

No. 25-840

IN THE
Supreme Court of the United States

INTERNATIONAL PARTNERS FOR
ETHICAL CARE, INC., *et al.*,

Petitioners,

v.

BOB FERGUSON, GOVERNOR OF WASHINGTON, *et al.*,

Respondents.

ON A WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE NINTH CIRCUIT

**BRIEF OF *AMICUS CURIAE*
CENTER FOR REPRODUCTIVE RIGHTS
IN SUPPORT OF RESPONDENTS**

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STATEMENT OF INTEREST ¹

The Center for Reproductive Rights (the “Center”) works to ensure reproductive rights are protected in law as fundamental human rights. Since its founding in 1992, the Center has litigated and appeared as amici before the Supreme Court and state and federal courts in dozens of cases about critical reproductive health and constitutional issues, many of which raised standing to challenge laws that impact contested healthcare access. The Center’s litigation and policy also addresses issues around receipt of information about healthcare, confidential access to care, and the ability to autonomously consent, including for young people. The Center submits this brief to support core precedent that opens the federal courts only to litigants who can demonstrate concrete, particularized, and actual injury and causation when seeking to challenge laws that may determine access to essential healthcare and related information for others. This bedrock standing principle has been a bulwark against litigants using the federal courts to pursue moral, ethical, and conscience-based objections to laws that do not impose injury, in accordance with the requirements of Article III, while ensuring that the judicial process is available when people face real harms around healthcare access.

SUMMARY OF ARGUMENT

Article III incontrovertibly requires a plaintiff to establish an injury in fact that is concrete, particularized,

1. Pursuant to Supreme Court Rule 37.6, Amicus states that no counsel for any party authored this brief in whole or in part, and that no entity or person other than Amicus made any monetary contribution toward the preparation and submission of this brief.

and demonstrably caused by the defendant. These requirements are especially crucial when a challenger in a lawsuit seeks to limit or restrict another person's ability to access healthcare, given that others' health and well-being is at stake. Petitioners here assert complex theories to claim that Washington laws injure them by increasing the likelihood of youth access to outpatient behavioral health services, relying on speculation instead of real effects, and factual misunderstandings about how the laws operate. They follow an alarming trend by plaintiffs in recent cases involving reproductive healthcare for others who have jettisoned key limitations in asserting injury. In *FDA v. Alliance for Hippocratic Medicine*, 602 U.S. 367 (2024), this Court recently rejected the argument that standing for unregulated plaintiffs can turn on a chain of third-party events with multiple contingent steps, noting that these theories of harm invite a universe of speculation. This case presents the same underlying problem, and the Court should again reject standing that is based on contingent facts that may never materialize.

Petitioners here misconstrue how the Washington state laws operate in relation to healthcare access, asserting harms that the laws do not by their terms impose. Resp. Br. 6-12, 22. Factual confusion aside, their theories of injury are unworkable in the healthcare context and would allow for no meaningful limits on litigation by plaintiffs with moral, ethical, or conscience objections to care. Contrary to this Court's precedent, Petitioners' "object" theory would enable those who oppose a healthcare law to challenge any legal change that they claim impacts their status, with no workable criteria for courts to apply. Petitioners' "increased-risk-of harm" theory would permit challenges to any law or policy that supports access to

healthcare services that plaintiffs allege violate their rights, based merely on a theoretical risk that it increases the chances that access will occur. And Petitioners’ “voluntary changes to parenting strategies” theory would condition standing on deeply felt but subjective reactions to laws in the absence of direct regulation, resulting in a deluge of litigation over reproductive healthcare policies by both supporters and opponents of access. If accepted, these boundless standing theories would enable challenges to healthcare regulation across the country irrespective of states’ different public policy approaches, including to laws existing in a majority of states that mandate or conversely limit parental involvement with reproductive and sexual healthcare.

ARGUMENT

I. Plaintiffs’ Theories of Injury Upend this Court’s Standing Doctrine, Including in Cases about Healthcare Access.

Article III incontrovertibly requires a plaintiff to establish an injury in fact that is concrete, particularized, and demonstrably caused by the defendant. But plaintiffs in recent cases involving sexual and reproductive healthcare for others have jettisoned these key limitations in asserting injury. In *FDA v. Alliance for Hippocratic Medicine*, 602 U.S. 367 (2024), this Court recently rejected plaintiffs’ attenuated assertions of injury and causation. Noting that the plaintiffs’ arguments turned on a chain of third-party events with multiple contingent steps, the Court refused to expand Article III standing to accommodate plaintiffs’ theories. This case presents the same shortcomings, and is not different because Petitioners assert injuries that

include infringement on parental rights. The Court should once again reject assertions of standing that are based on contingent facts and multiple layers of speculation that may never materialize.

