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The Oliver C. Schroeder, Jr. Scholar-in-Residence Lecture: Sneaking Around the Constitution: Pretextual "Health" Laws and the Future of *Roe v. Wade*

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*THE OLIVER C. SCHROEDER, JR.
SCHOLAR-IN-RESIDENCE LECTURE*

SNEAKING AROUND THE
CONSTITUTION: PRETEXTUAL
“HEALTH” LAWS AND THE FUTURE
OF *ROE V. WADE*†

*Nancy Northup*¹

I² am pleased to be here and be able to share with you my perspectives as the leader of an organization that has, for over 20 years—since the time of the case *Planned Parenthood v. Casey*, argued by one of our founders, Kathryn Kolbert—been on the front lines of protecting women’s access to reproductive healthcare in the U.S. and around the world.

At the Center for Reproductive Rights, we work to advance reproductive health and rights as fundamental human rights that all governments around the world are legally obligated to protect, respect, and fulfill. We work on a range of issues from access to essential obstetrics care and access to contraception, and also against violations of human rights, such as child marriage and female genital mutilation (FGM). We also work on the issue that brings us here today, what amounts to a crisis in the United States: severe restrictions on access to abortion services.

In preparing for the Schroeder lecture, I looked to see who some of my predecessors were on this podium, and it has been nine years since the topic of reproductive rights has been addressed by one of the Schroeder lecturers, when Susan Wood was here to talk to you about the battle for getting emergency contraception over the counter in the United States. Professor Wood was the former Assistant Commissioner for Women’s Health at the Food and Drug Association,

† Edited from the annual Schroeder Scholar-in-Residence Lecture sponsored by the Law-Medicine Center on September 24, 2015, at Case Western Reserve University School of Law. This version has been edited for publishing purposes and does not contain the lecture in its entirety. The full transcript is on file with the editors of Health Matrix. Please direct all inquiries to h-matrix@case.edu.

1. President and CEO, Center for Reproductive Rights
2. I am indebted to Hillary Schneller, Legal Fellow at the Center for Reproductive Rights, for her research and editing support for this lecture.

who resigned in protest over the lack of evidence-based medicine used to make the initial decision about over-the-counter availability of emergency contraception.

The Center for Reproductive Rights sued the FDA in that case. Here we are nine years later, and we are still talking about the topic of Professor Wood’s remarks: how do we get science and evidence-based medicine to be the primary drivers of policy and law when it comes to women’s reproductive health?

I particularly enjoyed preparing for today’s lecture because I knew that I would be in the halls of the Center for Law and Medicine: where facts matter, where evidence-based medicine matters, where the rule of law is respected, and where reasoned argument is the mode of discourse. This is unfortunately not the world in which I live.

I live in a world in which the issue of women’s reproductive healthcare has become so politicized that facts, medicine, and reasoned argument often do not carry the debate. The case that will be before the Supreme Court is about whether fact-based medicine is relevant to the standard by which laws and regulations that have an impact on abortion are evaluated, or whether what is put forward by politicians seeking to block access to abortion gets a rubber stamp by the courts.³ Will there be realistic review, or a rubber stamp?

Before we begin, because this issue of women’s reproductive health is so politicized, I want to ground us a little bit in biology and some public health facts. Then I am going to lay out the latest tactics of those who would seek to ban abortion—namely, the pretextual state laws that are passed under the guise of health and safety but are in fact designed to shut down clinics and ban access to abortion services. I will then focus on Texas, both because it is one of the most radical examples of those laws, but also because it is the case most likely to be taken by the Supreme Court this term. I will take a look at some of the legal arguments we will be making in that case.

Finally, I am going to end by talking a little bit about what I think is very necessary in the area of law and policy and reproductive health and specifically access to abortion services: a federal statutory claim that addresses some of these laws and makes sure that evidence, facts, and science are relevant to evaluating the permissibility of these regulations.

But I want to pause at the outset to say a few things about a 10,000 foot view on women’s reproductive health and some basic facts about contraception and pregnancy.

3. The Supreme Court granted certiorari in the case, *Whole Woman’s Health v. Cole*, 790 F.3d 563 (5th Cir. 2015). Before oral argument on March 2, 2016, the case’s name was updated to *Whole Woman’s Health v. Hellerstedt*.

