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NOTE

WIDENING THE BATTLEFIELD: USING EMERGENCY CONTRACEPTION TO GET FROM ABORTION TO BIRTH CONTROL

Briana C. Hill¹

I. INTRODUCTION

In the spring of 2005, Representative Daniel LaMahieu² noticed a Health Services at University of Wisconsin advertisement in a student newspaper, advising students to prepare for spring break by obtaining emergency contraception (“EC”) from the university health centers. LeMahieu was “outraged” that the advertisement was giving the students the “tools for having promiscuous sexual relations.”³ In response, LeMahieu proposed what became A.B. 343, a bill that, if enacted, would have resulted in a law prohibiting anyone, including the University Health Services centers, from prescribing, dispensing, or advertising any hormonal medication intended for use as EC on any of the University of Wisconsin’s twenty-six campuses.⁴

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2. Wisconsin State Assembly Member, Republican, from Oostburg.

3. Anita Weier, *AG: Pill Bill Violates Rights; But Push For UW Ban Won't End*, CAP. TIMES, Apr. 6, 2005, at A3.

4. The relevant text of the bill reads: “No person whom the board employs or with whom the board contracts to provide health care services to students registered in the system may advertise the availability of, transmit a prescription order for, or dispense a hormonal medication or combination of medications that is administered only after sexual intercourse for the postcoital control of fertility to a registered student or to any other person entitled to receive university health care services.” A.B. 343, 97th Leg., Reg. Sess. (Wis. 2005).

A.B. 343 represents a new front in the reproductive rights battleground. Since 1973, the focus of both the media and various action groups in the United States has been on the controversy surrounding abortion. However, in recent years various political groups have begun focusing on restricting birth control access and are succeeding in making it a contested area once again. The proposal of A.B. 343 provides an opportunity to examine the potential constitutional claims that could result from the passage of a bill restricting access to birth control. The purpose of this paper is to explore both the legal and public policy issues presented by this bill and potential federal and state constitutional claims that could be brought to challenge it. Section II provides an overview of the current state of birth control issues. Section III explains what EC is, both according to the Food and Drug Administration ("FDA") and various other groups, and why it is so controversial. Section IV examines Wisconsin A.B. 343 and its potential impact on the University of Wisconsin system in further detail. The possible federal and state constitutional challenges are applied in Section V. Section VI addresses the public policy arguments against passage of A.B. 343.

II. THE CURRENT STATE OF BIRTH CONTROL ISSUES

The constitutionality of birth control use via a right to privacy has been settled law for over thirty years. In 1965, the Supreme Court held that Connecticut's statute forbidding the use of contraceptives by married people violated a fundamental right to marital privacy in *Griswold v. Connecticut*.⁵ The Court extended this right to privacy from the marital relationship to unmarried persons in *Eisenstadt v. Baird*⁶, in which the Court found that a Massachusetts statute prohibiting the distribution of contraceptive items to unmarried persons violated the Equal Protection Clause of the Fourteenth Amendment, because of its differing treatment of married and single people with respect to contraceptives.⁷ The Court held that "[i]f the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."⁸

5. 381 U.S. 479, 485-86 (1965).

6. 405 U.S. 438, 453 (1972).

7. *See id.*

8. *Id.*

In 1973, the Court expanded the scope of “the decision to bear or beget a child” to include a woman’s decision to terminate a pregnancy. In *Roe v. Wade*⁹ the Court utilized a trimester framework, weighing the privacy interests of the woman versus the state interests of protecting potential life and the life of the fetus.¹⁰ Post-*Roe*, the majority of litigation regarding reproductive rights centered on abortion. Birth control, in the post-*Griswold* and post-*Eisenstadt* world, was considered a settled area of law, except in two special areas of birth control regulations. The first such exception concerns minors’ access to birth control devices or information without parental notification or consent at schools or family planning centers, and whether such access violates parental rights. Various courts have found that minor access does not infringe on parental rights.¹¹ The second area of litigation has surrounded the constitutionality of statutes restricting the distribution of birth control information, either in person or by mail.¹² The Supreme Court has held that informational mailings or presentations regarding birth control are protected non-commercial speech under the First Amendment.¹³

Now there is a third emerging area of controversy: conscience clauses. Most states passed some version of a conscience clause following the Court’s decision in *Roe v. Wade*. Conscience clauses protect doctors and hospital employees for whom performing an abortion conflicts with religious or moral beliefs.¹⁴ While conscience clauses have existed in the abortion context for years, only recently have they been utilized to refuse distribution of birth control or EC. There are two important, and equally

9. 410 U.S. 113 (1973).

10. *See id.* at 161-66.

11. *See, e.g., Doe v. Irwin*, 615 F.2d 1162 (6th Cir. 1980) (holding that family planning center did not infringe on parent’s constitutional rights by distributing birth control to minor children without parental consent). *See also Decker v. Carroll Acad.*, 1999 Tenn. App. LEXIS 336 (affirming that allowing minor access to birth control supplies and information without parental consent did not violate parent’s right to religious freedom or parental rights).

12. *See Associated Students v. United States*, 368 F. Supp. 11 (C.D. Cal. 1973) (finding that a federal statute prohibiting mailing of unsolicited advertisements of birth control devices violated First Amendment right to free speech). *See also Bolger v. Youngs Drug Prods. Corp.*, 463 U.S. 60 (1983) (finding that a federal statute prohibiting mailing of birth control information violated First Amendment right to free speech).

13. *See id.*

14. *See Guttmacher Institute, State Policies in Brief: Refusing to Provide Health Services* (Nov. 1, 2006), http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf.

significant, differences between the *traditional* conscience clauses and these *modern* incarnations. The first difference is whom the clauses are drafted to protect. The traditional conscience clauses protected health care workers such as doctors and nurses, who were morally opposed to performing abortions, by allowing them to abstain from performing or participating in them. States drafting modern conscience clauses expand them to include all other health care workers, including pharmacists.¹⁵ Expanding coverage to include other types of health care workers is significant, because it increases the opportunity for encountering an objecting employee from a hospital or doctor's office to encounters in "public" places, such as pharmacies. Although pharmacies are located in privately owned businesses, they are open to the public in a different way than a doctor's office or hospital. The second difference in the newly drafted clauses lies in the scope of behaviors that the clauses cover. Traditionally, the primary excused activity was abortion. The modern approach to the clauses incorporates two new matters: birth control and stem cell research.¹⁶ The net result is that the opportunity for refusal to treat has expanded from a doctor in private practice, declining to perform an abortion, because it is against his or her religious (or moral) beliefs, to a pharmacist with the same objections, in a store that is open to the public, declining to dispense a doctor's prescription for birth control (or EC). One significant effect of the pharmacist refusals is that the refusing pharmacist is interjecting him or herself into the doctor/patient relationship. While pharmacists generally have discretion to refuse to dispense prescriptions because of possible drug interactions, they do not have a similar discretion to refuse to dispense a prescription for a medically unfounded reason. To date, four states have passed legislation that allow pharmacists to refuse to dispense contraceptives, and four more states have implemented other restrictions.¹⁷

15. There is some variance in coverage from state to state. *See id.*

16. Some argue that the *modern* refusals to distribute oral contraceptives or EC should fall under the abortion category because it is their personal belief that oral contraceptives and EC cause abortions.

