

Health Care in Motion

Timely, Substantive Updates on Policy Shifts · Actionable Advocacy to Protect Health Care

April 24, 2020

The United States of Reform: Reproductive Rights

This week, we're (mostly) taking a break from the deluge of coronavirus-related news to bring you a *Health Care in Motion* on reproductive rights and the shifting balance of power between the federal and state governments. The results of this shift have been on full display over the past few weeks. As the United States faces a health emergency wrought by COVID-19, some state government officials are exploiting the crisis to further their anti-choice agenda. In March, several state governments used the conservation of medical supplies for essential health services as pretext to [ban](#) so-called "elective" abortions. Unfortunately, a federal appeals court allowed Texas' ban to go into effect—even though, as patients, doctors, and advocates already know, abortion *is* essential health care. Elsewhere, advocates for reproductive health are [calling on state and federal governments to increase](#), not restrict, crucial access to abortion during the pandemic.

It is hopeful and important to see states stepping in to fill a void left by unsound federal policy. But decentralization inevitably reintroduces more variation—and, therefore, more inequity—in access to health care across the country. It becomes essential to mobilize, as broadly and swiftly as possible, state officials, and to leverage advances in innovative, progressive states to encourage similar reforms elsewhere.

The United States of Reform is a *Health Care in Motion* [mini-series](#) highlighting **state-level** legislative and regulatory responses to **federal-level** health care policy changes. We identify and explore the types of initiatives that states are rolling out to reinforce, reproduce, or even expand federal policies under attack, as well as implications of this evolving environment.

This issue focuses on **reproductive rights**, specifically abortion. Read on for an overview of the current federal policy landscape, implications for states, and trends in the design of state-level protections.

Federal Policy Change Overview: Reproductive Rights Reach the Supreme Court in 2020 Term

This term, the Supreme Court is set to rule on two cases with major repercussions for reproductive rights protections at the state and federal levels: *June Medical Services v. Russo* and *Trump v. Pennsylvania*.

June Medical Services v. Russo

In *June Medical Services*, the Court will decide the constitutionality of a Louisiana ["TRAP" law](#) (Targeted Regulation/Restriction of Abortion Providers) that requires abortion providers to have admitting privileges at a local hospital. In Louisiana alone, the impact could be jarring; if the law goes into effect, the entire state will be left with just [one](#) abortion provider. The Court's decision could also devastate abortion access nationwide.

Louisiana is one of many states that has enacted anti-choice TRAP laws. These laws take many forms—from requiring

that abortion providers have admitting privileges at local hospitals, to dictating the width of hallways in abortion clinics. All TRAP laws have in common the imposition of onerous, expensive, and unnecessary regulations on abortion providers under the guise of improving health and safety. The reality is that these laws do [nothing](#) to improve health or safety. (Complications arising from abortions are [extremely rare](#), and abortion providers already have plans in place should a patient need emergency care.) The true driving force behind a TRAP law is to shut down abortion clinics and reduce access to vital reproductive health care. (TRAP laws and regulations caused nearly half of all clinics in Arizona, Kentucky, Ohio, and Texas to [close](#) between 2011 and 2017.)

In theory, this should be an easy case since the Court decided this exact issue in 2016 when it struck down an identical TRAP law out of Texas as an unconstitutional undue burden on abortion access. In that case, [Whole Woman's Health v. Hellerstedt](#), the Court ruled that Texas' admitting privileges requirement provided no medical benefit and put a "substantial obstacle" in the way of abortion access. The TRAP law thus violated the Constitution.

The law at issue in *June Medical Services* may be [identical](#) to the one the Court just struck down in *Whole Woman's Health*, but the [makeup](#) of the Court has changed dramatically since 2016. Justice Kennedy, who provided the crucial swing vote in *Whole Woman's Health*, has been replaced by Justice Kavanaugh, an [opponent](#) of abortion rights. Chief Justice Roberts, who sided with the dissent in *Whole Woman's Health*, will likely be the [deciding vote](#) in this case.

While there is some [concern](#) the Court will overturn *Roe v. Wade*, the Court could use more insidious tools to undermine abortion access and avoid the political blowback of overturning longstanding precedent. At the most basic level, the Court could uphold the Louisiana law, either by distinguishing the law from its Texas counterpart or by simply overturning the earlier case. This outcome would devastate abortion access in Louisiana, with the brunt of that change falling largely on [already vulnerable](#) communities. Additionally, other states would likely take such a decision as a greenlight to enact similar laws to shutter abortion clinics across the country.

Commentators also [fear](#) that the Court could use *June Medical Services* to end its longstanding recognition of third party standing for abortion providers. Third party standing allows doctors to vindicate the rights of patients who would otherwise not have the resources to bring lawsuits on their own. Without it, legal challenges to abortion restrictions would become nearly impossible.

Oral arguments for *June Medical Services* took place on March 4th. (You can [listen to a recording here](#).) Most accounts indicate that arguments went as well [as possible](#), considering the makeup of the Court. Here's hoping for good news in the upcoming months.