It is good to remember that without access to contraception, a sexually active heterosexual woman will have significantly more unintended pregnancies in her lifetime, and without access to emergency obstetrics care, many women die. That is true today in the world. It was true in our history here in this country.

To give you a stark sense of the difference that healthcare makes in a woman’s life, in Chad today, your lifetime risk of dying in connection with pregnancy is 1 in 18. In Norway, it is 1 in 11,500. There is nothing different biologically from women in Chad and women in Norway.

A major difference between the 1 in 15 and 1 in 15,000 is access to emergency obstetrics care and also access to contraception, because that leads to fewer pregnancies, and each pregnancy causes a risk of serious health issues and even death. One of the things that is true and fascinating and interesting about the area of pregnancy in the law is that pregnancy, as the Supreme Court has said, is *sui generis* to the human experience and, thus, *sui generis* to law. Pregnancy is not a disease, but it can kill you. It can run serious health risks, but it is a natural part of life, and it is a necessity for the continuation of the species. So it creates an issue like no other for courts and law and policy.

The other issue that arises in connection with the death risk in Chad and elsewhere in the world is whether or not women have access to safe abortion. Women in the world have had, and will continue to have, abortions—whether they are legal or illegal. Globally, there is virtually no difference in abortion rates whether the law makes abortion illegal or legal.

This is important to remember, because we spent so much time here in the United States trying to regulate women’s behavior with the criminal law. To the north, our neighbors in Canada have no criminal laws regulating abortion. They were struck down in 1988 in a case called *Morgentaler*. In the wake of that case, there has not been a repositioning of criminal laws in Canada, and yet women in Canada have abortions at the same time in pregnancy as they do in the United States. The vast majorities are in the first trimester, a smaller percentage in the second trimester, and virtually none in the third trimester. This is not based on criminal law or the law telling women what they can and cannot do, but on women’s experiences, decisions, and choices.

I want to now turn to some facts about abortion safety. This is relevant to the trial and the evidence we are going to talk about in the Texas case. In the United States, abortion is a very safe procedure. In fact, it is one of the safest medical procedures. The risk of death is exceptionally low. If you go forward with a pregnancy versus having an abortion in the first trimester, the risk with childbirth is 14 times higher than that of abortion.

Ninety-five percent of abortions are in outpatient settings. That means they are done in doctors’ offices or clinics, not in a hospital-based setting, and less than a fraction of 1 percent risk of complications exists. This is why abortions can be safely performed in an outpatient setting. The data I have up here is from the American Medical Association, which they have introduced in a friend of the court brief, an amicus brief, in the Texas case that we will be talking about.

U.S. Abortion Safety Medical Facts

- * One of the safest medical procedures
- * Risk of death exceptionally low
- * Risk associated with childbirth is 14 times higher
- * 95% of abortions are in outpatient settings
- * Less than a 0.2% risk of major complications

Source: Amicus Brief of American Medical Assoc. and American College of Obstetricians and Gynecologists, *Whole Women’s Health v. Cole* (5th Cir. 2014)

Source: Center for Reproductive Rights (citing Brief for Am. Med. Assoc. & Am. College of Obstetricians as Amici Curiae Supporting Plaintiffs-Appellees, *Whole Women’s Health v. Lakey*, 769 F.3d 285 (5th Cir. 2014) (No. 14-50928).

What’s important to note—and we will see some more evidence from the American Medical Association later—is that the American Medical Association doesn’t take a policy position on abortion itself, whether it should be legal or illegal, but it has taken a position in these cases against the type of laws we will discuss because the laws are not evidence-based, and are not justified as a matter of science and health.

I should also add to this the prevalence of abortion in the United States. About one in three women will make the decision in her lifetime to have an abortion; another way to look at those numbers is about 21 percent of pregnancies in the United States end in abortion. So the issues that we are talking about here and the issues presented by the case in Texas effect a large number of women.

In 1992’s *Planned Parenthood v. Casey*, this was the last time the Supreme Court took a major look at what was the substantive constitutional right to abortion. The Court, of course, had decided the issue first in 1973 in *Roe v. Wade*.

There had been battles over restrictions ever since *Roe* was decided, and they all came to a culmination in 1992 in *Planned Parenthood v. Casey*, which involved a series of laws coming out of the state of Pennsylvania. One law required the state to give women informational materials on abortion and then wait a mandatory 24 hours before having the procedure. That was a law that the Supreme Court upheld in that case, saying it was an appropriate way for the woman to consider her decision.

