Podcast Transcript

Dobbs on Demand: The Uncertainty for Healthcare Providers in a Post-Roe Environment

Date: August 4, 2022

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Run Time: 24:54

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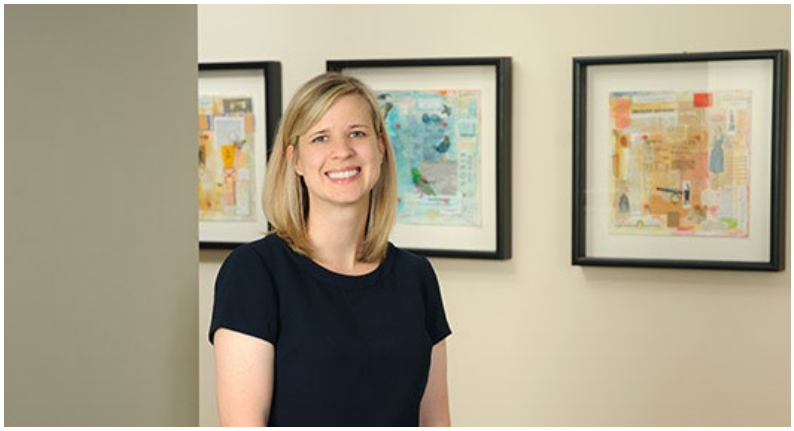

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Kattman: Since the recent *Dobbs* decision, which overturned *Roe v. Wade*, companies have been impacted nationwide and have several new legal angles to consider as it relates to their employees and their businesses. With that in mind, we've created a new podcast series, *Dobbs* on Demand, designed to help you navigate this new and evolving landscape. We'll feature partners from our Labor and Employment, Employee Benefits, White Collar, Digital Assets and Data

Management, and Healthcare practices as we break down the top issues and changes in law. I'm Amy Kattman and you're listening to BakerHosts.

On this episode of *Dobbs* on Demand, we will discuss several legal perspectives that employers should consider in light of the *Dobbs* decision. Our guests today are Amy Fouts, partner in our Healthcare practice, and Claire Bass, associate on our Healthcare practice. Both of whom are members of our *Dobbs* Decision Task Force. Welcome to the show, Amy and Claire.

Fouts: Thanks for having us, Amy.

Bass: It is great to be here.

Kattman: Amy, can you provide us with an overview of where things stand on the impact to healthcare providers as a result of the *Dobbs* decision?

Fouts: Sure, I'd be happy to. Well, it has been a little bit over a month since we had the *Dobbs* decision, and many healthcare providers are finding themselves in a place of uncertainty. So, by overturning *Roe* and *Casey*, the *Dobbs* decision now allows states to implement far more restrictive abortion laws than we've seen, and healthcare providers are finding themselves in situations that they've really never had to address before and didn't really have time to contemplate, and that is because a lot of states immediately banned all or most abortions through what are called trigger laws. And these are rules that were drafted to go in effect if *Roe* or *Casey* were overturned. The states right now are split. At the end of the day, we are expecting that 25 or 26 will ultimately ban all or nearly all abortions. And these restrictions will pose a lot of hard questions on healthcare providers, and we're already starting to see them. Not only are we going to see variations from state to state in how these rules are applied, but I think we're going to see variations within states. Many local prosecutors and DAs have come out stating that they are not going to enforce any bans, and it is uncertain whether this will bring any comfort to physicians and other providers. Most likely not, as they don't want to violate the law, and even if prosecutors aren't going to prosecute, it doesn't mean that the state can't come after their license.

So, there is just a lot of uncertainty going on. In the strictest state, we're also seeing a lot of abortion clinics having to close their doors because they can't afford to stay open. A recent study published last week identified 43 clinics across 11 states that have had to stop offering abortion care. More expected in the days and weeks to come. Given these restrictions and the loss of access to care, there has been a lot of pressure put on the current administration. As a result of this, Biden issued an executive order on July 8th, which is entitled Protecting Access to Reproductive Healthcare Services, and this executive order is meant to accomplish several goals.