A. Article III’s injury-in-fact requirement is a critical limitation in the healthcare context.

The “bedrock constitutional requirement” of Article III standing requires a plaintiff to demonstrate they have suffered or will suffer an injury in fact caused by the defendant and redressable by a court order. *All. for Hippocratic Med.*, 602 U.S. at 378 (quoting *United States v. Texas*, 599 U.S. 670, 675 (2023)). To establish an injury in fact, the plaintiff must identify the “invasion of a legally protected interest” that is “concrete and particularized” and “actual or imminent, not conjectural or hypothetical.” *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560 (1992) (citation and internal quotation marks omitted). Time and again, the Court has emphasized that neither the “intensity of the litigant’s interest” nor “strong opposition to the government’s conduct” is a substitute for a concrete and particularized injury. *All. for Hippocratic Med.*, 602 U.S. at 394 (quoting *Valley Forge Christian Coll. v. Ams. United for Separation of Church & State, Inc.*, 454 U.S. 464, 486 (1982)); *see also Diamond v. Charles*, 476 U.S. 54, 62 (1986) (“The presence of a disagreement, however sharp and acrimonious it may be, is insufficient by itself to meet Article III’s requirements.”). The Court has never held that there is an alternative to showing concrete and particularized harm, whether based on an attribute of a statute, or the nature of the asserted rights violation.

An injury suffices for Article III standing only if it is “fairly traceable to the challenged action of the defendant, and not the result of the independent action of some third party not before the court.” *Lujan*, 504 U.S. at 560 (citation, brackets, and ellipses omitted). When, as here, the challenged conduct does not “require or forbid some action by the plaintiff,” the plaintiff faces the “substantially more difficult” task of “linking their asserted injuries to the government’s regulation (or lack of regulation) of someone else.” *All. for Hippocratic Med.*, 602 U.S. at 368 (quoting *Lujan*, 504 U.S. at 562). In doing so, this Court has explained, the plaintiff cannot rely on “speculative links,” i.e., “where it is not sufficiently predictable how third parties would react to government action or cause downstream injury to plaintiffs.” *Id.* at 383. Nor can a plaintiff rely on “attenuated links,” i.e., “where the government action is so far removed from its distant (even if predictable) ripple effects.” *Id.* The Court has repeatedly admonished theories of standing that rest on a “speculative chain of possibilities,” *Clapper v. Amnesty Int’l USA*, 568 U. S. 398, 410 (2013), especially when those possibilities depend on “unfettered choices made by independent actors,” *Lujan*, 504 U.S. at 562 (citation omitted).

Article III’s requirements that an injury be “concrete and particularized,” *Lujan*, 504 U.S. at 560, and traceable to the defendant, *see Allen v. Wright*, 468 U.S. 737, 738 (1984), are particularly crucial in suits against laws that support healthcare access for people other than the plaintiffs. That is because healthcare is distinct from many circumstances raising standing for unregulated parties, such as economic regulations that limit profits for third-party businesses, *e.g.*, *General Motors Corp. v. Tracy*, 519

U.S.. 278, 287 (1997) (asserting standing based on harm to financial interests of large purchaser of natural gas that was liable for paying a tax imposed only on subset of out-of-state sellers who were the regulated parties); laws governing parks and national forests that impact the people who use them, *e.g.*, *Summers v. Earth Island Inst.*, 555 U.S. 488, 494 (2009) (asserting harm to recreational interests of environmental organization’s members from regulation applying to forest service decision process); and property regulation that impacts the value of other properties. *See All. for Hippocratic Med.*, 602 U.S. at 384-85 (discussing different types of cases where laws may injure third parties for standing purposes).

Unlike business issues and those involving enjoyment of natural resources and property, healthcare access necessarily involves individuals who need treatment directly impacting their bodies and sometimes the sustenance of their lives. These individuals may lose access to vital care and suffer devastating consequences based on asserted harms to third parties. Given the human stakes, it is imperative for an unregulated party that wants to curtail healthcare for others to demonstrate concrete injury, just as Article III requires.

B. This Court rejected “attenuated” or “speculative” theories relying on third party chains of action in *Alliance*.

Like Petitioners here, unregulated parties in recent cases have tried to jettison the requirement that they demonstrate a concrete, particularized, and actual or impending harm when seeking to challenge laws that neither require nor prohibit any action on their part, but

instead govern healthcare access for others. At bottom, they allege what are disagreements with governmental policy, or deeply-feared but hypothetical harms at the end of a multistep chain of contingencies involving independent actions by third parties. These standing theories lack a principled endpoint and threaten to inundate the courts with injured litigants, in defiance of this Court's precedents and Article III's mandates.

