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ARTICLE

THE NEW ABORTION BATTLEGROUND

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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 will spawn 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 this aspect of the aftermath of* Roe*'s reversal.*

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 intervene, attempting to use federal laws to preempt state bans and possibly to use federal land to shelter abortion services. Ultimately, once the constitutional protection for previability 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.*

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

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 right has become a state-by-state patchwork.[2] In a post-*Roe* country, states will attempt to impose their local abortion policies as

1. In *Roe v. Wade*, the Supreme Court held that criminal laws banning abortion were an infringement of a constitutional right to privacy under the Fourteenth Amendment's Due Process Clause. 410 U.S. 113, 164 (1973). In *Planned Parenthood of Southeastern Pennsylvania 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) (plurality opinion). One of *Casey*'s central holdings is that a state cannot ban previability abortions. Id. at 872. On June 24, 2022, the Court overturned both of these precedents. Dobbs v. Jackson Women's Health Org., No. 19-1392, slip op. at 5 (U.S. June 24, 2022).

2. See generally David S. Cohen & Carole Joffe, Obstacle Course: The Everyday Struggle to Get an Abortion in America (2020) (exploring the various state laws restricting abortion and their impact on patients and providers). 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 id. at 88.

widely as possible, even across state lines, and will battle one another over these choices;[3] at the same time, the federal government may intervene to thwart state attempts to control abortion law.[4] 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 previability abortion everywhere in the country. The Court upended that long-standing precedent in *Dobbs v. Jackson Women's Health Organization*, holding that the U.S. Constitution lacks any abortion right.[5] As of November 2022,[6] twenty-one states—mostly in the Midwest and South—have banned or tried to ban abortion in almost all circumstances. Seven state bans, however, have been stymied by courts.[7] 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.[8]

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 previability abortion. According to this argument, these cases created an unworkably complex legal framework. In *Casey*, for instance, Justice Antonin Scalia wrote in dissent that the undue burden test for evaluating the constitutionality of

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3. See infra Part II.

4. See infra Part III.

5. See *Dobbs*, slip op. at 14–15. 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*, reiterated in *Casey*, that the Fourteenth Amendment protects previable abortion decisions. Id. at 5–6. 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." Id. at 77.

6. The state of the law and events described by this Article has developed at a rapid pace since the Supreme Court's decision in Dobbs v. Jackson Women's Health Organization and continues to do so. This Article reflects developments through November 5, 2022.

7. Caroline Kitchener, Kevin Schaul, N. Kirkpatrick, Daniela Santamariña & Lauren Tierney, Abortion Is Now Banned in These States. See Where Laws Have Changed., Wash. Post (June 24, 2022), https://www.washingtonpost.com/politics/2022/06/24/abortion-state-laws-criminalization-roe/ (on file with the *Columbia Law Review*) (last updated Oct. 10, 2022) (reporting that Alabama, Arkansas, Georgia, Idaho, Kentucky, Louisiana, Mississippi, Missouri, Oklahoma, South Dakota, Tennessee, Texas, West Virginia, and Wisconsin ban most or all abortions but that the bans in Arizona, Indiana, North Dakota, Ohio, South Carolina, Utah, and Wyoming are currently enjoined).

8. Abortion Policy in the Absence of *Roe*, Guttmacher Inst., https://www.guttmacher.org/state-policy/explore/abortion-policy-absence-roe [https://perma.cc/N226-J2EF] [hereinafter Guttmacher Inst., Abortion Policy] (last updated Oct. 1, 2022).

previability abortion restrictions was "inherently manipulable and will prove hopelessly unworkable in practice."[9] Abortion law will become simpler, the argument continues, because states will be able to craft laws without the threat of constitutional litigation.[10] Justice Samuel Alito adopted this argument in the *Dobbs* opinion, noting that *Casey* saddled judges with "an unwieldy and inappropriate task."[11]

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.[12] 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 on those who travel out of state for abortion care or on those who provide such care or facilitate its access.[13] 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.[14]

The country is seeing the start of these battles. A model law authored by the National Right to Life Committee bans assisting a minor across state

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9. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 986 (1992) (Scalia, J., concurring in the judgment in part and dissenting in part).

10. Stenberg v. Carhart, 530 U.S. 914, 956 (2000) (Scalia, J., dissenting) (arguing that overturning *Roe* and *Casey* will remove the Court from the "abortion-umpiring business" and "return this matter to the people" (quoting *Casey*, 505 U.S. at 995–96 (Scalia, J., concurring in the judgment in part and dissenting in part))).

11. *Dobbs*, slip op. at 62 (citing Lehnert v. Ferris Fac. Ass'n, 500 U.S. 507, 551 (1991) (Scalia, J., concurring in the judgment in part and dissenting in part)); see also id. at 59–62 (discussing the difficulty of applying *Casey*'s rules in prior cases).

12. See Caroline Kitchener, The Next Frontier for the Antiabortion Movement: A Nationwide Ban, Wash. Post (May 2, 2022), https://www.washingtonpost.com/nation/2022/05/02/abortion-ban-roe-supreme-court-mississippi/ (on file with the *Columbia Law Review*) ("Leading antiabortion groups and their allies in Congress have been meeting behind the scenes to plan a national strategy that would kick in . . . [post-*Roe*], including a push for a strict nationwide ban on the procedure . . . ."); 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/ (on file with the *Columbia Law Review*) [hereinafter Kitchener, *Roe*'s Gone] ("On the heels of their greatest victory, antiabortion activists are eager to capitalize on their momentum by enshrining constitutional abortion bans[] [and] pushing Congress to pass a national prohibition . . . .").

13. See infra sections II.A–.B.

14. See infra section II.D.

lines to get an abortion without parental consent, "[r]egardless of where [the] illegal abortion occurs."[15] At least one "sanctuary city" in Texas has likewise included such language, banning abortion for city residents "regardless of where the abortion is or will be performed."[16] 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[17] and a 2022 bill that imposed civil liability on those helping Missouri citizens travel out of state to obtain an abortion.[18] 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.[19] In the wake of *Dobbs*, twelve 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.[20]

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 pills—allows abortion provision to occur across state and country lines.[21] Virtual clinics, offering remote

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15. Memorandum from James Bopp, Jr., Gen. Couns., Nat'l Right to Life Comm., Courtney Turner Milbank & Joseph D. Maughon, to Nat'l Right to Life Comm. 14 (June 15, 2022), https://www.nrlc.org/wp-content/uploads/NRLC-Post-Roe-Model-Abortion-Law-FINAL-1.pdf [https://perma.cc/G46B-KZF7] [hereinafter NRLC Model Law].

16. See, e.g., Slaton, Tex., Ordinance 816, at 7 (Dec. 13, 2021) (on file with the *Columbia Law Review*); see also Cisco, Tex., Ordinance 0-2021-17, at 5 (Oct. 12, 2021) (on file with the *Columbia Law Review*) (declaring it illegal to "procure . . . an abortion in the City of Cisco, Texas," without limiting the geographical range of such procurement); cf. Isaiah Mitchell, From Waskom to Abilene: Behind the Movement of Sanctuary Cities for the Unborn, Texan (Apr. 13, 2022), https://thetexan.news/from-waskom-to-abilene-behind-the-movement-of-sanctuary-cities-for-the-unborn/ [https://perma.cc/QC9Y-AFK2] (reporting inaccurately that Cisco's ordinance contained the same language as Slaton's, whereas the version included in the reporting was not the one ultimately promulgated).

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

18. H.B. 2012, 101st Gen. Assemb., 2d Reg. Sess. (Mo. 2022).

19. See infra section II.D.

20. See infra section II.D.

21. The pandemic catapulted the idea of virtual abortion care from a distant dream to a new reality, revolutionizing how abortion care is offered. See Rachel Rebouché, Greer Donley & David S. Cohen, Opinion, The FDA's Telehealth Safety Net for Abortion Only Stretches So Far, Hill (Dec. 18, 2021), https://thehill.com/opinion/healthcare/586329-the-fdas-telehealth-safety-net-for-abortion-only-stretches-so-far/ [https://perma.cc/DB5S-6PCK] [hereinafter Rebouché et al., Safety Net] (noting that, during the COVID-19 pandemic, a federal district court enjoined the in-person dispensation requirement and the Biden Administration suspended enforcing it).

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.[22] Early abortion care has, as a result, become more portable in the states that permit telehealth for abortion.[23]

The portability of medication abortion will impact abortion access even in states that prohibit telehealth or ban abortion after *Roe*. In those jurisdictions, people[24] already obtain this medication through the mail, often through international physicians, pharmacies, and advocates, allowing patients to have an abortion at home in an antiabortion state.[25] 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 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

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22. Id.

23. Cf. Medication Abortion, Guttmacher Inst., https://www.guttmacher.org/state-policy/explore/medication-abortion/ [https://perma.cc/QC5W-Y872] [hereinafter Guttmacher Inst., Medication Abortion] (last updated Oct. 1, 2022) (noting restrictions placed by antiabortion states on provision of medication abortion, preventing portability in those states).

24. Not every person capable of becoming pregnant is a woman; trans men, girls, and gender nonbinary patients also need access to abortion and reproductive healthcare. There are also times, however, when gender's intersection with abortion is important and relevant. This Article does its best to thread that needle by using a variety of terms in its discussion. For more context, see Jessica A. Clarke, They, Them, and Theirs, 132 Harv. L. Rev. 894, 954–57 (2019); see also Loretta J. Ross & Rickie Solinger, Reproductive Justice: An Introduction 6–8 (2017).

25. See infra section I.B; see also Caroline Kitchener, Covert Network Provides Pills for Thousands of Abortions in U.S. Post *Roe*, Wash. Post (Oct. 18, 2022), https://www.washingtonpost.com/politics/2022/10/18/illegal-abortion-pill-network/ (on file with the *Columbia Law Review*) (describing efforts to provide covert access to medication abortion).

aftermath of *Dobbs* that creates this federal–state conflict, and members of Congress have advocated for more aggressive ideas.[26]

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 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 through 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 interstate 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 Biden 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 holes in state abortion bans. Moreover, because state law does not always apply on

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26. See Letter from Elizabeth Warren, U.S. Sen., et al., to Joseph R. Biden, President of the United States (June 7, 2022), https://www.warren.senate.gov/download/20220607-letter-to-potus-on-abortion-eo/ [https://perma.cc/CG37-C64R] [hereinafter Senate Letter] (encouraging presidential action to increase access to medication abortion, establish a reproductive health ombudsman at the Department of Health and Human Services, enforce "Free Choice of Provider" requirements, and use federal property and resources to increase access to abortion); Fact Sheet: President Biden to Sign Executive Order Protecting Access to Reproductive Health Care Services, The White House (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/ [https://perma.cc/ERE2-X5BP] [hereinafter White House, Protecting Access] (outlining the contents of President Joseph Biden's executive order, "Protecting Access to Reproductive Health Care Services").

federal land, some abortions provided on 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 the country's 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 long argued that *Roe* and its progeny created unworkable standards that vexed lower courts. Their list of concerns included that the undue burden standard—*Casey*'s constitutional test for vetting state abortion restrictions—was vague and difficult to apply,[27] that viability was a moving target,[28] and that a health-or-life exception[29] was malleable.[30] Abortion precedents should be overturned, in this vein of thinking, because the values underlying stare decisis failed in the face of unworkability.[31] The simpler, more workable alternative, they claimed, would be to allow each state to decide its own abortion laws. Justice Alito adopted this reasoning in full in *Dobbs*.[32] But he and those who came before him are wrong.

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27. *Casey* held that states could regulate previability abortions so long as the regulation did not create an undue burden. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 874 (1992) (plurality opinion). Courts applied this standard differently. See Dobbs v. Jackson Women's Health Org., No. 19–1392, slip op. at 60–62 (U.S. June 24, 2022) (discussing lower courts' inconsistent applications of the undue burden standard).

28. The Court had determined that viability starts when a fetus has a "realistic possibility of maintaining and nourishing a life outside the womb." *Casey*, 505 U.S. at 870. This point had changed over time. See id. at 860 ("[A]dvances in neonatal care have advanced viability to a point somewhat earlier [than had been recognized in *Roe*].").

29. The Court had always required that abortion bans include an exception for the life or health of the mother, unless a court determined that the law did not harm the health or life of the mother. See *Casey*, 505 U.S. at 846.

30. See Mary Ziegler, Taming Unworkability Doctrine: Rethinking Stare Decisis, 50 Ariz. St. L.J. 1215, 1218–20 (2018) (discussing how antiabortion attorneys exploited weaknesses in *Roe* and its progeny to further their strategies).

31. Id. at 1218.

32. *Dobbs*, slip op. at 56–59.

This Part explores a United States without any constitutional floor for abortion rights. Though before *Dobbs*, states restricted abortion to varying degrees, straining abortion access and making services all but absent in a few places, *Roe* and *Casey* ensured that no state could ban previability abortion.[33] Without those precedents, the legality of obtaining abortion care 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. It then explores how the now-varying legality of abortion will affect access to abortion. Such access for those who live in states that ban abortion comprises both traditional in-person services, accessed through interstate travel, and medication abortion mailed into antiabortion states. 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.[34] Thus, post-*Roe* America looks very different than much of the *Roe* and pre-*Roe* era.

A. *The Post-*Dobbs *Interjurisdictional Legal Landscape*

Without *Roe*, roughly half the country is expected to eventually make almost all abortion services illegal.[35] At the time of writing, fourteen states have done just that, while another seven states have had their bans blocked by courts.[36] 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.[37] Alabama, Arizona, and Georgia passed such laws before *Dobbs* but they were ultimately enjoined while *Roe* and *Casey* stood.[38] And the Louisiana legislature

33. *Casey*, 505 U.S. at 874.

34. See Rachel Rebouché, Remote Reproductive Rights, 48 Am. J.L. & Med. (forthcoming 2022) (manuscript at 1–3) (on file with the *Columbia Law Review*) [hereinafter Rebouché, Remote Reproductive Rights] (describing the wider scale emergence of telehealth for abortion).

35. Guttmacher Inst., Abortion Policy, supra note 8.

36. See Kitchener et al., supra note 7.

37. *Dobbs*, slip op. at 37–39.

38. See SisterSong Women of Color Reprod. Just. Collective v. Governor of Ga., 40 F.4th 1320, 1324–25 (11th Cir. 2022) (describing Georgia's law and a pre-*Dobbs* permanent injunction against it); Isaacson v. Brnovich, No. CV-21-01417-PHX-DLR, 2022 WL 2665932, at *1, *10 (D. Ariz. July 11, 2022) (describing Arizona's law and a pre-*Dobbs* preliminary injunction against it); Robinson v. Marshall, No. 2:19cv365-MHT (WO), 2022 WL 2314402, at *1 (M.D. Ala. June 24, 2022) (lifting a preliminary injunction against Alabama's law); see also Kitchener et al., supra note 7 (discussing these developments). Litigation over Arizona's laws has continued, but as of October 2022 an injunction remains in place. See Order, Planned Parenthood of Ariz., Inc. v. Brnovich, No. C127867 (Ariz. Ct. App. Oct. 7, 2022) ("The court . . . concludes the balance of hardships weigh strongly in favor of granting the

considered, but ultimately shelved, such a bill in May 2022.[39] Georgia's and Alabama's injunctions were lifted after *Dobbs*.[40]

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—and some are considering amendments to their state constitutions[41]—to protect abortion rights on their own regardless of a federal constitutional right.[42] These state provisions guarantee mostly unencumbered access to previability abortion and access to postviability abortion when necessary to protect the health or life of the pregnant person.[43] The remaining states will operate in a middle ground, keeping abortion legal but regulating it to varying degrees of strictness.[44] 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.[45]

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stay [of the lower court's decision vacating the injunction], given the acute need of healthcare providers, prosecuting agencies, and the public for legal clarity as to the application of our criminal laws.").

39. 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 (on file with the *Columbia Law Review*).

40. *SisterSong*, 40 F.4th at 1324 (lifting injunction against Georgia law); *Robinson*, 2022 WL 2314402, at *1 (lifting injunction against Alabama law).

41. For example, Vermont residents will vote on a legislatively referred constitutional amendment in November 2022, which reads: "That an individual's right to personal reproductive autonomy is central to the liberty and dignity to determine one's own life course and shall not be denied or infringed unless justified by a compelling State interest achieved by the least restrictive means." Prop. 5, 76th Sess. (Vt. 2021). On August 2, 2022, voters in Kansas rejected a proposed constitutional amendment that would have eliminated the right to abortion in the state. See Dylan Lysen, Laura Ziegler & Blaise Mesa, Voters in Kansas Decide to Keep Abortion Legal in the State, Rejecting an Amendment, NPR (Aug. 2, 2022), https://www.npr.org/sections/2022-live-primary-election-race-results/2022/08/02/1115317596/kansas-voters-abortion-legal-reject-constitutional-amendment/ [https://perma.cc/48BD-RV2A] (last updated Aug. 3, 2022).

42. Guttmacher Inst., Abortion Policy, supra note 8.

43. Id. (noting that jurisdictions like the District of Columbia have legalized abortion throughout pregnancy and others have protected abortion care providers from out-of-state abortion bans); see also After *Roe* Fell: Abortion Laws by State, Ctr. for Reprod. Rts., https://reproductiverights.org/maps/abortion-laws-by-state/ [https://perma.cc/9Q55-D4ZW] (last visited Sept. 23, 2022) (explaining that some states have made abortions more accessible by funding medically necessary abortions, requiring private insurers to cover abortions, and ensuring that abortion clinics are not physically obstructed by antiabortion protest).

44. Ctr. for Reprod. Rts., supra note 43 (identifying states in which abortion is "not protected" or is subject to "hostile" treatment).

45. See Rachel K. Jones, Jesse Philbin, Marielle Kirstein & Elizabeth Nash, 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 [https://perma.cc/WD8J-P79S]; 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-

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.[46] It found that "the average resident is expected to experience a 249-mile increase in travel distance, and the abortion rate is predicted to fall by 32.8%."[47] Indeed, regional gaps in abortion access have been stark for a while. Leading up to *Dobbs*, six states had only one abortion clinic.[48] 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.[49] Now that states can ban almost all abortions at any point in pregnancy, the size of the already-existing abortion deserts will increase. In the first 100 days after *Dobbs*, sixty-six clinics closed across fifteen states;[50] as a result, in the two months after *Dobbs*, an estimated 10,000 people were unable to travel to obtain legal abortions who otherwise would have.[51]

The impact of these abortion deserts is stark. Three quarters of abortion patients are poor or low income,[52] 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.[53] With the costs and logistical

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having-a-domino-effect-on-clinics-across-the-u-s/ [https://perma.cc/LZ6U-XLK4] (noting that wait times in neighboring states have become much longer and that the states accommodating the influx of patients severely lack capacity).

46. Caitlin Myers, Rachel Jones & Ushma Upadhyay, Predicted Changes in Abortion Access and Incidence in a Post-*Roe* World, 100 Contraception 367, 369 (2019).

47. Id. at 367.

48. Abortion Care Network, Communities Need Clinics 2021, at 5 (2021), https://abortioncarenetwork.org/wp-content/uploads/2021/11/CommunitiesNeed Clinics2021-1.pdf [https://perma.cc/8NGL-DZG9].

49. 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 and noting that such women must "traverse . . . very substantial distances—sometimes hundreds of miles—to reach an abortion provider").

50. Marielle Kirstein, Joerg Dreweke, Rachel K. Jones & Jesse Philbin, 100 Days Post-*Roe*: At Least 66 Clinics Across 15 U.S. States Have Stopped Offering Abortion Care, Guttmacher Inst. (Oct. 6, 2022), https://www.guttmacher.org/2022/10/100-days-post-roe-least-66-clinics-across-15-us-states-have-stopped-offering-abortion-care/ [https://perma.cc/97PW-TAXZ].

