The

PRACTICAL GUIDANCE Journal

REPRODUCTIVE HEALTHCARE ISSUES FOR EMPLOYERS

The Impact of State Laws Criminalizing Abortion

Insurance Issues after *Dobbs*

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Fall 2022

The PRACTICAL GUIDANCE Journal

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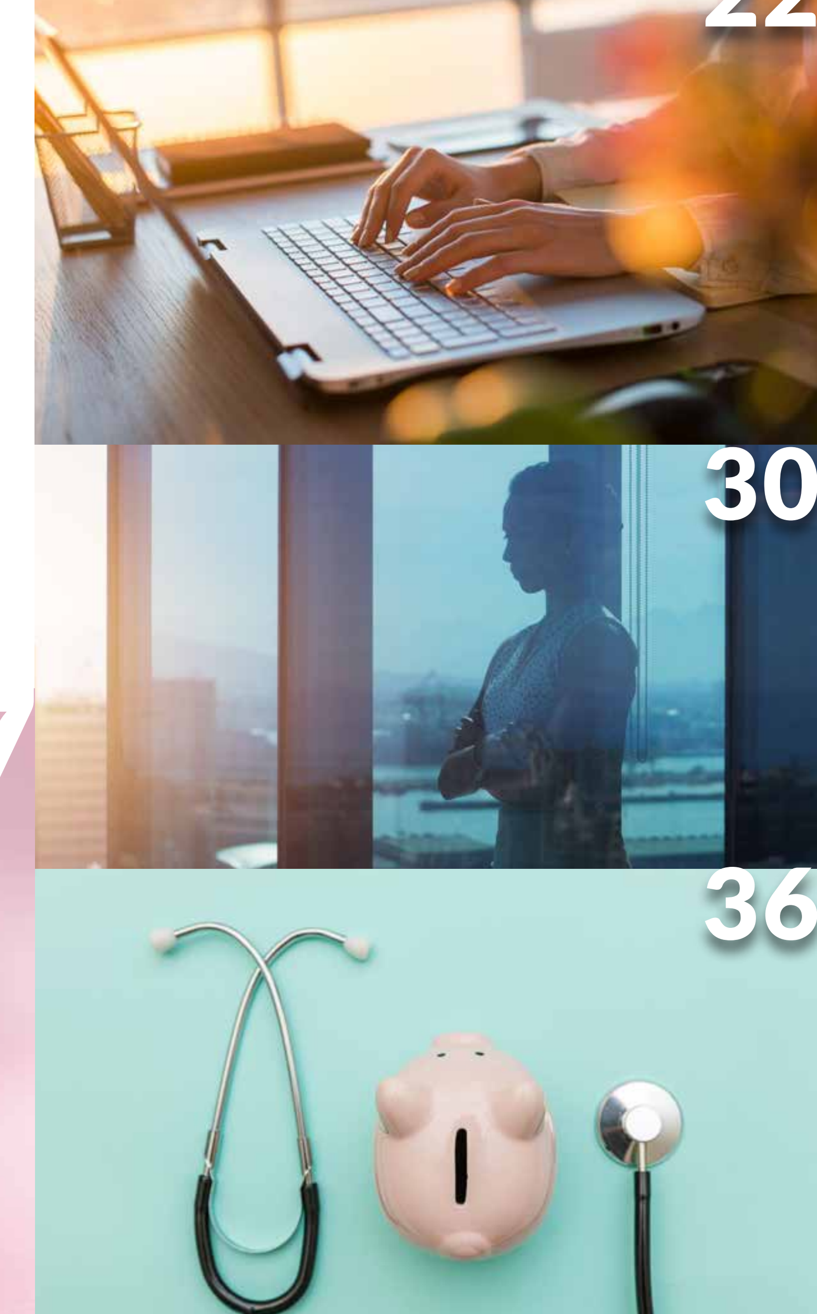

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IMPACTS FROM THE SUPREME COURT'S controversial decision in *Dobbs v. Jackson Women's Health Organization* will reverberate through the legal and healthcare worlds for decades. As challenges emerge and individuals and organizations address changes in the law, we provide initial guidance in this edition of The Practical Guidance Journal.

This edition offers a tracker showing the status of individual states' abortion laws. Review a summary of the current state laws criminalizing abortion, as well as the broader implications of those laws, with an eye on the significant variations from state to state with regard to the conduct each state prohibits, and any criminal penalties imposed.

We also bring you podcasts from several leading practitioners who are well-versed in assisting employers and large organizations with the sensitive issues emerging from this landmark change in the law. Employers face new privacy concerns in the wake of the *Dobbs* ruling and must evaluate how the decision affects their responsibilities as a sponsor of a group health plan and the privacy rights of their employees.

Finally, read a review of insurance considerations providing insights on how to guide your clients through a myriad of issues, including reconciling state-mandated coverage for reproductive health services with legislation restricting or prohibiting abortions.

Our mission

The Practical Guidance Journal is designed to help attorneys start on point. This supplement to our online practical guidance resource, Practical Guidance, brings you a sophisticated collection of practice insights, trends, and forward-thinking articles. Grounded in the real-world experience of our 1750+ seasoned attorney authors, The Practical Guidance Journal offers fresh, contemporary perspectives and compelling insights on matters impacting your practice.

The Lexis Practical Guidance Healthcare Team

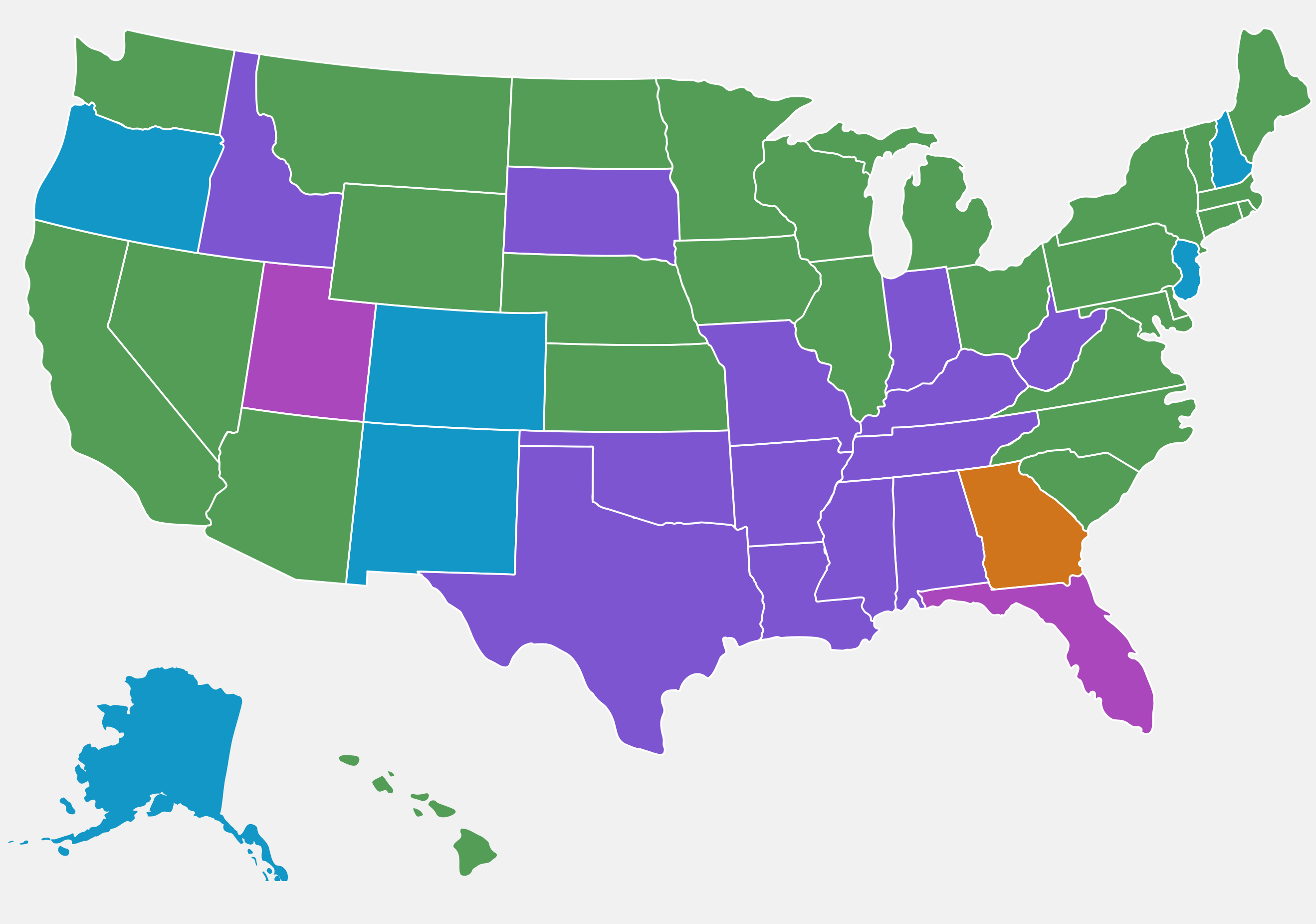
States Adopt New Laws
Following the Decision in *Dobbs v. Jackson Women's Health Organization*

A flurry of new laws and trigger laws went into effect following the U.S. Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*, 2022 U.S. LEXIS 3057 (S. Ct. June 24, 2022).

IN A 6–3 DECISION, THE *DOBBS* COURT REVERSED THE LOWER court's holding and upheld the Mississippi law at issue, which prohibited abortions after 15 weeks. The Court determined that the doctrine of stare decisis did not support the rule previously established in *Roe v. Wade*, 410 U.S. 113 (1973), and continued in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), that a woman's right to terminate her pregnancy extends to the viability of the fetus. A smaller 5–4 majority of the Court, excluding Chief Justice Roberts, voted further to overrule both *Roe* and *Casey* in their entireties.

As a result, *Dobbs* eliminated the federal constitutional right to obtain an abortion and returned the right to enact laws regarding reproductive healthcare to the states. The following visual shows each state's current status regarding the legality of abortion post-*Dobbs*.

Legality of Abortion by State



- Prohibited at conception
- Permitted until 15-18 weeks*
- Permitted at all times during gestational period
- Permitted until cardiac activity (approx. 6 weeks*)
- Permitted until 22-28 weeks*/viability

Visualization of Legality of Abortion by State (current as of September 20, 2022).

Legality of Abortion by State

The legality of abortion services varies from jurisdiction to jurisdiction. But even in those states that restrict or prohibit abortion, each state's law currently allows a healthcare provider to terminate a pregnancy to prevent the risk of death or serious harm to the pregnant woman.

Practical Guidance includes a tracker organized by jurisdiction. It provides the current legal status of abortion in each of the 50 states and the District of Columbia. It then highlights notable or significant news stories, press releases, executive orders, agency guidance, court cases and decisions, and proposed and enacted legislation regarding the legal evolution of reproductive healthcare in each jurisdiction. This tracker does not, however, attempt to document every state law—whether proposed or enacted—regarding reproductive health services (e.g., parental consent, waiting periods, medication abortion, or types of procedures permitted or prohibited), nor does it track every news story or statement on the topic.

For more information on the *Dobbs* decision and its impact on healthcare, employee benefits, labor and employment, and insurance, see *Dobbs v. Jackson Women's Health Organization* Resource Kit.

RESEARCH PATH: *Healthcare > Trackers*

Amanda Zablocki
and Mikela T. Sutrina
SHEPPARD MULLIN WILLIAMS MULLEN

The Impact of State Laws Criminalizing Abortion

On August 5, 2022, Indiana joined 19 states whose laws criminalize abortion prior to viability in the wake of the recent U.S. Supreme Court decision in *Dobbs v. Jackson Women's Health Organization*.[1]

IN MANY OF THESE STATES, PERFORMING AN ILLEGAL abortion constitutes a felony, giving rise to significant civil and criminal penalties, including jail time. While it remains to be seen which of these laws ultimately survives the many court challenges currently under way, providers are struggling to understand the line between what is legal and what constitutes a crime. That question, however, is only the tip of the iceberg. This article provides an overview of the current state laws criminalizing abortion and the broader implications of those laws.