17. The refusal states are Georgia, Arkansas, Mississippi, and South Dakota. An additional four states have broadly worded conscience clauses that could include pharmacists in their scope: Tennessee, Illinois, Maine, and Florida. *See* Guttmacher Institute, *supra* note 14. Texas and Indiana took steps to exclude EC from Medicaid Waiver coverage for family planning. Arkansas and North Carolina excluded EC from their state contraception coverage mandates. *See* Guttmacher Institute, State Policies in Brief: Emergency Contraception (Jan. 1, 2007), <http://guttmach.org/>

Wisconsin illustrates the two-part change in scope of conscience clauses. Like most other states Wisconsin has had a statutory conscience clause since the 1970s, that allows physicians, hospitals, and hospital employees to use religious or moral grounds as a basis for refusing to perform or participate in abortion or sterilization procedures.¹⁸ In 2004, the Wisconsin State Assembly and Senate passed A.B. 67, an extension of the codified conscience clause. The revision would have extended conscience exemption from physicians, hospitals, and hospital employees to all health care providers, including pharmacists. The scope of coverage of the revision would also have been widened, increasing from covering abortion and sterilization procedures to administration or dispensation of prescriptions, involvement in any procedure that is not beneficial to the human embryo at any stage, including embryonic research, and end-of-life health care actions.¹⁹ Wisconsin Governor Jim Doyle vetoed the proposed legislation, reasoning that the bill “improperly place[d] a higher priority on a health care provider’s own ideological beliefs than on a patient’s medical well being and right to make their own health care decisions.”²⁰ Noting that there were absolutely no patient protections included in the bill, but rather multiple protections for the health care providers refusing to give service, Governor Doyle proposed that it be called the “Unconscionable Clause” instead, because it would substantially restrict citizens’ access to medical information and treatment, in favor of certain health care providers’ ideological views.²¹ Not deterred by the governor’s veto, the Assembly proposed the same legisla-

statecenter/spibs/spib_EC.pdf. Eight states (Alaska, California, Hawaii, Maine, Massachusetts, New Hampshire, New Mexico, and Washington) limited allowances for pharmacists to dispense EC without a prescription, either under a collaborative practice agreement with a physician or under state protocol. *Id.* It is worth noting that Maine appears on both lists. Illinois is the only state that requires pharmacies that stock birth control to dispense EC. *Id.*

18. See WIS. STAT. §140.02 (1973) (current version at WIS. STAT. §253.09 (2005)). See also Stacy Forster, *Lawmakers push for “conscience clauses”; They’d let pharmacists refuse to offer service against their beliefs*, MILWAUKEE J. SENTINEL, Mar. 6, 2005, at B1.

19. A.B. 67, 95th Leg., Reg. Sess. (Wis. 2003) (vetoed Apr. 21, 2004).

20. Wis. Gov. Jim Doyle, Veto Message Assembly Bill 67 (Apr. 21, 2004), http://folio.legis.state.wi.us/cgi-bin/om_isapi.dll?clientID=40222433&infobase=vetomsg03.nfo.

21. See *id.*

tion again in 2005.²² Again, both houses of the state legislature voted to pass the expansion and Governor Doyle vetoed it.²³

Wisconsin is just one of the many state legislatures trying to expand existing conscience clause legislation.²⁴ Conscience clauses are important in the context of this discussion for two reasons. They are a developing area of legal conflict in the fight to preserve access to birth control. Moreover, they illustrate the growing difficulty of obtaining birth control when it is connected to the fight against legalized abortion. The modern refusal movement has been gestating for some time, but seems to have grown in an accelerated fashion in the years since the FDA approved on-label use of EC.²⁵ While conscience clauses allow the providers to refuse to dispense any contraception, including oral contraceptives, there is a greater focus on EC.²⁶ While the medically accepted mechanism of EC is that it *prevents* possible pregnancy, many people mistakenly believe that it *terminates* an existing pregnancy and therefore is an abortifacient.²⁷ Under the same reasoning, pro-life advocates extend the "termination" objections associated with anti-abortionism to oral contraceptives as well as to EC.

III. WHAT IS EMERGENCY CONTRACEPTION?²⁸

Although it has been available for over twenty-five years, EC did not receive either widespread attention or use until the late 1990s. EC is essentially a higher dose of the same or similar

22. A.B. 207, 97th Leg., Reg. Sess. (Wis. 2005) (vetoed Oct. 14, 2005).

23. *See id.* *See also* Steven Walters, *Senate set to pass ban on human cloning, Doyle promises veto; exemption to allow research to fight diseases is rejected in close vote*, MILWAUKEE J. SENTINEL, Sept. 28, 2005, at B1.

24. *See* Priya Jain, *The battle to ban birth control: Using bogus health facts to scare women about the "dangers" of contraception, a fledgling movement fights for a culture in which sex = procreation*, SALON, Mar. 20, 2006, http://www.salon.com/mwt/feature/2006/03/20/anti_contraception/index_np.html.

25. The first documented pharmacist refusal was in 1991, six years before the first FDA approval. *See generally* Julie Cantor & Ken Baum, *The Limits of Conscientious Objection – May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception?*, 351 NEW ENG. J. MED. 2008 (2004).

26. A more complete discussion of how EC functions will be addressed in Section III "What Is Emergency Contraception?"

27. Many also consider oral contraceptives to also function as abortifacients. A "Concerned Women for America" brochure states that "one function of the birth control pill . . . is to induce a 'chemical abortion'." Russell Shorto, *Contra-Contra-ception*, N.Y. TIMES, May 7, 2006, §6 (Magazine), at 48.

28. EC is also referred to as "the morning after pill." It is frequently confused with RU-486 (mifepristone, also known as "the abortion pill"), which actually is an abortifacient. RU-486 is taken after a woman has confirmed that she is pregnant.

hormones found in birth control pills, administered within a limited time period (usually seventy-two hours) after unprotected sexual intercourse.²⁹ The increased level of hormones acts to delay or inhibit ovulation, prevent fertilization, or prevent implantation of a fertilized egg in the uterine wall. EC is ineffective if the woman is already pregnant; it will not terminate or affect the pregnancy.³⁰ The effectiveness of EC of preventing pregnancy is estimated to be around seventy-four percent.³¹ In the marketplace, EC can be found in three basic forms. The first, which was used for years before its FDA approval in 1997, is an increased dosage of regularly prescribed birth control pills, commonly known as the Yuzpe regimen.³² Prior to FDA approval, EC was administered in what is termed an "off-label" use; the drug information enclosure or labeling could not contain instruction for use as EC, because the FDA had not approved it for that specific use.³³ Nevertheless, doctors could advise patients of the Yuzpe regimen. Then in 1997, the FDA approved four regimens of EC, each containing different doses of ethinyl estradiol and levonorgestrel, administered within seventy-two hours of the unprotected event in two doses occurring twenty-four hours apart.³⁴

First, the FDA approved two Yuzpe regimen doses. The decision included detailed instructions on the Yuzpe regimen to be included with six commonly used oral contraceptives, meaning that if a woman had one of the contraceptives on hand and knew about this information or was advised on how to do so by her physician, would be able to self-administer the EC.

