Op-Ed

The US Supreme Court and the Future of Reproductive Health

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IN THE DECADES SINCE REPRODUCTIVE HEALTH RIGHTS EMERGED as an issue before the US Supreme Court, there never has been a term quite like the current one, which will conclude several months before the 2016 presidential election.

The origins of the Court's involvement with reproductive rights can be traced to *Griswold v Connecticut* (381 US 479 [1965]), which established a constitutional right to marital privacy in the use of contraceptives. Eight years later, in *Roe v Wade* (410 US 113 [1973]), in a 7 to 2 ruling, the Court held that women's access to abortion was a protected constitutional right that could be strictly limited only once the third trimester of pregnancy was reached. Nearly 20 years later, in *Planned Parenthood of Southeastern Pennsylvania v Casey* (505 US 833 [1992]), the Court significantly altered *Roe*'s broad, trimester-based framework. Although technically upholding *Roe*, a more conservative majority redefined the constitutional standard, permitting states to enact laws restricting abortion before fetal viability but barring laws that imposed an "undue burden" on access to abortion, including "unnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion."

The politics of abortion led to a barrage of increasingly intrusive laws. For decades federal law has barred virtually all public funding for abortion. Federal law now bars "partial birth" abortions, a specific type of pregnancy termination procedure, regardless of whether it is carried out before or after viability (*Gonzales v Carhart*, 550 US 124 [2007]). Since 2010, states have enacted 282 abortion restrictions that run the gamut from the targeted regulation of abortion providers distinct from other routine, outpatient surgical procedures (of which abortion is the most common) to laws requiring waiting periods, restricting medication abortions, and curtailing access to abortion after the first trimester.¹ Opponents of abortion actively

advocate laws declaring that life begins at conception, which are designed to outlaw all abortions and certain forms of contraception (<http://www.prolifealliance.com/LCA%20Fact%20Sheet.pdf>).

In recent years, the focus increasingly has turned to improving access to contraception, as research has demonstrated its effectiveness, especially for young women,² and as a result of the Affordable Care Act (ACA), which makes contraceptives approved by the US Food and Drug Administration available to virtually all insured women free of charge. But with advances comes resistance, this time by employers who refuse to offer ACA-compliant coverage and by continued congressional attacks on public funding for family planning.

The paradox of combining abortion and contraception at the Court cannot be lost on anyone. The United States has a higher rate of abortions than that of other developed countries because use of contraceptives is relatively low. Nearly half of all US pregnancies are unplanned, and 4 in 10 end in abortion.³ According to the Guttmacher Institute, by age 45 at least half of American women will have had an unintended pregnancy and 3 in 10 will have had an abortion (http://www.guttmacher.org/pubs/fb_induced_abortion.html). The imperative for access to the most effective forms of contraception and to safe abortions thus could not be greater, given the health consequences of unplanned childbearing.³

The Contraceptive Cases

The Court has agreed to hear 7 consolidated cases. These follow its decision in *Hobby Lobby v Burwell* (573 US __ [2014]), in which the Court held that the 1993 Religious Freedom Restoration Act (RFRA) protects for-profit corporations that wish to exclude contraceptive coverage for religious reasons. The consolidated cases (http://www.supremecourt.gov/orders/courtorders/110615zr_j4ek.pdf) pose a different but related question: does the RFRA permit religiously affiliated nonprofit corporations (such as universities and hospitals) to refuse to comply with a regulatory accommodation designed to protect women's access to coverage even as it exempts organizations claiming religious objections from applicable penalties for failing to cover contraceptives? Under the accommodation, covered entities (which also can include certain for-profit companies) can notify

either the secretary of health and human services or their insurers (or third-party administrators in the case of self-insured plans) of their objection to covering contraceptives. Once notified, the insurers and plan administrators directly assume the legal coverage obligation, thereby shielding employers from penalties; the government pays the fees associated with third-party administrators' compliance with self-insured plans.

Nonetheless, the organizations claim, the accommodation makes them complicit in contraceptive coverage, and RFRA allows them to refuse to comply if they believe that the accommodation poses a substantial burden on their beliefs. They argue that the government lacks a compelling interest for requiring compliance with the accommodation and, furthermore, that there are less restrictive alternatives, such as public funding for contraceptives (an option that seems unrealistic at best, given the current climate for public funding of contraception). Seven appellate courts rejected these arguments, in several cases unanimously. But in October of this year, an eighth court sided with the challengers, setting up the split in the circuits that typically triggers the Court's intervention.

The Abortion Case

In *Whole Woman's Health v Cole* (790 F.3d 563 [5th Cir 2015]), a 3-judge panel on the Fifth Circuit Court of Appeals permitted two Texas laws to go into effect across virtually the entire state, whose impact is expected to reduce the number of the state's abortion providers from 42 to 10.⁴ (A separate 3-judge panel in the Fifth Circuit earlier struck down a similar Mississippi law that would have closed that state's only remaining abortion provider.) The Texas laws require that abortion facilities meet ambulatory surgical center standards and that physicians performing abortions have admitting privileges at area hospitals. Texas lawmakers claim they have acted with women's safety in mind. But the evidence shows that in combination, the two laws will so drain the state of safe abortion services that women living in El Paso would be forced to travel 500 miles to secure a legal abortion. The immediate question before the Court is whether Texas has crossed the line drawn by *Casey*. But the deeper question is whether the Court will once again redefine abortion rights.

Both abortion and contraception rest on a powerful evidence base. The Centers for Disease Control and Prevention concluded that by enabling planned pregnancies, contraception stands as one of the most important advances in public health science. In their brief supporting the petitioners' appeal in *Whole Woman*, the nation's leading medical organizations not only underscored the importance of safe abortions but also argued that Texas's restrictions "do nothing to protect the health and safety of women and are incongruous with modern medical practice."⁵

The ultimate question is whether public health will triumph in the Court.

References

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