The law, policy, and regulatory climate surrounding the *Dobbs* decision is complex and quickly developing. The information provided in this article summarizes the current legal landscape at the time of publication. This article samples a variety of state laws to address the topic of abortion criminalization, but it does not address all potential legal issues or jurisdictional differences. Moreover, certain of the criminal laws described in this article have been enjoined by court action since the *Dobbs* decision. This article does not address the scope of those injunctions, or the likelihood of those laws being overturned or modified due to such actions.

Understanding State Criminal Abortion Laws

Perhaps most challenging for women, providers, and other individuals and companies across the country is that there are significant variations from state to state with regard to the conduct each state prohibits, and the criminal penalties imposed for such conduct. For example, Texas bans abortion without regard to the gestational age of the fetus, with limited exceptions, and imposes maximum criminal and civil penalties. By contrast, Ohio's abortion trigger law (which, like other trigger laws, is designed to spring into effect upon the reversal of *Roe v. Wade*[2] or an amendment to the Constitution stating that there is no constitutional right to an abortion) prohibits abortion after the detection of cardiac activity and classifies abortion as a felony of the fifth degree. However, when examining these laws as a whole, a few key distinguishing features emerge that help to define the scope of potential liability and risk to providers and other organizations, each of which is discussed in turn below.

Blanket Prohibition Versus Gestational Limitation

A gating question under any of these laws is when the termination of a pregnancy is deemed to be illegal. Under *Roe*, the decision whether to have an abortion was relegated to women in the first trimester, with states afforded increasing ability to regulate abortion as the pregnancy progressed into the second and third trimester. The Supreme Court reaffirmed the right to abortion in *Planned Parenthood of Southeastern Pennsylvania v. Casey*,[3] but replaced the trimester-based approach with a theory of viability of the fetus (i.e., the point at which the fetus would have a chance of surviving outside the womb). In each case, women and their physicians had time not only to initially discover a pregnancy, but also time to make a decision about whether or not to continue the pregnancy. Following *Dobbs*, states are free to regulate the termination of a pregnancy at any time.

In response to this new freedom, over half the states with criminal prohibitions on abortion have enacted (or revived) a blanket prohibition regardless of the gestational age or maturity of the fetus. These states include Alabama,[4] Arkansas,[5] Idaho,[6] Indiana,[7] Kentucky,[8] Louisiana,[9] Mississippi,[10] Missouri,[11] North Dakota,[12] Oklahoma,[13] South Dakota,[14] Texas,[15] Utah,[16] West Virginia,[17] and Wyoming.[18]

In only a handful of these states, such as Arkansas and Kentucky, is it clear that the sale, use, prescription, and administration of contraceptives does not, in and of itself, give rise to liability under the relevant statutes.[19] In the other states with blanket prohibitions, it is possible that activities designed to prevent pregnancy in the first instance, such as birth control or emergency contraceptives, could give rise to liability to the extent they result in the termination of an unintended pregnancy.

In the states that criminalize abortions performed following a defined gestational period or after cardiac activity is detected (e.g., Ohio, South Carolina, Tennessee, and Wisconsin), there is more (albeit, very limited) time to discover a pregnancy exists before the termination of such pregnancy would become illegal, whether by use of emergency contraceptives or otherwise.[20]

Scope of Permitted Versus Prohibited Conduct

Another key distinction among the state laws is the scope of conduct prohibited. Even under the most restrictive of laws, abortion is generally permitted when necessary to prevent death or serious health risks to the mother. For example, in Kentucky abortion is permitted to "prevent the death or substantial risk of death due to a physical condition, or to prevent the serious, permanent impairment of a life-sustaining organ of a pregnant woman."[21] In addition to what constitutes substantial or serious health risks, a key question will be how certain the physician must be that a patient faces such a risk, and how imminent the risk of death or serious risk to the pregnant woman's health must be, for the abortion to be deemed lawful. Notably, this issue is the subject of a challenge to Idaho's anti-abortion law by the U.S. Department of Justice on the grounds that hospitals participating in Medicare must abide by the federal Emergency Medical Treatment and Labor Act (EMTALA).[22] Moreover, Idaho and Indiana both expressly state that a woman's psychological state or emotional or mental condition cannot be used to support an argument that the abortion is necessary to save the pregnant woman's life.[23]

Idaho, Mississippi, North Dakota, Oklahoma, and South Carolina also permit abortions in the case of rape and incest, with some limitations. In Idaho and Oklahoma, the rape must be reported to law enforcement, whereas in Mississippi and North Dakota, there is no reporting requirement. In South Carolina, abortion due to rape or incest is permitted only in the first 20 weeks of pregnancy. South Carolina also permits abortion in the case of a fetal anomaly.

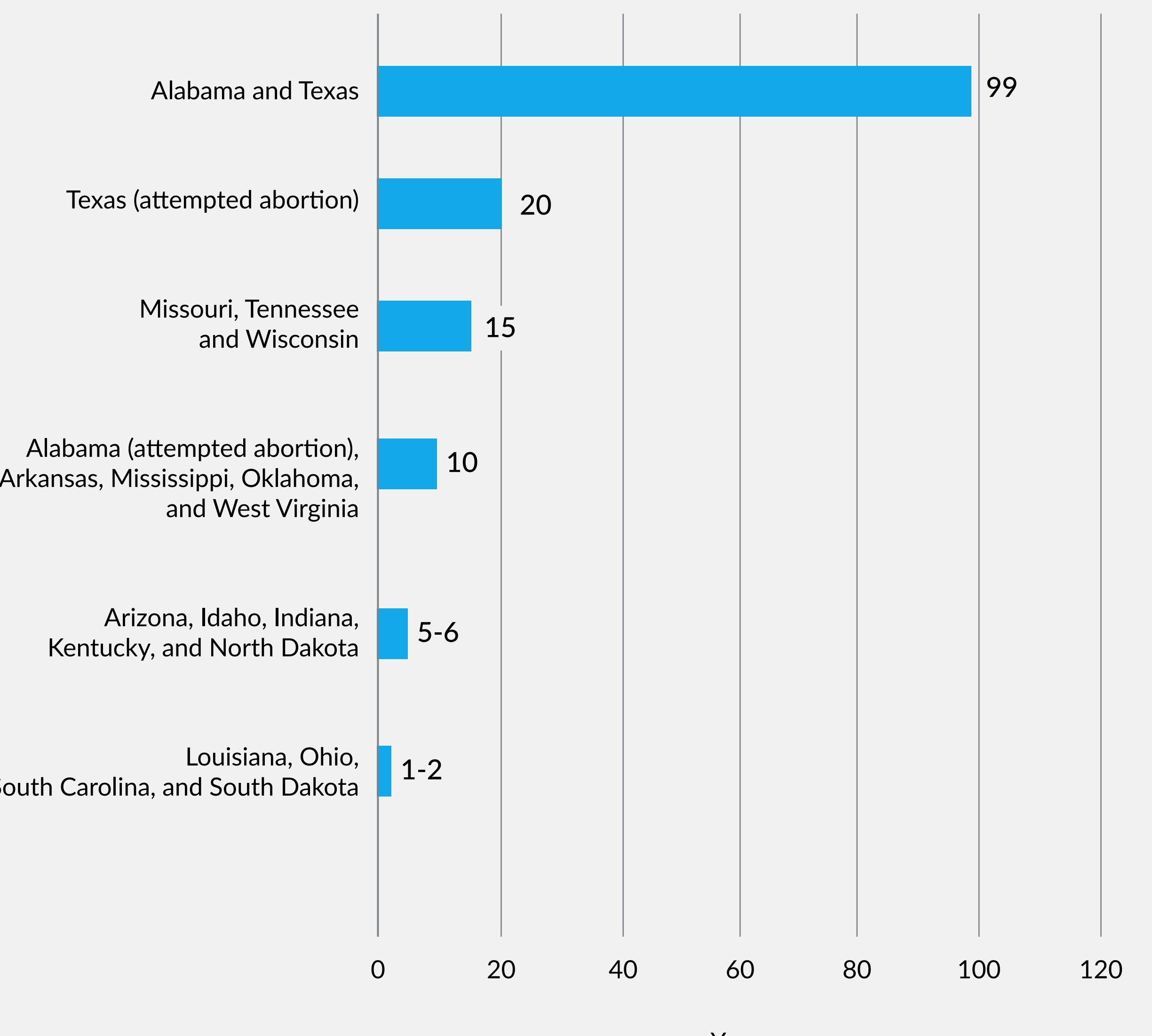
Importantly, in most of the criminal bans on abortion, permitted abortions are stated as exceptions to the ban, which effectively leaves the state with the burden of proof. In states like Idaho and North Dakota, however, the law does not include express exceptions for legal abortions, but rather provides for them in the form of affirmative defenses to enforcement. By using the term affirmative defense, the state shifts the burden of proof from the state to the person charged with the crime.

1. 142 S. Ct. 2228 (2022). 2. 410 U.S. 113 (1973). 3. 505 U.S. 833 (1992). 4. Ala. Code § 26-23H-4. 5. Ark. Code Ann. § 5-61-304. 6. Idaho Code § 18-622. 7. Ind. Code Ann. § 16-34-2-1. 8. Ky. Rev. Stat. Ann. § 311.772. 9. La. Rev. Stat. Ann. § 40:1061. 10. Miss. Code Ann. § 41-41-45. 11. Mo. Rev. Stat. § 188.017. 12. N.D. Cent. Code § 12.1-31-12. 13. Okla. Stat. tit. 63, § 1-731.4. 14. S.D. Codified Laws § 22-17-5.1. 15. Tex. Health & Safety Code Ann. § 170A.002. 16. Utah Code Ann. § 76-7a-201. 17. W. Va. Code Ann. § 61-2-8. 18. Wyo. Stat. Ann. § 35-6-102. 19. *See, e.g.*, Ark. Code Ann. § 5-61-304; Ky. Rev. Stat. Ann. § 311.772. 20. *See, e.g.*, Ohio Rev. Code Ann. § 2919.192; S.C. Code Ann. § 44-41.680; Tenn. Code Ann. § 39-15-216; Wis. Stat. § 940.04.

21. Ky. Rev. Stat. Ann. § 311.722. 22. https://www.justice.gov/opa/press-release/file/1523481/download. 23. *See* Idaho Code § 18-622; Ind. Code Ann. §§ 16-18-2-327.9, 16-34-2-1(a).

Criminal Penalties

States also vary widely when it comes to the criminal penalties imposed for an illegal abortion. Depending on the state, a person may be fined anywhere from $1,000 to $100,000. In addition to monetary penalties, a provider's license is also at risk. And, depending on the state, a person convicted of an illegal abortion may face the possibility of incarceration anywhere from a few months to life in prison, as follows:



> Most of the laws criminalizing abortion are targeted at the providers who perform or attempt to perform an abortion…

It remains to be seen whether and under what circumstances states and courts will impose maximum sentences or penalties against convicted offenders.

Targets for Abortion Laws; Potential Aiding and Abetting Liability

Most of the laws criminalizing abortion are targeted at the providers who perform or attempt to perform an abortion, with several states, like Arkansas, Idaho, and Indiana, expressly excluding women who are pregnant from criminal liability.[24] Certain states, like Texas and Oklahoma, include express provisions in their statutes for civil or criminal penalties for those who aid and abet an abortion. In other states, general principles of criminal law may give rise to criminal charges for aiding and abetting, conspiring to commit a crime, or being an accessory to the crime. While such theories remain untested under these laws, it is reasonable to expect that these theories could be used to impute liability against a wide range of actors, including:

- Employers who provide travel benefits to employees for purposes of obtaining an abortion in another state where it is legal
- Employers who provide the means for an employee to obtain abortion medication outside their state of residence, but who ingest the medication in the state in which such abortion is illegal
- Health plans that cover the cost of abortion drugs or procedures
- Individual directors, officers, and other senior leadership involved in making the foregoing decisions
- Hospital administrators and clinical or nonclinical staff involved in the performance of or otherwise provide assistance in connection with an illegal abortion

24. *See, e.g.*, Ark. Code Ann. § 5-61-304(c)(1); Idaho Code § 18-622(5); Ind. Code Ann. §§ 16-34-2-7(d)–(e), 35-42-1-6(a)(1).

