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The New Abortion Battleground

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The New Abortion Battleground

David S. Cohen, Greer Donley & Rachel Rebouché*

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This Article examines the paradigm shift that is occurring now that the Supreme Court has overturned Roe v. Wade. Returning abortion law to the states has spawned perplexing legal conflicts across state borders and between states and the federal government. This article emphasizes how these issues intersect with innovations in the delivery of abortion, which can now occur entirely online and transcend state boundaries. The interjurisdictional abortion wars are coming, and this Article is the first to provide the roadmap for the immediate aftermath of Roe's reversal and what lies ahead.

Judges and scholars, and most recently the Supreme Court, have long claimed that abortion law will become simpler if Roe is overturned, but that is woefully naïve. In reality, overturning Roe will create a novel world of complex, interjurisdictional legal conflicts over abortion. Some states will pass laws creating civil or criminal liability for out-of-state abortion travel while others will pass laws insulating their providers from out-of-state prosecutions. The federal government will also stake a claim. Beyond promoting access to medication abortion, federal regulations may preempt state abortion bans and federal land could provide shelter for abortion services. Ultimately, once the constitutional protection for pre-viability abortion disappears, the impending battles over abortion access will transport the half-century war over Roe into a new arena, one that will make abortion jurisprudence more complex than ever before.

This Article is the first to offer insights into this fast-approaching transformation of abortion rights, law, and access. It explores the interjurisdictional issues sure to arise while looking ahead to creative strategies to promote abortion access in a country without a constitutional abortion right.

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Table of Contents

INTRODUCTION.....1

I. POST-*ROE* ABORTION RIGHTS AND ACCESS.....6

 A. The Post-Roe Interjurisdictional Legal Landscape 7

 B. Beyond Legality: Accessing Abortion after Roe..... 10

II. INTERSTATE BATTLES OVER CROSS-BORDER ABORTION 17

 A. Extraterritoriality in Abortion Law Precedent..... 20

 B. Do Ordinary Criminal Abortion Laws Apply
 Extraterritorially? 23

 C. Can States Enforce Laws Specifically Targeting
 Extraterritorial Abortion?..... 27

 D. Can a State Insulate Providers from Out-of-State
 Prosecutions?..... 33

III. PREEMPTION, FEDERAL LAND, AND HEALTH POLICY40

 A. Federal Preemption 41

 B. Federal Land 63

 C. Expanding Access to Medication Abortion..... 70

CONCLUSION.....79

INTRODUCTION

The Supreme Court’s decision to overturn *Roe v. Wade* will usher in a new era of abortion law and access.¹ Borders and jurisdiction will become the central focus of the abortion battle. What had been, until now, a uniform national right² has become a state-by-state patchwork. In a post-*Roe* country, states will attempt to impose their local abortion policies as widely as possible, even across state lines, and will battle one another over these choices; at the same time, the federal government may intervene to thwart state attempts to control abortion law. In other words, the interjurisdictional abortion wars are coming. This Article is the first to offer insights into this fast-approaching transformation of abortion rights, law, and access.

Though access to abortion was already scarce in many regions, for the past fifty years, the Supreme Court had held steadfast to the principle that the Constitution protected the right to pre-viability abortion everywhere in the country. The Court upended that longstanding precedent in *Dobbs v. Jackson Women’s Health Organization*, holding that the U.S. Constitution lacks any abortion right.³ By the time of this publication, 17 states—mostly in the South and Midwest—have banned or tried to ban abortion in almost all circumstances, while another 3 states are expected to have bans in the near future.⁴ The remaining states—mostly along the coasts—continue to offer legal abortion, regulated to varying degrees, with some states codifying abortion rights and expanding access.⁵

¹ In *Roe v. Wade*, the Supreme Court held that criminal laws banning abortion were an infringement of a constitutional right to privacy. 410 U.S. 113, 164 (1973). In *Planned Parenthood v. Casey*, the Court preserved constitutional protection for abortion, but gave states greater discretion to restrict access to abortion. 505 U.S. 833, 873 (1992). One of *Casey*’s central holdings is that a state cannot ban pre-viability abortions *Id.* at 872. On June 24, 2022, the Court overturned both of these precedents. *Dobbs v. Jackson Women’s Health Organization*, No. 19-1392 (June 24, 2022).

² It is important to contrast what had been a national *right* to the national *reality* of access, which has always been marked by significant race and class disparities. See DAVID S. COHEN & CAROLE JOFFE, OBSTACLE COURSE, THE EVERYDAY STRUGGLE TO GET AN ABORTION IN AMERICA (2020).

³ The Supreme Court ruled that neither the history and tradition of abortion regulation nor the text of the Constitution supports the “egregiously wrong” judgment in *Roe* and reiterated in *Casey* that the Fourteenth Amendment protects pre-viability abortion decisions. States are free to regulate, even ban, abortion so long as there is “a rational basis on which the legislature could have thought that it would serve legitimate state interests.” *Dobbs*, slip op. at 77.

⁴ Caroline Kitchener, Kevin Schaul, N. Kirkpatrick, Daniela Santamariña and Lauren Tierney, *Abortion Is Now Banned In These States*. See *Where Laws Have Changed*, WASH. POST (last updated July 22, 2022), <https://www.washingtonpost.com/politics/2022/06/24/abortion-state-laws-criminalization-roe/>.

⁵ *Abortion Policy in the Absence of Roe*, GUTTMACHER INST., <https://www.guttmacher.org/state-policy/explore/abortion-policy-absence-roe>.

Antiabortion jurists and advocates have long forecasted that abortion law will become simpler if *Roe* is overturned. This claim has been a central part of their efforts to overturn *Roe* and *Planned Parenthood v. Casey*—the case that upheld *Roe*'s protection of pre-viability abortion—which created an unworkably complex legal framework, according to this argument. In *Casey*, for instance, Justice Scalia wrote in dissent that the undue burden test, which supplanted the trimester framework announced in *Roe*, was “inherently manipulable and will prove hopelessly unworkable in practice.”⁶ Abortion law will become simpler, the argument continues, because states will be able to craft laws without the threat of constitutional litigation. Justice Scalia went so far as to suggest that overturning *Roe* and *Casey* will remove the Court from the “abortion-umpiring business” because doing so would “return this matter to the people” to determine “State by State, whether this practice should be allowed.”⁷ Justice Alito adopted this argument in the *Dobbs* opinion, noting that *Casey* saddled judges with “an unwieldy and inappropriate task.”⁸

As this Article makes clear, the opposite is true: overturning *Roe* and *Casey* will create a complicated world of novel interjurisdictional legal conflicts over abortion. Instead of creating stability and certainty, it will lead to profound confusion because advocates on both sides of the abortion controversy will not stop at state borders in their efforts to apply their policies as broadly as possible. Antiabortion activists have made clear that overturning *Roe* is the first step toward their goal of making abortion illegal nationwide.⁹ Right now, there are not enough votes in Congress nor is there a supportive White House to achieve that goal. That will leave the effort to antiabortion states who will, with *Roe* overturned, not only pass laws that criminalize in-state abortion, but also attempt to impose civil or criminal liability for those who travel out of state for abortion care or those who provide that care for their citizens or help them get it.¹⁰ In a post-*Roe* country, abortion-supportive states will seek the opposite and, in an effort to expand abortion access as broadly as possible, pass laws that protect their providers from legal sanctions after helping out-of-state residents obtain care.¹¹

⁶ *Casey*, 505 U.S. at 986 (Scalia, J., dissenting).

⁷ *Id.*

⁸ Slip op. at 62; *see also id.* at 56-62.

⁹ Caroline Kitchener, *The Next Frontier of the Antiabortion Movement: A Nationwide Abortion Ban*, WASH. POST (May 2, 2022),

<https://www.washingtonpost.com/nation/2022/05/02/abortion-ban-roe-supreme-court-mississippi/>; Caroline Kitchener, *Roe's Gone. Now antiabortion lawmakers want more*, WASH. POST (June 25, 2022),

<https://www.washingtonpost.com/politics/2022/06/25/roe-antiabortion-lawmakers-restrictions-state-legislatures/>.

¹⁰ *See infra* Part II.A, B.

¹¹ *See infra* Part II.D.

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We have already seen the beginnings of these battles. A model law authored by the National Right to Life Committee bans assisting a minor across state lines to get an abortion, “[r]egardless of where [the] illegal abortion occurs.”¹² Multiple so-called “sanctuary cities” in Texas have likewise included such language, banning abortion for city residents “regardless of where the abortion is or will be performed.”¹³ Missouri has now twice considered passing a statewide law to this effect: with a 2021 bill that would have applied the state’s abortion restrictions to out-of-state abortions performed on Missouri citizens,¹⁴ and a 2022 bill that imposed civil liability on those helping Missouri citizens travel out of state to obtain an abortion.¹⁵ From the abortion-supportive side of the ledger, a Connecticut law adopted in April 2022 became the first in the nation to offer protection for those who provide and assist in the provision of abortions to out of state patients, and four other states have since followed suit. In the wake of *Dobbs*, ten governors from abortion-supportive states have issued executive orders indicating they will not extradite abortion providers and limiting state employees from participating in out of state investigations of abortions legally occurring within those states. These examples are the first of many to come.¹⁶

Roe’s demise is just one part of the story behind the seismic shift in abortion law; the other is that abortion *practice* has changed in ways that make borders less relevant. The rise of telehealth for medication abortion—abortion completed solely with medication during the first ten weeks of pregnancy—allows abortion provision to occur across state and country lines.¹⁷ Virtual clinics, offering remote medication abortion through telehealth, have begun to operate in greater numbers, and brick-and-mortar clinics have expanded their practice into virtual care as well. Early abortion care has, as a result,

¹² National Right to Life Committee, *Model Abortion Law*, <https://www.nrlc.org/wp-content/uploads/NRLC-Post-Roe-Model-Abortion-Law-FINAL-1.pdf>

¹³ Cisco Ordinance Outlawing Abortion, Aug. 19, 2021, <https://www.scribd.com/document/567480915/Cisco-Ordinance-Outlawing-Abortion-08-19-21-Docx-1>; Slaton, Texas Ordinance Outlawing Abortion Within the City Limits, July 8, 2021, <https://www.scribd.com/document/569256021/Slaton-Texas-Ordinance-Outlawing-Abortion-Within-the-City-Limits-07-08-2021-Docx-1>.

¹⁴ S.B. 603, 101st Gen. Assemb., Reg. Sess. (Mo. 2021).

¹⁵ HB 2012, 102nd Gen. Assemb., Reg. Sess. (Mo. 2022).

¹⁶ See *infra* Part II.D.

¹⁷ The pandemic catapulted the idea of virtual abortion care from a distant dream to a new reality, revolutionizing how abortion care is offered. Rachel Rebouché, Greer Donley & David Cohen, *The FDA’s Telehealth Safety Net for Abortion Only Stretches So Far*, *The HILL* (Dec. 18, 2021), <https://thehill.com/opinion/healthcare/586329-the-fdas-telehealth-safety-net-for-abortion-only-stretches-so-far>.

become more portable in the states that permit telehealth for abortion.¹⁸

The portability of medication abortion will impact abortion access even in states that prohibit telehealth or ban abortion after *Roe*. In those jurisdictions, people¹⁹ already obtain this medication through the mail, often with the help of an international organization.²⁰ Even for patients who travel to abortion supportive states to obtain medication abortion legally, if they consume one or both sets of medications in the antiabortion state, it raises novel questions about where an abortion occurred. Out-of-state and out-of-country providers could be guilty of state crimes if they knowingly send pills into antiabortion states; but antiabortion states will struggle to establish jurisdiction over these providers, while abortion-protective states will attempt to protect their providers from out-of-state prosecutions. The legal uncertainty in this newly developing world of remote abortion will shape the actions of patients, providers, and the networks that support them in the years to come.

Additional interjurisdictional conflicts will also arise because the federal government could play a more pronounced role in abortion regulation, whether deploying strategies to protect or limit abortion nationally. Whatever the political agenda, federal action in this area could create jurisdictional conflict with state regulation of abortion. The Biden Administration has already taken some executive action in the immediate aftermath of *Dobbs*, and members of Congress have advocated for more aggressive ideas.²¹

This Article tackles these tricky interjurisdictional issues while considering strategies to protect abortion access in a country without a constitutional right to abortion. Part I starts by describing what a post-*Roe* country looks like when each state is free to ban abortion at any point in pregnancy. It highlights both the legal heterogeneity across

¹⁸ *Medication Abortion*, GUTTMACHER INST., <https://www.guttmacher.org/state-policy/explore/medication-abortion>.

¹⁹ Not every person capable of becoming pregnant is a woman; trans men and gender non-binary patients also need access to abortion and reproductive healthcare. There are also times, however, where gender's intersection with abortion is important and relevant. We do our best to thread that needle by using a variety of terms in our discussion. For more context, see Jessica Clarke, *They, Them, and Theirs*, 132 HARV. L. REV. 894 (2019); LORETTA ROSS & RICKIE SOLINGER, REPRODUCTIVE JUSTICE: AN INTRODUCTION 6-8 (1st ed. 2017).

²⁰ See *infra* Part I.B.

²¹ The White House, *Fact Sheet: President Biden to Sign Executive Order Protecting Access to Reproductive Health Care Services* (July 8, 2022), <https://www.whitehouse.gov/briefing-room/statements-releases/2022/07/08/fact-sheet-president-biden-to-sign-executive-order-protecting-access-to-reproductive-health-care-services/>; Letter from Senator Elizabeth Warren to President Joseph Biden, June 27, 2022, <https://www.warren.senate.gov/download/20220607-letter-to-potus-on-abortion-eo>.

states and notes how the law will alter the practice of abortion on the ground, paying attention to the growth of self-managed abortion and remote abortion access across state and country lines.

Next, Part II focuses on the next generation of interstate abortion conflicts. It first explores the legal complexity that will result when antiabortion states attempt to punish extraterritorial abortion through general criminal laws, like conspiracy, or laws specifically targeting abortion providers, helpers, and even patients. The Constitution's general prohibition of state restrictions on interstate travel, burdens on interstate commerce, or application of a state's law outside its borders should make it difficult for antiabortion states to enforce these laws. Yet, these constitutional defenses are underdeveloped and subject to debate, leaving courts as the ultimate arbiters of these interjurisdictional battles. It then explores how states in which abortion remains legal might prevent antiabortion states from enforcing their laws in other jurisdictions. These dueling strategies, however, come at a cost by undermining key tenets of federalism and comity.

Finally, Part III highlights how the federal government, given the current Administration's commitments to reproductive rights, might protect abortion access in states that ban it. It argues that the supremacy of federal law provides a novel and untested argument for chipping away at state abortion bans. The FDA's exercise of authority over medication abortion since it was approved in 2000 suggests that FDA regulation preempts contradictory state laws, potentially granting a right to medication abortion in all fifty states. Other federal laws governing health privacy and emergency medical treatment could also poke additional holes in state abortion bans. Moreover, because state law does not always apply on federal land, some abortions provided on leased federal land within antiabortion states might not be subject to state abortion bans. Federal policy decisions could also promote access to medication abortion through telehealth and multi-state physician licensing.

Ultimately, without a constitutional right to abortion, the coming battles over abortion access will move the half-century war over *Roe* into a new interjurisdictional arena. These conflicts will make abortion jurisprudence much more complex than before, in ways that test the principles underpinning our federalist system of government. But these conflicts also open the door to unexamined possibilities in a new era of abortion access—a future that will no longer be tethered to constitutional rights. This Article concludes by highlighting how an abortion rights movement might pivot from defense to offense, from short game to long game, and capitalize on the same strategies that led to the antiabortion movement's success.

I. POST-*ROE* ABORTION RIGHTS AND ACCESS

Among the various arguments to overturn *Roe*, conservatives have long argued that *Roe* and its progeny created unworkable standards that have vexed lower courts. Their list of concerns includes that the undue burden standard—*Casey*'s constitutional test for vetting state abortion restrictions—is vague and difficult to apply,²² that viability²³ is a moving target, and that a health-or-life exception²⁴ is malleable.²⁵ Abortion precedents should be overturned, in this vein of thinking, because the values underlying *stare decisis* fail in the face of unworkability.²⁶ The simpler, more workable alternative, they claim, would be to allow each state to decide its own abortion laws. Justice Alito adopted this reasoning in full in *Dobbs*.²⁷ But he and those who came before him are wrong.

In this section, we explore a United States without any constitutional floor for abortion rights. Though states have restricted abortion to varying degrees, straining abortion access and making services all but absent in a few places, *Roe v. Wade*, as interpreted by *Planned Parenthood v. Casey*, established that no state may ban pre-viability abortion.²⁸ Without *Roe*, that has changed. The legality of obtaining any abortion care now hinges on where you live.

The heterogeneity that characterized abortion regulation for the past half century will be nothing like the complexity of what is unfolding now and what is to come. This part outlines the myriad ways in which states will ban (or protect) in-state and cross-border services with *Roe* now overturned. We then explore how the now-varying legality of abortion will affect access to abortion. Such access comprises both traditional in-person services, accessed through interstate travel, and remote services. We argue that due to innovations in abortion care, abortion access will not necessarily be tied to local abortion legality: people can and already do obtain abortion inducing drugs online and will continue to do so through telemedicine or other means. Thus, post-*Roe* America looks very different than much of the *Roe* and pre-*Roe* era.

²² *Casey* held that states can regulate pre-viability abortions so long as the regulation did not create an undue burden. *Casey*, 505 U.S. at 874. Courts apply this standard differently.

²³ The Court has determined that viability starts when a fetus has “realistic possibility of maintaining and nourishing a life outside the womb.” *Id.* at 870. This point has changed over time.

²⁴ The Court has always required that abortion bans include an exception for the life or health of the mother, unless the court determines that the law does not harm the health or life of the mother. *See id.* at 846.

²⁵ Mary Ziegler, *Taming Unworkability Doctrine: Rethinking Stare Decisis*, 50 ARIZ. ST. L.J. 1215, 1218-39 (2018).

²⁶ *Id.* at 1218.

²⁷ *Dobbs*, slip op. at 56-62.

²⁸ *Casey*, 505 U.S. at 874.

A. *The Post-Roe Interjurisdictional Legal Landscape and its Impact on Abortion-Related Travel*

Without *Roe*, roughly half the country is expected to make almost all abortion services illegal.²⁹ At the time of writing, 17 states have done just that, with three more coming soon.³⁰ Overturning *Roe* will not only result in states criminalizing abortion; according to the *Dobbs* majority, states can decree that life begins at conception, which could treat abortion as murder. Georgia, Arizona, and Alabama already have such a law in place (enjoined while *Roe* and *Casey* stood³¹), and the Louisiana legislature considered, but ultimately shelved, such a bill in May 2022.³²

Abortion-supportive states will comprise the other half of the country post-*Roe*. At present, sixteen states and the District of Columbia have passed laws to protect abortion rights on their own regardless of a federal constitutional right.³³ These state laws guarantee mostly unencumbered access to pre-viability abortion and access to post-viability abortion when necessary to protect the health or life of the pregnant person.³⁴ The remaining states will operate in a middle ground, keeping abortion legal, but regulating it to varying degrees of strictness.³⁵ Providers in all of the states where abortion remains legal will begin providing services to those traveling from states where abortion is banned, putting immense strain on their capacity to deliver services.³⁶

The effects of this new reality will have devastating consequences for all abortion seekers. A 2019 study mapped what abortion provision would look like if *Roe* were overturned.³⁷ It found that “the average resident is expected to experience a 249-mile increase

²⁹ *Abortion Policy in the Absence of Roe*, *supra* note 5.

³⁰ Kitchner et al., *supra* note X.

³¹ Ala. Code § 26-23H-1 to -8 (enjoined by *Robinson v. Marshall*, 415 F. Supp. 3d 1053 (M.D. Ala. 2019)).

³² Rick Rojas & Tariro Mzezewa, *After Tense Debate, Louisiana Scraps Plan to Classify Abortion as Homicide*, N.Y. TIMES (May 12, 2022), <https://www.nytimes.com/2022/05/12/us/louisiana-abortion-bill.html>.

³³ *Abortion Policy in the Absence of Roe*, *supra* note 5.

³⁴ Two states and the District of Columbia have codified the right to abortion throughout pregnancy without state interference. *Id.*

³⁵ *Id.*

³⁶ See Rachel Jones et al., *New Evidence: Texas Residents Have Obtained Abortions in at Least 12 States That Do Not Border Texas*, GUTTMACHER INST. (Nov. 9, 2021), <https://www.guttmacher.org/article/2021/11/new-evidence-texas-residents-have-obtained-abortions-least-12-states-do-not-border>; Mary Tuma, *Texas' Abortion Ban is Having a 'Domino Effect' on Clinics across the U.S.*, TEX. OBSERVER (Nov. 18, 2021), <https://www.texasobserver.org/texas-abortion-ban-is-having-a-domino-effect-on-clinics-across-the-u-s/>.

³⁷ Caitlin Myers et al., *Predicted Changes in Abortion Access and Incidence in a Post-Roe World*, 100 CONTRACEPTION 367, 369 (2019).

in travel distance, and the abortion rate is predicted to fall by 32.8%.³⁸ Indeed, regional gaps in abortion access are already stark. Leading up to *Dobbs*, six states had only one abortion clinic,³⁹ and providers throughout the country were increasingly concentrated in urban areas, creating “abortion deserts,” mostly in the Midwest and South, in which there were no providers within one hundred miles of many of a state’s residents.⁴⁰ Now that states can ban almost all abortions at any point in pregnancy, the size of the already-existing abortion deserts will balloon.

The impact of these abortion deserts is stark. Three quarters of abortion patients are poor or low income,⁴¹ and the costs associated with travel, time off work, and childcare already had significant impacts on their ability to obtain abortion care in the *Roe*-era.⁴² With the costs of travel increasing as distances double, triple, or quadruple, and corresponding logistical burdens growing, many abortion seekers will not be able to afford the costs. Abortion funds seek to help these patients, but it is unclear if they can help on the scale necessary, especially as states like Texas work to shut them down.⁴³ Without funding, poor women and women of color, who comprise over half of people seeking abortion care, are more likely to be left with the options of continuing an unwanted pregnancy or self-managing an abortion in a hostile state with the corresponding legal risks (discussed in the section below). Moreover, there are some people who will struggle to leave the state for other reasons—those who are institutionalized or hospitalized, those on parole, those who are undocumented, and those

³⁸ *Id.* at 367.

³⁹ COMMUNITIES NEED CLINICS REPORT 2021, ABORTION CARE NETWORK, 5 (2021), <https://abortioncarenetwork.org/wp-content/uploads/2021/11/CommunitiesNeedClinics2021-1.pdf>.

⁴⁰ See Lisa R. Pruitt & Marta R. Vanegas, *Urbanormativity, Spatial Privilege, and Judicial Blind Spots in Abortion Law*, 30 BERKELEY J. GENDER L. & JUST. 76, 79–80 (2015) (discussing the unique impacts antiabortion laws have on women living in rural areas).

⁴¹ *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>.

⁴² 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); Jenna Jerman, Lori Frohwirth, Meghan L. Kavanaugh, Nakeisha Blades, *Barriers to Abortion Care and Their Consequences For Patients Traveling for Services: Qualitative Findings from Two States*, 49 PERSP. SEXUAL & REPROD. HEALTH 95 (Apr. 10, 2017), <https://onlinelibrary.wiley.com/doi/epdf/10.1363/psrh.12024>.

⁴³ See Jolie McCullough & Neelam Bohra, *As Texans Fill Up Abortion Clinics In Other States, Low-Income People Get Left Behind*, THE TEXAS TRIBUNE (Sept. 3, 2021), <https://www.texastribune.org/2021/09/02/texas-abortion-out-of-state-people-of-color/>.

with disabilities that makes travel challenging.⁴⁴ As countless news stories have highlighted, many pregnant people with medical emergencies may also be denied an abortion, and they, too, may be unable to travel.⁴⁵

Moreover, the clinics that remain open will be inundated with out-of-state patients, delaying care for in and out-of-state patients alike.⁴⁶ Already, clinics in certain areas are booking over three weeks out or not scheduling new patients due to the surge in demand.⁴⁷ California abortion providers already served about 7,000 patients per year from other states; with *Roe* overturned, one study estimates that an additional 8,000-16,000 people will be traveling to the state for care.⁴⁸ A coalition of California officials and medical care professionals is scaling up efforts to provide financial and logistical support to abortion travelers, but it is unclear if these efforts can meet the needs of out-of-state patients.⁴⁹

Abortion travel will become an essential part of the post-*Roe* reality, but there will be attempts to outlaw it. Some state legislators are now focused on both regulating abortion outside their borders and stopping their citizens from traveling for abortion care. Abortion-supportive states likewise have already begun to craft legislation in anticipation of increased demand for services and the need to protect providers who offer care to patients who live out of state. Part II describes these laws in more detail as well as options for states looking to enact even more comprehensive abortion provider protections.⁵⁰

Though the focus in the coming years will be on state efforts to outlaw or to protect abortion access, the federal government will

⁴⁴ See Robyn Powell, Disability Reproductive Justice, forthcoming in the Penn. L. Rev.; see also Cohen & Joffe, *supra* note ??, at 72-83 (describing the pre-*Roe* challenge of getting to a clinic).

⁴⁵ See Jack Healy, *With Roe Set to End, Many Women Worry About High-Risk Pregnancies*, N.Y. TIMES, June 20, 2022, <https://www.nytimes.com/2022/06/20/us/abortion-high-risk-pregnancy.html>.

⁴⁶ Margot Sanger-Katz, Claire Cain Miller & Josh Katz, *Interstate Abortion Travel Is Already Straining Parts of the System*, N.Y. TIMES (July 12, 2022), <https://www.nytimes.com/2022/07/23/upshot/abortion-interstate-travel-appointments.html?referringSource=articleShare>.

⁴⁷ *Id.*

⁴⁸ Brad Sears, Cathren Cohen, Lara Stemple, *People Traveling to California and Los Angeles for Abortion Care if Roe v. Wade is Overturned* (June 2022), https://law.ucla.edu/sites/default/files/PDFs/Center_on_Reproductive_Health/California_Abortion_Estimates.pdf.

⁴⁹ *Id.*

⁵⁰ This article has played an interesting role in the passage of these laws. Before its appearance online in draft form, we advised legislators in Connecticut about options for protecting abortion providers. They took many of our ideas and molded them into a bill, that we advised on and testified in support of. This bill ultimately passed. Legislators in New York did not contact us, but several of the narratives supporting their proposed bills lifted language almost directly from our draft article.

also enter the fray in this new landscape. The Biden Administration has preliminarily indicated that it wants to protect interstate travel and access to medication abortion in the aftermath of *Dobbs*, and multiple members of Congress have encouraged President Biden to explore leasing federal land to abortion providers.⁵¹ Part III discusses the legal complexities of these actions.

B. *Beyond Legality: Avenues for Accessing Abortion After Dobbs*

Abortion becoming illegal in half of the country will be devastating for people seeking abortion generally and, as we note above, disproportionately so for poor people and women of color.⁵² But legal scholarship has not yet explored or developed how abortion care will be different in a post-*Roe* world, compared to a pre-*Roe* world.⁵³ The country's pre-*Roe* history coupled with the comparative experience of other countries points to one thing, however: abortions will not stop occurring just because they are illegal.⁵⁴

One important difference between illegal abortion in the future and illegal abortion decades ago is that people will be able to safely terminate a pregnancy without leaving their homes. To be sure, abortion travel will always be a necessary and significant part of abortion care post-*Roe*, but with the uptake of mailed medication abortion, it will not be the only way to find a safe and effective abortion.

In 2000, the FDA paved the way for abortion done solely with medication when it approved the first drug to end a pregnancy: mifepristone (previously known as RU-486).⁵⁵ Today, medication abortion in the United States is accomplished with two drugs. The first, mifepristone, blocks the hormone progesterone, which is necessary for

⁵¹ Fact Sheet, President Biden Announces Actions in Light of Today's Supreme Court Decision on *Dobbs v. Jackson Women's Health Organization* (June 24, 2022), <https://www.whitehouse.gov/briefing-room/statements-releases/2022/06/24/fact-sheet-president-biden-announces-actions-in-light-of-todays-supreme-court-decision-on-dobbs-v-jackson-womens-health-organization/>.

