2023

The Promise of Telehealth for Abortion

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*This is a **DRAFT** of a chapter that will appear in* Digital Health Care Outside of Traditional Clinical Settings: Ethical, Legal and Regulatory Challenges and Opportunities*, which is under contract with Cambridge University Press. We would like to thank the Petrie-Flom Center for Health Law Policy, Biotechnology, & Bioethics at Harvard Law School for inviting us to participate.*

The Promise of Telehealth for Abortion

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Introduction

The COVID-19 pandemic catalyzed a transformation of abortion care. For most of the last half century, abortion was provided in clinics outside of the traditional healthcare setting.[1] Though a medication regimen was approved in 2000 that would terminate a pregnancy without a surgical procedure, the Food & Drug Administration required, among other things, that the drug be dispensed in person.[2] This requirement dramatically limited the medication's promise to revolutionize abortion because it subjected medication abortion to the same physical barriers of procedural care.[3]

Over the course of the COVID-19 pandemic, however, that changed. The pandemic's early days exposed how the FDA's in-person requirement facilitated virus transmission and hampered access to abortion without any medical benefits.[4] This realization created fresh urgency to lift the FDA's unnecessary restrictions. The advocacy of researchers and litigators, working in concert to advance evidence undermining the purpose of the in-person dispensing requirement, [5] culminated in the FDA permanently removing it in December of 2021.[6]

The result is an emerging new normal for abortion through ten weeks of pregnancy—telehealth—at least in the states that allow it.[7] Abortion by telehealth (what an early study dubbed "Telabortion") generally involves a pregnant person meeting online with a healthcare professional, who evaluates whether the patient is a candidate for medication abortion, and if so, satisfies informed consent requirements.[8] Pills are then mailed directly to the patient, who can take them and complete an abortion at home. This innovation has made early abortion cheaper, less burdensome, and more private, reducing some of the barriers that delay abortion and compromise access.[9]

In this chapter, we start with a historical account of how telehealth for abortion emerged as a national phenomenon. We then offer our predictions for the future: a future in which the digital transformation in abortion care is threatened by the demise of constitutional abortion rights. We argue, however, that the de-linking of medication abortion from in-person care has triggered a zeitgeist that will create new avenues to access safe abortion, even in states that ban it. As a result, the same states that are banning almost all abortion after the Supreme Court overturned *Roe v. Wade* will find it difficult to stop their residents from accessing abortion online. Abortion that is de-centralized and independent of in-state physicians will undermine traditional state efforts to police abortion, but will also create new challenges of access and disproportionate risks of criminalization.

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[1] Greer Donley, *Medication Abortion Exceptionalism*, 107 CORNELL L. REV. 627, 647 (2022).

[2] *Id.* at 643-51.

[3] *Id.*

[4] *Id.* at 648-51; Rachel Rebouché, *The Public Health Turn in Reproductive Rights*, 78 WASH & LEE L. REV. 1355, 1383-86 (2021).

[5] Rebouché, *supra* note 3, at 1383-86.

[6] Donley, *supra* note 1, at 648-51.

[7] *Id.* at 689-73.

[8] David Cohen, Greer Donley & Rachel Rebouché, *The New Abortion Battleground*, 123 COLUM. L. REV. __, 10-11 (forthcoming 2023), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4032931.

[9] *Id.*

I. The Early Abortion Care Revolution

Although research on medication abortion facilitated by telehealth began nearly a decade ago, developments in legal doctrine, agency regulation, digital technology, and online availability over the last few years ushered in remote abortion care and cemented its impact. This part reviews this recent history and describes the current model for providing telehealth for abortion services.

a. *The Regulation of Medication Abortion*

Medication abortions now make up 54% of the nation's total abortions, which is a statistic that has steadily increased over the past two decades.[10] A medication abortion involves taking two types of drugs, mifepristone and misoprostol, typically within 24 to 48 hours apart.[11] The first medication detaches the embryo from the uterus and the second induces uterine contractions to expel the tissue.[12] Medication abortion is approved to end pregnancies through ten weeks of gestation.[13]