51. See Maggie Koerth & Amelia Thomson-DeVeaux, Overturning *Roe* Has Meant at Least 10,000 Fewer Legal Abortions, FiveThirtyEight (Oct. 30, 2022), https://fivethirtyeight.com/features/overturning-roe-has-meant-at-least-10000-fewer-legal-abortions/ [https://perma.cc/ZX8X-SCPG] (calculating this figure).

52. Abortion Patients Are Disproportionately Poor and Low Income, Guttmacher Inst. (May 9, 2016), https://www.guttmacher.org/infographic/2016/abortion-patients-are-disproportionately-poor-and-low-income [https://perma.cc/WV62-8D9A] [hereinafter Guttmacher Inst., Abortion Patients].

53. Jenna Jerman, Lori Frohwirth, Meghan L. Kavanaugh & Nakeisha Blades, Barriers to Abortion Care and Their Consequences for Patients Traveling for Services: Qualitative

burdens of travel increasing as distances double, triple, or quadruple, 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.[54] Without funding, poor people and women of color 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. 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 with disabilities that make travel challenging.[55] As countless news stories have highlighted, many people with medical emergencies related to their pregnancies may also be denied a health- or life-saving abortion, and they too may be unable to travel.[56] Abortion costs with travel can add up to thousands of dollars.[57]

Clinics that remain open in this new era will be inundated with out-of-state patients, delaying care for in- and out-of-state patients alike.[58] Already, clinics in certain areas are booking over three weeks out or are not scheduling new patients due to the surge in demand.[59] Before *Dobbs*, California abortion providers served about 14,000 patients per year from other states;[60] with *Roe* overturned, one study estimates that an additional

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Findings From Two States, 49 Persps. on Sexual & Reprod. Health 95, 96 (2017) (noting that "barriers to abortion care—including travel and its associated costs, such as lost wages and expenses for child care, transportation and accommodations—may be significant for many women"); 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. Pub. Health 1687, 1689–91 (2014) ("[T]he most commonly reported reason for not obtaining an abortion after being denied one were procedure and travel costs . . . .").

54. See Jolie McCullough & Neelam Bohra, As Texans Fill Up Abortion Clinics in Other States, Low-Income People Get Left Behind, Tex. Trib. (Sept. 3, 2021), https://www.texastribune.org/2021/09/02/texas-abortion-out-of-state-people-of-color/ [https://perma.cc/S53S-V9SR].

55. See Cohen & Joffe, supra note 2, at 72–83 (describing the pre-*Roe* challenge of getting to a clinic).

56. See, e.g., 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 (on file with the *Columbia Law Review*) (last updated June 26, 2022).

57. Allison McCann, What It Costs to Get an Abortion Now, N.Y. Times (Sept. 28, 2022), https://www.nytimes.com/interactive/2022/09/28/us/abortion-costs-funds.html?smid=nytcore-ios-share&referringSource=articleShare&blm_aid=397749857/ (on file with the *Columbia Law Review*).

58. Margot Sanger-Katz, Claire Cain Miller & Josh Katz, Interstate Abortion Travel Is Already Straining Parts of the System, N.Y. Times: The Upshot (July 23, 2022), https://www.nytimes.com/2022/07/23/upshot/abortion-interstate-travel-appointments.html (on file with the *Columbia Law Review*).

59. Id.

60. See Adam Beam, California Plans to Be Abortion Sanctuary if *Roe* Overturned, AP News (Dec. 8, 2021), https://apnews.com/article/abortion-california-sanctuary-625a11

8,000 to 16,000 people will be traveling to the state for care.[61] A coalition of California officials and medical care professionals has scaled 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.[62]

As the next Part illustrates, 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.[63] Abortion-supportive states likewise have crafted legislation in anticipation of increased demand for services and the need to protect providers who offer care to patients who live out of state.[64]

Though the focus in the coming years will be on state efforts to outlaw or to protect abortion access, the federal government will 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*,[65] and multiple members of Congress have encouraged President Joseph Biden to explore leasing federal land

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8108bcda253196697c83548d5b [https://perma.cc/B85Y-XJ8Y] (noting that Planned Parenthood in California annually performs 7,000 abortions on out-of-state residents and represents about half of such abortions performed in California every year).

61. See Brad Sears, Cathren Cohen & Lara Stemple, People Traveling to California and Los Angeles for Abortion Care if *Roe v. Wade* Is Overturned 1 (2022), https://law.ucla.edu/sites/default/files/PDFs/Center_on_Reproductive_Health/California_Abortion_Estimates.pdf [https://perma.cc/RVS7-CXTS].

62. Id. at 1–2, 10.

63. See infra sections II.A–.C.

64. See infra section II.D. This Article has played an interesting role in the passage of these laws. For example, before the Article's appearance online in draft form, the authors had the privilege of advising legislators in Connecticut about options for protecting abortion providers. These legislators adopted many of the ideas appearing in this Article and molded them into a bill that the authors advised on and testified in support of. See generally Letter from David S. Cohen, Greer Donley & Rachel Rebouché, Law Professors, to Joint Comm. on the Judiciary, Conn. Gen. Assembly (Mar. 21, 2022), https://www.cga.ct.gov/2022/juddata/tmy/2022HB-05414-R000321-Cohen,%20David%20S.,%20Professor%20of%20Law-Drexel%20Kline%20School%20of%20Law-TMY.PDF [https://perma.cc/GP7V-RNLH]; CGA – Judiciary Committee, 3/21/22 JUD DV, Family, Victims Public Hearing, YouTube, at 04:12:10 (Mar. 21, 2022), https://youtu.be/10NDU433YFk?t=15131 (on file with the *Columbia Law Review*) (featuring the oral testimony of Professor David S. Cohen). This bill ultimately passed. See Pub. Act No. 22-19 (Conn. May 5, 2022) (codified as amended at Conn. Gen. Stat. Ann. §§ 54-82i(b), 54-162, 19a-602 (West 2022)).

65. See Fact Sheet: President Biden Announces Actions in Light of Today's Supreme Court Decision on *Dobbs v. Jackson Women's Health Organization*, The White House (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/ [https://perma.cc/S9FM-25S4] [hereinafter White House, Actions in Light of *Dobbs*].

to abortion providers.[66] Part III discusses the legal complexities of these actions.

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

Abortion made illegal in half of the country will be devastating for people seeking abortion generally and, as noted above, disproportionally so for poor people and women of color.[67] But legal scholarship has not yet explored or developed how abortion care will be different after *Roe*'s reversal, compared to a pre-*Roe* era.[68] The United States'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.[69]

One important difference between illegal abortion in the future and illegal abortion decades ago is that some people will be able to safely terminate a pregnancy without leaving their homes. With the uptake of mailed medication abortion, abortion travel will not be the only way to find a safe and effective abortion. Unlike the pre-*Roe* era, people can end their pregnancies without traveling to find a provider.

In 2000, the FDA approved the first drug to end a pregnancy: mifepristone (previously known as RU-486).[70] Today, medication abortion in the United States is accomplished with two drugs. The first, mifepristone, blocks the hormone progesterone, which is necessary for a pregnancy to continue.[71] The second drug, misoprostol, is typically taken

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66. See, e.g., Emma Platoff, Senator Elizabeth Warren Calls on Biden to Use Federal Lands to Protect Abortion Access, Bos. Globe, https://www.bostonglobe.com/2022/06/24/metro/senator-elizabeth-warren-calls-biden-use-federal-lands-protect-abortion-access/ (on file with the *Columbia Law Review*) (last updated June 24, 2022).

67. Khaleda 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 [https://perma.cc/D8FR-DW2R].

68. But see Rachel Rebouché, The Public Health Turn in Reproductive Rights, 78 Wash. & Lee L. Rev. 1355, 1416–28 (2021) (describing abortion access in the United States "without *Roe*").

69. See Yvonne (Yvette) Lindgren, When Patients Are Their Own Doctors: *Roe v. Wade* in an Era of Self-Managed Care, 107 Cornell L. Rev. 151, 169 (2021) ("The rate of abortion has remained relatively constant over time despite its illegality . . . ."); Michelle Oberman, What Will and Won't Happen When Abortion Is Banned, 9 J.L. & Biosciences 1, 3–4 (2022) (noting countries that ban abortion and still have relatively high abortion rates).

70. Greer Donley, Medication Abortion Exceptionalism, 107 Cornell L. Rev. 627, 638 (2022).

71. See id. at 633; see also Mifeprex (Mifepristone) Information, FDA, https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information [https://perma.cc/8E9Y-628C] [hereinafter FDA, Mifepristone Information] (last updated Dec. 16, 2021); Questions and Answers on Mifeprex, FDA, https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-

twenty-four-to-forty-eight hours after mifepristone and causes uterine contractions that expel the pregnancy from the uterus.[72] Misoprostol is not FDA-approved to terminate a pregnancy but is used off-label for this and a variety of other obstetric purposes.[73]

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 an abortion provider working at an abortion clinic.[74] 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.[75] It nevertheless maintained other restrictions on medication abortion that, based on evidence of the drug's safety and efficacy, are unnecessary and not applied to comparably safe drugs.[76]

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.[77] The new ease of access, facilitated by mailed delivery, will likely increase the number of persons utilizing these services moving forward.[78] 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

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and-providers/questions-and-answers-mifeprex/ [https://perma.cc/497Y-KDKC] [hereinafter FDA, Questions and Answers] (last updated Dec. 16, 2021).

72. See Donley, supra note 70, at 633; see also Rebecca Allen & Barbara M. O'Brien, Uses of Misoprostol in Obstetrics and Gynecology, 2 Revs. Obstetrics & Gynecology 159, 159–60 (2009).

73. Allen & O'Brien, supra note 72, at 161–62.

74. Donley, supra note 70, at 642.

75. FDA, Mifepristone Information, supra note 71.

76. See Letter from Patrizia A. Cavazzoni, Dir., Ctr. for Drug Evaluation & Rsch., FDA, to Donna J. Harrison, Exec. Dir., Am. Ass'n Pro-Life Obstetricians & Gynecologists & Quentin L. Van Meter, President, Am. Coll. of Pediatricians 6 (Dec. 16, 2021), https://www.regulations.gov/document/FDA-2019-P-1534-0016 [https://perma.cc/JWH9-XJN6] [hereinafter FDA, Cavazzoni Letter] (explaining that "healthcare provider certification and dispensing of mifepristone to patients with evidence or other documentation of safe use conditions continue to be necessary"); cf. Donley, supra note 70, at 651–67 (critiquing these remaining requirements as unnecessary and inappropriate).

77. 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 [https://perma.cc/5G2L-Q64J] [hereinafter Baker, Telemedicine Startups] (last updated Dec. 15, 2020); Rebouché et al., Safety Net, supra note 21.

78. See The Availability and Use of Medication Abortion, Kaiser Fam. Found. (Apr. 6, 2022), https://www.kff.org/womens-health-policy/fact-sheet/the-availability-and-use-of-medication-abortion/ [https://perma.cc/8TZS-S65N].

operates in twenty-two states.[79] The AOD founder, who writes patients' prescriptions, is a physician licensed in each of those twenty-two states. AOD initially prescribed medication abortion through eight weeks of pregnancy, rather than the ten weeks allowed by the FDA, and only for those over eighteen to ensure compliance with parental involvement restrictions.[80] According 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.[81]

AOD built the platform it uses with telehealth regulations in mind: The process is designed to protect patient privacy and to comply with the privacy protections of the Health Insurance Portability and Accountability Act.[82] It is the same for every state in which AOD operates, even in states with twenty-four hour waiting periods.[83] 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—typically takes between two to five days, depending on the state. 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.[84]

Before *Dobbs* and even with the in-person restriction jettisoned, remote abortion care was not available everywhere. Virtual providers could not operate in the nineteen states that had banned telemedicine for abortion or required in-person dispensation of abortion medication.[85]

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79. Where Is AOD Available?, Abortion on Demand, https://abortionondemand.org/ [https://perma.cc/JH6L-2JZ3] [hereinafter AOD, Where Is AOD Available?] (last visited Sept. 26, 2022). Remote medication abortion first became more broadly available two years ago after a federal district court issued an injunction that temporarily suspended in-person collection during the COVID-19 pandemic. See Am. Coll. of Obstetricians & Gynecologists v. U.S. Food & Drug Admin., 472 F. Supp. 3d 183, 233 (D. Md. 2020) (issuing "a preliminary injunction enjoining" the application of "In-Person Requirements contained in the mifepristone REMS as to medication abortion patients"), clarified by 2020 WL 8167535 (2020).

80. AOD, Where Is AOD Available?, supra note 79. Other virtual clinics, such as Choix and Hey Jane, provide medication abortion through ten weeks of pregnancy. Baker, Telemedicine Startups, supra note 77.

81. Telephone Interview with Jamie Phifer, Founder, Abortion on Demand (Aug. 3, 2021) (on file with the *Columbia Law Review*) [hereinafter AOD Interview].

82. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 264, 110 Stat. 1936, 2033–34 (codified as amended at 42 U.S.C. § 1320d-2).

83. Online counseling is time stamped and shipment of medication abortion does not mail until twenty-four hours have passed. Patients' digital signatures have an audit trail with an email only the patient has access to. AOD Interview, supra note 81.

84. Frequently Asked Questions, Abortion on Demand, https://abortionon demand.org/faq/ [https://perma.cc/N2J7-CL97] (last visited Sept. 2, 2022).

85. Guttmacher Inst., Medication Abortion, supra note 23.

Beyond the fourteen states that ban all abortion before ten weeks of pregnancy, an additional eight states require physician presence when medication abortion is dispensed.[86] AOD verifies that the patient is in a state permitting remote provision by tracking IP addresses to confirm location at patient intake.[87] 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.[88]

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 have built satellite sites or placed mobile clinics at antiabortion state borders to make telehealth visits easier.[89]

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.[90] 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.[91] Some virtual providers warn against trying to circumvent state law through, for example, VPNs or mail forwarding.[92] Extralegal strategies can have costs, particularly for those already vulnerable to state surveillance and punishment.[93] Though it is unclear how these extralegal strategies will be policed, the ability to receive abortion pills by mail in ways that defy detection is sure to encumber efforts to eliminate abortion in this country.[94]

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86. Rebouché, Remote Reproductive Rights, supra note 34, at 12.

87. AOD Interview, supra note 81.

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

89. Rebecca Pifer, Abortion Clinics Go Mobile, Seeking Flexibility Amid Patchwork State Restrictions, Healthcare Dive (Aug. 1, 2022), https://www.healthcaredive.com/news/abortion-mobile-state-law-roe-v-wade-dobbs/627178/ [https://perma.cc/YN7A-EUPY].

90. Baker, Telemedicine Startups, supra note 77.

91. How to Get Abortion Pill Access by Mail in Texas, Plan C, https://www.plancpills.org/states/texas#results-anchor/ [https://perma.cc/68PZ-VHDH] (last visited Sept. 7, 2022).

92. See AOD Interview, supra note 81. But see Donley, supra note 70, at 696 (noting that Plan C offers "detailed instructions" for mail-forwarding strategies).

93. See Donley, supra note 70, at 699 (noting the "serious legal risks associated with self-management").

94. See Greer Donley, Rachel Rebouché & David S. Cohen, Opinion, Abortion Pills Will Change a Post-*Roe* World, N.Y. Times (June 23, 2022), https://www.nytimes.com/2022/06/23/opinion/abortion-pills-online-roe-v-wade.html (on file with the *Columbia Law Review*) [hereinafter Donley et al., Post-*Roe* World] ("Medication

Third, people can (and do) circumvent legal requirements by ordering medication abortion online and having it delivered directly to their residence in the antiabortion state. Even when *Roe* was in place, gaining access to abortion was a struggle for many people, particularly those who lived in rural areas or below the poverty level.[95] Aid Access is an international nonprofit that offers medication abortion to people across the United States—including those who live in states that ban abortion—for $105.[96] 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.[97] The organization saw a dramatic increase in requests from Texans after SB 8, the law that bans abortion after detection of a fetal heartbeat or around six weeks, went into effect in September 2021.[98] 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.[99]

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

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abortion delivered through the mail opens up possibilities for cross-border care, even if that care is outlawed in the patient's state.").

95. Pruitt & Vanegas, supra note 49, at 81–83.

96. Consultation, Aid Access, https://aidaccess.org/en/i-need-an-abortion/ [https://perma.cc/M6G9-Z5HN] (last visited Sept. 7, 2022).

97. Id.

98. Abigail R.A. Aiken, Jennifer E. Starling, James G. Scott & Rebecca Gomperts, Association of Texas Senate Bill 8 With Requests for Self-Managed Medication Abortion, JAMA Network Open, Feb. 2022, at 1, 1; see also Tanya Basu, Activists Are Helping Texans Get Access to Abortion Pills Online, MIT Tech. Rev. (Sept. 15, 2021), https://www.technologyreview.com/2021/09/15/1035790/abortion-pills-online-texas-sb8/ [https://perma.cc/9ALT-6JJZ] (describing efforts to assist Texans seeking abortions after SB 8's passage).

99. Even under the Trump Administration, the federal government was unable to stop the organization. See Kimberly Kindy, Most Abortions Are Done at Home. Antiabortion Groups Are Taking Aim., Wash. Post (Aug. 14, 2022), https://www.washingtonpost.com/politics/2022/08/14/medicated-abortions-drugs-students-for-life/ (on file with the *Columbia Law Review*) (noting that "[t]he Trump administration unsuccessfully attempted in 2019 to shut down Aid Access's work in the United States"); Letter from Thomas Christi, Dir., Off. of Drug Sec., Integrity & Response, Ctr. for Drug Evaluation & Rsch., Food & Drug Admin., to Aidacess.org (Mar. 8, 2019), https://www.fda.gov/inspections-compliance-enforcement-and-criminal-investigations/warning-letters/aidaccessorg-575658-03082019/ [https://perma.cc/B9VM-HQJE] (threatening that if Aid Access continues to distribute abortion medication, the FDA may take "regulatory action, including seizure or injunction, without further notice").

this action as illegal.[100] 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.[101] 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.[102] Unlike the "back-alley abortions" of generations ago, self-managed medication abortion early in pregnancy opens the door for safe abortions 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 important limitations.[103] Even if medication abortion can be prescribed remotely in a safe way, there remain legal risks.[104] 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 nonexistent, suggests that enforcement of state abortion laws will target the people who seek abortion or those who assist them.[105] Poor people and people of color will be prosecuted disproportionately and face greater legal

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100. See Plan C, https://www.plancpills.org/ [https://perma.cc/L5P7-RJD5] (last visited Sept. 26, 2022); see also Patrick Adams, Opinion, Amid Covid-19, a Call for M.D.s to Mail the Abortion Pill, N.Y. Times (May 12, 2020), https://www.nytimes.com/2020/05/12/opinion/covid-abortion-pill.html (on file with the *Columbia Law Review*) (describing Plan C's background and organizing efforts to expand access to medication abortion).

101. In Tennessee, a physician is required to examine a patient before providing an abortion-inducing drug because—the statute claims—pregnant patients risk complications from the procedure if not monitored. H.B. 2416, 112th Gen. Assemb., 2d Sess. § 2 (Tenn. 2022) (codified as amended at Tenn. Code Ann. § 63-6-1104(a) (2022)). The statute takes effect on January 1, 2023. Id.

102. Abigail R.A. Aiken, Jennifer E. Starling, Alexandra van der Wal, Sascha van der Vliet, Kathleen Broussard, Dana M. Johnson, Elisa Padron, Rebecca Gomperts & James Scott, Demand for Self-Managed Medication Abortion Through an Online Telemedicine Service in the United States, 110 Am. J. Pub. Health 90, 95 (2020).

103. There may be new legal battles on the way as well, including the possibility that the FDA will face pressure to add or remove barriers to accessing medication abortion and whether the use of abortion-inducing drugs to start a period, rather than knowingly induce an abortion, will run afoul of bans. 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/ [https://perma.cc/E2C4-MW7Z]; see also Donley et al., Post-*Roe* World, supra note 94.

