CLINICAL JURISPRUDENCE COLUMN

4 Supreme Court decisions important to ObGyns from the 2015–2016 term

Abortion, contraception access top the past year's decisions most relevant to your practice

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IN THIS ARTICLE

Each year, the decisions of the Supreme Court have a significant impact on ObGyn practice. During the 2015–2016 term, which ended in June, the Court issued important rulings on abortion facilities, Affordable Care Act (ACA) contraception coverage, health care False Claims Act (FCA) liability, and state health care data collection. The American Medical Association (AMA), the Association of American Medical Colleges (AAMC), the American College of Obstetricians and Gynecologists (ACOG), and other organizations that represent health care professionals play an important role in health-related Supreme Court cases. For example, amicus curiae ("friend of the Court") briefs are filed not by parties to a case but by organizations that have a special insight into or interest in a case. Although the extent to which amicus briefs influence cases is often unclear, organization representatives think their briefs make a difference, and briefs undoubtedly do in some cases.

The 2016 presidential election will determine the Supreme Court make-up for the next term, but in this article we consider recent cases that affect ObGyns' practice in particular. We start with the cases in which professional organizations filed amicus briefs and then turn to other notable cases.

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1. Abortion access in Texas and other states

The most important ObGyn case of the 2015–2016 term was *Whole Woman's Health v Hellerstedt*.[1]

At stake. Texas adopted a statute requiring 1) that physicians who perform abortions have admitting privileges at a hospital within 30 miles of the clinic and 2) that abortion clinics meet the state's standards for ambulatory surgical centers. The current law, upheld by the Court some years ago, is that state laws affecting abortion are unconstitutional if they "unduly burden" the right to abortion. By *undue burden,* the Court meant, "Regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an

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More notable 2015–2016 Supreme Court decisions

The Court:

- permitted limited consideration of race in university admissions. ACOG, AAMC, and AMA with many other groups filed an amicus brief supporting medical school and university affirmative action programs.[1]
- held that a state must give full faith and credit to the adoption orders of the courts of other states (this case involved an LGBT couple).[2]
- held that states may require (without a search warrant) a breathalyzer test, but not a blood test, for a driver suspected of drinking.[3]
- narrowed the ability of the federal government to seize or restrain (before trial) the assets of a person charged with criminal health care offenses.[4]
- temporarily stayed the August 2016 US Department of Education order to schools to allow transgender students to use the facilities in which they feel "most comfortable." The Court likely will take up this case very soon.[5]

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undue burden on the right." The question in the Texas case was whether the statute's 2 requirements were undue.

ACOG, AMA, and other groups filed a brief stating that the Texas law did not promote the welfare of women but instead was unnecessary and not "supported by accepted medical practice or scientific evidence."[2] In another brief the Society of Hospital Medicine and the Society of ObGyn Hospitalists also indicated that having admitting privileges is appropriate only for physicians who regularly admit patients to a hospital.[3]

A brief filed by the American Association of Pro-Life Obstetricians and Gynecologists and several other organizations argued the other side: "The surgical center and admitting privileges requirements imposed by the Act reflect the professional standard of practice for outpatient gynecological and similar surgery."[4]

Final ruling. In a 5–3 decision, the Court struck down the Texas law for providing little or no health benefits while significantly burdening abortion facility access. Many clinics had closed or were in plans to because of the difficulty and expense of complying with the law. This case has national implications. Similar laws, either in place or being considered in other states, will almost certainly be ruled unconstitutional.

2. Contraceptive coverage

The case of *Zubik v Burwell* was closely watched this past year.

At stake. Under the ACA, a nonprofit religious organization may certify its objection to its insurance plan's contraception coverage, at which point other arrangements are made to provide contraceptive coverage through the same plan. Religious organizations objected to the certification requirement.