The FDA restricts mifepristone under a system intended to ensure the safety of particularly risky drugs – a Risk Evaluation and Mitigation Strategy (REMS).[14] The FDA can also issue a REMS with Elements to Assure Safe Use (ETASU), which can circumscribe distribution and limit who can prescribe a drug and under what conditions.[15] The FDA instituted a REMS with ETASU for mifepristone, the first drug in the medication abortion regimen, which mandated, among other requirements, that patients collect mifepristone at a clinic, physician's office, medical center, or hospital (the "in-person dispensing requirement").[16] Thus, under the ETASU, certified providers could not dispense mifepristone through the mail or a pharmacy. Several states' laws impose their own restrictions in addition to the FDA's regulations, including mandating in-person pick-up, prohibiting telabortion, or banning the mailing of medication abortion; at the time of writing, most of those same states, save eight, ban almost all abortion, including medication abortion, from the earliest stages of pregnancy.[17]

In July 2020, a federal district court in *American College of Obstetricians & Gynecologists (ACOG) v. FDA* temporarily suspended the in-person dispensing requirement and opened the door to broader adoption of telabortion during the course of the pandemic.[18] Well before the case, in 2016, the non-profit organization, Gynuity, received an Investigational New Drug Approval to study the efficacy of providing medication abortion care by videoconference and mail.[19] In the study, "TelAbortion" providers counseled patients online, and patients confirmed gestational age with blood tests and ultrasounds at a location of their choosing.[20] As the pandemic took hold, patients who were not at risk

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[10] Rachel Jones et al., *Abortion Incidence and Service Availability in the United States*, GUTTMACHER INSTITUTE (2022)
[11] Donley, *supra* note 1, at 633.
[12] *Id.*
[13] *Id.*
[14] *Id.* at 637-43.
[15] *Id.*
[16] *Id.*
[17] Nineteen states mandate that the prescribing physician be physically present during an abortion or require patient-physician contact, such as mandatory pre-termination ultrasounds and in-person counseling. Medication Abortion, Abortion Law Project, Center for Public Health Law Research. Dec. 2021, http://lawatlas.org/datasets/medication-abortion-requirements. Of those states, currently only Arizona, Indiana, Kansas, Montana, Nebraska, North Carolina have laws that preclude telehealth for abortion but otherwise have not banned abortion before ten weeks.
[18] Order for Preliminary Injunction, ACOG v. FDA, No. 8:20-cv-01320-TDC 80 (D. Md. Jul. 13, 2020).
[19] *See* Elizabeth Raymond et al., *TelAbortion: Evaluation of a Direct to Patient Telemedicine Abortion Service in the United States*, 100 Contraception 173, 174 (2019).
[20] *Id.*

for medical complications, were less than 8 weeks pregnant, and had regular menstrual cycles could forgo ultrasounds and blood tests, and rely on home pregnancy tests and self-reporting the first day of their last menstrual period. Results of the study indicated that "direct-to-patient telemedicine abortion service was safe, effective, efficient, and satisfactory."[21] Since the commencement (and conclusion) of Gynuity's study, additional research has demonstrated that abortion medication can be taken safely and effectively without in-person oversight.[22]

The *ACOG v. FDA's* temporary suspension of the in-person dispensing requirement in 2020 relied on this research. The court held that the FDA's restriction contradicted substantial evidence of the drug's safety and singled out mifepristone without any corresponding health benefit.[23] The district court detailed how the in-person requirement exacerbated the burdens already shouldered by those disproportionately affected by the pandemic, emphasizing that low-income patients and people of color, who comprise the majority of abortion patients, are more likely to contract and suffer the effects of COVID-19 in part because of the health inequalities that define U.S. healthcare.[24] While the district court's injunction lasted, virtual clinics began operating, providing abortion care without any in-person requirements.[25]