The FDA also approved two other products, which pharmaceutical companies manufactured specifically to be sold and ad-

29. There are a number of incidents that could lead to the necessity of EC, including unprotected intercourse, condom failure, or rape.

30. See Prescription Drug Products; Certain Combined Oral Contraceptives for Use as Postcoital Emergency Contraception, 62 Fed. Reg. 8610 (Feb. 25, 1997) [hereinafter Prescription Drug Products].

31. *Id.* It is difficult to determine the actual effectiveness because not every unprotected coital act leads to pregnancy.

32. *Id.* The most common regimen of this type is known as the Yuzpe regimen and also is approved for use by Germany, Sweden, and Switzerland, the United Kingdom, and New Zealand. The Yuzpe regimen involves two doses of regular birth control pills. The first dose, taken within 72 hours of unprotected intercourse is one pill containing 0.05 mg of ethinyl estradiol and 0.50 mg of norgestrel. A second dose of the same quantity is taken 24 hours later. *Id.*

33. Many drugs are used in an "off-label" manner; one of the most popular ones in recent years is Botox, which is commonly injected into the forehead to smooth out wrinkles by paralyzing the muscles.

34. See Prescription Drug Products, *supra* note 30.

ministered as EC (meaning that they would not be packaged or sold as regular oral contraceptives). The second EC product approved by the FDA was Preven, which received approval in 1998.³⁵ The third and final approval was for Plan B, in 1999. One benefit of Plan B is that the progestin-only pill is more effective: it decreases the risk of pregnancy by eighty-nine percent, rather than by seventy-five percent under the traditional Yuzpe regimen.³⁶ Plan B also presents a "superior safety profile" for nausea and vomiting over the Yuzpe regimen, decreasing the chances of nausea from 50.5% to 23.1% and vomiting from 18.8% to 5.6%.³⁷

Once called the "best-kept secret in America," even after the FDA approvals brought EC increased attention, EC continues to be plagued by issues of accessibility.³⁸ Because it is most effective when taken within seventy-two hours of unprotected intercourse, and is more effective the sooner it is taken within those seventy-two hours, timely access is essential to the drug's effectiveness. The longer it takes or the harder it is for women to access EC, the less effective it is. Whereas prior to the FDA approvals accessibility was more a question of doctors not knowing enough about EC and women not knowing to ask for EC, now accessibility tends to be more a question of women having problems obtaining EC.³⁹ This difficulty stems from a number of sources. The first is some doctors' unwillingness to prescribe EC, or the inability to get in touch with a doctor in a timely manner.⁴⁰ Secondly, some businesses have elected not to stock EC.⁴¹

35. In the first three months Preven was on the market, 1.3 million packages were sold. See Patricia Miller, *Morning-After Pill Ban; Postcoital Contraceptives*, THE NATION, Jun. 21, 1999, at 7.

36. See Elena Portyansky, *Make Way for Progestin-only Emergency Contraceptive*, DRUG TOPICS, Sept. 6, 1999, at 24.

37. *Women's Capital Corporation—A New Generation of Emergency Contraception Has Arrived; FDA Approves Progestin-Only Emergency Contraceptive, Plan B (levonorgestrel) Tablets*, PR NEWSWIRE, Jul. 28, 1999.

38. Sandra G. Boodman, *Emergency Contraception: 'Morning After' Pill Has Long Been Available but Many Women Don't Know About It*, WASH. POST, Apr. 4, 1995, at Z7 (quoting David A. Grimes, Chief of Obstetrics and Gynecology at San Francisco General Hospital).

39. *Id.*

40. Women commonly need EC on the weekends, the time when it is most difficult to get an appointment to see a doctor.

41. Wal-Mart was one of these companies. On its decision to not carry EC, Wal-mart executives said it was a "business decision." This is more than unfortunate for the women who live in many of the under-served areas that rely on Wal-Mart pharmacies and who have few or no other options of obtaining EC. See Krista Larson, *Wal-Mart Clarifies Contraceptive Policy: Pharmacists Who Won't Fill Emer-*

Lastly, some pharmacists refuse to fill prescriptions for EC, or even for oral contraceptives if they think it might be used for EC.⁴²

Numerous groups that support the accessibility and availability of EC petitioned the FDA to approve its over-the-counter (“OTC”) distribution. OTC circumvents some of the accessibility problems that women face in trying to obtain EC. Women no longer need a doctor’s prescription, and do not need to rely on a pharmacist as an intermediary. It does not, however, alleviate the problem of pharmacies that refuse to stock EC. In those cases, women would still need a prescription for an increased dose of oral contraceptives in order to use the Yuzpe regimen. In May 2004, the FDA rejected an application to distribute Plan B as an OTC drug and suggested that the manufacturer, Barr Laboratories, submit a revised application for “behind the counter” distribution.⁴³ The revised application was promptly submitted as suggested, but was not approved until August 2006. Prior to the approval, the Government Accountability Office, in response to the request of a number of United States Representatives and Senators, conducted an investigation concerning the delay, and found the process of denial “unusual.”⁴⁴

gency-Use Prescriptions Must Offer Options, DALLAS MORNING NEWS, Sept. 15, 1999, at A3. Wal-Mart reversed their position on stocking EC and now carries it in their pharmacies, although they do not require their pharmacists to dispense it. This change in position immediately followed state level determinations in Connecticut and Massachusetts requiring the retailer to stock EC. See Jessica Fargen, *State Forces Wal-Mart to Go to Plan B*, BOSTON HERALD, Feb. 15, 2006, at A6; William Hathaway, *Access to Contraceptive Urged—Advocates, Officials Want ‘Morning-After Pill’ Widely Available*, HARFORD COURANT, Feb. 22, 2006, at A1.