104. Donley, supra note 70, at 661–62.

105. See Andrea Rowan, Prosecuting Women for Self-Inducing Abortion: Counterproductive and Lacking Compassion, 18 Guttmacher Pol'y Rev. 70, 71 (2015) ("The advent of medication abortion has further allowed some women to take matters into their own hands; however, doing so has exposed them to the risk of criminal prosecution."); see also Greer Donley & Jill Wieber Lens, Abortion, Pregnancy Loss, & Subjective Fetal Personhood, 75 Vand. L. Rev. 1649, 1705–06 (2022).

risks compared to those who are white or have wealth.[106] The story of Lizelle Herrera offers a stark warning: In April 2022, Herrera was charged with murder for self-inducing an abortion. The charges were quickly dropped,[107] 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 those seeking to terminate pregnancies.

Another limitation is that the FDA has approved use of abortion pills only through the first ten weeks even though research suggests they can be safely used weeks beyond that and some providers prescribe it off-label through twelve weeks.[108] Though some people will use medication abortion past the ten-week limit, second- or third-trimester abortion patients will typically need clinics for procedural abortions.[109] However, as medication abortion becomes more prevalent at lower cost, the financial sustainability of brick-and-mortar clinics will be put to the test, even when facilities in abortion-supportive states see more patients.[110] Many facilities already operate at a loss, due in no small part to the costs of complying with state restrictions.[111] If more people access early abortion without clinic involvement, new issues of sustainability will arise for some clinics.

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106. Michele Goodwin, Policing the Womb: Invisible Women and the Criminalization of Motherhood 41–43 (2020) (illuminating the extent to which women of color and low-income people are disproportionately punished by increased surveillance and criminalization of pregnancy in the United States).

107. Giulia 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 (on file with the *Columbia Law Review*).

108. Donley, supra note 70, at 628–29 (describing the FDA's restrictions); Laurie McGinley & Katie Shepherd, FDA Eliminates Key Restriction on Abortion Pill as Supreme Court Weighs Case that Challenges *Roe v. Wade*, Wash. Post (Dec. 16, 2021), https://www.washingtonpost.com/health/2021/12/16/abortion-pill-fda/ (on file with the *Columbia Law Review*) (reporting that the drug's off-label use is safe).

109. Second trimester abortion is rare—only 6.2% of abortions occur in the second trimester. Third trimester abortions are extremely rare, accounting for less than 1% of abortions. 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. CDCs Abortion Surveillance System FAQs, CDC, https://www.cdc.gov/reproductivehealth/data_stats/abortion.htm [https://perma.cc/2HF6-XEJT] (last updated Nov. 22, 2021).

110. Cf. About Us, Abortion on Demand, https://abortionondemand.org/about/ [https://perma.cc/26DH-YNAK] (last visited Oct. 20, 2022) ("In order to ensure that pregnant people will always have a place to go when they need or want in-clinic care, AOD donates to Keep Our Clinics.").

111. Cf. Michelle L. McGowan, Alison H. Norris & Danielle Bessett, Care Churn: Why Keeping Clinic Doors Open Isn't Enough to Ensure Access to Abortion, 383 New Eng. J. Med. 508, 509 (2020) (noting that compliance costs contribute to "care churn"—"clinic-

As smaller clinics are driven out of business, large clinical centers will concentrate in the urban areas of states with supportive abortion laws.[112] Patients requiring abortions after the first trimester or who are not candidates for medication abortion—because of preexisting conditions, for example—will have fewer options outside of the most populous areas of certain states.[113]

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 28% of people using Google to search for abortion care attempt self-managed abortion, 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.[114] In the same study, only 18% used medication abortion.[115] The response to SB 8 in Texas provides another illustration. Although Aid Access received a large increase in requests from Texans after SB 8,[116] clinics across the country were also

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level instability of abortion care services and chronic uncertainty about potential closure or changes in service"); Max Zahn, Abortion Clinics in Embattled States Face Another Challenge: Money, ABC News (Aug. 15, 2022), https://abcnews.go.com/Business/abortion-clinics-embattled-states-face-challenge-money/story?id=87945089 [https://perma.cc/5UKT-2272] ("The budgets at many clinics strain under the weight of compliance with onerous regulations . . . [and] significant legal costs navigating a maze of measures at the federal, state and local level . . . .").

112. For instance, thinking ahead to the possibility of *Roe* being overturned, in 2019 Planned Parenthood opened a facility in Illinois designed as a regional hub. Grace Hauck, Planned Parenthood to Open Major Clinic in Illinois as 'Regional Haven' for Abortion Access, USA Today (Oct. 2, 2019), https://www.usatoday.com/story/news/nation/2019/10/02/illinois-planned-parenthood-mega-clinic-haven-abortion-access/3840714002/ [https://perma.cc/WU26-93NA] (last updated Oct. 3, 2019).

113. People taking certain kinds of blood thinners, for instance, are not good candidates for medication abortion. See GenBioPro, Mifepristone Prescribing Information 5 (2019), https://genbiopro.com/wp-content/uploads/2019/05/genbiopro-prescribing-information.pdf [https://perma.cc/2Q8L-ZDPC] (noting that a patient's anticoagulant therapy, or treatment with blood thinners, is a contraindication, grounds for not prescribing medication abortion). Particularly concerning is that people of color and low-income people are more likely to have preexisting conditions generally, conditions which render use of medication abortion ill-advised. See Ruqaiijah 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) (explaining key distinctions in medical treatment based on class and race).

114. Ushma D. Upadhyay, Alice F. Cartwright & Daniel Grossman, Barriers to Abortion Care and Incidence of Attempted Self-Managed Abortion Among Individuals Searching Google for Abortion Care: A National Prospective Study, 106 Contraception 49, 49 (2021). Respondents were permitted to identify multiple methods of self-managed abortion attempted; methods were not mutually exclusive. Id.

115. Id.

116. Basu, supra note 98.

inundated with demand from Texans.[117] While Aid Access may be significantly cheaper and more convenient than traveling for a legal abortion, prior to *Dobbs*, it had not become mainstream. Barriers to telehealth, described below, and fears about violating the law also likely impacted uptake.[118] In other words, given the legal risks, the need for abortion beyond the first trimester, and a lack of familiarity with abortion pills, abortion access will continue to depend on travel. And as noted, whether providers in abortion-supportive states can handle the influx of demand remains to be seen.[119]

A post-*Roe* country is a fractured legal landscape that necessitates time, resources, and tenacity to navigate. In the following two Parts, the Article sets out the jurisdictional complications that will arise. The picture that emerges is labyrinthine, and the ground covered is largely unexplored: Some states will assume roles as interstate abortion police, 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 nonexistent until this point,[120] antiabortion states are likely to attempt it

117. See Tuma, supra note 45 ("Texas patients are traveling hundreds and even thousands of miles from their homes to receive abortion procedures in places including Illinois, Washington, Ohio, California, Indiana, Tennessee, and Maryland."). The Guttmacher Institute reported that Texas patients were traveling to at least twelve other states. See Jones et al., supra note 45; see also Shefali Luthra, Abortion Clinics North of Texas Are Seeing Double the Number of Patients Than Before State Abortion Ban, 19th (Sept. 17, 2021), https://19thnews.org/2021/09/abortion-clinics-bordering-texas-are-seeing-double-the-number-of-patients/ [https://perma.cc/8CL2-HZ28].

118. See infra notes 505–537 and accompanying text for a discussion of such barriers.

119. See supra note 62 and accompanying text.

120. In 1996, a Pennsylvania woman was convicted 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 [https://perma.cc/AQ4V-JXSJ]; see also David Stout, Woman Who Took Girl for Abortion Is Guilty in Custody Case, N.Y. Times (Oct. 31, 1996), https://www.nytimes.com/1996/10/31/us/woman-who-took-girl-for-abortion-is-guilty-in-custody-case.html (on file with the *Columbia Law Review*) (reporting that the woman was ultimately convicted for violating a Pennsylvania parental-custody law facially unrelated to the abortion). Beyond that, there have been no publicized prosecutions for cross-border abortions. In theory, they could have happened even with *Roe* in place. 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. See Anne Godlasky, Nicquel Terry Ellis & Jim Sergent, Where Is Abortion Legal? Everywhere.

in the post-*Roe* future. This is hardly far-fetched: The antiabortion movement has been clear that the endgame is outlawing abortion nationwide.[121] 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."[122] Until there is a national ban, the movement will use state powers to stop as many abortions as possible, including outside state borders.

Missouri, which had almost no in-state abortions before *Dobbs* and roughly 10,000 of its residents traveling out of state to receive care each year,[123] has shown us the early phases of this strategy. In March 2021, a

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But . . . , USA Today (May 15, 2019), https://www.usatoday.com/in-depth/news/nation/2019/05/15/abortion-law-map-interactive-roe-v-wade-heartbeat-bills-pro-life-pro-choice-alabama-ohio-georgia/3678225002/ [https://perma.cc/H7WR-E3TE] (last updated Apr. 23, 2020); see also Rachel K. Jones & Jenna Jerman, Guttmacher Inst., Time to Appointment and Delays in Accessing Care Among U.S. Abortion Patients 8–9 & tbl.1 (2016), https://www.guttmacher.org/report/delays-in-accessing-care-among-us-abortion-patients [https://perma.cc/U95V-CACL] (finding that 7% of persons who obtained an in-clinic abortion did so "in a state other than the one they lived in"). To the best of available knowledge, none of these patients were prosecuted for doing so.

121. See Ximena Bustillo, Who and What Is Behind Abortion Ban Trigger Law Bills? Two Groups Laid the Groundwork, NPR (July 8, 2022), https://www.npr.org/2022/07/08/1110299496/trigger-laws-13-states-two-groups-laid-groundwork [https://perma.cc/HL2S-RPBQ] (describing the efforts of the National Right to Life Committee and Americans United for Life to enact a nationwide abortion ban). 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 of Amici Curiae Scholars of Jurisprudence John M. Finnis and Robert P. George in Support of Petitioners at 4–27, Dobbs v. Jackson Women's Health Org., No. 19-1392 (U.S. June 24, 2022), 2021 WL 3374325 (arguing that unborn children are constitutional persons entitled to equal protection of the laws).

122. Kitchener, *Roe*'s Gone, supra note 12 (internal quotation marks omitted) (quoting Kristan Hawkins, President of Students for Life).

123. See Kan. Dep't of Health & Env't, Abortions in Kansas, 2020: Preliminary Report 7 (2021), https://www.kdhe.ks.gov/DocumentCenter/View/10433/Abortions-in-Kansas-2020-PDF [https://perma.cc/NT2R-TAUS] (reporting that 3,201 Missourians obtained abortions in Kansas in 2020); Abortion Statistics, Ill. Dep't of Pub. Health, https://dph.illinois.gov/data-statistics/vital-statistics/abortion-statistics.html [https://perma.cc/QT4L-73EV] (last visited Sept. 2, 2022) (reporting that 6,578 Missourians obtained abortions in Illinois in 2020). These numbers are more than three times as large as the preliminary estimates from the Missouri Department of Health and Senior Services. See Josh Merchant, Nearly Half of Abortions in Kansas Are for Missouri Residents, but Voters Could End That, KCUR (Nov. 20, 2021), https://www.kcur.org/news/2021-11-20/nearly-half-of-abortions-in-kansas-are-for-missouri-residents-but-voters-could-end-that [https://perma.cc/N2QF-RUHU] (presenting estimates from the Missouri Department of Health and Senior Services that 3,391 Missourians traveled outside the state for abortion services, information accessible by hovering over the last yellow bar in the graph titled "In-state and out-of-state abortions for Missouri residents, 2007–2020"). According to state records, only 167 abortions occurred in Missouri in 2020, a decrease of 97% from a decade earlier. Id.

legislator introduced SB 603, 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 is 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.[124]

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 occurred, or helps someone from Missouri leave the state to get an abortion.[125] In the manner of Texas's SB 8, these provisions would have been enforced through civil suits rather than the criminal law, making it harder for courts to strike them down as unconstitutional.[126] After receiving national attention, this amendment failed to be included in the final bill,[127] 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.[128]

Not to be outdone by Missouri, Texas politicians have sought to restrict out-of-state abortions. The Texas Freedom Caucus, a group of antiabortion state legislators, issued cease and desist letters announcing the group's intention to target anyone who helps pay for an abortion "regardless of where the abortion occurs."[129] The state's attorney general is being sued in federal court over statements he has made indicating that abortion funds that assist Texans traveling out of state could be

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124. S.B. 603, 101st Gen. Assemb., 1st Reg. Sess. § 188.550.1(2), (3)(a), (3)(c) (Mo. 2021).

125. H.R. Journal, 101st Gen. Assemb., 2d Reg. Sess., at 1623–1630 (Mo. 2022), https://www.house.mo.gov/billtracking/bills221/jrnpdf/jrn042.pdf [https://perma.cc/2PTM-8MTX].

126. See id. at 1625; see also infra notes 259–263 and accompanying text discussing SB 8.

127. Tessa Weinberg, Missouri House Blocks Effort to Limit Access to Out-of-State Abortions, Mo. Indep. (Mar. 29, 2022), https://missouriindependent.com/2022/03/29/missouri-house-blocks-effort-to-limit-access-to-out-of-state-abortions/ [https://perma.cc/M7WT-5NKS].

128. Kitchener, *Roe*'s Gone, supra note 12 (describing Representative Elizabeth Mary Coleman as "eager to restrict abortion across state lines" and other legislative priorities of antiabortion legislators following *Dobbs*).

129. See, e.g., Letter from Mayes Middleton, Rep., Tex. H.R., to Yvette Ostolaza, Chair of the Mgmt. Comm., Sidley Austin LLP 1–3 (July 7, 2022), https://www.freedomfortexas.com/uploads/blog/3b118c262155759454e423f6600e2196709787a8.pdf [https://perma.cc/Y2KS-XJ27] (describing proposed legislation including this language and threatening law firm Sidley Austin with criminal prosecution for providing financial assistance to employees who seek abortions out of state).

prosecuted.[130] Moreover, within the state, several cities have passed ordinances declaring themselves "sanctuary cities for the unborn."[131] At least one of them has included in its ordinance a provision that bans city residents from getting abortions "regardless of where the abortion is or will be performed."[132]

Warnings about cross-border abortion restrictions are far from the "'ridiculous' scaremongering" the general counsel for the National Right to Life Committee has claimed they are.[133] In fact, that organization's model post-*Roe* law—a document drafted by the general counsel—includes a provision that prohibits assisting minors "[r]egardless of where an illegal abortion occurs."[134] Bills like those discussed here could become a reality in coming legislative sessions.

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 trust that as long as they follow the laws of the state where they are physically located, they are acting lawfully. Take fireworks or casino gambling as examples: The person who travels from a state that bans fireworks sales or casino gambling to purchase fireworks in another state or to gamble in Las Vegas would not expect her home state to punish her for evading its laws.

This sense of how law works across state borders finds some support in various constitutional doctrines. The Fifth and Fourteenth Amendments' Due Process Clauses have long protected a right to travel as part of their protections for liberty.[135] The Fourteenth 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

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130. Karen Brooks Harper, Abortion-Rights Groups Sue Texas AG, Prosecutors to Protect Ability to Help Pregnant Texans Seek Legal Abortions in Other States, Tex. Trib. (Aug. 23, 2022), https://www.texastribune.org/2022/08/23/abortion-funds-lawsuit-texas-travel/ [https://perma.cc/5HJS-79T8]; Eleanor Klibanoff, Attorney General Ken Paxton Ordered to Testify in Abortion Lawsuit After Evading Subpoena, Tex. Trib. (Oct. 4, 2022), https://www.texastribune.org/2022/10/04/ken-paxton-abortion-lawsuit-subpoena/ [https://perma.cc/2VMA-CAP4].

131. Sanctuary Cities for the Unborn, Tex. Right to Life, https://texasrighttolife.com/sanctuary-cities-for-the-unborn/ [https://perma.cc/BF8Q-LEK8] (last visited Sept. 27, 2022).

132. Slaton, Tex., Ordinance 816, at 7 (2021) (on file with the *Columbia Law Review*).

133. Nina Shapiro, Could Idaho Accuse a Washington Abortion Clinic of Murder? Some Are Worried, Chronicle (June 22, 2022), https://www.chronline.com/stories/could-idaho-accuse-a-washington-abortion-clinic-of-murder-some-are-worried,295760 [https://perma.cc/E8XH-H7KM] (quoting James Bopp, Jr., Gen. Couns., Nat'l Right to Life Comm.).

134. NRLC Model Law, supra note 15, at 14.

135. See, e.g., Jones v. Helms, 452 U.S. 412, 418–19 (1981) ("The right to travel has been described as a privilege of national citizenship, and as an aspect of liberty that is protected by the Due Process Clauses of the Fifth and Fourteenth Amendments."); Kent v. Dulles, 357 U.S. 116, 125 (1958) ("The right to travel is a part of the 'liberty' of which the citizen cannot be deprived without the due process of law under the Fifth Amendment.").

citizenship.[136] And the Dormant Commerce Clause prohibits certain state burdens on interstate commerce, including some that have extraterritorial effect.[137] As explained in detail below, however, 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. First, section II.A sets forth the thin body of precedent regarding extraterritoriality in abortion law. Then, section II.B considers 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. Section II.C then analyzes whether there are constitutional impediments to states passing and enforcing new laws that specifically target out-of-state abortion.[138] 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.

One further note: 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,[139] vicinage,[140] and problems of proof particular to interstate investigations.[141] It is for these reasons that antiabortion states, and even

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136. See, e.g., Saenz v. Roe, 526 U.S. 489, 511 n.27 (1999) ("[I]t is a privilege of citizenship of the United States . . . to enter any state of the Union, either for temporary sojourn or for the establishment of permanent residence therein and for gaining resultant citizenship thereof." (first alteration in original) (internal quotation marks omitted) (quoting Edwards v. California, 314 U.S. 160, 183 (1941) (Jackson, J., concurring))).

137. See, e.g., Healy v. Beer, Inst., 491 U.S. 324, 337 n.14 (1989) ("[T]he critical consideration in determining whether the extraterritorial reach of a statute violates the [Dormant] Commerce Clause is the overall effect of the statute on both local and interstate commerce." (citing Brown-Forman v. N.Y. State Liquor Auth., 476 U.S. 573, 579 (1986))).

138. These constitutional considerations would also apply to a state using already-existing laws to prosecute abortion travel. See infra sections II.B–.C for a discussion of these topics.

139. See Int'l Shoe Co. v. Washington, 326 U.S. 310, 316 (1945) (requiring "minimum contacts" with the forum state to have personal jurisdiction that comports with due process); Bullion v. Gillespie, 895 F.2d 213, 216–17 (5th Cir. 1990) (finding personal jurisdiction proper in Texas when a California doctor mailed medication to a patient in Texas).

140. See U.S. Const. amend. VI ("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 . . . ."); see also Seth F. Kreimer, Lines in the Sand: The Importance of Borders in American Federalism, 150 U. Pa. L. Rev. 973, 1018 (2002) (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").

141. Susan Frelich Appleton, Gender, Abortion, and Travel After *Roe*'s End, 51 St. Louis U. L.J. 655, 657–59 (2007) (discussing problems of proof in extraterritorial application of abortion laws).

the federal government under the Trump Administration, have not been able to stop Aid Access from delivering abortion pills in their states.[142] 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 U.S. 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.[143] The first is a lesser-known U.S. Supreme Court case, *Bigelow v. Virginia*.[144] That case concerned a Virginia statute prohibiting any publication from encouraging people to obtain an abortion.[145] 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.[146] The Virginia Supreme Court twice upheld the conviction of the newspaper's managing editor for violating the Virginia statute, both before and after *Roe* was decided.[147]

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, was infringing on its citizens' ability to travel to New York for an abortion.[148] 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

142. Rachel M. Cohen, The Abortion Provider that Republicans Are Struggling to Stop, Vox (May 7, 2022), https://www.vox.com/23056530/aid-access-abortion-roe-wade-pills-mifepristone/ [https://perma.cc/S2TL-NLGA] (detailing unsuccessful government efforts to stop Aid Access).

