June Medical Services v. Russo and the Work that Remains for Underserved Populations

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A. Short summary of the outcome

On June 29th, the Supreme Court ruled in *June Medical Services vs. Russo* that Louisiana's admitting privileges law is unconstitutional and blocked it from taking effect. This win for reproductive health advocates means that abortion clinics can remain open to serve patients who need abortion care in Louisiana and in several other states where similar laws have been enacted. Advocates for reproductive health, rights, and justice, including the National Health Law Program, are relieved by the decision, but we also know that we must do more work to expand abortion access for individuals who are low-income, BIPOC, as well as LGTBQ-GNC. Today and always, abortion is essential, time-sensitive health care that is constitutionally protected but not as accessible as it should be.

The case involved a Louisiana law that required physicians who provide abortion care to have admitting privileges at a hospital within 30 miles of an abortion clinic. Admitting privileges laws like Louisiana's shut down abortion clinics, making abortion less accessible and adding financial and health burdens to the individuals seeking them. The Supreme Court considered two main issues: First, the Court analyzed whether the admitting privileges law is unconstitutional, in light of their decision striking down an essentially identical law only four years ago. Second, the Court examined whether clinics and doctors have standing to bring lawsuits on behalf of their patients. NHeLP's amicus brief, submitted on behalf of NHeLP and the National Network of Abortion Funds (NNAF) argued, among other things, that Louisiana's admitting privileges requirement imposed an undue burden that disproportionately impacts already underserved populations in need of abortion care.

B. Importance of abortion access for Medicaid beneficiaries

Medicaid is the public insurance program designed to serve low-income people, and Louisianans rely on it more than any other form of health insurance. Poverty rates in Louisiana are the third highest in the nation. Medicaid covers 1.4 million people in the state, meaning that nearly one out of three Louisianans are covered by Medicaid.[1] Communities of color, survivors of intimate partner violence, and LGBTQ-GNC people are even more likely to live in poverty.

Abortion is a common health intervention; an estimated one in five women will have an abortion by age 30, and one in four by age 45.[2] It is especially important for low-income people; those with incomes less than 100 percent of the federal poverty level (FPL) accounted for almost half of all abortion patients in 2014.[3] Individuals seeking abortions at ten weeks of pregnancy with an income at the Medicaid eligibility ceiling would need to pay nearly one-third of their family's monthly income for their abortions.[4]

Moreover, people seeking abortions in Louisiana face 89 legal restrictions, including the admitting privilege law challenged in *June Medical Services*.[5] Among these restrictions are significant limits on insurance coverage of abortion. Louisiana prohibits abortion coverage in its marketplaces and provides Medicaid reimbursement for very few abortions due to restrictions imposed by the Hyde Amendment requirements. The Hyde Amendment is an appropriations bill rider that restricts the use of federal funds for abortions. Currently, federal funding is only available for abortion services when a pregnancy is the result of rape or incest or when "a woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed."[6]

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[1] CMS, March 2020 Medicaid & CHIP Enrollment Data Highlights, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html (last visited July 7, 2020).
[2] *See* Guttmacher Inst., *Fact Sheet: Induced Abortion in the United States* (Jan. 2018), https://www.guttmacher.org/fact-sheet/induced-abortion-united-states.
[3] *See* Rachel K. Jones & Jenna Jerman, Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014, Am. J. of Pub. Health (Dec. 2017), https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.304042
[4] *See* Sarah C.M. Roberts et al., *Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States*, 24 Women's Health Issues 211(2014), https://www.ncbi.nlm.nih.gov/pubmed/24630423.
[5] *See* Elizabeth Nash, Guttmacher Inst., Louisiana Has Passed 89 Abortion Restrictions Since Roe: It's About Control, Not Health (June 29, 2020), https://www.guttmacher.org/article/2020/02/louisiana-has-passed-89-abortion-restrictions-roe-its-about-control-not-health
[6] U.S. Dep' t of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019, Pub. L. No. 115-245, 132 Stat. 2981, 3118, §§ 506-07 (2018).

C. NHeLP's Amicus Brief discusses how Admitting Privileges Laws Disproportionately Harm Unserved Populations

NHeLP's amicus brief in *June Medical Services* demonstrated that Louisiana's admitting privileges law imposed an even bigger burden for Medicaid and other underserved communities than for the population as a whole. It was important to put this information in front of the Court to illustrate how striking down the law was necessary to ensure that everyone who needs abortion care can exercise their fundamental right to access it, and that upholding the law would disproportionately burden people who are low-income, Medicaid beneficiaries, BIPOC communities, intimate partner violence survivors, and LGBTQ-GNC individuals.

