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Two years after Dobbs: the complex landscape of reproductive health care

By Emily L. Brinkman, Esq., Rachel L. Zacharias, Esq., and Aneliese Castro, Esq., Hooper, Lundy & Bookman PC

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Two years ago, the Supreme Court issued its decision in *Dobbs v. Jackson Women's Health Organization*, overruling *Roe v. Wade* and *Casey v. Planned Parenthood* and initiating a new era for reproductive health care. The Dobbs decision ended nationwide constitutional protection of abortion care. In the two years since, abortion care has become increasingly fragmented, with disparate state laws oscillating between outright banning abortion care and enacting state constitutional protections for the care.

In addition to state laws either protecting or restricting access to abortion care (and legal challenges to those laws), the legality of reproductive health care post-*Dobbs* has become further convoluted by legal challenges to a medication used in abortion and to the availability of abortion care in emergency circumstances in states that prohibit or severely limit such care. Moreover, state and federal courts have relied on the Supreme Court's reasoning in *Dobbs* to issue decisions impacting access to other reproductive and gender-affirming health care.

Legality of abortion care at large after *Dobbs*: patchwork of state laws

The most immediate impact of the *Dobbs* decision was the near-instant emergence of a patchwork of state laws affecting reproductive health. At the time of writing, as profiled in KFF, a website on health policy research (https://bit.ly/3xhJntc), 14 states completely ban abortions and 11 states ban abortions provided after a particular point between six and 22 weeks of pregnancy (and impose additional requirements to obtain care).

Some of these laws penalize procuring abortions and create private rights of action for citizen suits against patients (including those who seek out-of-state abortion care), providers, and individuals who facilitate others' receipt of abortion care. Adding to the complexity, some state bans — both in states with other active abortion restrictions and those without — are currently blocked or on hold by court orders in legal challenges.

On the opposite end of the spectrum, abortion care (up through at least 22 weeks of pregnancy) is presently legal in 25 states and the District of Columbia, as seen in the KFF profile. Some of these states have enacted new protections for abortion care, have no gestational limit to obtaining abortion care, and/or have enshrined the rights to abortion in the state's constitution.

States are also taking legislative steps to affirmatively protect reproductive health care, including increasing privacy protections for personal reproductive health information beyond the protections offered by federal law (as in California (https://bit.ly/3KDmPpO) and Maryland (https://bit.ly/3X8yCUM)), allowing or requiring state Medicaid dollars and private plans (https://bit.ly/3xedOAw) to fund abortion care, shielding abortion providers (https://bit.ly/3RiLy6O) from penalization for facilitating abortion care in states where it might be illegal, and initiating statewide referendums protecting the right to abortion care (in 2022, Kansas voters rejected (https://bit.ly/3x3sEdf) a proposed state constitutional amendment that would have declared no right to abortion or to government funding for abortion to exist in the state's constitution, while referendums to establish state constitutional rights to abortion are in process in Florida (https://bit.ly/3z25nc0) and Arizona (https://bit.ly/3VxRStq)).

In the two years since Dobbs*, abortion care has become increasingly fragmented, with disparate state laws oscillating between outright banning abortion care and enacting state constitutional protections for the care.*

No two states are identical in their governance of reproductive health care, and the disparity between state laws has potential to create conflicts between state laws and possible interstate litigation.

Legality of medication abortion: *Alliance for Hippocratic Medicine*

Mifepristone is one of two medications used for medication abortions, the method that currently accounts for 63% of all abortions (https://bit.ly/3RiJDPt) performed in the formal health care system, according to the Guttmacher Institute. In *FDA v. Alliance for Hippocratic Medicine*, a group of doctors and

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associations of doctors filed a legal challenge to the U.S. Food and Drug Administration's (FDA) 2000 initial approval of mifepristone and subsequent actions taken in 2016, 2019, and 2021 to update prescribing, dispensing, usage period, dosing, and distribution requirements in the Northern District of Texas.

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The 5th U.S. Circuit Court of Appeals upheld the doctors' challenges with regards to the FDA's 2016 and 2021 actions, which specifically included (in 2016) updates to mifepristone's approval to allow prescribing and dispensing by licensed non-physician health care providers, extend the usage period to 10 weeks of pregnancy, remove requirements for multiple in-person visits, alter the dosing regimen, and (in 2021) exercise enforcement discretion to allow the medication to be distributed by mail from certified sources and approved pharmacies.

The Supreme Court is now deciding: (1) whether the doctors have standing to bring the suit (see more on this question here: https://reut.rs/4aWzcZm), (2) if so, whether the FDA's 2016 and 2021 actions regarding mifepristone were arbitrary and capricious, and (3) whether the district court properly granted the doctors preliminary relief.

The Supreme Court heard oral arguments on March 26, 2024, when a majority of the justices appeared skeptical that the providers had standing to bring the suit. The Court's written opinion is expected to be published by the end of the Court's term in June.

If the Supreme Court goes beyond the standing arguments and decides FDA's 2016 and 2021 actions were unlawful, the decision may impact those providing and seeking to access abortion. Accessing in-person abortion care can require individuals to assume financial, time, travel, work leave, and child care burdens.