143. *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 possible now that *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, this section does not include *Doe* in this line of precedent that has already addressed the issues covered here.

144. 421 U.S. 809 (1975).

145. Id. at 811.

146. Id. at 811–12. For additional background on the passage of the New York state law, see 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 [https://perma.cc/T7SL-6WJ2].

147. *Bigelow*, 421 U.S. at 814–15.

148. Id. at 812–13.

the State conceded [at oral argument], prosecute them for going there."[149] 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."[150]

The other case comes from Missouri, and it relied on *Bigelow* to reach the same conclusion. In *Planned Parenthood of Kansas v. Nixon*, the Missouri Supreme Court reviewed a Missouri law providing a civil cause of action against any person who caused a minor to obtain, or aided or abetted them in obtaining, an abortion without first getting parental consent or a judicial bypass.[151] As part of the lawsuit, the plaintiffs lodged a challenge to a unique provision of the Missouri law that effectively required Missouri minors who traveled out of state for an abortion to follow Missouri's parental consent law, even if the other state had a different requirement for parental involvement or none whatsoever.[152]

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."[153] Because of this principle against extraterritorial application, the court held that the law was only valid as to conduct occurring at least in part in Missouri.[154] 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."[155]

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.[156] The current U.S. Supreme Court, now that it has eviscerated *Roe*, could revisit *Bigelow*'s anti-extraterritoriality principle.[157] Moreover, scholars have argued for decades

149. Id. 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.").

150. Id. at 824.

151. 220 S.W.3d 732, 736 (Mo. 2007) (en banc).

152. Id. at 744–45.

153. Id. at 742 (citing *Bigelow*, 421 U.S. at 827–28).

154. See id. at 742–43.

155. Id. at 743.

156. See *Bigelow*, 421 U.S. at 821–22 (noting that appellant's First Amendment interests as a news service supplied a basis for overturning the conviction and referencing *Roe* to reiterate that Virginia's statute prohibited activity that "pertained to constitutional interests").

157. The question of *Bigelow*'s continuing validity looms as yet another complicated constitutional issue now that *Roe* has been overturned. Cf. Cat Zakrzewski, South Carolina

about whether *Bigelow*'s statements against extraterritorial application are mere dicta.[158] *Nixon* is applicable only in Missouri, gives no clear guidance as to what is "conduct that occurs wholly outside" the state,[159] and has never been cited by any court for its discussion of extraterritorial application of state law.[160]

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*.[161] 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.[162] 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?[163]

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/ (on file with the *Columbia Law Review*) (describing a South Carolina law that—analogously to the Virginia law in *Bigelow* that criminalized advertising abortion services—criminalizes providing online information on abortion access, thereby providing an opportunity for the U.S. Supreme Court to revisit *Bigelow*'s holding).

158. Compare Seth F. Kreimer, The Law of Choice and Choice of Law: Abortion, the Right to Travel, and Extraterritorial Regulation in American Federalism, 67 N.Y.U. L. Rev. 451, 459–63 (1992) [hereinafter Kreimer, Law of Choice] (arguing that the extraterritorial principle in *Bigelow* is not simply dictum), with Mark D. Rosen, Extraterritoriality and Political Heterogeneity in American Federalism, 150 U. Pa. L. Rev. 855, 891 (2002) [hereinafter Rosen, Heterogeneity] (arguing that "a careful review" of *Bigelow*'s discussion of extraterritoriality strongly supports the conclusion that it is dictum), and Mark D. Rosen, "Hard" or "Soft" Pluralism?: Positive, Normative, and Institutional Considerations of States' Extraterritorial Powers, 51 St. Louis U. L.J. 713, 723–25 (2007) [hereinafter Rosen, Pluralism] (arguing that "the language from *Bigelow* was dicta" and, if taken literally, would disrupt various doctrines of constitutional law "without so much as mentioning" them).

159. *Nixon*, 220 S.W.3d at 742.

160. Cf., e.g., State v. Collins, 648 S.W.3d 711, 716 (Mo. 2022) (en banc) (citing *Nixon* for a proposition about construing statutes narrowly to avoid constitutional complications); Bldg. Owners & Managers Ass'n of Metro. St. Louis, Inc. v. City of St. Louis, 341 S.W.3d 143, 149 (Mo. Ct. App. 2011) (citing *Nixon* for a proposition about ripeness of pre-enforcement constitutional claims).

161. Medication abortion was approved by the FDA in 2000. See supra note 70 and accompanying text. In 2007, when *Nixon* was decided, medication abortion accounted for just under 17% of abortions nationwide, compared to 54% in 2020. See Rachel K. Jones, Elizabeth Nash, Lauren Cross, Jesse Philbin & Marielle Kirstein, Medication Abortion Now Accounts for More Than Half of All US Abortions, Guttmacher Inst. (Feb. 24, 2022), https://www.guttmacher.org/article/2022/02/medication-abortion-now-accounts-more-half-all-us-abortions/ [https://perma.cc/VHZ7-PU6D] (last updated Mar. 2, 2022) (graphing this information).

162. See supra section I.B.

163. See, e.g., Katheryn Houghton & Arielle Zionts, Montana Clinics Preemptively Restrict Out-of-State Patients' Access to Abortion Pills, NPR (July 7, 2022),

Thus, this area of law is ripe for reassessment once interjurisdictional abortion prosecutions occur. Antiabortion states and cities will not wait for the U.S. Supreme Court to give them permission to apply their laws extraterritorially; as the Missouri bills and sanctuary city ordinances described above make clear, they will just do it.[164] It could take years before the litigation surrounding these developments reaches the Court, and in the meantime, states will try what they can to stop abortion, waiting for courts to call their bluff. Litigation surrounding Texas's SB 8 illustrates that some courts will exploit any legal uncertainty to uphold abortion restrictions. No one believed SB 8 was constitutional, yet it has survived court challenges and effectively outlawed a large portion of abortions in Texas nine months before *Dobbs*.[165] Indeed, the 2022 Missouri bill relied on a similar enforcement mechanism as SB 8, ostensibly to shield the law, if enacted, from federal court review.[166] 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.

B. *Extraterritorial Criminal Law*

If Kentucky does ban abortion after *Dobbs*, can Kentucky prosecutors apply, for instance, Kentucky's abortion ban—which says nothing about extraterritorial application—to someone from Kentucky who travels to Illinois to obtain an abortion that is legal there 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 could be applied to legal, out-of-state abortions or to travel to obtain them. 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.[167]

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https://www.npr.org/sections/health-shots/2022/07/07/1110078914/montana-abortion-pills [https://perma.cc/F4W3-ZJ4M].

164. See supra notes 16–18 and accompanying text.

165. See Whole Woman's Health v. Jackson, 141 S. Ct. 2494, 2495–96 (2021) (declining to enjoin the enforcement of SB 8 while emphasizing that the decision was "not based on any conclusion about the constitutionality of Texas's law"); Whole Woman's Health v. Jackson, 31 F.4th 1004, 1006 (5th Cir. 2022) (per curiam) (directing the district court to "dismiss all challenges to the private enforcement provisions of the statute").

166. See supra note 124 and accompanying text.

167. See, e.g., Commonwealth v. Dischman, 195 A.3d 567, 568 & n.1 (Pa. Super. Ct. 2018) (involving a charge against a pregnant woman for violating state "aggravated assault of an unborn child" law despite clear language in the statute that the law could not be

As a general matter, states cannot use ordinary criminal laws to prosecute people for crimes committed outside of their borders.[168] This "general rule" is, according to the Massachusetts Supreme Judicial Court, "accepted as 'axiomatic' by the courts in this country."[169] This general rule against extraterritorial application of criminal law, however, 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 the 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."[170] This doctrine could have a sweeping impact without *Roe*. Take Georgia's six-week abortion ban: It was passed in 2019 and immediately enjoined as unconstitutional but is now back in effect after *Dobbs*.[171] In addition to banning abortion at six weeks, it also declared that "unborn children are a class of living, distinct persons" who deserve "full legal protection."[172] 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 recognition."[173] An aggressive prosecutor could use the effects doctrine to argue that the out-of-state killing has the in-state effect of removing a recognized member of

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construed to "impose criminal liability . . . [u]pon the pregnant woman in regard to crimes against her unborn child" (alteration in original) (internal quotation marks omitted) (quoting 18 Pa. Stat. and Cons. Stat. Ann. § 2608(a)(3) (West 1997))).

168. Much of the discussion in this section and the one that follows covers *criminal* law. Many of the same considerations, though not all, apply to extraterritorial application of civil law, especially punitive civil laws like SB 8. See infra note 259. Additional considerations beyond the scope of this Article arise as well, such as principles in the field of choice of laws. See, e.g., Appleton, supra note 141, at 677–82 (discussing conflict of laws questions arising out of application of tort liability and statutory causes of actions against extraterritorial abortion).

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

170. 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) (noting, in the context of a state's fraud prosecution, that "[a]cts done outside a jurisdiction, but . . . producing detrimental effects within it, justify a State in punishing the cause of the harm as if he had been present at the effect").

171. See H.B. 481, 155th Gen. Assemb., Reg. Sess. (Ga. 2019) (codified as amended at Ga. Code Ann. § 16-12-141 (2022)); see also SisterSong Women of Color Reprod. Just. Collective v. Governor of Ga., 40 F.4th 1320, 1323–24 (11th Cir. 2022) (permitting the law's enforcement after *Dobbs*).

172. See Ga. H.B. 481, § 2(3)–(4); see also Ga. Code Ann. § 16-12-141 (2022) (recording in the section notes that the legislature made quoted findings but declined to codify them).

173. See Ga. H.B. 481, § 2(3)–(4).

the Georgia community from existence. While prosecutions for murders occurring in another state are rare under this doctrine,[174] states and prosecutors seeking to enforce new criminal laws 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, reaching anyone involved with the killing of a "living, distinct" resident of a state with an abortion ban. 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 myriad 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.[175]

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,[176] 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, or solicitation of a conspiracy; or an omission of a legal duty.[177] 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."[178]

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174. See, e.g., Heath v. Jones, 941 F.2d 1126, 1139 (11th Cir. 1991) (allowing prosecution in Alabama of a murder that took place in Georgia); State v. Willoughby, 892 P.2d 1319, 1330–32 (Ariz. 1995) (allowing prosecution in Arizona for a murder that took place in Mexico).

175. 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), https://www.npr.org/sections/itsallpolitics/2011/11/08/142159280/mississippi-voters-reject-personhood-amendment [https://perma.cc/YP7J-KR3C] (noting that in 2010, Mississippi voters, concerned about the "troubling prospects" of declaring fetuses legal persons, rejected a state constitutional amendment that "would have legally defined human life at the moment of fertilization"). But there is no reason to be confident that would be the case in the future, especially with an energized antiabortion movement now that *Roe* is overturned.

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

177. 18 Pa. Stat. and Cons. Stat. Ann. § 102(a)(1)–(5) (West 1997).

178. Id. § 102(a)(6); see generally Commonwealth v. Peck, 242 A.3d 1274 (Pa. 2020) (discussing the application of the jurisdictional statute to out-of-state drug crimes).

Provisions like these create opportunities for chaos in the application of criminal laws to extraterritorial conduct. The scenarios outlined above with respect to Georgia's personhood law are illustrative.[179] 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 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.[180] As Chin points out, statutes like Pennsylvania's generally "require that the offense be criminalized in the out-of-state jurisdiction."[181] However, not all states follow this rule. The California Supreme Court reserved this question "for another day,"[182] and Alabama's criminal jurisdiction statute leaves out the requirement that the crime be punishable in the destination state.[183]

These wrinkles become even more visible in the context of medication abortion, when the provider might follow their home state's laws by prescribing pills to an out-of-state patient who travels to the abortion-supportive state to obtain the medication, but then returns to

179. See supra notes 171–174 and accompanying text.

180. Generally, a conspiracy exists when two or more people intend to promote or facilitate the commission of a crime and an overt act is committed in furtherance of the agreement. See, e.g., 18 Pa. Stat. and Cons. Stat. Ann. § 903(a), (e) (West 1978).

181. Chin, supra note 176, at 951–52.

182. 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.").

183. See Ala. Code § 13A-4-4 (1975) ("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 as 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 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.

take the pills in the patient's antiabortion home state. Returning to the Kentucky–Illinois jurisdictional hypothetical above, would the illegal act be the provider's actions that occurred in Illinois, where abortion was legal, or the patient's actions in Kentucky, where it was not? 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.[184]

C. *Extraterritoriality and the Constitution*

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.[185] 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 who obtains or helps someone obtain an abortion anywhere, not just in the state.[186] 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 from aiding or abetting someone in traveling out of state to get an abortion.

Without well-established doctrine or case law as guideposts, a small cohort 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;[187] those who believe it would not;[188] 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.[189]

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

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184. See supra section I.B (detailing current regulations on and availability of medication abortion).

185. These constitutional issues also arise in the situations described in the previous section—when state prosecutors attempt to use already-existing criminal laws to capture cross-border abortion care. See supra section II.B.

186. See supra notes 124–128 and accompanying text.

187. See infra notes 190–196 and accompanying text.

188. See infra notes 197–203 and accompanying text.

189. See infra notes 204–206 and accompanying text.

explained that the Constitution's framers 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.[190] This commitment is evident in the Commerce Clause, Article IV's Privileges and Immunities Clause, and the Citizenship Clause of the Fourteenth Amendment.[191] In a separate article, he argued that, normatively, the right to travel to other states and take advantage of their laws is an essential component of liberty[192] and that to further the Constitution's goal of "establishing a single 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.[193] 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."[194]

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.[195] Taking a different approach, Professor Susan Lorde Martin, though touching on abortion only passingly, opined that the modern Dormant Commerce Clause doctrine prohibits extraterritorial

190. See Kreimer, Law of Choice, supra note 158, at 464–72 (explaining how, at both the founding and at the time of the Civil War amendments, "the [constitutional] equilibrium . . . apportioned each state moral sovereignty within its own boundaries and obliged neighboring states to accede to that sovereignty"); id. at 497–508 (explaining the role of the conception of national citizenship in the Constitution and its relation to a national right to travel).

191. See id. at 488–97 (arguing that "[f]or state citizens who seek more hospitable jurisdictions in which to engage in morally-contested activities barred to them at home, the federal protection of interstate commerce offers shelter"); id. at 497–508 (explaining that "[t]he purpose of the privileges and immunities clause . . . was to recognize a national identity" which entailed a "right of citizens of each of the newly-formed United States to travel among the states on a basis of equality," a purpose furthered with the Fourteenth Amendment).

192. Seth F. Kreimer, "But Whoever Treasures Freedom . . . ": The Right to Travel and Extraterritorial Abortions, 91 Mich. L. Rev. 907, 914–15 (1993).

193. Id. at 919–21 ("[A] system in which my opportunities upon entering California remain subject to the moral demands of Pennsylvania undercuts this sense of national unity.").

194. Id. at 938.

195. 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, 1121–22 (2009) (arguing that, compared with ex ante regulation, the imposition of liability "tends to imply less of a moral judgment" and "permits prospective actors more freedom to continue to engage in the conduct at issue").

application of a state's laws; indeed, she called this principle a "bedrock of a federalist system."[196]

At the other end of the spectrum lie 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.[197] According to Rosen, the Supreme Court, state courts, and model codes have long supported states regulating out-of-state activity.[198] Rosen recognized that the Constitution places some limits on extraterritorial application of state law, but he argued that those narrow doctrines have no applicability when one state applies its criminal law to its own citizens acting in another state.[199] Allowing states to determine the reach of their own powers, according to Rosen, is normatively preferable to prevent people picking and choosing which state policies to follow and to ensure that states are actually able to enact and enforce different policies that suit their interests.[200]

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.[201] Professor William Van Alstyne similarly contended that there is no constitutional right to "eva[de]" your home state's criminal law by traveling to another state,[202] and Professor Joseph Dellapenna

196. See Susan Lorde Martin, The Extraterritoriality Doctrine of the Dormant Commerce Clause Is Not Dead, 100 Marq. L. Rev. 497, 526 (2016).

197. Rosen, Heterogeneity, supra note 158, at 896–933 (discussing Article IV's Privileges and Immunities Clause, the right to travel, and the Dormant Commerce Clause); Rosen, Pluralism, supra note 158, at 726–30, 733–38 (discussing the Dormant Commerce Clause, Article IV's Privileges and Immunities Clause, the right to travel, and the Citizenship Clause of the Fourteenth Amendment); Mark D. Rosen, State Extraterritorial Powers Reconsidered, 85 Notre Dame L. Rev. 1133, 1134 (2010) [hereinafter Rosen, State Extraterritoriality Powers] (critiquing Professor Katherine Florey's treatment of due process and the Dormant Commerce Clause and suggesting that "the Constitution itself does not set the limits on state extraterritorial powers"). Rosen is clear in his work that Congress could enter this field and prohibit extraterritoriality. See Rosen, State Extraterritoriality Powers, supra, at 1134.

198. See Rosen, Pluralism, supra note 158, at 719–23.

199. See id. at 733–40.

200. Rosen, Heterogeneity, supra note 158, at 883–91.

201. 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).

202. See William Van Alstyne, Closing the Circle of Constitutional Review From *Griswold v. Connecticut* to *Roe v. Wade*: An Outline of a Decision Merely Overruling *Roe*, 1989 Duke L.J. 1677, 1684–85.

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.[203]

The third camp straddles these two positions. Unlike the other two, which hold either that constitutional law already permits or prohibits such state laws, the third camp believes constitutional law provides no clear answers to these questions that can be separated from the various legal issues associated with abortion itself. Professor Richard Fallon took this approach: If *Roe* were overturned, he maintains, then "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."[204] After surveying the issues, Fallon explained that he could not "pronounce a confident judgment" but had "no hesitation in concluding that this question would be a difficult one that is not clearly resolved" by Supreme Court precedent.[205] 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."[206]

While the first camp is more convincing both doctrinally and normatively, Fallon's and Appleton's position is 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 intrusion.[207] Only once has the Court used the clause to strike down

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203. See Joseph W. Dellapenna, Abortion Across State Lines, 2008 BYU L. Rev. 1651, 1694; cf. Reva B. Siegel, ProChoiceLife: Asking Who Protects Life and How—And Why It Matters in Law and Politics, 93 Ind. L.J. 207, 218–21 (2018) (explaining that "large numbers of women who choose abortion are poor and end pregnancies as a way of preserving scant resources to support themselves and their families").

204. Richard H. Fallon, Jr., If *Roe* Were Overruled: Abortion and the Constitution in a Post-*Roe* World, 51 St. Louis U. L.J. 611, 613 (2007).

205. Id. at 632.

206. Appleton, supra note 141, at 682–83.

207. Slaughter-House Cases, 83 U.S. (16 Wall.) 36, 78–80 (1873) (providing a very narrow reading of the rights protected by the clause).

a state law.[208] Since then, the Court has not taken any opportunity to further develop the clause's jurisprudence.[209]

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."[210] 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.[211] Commentators have noted the confusion, calling it "all but clear"[212] and bemoaning the "difficulty of its application," which has resulted in "courts struggl[ing] to define the extraterritorial principle's precise scope."[213] Yet, the extraterritoriality principle continues to appear in lower court opinions from time to time as the basis for striking down the occasional law,[214] and the Supreme Court, in its 2022 term, will decide whether the principle is "now a dead letter."[215] Similarly, outside of debates about

208. See Saenz v. Roe, 526 U.S. 489, 502–07 (1999) (holding that the right to travel prohibits states from imposing durational residency requirements that withhold the privileges and immunities of a state's citizens from people who have newly arrived in that state). The Court did rely on the clause to strike down a state law that imposed a discriminatory income tax on out-of-state loans in Colgate v. Harvey, 296 U.S. 404, 419 (1935), but overruled that decision five years later in Madden v. Commissioner, 309 U.S. 83, 93 (1940).