⁵² Khaleida Rahman, *Roe v. Wade Being Overturned Will Harm Black Women the Most*, NEWSWEEK (Nov. 29, 2021), <https://www.newsweek.com/overturning-roe-harm-black-women-most-1653082>.

⁵³ *But see* Rachel Rebouché, *The Public Health Turn in Reproductive Rights*, 78 WASH. & LEE L. REV. 1355, 1416-28 (2021) (describing the abortion access in “without *Roe*”).

⁵⁴ Michelle Oberman, *What Will and Won't Happen When Abortion is Banned*, 9 J. L. & BIOSCIENCES 1 (2022) (noting countries that ban abortion and still have relatively high abortion rates); Yvonne Lindgren, *When Patients Are Their Own Doctors: Roe v. Wade in An Era of Self-Managed Care*, 107 CORNELL L. REV. __ (forthcoming 2022), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3793851.

⁵⁵ Greer Donley, *Medication Abortion Exceptionalism*, 107 CORNELL L. REV. 627, 10 (2022), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3795414.

a pregnancy to continue.⁵⁶ The second drug, misoprostol, is taken 24 to 48 hours after mifepristone and causes uterine contractions that expel the pregnancy from the uterus.⁵⁷ Misoprostol is not FDA-approved to terminate a pregnancy, but is used off label for this and a variety of other obstetric purposes.

As discussed further in Part III, the FDA has historically prevented mifepristone from being prescribed in the same manner as most other drugs. Until recently, the agency required patients to pick up the drug in person from a “certified provider,” which was almost always at an abortion clinic.⁵⁸ In December 2021, based on years of evidence showing the drug can be prescribed and used safely without such strict controls, the FDA removed the requirement that patients pick up the drug in person.⁵⁹ It nevertheless maintained other restrictions on medication abortion that are unsupported by the evidence and not applied to comparably safe drugs.⁶⁰

The removal of the in-person dispensing requirement opened the door for what will become a key part of abortion’s future: abortion untethered to a clinical space. Patients now can obtain a legal abortion after meeting via telehealth with an abortion provider who prescribes abortion medication that they then take at the location of their choice.⁶¹ For example, the first large-scale telehealth abortion service run by a U.S.-based provider, Abortion on Demand (AOD), launched in April 2021 and operates in 22 states.⁶² The AOD founder is a physician licensed in each of those 22 states. AOD prescribes medication abortion through eight weeks of pregnancy, rather than ten weeks as allowed by the FDA, and only for those over eighteen in order to ensure compliance with parental involvement restrictions.⁶³ According

⁵⁶ *Mifeprex (mifepristone) Information*, U.S. FOOD & DRUG ADMIN., (last updated Dec. 16, 2021), <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information>.

⁵⁷ Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2014*, 49 PERSP. SEXUAL & REPROD. HEALTH 1, 6 (2017).

⁵⁸ Donley, *supra* note 54, at 15-21.

⁵⁹ *Mifeprex (mifepristone) Information*, *supra* note 55.

⁶⁰ Response Letter from FDA CDER to American Association of Pro-Life Obstetricians and Gynecologists and American College of Pediatricians (Dec. 16, 2022), <https://www.regulations.gov/document/FDA-2019-P-1534-0016>. [hereinafter FDA Letter]

⁶¹ Rebouché, Donley & Cohen, *supra* note 16; Carrie N. Baker, *How Telemedicine Startups Are Revolutionizing Abortion Health Care in the U.S.*, MS. MAG. (Nov. 16, 2020), <https://msmagazine.com/2020/11/16/just-the-pill-choix-carafem-honeybee-health-how-telemedicine-startups-are-revolutionizing-abortion-health-care-in-the-u-s>.

⁶² *Where is AOD Available?*, ABORTION ON DEMAND (last visited Jan. 30, 2022), <https://abortionondemand.org/>. Remote medication abortion first became available two years ago after a federal district court issued an injunction that temporarily suspended in-person collection during the COVID-19 pandemic.

⁶³ *Id.* Other virtual clinics, such as Choix and Hey Jane, provide medication abortion through ten weeks of pregnancy. Baker, *supra* note 60.

to its founder, AOD is built for scale over scope, delivering medication abortion to patients who do not present complicated cases and adopting a patient protective strategy through a rigorous screening process.⁶⁴

The platform used by AOD was built with telehealth regulations in mind: the process is designed to protect patient privacy and in compliance with the privacy protections of the Health Insurance Portability and Accountability Act.⁶⁵ It is the same for every state in which AOD operates, even in states with 24-hour waiting periods.⁶⁶ The intake is asynchronous with informed consent delivered by a pre-recorded video; a video appointment with the physician follows. AOD works with an online pharmacy that then ships the medication directly to the patient with an option for express overnight shipping. The entire process—from counseling to receipt of abortion pills—takes between two to five days, depending on the state, and AOD charges \$289 (and \$239 for patients self-reporting financial need), which is around two to three hundred dollars less than abortions offered by a clinic.⁶⁷

Before *Dobbs* and even with the in-person restriction jettisoned, remote abortion care was not available everywhere. Virtual providers could only operate in states that had not banned telemedicine for abortion or did not require in-person dispensation of abortion medication—nineteen states have such laws.⁶⁸ AOD verifies that the patient is in a state permitting remote provision by tracking IP addresses to confirm location at patient intake. If the IP address indicates a location different than the location claimed by the patient, the patient is asked to provide an in-state identification.⁶⁹

Nevertheless, there are three ways in which remote care can assist people in states that ban abortion. First, patients traveling to a state that allows remote abortion care could travel across the border to have their telehealth appointment, rather than travel further into the state to a brick-and-mortar clinic. This can mean the difference of hundreds of miles—and the extra cost of gas and time that come with it. Indeed, some providers are considering building satellite sites or

⁶⁴ Telephone interview with AOD Founder, held by Rachel Rebouché (Aug. 3, 2021) (on file with author) [hereinafter AOD Interview].

⁶⁵ Health Insurance Portability and Accountability Act of 1996, 42 U.S.C.S. § 553-57.

⁶⁶ Counseling online is time stamped and shipment of medication abortion does not mail until 24 hours have passed. Patients' digital signatures have an audit trail with an email only the patient has access to. AOD Interview, *supra* note 6364.

⁶⁷ Baker, *supra* note 60.

⁶⁸ *Medication Abortion*, *supra* note 17.

⁶⁹ This can happen when a patient is close to a border of a state with a law prohibiting telehealth for abortion. *Id.*

DRAFT 8/4/22
IF QUOTING, PLEASE INDICATE THIS IS A DRAFT

placing mobile clinics at antiabortion state borders to make telehealth visits easier.⁷⁰

Second, some providers do not rely on IP addresses to assess a person's location, but, as is the standard of care for most health services, ask patients to provide their address.⁷¹ Providers would thus have difficulty knowing if a person is using the mailing address of a friend or family member or renting a post office box in a state where telabortion is legal.⁷² Some virtual providers warn against trying to circumvent state law through, for example, VPNs or mail forwarding.⁷³ Extralegal strategies can have costs, particularly for those already vulnerable to state surveillance and punishment.⁷⁴ How such measures will now be policed raises additional questions.⁷⁵ The ability to receive abortion pills by mail in ways that defy detection is sure to encumber efforts to eliminate abortion in this country.⁷⁶

Third, people can (and do) circumvent legal requirements and order medication abortion online regardless of where they live. Even when *Roe* was in place, gaining access to abortion was a struggle for many people, particularly those who live in rural areas or below the poverty level. Aid Access is an international non-profit that serves people across the country, including those who live in states that ban abortion.⁷⁷ Asserting jurisdiction over international actors is difficult for any state, so even though a state may view this conduct to be illegal, state and federal actors have so far been unable to stop it.⁷⁸ Aid Access offers medication abortion to patients within the first 10 weeks of pregnancy and costs \$110.⁷⁹ For states where either abortion or telehealth for abortion is banned, European-based physicians review the patients' consultation forms and prescribe them the medications, which are delivered by an India-based pharmacy within one to three weeks. The organization saw a dramatic increase in requests from

⁷⁰ See Melville House (@melvillehouse), TWITTER (Oct. 26, 2021, 1:45 PM), <https://twitter.com/melvillehouse/status/1453055176684748810>.

⁷¹ Baker, *supra* note 60.

⁷² *The Plan C Guide to Abortion Pills*, PLAN C (last visited Jan. 5, 2022), <https://www.plancpills.org/states/texas#results-anchor>.

⁷³ Donley, *supra* note 54, at 66; AOD Interview, *supra* note 63.

⁷⁴ Donley, *supra* note 54, at 32.

⁷⁵ 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 (2021).

⁷⁶ Greer Donley, Rachel Rebouché, & David S. Cohen, *Abortion Pills Will Change a Post-Roe World*, N.Y. TIMES (June 6, 2022), <https://www.nytimes.com/2022/06/23/opinion/abortion-pills-online-roe-v-wade.html>.

⁷⁷ *Consultation*, AID ACCESS (Sept. 14, 2021), <https://perma.cc/8BWQ-2WSQ>.

⁷⁸ Even under the Trump Administration, the federal government was unable to stop the organization. <https://www.fda.gov/inspections-compliance-enforcement-and-criminal-investigations/warning-letters/aidaccessorg-575658-03082019>.

⁷⁹ The cost is \$150 when using a US-based provider and when the patient is in a state permitting mailed medication abortion. Aid Access, *Consultation*, July 30, 2022, <https://aidaccess.org/en/i-need-an-abortion>.

Texans after SB8 went into effect, increasing demand over 1000% for a few weeks and eventually leveling out to 250% of its pre-SB8 demand.⁸⁰ And, “[a]t the county level, distance to an abortion clinic and living below the federal poverty level were associated with a higher rate of requests.”⁸¹ In other words, those who cannot travel will be more likely to self-manage.

People seeking abortion also can self-manage their abortions—that is, buy the medication online from an international pharmacy—without any involvement from a healthcare provider or organization like AOD or Aid Access. Plan C is a website that informs pregnant people how they can order abortion medication from foreign suppliers, even in states that view this action as illegal.⁸² Although Plan C offers detailed instructions about how to use the medication, some worry that the lack of a provider’s involvement may increase the abortion’s risks. However, studies conducted in both this country and others demonstrate that people can safely and effectively end their own pregnancies without the involvement of a provider.⁸³ Unlike the “back-alley abortions” of generations ago, self-managed medication abortion early in pregnancy opens the door for safe access even without legal permission. Thus, with *Roe* overturned, people in the states that ban abortion can have access to safe and effective remote abortion care.

There are some important limitations to note.⁸⁴ Even if medication abortion can be prescribed remotely in a safe way, there remain legal risks.⁸⁵ Historically, abortion bans have targeted providers, but the rise of telehealth and self-management, where the provider might be beyond the state’s reach or non-existent, suggests that enforcement of state abortion laws will target the people who seek abortion or those who assist them.⁸⁶ Poor people and people of color will be prosecuted disproportionately and face greater legal risks

⁸⁰ Tanya Basu, *Activists Are Helping Texans Get Access to Abortion Pills Online*, MIT TECH. R. (Sept. 15, 2021), <https://www.technologyreview.com/2021/09/15/1035790/abortion-pills-online-texas-sb8/>.

⁸¹ *Id.*

⁸² Patrick Adams, *Amid Covid-19, a Call for M.D.s to Mail the Abortion Pill*, N.Y. TIMES (May 12, 2020).

⁸³ Abigail R. A. Aiken et al., *Demand for Self-Managed Medication Abortion Through an Online Telemedicine Service in the United States*, 110 AM. J. PUB. HEALTH 90 (2020).

⁸⁴ As well as many new legal battles on the way. Rachel Rebouché, David S. Cohen, & Greer Donley, *The Coming Legal Battles Over Abortion Pills*, POLITICO (May 24, 2022), <https://www.politico.com/news/magazine/2022/05/24/coming-legal-battles-abortion-pills-00034558>.

⁸⁵ Donley, *supra* note 54, at 31-33.

⁸⁶ Greer Donley & Jill Weiber Lens, *Abortion, Pregnancy Loss, and Subjective Fetal Personhood*, 75 Vand. L. Rev. (forthcoming 2022); Andrea Rowan, *Prosecuting Women for Self-Inducing Abortion: Counterproductive and Lacking Compassion*, 18 GUTTMACHER POL’Y REV. 70 (2015).

compared to those who are white or have wealth.⁸⁷ The story of Lizelle Herrera offers a stark warning: In April 2022, Hererra was charged with murder for self-inducing an abortion. The charges were quickly dropped,⁸⁸ but allowing criminal charges against the people seeking abortion could be next in antiabortion states. Even if states do not target patients with laws or policies, prosecutors could use unlawful arrests such as Herrera’s as a way to scare and chill illegal abortion.

Another qualification is that the FDA has approved use of abortion pills only through the first ten weeks even though research suggests it can be safely used a few weeks beyond that and providers can prescribe it off-label past ten weeks.⁸⁹ Though some people will use it through the 11th or, for some patients, the 12th week of pregnancy, when the same protocol is still safe and effective, the standard of care is to recommend that second or third trimester abortion patients travel to a state where clinics can perform a procedural abortion.⁹⁰ However, as medication abortion becomes more prevalent, particularly as an online service at lower cost, the financial sustainability of brick-and-mortar clinics will be put to the test, even at a time when facilities in abortion-supportive states see more patients.⁹¹ Many facilities already operate at a loss, due in no small part to the costs of complying with state restrictions.⁹² If more people access early abortion without clinic involvement, new issues of sustainability will arise for some clinics.

As smaller providers are driven out of business, large clinical centers will concentrate in the urban areas of states with supportive abortion laws.⁹³ Patients requiring abortions after the first trimester or

⁸⁷ MICHELE GOODWIN, *POLICING THE WOMB: INVISIBLE WOMEN AND THE CRIMINALIZATION OF MOTHERHOOD* (2020).

⁸⁸ Guilia Heyward & Sophie Kasakove, *Texas Will Dismiss Murder Charge Against Woman Connected to ‘Self-Induced Abortion,’* N.Y. TIMES (Apr. 10, 2022), <https://www.nytimes.com/2022/04/10/us/texas-self-induced-abortion-charge-dismissed.html>.

⁸⁹ Donley, *supra* note 54, at 63.

⁹⁰ Second trimester abortion is rare—only 6.2% of abortions occur in the second trimester. Third trimester abortions are extremely rare, less than 1%. But as abortion becomes more difficult to access, it is possible that the number of later abortions increase, and that some of these abortion seekers will self-manage with pills. There are protocols online where one can find a more accurate dose for a later pregnancy that is still reasonably safe and effective, although less so than a procedural abortion. *CDC’s Abortion Surveillance System FAQs*, CTRS. DISEASE CONTROL (last reviewed Nov. 21, 2021), https://www.cdc.gov/reproductivehealth/data_stats/abortion.htm.

⁹¹ AOD contributes 60 percent of all profits to the Save Our Clinics fund of the Abortion Care Network. Baker, *supra* note 60.

⁹² Michelle L. McGowan et al., *Care Churn—Why Keeping Clinic Doors Open Isn’t Enough to Ensure Access to Abortion*, 383 NEW ENG. J. MED. 508, 509 (2020).

⁹³ For instance, a Planned Parenthood designed as a regional hub recently opened in Illinois. Grace Hauck, *Planned Parenthood To Open Major Clinic In Illinois As ‘Regional Haven’ For Abortion Access*, USA TODAY (updated Oct. 3, 2019),

who are not candidates for medication abortion (because of pre-existing conditions, for example) will have far fewer options located in only the most populous areas of certain states.⁹⁴

Further, while online medication abortion may be increasingly available, it is an option that is only now becoming more widely understood or embraced. A study from 2021 found that 25% of people seeking abortions at clinics attempt self-managed abortion first and the vast majority of them use an ineffective and potentially dangerous method: 52% use supplements, herbs, or vitamins; 19% use many contraceptive pills; and 18% use physical trauma.⁹⁵ In the same study, only 18% used medication abortion.⁹⁶ The response to SB8 in Texas provides another illustration. Although Aid Access received a large increase in requests from Texans after SB8,⁹⁷ clinics across the country were also inundated with demand from Texans.⁹⁸ While Aid Access may be significantly cheaper and more convenient than traveling for a legal abortion, prior to *Dobbs*, it had not yet become mainstream and as noted below, barriers to telehealth may also have impacted uptake. In other words, given the need for abortion beyond the first trimester, the barriers to telehealth, and a lack of familiarity with abortion pills, some abortion access will depend on travel. As we have noted, whether providers in abortion-supportive states can handle the influx of demand remains to be seen.

A post-*Roe* country is a fractured legal landscape that necessitates time, resources, and tenacity to navigate. In the following parts, we set out the jurisdictional complications that will arise. The picture we paint is labyrinthine, and the ground we cover is largely unexplored: some states will assume roles as interstate abortion police,

<https://www.usatoday.com/story/news/nation/2019/10/02/illinois-planned-parenthood-mega-clinic-haven-abortion-access/3840714002/>.

⁹⁴ People taking certain kinds of blood thinners, for instance, are not candidates for medication abortion and are disproportionately people of color and people with low incomes. See Ruqaiyah Yearby, *Breaking the Cycle of "Unequal Treatment" with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias*, 44 CONN. L. REV. 1281, 1305-06 (2012).

⁹⁵ *Explained: Barriers to Abortion and Attempted Self-Managed Abortion*, ADVANCING NEW STANDARDS IN REPROD. HEALTH (Oct. 26, 2021), <https://www.ansirh.org/research/infographic/explained-barriers-abortion-and-attempted-self-managed-abortion>.

⁹⁶ *Id.*

⁹⁷ Basu, *supra* note 79. The Guttmacher Institute reported that patients were traveling beyond those states that immediately border Texas, going instead to at least twelve other states. Jones et al., *supra* note 43; Tuma, *supra* note 43; Shefali Luthra, *Abortion clinics north of Texas flooded with patients after severe state ban*, THE GUARDIAN (Sep. 21, 2021), <https://www.theguardian.com/world/2021/sep/21/abortion-clinics-bordering-texas-are-seeing-double-the-number-of-patients>.

⁹⁸ Mary Tuma, *Texas' abortion ban is having a 'domino effect' on clinics across the U.S.*, TEXAS OBSERVER, Nov. 18, 2021, <https://www.texasobserver.org/texas-abortion-ban-is-having-a-domino-effect-on-clinics-across-the-u-s/>.

others will attempt to protect all abortion provision however they can, while the current federal government might create new spaces, within and outside of hostile states, for abortion access.

II. INTERSTATE BATTLES OVER CROSS-BORDER ABORTION

After *Roe*, state prosecutors and legislators will likely try to impose civil or criminal liability on their citizens who travel out of state to obtain an abortion, those who help them, and the providers who care for them. Though targeting cross-border abortion provision has been almost non-existent until this point,⁹⁹ antiabortion states are likely to attempt it in the post-*Roe* future. This is hardly far-fetched: the antiabortion movement has been clear that the endgame is outlawing abortion nationwide.¹⁰⁰ Since *Dobbs*, some in the movement have been explicit about their goal of ending abortion travel, such as the president of Students for Life who advocated as part of national post-*Roe* plans that “if you travel out of state for an abortion, that abortionist can be held liable.”¹⁰¹ Until there is a national ban, the movement will use state powers to stop as many abortions as possible, including outside state borders.

Missouri, with almost no in-state abortions yet roughly 10,000 of its residents traveling out of state to receive care each year,¹⁰² has

⁹⁹ In 1996, a Pennsylvania woman was prosecuted for taking a minor to New York for an abortion (with the minor’s consent). *Woman Faces Trial For Taking 13-Year-Old To Outstate Abortion Clinic*, AP NEWS (Oct. 27, 1996) <https://apnews.com/article/9d6313302114d7881dd2ecaa083f9b91>. Beyond that, there have been no publicized prosecutions for cross-border abortions. In theory, they could happen. Before *Dobbs*, forty-three states banned abortion after a particular point in pregnancy, yet patients who needed care later in pregnancy regularly traveled to states where later abortion care was legal. To the best of our knowledge, none of these patients were prosecuted for doing so.

¹⁰⁰ Amici in *Dobbs* argued as well that the Court should overturn *Roe* by finding that fetuses are protected persons under the Fourteenth Amendment; doing so could have the effect of outlawing abortion everywhere. Brief Amici Curiae for Scholars of Jurisprudence John M. Finnis and Robert P. George in Support of Petitioners, *Dobbs v. Jackson Women’s Health Org.*, 141 S. Ct. 2619 (2021) (No. 19-1392).

¹⁰¹ Kitchener, *Roe’s Gone*, *supra* note 8.

¹⁰² According to state records, in 2020, only 167 abortions were performed in the state, down from over 6,000 a decade earlier. Josh Merchant, *Nearly Half of Abortions in Kansas Are for Missouri Residents, but Voters Could End That*, KAN. CITY BEACON (Nov. 20, 2021), <https://www.kcur.org/news/2021-11-20/nearly-half-of-abortion-in-kansas-are-for-missouri-residents-but-voters-could-end-that>. Yet, almost 10,000 Missouri patients obtained abortions that year by traveling to Illinois and Kansas. According to the Illinois Department of Public Health, in 2020, 6,578 people from Missouri obtained abortions in Illinois, up from 1,035 in 2015. Illinois Department of Public Health, *Abortion Statistics 2020*, <https://dph.illinois.gov/data-statistics/vital-statistics/abortion-statistics.html>. And according to data from the Kansas Department of Health and Environment’s Division of Public Health, that same year 3,201 people from Missouri obtained abortions in Kansas. Kansas Department of Health and Environment, *Abortions in Kansas, 2020*, <https://www.kdhe.ks.gov/DocumentCenter/View/10433/Abortions-in-Kansas->

DRAFT 8/4/22
IF QUOTING, PLEASE INDICATE THIS IS A DRAFT

shown us the early phases of this strategy. In March 2021, a legislator introduced SB603, which would apply all Missouri abortion restrictions to conduct occurring “[p]artially within and partially outside this state” as well as conduct wholly outside the state when any one of the following conditions are met: the pregnant person resides in Missouri; there is a substantial connection between the pregnant person and Missouri; the “unborn child” is a resident of Missouri at the time of conception; the pregnant person intends to give birth in Missouri if the pregnancy is carried to term; the individual had sex in Missouri that “may have” conceived this pregnancy; or the patient sought prenatal care in Missouri during the pregnancy.¹⁰³

Then, in March 2022, a different legislator introduced an amendment to another antiabortion bill that would have created civil liability for anyone who performs an abortion on a resident of Missouri, no matter where the abortion is performed, or helps someone from Missouri leave the state to get an abortion.¹⁰⁴ These laws would have been enforced through civil suits rather than the criminal law, making it harder for courts to strike them down as unconstitutional.¹⁰⁵ After receiving national attention, this amendment failed to be included in the final bill,¹⁰⁶ though after *Dobbs* the legislator who drafted the bill vowed to continue this effort; reports indicate antiabortion legislators in other parts of the country are considering similar measures.¹⁰⁷

Several cities in Texas have adopted the label “sanctuary city for the unborn.” At least two of them have included in the ordinances adopting this moniker a provision that bans their residents from getting abortions “regardless of where the abortion is or will be performed.”¹⁰⁸ Warnings about cross-border abortion restrictions are far from the “ridiculous scaremonger[ing]” the general counsel for the

2020-PDF. These numbers are more than three times the preliminary estimates from the Missouri Department of Health and Senior Services. See Merchant, *supra* (graph showing estimate of 3391 total abortions for Missouri residents with only 167 occurring in state).

¹⁰³ S.B. 603, 101st Gen. Assemb., Reg. Sess. (Mo. 2021).

¹⁰⁴ HB 2012, 102nd Gen. Assemb., Reg. Sess. (Mo. 2022).

¹⁰⁵ See discussion of SB8 *infra* notes 196-200 and accompanying text.

¹⁰⁶ Tessa Weinberg, *Missouri House Blocks Effort to Limit Access to Out-of-State Abortions*, MISSOURI INDEPENDENT, Mar. 29, 2022,

<https://missouriindependent.com/2022/03/29/missouri-house-blocks-effort-to-limit-access-to-out-of-state-abortions/>

¹⁰⁷ Kitchener, *Roe’s Gone*, *supra* note 8.

¹⁰⁸ Cisco Ordinance Outlawing Abortion, Aug. 19, 2021,

<https://www.scribd.com/document/567480915/Cisco-Ordinance-Outlawing-Abortion-08-19-21-Docx-1>; Slaton, Texas Ordinance Outlawing Abortion Within the City Limits, July 8, 2021.

<https://www.scribd.com/document/569256021/Slaton-Texas-Ordinance-Outlawing-Abortion-Within-the-City-Limits-07-08-2021-Docx-1>.

National Right to Life Committee has claimed they are.¹⁰⁹ In fact, that organization’s model post-*Roe* law—a document drafted by the general counsel—includes a provision that prohibits assisting minors “regardless of where an illegal abortion occurs.”¹¹⁰ Bills like those discussed here could become a reality in a future with no constitutional right to abortion, as antiabortion legislators look for ways to not only stop abortions in their borders, but also to stop their residents from obtaining abortions anywhere.

To many people, the immediate response to these possibilities is that various parts of the federal Constitution protect the right to travel and to engage in interstate commerce. After all, most people think that as long as they follow the laws of the state where they are physically located while traveling, they are being a law-abiding citizens. Take fireworks or casino gambling as examples. The person who travels out of her state that bans the sale of fireworks or casino gambling in order to purchase fireworks in another state or gamble in Las Vegas or Atlantic City probably gives no thought whatsoever to the possibility that her home state would try to punish her for evading state law.

This sense of how law works across state borders finds some support in various constitutional doctrines. The Fourteenth Amendment’s Due Process Clause has long protected a right to travel as part of its protection for liberty.¹¹¹ The same Amendment’s Privileges or Immunities Clause, in conjunction with the Citizenship Clause, has also protected a right to travel rooted in the notion of national citizenship.¹¹² And the Dormant Commerce Clause prohibits certain state burdens on interstate commerce, including some that have extraterritorial effect.¹¹³ However, as explained in detail below, these parts of the Constitution and the doctrines they have inspired do not so clearly apply to the situations addressed here.

This Part addresses the complex array of interjurisdictional issues that arise from the possible extraterritorial application of state laws. It assesses the possibilities of using already-existing law to prosecute actions in another state and of adopting specific civil or criminal laws that target extraterritorial abortion and the likelihood of success of constitutional objections to doing so. It then addresses the complicated issues that would arise when abortion-supportive states

¹⁰⁹ Kent Nishimura, *Could Idaho Accuse a Washington Abortion Clinic of Murder? Some Are Worried*, THE CHRONICLE, June 22, 2022, <https://www.chronline.com/stories/could-idaho-accuse-a-washington-abortion-clinic-of-murder-some-are-worried,295760>.

¹¹⁰ NRLC Model Law, *supra* note 11.

¹¹¹ *Shapiro v. Thompson*, 394 U.S. 618 (1969).

¹¹² *Saenz v. Roe*, 526 U.S. 489 (1999).

¹¹³ *Healy v. Beer Inst. Inc.*, 491 U.S. 324 (1989).

attempt to protect their providers from extraterritorial investigations and prosecutions.

One further note before proceeding: even if courts permit these interjurisdictional prosecutions and lawsuits to proceed, states may struggle to enforce their laws extraterritorially against providers who refuse to appear at a summons or participate in a lawsuit. There will be difficulties related to personal jurisdiction,¹¹⁴ vicinage,¹¹⁵ and problems of proof particular to interstate investigations.¹¹⁶ It is for these reasons that antiabortion states, and even the federal government under the Trump Administration, have not been able to stop Aid Access from delivering abortion pills in their states. Though this Article does not plumb these practical issues, they will certainly add to the interjurisdictional complexities explored throughout.