The FDA appealed the district court's decision to the U.S. Court of Appeals for the Fourth Circuit and petitioned the Supreme Court for a stay of the injunction in October and again in December 2020. The briefs filed by the Trump Administration's Solicitor General and ten states contested that the in-person dispensing requirement presented any heightened risks for patients.[26] Indeed, some of the same states that had suspended abortion as a purported means to protect people from COVID-19 now argued that the pandemic posed little threat for people seeking abortion care.[27] ACOG highlighted the absurdity of the government's position. The FDA could produce no evidence that any patient had been harmed by the removal of the in-person dispensing requirement whereas, in terms of COVID-19 risk, "the day Defendants filed their motion, approximately 100,000 people in the United States were diagnosed with COVID-19—a new global record—and nearly 1,000 people died from it."[28]

The Supreme Court was not persuaded by ACOG's arguments. In January 2021, the Court stayed the district court's injunction pending appeal without offering any analysis.[29] Chief Justice Roberts, in a concurrence, argued that the Court must defer to "politically accountable entities with the background, competence, and expertise to assess public health."[30] Justice Sotomayor dissented,

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[21] *Id.* at 174.
[22] Hillary Bracken, *Alternatives to Routine Ultrasound for Eligibility Assessment Prior to Early Termination of Pregnancy with Mifepristone-misoprostol*, 118 BJOG 17-23 (2011).
[23] Am. Coll. of Obstetricians & Gynecologists v. U.S. Food & Drug Admin., No. TDC-20-1320, 2020 WL 8167535 at 210-11 (D. Md. Aug. 19, 2020).
[24] *Id.*
[25] Donley, *supra* note 1, at 631.
[26] Solicitor General Brief to U.S. District Court of the District of Maryland, Case 8:20-cv-01320-TDC, Nov. 11, 2020.
[27] Rebouché, *supra* note 3, at 1383-89; Greer Donley, Beatrice A. Chen & Sonya Borrero, *The Legal and Medical Necessity of Abortion Care Amid the COVID-19 Pandemic*, 7 J.L. & BIOSCIENCES 1, 13 (2020).
[28] Plaintiff Brief in Opposition to Defendants' Renewed Motion to Stay the Preliminary Injunction, at 1, No. 20-1320-Tdc, Nov. 13, 2020.
[29] Food & Drug Admin. v. Am. Coll. of Obstetricians & Gynecologists, 141 S.Ct. 578 (2021)
[30] *Id.* (Roberts, J., concurring); Rebouché, *supra* note 3, at 1389.

citing the district court's findings and characterizing the re-imposition of the in-person dispensing requirement as "unnecessary, unjustifiable, irrational" and "callous."[31]

The impact of the Supreme Court's order, however, was short lived. After President Biden's inauguration in 2021, FDA leadership changed and so did the agency's position on the in-person dispensing requirement. In April 2021, the FDA suspended enforcement of the requirement for the life of the pandemic and announced that it would reconsider aspects of the REMS.[32] In December 2021, the FDA permanently lifted the in-person dispensing requirement, which allowed providers to mail medication abortion to patients and certified pharmacies to eventually dispense it.

Other aspects of the mifepristone REMS, however, have not changed. The FDA still mandates that only certified providers, who must register with the drug manufacturer, may prescribe the drug, which is an unnecessary administrative burden that reduces the number of abortion providers.[33] An additional informed consent requirement—the Patient Agreement Form, which patients sign before beginning a medication abortion—also stays in place despite repeating what providers already communicate to patients.[34] The FDA also added a new ETASU: that only certified pharmacies can prescribe mifepristone.[35] Though the details of pharmacy certification have not been announced, this requirement could mirror the burdens associated with the certified provider requirement, perpetuating FDA's unusual treatment of this safe and effective drug.[36]

Despite the restrictions that have stayed in place, permission for providers and, at present, two online pharmacies to mail medication abortion, has allowed virtual abortion clinics to proliferate in states that permit telabortion.[37] As explored below, this change has the potential to dramatically increase access to early abortion care, but there are obstacles that can limit such growth.

b. Telehealth for Abortion

A new model for distributing medication abortion is quickly gaining traction across the country: certified providers partner with online pharmacies to mail medication abortion to patients after online intake and counseling.[38] For example, the virtual clinic, Choix, prescribes medication abortion up to 10 weeks of pregnancy in Maine, New Mexico, Colorado, Illinois, and California.[39] The founders describe how Choix's asynchronous telehealth platform works:

