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August 30, 2022

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10 Questions on Dobbs v. Jackson's Reproductive Health Impact and More

Summary: Uncertainty related to the Dobbs ruling could have downstream effects on reproductive healthcare that go beyond abortion.

The Supreme Court's ruling in Dobbs v. Jackson raises a wide range of questions about potential impacts on patients. The ruling could affect insurance coverage of out-of-state abortion services as well as access to other reproductive health services and products. In addition to affecting patients, the ruling also has broader implications for the healthcare ecosystem (e.g., for payers) and for state and federal elections.

1. Will patients be able to access abortion services out of state?

Following the Dobbs ruling, patients living in states restricting abortion access may travel to other states to access these services, raising questions about cross-state insurance coverage and network status. For each patient, insurance coverage and state of residence will greatly affect access to and coverage for abortion services.

Under Medicaid, the Hyde Amendment prohibits the use of federal funding for abortion except in cases of rape or incest, or when the mother's life is in danger. However, 16 states currently allow their state Medicaid funds to be used for all or most abortions. When treatment is not available in the Medicaid beneficiary's home state, federal regulations generally allow those beneficiaries to obtain out-of-state care. However, there is likely to be a lot of state variation in interpretation of these regulations. Although the patient's home state would generally cover that patient's out-of-state care, access to that care among Medicaid beneficiaries could be influenced by several factors, including the following:

- Whether the out-of-state provider is enrolled in the Medicaid program of the patient's home state, and the ease or difficulty of the home state's provider enrollment and screening processes
- How the patient's home state establishes reimbursement rates for out-of-state providers
- Whether a given state's Medicaid program provides support for patients' travel costs (e.g., meals, lodging, transportation)

For individuals enrolled in state-regulated commercial plans, access will be informed by those insurers' plan designs—particularly the breadth of their provider networks—and the laws of the state. Whereas some states prohibit commercial insurers from covering abortion services, other states mandate coverage of those same services, and a third group of states ban abortion but do not prohibit plan coverage. If a patient's plan covers abortion services, obtaining an out-of-state abortion may result in unexpected costs if the provider is outside the plan's network, especially for plans with narrow provider networks (e.g., health maintenance organizations).

2. Will states scale back flexible telehealth policies, especially those allowing providers to practice across state lines?

During the COVID-19 Public Health Emergency (PHE), the federal government and many states adopted a range of flexibilities allowing patients to access healthcare virtually and ensuring that telehealth and in-person services were reimbursed at the same rate. Some of these flexibilities included allowances for out-of-state providers to serve in-state residents via telehealth.

Because abortion policies now vary by state, some patients may view telehealth flexibilities as a way to obtain abortion care from out-of-state providers without traveling out of state for a surgical abortion. In December 2021, the Food and Drug Administration (FDA) eliminated the requirement that abortion medications be dispensed in person, thus allowing patients to receive the requisite drugs by mail. Following the Dobbs ruling, some patients may be able to obtain a medication-based abortion by consulting with an out-of-state provider by telehealth and receiving the medication by mail.

Several states have adopted legislation to end this practice. Nineteen states require 2 or more in-person visits to access medication abortion, and 9 others require at least 1 visit. In 2021, 6 states passed laws prohibiting medication abortion through telehealth, and South Dakota's Governor Kristi Noem signed an executive order prohibiting the use of telehealth to obtain medication-based abortions. However, these policies could be challenged in court on the grounds that they may conflict with federal government statements asserting that states may not "ban" the use of FDA-approved products.

It is unclear how state telehealth policies will evolve following the Dobbs decision. States with bans on abortion services are also likely to ban medication-based abortions via telehealth. However, it remains to be seen whether these abortion-specific policies have any relation to broader access to telehealth for other healthcare needs.

3. Who decides whether abortion is necessary to preserve a pregnant person's life or health?

Some states with abortion bans include exceptions for cases to preserve the pregnant person's life or health. Michigan, for example, bans abortion unless it "shall have been necessary to preserve the life of such woman." However, it is unclear whether these states define "necessary" or defer that question to provider discretion. This ambiguity could leave providers with questions about what cases the law would classify as eligible for an abortion procedure. For example, if continuing a pregnancy could result in life-threatening complications, could a

provider legally perform an abortion before those complications occur, or must they already have occurred? Would a condition such as cancer qualify a pregnant person for a legal abortion on the grounds that it could preserve their health or prolong their life?

States with clauses regarding a pregnant person's life or health must consider whether to codify specific guidelines for providers making these decisions, processes for documenting their rationale, any oversight or review that may be conducted, and the consequences that would apply to providers whose decisions are ruled unjustified.

