OCTOBER 2024

CENTER FOR HEALTH POLICY & THE LAW

ACCESS TO REPRODUCTIVE HEALTH CARE

AND THE GROWING ROLE OF THE FEDERAL COURTS

By Sheela Ranganathan, Rebecca Reingold, Emily Schneider, and Sarah Wetter

TABLE OF CONTENTS

3 EXECUTIVE SUMMARY

4 FOREWORD

7 REPRODUCTIVE HEALTH CARE IN THE SUPREME COURT'S OCTOBER 2023 TERM

8 ABORTION MEDICATION: *FOOD AND DRUG ADMINISTRATION V. ALLIANCE FOR HIPPOCRATIC MEDICINE* (ALLIANCE)

Background

The Decision

Status of Mifepristone Litigation Now

12 EMERGENCY ABORTION: *IDAHO AND MOYLE, ET AL. V. UNITED STATES* (IDAHO)

Background

The Decision

Status of EMTALA Litigation Now

16 CROSS-CUTTING CONSIDERATIONS

Fetal Personhood

Associational Standing

Federal Conscience Protections

The Comstock Act

18 WHAT COMES NEXT?

19 THE SUPREME COURT'S OCTOBER 2024 TERM

20 LOWER COURT CASES TO WATCH

State Law Reform Efforts

Regulation of Speech

Restrictions on Travel

Federal Regulations

23 CONCLUSION

EXECUTIVE SUMMARY

In *Dobbs v. Jackson Women's Health Organization,* the Supreme Court overturned the federal right to abortion in 2022, ostensibly to return the "issue of abortion" to the states.

Since then, federal courts are being asked to weigh in on many state laws, federal regulations, and enforcement actions involving abortion and other essential reproductive health care. While the debates at the heart of these cases entered the national spotlight in the immediate aftermath of *Dobbs*, the consequential role of federal courts in framing and answering the complex and, in many instances, novel legal questions involved is still taking shape. The public, indeed even policymakers, researchers, patient advocates, industry stakeholders, and the media, tend to remain in the dark about these cases and their implications until they reach the Supreme Court—often when one side is seeking emergency relief through obscure procedures. This report is intended to demystify the continued role of the federal courts in shaping access to abortion and other essential reproductive care.

In its October 2023 term, the Court heard two major cases about abortion access—*Food and Drug Administration v. Alliance for Hippocratic Medicine* and *Idaho and Moyle et al. v. United States*—and dismissed them on procedural grounds, dodging the merits. The first involves the approval and regulation of mifepristone, a safe and effective drug used for medication abortion. The second involves the effect of a federal law requiring Medicare-funded hospitals to provide stabilizing care to patients experiencing medical conditions on state abortion bans. Though the Court did not weigh in on these issues, oral arguments and opinions revealed how some of the justices are thinking about fetal personhood, associational standing, federal conscience protections, and the mailing of abortion materials (especially abortion medication).

While those two cases return to the lower courts, there are numerous other cases moving through the district and appellate courts that could return questions involving abortion and other essential reproductive health care to the Supreme Court in coming years. **Cases pending before the lower courts involve state law reform efforts, regulation of speech involving reproductive health care, restrictions on travel for abortion care, and federal regulations that implicate access to care and data privacy.** The Supreme Court, however, has declined to add cases about abortion to its October 2024 docket.

Litigation in the federal courts continues to shape access to reproductive health care nationwide. This publication synthesizes key take-aways from the Court's most recent abortion decisions, previews cases involving other essential reproductive health services on the Supreme Court's October 2024 docket, and reports about the status of the many lower court cases emerging from the post-*Dobbs* landscape of confusion and uncertainty.

FOREWORD

On August 2, 2022, just 18 weeks into her pregnancy, Mylissa Farmer arrived at the University of Kansas Hospital with preterm premature rupture of membranes (PPROM), meaning that her water had broken far too early—and by the time she arrived, her pregnancy was no longer viable. She was heartbroken, for she had dreamed of and longed for this pregnancy. But she was also in excruciating pain, and was at high risk of severe blood loss, sepsis, loss of fertility, and death. There was no chance that she could give birth, and because fetal cardiac activity was still detectable, she needed emergency abortion care.

Mylissa expected her physicians to provide the care that she needed. But to her surprise, they refused to even take her temperature or assess her pain. She had lost all of her amniotic fluid, she was bleeding heavily, her brain was getting foggy, and she felt intense pain and pressure in her lower abdomen. Despite confirming that the pregnancy was non-viable and that she faced grave risks if she did not receive an abortion, her physicians turned her away without even providing antibiotics or Tylenol for the pain.

Mylissa had no choice but to leave Kansas and travel all the way to Illinois for an emergency abortion two days after doctors turned her away. But by the time she arrived at a clinic in Illinois, four days after her water broke, she already faced extensive complications from the hours of agonizing labor that she had endured in the car.

Just a few weeks before Mylissa had arrived at that emergency department, those same physicians had provided abortion care to another PPROM patient under similar circumstances. But Mylissa happened to arrive on the very evening that Kansas was to vote on an abortion ban, so the hospital chose to accept the consequences of denying patients urgent and essential reproductive health care over the risks posed by the "heated political environment." While Mylissa continues to suffer physically, psychologically, and financially in the wake of the hospital's decision to deny care, that 2022 abortion ballot measure failed to pass in Kansas.

Ultimately, Mylissa suffered from the politics of a potential state abortion ban and her hospital's decision to avoid its duty to stabilize her under federal law. And Mylissa's story is just one example of what the *Dobbs* decision—and the patchwork approach to abortion law and policy it paved the way for—has meant for the lives, health and well-being of people who are or may become pregnant in the United States. This is what is at stake.

