Winning an equitable abortion landscape

“Just because abortion is legal does not mean it is accessible.” Cat Duffy.

Dispatcher: 911, what’s your emergency?

Caller: America’s healthcare system is broken and people are dying! (ambulance siren)

Welcome to **Code WACK!**, where we shine a light on America’s callous healthcare system, how it hurts us and what we can do about it. I'm your host, **Brenda Gazzar**.

(music)

This time on Code WACK! How have health clinics that perform abortions been affected by the reversal of **Roe vs. Wade** one year ago? What kind of legal challenges have there been to individual states' limitations on abortion since then? To find out, we spoke to **Cat Duffy**, a policy analyst in the **National Health Law Program**’s Washington DC office. This is the second part of our recent interview on the state of abortion access in America.

Welcome back to Code WACK!, Cat!

Q: What kind of impact has the reversal of Roe vs. Wade had on health clinics that perform abortions? Last time we spoke, you mentioned that some of them have closed down.

(01:14):

Duffy: Yeah, a lot of clinics have closed or shifted to providing other sexual and reproductive health services, but even those centers still face attacks due to the stigma associated with being an abortion provider, even if they're no longer actually providing abortions, which is really sad. But there's another study that's currently being conducted by **Ansirh**. It's called the Care Post-Roe study and they actually just published some preliminary findings and the study is focused on figuring out how clinical care has changed by documenting cases of care that were different from the usual standard of care due to abortion restrictions that went into effect since Dobbs. And the preliminary findings showed that like post Dobbs laws and how they're being interpreted have altered the standard of care in ways that have contributed to delays in accessing care, worsened health outcomes, and increased the cost and logistics complexity of care.

(02:13):

And it's cuz providers are understandably scared to provide care in situations where the best course of action is to terminate a pregnancy. And so it's causing them to delay to ensure that they have a situation that firmly falls into the sort of life endangerment category.

Oh, no!

Duffy: And I also want to point out that this is going to have a long-term effect on the healthcare infrastructure, especially in states that have banned abortion because doctors don't want to work there anymore. A survey of current and future physicians was published earlier this year and 76% of the respondents said that they would not apply to work or train in states that had abortion restrictions. And a different study from the American Medical Colleges said that states with abortion bans saw a larger decline in medical school seniors, folks who were applying for residency in 2023 compared with states without bans. And in general, overall there was more than a 5% drop in the number of applications for OBGYN residencies. So it's very clear that this is having an actual impact on the practice of medicine.

(03:28):

Q: Oh, wow. That's alarming. What kind of legal challenges have there been to either Dobbs versus Jackson, which reversed Roe versus Wade, or to individual state's limitations and have any of them been successful?

(03:39):

Duffy: So there have been a ton of litigation around state bans. Some has been successful, some hasn't. There's honestly like too much to get like deep into the weeds on it and it's a constantly shifting landscape. So I'll just give some highlights. As of May, 2023, a total of 38 cases had been filed challenging abortion bans in 21 states and 28 remain pending. And there have been some wins. So the South Carolina Supreme Court held that its state constitution protects the right to an abortion and permanently blocked a six-week abortion ban that the legislature had passed and it found that it violated the state's right to privacy. And in Utah, a state court temporary blocked a law that would have likely forced all the health centers in the state that provided abortion services. It would've forced them to close.

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And the last one that I would highlight is in Montana, the state Supreme Court permanently struck down a restriction that would have prohibited non-physician clinicians from providing abortion services. And it also blocked several abortion bans and a regulation that would have effectively eliminated abortion access for Medicaid enrollees. So all those were like very large wins in terms of preserving access.

But there have also been some decisions that have harmed access. The Idaho Supreme Court upheld the state's trigger ban and a six-week ban that the state had implemented and held that the state constitution doesn't provide - implicitly - a fundamental right to abortion because such a right is not deeply rooted in the state's traditions and history.

I'm not going to talk more about the losses because that's depressing. So instead there are a couple of resources where folks can go... The Brennan Center for Justice has a really good litigation tracker that is updated regularly and the Kaiser Family Foundation also has one and they separate it into both state and federal litigation, which is very helpful.