This Court recently rejected that standing can turn on a chain of third-party events with multiple contingent or speculative steps in *Alliance*, the only case involving an unregulated party's challenge to healthcare access for others it has recently decided. Just two years ago, physicians who did not use or prescribe the drug mifepristone asserted standing to challenge FDA's actions regarding the drug based on claims that if they had to treat patients who experienced complications from the medication, they might suffer future injuries to their religious liberty rights or economic interests.

In rejecting the *Alliance* plaintiffs' standing based on both conscience injuries and economic injuries, this Court focused on the "difficulty [of] establishing causation" when the regulated party is not the plaintiff and causation depends on the responses of regulated parties "and perhaps on the response of others as well." *All. for Hippocratic Med.* 602 U.S. at 383 (quoting *Lujan*, 504 U.S. at 562). This Court held that a chain of events that would require doctors to provide abortion or related treatments in spite of federal laws that allow conscience objectors to refuse was plaintiffs' speculative assertion. *See id.* at 383. Similarly, the Court rejected a causal pathway that alleged economic harm from an

increase in patients with complications, the need to divert resources to their treatment, and increased liability and insurance costs. These things might never happen, the Court explained, and federal regulation of mifepristone would not have caused the doctors' harms even if they did. *See id.* at 386-90. Harm instead depended on actions by third parties—patients, insurers, lawyers, others—each of which was “highly speculative.” *Id.* at 390. The Court rejected the doctors' “limitless” theory that would not only allow physicians to challenge any FDA action approving a new drug (virtually all of which come with complications and risks) but also permit various kinds of plaintiffs to challenge “almost any policy affecting public health” on the basis that such actions may reach them through a long chain of uncertain effects. *Id.* at 391-92. In requiring direct and predictable personal harms, the Court held that “a plaintiff's desire to make a drug less available *for others* does not establish standing to sue.” *Id.* at 374.

Although *Alliance* dealt with physicians' concern about rights violations caused by patient access to medication, and this case concerns parents' concern about rights violations if their children were to receive a referral for behavioral healthcare, both cases involved alleged constitutional injuries, and the requirement that plaintiffs establish a concrete, particularized, and actual or imminent injury, which remains “an essential and unchanging part of the case-or-controversy requirement of Article III,” *All. for Hippocratic Med.*, 602 U.S. at 380—not one that can be dispensed with depending on the factual context.

Given the potent “value interests” involved on all sides in reproductive and gender-related healthcare, *All. for*

Hippocratic Med., 602 U.S. at 382 (citation omitted), it is unsurprising that litigants assert harms to themselves derived from potential access to services by others, and fear consequential infringements on their own rights from a chain of hypothetically possible events. For instance, a federal district court recently held that physicians and organizations with moral, ethical, and conscience objections who did not provide abortion services lacked standing to have Minnesota’s laws protecting abortion access declared unconstitutional. *Women’s Life Care Center v. Ellison*, 811 F. Supp. 3d 996 (D. Minn. 2025) (*appeal filed*). The laws did not impose any requirement or prohibition on the plaintiffs, and the asserted injuries—that Minnesota’s alleged under-regulation of providers may lead more patients to show up at plaintiffs’ offices with follow-on injuries—were the type deemed insufficient for Article III in *Alliance*. And a Michigan federal court recently rejected standing for a group of plaintiffs opposed to abortion who sought to challenge the state’s newly ratified constitutional amendment guaranteeing “the right to make and effectuate decisions about all matters relating to pregnancy, including but not limited to prenatal care, childbirth, postpartum care, contraception, sterilization, abortion care, miscarriage management, and infertility care.” *Right To Life of Mich. v. Whitmer*, No. 25-1973, 2026 WL 1471210, at *1 (6th Cir. May 26, 2026) (quoting Mich. Const. art. I, § 28(1)). The plaintiffs included a non-profit that felt the amendment would limit its legislative anti-abortion efforts, women who had been pregnant and planned to be pregnant again who feared negative impacts on their care, and parents of public school children who alleged that the amendment would allow schools to aid in activities that would violate their parental rights. *Id.* The Sixth Circuit affirmed that the plaintiffs lacked standing

because they failed to show how the amendment or state officials who were named defendants could cause their asserted injuries. *Id.* at *2-3.

That the plaintiffs in these cases had deep and subjectively real fears that laws addressing healthcare would impact them through a chain of hypothetical events is undisputed. But this Court has stated many times that deeply-felt interests cannot stand in for concrete and particularized personal harm. *Valley Forge*, 454 U.S. at 473; *Allen*, 468 U.S. at 756; *United States v. SCRAP*, 412 U.S. 669, 687 (1973). Maintaining this limitation is crucial in the face of efforts to convert third-party actions and access into legally cognizable injury that would quickly extend to all forms of stigmatized care if the door were opened, even in the absence of foundational Article III requirements.