**Mylissa Farmer's experience was described in the Complaint in Farmer v. University of Kansas Health System and a first-person perspective op-ed. We are grateful to her for sharing her story.*

INTRODUCTION

Two years ago, the Supreme Court overturned the federal right to abortion in *Dobbs v. Jackson Women's Health Organization*—a culmination of a decades-long effort by anti-abortion policymakers, ideological organizations, and other stakeholders to reverse *Roe v. Wade*.

Indeed, the states responded. While many with **"trigger" bans**—state abortion bans passed after *Roe* that became enforceable when *Dobbs* returned abortion to the states—other states enacted new, very restrictive laws. As of October 7, 2024, **broad abortion bans** are in effect in 17 states across the country—13 states ban all abortions, with limited exceptions, and four states ban abortion after six weeks of pregnancy. In states with near-total bans, physicians potentially face civil penalties, criminal liability, or loss of their licenses for providing abortion care. And while anti-abortion policymakers and advocates attempt to minimize the severity of abortion bans by including certain exceptions, **these exceptions** tend to be narrow and vague in scope and onerous in practice. Abortion rights advocates and the Biden administration have sued to clarify not only the confusing or unclear language these state bans rely on, but also whether they are preempted by conflicting federal obligations. Meanwhile, **patients are suffering** the consequences of delayed, restricted, and heavily scrutinized care.

People in states with abortion bans are increasingly relying on telehealth or interstate travel to terminate pregnancies. Anti-abortion policymakers and advocates are in turn testing new legal strategies to curtail access to abortion medication and support for out-of-state abortion care. At the federal level, they have challenged the approval and regulation of a drug used in medication abortion and attempted to revive an archaic law that prohibits the mailing of abortion-related materials. At the state level, they have passed laws to criminalize efforts to help patients who are **now traveling** to access care.

BROAD ABORTION BANS ARE IN EFFECT IN 17 STATES*

States that ban all abortions:

- ALABAMA
- ARKANSAS
- IDAHO
- INDIANA
- KENTUCKY
- LOUISIANA
- MISSISSIPPI
- MISSOURI
- OKLAHOMA
- SOUTH DAKOTA
- TENNESSEE
- TEXAS
- WEST VIRGINIA

States that ban abortions after six weeks of pregnancy:

- FLORIDA
- GEORGIA
- IOWA
- SOUTH CAROLINA

**As of October 10, 2024*

State courts are considering many of these issues and weighing in on the permissibility of state abortion laws. But despite the Court's previous signaling that the "issue of abortion" would be left to the states in the wake of *Dobbs*, federal judges at all levels are continuing to issue rulings with profound consequences for abortion access. The Supreme Court decided two high-stakes cases involving abortion during the October 2023 term: ***Food and Drug Administration v. Alliance for Hippocratic Medicine*** and ***Idaho v. United States***. In both cases, the Court declined to rule on the merits—failing to answer questions that may return to the Court in the coming years. And in a separate case heard during the October 2023 term, the Court **overturned the *Chevron* doctrine**, giving federal judges even more power to disregard the expertise of administrative agencies in statutory interpretation cases. That decision is already affecting challenges to regulations involving reproductive health care.

The federal courts are playing a central role in framing and resolving many of the new and complex legal questions stemming from the country's new patchwork approach to abortion law and policy.

The federal courts are playing a central role in framing and resolving many of the new and complex legal questions stemming from the country's current patchwork approach to abortion law and policy. The public, however, often remains in the dark about these cases and the threats they pose to reproductive health until they are brought to the nation's highest court—often when a party requests emergency relief through obscure court procedures. This publication seeks to raise awareness of the federal courts' current power to shape access to reproductive health care throughout the country: the broadly discussed cases that the Supreme Court heard during its most recent term, as well as the lesser-known cases that are making their way through the lower federal courts.

REPRODUCTIVE HEALTH CARE
IN THE SUPREME COURT'S
OCTOBER 2023 TERM

Abortion Medication: ***Food and Drug Administration v. Alliance for Hippocratic Medicine*** *(Alliance)*

BACKGROUND

Mifepristone is one of two drugs that the Food and Drug Administration (FDA) approved to be used together to terminate pregnancies, manage miscarriages, and treat other pregnancy complications. FDA approved the drug for use through seven weeks gestation in 2000, but added certain restrictions on its distribution and use that **needlessly** made the drug harder to access.

In 2016, FDA amended mifepristone's Risk Evaluation Mitigation Strategy (REMS) to allow use of the drug through ten weeks of pregnancy, reduce the dosage, and ease certain burdens on health care delivery systems. In 2019, FDA approved a generic version of mifepristone and included it under the existing REMS. In 2021, during the COVID-19 pandemic, FDA acknowledged the safety of the drug and relaxed several of its REMS restrictions, such as eliminating the in-person dispensing requirement, allowing mifepristone to be distributed by mail. Other parts of the REMS remained unchanged.

In November 2022, the Alliance for Hippocratic Medicine (AHM), along with other anti-abortion groups and four physicians, **challenged** FDA's approval of mifepristone and subsequent REMs revisions in a Texas federal court. AHM **argued** that FDA lacked the safety evidence necessary to approve the use of mifepristone for pregnancy termination. AHM asked the court to overturn its approval and withdraw it from the market. Danco Laboratories, the manufacturer of name-brand mifepristone, **intervened** in the case shortly after the complaint was filed.

MIFEPRISTONE
(Approved by FDA in 2000)

Used for:

Terminating pregnancy

Managing miscarriages

Treating other pregnancy complications

FDA Approval:

Used with misoprostol to end an intrauterine pregnancy through the first ten weeks of pregnancy.

