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Practice Update

Providing Healthcare in a Post-*Dobbs* America Presents Evolving Challenges

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The Supreme Court's landmark decision in *Dobbs v. Jackson Women's Health Organization* represents a sea-change in Constitutional law that has already impacted our country in multiple ways. By overruling *Roe v. Wade* (1973) and *Planned Parenthood v. Casey* (1992), the Court concluded that the United States Constitution does not, in fact, confer a fundamental right for women to terminate a pregnancy prior to term and deferred regulation of abortion to the states. While the legal landscape is evolving daily, there are multiple issues that healthcare providers need to evaluate in the short-term. The purpose of this article is to discuss several of these concerns so that providers can assess their risks and strategic decisions moving forward.

We highlight below a number of issues that the *Dobbs* decision has created for healthcare providers, including:

- The plethora of challenges to state laws addressing reproductive health;
- Criminal, civil, and administrative considerations for providers;
- The tension between the Federal Emergency Treatment and Labor Act (EMTALA) and state laws restricting reproductive health services;

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- Considerations for pharmacists, including the tension between the Food & Drug Administration ("FDA") regulations and state laws;
- Considerations for academic medical centers and medical education, generally;
- Preserving the privacy of patient information, particularly in states that have restricted reproductive health services; and
- Litigation risks.

I. The Role of Injunction, States, and Abortion Access Post *Dobbs*

As a result of the *Dobbs* decision, health care providers, especially those licensed in multiple jurisdictions, now must navigate a patchwork of conflicting state laws addressing reproductive health services.

Within the United States, thirteen states currently have laws in place that would "trigger" automatic state action to ban abortion following *Dobbs*—Arkansas, Idaho, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, Oklahoma, South Dakota, Tennessee, Utah, Texas, and Wyoming.[1] However, litigants in some states are taking immediate legal action to block these state bans from taking effect.

Beginning on June 27, 2022, organizations such as the Center for Reproductive Rights and its partners have gathered in courthouses across the country to challenge state abortion bans. They have been successful in states such as Louisiana, Utah, and Texas in temporarily blocking trigger laws, thus allowing abortion to remain legal within those states. The state judges in those cases concluded that trigger abortion bans violate their state constitutions and are worthy of thorough litigation before imposing such harsh restrictions. Subsequently, litigants have filed lawsuits in other states such as Kentucky, Wyoming, and Mississippi to temporarily allow abortion access, with decisions forthcoming. [2]

State constitutions, state precedent, and state courts are a few of the numerous factors that can affect the outcome of state lawsuits seeking to preserve abortion access post-*Dobbs*. With the dismissal of federal precedent, litigants in many states have turned to their state constitutions to decide their course of action post-*Dobbs*.[3] Utilizing a state constitution's right to privacy has been a common component of the argument to allow or restrict abortion access within the states. State supreme courts in Alaska and Montana have already decided that the right to privacy granted by their states' constitutions creates a fundamental right to abortion.[4] Yet, in states such as Florida and Iowa, prior decisions finding a state constitutional right to privacy have been recently overturned due to changes in judicial constituency.[5]

Challenges to state trigger laws are just the beginning of the *Dobbs* decision's legal ramifications. While litigants in some states have seen success, these injunctions are temporary and will be subject to further litigation. Whatever the ultimate outcome, healthcare professionals and lawyers are needed now more than ever for this ever-evolving situation. We examine two states where state court judges have granted temporary injunctions blocking those states from imposing their trigger laws banning abortion below.

1. Louisiana

In immediate response to the *Dobbs* decision, Hope Medical Group for Women in Shreveport, LA and other organizations such as the Center for Reproductive Rights filed suit against Louisiana Attorney General Jeff Landry and state health secretary, Courtney N. Phillips.[6] The plaintiff providers asserted several legal claims against the enforcement of the trigger laws within Louisiana, including that the trigger laws are "unconstitutionally vague."[7] In the pleadings, the providers argued that it is impossible to tell which, if any, of Louisiana's trigger laws are now in effect or

