneous details, such as the method of payment, personal history of the patient, and the reasons for obtaining an abortion.[204] It is important to note that because of the vagaries and complexities of ever changing abortion litigation, there are absolutely current state statutes that require this level of detail from abortion tracking.[205] Indeed, according to the Guttmacher Institute, sixteen states require information about why a patient is seeking an abortion, eight states collect the payment method, and eight states ask whether the abortion was undertaken due to rape or incest.[206] However, we should return to the ethos of this previous case: that it is a violation of informational privacy to seek data in abortion reports that go beyond legitimate public health goals.

Extraneous questions added to reporting requirements is closely related to the mission creep expanding the purposed of the overall reporting regime. When a goal of reporting is to ensure compliance with, often onerous, state laws, it requires providers to report a greater amount of information, such as the reasons for abortion, confirmation that an ultrasound was performed (with some states requiring providers to upload the ultrasound image)[207], and

---

[201] Knight, *supra* note 198.

[202] Dreweke, *supra* note 40, at 40 (noting that "official governmental reporting systems that go beyond this limited scope have the effect of stigmatizing women obtaining abortions or harassing abortion providers for the purpose of promoting an antiabortion policy agenda.").

[203] *Id.* (arguing that "abortion rights opponents have co-opted abortion reporting to advance their political agenda by requiring information that has no discernible public health purpose, can be highly intrusive into patient privacy and can risk patient confidentiality.").

[204] Thornburgh v. Am. Coll. of Obstetricians and Gynecologists, 476 U.S. 747, 767 (1986).

[205] GUTTMACHER Abortion Reporting Requirements, *supra* note 67.

[206] *Id.*

[207] Dreweke, *supra* note 40, at 45–46.

whether or not parental notification or informed consent mandates were met.[208] This shift from collection for public health reasons to compliance is especially detrimental to informational privacy because, in some instances, it forces providers to collect information that they otherwise would not have.

One of the most notable examples are requirements to report the reasons that a patient was seeking an abortion.[209] This forces providers not only to report on the reasons, but in many instances for the provider to begin asking their patients why they are seeking the procedure.[210] While it may be beneficial to undertake research understanding the reasons why individuals seek abortions, the government should not require providers to collect this extremely sensitive data point and subsequently share it without patient consent.[211]

Extensive reporting requirements more closely linked to ensuring compliance with laws than to public health goals mirror strategies of TRAP laws—the goal is to add onerous requirements to abortion providers, not to improve patient health.[212] States seeking to shore up privacy of abortion surveillance systems should ensure that the questions asked in reporting requirements are narrowly tailored for research purposes. This can be done by consulting researchers and institutions like the Guttmacher Institute to understand which data is most important and useful for legitimate public health research.

Minnesota provides a recent example of a state that amended its abortion

---

[208] GUTTMACHER Abortion Reporting Requirements, *supra* note 67.

[209] Another is preexisting medical conditions that would complicate a pregnancy. AMERICANS UNITED FOR LIFE, *supra* note 110, at 7 (suggesting § 4(b)(7)).

[210] Dreweke, *supra* note 40, at 45; In April 2024, the Governor of Kansas vetoed a bill that would have required reporting of the reason that a patient sought an abortion. In the veto message, Governor Kelly stated,

> There is no valid medical reason to force a woman to disclose to the legislature if they have been a victim of abuse, rape, or incent prior to obtaining an abortion. There is no valid reason to force a woman to disclose to the legislature why she is seeking an abortion.

Press Release, Kan. Off. of the Governor, Governor Kelly Vetoes Bills, Allows One to Become Law Without Signature (Apr. 12, 2024) (on file with author). The bill was passed over Governor Kelly's veto. H.B. 2749, Reg. Sess. (Kan. 2023).

[211] Dreweke, *supra* note 40, at 43, 45 (noting other data points that can have public health significance, but would be inappropriate for the government to collect, such as religious affiliation); *see also* Walker Orenstein, *DFL Lawmakers Want to End a State Report on Abortion Data in Minnesota*, MINNPOST (Mar. 8, 2023), https://www.minnpost.com/state-government/2023/03/dfl-lawmakers-want-to-end-a-state-report-on-abortion-data-in-minnesota [https://perma.cc/92E5-SRZX] (reporting on a proposed bill that would have completely repealed Minnesota's abortion reporting rather than implement that more tailored amendments that passed).