There is a strong argument that the application of state laws to interfere with interstate travel would violate the interstate commerce clause of the Constitution, as highlighted by Justice Brett Kavanaugh's concurring opinion in *Dobbs*, in which he answered the rhetorical question whether a state may bar its residents from traveling to another state to obtain an abortion with, "In my view, the answer is no based on the constitutional right to interstate travel."

Nonetheless, in the short term, employers, plans, and providers should monitor state legislative activity to identify newly enacted (or revived) criminal sanctions potentially applicable to abortion-related travel. Likewise, they should also monitor state enforcement of those new and pre-*Roe* criminal sanctions.

Broader Implications of Criminalizing Abortion

In addition to liability under applicable state law, there are several additional, and at times competing, legal considerations that should be weighed in evaluating potential legal liability for providers and healthcare organizations:

- **Other state criminal laws.** In states with restrictive anti-abortion statutes, physicians may delay medical treatment of women who are pregnant out of fear of violating the relevant anti-abortion law as long as the woman's life is not currently in danger. If the woman is hospitalized, intentionally depriving that woman of medical care while she is an inpatient and unable to seek care elsewhere may give rise to other criminal charges, such as reckless endangerment, if that woman dies as a result.
- **Liability across state lines.** Certain states, like Texas, are aggressively seeking to enforce abortion bans against out-of-state residents who aid or assist residents of their state in obtaining abortions, whether because such out-of-state residents helped fund travel expenses, provided abortion-related counseling via telehealth, or engaged in other activity with the intention of facilitating an abortion. States like New York and Connecticut have adopted laws that attempt to shield their residents from such liability, but those laws have not been tested by the courts.[25] This is likely to be an issue that plays out in the courts as states test the limits of their ability to enforce their laws beyond their borders.
- **Interaction with federal laws.** Federal laws, such as EMTALA, and federal civil rights and anti-discrimination laws, may preempt certain state anti-abortion laws or narrow their application. For example, as noted above, the U.S. Department of Justice recently challenged the Idaho anti-abortion law on the basis that it conflicts with EMTALA's requirement that emergency medical treatment must be provided to all patients of a hospital that participates in the Medicare program.
- **Malpractice liability insurance.** Most medical malpractice and professional liability insurance policies exclude coverage for criminal conduct. Any claims brought against the physician or hospital for medical malpractice with respect to the fetus could be excluded from coverage.
- **Indemnification obligations.** While it is not possible to indemnify individuals against potential imprisonment, contractual provisions and indemnification policies may exist (or be adopted) that indemnify providers, executives, directors and officers, and employees for actions taken in such capacity from certain monetary losses arising from an action brought under these statutes. These obligations may be subject to limitations, such as the requirement that the individual's conduct was otherwise consistent with the standards of care, policies and procedures of the hospital or practice, and determined to be lawful.

Related Content

For the current status of abortion laws in each of the 50 states and the District of Columbia, see

STATE ABORTION LAWS TRACKER AFTER *DOBBS V. JACKSON WOMEN'S HEALTH ORGANIZATION*

For more information on the Dobbs decision and its impact on healthcare, as well as on other areas of law, like employee benefits, insurance, labor and employment, and tax, see

***DOBBS V. JACKSON WOMEN'S HEALTH ORGANIZATION* RESOURCE KIT**

For an explanation on the of guidance provided to hospitals by the U.S. Department of Health and Human Services regarding the provision of abortion services in emergency situations, see

HOSPITALS MUST PROVIDE EMERGENCY ABORTION CARE, FEDS SAY

For an analysis regarding state restrictions of abortion medications and health plan coverage of medication abortion, respectively, see

CAN STATES LEGALLY BAN FDA-APPROVED ABORTION PILLS?

For a discussion of medication issues facing employer-provided health plans in the wake of the Dobbs decision, see

MEDICATIONS FOR PREGNANCY TERMINATION IN A POST-*DOBBS* WORLD

For an article that addresses issues that healthcare providers should consider relating to prescribing abortion-inducing medication when utilizing telemedicine modalities, see

MEDICATION ABORTION, TELEMEDICINE, AND *DOBBS*—KEY CONSIDERATIONS FOR HEALTHCARE PROVIDERS

For recommendations on items that employer health plan sponsors should review with their employee benefits counsel as a result of Dobbs, see

ACTION ITEMS PLAN SPONSORS SHOULD CONSIDER IN THE WAKE OF THE U.S. SUPREME COURT *DOBBS* DECISION ON ABORTION

25. *See, e.g.*, N.Y. Crim. Proc. Law §§ 140.10, 570.17; H.R. (Conn.) 5414, 2022 Gen. Assemb., Feb. Sess.

Beyond the legal risks, severe penalties and vaguely drafted laws may create challenges and barriers to women's healthcare, including, but not limited to:

- Hospitals may find it challenging to staff obstetrics departments, which may in turn reduce access to quality maternal and reproductive healthcare within the state.
- Women who are or may become pregnant may find it difficult to obtain medication for unrelated conditions such as chemotherapy, or treatment of autoimmune disorders like lupus and rheumatoid arthritis, that present or could present a risk to a pregnancy.
- Pregnant women may face new barriers to care as physicians hesitate to provide any treatment or prescribe any medication that could lead to the termination of a pregnancy.

Each of these challenges will need to be navigated in the months and years to come.

Potential Chilling Effect on Women's Healthcare

In the period between *Roe* and *Dobbs*, states had adopted various laws restricting and limiting access to abortions, but there was at least a common baseline that created some degree of uniformity across state lines. In the wake of *Dobbs*, that common thread has been eviscerated, and the landscape today is subject to significant upheaval as these criminal statutes are challenged in the courts and by federal agencies. Given the rapidly evolving legal landscape, the ultimate impact of the criminalization of abortion has not yet been fully realized, but it is reasonable to expect that there will continue to be a chilling effect on measures to protect women's health in the states where the penalties are severe, and the restrictions are broad and sweeping.

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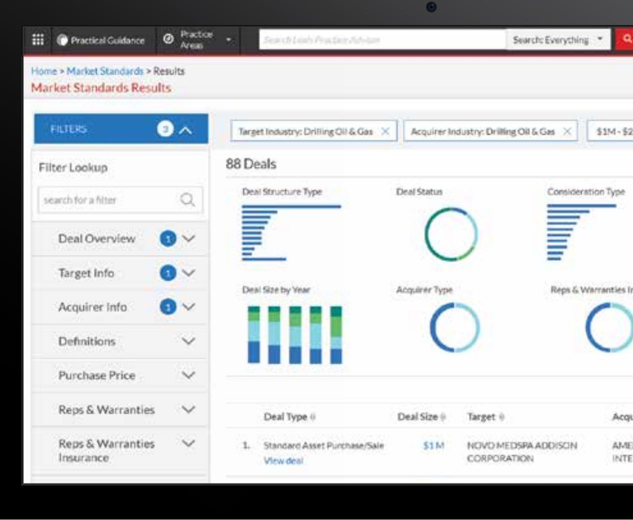
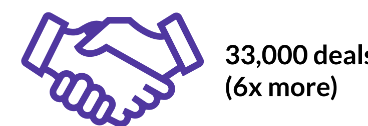


COMPARED TO OTHER OFFERINGS*



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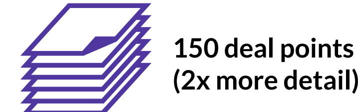

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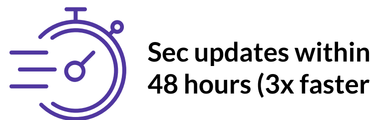

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Medication Abortion, Telemedicine, and *Dobbs*—Key Considerations for Healthcare Providers

The U.S. Supreme Court's recent decision in *Dobbs v. Jackson Women's Health Organization*[1] has impacted access to abortion in the United States. In light of the Court's decision, which returned the right to enact laws regarding reproductive healthcare to the states, many healthcare providers are navigating available ways to provide abortion services to patients, including by utilizing innovative telemedicine care modalities.

HEALTHCARE PROVIDERS MUST COMPLY WITH MULTIPLE and sometimes conflicting state laws when providing abortion-related services utilizing telemedicine. This article will address several issues that healthcare providers should consider relating to prescribing abortion-inducing medication utilizing telemedicine modalities. This article will highlight several states' laws to examine relevant legal and practical considerations for providers interested in providing medication abortions via telemedicine.

Terminating Pregnancy by Medication

A medication abortion and administering an abortion-inducing drug are terms that are used to describe the process whereby a patient is prescribed a medication that will end a pregnancy. As described in more detail below, the federal Food and Drug Administration (FDA) has approved a medication protocol that will safely terminate a pregnancy within the first nine weeks of pregnancy. The FDA-approved protocol for medication abortion involves taking two medications and does not require a procedure performed by a clinician. However, the protocol is subject to many of the same restrictions as other abortion methods, at both the state and federal levels. State law restrictions can be particularly burdensome, and, in some cases prohibitive, for virtual-based providers that do not have physical clinic locations in a particular state.

1. 142 S. Ct. 2228 (2022).

Federal and State Abortion Laws Pre-*Dobbs*

When considering how to provide abortion services, healthcare providers must consider both federal and state laws and regulations that apply to the service. Prior to *Dobbs*, Supreme Court precedent provided federal protection to an individual's ability to obtain an abortion prior to viability of a fetus. In *Roe v. Wade*,[2] the Court held that abortion was within the scope of the personal liberty guaranteed by the U.S. Constitution's Due Process Clause of the 14th Amendment, and that an individual had a right to obtain an abortion in the first trimester of pregnancy.

In *Planned Parenthood of Southeastern Pennsylvania v. Casey*,[3] the Court affirmed an individual's right to an abortion but modified the legal framework in evaluating laws that restricted abortion. The standard announced in *Casey* was that states could implement abortion restrictions as long as the purpose or effect of the laws did not place an undue burden on obtaining an abortion.

During the time that *Roe* and *Casey* were in effect, Congress did not pass a federal law to protect an individual's right to an abortion, and the Constitution was not amended to specify this right. The recent decision in *Dobbs* reversed the precedent established by *Roe* and *Casey* and determined that the Constitution does not confer a right to abortion. As a result, there is no longer a federal legal doctrine protecting the right to an abortion.

Federal Regulation of Abortion Medications

While there is no federal law affirming a right to an abortion, federal agencies have nonetheless approved the use of abortion-inducing drugs. These agency approvals, and their regulatory underpinnings, are an essential part of the consideration a provider must undertake when delivering medication abortion services. The FDA has approved a two-medication regimen of mifepristone and misoprostol to end a pregnancy through 70 days gestation (i.e., 70 days or less since the first day of the woman's last menstrual period).[4] When this regimen was first approved, the FDA adopted a Risk Evaluation and Mitigation Strategy (REMS) for mifepristone which, among other things, limited dispensing of mifepristone to patients in certain healthcare settings (clinics, medical offices, and hospitals) under the supervision of a certified prescriber.[5]

On December 16, 2021, the FDA issued modifications to the mifepristone REMS that removed the in-person dispensing requirement and added provisions allowing mifepristone to be dispensed by certified pharmacies and through the mail. These changes will take effect after the medication's manufacturers submit proposals to the FDA regarding how to implement the REMS modifications, and the FDA reviews and approves those submissions. Although the in-person dispensing requirements have ostensibly been lifted, the FDA still limits prescribing and dispensing authority to certified prescribers and pharmacies.