During COVID-19:

FDA eliminated the need for in-person dispensing, allowing mifepristone to be distributed by mail.

At the district court level, Judge Matthew Kacsmaryk, a Trump appointee, **granted** a preliminary injunction that suspended FDA's 2000 approval of mifepristone nationwide. On appeal, a Fifth Circuit panel partially **granted** FDA's request for a stay, allowing the 2000 approval of mifepristone to stand but upholding the lower court's order suspending FDA's easing of restrictions in 2016 and beyond. On emergency appeal, however, the Supreme Court **temporarily blocked** both lower court decisions, allowing all of FDA's approvals and subsequent regulation of mifepristone to stand. The Fifth Circuit subsequently **invalidated** FDA's 2016 and 2021 REMS revisions, and the Supreme Court **decided** to hear the case.

THE DECISION

In ***Alliance***, the Supreme Court unanimously held that AHM did not have standing to challenge FDA's approvals and regulation of mifepristone because AHM did not sufficiently show that it had been harmed by FDA's actions. The majority opinion, written by Justice Kavanaugh, rejected each of AHM's theories of harm.

The Court held that though anti-abortion doctors and associations had "legal, moral, ideological, and policy objections" to mifepristone, they lacked a personal stake in the dispute.

First, the Court held that though anti-abortion physicians and associations had "legal, moral, ideological, and policy objections" to mifepristone, those objections were not sufficient to establish a stake in FDA's actions over medication abortion. The Court explained that because AHM members "do not prescribe, manufacture, sell, or advertise mifepristone or sponsor a competing drug, the plaintiffs suffer no direct monetary injuries from FDA's actions relaxing regulation of mifepristone." Further, the Court explained, "[b]ecause the plaintiffs do not use mifepristone, they obviously can suffer no physical injuries from FDA's actions relaxing regulation of mifepristone."

Second, the Court rejected plaintiff's "complicated causation theories" to connect FDA's actions to their alleged injuries. For example, AHM argued that making mifepristone more accessible could cause more women to suffer complications from the drug. In turn, these complications would require more women to seek emergency care, and subsequently require AHM's physicians to provide abortion care against their conscience. The Court ultimately rejected these theories, noting that "federal conscience laws have protected pro-life doctors ever since FDA approved mifepristone in 2000." Similarly, the Court rejected AHM's argument that increased mifepristone complications would result in diversion of resources from other patients, exposure to malpractice liability, and increased insurance costs to AHM's physicians, reasoning that the theory was "too speculative, lack[ed] support in the record, and [wa]s otherwise too attenuated to establish standing."

Finally, the Court rejected AHM's assertion that the associations had organizational standing because FDA's actions "impaired their ability to provide services and achieve their organizational missions." AHM had argued that the FDA's actions led them to spend considerable time, effort, and resources to prepare studies on mifepristone, litigate the case, and provide public education. In response, the Court held that "an organization that has not suffered a concrete injury caused by a defendant's action cannot spend its way into standing simply by expending money to gather information and advocate against the defendant's action."

Though the Court found that the plaintiffs in *Alliance* lacked standing to challenge FDA's regulatory actions related to mifepristone, it left the door open to other possible challengers, concluding that "it is not clear that no one else would have standing to challenge FDA's relaxed regulation of mifepristone."

Justice Thomas on Associational Standing:

In a concurrence, Justice Thomas challenged the constitutionality of the associational standing doctrine, calling on the Court to consider whether the doctrine could be squared with Article III requirements in an appropriate case. His arguments included that the doctrine:

1. **Allows an entire association to seek relief for a single plaintiff's injury**
2. **Might allow a member "two bites at the apple," i.e. multiple chances to litigate a claim**
3. **Does not always present an injury that the court can remedy**

STATUS OF MIFEPRISTONE LITIGATION NOW

Though the Supreme Court found that the plaintiffs in *Alliance* could not bring the case, courts across the country continue to hear cases involving the approval and regulation of, as well as restrictions on, medication abortion. At the district court level, **Missouri, Kansas and Idaho intervened** in *Alliance* to challenge FDA's mifepristone approvals and regulation. They argued that use of the medication has led to higher hospitalization rates and therefore higher costs to the states, resulting in economic injuries. The states also asserted that FDA's mifepristone approvals interfere with their sovereign interests in enforcing their respective abortion bans. The states will likely argue that they have a better chance of succeeding on their theories of injury than AHM. In September 2024, the intervening states **filed a status report** indicating that they plan to file an amended complaint challenging FDA's actions from 2016 to 2023 regarding mifepristone.