[212] *See supra* Section III.B.1.

reporting rules to narrow its data collection to be more focused on public health.[213] Most notably, the state legislature limited the number of variables required to be reported under state law.[214] The statute still collects information on the number of abortions performed by the physician in a year, the method used, the patient's age and gestational age. However, the statute no longer requires providers to disclose the reason for abortion, the patient's abortion history, how the abortion was paid for, and reporting surrounding "born alive infants."[215] The bill also repealed reporting requirements regarding out-of-state abortions and onerous 'informed' consent provisions.[216]

B. Confidentiality of Information Collected

Once information is collected by the state, the confidentiality of this information is paramount.[217] There are several concrete assurances that states can provide in their abortion surveillance laws, some of which are currently in place across some states, others which should be implemented in the post-*Dobbs* era.

1. Aggregate Reporting

To help ensure privacy, information collected for public health surveillance should only be publicly reported in the aggregate. The value of public health data is to identify trends across populations, so individual level data is not necessary to meet these goals.[218] Some have further suggested that health departments use data suppression protocols to limit patient reidentification.[219] This recommendation is mirrored in the cancer surveillance space, where state laws often affirm that cancer data must be kept confidential, but can be used for statistical reporting. States could explore incorporating a research exception for individual, deidentified

---

[213] *See* MINN. DEP'T HEALTH, INDUCED ABORTIONS IN MINNESOTA, JANUARY-DECEMBER 2023: REPORT TO THE LEGISLATURE v–vi (Dec. 31, 2024) (delineating the recent changes to abortion reporting rules).

[214] M.S.A. § 145.4131 (1)(b).

[215] 2023 Minn. Sess. Law Serv. Ch. 70 (S.F. 2995) (West).

[216] 2023 Minn. Sess. Law Serv. Ch. 70 (S.F. 2995) (West) (repealing M.S.A. 145.4133 & 145.4241–145.4249).

[217] The privacy of information is important for several key reasons. First, this most closely hews to respecting the sanctity of the privacy of the patient/physician relationship. Second, relatedly, breaking public expectations of confidentiality can threaten the patient/physician relationship. REGISTRIES FOR EVALUATING PATIENT OUTCOMES: A USER'S GUIDE 5 (Richard E. Gliklich et al, eds., 3d ed. 2014).

[218] Lens, *supra* note 32, at 573.

[219] Hill, *supra* note 39, at 224–25

reports, although this could increase the risk of misuse of this exception.

2. Limited Public Access

The flip side of the recommendation related to statistical reporting is that individual abortion reports, as opposed to the published, aggregate statistics, should not be available to the general public, especially if there is reason to believe that information can be used to re-identify individuals.[220] Many state laws require reporting of a wide range of demographics, such as an individual's county, age, race, number of previous pregnancies, births, and abortions, and the gestational age. Even without names attached, demographic information can be pieced together to re-identify individuals.[221] This is especially a risk when there are low numbers of reports, such as in rural communities.[222] For example, between questions regarding race, age, marital status, and number of previous live births, one could quickly narrow the possible individuals in a zip code with a small population.[223] This is especially true in states with abortion restrictions since the number of reported abortions will drop, making re-identification of any that do occur more likely.

In 2023, the Indiana Public Access Counselor recognized these concerns regarding the confidentiality of individual reports, called terminated pregnancy reports (TPRs), and recommended that they not be available to the public via records requests. The public access counselor interpreted the TPRs as part of the patient medical records, and thus confidential from public access requirements.[224] This was a change in practice, as these reports had been previously publicly available since the 1970s.[225] However, changes

---

[220] Alternatively, some have argued that, when providing the public access to forms, health departments should redact information that could lead to individual disclosure. *Id.* at 223–24.

[221] *See, e.g.*, Paul Ohm, *Broken Promises of Privacy: Responding to the Surprising Failure of Anonymization*, 57 UCLA L. REV. 1701 (2009).

[222] *Abortion Reporting*, *supra* note 69 (noting that "[w]hile the reporting form does not include the patient's name, the demographic data is so extensive that it would not take great skill to identify the individual, particularly in a small town.").