2. 410 U.S. 113 (1973). 3. 505 U.S. 833 (1992). 4. https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information. 5. https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020RemsR.pdf.

When telehealth technology is used for a patient exchange, the care is considered to be rendered in the state where the patient is located. This means ... an individual provider needs to be licensed in the state where the patient is located...

As discussed in more detail below, healthcare providers must comply with applicable state laws relating to dispensing and prescribing abortion-inducing drugs. There are unsettled questions as to whether those state laws are preempted by the FDA's approved REMS for this medication.

To ensure compliance with federal law, healthcare providers interested in prescribing abortion-inducing drugs must be certified by one of the two mifepristone drug manufacturers. In addition, the providers will need to consider several aspects of state law pertaining to abortion services, as discussed in more detail below.

Compliance with State Telemedicine Laws

When telehealth technology is used for a patient exchange, the care is considered to be rendered in the state where the patient is located. This means that, in most cases, an individual provider needs to be licensed in the state where the patient is located in order to provide care to that patient. Similarly, the laws of the state where the patient is located will govern the informed consent process, the standard of care for the encounter, and any telemedicine-specific laws that a state may have adopted.

Definitions of Abortion

Healthcare providers will need to know the state laws that apply to abortions in the state where the patient is located. Most state laws define an abortion to include prescribing a medication with the intent of terminating a pregnancy. For example, North Carolina defines an abortion in part to include the use or prescription of any "instrument, medicine, drug, or other substance or device" to terminate a woman's pregnancy.[6]

Prohibitions on Abortion

If a provider is interested in prescribing an abortion-inducing drug, it is important to know whether an abortion can generally be performed in the state. In the wake of *Dobbs*, the legal status of abortion care in several states is in flux. Multiple states have so-called trigger laws prohibiting or significantly restricting abortion that have gone, or will go, into effect following the *Dobbs* decision. Other states have laws that prohibited abortion prior to the Supreme Court's decision in *Roe* (sometimes referred to as zombie laws). During the period of time when *Roe* and *Casey* were in effect, states could not enforce their pre-*Roe* laws universally prohibiting abortion in the state. Many states did not formally repeal those unenforceable laws from state statutes, however, and with the *Dobbs* decision, those state laws are now potentially enforceable. In addition, abortion laws in several states are temporarily enjoined by court order, or state actors are exercising enforcement discretion and adopting policies on how the law will be applied in the state. It is important for healthcare providers to confirm that an abortion may be provided to a patient in a particular state in general, prior to exploring the option for prescribing an abortion-inducing drug to the patient.

Limitations on Medication Abortions

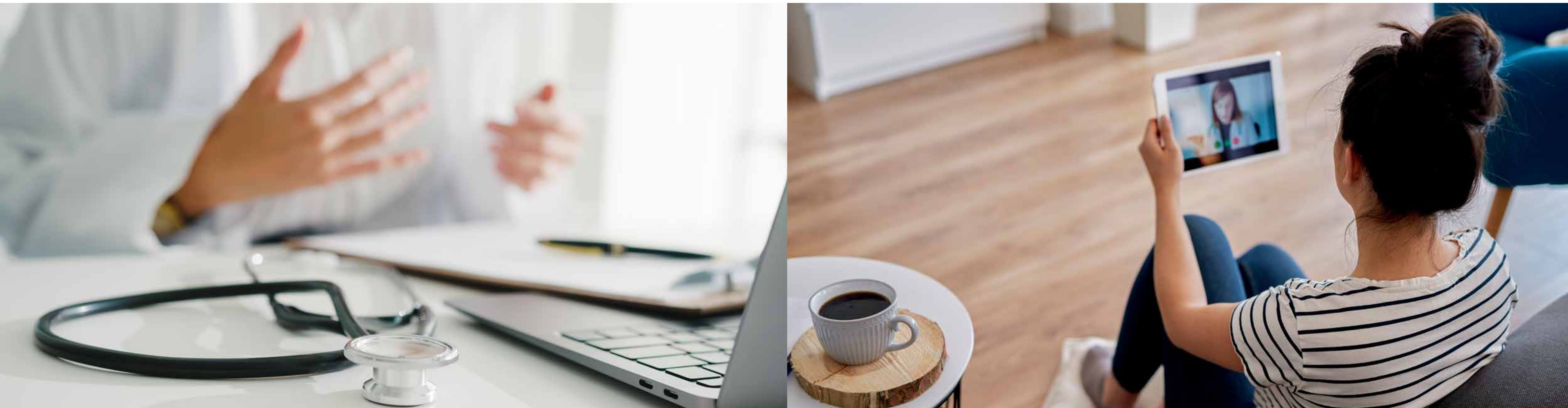
Assuming that abortions can legally be provided in the state, healthcare providers will then need to consider whether there are limitations to the modality that can be utilized to provide abortion-inducing medication. This is particularly important for providers using telemedicine to engage with patients, as there are several state laws that could limit this modality for abortion care. The limitations on utilizing telemedicine to prescribe abortion medication may appear in a variety of state laws.

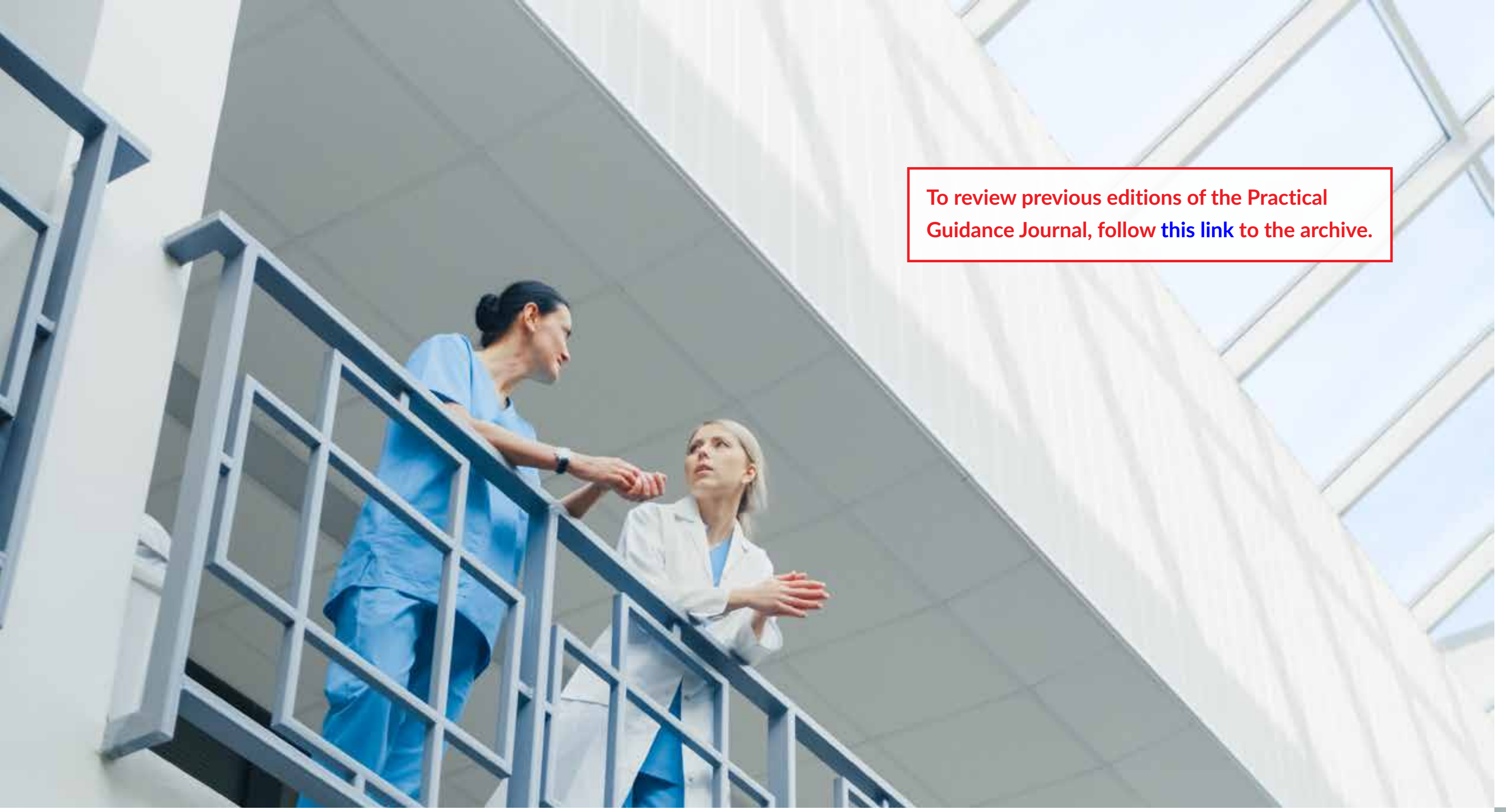
Some states, such as Kansas, explicitly prohibit the use of telemedicine modalities to provide abortion services.[7] Other states, such as Wisconsin, implicitly prohibit or restrict use of telemedicine modalities by requiring an initial dose of mifepristone or other abortion-inducing drug to be administered to the patient in the same room and in the physical presence of the physician who prescribed the medication.[8] Additionally, many states require an ultrasound be performed prior to an abortion or require in-person components to the abortion informed consent process. For example, Arizona requires both a pre-abortion ultrasound and that the provider meet in person with the pregnant woman to explain the procedure before the abortion can be performed.[9]

These types of state laws also serve as de facto limitations on utilizing telemedicine to prescribe abortion-inducing medication, because they require some level of service or care to be provided in person.

6. N.C. Gen. Stat. § 90-21.81(1).

7. Kan. Stat. Ann. § 40-2,215. 8. Wis. Stat. § 253.105(2). 9. Ariz. Rev. Stat. §§ 36-2153(A), 36-2156(A)(1)(a).





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Additional Restrictions on Patients and Prescribers

Providers must also take into account whether the laws in a particular state place other restrictions on abortion-inducing medication that impact care delivery. Many states only allow a physician to prescribe an abortion-inducing drug, even though other allied health professionals may be authorized to prescribe medication in the state. For example, Nebraska only allows physicians to prescribe an abortion-inducing drug,[10] even though Nebraska allows physician assistants and nurse practitioners to prescribe medication in other contexts.[11] This means that if a healthcare provider utilizes allied health professionals as part of routine care, those providers could not prescribe medication for abortions, and patients would need to have an appointment with a physician for this service.

Because abortions are usually defined to include prescribing medication to cause a pregnancy termination, providers also must comply with the detailed informed consent requirements for obtaining an abortion in the state. These informed consent requirements can include waiting periods, an obligation to provide information about the physical and psychological risks of an abortion, and information about child support options.[12] Some state laws require providers to give patients specific information about abortion-inducing medication, including the possibility of reversing the effects of mifepristone.[13]

Related Content

For an analysis regarding state restrictions of abortion medications and health plan coverage of medication abortion, respectively, see

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MEDICATIONS FOR PREGNANCY TERMINATION IN A POST-*DOBBS* WORLD

For an up-to-date summary of abortion laws in each of the 50 states and the District of Columbia, see

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For more information on the Dobbs decision and its impact on healthcare, as well as on other areas of law, including employee benefits, insurance, labor and employment, and tax, see

***DOBBS V. JACKSON WOMEN'S HEALTH ORGANIZATION* RESOURCE KIT**

10. Neb. Rev. Stat. Ann § 28-335(1). 11. Neb. Rev. Stat. Ann. §§ 38-2055, 38-2315(2)(c). 12. E.g., Wis. Stat. § 253.10(3)(c)(1)(f), (c)(2)(b). 13. E.g., Mont. Code Ann. § 50-20-707(5)(f).