Another law in that case, which required a woman to notify her husband if she was having an abortion, was struck down by the Supreme Court as putting an unwarranted burden on a woman’s right to choose, because for those women for whom it would be potentially problematic, even threatening to their health and wellbeing to tell their husbands, it was a substantial obstacle to accessing abortion.

In *Casey*, the Court established a new standard for constitutional review of abortion restrictions—that a finding of an undue burden is shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus. This is now the standard for constitutional review of abortion restrictions. A law that places an undue burden on access to pre-viability abortion—defined as a state regulation with the purpose or the effect of placing a substantial obstacle to abortion—is unconstitutional.

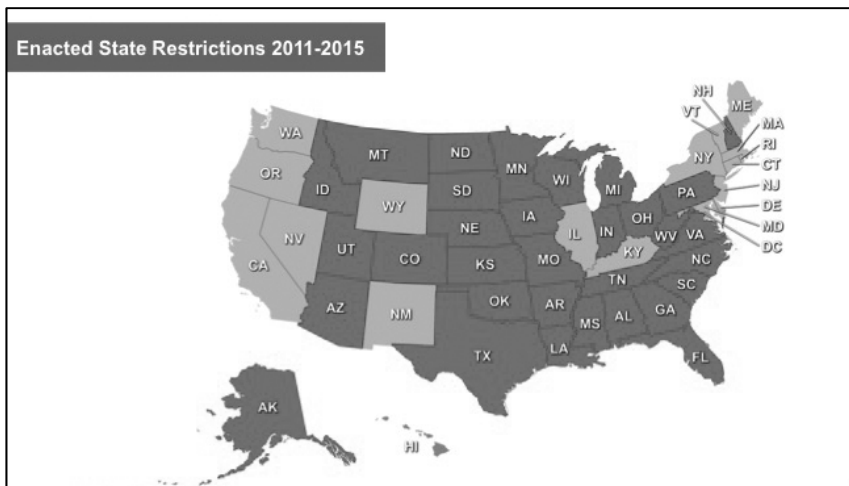
I was saying this morning that when I talk to lay audiences that aren’t lawyers, I reassure them when they are feeling lost, that there is some kind of deep legal basis behind this that defines all those terms exactly what is an undue burden, what does it mean to have the purpose and effect, what’s a substantial obstacle. I tell them don’t worry, there isn’t any.

All that we have basically is the statement of the court here and the examples of how they applied the standard in *Planned Parenthood vs. Casey*. They also made reference to what is going to be very relevant in the next case before the Supreme Court about unnecessary health regulations, and they say again, if those unnecessary health regulations have the purpose or effect of presenting a substantial obstacle, then they can constitute an undue burden on the right. It is key to pull this out because the issues in *Planned Parenthood vs. Casey* were not about health regulations per se; they were about requiring you to inform your spouse, requiring you to go home and wait for 24 hours before having the actual procedure—issues that did not address the procedure itself or health and safety standards. These requirements in *Casey* instead addressed the woman’s decision-making process, and we will see soon why that is relevant.

Since *Casey*, there have been a series of laws passed that restrict abortion access, but in the last five years, we have seen a tremendous

increase in the breadth and frequency of these laws. Since 2011, there have been over 200 of these laws passed, and they are having a significant effect in many states in restricting services.

These restrictions take many forms. Some of them are outright bans on abortion as early as six weeks in the case of North Dakota, which is currently going through the courts; as early as 12 weeks in Arkansas; and then the set of cases that we are going to be talking about today, which impose health and safety standards that we have established as unnecessary in trial court after trial court.