4. What effect might declining abortion rates have on the disparities in maternal mortality rates?

For every 100,000 live births in 2018, the US had 17.4 maternal deaths—a ratio more than double that of most other high-income countries. If state bans on abortion lead to more births, a commensurate increase in the number of maternal deaths would be expected. However, if the ruling also results in more births among individuals with high-risk pregnancies (who might otherwise have had an abortion), maternal mortality in the US could increase further.

US maternal mortality rates differ significantly by race: rates for non-Hispanic Black women are more than 2.5 times those for non-Hispanic White women (37.1 and 14.7 deaths per 100,000 births, respectively). In states that ban abortion, births will likely increase more among non-Hispanic Black women, given that they have higher rates of unintended pregnancy and are more likely to obtain an abortion than non-Hispanic White women. The disproportionate increase in births expected for Black women coupled with the inequity in current mortality rates is likely to exacerbate racial disparities. Some researchers have predicted a 24% increase in overall maternal mortality, affecting non-Hispanic Black women substantially more than non-Hispanic White women (39% and 15% increases, respectively).

To mitigate potential increases in maternal mortality, stakeholders have stressed the importance of advancing policies to increase utilization of preventive and prenatal care options such as contraceptives, risk factor and disease screenings, smoking cessation, nutrition counseling, and glucose monitoring. Many states have taken steps to increase access to these care options, such as by enhancing Medicaid benefits, expanding access to family planning services, and creating provider performance incentives. To date, however, the states taking this approach tend to have less restrictive abortion policies, and thus likely have less risk of increasing mortality rates compared to states with trigger laws and more restrictive policies.

5. Has the outlook for November's state and federal elections changed following the Dobbs ruling, and what will that mean for abortion policy in the future?

Reproductive health and the consequences of the Dobbs decision are sure to play a central role in this year's state and federal elections. At the federal level, midterm elections are historically difficult for the party of the President, and Democrats face a difficult political environment given rising inflation and the state of the economy. In general, these factors tend to predict Republican gains in Congress. However, strong sentiment about the Dobbs decision (both for and against) could change voters' perceptions of which party should hold power in Congress and energize

people to go to the polls. As the elections approach, it will be important to watch for any significant changes to generic ballot polling to see whether voter preferences are changing and how those changes may impact federal outcomes in the midterms.

Because the Dobbs decision effectively delegated abortion policy to the states, voters will likely increase their focus on state-level elections as well. Governors will be elected in 36 states, including at least 9 states with current abortion bans or gestational limits. The results of elections for governors and state legislators will in part determine each state's legislative priorities and judicial approach to abortion policy for years to come.

Beyond elections for state officials, some states will also vote on ballot initiatives related to abortion. Initiatives in California and Vermont aim to protect abortion, whereas residents of Kentucky will decide whether to clarify that their state constitution does not establish a right to abortion. In early August, Kansas voters rejected a similar ballot measure. Other states could still approve abortion-related initiatives to be included on the ballot in November.

The outcomes of November's federal and state elections will affect policymaking on many healthcare issues, including drug pricing, insurance coverage, and coverage and cost transparency. Understanding the most likely outcomes will give stakeholders more time to prepare for potential shifts in the political environment. Following the Dobbs decision, stakeholders must now consider how debates about reproductive health will influence election outcomes.

6. How might Dobbs affect patient access to contraception?

The Dobbs decision does not directly impact legality, coverage, or access to contraception, but the uncertain federal and state legal landscape could impact provider decision making and patient access to contraceptives.

Justice Clarence Thomas's concurring opinion in Dobbs explicitly argued that other substantive due process cases—including one that guarantees the right to obtain contraception—"should be reconsidered." In the dissenting opinion, Justices Stephen Breyer, Sonia Sotomayor, and Elena Kagan noted the legal relationship between the cases that Dobbs struck down (Roe v. Wade and Planned Parenthood v. Casey) and the right to purchase and use contraception.

The Dobbs decision prompted the House to pass the Right to Contraception Act on July 21, generally along party lines. This bill would codify an individual's right to access, and a provider's right to provide, contraceptives. However, with Democrats' slim Senate majority, the bill is unlikely to become law.

State lawmakers may soon shift their attention to contraceptive access. The 2007 Gonzales v. Carhart decision provides state and federal lawmakers "wide discretion to pass legislation in areas where there is medical and scientific uncertainty." Per the federal definition of pregnancy, contraceptives such as intrauterine devices (IUDs) and emergency contraceptives do not cause abortion, but Gonzales would allow state lawmakers to argue otherwise. Under this ruling,

states looking to ban specific types of contraceptives are not required to prove that they cause abortion, but simply to convince a court that there is "uncertainty."