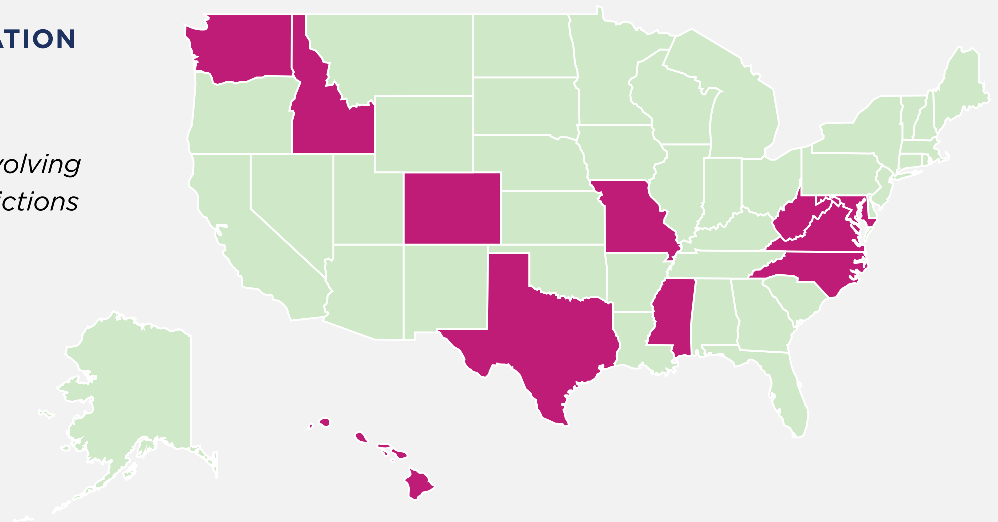
Lower courts paused several other cases involving mifepristone while the Supreme Court heard *Alliance*. In ***Washington v. FDA***, several states that support enhanced access to reproductive health care **filed a lawsuit** to stay FDA's January 2023 changes to the REMS. They argued that mifepristone does not require REMS and other restrictions under the statute. They also asserted that the REMS violates the Equal Protection Clause of the U.S. Constitution. Several other states seeking to restrict access to mifepristone, led by Idaho, **petitioned to intervene** in the case, arguing that they had special interests in its outcome. Just hours after the district court in Texas stayed FDA's approvals and regulation of the drug in *Alliance*, the district court in Washington **ordered** FDA to ensure that mifepristone remained available in the states involved in the case until there was a final determination on the merits of the issue. In July 2024, the **Ninth Circuit Court denied** Idaho's and other states' motion to intervene, **holding that** the states did not have standing under *Alliance*. The case is still proceeding at the district court level in Washington.

District courts in Hawaii and Virginia are considering similar cases alleging that the REMS restrictions are medically unjustified and burden patients and the health care system. Briefing is now proceeding in both ***Purcell v. Becerra*** and **Whole Woman's Health Alliance** in the wake of *Alliance*. Meanwhile, one case in district court in Maryland, ***GenBioPro v. FDA***, was paused again in July 2024 because both parties agreed that "they would benefit from understanding how *Alliance* will proceed" with regards to the three intervening states.

On the other hand, federal courts in West Virginia and North Carolina are weighing the legality of state bans or restrictions on medication abortion. In ***GenBioPro v. Raynes***, where a generic mifepristone manufacturer argues that West Virginia's abortion ban is preempted because it restricts access to an FDA-regulated drug, a district court dismissed many of the manufacturer's claims related to the major questions doctrine, federal preemption, the Dormant Commerce Clause, and more. The plaintiffs **appealed** the decision, and the Fourth Circuit has tentatively scheduled oral arguments for late October 2024. In ***Bryant v. Stein***, a district judge held in April 2024 that federal law preempts North Carolina's additional requirements for distribution of mifepristone—a holding that the North Carolina Attorney General is now **appealing at the Fourth Circuit**.

MIFEPRISTONE LITIGATION ACROSS THE U.S.

Federal courts across the country hearing cases involving the approval of and restrictions on medication abortion.



Emergency Abortion: ***Idaho and Moyle, et al. v. United States*** *(Idaho)*

BACKGROUND

The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law that requires Medicare-participating hospitals to stabilize patients with emergency medical conditions (EMCs). The 1986 law sought to address the practice of patient dumping whereby hospitals refused to treat low-income patients who could not pay for their care. Under the statute, **hospitals are required** to screen patients to determine whether they have an EMC, and then either provide the patient with stabilizing treatment to prevent further harm or, if necessary, transfer them to a more appropriate facility that is able to provide such care. After *Dobbs*, the Biden Administration issued **guidance** affirming that EMTALA's requirements included emergency abortion care when appropriate to stabilize an EMC.

Following *Dobbs*, the state of Idaho passed a near-total ban on abortions with very narrow exceptions. The Department of Justice (DOJ) **challenged the law** before it went into effect, arguing that the Idaho law was invalid to the extent that it prohibits the provision of care required under EMTALA. The district court ruled in favor of DOJ in August 2022, finding that it was impossible for physicians to comply with both EMTALA and the Idaho abortion ban under certain circumstances. The district court granted a preliminary injunction that prevented Idaho from implementing the abortion ban to the extent it conflicted with EMTALA. Idaho **appealed** this decision to the Ninth Circuit, where a three-judge panel temporarily stayed the injunction in September 2023.

After DOJ petitioned for a rehearing of the case, a broader panel of judges on the Ninth Circuit reversed the initial decision in November 2023, affirming the district court injunction. The Supreme Court then granted certiorari for the case and stayed the injunction in January 2024, allowing the Idaho abortion ban to take full effect.

EMTALA
(enacted in 1986)

About:

Federal law that requires Medicare-participating hospitals to stabilize patients with emergency medical conditions.

Requires hospitals to provide all patients with:

Screening

Stabilization

Transfer

Nondiscrimination

**Under Biden Administration, EMTALA obligation includes providing abortion care when necessary to stabilize a pregnancy-related emergency condition*

THE DECISION

On June 27, 2024, the Supreme Court **dismissed the case** and returned it to district court for further proceedings. Six of the Justices—Kagan, Sotomayor, Jackson, Barrett, Roberts, and Kavanaugh—voted to affirm the Ninth Circuit injunction, while three—Justices Alito, Thomas and Gorsuch—voted to lift it. Five justices voted for dismissal, while Justice Jackson opined that the Court should have decided the case in favor of DOJ and Justices Alito, Thomas and Gorsuch asserted that the Court should have ruled in favor of Idaho. Ultimately, the Court's decision temporarily reinstated EMTALA's requirement to provide emergency abortion care when necessary to stabilize a patient, even if such care conflicts with the Idaho abortion ban, while the case continues in the lower courts.