A. *Extraterritoriality in Abortion Law Precedent*

Only two cases decided after *Roe*—one by the US Supreme Court and the other by the Missouri Supreme Court—have addressed whether states can penalize out-of-state abortion conduct, and the modern application of those cases is unclear at best.¹¹⁷ The first is a lesser-known Supreme Court case, *Bigelow v. Virginia*.¹¹⁸ That case concerned a Virginia statute prohibiting any publication from encouraging people to obtain an abortion.¹¹⁹ In 1971, two years before *Roe*, a weekly newspaper distributed on the University of Virginia campus ran an advertisement for a New York City service that would refer people to an abortion provider in New York, where abortion had recently become legal.¹²⁰ The Virginia Supreme Court twice upheld the

¹¹⁴ See *Int'l Shoe Co. v. Washington*, 326 U.S. 310 (1945); *Bullion v. Gillespie*, 895 F.2d 213, 214 (5th Cir. 1990).

¹¹⁵ “In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial, by an impartial jury of the State and district wherein the crime shall have been committed” U.S. CONST. amend. VI; see also Seth Kreimer, *Lines in the Sand, The Importance of Borders in American Federalism*, 150 U. Penn. L. Rev. 973, 1018-19 (2002) (Appendix listing “[t]hirty-three states [that] have constitutional provisions that require juries in criminal trials to be drawn from the geographical district in which the crime occurred).

¹¹⁶ Susan F. Appleton, *Gender, Abortion, and Travel After Roe's End*, 51 ST. LOUIS U. L.J. 655 (2007).

¹¹⁷ *Roe's* companion case, *Doe v. Bolton*, 410 U.S. 179 (1973) addressed a provision of Georgia law that prohibited out-of-staters from getting an abortion in Georgia. This type of restriction seems far afield from extraterritorial application of abortion law we foresee if *Roe* is overturned, since it is hard to imagine in the current political climate that a state which continues to allow abortion within its borders would pass a new law also restricting it to state citizens. Thus, we are not including *Doe* in this line of precedent that has already addressed the issues we are covering here.

¹¹⁸ *Bigelow v. Virginia*, 421 U.S. 809 (1975).

¹¹⁹ *Id.* at 811.

¹²⁰ *Id.* at 811-12.

conviction of the newspaper’s managing editor for violating the Virginia statute, both before and after *Roe* was decided.¹²¹

The U.S. Supreme Court disagreed. In finding that the statute infringed on the publisher’s First Amendment rights, the Court made several statements casting doubt on the ability of states to legislate the behavior of their citizens when they travel to another state. The Court was concerned that Virginia, a state where abortion was illegal when the newspaper advertisement in question was published,¹²² was infringing on its citizens’ ability to travel to New York for an abortion.¹²³ In discussing these cross-border issues, the Court wrote that Virginia could not “prevent its residents from traveling to New York to obtain [abortion] services or, as the State conceded [at oral argument], prosecute them for going there.”¹²⁴ Broadening this position to a more general statement about extraterritorial application of state law, the Court stated categorically that a “State does not acquire power or supervision over the internal affairs of another State merely because the welfare and health of its own citizens may be affected when they travel to that State.”¹²⁵

The other case comes from Missouri, and it relied on *Bigelow* to reach the same conclusion. In *Planned Parenthood of Kansas v. Nixon*,¹²⁶ the Missouri Supreme Court reviewed a Missouri law providing a civil cause of action against any person who causes, aids, or abets a minor obtaining an abortion without first getting parental consent or a judicial bypass.¹²⁷ As part of the lawsuit, the plaintiffs lodged a challenge to a unique provision of the Missouri law that effectively required Missouri minors who travel out of state for an abortion to follow Missouri’s parental consent law, even if the other state has a different requirement for parental involvement or none whatsoever.¹²⁸

In response to this argument, the Missouri Supreme Court reiterated the main points from *Bigelow*. It wrote that “it is beyond Missouri’s authority to regulate conduct that occurs wholly outside of Missouri Missouri simply does not have the authority to make lawful out-of-state conduct actionable here, for its laws do not have extraterritorial effect.”¹²⁹ Because of this principle against

¹²¹ *Id.* at 814-15.

¹²² *Id.* at 812-13.

¹²³ Bill Kovach, *Rockefeller, Signing Abortion Bill, Credits Women's Groups*, N.Y. TIMES (Apr. 12, 1970), <https://www.nytimes.com/1970/04/12/archives/rockefeller-signing-abortion-bill-credits-womens-groups.html>.

¹²⁴ *Bigelow*, 421 U.S. at 824; *see also id.* at 827 (“[The public interest] would not justify a Virginia statute that forbids Virginians from using in New York the then legal services of a local New York agency.”).

¹²⁵ *Id.*

¹²⁶ *Planned Parenthood of Kansas v. Nixon*, 220 S.W.3d 732 (Mo. 2007).

¹²⁷ *Id.* at 736.

¹²⁸ *Id.* at 745.

¹²⁹ *Id.* at 742.

extraterritorial application, the court held that the law was only valid as to conduct occurring at least in part in Missouri. Thus, the legality of an out-of-state abortion must be a defense to crimes charged under the law that consisted of “wholly out-of-state conduct.”¹³⁰

Though these two precedents contain strong statements against the application of extraterritorial abortion law, they might not be the final say on the matter. *Bigelow* is dated, relies in part on the now-overturned *Roe*, and concentrated on the First Amendment. The current U.S. Supreme Court, now that it has eviscerated *Roe*, could revisit *Bigelow*’s anti-extraterritoriality principle.¹³¹ Moreover, scholars have argued for decades about whether *Bigelow*’s statements against extraterritorial application are mere dicta.¹³² *Nixon* is applicable only in Missouri, gives no clear guidance as to what is “conduct that occurs wholly outside” the state, and has never been cited by any court for its discussion of extraterritorial application of state law.

Complicating this picture even further is how these rules apply to medication abortion. Abortion pills did not exist at the time of *Bigelow* and were not widely used at the time of *Nixon*. These medications can be legally obtained in one jurisdiction, one or both of the drugs can be taken elsewhere, and the pregnancy can end somewhere else entirely. In the immediate aftermath of *Roe*’s demise, abortion providers and lawyers reviewing medication abortion protocols are struggling to answer what had been a simple question with procedural abortion: where does the abortion occur?¹³³

Thus, this area of law is ripe for reassessment once interjurisdictional abortion prosecutions occur. Antiabortion states and cities will not wait for the Court to give them permission to apply their laws extraterritorially; as the Missouri bills and sanctuary city

¹³⁰ *Id.* at 743.

¹³¹ The question of *Bigelow*’s continuing validity has been overturned looms as yet another complicated constitutional issue now that *Roe* has been overturned. *See, e.g.,* Cat Zakrzewski, *South Carolina Bill Outlaws Websites That Tell How to Get an Abortion*, WASH. POST, July 22, 2022, <https://www.washingtonpost.com/technology/2022/07/22/south-carolina-bill-abortion-websites/>.

¹³² Compare Seth F. Kreimer, *The Law of Choice and Choice of Law: Abortion, the Right to Travel, and Extra Territorial Regulation in American Federalism*, 67 N.Y.U. L. REV. 451, 462-64, 487-519 (1992), with Mark D. Rosen, “Hard” or “Soft” Pluralism?: Positive, Normative, and Institutional Considerations of States’ Extraterritorial Powers, 51 ST. LOUIS. UNIV. L.J. 713, 714 (2007) [hereinafter Rosen, *Pluralism*]; Mark D. Rosen, *State Extraterritorial Powers Reconsidered*, 85 NOTRE DAME L. REV. 1133 (2010) [hereinafter Rosen, *State Powers*]; Mark D. Rosen, *Extraterritoriality and Political Heterogeneity in American Federalism*, 150 U. PENN. L. REV. 855 (2002) [hereinafter Rosen, *Heterogeneity*].

¹³³ *See, e.g.,* Kathryn Houghton & Arielle Zions, *Montana Clinics Preemptively Restrict Out-of-State Patients’ Access to Abortion Pills*, NPR, July 7, 2022, <https://www.npr.org/sections/health-shots/2022/07/07/1110078914/montana-abortion-pills>.

ordinances described above make clear, they will just do it. It could take years before the litigation surrounding these cases reaches the Supreme Court, and in the meantime, states will proceed as if they have the power, waiting for courts to call their bluff. Indeed, litigation surrounding SB8 illustrates that some courts will exploit any legal uncertainty to uphold abortion restrictions. No one believed SB8 was constitutional, yet it has survived court challenges so far.¹³⁴ Indeed, the 2022 Missouri bill relied on a similar enforcement mechanism as SB8, ostensibly to shield the law, if enacted, from federal court review. The Supreme Court may very well ultimately reaffirm its previous statements from *Bigelow*, but that is far from a foregone conclusion.

Amidst this less-than-certain legal backdrop, prosecutions and civil liability related to extraterritorial conduct are on the horizon. There are two different questions that arise in the context of extraterritorial application of abortion law. The first, considered below in section II.B, is whether a state can apply its general abortion laws, by themselves or in conjunction with other non-abortion criminal laws, to out-of-state abortions even though these laws do not explicitly cover them. The second question, considered in section II.C, is whether there are constitutional impediments to states passing and enforcing new laws that specifically target out-of-state abortion.¹³⁵ Finally, section II.D explores how abortion-supportive states are legislating to protect their providers, as well as traveling patients and those who help them, from application of another state's abortion law.

B. *Do Ordinary Criminal Abortion Laws Apply Extraterritorially?*

If, say, Kentucky bans all abortion following *Dobbs*, can prosecutors apply that abortion ban, which says nothing about extraterritorial application, to someone from Kentucky who travels to Illinois to obtain a legal abortion or to the Illinois provider who performs that abortion? Or, could Kentucky use its non-abortion conspiracy laws to charge the patient's friend who helps the patient travel to Illinois to obtain the out-of-state abortion? An aggressive prosecutor or other state official would not need any specific law governing extraterritorial abortions if existing state law can be applied to legal abortions obtained in other states or to travel to obtain those legal out-of-state abortions. In fact, even if existing state law *cannot* be applied in these situations, an aggressive prosecutor could still chill people from obtaining lawful out of state abortions just by threatening legal sanctions in these situations or even by initiating legal proceedings knowing they will fail.¹³⁶

¹³⁴ *Whole Woman's Health v. Jackson*, 142 S. Ct. 522 (2021); *Whole Woman's Health v. Jackson*, 31 F.4th 1004 (5th Cir. 2022).

¹³⁵ These constitutional considerations would also apply to a state using already-existing laws to prosecute abortion travel.

¹³⁶ *See, e.g., Commonwealth v. Dischman*, 195 A.3d 567 (Pa. Super. 2018) (prosecutor charged pregnant woman with violating state "aggravated assault of an

DRAFT 8/4/22
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As a general matter, states cannot use ordinary criminal laws to prosecute people for crimes committed outside of their borders. This “general rule” is, according to the Massachusetts Supreme Judicial Court, “accepted as ‘axiomatic’ by the courts in this country.”¹³⁷ However, this general rule against extraterritorial application of criminal law has enough gaps to allow prosecution of a wide variety of crimes that take place outside the jurisdiction of a state. It is beyond the scope of this Article to explore all the twists and turns of this rule, but a few examples suffice to support our general point here.

First, the “effects doctrine” allows states to prosecute someone for actions that take place outside the state that have detrimental effects in the state. The California Supreme Court has explained that “a state may exercise jurisdiction over criminal acts that take place outside of the state if the results of the crime are intended to, and do, cause harm within the state.”¹³⁸ This doctrine could have a sweeping impact without *Roe*. Take Georgia’s six-week abortion ban that was passed in 2019, immediately enjoined as unconstitutional, but now is back in effect after *Dobbs*¹³⁹; in addition to banning abortion at six weeks, it also declared that “unborn children are a class of living, distinct person” who deserve “full legal protection.”¹⁴⁰ The actions of a pregnant Georgian who crosses state lines to obtain a legal abortion outside Georgia would have the effect of killing a “living, distinct” Georgian deserving of “full legal protection.”¹⁴¹ An aggressive prosecutor could use this effects doctrine to argue that the out-of-state killing has the in-state effect of removing a recognized member of the Georgia community from existence and prosecuting in this instance recognizes the full legal protection required under the statute. While prosecutions for murders occurring in another state are rare under this doctrine,¹⁴² states and prosecutors seeking to enforce new criminal laws

unborn child” law despite clear language in the statute indicating the law does not permit such charges).

¹³⁷ *In re Vasquez*, 705 N.E.2d 606, 610 (Mass. 1999).

¹³⁸ *People v. Betts*, 103 P.3d 883, 887 (Cal. 2005) (discussing the effects doctrine in the context of “lewd acts committed on a child,” some of which occurred outside the state of California); *see also* *Strassheim v. Daily*, 221 U.S. 280, 285 (1911) (discussing this doctrine in the context of fraud committed outside the state of Michigan but prosecuted by that state and stating that “[a]cts done outside a jurisdiction, but intended to produce and producing detrimental effects within it, justify a state in punishing the cause of the harm as if he had been present at the effect, if the state should succeed in getting him within its power.”).

¹³⁹ *Sistersong Women of Color Reprod. Just. Collective v. Kemp*, 2022 WL 2824904 (11th Cir. July 20, 2022).

¹⁴⁰ *Sistersong Women of Color Reprod. Just. Collective v. Kemp*, 472 F. Supp. 3d 1297 (N.D. Ga. 2020).

¹⁴¹ O.C.G.A. §§ 16-12-141(c)(1)(A–B).

¹⁴² *See, e.g., Heath v. Jones*, 941 F.2d 1126 (11th Cir. 1991) (allowing prosecution of murder in Alabama that took place in Georgia); *State v. Willoughby*, 892 P.2d 1319 (Ariz. 1995) (allowing prosecution in Arizona for murder that took place in Mexico).

prohibiting abortion or protecting fetal “persons” may wish to deploy this legal strategy to the maximum extent possible.

This doctrine could apply even more broadly. Anyone involved with the killing of a “living, distinct” resident of a state with an abortion ban could be prosecuted for the effect of depriving the state of that now-recognized person’s life. That would include anyone who worked at the out-of-state abortion clinic and anyone who helped the patient travel to the clinic. Once a state declares a fetus a separate life, the effects doctrine could result in almost endless criminal prosecutions related to out-of-state abortions. Whether courts are willing to give prosecutors this much authority over otherwise lawful out-of-state activity will become a complicated jurisdictional issue that state and possibly federal courts will confront now that *Roe* has been overturned.¹⁴³

Second, most states already have general criminal jurisdictional provisions that could offer avenues for extraterritorial application of abortion law. For instance, borrowing what Professor Gabriel Chin calls the “reasonably representative” jurisdictional statute from Pennsylvania,¹⁴⁴ the complexities become obvious. The Pennsylvania statute provides jurisdiction over any person when any of the following occur in the state: an element of the offense; an attempt to commit an offense; a conspiracy, attempted conspiracy, solicitation of a conspiracy, or overt act; or an omission of a legal duty.¹⁴⁵ The statute also provides that any Pennsylvania law specifically applying outside its borders creates jurisdiction if “the conduct bears a reasonable relation to a legitimate interest of [Pennsylvania] and the actor knows or should know that his conduct is likely to affect that interest.”¹⁴⁶

Provisions like these create opportunities for chaos in application of criminal laws to extraterritorial conduct. The scenarios outlined above with respect to Georgia’s personhood law are illustrative. Would a conspiracy between two people to obtain an abortion out of state be chargeable in Georgia if the agreement and travel taking place in state is considered an “overt act” in furtherance of the conspiracy to murder the fetus (a person under Georgia law)? Would obtaining the assistance of abortion funds or travel support while in state be an act that provides sufficient jurisdiction to criminalize the out-of-state abortion? How about a neighbor watching

¹⁴³ These kinds of complicated legal questions have doomed antiabortion efforts in the past (see Frank James, *Mississippi Voters Reject Personhood Amendment by Wide Margin*, NPR (Nov. 8, 2011)), but there is no reason to be confident that would be the case in the future, especially with an energized antiabortion movement once *Roe* is overturned.

¹⁴⁴ Gabriel J. Chin, *Policy, Preemption, and Pot: Extra-Territorial Citizen Jurisdiction*, 58 B.C. L. REV. 929, 933 (2017).

¹⁴⁵ 18 PA. C.S.A. § 102.

¹⁴⁶ *Id.* § 102(a); see generally *Commonwealth v. Peck*, 242 A.3d 1274 (Pa. 2020) (discussing application of jurisdictional statute to out of state drug crimes).

an abortion-seeker's children while she travels to another state? Or, thinking about medication abortion, would a Georgia resident who receives pills by mail at a friend's house over the border in North Carolina but returns home and takes some or all of the pills in her home state be guilty of homicide, either because consumption of the pills occurred in Georgia or because the fetal remains are in Georgia? And would the friend in North Carolina be guilty of the Georgia crime of conspiracy or aiding and abetting? These questions would be answered state-by-state and case-by-case, all but ensuring disparate results even within a state.

Third, even if a court found that the in-state conduct was sufficient to establish jurisdiction, a related point of contention would be whether a state can criminalize a conspiracy to commit an act that is legal in the destination state but illegal in the home state.¹⁴⁷ As Chin points out, statutes like Pennsylvania's generally "require that the offense be criminalized in the out-of-state jurisdiction."¹⁴⁸ However, not all states follow this rule. The California Supreme Court reserved this question "for another day,"¹⁴⁹ and Alabama's criminal jurisdiction statute leaves out the requirement that the crime be punishable in the destination state.¹⁵⁰

These wrinkles become even more visible in the context of medication abortion where *the provider* might follow their home state's laws by prescribing pills to someone in their state, but the out-of-state patient takes the pills in their home state. Would the illegal act, to go back to the hypothetical states that started this section, as Kentucky views it, be the provider's actions that occurred in Illinois, where abortion was legal, or the patient's actions in Kentucky? That the provider and the patient can be in two different jurisdictions over the course of abortion care in the age of medication abortion creates a messy situation for extraterritorial jurisdiction.¹⁵¹

Even without new statutes that specifically target out-of-state abortions, prosecutors could attempt to use already existing tools to try to limit or completely prohibit people in their state from going

¹⁴⁷ Generally, a conspiracy exists when two people intend to promote or facilitate the commission of a crime. *See, e.g.*, 18 PA. C.S.A. § 903.

¹⁴⁸ Chin, *supra* note 134, at 951-52.

¹⁴⁹ *People v. Morante*, 975 P.2d 1071, 1086 (Cal. 1999) ("We reserve for another day the issue whether a conspiracy in state to commit an act criminalized in this state but not in the jurisdiction in which the act is committed, also may be punished under California law.").

¹⁵⁰ ALA. ST. 13A-4-4 states as follows: "A conspiracy formed in this state to do an act beyond the state, which, if done in this state, would be a criminal offense, is indictable and punishable in this state in all respects if such conspiracy had been to do such act in this state." This law has not appeared in any reported decisions, so it would be ripe for testing from an aggressive antiabortion prosecutor trying to stop people in the state from working with others to obtain an out-of-state abortion now that *Roe* has been overturned.

¹⁵¹ *See* discussion *supra* note 148 and accompanying text.

elsewhere to obtain legal abortions. And in doing so, state and federal judges would ultimately be put in the position of sorting through the complex jurisdictional questions regarding which of these applications of already-existing law are within the bounds of state jurisdiction principles and which exceed those limits.

C. Can States Enforce Laws Specifically Targeting Extraterritorial Abortion?

Separate from whether ordinary criminal abortion law applies extraterritorially is the constitutionality of laws that specifically target extraterritorial abortions instead of using existing state law to prosecute out-of-state abortions. Much like the introduced Missouri bills discussed above, such a law could create civil or criminal liability for anyone with sufficient ties to the antiabortion state to obtain an abortion anywhere, not just in the state. Or the law could impose liability for anyone who performs or aids and abets the performance of an abortion on a person with sufficient ties to the antiabortion state. The law could also target abortion travel, prohibiting anyone from traveling out of state to get an abortion or for aiding or abetting someone in traveling out of state to get an abortion.

Without well-established doctrine or caselaw as guideposts, a small number of scholars have attempted to parse these issues in the past, and they fall largely into three different camps: those who believe that extraterritorial application of abortion law would violate various provisions of the Constitution; those who believe it would not; and those who believe that it would raise complicated and unanswered issues of constitutional law that would throw the Court into bitter disputes about foundational issues of federalism.

In the first camp, scholars have relied on a right to travel, conflict of laws, and the dormant commerce clause to cast doubt on states' extraterritorial reach. Professor Seth Kreimer provided the most developed explanation of the position in the early 1990s. In two different articles, he developed both an originalist and a normative argument against extraterritorial application of abortion laws. In the originalist argument, he explained that the Constitution's framers, as evidenced by the Commerce Clause, Article IV's Privileges and Immunities Clause, and the citizenship clause of the Fourteenth Amendment, held a strong commitment to a legal system in which state sovereignty was limited to application within its own borders and to a conception of national citizenship that protected a strong right to travel to other states.¹⁵² He argued that the right to travel to other states and take advantage of their laws is an essential component of liberty,¹⁵³ and that to further the Constitution's goal of "establishing a single

¹⁵² Kreimer, *supra* note 132, at 487-519.

¹⁵³ Seth F. Kreimer, "But Whoever Treasures Freedom . . .": *The Right to Travel and Extraterritorial Abortions*, 91 MICH. L. REV. 907, 914-15 (1993).

national identity,” there is value in people having the same privileges and responsibilities when located within a state, whether as a visitor or a resident.¹⁵⁴ His ultimate conclusion is that “citizens who reside in each of the states of the Union have the right to travel to any of the other states in order to follow their consciences, and they are entitled to do so within the frameworks of law and morality that those sister states provide.”¹⁵⁵

A small group of scholars have agreed with Kreimer. Professor Lea Brilmayer, applying conflict-of-laws principles, argued that the policy of the “territorial state” should trump the state of residence because states that permit abortion have a strong interest in regulating what happens within their state.¹⁵⁶ Taking a different approach, Professor Susan Lorde Martin, though touching on abortion only passingly, opined that the modern Dormant Commerce Clause doctrine prohibits extraterritorial application of a state’s laws; indeed, she called this principle a “bedrock of a federalist system.”¹⁵⁷

At the other end of the spectrum lie those scholars who have analyzed the same doctrines and concluded that there is nothing in the Constitution that prohibits states from enforcing laws targeting out-of-state abortions or abortion travel. Professor Mark Rosen has provided the most detailed analysis, concluding that none of the previously identified constitutional doctrines prohibit states from applying their criminal laws outside state borders.¹⁵⁸ According to Rosen, the Supreme Court, state courts, and model codes have long supported states regulating out-of-state activity.¹⁵⁹ Rosen recognizes that the Constitution places some limits on extraterritorial application of state law but argues that those narrow doctrines have no applicability when one state applies its criminal law to its own citizens acting in another state.¹⁶⁰ Allowing states to determine the reach of their own powers, according to Rosen, is normatively preferable in order to prevent people picking and choosing which state policies to follow and to ensure actual political heterogeneity among the states.¹⁶¹

¹⁵⁴ *Id.* at 919-921. (“[A] system in which my opportunities upon entering California remain subject to the moral demands of Pennsylvania undercuts this sense of national unity.”).

¹⁵⁵ *Id.* at 938.

¹⁵⁶ Lea Brilmayer, *Interstate Preemption: The Right to Travel, the Right to Life, and the Right to Die*, 91 MICH. L. REV. 873, 884-90 (1993); see also Katherine Florey, *State Courts, State Territory, State Power: Reflections on the Extraterritoriality Principle in Choice of Law and Legislation*, 84 NOTRE DAME L. REV. 1057 (2009).

¹⁵⁷ Susan Lorde Martin, *The Extraterritoriality Doctrine of the Dormant Commerce Clause Is Not Dead*, 100 MARQ. L. REV. 497, 526 (2016).

¹⁵⁸ Rosen, *Pluralism*, *supra* note 132, at 714; Rosen, *State Powers*, *supra* note 127; Rosen, *Heterogeneity*, *supra* note 127. Rosen is clear in his work that Congress could enter this field and prohibit extraterritoriality. See *id.*

¹⁵⁹ Rosen, *Pluralism*, *supra* note 132, at 719-23.

¹⁶⁰ *Id.* at 733-40.

¹⁶¹ Rosen, *Heterogeneity*, *supra* note 127, at 883-891.

DRAFT 8/4/22
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Rosen has developed the most sustained defense of extraterritorial enforcement of criminal abortion law, but he is not alone. Professor Donald Regan argued that the “reality and significance of state citizenship” includes states having an interest in controlling their citizens’ conduct no matter where they are.¹⁶² Professor William Van Alstyne similarly contended that there is no constitutional right to “evade” your home state’s criminal law by traveling to another state,¹⁶³ and Professor Joseph Dellapenna maintained that states can apply their own law extraterritorially because people always have the option of moving to a different state if they want to take advantage of more permissive abortion laws.¹⁶⁴

The third camp straddles these two positions. Professor Richard Fallon took this approach: if *Roe* were overturned, “very serious constitutional questions would arise—and, somewhat ironically, a central issue for the Supreme Court would likely be whether the states’ interest in preserving fetal life is weighty enough to justify them in regulating abortions that occur outside their borders.”¹⁶⁵ After surveying the issues, Fallon explained that he had no basis to “pronounce a confident judgment” on the issue but had “no hesitation in concluding that this question would be a difficult one that is not clearly resolved” by Supreme Court precedent.¹⁶⁶ Professor Susan Appleton agreed with Fallon, arguing that choice of law doctrine would make any prosecution of out-of-state individuals (like the abortion provider or the clinic worker) a highly contentious matter, presenting courts with “excruciatingly challenging constitutional issues.”¹⁶⁷

While we find the first camp convincing both doctrinally and normatively, we find Fallon’s and Appleton’s position a better prediction of what the future holds for four reasons. First, constitutional doctrines related to extraterritoriality are notoriously underdeveloped. For instance, the Fourteenth Amendment’s Privileges or Immunities Clause was given very limited application early in its history when the Court ruled that only a very narrow set of national privileges or immunities were protected against state

¹⁶² Donald H. Regan, *Siamese Essays: (I) CTS Corp. v. Dynamics Corp. of America and Dormant Commerce Clause Doctrine; (II) Extraterritorial State Legislation*, 85 MICH. L. REV. 1865, 1908-12 (1987).

¹⁶³ William W. Van Alstyne, *Closing the Circle of Constitutional Review from Griswold v. Connecticut to Roe v. Wade: An Outline of Decision Merely Overruling Roe*, 1989 DUKE L.J. 1677, 1684-85 (1989).

¹⁶⁴ Joseph W. Dellapenna, *Abortion Across State Lines*, 2008 BYU L. REV. 1651, 1694 (2008); cf. Reva B. Siegel, *Prochoicelife: Asking Who Protects Life and How--And Why It Matters in Law and Politics*, 93 INDIANA L.J. 207 (2018)

¹⁶⁵ Richard H. Fallon Jr., *If Roe Were Overruled: Abortion and the Constitution in a Post-Roe World*, 51 ST. LOUIS. UNIV. L.J. 611, 613 (2007).

¹⁶⁶ *Id.* at 632.

¹⁶⁷ Appleton, *supra* note 112, at 682-83.

intrusion.¹⁶⁸ Only once has the Court used the clause to strike down a state law.¹⁶⁹ Since then, the Court has not taken any opportunity to further develop the clause’s jurisprudence.¹⁷⁰

The same can be said of the Dormant Commerce Clause and the Citizenship Clause in this context. Before he became a Supreme Court Justice, Tenth Circuit Judge Neil Gorsuch called the extraterritorial principle “the least understood of the Court’s three strands of dormant commerce clause jurisprudence.”¹⁷¹ Unable to resist the pun, Judge Gorsuch continued that this strand is “certainly the most dormant” considering the Court has used it to strike down only three state laws.¹⁷² Commentators have noted the confusion, calling it “all but clear”¹⁷³ and bemoaning its “difficulty of application [resulting in] courts struggl[ing] to define the extraterritorial principle’s precise scope.”¹⁷⁴ Yet, the extraterritoriality principle continues to appear in lower court opinions from time to time as the basis for striking down the occasional law, and the Supreme Court, in its 2022-23 term, will decide whether the principle is “now a dead letter.”¹⁷⁵ Similarly, outside of debates about birthright citizenship, the Citizenship Clause’s implications for federal identity—and the

¹⁶⁸ Slaughter-House Cases, 83 U.S. 36 (1872).