> Patients first sign up on our website and fill out an initial questionnaire, then we review their history and follow up via text with any questions. Once patients are approved to proceed, they're able to complete the consent online. We send

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[31] *Id.* at 583 (Sotomayor, J, dissenting).
[32] Joint Motion to Stay Case Pending Agency Review at 2, Chelius v. Wright, No. 17-cv-493 (D. Haw. May 7, 2021), ECF No. 148.
[33] Donley, *supra* note 1, at 643-48.
[34] *Id.*
[35] *Id.*
[36] *Id.*
[37] Rachel Rebouché, *Remote Reproductive Rights*, 48 AM. J. L. & MED. __(forthcoming 2022). While pharmacy certification is implemented, the FDA has granted permission to two online pharmacies to dispense medication abortion. Abagail Abrams, *Meet the Pharmacist Expanding Access to Abortion Pills Across the U.S.*, TIME, June 13, 2022, https://time.com/6183395/abortion-pills-honeybee-health-online-pharmacy/.
[38] Carrie N. Baker, *How Telemedicine Startups Are Revolutionizing Abortion Health Care in the U.S.,* MS. MAG., Nov. 16, 2020.
[39] *Id.*

> our video and educational handouts electronically and make them available via our patient portal. We're always accessible via phone for patients.[40]

The entire process, from intake to receipt of pills, takes between two to five days and the cost is $289, which is significantly cheaper than medication abortions offered by brick-and-mortar clinics.[41] Advice on taking medication abortion or on possible complications is available through a provider-supported hotline.[42] Choix is just one of many virtual clinics. Another, Abortion on Demand, provides services to 22 states.[43] Many virtual clinics translate their webpages to Spanish but do not offer services in Spanish or other languages, though a number are planning to incorporate non-English services.[44]

As compared to brick-and-mortar clinics, virtual clinics and online pharmacies offer care that costs less, offers privacy, increases convenience, and reduces delays without compromising the efficacy or quality of care.[45] Patients may no longer need to drive long distances to pick up a safe and effective drug before driving back home to take it. In short, mailed pills can untether early abortion from physical place.[46]

Telehealth for abortion, however, has clear and significant limitations. As noted above, laws in about half of the country prohibit, explicitly or indirectly, telemedicine for abortion. And telemedicine depends on people having internet connections, computers or smartphones, which is a barrier for low-income communities.[47] Even with a telehealth-compliant device, "[patients] may live in communities that lack access to technological infrastructure, like high-speed internet, necessary to use many dominant tele-health services, such as virtual video visits."[48] Finally, the FDA has approved medication abortion only through ten weeks of gestation.

These barriers, imposed by law and in practice, will test how far telehealth for abortion can reach. As discussed below, the portability of medication abortion opens avenues that test the bounds of legality, facilitated in no small part by the networks of advocates that have mobilized to make pills available to people across the country.[49] But extralegal strategies could have serious costs, particularly for those already vulnerable to state surveillance and punishment.[50] And attempts to bypass state laws could have serious consequences for providers, who are subject to professional, civil, and criminal penalties, as well as those who assist providers and patients.[51]

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[40] Carrie Baker*, Online Abortion Providers Cindy Adam and Lauren Dubey of Choix: "We're Really Excited About the Future of Abortion Care,"* MS. MAG., (Apr. 14, 2022).
[41] *Id.* Choix also offers a sliding scale of cost, starting at $175, for patients with financial need. Choix, Learn, FAQ, https://choixhealth.com/faq/.
[42] Choix, Learn, FAQ, https://choixhealth.com/faq/.
[43] Carrie Baker, *Abortion on Demand Offers Telemedicine Abortion in 20+ States and Counting: "I Didn't Know I Could Do This!"*, MS. MAG. (June 7, 2021), https://msmagazine.com/2021/06/07/abortion-on-demand-telemedicine-abortion-fda-rems-abortion-at-home/.
[44] Ushma Upadhyay, Provision of Medication Abortion via Telehealth after *Dobbs* (draft presentation on file with the authors).
[45] Donley, *supra* note 1, at 690-92.
[46] *Id.*
[47] David Simon & Carmel Shachar, *Telehealth to Address Health Disparities: Potential, Pitfalls, and Paths*, 49 J. L. MED. & ETHICS 415, 415 (2022).
[48] *Id.*
[49] Jareb A. Gleckel & Sheryl L. Wulkan, *Abortion and Telemedicine: Looking Beyond COVID-19 and the Shadow Docket*, 54 U.C. DAVIS L. REV. ONLINE 105, 112, 119-20 (2021).
[50] Carrie N. Baker, *Texas Woman Lizelle Herrera's Arrest Foreshadows Post-Roe Future*, MS. MAG (April 16, 2022), https://msmagazine.com/2022/04/16/texas-woman-lizelle-herrera-arrest-murder-roe-v-wade-abortion/.
[51] Cohen, Donley & Rebouché, *supra* note 8, at 16-31.