Justice Barrett found that "Idaho law has materially changed" since the Court took up the case.

Justice Barrett, joined by Justices Roberts and Kavanaugh, focused on how "the shape of these cases has substantially shifted" because "the parties' positions are still evolving." She pointed to the Administration's clarification that "EMTALA's reach is far more modest than it appeared," referencing the Solicitor General's **concessions during oral argument** that: 1) abortion is not the standard of care for any mental health condition, and 2) EMTALA's requirements for hospitals did not override the federal conscience protections afforded physicians. She also found that "Idaho law has materially changed since the District Court entered the preliminary injunction" because Idaho argued that physicians could terminate pregnancies to treat conditions such as PPROM, placental abruption, pre-eclampsia, and eclampsia "even if the threat to the women's life is not imminent."

JUSTICE ALITO RELIED ON "UNBORN CHILD" LANGUAGE TO ARGUE FOR FETAL PERSONHOOD RIGHTS.

The dissent, authored by Justice Alito and joined by Justices Gorsuch and Thomas, focused on EMTALA's references to the "unborn child," which legislators added to the statute in 1989 to ensure that a pregnant woman could also demand care for her fetus in the context of active labor and delivery. Although EMTALA's text refers to an "unborn child" in the context of active labor, Alito argued that EMTALA generally "obligates Medicare-funded hospitals to treat, not abort, an unborn child." He also advocated for an exception based on a risk of death rather than a serious risk to health because there are many pregnancy-related health conditions, like PPROM, where physicians might "try to delay delivery long enough to save the child's life" unless the condition "becomes sufficiently severe to cause infection and serious risk of sepsis." In the same section, he warned that "the Members of this Court are not physicians and should therefore be wary about expressing conclusions about medical issues."

Justice Kagan's concurrence, joined by Justice Sotomayor and joined partially by Justice Jackson, centered on the realities faced by women on the ground, noting that the state's largest provider "had to airlift pregnant women out of Idaho roughly every other week, compared to once in all of the prior year (when the injunction was in effect)." Justice Kagan also emphasized the large gap between EMTALA's "grave health consequences" standard and Idaho's "imminent death" standard, explaining that the latter would allow damage to a woman's uterus that impaired her ability to have children. And responding to the "unborn child" argument in Justice Alito's dissent, Justice Kagan emphasized that an additional duty to care for an "unborn child" in certain circumstances "does not displace the hospital's duty to a woman."

Justice Kagan emphasized the large gap between EMTALA's "grave health consequences standard" and Idaho's "imminent death" standard.

Justice Jackson agreed with Justice Kagan's statutory analysis but disagreed with the Court's decision to return the case to lower courts. She warned that the EMTALA preemption issue "is not going away anytime soon and will most certainly return," pointing to a similar case in Texas that DOJ recently appealed to the Court. She also observed that though Idaho's lawyers "have changed their tune" about the contours of the state's abortion ban—a "convenient rhetorical maneuver"—there is a plain textual conflict between state and federal law in this case. Justice Jackson noted that physicians often do "not know what the exact risks are or whether a patient might face death." She then observed that the threat of severe criminal penalties for a miscalculation is already driving many physicians to forgo providing abortion care that "medical standards warrant and federal law requires." Justice Jackson concluded that the Court's decision to delay resolution of this issue is only "facilitating the suffering of people in need of urgent medical treatment," leaving pregnant patients "in a precarious position as their physicians are kept in the dark about what the law requires."

JUSTICE JACKSON WARNED THAT DELAYED RESOLUTION IS ONLY "FACILITATING THE SUFFERING OF PEOPLE IN NEED OF URGENT MEDICAL TREATMENT"

Idaho also introduced a novel argument on appeal that because Congress passed EMTALA using its Spending Clause authority, the federal law could not preempt state laws. While the three liberal Justices did not address it, Justice Barrett suggested that this new argument should be fully briefed below, and Justice Alito hinted that he agreed with Idaho's assertion. As the Solicitor General warned during oral arguments, if adopted by the Court, this reasoning would "seriously interfere with the ability of the federal government to get its benefit of the bargain" in major Spending Clause programs like Medicare.

STATUS OF EMTALA LITIGATION NOW

Because the Supreme Court dismissed *Idaho* without deciding the merits, the case returned to the Ninth Circuit, which will decide whether to affirm the **district court's preliminary injunction** of the state abortion ban to the extent it conflicts with EMTALA. **Moyle** and **Idaho** have filed briefs at the Ninth Circuit with the same arguments they brought before the Court in early 2024, including the Spending Clause argument. Oral argument will take place during the **week of December 9, 2024**. Meanwhile, the district court's preliminary injunction, which prohibits Idaho from enforcing its abortion ban as applied to medical care required by EMTALA, remains in place.