C. Attenuated theories of harm like those here force courts to speculate about causation.

Unlike a basis for standing that relies on direct enforcement of a law or regulation against a plaintiff, theories of injury and causation in *Alliance* required multiple steps by third parties that vastly expand speculative pathways for how plaintiffs will be impacted. This case presents the same challenge, and the Court should reject standing that is based on contingent facts that may never materialize.

Here, Petitioners offer confoundingly “complicated causation theories,” *All. for Hippocratic Med.* 602 U.S. at 368, to connect the laws at issue to their assertions of injury, articulated as a bucket of present harms around

changes to their current parenting, and a separate bucket of potential future harms that turn on their children running away to a licensed shelter and coming into contact with the challenged laws. Pet'rs'. Br. 3-4, 18-19, 43, 50. The causal chain leading from the challenged laws to any of these asserted harms is inherently speculative, requiring action by at least one and often multiple third parties, including youth, shelters, youth department authorities, and providers of behavioral health services. Future harms turning on an inability to be involved with their adolescent's behavioral healthcare require a lengthy string of theoretical events, including at minimum: youth to run away to a shelter; to inform the shelter that they are seeking gender-affirming care, and the shelter to then notify the Department; youth to refrain from giving contact information for parents; to accept a behavioral health service referral; and to secure outpatient behavioral health services without state assistance (which the law does not provide for) before parents are contacted within the statutorily required seventy-two hour period with an offer of reconciliation services. *See* Resp. Br. 41-42. For any alleged harm turning on longer-term outpatient mental health treatment, the Department would need to invoke a separate provision permitting an extended stay in the shelter if parents do not request return of the youth or cannot be reached. *See* Resp. Br. 6-7.

Stretching causation even farther, Petitioners' asserted "present" harms to parenting depend on the extra step of parents' *contemplation* of an attenuated chain of events in which their children *might* run away and trigger the law, involving even more speculation about third-party actions and future contingencies, in addition

to parents’ subjective decisions to alter their behavior that the law in no way requires.² *See infra* II.C.

Notably, showing the extent to which these chains are speculative, the overwhelming majority of youth who do run away stay with friends or family, not in licensed shelters. National Center for Homeless Education, *Student Homelessness in America: School Years 2017-18 to 2019-20* at 1 (2021), <https://perma.cc/4CD8-NDRJ>. And, as Respondent’s brief explains, for youth who do go to licensed shelters, the State offers them only contact information for mental healthcare providers that is readily obtainable online. Resp. Br. 23. “[I]t is irrational to assume that children would run away from home to get information they could easily obtain online.” *Id.* at 39-40. Indeed, since the shelter laws were enacted more than three years ago, licensed shelters have not once contacted the Department about a runaway youth seeking gender-affirming care or reproductive care. *Id.* at 13.

2. Petitioners assert that these harms infringe on parental rights and speech (a religious liberty claim appears to have been mooted at this stage, Resp. Br. 22). While they focus mainly on parental rights, to establish an injury in fact based on censored speech such as their use of pronouns they would otherwise reject, it is similarly not enough merely to rely on subjective fears. *Laird v. Tatum*, 408 U. S. 1, 11–16 (1972). This Court has held that a plaintiff cannot establish an injury in fact by alleging only that their constitutional speech rights are chilled “by the mere existence” of a government program they perceive to be “inappropriate,” consider “inherently dangerous,” or allegedly gives them a “generalized yet speculative apprehensiveness” that the government “may at some future date” take an action that “would cause direct harm.” *Id.*

On top of that, Petitioners’ fail to confront that the shelters’ parental notification process cannot be the cause of their asserted injuries because another law stands in the way. Similar to the alleged conscience injuries in *Alliance*, which the Court held were foreclosed by conscience protections in federal law that broke the causal chain, 602 U.S. at 390, Petitioners’ theories of causation and redressability for the shelter law fail here. This is because Wash. Rev. Code § 71.34.530, a different statute dating to 1985, already allowed youth ages 13 and older to request and receive outpatient behavioral health treatment (but not medication or other physical treatment) without parental involvement even prior to and in the absence of the shelter law. Resp. Br. 14. Wash. Rev. Code § 71.34.530 confers this ability on youth whether they are in a shelter or not, breaking the chain of causation for the shelter law to cause Petitioner’s asserted injuries. And while Petitioners also seek to challenge § 71.34.530, they face no individualized harm that would give them standing; that law is decades old, similar to many others across the healthcare context, Resp. Br. 15, and does not meet the criteria for Petitioners’ standing theories even as they articulate them, as discussed in more detail below. *See infra* II.A.

