

Center for American Progress



# June Medical Services v. Russo

The Potential Impact on Abortion, Civil, and Human Rights

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By Jamille Fields Allsbrook and Nora Ellmann    February 2020



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# Introduction and summary

**Note:** On February 6, 2020, *June Medical Services v. Gee* changed to *June Medical Services v. Russo* due to a staffing change at the Louisiana Department of Health. All references in this report have been updated to reflect this change.

As a result of unrelenting attacks on abortion access, the promise of *Roe v. Wade* has never been fulfilled in the United States. Now, *June Medical Services LLC v. Russo* threatens to undermine this promise once again. In taking up *June Medical*, the U.S. Supreme Court will hear arguments on its first major abortion case since the appointments of Justices Neil Gorsuch and Brett Kavanaugh—the latter of whom has penned opinions hostile to abortion rights—solidified the conservative leaning of the court. Even in the current era of deep division and partisanship, both nominations were notable for their contentiousness. Senate Majority Leader Mitch McConnell (R-KY) subverted long-standing procedures to push their nominations through—both by blocking the process for former President Barack Obama’s nominee Merrick Garland and by changing the rules to make it easier to appoint ideologically extreme judges.<sup>1</sup> President Donald Trump, prior to his election, promised his supporters that he would appoint anti-choice justices to the Supreme Court, raising serious concerns about whether his nominees would advance an ideological agenda that would undermine the integrity of the judiciary, rather than uphold the rule of law.<sup>2</sup>

Now, the Supreme Court will consider a legal challenge involving a law intended to eviscerate the availability of abortion care. Its decision could significantly undermine abortion access—particularly for those who already have limited access—as well as patients’ ability to enforce in court the right to have an abortion. The case could also have broad implications beyond abortion access, affecting the enforcement of civil and human rights.

The law at issue in *June Medical* is Louisiana’s Act 620, which “requires an abortion provider to have admitting privileges at a hospital within 30 miles of where any abortion is performed,” among other changes.<sup>3</sup> Act 620 is an example of a “targeted regulation of abortion providers,” or TRAP law, legislation expressly crafted to impose unnecessary regulations on clinics and physicians providing abortion care in an effort to curtail or cease their ability to operate.<sup>4</sup> The outcome of *June Medical* could threaten the health and financial security of people in Louisiana and the surrounding region, especially those experiencing intersecting forms of oppression, such as people of color as well as transgender and nonbinary people.

Overall, an adverse decision could set a bad precedent that could harm people around the country and affect future cases beyond abortion rights. First, such a precedent could allow harmful state abortion restrictions to continue and proliferate. Furthermore, the case could set a negative standard for how much weight the Supreme Court will give its previous decisions in future cases, given the law at issue is identical to a Texas law that it struck down in 2016 in *Whole Woman’s Health v. Hellerstedt*.<sup>5</sup> Additionally, in agreeing to hear *June Medical*, the Supreme Court also granted a cross petition from the Louisiana government that questions the validity of third-party standing for abortion providers—the ability of abortion providers to bring cases challenging restrictive abortion laws on behalf of their patients—and that could affect other third parties’ ability to enforce civil and human rights.

*June Medical* illustrates that reliance on courts and precedent alone is not enough; state and federal legislation is also necessary to prevent attacks on abortion care and proactively improve access to abortion. Act 620 is an example of such an attack; it represents a systemic tool that has been put in place to control women’s bodily autonomy. Such laws are rooted in gender—and, often, racial—oppression. In this way, *June Medical* is a stark reminder of what is at stake in federal, state, and local elections—which will shape not only the future of abortion rights but also the integrity of the nation’s judiciary.

# Abortion restrictions and the courts: A brief history

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## Supreme Court precedent

Understanding the Supreme Court's history of jurisprudence—or legal philosophy<sup>6</sup>—around abortion is key to understanding the issues at stake in and the implications of *June Medical*. The foundational Supreme Court case for abortion rights is *Roe v. Wade*.<sup>7</sup> In this case, the court ruled that the constitutional right to privacy includes the right to access an abortion.<sup>8</sup> After the 1973 *Roe* decision made abortion legal across the United States, anti-abortion advocates began passing laws designed to restrict access to and limit abortion. In a 1992 example of one such case, the Supreme Court decision in *Planned Parenthood v. Casey* established the “undue burden” standard: States could enact laws restricting abortion so long as they did not present an “undue burden” to accessing abortion care.<sup>9</sup>