Source: Center for Reproductive Rights

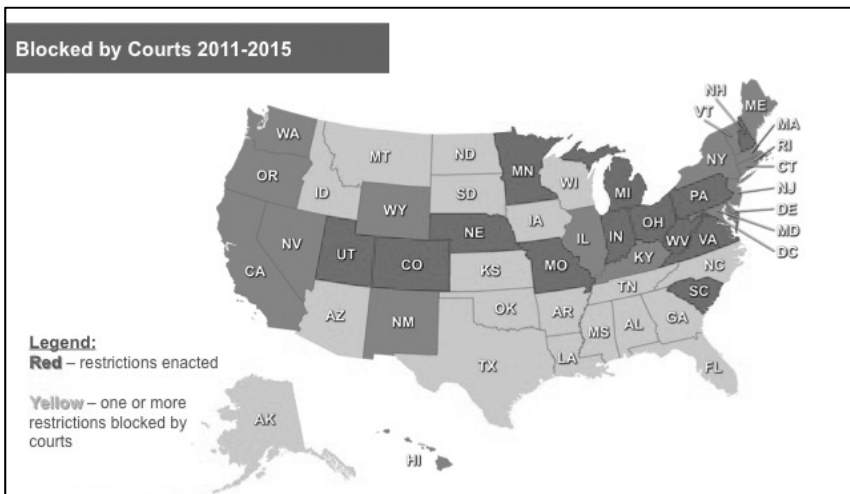
Note: the "red" states include AK, AL, AR, AZ, CO, FL, GA, IA, ID, IN, NH, KS, LA, MI, MN, MO, MS, MT, NC, ND, NE, OH, OK, PA, SC, SD, TN, TX, UT, VA, WI, WV

So this is a map of what I have just described, which is the state restrictions that have been passed in the last four years. These are the states that have passed significant types of restrictions, and in many of those, it is not just one restriction. In Texas, we will be talking about the series of restrictions that have been enacted and will specifically be focusing on two. You have also had restrictions imposed here in Ohio.

The next slide shows how many of those restrictions are enjoined by court orders. We have put a significant effort into applying that undue burden standard in the state and federal courts, and we sue in both state and federal courts to keep these laws from going into effect.

I want you to also remember this map because it shows what is at stake in the next Supreme Court case. Should the Supreme Court side with the Fifth Circuit, which I will talk about in a minute, we would see all that yellow go back to red, and those state laws would

go into effect. Should they decide, as many of the lower courts have, that there needs to be some real examination of the medical justification for laws that are having such an impact on access to services, then you should see the yellow stay as it is.



Source: Center for Reproductive Rights

Note: the “red” states include CO, IN, MI, MN, MO, NE, NH, OH, PA, SC, UT, VA, and WV. The “yellow” states include AK, AL, AR, AZ, FL, GA, IA, ID, KS, LA, MS, MT, NC, ND, OK, SD, TN, TX, and WI.

One of the issues that I want to talk about today is Texas House Bill 2 passed in 2013, which we often times refer to as a TRAP law. TRAP stands for targeted regulation of abortion providers. These laws are only imposed on abortion providers; they are not imposed on similarly situated professionals.

In 2013, Governor Rick Perry called the Texas legislature back for a special session to consider this omnibus bill regulating abortion. Wendy Davis, who was a state legislator, famously filibustered for about 13 hours, during which time she was not allowed to leave the stage or podium for any minute, for any reason.

But nevertheless, eventually House Bill 2 passed, and the two requirements, an admitting privileges requirement and an ambulatory surgical center requirement, were challenged. These are the requirements that will be at issue in the Supreme Court case.

Admitting privileges are what allows doctors in private practice to come into a hospital and take care of a patient once they are hospital-based. Doctors may or may not have admitting privileges based on whether or not they have been granted them by a hospital, and whether or not they are in the kind of practice that causes them to have a hospital-based practice.

An ambulatory surgical center is, simply put, like a mini hospital. They have specifications for the physical plants that require them to maintain the sterile-like conditions used when you are doing surgical cuts into the body. That is not the kind of surgery that is done in abortions.

So Texas passed this law, and as we are going to talk about in a minute, it has been really effective in closing clinics. This is because it is very hard for abortion providers to comply with the requirements. In terms of the admitting privileges, there are a host of reasons that abortion providers don't have them or, after this law went into effect, could not get them.

One of the reasons is, as we go back to that first slide about the safety of abortion procedures, that because abortion is so safe, it is very rare to have hospital admissions during first trimester abortions. Furthermore, Texas already requires abortions after 16 weeks be done in ambulatory surgical centers. That has not been challenged in this litigation, and so that's the law for 16 weeks and up in Texas.

So hospital admissions are rare, and hospitals, therefore, don't give admitting privileges to those who don't actually admit patients to their hospital, or they have requirements that you have to admit a certain number of patients a year for them to grant you privileges.

To give an example, one of our clients in Texas is a clinic that has performed about 17,000 abortions in the last ten years. They have not had any hospital admissions. So that would be an instance of a doctor not being able to meet a hospital's requirement that doctors have a certain number of admissions a year to have privileges.