[223] For example, a small number of demographic variables can be used to uniquely identify individuals. Latanya Sweeney, *Simple Demographics Often Identify People Uniquely,* CARNEGIE MELLON UNIV., DATA PRIVACY WORKING PAPER (2000), https://dataprivacylab.org/projects/identifiability/paper1.pdf [https://perma.cc/2CT2-WAXN].

[224] Letter from Luke H. Britt, Public Access Counselor, State of Indiana, to Kelly MacKinnon, Chief Legal Counsel, Indiana Department of Health (Dec. 19, 2023) (regarding 23-INF-15, Terminated pregnancy reports).

[225] Abigail Ruhman, *Indiana Attorney General Pushes to Disclose Terminated Pregnancy Reports*, LOUISVILLE PUB. MEDIA (Apr. 12, 2024), https://www.lpm.org/news/2024-04-12/indiana-attorney-general-pushes-to-disclose-terminated-pregnancy-reports [https://perma.cc/4M4G-RXPE].

in the amount of information requested[226] and restrictions placed on abortion that would lower the rate reported necessitated a reconsideration of the privacy implications.[227]

In response, the Indiana Attorney General wrote his own advisory opinion stating that the TPRs should be accessible to the public because he did not view these reports as a patient medical record.[228] He argued that access to the TPRs are essential for ensuring compliance with state statutes regarding abortion and that confidentiality could be met via redaction of information that could reasonably identify an individual.[229] He specifically noted that the reports had been used for investigations and licensing in the past.[230] Thus, the attorney general argued for public access to TPRs, not for public health purposes, but to aid in ensuring compliance with the law. Both the public access counselor and attorney general's opinions were advisory, so it was unclear whether TPRs would be treated as public records. More recently, the Indiana Department of Health settled a suit to provide access to the records with some information, but not all, redacted.[231] This decision, however, has been challenged in an ongoing lawsuit.[232] While the ultimate outcome may change based on ongoing litigation, the Indiana example highlights the importance of limiting public access to individual reports, and the increasing pressure that may come to make these reports public.

Other states more explicitly say that abortion reports should not be public records. For example, the model Abortion Reporting Act by the Americans United for Life states that reports "shall not be deemed public records and shall remain confidential . . ."[233] Cancer surveillance statutes also

---

[226] A new state statute in 2022 increased the amount of information that needed to be reported on TPRs up to thirty categories of data. Letter from Luke H. Britt, Public Access Counselor, State of Indiana, to Kelly MacKinnon, Chief Legal Counsel, Indiana Department of Health (Dec. 19, 2023) (regarding 23-INF-15, Terminated pregnancy reports).

[227] Ruhman, *supra* note 225.

[228] Letter from Todd Rokita, Attorney General of Indiana, to Andy Zay, Indiana Senate (Apr. 11, 2024) (regarding Nondisclosure of Terminated Pregnancy Reports).

[229] *Id.*

[230] *Id.*

[231] Settlement Agreement, Voices for Life, Inc. v. Ind. Dep't of Health, Case No. 49D02-2405-MI-019876 at 5 (Ind. Super. Ct. Aug. 22, 2024), https://cdn.prod.website-files.com/63d954d4e4ad424df7819d46/67a14382ac8d958bbb28660e_Signed%20Agreement_Voices%20for%20Life.pdf [https://perma.cc/MUH4-HBB3].

[232] Complaint, Bernard v. Ind. State Health Comm'r, Case No. 49D13-2502-PL-006359 (Marion Sup. Ct. Feb. 6, 2025), https://indianacitizen.org/wp-content/uploads/2025/02/filed-a-lawsuit.pdf [https://perma.cc/RN5K-G8SX]. The district court has issued a temporary restraining order and this decision has been appealed.

[233] AMERICANS UNITED FOR LIFE, *supra* note 110, at 8 (suggesting §5(d)). This language has been incorporated into legislations in states adopting this model law. *See, e.g.*, H.B. 3, Reg. Sess. § 4(11)(c) HB3 (Ky. 2022).

often include statements insulating the collected information from public records.

However, states considering the privacy protections of their abortion surveillance should carefully consider the effectiveness of public records bars as even this provision does not necessarily guarantee privacy. For example, in 2018 Idaho enacted the Abortion Complications Reporting Act, which requires providers to report many statistics regarding abortions, including regarding complications.[234] The Act specifically states that reports filed under the new rules are confidential and will not be deemed to be the public record.[235] However, Idaho has a previous Public Records Act that voids any future provisions that seek to close items from the public record,[236] making Idaho's abortion reporting records open to the public.[237] To the extent that other states have similar constraints prohibiting public access to sensitive information, states should identify other ways to protect individual abortion reports from public scrutiny.