The 2016 Supreme Court case *Whole Woman's Health v. Hellerstedt* was the latest to put the undue burden standard to the test. In 2013, Texas passed H.B. 2, which required facilities providing abortion care to meet the building requirements of an ambulatory surgical center and required doctors providing abortion care to have admitting privileges at a hospital within 30 miles of the clinic.<sup>10</sup> The law was passed under the guise of protecting women's health, but its actual effect was that it forced clinics to close: Before it was blocked by the courts, H.B. 2 led to the closure of more than half of Texas' facilities that provided abortion care, reducing the number of facilities providing abortion care from 40 to 19 between 2013 and 2015.<sup>11</sup> The 5th U.S. Circuit Court of Appeals upheld the law, but the Supreme Court overturned the decision, ruling H.B. 2 unconstitutional, citing the undue burden standard in *Casey*.<sup>12</sup> In *Whole Woman's Health*, the Supreme Court made clear that a law that restricts abortion must meet the following three requirements: (1) further a valid state interest, (2) have benefits that outweigh the burdens it places on people seeking abortion care, and (3) be based on credible evidence.<sup>13</sup> The high court found that Texas' admitting privileges law failed to meet these three requirements and, in particular, posed an unconstitutional undue burden on abortion access. Notably, Louisiana's Act 620, at issue in *June Medical*, contains an admitting privileges requirement identical to the Texas law declared unconstitutional in *Whole Woman's Health*.<sup>14</sup>



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## Case trajectory

In October 2019, the Supreme Court granted cert in *June Medical Services v. Russo*, agreeing to hear both the plaintiffs' appeal challenging the constitutionality of Louisiana's admitting privileges law and the state's cross petition challenging the standing of providers to bring cases around abortion restrictions.<sup>15</sup> This litigation began in August 2014 when the Center for Reproductive Rights first brought the legal challenge to Act 620.<sup>16</sup> The U.S. District Court for the Middle District of Louisiana blocked the law from going into effect and, in light of *Whole Woman's Health*, ruled that the law posed an unconstitutional undue burden on abortion access.<sup>17</sup> Upon Louisiana's appeal, however, the 5th Circuit overturned the District Court's decision.<sup>18</sup> It is worth noting that the state did not challenge the plaintiffs' standing to bring this litigation in any lower courts. Therefore, this issue, as it pertains to this case, will first be debated before the Supreme Court.

The law would force all but one provider at one clinic to stop providing abortion care.

The 5th Circuit's decision was troubling in a number of ways. For one, the court conducted its own fact-finding—a task traditionally reserved for the District Courts.<sup>19</sup> The Circuit Court reasoned that even though Louisiana's Act 620 was identical to the Texas law, it would not impose a substantial burden on abortion access in Louisiana.<sup>20</sup> The court, based on its own fact-finding, claimed that only one provider at one clinic would be unable to obtain admitting privileges, contrary to the District Court's finding that the law would force all but one provider at one clinic to stop providing abortion care.<sup>21</sup>

Subsequently, the plaintiffs requested an emergency stay from the Supreme Court to prevent the law from going into effect while they appealed the 5th Circuit's decision, and the justices granted the stay by a 5-4 vote.<sup>22</sup> Justice Kavanaugh filed a dissent, which essentially argued that there is no way of knowing whether Act 620 would pose an undue burden on abortion access if it is not allowed to go into effect.<sup>23</sup> Kavanaugh claimed that the law's 45-day implementation period meant that the "question could be readily and quickly answered without disturbing the status quo or causing harm to the parties or the affected women."<sup>24</sup> This wait-and-see approach ignores the law's impact on people being forced to carry a pregnancy to term while the court waits, as illustrated in the statements of the Louisiana providers and clinics who said that they would not be able to obtain admitting privileges and therefore would be forced to stop providing abortion care. Furthermore, this approach does not consider the impact that the identical Texas law had in closing clinics in that state. Kavanaugh ignored the reality that most clinics that are forced to stop providing abortion care do not immediately start again if the law changes; in fact, many never reopen. When a clinic closes, staff are let go, equipment may be sold, and building leases might expire.<sup>25</sup> In Texas, the Supreme Court struck down H.B. 2, but more than three years later, there are only 22 clinics open, slightly more than half the number of clinics that were open before the law went into effect.<sup>26</sup>

Justice Kavanaugh's dissent is all the more concerning in that it echoes his 2017 decision in the D.C. Circuit Court case *Garza v. Hargan* to deny access to abortion care for an immigrant minor in the custody of the Office of Refugee Resettlement (ORR). In his opinion, Kavanaugh said that the ORR should be given more time to find a sponsor who would take the young woman out of custody, which the office had not successfully done in the preceding months. This decision, which was ultimately overturned, would have further delayed her ability to access abortion care.<sup>27</sup> Overall, Kavanaugh has demonstrated a disregard for precedent—despite promising otherwise during his confirmation—and a pattern of hostility toward abortion rights. His opinions show a repeated ignorance of the real-world consequences of his decisions, which would deny countless people access to health care and bodily autonomy.<sup>28</sup>

If people are not able to access their rights, *Roe's* promise becomes irrelevant and empty for many.