(05:43):

Q: Great, thank you. Where has the National Health Law Center been focusing its policy and advocacy work since Dobbs versus Jackson? And are there any victories that you can share?

(05:55):

Duffy: Yeah At NHeLP, we work on improving insurance coverage of a variety of different things, but I focus on insurance coverage of abortion and while we're a

national organization, we believe strongly in the importance of focusing on state policy, particularly in the post Dobbs landscape. I firmly believe that the way to build an equitable abortion landscape starts at the state level and so we are a steering council member of the California Future of Abortion Council, which is a coalition of more than 40 organizations convened to identify barriers to abortion services and to propose policy solutions. And so in 2022, NHeLP co-sponsored SB 245, which is the Abortion Accessibility Act and that removes cost barriers to abortion by requiring all state regulated plans to cover abortion services without any type of cost sharing requirements. So it can't implement copays or deductibles, and it means that those services are covered in its entirety because we know that insurance coverage is one of the most crucial factors in building an equitable abortion landscape.

(07:12):

And the data's very clear that even nominal cost sharing requirements can be a huge barrier to folks accessing care, particularly people who face structural barriers to care. And so SB 245 was one of the bills in the major legislative package that the Future of Abortion Council endorsed last year and was ultimately signed into law in addition to securing more than 200 million in the state budget in new funding for abortion access and sexual and reproductive healthcare services. And so NHeLP cannot take credit for everything that the FAB Council has done, but we are really proud to have been a part of that effort. And I think that California's really been a leader in many ways for other states that are looking to shore up abortion access.

Oh, that's great!

And the other thing that I would highlight really quickly is our work around telehealth. We sort of talked about this a little bit earlier that we've seen just sort of like a market increase in the utilization of telehealth.

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And while it's not a silver bullet for access issues, it can be crucial in reducing time and resource barriers for people who are trying to access abortion care. And so we've done a lot of research and advocacy around ensuring that there's comprehensive insurance coverage of telehealth service delivery. And at the end of last year in December, 2022, we published a comprehensive report that mapped out the coverage and reimbursement landscape in six different states that use state funding to cover abortions for Medicaid enrollees, and provided a

series of recommendations for steps that states can take to ensure that their Medicaid programs have really quality and robust coverage of telehealth.

(09:02):

Q: Got it. Can you explain to us the ongoing battle over the abortion pill mifepristone and what's the Comstock Act and its relevance today?

(09:11):

Duffy: Yeah. There is ongoing litigation called the Alliance for Hippocratic Medicine v FDA and it's a lawsuit that's being brought by a group of anti-abortion organizations that is asking the court to essentially force the FDA to withdraw its approval of Mifepristone in order to remove it from the market. So Mifepristone is one of the two pills used in a medication abortion. It was approved by the FDA back in 2000 and has had a (Risk Evaluation and Mitigation Strategy) in place, which has regulated its use and how it can be dispensed as we talked about earlier. And so in this lawsuit, the plaintiffs are arguing that the FDA acted improperly in approving Mifepristone and it argues that its initial approval wasn't supported by evidence of safety and efficacy, which is just patently wrong and there have been 20 years of studies since then that show how safe and effective Mifepristone is.

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But they've also made arguments that the FDA lacked the authority to approve Mife because mailing and delivering drugs for a medication abortion violates the Comstock Act, which is an anti-obscenity law from the 1800s that makes it a federal crime to send or deliver obscene, lewd, or lascivious material through the mail or by other carriers and it specifically includes items used for abortion and birth control. This law is wildly outdated and has never been interpreted in the manner in which the plaintiffs want it to be, but it's being revived specifically to gut access to abortion. So this lawsuit has gone through a series of twists and turns, and there have been contradictory rulings in other lawsuits that are going on, but Judge (Matthew) Kacsmaryk is the district judge who ruled on it initially, and his ruling would have effectively pulled Mife from the market.