¹⁶⁹ Saenz v. Roe, 526 U.S. 489 (1999).

¹⁷⁰ *Saenz* has been cited only six times by the Court, and only once in a majority opinion. See Alden v. Maine, 527 U.S. 706, 751 (1999) (citing *Saenz* merely for a general quote about federalism).

¹⁷¹ Energy & Env’t Legal Inst. v. Epel, 793 F.3d 1169, 1172 (10th Cir. 2015).

¹⁷² *Id.*; see also Am. Beverage Ass’n v. Snyder, 735 F.3d 362, 378–79 (6th Cir. 2013) (Sutton, J., concurring) (calling the doctrine “a relic of the old world with no useful role to play in the new”).

¹⁷³ Tyler L. Shearer, *Locating Extraterritoriality: Association for Accessible Medicines and the Reach of State Power*, 100 B.U. L. Rev. 1501, 1504 (2020).

¹⁷⁴ *Dormant Commerce Clause—Extraterritoriality Doctrine—Fourth Circuit Invalidates Maryland Statute Regulating Price Gouging in the Sale of Generic Drugs*, 132 HARV. L. REV. 1748, 1748 (2019); Brannon P. Denning, *Extraterritoriality and the Dormant Commerce Clause: A Doctrinal Post-Mortem*, 73 L.A. L. REV. 979, 990-92 (2013) (arguing that *PfRMA v. Walsh* marked the Court’s abandonment of a freestanding rule against extraterritorial regulation under the dormant Commerce Clause doctrine).

¹⁷⁵ See Ass’n for Accessible Med. v. Frosh, 887 F.3d 664, 670 (4th Cir. 2018) (striking a Maryland price gouging law because “the Act controls the prices of transactions that occur outside the state”); see National Pork Producers v. Ross, No. 21-468 (cert. granted Mar. 28, 2022) (deciding “[w]hether allegations that a state law has dramatic economic effects largely outside of the state and requires pervasive changes to an integrated nationwide industry state a violation of the dormant commerce clause, or whether the extraterritoriality principle described in the Supreme Court’s decisions is now a dead letter...”); see generally John Fritze, *How a Supreme Court Case About Pig Farms Could Muddy Looming Debate Over Out-of-State Abortions*, USA TODAY, May 12, 2022, <https://www.usatoday.com/story/news/politics/2022/05/12/supreme-court-out-of-state-abortion-bans/9719136002/>.

promotion of a national citizenship that underpins a right to travel¹⁷⁶—has long been “neglected by courts and scholars.”¹⁷⁷

That leaves the Due Process Clause as the most likely basis for vetting the extraterritorial application of abortion law. This clause certainly has received more attention than the other three in this context, and Justice Kavanaugh’s *Dobbs* concurrence indicated his support for constitutional protection for the right to travel.¹⁷⁸ However, the Clause’s substantive dimension has been controversial. Indeed, although Justice Alito took pains to distinguish abortion from all other rights protected by the Due Process Clause,¹⁷⁹ the opinion’s limited view of substantive due process has caused many commentators to question how solid the foundation is for the doctrine as a whole.¹⁸⁰ Indeed, Justice Thomas’s *Dobbs* concurrence argues that the Due Process Clause provides no substantive protections; under this interpretation, constitutional protections for travel, family formation, and intimacy are all subject to Court reversal.¹⁸¹ Moreover, the due process extraterritoriality doctrine the Court has developed, which exists in the context of punitive damages for a defendant’s out-of-state actions, has not been expanded.¹⁸² This leaves the clause ripe for bitter dispute in how it should be applied to extraterritorial abortion law.

Similarly, other legal doctrines outside of constitutional law, like conflicts-of-law jurisprudence, are just as indeterminate. Professor Appleton has explained that “criminal law has customarily remained immune from scrutiny through a choice-of-law lens.”¹⁸³ And Professor Dellapenna wrote, despite forcefully arguing that conflicts doctrine allows extraterritorial application of abortion restrictions, that “[t]his domain is notoriously unstable and contested.”¹⁸⁴

Second, determining the legality of extraterritorial application of abortion law would involve resolving claims of competing

¹⁷⁶ Kreimer, *supra* note 127, at 487-519.

¹⁷⁷ Rebecca E. Zietlow, *Belonging, Protection and Equality: The Neglected Citizenship Clause and the Limits of Federalism*, 62 *PITT. L. REV.* 281, 283 (2000).

¹⁷⁸ He wrote: “[M]ay a State bar a resident of that State from traveling to another State to obtain an abortion? In my view, the answer is no based on the constitutional right to interstate travel.” Slip op. at 10 (Kavanaugh, J., concurring). This discussion was in response to the dissenting opinion’s raising of this complicated issue, which cited and discussed this article. *See* slip op. at 36-37 (Breyer, Sotomayor, Kagan, JJ., dissenting).

¹⁷⁹ Slip op. at 66.

¹⁸⁰ *See, e.g.*, Jeannie Suk, *When the Supreme Court Takes Away a Long-Held Constitutional Right*, *THE NEW YORKER*, June 24, 2022, <https://www.newyorker.com/news/daily-comment/when-the-supreme-court-takes-away-a-long-held-constitutional-right>.

¹⁸¹ Slip op. at 1-7 (Thomas, J., dissenting).

¹⁸² *BMW of N. Am. v. Gore*, 517 U.S. 559 (1996).

¹⁸³ Appleton, *supra* note 112, at 667.

¹⁸⁴ Dellapenna, *supra* note 153, at 1654.

fundamental constitutional values. Among these values are, on the side of allowing extraterritorial application, local experimentation, preventing the proverbial “race to the bottom,” and judicial restraint. On the side of prohibiting extraterritorial application are the constitutional values of national citizenship, liberty of travel, and freedom of choice. And the interest in state sovereignty cuts both ways, as both restrictive and permissive states want their local policy choices to have the broadest possible reach. Having competing constitutional values would in no way be unique to this particular issue, as this is standard fare for most high-profile constitutional disputes. However, because these constitutional values, which are in theory separate from the values underlying the abortion debate, will become proxies for the abortion debate, the conflict of fundamental values will become even more difficult for courts to resolve.¹⁸⁵

Third, as the short sampling of scholarly treatment of the constitutional issues that extraterritorial application of state abortion law shows, any solution to the constitutional question here implicates not only competing constitutional foundational principles but also competing notions of constitutional interpretation. Historical disputes about the original understanding of the different clauses at issue will lead the Court to pick among different versions of complex history, which the Court does regularly.¹⁸⁶ However, when the Court is put in a position of choosing among different versions of history, longstanding concerns about judicial neutrality come to the fore.¹⁸⁷ And, perhaps to state the obvious, the present Supreme Court, which relied on a contested history of abortion regulation to overturn *Roe*,¹⁸⁸ might also marshal history and originalism in ways that undermine constitutional arguments against abortions laws with extraterritorial reach.

Fourth, and finally, given the various ways that states might attempt to restrict extraterritorial abortions, especially in an era of telabortion, courts will parse cases based on different facts and thus render different outcomes based on differing in-state and out-of-state activities. This will subject courts to the same criticism leveled at *Planned Parenthood v. Casey* that any resulting standard is not workable. Imagine different situations based on a variety of factors: the abortion patient’s ties to the state where abortion is illegal (does she live in the

¹⁸⁵ Fallon, *supra* note 154.

¹⁸⁶ For instance, compare the majority and dissenting opinion uses of history in *McDonald v. Chicago*, 561 U.S. 742 (2010), and *District of Columbia v. Heller*, 554 U.S. 570 (2008).

¹⁸⁷ Justice John Paul Stevens, *Originalism and History*, 48 GA. L. REV. 691 (2014); Saul Cornell, *Originalism on Trial: The Use and Abuse of History in District of Columbia v. Heller*, 69 OHIO. ST. L.J. 625 (2008).

¹⁸⁸ Compare *Dobbs*, slip op. at 45-56, with Brief of Constitutional Accountability Center as *Amicus Curiae* in Support of Respondents, *Dobbs*, No. 19-1392 (2021) (covering history to show the right to abortion is supported).

state where she is a citizen or live temporarily elsewhere?), the provider's ties to the state where abortion is illegal (is she licensed in that state but practicing elsewhere or does she have no connection to that state at all?), the type of assistance someone else provides the patient (does a friend provide a place to stay in the state where abortion is legal, drive the patient across state lines, or deliver her pills from a state where they are legal to a state where they are not?). For telabortion, these factors are compounded by complexities including where the provider and patient are located during the video visit, where the medication is received in the mail, where it is taken (which can possibly be multiple locations for the two different drugs), and where the pregnancy tissue is expelled.

It is possible that the Supreme Court and lower courts reach a consistent rule despite these varying interests and hold that these laws are always permissible or always prohibited. But it is much more likely that some combination of the scenarios listed above would strike some judges as appropriate and others as going too far, whether because of a sense of fundamental fairness,¹⁸⁹ the constitutional theories already discussed in this section, or other constitutional concerns.¹⁹⁰ Given the underdeveloped and contested jurisprudence, the competing fundamental constitutional principles involved, and the complex web of factual scenarios that could possibly arise, the post-*Roe* judiciary will soon be mired in interjurisdictional complexities that will make the workability of the previous era look simple in comparison.

D. Can a State Insulate Providers From Out-of-State Prosecutions?

So far, this section has explored the difficult legal issues that arise when antiabortion states attempt to apply their laws beyond state borders. However, antiabortion states are not alone in thinking about extraterritoriality after *Roe*. Abortion-supportive states have been exploring ways to thwart antiabortion states from applying their laws to abortions that occur within the abortion-supportive states. Since the online posting of the first draft of this article,¹⁹¹ Massachusetts has

¹⁸⁹ *Lassiter v. Dep't of Soc. Serv. of Durham Cnty.*, 452 U.S. 18, 24-25 (1981).

¹⁹⁰ This might include concerns over minimum contacts from personal jurisdiction doctrine, *see Int'l Shoe*, 326 U.S. at 310, or other the impact on other areas of law. *See* Brief of Firearms Policy Coalition as *Amicus Curiae* in Support of Granting Certiorari, *Whole Woman's Health v. Jackson*, ___ F.Supp.3d ___ (W.D. Tex. 2021) (No. 21-463), 2021 WL 3821062.

¹⁹¹ Some of the state efforts attempting to accomplish the protection described in this section have happened independent of this Article, such as the work of the California Future of Abortion Council. But others of these efforts have been in response to work we have done in exploring how our proposals might be implemented. The three of us have been actively involved in consulting with legislators and advocates in many different states on protecting abortion care from out-of-state legal action. Thus, the first draft of this Article we posted to SSRN in early February 2022 spoke of these efforts as possibilities; now, at the point of

passed the most comprehensive legislation, often referred to as an interstate shield law, with Connecticut, New York, Delaware, and New Jersey offering a panoply of protections as well.¹⁹² California, Illinois, and the District of Columbia have pending bills addressing the issue.¹⁹³ And governors of twelve states (California, Colorado, Maine, Massachusetts, Michigan, Minnesota, Nevada, New Mexico, North Carolina, Pennsylvania, Rhode Island, and Washington) have issued executive orders following *Dobbs* that accomplish some of the goals discussed here.¹⁹⁴ This section explores several avenues by which states can blunt the force of antiabortion states' extraterritorial reach. Importantly, each of these interventions would strike at the heart of basic, fundamental principles of law in our federalist system—interstate comity and cooperation. And none of them would protect the patients and helpers who stay in, or return to, an antiabortion state if a law targets their conduct.

With these risks in mind, an abortion-supportive state could nevertheless protect its providers' licenses and malpractice insurance rates. Ever since SB8 took effect in September 2021, some have wondered why Texas abortion providers have not engaged in civil disobedience and provided abortions after six weeks that violate the law.¹⁹⁵ The answer is not just the risk of being forced to pay the \$10,000 (or more) bounty. Texas abortion providers, many of whom also practice other areas of medicine or provide abortions in other states, also fear losing their medical licenses and facing cost-prohibitive malpractice insurance rates.¹⁹⁶ Lawsuits and complaints in which providers are named as defendants typically are reported to their

finalizing this Article for publication, we can point to concrete laws and executive orders that have been passed and bills that have been introduced, many – in part at least – because of our work.

¹⁹² H.B. 5090, 192nd Gen. Ct. (Mass. 2022); H.B. 455, 151st Gen. Assem. (Del. 2022); S. 2642, 220th Leg. (NJ 2022); S2633, 220th Leg. (NJ 2022); Pub. Act No. 22-19 (Conn. 2022); S. 9039A, 2021-2022 Leg. Sess. (NY); A. 9687B, 2021-2022 Leg. Sess. (NY); A. 9718B, 2021-2022 Leg. Sess. (NY); A. 9818A, 2021-2022 Leg. Sess. (NY); S. 9077A, 2021-2022 Leg. Sess. (NY); S. 9384A, 2021-2022 Leg. Sess. (NY).

¹⁹³ See H.B. 1464, 102nd Gen. Assem. (Ill. 2022); B. 24-0808 (D.C. 2022); B. 24-0726 (D.C. 2022).

¹⁹⁴ E.O. N-12-22 (Cal. 2022); D. 2022-032 (Colo. 2022); E.O. 4 (Maine 2022); E.O. 600 (Mass. 2022); E.O. 2022-4 (Mich. 2022); E.O. 22-16 (Minn. 2022); E.O. 2022-08 (Nev. 2022); E.O. 2022-107 (N.M. 2022); E.O. 263 (N.C. 2022); E.O. 2022-01 (Pa. 2022); E.O. 22-28 (R.I. 2022); D. 22-12 (Wash. 2022).

¹⁹⁵ Alexi Pfeffer-Gillett, *Civil Disobedience in the Face of Texas's Abortion Ban*, 106 MINN. L. REV. 203 (2021).

¹⁹⁶ United States' Emergency Motion for a Temporary Restraining Order or Preliminary Injunction, *United States v. Texas*, ___ F. Supp.3d ___, 2021 WL 4593319 (W.D. Tex. 2021), at 11, <https://s3.documentcloud.org/documents/21062495/9-14-21-us-motion-for-tro-pi-texas-sb8.pdf>.

DRAFT 8/4/22
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licensing bodies and insurers.¹⁹⁷ In this context, that means if an antiabortion state tries to impose criminal or civil liability on an abortion provider for providing an abortion to someone from another state that was legal in the provider's state, that prosecution or lawsuit could be reported to the provider's licensing board, which typically has broad discretion in governing provider ethics and standards of conduct.¹⁹⁸ Being named as a defendant too many times or being subject to a disciplinary investigation, even if the provider ultimately prevails, could result in licensure suspension, high malpractice insurance costs, and reputational damage, given that lawsuits are publicly available and figure into ratings of physician competence.¹⁹⁹ These effects threaten providers' ability to practice medicine and support themselves and their families.

To prevent this, an abortion-supportive state can pass legislation that prohibits its medical boards and in-state malpractice insurance companies from taking any adverse action against providers who face out-of-state legal consequences for assisting out-of-state patients. This would not be a blanket immunity for abortion providers but rather a targeted protection applicable to out-of-state investigations, disciplinary actions, lawsuits, or prosecutions arising from abortions performed in compliance with the home state's law. Several of the shield laws and executive orders offer this protection to abortion providers.²⁰⁰

Beyond this kind of professional insulation, abortion-supportive states might also attempt to thwart interstate investigations and discovery, both civil and criminal, into the care provided in their states for patients from other states. These investigations and discovery attempts, even if they do not result in liability, could be used to harass providers, chilling abortion provision on out-of-state patients, and to gather evidence that is used to form the basis of an extraterritorial lawsuit or prosecution. On the civil side, most states have enacted some form of the Uniform Interstate Depositions and Discovery Act which simplifies the process for litigants to take

¹⁹⁷ See About Physician Discipline, How State Medical Boards Regulate Physicians after Licensing, FEDERATION OF STATE MEDICAL BOARDS (last visited July 30, 2022), <https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/u.s.-medical-licensing-and-disciplinary-data/>. Malpractice payments are reported to the National Practitioner Data Bank, which is part of the HHS's Health Resource and Services Administration. Reporting Medical Malpractice Payments, NPDB, <https://www.npdb.hrsa.gov/guidebook/EMMPR.jsp>.

¹⁹⁸ Jaqueline Landess, *State Medical Boards, Licensure, and Discipline in the United States*, 17 FOCUS: AM. PSYCHIATRY PUBL. 337, 338 (2019) (summarizing the history of state medical boards and their "broad discretion").

¹⁹⁹ See *U.S. Medical Licensing and Disciplinary Data*, FEDERATION OF STATE MEDICAL BOARDS (last visited Feb. 3, 2022), <https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/u.s.-medical-licensing-and-disciplinary-data/>.

²⁰⁰ See, e.g., H.B. 5090, 192nd Gen. Ct. at §§ 5, 10, 11, 15, 16, 17, 23 (Mass. 2022); E.O. 2022-107 at ¶ 3 (N.M. 2022).

DRAFT 8/4/22
IF QUOTING, PLEASE INDICATE THIS IS A DRAFT

depositions and engage in discovery with people from another state.²⁰¹ The Act streamlines the process for an out-of-state court to enforce the original state’s subpoena. On the criminal side, the Uniform Act to Secure the Attendance of Witnesses from Without a State in Criminal Proceedings, a version of which every state has enacted, accomplishes the same goal for witness summons in criminal cases.²⁰² And even before witnesses are called, police departments usually work with one another across state lines via formal and informal cooperation agreements.²⁰³

States could protect their providers from antiabortion state investigations, lawsuits, and prosecutions by exempting abortion providers from the interstate discovery and interstate witness subpoena laws while also prohibiting state and local law enforcement agencies from cooperating with other states’ investigations into abortion-related crimes and lawsuits.²⁰⁴ As with the professional disciplinary exemptions above, this would not be for any and all abortions. Rather, it would apply only to abortions that are otherwise legal in the provider’s state. And a state passing such an exemption or waiver would not be able to protect the provider if she ever traveled to the antiabortion state, where she would then be subject to that state’s laws or a judgment entered in that state’s courts.²⁰⁵ This form of protection, however, would prevent the courts of the provider’s home state from enforcing these out-of-state subpoenas and discovery requests and the law enforcement agencies of the provider’s home state from becoming a cooperating arm of the antiabortion state’s investigation apparatus. All of the shield laws so far include these protections and several of the executive orders do as well.²⁰⁶

An abortion-supportive state could separately exempt abortion providers from the state’s extradition law for legal abortions in the provider’s home state. The Constitution requires states to extradite an accused criminal who flees to that state.²⁰⁷ Thus, for instance, Illinois

²⁰¹ Uniform Interstate Depositions and Discovery Act (2007), *available at* <https://www.uniformlaws.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=3900ce12-d2bd-cd09-4e4a-8ae173279559&forceDialog=0>.

²⁰² Uniform Act to Secure the Attendance of Witnesses from Within or Without a State in Criminal Proceedings (1936), *available at* https://www.hrw.org/legacy/pub/2006/Uniform_Act_to_Secure_the_Attendence_of_Witnesses.pdf.

²⁰³ Bridget A. Fahey, *Federalism By Contract*, 129 YALE L.J. 2326 (2020).

²⁰⁴ The Full Faith and Credit Clause is “inapplicable to the enforcement of an out-of-state court’s decision to issue a commission authorizing certain depositions and a demand for document production” because it only applies to final judgments. Barbara J. Van Arsdale, et al., *Operation and Effect of Full Faith and Credit Clause, Generally*; *Judgments*, 16B Am. Jur. 2d Constitutional Law § 1024 (2022).

²⁰⁵ Moreover, if a default judgment is entered against a provider in another state, creditors might try to collect on that judgment, creating a separate problem for the provider.

²⁰⁶ *See, e.g.*, Pub. Act No. 22-19 at §§ 3, 4 (Conn. 2022).

²⁰⁷ U.S. CONST. art. IV, § 2, cl. 2.

cannot constitutionally refuse to extradite an Illinois provider who travels to Kentucky, performs an illegal abortion there, and then goes back to Illinois. However, the Constitution’s extradition clause does not cover extradition of people who did not flee, meaning a state is not constitutionally required to extradite an Illinois provider who never stepped foot in Kentucky.²⁰⁸ Outside of constitutional requirements, some states’ extradition laws permit or obligate the state to extradite accused criminals, even if they have never been in the other state and thus have not fled.²⁰⁹ An abortion-supportive could exempt providers and others from these provisions so that the provider could perform abortions pursuant to their home state laws for out-of-state patients without fear of being extradited.²¹⁰ The shield laws that have passed so far exempt extradition in such cases, and almost all of the executive orders declare that the governors will not use their discretion in this context.²¹¹

Another concern that is spurring interstate protection is the threat of out-of-state civil judgments under laws such as Texas’s SB8.²¹² Imagine an Illinois abortion provider, volunteer driver, funder, or other helper assisting a Texas patient to obtain an abortion that is contrary to SB8 (one that is past six weeks and performed by a Texas-licensed physician). Under that law, anyone could sue that Illinois

²⁰⁸ *Hyatt v. People of State of N.Y. ex rel. Corkran*, 188 U.S. 691, 709–13. Constructive presence is not enough to qualify as a fleeing fugitive. *In re Rowe*, 423 N.E.2d 167, 171 (Ohio 1981) (requiring corporeal presence). Thus, an abortion provider who uses video conferencing to communicate with a patient in an antiabortion state will not have been considered to have been present in that state because, even though the video reached into the state, the provider’s physical presence was not. This means the Constitutional requirement of extradition does not apply. *See* Jack L. Goldsmith, *Against Cyberanarchy*, 65 *Univ. Chic. L. Rev.* 1199, 1220 (1990) (“[A] person who in State A transmits information flows that appear in and constitute a crime in State B will not likely be subject to extradition to State B under these provisions. This is because the extradition obligation only extends to fugitives who have fled State B, and these terms have long been limited to persons who were physically present in the demanding state at the time of the crime’s commission.”).

²⁰⁹ Uniform Criminal Extradition Act (UCEA); *see, e.g.*, CONN. STAT. § 54-162 (“even though the accused was not in that state at the time of the commission of the crime and has not fled therefrom”).

²¹⁰ Though, if the other state issues a warrant for the provider’s arrest, the provider would still face serious risks to their liberty because they might not be comfortable traveling to any state that does not have the protections discussed in this section. Thus, protection from extradition would help limit a provider’s risk, but in order to completely eliminate the provider’s risk, the provider would need to limit their own future travel.

²¹¹ *See, e.g.*, Pub. Act No. 22-19 at § 5 (Conn. 2022); E.O. 2022-01 at ¶ 5 (Pa. 2022).

²¹² Texas’s SB8 creates civil liability for anyone who performs or aids and abortion performed by a *Texas-licensed* provider. More recent SB8-style laws lacked any requirement of a connection to the home state. For instance, the Oklahoma copycat law creates civil liability for any abortion starting at conception without any explicit connection to Oklahoma required by the text, creating a much wider opening for these kinds of lawsuits.

DRAFT 8/4/22
IF QUOTING, PLEASE INDICATE THIS IS A DRAFT

person for \$10,000 or more.²¹³ If a Texas court issues a final judgment in that case finding the Illinois resident liable under SB8, the Full Faith and Credit Clause would ordinarily require Illinois' courts to enforce that judgment.²¹⁴ Individual Illinois litigants attempting to evade the force of the judgment could try to take advantage of two recognized exceptions to the Full Faith and Credit Clause by claiming the Texas court had no personal jurisdiction over them²¹⁵ or that SB8 is really a penal law.²¹⁶

But abortion-supportive states might chill the uptake of these judgment enforcement actions by creating a cause of action against anyone who interferes with lawful reproductive health care provision or support. This new cause of action, such as the clawback provision adopted by Connecticut and the other states with shield laws, would recognize the out-of-state judgment, as the Constitution requires, but subject the person seeking to enforce it to a new state tort claim for interfering with reproductive health care provision that was lawful in the abortion-supportive state.²¹⁷ In passing such a law, states would hope to thwart out-of-state enforcement actions in the first place because people would fear bringing these actions into a state with this new cause of action. Or, if there is an enforcement action in the abortion-supportive state, the new cause of action would lead to the negation of the financial impact of the out-of-state judgment by forcing both parties to pay damages of the same amount to each other.

In addition, abortion-supportive states could protect providers' home addresses from public discovery out of concern that they will be targeted by antiabortion extremists from afar now that they are caring for an increased number of out-of-state patients.²¹⁸ As part of their shield bills, New York and Massachusetts expanded their address confidentiality programs to include abortion providers and patients.²¹⁹

Finally, and much more controversially, states could attempt to protect providers who are not only providing care to those traveling to their state, but also to patients who stay where abortion is illegal by mailing medication to them. Telehealth policies and the relevant standard of care, which vary from state to state, define the location of

²¹³ SB8, 87th Gen. Assem., Reg. Sess. (Tex. 2021).

²¹⁴ U.S. CONST. art. IV, § 1.

²¹⁵ *Milliken v. Meyer*, 311 U.S. 457, 462 (1940) (“Where a judgment rendered in one state is challenged in another, a want of jurisdiction over either the person or the subject matter is of course open to inquiry.”).

²¹⁶ *Nelson v. George*, 399 U.S. 224, 229 (1970); *The Antelope*, 23 U.S. 66, 123 (1825) (“The Courts of no country execute the penal laws of another”); *City of Oakland v. Desert Outdoor Advert., Inc.*, 2676 P.3d 48, 49–50 (Nev. 2011).

²¹⁷ Pub. Act No. 22-19 at § 1(b) (Conn. 2022).

²¹⁸ See CAL. GOV'T CODE § 6215 (West 2003); N.J. REV. STAT. § 47:4-2 (2019).

²¹⁹ S. 9384A, 2021-2022 Leg. Sess. (NY); H.B. 5090, 192nd Gen. Ct. at §§ 2 (Mass. 2022).

care as where the patient is. Thus, if the patient remains in Kentucky, then the physician is acting illegally by practicing medicine without a license in Kentucky, even if abortion via telehealth is legal in their home state. Changing telehealth policies for abortion to define the location of care as where the provider is located would mean the provider's home state would not consider the provider to be practicing without a license or in violation of another state's law. Such a rule change would have significant consequences for the entire healthcare ecosystem, and as a result, current proposals are limited to abortion care. Even with that limitation, as section III.D notes, changing the location of care has ripple effects for interstate licensure compacts and model laws on telehealth. And, more significantly, abortion-supportive states could not protect their providers from consequences in the state where the patient is, which would consider the location of care differently and thus the provider's actions a violation of the state's abortion laws as well as its licensing laws. Thus, providers undertaking explicit out-of-state teleabortion care would likely become significant targets. Though their home state's shield law may protect them when in their state, any travel outside the state may be high risk. As of now, only the Massachusetts shield law has this form of protection.²²⁰

Beyond a provider who knowingly mails medication abortion to a person in a state that bans it, questions of location—in practice—will be much more unclear. The standard of care is to assume the patient is where the provider is. As a result, there will be instances in which a provider believes a patient is in an abortion-supportive state when they are not. Though some states have statutory or regulatory requirements that require providers ask for a patient's residence or location, some patients will lie or use work arounds like mail forwarding. Even when patients physically travel to the abortion supportive state, legal risks for providers increase if patients take medication abortion home with them into an antiabortion state. Inconsistent provider policies might emerge to respond to this dilemma. Under *Casey*, state laws that required reporting residency purported to serve the purpose of tracking abortion statistics—not to police from where patients hailed. Under that reasoning, they, along with other reporting requirements, continue to serve the purpose of collecting abortion data but that purpose must be balanced against the risk of extraterritorial punishment.