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## State laws targeting abortion

Since *Roe v. Wade* established that the constitutional right to privacy includes the decision to have an abortion, the ruling has been upheld time and time again, and has remained highly popular: A 2019 NPR/PBS NewsHour/Marist poll found that 77 percent of Americans support upholding *Roe*.<sup>29</sup> Yet for decades, anti-abortion activists have worked to chip away at abortion rights, enacting legislation that makes it increasingly difficult to access abortion care. Although TRAP laws such as Louisiana's Act 620 do not outright ban abortion, they do prevent doctors and clinics from providing quality abortion care and restrict access to abortion. Often proposed under the guise of promoting women's health and safety, TRAP laws have proliferated as an anti-choice strategy to close or hinder facilities providing abortion care. In reality, these laws do nothing to improve patient safety during a procedure that is already incredibly safe.<sup>30</sup> Rather, TRAP laws put onerous and unnecessary requirements on providers and health centers, effectively preventing them from providing safe, timely care and jeopardizing people's health and autonomy.<sup>31</sup>

If people are not able to access their rights, *Roe's* promise becomes irrelevant and empty for many. Moreover, the constitutional right to an abortion should not depend on where a person lives; as the authors discuss later in this report, people in the South—particularly in Louisiana—would have their right to access abortion care undermined.

Act 620 is just one of the many state laws enacted to undermine—or outright deny—a person's right to access an abortion. In the past decade, and under the Trump administration in particular, abortion access has increasingly come under attack, with anti-abortion activists and legislators emboldened by a Supreme Court that they



believe will rule in their favor to gut or completely overturn the right to access an abortion. Attacks on abortion access have further escalated since Justice Kavanaugh joined Justice Gorsuch in cementing the conservative lean of the Supreme Court. According to the Guttmacher Institute, in 2019, 17 states enacted a total of 58 abortion restrictions—25 of which would ban all or some abortions. Comparatively, 23 restrictive laws passed in 2018.<sup>32</sup>

Although some of the most extreme restrictions—such as a near-total ban in Alabama and six-week so-called heartbeat bans in Ohio, Georgia, Mississippi, and other states—have been blocked by the courts, many restrictive laws remain in effect across the country.<sup>33</sup> The restrictive abortion laws currently in effect range from bans—at varying weeks of gestation, on certain methods of abortion procedures, and on abortions for particular reasons, such as fetal diagnosis—to restrictions such as mandatory waiting periods and ultrasounds, mandated counseling with biased and inaccurate information, parental involvement requirements for minors, and more.<sup>34</sup> Recent analysis from the Center for Reproductive Rights found that if *Roe v. Wade* were significantly limited or overturned, abortion could effectively become illegal in as many as 24 states.<sup>35</sup> Many of these states are also among the 24 states that have TRAP laws in place, including regulations for facility structure and licensing, as well as requirements for abortion providers.<sup>36</sup>

Beyond the admitting privileges TRAP law at issue in *June Medical*, Louisiana in particular has laws restricting abortion that impose barriers on patients and providers. It has laws banning abortion at or after 20 weeks postfertilization—22 weeks after the last menstrual period—and banning the procedure used for abortions later in pregnancy, also known as dilation and extraction (D&X); laws mandating a 24-hour waiting period and requirements to receive an ultrasound and biased counseling; laws requiring parental involvement for minors; laws restricting public insurance coverage in line with the Hyde Amendment; and laws banning private insurance coverage for abortion care for plans in the state health exchange.<sup>37</sup> Louisiana has also passed additional restrictions that have been blocked by courts, including banning abortion at six and 15 weeks.<sup>38</sup> If Act 620 is allowed to go into effect, its additional barriers could force all but one clinic in the state to close, which would likely make abortion functionally unavailable for many in Louisiana. Additionally, if *Roe* is overturned or further gutted, the state has codified a “trigger ban” law that would outlaw abortion in almost all cases.<sup>39</sup>