II. The Future of Abortion Care

The COVID-19 pandemic transformed abortion care, but the benefits were limited to those living in states that did not have laws requiring in-person care or prohibiting the mailing of abortion medication.[52] This widened a disparity in abortion access that has been growing for years between red and blue states.[53] But the inequity of the previous abortion ecosystem has become even more stark.

On June 24, 2022, the Supreme Court issued its decision in *Dobbs v. Jackson Women's Health Organization*, upholding Mississippi's fifteen-week abortion ban and overturning *Roe v. Wade*.[54] Twenty four states have attempted to ban almost all abortion, though ten of those bans have been halted by courts.[55] Pregnant people in the remaining fourteen states face limited options: continue a pregnancy against their will, travel out of state to obtain a legal abortion, or self-manage their abortion in their home state.[56] Data from Texas, where SB8 effectively banned abortion after roughly six weeks of pregnancy suggests that only a small percentage of people will choose the first option—the number of abortions Texans received dropped by only 10-15% as a result of travel and self-management.[57] Evidence from other countries and our own pre-*Roe* history also demonstrate that abortion bans do not stop all, or even most, abortions.[58]

Traveling to a state where abortion is legal will not be an option for many people.[59] Yet unlike the pre-*Roe* era, there is another means to safely end a pregnancy—one that threatens the antiabortion movement's ultimate goal: self-managed abortion with medication. Self-managed abortion generally refers to abortion obtained outside of the formal healthcare system.[60] Thus, self-managed abortion can include a pregnant person buying medication abortion online directly from an international pharmacy (sometimes called self-sourced abortion) and a pregnant person interacting with an international or out-of-state provider via telemedicine, who ships them medication abortion directly or calls a prescription into an international pharmacy on their behalf.[61]

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[52] *See* Section I.

[53] Donley, *supra* note 1, at 694.

[54] Dobbs v. Jackson Women's Health Organization. 945 F.3d 265 (5th Cir. 2019), *cert. granted*, 209 L. Ed. 2d 748 (2021).

[55] *Tracking States Where Abortion is Now Banned*, N.Y. TIMES (Nov. 8, 2022), https://www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html.

[56] Thirteen states ban abortion from the earliest stages of pregnancy and Georgia bans abortion after six weeks. In addition to those fourteen states, Utah, Arizona and Florida ban abortion after fifteen weeks, Utah after eighteen and North Carolina after twenty. *Id.*

[57] *See* Margot Sanger-Katz, Claire Cain Miller & Quoctrung Bui*, Most Women Denied Abortions by Texas Law Got Them Another Way,* N.Y. TIMES (March 6, 2022), https://www.nytimes.com/2022/03/06/upshot/texas-abortion-women-data.html.

[58] Yvonne Lindgren, *When Patients Are Their Own Doctors: Roe v. Wade in An Era of Self-Managed Care*, 107 CORNELL L. REV. _, 5-6 (forthcoming 2022).