209. *Saenz* has been cited only seven times by the Court and only twice in a majority opinion. See Alden v. Maine, 527 U.S. 706, 751 (1999) (citing *Saenz* merely for a general quote about federalism); see also Cameron v. EMW Women's Surgical Ctr., P.S.C., No. 20-601, slip op. at 7 (U.S. Mar. 3, 2022) (quoting *Alden* which in turn quotes *Saenz* for the general federalism proposition).

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

211. Id.; see also Am. Beverage Ass'n v. Snyder, 735 F.3d 362, 378 (6th Cir. 2013) (Sutton, J., concurring) (describing the doctrine as "a relic of the old world with no useful role to play in the new").

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

213. Recent Case, Dormant Commerce Clause—Extraterritoriality Doctrine—Fourth Circuit Invalidates Maryland Statute Regulating Price Gouging in the Sale of Generic Drugs.—Association for Accessible Medicines v. Frosh, 887 F.3d 664 (4th Cir. 2018), 132 Harv. L. Rev. 1748, 1748 (2019); see also Brannon P. Denning, Extraterritoriality and the Dormant Commerce Clause: A Doctrinal Post-Mortem, 73 La. L. Rev. 979, 990–92 (2013) (arguing that Pharmaceutical Research & Manufacturers of America v. Walsh, 538 U.S. 644 (2003), marked the Court's abandonment of a freestanding rule against extraterritorial regulation under the Dormant Commerce Clause doctrine).

214. See Ass'n for Accessible Meds. 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").

215. See Petition for a Writ of Certiorari at i, Nat'l Pork Producers Council & Am. Farm Bureau Fed'n v. Ross, No. 21-468, 2021 WL 4480405 (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 this Court's decisions is now

birthright citizenship, the Citizenship Clause's implications for federal identity—and the promotion of a national citizenship that underpins a right to travel[216]—have long been "[n]eglected by courts and scholars."[217]

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 Brett Kavanaugh's *Dobbs* concurrence indicated his support for constitutional protection for the right to travel.[218] 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,[219] the opinion's limited view of substantive due process has caused many commentators to question the strength of the doctrine's foundation as a whole.[220] Justice Clarence Thomas's *Dobbs* concurrence argued that the Due Process Clause provides no substantive protections; under this interpretation, due process protections for travel,

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a dead letter"), cert. granted, 142 S. Ct. 1413, 1413 (2022) (mem); see also 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/ (on file with the *Columbia Law Review*).

216. Cf. Kreimer, Law of Choice, supra note 158, at 519 ("[T]he American Constitution as reformulated after the Civil War contemplates a national citizenship which gives to each of its members the right to travel to other states where, on a basis of equality with local residents, they can take advantage of the economic, cultural and moral options permitted there.").

217. Rebecca E. Zietlow, Belonging, Protection and Equality: The Neglected Citizenship Clause and the Limits of Federalism, 62 U. Pitt. L. Rev. 281, 283 (2000).

218. Dobbs v. Jackson Women's Health Org., No. 19-1392, slip op. at 10 (U.S. June 24, 2022) (Kavanaugh, J., concurring) ("[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."). This discussion responded to the dissenting opinion's raising of this complicated issue, which cited and discussed an initial draft version of this Article. See id. at 36 (Breyer, Sotomayor & Kagan, JJ., dissenting). That draft is preserved as David S. Cohen, Greer Donley & Rachel Rebouché, The New Abortion Battleground, 123 Colum. L. Rev. (forthcoming 2023) (on file with the *Columbia Law Review*).

219. See, e.g., id. at 30–32 (majority opinion) ("What sharply distinguishes the abortion right from the rights recognized in the cases on which *Roe* and *Casey* rely is something that both those decisions acknowledged: Abortion destroys what those decisions call 'potential life' and what the law [here] . . . regards as the life of an 'unborn human being.'" (citing Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 852 (1992); Roe v. Wade, 410 U.S. 113, 159 (1973))).

220. See, e.g., Jeannie Suk Gersen, When the Supreme Court Takes Away a Long-Held Constitutional Right, New Yorker: Daily Comment (June 24, 2022), https://www.newyorker.com/news/daily-comment/when-the-supreme-court-takes-away-a-long-held-constitutional-right/ (on file with the *Columbia Law Review*) (arguing that other due process rights might be overturned); Melissa Murray, John Garvey, Mary Ziegler, Mary Bonauto, Kathryn Kolbert & Erika Bachiochi, Opinion, 'Abortion Is Just the Beginning': Six Experts on the Decision Overturning *Roe*, N.Y. Times, https://www.nytimes.com/interactive/2022/06/24/opinion/politics/dobbs-decision-perspectives.html (on file with the *Columbia Law Review*) (last visited Sept. 3, 2022).

family formation, and intimacy are all subject to Court reversal or reinterpretation.[221] Moreover, the Court has developed a jurisprudence critical of extraterritoriality under due process only in the very specific context of punitive damages for a defendant's out-of-state actions,[222] and that doctrine has not been expanded.[223]

Similarly, other legal doctrines outside of constitutional law, like conflict of laws jurisprudence, are just as indeterminate. Professor Appleton has explained that "criminal law has customarily remained immune from scrutiny through a choice-of-law lens."[224] And Professor Dellapenna has written, despite forcefully arguing that conflicts doctrine allows extraterritorial application of abortion restrictions, that "[t]his domain is notoriously unstable and contested."[225]

Second, determining the legality of extraterritorial application of abortion law would involve resolving claims of competing fundamental constitutional values. Values on the side of allowing extraterritorial application include local experimentation, preventing the proverbial "race to the bottom," and judicial restraint.[226] On the side of prohibiting extraterritorial application are the constitutional values of national citizenship, liberty of travel, and freedom of choice.[227] 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.[228] 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.[229] However, because these constitutional values, which are in theory separate from the values underlying the abortion debate, will

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221. *Dobbs*, slip op. at 1–7 (Thomas, J., concurring) ("[I]n future cases, we should reconsider all of this Court's substantive due process precedents, including *Griswold*, *Lawrence*, and *Obergefell*.").

222. See BMW of N. Am., Inc. v. Gore, 517 U.S. 559, 572–74 (1996).

223. See Fallon, supra note 204, at 629–32 (noting that "the categorical claim that states may never enact or enforce extraterritorial criminal legislation seems too strong" and providing examples of states applying state criminal laws to out-of-state events).

224. Appleton, supra note 141, at 667.

225. Dellapenna, supra note 203, at 1654.

226. Cf. Appleton, supra note 141, at 656 (noting the "often-cited slogan of federalism" that states function as "laboratories" for democracy).

227. Cf. Fallon, supra note 204, at 639–40 (querying whether a "state's interest in protecting fetal life [can] outweigh a woman's asserted right, rooted in her national citizenship, to migrate to another state and to enjoy the privileges or immunities of citizenship of that other state").

228. Cf. Kreimer, Law of Choice, supra note 158, at 464–72 (describing a constitutional "equilibrium [which] . . . apportioned each state moral sovereignty within its own boundaries and obliged neighboring states to accede to that sovereignty").

229. See, e.g., Jamal Greene, Foreword: Rights as Trumps?, 132 Harv. L. Rev. 28, 31 (2018) (describing Masterpiece Cakeshop, Ltd. v. Colorado Civil Rights Commission, 138 S. Ct. 1719 (2018), as "a portrait of rights on all sides").

become proxies for the abortion debate, the conflict of fundamental values will become even more difficult for courts to resolve.[230]

Third, as this brief sampling of pertinent scholarship indicates, any solution to the constitutional questions raised 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.[231] Perhaps to state the obvious, the present Supreme Court, which relied on a contested history of abortion regulation to overturn *Roe*,[232] could also marshal history and originalism in ways that undermine constitutional arguments against abortions laws with extraterritorial reach. Differing interpretations of constitutional history will further enflame longstanding concerns about judicial neutrality.[233]

Fourth, and finally, given the various ways that states might attempt to restrict extraterritorial abortions, especially in an era of telehealth for abortion, courts will parse cases based on different facts and thus render different outcomes based on differing in- and out-of-state activities. This will subject courts to the same criticism leveled at *Casey* that any resulting

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230. Cf. Fallon, supra note 204, at 652–53 ("The obvious but unavoidable awkwardness is that differences about how to define, weigh, and accommodate [state] interests would implicate issues close to the heart of our deepest cultural divisions. Given the nature of the constitutional debate, courts could not simultaneously retreat to neutral ground and fulfill their constitutional obligations . . . .").

231. For instance, compare the majority and dissenting opinions' uses of history in McDonald v. Chicago, 561 U.S. 742 (2010), and District of Columbia v. Heller, 554 U.S. 570 (2008). See, e.g., *McDonald*, 561 U.S. at 914 (Breyer, J., dissenting) (noting that "the relevant history in [*Heller*] was far from clear" as "four dissenting Justices disagreed with the majority's historical analysis" and that "disputed history provides treacherous ground on which to build decisions written by judges who are not expert at history").

232. Compare Dobbs v. Jackson Women's Health Org., No. 19-1392, slip op. at 15–30 (U.S. June 24, 2022) (surveying historical statutory and common law treatment of abortion), with Brief for Amici Curiae American Historical Association and Organization of American Historians in Support of Respondents at 4, *Dobbs*, No. 19-1392, 2021 WL 4341742 (arguing that "historical evidence . . . refutes any claim that, from the adoption of the Constitution through 1868, our nation had a settled view on the criminality of abortion"), and Aaron Tang, After *Dobbs*: History, Tradition, and the Uncertain Future of a Nationwide Abortion Ban, 75 Stan. L. Rev. (forthcoming 2023) (manuscript at 11–30), https://ssrn.com/abstract=4205139 [https://perma.cc/2Y4W-N5A9] (presenting evidence that at the time of the Fifth Amendment's ratification in 1791, "the liberty interest in obtaining an abortion during early . . . pregnancy was . . . respected . . . by every state in the union").

233. See, e.g., Saul Cornell, Originalism on Trial: The Use and Abuse of History in *District of Columbia v. Heller*, 69 Ohio St. L.J. 625, 626 (2008) (arguing that, in the example of *Heller*, "plain-meaning originalism is not a neutral interpretive methodology, but little more than a lawyer's version of a magician's parlor trick—admittedly clever, but without any intellectual heft"); John Paul Stevens, Originalism and History, 48 Ga. L. Rev. 691, 693 (2014) (analyzing problems associated with the use of history in interpreting legal text).

standard is not workable.[234] Imagine different situations based on a variety of factors: the abortion patient's ties to the state where abortion is illegal (do they live in the state where they are a citizen or live temporarily elsewhere?), the provider's ties to the state where abortion is illegal (are they licensed in that state but practicing elsewhere or do they 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 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.[235]

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,[236] the constitutional theories already discussed in this section, or other constitutional concerns.[237] 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. *Shield Laws*

So far, this section has explored the difficult legal issues that arise when antiabortion states attempt to apply their laws beyond state borders. Antiabortion states are not alone, however, in thinking about extraterritoriality after *Roe*. Abortion-supportive states have been exploring ways to thwart antiabortion states from applying their laws to

234. See supra notes 9–11 and accompanying text.

235. See supra notes 179–180 and accompanying text.

236. See Lassiter v. Dep't of Soc. Servs., 452 U.S. 18, 24–25 (1981) ("Applying the Due Process Clause is therefore an uncertain enterprise which must discover what 'fundamental fairness' consists of in a particular situation by first considering any relevant precedents and then by assessing the several interests that are at stake.").

237. This might include concerns over minimum contacts from personal jurisdiction doctrine, see International Shoe Co. v. Washington, 326 U.S. 310, 316 (1945), or the impact on other areas of law, see Brief of Firearms Policy Coalition as Amicus Curiae in Support of Petitioners at 18, Whole Woman's Health v. Jackson, No. 21-463 (U.S. Dec. 10, 2021), 2021 WL 5029025 (expressing concern that "if pre-enforcement review can be evaded in the context of abortion it can and will be evaded in the context of the right to keep and bear arms").

abortions that occur outside their borders. Since the online posting of the first draft of this Article in February 2022,[238] Massachusetts has passed the most comprehensive legislation, often referred to as an interstate shield law, with California, Connecticut, Delaware, New Jersey, and New York offering a panoply of protections as well.[239] Illinois and the District of Columbia have pending bills addressing the issue.[240] 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.[241] This section explores

238. 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. Other efforts have emerged in direct response to this Article's exploration of how abortion-supportive proposals might be implemented. Over the past year, the authors have been actively involved in consulting with legislators and advocates in different states on protecting abortion care from out-of-state legal action. Thus, the first draft of this Article spoke of these efforts as possibilities; as of November 2022, lawmakers and executive officials have enacted or introduced concrete laws and executive orders inspired—at least in part—by this Article.

239. See generally Assemb. B. 1242, 2021–2022 Leg. Sess. (Cal. 2022) (codified as amended in scattered sections of Cal. Penal Code); Assemb. B. 2626, 2021–2022 Leg. Sess. (Cal. 2022) (codified as amended in scattered sections of Cal. Bus. & Prof. Code); Assemb. B. 1666, Leg. Sess. 2021–2022 (Cal. 2022) (codified as amended at Cal. Health & Safety Code § 123467.5 (2022)); Pub. Act No. 22-19, Gen. Assemb. (Conn. 2022) (codified as amended at Conn. Gen. Stat. Ann. §§ 54-82i(b), 54-162, 19a-602 (West 2022)); H.B. 455, 151st Gen. Assemb. (Del. 2022) (codified as amended in scattered sections of titles 10, 11, 18, and 24); H.B. 5090, 192nd Gen. Ct. (Mass. 2022); A3975, 220th Leg. (N.J. 2022) (codified as amended at N.J. Stat. Ann. §§ 2A:84A-22.18, -22.19, 45:1-21 (West 2022)); A3974, 220th Leg. (N.J. 2022) (codified as amended at N.J. Stat. Ann. § 2A:160-14.1 (West 2022)); S. 9039A, 2021–2022 Leg. Sess. (N.Y. 2022) (codified as amended at N.Y. Civ. Rights Law § 70-b (McKinney 2022)); S. 9077A, 2021–2022 Leg. Sess. (N.Y. 2022) (codified in scattered sections of N.Y. Crim. Proc. Law, N.Y. Exec. Law, and N.Y. C.P.L.R.); S. 9384A, 2021–2022 Leg. Sess. (N.Y.) (codified as amended at N.Y. Exec. Law § 108 (McKinney 2022)); A. 9687B, 2021–2022 Leg. Sess. (N.Y. 2022) (codified as amended at N.Y. Educ. Law §§ 6505-d, 6531-b (McKinney 2022), N.Y. Pub. Health Law § 230 (McKinney 2022)); A. 9718B, 2021–2022 Leg. Sess. (N.Y. 2022) (codified as amended at N.Y. Ins. Law § 3436-a (McKinney 2022)).

240. See generally B. 24-0808, 24th Council (D.C. 2022); B. 24-0726, 24th Council (D.C. 2022); H.B. 1464, 102nd Gen. Assemb. (Ill. 2022).

241. Cal. Exec. Order N-12-22 (June 27, 2022), https://www.gov.ca.gov/wp-content/uploads/2022/06/6.27.22-EO-N-12-22-Reproductive-Freedom.pdf [https://perma.cc/2PFK-EJ73]; Colo. Exec. Order D 2022 032 (July 6, 2022), https://ewscripps.brightspotcdn.com/ea/92/9ab8c1ad465d81a69889dd38faba/d-2022-032-reproductive-health-eo-3.pdf [https://perma.cc/ZW63-5FLK]; Me. Exec. Order 4 (July 5, 2022), https://www.maine.gov/governor/mills/official_documents/executive-orders/2022-07-executive-order-4-order-protecting-access-reproductive [https://perma.cc/RHR4-X5HG]; Mass. Exec. Order 600 (June 24, 2022), https://www.mass.gov/executive-orders/no-600-protecting-access-to-reproductive-health-care-services-in-the-commonwealth [https://perma.cc/BEF3-Z3NR]; Mich. Exec. Order 2022-4 (July 13, 2022), https://www.michigan.gov/whitmer/news/state-orders-and-directives/2022/07/13/executive-order-2022-4-unavailability-of-interstate-extradition [https://perma.cc/EY44-ECBE]; Minn. Exec. Order 22-16 (June 25, 2022), https://mn.gov/governor/assets/EO%2022-

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 the United States' 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 SB 8 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.[242] 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.[243] Lawsuits and complaints in which providers are named as defendants typically are reported to their licensing bodies and insurers.[244] In this context, that means that if an antiabortion state tries to impose criminal or civil liability on an abortion provider for providing an abortion to someone from

16_tcm1055-532111.pdf [https://perma.cc/HU5D-AN9E]; Nev. Exec. Order 2022-08 (June 28, 2022), https://gov.nv.gov/News/Executive_Orders/2022/Executive_Order_2022-08_Protecting_Access_to_Reproductive_Health_Services_in_Nevada/ [https://perma.cc/6M4D-J874]; N.M. Exec. Order 2022-107 (June 27, 2022), https://www.governor.state.nm.us/wp-content/uploads/2022/06/Executive-Order-2022-107.pdf [https://perma.cc/BK47-WE6G]; N.C. Exec. Order 263 (July 6, 2022), https://governor.nc.gov/media/3298/open [https://perma.cc/MA5C-8WJJ]; Pa. Exec. Order 2022-01 (July 12, 2022), https://www.governor.pa.gov/wp-content/uploads/2022/07/20220712-EO-2022-01.pdf [https://perma.cc/9P7Z-RYTX]; R.I. Exec. Order 22-28 (July 5, 2022), https://governor.ri.gov/executive-orders/executive-order-22-28 [https://perma.cc/7QHH-S7YV]; Wash. Exec. Order 22-12 (June 30, 2022), https://www.governor.wa.gov/sites/default/files/directive/22-12%20-%20Prohibiting%20assistance%20with%20interstate%20abortion%20investigations%20(tmp).pdf?utm_medium=email&utm_source=govdelivery [https://perma.cc/3C7V-ZMDL].

242. Cf. Alexi Pfeffer-Gillett, Civil Disobedience in the Face of Texas's Abortion Ban, 106 Minn. L. Rev. 203, 205 (2021) (analyzing the possibility of civil disobedience in response to SB 8).

243. See United States' Emergency Motion for a Temporary Restraining Order or Preliminary Injunction at 11, United States v. Texas, 566 F. Supp. 3d 605 (W.D. Tex. 2021) (No. 1:21-cv-796-RP), ECF No. 6-1 (supplying statements from providers that they fear the repercussions of lawsuits related to SB 8).

244. See About Physician Discipline: How State Medical Boards Regulate Physicians After Licensing, Fed'n of State Med. Bds., https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/guide-to-medical-regulation-in-the-united-states/about-physician-discipline/ [https://perma.cc/5YCE-Q5A8] (last visited Sept. 27, 2022). Malpractice payments are reported to the National Practitioner Data Bank, which is part of the Health Resource and Services Administration of the Department of Health and Human Services (HHS). Reporting Medical Malpractice Payments, Nat'l Prac. Data Bank, HHS, https://www.npdb.hrsa.gov/guidebook/EMMPR.jsp [https://perma.cc/TTM8-4GYG] (last visited Sept. 2, 2022).

another state—an abortion 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.[245] 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.[246] 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 abortion 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.[247]

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 for 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

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245. Jacqueline Landess, State Medical Boards, Licensure, and Discipline in the United States, 17 Focus 337, 338 (2019) (summarizing the history of state medical boards and their "broad discretion").

246. See Am. Coll. of Emergency Physicians, So, You Have Been Sued!: An Information Paper § C.7 (2019), https://www.acep.org/globalassets/uploads/uploaded-files/acep/clinical-and-practice-management/resources/medical-legal/so-you-have-been-sued.pdf [https://perma.cc/V6F5-TMSP] (noting that "premium rates will certainly go up" when a physician is subject to a malpractice suit, regardless of its outcome); Physician Discipline, Fed'n of State Med. Bds., https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/u.s.-medical-licensing-and-disciplinary-data/physician-discipline/ [https://perma.cc/YN47-EDMT] (last visited Sept. 27, 2022) (providing public access to data on physician disciplinary action).