## Federal abortion restrictions

In addition to states passing their own restrictive laws, the Trump administration has undertaken anti-choice actions on the federal level that also contribute to the already limited access to abortion in the United States.<sup>40</sup> The president has nominated a record-breaking number of federal judges to lifetime appointments at a rapid pace—made possible by Sen. McConnell’s obstruction of President Obama’s nominees.<sup>41</sup> The vast majority of these judges are members of the conservative Federalist Society, many with deeply hostile records on abortion rights.<sup>42</sup> And through the often opaque federal regulatory process, the administration has sought to undermine access to abortion care through insurance coverage and federal programs.<sup>43</sup> For instance, the Trump administration has recently finalized a rule that aims to undermine abortion coverage through private insurance sold on the the Affordable Care Act (ACA) marketplaces. Under the new rule, plans offering abortion coverage on the ACA marketplaces will be required to send consumers two bills: one for abortion coverage and one for all other health services. This could lead to consumer confusion and insurers dropping abortion coverage.<sup>44</sup> Additionally, the Trump administration’s proposed rule on Section 1557 of the ACA,

also known as the Health Care Rights Law, would remove nondiscrimination protections against people who have had or will have an abortion, as well as prohibitions against discrimination based on gender identity and sex stereotyping in health care.<sup>45</sup> These attacks have a particularly burdensome impact on low-income people, people of color, and young people.<sup>46</sup>

Long-standing abortion restrictions at the federal level also impede access to care. In particular, restrictions on funding for abortion place significant and often insurmountable barriers on abortion access for those affected. The Hyde Amendment, in place since 1976, prevents the use of federal funds for abortion coverage for people enrolled in Medicaid, the Children’s Health Insurance Program (CHIP), and other federal health programs, with limited exceptions.<sup>47</sup> These restrictions also prevent abortion coverage for Native Americans, federal employees, military personnel, people in federal detention, residents of Washington, D.C., and more.<sup>48</sup> Moreover, they further stigmatize abortion by treating it differently from any other type of health care service.

# Potential impact on abortion access

A ruling upholding the Louisiana law could further impede the already limited abortion access in the United States. A 2018 study from Advancing New Standards in Reproductive Health (ANSIRH) found that 27 cities in the United States are “abortion deserts”—cities in which people have to travel at least 100 miles to reach an abortion provider.<sup>49</sup> Moreover, a *New York Times* analysis found that more than 11 million women of reproductive age nationwide live more than an hour’s drive from an abortion provider.<sup>50</sup> And according to the Guttmacher Institute, as of 2017, 89 percent of counties in the United States have no known clinics that offer abortion care.<sup>51</sup>

Essentially, this demonstrates that the right to access an abortion, as established by *Roe v. Wade*, does not exist in reality for many in the United States, particularly those whose bodily autonomy and access to services are most threatened.

Louisiana claims that Act 620 is necessary to protect women’s health, but research indicates the law will actually harm women’s health and financial security. A 2017 Center for American Progress analysis found that women living in states with TRAP laws have less labor mobility—the ability to transition between jobs or from unemployment to employment—and that women living in states with better access to reproductive health care, including abortion access, have higher earnings and face less occupational segregation.<sup>52</sup> According to ANSIRH’s landmark Turnaway Study, women who are denied an abortion face serious consequences, including greater likelihood of living in poverty, staying in abusive relationships, and experiencing mental health issues, as well as increased chances of suffering health consequences from continuing a pregnancy.<sup>53</sup>

When assessing the potential harm of *June Medical*, it is key to understand the impact that Act 620, if found constitutional, would have on groups whose access to abortion is especially vulnerable, including people living in the Midwest and South, people of color, low-income people, people with disabilities, young people, and transgender and nonbinary people. As policymakers examine barriers to abortion access for particular groups, it is important to remember that people may hold identities across many of these categories, which only amplifies the barriers they face in accessing abortion care. The following sections consider the public health and financial implications for these particularly vulnerable groups.

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## People in the South

If Act 620 is allowed to go into effect, Louisiana will be left with just one clinic and one provider for the 1 million women of reproductive age in the state, including the approximately 10,000 people per year who obtain abortion care there.<sup>54</sup> Louisiana restricts access to abortion care after 20 weeks postfertilization. However, if Act 620 goes into effect, there will be no physician left in the state who provides abortion care after 17 weeks.<sup>55</sup> In other words, abortion access in Louisiana would be eliminated for those in need of care after 17 weeks, and ultimately, these people would be forced to incur additional costs to travel out of state; delay the procedure, which frequently leads to additional costs; or forgo abortion care entirely.