[59] Three quarters of abortion patients are poor or low income, *Abortion Patients are Disproportionately Poor and Low Income*, GUTTMACHER INST. (May 19, 2016), https://www.guttmacher.org/infographic/2016/abortion-patients-are-disproportionately-poor-and-low-income, and the cost and time associated with in-person abortion care delayed and thwarted abortion access even with *Roe* on the books. Ushma D. Upadhyay, Tracy A. Weitz, Rachel K. Jones, Rana E. Barar & Diana Greene Foster, *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 AM. J. PUBLIC HEALTH 1687, 1689-91 (2014).

[60] Rachel K. Jones & Megan K. Donovan, *Self-Managed Abortion May Be on the Rise, But Probably Not a Significant Driver of The Overall Decline in Abortion*, GUTTMACHER INST. (Nov. 2019), https://www.guttmacher.org/article/2019/11/self-managed-abortion-may-be-rise-probably-not-significant-driver-overall-decline.

[61] *See* Donley, *supra* note X, at 697; Jennifer Conti, *the Complicated Reality of Buying Abortion Pills Online*, SELF MAG. (April 9, 2019), https://www.self.com/story/buying-abortion-pills-online.

Because many states heavily restricted abortion for years, self-managed abortion is not new. The non-profit organization, AidAccess, started providing medication abortion to patients in the United States in 2017.[62] Each year, the number of U.S. patients served has grown.[63] Once Texas's SB8 became effective, AidAccess saw demand for their services increase 1,180%, leveling out to 245% of the pre-SB8 demand a month later.[64] Similarly, after *Dobbs*, the demand for AidAccess doubled, tripled, or even quadrupled in states with abortion bans.[65] There are advantages to self-managed abortion: the price is affordable (roughly only $105 for use of foreign providers and pharmacy) and the pregnant person can have an abortion at home.[66] The disadvantage is that the process can take one to three weeks and comes with legal risks explored below.

The portability of medication abortion, combined with the uptake of telehealth, poses an existential crisis for the antiabortion movement. Right as it achieved its decades-long goal of overturning *Roe*, the nature of abortion care has shifted and decentralized, making it almost impossible to police and control.[67] Before the advent of medication abortion, a pregnant person depended on the help of a provider to end their pregnancies.[68] They could not do it alone. As a result, states would threaten providers' livelihood and freedom, driving providers out of business and leaving patients with few options.[69] Many turned to unqualified providers who offered unsafe abortions that lead to illness, infertility, and death.[70] But medication abortion created *safe* alternatives for patients that their predecessors lacked. Because medication abortion makes the involvement of providers is no longer necessary to terminate early pregnancies, the classic abortion ban, which targets providers, will not have the same effect.[71] And out-of-country providers may help patients self-manage, but they will be outside of the antiabortion state's reach, making it difficult for the state to control them.[72]

The antiabortion movement is aware of this shifting reality. Indeed, antiabortion states are introducing and enacting laws specifically targeting medication abortion—laws that would ban it entirely, ban its shipment through the mail, or otherwise burden its dispensation.[73] Nevertheless, it is unclear how states will enforce these laws. Most mail goes in and out of a state without inspection, and the federal government may be able to use its authority over the post office to limit whether a state can investigate mail for abortion-related crimes.

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[62] Jones & Donovan, *supra* note 66.
[63] Donley, *supra* note 1, at 660.
[64] Abigail R.A. Aiken et al, *Association of Texas Senate Bill 8 With Requests for Self-managed Medication Abortion*, J. AM. MED. ASSN. (Feb. 25, 2022), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789428.
[65] Abigail R. A. Aiken et al, *Requests for Self-managed Medication Abortion Provided Using Online Telemedicine in 30 US States Before and After the Dobbs v Jackson Women's Health Organization Decision*, 328 J. AM. MED. ASSN. 1768, 1768 (Nov. 1, 2022).
[66] Cohen, Donley & Rebouché, *supra* note 8, at 12-13.
[67] *See id.*
[68] Lindgren, *supra* note 60, at 5-6.
[69] *See* Meghan K. Donovan, *Self-Managed Medication Abortion: Expanding the Available Options for U.S. Abortion Care*, GUTTMACHER INST. (Oct. 17, 2018), https://www.guttmacher.org/gpr/2018/10/self-managed-medication-abortion-expanding-available-options-us-abortion-care.
[70] Rachel Benson Gold, *Lessons from Before Roe: Will Past be Prologue?*, GUTTMACHER INST. (March 1, 2003), https://www.guttmacher.org/gpr/2003/03/lessons-roe-will-past-be-prologue.
[71] Greer Donley & Jill Wieber Lens, *Subjective Fetal Personhood*, 75 VAND. L. REV. __, 39-40 (forthcoming 2022).
[72] *Id.*; *see also* Cohen, Donley & Rebouché, *supra* note 8, at 16-31.
[73] Caroline Kitchener, Kevin Schaul & Daniela Santamariña, *Tracking New Action on Abortion Legislation Across the States*, WASH. POST (last updated April 14, 2022), https://www.washingtonpost.com/nation/interactive/2022/abortion-rights-protections-restrictions-tracker/.