One of those is to safeguard access to reproductive healthcare, and that is going to include both abortion and contraception, and so we've seen guidance on both of those. It is to protect the privacy of patients and their access to information to promote safety and security of patients and providers and clinics, and lastly, to

coordinate the implementation of federal efforts to protect reproductive rights in access to healthcare. As a result of the executive order, we've seen the executive branch departments mobilize, including the Department of Health and Human Services, the Department of Justice, the Department of Labor, and the Department of Treasury have all issued guidance recently in an effort to protect women's access to healthcare. The administration has also launched reproductiverights.gov, which is a website where patients can go for information about their rights. The Department of Justice has created the Reproductive Rights Task Force, and that is a working group that is set up to identify ways to protect access to reproductive healthcare. We're expecting more from them over the weeks and months to come. We've likely seen what is the beginning of funding for these programs, including $8.5 million for maternal health and Amy, currently the overview is that healthcare providers are in a state of uncertainty and the states are likely going to be split over those that are looking to expand women's access to reproductive healthcare and those that are looking to restrict it. And with that, I'll turn it over to Claire, who is going to walk through where the states stand as of today.

Bass: Thanks Amy. So, as you mentioned, we really are in kind of a state of flux and where states fall on the spectrum with respect to abortion legislation changes on a day-to-day basis right now. But when we're thinking about them, we can kind of group them into a few different buckets, the first of which I will call the conception bucket. So, these are states that have essentially a full abortion ban throughout the entire pregnancy. These are states like Alabama, Louisiana, Texas, probably most commonly known, and they have very few exceptions for any kind of life threatening injury, medical futility, that kind of thing. The next group is what I'll refer to as the heartbeat group, so these are states that ban abortions after around the six week mark, and the reason they're called heartbeat laws is because that is typically when they argue the first detectable human heartbeat can be found. These are states like Ohio, South Carolina, and Georgia. Then there is the group at 15 weeks, so this is Florida, Virginia, Arizona, although Virginia and Arizona are both in flux right now. There is then the, what I'll call pre-viability. So, these are between the 20 and 22 week mark, and that is an abortion after that period would be illegal. Then the biggest bucket that we see is kind of the 24 week mark, so typically a fetus is found to be viable at the 24 week mark so, I'll call these states the viability group and this is really the most common that we're seeing right now, but as I've mentioned, it is in flux, so we do expect to see some states depart that group. And finally, we have the full protection, so these are states that offer protection for women to receive an abortion throughout the pregnancy. These are states like Alaska, California, and Colorado, and a few more.

The next thing to think about when you're looking at buckets is the exceptions to the general abortion rule. So, nearly every state has some kind of exception for life or serious injury if the mother's life is in jeopardy, but how well that exception is defined varies by state. We also see some amount of medical futility exceptions, so that is where the fetus is incompatible with life, so a lethal fetal abnormality, for example. Then there are some rape or incest exceptions and implementation of those also varies by state, some require police reports

documenting the incident back when it happened and some limit that to a certain gestational age. And then on the other side you have states that are trying to implement broader protections, so protections for patients who come from a restrictive state to a state that allows abortions to receive that type of care and similar protections for the providers who provide that care to out of state patients.

Kattman: There is a lot going on. Claire, can you also talk about the current status of lawsuits and litigation?

Bass: Sure. There is a lot right now, so I'll just take a few examples. Notably, the Eleventh Circuit just stayed an injunction that was preventing Georgia's Life Act, which is the abortion rule, from being implemented. Pennsylvania also has Senate Bill 106. Senate Bill 106 seeks to amend their state constitution to say that it does not grant a right to abortion. Kansas has a similar amendment in progress. South Carolina, for example, has pending legislation regarding aiding and abetting the procurement of an abortion. Indiana actually is also in a current special legislative session, where on July 30th, the Senate approved a near full abortion ban, which will be a severe departure from their current abortion law, which is around the 20 week mark. Utah currently has a temporary restraining order issued on its conception abortion law, and then on the other side you have states like California and New York, which are currently seeking to amend their state constitutions to explicitly protect abortion rights in the state.

Kattman: Thanks, Claire. Amy, how does state bans impact decisions physicians make pursuant to the Emergency Medical Treatment and Labor Act, or EMTALA?