People in Louisiana, and the South at large, already face a landscape in which meaningful abortion access is not a reality in their lives, and *June Medical* could worsen access in the region. An administrator at Hope Medical Group, the clinic represented in *June Medical*, noted that they serve patients from all parts of Louisiana, as well as people from East Texas, Arkansas, Mississippi, and Oklahoma.<sup>56</sup> TRAP laws in the South have been particularly effective in forcing clinics to close and decimating access to abortion care—as seen in the impact of Texas’ H.B. 2. Louisiana itself went from having 17 abortion-providing facilities in 1992 to just three in 2018, likely affected by the range of restrictions on clinics, providers, and access to care, as well as the state’s hostile climate toward abortion.<sup>57</sup> The neighboring state of Mississippi is one of six states in the country—all located in either the South or the Midwest—with only one remaining abortion clinic.<sup>58</sup> Depending on the outcome of *June Medical*, Louisiana could become the seventh.

If abortion access is eroded in Louisiana, neighboring states will not be able to fill the void, as they, too, have severely restricted access to abortion care. In a ranking of state support or hostility to abortion rights based on state policies around abortion access, Louisiana, along with border states Arkansas and Mississippi, was among the states ranked “very hostile,” the lowest ranking.<sup>59</sup> Other neighboring or nearby states, including Texas, Oklahoma, Alabama, and Tennessee, received the second-lowest ranking of “hostile.”<sup>60</sup> Guttmacher Institute data analyzing how many women live in a county without an abortion clinic demonstrate the poor state of abortion access in the South: In 2017, 72 percent of women in Louisiana, 91 percent of women in Mississippi, and 77 percent of women in Arkansas aged 15 to 44 lived in a county with no abortion clinic.<sup>61</sup> In every Southern state with the exception of Florida, more than half of women of reproductive age lived in a county with no abortion clinic.<sup>62</sup>

If Act 620 is allowed to go into effect, its impacts on people in Louisiana and the surrounding region will be long-lasting. For those still able to access abortion care, the increased travel and wait times necessitated by clinic closures will increase the cost of the procedure itself as well as costs required to access abortion care, including child care, travel, and lodging costs. The financial strain of accessing abortion is compounded by the potential risk to employment and education, which can have long-term impacts on the economic success and equality of people seeking abortion care, who often already lack financial stability.<sup>63</sup> For those unable to access abortion care as a result of the law, the Turnaway Study shows that the economic consequences of being denied abortion care, in some instances, last for years following.<sup>64</sup>

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## People of color

People of color who need access to abortion care, particularly Black women, will undoubtedly experience the most harm if the Supreme Court finds Act 620 constitutional. Communities of color would bear a disproportionate burden of a negative outcome in *June Medical* and further restrictions to abortion access. These communities disproportionately live in states affected by restrictive abortion laws and face discrimination and bias in the health care system that affects their ability to access quality health care.<sup>65</sup> Women of color face disparities across sexual and reproductive health outcomes, including maternal health, sexually transmitted infections (STIs), and cervical and breast cancer, with worse outcomes than white women in every major health indicator.<sup>66</sup>

Some communities also face their own challenges in accessing abortion care. For example, a high uninsured rate, restrictions on immigrants accessing health care, and lack of linguistically and culturally competent care create obstacles for Latinx people as well as Asian Americans and Pacific Islanders seeking to access abortion and other reproductive health care.<sup>67</sup> In addition, federal coverage for abortion care is restricted for Native American people, many of whom access health care through the federal Indian Health Service.<sup>68</sup> People of color, particularly Black, Latinx, and Native American communities, have historically had—and continue to have—their reproductive autonomy violated through medical experimentation; forced sterilization and population control campaigns; and restriction of access to quality, comprehensive, noncoercive reproductive health care, including abortion care.<sup>69</sup>

## The disproportionate burden of abortion restrictions on Black women

Black women have limited access to abortion care and are more likely to experience delays in care, increased costs, and lack of access as a result of restrictive laws.<sup>70</sup> These restrictions on abortion access exist within the broader health care system, in which systemic racism and bias prevent access to quality care for certain groups. For Black women, these biases include stereotypes that oversexualize their bodies, ignore their pain, and devalue their agency over their own reproductive health care choices.<sup>71</sup> Such bias contributes to negative health outcomes; for example, Black women in the United States are three to four times more likely than non-Hispanic white women to die from pregnancy-related causes. Abortion restrictions only further subject them to pregnancy-related health risks.<sup>72</sup>