Conclusion: Staying Apprised of Changes to State Laws

In summary, there are many considerations that healthcare providers must assess and comply with when providing medication abortion services using telemedicine modalities. State laws restricting abortion in general and medication abortions in particular may have been in place prior to the *Dobbs* decision. After *Dobbs*, providers desiring to enter into this space will not only have to consider existing state law restrictions on this service, but they will also have to regularly keep track of whether abortions can be obtained in the state. Although there may be some uncertainty as to how this will develop, in the meantime healthcare providers in this space will need to be extremely cognizant of the legal requirements for abortion care in the state or states in which they are operating.

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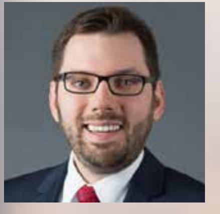

Eric W. Gregory DICKINSON WRIGHT PLLC

Reproductive Healthcare Issues for Employers: Privacy Issues

This article addresses privacy issues faced by employers following the U.S. Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization.*[1]

AFTER THE U.S. SUPREME COURT RULING IN *DOBBS* overruling the constitutionally protected right to an abortion, federal agencies have issued guidance intended to help protect the privacy of patients. Employers should carefully consider this guidance because it impacts their responsibilities as a sponsor of a group health plan and the privacy rights of their employees.

This article summarizes the Department of Health and Human Services (HHS) Office for Civil Rights (OCR) guidance and highlights the most critical elements for employers.

HHS Guidance under the Health Insurance Portability and Accountability Act (HIPAA)

On June 29, 2022, OCR issued new guidance[2] to protect patients seeking reproductive healthcare, as well as their providers. In general, this guidance does two things:

1. It addresses how federal law and regulations protect an individual's private medical information (protected health information or PHI under HIPAA) related to abortion and other sexual and reproductive health care—making it clear that providers are not required to disclose private medical information to third parties such as law enforcement.
2. It addresses the extent to which private medical information is protected on personal cell phones and tablets.[3] It also provides tips for protecting an individual's privacy when using period trackers and other health information apps.

HIPAA Privacy Protections Related to Reproductive Laws and Law Enforcement

OCR administers and enforces the HIPAA Privacy Rule (Privacy Rule), which establishes the requirements concerning the use, disclosure, and protection of PHI by covered entities (including group health plans and most health providers), and, to some extent, their business associates. These entities may use or disclose PHI without an individual's signed authorization, only as expressly permitted by the Privacy Rule.

Disclosures Required by Law

The Privacy Rule permits but does not require covered entities to disclose PHI about an individual without the individual's authorization when such disclosure is required by another law, and the disclosure complies with the requirements of the other law. This permission to disclose PHI as required by law is limited to "a mandate contained in law that compels an entity to make a use or disclosure of PHI and that is enforceable in a court of law." Further, where a disclosure is required by law, the disclosure is limited to the relevant requirements of such law.

Example: An individual goes to a hospital emergency department while experiencing complications related to a miscarriage during the tenth week of pregnancy. A hospital workforce member suspects the individual of having taken medication to end their pregnancy. State or other law prohibits abortion after six weeks of pregnancy but does not require the hospital to report individuals to law enforcement. Where state law does not expressly require such reporting, the Privacy Rule would not permit disclosure to law enforcement under the required by law permission. Therefore, such a disclosure would be impermissible.

1. 142 S. Ct. 2228 (2022). 2. *HIPAA Privacy Rule and Disclosures of Information Relating to Reproductive Health Care*, Health Information Privacy, U.S. Department of Health & Human Service. 3. *Protecting the Privacy and Security of Your Health Information When Using Your Personal Cell Phone or Tablet*, Health Information Privacy, U.S. Department of Health & Human Service.

...state fetal homicide laws generally do not penalize the pregnant individual and "appellate courts have overwhelmingly rejected efforts to use existing criminal and civil laws intended for other purposes . . . as a basis for arresting, detaining or forcing interventions on pregnant" individuals.

Disclosures for Law Enforcement Purposes

The Privacy Rule permits but does not require covered entities to disclose PHI about an individual for law enforcement purposes "pursuant to process and as otherwise required by law," under certain conditions. For example, a covered entity may respond to a law enforcement request made through legal processes such as a court order or court-ordered warrant, subpoena, or summons by disclosing only the requested PHI—provided that all of the conditions specified in the Privacy Rule for permissible law enforcement disclosures are met.

In the absence of a mandate enforceable in a court of law, the Privacy Rule's permission to disclose PHI for law enforcement purposes does not permit a hospital or other healthcare provider's workforce member to report an individual's abortion or other reproductive healthcare to law enforcement. That is true whether the workforce member initiated the disclosure to law enforcement or others or the workforce member disclosed PHI at the request of law enforcement. This is because, generally, state laws do not require doctors or other healthcare providers to report an individual who self-managed the loss of a pregnancy to law enforcement. Also, state fetal homicide laws generally do not penalize the pregnant individual, and "appellate courts have overwhelmingly rejected efforts to use existing criminal and civil laws intended for other purposes (e.g., to protect children) as the basis for arresting, detaining, or forcing interventions on pregnant" individuals.[4]

Example: A law enforcement official presents the sponsor of a group health plan with a court order requiring the plan to produce PHI about individuals who have obtained an abortion. Because a court order is enforceable in a court of law, the Privacy Rule would permit but does not require the group health plan to disclose the requested PHI. The group health plan may only disclose the PHI expressly authorized by the court order if it chooses to comply with the order.

[4] *HIPAA Privacy Rule and Disclosures of Information Relating to Reproductive Health Care.*

Disclosures to Avert a Serious Threat to Health or Safety

The Privacy Rule permits but does not require a covered entity, consistent with applicable law and standards of ethical conduct, to disclose PHI if the covered entity, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and the disclosure is to a person or persons who are reasonably able to prevent or lessen the threat. According to major professional societies,[5] including the American Medical Association and American College of Obstetricians and Gynecologists, it would be inconsistent with professional standards of ethical conduct to make such a disclosure of PHI to law enforcement or others regarding an individual's interest, intent, or prior experience with reproductive healthcare.

Example: A pregnant employee in a state that bans abortion informs the claims administrator of a group health plan that they intend to seek an abortion in another state where abortion is legal. An employee of the claims administrator, a business associate of the group health plan, wants to report the statement to state law enforcement to attempt to prevent the abortion. The Privacy Rule would not permit this disclosure of PHI to law enforcement under this permission because, according to HHS, a statement indicating the intent to obtain a legal abortion is "not a serious and imminent threat to the health and safety of a person or the public," would be inconsistent with the professional ethical standards, and may increase the risk of harm to the employee. Therefore, such a disclosure would be impermissible.

[5] *Decriminalization of Self-Induced Abortion*, American College of Obstetricians and Gynecologists.

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For guidance on whether expenses relating to abortion may be reimbursed from a health flexible spending account (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), see

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For a discussion of the HIPAA rules that impact employers and the group health plans they sponsor, see

HIPAA PRIVACY, SECURITY, BREACH NOTIFICATION AND OTHER ADMINISTRATIVE SIMPLIFICATION RULES

For a description of the impact of the Mental Health Parity and Addiction Equity Act and related provisions of the Affordable Care Act on employers providing behavioral health benefits through group health plans, see

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For an extensive review of the interpretation and implementation of the Pregnancy Discrimination Act, see

PREGNANCY DISCRIMINATION ACT: COMPLIANCE TIPS

HIPAA Generally Does Not Protect Privacy or Security of Health Information on Apps

Generally, the HIPAA rules only apply when PHI is created, received, maintained, or transmitted by a covered entity or a business associate. For example, HIPAA does not protect the privacy of an employee's internet search history, information that an employee voluntarily shares online, or their geographic location, unless the app is provided to the employee by a covered entity (such as the group health plan) or its business associate. HIPAA also does not protect the privacy of the data that an employee has downloaded or entered into mobile apps for personal use, regardless of the data source.

Although the HIPAA rules do not protect this information, employers may consider communicating with employees on steps that they can reasonably take to protect information when using a personal mobile device:

- Avoid downloading unnecessary or random apps
- Avoid, when asked, permitting access to a device's location data, other than apps where the location is absolutely necessary (e.g., navigation and traffic apps)

Although the steps described above can reduce a person's digital footprint, they will not eliminate it. The very nature of cell phones (and some tablets) permits tracking because the cellular service provider's network records identifying information (such as subscriber and device information) when connected to it.

Ultimately, the best way to protect health and personal information from being collected and shared without an individual's knowledge is to limit what personal information is sent and stored with a device.

Conclusion

Much of the guidance issued by HHS should be welcome news for employers, who may be concerned about the specter of local law enforcement officials requesting protected private data about their employees' healthcare. Nevertheless, these interpretations provided by HHS come in the form of sub-regulatory guidance, so the Biden Administration (or a new administration) could change its views on these issues quickly. In particular, one can easily imagine a different administration taking a very different view on whether abortion "is a serious and imminent threat to the health and safety of a person or the public." Employers will need to carefully keep abreast of developments in this area.

Also, listen to this podcast episode where Eric Gregory discusses additional employee benefits issues following the *Dobbs* decision. L

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Dobbs and Employee Benefits Issues

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Evandro C. Gigante PROSKAUER ROSE LLP

Employers React to the *Dobbs* Opinion Podcast

This podcast episode discusses the U.S. Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*, as decided by the Court on June 24, 2022.[1]

IN TEXAS AND OKLAHOMA, ABORTION IS NOW A CRIME. In other states, it remains legal. For companies working across state lines, the variances from state to state have created many employment issues that immediately require counsel from Labor & Employment (L&E) attorneys. In this episode, Proskauer Labor & Employment partner Evandro C. Gigante discusses sensitive employment issues following the decision in *Dobbs*.

1. *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228 (2022).

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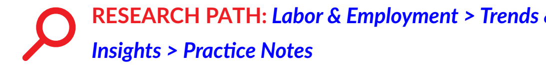
ABORTION ACCESS EMERGING AS UNION ISSUE POST-*ROE*

Here is an excerpt from the podcast:

> From an employment perspective, I've been looking at it mainly through the lens of employers looking to navigate the *Dobbs* decision, and again, avoid the risk of claims of discrimination or other mistreatment by employees based on whatever policies or procedures the company is planning to put into place. So part of that of course entails whether and how an employer can put into place policies that provide certain benefits for employees looking to have an abortion, but are unable to do so in the state in which they live and work. And likewise, whether providing those benefits, either one, could create some risk of a potential discrimination claim. Or two, just in terms of the employer's communication of its position and stance on abortion or employees doing the same, could create risk within the workplace involving claims of discrimination or harassment arising out of things such as pregnancy, religion, or all the other protected categories that touch upon this particular topic.

For additional guidance on issues related to social media concerns, employers operating across many states, and other *Dobbs* decision issues, follow the link below to listen to the complete podcast.

__Evandro C. Gigante__ is a partner in the Labor & Employment Law Department at Proskauer Rose LLP, and co-head of the Employment Litigation & Arbitration group and the Hiring & Terminations group. He represents clients on a variety of labor and employment matters, including allegations of sexual harassment, race, gender, national origin, disability, and religious discrimination. Evandro also counsels employers through reductions-in-force and other sensitive employment issues. Most recently, Evandro has developed expertise on, and represented clients in, various COVID-19 related matters, including those involving compliance with health and safety standards, the need to provide workplace accommodations and the ability to test and/or vaccinate the workforce.



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The Lexis Practical Guidance Attorney Team

Insurance Issues after *Dobbs*: **Fundamental Considerations**

This article is part of a series discussing the United States Supreme Court decision that reversed *Roe v. Wade*,[1] and its significant impacts on insurance.

THE REVERSAL OF *ROE*—OFTEN CITED AS THE 40-PLUS-year-old precedent holding that there is a federal constitutional right to obtain an abortion—came in the June 24, 2022, decision in *Dobbs v. Jackson Women's Health Org.*[2] *Dobbs* also effectively overruled *Planned Parenthood of Southeastern Pennsylvania v. Casey*,[3] which followed *Roe*. The immediate impact of *Dobbs*, within hours of its issuance, was a public uproar over a perceived dismantling of nearly 50 years of precedent woven into the social fabric of generations of Americans. But the impacts are widespread—and in less obvious places—like insurance.