A brief filed by ACOG, Physicians for Reproductive Health, and other groups emphasized the importance of providing contraceptives and contraceptive counseling as part of regular health care and suggested that the current accommodation for religious organizations is appropriate.[5]

After hearing the formal oral arguments, the Court asked for additional briefs on "whether contraceptive coverage could be provided to petitioners' employees, through petitioners' insurance companies, without any such notice from petitioners."[6]

Final ruling. The parties agreed such a system would resolve the issue, so the Court sent the case back to the lower court to work out the details. In effect, the case was mediated—an unusual if not unique action for the Court. The resolution probably will achieve what the briefs sought—access to contraceptives and continuity of care.

3. Fraud and abuse litigation

The FCA, which provides for triple damages (3 times actual damages) and stiff civil penalties for anyone who presents the federal government (Medicare, Medicaid) with false claims

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for goods or services, is a major means of uncovering and punishing health care fraud and abuse. In health care, this law has been used to prosecute cases involving services paid for but not provided, unnecessary services, and off-label pharmaceutical promotion.

An important part of the FCA is that it allows a private intervenor (whistleblower) to initiate an action against a health care provider. The government may then take up the case. If not, the intervenor may pursue it; the incentive is 15% to 30% of the damages the government is awarded.

At stake. The Court was asked if "implied certification" applies to FCA cases.[7] Implied certification means that requesting a payment from Medicare or Medicaid implies that the provider is not knowingly withholding information material to the government's decision to pay the claim. In separately filed briefs, AMA et al[8] and American Hospital Association (AHA) et al[9] argued that applying implied certification to FCA cases would expand FCA litigation (particularly by intervenors), which is already expensive for health care institutions.

Final ruling. The Court unanimously adopted implied certification but noted that nondisclosure of information must be shown to be a material misrepresentation rather than a trivial regulatory or contractual violation. Furthermore, the Court emphasized that the basis for a claim must be an allegation of fraud, not of malpractice. These findings, which certainly are not what the health care organizations had hoped for, likely will lead to an increase in FCA cases.

4. Collection of state health care data

In Vermont, and about 20 other states that collect data on health care utilization and costs, health insurers and other entities are required to submit detailed reports about health care claims.[10] Some insurers objected to this requirement.

At stake. An AHA–AAMC brief noted the importance of health care data and of Vermont's collecting these data as contributing to better, more efficient health care delivery.[11] Another brief, filed by AMA and the Vermont Medical Society, presented more legal or statutory arguments.[12]

Final ruling. The Court held that the Vermont plan and similar plans violate the

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federal Employee Retirement Income Security Act of 1974. As health insurance companies and other entities already provide detailed utilization and cost data to the federal government, producing up to 50 additional reports for state governments would be burdensome. Any state that wants the information, the Court said, should obtain it from the federal government.

What's to come

The Court's recent decisions on access to abortion services and contraceptives were good for patients of ObGyns, but its decisions on health care FCA liability and state health care data collection were, arguably, not as good for ObGyn business practices.

The Court itself had an unusual year. Justice Scalia died in February, and Congress's inaction on seating a replacement meant that most of the term's cases were decided by an 8-member Court. Nevertheless, the Court was deadlocked 4–4 on only 4 of the 80 cases it heard. In addition, it was relatively agreed on outcomes; in only about one-third of cases were there more than 2 justices disagreeing with the outcome.

It is unlikely that a replacement for Justice Scalia will be confirmed before the Court begins its new term in October. The need to replace Justice Scalia and the potential turnover of other Court members—Justice Ginsburg is 83, Justice Kennedy is 80, and Justice Breyer is 78—are reminders of the importance of this year's presidential election. In the meantime, the Court is accepting the cases that will make up the coming term's docket, and ObGyns undoubtedly will play a role in cases that involve health care.

FAST TRACK

The 2016 presidential election will determine Supreme Court decisions for the next term

›› The Supreme Court opinions described in this article are available at https://www.supremecourt.gov/opinions/slipopinion/15. Background on all cases considered by the Court is available at http://www.scotusblog.com.

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