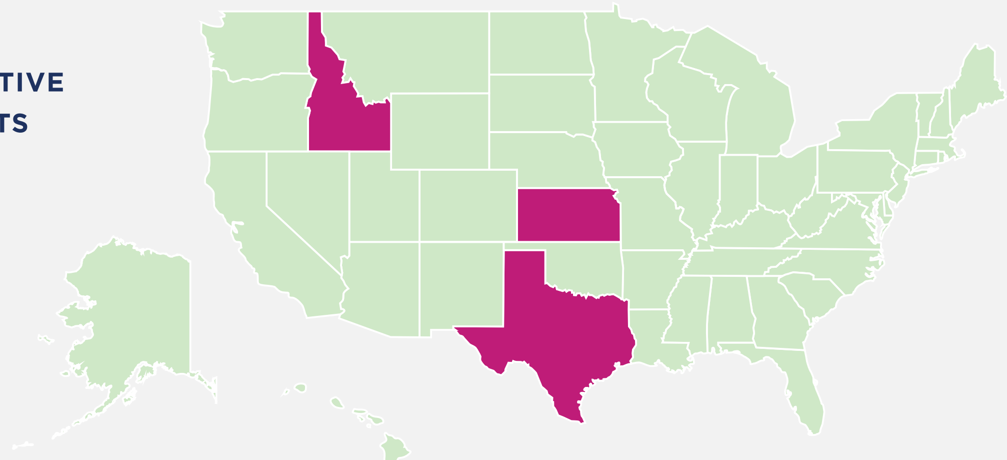
Other ongoing cases rely on different legal theories that also seek to expand the scope of the Idaho abortion ban's medical exception, including one **alleging** that "abortion remains constitutionally protected when continuing a pregnancy would subject a pregnant person to serious medical risks or the pregnancy is medically futile."

In January 2024, the **Fifth Circuit affirmed** a district court's decision to enjoin the Biden Administration's guidance on EMTALA within the state of Texas. This ruling only adds to the confusion and uncertainty surrounding the scope of the medical exception included in the Texas abortion ban, which **state courts** and the **Texas Medical Board** have similarly done little to address. The Supreme Court rejected DOJ's request to review the case in October 2024.

In Kansas, in July 2024, a patient **filed a lawsuit** against the University of Kansas Hospital Authority, alleging that the hospital's failure to provide her any type of medical care following a PPROM diagnosis violated EMTALA. The hospital has filed a motion to dismiss the case, arguing that classifying the patient's condition as "non-emergent" had been appropriate and that EMTALA "was never intended to require the provision of specific treatment to individual patients."

While EMTALA litigation proceeds in federal courts, the Biden Administration has also created a new portal allowing anonymous reporting of EMTALA violations. In August 2024, two women from Texas **filed administrative complaints** alleging that two hospitals' refusal to provide emergency treatment for their ectopic pregnancies led to permanent damage to their reproductive organs. The two women call on the Biden Administration to investigate the hospitals for EMTALA violations.

STATES WITH ACTIVE EMTALA LAWSUITS



Cross-Cutting Considerations

During its October 2023 term, the Court ultimately sidestepped the core legal questions at the heart of both *Alliance* and *Idaho*. The Court did not rule on the permissibility of FDA's approval and regulation of mifepristone in *Alliance* or whether broad abortion bans are preempted by EMTALA in *Idaho*. During oral arguments and in the dissenting opinions, however, some Justices hinted at how they may approach other legal questions that could fundamentally affect access to reproductive health care throughout the country:

FETAL PERSONHOOD

Idaho argued that EMTALA requires equal treatment of the pregnant patient and the unborn child—essentially, that hospitals have an obligation to stabilize a fetus to the same extent as a pregnant patient. In **oral argument** and dissents, Justices Alito, Thomas, and Gorsuch questioned whether providing abortion care could be reconciled with the duty to treat emergency medical conditions that place the health of the "unborn child" in serious jeopardy. A reading of EMTALA that would require hospitals to protect an "unborn child" from harm at every stage—rather than during active labor and delivery—legitimizes the notion that protecting the health of the fetus can displace the obligations owed to the pregnant person. Importantly, it echoes the views advanced by the fetal personhood movement and the reasoning relied upon by the **Alabama Supreme Court** in February 2024, when it held that embryos created through in vitro fertilization (IVF) are "children." This interpretation of EMTALA should serve as a stark warning to those monitoring the Court's pronouncements on fetal personhood and the potential implications for prohibiting or restricting access to a range of reproductive health services.

ASSOCIATIONAL STANDING

Justice Thomas's invitation to chip away at or overturn the associational standing doctrine in *Alliance* threatens an important pathway to legitimate legal redress—one that civil rights and patient advocacy organizations have relied on for nearly 50 years. There are numerous reasons why physicians and organizations rely on associational standing when bringing challenges on behalf of their patients, including the ability to shield them from stigma, criminal investigations, unwanted publicity, and violence. An endorsement of Justice Thomas's concurrence by a majority of the Court could lead to a substantial chilling of lawsuits challenging unfair laws and practices related to reproductive health.

FEDERAL CONSCIENCE PROTECTIONS

At oral arguments in *Alliance*, Solicitor General Prelogar told the Supreme Court that FDA's mifepristone approvals would not compel a physician to treat medication abortion-related complications because "under federal law, no doctors can be forced against their consciences to perform or assist in an abortion." In both cases, the Court signaled its willingness to not only adopt this expansive approach to interpreting the scope of federal conscience protections, but also broaden it. In *Idaho*, Justice Barrett found that Prelogar's clarification about conscience "alleviates Idaho's concern that...EMTALA would strip healthcare providers of conscience protections." In *Alliance*, the Court found that the protections covered not only abortion and sterilization but the "full range of medical care" and explained that this "strong protection for conscience remains true even in a so-called healthcare desert, where other doctors are not readily available." While some physicians have **leaned on conscience laws** to refuse care for decades, various experts argue that *Alliance*'s approach serves to broaden their scope further and seriously undermines federal obligations to provide emergency care under EMTALA.

THE COMSTOCK ACT

Though the *Alliance* opinion did not address the Comstock Act, during oral argument, Justices Alito and Thomas asked both parties whether the Act had been violated when FDA allowed Mifepristone prescriptions to be filled by mail in 2021. The Comstock Act is a centuries-old, now dormant anti-obscenity law that prohibits the mailing of pornography and abortion-related materials. In 2022, **DOJ issued guidance** explaining that the law does not prohibit the mailing of abortion medications because these drugs still have legal uses in all states—such as management of a miscarriage. But DOJ's current position on the applicability of the Comstock Act could be revisited by a different administration, and the Court may be asked to weigh in on this issue in future cases.

