



REPRODUCTIVE HEALTH Fact Sheet

Post-Dobbs Legal Avenues to Abortion Access

The Supreme Court's decision on June 24, 2022 in [*Dobbs v. Jackson Women's Health Organization*](#) (*Dobbs*) overturning [*Roe v. Wade*](#) (*Roe*) and [*Planned Parenthood v. Casey*](#) has resulted in severe limitations to abortion access among select states nationally. In the aftermath of the elimination of the fundamental constitutional right to abortion, identifying legal options to abortion access is critical to ensure the health and safety of individuals across the nation.

This fact sheet illustrates select legal avenues to access abortion services in the post-*Dobbs* United States under core specific categories including (1) federal preemption of state laws via the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986; (2) telehealth, mobile clinics, and medication abortion; (3) state Section 1115 Medicaid waivers to enable provision of abortion services for persons traveling from abortion-hostile states; and (4) additional federal preemption via Food and Drug Administration (FDA) regulations or other pathways.

I. Federal Preemption and EMTALA: Assuring Emergency Abortion Care

[EMTALA](#) provides protections designed to ensure persons access to emergency medical services regardless of their ability to pay. [EMTALA](#) requires most U.S. hospitals to screen and stabilize patients presenting with emergency medical conditions, including active labor, or arrange for their transfer to other hospitals able to provide care.

On July 8, 2022, President Biden released an [Executive Order Protecting Access to Reproductive Health Care Services \(14076\)](#). The order, among other initiatives, tasked the Department of Health and Human Services (HHS) with taking necessary steps to "[ensure all patients](#)—including pregnant women and those experiencing pregnancy loss—have access to the full rights and protections for emergency medical care afforded under the law," including through EMTALA.

In furtherance of the President's order, [HHS confirmed](#) in a July 11, 2022 press release that EMTALA "protects providers when offering legally-mandated, life- or health-saving abortion services in emergency situations." In a [letter](#) that same day to health care providers, HHS Secretary Becerra confirmed that, pursuant to EMTALA, "all patients [must] receive an appropriate medical screening, examination, stabilizing treatment, and transfer, if necessary, irrespective of any state laws or mandates that apply to specific procedures." Additional HHS [express guidance](#) clarified that:

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- (1) “emergency medical conditions” under EMTALA can include ectopic pregnancy, complications of miscarriage, and other conditions; and
 - (2) if a physician believes that an abortion “is the [stabilizing treatment necessary](#) to resolve that condition, the physician **must** provide that treatment.”

Consistent with Congressional language in EMTALA, HHS’ guidance posits that EMTALA’s legal requirement to provide screening and stabilizing care expressly preempts conflicting state laws limiting abortion care.

In response, Texas sued the Biden Administration, arguing that HHS was attempting to convert EMTALA into a federal [“Abortion Mandate.”](#) On August 23, 2022, a Texas district court preliminarily blocked enforcement of HHS’ EMTALA guidance in Texas. The court surmised that HHS exceeded its authority and failed to conduct notice-and-comment procedures before issuing its guidance. HHS [amended its guidance](#) on August 25 to indicate that it will not be enforced in Texas.

On August 2, the federal Department of Justice (DOJ) [initiated its own lawsuit](#) in Idaho. DOJ argued the state’s abortion trigger ban allowing exceptions only “to prevent the death of a pregnant woman” evaded full compliance with EMTALA. EMTALA requires screening and stabilizing care not only in life and death situations, but also when the *health* of a pregnant person is at risk. On August 24, 2022, [an Idaho district court](#) preliminarily blocked the state law on the grounds it conflicts with, and is thus preempted by, EMTALA.

Subject to continued litigation and appeals (e.g., in Texas), [EMTALA](#) stands as a basis for ensuring specific access to abortions for pregnant individuals presenting with emergency medical conditions at hospitals nationally.

II. Telehealth, Mobile Clinics, and Medication Abortion

Telehealth is a viable source for [safe](#), effective medication abortion care which typically entails use of two different drugs:

- (1) [mifepristone](#), a drug that is FDA-approved for use in abortions in pregnancies [up to 10 weeks](#); and
- (2) [misoprostol](#), a drug that is used in combination with mifepristone to end pregnancies. Misoprostol is not FDA-approved for abortions but is generally prescribed off-label.

Telehealth presents [a key abortion access route](#) by arranging patients’ remote access to health care providers who prescribe these drugs. Patients seeking abortions ingest the drugs in accordance with providers’ instructions and monitor for any adverse effects, which are rare.

Medical practitioner licensing and practice regulations are key to the provision of telehealth services. State laws [generally require](#) medical professionals to be licensed in the state where patients are located and receive care. State laws banning abortion, or which make it a crime to assist a patient with an abortion, may place health care providers’ medical licenses at risk if they treat patients in such jurisdictions. In addition, insurance coverage for telehealth services can vary state-to-state. States can also attempt to severely restrict access to medication abortion pills directly, discussed more in detail in Part IV below.