3. Insulation from use in investigations/prosecutions

Finally, the reports should not be made available to state law enforcement or state medical boards, both in state and out of state. While the model Abortion Reporting Act includes several confidentiality provisions, it allows for gaps in these protections by requiring reports to be filed with the state medical board[238], and allowing them to be accessed by law enforcement for "good cause."[239] These exceptions increase the risk of loss of privacy, investigation, criminalization of both patients and providers.[240] However, it is fairly common for privacy and confidentiality provisions to have law enforcement exceptions. These exceptions should be reexamined for abortion surveillance programs in a post-*Dobbs* era.

Instead, abortion reporting forms and surveillance data should be protected from use for investigations. These protections could extend to

---

[234] IDAHO CODE § 39-9501 (2018).

[235] *Id.* § 39-8504(6).

[236] *Id.* § 74-122.

[237] *See* Brief for Plaintiff-Appellant at 11, Planned Parenthood v. Wasden (No. 18-35926), 2018 WL 6606011 (9th Cir. Dec. 7, 2018).

[238] *Abortion Reporting Act: Model Legislation & Policy Guide*, AMERICANS UNITED FOR LIFE, *supra* note 110, at 8 (suggesting § 4(j)).

[239] *Id.* (suggesting § 4(f)).

[240] *See, e.g.*, *Abortion Reporting*, *supra* note 69 (highlighting the story of a medical board investigation into a provider of an abortion linked to a complication which led to the public identification of that patient).

restrict reporting forms from being admissible in litigation.[241] Some cancer surveillance programs have adopted similar protections that quite broadly insulate the data from use in legal proceedings and investigations. For example, Kansas provides that "[t]he information contained on the cancer registry . . . shall not be subject to subpoena, discovery or introduction into evidence in any civil or criminal proceeding."[242]

This recommendation to shore up privacy is perhaps the most important of all. In particular, it is imperative for states supporting abortion to insulate their abortion surveillance data from access and use by out-of-state actors. This mirrors robust discussion and trends regarding access to reproductive health information across state lines.[243] In the post-*Dobbs* era, there have been increasing efforts federally by the Biden administration and at the state level among abortion-protective states, to strengthen reproductive health privacy, especially as it relates to requests for information-sharing across state lines. However, as currently written, these protections may fall short of insulating abortion surveillance data.

At the federal level, after *Dobbs*, the Biden administration issued new HIPAA guidance increasing protections of reproductive information. Specifically, the regulations prohibit covered entities from disclosing information about reproductive health care to "conduct a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care" where such health care is lawful.[244] While these regulations could give some limited protection to abortion information within the healthcare realm, the public health agencies and other state regulatory body that maintain the abortion surveillance data likely are not covered entities under HIPAA.[245] Therefore, they would not be similarly restricted from disclosing information under the Biden-era HIPAA regulations.[246]

---

[241] Hill, *supra* note 39, at 222.

[242] KAN. STAT. ANN. § 65-1,171. Other states, such as California, Colorado, Oregon, and Texas have similar provisions.

[243] *See, e.g.*, Cohen et al., *Understanding Shield Laws*, 51 J. L. MED. & ETHICS 584 (2023).

[244] 45 C.F.R. § 164.502(a)(5)(iii).

[245] HIPAA covered entities are health plans, health care clearinghouses, health care providers, and their business associates. 45 C.F.R. § 160.103. *See, e.g.* Richard Gliklich et. al., *Registries for Evaluating Patient Outcomes: A User's Guide [Internet]*, AGENCY FOR HEALTHCARE RSCH AND QUALITY (2014) (noting that cancer registry entities may not be subject to HIPAA); *see also* Jennifer D. Oliva, *Expecting Medication Surveillance*, FORDHAM L. REV. 509, 530 (2024) (noting that prescription drug monitoring program state agencies are not HIPAA covered entities).