247. H.B. 455, 151st Gen. Assemb. §§ 1, 2, 5 (Del. 2022) (codified as amended at Del. Code tit. 18, § 2535 (2022); Del. Code tit. 24, §§ 1702, 1731(b)(26), 1733(c), 1922(d), 1935(b)(5) (2022)); H.B. 5090, 192nd Gen. Ct. §§ 5, 10, 11, 15, 16, 17, 23 (Mass. 2022); S2633, 220th Leg. § 3 (N.J. 2022) (codified as amended at N.J. Stat. Ann. § 45:1-21 (West 2022)); Assemb. 9687B, 2021–2022 Leg. Sess. §§ 1, 4 (N.Y. 2022) (codified as amended at N.Y. Educ. Law §§ 6505-d, 6531-b (McKinney 2022); N.Y. Pub. Health Law § 230.9-c (McKinney 2022); N.Y. Ins. Law § 3436-a (McKinney 2022)); N.M. Exec. Order 2022-107 ¶ 3 (June 27, 2022), https://www.governor.state.nm.us/wp-content/uploads/2022/06/Executive-Order-2022-107.pdf [https://perma.cc/BK47-WE6G].

Depositions and Discovery Act which simplifies the process for litigants to take depositions and engage in discovery with people from another state by streamlining the process for an out-of-state court to enforce the original state's subpoena or discovery order.[248] 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.[249] And even before witnesses are called, police departments usually work with one another across state lines via formal and informal cooperation agreements.[250]

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.[251] 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 providers if they ever traveled to the antiabortion state, where they would then be subject to that state's laws or a judgment entered in that state's courts.[252] 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. It would also prevent 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.[253]

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248. Unif. Interstate Depositions and Discovery Act § 3 (Unif. L. Comm'n 2007).

249. See Unif. Act to Secure the Attendance of Witnesses From Without a State in Crim. Proc. § 3 (Unif. L. Comm'n 1936) ("If a person in any state . . . is a material witness in a prosecution pending in a court of record in this state . . . a judge of such court may issue a certificate . . . stating these facts and specifying the number of days the witness will be required."); see also Attendance of Out-of-State Witnesses Act, Unif. L. Comm'n, https://www.uniformlaws.org/committees/community-home?communitykey=69a013a1-5b59-4d8d-aee3-deb474a4a6b8#LegBillTrackingAnchor/ (on file with the *Columbia Law Review*) (last visited Sept. 26, 2022) (providing a map indicating that every state has enacted the uniform law).

250. Bridget A. Fahey, Federalism by Contract, 129 Yale L.J. 2326, 2329 (2020) (exploring the different types of intergovernmental agreements).

251. 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. 16B Am. Jur. 2d Constitutional Law § 1024, Westlaw (database updated Nov. 2022).

252. 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.

253. Assemb. B. 1666, Leg. Sess. 2021–2022 (Cal. 2022) (codified as amended at Cal. Health & Safety Code § 123467.5 (2022)); Pub. Act No. 22-19 §§ 3, 4 (Conn. 2022) (section

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.[254] Thus, for instance, Illinois 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.[255] 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.[256] An abortion-supportive state 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

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4 codified as amended at Conn. Gen. Stat. Ann. § 54-82i(b) (West 2022)); H.B. 455, 151st Gen. Assemb. § 3 (Del. 2022) (codified as amended at Del. Code tit. 10, §§ 3926A, 3928 (2022)); S2633, 220th Leg. § 4 (N.J. 2022) (codified as amended at N.J. Stat. Ann. § 2A:84A-22.18 to -22.19 (West 2022)); S. 9077A, 2021–2022 Leg. Sess. § 2 (N.Y. 2022) (codified as amended at N.Y. Crim. Proc. Law § 140.10.3-a(3)(McKinney 2022); N.Y. Exec. Law § 837-w (McKinney 2022); N.Y. C.P.L.R. 3119(g), 3102(e) (McKinney 2022)).

254. See U.S. Const. art. IV, § 2, cl. 2. That provision reads:

> A Person charged in any State with Treason, Felony, or other Crime, who shall flee from Justice, and be found in another State, shall on Demand of the executive Authority of the State from which he fled, be delivered up, to be removed to the State having Jurisdiction of the Crime.

255. See Hyatt v. New York, 188 U.S. 691, 709–13 (1903) ("[T]he person who is sought must be one who has fled from the demanding state, and he must have fled (not necessarily directly) to the state where he is found."). Constructive presence is not enough to qualify as a fleeing fugitive. See 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 would not be considered present in that state because, even though the video reached into the state, the provider's physical presence did not. This means the constitutional requirement of extradition does not apply. See Jack L. Goldsmith, Against Cyberanarchy, 65 U. Chi. L. Rev. 1199, 1220 (1990) (noting that transmitting digital information into a state where such transmission constitutes a crime likely does not subject a person to extradition because extradition obligations "have long been limited to persons who were physically present in the demanding state at the time of the crime's commission"). See generally Alejandra Caraballo, Cynthia Conti-Cook, Yveka Pierre, Michelle McGrath & Hillary Aarons, Extradition in Post-*Roe* America, 26 CUNY L. Rev. (forthcoming 2023) (on file with the *Columbia Law Review*) (investigating current and historical extradition practices, including international extradition and pre-Civil War extraditions related to fugitive slaves, for their relation to abortion extraditions).

256. See, e.g., Cal. Penal Code § 1549.1 (2022) (providing for extradition to a demanding state where the accused's actions committed in the demanded-of state "intentionally result[ed] in a crime in the [demanding] state . . . even though the accused was not in the demanding state at the time of the commission of the crime, and has not fled therefrom"); N.J. Stat. Ann. § 2A:160-14 (West 2022) (similar).

being extradited.[257] 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.[258]

Another concern that is spurring interstate protection is the threat of out-of-state civil judgments under laws such as Texas's SB 8.[259] Imagine an Illinois abortion provider, volunteer driver, funder, or other helper assisting a Texas patient to obtain an abortion that is contrary to SB 8 (one that is past six weeks and performed by a Texas-licensed physician). Under

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257. If, however, 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 to completely eliminate the provider's risk, the provider would need to limit their own future travel.

258. Pub. Act No. 22-19 § 5 (Conn. 2022) (codified as amended at Conn. Gen. Stat. Ann. § 54-162 (West 2022)); H.B. 455, 151st Gen. Assemb. § 4 (Del. 2022) (codified as amended at Del. Code tit. 11, § 2506 (2022)); S2642, 220th Leg. § 1 (N.J. 2022) (codified as amended at N.J. Stat. Ann. § 2A:160-14.1 (West 2022)); S. 9077A, 2021–2022 Leg. Sess. § 1 (N.Y. 2022) (codified as amended at N.Y. Crim. Proc. Law § 570.17 (McKinney)); Colo. Exec. Order D 2022 032 § II.D (July 6, 2022), https://ewscripps.brightspotcdn.com/ea/92/9ab8c1ad465d81a69889dd38faba/d-2022-032-reproductive-health-eo-3.pdf [https://perma.cc/ZW63-5FLK]; Me. Exec. Order 4 § III (July 5, 2022), https://www.maine.gov/governor/mills/official_documents/executive-orders/2022-07-executive-order-4-order-protecting-access-reproductive [https://perma.cc/RHR4-X5HG]; Mass. Exec. Order 600 § 3 (June 24, 2022), https://www.mass.gov/executive-orders/no-600-protecting-access-to-reproductive-health-care-services-in-the-commonwealth [https://perma.cc/BEF3-Z3NR]; Mich. Exec. Order 2022-4 (July 13, 2022), https://www.michigan.gov/whitmer/news/state-orders-and-directives/2022/07/13/executive-order-2022-4-unavailability-of-interstate-extradition [https://perma.cc/EY44-ECBE]; Minn. Exec. Order 22-16 § 4 (June 25, 2022), https://mn.gov/governor/assets/EO%2022-16_tcm1055-532111.pdf [https://perma.cc/HU5D-AN9E]; Nev. Exec. Order 2022-08 § 3 (June 28, 2022), https://gov.nv.gov/News/Executive_Orders/2022/Executive_Order_2022-08_Protecting_Access_to_Reproductive_Health_Services_in_Nevada/ [https://perma.cc/6M4D-J874]; N.C. Exec. Order 263 § 4 (July 6, 2022), https://governor.nc.gov/media/3298/open [https://perma.cc/MA5C-8WJJ]; Pa. Exec. Order 2022-01 § 5 (July 12, 2022), https://www.governor.pa.gov/wp-content/uploads/2022/07/20220712-EO-2022-01.pdf [https://perma.cc/9P7Z-RYTX]; R.I. Exec. Order 22-28 § 2 (July 5, 2022), https://governor.ri.gov/executive-orders/executive-order-22-28 [https://perma.cc/7QHH-S7YV].

259. S.B. 8, 87th Gen. Assemb., Reg. Sess. (Tex. 2021) (codified as amended at Tex. Health & Safety Code Ann. §§ 171.201–.212 (West 2022)). Texas's SB 8 creates civil liability for anyone who performs or aids an abortion performed by a Texas-licensed provider. See id. §§ 171.201(4), 171.203(b), 171.208 (defining a "physician" as a "an individual licensed to practice medicine in this state," prohibiting physicians from performing abortions if a fetal heartbeat is detectible, and providing for private civil suits for violations of the act). More recent SB 8-style laws lack 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. See H.B. 4327, 2022 Leg., Reg. Sess. (Okla. 2022) (codified as amended at Okla. Stat. tit. 63, §§ 1-745.51, 1-745.55 (2022)) (defining "abortion" without reference to whether it is performed by an Oklahoman doctor or on an Oklahoman patient and providing for private civil suits against abortion providers).

that law, anyone could sue that Illinois person for $10,000 or more.[260] If a Texas court issues a final judgment in that case finding the Illinois resident liable under SB 8, the Full Faith and Credit Clause would ordinarily require Illinois's courts to enforce that judgment.[261] 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 them[262] or that SB 8 is really a penal law.[263]

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 healthcare provision or support. The states that have passed shield laws so far have included this new cause of action in the form of a clawback provision.[264] These provisions 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 healthcare provision that was lawful in the state it occurred. 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.[265] As part of their shield bills,

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260. See Tex. S.B. 8, § 3.

261. U.S. Const. art. IV, § 1.

262. 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.").

263. Nelson v. George, 399 U.S. 224, 229 (1970) ("[T]he Full Faith and Credit Clause does not require that sister States enforce a foreign penal judgment . . . ."); City of Oakland v. Desert Outdoor Advert., Inc., 267 P.3d 48, 49–50 (Nev. 2011) (deciding that a penal judgment in California is unenforceable in Nevada).

264. Pub. Act No. 22-19 § 1(b) (Conn. 2022); H.B. 455, 151st Gen. Assemb. § 3 (Del. 2022) (codified as amended at Del. Code tit. 10, § 3929 (2022)); S2633, 220th Leg. § 1(b) (N.J. 2022); S. 9039A, 2021–2022 Leg. Sess. § 3 (N.Y. 2022) (codified as amended at N.Y. Civ. Rights Law § 70-b (McKinney 2022)).

265. Cf. Cal. Gov't Code § 6215(a), (c) (2022) (declaring that "[p]ersons working in the reproductive health care field, specifically the provision of terminating a pregnancy, are often subject to . . . acts of violence" and that "it is necessary for the Legislature to ensure that the home address information of these individuals is kept confidential"); N.J. Stat. Ann. § 47:4-2 (West 2022) (making similar legislative findings and commitments).

Massachusetts and New York expanded their address confidentiality programs to include abortion providers and patients.[266]

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.[267] Telehealth policies and the relevant standard of care typically define the location of care as where the patient is.[268] Thus, if an Illinois-licensed provider is located in Illinois while caring via telehealth for a patient who 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 Illinois.[269] Changing this default means that the provider's home state would not consider the provider to be practicing without a license or in violation of another state's law when offering telabortion to out-of-state residents. As of now, only the Massachusetts shield law has this provision.[270]

Changing the default location of care would have significant consequences for the entire healthcare ecosystem, and as a result, current proposals are limited to abortion care (and in Massachusetts, gender-affirming care as well). Even with that limitation, as section III.D notes, this change 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 antiabortion state, which would view the provider's actions as a violation of the state's abortion laws as well as its licensing laws. Though their home state's shield

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266. H.B. 5090, 192nd Gen. Ct. § 2 (Mass. 2022); S. 9384A, 2021–2022 Leg. Sess. (N.Y. 2022) (codified as amended at N.Y. Exec. Law § 108 (McKinney 2022)).

267. See generally Emily Bazelon, Risking Everything to Offer Abortions Across State Lines, N.Y. Times Mag. (Oct. 4, 2022), https://www.nytimes.com/2022/10/04/magazine/abortion-interstate-travel-post-roe.html (on file with the *Columbia Law Review*) (last updated Oct. 7, 2022) (reporting on doctors' efforts to furnish abortion care under restrictive state regimes and describing shield laws as "[t]he most promising" route available for supportive states).

268. Telehealth Policy 101: Cross State Licensing & Compacts, Ctr. for Connected Health Pol'y, https://www.cchpca.org/policy-101/?category=cross-state-licensing-compacts [https://perma.cc/8BL3-JEWX] (last visited Sept. 2, 2022) ("Typically, during a telehealth encounter . . . the location of the patient [] is considered the 'place of service', and the distant site provider must adhere to the licensing . . . regulations of the state [where] the patient is located, even if the . . . provider is not a resident [thereof] . . . .").

269. Cf. Information Release, Interstate Med. Licensure Compact (June 29, 2022), https://www.imlcc.org/wp-content/uploads/2022/06/IMLCC_Information-Release_June-29-2022_Physicians-licensed-in-multiple-states-1.pdf [https://perma.cc/PAP9-H4VY] ("[Under the Interstate Medical Licensure Compact, a] physician must be licensed in the state where the patient is . . . receiving care . . . and "care received is based on the [state's] medical practice act . . . where the patient is located . . . [when] they . . . receiv[e] care.").

270. See Mass. H.B. 5090 § 1 ("[T]he provision of such a health care service by a person duly licensed under the laws of the commonwealth and physically present in the commonwealth . . . shall be legally protected if the service is permitted under the laws of the commonwealth.").

law may protect them when in their state, any travel outside the state may be high risk.

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, and states may choose to embrace that ambiguity. For in-person care, the provider and patient are in the same place, so location of care is not at issue. But for remote care, 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 abortion providers to ask for a patient's residence,[271] some patients will evade questions of location 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. Under *Casey*, state laws that required reporting purported to serve the purpose of "medical research"[272]—not to police from where patients hailed. By 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. Abortion-supportive states could revisit laws requiring providers to collect or report data on a patient's location or residence, and professional organizations might rethink advising providers to confirm patient location in the abortion context.[273]

Moreover, abortion providers with the support of national professional organizations are tailoring their policies to comply with the threat of extraterritorial prosecutions. Some providers are offering different services to out-of-state patients or considering 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 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-

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271. See, e.g., Abortion Reporting, Elec. Frontier Found., https://www.eff.org/issues/abortion-reporting [https://perma.cc/3XTM-99PS] (last visited Sept. 2, 2022) (citing the example of Nebraska, "[a] typical state reporting form," which uses a reporting form that includes the patient's legal residence).

272. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 900–01 (1992) (plurality opinion) ("The collection of information with respect to actual patients is a vital element of medical research, and so it cannot be said that the requirements serve no purpose other than to make abortions more difficult.").

273. Fed'n of State Med. Bds., The Appropriate Use of Telemedicine Technologies in the Practice of Medicine 6 (2022), https://www.fsmb.org/siteassets/advocacy/policies/fsmb-workgroup-on-telemedicineapril-2022-final.pdf [https://perma.cc/VVP6-DYPK] ("[P]hysician[s] [are] discouraged from rendering medical advice and/or care using telemedicine technologies without . . . fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient . . . .").

border liability and punishment, potentially adopting policies that impose restrictions not required by their own state's law.[274]

Even if the suggestions included in this section are on constitutionally firm ground,[275] 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? The shield provisions discussed here would go a long way toward protecting a state's providers and increasing access for out-of-state patients seeking out those providers, but they would also intensify interstate conflict in a way that could have unintended consequences for other areas of law as well as for the general fabric of the country's federalist form of government. As this Article maintains throughout, these are 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. This Part will explore how possible federal actions in the wake of *Dobbs* would 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 faces increasing pressure to use its power, however untested, to protect abortion rights. This Article contemplates the avenues for how it can do so in the immediate future.[276]

The President cannot restore the right to abortion, but he can use executive power to improve abortion access, even without currently

274. 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 six-to-eight 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 & CEO, Planned Parenthood of Mont., to Staff, Planned Parenthood of Mont. (June 30, 2022) (on file with the *Columbia Law Review*).

275. 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 judiciary might not change existing well-settled constitutional principles to strike down these provisions.

276. In the days following *Dobbs*, 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 and should be done. See David S. Cohen, Greer Donley & Rachel Rebouché, Opinion, 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 (on file with the *Columbia Law Review*).

stalemated legislative proposals.[277] One possible tool at the federal government's disposal is preemption—the doctrine that federal laws trump conflicting state laws. Section III.A discusses 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; this is the subject of section III.B. 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, the subject of section III.C.

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.[278] For this reason, if Congress were to create a federal right to abortion, passing, for instance, the Women's Health Protection Act,[279] this federal law arguably 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 existing federal law and regulation might already conflict with aspects of state abortion bans. If that is the case, federal law could be a sword to poke holes in state abortion bans; it could also be used as a shield against criminal prosecution or civil liability when the conduct at issue is protected or required under federal law. This section starts with the boldest preemption argument: that states cannot ban medication abortion or regulate it more harshly than the FDA. This would force states to permit medication abortion through ten weeks. The discussion concludes with additional preemption arguments related to medically necessary abortions and reporting of abortion-related crimes.

1. *The 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

277. See Women's Health Protection Act of 2021, H.R. 3755, 117th Cong. (2021) (prohibiting government restrictions on access to abortion services by providers); see also Press Release, Statement From President Biden on the Senate Vote on the Women's Health Protection Act, The White House (May 11, 2022), https://www.whitehouse.gov/briefing-room/statements-releases/2022/05/11/statement-from-president-biden-on-the-senate-vote-on-the-womens-health-protection-act/ [https://perma.cc/44RF-JDSK] (expressing President Biden's dissatisfaction after a Senate cloture vote on the Women's Health Protection Act failed).

278. U.S. Const. art. VI, cl. 2.

279. H.R. 3755.

medical abortions—includes a Risk Evaluation and Mitigation System (REMS).[280] 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.[281] 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.[282]

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.[283]

In the process of revising the REMS numerous times over the past decade, the FDA has removed or modified requirements based on specific scientific findings that they were unnecessary for safety and efficacy.[284] In 2016, the agency removed its earlier requirement that patients consume the drug in-person, allowing patients to take the pills at home after picking them up at a healthcare facility.[285] It also removed the requirement that only physicians could prescribe the drug, allowing physician assistants and nurse practitioners to prescribe as well.[286] It moreover approved the drug's use through the tenth week of pregnancy when it had previously only approved the drug's use through the seventh week.[287] 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.[288]

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 entirely remote abortion impossible.[289] State legislation that requires in-person visits for counseling

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280. FDA, Mifepristone Information, supra note 71.

281. 21 U.S.C. § 355-1(a)(1) (2018) (requiring the submission of a REMS plan if "the Secretary . . . determines that a [REMS] is necessary to ensure that the benefits of the drug outweigh the risks of the drug"); see also Donley, supra note 70, 663–66 (arguing that the REMS is improper because "the benefits of mifepristone outweigh the risks without" the REMS).

282. Donley, supra note 70, at 654 (maintaining that "the REMS is not actually correlated with any of mifepristone's safety risks").