The 2016 and 2021 FDA actions, which loosened in-person visit requirements to obtain mifepristone, may have reduced some of these burdens for marginalized individuals and/or individuals living in rural areas. The legality of the 2016 action also may impact providers' ability to prescribe up-to-date dosing regimens, and patients' abilities to receive care from a broader group of health care providers and obtain medication abortion in later weeks of pregnancy.

The Supreme Court's decision could also impact other existing court orders, such as a preliminary injunction issued by a federal district court in Washington state (https://bit.ly/4c8XEYe) forbidding the FDA from "altering the status or rights of the parties" and requiring it to retain access to mifepristone in 17 states and the District of Columbia.

This and future decisions could also revive decisions that the Comstock Act (https://bit.ly/4eenaNC), an 1873 law prohibiting the mailing of "obscene" matter used to produce abortion, prohibits mailing not just of mifepristone, but also of other materials and instruments used to perform abortions and other reproductive health care, including miscarriage management. (Two Justices raised this issue during the case's oral argument.)

Regardless of the decision in this case, some states have already initiated legislation classifying abortion medication as controlled substances (See, "Louisiana Lawmakers Vote to Make Abortion Pills Controlled Substances," The New York Times, May 23, 2024), paving the road to criminally penalizing possession of the medications without a prescription.

Legality of emergency abortion care amidst state abortion bans: *Idaho v. United States*

Concurrently, there is litigation in both federal and state courts that seeks to clarify the legality of abortion care provided specifically in emergency situations. The federal government and individual patients and providers have sued to challenge state abortion bans that appear to conflict with the requirements under the federal Emergency Medical Treatment and Labor Act ("EMTALA"), while one state (Texas) with such a ban sued to challenge HHS guidance applying EMTALA's preemptive effect to state abortion laws in emergency cases. (For a more in-depth analysis of these cases, see here: https://reut.rs/3x5bDzo); since the time of this article's publication, the Texas Supreme Court denied claims (https://bit.ly/4bP2KJd) brought by patients denied abortion care amidst dangerous pregnancy complications and declined to clarify exceptions to the state's abortion bans. (*State of Texas v. Zurawski et al.*))

This term, in *Idaho v. United States*, the Supreme Court is examining whether EMTALA preempts state abortion laws such as Idaho's ban. If the Court holds that there is no preemption, hospitals and health care providers in emergency settings may find themselves subject to state abortion restrictions that do not contain exceptions for life-threatening conditions or that draw exceptions more narrowly than EMTALA.

Legality of reproductive and gender-based health care beyond abortion

Dobbs' reasoning has impacted reproductive and other gender-based health care beyond abortion. In a 2024 wrongful death case (https://bit.ly/4c7XL6j) brought against an in vitro fertilization (IVF) clinic at which the plaintiffs' embryos were lost, the Alabama Supreme Court cited *Dobbs* for multiple propositions, including that the frozen embryos were "unborn children," and recognized as living persons with rights and interests. The court *in LePage et al. v. Center for Reproductive Medicine and Mobile Infirmary Association* found that the wrongful death claim could proceed by reasoning that there is no exception to Alabama's Wrongful Death of a Minor Act for "unborn life" created in vitro.

The holding has raised concerns about the federal legality of IVF care and chilled the provision of such care in Alabama and other states. A proposal has been raised in the U.S. Congress to protect IVF and address the concerns raised in Alabama.

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Additionally, the *Dobbs* decision has and will continue to impact access to, and the provision of, gender-affirming health care. Federal appeals courts have cited *Dobbs* (https://bit.ly/3yNAsAh) to hold both that gender-affirming care is not "deeply rooted" in the nation's history and thus not protected by the Fourteenth Amendment, and that state laws banning gender-affirming care do not discriminate on the basis of sex.

Twenty-five states (https://bit.ly/3JpGRDS) currently have passed laws restricting or banning gender-affirming care for minors, and legal challenges continue regarding these state bans. As such, *Dobbs*' legacy is likely to have an ever-increasing real-world impact on access to multiple kinds of health care.

Conclusion

In the past two years, the *Dobbs* decision has led to significant legal variation and confusion across states regarding the availability of abortion care and other gender-based health care. It is likely that *Dobbs*, and the numerous cases decided in its wake, will only continue to increase disruption in health care.

About the authors

Emily L. Brinkman (L) is senior counsel at **Hooper, Lundy & Bookman PC** in the San Francisco office. She is a litigator with over 20 years in government and private practice, with the last four years at the firm specializing in medical staff practice. She can be reached at ebrinkman@hooperlundy.com. **Rachel L. Zacharias** (C) is an associate in the Washington, D.C., office of the firm, focusing on regulatory litigation and other matters involving reimbursement, operations, medical ethics and consent, and reproductive health. She can be reached at rzacharias@hooperlundy.com. **Aneliese Castro** (R) is an associate in the Los Angeles office of the firm. She focuses her practice on advising health systems, hospitals, and long term care providers on regulatory matters involving reimbursement, compliance, operational issues, and reproductive health. She can be reached at acastro@hooperlundy.com. Sheryl Xavier, an associate at the firm, contributed to this article.

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