42. A pharmacist in Texas, citing religious beliefs, turned away a rape victim trying to fill a prescription for EC. The pharmacist was subsequently fired. See Liz Austin, *Denial of ‘Morning-After’ Pill to Rape Victim Stirs Debate*, MILWAUKEE J. SENTINEL, Feb. 29, 2004, at A14. Due to her religious beliefs, a pharmacist refused to dispense Plan B to two customers and told them to “come back later.” According to the pharmacy, these actions complied with company policy and state law. See Jim Ritter, *Planned Parenthood Protests Over Morning-After Pill: Downtown Pharmacist Wouldn’t Sell Emergency Contraceptive*, CHI. SUN TIMES, Mar. 23, 2005, at B10. See also Editorial, *Moralists at the Pharmacy*, N.Y. TIMES, Apr. 3, 2005, at D12.

43. According to the Government Accountability Office investigation that concluded in November 2005, the process leading to the rejection was “unusual.” Top agency officials, whose involvement in the process was “rare,” ignored the recommendation of the independent advisory committee and the agency’s scientific review staff. Barr, the Plan B manufacturer, submitted a “behind-the-counter” application in July 2004. In accordance with FDA rules, a decision should have been issued in January 2005. See Gardiner Harris, *Report Details F.D.A. Rejection of Next-Day Pill*, N.Y. TIMES, Nov. 15, 2005, at A1.

44. *Id.*

The approval, when it finally came in August 24, 2006, was only a moderate success for reproductive rights advocates.⁴⁵ When the FDA order becomes effective in early 2007, OTC EC will only be available to women aged eighteen and older, and will still be kept behind the pharmacist's counter. Women will be required to show identification of their age to the pharmacist before they are allowed to purchase the EC. While this new protocol eliminates the need for a doctor's prescription, which can be difficult to obtain, there are a number of concerns that it does not ameliorate. It does not help women under the age of eighteen. It does not solve the problem of pharmacies who refuse to stock EC. Finally, and perhaps most importantly, it still requires a pharmacist to hand over the product, which will still result in pharmacists making conscience-based refusals. So, while this is an improvement on the old prescription-required standard, it still leaves a number of concerns unaddressed.

IV. WISCONSIN A.B. 343 AS A TEST CASE

Wisconsin A.B. 343 was drafted to apply to the University of Wisconsin ("UW") system.⁴⁶ The UW system consists of twenty-six campuses: thirteen four-year campuses and thirteen two-year campuses, at which over 160,000 students attend classes.⁴⁷ Fifty-five percent of the students are female.⁴⁸ The largest campus in the system is UW-Madison.⁴⁹ Although women make up fifty-five percent of the UW-Madison student body, they make up sev-

45. Press Release, U.S. Food & Drug Admin., F.D.A. Approves Over-the-Counter Access for Plan B for Women 18 and Older: Prescription Remains Required for Those 17 and Under (Aug. 24, 2006), available at <http://www.fda.gov/bbs/topics/NEWS/2006/NEW01436.html>; Letter from Steven Galson, Director, Center for Drug Evaluation and Research, to Joseph Currando, Vice President for Clinical and Regulatory Affairs, Duramed Research, Inc. (Aug. 24, 2006), available at <http://www.fda.gov/cder/foi/appletter/2006/021045s0111tr.pdf>.

46. The modern UW was created in a merger in 1971 of the former University of Wisconsin system (established in 1848) and the former Wisconsin State University system (initiated by act in 1857), although the bill for the merger did not pass until 1974. See University of Wisconsin, About UW System (Nov. 19, 2005), <http://www.wisconsin.edu/about>.

47. 2005 enrollment for the UW system was 148,536 four-year students and 11,737 two-year students. See University of Wisconsin, Campuses (Nov. 19, 2005), <http://www.wisconsin.edu/campuses/index.htm>.

48. The total number of students enrolled in 2003, was 160,703. Of these, 89,035 were female and 71,668 were male. See University of Wisconsin, 2004 UW System Factbook (Nov. 19, 2005), http://www.uwsa.edu.univ_rel/publicat/factbook.2004.pdf.

49. In 2006, there were 41,169 students enrolled at UW-Madison, 21,631 of whom are women. See University of Wisconsin, Facts (Nov. 19, 2005), <http://www.wisc.edu/about/facts/#community>.

enty-one percent of the student visits to University Health Services (UHS) on the Madison campus.⁵⁰ Overall, UHS receives 65,000 annual student visits, 46,000 of which are made by female students.⁵¹ Last year 12,000 female students utilized UHS. Of the 46,000 total visits made by female students, there were 5,386 contraception-specific visits, and 543 EC specific visits.⁵² The number of EC-coded visits does not include over-the-phone or “just-in-case” prescriptions requested in advance by students.⁵³ Each year, approximately 35,000 prescriptions are filled through the health services pharmacy, most of which are for birth control.⁵⁴ In addition to prescribing and distributing EC to the students, UHS also has a comprehensive informational page on their website that enables students to learn more about EC, including its availability, effectiveness, risks, and side effects.⁵⁵ It appears that the availability of EC at UHS has had a positive impact on pregnancy rates for students; since EC has become available on campuses positive pregnancy test rates have dropped from thirteen percent to seven percent.⁵⁶ Student fees, not state or federal dollars, fund the services provided to UW students.⁵⁷

Wisconsin A.B. 343 represents a new area of legislation in the birth control context, creating further politicization of the conflict over EC. Only one other state to date has attempted to pass similar legislation. In 2004, the Virginia State Senate Education and Health Committee voted to defeat House Bill 1414. The State House had earlier voted to pass the bill that would ban EC from student health centers on Virginia’s public college cam-

50. Letter from Kathleen K. Kuhn, Nurse Clinician, Women’s Clinic, University Health Services, University of Wisconsin-Madison (Nov. 10, 2005) (on file with author).

51. *Id.*

52. *Id.*

53. *Id.*

54. See Karen Rivedal, *Health Care for UW Students; University Health Services Provides Basics*, WIS. STATE J., Sept. 6, 2005, at B1.

55. See University of Wisconsin, *Emergency Contraception* (Nov. 19, 2005), http://www.uhs.wisc.edu/display_story.jsp?id=402&cat_id=38. This type of information would most likely be included under A.B. 343’s ban.

56. See Tom Berger, Editorial, *Don’t Forbid Birth Control in UW System*, MARSHFIELD NEWS-HERALD, Sept. 20, 2005, at A4.

57. See Matt Pommer, *Dems Seek AG’s Opinion on RX Limit on UW Clinics*, CAP. TIMES, Mar. 31, 2005, at A3.

puses.⁵⁸ Like the UW system, student fees pay for health services in the Virginia system.⁵⁹

Wisconsin State Representative Dan LeMahieu introduced A.B. 343 after he saw an ad in a student newspaper suggesting that female students "stock up" on emergency contraceptives before going on spring break. LeMahieu said that he was "outraged that our public institutions are giving young college women the tools for having promiscuous sexual relations, whether on campus or thousands of miles away on spring break."⁶⁰ He also stated that it made it very difficult to show his constituents why the UW system needed higher budgets when the system was advertising and providing birth control.⁶¹ However, UHS and the services they provide students are not supported by federal or state tax dollars; they are supported entirely by student fees.⁶² Initially, LeMahieu intended to prohibit the UW system from distributing all oral contraceptives, because he felt that the schools should not be involved in family planning.⁶³ By the time the legislation came to the legislature, it addressed only emergency contraceptives, referring to "a hormonal medication or combination of medications that is administered only after sexual intercourse for the postcoital control of fertility."⁶⁴ The state legislature passed A.B. 343 twice.⁶⁵ Both times, Governor Doyle prevented its enactment, but it is not hard to imagine a future version of A.B. 343 succeeding with a different governor in a different state.