283. FDA, Mifepristone Information, supra note 71.

284. See Ctr. for Drug Evaluation & Rsch., Application Number: 020687Orig1s020: Summary Review 5–9 (2016), https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020SumR.pdf [https://perma.cc/9AGC-UF22] (discussing clinical research into mifepristone's efficacy).

285. See id. at 15, 17.

286. See id. at 16–17.

287. See id. at 3, 15, 17.

288. See supra notes 74–75 and accompanying text.

289. See Guttmacher Inst., Medication Abortion, supra note 23 (highlighting that "19 states require the clinician providing a medication abortion to be physically present when

or ultrasounds precludes a wholly remote process.[290] Moreover, twenty-nine states only allow physicians to prescribe medication abortion.[291] Many states have required patients to consume the drug in the presence of a provider—that is, they cannot take the drug at home.[292] In September 2021, Texas enacted a law making it illegal to use medication abortion after the first seven weeks of pregnancy.[293] More urgently, many states have now banned abortion entirely, essentially prohibiting the provision of medication abortion in their borders.

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.[294] There are now deeper incentives to

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the medication is administered, thereby prohibiting the use of telemedicine to prescribe medication for abortion"). Seven states also have statutes that explicitly ban the use of telemedicine for abortion even though existing in-person requirements accomplish the same end. See Laurie Sobel, Amrutha Ramaswamy & Alina Salganicoff, The Intersection of State and Federal Policies on Access to Medication Abortion via Telehealth, Kaiser Fam. Found. (Feb. 7, 2022), https://www.kff.org/womens-health-policy/issue-brief/the-intersection-of-state-and-federal-policies-on-access-to-medication-abortion-via-telehealth [https://perma.cc/3YW5-CJMG] (providing this information in an appendix to the article). State courts in two of those states have enjoined the in-person requirement. See Planned Parenthood of the Heartland, Inc. v. Iowa Bd. of Med., 865 N.W.2d 252, 269 (Iowa 2015) (enjoining Iowa's in-person requirement); Carrie N. Baker, Advocates Cheer FDA Review of Abortion Pill Restrictions, Ms. Mag. (May 11, 2021), https://msmagazine.com/2021/05/11/fda-review-abortion-pill-restrictions-mifepristone-biden/ [https://perma.cc/LYM4-5WFW] (describing Ohio's in-person requirement and the state court injunction against it).

290. See Counseling and Waiting Periods for Abortion, Guttmacher Inst., https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion [https://perma.cc/MYS5-NMHS] (last updated Sept. 1, 2022) (noting that of the "32 states [that] require . . . patients [to] receive counseling before an abortion is performed," "15 states require that counseling be provided in person and that the counseling take place before the waiting period begins, thereby necessitating two separate trips to the facility"); Requirements for Ultrasound, Guttmacher Inst., https://www.guttmacher.org/state-policy/explore/requirements-ultrasound [https://perma.cc/H78A-Z8AJ] (last updated Sept. 1, 2022) (noting that "6 states mandate that an abortion provider perform an ultrasound on each person seeking an abortion and require the provider to show and describe the image," and "10 states mandate that an abortion provider perform an ultrasound on each person seeking an abortion").

291. Guttmacher Inst., Medication Abortion, supra note 23 (noting that "29 states require clinicians who administer medication abortion to be physicians").

292. See id. (noting that nineteen states carry such an in-person consumption requirement).

293. See S.B. 4, 87th Sess., 2d Sess. § 5(c)(6) (Tex. 2021).

294. Jason Laughlin, What to Know About the Abortion Pill in Pennsylvania and New Jersey After the *Dobbs* Decision, Phila. Inquirer (May 3, 2022), https://www.inquirer.com/health/abortion-pill-access-pennsylvania-nj.html [https://perma.cc/FMJ3-HMQ3] (last updated June 24, 2022) ("Both Pennsylvania and New Jersey allow people to receive abortion pills prescribed by a medical provider through the mail . . . . Pennsylvania patients must have a consultation with a certified abortion provider 24 hours before they can be

challenge these specific laws under preemption doctrines to expand access in states that have not banned abortion. Whether preemption could go even further and partially invalidate general abortion bans—that is, force states to allow the sale and use of medication abortion—is uncertain.

The crux of any preemption argument is congressional purpose, which is "the ultimate touchstone in every pre-emption case."[295] 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 expressly preempted state law when it created legislation that governed medical devices but never did so for pharmaceuticals.[296]

Implied preemption of state law occurs in a few contexts: when it is impossible to comply with both state and federal law (impossibility preemption),[297] when a state law would frustrate the purpose underlying federal law (obstacle preemption),[298] or when federal law entirely occupies a field (field preemption).[299] 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.[300] The Supreme Court has considered whether the Food, Drug, and Cosmetic Act (FDCA), and the regulatory scheme implementing it, preempt state law a few times in the past decade—all using conflict preemption theories.[301] Recent decisions increasingly have accepted the preemptive force of FDA rules.

The framing of congressional purpose is key to an obstacle preemption theory.[302] In the context of state regulation of mifepristone, there are three potential purposes plaintiffs could rely upon: (1) Congress envisioned the FDA's role, in part, as protecting patient access to safe and effective drugs, and thus state laws that restrict drug access thwart this purpose; (2) Congress created the FDA with the purpose of establishing a

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prescribed the medication and provide signed consent, but that can be done virtually . . . .").

295. Wyeth v. Levine, 555 U.S. 555, 565 (2009) (internal quotation marks omitted) (quoting Medtronic, Inc. v. Lohr, 518 U.S. 470, 485 (1996)).

296. Id. at 567; Patricia J. Zettler, Pharmaceutical Federalism, 92 Ind. L.J. 845, 862 (2017).

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

298. Id.

299. Id.

300. See Zettler, supra note 296, at 862. Because the Food, Drug, and 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. Id. at 859, 874.

301. See Mut. Pharm. Co. v. Bartlett, 570 U.S. 472, 475 (2013); PLIVA, Inc. v. Mensing, 564 U.S. 604, 609 (2011); *Wyeth*, 555 U.S. at 565.

302. See Medtronic, Inc. v. Lohr, 518 U.S. 470, 485 (1996) ("[T]he purpose of Congress is the ultimate touchstone in every pre-emption case." (internal quotation marks omitted) (quoting Retail Clerks v. Schermerhorn, 375 U.S. 96, 103 (1963))).

nationally uniform, definitive, and rigorous drug approval system, and thus state laws creating variation across states 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 state laws that balance these goals differently for drugs subject to a REMS thwart this purpose. Each of these congressional purposes is supported either by statutory text or by legislative history.[303]

The third purpose is most relevant to preemption challenges to state laws regulating mifepristone more harshly than the FDA—laws like physician-only mandates or in-person dispensing laws that might control in a few states that do not ban abortion after *Dobbs*. This is because those 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 public.[304] The statute specifically said that the REMS may "not be unduly burdensome on patient access to the drug."[305] 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

303. As for (1), the FDA's codified mission statement provides some support for the idea that the FDA's mission is not only to protect consumers from dangerous products but also to advance the public health by approving helpful products, Food and Drug Administration Modernization Act of 1997, Pub. L. No. 105-115, § 406(a), 111 Stat. 2296, 2369 (codified as amended at 21 U.S.C. § 393(b) (2018)), as do various agency statements about its mission on the agency's website, What We Do, FDA, https://www.fda.gov/about-fda/what-we-do [https://perma.cc/45ZF-J2D5] (last updated Mar. 28, 2018) ("FDA is responsible for advancing the public health by helping to speed innovations that make medical products more effective, safer, and more affordable and by helping the public get the accurate, science-based information they need to use medical products and foods to maintain and improve their health."). As for (2), Peter Hutt and other authors have argued that "[t]he appeal of national uniformity was an important argument in favor of federal [food and drug] legislation." Peter Barton Hutt, Richard A. Merrill & Lewis A. Grossman, Food and Drug Law: Cases and Materials 7 (4th ed. 2013). The argument for (3) is the strongest because it is located in the operative text of the REMS statute, which demands that the REMS "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)." 21 U.S.C. § 355-1(f)(2)(C).

304. The statute requires that the Elements to Assure Safe Use (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)(A), (C), (D)(i). The statute also required that the agency, "to the extent practicable, . . . minimize the burden on the health care delivery system." Id. § 355-1(f)(2)(D).

305. Id. § 355-1(f)(2)(C).

to a REMS.[306] And, in exercising that control, it has had to justify its decisions with evidence that balanced safety and efficacy with access.[307]

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;[308] (2) used through ten weeks of pregnancy;[309] (3) consumed at home;[310] and (4) dispensed by mail or certified pharmacy.[311] Thus, in addition to bans on all abortion, discussed below, any state laws that remain after *Dobbs* that require physician prescribing, limit the length of use, mandate in-person pickup 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.[312] 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 rejected as not necessary.[313] Because this REMS-focused purpose would only apply to a small subset of drugs, it might be less likely to have unintended consequences on state public health efforts related to other FDA-regulated products, like tobacco.

When the congressional purpose changes to drug accessibility, there is case law suggesting that states cannot remove an FDA-approved drug from the market or make it less accessible. For instance, the U.S. District Court for the District of Massachusetts invalidated a state's attempt to

306. Donley, supra note 70, at 656.

307. See supra notes 283–287.

308. Ctr. for Drug Evaluation & Rsch., supra note 284, at 17 ("[H]ealthcare providers other than physicians can effectively and safely provide abortion services, provided that they meet the requirements for certification described in the REMS.").

309. Id. at 9 ("The data and information reviewed constitute substantial evidence of efficacy to support the proposed dosing regimen . . . for pregnancy termination through 70 days [or ten weeks] gestation.").

310. Id. at 15 (explaining that "there is no clinical reason to restrict the location in which misoprostol may be taken" because "allowing dosing at home increases the chance that the woman will be in an appropriate and safe location when the process begins").

311. FDA, Cavazzoni Letter, supra note 76, at 6 ("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.").

312. It is worth noting that the FDA reviewed and reiterated its scientific conclusions from 2016 in 2021. Id. at 3.

313. 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); see also In re Zofran (Ondansetron) Prods. Liab. Litig., 541 F. Supp. 3d 164, 203 (D. Mass. 2021) (same).

regulate a newly approved and controversial opioid, Zohydro, more harshly than the FDA.[314] Of particular concern was the state requirement that a prescribing physician verify "that other pain management treatments had failed."[315] The court evaluated "whether the regulations prevent[ed] the accomplishment of the FDA's objective that safe and effective drugs be available to the public."[316] 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."[317] 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.[318] 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).[319] But this accessibility purpose is clearly incorporated into the REMS statute,[320] strengthening the argument that congressional purpose would be frustrated if states attempt to ban a drug regulated through the REMS program. Professor Patricia 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."[321] As a result, any additional restrictions might "pose an obstacle to the FDA's responsibility to satisfy these Congressional objectives."[322] Recently, Professors Zettler and Sarpatwari applied this line of reasoning to medication abortion:

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314. Zogenix, Inc. v. Baker, No. 14-11689-RWZ, 2015 WL 1206354, at *3–4 (D. Mass. Mar. 17, 2015). The FDA's 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. Lars Noah, State Affronts to Federal Primacy in the Licensure of Pharmaceutical Products, 2016 Mich. St. L. Rev. 1, 3 n.9.

315. *Zogenix*, 2015 WL 1206354, at *2.

316. Id. at *4.

317. Zogenix, Inc. v. Patrick, No. 14-11689-RWZ, 2014 WL 3339610, at *4 (D. Mass. July 8, 2014), vacated in part, No. 14-11689-RWZ, 2014 WL 4273251 (D. Mass. Aug. 28, 2014).

318. Id. at *3.

319. See Noah, supra note 314, at 8–12.

320. 21 U.S.C. § 355-1(f)(2)(C) (2018) (noting that "elements to assure safe use under" the REMS protocol provided for in "paragraph (1) shall . . . not be unduly burdensome on patient access to the drug").

321. Zettler, supra note 296, at 875.

322. Id.

> 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.[323]

They note that these laws are troubling when they "are grounded in drug-safety arguments" because they encroach on the FDA's clear authority.[324]

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.[325] As scholars have explained, "[C]ourts, lawmakers, and the FDA itself have long opined that state jurisdiction is reserved for medical practice—the activities of physicians and other healthcare professionals—and federal jurisdiction for medical products, including drugs."[326] The practice-of-medicine defense was raised and rejected in the Zohydro litigation, however.[327] 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."[328] 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.[329]

And that raises the much more urgent and complex question: Can FDA regulations preempt a state's general ban on abortion?[330] 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

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323. Patricia J. Zettler & Ameet Sarpatwari, State Restrictions on Mifepristone Access—The Case for Federal Preemption, 386 New Eng. J. Med. 705, 706 (2022).

324. Id.

325. Zettler, supra note 296, at 869 n.160.

326. Id. at 849.

327. Id. at 872.

328. Id. at 886.

329. Id. at 887.

330. In addition to general abortion bans, some states have introduced laws that would simply ban mifepristone. See, e.g., H.R. 261, 2022 Leg., Reg. Sess. § 3(a) (Ala. 2022) ("It is unlawful for any person or entity to manufacture, distribute, prescribe, dispense, sell, or transfer the 'abortion pill,' otherwise known as RU-486, 8 Mifepristone, Mifegyne, or Mifeprex, or any substantially similar generic or non-generic abortifacient drug in Alabama."); H.R. 2811, 55th Leg., 2d. Reg. Sess. § 1 (Ariz. 2022) (making it illegal to "prescribe . . . [or] dispense . . . an abortion medication that is intended to cause or induce an abortion"). The preemption argument in the context of these laws would be strong and nearly identical to the Zohydro litigation.

proving that the drug is safe and effective.[331] If they are successful, they can sell their product in every state; if unsuccessful, they cannot sell their product anywhere.[332] 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 in a trio of cases 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.[333] 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 its drug labels to be more protective, though not less, without the FDA's approval.[334] The Court also rejected an obstacle preemption argument, finding that Congress's "silence on the issue, coupled with its certain 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."[335] 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.[336]

Two years later, however, the Court distinguished *Wyeth* in the context of generic drugs. In *PLIVA, Inc. 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 its labels to avoid a failure-to-warn tort action, while also remaining compliant with FDA law.[337] In this case, a plurality of the Court seemed to shift its understanding of preemption doctrine to recognize implied invalidation of state law, concluding that courts "should

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331. See Cost of Clinical Trials for New Drug FDA Approval Are Fraction of Total Tab, Johns Hopkins Bloomberg Sch. of Pub. Health (Sept. 24, 2018), https://publichealth.jhu.edu/2018/cost-of-clinical-trials-for-new-drug-FDA-approval-are-fraction-of-total-tab/ [https://perma.cc/NF9R-7JRP] (noting that the cost of developing an individual drug is only around nineteen million dollars on average, but that number balloons to over a billion dollars when taking into account failed drugs).

332. See FDA Activities to Remove Unapproved Drugs From the Market, FDA, https://www.fda.gov/drugs/enforcement-activities-fda/fda-activities-remove-unapproved-drugs-market/ [https://perma.cc/CSJ7-Q3DB] (last updated June 2, 2021) (noting the number of unapproved prescription drugs that the FDA has taken off the market).

333. 555 U.S. 555, 569 (2009).

334. Id. at 569–72.

335. Id. at 575.

336. Id. at 576–79.

337. 564 U.S. 604, 618–19 (2011).

not distort federal law to accommodate conflicting state law."[338] 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.[339] Then, in *Mutual Pharmaceutical Co. v. Bartlett*, in 2013, the Court reiterated that conclusion by finding preemption of a design defect tort action against a generic manufacturer on the ground that a generic manufacturer similarly cannot alter the composition of a drug.[340]

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."[341] 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 "all but meaningless."[342] Thus, the Supreme Court implied in *Mensing* and *Bartlett* that states cannot ban FDA-approved drugs: "[I]f 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."[343] 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.[344] In issuing a preliminary injunction, the U.S. District Court for

338. Id. at 623.

339. Id.

340. See 570 U.S. 472, 475–76 (2013) (invalidating a state law that, where underlying drug chemistry could not be altered, required a manufacturer to provide stronger label warnings—an outcome disallowed by Supreme Court jurisprudence because the "state law imposed a duty on [the manufacturer] not to comply with federal law").

341. Id. at 488.

342. Id. (quoting *Mensing*, 564 U.S. at 621).

343. Noah, supra note 314, at 35.

344. 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. 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

the District of Massachusetts concluded that the drug manufacturer 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 protect the public health."[345] The court distinguished *Wyeth* by noting that there, the Supreme Court "assumed the availability of the drug at issue."[346]

Though many FDA law scholars agree that a state ban of an FDA-approved drug would be preempted,[347] as noted above, 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.[348] 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.[349] 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.[350] Instead, Noah suggests, 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.[351] 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

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of a product that travels in interstate commerce." Id. at *7–8. 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. at *7.

345. *Zogenix*, 2014 WL 1454696, at *2.

346. Id.

347. See Noah, supra note 314, at 54 (noting that if "one takes seriously the Supreme Court's expansive approach to implied preemption in . . . *Bartlett*" then a state ban on an FDA-approved drug would "run afoul of the Constitution"); Zettler, supra note 296, at 865 ("[T]he Court may find a prohibition on an FDA-approved drug . . . to be preempted on impossibility grounds in some circumstances.").

348. Noah, supra note 314, at 8–12 (arguing that "the FDA's . . . mission statement" that its purpose is to make available beneficial drugs "hardly supports" the court's "claim of an overriding federal purpose to promote patient access to approved drugs").

349. Id. ("[L]icense holders generally have no obligation to commercialize their products, to do so at an affordable price, or in a manner that ensures easy access.").

350. Id. at 8 ("Congress crafted the current version of the licensing scheme for new drugs in order to prevent the introduction of unsafe or ineffective pharmaceutical products . . . .").

351. Id. at 12.

that meet the demands of an onerous review process.[352] 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 realign their research and development of drugs if states could ban products after companies have invested tens of millions of dollars in obtaining FDA approval.

Consumer safety often is offered as a reason to oppose preemption in the context of state efforts to regulate drugs.[353] 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. There is the fear that a preemption win for medication abortion 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.[354] For instance, the dissenters in *Bartlett* who opposed preemption 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."[355] Thus, a finding that states cannot ban or overregulate medication abortion might not preclude states from regulating dangerous products.

Justice Sotomayor's dissent in *Bartlett* provides further support for a REMS-tailored preemption doctrine. There, she suggested that the Court should "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)."[356] In the context of a drug regulated under a REMS, the statute envisions not just a regulatory floor, but a ceiling that accounts for patient

352. Id.

353. 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. See, e.g., id. at 15 (critiquing preemption challenges by pharmaceutical companies on the ground that "Congress evidently did not intend . . . to intrude upon the well-accepted powers of the states to regulate the activities of health care professionals"); see also Eric Crosbie & Laura A. Schmidt, Preemption in Tobacco Control: A Framework for Other Areas of Public Health, 110 Am. J. Pub. Health 345, 345 (2020) ("State preemption has been detrimental to tobacco control by dividing the health community, weakening local authority, chilling public education and debate, and slowing local policy diffusion.").

354. See Donley, supra note 70, at 641–49 (arguing that medication abortion has been subject to exceptional treatment).

355. Mut. Pharm. Co. v. Bartlett, 570 U.S. 472, 494 (2013) (Breyer, J., dissenting).

356. Id. at 514 (Sotomayor, J., dissenting).

access.[357] Combined, mifepristone's strong safety profile and regulation under a REMS makes the preemption arguments stronger than past cases.[358] The authors 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 these lawsuits, so courts will decide these questions regardless. It would be a missed opportunity to not take advantage of these cases to *further* public health by expanding abortion access.