Moreover, abortion providers with the support of national professional organizations could tailor their policies to meet patient need and to comply with the law. They may offer different services to out-of-state patients or consider having patients sign a waiver that states, "I have been advised to take this medication in [the abortion-supportive state]." But herein lies another problem: waivers shift liability to the patient, and if state laws begin to target patients, then

²²⁰ H.B. 5090, 192nd Gen. Ct. at lines 17-18, 74 (Mass. 2022).

those individuals will bear all the costs. It also highlights an under-analyzed issue: how clinical practice will change to respond to threats of cross-border liability and punishment, potentially adopting policies that impose restrictions not required by their own state's law.²²¹

Even if the particular suggestions included in this section are on constitutionally firm ground,²²² there is no denying that each of these proposals would threaten basic principles of comity between states, possibly resulting in the breakdown of state-to-state relations and ultimately retaliation. After all, if Illinois refuses to extradite an abortion provider to Kentucky, will Kentucky retaliate and refuse to extradite a gun dealer to Illinois? A state passing the shield provisions discussed here would go a long way to protecting its providers and increasing access for out-of-state patients who seek out those providers, but would also intensify interstate conflict in a way that could have unintended consequences for other areas of law as well as the general fabric of our federalist form of government. As we argue throughout this Article, these will be the inevitable effects of overturning *Roe*.

III. PREEMPTION, FEDERAL LAND, AND HEALTH POLICY

Interstate issues are not the only area that will cause deep confusion: interaction between federal and state law will also be complicated and in flux. Indeed, in the days following the Supreme Court's decision, the Biden Administration issued statements and guidance promoting many of the theories mentioned below (some of which have already been challenged in court), but more could be done.²²³ This Part will explore how possible federal actions that might be taken in the wake of *Dobbs* interact with—and possibly preempt—state laws to the contrary. As with everything described already in this Article, each move will face legal uncertainty and depend on political mobilization. But with *Roe* overturned, the Biden Administration is

²²¹ At the time of writing, some examples of emerging clinical practice seek to minimize provider liability by contemplating a protocol that administers medication abortion in one visit—over 6 to 8 hours—rather than over one to two days, presumably so that the patient can complete an abortion at a clinic rather than take pills at home. Another facility stopped providing medication abortion to out-of-state patients. Email from Martha Fuller, President and CEO of Planned Parenthood Montana, June 30, 2022 (on file with the authors).

²²² The suggestions as described here are constitutionally sound. That does not mean that every aspect of the various bills that have been introduced in different states that mirror these suggestions is constitutionally sound as the particular language of each provision must be assessed individually. Nor does it mean that a motivated conservative judiciary might not change existing well-settled constitutional principles in order to strike down these provisions.

²²³ We have publicly argued more should be done. David S. Cohen, Greer Donley, & Rachel Rebouché, *Joe Biden Can't Save Roe v. Wade Alone. But He Can Do This*, N.Y. TIMES (Dec. 30, 2021), <https://www.nytimes.com/2021/12/30/opinion/abortion-pills-biden.html>.

facing increasing pressure to use its power, however untested, to protect abortion rights—and we offer avenues for how it can do so in the immediate future.

The President cannot restore the right to abortion, but he can use executive power to improve abortion access, even without currently-stalelegated legislative proposals.²²⁴ One possible tool at the federal government’s disposal is preemption—the doctrine that federal laws trump conflicting state laws. This Part discusses a few federal laws that could partially preempt state abortion bans, the most significant of which relates to the FDA’s regulatory authority over abortion-inducing drugs. Asserting another form of power, the federal government could take the novel approach of using its jurisdiction over federal land within antiabortion states to insulate providers who offer abortion care on that land. Complementing these strategies, and in partnership with states, the executive branch could encourage investment in telehealth and the adoption of interstate compacts that will improve abortion care throughout the country. We begin with the example of preemption and highlight throughout this section how the scope of federal power—especially as it impacts antiabortion states—will become critical to future abortion debates.

A. Federal Preemption

The U.S Constitution’s Supremacy Clause states that federal law is the “supreme law of the land,” and trumps any state law to the contrary.²²⁵ Thus, federal law could be a sword to poke holes in state abortion bans; it could also be used as a defense to criminal prosecution or civil liability. We start with the boldest preemption argument: that states cannot ban mifepristone or regulate it more harshly than the FDA. This would force states to permit medication abortion through ten weeks. We conclude with additional preemption arguments related to medically necessary abortions and reporting of abortion-related crimes.

1. FDA’s Power Over Medication Abortion

Ever since the FDA approved medication abortion in 2000, it has used its authority to restrict access to the drug in a variety of ways. The FDA’s current regulation of mifepristone—the first medication in the two-medication regimen for medical abortions—includes a Risk Evaluation and Mitigation System (REMS). The imposition of a REMS is a rare action that, by statute, can only be imposed if a REMS is necessary to ensure that the drug’s benefits outweigh its risks.²²⁶

²²⁴ WHPA

²²⁵ U.S. Constitution, Art. IV.

²²⁶ Donley, *supra* note 54, at 22-36.

Scholars have argued that the FDA’s use of the REMS for mifepristone is unnecessary and contrary to the REMS statute, “unduly burdens” access to the drug.²²⁷

The FDA’s current REMS, which now reflects a recent policy change that clears the way for virtual care, has the following requirements: (1) only certified providers can prescribe the drug, (2) patients must sign a Patient Agreement Form, and (3) only certified providers or certified pharmacies can dispense the drug.²²⁸ In the process of revising the REMS numerous times over the past decade, the FDA has made specific scientific findings about the drug’s safety and efficacy. On the basis of these findings, in 2016, the agency removed its earlier requirements that patients consume the drug in-person, allowing patients to take the pills at home after picking them up at a healthcare facility.²²⁹ It removed the requirement that only physicians could prescribe the drug, allowing physician assistants and nurse practitioners to prescribe as well.²³⁰ It approved the drug’s use through the tenth week of pregnancy, beyond the seventh week, as it had previously determined.²³¹ And finally, in December 2021, the agency lifted the REMS provision that forced patients to pick up the medication at a healthcare facility, paving the way for abortion via telehealth with medication delivered through the mail.²³²

Various state laws conflict with these determinations. Up until and even after *Dobbs*, nineteen states require a physician to be present upon delivery of medication abortion, thus rendering completely remote abortion impossible.²³³ State legislation that requires in-person visits for counseling or ultrasounds preclude a wholly remote process. Moreover, thirty-two states only allow physicians to prescribe medication abortion, even though the FDA found it safe for non-physician providers to prescribe it.²³⁴ Many states, like Mississippi, also have required patients to consume the drug in the presence of a provider—i.e., they cannot take the drug at home. And in September

²²⁷ *Id.*

²²⁸ *Mifepristone (mifepristone) Information*, *supra* note 55.

²²⁹ CENTER FOR DRUG EVALUATION & RESEARCH, APPLICATION NUMBER 020687ORIG1S020, SUMMARY REVIEW FOR REGULATORY ACTION 17 (Mar. 29, 2016), https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020SumR.pdf.

²³⁰ *Id.*

²³¹ *Id.*

²³² *Mifepristone (mifepristone) Information*, *supra* note 55.

²³³ *Medication Abortion*, *supra* note 18. Ten states also have statutes that explicitly ban the use of telemedicine for abortion even though existing in-person requirements accomplish the same end; state courts in two of those states have enjoined the in-person requirement. *See* *Planned Parenthood of the Heartland v. Iowa Bd. of Med.*, 865 N.W.2d 252, 269 (Iowa 2015); *Carrie N. Baker, Advocates Cheer FDA Review of Abortion Pill Restrictions*, MS. MAG., May 11, 2021 (describing the Ohio law and state court injunction).

²³⁴ *Medication Abortion*, *supra* note 1718.

2021, Texas enacted a law making it illegal to use medication abortion after the first seven weeks of pregnancy, even though the drug has been approved for use through the tenth week of pregnancy.²³⁵ Some of these laws have been on the books for decades, but until very recently, had never been challenged for contradicting the FDA's regulation. But there are deeper incentives now that *Roe* has been overturned to challenge these laws under preemption doctrines, especially given that the antiabortion movement has been focused in recent years on hampering access to abortion pills.²³⁶ Though many of the laws that specifically target medication abortion will be subsumed by a state's general abortion ban, not all will. For instance, Pennsylvania is not expected to ban abortion, but it still requires abortion providers to be physicians.²³⁷

There is a strong, though legally uncertain, argument that federal law preempts these state restrictions on medication abortion; it could even preempt general abortion bans, though that is even more uncertain. As noted, the U.S. Constitution's Supremacy Clause establishes that when state and federal laws conflict, the federal law will preempt state law.²³⁸ For this reason, if Congress were to pass the Women's Health Protection Act,²³⁹ or a similar law that created a federal right to abortion, this federal law would preempt state abortion bans. However, given the current stalemate in the Senate, the prospects of a new federal law protecting abortion rights are slim to none in the short term. But if the FDA's regulation of medication abortion preempts state restrictions on the pills or, more broadly, state laws that ban all abortion, medication abortion as approved by the FDA would be available in all fifty states.

The crux of any preemption argument is Congressional purpose, which "is the ultimate touchstone in every preemption case."²⁴⁰ Congress can express this preemptive purpose explicitly or implicitly, but in the context of federal preemption of state drug law, plaintiffs must rely on implied preemption theories. Congress

²³⁵ See S.B. 4, Sess. 87(2) (Tex. 2021).

²³⁶ See, e.g., Cheryl Sullenger, *The Status of American Abortion Facilities: Telemedicine's Impact in 2021*, OPERATION RESCUE (Jan. 11, 2022), <https://www.operationrescue.org/archives/the-status-of-american-abortion-facilities-telemedicines-impact-in-2021>; Veronica Stracqualursi, *South Dakota Places Further Restrictions on Medication Abortions*, CNN (Jan. 8, 2022), <https://www.cnn.com/2022/01/08/politics/south-dakota-medication-abortions/index.html>.

²³⁷ <https://www.attorneygeneral.gov/wp-content/uploads/2022/06/Consumer-Abortion-QA-FINAL-6-30-22.pdf>.

²³⁸ U.S. CONST. art. VI, cl. 2.

²³⁹ WHPA cite.

²⁴⁰ *Wyeth v. Levine*, 555 U.S. 555, 565 (2009).

expressly preempted state law when it created legislation that governed medical devices but never did so for pharmaceuticals.²⁴¹

Implied preemption of state law occurs in a few contexts: when it is impossible to comply with both state and federal law (impossibility preemption),²⁴² when a state law would frustrate the purpose underlying federal law (obstacle preemption),²⁴³ or when federal law entirely occupies a field (field preemption).²⁴⁴ The former two types of implied preemption—impossibility and obstacle preemption, together considered conflict preemption—are more commonly relied upon to prove preemption in the context of federal drug law.²⁴⁵ The Supreme Court has considered whether the Food, Drug, and Cosmetic Act (FDCA), and the regulatory scheme implementing it, preempts state law a few times in the past decade—all using conflict preemption theories. Recent decisions increasingly have accepted the preemptive force of FDA rules.

The framing of Congressional purpose is key to an obstacle preemption theory. In the context of state regulation of mifepristone, there are three primary purposes: (1) Congress envisioned the FDA's role, in part, as protecting patient access to safe and effective drugs, and thus state laws that restrict access thwart this purpose; (2) Congress created the FDA with the purpose of establishing a nationally uniform, definitive, and rigorous drug approval system, and thus state laws creating variation thwart that purpose; and (3) Congress created the REMS program specifically so that the FDA could balance the important goals associated with drug safety and drug access, and thus states laws that balance these goals differently for drugs subject to a REMS thwart this purpose. Each of these congressional purposes are supported either by statutory text or legislative history.

For a preemption challenge state laws that regulate mifepristone more harshly than the FDA—laws that still might be controlling in some states after *Roe*, such as physician-only mandates—the third purpose is most relevant because states laws directly conflict with the FDA's determinations under the REMS. Indeed, it is the FDA's imposition of a REMS—and the extra control that comes with it—that strengthens a preemption argument. When Congress created the REMS program in 2007, it gave the FDA the ability to impose additional controls on certain approved drugs, but in doing so, required the agency to use the least restrictive means of protecting the

²⁴¹ *Wyeth*, 555 U.S. at 567; Patricia J. Zettler, *Pharmaceutical Federalism*, 92 IND. L.J. 845, 862 (2017).

²⁴² *English v. Gen. Elec. Co.*, 496 U.S. 72, 79 (1990).

²⁴³ *Id.*

²⁴⁴ *Id.* at 78.

²⁴⁵ Because the Food, Drug & Cosmetic Act (FDCA) does not disrupt the states' ability to regulate drugs in certain confined contexts, like tort law or the practice of medicine, the FDA may not presumptively occupy the entire field. Zettler, *supra* note 222, at 859-62.

public.²⁴⁶ The statute specifically said that the REMS may “not be unduly burdensome on patient access to the drug.”²⁴⁷ Thus, in imposing a REMS for mifepristone, the FDA has chosen to exercise more control over the drug than it does for the 95% of approved drugs that are not subject to a REMS.²⁴⁸ And in exercising that control, it has had to justify its decisions with evidence that balanced safety and efficacy with access.

State laws that overregulate medication abortion rest on scientific conclusions that are directly at odds with those that Congress required the FDA to make when issuing a REMS. As noted, the FDA has specifically considered and rendered judgment about whether medication abortion can be safely and effectively (1) prescribed by non-physician providers;²⁴⁹ (2) used through ten weeks of pregnancy;²⁵⁰ (3) consumed at home;²⁵¹ and (4) dispensed by mail or certified pharmacy.²⁵² Thus, in addition to bans on all abortion, which we discuss below, any state laws that remain after *Dobbs* that require physician prescribing, limit the length of use, require in-person pick up or consumption, ban the use of telehealth, or prohibit mailing medication abortion conflict directly with the agency’s evidence-based conclusions required by the REMS statute.²⁵³ Courts have preempted state laws that are directly at odds with the FDA’s determinations in other contexts. For instance, state tort laws are preempted when they require risk disclosures that the FDA has specifically considered and

²⁴⁶ The statute requires that the ETASU be “commensurate with the specific serious risk listed in the labeling of the drug,” “not be unduly burdensome on patient access to the drug, considering in particular . . . patients who have difficulty accessing health care (such as patients in rural or medically underserved areas),” and “conform with elements to assure safe use for other drugs with similar, serious risks.” 21 U.S.C. § 355–1(f)(2). The statute also required the agency “to the extent practicable . . . minimize the burden on the healthcare delivery system.” 21 U.S.C. § 355–1(f)(2).

²⁴⁷ 21 U.S.C. § 355–1(f)(2).

²⁴⁸ Donley, *supra* note 54, at 31.

²⁴⁹ CENTER FOR DRUG EVALUATION & RESEARCH, *supra* note 229, at 17.

(“healthcare providers other than physicians can effectively and safely provide abortion services, provided that they meet the requirements for certification described in the REMS.”).

²⁵⁰ *Id.* at 9 (“the data and information reviewed constitute substantial evidence to support the proposed dosing regimen . . . for pregnancy termination through 70 days [or ten weeks] gestation.”).

²⁵¹ *Id.* at 15 (“there is no clinical reason to restrict the location in which misoprostol may be taken. . . . Given the fact that the onset of cramping and bleeding occurs rapidly (i.e., generally within 2 hours) after misoprostol dosing, allowing dosing at home increases the chance that the woman will be in an appropriate and safe location when the process begins.”).

²⁵² FDA Letter, *supra* note 59 (“We have concluded that mifepristone will remain safe and effective for medical abortion if the in- person dispensing requirement is removed, provided all the other requirements of the REMS are met and pharmacy certification is added.”).

²⁵³ It is worth noting that the FDA reviewed and reiterated its scientific conclusions from 2016 in 2021. *Id.*

rejected as not necessary.²⁵⁴ This REMS-focused purpose is narrower than what we describe below and might be less likely to have unintended consequences on other state public health efforts related to other FDA-regulated products, like tobacco.

Viewed through the different Congressional purpose of drug accessibility, there is case law suggesting that states cannot regulate FDA-approved drugs in a way that would remove them from the market or make them less accessible. One such case in the District of Massachusetts invalidated a state's attempt to regulate a newly approved and controversial opioid, Zohydro, more harshly than the FDA.²⁵⁵ Of particular concern was the state requirement that a prescribing physician verify "that other pain management treatments have failed."²⁵⁶ The court evaluated "whether the regulations prevent the accomplishment of the FDA's objective that safe and effective drugs be available to the public."²⁵⁷ The judge preliminarily enjoined the regulation, finding the plaintiffs likely to succeed on their preemption theory because "if the Commonwealth interprets its regulation to make Zohydro a last-resort opioid, it undeniably makes Zohydro less available."²⁵⁸ When the state changed the requirement to only require a showing that other pain-management treatments were "inadequate," mimicking the FDA-approved label, the court upheld the law.²⁵⁹ Based on this reasoning, a state law that makes a drug less accessible than the FDA frustrates Congress's purpose in ensuring the accessibility of safe and effective drugs.

Some scholars have been skeptical that one of Congress's purposes in creating the national drug review system was to make approved drugs accessible (instead of just safe and effective).²⁶⁰ However, this accessibility purpose is clearly incorporated into the REMS statute,²⁶¹ suggesting that congressional purpose would be frustrated if states attempt to ban a drug that the FDA regulates

²⁵⁴ See e.g., *Seufert v. Merck Sharp & Dohme Corp.*, 187 F. Supp. 3d 1163, 1175-77 (S.D. Cal. 2016) (finding that a state duty-to-warn case was preempted because the manufacturer could not have been required to warn patients of a risk that the FDA has specifically concluded did not exist); *In re Zofran (Ondansetron) Prod. Liab. Litig.*, No. 1:15-MD-2657-FDS, 2021 WL 2209871, at *33 (D. Mass. June 1, 2021) (same).

²⁵⁵ Its own advisory committee had recommended against approving Zohydro on the ground that there was no "need for a new form of one of most widely abused prescription drugs in the United States," but the FDA nevertheless approved it. *In re Zofran*, at 3, n.9.

²⁵⁶ *Zogenix, Inc. v. Patrick*, No. CIV.A. 14-11689-RWZ, 2014 WL 3339610, at *1 (D. Mass. July 8, 2014), *vacated in part*, No. CIV.A. 14-11689-RWZ, 2014 WL 4273251 (D. Mass. Aug. 28, 2014).

²⁵⁷ *Id.* at *4.

²⁵⁸ *Id.*

²⁵⁹ *Zogenix, Inc.*, 2014 WL 3339610, at *3.

²⁶⁰ See Lars Noah, *State Affronts to Federal Primacy in the Licensure of Pharmaceutical Products*, 2016 MICH. ST. L. REV. 1, 8-12 (2016).

²⁶¹ 21 U.S.C. 355-1.

through the REMS process. Professor Patti Zettler agrees that in the context of a REMS, the preemption argument is stronger because “Congress has arguably required the FDA to do a complex balancing of numerous considerations, both in determining whether a REMS is necessary at all, and in determining what to include in a REMS when one is needed.”²⁶² As a result, any additional restrictions might “pose an obstacle to the FDA’s responsibility to satisfy these Congressional objectives.”²⁶³ Recently, Zettler and Ameet Sarpatwari applied this line of reasoning to medication abortion:

While the mifepristone REMS remains in place, a strong case can be made that state-required measures that go beyond the conditions in the REMS . . . upset the complex balancing of safety and burdens on the health care system that federal law requires of the FDA when it imposes a REMS like the one for mifepristone.²⁶⁴

They note that these laws are troubling when they are “are grounded in drug-safety arguments,” because they encroach on the FDA’s clear authority.²⁶⁵

One effort to test these theories began before the *Dobbs* decision. In 2020, mifepristone’s generic manufacturer, GenBioPro, recently sued Mississippi on preemption grounds. Mississippi law requires physicians to physically examine a patient prior to offering medication abortion and for patients to ingest the medication “in the same room and in the physical presence of the physician who gave, sold, dispensed or otherwise provided or prescribed the drug or chemical to the patient.”²⁶⁶ GenBioPro argued that Mississippi’s law, which is far stricter than the current REMS, is preempted because it is “an impermissible effort by Mississippi to establish its own drug approval policy and directly regulate the availability of drugs within the state.”²⁶⁷ In short, GenBioPro argues that the FDA’s actions preempt state efforts to restrict dispensation of mifepristone.²⁶⁸ (In July 2022, GenBioPro moved to amend the complaint to challenge Mississippi’s general abortion ban, discussed below.²⁶⁹) Thus far, the FDA has not

²⁶² Zettler, *supra* note 222, at 875.

²⁶³ *Id.*

²⁶⁴ Patricia J. Zettler & Ameet Sarpatwari, *State Restrictions on Mifepristone Access—The Case for Federal Preemption*, NEW ENG. J. MED. (Jan. 12, 2022), <https://www.nejm.org/doi/full/10.1056/NEJMp2118696>.

²⁶⁵ *Id.*

²⁶⁶ Miss. Code Ann. § 41-41-107(2)-(3).

²⁶⁷ Brief of Plaintiffs GenBioPro at 27, *Genbiopro, Inc. v. Dobbs*, (No. CV TDC-20-652), 2020 WL 2771735 (S.D. Miss. Oct. 9, 2020).

²⁶⁸ *Id.* at 28. In addition, GenBioPro argues that the Mississippi statute is a “significant burden on interstate commerce because [it] interferes with the FDA’s national and uniform system of regulation,” in violation of the Commerce Clause.

²⁶⁹ GENBIOPRO, INC.’S MEMORANDUM IN SUPPORT OF ITS

weighed in on the case, but the agency could intervene as *amici* or work with the Department of Justice to assert its authority in its own litigation.²⁷⁰

Antiabortion states will resist these efforts, and one of their primary arguments will be that states have the sole authority to regulate the practice of medicine, which includes what drugs providers may prescribe.²⁷¹ As scholars have explained, “courts, lawmakers, and the FDA itself have long opined that state jurisdiction is reserved for medical practice—the activities of physicians and other health care professionals—and federal jurisdiction for medical products, including drugs.”²⁷² However, the practice-of-medicine defense was raised and rejected in the Zohydro litigation.²⁷³ Professor Zettler contends that the Zohydro litigation is one of many recent examples showing that “the distinction between regulating medical practice and medical products is nebulous” and “the FDA’s preemptive reach can extend into medical practice regulation in certain circumstances.”²⁷⁴ Zettler suggests that if the state is attempting to regulate drugs—even if it does so through the smokescreen of provider conduct—it is attempting to displace federal law and frustrate congressional purpose.²⁷⁵

And that raises the much more complex question: can FDA regulations preempt a state’s general ban on abortion?²⁷⁶ Returning to the purpose of the FDA, its most famous and uncontested role is to act as a gatekeeper. To earn the right to sell a drug product, manufacturers must produce years, if not decades, of expensive, high-quality research proving that the drug is safe and effective.²⁷⁷ If they are successful, they can sell their product in every state; if unsuccessful,

MOTION FOR LEAVE TO FILE AMENDED COMPLAINT, Genbiopro, Inc. v. Dobbs, Docket No. 3:20-cv-00652 (S.D. Miss. July 21, 2022)

²⁷⁰ See Press Release, Dept. of Just., Justice Department Files Preemption Lawsuit Against the State of California to Stop Interference with Federal Immigration Authorities (Mar. 7, 2018), <https://www.justice.gov/opa/pr/justice-department-files-preemption-lawsuit-against-state-california-stop-interference> (describing a lawsuit filed to invalidate a state law that the federal government viewed as preempted).

²⁷¹ Zettler, *supra* note 222, at 869 n.160.

²⁷² *Id.* at 849.

²⁷³ *Id.* at 872.

²⁷⁴ *Id.* at 886.

²⁷⁵ *Id.* at 887.

²⁷⁶ In addition to general abortion bans, some states have introduced laws that would simply ban mifepristone. The preemption argument in the context of these laws would be strong and nearly identical to the Zohydro litigation.

²⁷⁷ See *Cost of Clinical Trials For New Drug FDA Approval*, JOHNS HOPKINS (Sept. 24, 2018), <https://publichealth.jhu.edu/2018/cost-of-clinical-trials-for-new-drug-fda-approval-are-fraction-of-total-tab> (noting that the cost of developing an individual drug is only around \$19 million on average, but that number balloons to over a billion dollars when taking into account failed drugs).

they cannot sell their product anywhere.²⁷⁸ When a state bans abortion, it bans the sale of an FDA-approved drug. And whether a state has the authority to do that has been considered peripherally by the Supreme Court and directly by a lower court in a series of cases.

In 2009, the Court held in *Wyeth v. Levine* that the FDA’s regulatory scheme did not preempt state tort laws that would have required greater drug warnings than those required by the FDA.²⁷⁹ There, the Court rejected the impossibility preemption theory because it was not impossible for the brand name manufacturer to comply with both state and federal law—FDA regulation allowed the manufacturer to change their drug labels to be *more* protective, though not less, without the FDA’s approval.²⁸⁰ The Court also rejected an obstacle preemption argument, finding that Congress’s “silence on the issue, coupled with its awareness of the prevalence of state tort litigation, is powerful evidence that Congress did not intend FDA oversight to be the exclusive means of ensuring drug safety and effectiveness.”²⁸¹ Though the FDA had stated in a piece of regulatory preamble that its labeling regulations preempt state tort laws, the Court refused to defer to the agency’s conclusions regarding preemption because its determination was conclusory, procedurally defective, and contrary to its past position.²⁸²

But two years later, the Court distinguished *Wyeth* in the context of generic drugs. In *PLIVA v. Mensing*, the Court held that because generic drugs are required to adhere to the brand drug’s labeling—and companies are unable to make a drug’s label more stringent without departing from the brand label—it would be impossible for a generic drug company to change their labels to avoid a failure-to-warn tort action, while also remaining compliant with FDA law.²⁸³ In this case, a plurality of the Court seemed to shift their understanding of preemption doctrine to recognize *implied* invalidation of state law, concluding that courts “should not distort federal law to accommodate conflicting state law.”²⁸⁴ Thus, in a case with very similar facts to *Wyeth*, the Court found that federal drug law preempted state failure-to-warn tort actions against generic manufacturers.²⁸⁵ Then, in *Mut. Pharm. Co. v. Bartlett*, in 2013, the Supreme Court reiterated that conclusion by preempting a design defect tort action against a generic

²⁷⁸ See *FDA Activities to Remove Unapproved Drugs from the Market*, FOOD & DRUG ADMIN. (last updated June 2, 2021), <https://www.fda.gov/drugs/enforcement-activities-fda/fda-activities-remove-unapproved-drugs-market>.

²⁷⁹ *Wyeth*, 555 U.S. at 569.

²⁸⁰ *Id.* at 569-72.

²⁸¹ *Id.* at 575.

²⁸² *Id.* at 576-79.

²⁸³ *PLIVA Inc. v. Mensing*, 564 U.S. 604, 604 (2011).

²⁸⁴ *Id.* at 622.

²⁸⁵ *Id.*

manufacturer on the ground that a generic manufacturer similarly cannot alter the composition of a drug.²⁸⁶

Importantly, in both *Mensing* and *Bartlett*, which relied on impossibility preemption, the tort plaintiffs argued that the manufacturer could comply with both state and federal law by refusing to sell their product in those states. The Court rejected this argument explicitly in *Bartlett*: “We reject this ‘stop-selling’ rationale as incompatible with our pre-emption jurisprudence. Our pre-emption cases presume that an actor seeking to satisfy both his federal- and state-law obligations is not required to cease acting altogether in order to avoid liability.”²⁸⁷ In fact, the Court went so far as to say that requiring a manufacturer to remove a product from a state market would render the entire doctrine of impossibility preemption meaningless.²⁸⁸ Thus, the Supreme Court implied in *Mensing* and *Barrett* that states cannot ban FDA-approved drugs: “if the relatively more attenuated command of design defect scrutiny in tort law created an actual conflict with federal law governing FDA-approved drugs, then surely an outright sales prohibition imposed by state officials would do so.”²⁸⁹ Notably, it was the conservative justices who tend to be more sympathetic to business interests that were in the majority.