Research has repeatedly shown that funding restrictions force many Medicaid-eligible individuals to carry pregnancies to term against their will. One study found that lack of funding influences about a quarter of Medicaid-eligible women to continue unwanted pregnancies.[7] Another study conducted in Louisiana found that "about 29% . . . of Medicaid-eligible pregnant women who would have an abortion if Medicaid covered abortion instead give birth."[8] This means that, even without the admitting privileges law, every year approximately 3,000 women in Louisiana give birth instead of having abortions due to the lack of abortion coverage in Medicaid.[9]

People's inability to access wanted abortions, including by limiting funding, can have serious consequences for a person's health and financial well-being. In Louisiana, the average cost of a first-trimester abortion is about $500 and a second-trimester abortion is about $850. These costs alone pose an enormous barrier for people living in poverty. These figures account only for the healthcare service itself—not the attendant costs of travel, overnight stays, childcare, or lost wages incurred by abortion patients. A person working full-time earning minimum wage in Louisiana who earns just $1,256 a month, before paying rent, utilities, food, and transportation expenses. Thus, the out-of-pocket costs for abortion care are prohibitive. By closing clinics, the Louisiana law would have forced people to travel longer distances to reach care, which would consequently drive up expenses due to increased attendant expenses and delays. In addition, cost often forces low-income people to carry unwanted pregnancies longer and delay abortions

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[7] See Diana Green Foster & M. Antonia Biggs, Advancing New Standards in Reproductive Health, Effect of an unwanted pregnancy carried to term on existing children's health, development and care, https://doi.org/10.1016/j.jpeds.2018.09.026.
[8] *See* Sarah C.M. Roberts et al., Estimating the proportion of Medicaid-eligible pregnant women in Louisiana who do not get abortions when Medicaid does not cover abortion, BMC WOMEN'S HEALTH, 4 (2019), https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-019-0775-5.
[9] *Id.*

while they attempt to pull together the funds to pay for the procedure.[10] While the risks posed by later term abortion are still very low, they are higher than the risks of first-trimester abortion care.[11]

D. This decision makes it clear that we still have work to do to ensure that people have access to abortion care.

The Supreme Court's decision in *June Medical Services* is a momentous victory against the ongoing attacks on reproductive health, rights, and justice throughout the country. With this decision, the Court has affirmed the fundamental right to an abortion, and in these times, that is cause for celebration.

The Supreme Court heavily relied on the findings of the District Court, which confirmed that the heaviest burden of the admitting privileges law would fall disproportionately on low-income individuals. The Louisiana admitting privileges law would have exacerbated the steep financial hurdles to abortion access already experienced by pregnant people living in poverty, including Medicaid beneficiaries. Individuals who are unable to pay for these expenses and are forced to carry their pregnancies are three times more likely to be in poverty two years later.[12] The District Court concluded that the admitting privileges law "would do little or nothing for women's health, but rather would create impediments to abortion, with especially high barriers set before poor, rural, and disadvantaged women."[13] It is also important to note that adding financial barriers for abortion access is a particularly pernicious outcome when people living in poverty are the group more likely to need abortion care. In addition to worsening poverty, forcing people to endure childbirth and tying intimate-partner violence survivors with their abusers would actually threaten their lives and well-being.

Notably, the Court's decision did not garner a majority opinion, even as it observed that Louisiana's restrictive law was "almost word-for-word identical" to the Texas law that the Court struck down just four years ago in *Whole Woman's Health v. Hellerstedt*. The principle of stare decisis—or deferring to decisions in prior cases—preserved the status quo on abortion access. In considering whether Louisiana's law posed an "undue burden" on the fundamental right to an abortion, Justice Roberts, in his concurring opinion, accepts the facts found by the District Court, noting that the Court "will not disturb the factual conclusions of the trial court unless we

[10] *See* Rachel K. Jones & Jenna Jerman, *Characteristics and Circumstances of U.S. Women Who Obtain Very Early and Second-Trimester Abortions,* 12 Plos One e0169969 (2017); Rachel K. Jones et al., *At What Cost? Payment for Abortion Care by U.S. Women*, 23 Women's Health Issues 173 (2013).
[11] *See* Suzanne Zane et al., *Abortion-Related Mortality in the United States: 1998-2010*, 126 Obstet. & Gynecol. 258 (2015).
[12] *See* Diana Green Foster & M. Antonia Biggs, supra note 7.
[13] *June Medical Services LLC v. Kliebert*, 250 F. Supp. 3d 27, 84 (M.D. La. 2017).

are 'left with the definite and firm conviction that a mistake has been committed.'"[14] Justice John Roberts presided over the Court when W*hole Woman's Health v. Hellerstedt* was decided, although he dissented in that case and reaffirmed his opposition to its outcome in *June Medical Services*. However, he posits, no one can argue that the issues in these cases are not the same and that precedent as well as the rule of law must be preserved. On the other hand, Roberts' concurring opinion seems to attempt to weaken the undue burden standard established by precedent and instead proposes a "substantial obstacle" test when an individual seeks abortion access.