The insurance industry and persons involved in it, insurance entities of all types, less-conventional risk-bearing structures, and occupations that *Roe* touched must be alert to the changes wrought by *Dobbs*, made ready to react, and counseled on how to adapt. Attorneys will need to guide many of their clients on how they should conduct their businesses and acclimate themselves to this potentially momentous change in the insurance landscape.

Overview of *Dobbs* and the Mississippi Gestational Age Act

The context of *Dobbs* was a challenge to the constitutionality of Mississippi's Gestational Age Act.[4] The challengers contended that the Mississippi statute violated *Roe* by imposing more stringent limitations on when and the circumstances under which an elective abortion could be had. Specifically, the law provided that except in a medical emergency, severe danger to maternal health, or in the event of a severe fetal abnormality, no one could perform, induce, or attempt to perform or induce an abortion after 15 weeks of gestation. The statute defined terms including abortion, conception, gestation, gestational age, medical emergency, and severe fetal abnormality.

The Mississippi statute recited factors upon which the legislature relied in implementing the abortion limitations. They included:

- That the United States is one of only seven countries that permits elective abortions after the 20th week of gestation except, in most cases, to preserve the health of the mother
- Factors related to advanced and recent scientific knowledge about prenatal development, such as pre-birth physiological function, movement, and reaction to outside stimuli
- The State's "important and legitimate interest in protecting the potentiality of human life" as stated in *Roe*, and that "the State has an interest in protecting the life of the unborn" as held in *Casey*
- The procedures used to perform abortions, which the legislature characterized as "barbaric," dangerous for the maternal patient, and demeaning to the medical profession if used for nontherapeutic or elective purposes
- That most obstetricians and gynecologists in Mississippi do not offer or perform nontherapeutic or elective abortions, and fewer offer dilation and evacuation procedures

The Supreme Court rejected the statutory challenge and upheld the Mississippi law. It found that Mississippi was within its rights to impose more stringent limitations on abortions than *Roe* or *Casey* provided. It did not, however, stray from its holding in those cases that states have important and legitimate interests in protecting life; indeed, that was integral to the *Dobbs* ruling.

1. 410 U.S. 113 (1973). 2. 142 S. Ct. 2228 (2022). 3. 505 U.S. 833 (1992). 4. Miss. Code Ann. § 41-41-191.

> Complexities can result because a plan may cover employees or members in several states....whether or not there is abortion coverage may vary by state depending on whether the state allows, prohibits or restricts abortion.

The Reasoning of *Dobbs*

The Supreme Court's decision was based essentially on a finding of faulty reasoning by the *Roe* court and that the reasoning was neither questioned nor corrected by the *Casey* court. The main points raised by the Supreme Court in *Dobbs* as the basis for overruling *Roe* rested in what might be considered a strict construction of the Constitution and included:

- No explicit right to abortion is found in the Constitution.
- A right to an abortion cannot be found within an individual's right to privacy nor within an amorphous right to liberty.
- There is no such right rooted in American history.
- The Due Process Clause of the 14th Amendment is unavailing because it protects only two classes of rights: those in the first eight amendments and those that are deemed fundamental rights but are not mentioned elsewhere in the Constitution. Fundamental rights are a group of rights that have been recognized by the Supreme Court as requiring a high degree of protection from government encroachment. They are specifically identified in the Constitution (especially in the Bill of Rights) or have been determined to exist as part of due process.
- Ordered liberty sets limits and defines boundaries between competing interests (i.e., favoring vs. opposing abortion). Citizens of states may evaluate those interests differently.
- The Mississippi law is supported by the state's findings that include its interest in protecting the life of the unborn. State health and welfare laws, such as those regarding abortion, are entitled to a strong presumption of validity and must be sustained if there is a rational basis for them. The Court found a rational basis and refrained from second-guessing the Mississippi legislature.

Beyond Mississippi

A Mississippi statute was involved in *Dobbs*. But significantly, many states restrict abortions irrespective of the *Dobbs* decision. Most contain exceptions when the mother's life is jeopardized, but many do not, except in cases of incest or rape. Other states have statutes prohibiting abortions that are set to be triggered within weeks or months after *Dobbs*. Some states have pre-*Roe* laws that can be reimplemented now that the *Dobbs* decision has been issued, and others are promulgating new statutes, some of which may be similar to Mississippi's. In all, nearly 50% of states have or will have prohibited or placed more restrictions on the ability to obtain an abortion.

Insurance Tumult Looms from the *Dobbs* Decision

Insurance tumult looms because of the *Dobbs* decision. How could a U.S. Supreme Court decision that is expected to result in nearly half of the jurisdictions in the nation prohibiting or restricting abortion not have a drastic impact on a state-based practice area? The effect of *Dobbs* cuts through the entire industry and across coverages.

Health Insurance Companies and Managed Health Care Plans

Health coverage may be the first kind of coverage that comes to mind when considering abortions. Although not all health plans cover it, many do. Because insurance is state-regulated, there is a patchwork of sometimes inconsistent state laws governing insurance. There can also be federal implications, such as Patient Protection and Affordable Care Act Marketplace plans, Medicaid regulations, and the Employee Retirement Insurance Security Act (ERISA), which make things even more complex.

The regulation of abortion also varies by state. The applicable law is usually statutory, with some states being more restrictive than others. Factors include the viability, health, and stage of development of the unborn and the health risk to the mother in continuing with the pregnancy. Nowhere is there an unfettered right to an abortion.

Each state also regulates insurance conducted within its jurisdiction. A few jurisdictions (California, Illinois, Maine, New York, Oregon, and Washington) mandate coverage for abortion in all private insurance policies. Nearly half of all states limit coverage to situations involving risk to the mother's health, fetal abnormality (as in the *Dobbs* decision), and other severe exigent circumstances. Currently, half of all states prohibit abortion coverage in insurance offered through insurance exchanges except when rape or incest has occurred or when the mother's life is jeopardized.

Dobbs returns to the states the right to determine the timing and circumstances under which an abortion may be had. That is, the states are no longer obliged to follow timelines or guidelines established by *Roe*. Private insurers may design their health plans to include, exclude, or provide limited or contingent benefits for abortion consistent with applicable state law. That fact underscores that while *Dobbs* overruled *Roe*, it had the overarching result of leaving to each state the power to regulate abortion and insurance for it as its legislature sees fit.

Employers

Much health insurance comes through employer-based group plans. Employer-sponsored group plans can be, and usually are, subject to ERISA. The plans can be fully-insured or self-funded. A fully-insured plan is one where a licensed insurer is financially responsible for the payment of claims.

Because of *Dobbs*, whether abortion services are covered or permitted and to what degree will depend on state law and the plan design. State insurance law is involved because insurance statutes may dictate that abortion benefits must be provided to some extent. The design of the plan is a factor because an employer, as a plan sponsor, is broadly free to offer the benefits that it desires.

Complexities can result because a plan may cover employees or members in several states. Therefore, whether or not there is abortion coverage may vary by state depending on whether the state allows, prohibits, or restricts abortion. Again, *Dobbs* removed the bright-line test for abortion that *Roe* and some of its progeny provided (trimesters and informed consent, for example) and replaced it with state autonomy about abortions. That state autonomy existed pre-*Roe*. Consequently, a lawyer representing a health insurer that issues group health insurance policies to employers that provide benefits for abortion must analyze the law of the states in which benefits will be offered and determine the circumstances when abortion is permissible, if at all. An existing policy or plan may need to be altered to comply with changes in state law resulting from *Dobbs* if the state changes its position on abortion. Stated otherwise, master policy forms (and certificates delivered to employees as evidence of coverage) may need changes in wording to clarify the extent of benefits available to the certificate holder if there are changes in state law concerning abortion.

In addition, since the scope of coverage may effectively be reduced, there can be other regulatory concerns, including about rates. Rates can become an issue because the rate initially charged may have included an element attributable to abortion benefits. If the benefit is eliminated, it might be argued that the rate should be reduced due to the removal. However, the abortion element of the rate may be *de minimus* so as not to warrant a dispute.

Self-Funded Group Health Plans

A self-funded group health plan is one where the plan's sponsor, usually an employer, a union, or another kind of bona fide group, is itself financially responsible for the payment of claims. Such plans are entirely governed by a body of federal law under ERISA. In contrast, an ERISA plan that an insurer funds is subject to dual regulation—a state insurance regulator governs the insurer funding the plan, and the federal government, by ERISA, governs the benefit plan itself. As such, self-funded group health plans can be more flexible than fully-insured group health plans in what they can cover or exclude because they are not subject to state-mandated coverage. A self-funded ERISA plan may or may not offer abortion benefits to members as it deems fit. Therefore, *Dobbs* should have less impact on fully self-funded plans.

Providers and Hospitals

The overturning of *Roe v. Wade* by the recent *Dobbs* decision and the resulting elimination of a federal constitutional right to abortion, however limited it may have been, has created a morass of problems for medical providers and hospitals that perform abortions.

The immediate outgrowth of *Dobbs* has been confusion among providers and hospitals regarding how to conduct themselves professionally while still upholding their responsibilities to patients. That confusion has existed since *Roe* was earnestly called into question. But it reached a fevered pitch with the leak of a draft of the *Dobbs* decision, made only worse by its final release.

Dobbs removes all predictability for providers and multistate hospitals and requires them to re-think their abortion policies based on the location of their facilities and practices. It also raises questions about their ability to transfer patients interstate to another hospital located where there are different, presumably stricter, abortion laws. What are the consequences if they do? If they don't? If the patient must have a prohibited procedure but cannot or does not get it due to the legal restrictions on abortion? How is the balance to be resolved between state abortion restrictions and the Emergency Medical Treatment and Labor Act?

Medical Malpractice Insurance

Exclusions for illegal or criminal acts are common in all types of insurance, medical malpractice included. Furthermore, insurers frequently take other adverse action against policyholders who engage in those acts, such as canceling an existing policy, refusing to insure in the future, limiting the breadth of future coverage by exclusions, or charging substantially higher premiums. To the extent that performing abortions may become illegal in more jurisdictions because of *Dobbs*, a provider who performs one is likely guilty of an unlawful or criminal act and rendered unable to obtain malpractice insurance. Because malpractice insurance is typically required to practice medicine or operate a healthcare facility, the provider may be unable to do so. In response, legislators in some states, like New York, have introduced legislation prohibiting insurers from taking adverse action against abortion providers who provide abortions to out-of-state patients.[5]

5. See 2021 NY S.B. 9080.

Individuals/Patients

While not detrimental reliance in the legal sense, in other ways, *Dobbs* has much changed patients' expectations and what they perceived as a right to a type of medical care based on the long-standing *Roe* rules. Immediately after the issuance of the opinion, many patients faced canceled appointments at private medical offices for scheduled abortions, including declinations of the procedure after arrival. Doors and windows were sometimes shuttered at abortion clinics serving patients with insurance and those who relied on public benefits for abortions. Hereafter, each state will be free to enact its own rules about abortion, limiting it as desired and unfettered by the dictates of *Roe*.

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For a look at the anticipated impact of the Dobbs *ruling on health insurance, see*

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Looking Ahead

In conclusion, the plethora of issues raised by *Dobbs* is boggling. They are both social and personal. They relate to the practice of medicine and the delivery of healthcare services. They relate to how healthcare services are financed, including by insurance. They relate to how businesses not directly related to either healthcare or insurance were run in the past and can be run henceforth. They relate to the interaction between individuals with other individuals, legal entities, and government. They relate to issues as yet unforeseen and perhaps foreseeable. What is predictable, however, is that as long as *Dobbs* remains the law, things will be different from what they have been for two generations.

The following article explores implications the *Dobbs* decision will have on health insurers and health insurance.