Fouts: Well, Amy, let us start with what EMTALA is. EMTALA is a long standing federal law that guarantees that anyone who comes to an emergency department will receive an examination to determine whether an emergency medical condition exists, and it is regardless of their ability to pay or their insurance status. So, in response to the executive order protecting women’s access to care, HHS issued guidance on July 11th stating that under EMTALA, providers had a legal duty to provide stabilizing medical treatment to a patient who presents to an emergency department is found to have an emergency medical condition, and that duty preempts any conflicting state law or mandate.

So, what does that mean? Therefore, if a physician believes that a pregnant patient is experiencing an emergency medical condition and that an abortion is the stabilizing treatment necessary to resolve that condition, the physician must provide that treatment, and what the guidance from HHS is telling providers is that it is going to use EMTALA as both a shield and a sword to protect women's access to healthcare. The guidance specifically states that providers can use it to justify an abortion if it is necessary stabilizing treatment and that any conflicting state law is preempted, but what it also does is it warns hospitals that they cannot deny these services if the treatment is necessary to stabilize the health of the mother. If it does, it is going to risk facing fines or possibly even termination from the Medicare program.

This, however, still leaves providers with uncertainty and open questions. First, it is likely to put hospitals at odds with providers and vice versa. We're likely going to see instances where hospitals want to comply with EMTALA, but a physician may be afraid to violate the law and possibly lose their license, or you could have a physician who feels it is necessary to save the life of the mother but it is the hospital who doesn't agree and wants them to wait. I think they're likely, we're going to see disputes surrounding what constitutes stabilizing treatment. In fact, this was just the case of a young woman in Texas whose membranes ruptured at 18 weeks, so despite there being virtually zero chance that the baby would survive, the physicians couldn't agree on whether the mother's condition constituted an emergency, and therefore she couldn't undergo a procedure to remove the fetus. The physicians were scared to act as long as the fetus had a heartbeat, and in turn that put the mother's health at risk. I think this is just one of the issues that will have to be addressed by Texas as it recently sued HHS in response to the guidance on EMTALA. And with that alternative, I'll turn it over to Clair, who is going to walk through the suit.

Bass: Yeah, thank you Amy. So, the Texas Attorney General, as you mentioned, is suing HHS over the EMTALA directive and essentially what the Texas AG is saying is that the directive is an attempt to use federal law to transform, in their words, every emergency room in the country into a walk-in abortion clinic. The Texas AG is claiming that what they're calling the abortion mandate tries to preempt Texas laws, which violates Texas' right to its sovereign interest in the power to create and enforce its own legal code. And essentially what it comes down to is that Texas claims that this is putting hospitals and providers in a bad position where they're now threatened between having to choose to violate the state law and potentially expose themselves to the criminal penalty under the Texas abortion law or jeopardize their ability to participate in the Medicare program, as you mentioned.

What is interesting is that the directive really says that EMTALA will continue to apply as it always has and clarifies that emergency care for pregnant women may necessarily involve pregnancy termination, but it is not limited to pregnancy termination, and I don't believe that is what the directive's intent was but it clarifies that emergency medical conditions may include ectopic pregnancy, complications of pregnancy loss, emergent hypertensive disorders, and that stabilizing treatment could include medical or surgical interventions such as the removal of fallopian tubes, antihypertensive therapy, which would be methotrexate therapy regardless of state laws or mandates on such procedures. So, where Texas and HHS are kind of at a disconnect here is that HHS is saying that any state laws or mandates, such as the Texas abortion laws, that employ a more restrictive definition of emergency medical condition that wouldn't allow for this type of treatment, such as the example you provided with the woman whose membranes ruptured at 18 weeks, those laws would be preempted by EMTALA. So, that is where the Texas Attorney General and HHS are kind of butting heads on this.

Kattman: What other implications from *Dobbs* should be of concern for healthcare providers? Claire, let us start with you.

Bass: Yeah, so I think a big one is restrictions on prescription medications. So, there are states such as Texas again, that are restricting medications that are used for causing abortions. These include misoprostol, methotrexate and mifepristone. So, Texas actually prohibits a pharmacy from dispensing or a physician from prescribing abortion inducing drugs, which include the three that I just mentioned. One of the problems with this is that those medications are often used to treat other conditions that are not abortion related. For example, misoprostol can be used to reduce stomach acid and is used to treat ulcers. Methotrexate is used to treat cancers, to control severe psoriasis, inflammatory arthritis, Crohn's disease, and more. So, what we're seeing now is reports of women who are struggling to find access to these medications for non-abortion purposes in these restrictive states.

