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Regulating Reproductive Health Services After *Dobbs v. Jackson Women's Health Organization*

Introduction

In *Dobbs v. Jackson Women's Health Organization*, a five-Justice majority overruled the Supreme Court's prior decisions in *Roe v. Wade* and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, holding that the U.S. Constitution does not confer a right to an abortion. By overruling *Roe* and *Casey*, the Court maintained that it was returning the regulation of abortion to the people and their elected representatives.

Following *Dobbs*, bills that would have established a statutory right to abortion and protected access to the procedure were passed by the House in the 117th Congress, but were not considered in the Senate. At the same time, legislation that would have imposed a gestational age limit on the procedure's availability was also introduced in both chambers. Bills that would promote abortion access, as well as those that would restrict its availability, have been introduced in the 118th Congress. This In Focus reviews the Court's *Dobbs* decision, discusses Congress's authority to regulate reproductive health services, and examines the regulation of medication abortion, which represents a sizable portion of all abortions in the United States.

Dobbs v. Jackson Women's Health Organization

In overruling *Roe* and *Casey*, the *Dobbs* Court reconsidered whether the Constitution guarantees a right to an abortion. Noting the absence of any reference to abortion in the Constitution, the Court nevertheless acknowledged that the Fourteenth Amendment's Due Process Clause could guarantee some rights that are not explicitly mentioned. The Court indicated, however, that substantive due process rights, such as a right to abortion, may be found only when they are "deeply rooted in [the] Nation's history and tradition" and are "implicit in the concept of ordered liberty." Reviewing common law and statutory restrictions on abortion from before and after the Fourteenth Amendment's ratification, the Court concluded that "a right to abortion is not deeply rooted in the Nation's history and traditions." The Court emphasized, for example, that abortion was prohibited in three-quarters of the states when the Fourteenth Amendment was adopted, and 30 states still prohibited the procedure when *Roe* was decided in 1973.

Although the Court found no historical support for a right to an abortion, it considered whether a right to the procedure was nevertheless part of a broader entrenched right that was supported by the Court's other precedents, particularly those involving the right to privacy. Citing its prior privacy decisions concerning activities such as marriage and obtaining contraceptives, the Court distinguished abortion

from the rights recognized in those decisions because of the "critical moral question posed by abortion."

In addition to determining that the Constitution does not confer a right to an abortion, the Court also considered whether the doctrine of stare decisis should guide it to uphold *Roe* and *Casey*. After evaluating five traditional stare decisis factors, including the quality of the Court's reasoning in those decisions, the Court determined that continued adherence to *Roe* and *Casey* was inappropriate.

In overruling *Roe* and *Casey*, the Court not only held that the Constitution does not guarantee a right to abortion, it also determined that abortion regulations will no longer be subject to judicial review under the viability and undue burden standards established by those decisions. The Court held that, if challenged, abortion regulations will now be evaluated under rational basis review, a judicial review standard that is generally deferential to lawmakers. The Court explained that under rational basis review, a law regulating abortion "must be sustained if there is a rational basis on which the legislature could have thought it would serve legitimate state interests." These interests, the Court continued, may include protecting prenatal life, the mitigation of fetal pain, and preserving the medical profession's integrity.

Congress's Constitutional Authority to Regulate Reproductive Health Services

Dobbs has led to renewed interest in Congress's authority to set federal standards to protect or limit access to abortion. The Constitution establishes a system of dual sovereignty between the states and the federal government. The federal government cannot force the states to enact or enforce federal policies, but under the Supremacy Clause, Congress can preempt state laws and thus prevent the states from undermining federal policy. States generally have broad authority to enact legislation on matters related to the health and welfare of its citizens, while Congress may enact legislation only pursuant to specified powers enumerated in the Constitution. Congress's powers under the Commerce Clause (U.S. Const. art. I, § 8, cl. 3), Spending Clause (U.S. Const. art. I, § 8, cl. 1), and Section 5 of the Fourteenth Amendment are three potentially relevant enumerated powers that Congress might rely on should it choose to legislate on reproductive-health-related matters.

Under the Commerce Clause, Congress may regulate the channels and instrumentalities of interstate commerce, along with activities that substantially affect interstate commerce. In determining whether an activity substantially affects interstate commerce, courts consider factors such as the economic nature of the regulated activity, whether the

statute contains a jurisdictional element requiring a link to interstate commerce, and whether congressional findings demonstrate the activity's effect on interstate commerce.