what conduct is actually prohibited and that, in order to criminalize something, those potentially implicated need to know exactly what is being criminalized and when. For example, statutes permit abortions for medically futile pregnancies. But the list of what is considered "medically futile" has not yet been promulgated by the Louisiana Department of Health, as the statute required.[8] In addition, the suit also claims that the statutes conflict on whether abortion is prohibited after fertilization or after implantation.[9] "In a stunning state of affairs, the day [the Supreme Court's abortion ruling] was issued, state and local officials issued conflicting statements about whether and which trigger laws were actually in effect and thus what conduct — if any — was prohibited," the providers argued. "Due process requires more."[10] In granting the temporary injunction in this case, Judge Robin M. Giarrusso of the Orleans Parish Civil District Court had no additional comments on the case's merits. Rather, his order simply approved the application for the temporary injunction based on the plaintiff providers' "unconstitutionally vague" argument and set a hearing for a later date July 8, 2022 on the matter.[11] The Louisiana Supreme Court denied the State's application for a stay of the injunction and declined to "exercise its plenary supervisory jurisdiction at this preliminary stage of the proceedings."[12] Following the July 8 hearing, Judge Ethel Julien granted the State's motion for a change in venue to Baton Rouge, thus depriving that court of its power to maintain the injunction.[13]

2. Utah

Utah is another state where a state court blocked a total ban of abortion post-*Dobbs,* at least temporarily. On June 27, 2022, Judge Andrew Stone of the Third District granted a request for a temporary restraining order filed by Planned Parenthood Association of Utah ("PPAU) to stop Utah's trigger law for a period of two weeks.[14] In the order granting the injunctive relief, Judge Stone concluded that the impact of taking away the right to an

abortion greatly outweighed Utah's interest in banning abortions and that the legal issues warranted further legal consideration prior to imposing any permanent ban.[15] At the conclusion of the two weeks, the PPAU filed another brief petitioning the court for a preliminary injunction to allow for a longer period of legal abortion access.[16]

PPAU has brought several legal claims against the enforcement of trigger laws banning abortion in the state of Utah. Primarily, PPAU argues that the trigger law — passed by the Utah Legislature in 2020 as SB174 ("Criminal Abortion Act")[17] — violates the Utah Constitution by taking away people's right to determine their own family composition free from government interference.[18] PPAU argued that the State cannot show any compelling interest that would pass strict scrutiny to permit a ban on abortions and that without an injunction against SB174, the abortion ban will cause irreparable harm to doctors and patients alike through physical, emotional, and financial costs from forced pregnancies and out-of-state abortions.[19] In addition, PPAU argued the public interest and balance of equities, specifically the interests of PPAU and its patients, greatly outweigh the need to disturb the status quo that Utah women and families have relied upon for decades. Below are additional claims PPAU argued in their brief seeking a temporary injunction of a statewide abortion ban:

- The Act violates the Utah Constitution's guarantee that state laws shall have a uniform operation;
- The Criminal Abortion Ban violates the Utah Constitution's Equal Rights Provision;
- The Criminal Abortion Ban violates Utahns' right to bodily integrity;
- The Criminal Abortion Ban violates Utahns' right to freedom of conscience; and
- The Criminal Abortion Ban violates Utahns' right to privacy. [20]

Another hearing on the granting of a temporary injunction against abortion restriction and the response from Utah occurred on July 11.[21] The Court granted the request from PPAU to further delay the implementation of Utah's trigger law banning most abortions. Judge Andrew Stone believes the status quo should remain in effect until the challenge from PPAU can be fully heard.[22]

II. Key Implications for Healthcare Providers as a Consequence of the *Dobbs* Decision

1. Criminal, Civil, Licensure, and Credentialing Ramifications

Absent a federal constitutional right to abortion, obstetricians, gynecologists, emergency room doctors, and any other types of prenatal care practitioners may face legal consequences for providing abortion services and those services that may be considered abortion services (standard of care for spontaneous miscarriages, prescribing certain drugs, performing certain services provided adjacent to infertility services, possibly offering genetic counseling services, and others). These consequences include criminal prosecution in certain states for "aiding and abetting" an abortion; it is unclear what that means under state law and who might be implicated – could it include nurses, pediatricians, obstetricians, etc. in the room of a delivery where a baby is stillborn as a result of a spontaneous miscarriage? Even a physician working squarely within the bounds of a seemingly clear law may be hesitant to perform treatments that have abortive elements such as the dilation and curettage (D&C) procedure, typically performed after a patient has suffered a miscarriage. Physicians must take steps to ensure that they preserve evidence of a permissible exception to combat potential covert abortion accusations. This requirement of proof requires physicians to be more meticulous about their documentation and to preserve proof of an exception for an abortion if faced with an accusation.