V. POTENTIAL CONSTITUTIONAL CHALLENGES

Should a state ban the distribution of EC on its university campuses, there are a number of constitutional challenges, on

58. See H.B. 1414, 2004 Leg., Reg. Sess. (Va. 2004). See also Tammie Smith, *Contraception Bill Defeated: Emergency Pills Will Remain Available at State's Public Colleges*, RICH. TIMES-DISPATCH, Feb. 27, 2004, at A1.

59. See *id.*

60. Matt Pommer, *UW Birth Control Help 'Outrages' Rep.*, CAP. TIMES, Mar. 16, 2005, at 3A.

61. See *id.*

62. See Phil Brinkman, *Battle Over Birth Control - Bill Will Try to Bar UW from Giving Out Pills*, WIS. ST. J., Mar. 20, 2005, at A1.

63. *Id.*

64. A.B. 343, 97th Leg., Reg. Sess. (Wis. 2005).

65. See, e.g., Wisconsin Assembly, Bill History (June 16, 2005), <http://www.legis.state.wi.us/2005/data/votes/av1052.pdf>.

both a federal and state level, that could be brought.⁶⁶ In response to the request of two Democratic representatives, Wisconsin's Senate Minority Leader, Judith Robson, Assembly Assistant Minority Leader, Jon Richards, and Attorney General, Peggy A. Lautenschlager, issued an advisory opinion on the proposed legislation. In the advisory opinion, Lautenschlager noted that A.B. 343 would "violate several provisions of the United States and Wisconsin Constitutions."⁶⁷ The opinion advised that the proposed legislation would raise issues of privacy, equal protection, and free expression under both constitutions.⁶⁸ In addition, the opinion noted that the language of the statute would be unconstitutionally vague.⁶⁹ The following sections will examine the viability of the privacy and Equal Protection arguments raised by the Wisconsin Attorney General.⁷⁰

66. Although many supporters of A.B. 343 consider EC to be an abortion, this paper will not consider potential constitutional challenges in the abortion context in light of the fact that the medical establishment, including the FDA, categorizes EC as birth control, not an abortifacient.

67. Proposed Legislation Banning Emergency Contraception at UW, 2005 Wisc. AG LEXIS 2 [hereinafter AG Opinion]. The following year Wisconsin Attorney General Peggy A. Lautenschlager requested permission for the State of Wisconsin to join the New York lawsuit brought by the Center for Reproductive Rights against the F.D.A. for delaying over-the-counter approval for Plan B. See Judith Davidoff, *Lautenschlager Asks to Join Plan B Lawsuit*, CAP. TIMES, Mar. 15, 2006, at C2.

68. Specifically, the Attorney General foresaw interference with the federal constitutional right to privacy, the Equal Protection Clause of the Fourteenth Amendment of the U.S. Constitution, the corresponding protections in Article I, Section 1 of the Wisconsin Constitution, the right to free speech under the First Amendment of the U.S. Constitution, and the parallel provisions in Article I, Section 3 of the Wisconsin Constitution. See *id.*

69. See *id.*

70. An earlier Wisconsin case regarding First Amendment claims and contraception, *Baird v. La Follette*, involved William R. Baird, who sought declaratory judgment regarding the unconstitutionality of a Wisconsin statute that prohibited the public exhibition and display of contraceptive products. Baird intended to display contraceptives at a public informational presentation he was going to make at the University of Wisconsin-Madison, but instead he used facsimiles out of fear of prosecution under the statute. The court chose to narrowly construe the statute as prohibiting only "purely commercial" exhibitions or displays. 239 N.W.2d 536 (1976). This is the same William R. Baird of *Baird v. Eisenstadt*, 405 U.S. 438 (1972), *Baird v. Bellotti*, 724 F.2d 1032 (1st Cir. 1984), and *Baird v. Barry*, 401 F.Supp. 762 (E.D.N.Y. 1975), who traveled around the country educating women about their reproductive choices and challenging local statutes that prohibited various aspects of information dissemination relating to contraceptives. See also *Baird v. Dep't of Pub. Health*, 599 F.2d 1098 (1st Cir. 1979).

A. Constitutional Right to Privacy – Substantive Due Process

The Supreme Court determined that there is a constitutional right to privacy that protects a woman's right to choose to use contraception.⁷¹ Generally, privacy rights may be infringed upon, so long as that infringement is narrowly tailored to advance a compelling government interest.⁷² This right was initially articulated for married couples in the Court's decision in *Griswold v. Connecticut*⁷³, where the Court held that a Connecticut statute forbidding use or distribution of contraception impermissibly intruded upon married couples' right to privacy.⁷⁴ The Court noted that the Connecticut law not only interfered with the relationship between husband and wife, but also on "their physician's role in one aspect of that relation."⁷⁵ This privacy right was soon extended to include unmarried people in *Eisenstadt v. Baird*.⁷⁶ These early cases found a number of specific infringements impermissible, without applying the clearer narrowly-tailored-to-compelling-state-interest test modern courts apply. Nevertheless, the reasoning in these early birth control cases can still be applied to EC bans.

First, the interests advanced by A.B. 343 may not be sufficiently compelling to justify any interference with the privacy right given the precedent set in *Eisenstadt*. The Court held in *Eisenstadt* that the Massachusetts law in question, which prohibited the contraceptive use by, or distribution to, an unmarried person violated the Equal Protection Clause by treating married and unmarried people differently; "[i]f the right to privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."⁷⁷ Considering the possibility that the statute was intended to deter premarital sex, the Court concluded "it would be plainly unreasonable to assume that Massachusetts has prescribed pregnancy and the birth of an unwanted child as punishment"⁷⁸ Applying the same logic in Wisconsin's case, it

71. See generally *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Eisenstadt*, 405 U.S. at 453.

72. *Id.*

73. *Griswold*, 381 U.S. at 485-86.

74. See *id.*

75. *Id.* at 482.

76. 405 U.S. 438, 443, 453 (1972).

77. *Id.* at 453.