Hospitals also can deny admitting privileges for any reason that they so choose, so there are hospitals in many of these areas that deny admitting privileges to doctors who provide abortions because either they object, or because they are concerned that they will get boycotted, or in other ways will bring controversy to the hospital.

In fact, some doctors in Texas have received letters to that effect. Other hospitals are moving towards a different kind of care, where they mainly have hospitalists, doctors who specialize in hospital-based medicine, on their staff. That's their economic model. That's their delivery care model and so, again, those hospitals are not in a position to give admitting privileges to other doctors.

Additionally, some hospitals require that the doctors live near the hospital. Because of the stigma and the harassment and the outright violence against abortion providers in the history of this nation, as recently as the murder of Dr. Tiller in Kansas five years ago, some doctors do not live in the communities, but have to come in and serve from outside the communities. So for that reason, they may not get admitting privileges.

If we go back and remember the standard in the *Casey* case, it talked about laws that have a purpose or effect of presenting a

substantial obstacle to women seeking abortion. It is obvious to those who live in the politics of abortion that these laws have been passed with the purpose of blocking access to abortion. Sometimes that purpose is pretty blatant.

In Mississippi, which has an admitting privileges law that applies to the one clinic left in the state, the sponsor of the bill was pretty clear in its introduction that the purpose of the bill was to make Mississippi an abortion-free state. But when we go to court to try the case, we have to try to prove this in other ways than just the anecdotal statements of legislators. So the three ways you would assess purpose in constitutional law would be:

1. Does the law target a specific group? If the law was targeting a group in ways that it was not targeting a similarly situated group, it may suggest there is an illicit purpose.
2. Does the law serve its stated purpose? If it is supposed to promote safety, does it promote safety?
3. What kind of effect does the law have?

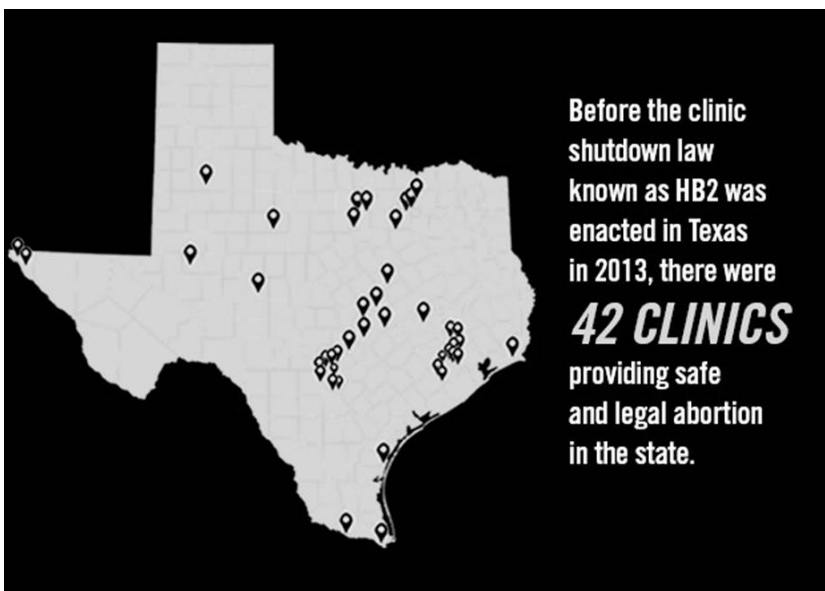
It is an inference in the law that you can derive purpose from effect. If you are closing 80 percent of the clinics in the state, it is evidence that your purpose was to do just that when you enacted the law. So in looking at how these apply in the cases, and in Texas, specifically with HB2, the answer is absolutely. Of all of the doctors in the state, only abortion providers are subject to the ambulatory surgical center requirement. So it does not apply, for example, if you are an OB/GYN and you are doing miscarriage management, which is essentially the same as an abortion procedure. In that case, it's fine for you to perform the procedure in your office as part of your practice. Only abortion providers are subject to the ASC requirement and to the admitting privileges requirement.

In both of these requirements, only abortion providers were ineligible for waivers. Ordinarily when this kind of health regulation is enacted, you could go to the government and say, “I have been practicing safely for 25 years and would like a waiver for my facility, or for my facility to be grandfathered in.” Ordinarily it is granted. In fact, we have had states where such waivers have been granted. But in Texas, that was not an option, which was further evidence of unusual treatment of a specifically targeted class, which is evidence of illicit purpose.