Practitioners in the most restrictive abortion states could face revocation of their medical licenses, civil penalties, and criminal penalties that may include being charged as a felon and being sentenced to a term of imprisonment. In turn, these actions may lead to a domino effect for these physicians' credentialing, including exclusion from participation in Medicare, Medicaid, and private insurance plans; disciplinary action by medical staffs of hospitals and other facilities, including termination; and loss of specialty certifications.

Erring on the side of caution may prove difficult even for the most risk-averse entities and individuals because of the uncertainty surrounding the permissible scope of abortion services in each state. For example, under Utah law, an exception to the abortion ban can only be made if the pregnancy was the result of a medical emergency or rape or incest or if the mother's life is at risk.[23] However, the degree of risk to the mother required to trigger this exception remains unknown.

2. Impact on Telehealth

The impact of the *Dobbs* decision on practitioners who are licensed in different states is an equally important consideration. Practitioners are more frequently licensed in multiple states nowadays, especially within the digital/telehealth space. Physicians licensed in a particular state must now evaluate the consequences they may face for preparing their patients to receive out-of-state abortions by doing bloodwork and other pre-operative procedures. It is possible that physicians licensed in a state where abortion is illegal could face disciplinary action for performing or assisting with abortions in a legal state. Healthcare providers will need to assess the laws surrounding any procedures or services that could fall within the scope of what is being defined as abortion.

Providers in states where abortion remains legal must be mindful of the intersection between state-

specific and federal regulations that govern the provision of medication abortion using telemedicine. Providers in states like California must be prepared for the onslaught of out-of-state patients seeking pre-natal attention. Telehealth strategies are an attractive solution in part because of the Federal Food and Drug Administration's ("FDA") decision to eliminate the in-person dispensing requirements for abortion medication.[24] Under virtual abortions, the option of abortion medication has become increasingly popular, making up more than half of abortions in the U.S. in 2020.[25] Before *Roe*, there were nineteen states that required the presence of a physician when abortion medication is administered.[26] Understanding this, some states are working proactively to protect clinicians from civil and criminal liability for caring for out-of-state patients via telehealth by enacting legal protections.[27] It is unclear whether or not providers will be able to handle the demand from out-of-state patients, particularly if the associated specialties such as obstetrics and gynecology and maternal fetal medicine experience attrition.

3. Impact on Standard of Care

The *Dobbs* case is likely to have a chilling effect on the standard of care provided by practitioners in the areas of obstetrics and gynecology—two of the most challenging specialties of medicine because of high-pressure decision-making and high-risk surgeries. Specifically, many physicians are apprehensive of taking appropriate life-sustaining measures for pregnant women because those actions could be seen as unlawfully terminating a woman's pregnancy, exposing them to legal risk. EMTALA Guidance from the federal government attempts to emphasize that terminating a pregnancy can be part of the standard of care for some patients, but that Guidance has been met with resistance, as discussed below.

4. Implications for Emergency Medical Treatment and Labor Act

(EMTALA) Mandates

The Emergency Medical Treatment and Labor Act ("EMTALA") requires hospitals that have emergency departments to stabilize and treat any person who presents at the hospital with a medical emergency, regardless of their insurance status or ability to pay. [28] Pregnant women typically fall within the scope of people EMTALA was meant to protect. Common emergences such as preeclampsia, ectopic pregnancies, infections, and more could qualify as medical conditions under EMTALA that could require stabilizing treatments such as termination of a pregnancy.

Despite EMTALA's federal protections, however, many existing state anti-abortion laws would criminalize the performance of abortions even in the event of an emergency medical situation or serious bodily harm. This tension between federal law and state-specific anti-abortion laws creates a serious conflict for hospitals and practitioners that could critically impair the performance of necessary treatments and procedures.

a. Executive Order 14076: Protecting Access to Reproductive Healthcare Services

On July 8, 2022, President Biden issued an Executive Order 14076, Protecting Access to Reproductive Healthcare Services, in which he directed:

- HHS to consider updating existing guidance on EMTALA's obligations specific to emergency conditions and stabilizing care;
- OCR to consider providing guidance under HIPAA to strengthen protections for sensitive information related to reproductive health services; and
- the FTC to consider actions to protect consumers' privacy when seeking information about the

provision of reproductive health services.