Even if not factually or legally foreclosed by the way the laws operate, Petitioners’ harms depend on the kind of speculation about the decisions of independent third parties this Court has long recognized does not establish injury in fact. *See, e.g., All. for Hippocratic Med.*, 602 U.S. at 383; *Clapper*, 568 U.S. at 415. Petitioners must show that “third parties will likely react in predictable ways that in turn will likely injure them.” *Clapper*, 568 U.S. at 413 (internal citations omitted). And this Court has repeatedly

declined to endorse standing theories when key links in the chain require it to engage in “guesswork as to how independent decisionmakers will exercise their judgment.” *Id.* *Alliance* reiterated these longstanding, key limitations on federal judicial authority, even as plaintiffs try to loosen them based on deeply-held but speculative fears around sexual and reproductive healthcare as discussed above. The Court should follow that established precedent here.

II. The Theories of Injury that Petitioners Assert Would Open the Floodgates to Litigation Over Healthcare Access.

Petitioners assert three theories of injury, each of which is entirely unworkable in the healthcare context and would place no meaningful limits on litigation by plaintiffs who oppose access for others. First, Petitioners’ “object” theory is unsupported by any case providing criteria for courts to apply, and as articulated for the first time here would enable plaintiffs to challenge any change to a healthcare law that imposes or removes conditions under which providers can offer a treatment to patients. Second, Petitioners’ “increased-risk-of harm” theory would permit challenges to any law or policy that supports access to healthcare services that plaintiffs allege violate their rights, based merely on a theoretical risk that it increases the chances that access will occur. And third, Petitioners’ “voluntary changes to parenting strategies” theory would condition standing on deeply felt but subjective reactions to a law in the absence of direct regulation, resulting in a deluge of litigation over reproductive healthcare policies by both supporters and opponents of access. These limitless standing theories would enable challenges to healthcare regulation in every state, including when states

adopt a public policy requiring parental consent or notice for youth access to sexual and reproductive services such as abortion, prenatal care, and contraception; and when they permit youth to confidentially and independently obtain these types of care.

A. The “object of the law” theory is unworkable in the healthcare context, and *Alliance* functionally rejected it.

Seeking to sidestep the problems with attenuated and speculative asserted injury in the absence of concrete facts, Petitioners advance a sweeping theory that they are “objects” of the law and have standing on that basis alone, although they are not directly regulated, and even absent a showing of individualized harm, causation, and redressability. Petitioners rely on *Diamond Alternative Energy, LLC v. EPA*, 606 U.S. 100 (2025) and *Mirabelli v. Bonta*, 607 U.S. 492 (2026), cases that offered bare gestures to an “object of the law” theory without detailing what it would require, and certainly without holding that it could obviate bedrock standing requirements. Plaintiffs in these cases are dissimilarly situated to Petitioners, given that they were already in direct reach of the laws they challenged, without any need for attenuated and speculative chains of events to inflict harm.³ And Petitioners further

3. Neither *Diamond* nor *Mirabelli* held that anyone whom the government knows a law will affect or allegedly intends a law to affect is an “object” of the law. Nor did they hold that anyone who is indirectly implicated by a law is treated like a directedly regulated party for the purpose of injury-in-fact. *Diamond*—in which injury and causation were undisputed—did not involve a constitutional right but rather the “familiar circumstance where government regulation of one business may be likely to cause injuries” to other

ignore that *Alliance* functionally rejects such a theory, in part because it would be unworkable in a healthcare access context, like that Petitioners construe the Washington laws to present.

Petitioners fail to offer coherent criteria to assess when an unregulated party should be deemed the “object” of a statute, reflecting that caselaw does not establish the theory, and a decision accepting it here would drastically distort precedent. They first suggest the “text and design” of the shelter laws make “parents unwilling to affirm their gender-confused children” the object of the laws because they “reclassify parents” from “one legal category to a less favorable one,” essentially “chang[ing] . . . how the statute treats these parents.” Pet’rs’ Br 24-25. This theory would make any unregulated person eligible to challenge a change in healthcare law or policy if they view its obligations as “less favorable” to them, or if it authorizes providers to do something new or different to which they object.

directly connected businesses based on “commonsense economic principles.” 606 U.S. at 116-17. In upholding standing, the Court declined to resolve the question of whether fuel producers were in fact objects of the regulations. *Id.* And *Mirabelli*—in holding that a class of parents had standing to challenge policies adopted and employed by schools that their children actually attended—included a single unexplained reference to parents as “objects of the [law]”, *see* 607 U.S. at 498. That aside, its central focus was on detailed allegations by named plaintiffs that schools had already applied the challenged law to their children. By contrast, Petitioners will come within the reach of the challenged laws only after a series of intervening events, including individualized decisions by young people, parents, shelters, and outpatient behavioral healthcare providers.