The next question: does the law serve its stated purpose? We had 19 witnesses at trial, including those who established that it did not. Again, I am going to refer to the American Medical Association's brief in this case, which is pretty clear. This brief is from a group that doesn't take a position on abortion itself. They say there is simply no medical basis for requiring ambulatory surgical

center standards or local admitting privileges; no safety benefits at all, not even marginal safety benefits. The brief further says that the requirements jeopardize women’s health by restricting access to abortion providers, and that they are devoid of any medical or scientific purpose. So the AMA could not be clearer on their view of this: it doesn’t serve its stated purpose.

One of the state of Texas’ arguments in this case has been that it is okay if all the clinics in a particular area close—even if it makes it impossible to get services in any near distance in Texas—because women can just go to New Mexico. Well, there is an illogic there. If New Mexico doesn’t have the same purported safety requirements as Texas, like ambulatory surgical centers, then why is the state saying, well, we can just send them across state lines? Again, this is evidence of unlawful purpose.



Source: Center for Reproductive Rights

Then, we come to the effects of the law, and again, one can think that the effect is strong evidence of purpose. What this map shows is the composition of abortion clinics in the state of Texas before and after HB2 passed. So you see on the far left here, there were a little over 40 clinics in the state of Texas before HB2 passed in 2013. The admitting privileges law, after some unsuccessful litigation, went into effect on October 31, 2013, and half the clinics in the state closed overnight.

You can see that the clinics post-November 2013 are concentrated in major urban areas: Dallas, Houston, Austin, and Fort Worth, where there were doctors with admitting privileges. But in other parts of the state, including very under-served parts like the Rio Grande Valley, clinics were not able to stay open.



Source: Center for Reproductive Rights

We then brought this current case. The ambulatory surgical center requirement had not yet gone into effect. We also brought a lawsuit specifically on behalf of or as applied to the clinic in El Paso.

The El Paso clinic would be the one to the far west, and the clinic in the Rio Grande Valley is the one to the furthest south. So we argued that, not only were the doctors denied privileges for reasons that had nothing to do with their competency as medical professionals, but that if you close those clinics, women who are either west of San Antonio or south of San Antonio have no access to clinics. Many of those women would have to drive more than 300 miles round trip. So we brought an as applied challenge, and in August of 2014 the District Court gave us an injunction in that case.

In terms of what will happen at the next stage, you can see by this map on the far right. If we do not succeed in this case in the Supreme Court, Texas will go down to ten clinics or fewer. This is what happened for a small period of time in November of 2014, until we won the case in the trial court. The trial court found there was a

severe limitation on access to abortion services in Texas, and that the law served no medically-justified purpose. The state of Texas appealed to the Fifth Circuit.

The Fifth Circuit lifted the injunction, pending appeal. We went to the Supreme Court immediately. In the 12 days as we went up to the Supreme Court, another half of the clinics in Texas had closed, taking the number down to about eight clinics in the state.

The Supreme Court reinstated the stay pending the appeal in the Fifth Circuit. We were not successful in the case in the Fifth Circuit, which did not surprise us, and once again, the Fifth Circuit was going to lift the injunctions that had been in place. We went back to the Supreme Court last summer, and again, the Supreme Court put the injunction back in place, pending our request for certiorari review. So the status now is what you see there, with the El Paso clinic and the clinic in McAllen, Texas, opened. The threat though, is what is shown here, with only nine clinics remaining open.

So that is the "brutally effective" impact. District Court Judge Yeakel found that these two unjustifiable medical restrictions together (the ambulatory surgical center requirement and the admitting privileges requirement) were a brutally effective way to cut off access to abortion services in Texas.

Just to remind all of us, Texas is the second largest state in the country by population and land mass. I am from New York, and I thought that we were the second largest state in the country, and this has reminded me this is not the case. It is the state of Texas, which is also the second largest by land mass. Texas has over 5 million women of reproductive age spread out over a vast amount of land. As you can imagine, based on our previous discussion about what the public health facts are, ten abortion providers will struggle to cover that amount of the population.