b. CMS' EMTALA Guidance

Following President Biden's Executive Order, on July 11, 2022, CMS issued guidance ("EMTALA Guidance") to remind hospitals of their existing EMTALA obligations specific to patients who are pregnant or are experiencing pregnancy loss. Specifically, EMTALA requires that all patients receive an appropriate medical screening, stabilizing treatment, and transfer, if necessary, "irrespective of any state laws or mandates that apply to specific procedures." Further, physicians and hospitals "have an obligation to follow the EMTALA definitions [including 'emergency medical condition'], even if doing so involves providing medical stabilizing treatment that is not allowed in the state in which the hospital is located."

In a letter to providers issued concurrently with EMTALA Guidance ("Provider Letter"), HHS Secretary Becerra stated that "a physician or other qualified medical personnel's professional and legal duty to provide stabilizing medical treatment to a patient who presents to the emergency department and is found to have an emergency medical condition preempts any directly conflicting state law or mandate that might otherwise prohibit such treatment." Specifically, if a physician believes that a pregnant patient presenting to the emergency department "is experiencing an emergency medical condition as defined in EMTALA, and that abortion is the stabilizing treatment necessary to resolve that condition, the physician must provide that treatment."

The Provider Letter and EMTALA Guidance state that determining whether an emergency medical condition exists and the course of treatment necessary to stabilize the emergency medical condition is the responsibility of the examining physician or other qualified medical personnel. According to the Provider Letter, emergency medical

conditions involving pregnant patients may include, but are not limited to, ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features. State laws or mandates that "employ a more restrictive definition of an emergency medical condition are preempted by the EMTALA statute." Also, stabilizing treatment may include "medical and/or surgical interventions (*e.g.*, abortion, removal of one or both fallopian tubes, anti-hypertensive therapy, methotrexate therapy, etc.), irrespective of any state laws or mandates that apply to specific procedures."

The EMTALA Guidance also reminds hospitals and physicians that they could be subject to civil monetary penalties for refusing to provide necessary stabilizing treatment or an appropriate transfer to a hospital with the ability to provide stabilizing treatment. Additionally, the HHS Office of Inspector General may exclude a physician from the Medicare program and may terminate a hospital's provider agreement. Patients who are harmed by a physician's or hospital's failure to provide stabilizing treatment may bring a civil suit against the hospital for damages and equitable relief.

Determining whether a particular state law "directly conflicts" with EMTALA may require a nuanced fact-specific analysis that may difficult when physicians are confronted with patients with emergency medical conditions, which by their nature require immediate treatment.

c. Litigation Following the EMTALA Guidance

In response to the EMTALA Guidance and Provider Letter, the State of Texas on July 14, 2022 sued HHS and CMS alleging that rather than reminding providers of their existing obligations under EMTALA, the EMTALA Guidance and the Provider Letter (collectively referred to as the "Abortion Mandate" in the Complaint) "includes a number of

new requirements related to the provision of abortions that do not exist under federal law."[29] The complaint alleges that the EMTALA Guidance is a pretext for mandating that hospitals and emergency medicine physicians perform abortions, a requirement that has never been a part of EMTALA.[30] This requirement "forces hospitals and doctors to commit crimes and risk their licensure under Texas law."[31] Texas alleges that, among other things, in issuing the EMTALA Guidance, HHS engaged in arbitrary and capricious action, failed to conduct notice-and-comment rulemaking, lacked statutory authority to promulgate regulations, and violated the Tenth Amendment by superseding the police powers of the State of Texas.[32] As a result, Texas seeks a declaratory judgment that the EMTALA Guidance is unlawful and requests that it be set aside.[33]

Conversely, on August 2, 2022, the Department of Justice filed a lawsuit against the State of Idaho seeking to block Idaho Code § 18-622, which will criminalize abortions there if it takes effect August 25. The DOJ asserts that the state statute violates EMTALA by subjecting health care providers to criminal penalties when providing the requisite stabilizing treatment to pregnant women that may include terminating a pregnancy.[34] Resolution of these cases in Texas and Idaho will likely touch upon agency authority and Administrative Procedures Act issues.[35]

Hospitals and physicians should monitor these cases and any other litigation challenging the EMTALA Guidance in case a court temporarily enjoins the guidance pending the ultimate resolution.