WHAT COMES NEXT?

Access to abortion medication and the scope of medical exceptions to state abortion bans took center stage before the Supreme Court during its October 2023 term. Federal courts, however, are considering cases involving a range of complex legal questions regarding access to abortion, as well as other essential reproductive health care. Though the Supreme Court has declined to hear a handful of cases involving reproductive health care this term, several others are pending before lower courts. The courts' decisions in each of these cases could severely affect access to essential reproductive health services, particularly for those living in restrictive legal contexts.

The Supreme Court's October 2024 Term

As discussed above, the Fifth Circuit affirmed a district court's decision to enjoin the Biden Administration's guidance on EMTALA with respect to Texas's abortion ban in January 2024. In April 2024, **DOJ petitioned** the Supreme Court to hear the case while the Idaho case was being briefed before the Court. On October 7, 2024, the Supreme Court rejected the petition, leaving the Fifth Circuit decision in place. As a result, Medicare-funded hospitals in Texas are not currently required to provide abortion care for pregnant patients with emergency medical conditions where it would violate state law, but the issue could return to the Court once the Idaho case moves through the lower courts again.

In ***LePage v. Mobile Infirmary Association***, the Alabama Supreme Court ruled that extrauterine embryos—such as those used in IVF treatments—are "unborn children" **with personhood status** under state law. That ruling triggered fierce political backlash, and legislative responses at the state and federal levels. The state legislature responded quickly by **passing a bill** they claimed would restore access to IVF in Alabama, which was signed into law by the Governor in March 2024. The U.S. Senate has **voted twice** on a measure to ensure access to IVF nationwide—though the law failed to pass due to nearly every Republican member voting against it both times. In August 2024, the defendant in *LePage*, a fertility clinic, **asked** the Supreme Court to overturn the February 2024 ruling. The clinic argued that the state court's decision violates traditional principles of justice by severely punishing the clinic under a centuries-old statute without fair notice. The Supreme Court declined to hear the case on October 7, 2024.

Notably, the Supreme Court **issued an order** in September 2024 denying Oklahoma's request to review a decision upholding a Biden Administration rule that ties federal funding for family planning under Title X of the Public Health Service Act of 1970 to certain abortion counseling and referral requirements. Oklahoma argued that the rule was invalid because Congress did not authorize the rule. The Supreme Court may be asked to intervene on this issue again in the context of ongoing litigation in Tennessee and Ohio involving the same rule.

Lower Court Cases to Watch

STATE LAW REFORM EFFORTS

In ***Right to Life Michigan v. Whitmer***, a coalition of local anti-abortion groups challenged a ballot initiative that amends the Michigan constitution to explicitly guarantee a right to reproductive freedom. The plaintiffs alleged that the ballot initiative violates various constitutional rights, including a fetus's equal protection and due process rights under the Fourteenth Amendment and medical professionals' free speech rights under the First Amendment. The case is currently being briefed before a district court in Western Michigan.

In ***Planned Parenthood South Atlantic v. Stein***, a local Planned Parenthood chapter and a physician challenged the North Carolina legislature's adoption of an abortion ban starting at 12 weeks of pregnancy following *Dobbs*. The complaint focused on the law's requirements that a patient be hospitalized and receive an ultrasound prior to receiving a medication abortion. On July 19, 2024, a **district judge held** that the ultrasound provision was void for vagueness but found that the hospitalization requirement did not violate the Equal Protection or Due Process Clause. The case has not yet been appealed.

REGULATION OF SPEECH

In ***Idaho Federation of Teachers v. Labrador***, university professors and unions challenged an Idaho law that curtails abortion-related speech by entities that receive state funding. Plaintiffs argued that the law violated the First and Fourteenth Amendments because it only restricted speech of those in favor of abortion. On July 2, 2024, a district judge **dismissed the case** on procedural grounds while also raising concerns about the merits—specifically, that the statute was not "clear and well-understood as to what speech was covered and what was not." The case has not yet been appealed.

In ***A Woman's Concern v. Healey***, a crisis pregnancy center (CPC) alleged that Massachusetts' treatment of **CPCs**—facilities that represent themselves as legitimate reproductive health care clinics but actually aim to dissuade people from accessing certain health services—violates their rights to freedom of speech and free exercise of religion. The lawsuit also argues that government advisories warning the public that CPCs are fake, dangerous, and deceptive violate their right to equal protection. The lawsuit comes just a year after a **district judge in Illinois** invalidated a law banning CPCs from using "misinformation, deceptive practices, or misrepresentation" to interfere with access to abortion services or emergency contraception.

RESTRICTIONS ON TRAVEL

Two consolidated cases in Alabama, ***Yellowhammer Fund v. Marshall*** and ***West Alabama Women's Center v. Marshall***, challenged the state Attorney General's interpretation of laws criminalizing the provision of support to pregnant Alabamans who access abortion care in other states. The plaintiffs argued that prosecution would violate their rights to travel and freedom of expression, as well as the constitutional limitations on applying state law beyond state boundaries. In May 2024, a district judge allowed the case to move forward. Both parties have filed motions for summary judgment. In August 2024, DOJ filed a statement of interest in support of the plaintiffs in both cases.