Black people also disproportionately live in states that will be most directly and immediately affected by an adverse decision in *June Medical*. In 2018, 32.4 percent of people in Louisiana and 19.3 percent of people in the South identified as Black or African American, compared with 12.7 percent of the overall U.S. population.<sup>73</sup> In 2015, Black women received more than 62 percent of abortions in Louisiana, meaning that they would disproportionately be affected if *June Medical* eroded abortion access in the state.<sup>74</sup> Louisiana already has one of the highest maternal mortality rates of any state in the country; Act 620's unnecessary abortion restrictions—given that the law limits people's ability to plan and space pregnancies and childbirth—would undoubtedly exacerbate this public health crisis and its disproportionate impact on Black women.<sup>75</sup>

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### Low-income people

Further abortion restrictions will disproportionately affect people with low incomes. In 2011, the rate of unintended pregnancy for women aged 15 to 44 was more than five times higher for women with incomes below the federal poverty level than it was for those with incomes at or above 200 percent of the poverty level.<sup>76</sup> In 2014, 49 percent of abortion patients in the United States had incomes below the federal poverty level, double the share from 1994 and much greater than the 19.7 percent of all women who had incomes below the federal poverty level in 2014.<sup>77</sup> Women with low incomes are more likely to have to drive more than an hour to reach an abortion provider.<sup>78</sup> A majority of those low-income women are also subject to state waiting-period laws that require multiple trips in order to access abortion care.<sup>79</sup> Such requirements, as well as factors such as access to a car or other mode of transportation, money for gas and hotel, ability to take time off work, and child care costs, can amount to insurmountable barriers to abortion care access for low-income people.

Louisiana already restricts both public and private insurance funding for abortion care,<sup>80</sup> and if the *June Medical* decision allows Act 620 to go into effect, the additional travel and wait times required to access abortion care will further increase the cost of the procedure—in part by forcing people to delay care and therefore have more expensive procedures later in pregnancy—making it even more inaccessible for low-income people in Louisiana.



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## People with disabilities

People with disabilities already face barriers to abortion access. If the Supreme Court upholds the law in *June Medical*, those barriers will only be amplified. People with disabilities must often contend with reproductive coercion and threats to their bodily autonomy, and they continue to be targets of sterilization campaigns and have their constitutional right to parent threatened.<sup>81</sup> People with disabilities may also be under legal guardianship or otherwise not allowed or trusted to make their own reproductive health care decisions. Moreover, they often face discrimination by providers who are not properly educated on providing care for people with disabilities, which can lead to inaccurate medical information and harmful medical practices.<sup>82</sup>

Along with discrimination from providers and caregivers and systemic violation of their bodily autonomy, people with disabilities face additional barriers to abortion access. According to census data, in 2015, women with disabilities were three times more likely than men without disabilities to live in poverty, making it more difficult to pay for abortion care.<sup>83</sup> In addition, disabled people may have difficulty traveling to a clinic to access abortion care; 17 states ban the use of telemedicine for abortion care, which could be a tool to increase access to care for people with disabilities.<sup>84</sup>

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## Young people

Laws restricting abortion access have for years targeted young people. Thirty-seven states have laws requiring some form of parental involvement in a minor's abortion.<sup>85</sup> Minors in 36 of these states can obtain a judicial bypass—a court order allowing them to access abortion care without parental involvement—but these processes take time, money, and knowledge of the legal system that may be inaccessible to many minors.<sup>86</sup>

Young people face additional barriers to accessing abortion care beyond state laws. According to analysis from Advocates for Youth, young people may be less able to take time off from work or school and travel to access abortion care; have lower or no incomes; and tend to have less regular periods, making it more difficult to know when they are pregnant.<sup>87</sup> Louisiana already has a law requiring parental consent for minors.<sup>88</sup> If Act 620 goes into effect, it will force clinics to close, and young people seeking abortion care in the state will face even further barriers to access.