5. Pharmacy and Pharmacist Considerations

While most people think of abortions as taking place at abortion clinics, currently slightly over half of the abortions in the U.S. are medically-induced

abortions involving the patient's ingestion of two prescribed medications, Mifepristone and Misoprostol, and generally the abortion takes place in the home. The FDA Risk Evaluation and Mitigation Strategy ("REMS") for Mifepristone was amended during the pandemic by removing the in-person dispensing requirement, though pharmacies dispensing it must be certified. The FDA labeling for Mifepristone provides that it may be used to terminate pregnancies within 70 days (10 weeks) of the patient's last menstrual cycle. States that allow abortions for periods of 10 weeks or longer should continue to allow the use of the combination of these two drugs. In states that prohibit abortions altogether, the legal challenge will likely be whether a state has authority to prohibit the use of a prescription drug that the federal government, through the FDA, allows.

Federal law regulates whether a substance is a prescription drug and the uses, labeling, and approval process of such a drug. Who can and cannot prescribe drugs and what drugs they may prescribe is generally left to the states, though Congress could legislate in this space. We have also seen states extend their reach by placing limitations on the prescribing and dispensing of opioids beyond that required by FDA and DEA. Likewise, during the COVID-19 pandemic we have seen the federal government involved in deciding who can and cannot test and treat patients with COVID.

A state's authority to prohibit Mifepristone is already being tested in federal court in Mississippi where the generic manufacturer of Mifepristone, GenBioPro, Inc., is suing the State of Mississippi over its ban on the drug. *GenBioPro, Inc. v. Dobbs,* Case No. 3:20-cv-00652. This case and possibly others like it will likely turn on the exact language of the state's abortion statute as well as addressing the Supremacy Clause (whether Congress intended that the federal government have exclusive authority to say what drugs may be prescribed and dispensed in the U.S. such that states are preempted from doing so),

whether a state saying that a drug may not be used for abortions is different than saying it cannot be prescribed or dispensed, and perhaps Commerce Clause arguments addressing the impact of having different laws, requirements, and interpretations in each state.

Given the abortion prohibitions in several states, pharmacies and pharmacists licensed in those states will need to follow their own state laws. And even pharmacies that that are located in states that allow abortion could face discipline or other penalties for shipping the dispensed medication to a patient in a state that prohibits such abortions.

6. Effect on Medical Education and Academic Medical Centers

Dobbs will significantly impact the practice of prenatal disciplines and prenatal training. According to the American College of Obstetrics & Gynecology ("ACOG"), approximately 44% of the nation's current obstetrics and gynecology residents train in states that are poised to ban abortions.[36] If residents are not trained to perform D&Cs due to abortion bans, this absence of training will impact delivery of care for women experiencing spontaneous miscarriages and other potentially life-threatening conditions that obstetricians and gynecologists, family practice physicians, and emergency room physicians, among others, will encounter upon licensure. It will also place current accreditation requirements at odds with state laws.[37] It remains to be seen whether this contradiction will result in accreditation bodies revising their current standards or if fewer institutions will be able to maintain accreditation. Nevertheless, there can be no doubt a significant challenge lies ahead for medical education programs nationwide.

III. HIPAA and Other Privacy Laws

In response to patient privacy concerns arising from the *Dobbs* decision, the Biden Administration has

issued several guidance documents intended to reiterate existing legal obligations of healthcare providers and other entities holding individuals' health information and to educate individuals about how they can try to protect their personal health information.

1. OCR Privacy Rule Guidance

The U.S. Department of Health and Human Services Office for Civil Rights ("OCR") recently issued guidance on the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Privacy Rule and disclosure of information related to reproductive healthcare "to help protect patients seeking [such services], as well as their providers." Issued as two documents, the guidance (i) clarifies that the HIPAA Privacy Rule does not require providers to disclose protected health information ("PHI") to third parties and (ii) provides tips for protecting individuals' privacy when using health information apps such as period trackers.

2. HIPAA Guidance Document

According to the HIPAA Guidance, covered entities, and to some extent, business associates, may use or disclose PHI without the individual's written authorization only as expressly permitted or required by the Privacy Rule. OCR states that the permitted disclosures for purposes unrelated to healthcare, notably disclosures to law enforcement officials, are "narrowly tailored" to protect individuals' privacy and access to healthcare services.