In past legislation, Congress has relied on the Commerce Clause to enact the Freedom of Access to Clinic Entrances Act of 1994 (which created a federal remedy for certain interferences with people seeking reproductive health services) and the Partial-Birth Abortion Ban Act of 2003 (which criminalized performance of partial-birth abortions). In upholding these laws, lower courts concluded that providing reproductive health services is commercial activity that Congress may regulate under the Commerce Clause. The Supreme Court has not directly ruled on the issue, although Justice Clarence Thomas's concurrence in *Gonzales v. Carhart* (which involved the Partial-Birth Abortion Ban Act) questioned whether the Commerce Clause could support general federal abortion regulation.

Under the Spending Clause, Congress may influence state policy by attaching conditions to the receipt of federal funds. In *South Dakota v. Dole*, for example, the Supreme Court upheld legislation that denied a percentage of federal highway funds to states that did not change their laws to ban the purchase of alcohol by people under 21 years old. If Congress wished to affect state and local laws on abortion (or other reproductive health services) through the Spending Clause, it could use conditional funding to encourage states to alter their laws to expand or restrict access to reproductive health services. However, states must receive clear notice of those spending conditions, and the conditions must not be unduly coercive. In *National Federation of Independent Business v. Sebelius*, the Supreme Court held that a provision in the Patient Protection and Affordable Care Act withholding all existing Medicaid grants (roughly 10% of most states' revenue) from any state that refused to expand its Medicaid program was unconstitutionally coercive.

Dobbs's holding that abortion rights are not protected by the Fourteenth Amendment largely forecloses Congress's ability to rely directly on Section 5 of that Amendment to protect or limit access to abortion. Congress could rely on Section 5 to prevent and deter *other* constitutional violations related to abortion access, but the Supreme Court has limited the availability of "prophylactic" Section 5 legislation in *City of Boerne v. Flores* and its progeny. To align with the Court's precedents, Congress would need to identify a pattern of state constitutional violations associated with abortion and further determine that increased or decreased access to abortion was necessary to prevent those constitutional violations.

Medication Abortion

Following *Dobbs*, questions have been raised about continued access to medication abortion, a pregnancy termination method involving the use of prescription drugs. Recent attention has centered on the availability of these drugs, particularly mifepristone, for those residing in areas with few or no abortion providers. The Food and Drug Administration (FDA) regulates the distribution of mifepristone using its authority under the Federal Food, Drug, and Cosmetic Act (FD&C Act). Some states have

also taken steps to restrict access to medication abortion, including bans on medication abortion drugs under particular circumstances.

Like other prescription drugs available on the market, FDA evaluated and approved medication abortion drugs pursuant to FD&C Act requirements. As a condition of mifepristone's approval, FDA requires compliance with a risk evaluation and mitigation strategy, or REMS. In general, a REMS is an FDA-imposed drug safety plan designed to ensure that the benefits of a drug with serious potential safety concerns outweigh its risks.

While the mifepristone REMS has been modified over time, the recent version requires health care professionals who prescribe the drug to be certified, meet particular qualifications, and ensure that patients receive and sign a patient agreement form relating to mifepristone use. Earlier REMS versions also specified that mifepristone had to be dispensed in-person in certain specified health care settings. A January 2023 update to the REMS enables patients to obtain the drug without an in-person visit to a clinician, including through the mail from certified prescribers or pharmacies. In April 2023, two federal district courts issued conflicting decisions in litigation over current federal requirements for mifepristone. In the first suit, a Texas district court ordered a stay of FDA's approval of the drug and its REMS, thus suspending the legal basis for the drug's sale and distribution nationwide. The Supreme Court is considering whether to stay enforcement of that order pending appeal. In the second case, a Washington district court barred FDA from altering the availability of mifepristone in 17 states and the District of Columbia. Litigation in the Washington case also remains ongoing.

Several states have also enacted laws to restrict access to medication abortion drugs. For instance, many states require a clinician to be in the physical presence of a patient when prescribing these drugs or place other restrictions on the use of telehealth. Some states have adopted more stringent requirements on medication abortion access, including measures to ban the prescribing of medication abortion drugs except under limited circumstances. These types of state provisions aim, at least in some cases, to restrict the drug's access beyond what federal law would otherwise permit. Questions have arisen about the federal preemption of these state laws and the extent to which states may set controls on medication abortion.

The 118th Congress could choose to consider legislation addressing FDA's regulation of medication abortion drugs, including bills that would set federal standards for the prescribing or dispensing of medication abortion. Congress might also clarify the degree to which federal regulation of medication abortion drugs preempts state measures inconsistent with federal policy. Such legislation could speak to the extent to which states may set controls on medication abortion drugs subject to FDA oversight.

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