To give you a comparison, California has about 500 abortion providers in their state. So that is a severe restriction, and all of this led Judge Yeakel to say in his decision that it would lead to an unprecedented percentage of licensed abortion facilities closing across the state and would severely limit access. I should say that Judge Yeakel is an appointee to the Federal District Court in Austin by George W. Bush and so, again, hardly someone that you might think was looking at this as a matter of politics as opposed to facts and application of law.

So reprising what Judge Yeakel was looking at, what the Fifth Circuit was looking at, what the Supreme Court was looking at: what does this mean? What is going to give content to the standard? What is an unnecessary health regulation that has the purpose and effect of presenting a substantial obstacle? That is what is going to be at issue.

Some other courts have been wrestling with defining this as well. In the Seventh Circuit, there is a case on admitting privileges in Wisconsin. In the appeal from the preliminary injunction that had been put in place, the Seventh Circuit, in a decision by Judge Posner, set out a test that I think is strong and valid and one that I think the Supreme Court ought to consider.

That test says you have to have evidence. If you are going to pass medical restrictions that close over 75 percent of the abortion facilities in the state, you need some evidence that there is a sound reason in science and medicine to do so because we are talking about access to a constitutionally-protected right.

In addition, Judge Posner says: the feebler the medical justification and the likelier the burden, even if slight, the more undue the burden is. In other words, if you have no justification for this law whatsoever, any burden really should not be justified. He puts it in a way that I think makes sense to people: undue means it is disproportionate or it is gratuitous.

So it is undue if there is no basis whatsoever, whatever burden it is imposing, right? Or it is undue if it is disproportionate, that is, if there might be some particularly marginal safety benefit? Again, that was not the argument made about either ambulatory surgical centers or admitting privileges, but if the law is closing all the abortion facilities in Texas, then it is an undue burden. Undue, unjustified, gratuitous.

The Ninth Circuit adopted a similar standard when they were looking at a medication abortion restriction that was denying women access to, and doctors' ability to use, the best standard of care for their patients on medication abortion. The Ninth Circuit, too, says we have to look at whether it actually advances the stated purpose. It is not enough for the states to just say we are going to do something. It has to actually advance the interest. And if the burden exceeds what's necessary to advance that interest, then it is undue.

Similarly, in Alabama—which has also passed an admitting privileges law—the district court looked again at the relationship between severity of the obstacle and the weight of the justification. You can't close every abortion clinic in the United States based on something that is marginal at best.

Now, the one circuit that is an outlier on this is the Fifth Circuit Court of Appeals, which, of course, is a court of appeals that oversees the state of Texas. The Fifth Circuit doesn't balance. They are not going to balance how effective the law is at advancing the state's interest against the burden the law imposes. What they said in a prior case was, basically, mere speculation by the state legislature about whether the law advances its stated goal is enough. And as you can imagine under this standard, it is pretty easy to uphold the laws, even the ones the district court found to be unlawful.

That is going to be the issue in the Supreme Court, and we are going to be looking at the viability of laws in those states right now that have yellow. I would say that most of those, though there are some that are a little different in the way they present themselves, will stand or fall based on what the Supreme Court’s decision. If they fall and we go back to all the red on the map, you are going to see a sort of remapping of access to abortion services that existed before *Roe v. Wade* because, of course, there were states—New York being one, California being one—that did have access to abortion services before *Roe*. But we are seeing a kind of re-patterning of blocking of access in the wake of these newest TRAP laws.

So where does it end? We ask ourselves this a lot at the Center for Reproductive Rights. We have been playing whack-a-mole for a really long time with laws that pop up. Take the state of Oklahoma, for example. We have sued repeatedly in state and federal court over the last five years, and we have won, and we have won, and we have won, and we have won. But we are back suing Oklahoma again this year because the state legislature comes back every year and passes new laws and new restrictions. And that is true in state after state after state.

So to make the right to abortion real, there is going to need to be true federal protection with a reassertion of the standard of undue burden, which I believe the Supreme Court intended in 1992. Justice Kennedy was part of the plurality opinion there, saying that undue burden was to be a real standard that was to really balance access to abortion services with the states’ other interests. Otherwise, we are at a point where it is going to be necessary for the United States Congress to establish a law that gives us the parameters in which we can litigate these cases that make facts, medical evidence, standard of care, and scientific data the standard by which these laws have to stand or fall.