There is very little case law directly evaluating whether a state can ban an FDA-approved drug, mainly because states rarely attempt it. The most analogous case to date is an earlier iteration of the same District of Massachusetts case discussed above. Before Massachusetts crafted extra restrictions for Zohydro, it first banned the drug entirely, and the court considered whether that ban was invalid under an obstacle preemption theory.²⁹⁰ In issuing a preliminary injunction, the District of Massachusetts concluded that the state was likely to succeed at showing that the ban would frustrate Congress’s purpose in ensuring that drugs are accessible, not only safe and effective: “If the Commonwealth were able to countermand the FDA’s determinations [on safety and efficacy] and substitute its own requirements, it would undermine the FDA’s ability to make drugs available to promote and

²⁸⁶ *Mut. Pharm. Co. v. Bartlett*, 570 U.S. 472, 475 (2013).

²⁸⁷ *Id.* at 487.

²⁸⁸ *Id.* at 488.

²⁸⁹ Noah, *supra* note 260, at 35.

²⁹⁰ *Zogenix, Inc. v. Patrick*, No. 14-11689-RWZ, 2014 WL 1454696, at *2 (D. Mass. Apr. 15, 2014). The manufacturer also brought a Dormant Commerce Clause challenge, which the judge rejected. *Zogenix, Inc. v. Baker*, No. CIV.A. 14-11689-RWZ, 2015 WL 1206354, at *7 (D. Mass. Mar. 17, 2015). The court found that the state interest in “promoting public health and safety” outweighed these interstate commerce effects: “It does not contravene the dormant commerce clause for a state merely to regulate the distribution within its borders of a product that travels in interstate commerce.” *Id.* The court did admit that “Zohydro’s theory about national pharmacies refusing to dispense Zohydro may be sufficient to show a burden on interstate commerce,” but found the plaintiff’s allegations too speculative. *Id.*

protect the public health.”²⁹¹ The court distinguished *Wyeth* by noting that there, the Supreme Court “assumed the availability of the drug at issue.”²⁹²

Though many FDA law scholars agree that a state ban of an FDA-approved drug would be preempted²⁹³—and to be clear, some states have introduced laws that directly prohibit the dispensation or use of medication abortion²⁹⁴—some scholars have disagreed with the district court’s reasoning, which emphasized that one of the FDA’s purposes was to ensure that drugs are accessible.²⁹⁵ Though there is certainly some statutory support for the proposition that Congress wanted the FDA to safeguard drug safety, efficacy, *and* access, outside the context of a REMS, the agency’s primary role as a gatekeeper cuts against this view. Professor Lars Noah has argued, for instance, that the agency typically has no say over whether pharmaceutical companies charge reasonable prices or remove important, but unprofitable, drugs from the market—both of which impede access.²⁹⁶ To the extent the FDA has any role in promoting access to drugs, it is secondary to its role in protecting patients from unsafe or ineffective drugs. Instead, Noah suggests that a state ban on an FDA-approved drug likely frustrates a different Congressional purpose: the creation of a uniform, national, definitive judgment about drug safety and efficacy. When seen through this lens, a state ban is problematic because it frustrates the uniformity promised by a national drug review system; it revokes the promise of a national market for drugs that meet the demands of an onerous review process. Certainly, if a state can ban a drug—either directly or indirectly—it frustrates the purpose of having one uniform system of drug approval. And pharmaceutical companies would be shocked to learn that states can just ban products they don’t like after they invested tens of millions of dollars in the FDA review system.

Consumer safety often is offered as a reason to oppose preemption in the context of state efforts to regulate drugs.²⁹⁷ After all, the FDA regulates all sorts of products, such as tobacco, and states have often tried innovative approaches to protect their citizen’s health.

²⁹¹ *Zogenix, Inc.*, 2014 WL 1454696, at *2.

²⁹² *Id.*

²⁹³ See Noah, *supra* note 241, at 8-12; Zettler, *supra* note 222, at 870-78.

²⁹⁴ Christine Vesca, *As Abortion Pills Take Off, Some States Move to Curb Them*, PEW TRUST, March 16, 2022, <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2022/03/16/as-abortion-pills-take-off-some-states-move-to-curb-them> (“Outright bans on dispensing or using the FDA-approved medications have been proposed in Alabama, Arizona, Iowa, South Dakota, Illinois, Washington and Wyoming.”).

²⁹⁵ Noah, *supra* note 241, at 8-12.

²⁹⁶ *Id.*

²⁹⁷ For years, liberal scholars have opposed preemption challenges based on food and drug law because they were often brought by pharmaceutical and tobacco companies who were attempting to invalidate state efforts to require additional warnings or impose stricter safety regulations.

There is the fear that a win in this context would have collateral consequences on state efforts to protect health and safety. But medication abortion’s excellent safety record and unique regulatory history challenge this critique.²⁹⁸ Because, though the dissenters in *Bartlett* focused on the state interest in protecting patients, they made clear that the particulars of the drug at issue matter. For instance, Justice Breyer’s dissent, which was joined by Justice Kagan, noted that “the more medically valuable the drug, the less likely Congress intended to permit a State to drive it from the marketplace.”²⁹⁹ And Justice Sotomayor’s dissent suggested that an obstacle preemption framework, instead of impossibility preemption, would help the Court better account for safety by “allow[ing] the Court to consider evidence about whether Congress intended the FDA to make an optimal safety determination and set a maximum safety standard (in which case state tort law would undermine the purpose) rather than a minimal safety threshold (in which case state tort law could supplement it).”³⁰⁰ Justice Sotomayor’s comments are apt in the context of the REMS program, where the statute envisions not just a regulatory floor, but a ceiling that accounts for patient access.³⁰¹ Mifepristone’s strong safety profile and regulation under a REMS makes the preemption arguments stronger than past cases.³⁰² We are not blind to concerns that preemption for abortion inducing drugs could have effects that impact other state regulation of health products. But the industry already is bringing, and winning, these lawsuits, so courts will decide these questions regardless.

There are important counterarguments to the preemption theory in the context of general abortion bans.³⁰³ First, states will argue that their laws do not ban medication abortion drugs entirely because they could be sold and used for other uses.³⁰⁴ Misoprostol, in particular, is used for a variety of obstetric purposes, including inducing labor and

²⁹⁸ Donley, *supra* note 54, at 14-22.

²⁹⁹ *Mensing*, 564 U.S. at 494 (Beyer, J., dissenting).

³⁰⁰ *Id.* at 514-15 (Sotomayor, J., dissenting).

³⁰¹ Of note, the mifepristone REMS required the FDA to make an on-the-record agency determination related to risk, benefit, and access that the Court found missing in *Wyeth*. Jennifer L. Bragg & Maya P. Florence, *Life with A Rems: Challenges and Opportunities*, 13 J. HEALTH CARE L. & POL’Y 269, 278 (2010).

³⁰² Zettler & Sarpatwari, *supra* note 245, at 3 (“preemption challenges to state mifepristone restrictions should not be understood as risking the future viability of public health federalism more broadly.”).

³⁰³ One challenge not mentioned above is that though the practice-product distinction may be less stark than previously assumed, courts might also be more willing to find that a state’s regulation or prohibition of all abortion (even procedure-based abortion) to more obviously fit a practice-of-medicine regulation reserved for the states than a ban on an FDA-approved product. This might be the case, but the preemption challenge would not be to the whole law, but to the law’s application over medication abortion.

³⁰⁴ Donley, *supra* note 54, at 32-33.

treating miscarriage, and was originally approved to treat ulcers. Thus, the ban would not be on a drug, but on a use of the drug.

This distinction may be less important than it initially appears. The FDA has approved mifepristone only for abortion, and its manufacturers are only legally allowed to market it for that one use.³⁰⁵ And though providers, as distinct from manufacturers, are generally allowed to prescribe drugs off label, the REMS has made it almost impossible for them to do so with mifepristone³⁰⁶—underscoring that an abortion ban is a *de facto* ban on mifepristone.³⁰⁷ The drug company would not be able to market its product at all in half the country. Recall that the payoff at the end of the long, expensive drug approval process is an assurance that manufacturers can sell their drug throughout the country.³⁰⁸ Without that assurance, manufacturers would never invest the time and money to complete the drug review process. In this way, FDA approval “represent[s] more than simply federal permission to market a pharmaceutical product; [it] amount[s] to licenses, which qualify as a form of intangible property entitled to constitutional recognition.”³⁰⁹ When a state bans the only use of an approved drug, that state has thwarted the purpose of the FDA approval process by banning the drug.

This argument is more complex with misoprostol given that the drug manufacturer was never legally allowed to market the drug for abortion, since that is an off-label use, and it could continue to market the drug to treat ulcers.³¹⁰ However, even with misoprostol, abortion bans are affecting access to the drug for other uses. For instance, some pharmacies have stopped dispensing misoprostol for any purpose in states that ban abortion.³¹¹ Typically, pharmacies are not given any information related to the use of the drug, so the pharmacist cannot be sure whether the drug is being used for ulcers, miscarriage, or

³⁰⁵ 86 Fed. Reg. 41383 (Aug. 2, 2021) (2021 Final Rule), <https://www.govinfo.gov/app/details/FR-2021-08-02/2021-15980/summary>.

³⁰⁶ Donley, *supra* note 54, at 662 (arguing that the REMS burdens the use of the drug for miscarriage management even though it is the most effective drug treatment option for that use).

³⁰⁷ *Id.*

³⁰⁸ See discussion *supra* notes 308-11 and accompanying text.

³⁰⁹ Noah, *supra* note 260, at 32.

³¹⁰ The preemption argument is also harder for misoprostol because it lacks a REMS and therefore the arguments presented above that depend on the presence of a REMS might be inapplicable. However, one could argue that misoprostol is incorporated explicitly by reference into the mifepristone REMS because the mifepristone use depends on its combination with misoprostol.

³¹¹ See Christina Cauterucci, *Abortion Bans Are Already Messing Up Access to Other Vital Meds*, SLATE (May 24, 2022), <https://slate.com/news-and-politics/2022/05/abortion-texas-pharmacies-refusing-prescriptions-misoprostol-methotrexate.html>.

abortion. An abortion ban thus impedes access to abortion inducing drugs for *all* uses.³¹²

Second, states will argue that even if FDA regulations can preempt state laws concerning public health, they cannot preempt state laws concerning morality, which is outside the FDA's purview and within states' historic police powers. Many state abortion laws *are* justified on public health grounds, especially those that impose extra hurdles in accessing medication abortion, but many general abortion bans will likely be justified on moral grounds, like, to borrow a state interest cited in *Dobbs*, "respect for preservation of prenatal life at all stages of development."³¹³ Preemption is always anchored in Congressional intent, so the argument would be that Congress did not intend FDA's reach to extend into states' control of moral questions. Courts will have to decide whether the purpose of the state statute matters when the effect—the inability to sell an FDA-approved drug in half the country—is the same. Certainly, it would violate the FDCA if a state tried to *permit* the sale of a new drug treatment for its citizens on moral grounds when the FDA refused to approve it, so it is not clear why the opposite would not also violate the law.

The strongest counterargument is that the FDCA, setting out the duties of the FDA, does not evince congressional intent for the

³¹² Secretary Becerra has issued a guidance document arguing that this pharmacy conduct is illegal sex discrimination, but it is unclear whether it will have an effect. HHS Issues Guidance to the Nation's Retail Pharmacies Clarifying Their Obligations to Ensure Access to Comprehensive Reproductive Health Care Services (July 13, 2022), <https://www.hhs.gov/about/news/2022/07/13/hhs-issues-guidance-nations-retail-pharmacies-clarifying-their-obligations-ensure-access-comprehensive-reproductive-health-care-services.html>.

³¹³ *Dobbs*, 547 U.S. ___ (2022), slip op. at 78. One example sometimes raised is life-ending medications, which are FDA-approved drugs that are used off label to end a person's life. Physician aid in dying is banned in most states, potentially raising many of the same issues. This example, however, is inapt given the agency's extensive history with life-ending drugs in the capital punishment context where it has explicitly over the course of decades disclaimed any jurisdiction over the drugs. Over the course of decades, the FDA has explicitly avoided wading into life-ending medications. This avoidance was the subject of a Supreme Court case, *Heckler v. Chaney*, 470 U.S. 821 (1985) concerning drugs used for lethal injections. In 2012, the U.S. District Court for the District of Columbia issued a permanent injunction forcing the FDA to block the importation of drugs used for lethal injections that were not sold in the U.S. *Beaty v. FDA*, 853 F. Supp. 2d 30 (D.D.C. 2012). Finally in 2019, the Office of Legal Counsel for the Department of Justice wrote a slip opinion arguing that the FDA lacked jurisdiction over capital punishment drugs because they could never be found safe or effective. *WHETHER THE FOOD AND DRUG ADMINISTRATION HAS JURISDICTION OVER ARTICLES INTENDED FOR USE IN LAWFUL EXECUTIONS* (May 3, 2019), <https://www.justice.gov/olc/opinion/file/1162686/download>. Though the analogy between physician aid in dying and lethal injection is not perfect, surely the conclusion that the drugs cannot be safe or effective would apply to both situations, undercutting any argument that the FDA has occupied the space or preempted state regulation. If anything, the agency has gone out of its way to suggest that it has no power in this space.

FDA to regulate abortion. A similar argument was raised when the FDA attempted to regulate tobacco products by claiming that nicotine met the definition of a drug and that a cigarette was therefore a drug delivery device. In *Brown & Williamson*, the Supreme Court rejected that interpretation, holding that “we are confident that Congress could not have intended to delegate a decision of such economic and political significance to an agency in so cryptic a fashion.”³¹⁴ *Brown & Williamson* is often pinpointed for the emergence of the “no-elephants-in-mouseholes” doctrine—the concept that Congress does not hide huge, politically-relevant policy decisions in the interstices of a statute.³¹⁵ The Court found it anomalous that the FDCA could be interpreted to regulate (maybe even ban) a product, cigarettes, that were so politically and economically important to states when Congress never considered or debated that possibility when it passed the statute. One could imagine the same type of analysis in the case of mifepristone. If Congress wants to preempt any state action on abortion, the argument goes, it must say so explicitly.

To the extent the FDA gets involved in such a lawsuit and claims its interpretation is entitled to deference, a related doctrine—the major questions exception—could likely be used to reject deference.³¹⁶ This doctrine states that courts should not defer to agencies when their interpretation concerns a major economic or political question.³¹⁷ As part of its broader efforts to dismantle the administrative state, the current Supreme Court has struck down many important agency decisions in recent years relying on this doctrine, including a case this term.³¹⁸ “Under this body of law. . . given both separation of powers principles and a practical understanding of legislative intent, the agency must point to ‘clear congressional authorization’ for the authority it claims.”³¹⁹ This doctrine would certainly be a large obstacle to the FDA claiming that its preemption interpretation deserves deference because arguably, the agency is “adopt[ing] a regulatory program that Congress had conspicuously declined to enact itself.”³²⁰ However, the FDA need not be involved in abortion preemption lawsuits. Indeed, if one of the drug manufacturers brings suit and the FDA remains neutral, then deference is not an issue in the case. The Court would decide the statutory interpretation and Congressional purpose questions on its own. The FDA’s involvement could divert attention from the drug

³¹⁴ Food & Drug Admin. v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 159-60 (2000).

³¹⁵ Jacob Loshin & Aaron Nielson, *Hiding Nondelegation in Mouseholes*, 62 ADMIN. L. REV. 19 (2010).

³¹⁶ See Jonas J. Monast, *Major Questions About the Major Questions Doctrine*, 68 MICH. J. ENVIR. & ADMIN. L. 445 (2016).

³¹⁷ See *King v. Burwell*, 576 U.S. 473 (2015).

³¹⁸ *West Virginia v. Environmental Protection Agency*, 597 U.S. ____ (2022).

³¹⁹ *Id.* at 4.

³²⁰ *Id.* at 5.

manufacturer’s claim and the business interests involved, allowing the Court to opine on agency overstep instead of the preemption issue, hampering the lawsuit more than helping it.

Though these related doctrines provide a much stronger argument against preemption, they are not failproof. Unlike the tobacco regulation in the *Brown & Williamson* era,³²¹ the FDA has authority to regulate mifepristone and has been closely regulating it for decades. Its regulation of the product is not new or controversial—its particular regulatory decisions might be, but not its ability to regulate. Indeed, *Brown & Williamson* relied on the fact that the FDA had previously denounced its ability to regulate tobacco products, while, in the meantime, Congress had assumed that role.³²² The opposite is true in the case of medication abortion: the FDA has exercised sustained control over medication abortion—even imposing a REMS so that it could regulate the drug even more closely than 95% of the drugs it approves—and Congress has done nothing to impede agency actions and decisions.³²³ Quite the opposite: members of Congress routinely issue letters to FDA about its regulation of this drug, never overruling the FDA’s decision by statute or removing the FDA’s power to regulate in this space. It is not using “vague language of a long-extant, but rarely used, statute” to assert new authority, but continuing its decades-long regulation of medication abortion.³²⁴

After the *Dobbs* decision, the Biden Administration appears to have some level of support for this theory.³²⁵ The strongest statement came from Attorney General Garland who said: “the FDA has approved the use of the medication Mifepristone. States may not ban Mifepristone based on disagreement with the FDA’s expert judgment about its safety and efficacy.”³²⁶ Shortly thereafter, President Biden signed an Executive Order directing HHS to take “additional action to protect and expand access to abortion care, including access to medication that the FDA approved as safe and effective over twenty years ago.”³²⁷ Though this suggests the administration supports this theory, it is not clear whether it will choose to participate in litigation based on political or strategy considerations, including whether any

³²¹ The FDA gained authority to regulate tobacco by statute decades later. *See* Family Smoking Prevention and Tobacco Control Act, H.R. 1256 (Pub. L. No. 111–31, June 22, 2009).

³²² *Brown & Williamson*, 529 U.S. at 157-60.

³²³ Congress knows about the agency’s regulation of these drugs; individual congresspeople frequently write to the agency when they disagree with its choices.

³²⁴ *West Virginia v. EPA*, at 5.

³²⁵ President Biden’s statement included this: “the President directed the Secretary of Health and Human Services to identify all ways to ensure that mifepristone is as widely accessible as possible.”

³²⁶ <https://www.justice.gov/opa/pr/attorney-general-merrick-b-garland-statement-supreme-court-ruling-dobbs-v-jackson-women-s>.

³²⁷ Fact Sheet, *supra* note 20.

lawsuit might fare better without the government’s involvement. But regardless, the issue will be litigated.

Indeed, when Mississippi banned abortion after *Dobbs*, GenBioPro moved to amend the complaint in its pre-existing lawsuit to challenge Mississippi’s general ban, arguing that it “operates as a de facto ban on mifepristone and renders it essentially impossible for GBP to operate in Mississippi,” citing the Zohydro litigation.³²⁸ GenBioPro does not need the FDA’s support to challenge to lodge a preemption challenge based on its business interests.

2. HHS’s Role in Other Healthcare Matters

The preemption theory concerning medication abortion, if accepted, would be transformative. But there are other federal statutes that could also be used to preempt state abortion laws on a smaller—and perhaps, less controversial—scale. We do not purport to offer an exhaustive list of federal statutes that could be used to preempt state abortion bans,³²⁹ but we did want to highlight a few opportunities for HHS to use its interpretive and enforcement authority to protect abortion access.³³⁰

³²⁸ GenBioPro’s Memorandum in support of its motion to amend the complaint, *supra* note X at 6.

³²⁹ Other preemption arguments rooted in existing federal statutes, though not evaluated in any depth are: (1) whether the Employee Retirement Income Security Act of 1974, which governs employer sponsored insurance plans and preempts state law, would provide protection for employers that cover abortion care or abortion-related travel in states that ban it, *see* Brendan S. Maher, *Pro-Choice Plans* (July 25, 2022). Available at SSRN: <https://ssrn.com/abstract=>; (2) whether the Medicare conditions of participation, which create rules for hospitals that accept Medicare, could be used to require hospitals to offer abortion care. Before the Supreme Court decided *Obergefell v. Hodges*, the federal government required hospitals everywhere to allow same sex couples visitation rights, *see* *See Medicare and Medicaid Program; Revisions to Certain Patient's Rights Conditions of Participation and Conditions for Coverage*, 79 Fed. Reg. 73,873 (Dec. 12, 2014).; (3) whether the Affordable Care Act’s prohibition of sex discrimination in healthcare, known as Section 1557, might also be used to supplement these efforts. HHS Secretary Becerra used Section 1557 to issue a guidance document to pharmacies, explaining that withholding medications because they might cause miscarriage or abortion violated federal law, *see* <https://www.hhs.gov/about/news/2022/07/13/hhs-issues-guidance-nations-retail-pharmacies-clarifying-their-obligations-ensure-access-comprehensive-reproductive-health-care-services.html>; and (4) whether the Hyde Amendment’s exceptions for life, rape, and incest could be used to force states with abortion bans that do not include these exceptions to allow Medicaid patients to obtain abortions under these circumstances.

³³⁰ Notably, in a similar context, the Third Circuit—in an opinion joined by then judge Samuel Alito—previously held that HHS’s interpretation of the Hyde Amendment preempted state abortion laws to the contrary. *Blackwell v. Knoll* 61 F.3d 170 (3d Cir. 1995). There, HHS had interpreted Hyde’s rape and incest exceptions to permit states to require that the person report the crime to law

The first, the Emergency Medical Treatment and Labor Act (EMTALA), is a federal statute that requires all hospitals participating in Medicare and have an emergency room to screen patients for medical emergencies and provide stabilizing treatment.³³¹ This statute can be used to preempt state abortion that do not have exceptions to save the health of the pregnant person or the life of the pregnant person; it could also preempt state abortion bans when their health-or-life exceptions are more narrow than the demands of EMTALA.³³² Notably, as the antiabortion movement grows more extreme, its recent abortion bans rarely contain health exceptions, and some states are even considering bans without a life exception.³³³

Even when a state has exceptions for the life and health of the pregnant person, they are notoriously vague or narrow, and, fearing liability under the state law, doctors have delayed medically necessary abortion care even though the patient's life is on the line.³³⁴ Waiting too long to treat a patient, for example, can cause the patient to hemorrhage, lose their uterus and future fertility, or die.³³⁵ Since *Dobbs*, throughout the country, there have been numerous media reports of patients who have been forced to travel in the middle of a medical emergency to access lifesaving abortion care because of physician delay and uncertainty.³³⁶ In one study conducted in two Dallas hospitals after SB8 made post-six-week abortions illegal found that that 57% of the patients whose life-saving abortions were delayed to accommodate abortion bans developed a serious morbidity, including the loss of a

enforcement, but only if there was an option for a physician to waive that requirement. The Court found that a Pennsylvania law requiring a patient to report their rape or incest to law enforcement to be eligible for Medicaid funding that lacked a waiver was preempted.

³³¹ 42 U.S. Code § 1395dd.

³³² See generally, Greer Donley & Kimberly Chernoby, *How to Save Women's Lives After Roe*, ATLANTIC (June 13, 2022), <https://www.theatlantic.com/ideas/archive/2022/06/roe-v-wade-overtturn-medically-necessary-abortion/661255/>.

³³³ See e.g., <https://www.theatlantic.com/ideas/archive/2022/07/abortion-ban-life-of-the-mother-exception/670582/>.

³³⁴ Madeline Heim, If Roe is overturned, Wisconsin law would allow abortion only 'to save the life of the mother.' Doctors say it's not always so clear-cut, USA Today (May 10, 2022), <https://www.postcrescent.com/story/news/2022/05/10/doctors-say-wisconsin-abortion-laws-lifesaving-exception-vague-if-roe-v-wade-overturned/740220001/>; Sneha Dey & Karen Brooks Harper, Abortion restrictions threaten care for pregnant patients, providers say, Texas Tribune (May 24, 2022), <https://www.texastribune.org/2022/05/24/texas-abortion-law-pregnancy-care/>.

³³⁵ In Ireland, for instance, Savita Halappanavar died while waiting for life-saving abortion care, spurring a massive backlash to the country's abortion laws. Megan Specia, How Savita Halappanavar's Death Spurred Ireland's Abortion Rights Campaign, N.Y. Times (May 27, 2018), <https://www.nytimes.com/2018/05/27/world/europe/savita-halappanavar-ireland-abortion.html>

³³⁶ See e.g., <https://www.washingtonpost.com/health/2022/07/16/abortion-miscarriage-ectopic-pregnancy-care/>.

uterus, and none of their babies survived.³³⁷ Patients are suffering because of medical inaction, and one day soon, one of them will die.³³⁸

Shortly after SB8 went into effect in Texas, in September 2021, HHS Secretary Becerra sent a memorandum to hospitals entitled, “Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss.”³³⁹ This memo reminded hospitals of their obligations under EMTALA, noting that EMTALA duties “preempt[] any directly conflicting state law or mandate that might otherwise prohibit or prevent such treatment” and that “[a] hospital cannot cite State law or practice as the basis for transfer” out of state.³⁴⁰ It specifically mentioned that ectopic pregnancy and complications from pregnancy loss would qualify as emergency medical conditions.³⁴¹ Secretary Becerra announced this position in a press release entitled, “HHS Secretary Xavier Becerra Announces Actions to Protect Patients and Providers in Response to Texas’ SB 8,” implying that the policy was a direct response to Texas’s abortion ban.³⁴²

Contrary to the press release’s title, which did not go to hospitals, the memorandum was ambiguous and tepid. The memorandum did not use the word abortion once.³⁴³ Instead it focused on people experiencing pregnancy loss. Many clinicians call abortions in the context of inevitable or impending pregnancy loss by a different name: miscarriage management—a term that more traditionally refers to treatment for someone whose pregnancy has already ended. But the euphemism “pregnancy loss” creates confusion. Hospitals may decide that they are only obligated to provide treatment for “pregnancy loss” after the fetus’s heart has stopped, thereby creating no conflict with state law. Certainly, there is precedent for this interpretation. For decades, religious hospitals have delayed medically necessary abortion care until the fetus’s heart had stopped or the woman’s death was

³³⁷ <https://www.ajog.org/action/showPdf?pii=S0002-9378%2822%2900536-1>.

³³⁸ Jack Healy, *With Roe Set to End, Many Women Worry About High-Risk Pregnancies*, N.Y. TIMES (June 20, 2022), <https://www.nytimes.com/2022/06/20/us/abortion-high-risk-pregnancy.html>; Carole Joffe and Jody Steinauer, *Even Texas Allows Abortions to Protect a Woman’s Life. Or Does It?*, N.Y. TIMES (Sept. 12, 2021), <https://www.nytimes.com/2021/09/12/opinion/abortion-texas-roe.html>.

³³⁹ Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss, CMS (Sept. 17, 2021), <https://www.cms.gov/files/document/qso-21-22-hospital.pdf>. [hereinafter CMS memo]

³⁴⁰ *Id.* at 1, 3.

³⁴¹ *Id.* at 4.

³⁴² HHS Secretary Xavier Becerra Announces Actions to Protect Patients and Providers in Response to Texas’ SB 8, HHS (Sept. 17, 2021), <https://www.hhs.gov/about/news/2021/09/17/hhs-secretary-xavier-becerra-announces-actions-protect-patients-and-providers-response-texas-sb.html>

³⁴³ CMS Memo, *supra* note 312.

imminent.³⁴⁴ By not saying the word abortion, HHS implicitly supported the far-too-common approach of requiring a pregnancy loss to be completed before offering care.

Providers needed clear, unequivocal guidance that, when an emergency medical condition is present, EMTALA *requires* hospitals and doctors to offer stabilizing abortion care without delay even when the state bans it.³⁴⁵ Under the statute, a person is having a medical emergency if they are in labor or suffering from a condition that, without immediate attention, could be reasonably expected to place their health in serious jeopardy, seriously impair their bodily function, or cause serious dysfunction to an organ.³⁴⁶ This definition covers many urgent pregnancy conditions, including preterm premature rupture of membranes, ectopic pregnancy, and complications from incomplete miscarriage or self-managed abortion, where offering abortion is often the standard of care.³⁴⁷ Notably, because possible damage to an organ qualifies, EMTALA would require abortion treatment that, if delayed, could damage the uterus and fallopian tubes, not just threaten a life.