For example, any change to a healthcare regulation that imposes or removes conditions under which patients can access a treatment—e.g. based on whether they have health insurance, or health risks and benefits for groups with different attributes (including, for example, pregnancy)—would automatically confer standing on patients who oppose the changes to their status under the law, irrespective of whether they would ever seek the treatment, and even if they are not regulated parties. The same goes for providers who would never provide a type of healthcare and are not directly regulated, such as when a regulatory scheme for a medication is altered in a way that they believe is less favorable. But this reasoning could have conferred standing on the plaintiff physicians in *Alliance* based on numerous perceived negative changes to their status and treatment under the law—for example, through approval of nurse practitioners to prescribe the medication along with physicians who previously had sole privileges and the legal advantages that implies. *All. for Hippocratic Med.*, 602 U.S. at 375-76. And while changes to legal status could confer standing if a challenger showed more specific likelihood of individual injury, causation, and redressability—for example if a patient can show that they use or are likely to use a treatment, or a provider offers it—those changes must fail under an “object theory” that is based simply on asserted legal “reclassification,” particularly when the perceived change in category is based solely on the regulation of others.

Second, Petitioners claim that statements made by legislators before the bill’s passage show “a purpose to thwart parental influence and authority” which makes parents the “objects” of the law even though they are not directly regulated. Pet’rs’. Br. 25. The cases that they

rely on for their glancing reference to “object” standing make no mention of legislative history. *See Diamond*, 606 U.S. at 116 (looking to “commonsense economic realities” to determine plaintiffs had satisfied redressability); *Mirabelli*, 607 U.S. at 494 (involving parents who had been denied information under the challenged policies or had children in public schools that were following the policies). Moreover, basing a standing theory on the purported “stated purposes” of legislators is inherently subjective, given that legislative bodies are diverse and statements will conflict. *See* Resp. Br. 29 (“[F]loor statements by individual legislators rank among the least illuminating forms of legislative history” (quoting *NLRB v. SW Gen., Inc.*, 580 U.S. 288, 307 (2017))).

A theory of standing based on an alleged purpose to implicate groups that fall outside the regulation is particularly unworkable in the healthcare context, where laws operate through providers, medical institutions, drug approvals, insurers, patients, and many other interrelated entities, and legislative records are replete with statements about complex purposes and effects. Reflecting that complexity, this Court in *Alliance* rejected physician plaintiffs’ standing to challenge regulation of a medication that they would not prescribe or administer, in spite of their assertions that calling on emergency doctors to treat complications “is not a bug in the FDA’s abortion-drug plan, but part of its very design,” and the FDA had repeatedly made statements showing that “the harm caused [to emergency doctors like Respondents] is not just predictable; it is embedded in FDA’s plan.” Resp. Br. in Opp. 2, 25, *All. for Hippocratic Med.*, 602 U.S. 367 (2024). If, as Petitioners claim here, a mere “stated purpose” to affect unregulated parties in allegedly rights-depriving

ways made them “objects” for standing without any actual demonstrated involvement, cherry-picked statements made in the course of healthcare regulatory processes could enable the kind of challenge that *Alliance* rejected.

To the extent the “object” theory depends on either a new legal disadvantage or intent to target an unregulated group (which, as noted, this Court has never held), it would certainly have conferred Article III standing on the plaintiffs in *Whole Woman’s Health v. Jackson*, 595 U.S. 30 (2021). The *Jackson* plaintiffs were abortion providers bringing a constitutional challenge to Texas statute S.B.8, which authorized private parties to file civil actions in state court for injunctions and damages against anyone they believed performed or assisted in prohibited abortions, defined to include those that at that time were protected and could not be banned under *Roe v. Wade*. This Court held that the providers lacked Article III standing to sue the state court clerks and judges who would be responsible for docketing and administering the private lawsuits, given that they were not “adverse.” *Id.* The plaintiffs similarly lacked standing to sue a private individual who opposed abortion and was positioned to bring an S.B.8 lawsuit, but had so far disclaimed an intent to do so, because they could not show injury traceable to that individual’s conduct. Under the ill-defined object theory that Petitioners assert here, however, S.B.8 absolutely inflicted a devastating change to providers’ legal status. And while S.B.8 intentionally impeded standing by limiting who could enforce the law, legislative intent to target and harm the rights of providers to provide constitutionally-protected care was the law’s *raison d’être*. *Whole Woman’s Health* 595 U.S. at 61 (Roberts, C. J., concurring in the judgment in part

and dissenting in part) (“The clear purpose and actual effect of S. B. 8 has been to nullify this Court’s rulings.”). If anything like an object theory of standing exists to replace fundamental constitutional requirements of imminent injury and causation, it would have conferred standing on the plaintiffs in *Jackson*. But it does not, and any application would cut against innumerable decisions and core Article III requirements of this Court.