Just to show where the two are going to play out, there are two cases right now that are sitting, cert. pending, in the Supreme Court. One is the case from Mississippi that is an admitting privileges case. It has been sitting for cert. review. We won in the district court, and in that case, we actually had the Fifth Circuit Court of Appeals affirm the preliminary injunction on the grounds that Mississippi would lose its only clinic, and the state of Mississippi cannot deprive its citizens of their constitutional rights by forcing them to go out of state.

At the oral argument in that case, Mississippi’s argument was that women can just go out of state. Again, a health and safety regulation that actually doesn’t allow any services in your state is questionable. But that was their argument, and we argued back that it was good Supreme Court law that a state can’t deny its citizen their constitutional rights by saying they are available next door. In

a case out of Missouri in I believe the 1930s or '40s, Missouri was denying its African American citizens the right to attend its state law school, and Missouri's argument was we will pay those students to go to law school in another state. The Supreme Court, even then, before having the robust race protection standards that they have now in constitutional law, said you can't do that. You can't offload to your neighbors the constitutional rights which you need to guarantee to your citizens.

So that was the grounds on which the Fifth Circuit upheld, at least to date, the injunction against the admitting privileges law in *Jackson Women's Health Organization v. Currier*. The second case, of course, is the one that we were talking about, *Whole Woman's Health v. Cole* out of Texas. The Supreme Court has stepped in twice in that case to put the injunction back in place. That means it acted with five votes to put the injunction back in place. And so it looks likely, both because of their actions and because of the impact that the case would have nationwide if it were not taken, that the Court may be looking at it this term. We have filed our petition for cert., and if the state of Texas files its response on time, it could be as early as November that the Supreme Court could announce that they are taking the case.

I want to end by talking about the Women's Health Protection Act proposed in Congress this term. The United States Congress stepped in in the early 1990s when there was a different crisis happening in access to abortion services. That was in the wake of the repeated blockades, violence, and harassment against abortion providers. Finally, Congress stepped in and said, you know, enough already. Yes, there are local anti-picketing laws and local laws on trespass, but we need to step in with stronger protections so we have nationwide accessibility. The parallels to the present day are striking.

The Senate report on the Freedom of Access to Clinic Entrances Act described the problem the country was facing that needed a remedy. The report stated that the blockades were, "interfering with the exercise of the constitutional right of a woman to choose to terminate her pregnancy," and that such conduct "threatens to exacerbate an already severe shortage of qualified providers available to perform safe and legal abortions in this country."

It is the same problem that Congress is facing today, only made worse because the shortage of providers has increased. With the Act, Congress should look down the road to establish protection so that through legislation, they achieve the effects that were non-achievable because of those earlier blockades. Such a protection obviously is not passing next week in the United States Congress, but we need to look at it for the long-term because it would prohibit the singling out of abortion services for regulations that are more burdensome than those restrictions imposed on medically comparable services. It is not that

there would be any special protection for abortion services. They can be regulated as any comparable procedures would be. What the Act would do is establish a private right of action similar to the Voting Rights Act, which allows you to sue either under the Constitution or under the Voting Rights Act. It gives more structure to the courts looking at the burdens placed, in that case, on voting, and in this case, on reproductive rights. And it would give the Department of Justice jurisdiction to be able to look at these violations themselves.

This just gives you a quick look at how the Women’s Health Protection Act would operate. It would specifically prohibit some types of restrictions, like prohibiting providers from using fact-based standards of care for medication abortion. But the key is that it would have factors that the courts could look at when analyzing the new, different, and creative regulations that pop up year after year after year. Courts would look at these objective factors to determine the answer to that question we have been talking about today: is this a true health and safety regulation, or is this actually designed to limit the constitutional right to access abortion services?

I want to end by saying, like all of us here, I come to the issue of access to abortion and abortion rights with my own set of life experiences, personal commitments, and my own religious beliefs. And as the Supreme Court noted wisely in the *Planned Parenthood vs. Casey* case, men and women of good conscience can disagree, and probably always will, about the moral and spiritual implications of ending a pregnancy. In reaffirming in *Casey* the right that they had originally addressed in *Roe v. Wade*, the Court reminded us that it is “the promise of the Constitution that there is a realm of personal liberty which the government may not enter.” And whether these principles of *Casey* will endure in the next battle in the Supreme Court will depend on whether facts, the rule of law, and reasoned argument prevails. So it is not just women’s rights that are at stake in this case, but the integrity of our democracy itself.

Thank you.