Such laws—or even discussion of such laws—could prompt enough confusion about the legal status of contraception to affect providers' willingness to prescribe or administer contraceptives. This effect may be especially strong among safety-net providers who have been at the center of political debates in recent years, including Planned Parenthood providers and entities funded through the Title X national family planning program. Further, lawmakers who believe that fetal life begins at egg fertilization (rather than implantation) may seek to restrict or stigmatize forms of contraception that prevent implantation, such as IUDs.

7. What effects might this ruling have on care following pregnancy losses such as miscarriages?

The ruling may also indirectly inhibit patient access to care following pregnancy loss. Although Dobbs does not directly restrict miscarriage services, in practice miscarriage and abortion services often involve the same procedures and medications. Doctors and hospitals may be hesitant to provide miscarriage management services that they or others may interpret as abortion care. This situation may be most likely to arise in states such as Texas and Oklahoma, which allow private citizens to sue abortion providers and anyone who "aids and abets" an abortion. Additionally, pregnancy loss diagnosis and management services are referred to in medical terminology and diagnosis codes as "spontaneous abortion," further raising the likelihood of confusion regarding healthcare professionals offering miscarriage management services.

8. How will the definition of "personhood" impact the assisted reproductive technology (ART) industry?

The overturning of Roe v. Wade leaves the definition of "personhood" to be defined at the state level. For many states that define life as beginning at "the moment of fertilization" with no other explanatory language related to pregnancy or gestation, it is unclear whether embryos that are created as part of in vitro fertilization (IVF) will be granted personhood. Currently, Louisiana is the only state that specifically defines embryos created through IVF in its statutory language regarding personhood, stating that these "juridical persons" are the responsibility of the medical facility and cannot be intentionally destroyed. Notably, other elements of Louisiana's law contradict the definition above, saying that personhood for juridical persons begins at birth. Other states do not specifically refer to ART or IVF in their statutory definitions and may have similarly contradictory or unclear terms (e.g., pregnancy, termination of life, unborn child, fetus, embryo) with varying applicability to IVF. Payers, third-party fertility benefit managers, and especially ART providers will need to closely monitor how states define personhood with respect to embryos created through IVF.

Ambiguous state laws could affect common ART practices such as disposal of unused or unwanted embryos (e.g., those having genetic defects) or the use of embryos for research. Requiring ART providers to continue long-term or lifetime storage of unused embryos could lead

providers to fertilize fewer eggs per IVF cycle, requiring more cycles to produce a live birth and adding to provider and patient costs for transporting or storing excess frozen embryos. The increased burden on providers may lead to higher costs for payers, third-party fertility benefit managers, and patients and could cause some clinics to close. Alternatively, clinics may require patients to be responsible for storing or disposing of embryos, which would raise a separate set of ethical or legal issues.

9. Could this ruling impact patients' relationships with providers and pharmacists?

Patients who are unsure of their state's abortion laws or unclear on the Dobbs ruling's applicability to other forms of reproductive care may be less likely to discuss their reproductive health concerns with their providers. This reluctance could result in patients foregoing other preventive care services, including contraceptives, that they otherwise would have discussed with, and obtained from, a provider.

Further, providers in states that have adopted civil and/or criminal penalties for "aiding and abetting" abortion care or that have unclear legal landscapes surrounding contraception and miscarriage management services may be less willing to offer reproductive care more broadly. Similarly, confusing federal and state policies could lead some pharmacies or pharmacists to refuse to fill prescriptions for contraception, emergency contraception, or medications that may result in pregnancy loss, including those approved for abortions.

10. How might Dobbs influence the popularity of, or investment in, digital reproductive health solutions?

During the SCOTUS review of the Dobbs case, stakeholders raised concerns about the privacy and use of personal data entered into applications that track fertility and menstruation patterns. With millions of users, these apps collect and store large amounts of sensitive data, prompting stakeholders to question who can access those data and how they can be used. In particular, questions have arisen about whether states that criminalize abortion can use an individual's data from these apps as evidence in their prosecution—especially given existing precedent in abortion-related cases allowing a person's text messages and online search history as evidence.

Fears about data privacy may reduce the popularity of these apps among some users. However, leading app developers have noted that users are switching to apps with greater privacy protections. Developers are seeking to address users' concerns by anonymizing their data, but the future of app data security, and of resulting behavior patterns among app users, remain unknown.

Future Outlook

Stakeholders are just beginning to identify, understand, and experience Dobbs's impacts, and federal policymakers are grappling with its implications. Over time, the ruling's direct and indirect effects are likely to have widespread implications across the healthcare system. As the Dobbs ruling and other health policy developments change the healthcare landscape, Avalere's 360-degree perspective on healthcare can help your organization to prepare for success in the new environment.