Limitations also surface with respect to who dispenses the drugs. The FDA used to [stringently limit dispensation of mifepristone](#) to health care providers who could also prescribe the drug. It required that mifepristone be dispensed under the [“supervision of a certified healthcare provider,”](#) essentially preventing mail-order and dispensation by pharmacies. The FDA [updated that requirement in December of 2021](#) to enable mail-order and certified pharmacy dispensation, but it has yet to become fully effective. The updating process [requires](#) mifepristone manufacturers to prepare modifications to their applications based on the new language, which the FDA will then approve. Even while this access route is opening, it [still imposes restrictions which limit access](#)



(e.g., requiring pharmacies which dispense mifepristone to become “certified”). States may also impose their own limitations on dispensation of mifepristone, limiting it to certain healthcare providers in certain locations, teeing up a potential battle for power between abortion-hostile states and the FDA, as discussed in Part V below.

Despite these limitations, telehealth providers are seeking to provide as much access as possible in a post-Roe landscape. [Abortion on Demand](#) (AOD) offers telehealth abortion access in states where abortion is still legal, facilitating easier access for individuals up to 9 weeks pregnant. The World Health Organization supports [prescribing medication abortion](#) for patients up to 12 weeks pregnant, which may extend patient access considerably if adopted in the U.S. Some providers are taking preventative approaches, prescribing abortion medication [before a patient becomes pregnant](#). Through [advance provision](#), similar to other medication regimens, patients gain access to these drugs pursuant to medical screenings before being prescribed and taking the pills.

Many groups are establishing [clinics](#) lawfully located on the borders of states that have prohibited abortion access. For example, [Just the Pill](#) has created clinics in Colorado and plans to create more in California, New Mexico, and Illinois. [Mobile surgical clinics](#) on the borders of abortion-hostile states can provide additional, lawful care to later term pregnant individuals.

III. Medicaid Waivers: Enabling Cross-State Abortion Provision

Following executive orders issued by President Biden, [HHS released a report](#) in August 2022 detailing possible programs for increasing reproductive health care access across the U.S, including through the use of what is known as a [Section 1115 waiver](#) of Medicaid program requirements. This legal option allows states to request specific waivers of federal Medicaid requirements. On August 26, CMS formally announced [in a letter to state governors](#) that it will work with interested states to advance access to abortions and other reproductive health care through § 1115 travel waivers. HHS Secretary Becerra invited states to work with CMS on procuring federal funding to design programs regarding cross-state abortion access, while recommending states continue to develop their own additional approaches to improve access to abortion services. These travel waivers likely aim at covering [“certain costs related to traveling for abortion.”](#) as individuals experiencing low incomes may lack resources needed to travel to states that provide abortion care.

Yet, there are clear legal limitations in designing § 1115 waiver programs. The [Hyde Amendment](#), for example, prevents use of federal funds to directly pay for abortions with narrow exceptions (e.g., cases of rape or incest, or when pregnancy risks the life of the mother necessitating an abortion). Hyde limitations, however, [do not apply](#) to state-based funding. Additional limitations surface politically, as different presidential administrations approach § 1115 waivers in distinct ways. For example, President Trump’s administration approved the use of § 1115 waivers to restrict access to Medicaid through the [imposition of work requirements on recipients](#), and [approved in 2020](#) Texas’s § 1115 waiver which sought to exclude abortion providers from family planning funding. Understanding these potential limitations is key for states applying for § 1115 waivers.

IV. Additional Preemption Pathways

[Prior to the Dobbs decision](#) an argument began circulating regarding [federal preemption of state laws restricting medication abortion access](#). [FDA has authority](#) over the safety and efficacy of medications in interstate commerce in the U.S. State laws interfering or conflicting with FDA’s authority to authorize or approve drugs as safe and effective (including mifepristone for abortion use) may arguably be preempted. This argument has gained traction as more [states have set more stringent limitations](#) on access to medication abortion than what FDA requires. Yet, [federalism issues](#) related to federal-state power balances come into play. States traditionally regulate the practice of medicine and medical licensing in their jurisdictions. They may counter-argue that their abortion restrictions pertain to the practice of medicine rather than to the safety and efficacy of a drug.



In [GenBioPro v. Dobbs](#), generic mifepristone manufacturer GenBioPro challenged Mississippi’s laws imposing more stringent restrictions on mifepristone than what FDA required (e.g., requiring dispensation and ingestion of the pills in person, under the supervision of a health care provider). However, after issuance of the *Dobbs* decision, GenBioPro [voluntarily withdrew the suit](#), claiming a need to adjust its strategy. [GenBioPro currently plans to refile the case in a different forum](#). Still, the central argument may resurface in separate challenges or filings in the coming months as additional legal battles regarding abortion access are generated. Clarity on the scope of FDA authority as a preemptive limit over abortion-hostile state laws may help ensure additional access to care.

Beyond FDA-based preemption, the U.S. Department of Veteran Affairs (VA) published an [interim final rule](#) on September 2, 2022 indicating that it plans to offer certain abortion services in every state irrespective of contrary state laws. Concerning veterans and their beneficiaries, abortion will be accessible when medically necessary and/or in circumstances that involve rape or incest as allowed pursuant to the Hyde Amendment (noted above).

Additional Resources

The Network for Public Health Law has developed (and is regularly updating) [a series of reproductive health resources](#) in the aftermath of the *Dobbs* decision, including: (1) [Abortion Access: Post-Dobbs Litigation Themes](#); (2) [Ballot Measures on Abortion Access](#); (3) [State-Based Abortion Protections](#); (4) [Abortion Access: A Post-Roe Public Health Emergency](#).

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