In response, the DOJ has issued a statement saying that states cannot ban mifepristone based on disagreement with the FDA's expert judgment that it is safe, and HHS has also issued guidance saying that pharmacies can't discriminate on the basis of race, color, national origin, disability, age, or sex in their programs or activities, which includes prescribing medication from their pharmacy, and I think this goes to show kind of the gray area that pharmacists and providers are operating in in these restrictive states as to whether or not they can use these abortion-inducing drugs when they're for other conditions. Amy, does anything else come to mind here?

Fouts: Yeah, Claire, you touched upon this briefly earlier, and if anybody has been watching the news, you're likely aware of the 10-year-old that traveled from Ohio to Indiana for an abortion. As a result of the *Dobbs* decision, there are going to be an influx of women who will travel across state lines for an abortion, and we know that states that want to restrict access to abortion rights like Texas are looking at legislation now that would restrict people from crossing state lines for these services. Several states are also considering legislation that would allow a private citizen to sue anyone who helps or assists a resident of a state that has a ban from terminating a pregnancy outside of the state. This opens up a host of issues that we'll have to address on a separate podcast, but definitely traveling across state lines is going to be an issue we watch and just like there are states that are trying to restrict access, there are other states that are offering broad protections from anti-abortion laws. Connecticut, for example, recently passed a law that would shield people from out of state summons or subpoenas issued in cases related to abortion procedures that are legal in Connecticut, and it would also prevent Connecticut authorities from adhering to another states request to investigate or punish anyone involved in facilitating a legal abortion in Connecticut.

So, we will continue to watch these issues as the legislation and issues develop, and Claire, in talking about these cross state restrictions, haven't you been looking at how Telehealth restrictions may come into play?

Bass: Yeah, and that actually plays into it a lot because the states like Connecticut which are trying to protect providers, are kind of implementing a rule that implicates Telehealth providers where a provider may be in a state like

Connecticut that has these protections and offering services to a patient who is in a state that is much more restrictive and that begs the question, can out of state providers provide Telehealth abortion services to a patient in a restrictive state? And I think we'll see that play out, but right now, we don't really have an answer to that question. We'll have to keep watching it, it also goes back to the medication abortions that I was talking about earlier.

There are state requirements to examine patients in person that could effectively end Telehealth access to abortions in those states. There was a proposed law in Georgia that ultimately did not become law that would have effectively ended Telehealth by requiring that all pregnant persons undergo an ultrasound to determine a fetal heartbeat, and that no prescriptions could be provided without an in-person visit, and I think we'll see this particularly be impactful in rural areas where the only access to abortion may be through Telehealth services, unless they want to drive an incredible distance that may not be feasible.

So, like I said, I think we'll continue to see this play out and we'll have to watch to see where states land on that, but in the meantime, providers need to be cognizant of any state restrictions in the state where their patient is located if they're providing Telehealth services, and this could be in-person exams, heartbeat determinations, counseling requirements, waiting periods, and any number of things.

Kattman: As we close out today's program, Amy, are there any other impacts we should discuss?

Fouts: Well, Amy, we've only just scratched the surface of issues and questions we are going to encounter as a result of *Dobbs*. We know that states with all or nearly all out bans are putting many women in untenable situations. We have to consider women who are in a health crisis during a pregnancy. What about the woman who receives a cancer diagnosis? Can she undergo chemotherapy? Can she opt for an abortion if it is necessary to save her life? What about clinical trials? Will women of childbearing ages be excluded from clinical trials in the future for medications that could potentially lead to an abortion, or what if they become pregnant while on a trial in a restrictive state? There is a lot of talk about whether these new restrictions will impact fertility clinics and IVF, and we promise we will be back with additional information as it becomes available.

Kattman: Amy and Claire, thank you so much for joining us today.

Fouts: Thanks for having us, Amy.

Bass: It's been a pleasure.

Kattman: If you have any questions for Amy and Claire, their contact information is in the show notes. For more information on the impact of the *Dobbs* decision, visit the post *Roe* Resource Center on bakerlaw.com and check out all *Dobbs* on Demand episodes by subscribing to BakerHosts wherever you get your podcasts. Tune in to future episodes as we continue to track the changes in laws

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