RESEARCH PATH: *Insurance > Trends & Insights > Articles*

The Lexis Practical Guidance Attorney Team

Insurance Issues after *Dobbs*: **Health Insurers and Health Insurance**

This article discusses the impacts that are anticipated on health insurance and health insurers as a result of the Supreme Court decision in *Dobbs v. Jackson Women's Health Org.*[1]

THAT CASE USED A MISSISSIPPI STATUTE AS THE VEHICLE to overturn the essence of *Roe v. Wade*[2] and, by implication, *Planned Parenthood of Southeastern Pennsylvania*.[3] The practical effect of *Dobbs* was to return to each state the power to determine the timing and circumstances under which an abortion could be obtained in that state. *Roe* had permitted a virtually unfettered right to abortion during the first trimester of pregnancy. *Casey* abandoned *Roe's* trimester framework and its strict scrutiny standard of review of state laws on abortion and replaced it with an undue burden test, yet followed the central holding of *Roe*.

The issues considered by the Supreme Court in *Dobbs* were the mechanism by which the Mississippi Gestational Age Act was enacted and whether there was a rational basis for passing it, even though the statute placed more stringent restrictions on abortion than *Roe*. The court found in favor of Mississippi on both counts.

The net result of upholding the challenge to the law was to overrule *Roe's* authorization of abortion as a constitutional right. Instead, it returned to each state the power to regulate abortion—as was the case before *Roe* was decided. More specifically, it returned to the citizens of each state the power to regulate abortion through the legislators they elected. Just like voters elected legislators and entrusted them with reflecting their interests concerning other laws, *Dobbs* returned the issue of abortion to the state legislators elected by the citizens of the state, which is where it had traditionally rested. Although *Dobbs* significantly changed the core holdings of *Roe* and *Casey*, it did not contradict their statements about the essential and valid state interest in protecting life, but rather echoed those statements.

The implications of *Dobbs* are wide-ranging, given the reliance of insurance consumers and the insurance industry on *Roe*. This article will address these developing issues.

The Anticipated Impact of *Dobbs* on Health Insurance

Whether you are a lawyer who practices in the area of insurance or are involved with insurance in some other way, *Dobbs* promises to have (and is already having) a significant effect on the insurance industry, especially in the context of health insurance.

Defining Health Insurance

Broadly, health insurance is a contract by which an insurer contracts with another party (an insured) to pay money because of an accident, sickness, hospitalization, or disability. Health insurance can be issued on either an individual basis (privately purchased and issued, for example, to cover a single individual or a family) or on a group basis (purchased and issued, for example, to cover the employees of an employer or members of a bona fide association). With group health insurance, other factors may come into play, such as the Employee Retirement Income Security Act, but those factors are beyond the scope of this discussion.

State Licensure and Regulation/Issuance of Health Insurance Policies after *Dobbs*

Health insurance policies are issued by insurers having licenses (certificates of authority) issued by states to issue that form of insurance. The companies may also be authorized to issue life insurance, disability insurance, annuities, and related risk-bearing products. A state's legislature may have joined all those types of insurance under a statutory umbrella called life and health insurance. However, a particular insurer may decide to issue only one or several, but not all, of the types of insurance that come under that umbrella.

The focus here relative to *Dobbs* is on health insurance, irrespective of what other specific types of insurance an insurer is authorized to or decides to write. More specifically, the focus is on that element of health insurance that provides a source of payment for expenses connected with hospital expenses, surgery, physicians, and other kinds of healthcare providers and their services. It is critical to emphasize that point because the insurance statutes of some states define health insurance to include what is more commonly called disability insurance. Disability insurance is intended to replace income if a covered illness, sickness, or injury occurs, and is not at issue here.

State Financial Regulation of Health Insurers

Depending on the jurisdiction where an insurer chooses to transact health insurance, state law imposes financial requirements to obtain and maintain a license (certificate of authority). The requirements include regulatory approval of the rates (from which premiums derive) to ensure that they are not inadequate, excessive, or unfairly discriminatory. Health insurers and other kinds of insurers must also meet statutory reserve and reinsurance requirements, to ensure the insurer's solvency and ability to pay claims as they are incurred.

The financial requirements are actuarial/mathematical and not subject to what might be considered popular vote. Instead, they are objective and based on calculable economic probabilities for paying expected claims under the health insurance policies. Those probable

1. 142 S. Ct. 2228 (2022). 2. 410 U.S. 113 (1973). 3. 505 U.S. 833 (1992).

claim amounts vary, in part, according to the benefits provided by the policy. Thus, a health insurer offering policies with fewer benefits can generally anticipate fewer claims, or at least claims with lower financial impact, because fewer benefits are provided, a reduced benefit is available, or some combination of those. As such, rates may be lower, translating into lower premiums than policies with greater benefits, and these are issues of hard financial calculation rather than a legislative mandate. Still, even when state law mandates coverage, such as coverage for elective abortion, the actuarial/financial cost of providing it is considered and factored into the rate ultimately charged. Therefore, either way, the financial regulation of health insurance isn't subjective or based on what might be regarded as being akin to the social desires of the public, as evidenced by laws legislators enact, like those regarding the availability of therapeutic abortion.

State Regulation of Health Insurance Policy Forms

In contrast to the objectivity of financial regulation of insurers is the regulation of policy contracts (usually called forms). State insurance regulators must approve policy forms that an insurer proposes to use. To obtain regulatory approval of a policy form, insurers must comply with general state law and state insurance law, some of which may mandate, permit, or prohibit coverages, exclusions, exceptions, and other limitations on benefits. Otherwise stated, the policy's provisions cannot circumvent state law or, in some cases, federal law.

The mechanism of form approval differs by state. The continuum ranges from a strict approach whereby a regulator must formally approve the policy before it can be used at all, to one so flexible that the form may be used until it is officially disapproved by the insurance regulator, irrespective of how long that may take. The middle ground is an approach involving an advanced filing of the proposed policy form and the allowance of its use unless the regulator disapproves it within a particular time. When the state uses the first or last approach, there is often interim communication and negotiation between the insurer and the regulator to facilitate ultimate approval.

There is a correlation between the coverage provided by the policy form and the rate (from which the premium derives) charged. Low policy benefits may correlate with an excessive premium (because the policyholder may not be getting adequate benefits to justify the premium charged). In contrast, a rate that is too low for the benefits provided may not generate sufficient funds for the insurer to pay expected claims. If that happens, an insurer could become insolvent because the claim payments are greater than the premium collected plus investment income on those premiums. It is part of the insurance regulator's function to balance policy benefits fairly with the rate (premium) and in a way to promote the insurer's solvency and ability to remain in business.

> . . . the risk exists that a state legislature may outlaw abortion or place new restrictions . . . such that a health insurer whose policy benefits are inconsistent becomes non-compliant . . . and subject to regulatory or civil action.

The thrust of *Dobbs* is to return to each state the freedom to legislate the allowance of abortion within that state and under what circumstances. Before *Dobbs*, states differed on their abortion legislation, but where abortion was an element of covered medical treatment, *Roe* was a touchstone. While some health insurance policies, by their very language, gave abortion benefits, some did not. As long as state law did not require that health policies provide abortion benefits, neither a policy that did not so provide nor the insurer issuing that policy ran afoul of the law. Since *Dobbs*, the risk exists that a state legislature may outlaw abortions or place new restrictions on them, such that a health insurer whose policy benefits are inconsistent becomes non-compliant with state law and subject to regulatory or civil sanction.

Will *Dobbs* Affect Managed Care?

Managed care is usually defined as a type of delivery system for healthcare services more than it is health insurance as such. It has existed for decades and generically refers to a defined scope of medical services, a mechanism for accessing (delivering) them, and paying for them. An overall goal is to reduce costs for participants (called members) through a closer oversight of service utilization than in a traditional indemnity health insurance arrangement.

An important factor to understand is that different managed care models allow differing degrees of latitude to members about obtaining care from providers and entities (hospitals, labs, etc.) and also allow a greater or lesser range of services. Some managed care models are essentially self-contained in that they resemble clinics where employed providers can deliver most healthcare services that members need. When they can't, members are referred to outside specialists. Others use a network of approved and affiliated independent professionals and service providers with whom the managed care entity has contracted to furnish specified services for specified charges. In all cases, the member pays to participate in the arrangement, akin to an insurance premium.

While managed care differs from traditional health insurance in those services for which traditional health insurance pays are delivered unbundled, some similarities are pertinent to *Dobbs*.

How services are financed and specified in the members' contract gives managed care arrangements their closest resemblance to health insurance; in fact, many individuals do not distinguish between the two. Notably, a managed care contract, like an insurance policy, specifies the healthcare services and supplies to which a member is entitled, as well as related exclusions, exceptions, conditions, and other terms. Also importantly, a managed care arrangement, whether an HMO or a PPO, is risk-bearing—which means that members pay in advance for the suite of services and supplies to which they are entitled under the contract. As

such, the financial soundness of both insurers and managed care arrangements are among insurance regulators' concerns.

Also similar to health insurance *per se*, state law invests an insurance regulator (or equivalent state regulator that oversees managed care) with authority over the contract forms used by managed care entities. To the extent that *Dobbs* leaves it to legislators to rule on abortion for their states, and because health insurance and health insurance-like contracts must comport with state law, the issuers of managed care contracts will be affected. Needless to say, this is a new issue for all health-related risk bearers, and they must keep abreast of developments, including insurance regulatory bulletins that affect their business. Too, some states, such as Florida, dually regulate some managed care entities with oversight coming from insurance and health regulators. To the extent that state health-related law and regulation changes from what it had been pre-*Dobbs*, health law should also be monitored.

The Ultimate Health Insurance Complexity

To say that *Dobbs* has exacerbated the complexity of health insurance coverage for abortion is an understatement.

Women had come to rely upon *Roe* and, later, *Casey*, for nearly two generations as at least a partial grounding to a federal constitutional right to obtain an abortion. While *Casey* slightly modified aspects of the right that *Roe* found, it upheld that a period did exist during which the state could not interfere with an elective abortion. *Roe* is the usually-cited authority for the right, but *Casey* embellished the metes and bounds of the right. Notwithstanding, *Roe* is usually cited as the source of the constitutional right. Concomitantly, when women had health insurance, they anticipated that the insurer would pay for at least a part of the abortion costs.

The essence of *Roe* was that during the first trimester, the decision to terminate a pregnancy rested entirely with the pregnant woman. After the first trimester, the state could regulate procedure. During the second trimester, the state could regulate abortions in the interests of the mother's health but not render them illegal. After that, it was deemed that the fetus was viable, and the state could both regulate and outlaw abortions in the interests of the potential life. There were, however, exceptions, mostly when the mother's life or health was jeopardized. Some states addressed by statute third-trimester abortions even before *Dobbs*. Florida, for example,

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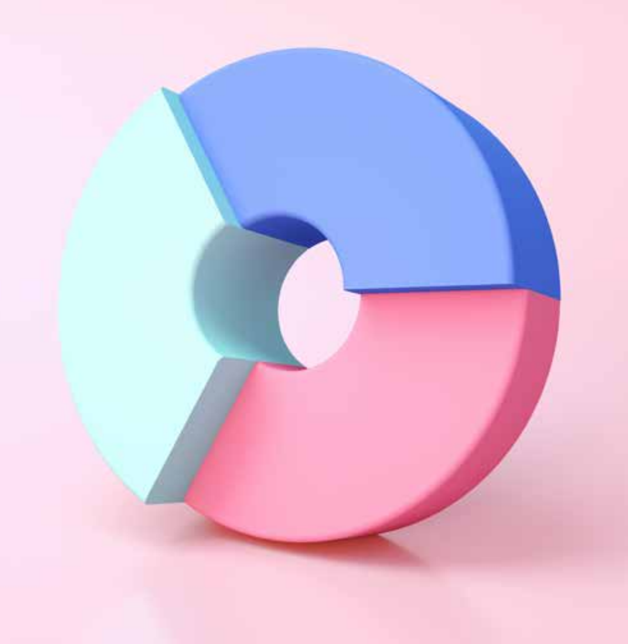
required showings by physicians that an abortion was necessary to save a woman's life or to avert the impairment of a major bodily function and imposed other requirements.[4]

Dobbs changes all that by returning to states full autonomy to legislate on abortion as they see fit without the constraints of *Roe*.