78. *Id.* at 448. See also *Carey v. Pop. Servs. Int'l*, 431 U.S. 678, 695 (1977).

would be “plainly unreasonable” to assume that Wisconsin prescribed abortion or the birth of an unwanted child as punishment for the sexual activities of female college students. Notably, in *Eisenstadt* the Court rejected Massachusetts’ argument that the statute prohibiting access to contraceptives by unmarried people served to “protect purity” and “preserve chastity.”⁷⁹ The stated intent behind A.B. 343 was to discourage promiscuous behavior; in other words, to encourage *purity* and *chastity* by making EC unavailable to female students. If this was not a viable argument when the Supreme Court considered *Eisenstadt*, then it is not likely to be a viable argument now, especially in light of the fact that there are many types of birth control available.

Moreover, even if the intent of the legislature was to advance a compelling government interest, legislation like A.B. 343 is unlikely to meet the strict scrutiny with which the court applies the narrowly tailored prong of their due process analysis. Lautenschlager reasoned that prohibiting student access to EC on campus would be “an impermissible infringement” of those students’ privacy rights by making them go somewhere else to get birth control.⁸⁰ By prohibiting access to contraception on the UW campuses, the proposed legislation would interfere with the privacy right to choose to use contraceptives. Lautenschlager further note that in addition to having no compelling government interest, by denying access to health care, the legislation is contrary to the state’s interest in health.⁸¹ This reasoning is consistent with the reasoning of *Eisenstadt*, in which the Court rejected the State’s piecemeal approach to public health and morals by prohibiting birth control access to unmarried persons. Targeting only one method of birth control when others are readily available, and applying that limitation to a certain group (female students) is not narrowly tailored to fulfill a compelling state interest. Instead it places an obstacle between a woman and her right to determine whether to “bear or beget a child.”⁸² The Court endorsed this reasoning in *Carey v. Population Services International*,⁸³ which held, in part, that a New York statute allowing only pharmacists to distribute contraceptives, impermissibly “burden[ed] the freedom to make such deci-

79. See generally *Baird v. Eisenstadt*, 405 U.S. 438 (1972).

80. AG Opinion, *supra* note 67.

81. *Id.*

82. *Eisenstadt*, 405 U.S. at 453.

83. *Pop. Servs. Int'l*, 431 U.S. at 695.

sions.”⁸⁴ In that decision, the Court emphasized, “access is essential to exercise of the constitutionally protected right of decision in matters of childbearing.”⁸⁵ The Court analogized to the post-*Roe* cases, in which they held statutes restricting access to abortion would be held to the same standard as statutes banning it outright.⁸⁶ Although a restriction on the sale of contraceptives would not create the same level of burden on the decision as an outright ban would, the Court determined in the post-*Roe* cases that restricting access created a “significant enough” burden on the exercise of the right to determine whether or not to bear a child to warrant invalidation.⁸⁷ This line of reasoning effectively counters Wisconsin’s argument that the legislature is not enacting an overall ban, which would clearly be unconstitutional, but merely restricting access in one area. After all, even in light of the UW ban, students would still be able to attain EC from private doctors and other pharmacies. However, removing their primary source of access through implementation of a law like A.B. 343, would likely impermissibly interfere with the students’ right to determine whether to use contraception or not.

In both the intent and the impact prongs of A.B. 343, the proposed legislation does not meet the narrowly tailored/compelling state interest standard set for regulation of a woman’s decision whether or not to bear a child. The stated intent of the legislation, to discourage promiscuity, has been repeatedly rejected by the Court as a compelling state interest. The legislation was also too narrow, targeting only female college students, impacting only one segment of the state population. It is not unreasonable to believe that there are women acting promiscuously and utilizing EC in other parts of Wisconsin. A.B. 343 looks more like legislation intended to punish sexually active behavior, than a measure designed to accomplish a compelling public health goal.

84. *Id.* at 688; Proposed Legislation, *supra* note 67.

85. *Pop. Servs. Int'l*, 431 U.S. at 688.

86. *Id.* There is some question as to whether the Court would take the same position today in light of *Planned Parenthood v. Casey*’s “undue burden” standard. 505 U.S. 833 (1992). However, in the birth control context the state does not have the same interest in protecting potential life, and so may not be given the same leniency in restricting access to birth control as they are with respect to abortion. Then again, in light of recent changes to the Court, there is a great deal of uncertainty as to how questions such as these will be resolved in the future.

87. *Pop. Servs. Int'l*, 431 U.S. at 689.

B. *Equal Protection*

If a law like A.B. 343 were enacted, it would also violate the Equal Protection Clauses of the Fourteenth Amendment of the United States Constitution and Article 1, Section 1 of the Wisconsin Constitution.⁸⁸ To meet the Equal Protection standard for gender-based state action, the statute must be substantially related to an important government interest.⁸⁹ Lautenschlager notes in her opinion that the proposed legislation, by prohibiting access to contraceptives that only women need, discriminates against those female students on “the basis of their gender without any important government objective.”⁹⁰ The stated objective, of discouraging promiscuity among female college students, does not meet previously accepted important state interests such as remedying past discrimination or diversity in education.⁹¹ As proposed, A.B. 343 did not serve to further either of these interests, nor does it serve some other clearly important goal. Wisconsin best argument is that there is an important state interest in the protection of public health and safety, and that restricting access to EC will discourage female college students from acting in a promiscuous manner. This argument, however, is likely to fail, because if this interest were determined to be important, the means are not substantially related to it.⁹²

Even if Wisconsin successfully asserted an important government interest in public health and safety, proving substantial advancement by a law like A.B. 343 is seemingly impossible. First, there is no equivalent legislation intended to decrease male promiscuity. The *de facto* gender line in this case (because men do not use emergency contraceptives) places the entire burden on the female students who happen to need EC, and none on the males who are participating in said promiscuity. There is no legislative equivalent for male students. The claim that this sort of discriminatory treatment is allowable sounds very much like

88. U.S. CONST. amend. XIV, §1; WIS. CONST. art. I, § 1 (“All people are born equally free and independent, and have certain inherent rights; among these are life, liberty, and the pursuit of happiness; to secure these rights governments are instituted, deriving their just powers from the consent of the governed.”).

89. See *United States v. Virginia*, 518 U.S. 515, 533 (1996). Lautenschlager also refers to *Marshfield Clinic v. Discher*, 314 N.W.2d 326, 330 (Wis. 1982), as the controlling Wisconsin case on the Equal Protection Standard. See AG Opinion, *supra* note 67.

90. AG Opinion, *supra* note 67, at 5.

91. *Virginia*, 518 U.S. at 529.

92. See *Craig v. Boren*, 429 U.S. 190 (1976).

those that the Court has consistently rejected in cases such as *Reed v. Reed*⁹³ and *Mississippi University for Women v. Hogan*.⁹⁴ A.B. 343 was nothing if not arbitrary, overbroad, and archaic. It relies on an antiquated view that if EC is available, it will encourage promiscuity. This kind of legislation restricts access to only one type of contraception, so if the female students want to be promiscuous without the potential burden of pregnancy, there are still other alternatives available.⁹⁵ Although discussion under an abortion standard is outside the scope of this discussion, it seems very improbable that Wisconsin would want to make EC unavailable when doing so would quite feasibly lead to more abortions.⁹⁶ This type of legislation also only addresses the contingency that female students will need EC because they are promiscuous; there is no acknowledgment that there might be a need for EC resulting from rape or contraceptive failure.