Trump v. Pennsylvania

In [Trump v. Pennsylvania](#) (consolidated with *Little Sisters of the Poor Saints Peter and Paul Home v. Pennsylvania*), the Court will hear a challenge to the Trump Administration's expansion of conscience exemptions to the Affordable Care Act's preventive services mandate. The mandate requires that health insurance plans provide zero-copay coverage of the full array of FDA-approved contraceptive methods (including intrauterine devices and birth control pills). The Trump Administration's new rules exempt employers and other entities with religious or moral objections to contraception from providing no-cost coverage of this care and from notifying the federal government of their objections. These new rules are currently prohibited from taking effect across the country because of a preliminary injunction handed down by the U.S. Court of Appeals for the Third Circuit.

As a result of these exemptions, tens of thousands of people could lose coverage for birth control and be forced to pay out of pocket for (or otherwise forgo) basic preventive care. The U.S. Department of Health and Human Services [estimates](#) that between 6,400 to 127,000 people would lose health insurance coverage for contraceptives should the rules take effect.

Ironically, these steps will likely result in more unplanned pregnancies, since cost is a [significant reason](#) many people use less effective forms of birth control, or use no birth control at all. The Center for Health Law & Policy Innovation of Harvard Law School (CHLPI), together with 15 other organizations, filed an [amicus brief](#) to the Court that also warns of the rules' potential for widespread harm should it pave the way for objectors to discriminate at will and cut other essential health care services, such as pre-exposure prophylaxis for the prevention of HIV, from the guarantees of the ACA's preventive services mandate.

The Supreme Court was scheduled to hear oral arguments in late April, though arguments are now rescheduled to occur via teleconference on May 6, 2020 due to COVID-19. [A live audio feed is expected to be available.](#)

Advancing a State-Level Right: Protections Target Equitable Access to Safe and Affordable Care

In the face of these threats, some states have stepped forward with reforms of their own. In 2019, states including [New York](#) and [Illinois](#) passed comprehensive legislation, while advocates in other states, such as [Massachusetts](#), have been powerfully organized around a push for the same. Initiatives commonly tackle one or more of the following: (1) changing the narrative to recognize abortion as a fundamental right; (2) addressing the line between legal and illegal abortions; and (3) removing structural barriers to care. Each of these issues is explored in turn below.

1. Establishing Abortion as a Fundamental Right

Since the Supreme Court's landmark decision in *Roe v. Wade*, the Supreme Court has recognized a right to abortion founded in the United States Constitution. Donald Trump's election and his subsequent appointment of two new anti-choice Justices on the Supreme Court, along with appointments of numerous other federal judges, has put that basic, longstanding right in jeopardy. Fearing that federal protections for abortion will continue to be stripped away, several states have moved to enshrine the rights guaranteed by *Roe* in state law. These laws ensure that even if *Roe* is overturned, abortion will still be protected in the states.

- New York's [Reproductive Health Act](#) (signed into law on Jan. 22, 2019) declares a "fundamental right" to abortion. The law also moves abortion from the criminal code to the public health code, and allows abortions after 24 weeks to protect the life or health of the pregnant person.
- Vermont's [Freedom of Choice Act](#) (signed into law on June 10, 2019) declares a "fundamental right" to abortion. The law also forbids the criminalization of abortion.
- Illinois' [Reproductive Health Act](#) (signed into law on June 12, 2019) declares a "fundamental right" to abortion. The law also requires public and private health insurance plans to cover abortion, forbids the criminalization of abortion and pregnancy, and allows "medically necessary" abortions later in pregnancy.
- Rhode Island's [Reproductive Privacy Act](#) (signed into law on June 19, 2019) codifies the "privacy rights" guaranteed by *Roe* under state law.

These laws are a significant, if long overdue, win for abortion rights. By enshrining abortion as a fundamental right, decriminalizing abortion, and making reproductive health care more accessible, these laws ensure that, for the foreseeable future, people in these states (and those traveling from out-of-state) can access the care they need without unnecessary restrictions. These laws are also powerful rhetorical counterpoints to the alarming "[trigger bans](#)" that numerous states have passed, which would outlaw abortion the moment *Roe* is overturned.

2. Reconsidering the Dividing Line Between Legal and Illegal Abortion

In the 1973 decision in *Roe v. Wade*, the U.S. Court treated the right to abortion differently based on trimester. The Court abandoned a trimester-based approach in the 1992 case *Planned Parenthood v. Casey*, choosing instead to use

fetal viability as the dividing line. This means that while states must not unduly burden access to abortions early in a pregnancy, they can more intensively regulate or even ban abortions once a fetus is considered viable provided that the law maintains exceptions in cases regarding the life and health of the mother.

Today, [43 states](#) have exercised authority under *Roe* and *Casey* to place some form of limitation on the right to choose based on gestation. Laws vary greatly, however, with some states implementing a viability standard, some setting a statutory limit set at 20- or 24-weeks, and Virginia still stuck on the trimester framework from *Roe*.