To say that *Dobbs* has exacerbated the complexity of health insurance coverage for abortion is an understatement.

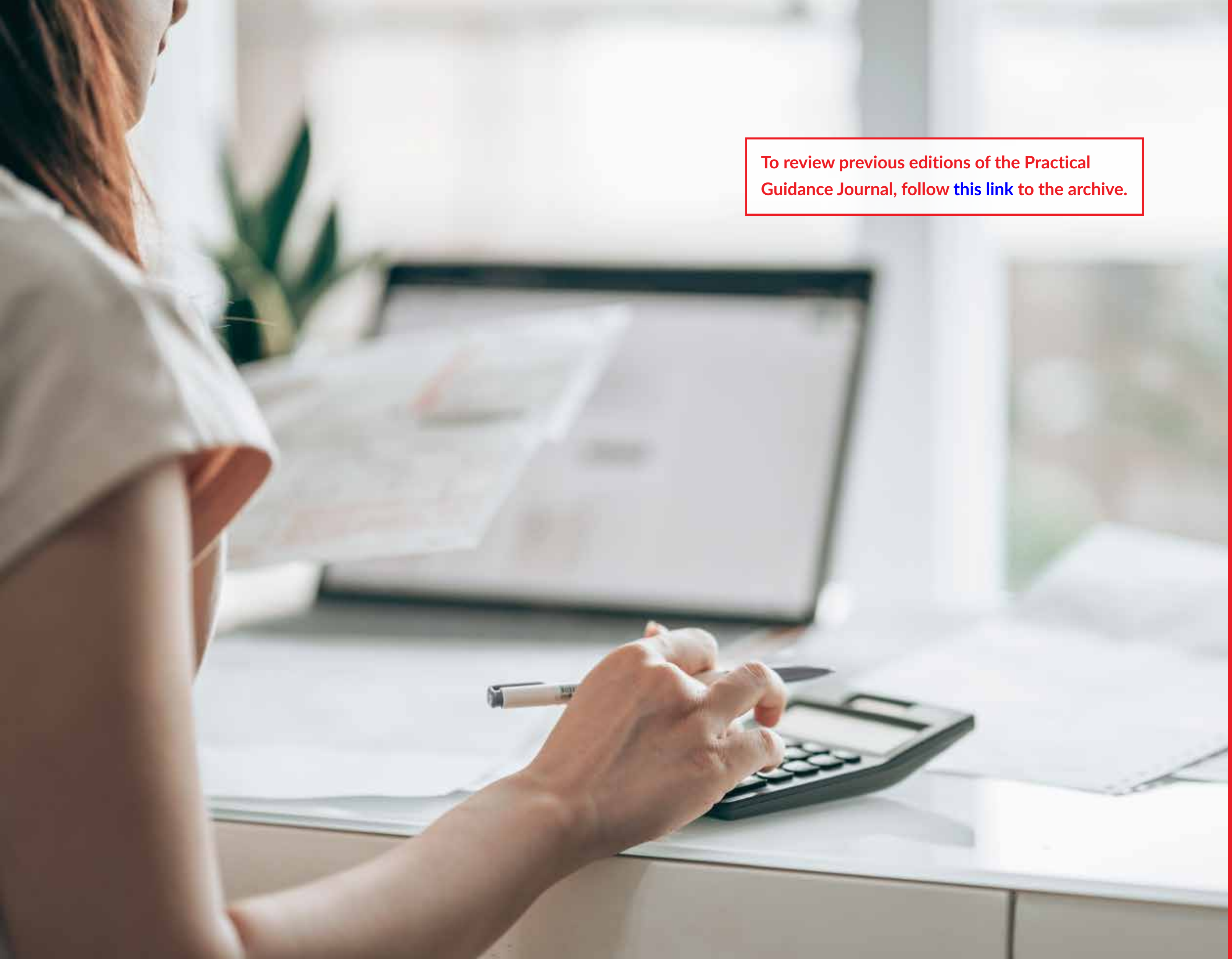
For insurers, although *Roe* did leave a patchwork of state abortion laws in place, it imposed some commonality and predictability through the restrictions that it imposed: an essentially unrestricted right to an abortion during the first trimester declining to an abolition of the right as pregnancy progressed.

Initial Next Steps for Health Insurers

Following *Dobbs*, those commonalities and predictabilities are gone—both for each state's citizens and its health insurers. When they existed, a rough analogy might have been drawn to factors relevant to actuarial calculations that health insurers could use to calculate premiums: individuals of a certain gender, a certain age group, and in a certain geographic area were likely to incur costs related to an abortion for which insurers had to pay. When *Roe* was the law, insurers had a more stable base (a fixed measure of when abortion was allowed and when it wasn't) with fewer variables (i.e., changes in what had been stable law on abortion) on which to transact business.

Insurers that transact health insurance business in multiple, if not all, states, will face these complexities on a large scale. Some of the jurisdictions in which they do business will allow elective abortions, some will not, and some will impose restrictions of various kinds.

4. *See* Fla. Stat. Ann. § 390.0111.



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Multistate insurers will need to rethink business strategies, redraft forms to comport with differing abortion laws of the states in which they do business, and get the new forms approved. They will also have to recalculate rates to be consistent with the benefits offered in those states.

Insurers will also have to adapt quickly. In anticipation of *Dobbs*, some states enacted trigger laws designed to put abortion regulations that predated *Dobbs* or, in some cases, *Roe* in place. While litigation is pending about the validity of those actions, insurers must stay abreast of them and all *Dobbs*-related activity in all jurisdictions in which they conduct business or have policyholders.

Looking Ahead

In conclusion, the potential ramifications of *Dobbs* for health insurers and their products cannot be over-amplified. As examples, *Dobbs* will motivate insurers' rethinking of where they wish to do business, the products they decide to sell, how the products are designed and priced, and the markets for them. These matters will in turn affect insurance consumers in states that do not change their abortion laws as well as those that do. Insurers that transact health insurance in multiple states will be affected the most to the extent that they may have to comply with the law of jurisdictions that differ in their approach to elective abortion. It is foreseeable that insurers will have to confront situations where individuals travel to states where abortion is permitted from states where it is not for the procedure. If an insurer pays for the procedure, issues may be raised concerning the aiding and abetting of an unlawful act.

Go to Practical Guidance to review additional coverage on the implications of *Dobbs* for employers, individuals, policyholders, physicians, and other medical providers.

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A INITIATIVE SPONSORED BY THE LEXISNEXIS RULE OF LAW FOUNDATION, the Center includes a searchable database of legislation, including proposed, enacted, and failed voting laws; a continuously updated summary of the voting methods and options permitted by law for each state; a tracker with links to bills currently pending in the various state legislatures; and a color-coded map providing a quick view of the number of bills under consideration in each state.

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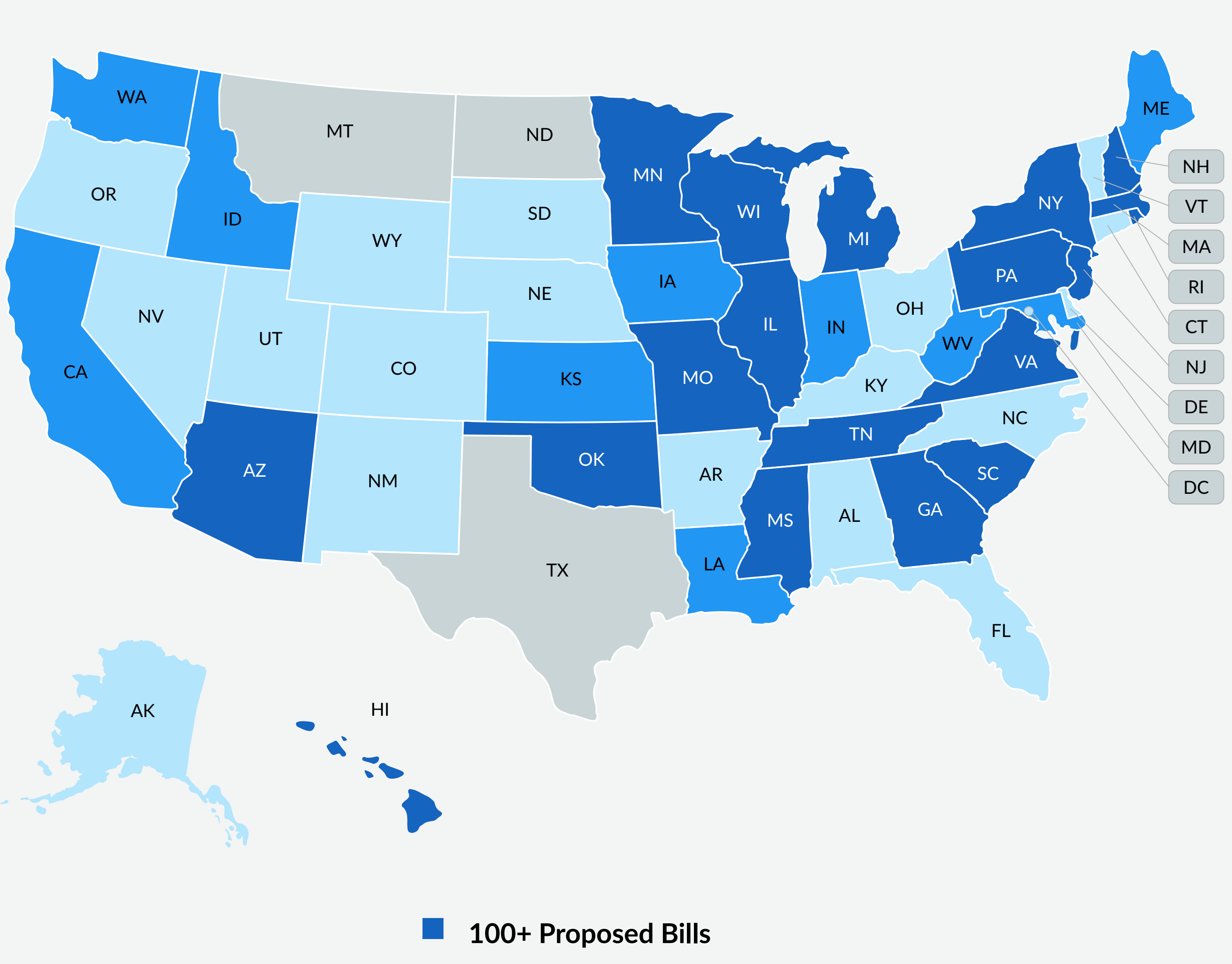

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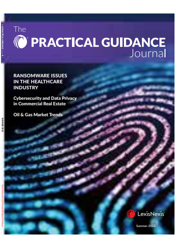

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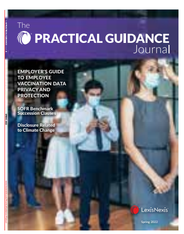

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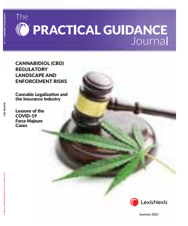

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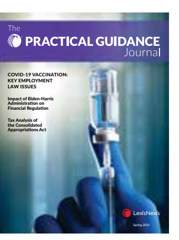

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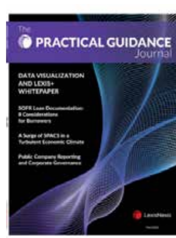

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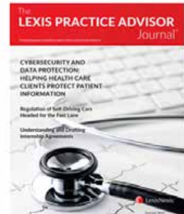

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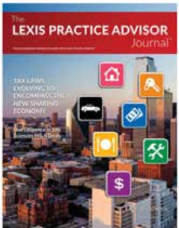

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