OCR then addresses several exceptions in the Privacy Rule that allow covered entities to disclose PHI without the individual's authorization, notably, disclosures that are "required by law," disclosures for law enforcement purposes, and disclosures to avert a serious threat to health or safety.

According to OCR, the "required by law" exception in the Privacy Rule permits, but does not require, covered entities to disclose PHI about an individual without the individual's authorization when the disclosure is required by another law and the disclosure complies with the requirements of the other law. The "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.'" A disclosure of PHI that does not meet the "required by law" definition in the Privacy Rule or that exceeds what is required by such law does not qualify as a permissible disclosure.

The HIPAA Guidance states that the exception for disclosures for law enforcement purposes allows 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," subject to certain conditions. For example, covered entities may disclose PHI in response to a court order, a court-ordered warrant, a subpoena, or a summons provided that all conditions of the exception are satisfied. OCR further states that where there is no mandate enforceable in a court of law, the Privacy Rule does not permit a hospital or other healthcare provider's workforce member to disclose to law enforcement the fact that an individual had an abortion or other reproductive health services. ***According to OCR's Guidance, when a law enforcement official presents a health clinic with a court order requiring the clinic to produce PHI about an individual who had an abortion, the Privacy Rule permits but does not require the clinic to disclose the requested PHI***.

Finally, the HIPAA Guidance addresses the exception that permits, but does not require, a covered entity, consistent with applicable law and ethics, to disclose PHI if the covered entity has a good faith belief that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public, and the disclosure is

to a person who is reasonably able to prevent or lessen the threat. OCR notes that professional medical societies have said that it is inconsistent with professional standards to disclose to law enforcement or others an individual's "interest, intent, or prior experience with reproductive healthcare." Based on this, ***OCR concludes that when pregnant individuals in a state that bans abortion tell their healthcare providers of their intent to go to another state to obtain an abortion, the Privacy Rule prohibits the healthcare providers from disclosing that PHI to law enforcement***.

3. Health App Guidance Document

The Health App Guidance reminds individuals that the HIPAA Privacy Rule applies only to PHI that is created, received, maintained, or transmitted by covered entities and business associates; the Privacy Rule does not apply to information that individuals download or enter in mobile apps for their personal use. OCR then provides tips in an FAQ format on how individuals can limit the data that their cell phones and other mobile devices collect and share about them, including how to turn off location services on mobile devices.

Following publication of OCR's guidance, Google announced that it will delete entries tracking user visits to abortion clinics, fertility centers, addiction treatment facilities, weight loss clinics, cosmetic surgery clinics, and other sensitive locations "soon after they visit." Google also stated that it remains "committed to protecting our users against improper government demands for data, and we will continue to oppose demands that are overly broad or otherwise legally objectionable."

Healthcare providers (and health plans) subject to HIPAA should consider re-visiting their records release policies to assess whether updates are needed to identify records containing information about abortion and other reproductive health services and to conduct further diligence on third-

party requests for such records. Healthcare providers should communicate any changes in policies to their records request vendors and train or re-train their workforce members on HIPAA and state law restrictions on disclosures of PHI for purposes other than treatment, payment, or healthcare operations, particularly regarding reproductive health services. Moreover, providers may consider reviewing the information their websites collect about individuals seeking information about abortion or other reproductive health services and with which third parties such data is shared.

4. Information Blocking Rule

Healthcare providers subject to the Office of the National Coordinator for Health Information Technology's ("ONC") Information Blocking Rule ("IBR") should assess how to comply with that rule and HIPAA in the context of state laws limiting or banning abortion and other reproductive health services. The IBR is intended to promote the free flow of health information and generally prohibits healthcare providers, health IT developers, and health information exchanges from knowingly interfering with the access, exchange, or use of electronic health information unless an exception applies.[38]

5. State Privacy Laws

Providers should always consider whether their state medical records laws impose more restrictions on the sharing of patient records than HIPAA does because HIPAA does not preempt state laws that provide more stringent protection of PHI.[39]

IV. Broader Litigation Implications

In addition to pending litigation challenging laws criminalizing abortions in several jurisdictions (discussed above), the *Dobbs* decision has also created both direct and ancillary litigation risks associated with abortion. For the purposes of this

update, direct litigation refers to lawsuits that directly result from the provision (or potential provision) of abortion services by hospitals, clinics, providers, etc. Ancillary risks refer to the litany of potential scenarios in which individuals or entities not directly involved in patient care (*e.g.*, employers, family members, Uber or taxi drivers, etc.) could nonetheless potentially face litigation attendant to a patient's efforts to seek out a legal abortion.