Fortunately, the Biden Administration has taken further steps in the months following *Dobbs* to clarify EMTALA's relevance. The new government website that was launched on the day *Dobbs* was decided, [reproductiverights.gov](https://www.reproductiverights.gov), states that under EMTALA, a “hospital is required to provide you with the emergency care necessary to save your life, including abortion care.” And President Biden’s

³⁴⁴ See e.g., Lori Freedman et al., *When there's a heartbeat: miscarriage management in Catholic-owned hospitals*, 98 AM. J. PUBLIC HEALTH 1774 (2008); Lee Hasselbacher et al., *"My Hands Are Tied": Abortion Restrictions and Providers' Experiences in Religious and Nonreligious Health Care Systems*, 52 PERSPECTIVES SEXUAL REPRODUCTIVE HEALTH 107 (2020). Though the ACLU attempted to sue a Catholic hospital system under EMTALA in 2016, the lawsuit was dismissed for lack of standing. *Am. Civil Liberties Union v. Trinity Health Corp.*, 178 F. Supp. 3d 614, 621 (E.D. Mich. 2016). However, when an OBGYN was effectively fired for providing a medically necessary abortion, he sued arguing that he was obligated to provide the abortion to stabilize the patient under EMTALA. The Court refused to dismiss the lawsuit and it settled before trial. *Ritten v. Lapeer Reg'l Med. Ctr.*, 611 F. Supp. 2d 696, 704 (E.D. Mich. 2009).

³⁴⁵ Until recently, hospitals and hospital systems that were considering their obligations after *Dobbs* were not taking EMTALA into account. See Lisa Harris, *Navigating Loss of Abortion Services—A Large Academic Medical Center Prepares for the Overturn of Roe v. Wade*, NEW ENGLAND J. MEDICINE (June 2, 2022), <https://www.nejm.org/doi/full/10.1056/NEJMp2206246>.

³⁴⁶ 42 U.S. Code § 1395dd.

³⁴⁷ Donley & Chernoby, *supra* note 310. Indeed, the Office for Civil Rights within HHS said as much in a guidance document released on the same day, but also not sent to hospitals: “Lawful abortions under the Church Amendments also include abortions performed in order to stabilize a patient when required under the Emergency Medical Treatment and Active Labor Act.” Guidance on Nondiscrimination Protections under the Church Amendments for Health Care Personnel, HHS (Sept. 17, 2021), <https://www.hhs.gov/sites/default/files/church-guidance.pdf>.

Executive Order mentioned above also directs HHS to “ensure that all patients—including pregnant women and those experiencing pregnancy loss, such as miscarriages and ectopic pregnancies—receive the full protections for emergency medical care afforded under the law.”³⁴⁸ Very soon after these actions were taken, Texas’s Attorney General filed a lawsuit against HHS, arguing that its interpretation of EMTALA “attempt[ed] to use federal law to transform every emergency room in the country into a walk-in abortion clinic” and that EMTALA cannot “compel healthcare providers to perform abortions.”³⁴⁹ As of yet there has been no ruling in this case.

But HHS was not deterred; instead, it worked with the DOJ to file its own lawsuit that facially challenges Idaho’s abortion ban as violating EMTALA for lacking a health exception (only containing a narrow life exception).³⁵⁰ This development is very important—guidance documents mean nothing without corresponding action. HHS should also enforce the statute against specific hospitals that are accused of delaying care, but those enforcement actions require patients to file complaints with the agency. HHS should continue to spread awareness about the law and makes the complaint filing system more user friendly so that more patients complain, and the agency can enforce the statute.³⁵¹

A second federal law, the Health Insurance Portability and Accountability Act (HIPAA), preempts policies or actions that compromise the privacy of abortion seekers.³⁵² This law generally prohibits healthcare providers from disclosing peoples’ private health information, and it can be enforced against providers who report patients to law enforcement for suspected abortion unless one of the law enforcement exceptions are met. A hard-to-determine number of people who use medication abortion without legal permission will seek medical care at a hospital. We know from past cases, that some hospital staff will report those they suspect of self-managed abortion.³⁵³ These people are violating HIPAA if they are not acting pursuant to a legal exception.

The relevant exceptions are all created by regulations: (1) if a state law mandates disclosure, (2) if the provider is complying with a

³⁴⁸ Fact Sheet, *supra* note 20. The state of Texas has sued the Biden Administration, arguing that HHS has misinterpreted the requirements of EMTALA, overstepped its authority, and acted arbitrarily. *Texas v. Becerra*, Civil Action 5:22-cv-00185-H (N.D. Tex. July 14, 2022).

³⁴⁹ https://www.texasattorneygeneral.gov/sites/default/files/images/executive-management/20220714_1-0_Original%20Complaint%20Biden%20Admin.pdf.

³⁵⁰ <https://www.justice.gov/opa/press-release/file/1523481/download>.

³⁵¹ Donley & Chernoby, *supra* note 310.

³⁵² 42 U.S. Code § 1320d–6

³⁵³ Carrie N. Baker, *Texas Woman Lizelle Herrera’s Arrest Foreshadows Post-Roe Future*, MS. MAGAZINE (April 16, 2022), <https://msmagazine.com/2022/04/16/texas-woman-lizelle-herrera-arrest-murder-roe-v-wade-abortion/>.

lawfully executed subpoena, (3) if the person suspects a crime occurred involving the death of a person, (4) if the person suspects child abuse, (5) to avert a serious threat to health or safety, or (6) if the person suspects a crime occurred on hospital property.³⁵⁴ These exceptions create many problems. First, states can get around HIPAA if they pass a law requiring healthcare providers to report suspected abortion, similar to how many states require providers to report child abuse to law enforcement. As of right now, we are not aware of any state that has such a law, but mandated disclosure could eventually come into play. Second, providers cannot use HIPAA as a shield if served with a summons, warrant, subpoena, or administrative request. Note, though, that for this exception to apply, the provider would be responding to, not initiating contact with law enforcement.

Third, if a state passes a law endowing fetuses with personhood status, like in Georgia, then a provider might be able to evade HIPAA and affirmatively report a patient to law enforcement on the premise that they suspect that a crime occurred involving the death of a person (the fetus). The child abuse exception is similar—some states interpret a fetus to be a child under child abuse laws.³⁵⁵ To address this issue, the federal government can issue guidance that, under federal law, a fetus is not a person or a child, preempting state interpretations to the contrary under HIPAA.

Finally, a provider could argue that HIPAA does not apply in the context of self-managed abortion because a crime is occurring on their property. This is the most attenuated argument, suggesting that an abortion crime continues past the act of taking the medication and into the process of expelling pregnancy tissue over the course of days or weeks. Again, the federal government could clarify that this exception is met only if a patient takes abortion-inducing drugs on hospital property. Like the EMTALA discussion above, HHS would not only need to issue guidance, but also enforce the statute if it wants to pressure covered entities in a way that mitigates the risk on the other side.

In June 2022, the Biden Administration issued guidance seeking to clarify how HIPAA relates to abortion-related crimes. Though there is more that can be said, as noted above, and more that can be done, this was an important step. The guidance discussed the mandated disclosure exception, stating that “[w]here state law does not expressly require [the reporting of abortion crimes], the Privacy Rule would not permit a disclosure to law enforcement under the ‘required

³⁵⁴ Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule: A Guide for Law Enforcement, HHS, https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/special/emergency/final_hipaa_guide_law_enforcement.pdf.

³⁵⁵ See e.g., *Whitner v. South Carolina*, 492 S.E.2d 777 (S.C. 1997).

by law’ permission.”³⁵⁶ For the court order exception, the guidance stated: “[i]f the request is not accompanied by a court order or other mandate enforceable in a court of law, the Privacy Rule would not permit the clinic to disclose PHI in response to the request.”³⁵⁷ It also addressed the exception allowing disclosures to “avert a serious threat to health or safety,” noting that healthcare workers cannot disclose protected health information just because they believe such a disclosure would prevent harm to a fetus.³⁵⁸ Specifically, the agency addressed the example where a patient tells a healthcare worker that they plan to obtain an abortion out of state. The healthcare workers may not share that with law enforcement absent a court-order document.³⁵⁹

Outside of issuing guidance, the Biden Administration could go further. All of the law enforcement exceptions are created by regulation, meaning that HHS could initiate rulemaking to modify the regulations to specifically exempt abortion-related crimes from each exception, even when the state mandates disclosure or issues a subpoena. If that were to happen, federal law theoretically would preempt the state law, subject to some of the counterarguments raised in the section above.

As the arguments for and against preemption make clear, the stakes are high for federal agencies and for states deploying what they consider to be their police powers to ban abortion. The uncertainty of the result is perhaps why preemption has not been litigated by abortion supporters until now. But as the abortion crisis intensifies, the stakes have changed. This effort, along with more like it in the future, will spark new debates about the balance of state–federal power in abortion law.

B. *Federal Land*

Another opportunity the federal government has to promote abortion access is to use federal land. There is neither a general federal prohibition on abortion, nor, for purposes of this section, a prohibition on abortions being performed on federal land. There is, under the Hyde Amendment, a prohibition on federal dollars being used to perform abortions that do not fall within the provision’s exceptions for life, incest, or rape.³⁶⁰ However, that leaves space for the federal government to lease space on federal land to some private entity to

³⁵⁶ HIPAA Privacy Rule and Disclosures of Information Relating to Reproductive Health Care, DEP’T HEALTH & HUMAN SERV., <https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/phi-reproductive-health/index.html>.

³⁵⁷ *Id.*

³⁵⁸ *Id.*

³⁵⁹ *Id.*

³⁶⁰ Consolidated Appropriations Act, 134 Stat. 1182, div. H, §§ 506–07 (Pub. L. No. 116260, Dec. 27, 2020).

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perform abortions there.³⁶¹ Those providers would have a reasonable—though certainly controversial—argument that state criminal and civil abortion bans do not apply on federal land, and they are therefore free to lawfully provide abortions there, even if the state within which the federal land is situated has otherwise banned abortion.

The key to this legal analysis is the Assimilative Crimes Act (ACA).³⁶² This relatively little-known federal law is the mechanism by which the federal government bans criminal activity on federal land³⁶³ without passing specific laws to do so. When someone engages in behavior on federal land for which there is no crime “punishable by any enactment of Congress,” this Act makes it a federal crime if that behavior “would be punishable if committed or omitted within the jurisdiction of the State, Territory, Possession, or District in which [the federal land] is situated.”³⁶⁴ Someone falling under this provision is “guilty of a like offense and subject to a like punishment.”³⁶⁵

The ACA in this regard applies only on particular federal land. The statute differentiates between federal land that is considered an exclusive enclave, which would mean it is covered by the ACA, and federal land over which the state reserved jurisdiction when it transferred the land to the federal government, which would put it

³⁶¹ Under a lease between the federal government and an abortion provider, the money would flow from abortion providers to the federal government rather than the other way around; thus, the Hyde Amendment would not be implicated. Further, leasing property to an abortion provider would be no different than leasing property to any other business on federal land, such as, in *Peoples v. Puget Sound’s Best Chicken!, Inc.*, 345 P.3d 811 (Wash. Ct. App. 2015), a Popeye’s chicken restaurant. The President would not need to be involved through any executive order or any new agency regulation (just as neither was needed, for instance, to lease property to Popeye’s). However, knowing that the current administration supports this option would be almost a necessary prerequisite to a provider considering exploring this possibility because of the role the Department of Justice has in directing enforcement of federal law and the President has in issuing pardons. *See* discussion *infra* notes 375-77 and accompanying text. So far, the Biden administration has shown little interest in this option despite other Democrats urging the President to try. Emma Platoff, *Senator Elizabeth Warren Calls on Biden to Use Federal Lands to Protect Abortion Access*, BOSTON GLOBE, June 24, 2022, <https://www.bostonglobe.com/2022/06/24/metro/senator-elizabeth-warren-calls-biden-use-federal-lands-protect-abortion-access/>.

³⁶² 18 U.S.C.A. § 13.

³⁶³ 18 U.S.C.A. § 7(3) defines federal land as “Any lands reserved or acquired for the use of the United States, and under the exclusive or concurrent jurisdiction thereof, or any place purchased or otherwise acquired by the United States by consent of the legislature of the State in which the same shall be, for the erection of a fort, magazine, arsenal, dockyard, or other needful building.”

³⁶⁴ 18 U.S.C.A. § 13(a).

³⁶⁵ *Id.*

outside the coverage of the ACA.³⁶⁶ Unfortunately, there is no easily- and publicly-accessible way to tell the difference for any particular part of federal land as this determination involves intense factual analysis relying on dated documents and often contested history.³⁶⁷ Thus, as a preliminary matter, discerning exactly where the ACA applies and where it does not is a difficult hurdle.³⁶⁸

At first blush, it may seem that state laws criminalizing abortion would be actionable under the ACA. But there are a few pieces of the ACA that are important to understand for our argument. First, someone who engages in behavior on federal land that is punishable as a crime under state law is not prosecuted by the state. Rather, the ACA incorporates the state crime into federal law so that technically, the person has violated the federal ACA, not the state law.³⁶⁹ That means that federal prosecutors prosecute these crimes in federal court, not state prosecutors in state court.³⁷⁰ Federal prosecutors in an administration that supports abortion rights could exercise enforcement discretion on federal land, and state prosecutors who disagree would have no ability to prosecute on their own. Further, a President who supports abortion rights but is fearful that a successor who feels otherwise might later prosecute within the statute of limitations could pardon the providers on federal land for all potential abortion-related crimes under the ACA.³⁷¹ If that were to happen, those providers would be immune from prosecution for past abortions even if the White House's position on abortion changes. Abortion provision in the future, however, would be vulnerable.

³⁶⁶ It is estimated that just 6% of federal land is considered a federal enclave. JOHN D. LESHY, ROBERT L. FISCHMAN, & SARAH A. KRAKOFF, *FEDERAL PUBLIC LAND AND RESOURCES LAW* 142 (8th ed. 2022).

³⁶⁷ *Paul*, 371 U.S. 245.

³⁶⁸ National parks are federal enclaves, *see* *United States v. Harris*, 10 F.4th 1005, 1008 (10th Cir. 2021), as are many military bases and related locations, *see, e.g., Stiefel v. Bechtel Corp.*, 497 F. Supp. 2d 1138 (S.D. Cal. 2007). However, federal properties located on state land, such as post office buildings, courthouses, office buildings, and prisons are not enclaves unless they are located on federal land that qualifies. *See West River Elec. Ass'n, Inc. v. Black Hills Power & Light Co.*, 719 F. Supp. 1489, 1499 (D.S.D. 1989).

³⁶⁹ "Prosecution under the ACA is not for enforcement of state law but for enforcement of federal law assimilating a state statute." *United States v. Brown*, 608 F.2d 551, 553 (5th Cir. 1979).

³⁷⁰ *United States v. Ware*, 190 F. Supp. 645, 659 (N.D. Cal. 1960), *affirmed in part, vacated in part*, *Paul v. United States*, 371 U.S. 245 (1963). *Paul* reaffirmed the principle that Congressional regulation of federal land "bars state regulation without specific congressional action." *Id.* at 263.

³⁷¹ *Ex parte Garland*, 71 U.S. 333, 351 (1866) ("The Constitution gives him unlimited power in respect to pardon, save only in cases of impeachment. . . . It is, therefore, within the power of the President to limit his pardon, as in those cases in which it is individual and after conviction, to the mere release of the penalty—it is equally within his prerogative to extend it so as to include a whole class of offenders—to interpose this act of clemency before trial or conviction; and not merely to take away the penalty, but to forgive and obliterate the offence.").

Second, the ACA does not incorporate all state criminal law. In *Lewis v. U.S.*, the Court laid out a two-step test for determining if the ACA assimilates state criminal law. First, if the defendant’s act or omission is not made punishable by a federal law, “that will normally end the matter” because without federal law criminalizing the conduct, “the ACA presumably would assimilate the [state] statute.”³⁷² Lower courts have made clear that this inquiry includes exploring whether federal regulations cover the conduct.³⁷³ If federal law does make the act punishable, courts must ask the second question of whether application of state law would interfere with federal policy, rewrite an offense Congress carefully considered, or federal law occupies the field.³⁷⁴ This two-step analysis poses a challenge because the answer to the first question with respect to almost all state abortion law is that Congress has not made abortion punishable by federal law.³⁷⁵

However, the Court in *Lewis* indicated that incorporating state law if there is no federal law criminalizing the conduct is only the “normal” and “presumptive” conclusion; it did not foreclose a different conclusion in all situations. In the context of state abortion law, there is a strong argument—though untested post-*Lewis*—that this reaching the conclusion that state abortion law applies because there is no federal law prohibiting abortion is not the right answer. The *Lewis* inquiry was developed in the context of criminal activity that is universally prohibited, such as the homicide at issue in that case, because the inquiry answers which sovereign’s law should apply. *Lewis* makes less sense for actions that are not inherently criminal. In fact, it is hard to argue that *Lewis* has any application when the current federal government has a policy of *protecting* the behavior the state government makes criminal, something that is certainly not the case for homicide but is the case for abortion.³⁷⁶ There is precedent for this line of argument under the ACA from multiple lower courts that refused to apply state bans on union shop agreements on federal land because federal law “expressly permits union shop agreements.”³⁷⁷ Although these lower court cases about federal law *permitting* behavior predate

³⁷² *Lewis v. United States*, 523 U.S. 155, 164 (1998).

³⁷³ *See, e.g., United States v. Hall*, 979 F.2d 320, 322 (3d Cir. 1992) (“We agree with those courts that have concluded that a federal regulation does qualify as ‘an enactment of Congress.’”); *United States v. Palmer*, 956 F.2d 189, 191 (9th Cir. 1992).

³⁷⁴ *Id.*

³⁷⁵ With the exception of 18 U. S. C. §1531 (2000 ed., Supp. IV), which prohibits a particular form of later abortion Congress dubbed “partial-birth abortion.”

³⁷⁶ The White House, Remarks by President Biden on Protecting Access to Reproductive Health Care Services, July 8, 2022, <https://www.whitehouse.gov/briefing-room/speeches-remarks/2022/07/08/remarks-by-president-biden-on-protecting-access-to-reproductive-health-care-services/>.

³⁷⁷ *King v. Gemini Food Serv., Inc.*, 438 F. Supp. 964, 966 (E.D. Va. 1976); *Lord v. Local Union No. 2088*, 646 F.2d 1057, 1061-62 (5th Cir. 1981); *Vincent v. Gen. Dynamics Corp.*, 427 F. Supp. 786, 800 (N.D. Tex. 1977).

Lewis and its focus on federal laws that *criminalize* behavior, they are consistent with the Supreme Court’s statements about the ACA’s goals.³⁷⁸

Providers who want to avoid state abortion bans post-*Roe* by leasing space from federal agencies or programs, would have several similar arguments at their disposal, many of which dovetail with the preemption arguments described above.³⁷⁹ Because federal regulations can be the source of federal law under the ACA, the FDA or its parent, HHS, could assist this effort by issuing a regulation about its authority over medication abortion, particularly on federal land. As described earlier, the FDA closely regulates this medication and has approved it because it is safe and effective.³⁸⁰ An FDA or HHS statement to this effect mentioning federal land in particular would give providers a strong argument that they could prescribe and distribute abortion medication without fear of legal punishment while on federal land. This would not mean that people on federal land would have access to abortion in the same manner as before *Roe* was overturned because abortion medication is, at this time, only FDA-approved for terminating pregnancies up through ten weeks of gestation.³⁸¹ However, early abortion access would remain in a post-*Roe* world—even within states where abortion is illegal—as long as the medication was distributed (and perhaps, taken) on federal land.³⁸²

There is also an argument that federal law, as it currently exists, *already* precludes the application of state law regarding abortion on federal land. This argument could take several different forms. For instance, providers could argue that even in the absence of an agency statement, the FDA’s approval of the medication abortion regimen along with its strong statements about the safety of the drug protocol³⁸³ are not merely permission from the federal government for providers

³⁷⁸ *Sadrakula*, 309 U.S. at 103-04 (“But the authority of state laws or their administration may not interfere with the carrying out of a national purpose. Where enforcement of the state law would handicap efforts to carry out the plans of the United States, the state enactment must, of course, give way.”).

³⁷⁹ As discussed in this paragraph and the two that follow, the issue is whether the federal government has a policy, either through FDA regulation of mifepristone or through federal abortion law more generally, that precludes application of state law on federal land because of a conflict between the two under the terms of the ACA. The preemption argument in Part III.A. of this Article is similar in that it looks to conflict between state and federal law, but it is independent of the ACA and its unique case law. Moreover, the general preemption argument would apply beyond federal land and in all parts of a state.

³⁸⁰ *See supra* Part I.B.

³⁸¹ *Id.*

³⁸² The background rule for dispensation of drugs is that the care is provided where it is dispensed, not consumed, but one could imagine an antiabortion state taking the position that the abortion occurs on their land when the pills are consumed there. For this reason, it might be safer to require the patient to consume the drugs on federal land as well.

³⁸³ *See supra* Part III.A.

to perform abortions in this manner, but constitute the policy of the federal government, something that was certainly absent in *Lewis* for homicide and is more akin to the lower court union shop cases mentioned above. That the FDA has expressly permitted the use of medication abortion could mean that state bans on the use of this protocol—whether through specific bans on medication abortion or general bans on abortion—should not be applicable on federal lands under the ACA.

Taking this argument further, providers could argue that the federal government’s regulation of abortion occupies the field with respect to the matter. In addition to FDA regulation, Congress has prohibited so-called “partial-birth abortion”³⁸⁴ and outlawed acts that cause the death of an “unborn child.”³⁸⁵ Every year, Congress renews the Hyde Amendment, which prohibits federal dollars from being spent on abortion.³⁸⁶ Under the Affordable Care Act, Congress bans abortion from being part of the insurance options offered on Obamacare exchanges,³⁸⁷ and there are many different provisions protecting freedom of conscience with respect to abortion provision and refusal.³⁸⁸ These different laws, taken together, could be seen as the complete set of laws that Congress has chosen to adopt for purposes of federal abortion law, making anything that is not explicitly illegal, legal on federal lands. This interpretation would permit abortions on federal land at any point in pregnancy, so long as it complies with federal abortion laws. The Supreme Court has made clear that “through the comprehensiveness of its regulation,” Congress can occupy the field and thus preclude the application of state law through the ACA.³⁸⁹ This argument would posit that these federal abortion laws and regulations do just that with respect to how the federal government wants to treat abortion within its own laws, meaning on federal lands.³⁹⁰

³⁸⁴ 18 U.S.C. § 1531.

³⁸⁵ 1 U.S.C. § 8.

³⁸⁶ Consolidated Appropriations Act (2021), *supra* note 329.

³⁸⁷ 42 U.S.C. §18023

³⁸⁸ For a thorough list of federal laws relating to abortion refusal, *see* SECRETARIAT OF PRO-LIFE ACTIVITIES, CURRENT FEDERAL LAWS PROTECTING CONSCIENCE RIGHTS (May 2019), <https://www.usccb.org/issues-and-action/religious-liberty/conscience-protection/upload/Federal-Conscience-Laws-Fact-Sheet.pdf>.

³⁸⁹ *Lewis*, 523 U.S. at 165 (*citing* *Wis. Pub. Intervenor v. Mortier*, 501 U.S. 597, 604-05 (1991)).

³⁹⁰ Providers might even claim that because the United States already prohibits one form of abortion, so-called “partial-birth abortion,” other forms of abortion are presumed to be lawful under federal law and that this presumption should preclude the application of state law to the contrary. *United States v. Butler*, 541 F.2d 730, 737 (8th Cir. 1976) (“[T]he fact that the federal statutes are narrower in scope does not allow the federal government to use state law to broaden the definition of a federal crime.”).

Although the ACA concerns whether criminal abortion law applies on federal land, states have also passed abortion laws that are civil in nature—infamously, Texas’s SB8. For civil law on federal land, there is no law comparable to the ACA that wholesale incorporates non-conflicting state civil law. Rather, there are individual statutes that incorporate some specific state civil laws, such as wrongful death or personal injury.³⁹¹ For other civil actions, “[w]hen federal law neither addresses the civil law question nor assimilates pertinent state law, the applicable law is the state law that was in effect at the time that the state ceded jurisdiction to the United States.”³⁹² Because Texas’s SB8 and any copycat laws from other states are of such recent vintage, they would be precluded from being incorporated on federal land.³⁹³ Abortion providers *would* have to deal with the possibility of a wrongful death lawsuit if allowed under state law in a post-*Roe* world. The risk of such a lawsuit, particularly from patient relatives who might disagree with the patient’s decision, might be an insurmountable barrier for some providers. Abortion providers concerned about this liability, however, could require patients—and possibly others related to the patient—to sign waivers from suing under state wrongful death provisions.

We also want to be careful to highlight that our ACA analysis is limited to the legal risk people will face while on federal land. Once those people—whether provider, patient, or helper—are back on state land, the state’s abortion laws would apply. This could subject providers, patients, and helpers to state abortion criminal or civil law when they travel to or from federal land,³⁹⁴ even if the ACA protects providers, patients, and helpers while on that federal land. Moreover, the location of the clinic within an antiabortion state’s borders, albeit on federal land, would make it easy to surveil for the purpose of identifying the people visiting it. While this risk would be real, for over 150 years the Supreme Court has recognized, under the Fourteenth Amendment’s Privileges or Immunities Clause, that every American has the right to travel to and from federal lands to conduct business there.³⁹⁵ While these precedents specifically refer to conducting business with the federal government, the same rationale of prohibiting states from interfering with people traveling to enjoy the

³⁹¹ 28 U.S.C.A. § 5001.

³⁹² JAMES RASBAND, JAMES SALZMAN, & MARK SQUILLACE, PUBLIC NATURAL RESOURCES LAW § 3:8 (2d ed. 2009) (using *Arlington Hotel Co. v. Fant*, 278 U.S. 439 (1929) as an illustrative example of this point).

³⁹³ See, e.g., *Balderrama v. Pride Indus., Inc.*, 963 F. Supp. 2d 646, 656 (W.D. Tex. 2013).

³⁹⁴ With all of the complications discussed above in Section II regarding states punishing abortion travel or extraterritorial abortion.

³⁹⁵ *Slaughterhouse Cases*, 83 U.S. 36, 79-80 (1872); *Crandall v. Nevada*, 73 U.S. 35, 43-44 (1867).

privileges and immunities of their federal government should apply to conducting any federally approved business on federal land.

We recognize that the arguments put forth here are based on untested interpretations of federal law that raise thorny questions about the relationship between the federal government and the states. These questions as they apply to federal lands are not well developed in scholarship or federal court decisions, as “relatively few published decisions have engaged the ACA, and even fewer scholars have done so. As a result, the ACA has received little analytical treatment.”³⁹⁶ But the point here is the same as with the other issues covered in this Article: reliance on the ACA to shield abortion provision on federal land from the application of state criminal abortion bans would raise unexplored interjurisdictional legal issues that have previously been unaddressed in the long history of abortion conflict.³⁹⁷

C. Expanding Access to Medication Abortion

The federal government, sometimes along with abortion-supportive states, can apply various policies to remove obstacles to medication abortion. If they attempt to do so, medication abortion will become more accessible everywhere, including in states that ban abortion. Antiabortion states will try to resist this new abortion frontier but might see their efforts thwarted by federal policies and a lack of cooperation from other states. This section explores some of these possibilities and notes the areas in which federal intervention could make a significant difference, namely, in FDA regulation, telehealth infrastructure, medical licensure, and the standard of care for medication abortion.

First, the FDA could lift the remaining restrictions on the dispensation of mifepristone that make the drug harder to access across the country.³⁹⁸ The first two REMS requirements—that

³⁹⁶ Nihkil Bhagat, *Filling the Gap? Non-Abrogation Provisions and the Assimilative Crimes Act*, 111 COLUM. L. REV. 77, 80 (2011).