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## Transgender, nonbinary, and gender-nonconforming people

Transgender men and nonbinary or gender-nonconforming people may also have the capacity for pregnancy and therefore the need to access comprehensive reproductive health care services, including abortion. However, they face unique barriers to accessing care. Major barriers that transgender and gender-nonconforming people face in accessing abortion care include discrimination, bias, and lack of knowledge about these groups' health care needs from providers. The 2015 U.S. Transgender Survey Report from the National Center for Transgender Equality found that among respondents who had been to a health care provider in the past year, 33 percent had a negative experience related to their gender identity.<sup>89</sup> A 2017 nationally representative survey from the Center for American Progress found that 29 percent of transgender people who had visited a health care provider in the past year had a provider refuse to see them because of their gender identity.<sup>90</sup> In addition, 12 percent said a provider refused to give them care related to gender transition, 23 percent were intentionally misgendered, and 29 percent experienced unwanted physical contact from a provider.<sup>91</sup>

Such mistreatment and discrimination compound the barriers that transgender and gender-nonconforming people face in accessing health care. The U.S. Transgender Survey found that 23 percent of respondents avoided going to the doctor out of fear of being mistreated, and 33 percent did not go to a doctor because of cost.<sup>92</sup> Being denied care and given inaccurate medical information can contribute to delays in accessing abortion care.<sup>93</sup> In addition, transgender and gender-nonconforming communities face higher rates of poverty, which limits access to abortion. These groups may not have a safe option for accessing abortion care, let alone an affirming experience.<sup>94</sup> A bad decision in *June Medical* would even further restrict the safe, unbiased options for transgender and gender-nonconforming people in Louisiana seeking abortion care.

In short, this case threatens abortion access—particularly for those who already have limited access—and could set a dangerous precedent going forward. If the Supreme Court allows Act 620 to go into effect, directly contradicting its own decision in *Whole Woman's Health* in 2016, it will tell lower courts that are rapidly being filled with unqualified, conservative Trump-nominated judges that they are free to ignore Supreme Court precedent and set their own constitutional law.<sup>95</sup> Moreover, it could embolden the anti-abortion movement, signaling to lawmakers that they are free to continue legislating abortion access out of existence.

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# Third-party standing and the impact on abortion, civil, and human rights

The third-party standing issue in *June Medical* could have far-reaching implications for abortion and other rights. The concept of “third-party standing” may seem obscure, but it is critical to enforcing a range of rights, particularly abortion rights.<sup>96</sup> Generally, a person can only bring a case if the law or government action violates their own rights and cannot claim that the law violates the rights of someone else.<sup>97</sup> However, this rule has key exceptions, and for nearly 50 years, these exceptions have included providers’ ability to bring litigation on behalf of their patients.<sup>98</sup> As a result, anti-abortion activists have targeted third-party standing to thwart and undermine the right to access abortion care because they understand its importance as the basis for the vast majority of challenges to restrictive and unconstitutional legislation.<sup>99</sup> In addition to enforcing abortion rights, the ability of third parties to bring litigation has been key to a range of cases defending people’s civil and human rights. Below are Supreme Court and other federal cases where third-party standing has been granted to enforce rights.

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## Right to access an abortion

The vast majority of abortion rights cases, including precedent-setting cases such as *Casey* and *Whole Woman’s Health*, have been brought by providers and clinics.<sup>100</sup> The third-party standing exception was first applied to abortion rights in the 1973 Supreme Court case *Doe v. Bolton*, a companion case to *Roe*.<sup>101</sup> In *Doe*, a woman who was denied an abortion after eight weeks challenged a Georgia law on her own behalf and on behalf of similarly situated people, and physicians were also found to have standing in the case because the criminal statute directly regulated their behavior. In a 1976 case, *Singleton v. Wulff*, the Supreme Court determined that physicians had standing to bring a case regarding Medicaid benefits for abortion care because of both the physicians’ financial interest in the case and their interconnected relationship with the patients. The Supreme Court also acknowledged here the obstacles and privacy concerns that might prevent a woman seeking abortion care from litigating.<sup>102</sup> *June Medical* creates uncertainty for every case currently moving through the federal courts challenging unconstitutional state laws restricting or banning abortion access that does not have a pregnant person as the plaintiff.<sup>103</sup>

Third-party standing is particularly key for challenging restrictive abortion laws because filing litigation is unrealistic for many people seeking to access abortion. First, pregnancy is time-limited, and people must file litigation while they are still pregnant, which can be unrealistic for those seeking to access an abortion. Additionally, a lengthy litigation process can result in people delaying an abortion, incurring increased health and financial risks; and the litigation—which can take years—is likely to outlast pregnancy.<sup>104</sup> Moreover, people seeking abortion care may experience financial and personal barriers that prevent them from having the time and resources available for a potentially yearslong legal fight. Furthermore, given the stigma associated with abortion, these potential plaintiffs often do not want to undergo the strain of litigation and the potential for information to be made available to friends, family, and the public.