Wisconsin would not be able to offer a convincing argument that there is an important state interest of decreasing promiscuity that will be substantially accomplished by restricting college student access to EC on University of Wisconsin campuses.⁹⁷ In light of the above arguments, a proposal like A.B. 343 does not appear to serve an important state interest by prohibiting the prescription or dispensation of EC on University of Wisconsin campuses. Instead, such legislation would violate the Equal Protection Clause of the Fourteenth Amendment by discriminating against female students.

VI. RESTRICTING ACCESS TO EC IS AGAINST PUBLIC POLICY

In addition to the viable legal arguments, there are a number of strong public policy arguments to be made against legislation like A.B. 343. The State of Wisconsin has an interest in decreasing the frequency of abortions as recognized by the Court

93. 404 U.S. 71, 76 (1971) (holding that arbitrary, gender-based legislation violates the Equal Protection Clause of the Fourteenth Amendment).

94. 458 U.S. 718, 730 (1982) (finding that legislation premised on archaic and overbroad stereotypes did not meet Equal Protection standards).

95. These choices include the ultimate alternative: abortion. In fact, this approach to public health runs counter to the goal of preventing illegitimate pregnancy that the court accepted in *Michael M. v. Superior Court*, 450 U.S. 464 (1981).

96. This stance would be contrary to state interests in protecting potential life. See *Roe v. Wade*, 410 U.S. 113 (1973); *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

97. Although Wisconsin could argue that this legislation should fall under a "real differences" standard and therefore can be related more loosely to the state interest rather than substantially related, this argument likely would not succeed.

in *Roe* and the subsequent abortion cases.⁹⁸ Even some abortion-rights advocates would like to see a decrease in abortions, while maintaining the right to its access.⁹⁹ Allowing access to EC results in fewer abortions, because it prevents unwanted pregnancies, so encouraging, rather than discouraging, the use of EC would help the state attain the goal of lessening the frequency of abortion.¹⁰⁰ As noted earlier, positive pregnancy tests have significantly decreased at UW-Madison UHS since EC became available on the campus.¹⁰¹ EC can uniquely occupy the space between pro-active birth control (or planned intercourse) and abortion (or an unwanted child). Women do not use EC as *everyday* contraception; it is a next-to-the-last resort (hence the name “emergency contraception;” nobody plans on an emergency). Therefore, it is unlikely that the lack of availability will cause female students to restrict their sexual behavior, because no one really plans on having an emergency.

The proposed legislation would inordinately impact a distinct population: female college students. By prohibiting the advertisement, prescription, or dispensation of EC, the legislature is hindering the University health care providers from providing critical health care. There is no such restriction on health care available to male students. EC is not an invasive procedure; it does not have extensive side effects.¹⁰²

Aside from the adverse impact on the availability of physical care, there is also a question of compromised mental health. The fear of an unwanted pregnancy can exact a serious toll on a woman’s mental health, and this legislation would deny students the availability of a prescription drug that can alleviate that fear. This is one of the populations most in need of this kind of health

98. In establishing the undue burden test in *Planned Parenthood*, the Court approved the use of measures designed to encourage women to choose childbirth over abortion. See *Planned Parenthood*, 505 U.S. at 877-8.

99. This is a logical extension of the reasoning behind making contraception more readily available: it will result in fewer unwanted pregnancies, which will in turn result in a decrease in the number of abortions. Planned Parenthood itself has stated that “access to birth control is a powerful tool to prevent unintended pregnancies and reduce the need for abortion.” Planned Parenthood, Access to Birth Control, <http://www.plannedparenthood.org/news-articles-press/politics-policy-issues/birth-control-access-and-prevention.htm>.

100. It is worth mentioning once more that contrary to the anti-choice position, the medically accepted standard is that EC functions as a contraceptive and *does not* cause an abortion.

101. See Tom Berger, *supra* note 56.

102. The most common side effect is nausea, which is experienced less with Plan B than with the Yuzpe regimen.

care. College students can be isolated, and many do not have convenient access to other sources of EC, such as Planned Parenthood. Many students rely on University Health Services for the majority of their health care. There is no guarantee that students who are unable to obtain EC on campus will be able to find it at a nearby pharmacy. In some Wisconsin cities, EC is available in less than half of the pharmacies.¹⁰³

If, as the sponsor of this bill has proclaimed, the bill was intended to discourage promiscuous sexual relations among the students of the University of Wisconsin system, it would do so by placing the entire burden on the female students, while the male students, who are also participating in this promiscuity, bear none of the burden. Using legislation such as this is old-fashioned and falls under the notion that female students should be punished for their sexual behavior, while male students carry on as usual. It is highly unlikely that the State of Wisconsin is ever going to convince young women to stop having sex while they are in college. Furthermore, the idea that making EC available increases promiscuity is unfounded.¹⁰⁴ This argument has been used historically to challenge the availability of all types of contraception.¹⁰⁵ The State's goals would be far better served by providing young women with the education and the health care services, rather than with an archaic notion of *proper* behavior. It is a far wiser course, if the legislation stems from the desire to protect female students from the costs of sexual activity, to give them the best resources possible, rather than prohibiting resources, thereby making them more vulnerable.

103. A phone survey performed by the State of Wisconsin found that forty-two percent of 256 pharmacies surveyed in sixteen Wisconsin cities do not carry EC, and in nine cities over fifty percent didn't carry it. As expected, EC is more accessible in cities (seventy percent) than in rural areas (forty-one percent). However, even in cities accessibility varies according to location (seventy-six percent accessible in Madison versus sixty-three percent accessible in Milwaukee). See Judith Davidoff, *Plan B Can Be Out of Reach in Wisconsin; Many Pharmacies Don't Stock Morning-After Pill*, CAP. TIMES, Nov. 1, 2005, at A1. Even if EC is available at a pharmacy there is still the possibility of encountering a pharmacist refusal.

104. A study published in the Journal of the American Medical Association found that access to EC did not increase promiscuity. See Tina R. Raine et al., *Direct Access to Emergency Contraception Through Pharmacies and Effect on Unintended Pregnancy and STIs: A Randomized Controlled Trial*, 293 J. AM. MED. ASSOC., Jan. 5, 2005, at 54.

105. The Court rejected this argument entirely in *Carey* stating that when burdening a fundamental right there must be more than "... a bare assertion, based on a conceded absence of supporting evidence." *Carey v. Pop. Servs. Int'l*, 431 U.S. 678, 696 (1977).