³⁹⁷ Interjurisdictional issues would also arise with abortion provision on Native land, though we do not cover this thicket of a topic here as it involves different issues of national and tribal sovereignty that are beyond the scope of this Article’s focus on states battling each other and the federal government. See Heidi L. Guzmán, *Roe on the Rez: The Case for Expanding Abortion Access on Tribal Land*, 9 Colum. J. Race & L. 95 (2018); Lauren van Schilfgaarde et al., *The Indian Country Abortion Safe Harbor Fallacy*, Law & Political Economy Blog, June 6, 2022, <https://lpeproject.org/blog/the-indian-country-abortion-safe-harbor-fallacy/>. Importantly, we agree with the concern that it is racially insensitive and wrong to suggest that indigenous peoples, who struggle to access equitable healthcare, have any obligation to use their land for this purpose. Moreover, a week after *Dobbs*, the Supreme Court drastically cut back on tribal sovereignty over their own land. See *Oklahoma v. Castro-Huerta*, No. 21-429 (June 29, 2022).

³⁹⁸ The FDA could also permit medication abortion through 12 weeks of pregnancy, which is supported by evidence of the drug’s effectiveness through that

providers become “certified” to prescribe the drug with the manufacturer and that patients sign an extra informed consent form—have existed since the FDA first approved mifepristone.³⁹⁹ The certification process requires providers to register with the drug manufacturer, affirming that they can identify and treat mifepristone’s rare adverse effects.⁴⁰⁰ Doing so is an extra administrative burden that discourages providers from prescribing mifepristone given that it might expose them to boycotts, protests, and violence if their status as an abortion provider becomes known to the public.⁴⁰¹ This process also disincentivizes general obstetricians and primary care providers from offering medication abortion as part of their practices.⁴⁰² In the same vein, the FDA’s additional informed consent requirement—the Patient Agreement Form, which patients sign before beginning a medication abortion—remains in place despite duplicating what providers already communicate to patients.⁴⁰³

The FDA re-evaluated the mifepristone REMS in December 2021, removing the requirement that patients pick up the drug in person and creating two additional ways that patients can receive mifepristone.⁴⁰⁴ The first is through the mail, supervised by a certified provider, which was a practice the FDA allowed over the course of the pandemic. The second is new: dispensation by a pharmacy. However, the FDA added a new REMS element that pharmacies also must seek certification to dispense mifepristone. As of today, the path ahead for pharmacies is not clear as the FDA has not yet defined the process of pharmacy certification.

Based on the pharmacy certification requirements for other drugs, a range of requirements could be enacted.⁴⁰⁵ For example, the

time. The FDA has done this previously, in 2016, when it approved mifepristone use through 10, rather than 7, weeks. Donley, *supra* note 54, at 14.

³⁹⁹ *Id.*

⁴⁰⁰ Donley, *supra* note 54, at 11.

⁴⁰¹ See generally DAVID S. COHEN & KRISTEN CONNOR, *LIVING IN THE CROSSHAIRS: THE UNTOLD STORIES OF ANTI-ABORTION TERRORISM* (2015).

⁴⁰² Carrie N. Baker, *Online Abortion Provider and “Activist Physician” Michele Gomez Is Expanding Early Abortion Options Into Primary Care*, *MS. MAG.* (Jan. 19, 2022), <https://msmagazine.com/2022/01/19/online-abortion-primary-care-doctor-michele-gomez-mya-network/>.

⁴⁰³ Rachel Rebouché, Greer Donley, David S. Cohen, *Progress In The Bid To Make Abortion Pills More Widely Available*, *BOS. GLOBE* (Dec. 22, 2021), <https://www.bostonglobe.com/2021/12/22/opinion/progress-bid-make-abortion-pills-more-widely-available/>.

⁴⁰⁴ Questions and Answers on Mifeprex, U.S. Food & Drug Administration, Dec. 16, 2021, <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifeprex>.

⁴⁰⁵ Other drugs are subject to pharmacy certification under a REMS, and those requirements vary in what additional dispensation and administrative restrictions they impose. FOOD & DRUG ADMIN., *REMS DISPENSER CERTIFICATION REQUIREMENTS* (June 1, 2013),

FDA could require pharmacies to apply for an authorization number that marks the prescription as valid for a certain period of time or limit the number of times that a drug is dispensed to an individual.⁴⁰⁶ Other requirements might be imposed as well, such as a system that documents compliance with the REMS, ongoing education and training for pharmacists, and counseling for patients.

The FDA can ensure that the yet-to-be-determined pharmacy certification process is reflective of mifepristone’s safety and imposes minimal requirements. A simple way to implement certification is to have a pharmacy representative attest, when ordering mifepristone from the distributor, that there are licensed pharmacists at the pharmacy or within the pharmacy chain willing to dispense it. As is true for provider certification, overly burdensome obligations on pharmacies will discourage them from carrying mifepristone.⁴⁰⁷

At present, only two mail-order pharmacies dispense mifepristone. The leading entity is Honeybee Health, which started in 2018 and began dispensing medication abortion when the in-person requirement was suspended during the pandemic.⁴⁰⁸ Operating in a space of regulatory transition while the FDA defines pharmacy certification, Honeybee Health has seen an “80% increase in demand for abortion pills, which now make up roughly 30% of the company’s orders.”⁴⁰⁹ Restrictions that make pharmacy certification easier could entice some pharmacies to carry medication abortion, but, of course, the nature of the certification process is only one factor: pharmacies may not be willing to risk the costs of stigma and harassment unless those costs decrease and the benefits—symbolic, political or financial—increase.⁴¹⁰ At the moment, there are few signs that retail pharmacies

<https://www.fda.gov/files/about%20fda/published/REMS-Dispenser-Certification-Requirements.pdf>.

⁴⁰⁶ This rule might attempt to stop a pregnant abortion rights supporter from obtaining multiple prescriptions with the purpose of sending the drugs to people in other states. It could also impede advance provision of medication pills, the availability of which could vary by state law. Carrie N. Baker, *Online Abortion Provider Robin Tucker: “I’m Trying to Remove Barriers. ... It Feels Great To Be Able To Help People This Way”*, MS. MAG. (Jan. 1, 2022), <https://msmagazine.com/2022/01/04/online-abortion-pills-provider-robin-tucker-virginia-maryland-maine/>.

⁴⁰⁷ Rachel Rebouché, *Remote Reproductive Rights*, 100 AM. J. L. MED. ___ (forthcoming 2022); Donley, *supra* note X, at 646-47.

⁴⁰⁸ Abigail 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/>.

⁴⁰⁹ *Id.*

⁴¹⁰ When the draft *Dobbs* opinion leaked in May 2022, many companies made it publicly known they would cover travel expenses for employees required to travel out of state for abortion care. That number has only increased since the final opinion was issued on June 24, 2022. In its statement, for example, Levi Strauss sought to rally private industry support: “[g]iven what is at stake, business leaders need to make their voices heard.” Emma Goldberg, *These Companies Will Cover*

are eager to dispense mifepristone.⁴¹¹ In June 2022, the five largest pharmacy companies declined to comment on whether they would seek certification: CVS indicated it would assess future facts once permitted to dispense mifepristone, and Walgreens implied that it will not seek pharmacy certification.⁴¹² And no pharmacy is willing to knowingly dispense medication abortion in states that ban it.

In sum, easing or eliminating FDA restrictions on medication abortion would make it easier for new providers to practice in abortion supportive states, and pharmacies to dispense it, helping them scale up to meet the demand of out-of-state patients traveling there. Because this decision is supported by medical experts and is part of the FDA's ordinary functions, the agency would not need to rely on any novel legal theories to act.⁴¹³ In fact, any challenge to the agency's action here, which would inevitably come, would be unlikely to succeed.⁴¹⁴

Second, general barriers to telehealth impede access to remote medication abortion care, which the federal government, along with states, can work to improve. Specifically, the Biden Administration could deploy its power to declare a public health emergency or engender action through a series of executive orders.⁴¹⁵ The executive branch used both types of measures in recent years as responses to the COVID-19 pandemic.

During the pandemic, telehealth exploded across many healthcare sectors and nationally, in part because of the support of federal orders.⁴¹⁶ Despite this growth, there remains unequal access to telehealth, mirroring broader disparities in the distribution of health resources.⁴¹⁷ Most abortion patients live below the federal poverty line and indicate that their chief reason for terminating a pregnancy is the inability to afford the costs of raising a child.⁴¹⁸ Those same patients need access to a telehealth-capable device, high-speed data transmission, and digital literacy. Take for instance unequal access to

Travel Expenses for Employee Abortions, N.Y. Times (June 30, 2022), <https://www.nytimes.com/article/abortion-companies-travel-expenses.html>.

⁴¹¹ Donley, *supra* note 54.

⁴¹² *Id.*

⁴¹³ Ironically, if the FDA removed the entire REMS, this might harm the preemption argument made in this Part's first section, but it would nevertheless provide broader access to everyone.

⁴¹⁴ Donley, *supra* note X, at 686-89.

⁴¹⁵ *Fact Sheet*, *supra* note 20.

⁴¹⁶ David Hoffman, *Increasing Access to Care: Telehealth During COVID-19*, 7 J.L. & BIOSCIENCES 1, 2 (2020).

⁴¹⁷ Cason Schmit et al., *Telehealth in the COVID-19 Pandemic*, in ASSESSING LEGAL RESPONSES TO COVID-19, at 102 (Scott Burris et al. eds., 2020).

⁴¹⁸ See DIANA GREENE FOSTER, *THE TURNAWAY STUDY: TEN YEARS, A THOUSAND WOMEN, AND THE CONSEQUENCES OF HAVING – OR BEING DENIED – AN ABORTION* (2020).

broadband internet service.⁴¹⁹ The “digital divide” disproportionately affects communities of color and low-income individuals as well as rural populations that lack the infrastructure that can make telehealth methods broadly available.⁴²⁰ Non-English speakers have additional barriers for navigating telehealth, and people with cognitive difficulties or other disabilities may have trouble interacting via video.⁴²¹ The federal government could use its spending power, as it did over the course of the pandemic, to invest in the infrastructure that makes telemedicine work. The ripple effects of doing so would benefit those seeking abortion via telehealth.

These efforts, however, depend on state cooperation, and, here, the federal government would have to play an advocacy role in promoting permissive state telehealth policies.⁴²² During the pandemic, with the assistance of federal agencies like HHS, DOJ, and CDC, states began to recognize various modes of telehealth delivery, such as over the telephone for some services, thereby removing the requirement of a video link.⁴²³ Also with federal guidance and federal protection from liability, many states waived and some states repealed rules limiting the reach of telehealth, such as how a patient-provider relationship is established or permitting out-of-state providers to practice in state.⁴²⁴ Many of these interventions stemmed from powers accorded to the Administration to declare a public health emergency. Although some have called for President Biden to declare a public health emergency in response to Dobbs, the Administration is still considering the option and weighing the language of relevant statutes that grant the President such power, including the challenges that any declaration would certainly face in courts.⁴²⁵

⁴¹⁹ See Betsy Lawton, *COVID-19 Illustrates Need to Close the Digital Divide*, in ASSESSING LEGAL RESPONSES TO COVID-19, *supra* note 379, at 191.

⁴²⁰ Alexandra Thompson et al., *The Disproportionate Burdens of the Mifepristone REMS*, 20 CONTRACEPTION 1, 3 (2021).

⁴²¹ Jorge A. Rodriguez et al., *Disparities in Telehealth Use among California Patients with Limited English Proficiency*, 40 HEALTH AFF. 487 (Mar. 2021), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00823>.

⁴²² Hudson Worthy, *The New Norm in Healthcare: Telehealth*, 15 CHARLESTON L. REV. 549, 550 (2020).

⁴²³ See Schmit et al., *supra* note 379.

⁴²⁴ See Kyle Faget, *Telehealth in the Wake of COVID-19*, 22 J. HEALTH CARE COMPLIANCE 5, 6 (2020).

⁴²⁵ Associated Press, *Biden Says He’s Mulling Health Emergency for Abortion Access*, POLITICO, July 10, 2022, <https://www.politico.com/news/2022/07/10/biden-health-emergency-abortion-access-00044936>. Under this approach, the Biden Administration could declare a public health emergency under a statute like the Public Readiness and Emergency Preparedness (Prep) Act. Under the Prep Act, the Secretary of HHS can issue a declaration that offers immunity from liability, except for willful misconduct, for “entities and individuals involved in the development, manufacture, testing, distribution, administration, and use of [] countermeasures” to fight an epidemic or pandemic. 45 U.S.C.S. § 247d-6d. Countermeasures are approved products that assist in fighting an epidemic or pandemic, which can

Third, the federal government, along with supportive states, can work to improve the national distribution of abortion providers by making it easier to practice medicine across states. Over the past few years, an increasing number of states permitted physicians to treat out-of-state patients, using telemedicine, if providers were in good standing in their home jurisdiction and registered with state boards.⁴²⁶ Although most pandemic-related waivers of state telehealth restrictions have expired,⁴²⁷ the growing acceptance of telehealth across state lines has prompted calls for uniform policy, particularly as related to physician licensure.⁴²⁸ Thirty states are currently members of the Interstate Medical Licensure Compact (IMLC), which “offers a voluntary, expedited pathway to licensure for physicians who qualify.”⁴²⁹ Three additional states have legislation pending.⁴³⁰ The IMLC utilizes a “mutual recognition” model that aims to increase access to health care for patients in rural and underserved areas. The IMLC does not grant automatic cross-border licensure but makes the process of obtaining practice permission in another state easier. Professionals obtaining licensure through the IMLC “still face in-state barriers because approval ultimately remains within the individual state medical board’s discretion and physicians still need to retain a license in every state they practice in.”⁴³¹ Reiterating a theme of this Article, polarized approaches to abortion regulation could undermine the emerging consensus

include material assistance and drugs. So a declaration under the Act could “enable out-of-state prescribing and dispensing of medications for abortion for those in states with abortion bans.” Nancy Northup, *Biden Must Declare a Public Health Emergency for Abortion*, WASH. POST, June 30, 2022, <https://www.washingtonpost.com/opinions/2022/06/30/declare-abortion-public-health-emergency/>. The Act does not define epidemic or pandemic, so application of the law would turn on making the case for why abortion bans and the abortion care shortage result in widespread and dire health consequences for millions of people. Jennifer L. Piatt, Summer Ghaith, & Madisyn Puchebner, *The Network for Public Health Law, Abortion Access: A Post-Roe Public Health Emergency*, June 21, 2022, <https://www.networkforphl.org/>

⁴²⁶ Kate Nelson, “*To Infinity and Beyond*”: *A Limitless Approach to Telemedicine Beyond State Borders*, 85 BROOK. L. REV. 1017 (2020).

⁴²⁷ See also Kerri Pinchuk, *California Policy Recommendations for Realizing the Promise of Medication Abortion: How the Covid-19 Public Health Emergency Offers a Unique Lens for Catalyzing Change*, 18 HASTINGS RACE & POVERTY L.J. 265 (2021); Katherine Fang & Rachel Perler, *Abortion in the Time of COVID-19: Telemedicine Restrictions and the Undue Burden Test*, 32 YALE J.L. & FEMINISM 134, 135 (2021).

⁴²⁸ Nathaniel M. Lactman et al., *Top 5 Telehealth Law Predictions for 2021*, 11 NAT’L L. REV. 12 (2020).

⁴²⁹ *Introduction*, INTERSTATE MEDICAL LICENSURE COMPACT (last visited Dec. 8, 2021), <https://www.imlcc.org/a-faster-pathway-to-physician-licensure/>; Eli Y. Adashi, et. al., *The Interstate Medical Licensure Compact: Attending to the Underserved*, 325 J. AM. MED. ASS’N, 1607, 1607 (2021).

⁴³⁰ *Compact State Map – Participating States*, INTERSTATE MEDICAL LICENSURE COMPACT, <https://www.imlcc.org/participating-states/>.

⁴³¹ Nelson, *supra* note 390, at 1038. Additionally, only physicians belonging to the American Board of Medical Specialties or the American Osteopathic Association’s Bureau of Osteopathic Specialists are eligible for IMLC. *Id.*

among states—states across the political spectrum—that cross-state medical care should be promoted. As the shield laws and travel bans explored in Part II illustrate, the *Dobbs* era will be one marked by animosity between states rather than the cooperation that has informed telehealth expansion and licensure compacts.

Nevertheless, among abortion-permissive states, license compacts could improve interstate abortion provision, thus blunting the effect of state laws and state borders. For instance, a pool of providers across abortion-supportive states could better manage the demand in those states. This pooling of resources would reduce pressure on individual abortion providers, especially those in states immediately abutting antiabortion states, who, as a result, will likely see more patients traveling from antiabortion states. Thus, if Illinois experiences an increase in patients due to its proximity to Kentucky, providers in Maine with permission to practice in Illinois could offer early abortions by telemedicine to those in the first ten weeks, freeing Illinois-based providers to focus their attention on the procedural abortions after ten weeks. Licensure compacts will also improve flexibility. If an abortion provider in Kentucky is now unable to perform abortions in Kentucky, she could register in other states permitting telehealth for abortion and provide abortions to patients scattered throughout abortion-supportive states, even if she remains in Kentucky.⁴³²

The Uniform Law Commission is drafting a model act on telehealth for states to adopt. The draft act creates a registration process for out-of-state practitioners seeking to practice telehealth in a patient’s resident state; registered out-of-state physicians would have the same privileges as in-state physicians, as would physicians who are subject to an interstate compact or who consult with a practitioner who has “established a practitioner–patient relationship with the patient.”⁴³³ The scope of care is broadly defined under the draft act: “A practitioner may provide a telehealth service to a patient located in this state if to do so is consistent with the practitioner’s scope of practice in this state, the applicable professional practice standard in this state, and the requirements of federal law and law of this state.”⁴³⁴

⁴³² One risk, however, would be if Kentucky passed a law or issued a policy through its medical board that providing abortion services anywhere in the United States could subject the provider with a Kentucky license to disciplinary action. We discuss the ramifications of disciplinary actions for licensure and malpractice insurance in Part II.D and below.

⁴³³ Uniform Law Commission, Telehealth Act, § 5(a) (Draft, Nov. 2021). In addition, an out-of-state physician may provide “follow-up care to treatment provided in the state in which the out-of-state practitioner is licensed, certified, or otherwise authorized by law to provide the treatment; and the follow-up care is infrequent or episodic and occurs not later than [one year] after the previously provided in-person treatment.” *Id.* § 5(a)(4)(A)-(B).

⁴³⁴ *Id.* § 3(a).

A few aspects of the ULC’s draft are noteworthy for the coming questions about how states might regulate telehealth for medication abortion by regulating telehealth services, licensure, and professional discipline generally. First, the draft tracks the standard of care in telehealth, which is to identify the controlling state law as the law where the patient is. As Part II noted, Massachusetts enacted a shield law that applies “regardless of the patient location”⁴³⁵ and some jurisdictions, given the nature of medication abortion, are considering defining care as where the provider is. If care is defined as occurring where the provider was, at least in the abortion context, it would change what law governs. There is a catch, however, under the model act, which seeks to represent common practices and standards across states. The act includes an exception for state-banned health care, precluding “provision of a health care service otherwise prohibited by federal law or the law of this state.”⁴³⁶ Taken on its face, this would apply to abortion bans unless an exception for abortion was made or the relevant care is defined by the location of the provider. (And a further complication: Section 4 of the draft act forbids any law treating telehealth differently than in-person care except for prescribing controlled substances, thus a carve out for telehealth for abortion may contradict the terms of Section 4.) In addition, the act could exclude providers from interstate registration if they are subject to disciplinary investigation in any state. Without clarification, there could be a conflict with the shield laws discussed earlier, as passed by New York and Connecticut, which seek to protect providers from in-state repercussions of disciplinary actions taken in other states. There is a similar conflict between shield laws and interstate licensure compacts under the IMLC. Licensure compacts as enacted by states, like New Jersey, require reciprocal recognition of disciplinary actions taken by other compact states. In participating in an interstate licensure compact, New Jersey pledges to recognize a disciplinary action taken in Alabama, for example.⁴³⁷

The ULC’s model act spotlights the complexities inherent in mapping abortion care onto policies that govern telehealth, licensure, discipline across the board. Shield laws target some of those complications, but a word of caution is worth repeating. Although providers’ home state’s laws may seek to protect them from penalties imposed by other states, shield laws may not be able to fully insulate them from all negative consequences, especially when professional discipline is involved. And any travel outside the state may be high risk. For example, Kentucky courts could hear a civil suit and enter a default

⁴³⁵ See discussion *supra* Part II.D.

⁴³⁶ *Id.* § 3(b). A previous, now purposefully deleted, comment to this section listed abortion restrictions as a relevant example. The comment stated: “a state might prohibit the prescription of abortion-inducing medications or other controlled substances through telehealth.” *Id.* Comment to Section 3.

⁴³⁷ N.J. STAT. ANN. § 45:9-6.2 (2022).

judgment against a provider, though evidence would be difficult to amass if no one agrees to cooperate. For the reasons we discuss in Part II, pulling a non-resident provider into a state like Kentucky for criminal prosecution could be difficult. But if that person travels to Kentucky—even accidentally (e.g., their flight to California has an emergency landing there)—Kentucky could easily arrest them.

Moreover, in the scenario where a provider has a default judgment or disciplinary proceeding against them in another state, three dilemmas arise. First, under the Full Faith and Credit Clause, only in some circumstances can a state can decide to ignore a judgment entered against one of its residents in another state, even if that resident never stepped foot in the other state, but that state nonetheless established jurisdiction over the provider.⁴³⁸ Second, providers' home states may have little power to stop creditors from attacking the assets of providers if unpaid money judgments from other states are not satisfied.⁴³⁹ And, third, related to disciplinary action, the medical boards in other states in which a provider has a license but that do not have shield laws, assuming the home state has attempted to shield the person from disciplinary charges, can take account of legal sanctions anywhere in the country, with potential effects for the provider's good standing and malpractice insurance costs in that other state. Thus, even if supported by their home state, providers looking to engage in cross-border care would need to consider restricting future travel to avoid criminal prosecution and might still risk some civil and professional consequences.

Fourth and finally, the federal government could expand access to medication abortion, and all abortion, by supporting interstate travelers, removing unnecessary abortion restrictions that create barriers to efficient care, and working to improve the rate and efficiency of reimbursement for insurance coverage of abortion, both private and public.⁴⁴⁰ Senators Elizabeth Warren and Patti Murray, in a June 2022 letter, urged the Administration to secure material support for care: "Federal agencies could explore opportunities to provide vouchers for travel, child care services, and other forms of support for individuals seeking to access abortion care that is unavailable in their home state."⁴⁴¹ Because these measures do not fund abortion services,

⁴³⁸ See *supra* notes 198-200 and accompanying text.

⁴³⁹ See Edward H. Cooper, *Res Judicata Between State Courts*, 18B Fed. Prac. & Proc. Juris. 4467, n.14 (3d ed.).

⁴⁴⁰ David S. Cohen, Greer Donley, & Rachel Rebouché, *States Want to Ban Abortions Beyond Their Borders. Here's What Pro-Choice States Can Do*, N.Y. TIMES (Mar. 13, 2022), <https://www.nytimes.com/2022/03/13/opinion/missouri-abortion-roe-v-wade.html>.

⁴⁴¹ Letter to the President of the United States on Abortion Executive Orders, 2, (June 7, 2022), <https://www.warren.senate.gov/imo/media/doc/2022.06.07%20Letter%20to%20POTUS%20on%20Abortion%20EO.pdf>.

they arguably fall outside of the Hyde Amendment’s reach. Other resources, marshalled through federal agencies with varying powers and expertise, could be used to attempt to soften the material consequences for abortion patients after *Dobbs*.⁴⁴² Any efforts to streamline care, remove barriers, and increase the number of abortion providers will help *all* patients.

The federal government, with state cooperation in some areas, can improve access to medication abortion and telehealth for abortion; doing so would have collateral effects in anti-abortion states, regardless of their opposition. As early abortion access becomes more portable, it will be easier to obtain for everyone. Patients who travel from anti-abortion states to obtain an abortion at a brick-and-mortar clinic will find providers with greater capacity. Others who cross state lines to access abortion will have an easier time doing so because they can use telemedicine just over the border or at a friend’s house instead of being bound to the location of a clinic. In clinical spaces, facilities are emerging at locations that ease travel, such as near airports or land borders.⁴⁴³ And yet others who want to remain in antiabortion states might find more options to explore, including mail forwarding and “doctors of conscience,”⁴⁴⁴ if they are willing to take on the serious legal risks those measures include. As a result, the interjurisdictional conflicts described throughout this Article will intensify as antiabortion states’ policies are thwarted by the efforts of the federal government and abortion-supportive states.

CONCLUSION

In this Article, we have identified the seismic shifts in abortion law and practice that are coming now that the Supreme Court has abandoned *Roe*. The future will be one of interjurisdictional conflict, in all the ways identified here (and in many ways yet to be considered). But within these identified conflicts lies opportunities to untether abortion access to the pronouncement of constitutional abortion

⁴⁴² For example, the Centers for Medicaid & Medicare Services could ensure, as a condition of participation, that Hyde-compliant abortions are performed at participating hospitals and other facilities in every state. Centers for Medicaid & Medicare Services, Medicare Coverage Database, Abortion, Centers for Medicaid & Medicare Services, <https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCID=127&ncdver=2&bc=AAAAGa> (“Abortions are not covered Medicare procedures except: 1. If the pregnancy is the result of an act of rape or incest; or 2. In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.”)

⁴⁴³ Abortion Clinics are Opening Near Airports and State Borders, *TIME*, June 9, 2022, <https://time.com/6185519/abortion-clinics-travel-state-borders/>.

⁴⁴⁴ CAROLE JOFFE, *DOCTORS OF CONSCIENCE: THE STRUGGLE TO PROVIDE ABORTION BEFORE AND AFTER ROE V. WADE* (1996).

rights. As discussed throughout this Article, these opportunities include shielding abortion providers in abortion-supportive states from out-of-state investigations, lawsuits, or prosecutions; preempting state laws that contradict federal laws and regulations; providing abortion services on federal land; further loosening federal restrictions on medication abortion; and advancing teleabortion through licensure and telemedicine infrastructure.

There is no guarantee that all, or even any, of these strategies will work, especially because some of them will rely on courts that might be hostile to abortion rights, especially the current Supreme Court; other options involve risks and collateral consequences that people may not be willing to take.⁴⁴⁵ But thinking about interjurisdictional approaches to abortion access is important now more than ever because the abortion debate, and the conflicts it inspires, are going to fundamentally change. For half a century, the antiabortion movement has thrown whatever it can muster against the wall, hoping something will stick and without fear of defeat. They have lost many of their battles over the years, but have also had significant victories. They have learned lessons, relied on lower court and dissenting opinions, lobbied state legislators, influenced federal policy, and continued to press their novel, often legally tenuous, approaches. This steely-headed approach, coupled with the luck of Supreme Court vacancies, has put them in the position to usher in a post-*Roe* era. Without the protection of *Roe*, the abortion rights movement will be forced to emulate at least some parts of this approach and press their own novel strategies in the coming years⁴⁴⁶—strategies that will rely less on respecting borders and more on infiltrating them on federal land, preempting them with federal laws, or ignoring them altogether.

The coming interjurisdictional conflicts we have identified here clarify the stakes for the future of abortion access. But in those conflicts, there is also ample possibility for abortion advocates to reimagine law, policy, and activism in a post-*Roe* country. These coming battles will divide the nation and define this new abortion era but may eventually lead to abortion laws and practices that are built to last.

⁴⁴⁵ After all, if the Supreme Court is willing to overturn a half-century of precedent in *Dobbs*, the Court also might refuse to apply any of the precedent or doctrine that we discuss throughout this article, no matter how well established.

⁴⁴⁶ See generally David S. Cohen, Greer Donley, & Rachel Rebouché, *Re-Thinking Strategy After Roe*, 75 STAN. L. REV. ONLINE (forthcoming 2022).