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## Other reproductive and health care rights

Abortion is not the only reproductive health care service where third parties, including physicians, have been permitted to challenge unconstitutional laws. *Griswold v. Connecticut*, the landmark case that struck down a law preventing married people from using contraceptives because it violated their right to privacy, was brought by the executive and medical directors of the Planned Parenthood League of Connecticut, who were determined to have standing because of their close professional relationship with the married people they served—and the harm that they themselves would experience as a result of a law affecting their practice.<sup>105</sup> Similarly, *Eisenstadt v. Baird*, the 1972 precedent-setting case that established the constitutional right to privacy for all when the Supreme Court struck down a law prohibiting single people from accessing contraceptives, was litigated by a person who was married and able to obtain contraceptives.<sup>106</sup> The Supreme Court has also permitted a corporation that distributed mail-order contraceptives to challenge, on behalf of potential customers, a state law prohibiting the sale and distribution of contraceptives to minors under 16 and only permitting pharmacists to distribute contraceptives to people over 16 years old.<sup>107</sup> Furthermore, federal courts have relied upon Supreme Court precedent to grant standing to providers seeking to enforce patient rights related to other health care services, including mental health services.<sup>108</sup>

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## Rights in education

Third-party standing has been instrumental in allowing educators to defend the right to an education. For example, the Supreme Court granted standing to teachers challenging the constitutionality of a law that prohibited teaching in any language other than English and prohibited the teaching of languages other than English below the eighth grade.<sup>109</sup>

The Supreme Court has also allowed schools to challenge the constitutionality of a state law limiting student's school choice.<sup>110</sup> Moreover, federal courts have permitted a local school board and school superintendent to challenge the infringement on students' rights when the state's policies aimed to racially segregate schools.<sup>111</sup>

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## Housing rights

The right of individuals to choose where they live has been enforced by third parties. In the 1953 case *Barrows v. Jackson*, a white homeowner was allowed to challenge a housing covenant that prevented her from selling the house to people of color. The Supreme Court declared that it would be “difficult if not impossible for the persons whose rights are asserted to present their grievance before any court” and that damage to the white homeowner was “closely linked” to the damage of the discriminatory covenant.<sup>112</sup> In fact, as early as 1917, a white homeowner was able to challenge the constitutionality of a restrictive housing covenant prohibiting people of color from occupying certain homes.<sup>113</sup> Similarly, when a property development sought to redevelop a predominantly Hispanic community, a lower court granted standing to landlords, community organizations, and white—as well as the Hispanic—residents, alleging that the development was a targeted discriminatory action.<sup>114</sup>

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## Criminal justice

The Supreme Court has found that a criminal defendant had third-party standing to enforce the equal protection rights of jurors. Specifically, white defendants have, on more than one occasion, been able to challenge the exclusion of jurors on the basis of race.<sup>115</sup> Even though the defendants were not subject to racial discrimination, the Supreme Court recognized that their fate was tied to the composition of the jury, and therefore, the potential jurors and the defendants were both affected by the racial discrimination. Furthermore, the Supreme Court observed that those directly discriminated against, the potential jurors, “will leave the courtroom possessing little incentive to set in motion the arduous process needed to vindicate his own rights.”<sup>116</sup>

In sum, this nonexhaustive list demonstrates that *June Medical* could have far-reaching implications, undermining abortion and numerous other rights. As legal scholars noted in an amicus brief on this case: “Rejecting third-party standing doctrine ... would cut across numerous third-party standing contexts and have ripple effects throughout many areas of the law.”<sup>117</sup>

# Conclusion

The outcome of *June Medical Services v. Russo* could have both immediate and long-term impacts. First, access to abortion care for a whole region is in the balance, particularly for people who already face significant barriers to accessing abortion care. Second, the Supreme Court's decision will be a marker for the future of abortion rights and respect for long-standing precedent. Justice Kavanaugh has shown consistent personal and professional disregard for the bodily autonomy of women and people seeking reproductive health care, which demonstrates that he cannot be trusted to uphold the precedent of *Roe*, *Casey*, and *Whole Woman's Health*.

Given the current makeup of the Supreme Court and unrelenting legislative attacks on abortion access, the uncertainty surrounding *June Medical* is a reminder of the need to look beyond one case and beyond the courts and take proactive state and federal action to protect and expand access to abortion. No matter how the Supreme Court decides *June Medical*, the fight for the right to access abortion care in the United States is ongoing. To be successful, it must be multipronged and center the communities whose access to abortion is most threatened.



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