[246] Furthermore, under the new Trump administration, these expanded HIPAA protections are likely to come under threat. Indeed, they have already been challenged in court and scrubbed from the new administration's website. In June 2025, a lower court vacated most of the changes implemented by the Biden administration. *See generally* Carmen Purl v. Dep't of Health and Hum. Services, No. 2:24-cv-0028-Z (N.D. Tex. 2025).

Newly adopted state shield laws may provide broader protection. Shield laws are a common tactic in abortion-supportive states to insulate providers, helpers, and recipients of abortion from out-of-state prosecution and litigation.[247] For example, some states with shield laws limit the ability to summon or subpoena individuals to provide information about reproductive services.[248] California's shield law provides that state employee "shall not cooperate with or provide information to any individual or agency or department from another state . . . regarding an abortion that is lawful under the laws of this state and that is performed in this state."[249] California further legislates that

> No state court, judicial officer, or court employee . . . shall issue a subpoena pursuant to any state law in connection with a proceeding in another state regarding . . . an individual obtaining an abortion in this state, if the abortion is lawful under the laws of this state.[250]

These provisions together provide examples of language where state abortion reporting data, particularly individual-level deidentified reports, could be successfully insulated from subpoenas. Similarly, Colorado prohibits state agencies from disclosing provider information or data, "including patient medical records, patient-level data, or related billing information" to aid another state seeking to impose civil or criminal liability.[251] Here, patient-level data could possibly encompass individual-level abortion reports.

States should review existing shield laws or adopt new shield laws to ensure that public health abortion surveillance data is insulated from subpoenas and use in litigation. Even if a state has a robust shield law, they may wish to consider explicitly addressing abortion surveillance data in their protections.

4. Protections for providers

In the post-*Dobbs* world, state laws should also consider the privacy of the providers, not just the patients. While it has been relatively common practice to deidentify the patient's data in abortion reporting bills, the

---

[247] *See generally* David S. Cohen et. al., *Understanding Shield Laws*, 51 J. L. MED. & ETHICS 584 (2023) (describing general trends in shield law legislation).

[248] *Id.* at 586.

[249] CAL. PENAL CODE § 13778.2(b). At least seventeen states have provisions similar to this that restrict a state official's actions. Irene Kim et al., *Two Years After* Dobbs*: Analysis of State Laws to Protect Reproductive Healthcare Info from Interstate Investigations and Prosecutions*, CTR. FOR DEMOCRACY & TECH. (2024).

[250] CAL. PENAL CODE § 13778.2(c)(2).

[251] COL. REV. STAT. § 24-116-102(1).

providers' names have often been included.[252] For example, the model Abortion Reporting Act states that reports shall not include "the name of the woman" or other identifiers[253], but does require the identification of the physician who performed the abortion.[254] The concerns about privacy for the provider are relevant whether or not the state has abortion restrictions. While abortion providers within a restrictive state could certainly be open to investigation related to whether they are complying with the restrictions, there are also concerns that out-of-state providers could be targeted for prosecution if they provide abortion health care for the citizens of restrictive states.[255] Here again, state shield laws can be reassessed to ensure that reports containing provider information cannot be subpoenaed or otherwise used for investigation.

5. Reexamine any reporting requirements

In addition to focusing on abortion surveillance legislation, states should reexamine any laws that include a reporting requirement incidental to their express purpose, such as the fetal remains laws. Some of these laws should be repealed outright if they were passed as part of TRAP laws. Others, like informed consent provisions that are not overly onerous, may still be important, but collections of names or signatures should be ended. This recommendation holds both for states shoring up abortion surveillance privacy and for those states considering ending their abortion surveillance program.

C. Illinois as a Case Example

Since *Dobbs,* Illinois has made changes to its abortion surveillance in ways that balance privacy interests and continued public health collection.[256] In 2023, the Illinois legislature passed a shield law by amending the Reproductive Health Act.[257] The law broadly protects healthcare providers and patients and insulates them from civil and criminal investigations and extradition.[258] The law specifically also amended rules related to abortion

---

[252] *But see* Hill, *supra* note 39, at 225 (pointing to several states that also protect the identity of providers).

[253] AMERICANS UNITED FOR LIFE, *supra* note 110, at 7 (suggesting § 4(c)(4))

[254] *Id.* (suggesting § 4(b)(1)). The bill envisions that the statistical report will not include the physician's name, but the underlying reporting document will.

[255] Hill, *supra* note 39, at 221.

[256] Associated Press, *supra* note 88.