In ***Matsumoto v. Labrador***, a lawyer and two abortion rights advocacy groups challenged an Idaho law that criminalizes aiding a minor in obtaining an abortion outside the state. The plaintiffs argued that the law was unconstitutionally vague and infringes on the rights to travel and freedom of speech. The district court judge issued a preliminary injunction halting enforcement of the state law, which the Idaho Attorney General **appealed** at the Ninth Circuit. The Ninth Circuit heard oral arguments in May 2024 and may issue a decision anytime, after which litigation on the merits will proceed in district court.

Similarly, in ***Welty v. Dunaway***, abortion rights advocates challenged a Tennessee law that bans adults from assisting a minor in obtaining an abortion outside the state. The plaintiffs argued that the law violates the right to free speech, is void for vagueness, and is overbroad under the First and Fourteenth Amendments. On September 20, 2024, the district court judge **granted a preliminary injunction** halting enforcement of the law while the case proceeds, noting that the state "cannot make it a crime to communicate freely" about accessing a legal abortion even if abortion is illegal within the state.

FEDERAL REGULATIONS

On September 4, 2024, in ***Texas v. HHS***, the Texas Attorney General sued a Biden Administration regulation that enhances privacy protections for reproductive health care under the Health Insurance Portability and Accountability Act (HIPAA). The rule prohibits health care providers from releasing protected health information related to reproductive health care to aid law enforcement investigations that would penalize individuals who obtain legal abortions. The **complaint**, filed in Lubbock, Texas, challenges the 2024 rule for reproductive health as well as the initial 2000 privacy rule, arguing that the statute does not authorize HHS to interfere with state law enforcement investigations.

Also in Texas, two professors joined the Texas Attorney General's lawsuit challenging the Biden Administration's recent Title IX regulations, which **reaffirmed** that the federal law prohibits discrimination against pregnancy-related conditions, including the termination of a pregnancy. In particular, the professors **sought to penalize students** who miss class to obtain an abortion out of state. Judge Matthew Kacsmaryk—the same judge who invalidated FDA's approval and regulation of mifepristone in *Alliance*—**issued a temporary stay** of the regulations while the case is pending before the district court.

CONCLUSION

Two years post-*Dobbs*, the consequences of returning abortion to the states are numerous and often grave for patients, physicians, and their families. Within 100 days of the decision, **over 60 clinics in 15 states** stopped providing abortion care due to state abortion bans. As these brick-and-mortar facilities shut down, a new model emerged for abortion care: physicians practicing in progressive contexts under the protection of **shield laws** started to prescribe abortion medications through online telehealth services. Meanwhile, other patients—especially those in need of emergency abortion care due to pregnancy complications—**started traveling** (including getting airlifted) to states without abortion bans, navigating onerous financial and logistical hurdles in the process. Many of these patients remain worried that law enforcement in their home states will attempt to access their health records and use their private health data for criminal investigations. Accessing essential reproductive health care under these extremely difficult circumstances has no doubt taken a devastating toll on patients' lives, health, well-being, and dignity.

Physicians **are also facing** the impossible choice between providing safe, medically indicated abortion care and protecting themselves from potential criminal punishment, civil liability, and loss of licensure under state abortion bans. They must use their own reasonable judgment to discern between threats to life and health to comply with medical exceptions, and choose whether to violate federal or state law. Many OBGYNs have moved out of restrictive states in response, exacerbating **maternity care deserts** that already exist in many parts of the country. And while shield laws offer some level of protection to physicians offering telehealth abortion care in states with broad abortion bans, they do not **eliminate** the risk of punishment and other liability, especially now that these laws are the subject of legal challenges in various states.

Accessing essential reproductive health care under these extremely difficult circumstances has no doubt taken a devastating toll on patients' lives, health, well-being and dignity.

The number and nature of the cases referenced in this publication underscore the significant role federal courts are playing in shaping the legal landscape around reproductive health care. Litigation involving FDA's authority to approve and regulate abortion medication and whether states with broad abortion bans have an obligation to provide emergency abortions to protect the lives and health of pregnant patients are making their way through courts across the country. Meanwhile, judges are being asked to weigh in on the legality of state constitutional amendments, travel bans, and federal privacy protections. Many of these cases move back and forth between the lower and appellate courts—and many laws and regulations are being stayed or invalidated, just to be reinstated in later proceedings. The confusion and uncertainty generated by this context is untenable.

The outcome of the upcoming 2024 election, as with all elections, will have profound consequences for access to abortion and other essential reproductive health care. The two presidential tickets present diametrically opposed records on and approaches to law and policy related to reproductive health. Moreover, the next administration will shape the makeup of the judiciary because the president nominates and the Senate confirms all new federal judges, who have lifetime tenure once appointed. Trump nominated Neil Gorsuch, Brett Kavanaugh, and Amy Coney Barrett to the Supreme Court and appointed **234 federal judges** during his presidency, which **changed the balance** of the federal courts at all levels. A number of these judges have demonstrated their willingness to issue rulings upending well-established precedent and undermining access to critical health care services nationwide. Similarly, President Biden nominated Ketanji Brown Jackson to the Supreme Court and **appointed over 200 judges**, with a focus on increasing diversity within the federal judiciary and the number of judges with experience in civil rights, public defense, and labor law.

> ***Dobbs* created a legal landscape around the access to abortion and other essential reproductive health care characterized by confusion and uncertainty. It also left many of the complex legal questions it generated not to the states, but to the federal judiciary. How the federal judiciary decides the cases discussed in this publication will have immediate and lasting consequences for people across the country—whether they are patients seeking care, physicians attempting to provide safe, medically-indicated health services, or the families and communities that support them in the process.**

O'NEILL INSTITUTE
GEORGETOWN LAW
CENTER FOR HEALTH POLICY & THE LAW