Direct litigation risk exists for patients, health care providers, and related facilities who seek, provide, or facilitate abortions. Because these litigation risks are highly dependent on state laws, patients and providers alike must assess the legal and enforcement landscape in states that have implemented laws that prohibit abortions. Although considerable ink is justifiably being spilled thus far on the potential criminal implications of providing abortion care, providers would be well-served to consider civil litigation implications as well.

Civil litigation is a significant risk. For instance, most states (and every state discussed above) have codified some variation on a state level of the federal False Claims Act. The scope of this risk matters. At the federal level, yearly recoveries of False Claims Act litigation involving health care providers now account for the equivalent revenue of a large company. In 2021 alone, health care federal False Claims Act recoveries exceeded $5 Billion. Since 2015, the total healthcare False Claims Act recoveries have far exceeded $10 Billion. Although state-based analogs of the federal False Claims Act are used with less frequency as stand-alone cases, the risk of such lawsuits is ever-present. As just one representative example, in Utah, the state False Claims Act criminalizes and imposes material civil penalties on a "Person," broadly defined, who:

1. Makes or causes to be made a false statement or false representation of a material fact in an application for medical benefits.

2. Makes or causes to be made a false statement or false representation of a material fact for use in determining rights to a medical benefit.
3. Having knowledge of the occurrence of an event affecting the person's initial or continued right to receive a medical benefit or the initial or continued right of any other person on whose behalf the person has applied for or is receiving a medical benefit, may not conceal or fail to disclose that event with intent to obtain a medical benefit to which the person or any other person is not entitled or in an amount greater than that to which the person or any other person is entitled.[40]

The potential civil penalties are extensive. For instance, each "false" claim for payment in Utah includes a treble damage provision and, additionally, statutory damages of not less than $5,000 and no more than $10,000 per allegedly false claim.[41] Health care providers routinely certify to the state that they are complying with applicable state laws. Providers who in good conscience test the limits of that state's abortion ban or who provide emergency abortion medical care consistent with the guidance of the Department of Health and Human Services pursuant to EMTALA may nevertheless find themselves in the onerous position of defending against costly civil litigation under statutes like the Utah False Claims Act. Nor is the litigation risk for Providers limited to potential criminal or civil fraud claims. Given the heightened tensions surrounding this politicized issue, it is a virtual certainty that providers are going to face enhanced litigation process even if they are not parties to cases. Providers should plan now for an ever-increasing workload associated with responding to grand jury subpoenas, civil subpoenas, or civil investigative demands from government agencies.

Moreover, a communal response to the *Dobbs* decision has created ancillary litigation risk as well. Many states have implemented trigger laws that

immediately took effect upon the Supreme Court's rendering of the *Dobbs* decision. Other states are considering (or have, since *Dobbs* passed) restrictions on abortion access. More likely will follow. The result—*i.e.*, a societal subjugation of bodily autonomy by some (but not all) members of the population as a policy decision to protect the sanctity of pregnancies—has resulted in a related outcry by allies looking to enhance access to medical care for women who live or work in states that no longer recognize the right to an abortion. Individuals, nonprofit agencies, and corporations alike have pledged support for access to medical care in more progressive jurisdictions, which itself creates the potential for a host of associated litigation risks (*i.e.*, "Ally Risk"). Ally Risk can, for sure, take many forms. It is statutory and, therefore, state-specific. It could be rooted in the common law as well. And Ally Risk may, depending on a given jurisdiction, expose allies to civil damages or perhaps even criminal liability under an aiding or abetting theory. Those interested in being allies should understand their rights and related risks.

As one example, as of July 2, close to forty of the largest companies in America had vowed to protect the reproductive rights of employees by pledging to pay travel and health care expenses for employees who live and work in more restrictive jurisdictions. In the days and weeks since this publication, that number has likely grown exponentially. In so pledging, companies juggle a host of employment law, ERISA, and tax implications surrounding that decision. Litigation risk exists too.