(11:19):

And then it went to the Fifth Circuit, which partially stayed his ruling, and it would have kept the FDA approval of Mifepristone, but would've reinstated a lot of the restrictions that were previously in place under the Mifepristone REMS. And then the Supreme Court intervened and issued a stay and the Supreme Court stay will

remain in effect until and unless they're asked to intervene in the case again. So while the case is sort of working its way through the legal system, mifepristone remains on the market. It is legal, it is subject to the current regulations as outlined by the FDA, which means that there is no in-person dispensing requirement, and it also means that certified pharmacists are allowed to dispense.

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Q: ***Ok. Let's shift gears and get some historical context. Despite the landmark Roe vs. Wade ruling of 1973, 50 years ago, many individuals still faced significant hurdles in accessing abortion. Can you talk briefly about what hurdles they have increasingly faced even after Roe vs. Wade and why?***

(12:37):

Duffy: Yeah. I think that there is a misconception that having a constitutional right to abortion meant that people can access abortion and that is not true. Legality does not translate into actual access. It does not translate into having a provider nearby. It doesn't translate into having insurance coverage that actually covers that service and as a result of other litigation and Supreme Court decisions that over time sort of whittled down the protections of Roe and the result of compromises in major legislation like the Affordable Care Act that would often horse trade away protections for abortion access in service of, you know, securing the broader piece of legislation, it created a patchwork landscape where if you lived in a state that supported abortion access, access was like maybe pretty okay for you depending on what part of the state you lived in, how much money you make, ecetera.

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But in many states, abortion was technically legal, but there was maybe one abortion provider in the entire state and there are like bans on insurance coverage. For example, the Hyde Amendment, which is a federal budget rider that prohibits the use of federal funding for abortion coverage except for rape, incest, and life endangerment. That means for Medicaid enrollees, there's an effective abortion ban for them. They cannot use their Medicaid insurance to pay for abortion services unless they fall into one of those narrow instances. The exception to that is if they live in a state that uses their own state funding to cover abortions or Medicaid beneficiaries, because while there's like a federal restriction, states can do what they want with their own money, but I just think

that's like one example of how where you live, even post-Roe, largely determined whether or not you have reliable access to care.

(14:48):

And there's also, you know, just like so much stigma around abortion that has pervaded abortion policy and like, you know, discussion in popular culture for years. And I think we've made a lot of strides in de-stigmatizing abortion, but especially in the immediate aftermath of Roe and for decades after to be honest, like people didn't want to talk about their abortion. And that can make it harder to access care because like when you want to go see a doctor, if I need to go see a specialist, I'll often ask my friend and be like, 'oh, do you have an optometrist that you really like?' And that's not something that folks would feel comfortable doing if you were seeking an abortion.

And the final thing I'll just say is that all the travel barriers that we have talked about and like resource barriers have all existed since Roe. They just existed to a lesser extent, or it depended on where you live to determine how far you would have to travel to access an abortion.

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Q: Got it. How would you describe the outlook for the future of abortion access and what's at stake for our country?

(15:59):

Duffy: I like to remind myself that this is a marathon and not a sprint and just like the fall of Roe was many, many years coming, creating an equitable abortion landscape will take time. And I think it's really important to focus on investments at the state level. I firmly believe that one of the ways in which we got to the abortion access crisis that we are currently in was by ignoring the policy developments that were happening at the state level as anti-abortion opponents enacted restriction after restriction.

But I also know that there are amazing people at the state level doing incredible work to de-stigmatize abortion, to build power and to create a healthcare infrastructure that actually serves people. I think that centering questions of access in mapping out the solution to Dobbs is essential.

Focusing on the legal right to abortion is too narrow and it's just repeating the mistakes of the past because I'm a little bit like a broken record, but like, just because abortion is legal does not mean it is accessible and we should be building

a landscape where all people can have access to the care that they need regardless of where they live, how much money they make, their gender, their race, or any other factor.

(17:31):

Thank you Cat Duffy. Do you have a personal story you'd like to share about our 'wack' healthcare system? Contact us through our website at heal-ca.org.

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