This is not to suggest that self-management will solve the post-*Roe* abortion crisis. For one, self-managed medication abortion is generally not recommended beyond the first trimester, meaning later abortion patients, who comprise less than ten percent of the patient population, will either need to travel or face higher medical risks with self-management. [74] Moreover, pregnant patients may face legal risks in self-managing an abortion in an antiabortion state.[75] Historically, legislators were unwilling to target abortion patients themselves, but patients and their in-state helpers will become more vulnerable as legislatures and prosecutors reckon with the inability to target in-state providers. These types of prosecutions will occur in one of two ways.

First, even if shipments of medication abortion largely go undetected, a small percentage of patients will experience side-effects or complications that lead them to seek treatment in a hospital.[76] Self-managed abortion mimics miscarriage, which will aid some people in evading abortion laws, though some patients may reveal to a healthcare professional that their miscarriage was induced.[77] And even with federal protection for patient health information,[78] hospital employees could report those they *suspect* of abortion-related crimes.[79] This will lead to an increase in the investigation and criminalization of both pregnancy loss and abortion.[80] This is how many women have become targets in other countries that ban abortion.[81]

Second, the new terrain of digital surveillance will play an important role. Any time the state is notified of someone who could be charged for an abortion-related crime, police will be able to obtain a warrant to search their digital life if they have sufficient probable cause. Anya Prince has explained the breadth of the reproductive health data ecosystem, in which advertisers and period tracking apps can easily capture when a person is pregnant.[82] Pregnancy data combined with search histories regarding abortion options, geofencing data of out-of-state trips, and text histories with friends could easily be used to support abortion prosecutions.[83] Furthermore, antiabortion organizations could set up fake virtual clinics—crisis pregnancy centers for the digital age—to identify potential abortion patients and leak their information to the police.[84]

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[74] The FDA has approved medication abortion through the first ten weeks, but the protocol is the same through twelve weeks. LATER ABORTION INITIATIVE, CAN MISOPROSTOL AND MIFEPRISTONE BE USED FOR MEDICAL MANAGEMENT OF ABORTION AFTER THE FIRST TRIMESTER? (2019), https://www.ibisreproductivehealth.org/sites/default/files/files/publications/lai_medication_abortion_0.pdf. After that, patients typically need a higher dose for an effective abortion, which typically takes place in a clinical facility. In a post-*Roe* world, however, some patients will attempt to self-manage second trimester abortions. *Id.*

[75] Donley & Lens, *supra* note 76, at 39-43.

[76] *Id.*

[77] *Id.*

[78] Cohen, Donley & Rebouche, *supra* note X (discussing how HIPAA prohibits covered healthcare employees from reporting health information to law enforcement unless an exception is met). HIPAA's protections might not be a sufficient deterrent for motivated individuals who want to report suspected abortion crimes, especially if the Biden Administration is not aggressive in enforcing the statute.

[79] Donley & Lens, *supra* note 76, at 39-43.

[80] *Id.*

[81] *Id.*; Michelle Oberman, *Abortion Bans, Doctors, and the Criminalization of Patients,* 48 HASTINGS CTR. REP. 5, 5 (2018).

[82] Anya E.R. Prince, Reproductive Health ~~Privacy~~ Surveillance, B.C. L. Rev. (forthcoming 2023), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4176557.