Further showing the “object” standing theory is not a justiciable standard at all, Petitioners assert that parents who object to “outpatient treatment” without parental consent for their adolescents are also “objects” under a separate state law that they challenge, Wash. Rev. Code §71.34.530, which generally allows youth thirteen and older to ask for and consent to outpatient mental health treatment. Petitioners offer no argument or evidence that this law, enacted in 1985, on its face negatively “reclassif[ies]” parents or otherwise changes a parent’s legal status as the amendments to the shelter law allegedly do. Pet’rs. Br. 24. Nor does anything about the law suggest that its “stated purpose[]” is to undermine parental authority. Pet’rs. Br. 25. Petitioners’ object theory would thus confer standing on anyone who subjectively asserts negative impacts from a law that regulates others in the healthcare system.

Apart from having children who are “capable of understanding gender and running away,” Pet’rs’. Br. 29, the single potential limitation that Petitioners obliquely suggest is that only parents who object to their adolescents consenting to outpatient behavioral healthcare may have “object” standing, while other parents must rely on other theories. Pet’rs’. Br. 30. Essentially, then, Petitioners

assert automatic standing to challenge a healthcare regulation in the absence of other personalized and specific harms for those who don't like what they claim the regulation does. Healthcare issues in which challengers have voiced opposition to a policy and yet been found to lack the necessary individualized harms for standing span a range from vaccines, to reproductive health services, to insurance coverage. *See, e.g., Coal. for Mercury-Free Drugs v. Sebelius*, 671 F.3d 1275, 1276 (D.C. Cir. 2012) (group whose members opposed the use of thimerosal in vaccines lacked standing to challenge vaccine approval given that members would refuse vaccines or could obtain a thimerosal-free formula); *All. for Hippocratic Med.*, 602 U.S. at 386; *Kindler v. Geithner*, 695 F.3d 772, 776 (8th Cir. 2012) (plaintiff who objected to Affordable Care Act individual mandate to obtain insurance beyond “catastrophic” coverage lacked injury for standing purposes because she was in fact eligible to purchase a catastrophic plan and so would suffer no injury). A standing rule that empowers unregulated parties to bring suit, but only those who subjectively oppose the legislation, would flood the courts with disputes untethered from the very real harms that healthcare access regulation can impose on those who directly experience its effects.

B. The “increased risk of future access to healthcare” theory would inundate the courts with injured litigants asserting hypothetical harms.

Petitioners assert that “increased risk of harm” from the mere enactment of the law—even prior to any implementation—is an injury for standing purposes, contesting the Ninth Circuit’s conclusion that increased

risk “does not replace the foundational rule that a future injury must be imminent in order to satisfy the injury-in-fact requirement.” Pet’rs’. Br. 50. This theory would permit challenges to any law or policy that supports access to healthcare services that plaintiffs allege violate their rights, based merely on a theoretical risk that it increases the chances that access will occur.

Petitioners variously suggest basing this “increased risk” standard on “probability” of injury, *id.* 48, or “predictable effect,” *id.* 52, or increased probability “compared to the risk before the laws’ enforcement began,” *id.* But they offer no discernable limits on when any of these metrics would apply. The absence of limits reflects that any law supporting access to healthcare services—at least in theory—increases the risk of access, creates a theoretical “predictable effect” that third parties will access services, and raises the probability of access as compared to before the law’s passage. To take one example, regulatory approval for a method of contraception increases the theoretical risk that a pharmacist with conscience objections will need to prescribe it. A public insurance coverage requirement for contraception on its face creates a “predictable effect” that patients will seek to fill more prescriptions that “may be likely” to conflict with pharmacists’ objections. If allegedly objectionable forms of contraception were not approved, the risk of these harms would theoretically decrease. Indeed, an “increased risk of harm” theory would likely confer standing on the providers in *Alliance*, where the Court noted that FDA’s approval and regulation of mifepristone may predictably “yield more visits to doctors” because “virtually all drugs come with complications, risks, and side effects.” *All. for Hippocratic Med.*, 602 U.S. at 392. But it held that

speculative and attenuated intervening chains of events defeated Article III requirements.