[Most progressive states](#) use a viability standard that allows for abortions up to 28 weeks, depending on the health of the fetus. The minority of progressive states use a statutory 24-week framework. Importantly, both have their limitations. For example:

- Advancements in medical technology and neonatal care mean that viability-based access could be vulnerable to a gradual erosion of abortion access. Since *Roe*, medical outcomes for very premature babies (a proxy for fetal viability) have significantly improved, with the presumption of viability moving from 28 weeks to 24 weeks to potentially even [22 weeks](#). [California](#) cabins this risk in defining viability as the point at which “there is a reasonable likelihood of the fetus’s sustained survival outside the uterus without the application of extraordinary medical measures.”
- A statutorily-defined cutoff at 24-weeks allows for a clear application of the law, but may restrict some people from seeking abortions for nonviable pregnancies after the statutory limits. Recognizing such concerns, [New York](#) recently amended its law to expand access for nonviable pregnancies after the 24-week cutoff.

3. Ensuring Meaningful Access For All: Removing Structural Barriers to Care

Ensuring equitable, meaningful access is more than just establishing a legal right to abortion. It takes a conscious effort to raze structural barriers, also through legislation and regulation. Current innovations in states include:

- [Allowing non-physician health care professionals \(e.g., nurse practitioners\) to perform abortions and leveraging telehealth policy](#) to increase access to care in areas where there are few (if any) physicians providing abortion care;
- [Enabling public funding under Medicaid, including for undocumented people](#) - many states follow the restrictive federal standard (which permits funding only in cases of rape, incest, and the endangerment of life) but 16 states require that the Medicaid program pay for all or most medically necessary abortions; and
- Doing away with [dangerous, unnecessary parental consent and judicial bypass](#) requirements that restrict timely access to abortion for minors.

Fast Facts on Telehealth and Medication Abortion

- * [Research](#) shows that medication abortion via telemedicine is as safe and effective as in-person care.
- * In the [health-center-to-health-center model](#), patients receive services over video conferencing while visiting a local health center. Medications are dispensed at the local health center.
- * In the [direct-to-patient model](#), patients can participate in video conferencing from anywhere they want, and medications are dispensed by mail.
- * Among the barriers to tele-medication abortion is the U.S. Food and Drug Administration’s is the [excessive and unfounded](#) Risk Evaluation and Mitigation Strategy (REMS) governing mifepristone (one of two medications that make up a medication abortion). As part of the REMS requirement, mifepristone must be dispensed in a health care setting and by a registered provider. The TelAbortion Study, sponsored by Gynuity Health Projects, is challenging the validity of these requirements through a study involving the direct-to-patient model.

Next Steps for Advocates

We continue to be on the brink of major changes in federal health care policy regarding reproductive rights. Facing a window of opportunity to offset potential harms, it is more important than ever that advocates push for stronger protections at the state level. Massachusetts, for example, is on the verge of passing the [ROE Act](#), which would remove harmful parental consent requirements for abortion, improve access to later-term care, and expand abortion access for low-income people who do not qualify for the state Medicaid program. The Massachusetts ROE Act is one potential template for other states.

Advocates can also familiarize themselves with resources to help increase access to, and destigmatize, abortion. For example:

- **Know your local abortion fund.** Abortion funds provide advice and financial support to those seeking abortion services. Head to the website of the [National Network of Abortion Funds](#) to learn more about their work and find your local fund!
- **Help destigmatize abortion.** One of the most important ways to ensure the future of abortion rights is to destigmatize abortion today. One in four women in the United States will have an abortion by their 45th birthday, yet there remains intense societal pressure to keep these experiences secret. Thanks to the work of organizations like [Shout Your Abortion](#), this stigmatizing, shaming narrative is [changing](#). Shout Your Abortion empowers people to share their abortion stories in order to show the world that abortion is common, necessary, and normal. Join the movement to destigmatize abortion by sharing stories, talking with friends, and giving support to others who have received abortion care.

As the innovative policy reforms described above suggest, there is much work to be done to strengthen equitable access to safe and affordable reproductive care across the country. We encourage advocates to consider what opportunities exist to move the needle—even a little—in their home state. For example, where a state-level fundamental right to abortion is not a realistic reform at this time, are there structural barriers that could be tackled?

CHLPI will continue to monitor access to care issues in connection with the COVID-19 pandemic and cases currently before the Supreme Court with an eye on reproductive rights. Questions? Looking for additional guidance on advocacy strategy and options? Contact us at chlpi@law.harvard.edu.

Subscribe to all Health Care in Motion Updates

Health Care in Motion is written by Robert Greenwald, Faculty Director; Kevin Costello, Litigation Director and Associate Director; Phil Waters, Staff Attorney; Maryanne Tomazic, Senior Clinical Fellow; and Rachel Landauer, Clinical Fellow.

This issue was also authored by Health Law and Policy Clinic students Jenny Samuels and John Malchar.

For further questions or inquiries please contact us at chlpi@law.harvard.edu.