[83] *Id.*

[84] *See* Leslie Reagan, *Abortion Access in Post-Roe America vs. Pre-Roe America*, N.Y. TIMES (Dec. 10, 2021), https://www.nytimes.com/2021/12/10/opinion/supreme-court-abortion-roe.html.

Almost certainly, low income people and women of color will be targets in any pregnancy-related criminalization.[85] This is already true—even though drug use in pregnancy is the same in white and minority populations, black women are ten times more likely to get reported to authorities.[86] And because poor women and women of color are more likely to seek abortion and less likely to have early prenatal care, any pregnancy complications may be seen suspiciously.[87]

State legislatures and the federal government can help protect providers and patients in the coming era of abortion care, though the reach of their actions will be limited.[88] At the federal level, the FDA could argue that its regulation of medication abortion preempts contradictory state laws, potentially creating a nationwide, medication-abortion exception to state abortion bans.[89] The federal government could also use federal laws and regulations that govern emergency care, medical privacy, and Medicare and Medicaid reimbursement to preempt state abortion laws and reduce hospital-based investigations, though the impact would be more limited.[90] As this chapter goes to press, the Biden Administration is undertaking many of these actions.[91]

State policy, in jurisdictions supportive of abortion rights, can also improve access for patients traveling to them. States can invest in telehealth generally to continue to loosen restrictions on telemedicine, which many states have done in response to the pandemic, reducing demand at brick-and-mortar abortion clinics and disparities in technology access.[92] They can also join interstate licensure compacts, which could extend the reach of telabortion in the states that permit the practice and allow providers to pool resources and provide care across state lines.[93] States can also pass abortion shield laws to insulate their providers caring for out-of-state residents by refusing to cooperate in out-of-state investigations, lawsuits, prosecutions, or extradition requests for abortion-related lawsuits.[94] All of these efforts will help reduce, but by no means stop, the sea change to abortion law and access moving forward. And none of these efforts protect the patients or those that assist them in states that ban abortion.

Conclusion

A post-*Roe* country will be messy. A right that generations took for granted—even though for some, abortion was inaccessible—disappeared overnight in half the country. A twenty-first century, post-*Roe* landscape, however, will not be identical to the pre-*Roe* era. Innovations in medical care and telehealth have changed abortion care, thwarting the antiabortion movement's ability to control abortion, just as it gained the ability to ban it. Unlike generations ago, patients will be able to access safe abortion, even when it is illegal. But they will also face legal risks that were uncommon previously, and new ways for the state to investigate and criminalize them.

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[85] In her book, *Policing the Womb,* Michelle Goodwin explains in great detail how the state particularly targets black women and women of color during pregnancy. MICHELE GOODWIN, POLICING THE WOMB 21 (2020).
[86] *Id.*
[87] Donley & Lens, *supra* note 76, at 41.
[88] *Id.*
[89] Cohen, Donley & Rebouché, *supra* note 8, at 130-199.
[90] Greer Donley, Rachel Rebouché & David Cohen, *Existing Federal Laws Could Protect Abortion Rights Even if Roe Is Overturned*, TIME (Jan. 24, 2023), https://time.com/6141517/abortion-federal-law-preemption-roe-v-wade/.
[91] Cohen, Donley & Rebouché, *supra* note 8, at 130-199.
[92] *Id.* at 65-74
[93] *Id.*
[94] *Id.* at 31.

As courts and lawmakers tackle the changing reality of abortion rights, we should not be surprised by surprises—unlikely allies and opponents may coalesce on both sides of the abortion debate. Laws that seek to punish abortion will become harder to enforce as mailed abortion pills proliferate. This will create urgency for some antiabortion states to find creative ways to chill abortion, while other states will be content to ban abortion in law, understanding that it continues in practice. *Who* states seek to punish will shift, with authorities targeting not only providers but also patients and helpers, with the most marginalized being the most vulnerable.[95]

[95] In her book, *Policing the Womb,* Michelle Goodwin explains in great detail how the state particularly targets black women and women of color during pregnancy. GOODWIN, *supra* note 88, at 12–26.