The "undue burden" test requires courts to conduct a robust check to examine whether state's abortion restrictions confer benefits that outweigh the burdens they pose to people seeking abortions.[15] By contrast, Justice Roberts posits that the substantial obstacle test starts with a "the threshold requirement that the State have a 'legitimate purpose' and that the law be 'reasonably related to that goal.'"[16] If a state can meet that threshold, in Justice Roberts's view, then a court should only consider whether the law at issue places a substantial obstacle in the path of people seeking abortions, and need not weigh the law's benefits against its burdens.

However, as we argued in our amicus brief, the appropriate standard is the balancing test created in *Casey v. Planned Parenthood* and carefully developed in W*hole Woman's Health v. Hellerstedt,* which requires courts to weigh burdens placed on the patient's access to abortion to determine whether they are outweighed by the state's purported interest. Reproductive health advocates will be closely watching how courts in future cases apply *June Medical Services* to state laws that seek to restrict abortion access.

While we are confident that abortion restrictions significantly harm individuals who are already underserved, we reject Justice Roberts' suggestion that we must demonstrate a "substantial obstacle" since such a standard could be clearly manipulated by legislators and courts who do not seek to protect pregnant individuals' best interests and constitutional rights. Any "substantial obstacle" test will surely dismiss the plight of low-income, BIPOC, and LGBTQ-GNC individuals as well as intimate partner violence survivors, since, if a state can meet the test's relatively low threshold of showing that the law is related to a legitimate purpose, a court will not scrutinize the harm to people seeking abortions.

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[14] *June Med. Servs. v. Russo*, No. 18-1323, 61 (U.S. Jun. 29, 2020) (Roberts, J., concurring) (quoting *United States v. United States Gypsum Co*., 333 U. S. 364, 395 (1948)).
[15] *Planned Parenthood v. Casey,* 505 U.S. 833 (1992); *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016).
[16] *June Med. Servs. v. Russo*, No. 18-1323, 61 (U.S. Jun. 29, 2020) (Roberts, J., concurring).

Thus, while the outcome in *June Medical Services* is an important affirmation of the fundamental right to an abortion, the Chief Justice's concurring opinion shows a concerning desire to uphold other restrictions on abortion access and further curtail abortion access in other ways, as long as they are not deemed to be "substantial obstacles." Restrictions like mandatory ultrasounds and waiting periods, as well as bans of telemedicine-based abortion services and bans on abortions allegedly based on race, sex, or disability will have an enormous impact on abortion access, especially for people living with low-incomes, Medicaid beneficiaries, BIPOC communities, intimate partner violence survivors, and LGBTQ-GNC individuals. Yet, they may not be judged to be substantial obstacles by courts.

We must remain vigilant to ensure that courts preserve abortion access and that coverage of this time-sensitive, essential health service is preserved and expanded. A right is not real unless everyone can access it. NHeLP will continue to work for those at the margins and follow the leadership of black women, honor the experiences of abortion providers and patients, and advocate using a reproductive justice lens.[17] We will do so in the following way:

- Supporting the EACH Woman ACT, which would remove restrictions on insurance coverage of abortion care;
- Mandating abortion coverage in every state health insurance plan like Maine, Illinois, Washington, California, New York, and Oregon have done;
- Opposing any state laws that further curtail abortion access like targeted regulations against abortion providers (TRAP laws), ultrasound requirements, gestational age bans, waiting periods, reason bans (allegedly on race, sex, and disability), and bans on telehealth delivery of abortion; and
- Removing and opposing unnecessary and antiquated regulations that require the provision of medication abortions at a clinic, medical office, or hospital from a health provider who has pre-registered with the drug manufacturer and arranged to order and stock the pill in their health care facility (Also known as the Risk Evaluation and Mitigation Strategy or REMS requirements).[18] Abortion patients should be able to have the choice to administer medication abortion from a place of their convenience and receive support from their provider or pharmacist through telehealth.

[17] See e.g., SisterSong, https://www.sistersong.net (a Southern based, national membership organization whose purpose is to build an effective network of individuals and organizations to improve institutional policies and systems that impact the reproductive lives of marginalized communities).
[18] See FDA, Approved Risk Evaluation and Mitigation Strategies (REMS), https://www.accessdata.fda.gov/scripts/cder/rems/index.cfm?event=RemsDetails.page&REMS=390 (last visited July 15, 2020).

Conclusion

The National Health Law Program breathes a sigh of relief that the Supreme Court has again ruled that admitting privileges law are unconstitutional. Nevertheless, we know that our work is far from over. A right is not meaningful unless it is fully accessible. As we maintained in our amicus brief, people living in poverty, BIPOC communities, intimate partner violence survivors and LGTBQ-GNC individuals still face significant barriers to accessing abortion. We will continue to fight any restrictions and advance coverage in the courts and through other forms of advocacy.