Section 220 of the Delaware General Corporate Laws ("DGCL") requires that for-profit Delaware companies share their books and corporate records with shareholders.[42] Delaware is not alone. Many other states have similar statutory provisions that applied to for-profit corporations organized by that state's laws.

Nevertheless, this DGCL section has been particularly well traveled because many shareholder derivative suits are preceded by Section 220 "book and records" actions by shareholders searching for information to aid a claim of, for instance, breach of fiduciary duty or usurpation of corporate assets. DGCL Section 220 creates Ally Risk as well. Companies known to use corporate resources to assist employees obtain abortions carry an enhanced risk that a stockholder (and it only takes one) with a divergent view might coopt DGCL Section 220 (and like provision of other state laws) to explore potentially harmful information kept by the company. Defenses exist to such a claim. Typically, DGCL Section 220 cannot be used for political purposes.[43] But, there are a litany of ways that a shareholder can draft around this "improper purpose" and, regardless, we have seen recently that precedent (even for cases that have been called "super precedents") are revisited from time to time. It is at least conceivable that a Section 220 action could be sustainable to review company records in connection with an ally policy. The litigation risk is real. If a company chooses to defend a Section 220 proceeding, the net cost in fees could be extremely high. Even greater is the risk that stockholders may attempt to use the resulting information in an attempt to politicize corporate standards of care such as the duty of care, the duty of loyalty, and/or the business judgment rule.

Equally jarring is the risk that with a Company's largesse to help cure a perceived societal wrong, such companies may in the process be creating the precise sort of records necessary for prosecutors and civil litigants alike build cases against large numbers of individuals seeking patient care. This paper trail could take many forms – *e.g.*, travel records, expense reimbursements, hotel bills, provider invoices, among other possibilities. Companies that have decided to take this stand should do so with the guidance of experienced litigation counsel who can help navigate the unintended pitfalls of such policies.

Conclusion

As legal scholars, lawmakers, and litigators respond to a new constitutional landscape, health care providers are practicing in a precarious position of satisfying the standard of care owed to pregnant patients while navigating the restrictions of evolving laws and regulations. The evolution of the legal boundaries of abortion rights is unpredictable. Many were surprised when nearly 60% of voters in Kansas recently rejected a state constitutional amendment that would have removed protections of abortion rights from that state's constitution.[44] Analysis of that election result and other data has led some to project that voters in four out of five of the remaining states would support abortion rights if the issue appeared on their ballots.[45] Undeniably, *Dobbs* has created uncertainties that are unlikely to be resolved quickly. As long as the status of abortion rights remains in flux, it is essential that providers of health care services to pregnant patients maintain current knowledge of the rules of the state(s) within which they practice because in a post-*Dobbs* America, change is the only constant.[46]

This information is intended to inform firm clients and friends about legal developments, including recent decisions of various courts and administrative bodies. Nothing in this Practice Update should be construed as legal advice or a legal opinion, and readers should not act upon the information contained in this Practice Update without seeking the advice of legal counsel. Prior results do not guarantee a similar outcome.

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[31] *Id.* at ¶ 1.

[32] *Id.* at ¶¶ 50-56, 57-61, 62-66, 76-80; *compare Nat'l Fed. of Independent Businesses, et al. v. Dep't of Labor, et al.*, 595 U.S. ____ (Jan. 13, 2022) (issuing a stay against DOL rule that sought to mandate vaccines for all employers with 100 or more employees, citing OSHA).

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[34] *United States v. Idaho*, No. 1:22-cv-329-BLW (D. Idaho Aug. 2, 2022) (Complaint); *see* https://www.justice.gov/opa/pr/justice-department-sues-idaho-protect-reproductive-rights.

[35] *See, e.g.*, *Nat'l Fed. of Independent Businesses, et al. v. Dep't of Labor, et al.*, 595 U.S. ____ (Jan. 13, 2022) (issuing a stay against DOL rule that sought to mandate vaccines for all employers with 100 or more employees, citing limits of power granted to Secretary of Labor pursuant to OSHA); *Biden v. Missouri*, 595 U.S. _____ (Jan. 13, 2022) (finding mandatory vaccinations for health care workers valid pursuant to powers Congress granted to Secretary of HHS to impose conditions of participation for Medicare, Medicaid); *see also West Virginia v. EPA*, 595 U.S. _____ (Jun. 30, 2022) (finding EPA exceeded the power granted by the Clean Air Act by implementing emission caps).

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