[257] 775 ILL. COMP. STAT. 55 / 1-25 (2023).

[258] *Id.*

reporting in the state.[259] Illinois' original reporting requirements held that the forms should not "request of require information that identifies a patient."[260] The 2023 amendment added that the forms cannot seek information that identifies a health care professional.[261] The 2019 Illinois law already had protections recommended in this article, such as exempting the reports from public access laws and only allowing access to reports by authorized staff "who shall use the reports for statistical purposes only."[262] However, the 2023 amendments further protected the data by declaring the reports to be inadmissible as evidence and not available for discovery in "any action of any kind, in any court, or before any tribunal, board, agency, or person."[263] Additionally, the amendment allows for public reporting of the aggregate data "so long as such disclosure does not reveal any identifying information about a patient or health care professional."[264]

In response to these changes, the Illinois Department of Public Health revised both what information it collects from healthcare providers and how it shares it with the public. Historically, the department had collected data on a range of demographic and procedural variables, such as race/ethnicity, age, marital status, education, pregnancy history, abortion procedure, and county/state.[265] Now, the aggregate reporting on the department website reports only age groups, gestational age, procedure, and residence as "Illinois resident" or "out-of-state resident".[266] Thus, to protect against potentially identifying patients, the agency opted to no longer report "abortion number for Illinois counties . . . or by specific state of out-of-state residents."[267] Thus, across existing and newly established protections, Illinois has made progress towards each of this paper's recommended privacy protections for abortion surveillance data.

---

[259] *Id.*

[260] H.B. 2495, 101st Gen. Assemb. § 1-25(c) (Ill. 2019) (amended 2023).

[261] *Id.* § 1-25(c).

[262] Id. § 1-25 (d).

[263] 775 ILL. COMP. STAT. 55 / 1-25(d) (2023).

[264] *Id.*

[265] *See* ILL. DEP'T. HEALTH, ILLINOIS ABORTION STATISTICS 2018, https://dph.illinois.gov/content/dam/soi/en/web/idph/files/publications/illinois-abortion-statistics-2018.pdf [https://perma.cc/7FB3-UEGD].

[266] *Abortion Statistics*, ILL. DEP'T. HEALTH, https://dph.illinois.gov/data-statistics/vital-statistics/abortion-statistics.html [https://perma.cc/MB7M-UWE4] (last visited May 5, 2025).

[267] Press Release, State of Illinois Revises Abortion Data Collection to Better Protect Patient Privacy in Wake of Dobbs, Illinois Dep't. Pub. Health (June 30, 2023).

* * *

As the fallout from the *Dobbs* decision continues across the country, both pro-choice and anti-abortion advocates are eager to control the narrative of the impact of the Supreme Court case and subsequent state laws. It is no wonder that, in this scramble, there is interest from all parties to also shape the collection of data related to abortion post-*Dobbs*. After all, in the 1970s, important data from the CDC helped the public to understand the decrease in mortality rates from abortion complications post-*Roe* and helped to shape the narrative of the positive impacts of increasing access to safe and legal abortions.[268] Post-*Dobbs*, it is just as important as ever to track how access to abortion is changing as legal restrictions are implemented throughout the country. Yet, anti-abortion activists and government officials are increasingly employing data collection as a way to support enforcement of restrictive abortion laws and as an effort to shape the narrative of abortion as a dangerous procedure, despite widespread historical evidence showing it is not. Efforts also seek to turn state data collection into tools for law enforcement and compliance efforts. This politicization of abortion reporting is anathema to public health goals.

Yet, it would be counterproductive to eliminate abortion surveillance for legitimate public health goals for fear of abortion surveillance for criminal investigation.[269] Criminal cases are built on data, but so too are essential public health studies. Continuing to prioritize legitimate public health goals in abortion tracking makes sense given on-the-ground political realities and other more pressing privacy concerns for abortion patients and providers. Instead, to the extent possible, states should continue abortion surveillance, but with strong privacy protections in mind. In this way, states can balance the privacy and public health imperatives of the post-*Dobbs* era.

---

[268] *See supra* Section II.A.

[269] *See, e.g.*, Lens, *supra* note 32, at 574 (noting, in the context of advocating for a public health surveillance system for counting stillbirths, that "[p]otential blame and criminalization . . . are not reasons to avoid research . . . .").