The University of Wisconsin is a public state school. It is not a private institution, nor is it a religious one. The health center fees are not paid for by taxpayer dollars, but by student fees paid by the students who are utilizing the centers' services. If health care professionals in the centers are not allowed to prescribe or dispense EC, there is a very real chance that they are not going to be able to provide the best quality care for the students seeking their services. The students impacted are adults, not minors. The additional provision of the proposed legislation, to prohibit advertising EC, will further prevent female students from making informed health care decisions. Another factor to consider is just how available EC is at pharmacies; in both urban and rural areas, some pharmacies choose not to carry it at all. In light of the growing popularity of pharmacy refusals, it is even more important for students to have access to EC at school. When all of these elements are taken into consideration, the weight of the efforts being made seemed aimed at restricting female student's access to complete health care and information, rather than ensuring that they are able to exercise their constitutional right to determine whether or not to bear a child. Overall, this legislation does nothing to further sound public policy goals, it only hinders it them.

VII. CONCLUSION

Rather than consider A.B. 343 as an isolated piece of legislation, it is best understood within the larger battle over reproductive rights. The pro-life movement, although it has been successful in making abortion access more difficult, has not yet seen the reversal of *Roe v. Wade*.¹⁰⁶ While still working towards

106. Once again, the future of *Roe* is uncertain. Last term the Court decided *Ayotte v. Planned Parenthood*, 544 U.S. 1048 (2006). *Ayotte* appealed the First Circuit Court of Appeals' determination that New Hampshire's parental notification statute for minors seeking abortion was unconstitutional, because it did not provide an exemption for a minor's health, only an exemption for a minor's death. In remanding to the lower court for reexamination, the Court noted that striking the entire statute as unconstitutional was overbroad, that the case dealt with a question of remedy, not of constitutionality, and that the lower court could issue declaratory judgment and injunction only against the unconstitutional application of the act. Since then Justice Sandra Day O'Connor's swing-seat on the United States Supreme Court has been filled by Samuel Alito. There seems to be a significant chance that the balance of the Court will likely tip even more towards limiting, if not overturning, *Roe*. This term the Court heard two abortion cases, both concerning the federal Partial Birth Abortion Ban Act of 2003 (18 U.S.C.S. §1531). In both cases the Court upheld the constitutionality of the Act's exclusion of health exceptions for the health

the end of legalized abortion, the movement has expanded their targets to include EC. Since A.B. 343, ensuing events have affirmed that EC represents the entryway to contraception as the new battleground. There is a growing opposition to any form of birth control, especially among the religious right, who are working on furthering their "no sex without procreation" regime.¹⁰⁷ For each defeated attempt to hinder access to birth control, such as A.B. 343, there is, somewhere in the country, a corresponding victory in limiting access. The F.D.A. approval of over the counter Plan B is limited to women over eighteen and subject to pharmacies, which refuse to stock it, as well as pharmacists, who refuse to dispense it. Although Wal-Mart reversed their no-stock policy and agreed to start stocking EC under public pressure, they continue to support their pharmacists' refusal to dispense it. Attempts at legislation like A.B. 343 should not be taken lightly; they should be taken seriously and within the greater context of the new struggle over birth control and morality.

Supporters of the pro-life movement consider EC (and in many cases other forms of birth control such as oral contraceptives and condoms) to be an abortifacient. This misconception, at odds with the medically defined differences between birth control and abortion, forms the basis of both conscience clauses and the movement to make emergency contraceptives unavailable to college students. There is a well-acknowledged tension between a woman's determination over her own body and the state's interest in protecting life. If there is a movement towards restricting access to birth control, it begins to look like a state places a higher value on protecting possible life than in preserving the constitutional guarantees of women's rights to determine whether to have a child.

In recent years, there has been a concerted effort to restrict women's access to birth control, including EC. The effort began with individual pharmacist refusals. It can now be seen in the unusual approval process for EC by the FDA and in state legisla-

of the mother. See *Carhart v. Gonzales*, 413 F.3d 791 (8th Cir. 2005), *cert. granted*, 126 S. Ct. 1314 (2006); *Planned Parenthood v. Gonzales*, 435 F.3d 1163 (9th Cir. 2006), *cert. granted*, 126 S. Ct. 2901 (2006). The future of abortion rights at a federal level could very well rest on the Court's resolution of these two cases.

107. See Russell Shorto, *Contra-Contraception*, N.Y. TIMES, May 7, 2006, §6 (Magazine), at 50 ("Many Christians who are active in the evolving anti-birth-control arena state frankly that what links their efforts is a religious commitment to altering the moral landscape of the country. In particular, and not to put too fine a point on it, they want to change the way Americans have sex.").

tures enacting conscience clauses and legislation such as A.B. 343. The most disturbing aspect about this trend is its disproportionate impact on women who are most in need of EC, such as women in rural areas who rely on Wal-Mart pharmacies or students on college campuses. While supporters of this type of legislation claim it is protecting life, the sponsor of A.B. 343 has given the real answer behind it. It is about promiscuity, and by extension, women's sexuality. This legislation is intended to punish young women for having sex.

When the circumstances surrounding it are taken into consideration, A.B. 343 looks more like a punitive measure than a preventative one. The Wisconsin legislators who support its passage appear to prefer to punish sexually active young women with pregnancy than provide them with access to a safe and legal form of birth control. Even though the courts have rejected this punitive type of legislation for years, certain factions persevere in attempting to get it passed in order to promote their moral agendas. Representative LeMahieu's stated reason for the bill was to prevent female college students from behaving in a promiscuous manner. This type of morality focuses solely on women, but is silent when it comes to men. Because of the fundamental physical differences between women and men, women bear all of the physical burden and much of the emotional burden of an unwanted pregnancy. When legislators are placing all of their efforts behind restricting women's options rather than making them more easily accessible, they punish women for their behavior.¹⁰⁸ The net result is that a legislative majority's morality is being placed above the health and welfare of women. Based on

108. Evidence of this can be seen in the early reactions to the development of the first cancer vaccine ever – one that would prevent cervical cancer. The vaccine would prevent HPV (human papilloma virus), which causes most cervical cancer, the second most fatal cancer for women in the world. However, HPV is a sexually transmitted disease. Organizations such as the Family Research Council would rather see young women go without an inoculation against cervical cancer than give them a vaccine that might encourage them to engage in sexual activity. In light of other available information, it seems very unlikely that the availability of a cancer vaccine will lead women to be more promiscuous. However, the larger point at issue in this example is that there are influential organizations that are willing to place women's health at risk by denying them access to a cancer vaccine in order to discourage them from having sexual relations. Historically speaking, this is a lost cause. Women have been having sex for thousands of years, and are likely to continue to do so. See Janet Guyon, *The Coming Storm Over A Cancer Vaccine*, FORTUNE, Oct. 31, 2005, at 123.

this analysis, it seems unlikely that legislation such as A.B. 343 could survive constitutional challenges under either Equal Protection or a privacy right.