Importantly, as in *Alliance*, Petitioner’s theory is not limited to increased risk of a future rights violation based on a law’s application to their own actions, but instead turns on third-party youth seeking care. A standing theory based on increased risk of future harm that is triggered by access to healthcare by others—whether patients, beneficiaries, or youth—would make vital forms of care vulnerable to challenge from the moment a law is enacted, even without facts showing that a challenger faces individualized harm. Even more problematic, the more available and relied-on a form of healthcare is, the higher the risk of it being used, bolstering standing for anyone who objects and claims a related violation of their rights, however hypothetical.

C. The “voluntary changes to parenting strategies” theory would give parents sweeping leeway to challenge a policy based on their subjective reactions.

Even while asserting future harms or increased risk of harm, no Petitioner has alleged their own behavior or their children’s behavior has brought them within reach of the statutes. Resp. Br. 12 (citations omitted). Still, Petitioners claim that they have made voluntary present-day decisions to change their approach to parenting—from using different pronouns, to not disciplining their children—because of their undisputed opposition to gender-affirming treatment. But this kind of speculative and subjective reaction to a law cannot confer standing, however deeply felt. *See All. for Hippocratic Med.*, 602

U.S. at 368 (“Article III standing screens out plaintiffs who might have only a general legal, moral, ideological, or policy objection to a particular government action.”). Article III’s limitations on injuries of this kind are essential to prevent a deluge of litigation over reproductive healthcare policies, likely initiated by both supporters and opponents of access in states that have enacted laws limiting or facilitating care.

That parents may change their behavior in response to reproductive health law and policy is a truism. For example, a parent who objects to abortion in a state that lifts an abortion ban may limit their child’s activities that they believe increase the risk of pregnancy—from dating to unsupervised time with friends—out of fear that the child could become pregnant and choose termination under state law provisions. That same parent could choose an opposite parental strategy, concealing their opposition to abortion from their child in the hopes of being consulted about decisions they make. On the other side of the issue, a parent who supports reproductive autonomy in a state with an abortion ban may push their child to use a long-acting form of contraception, such as an intrauterine device (IUD), because they fear the consequences of unexpected pregnancy without a range of choices available. Certainly, parents across the country have made similar choices in response to different legal regimes. Arleigh Rogers & Michael Goldberg, *Families with Transgender Kids Are Increasingly Forced to Travel Out of State for the Care They Need*, ASSOCIATED PRESS (July 10, 2023), <https://perma.cc/4D4X-6NE8>.

Regarding parental involvement specifically, legal regimes in states across the country vary widely, based on

different public policy approaches. For example, 37 states mandate parental involvement in a young person’s decision to have an abortion, with varying requirements, while the remainder allow a young person to independently and confidentially seek care. Guttmacher Institute, *Minors’ Access to Abortion Care* (Aug. 1, 2026), <https://perma.cc/7FT9-TC3X>. Conversely, 38 states and the District of Columbia have enacted laws that permit youth to consent to prenatal care; and 49 states and the District of Columbia have laws that allow youth to consent to STI testing and treatment. Abigail English & Rebecca Gudeman, *Minor Consent and Confidentiality A Compendium of State and Federal Laws*, Nat’l Ctr. for Youth L. (Aug. 2026), <https://perma.cc/E38X-HH3Y>. While some parents believe lack of opportunity for notice and consent injures their rights, others perceive injury from state-mandated involvement with personal decision-making of their children. Parents with these different beliefs and views may voluntarily adapt their parenting based on what laws allow or require. If such adaptations become the basis for legal standing, any such law—or state failure to require involvement—will be open to challenge by parents regardless of whether it is likely to directly impact them or their children.

But precedent makes clear that contingent choices about parenting cannot satisfy Article III. This Court has repeatedly rejected the idea that plaintiffs can create their own injury, in particular when their responses could go one way or another, or are “riddled with contingencies and speculation that impede judicial review.” *Trump v. New York*, 592 U.S. 125, 131 (2020). *Alliance’s* core teaching was to reject a chain of causation that is not “predictable.” And how a parent will voluntarily change behaviors in response to health access regulation is inherently speculative.

So too here. Any causal chain from the challenged laws to Petitioners' assertion of present interference with parenting runs through the unpredictable black box of parents' personal decision-making—as it should. Parents can properly decide how to talk to, instruct, and discipline their children in diverse ways, but that does not confer standing to challenge a law that does not regulate them, based on how they carry out their objections to it. Any such rule would enable endless litigation irrespective of how states choose to require or limit parental involvement with healthcare access for youth, based on deeply-held convictions that must inform parenting, but cannot be a basis for challenging laws in the absence of the concrete, particularized, and actual injury that Article III has always required.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

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