There are important counterarguments to the preemption theory in the context of general abortion bans.[359] First, states will argue that their laws do not ban medication abortion drugs entirely because they could be sold and used for other uses.[360] Misoprostol, in particular, is used for a variety of obstetric purposes, including inducing labor and treating miscarriage, and was originally approved to treat ulcers.[361] 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. First, to be clear, some states have introduced laws that directly prohibit the sale or dispensation of mifepristone for any purpose.[362] If those bills became law, this criticism would not apply. Second, the FDA has approved mifepristone only for abortion, and its manufacturers are only legally allowed to market it for that one use.[363] And though providers, as distinct

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357. 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) (noting that "the REMS process is likely to generate a substantial administrative record demonstrating FDA's consideration of the specific risk and, perhaps, the agency's rationale in approving the ultimate balance reflected in the REMS").

358. Zettler & Sarpatwari, supra note 323, at 707 ("[P]reemption challenges to state mifepristone restrictions should not be understood as risking the future viability of public health federalism more broadly.").

359. One challenge not mentioned above is the following: Though the practice–product distinction may be less stark than previously assumed, courts might be more willing to find that a state's regulation 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: Instead, it would be to the law's application over medication abortion.

360. Donley, supra note 70, at 633–34 (noting non-abortion uses of medication abortion drugs).

361. Id. at 633.

362. Christine Vestal, As Abortion Pills Take Off, Some States Move to Curb Them, The Pew Charitable Trs. (Mar. 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/ [https://perma.cc/X8E8-KWZA] ("Outright bans on dispensing or using the FDA-approved medications have been proposed in Alabama, Arizona, Iowa, South Dakota, Illinois, Washington and Wyoming.").

363. See Ctrs. for Medicare & Medicaid Servs., Off-Label Pharmaceutical Marketing: How to Recognize and Report It 1 (2015), https://www.cms.gov/Medicare-Medicaid-

from manufacturers, are generally allowed to prescribe drugs off-label, the REMS has made it almost impossible for them to do so with mifepristone[364]—underscoring that an abortion ban is a de facto ban on mifepristone. 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.[365] Without that assurance, manufacturers would not 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[;] . . . [rather, it] amount[s] to licenses, which qualify as a form of intangible property entitled to constitutional recognition."[366] When a state bans the only use of an approved drug, that state has thwarted the purpose of the FDA approval process by effectively 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.[367] Even with misoprostol, however, abortion bans have affected access to the drug for other uses. For instance, some pharmacies have stopped dispensing misoprostol for any purpose in states that ban abortion.[368] Typically, pharmacies are not given any information related to the use of the drug, so the pharmacist cannot be sure whether the drug is

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Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/off-label-marketing-factsheet.pdf [https://perma.cc/8TXT-QKEQ] ("Unlawful off-label drug promotion has been the subject of significant health care fraud enforcement efforts by the United States Department of Justice (DOJ) and the States' attorneys general using the Federal False Claims Act (FCA).").

364. Donley, supra note 70, 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).

365. See supra notes 331–332 and accompanying text.

366. Noah, supra note 314, at 32.

367. See Donley, supra note 70, at 633 (describing misoprostol's on- and off-label uses). 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. One could argue, however, that misoprostol is incorporated explicitly by reference into the mifepristone REMS because the mifepristone use depends on its combination with misoprostol. FDA, Mifepristone Information, supra note 71.

368. 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 [https://perma.cc/PW84-PZA2] (reporting growing concerns among pharmacists about filling prescriptions for medication abortion drugs—even if not intended for such use—due to threats of civil and criminal litigation).

being used for ulcers, miscarriage, or abortion.[369] An abortion ban thus impedes access to abortion-inducing drugs for all uses.[370]

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, such as, to borrow a state interest cited in *Dobbs*, "respect for and preservation of prenatal life at all stages of development."[371] Preemption is always anchored in congressional intent,

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369. See Alice Miranda Ollstein & Daniel Payne, Patients Face Barriers to Routine Care as Doctors Warn of Ripple Effects From Broad Abortion Bans, Politico (Sept. 28, 2022), https://www.politico.com/news/2022/09/28/abortion-bans-medication-pharmacy-prescriptions-00059228 [https://perma.cc/YJU3-YZMU] ("While a doctor's prescription details the medication, it does not always specify the diagnosis, and pharmacists said the risk of a felony charge or loss of license is too high for them to simply take a patient's word.").

370. HHS Secretary Xavier 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. Off. for Civ. Rts., HHS, Guidance to Nation's Retail Pharmacies: Obligations Under Federal Civil Rights Laws to Ensure Access to Comprehensive Reproductive Health Care Services 2–3 (2022), https://www.hhs.gov/sites/default/files/pharmacies-guidance.pdf [https://perma.cc/9JXD-SYL4] [hereinafter HHS Guidance]; Press Release, HHS, 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 [https://perma.cc/FQ95-9YDN].

371. Dobbs v. Jackson Women's Health Org., No. 19-1392, slip op. at 78 (U.S. June 24, 2022). One example sometimes raised is life-ending medications, which are FDA-approved drugs that are used off-label to end a person's life. See Jennie Dear, The Doctors Who Invented a New Way to Help People Die, Atlantic (Jan. 22, 2019), https://www.theatlantic.com/health/archive/2019/01/medical-aid-in-dying-medications/580591/ (on file with the *Columbia Law Review*) (discussing Secobarbital, a preferred drug used in physician-assisted death that is intended to only be used as treatment for insomnia or pre-surgery anxiety). 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; there, the agency has long explicitly disclaimed any jurisdiction over such drugs. This avoidance was the subject of a Supreme Court case, Heckler v. Chaney, 470 U.S. 821, 827–38 (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 United States. Beaty v. Food & Drug Admin., 853 F. Supp. 2d 30, 35 (D.D.C. 2012). Finally, in 2019, the Office of Legal Counsel for the DOJ wrote a slip opinion arguing that the FDA lacked jurisdiction over capital punishment drugs because they could never be found safe or effective. See Whether the Food and Drug Administration Has Jurisdiction Over Articles Intended for Use in Lawful Executions, 43 Op. O.L.C. 1, 1–2 (2019). 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

so the argument would be that Congress may not have intended the 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. For instance, it would likely 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 does not evince congressional intent for the 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 *FDA v. 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."[372] *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.[373] The Court found it anomalous that the FDCA could be interpreted to regulate (maybe even ban) a product, cigarettes, that was so politically and economically important to states when Congress never considered or debated that possibility when it passed the statute.[374] 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.

Relatedly, to the extent the FDA gets involved in any future lawsuit and claims its interpretation is entitled to deference, another doctrine—the major questions exception—could thwart deference to the agency.[375] This doctrine states that courts should not defer to agencies when their interpretation concerns a major economic or political question.[376] As part of its broader efforts to dismantle the administrative state, the current Supreme Court has struck down many important agency decisions in recent

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state regulation. If anything, the agency has gone out of its way to suggest that it has no power in this space.

372. 529 U.S. 120, 159–60 (2000).

373. See, e.g., Jacob Loshin & Aaron Nielson, Hiding Nondelegation in Mouseholes, 62 Admin. L. Rev. 19, 21 (2010) (describing the doctrine).

374. *Brown & Williamson*, 529 U.S. at 146–47.

375. See Jonas J. Monast, Major Questions About the Major Questions Doctrine, 68 Admin. L. Rev. 445, 447 (2016) ("[T]he Court's reliance on the major questions doctrine potentially signals a significant limitation on *Chevron* deference . . . .").

376. See King v. Burwell, 576 U.S. 473, 486 (2015).

years relying on this doctrine.[377] 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."[378] But 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. Indeed, the FDA's involvement in such litigation could divert attention from the drug 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 tobacco regulation in the *Brown & Williamson* era,[379] FDA's close regulation of mifepristone has been ongoing for decades and is statutorily authorized.[380] Its regulation of the product is not new or controversial—its particular regulatory decisions might be but not its ability to regulate. Recall that *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.[381] 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 more closely than 95% of the drugs it approves,[382] and Congress has done nothing to impede the agency's actions and decisions.[383] And though members of Congress routinely issue letters to the FDA about its regulation of this drug, they have never overruled the FDA's decision by statute or removed its power to regulate in this space.[384] The FDA here is not using "vague language" of

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377. See West Virginia v. Env't Prot. Agency, No. 20-1530, slip op. at 28 (U.S. June 30, 2022) ("[T]he Government must—under the major questions doctrine—point to 'clear congressional authorization' to regulate in that manner.").

378. Id. at 5.

379. The FDA gained authority to regulate tobacco by statute decades later. See Family Smoking Prevention and Tobacco Control Act, Pub. L. No. 111-31, § 901(a), 123 Stat. 1776, 1786–87 (2009) (codified in scattered sections of 5, 10, 15, and 21 U.S.C.).

380. Donley, supra note 69, at 637–42 (describing the FDA's history of mifepristone regulation and its statutory powers to so regulate); see also 21 U.S.C. § 355-1 (2018) (providing for the REMS program under which the FDA has regulated mifepristone).

381. Food & Drug Admin. v. Brown & Williamson, 529 U.S. 120, 157–60 (2000).

382. Donley, supra note 70, at 640.

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

384. See, e.g., Letter from Jody Hice, U.S. Rep., et al., to Stephen Hahn, Comm'r, FDA (Sept. 1, 2020), https://hice.house.gov/uploadedfiles/house_fda_letter_hicecruz.pdf [https://perma.cc/3NZR-KVX9]; see also Letter from Gretchen Whitmer, Governor, State of Mich., to Robert Califf, Comm'r, FDA (July 21, 2022), https://content.govdelivery.com/

a "long-extant" but "rarely . . . used" statute to assert new authority but rather continuing its decades-long regulation of medication abortion.[385]

After the *Dobbs* decision, the Biden Administration has appeared to support this theory to some degree.[386] The strongest statement came from Attorney General Merrick 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."[387] Shortly thereafter, President Biden signed an executive order directing the Department of Health and Human Services (HHS) to identify potential actions to "protect and expand access to abortion care, including medication abortion."[388] Explaining his decision, he noted that this medication was approved by the FDA as "safe and effective over twenty years ago."[389] 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 lawsuit might fare better without the government's involvement. But regardless, the issue will be litigated.

Indeed, when Mississippi banned nearly all abortions after *Dobbs*, mifepristone's generic manufacturer, GenBioPro, which had already started a preemption lawsuit based on Mississippi's pre-*Dobbs* abortion laws, moved to amend the complaint to challenge Mississippi's general ban.[390] GenBioPro argued that Mississippi's new, general abortion ban

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attachments/MIEOG/2022/07/21/file_attachments/2223974/220721%20-%20FDA%20letter%20%28with%20signature%29.pdf [https://perma.cc/XJ8W-GTHG].

385. West Virginia v. Env't Prot. Agency, No. 20-1530, slip op. at 20 (U.S. June 30, 2022).

386. See White House, Actions in Light of *Dobbs*, supra note 65 ("[T]he President directed the Secretary of Health and Human Services to identify all ways to ensure that mifepristone is as widely accessible as possible . . . .").

387. Press Release, Merrick B. Garland, Att'y Gen., Attorney General Merrick B. Garland Statement on Supreme Court Ruling in *Dobbs v. Jackson Women's Health Organization* (June 24, 2022), https://www.justice.gov/opa/pr/attorney-general-merrick-b-garland-statement-supreme-court-ruling-dobbs-v-jackson-women-s [https://perma.cc/NG28-LMML].

388. Exec. Order No. 14,076, 87 Fed. Reg. 42,053 (July 8, 2022).

389. White House, Protecting Access, supra note 26.

390. See Complaint at 27, GenBioPro, Inc. v. Dobbs, No. 3:20-cv-00652-HTW-LRA (S.D. Miss. Oct. 9, 2020) (arguing that Mississippi's pre-*Dobbs* requirements that a physician prescribe mifepristone and that it be ingested in the physician's presence were preempted because they were "an impermissible effort by Mississippi to establish its own drug approval policy and directly regulate the availability of drugs within the state"). In addition, GenBioPro argued that the Mississippi statute is a "significant burden on interstate commence because [it] interferes with the FDA's national and uniform system of regulation," in violation of the Commerce Clause. Id. at 28. Mississippi countered that an arcane law, which bans mailing any "article, instrument, substance, drug, medicine, or thing may, or can, be used or applied for producing abortion," 18 U.S.C. § 1461 (2018), is now effective with *Roe* overturned, suggesting that federal policy does not permit mailing medication abortion. See Defendant's Memorandum in Opposition to Plaintiff's Motion for Leave to File Amended Complaint at 11, *GenBioPro*, No. 3:20-cv-00652-HTW-LRA. The

"operates as a de facto ban on mifepristone and renders it essentially impossible for GBP to operate in Mississippi," citing the Zohydro opioid litigation.[391] GenBioPro does not need the FDA's support to lodge a preemption challenge based on its business interests. Though GenBioPro moved to dismiss its own lawsuit on August 19, 2022,[392] its public statement suggests that it continues to believe in the litigation strategy—signaling that it will likely file in a more favorable jurisdiction.[393]

2. *HHS's Role in Other Healthcare Matters.* — Preemption theories concerning medication abortion, if accepted, could be transformative. But there are other federal statutes that could be used to preempt state abortion laws on a smaller—and perhaps, less controversial—scale. This section does not purport to offer an exhaustive list of federal statutes that could be used to preempt state abortion bans,[394] but it highlights a few

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statute Mississippi cites, however, has been limited by long-standing precedent. See United States v. One Package, 86 F.2d 737, 739 (2d Cir. 1936) (limiting the Comstock Act of 1873, from which the predecessor of 18 U.S.C. § 1461 derives, to "unlawful abortions" as other parts of the statute did explicitly).

391. GenBioPro, Inc.'s Memorandum in Support of Its Motion for Leave to File Amended Complaint at 6, *GenBioPro*, No. 3:20-cv-00652-HTW-LRA.

392. Notice of Voluntary Dismissal Without Prejudice at 1, *GenBioPro*, No. 3:20-cv-00652-HTW-LRA.

393. See Ian Lopez & Celine Castronuovo, GenBioPro Gives up Abortion Pill Suit Against Mississippi (2), Bloomberg L. (Aug. 19, 2022), https://news.bloomberglaw.com/health-law-and-business/genbiopro-gives-up-abortion-pill-suit-against-mississippi [https://perma.cc/ZRK4-TYY5] ("We continue to believe that GenBioPro's legal strategy is an important path forward to ensuring access to medication abortion care." (internal quotation marks omitted) (quoting Evan Masingill, GenBioPro President)).

394. Additional preemption arguments rooted in existing federal statutes, though not evaluated in depth here, include the following. First, the Employee Retirement Income Security Act of 1974, which governs employer-sponsored insurance plans and preempts state law, might provide protection for employers that cover abortion care or abortion-related travel in states that ban it. See Brendan S. Maher, Pro-Choice Plans 2, at 42–48 (July 25, 2022) (unpublished manuscript), https://ssrn.com/abstract=4172420 [https://perma.cc/6SPM-BTQQ] (arguing that "under ERISA, [a] bounty law" like Texas's SB 8 "is substantively preempted"). Second, the Medicare conditions of participation, which create rules for hospitals that accept Medicare, might 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 Medicare and Medicaid Program, Revisions to Certain Patient's Rights Conditions of Participation and Conditions for Coverage, 79 Fed. Reg. 73,873, 73,874 (Dec. 12, 2014) (to be codified at 42 C.F.R. pts. 416, 418, 482, 483, and 485) (providing regulatory changes "to promote equality and ensure the recognition of the validity of same-sex marriages when administering . . . patient rights and services"). Third, 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 HHS Guidance, supra note 370, at 1–3. Fourth, 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. Cf. Alina Salganicoff, Laurie Sobel & Amrutha Ramaswamy, The Hyde Amendment and Coverage for

opportunities for HHS to use its interpretive and enforcement authority to protect abortion access.[395]

The first, the Emergency Medical Treatment and Labor Act (EMTALA), is a federal statute that requires all hospitals participating in Medicare with an emergency room to both screen patients for medical emergencies and provide stabilizing treatment when emergencies exist.[396] This statute could preempt state abortion bans that do not have exceptions to save the health or the life of the pregnant person; it could also preempt state abortion bans when health-or-life exceptions are more narrow than the demands of EMTALA.[397] 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.[398]

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, physicians have delayed medically necessary

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Abortion Services, Kaiser Fam. Found. (Mar. 5, 2021), https://www.kff.org/womens-health-policy/issue-brief/the-hyde-amendment-and-coverage-for-abortion-services/ [https://perma.cc/2KPN-QQDV] (noting that the Hyde Amendment requires Medicaid coverage be available for abortion in cases of life endangerment, rape, and incest but that some states fail to offer such coverage). Fifth, and finally, the Department of Veterans Affairs (VA) has issued a guidance document arguing that it has authority pursuant to federal law to provide abortions in the context of rape, incest, and health (broadly defined) in VA hospitals even in states that ban abortion in those contexts due to federal preemption. See Reproductive Health Services, 87 Fed. Reg. 55,287, 55,293–94 (proposed Sept. 9, 2022) (to be codified at 38 C.F.R. pt. 17). In October, the authors submitted commentary to the VA supporting their new policy. See Letter from Greer Donley, David S. Cohen & Rachel Rebouché, Professors of L., to Shereef Elnahal, Under Sec. of Health, Dep't of Veteran Affs. (Oct. 11, 2022), https://www.regulations.gov/comment/VA-2022-VHA-0021-54578 [https://perma.cc/N6MG-TB5R].

395. 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. Elizabeth Blackwell Health Ctr. for Women v. Knoll, 61 F.3d 170, 172 (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 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. Id. at 182–83.

396. 42 U.S.C. § 1395dd(a)–(b)(2018).

397. 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-overturn-medically-necessary-abortion/661255/ [https://perma.cc/94VX-D4N5] (describing how EMTALA, which trumps state abortion laws, has a broader definition of a medical emergency that includes many urgent pregnancy conditions).

398. See, e.g., Mary Ziegler, Why Exceptions for the Life of the Mother Have Disappeared, Atlantic (July 25, 2022), https://www.theatlantic.com/ideas/archive/2022/07/abortion-ban-life-of-the-mother-exception/670582/ [https://perma.cc/9TSP-DRGY] (last updated Aug. 2, 2022) (describing how GOP leaders and antiabortion-rights groups in Idaho, Michigan, and Wisconsin oppose lifesaving exceptions to abortion bans).

abortion care even though the patient's life is on the line.[399] Waiting too long to treat a patient can cause hemorrhage, loss of a uterus and future fertility, or death.[400] 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.[401] One study conducted in two Dallas hospitals after SB 8 made post-six-week abortions illegal found that 57% of the patients whose life-saving abortions were delayed to accommodate abortion bans developed a serious morbidity, including the loss of a uterus, and none of their babies survived.[402] Patients are suffering, and some could lose their lives, because of medical inaction.[403]

Shortly after SB 8 went into effect in Texas, in September 2021, HHS Secretary Xavier Becerra sent a memorandum to hospitals entitled "Reinforcement of EMTALA Obligations specific to Patients Who Are

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399. Sneha Dey & Karen Brooks Harper, Abortion Restrictions Threaten Care for Pregnant Patients, Providers Say, Tex. Trib. (May 24, 2022), https://www.texastribune.org/2022/05/24/texas-abortion-law-pregnancy-care/ [https://perma.cc/T4HB-A3RG] ("Cheng, in San Antonio, doesn't use the word abortion anymore in her conversations with patients about their medical options—her hospital has asked her to try to be nonspecific."); 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., Post Crescent (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/7402200001/ [https://perma.cc/Q7NB-5UHC] (last updated May 15, 2022) (describing how doctors in Michigan, Tennessee, and Wisconsin are anticipating having to limit medical treatments due to the extremely narrow exceptions in these states' abortion laws).

400. In Ireland, for instance, Savita Halappanavar died while waiting for lifesaving abortion care, spurring a massive backlash to the country's abortion laws. See 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 (on file with the *Columbia Law Review*).

401. See Reena Diamante, 'We Have Already Reached Capacity': Abortion Clinics Overwhelmed by Out-of-State Travel, Bay News 9 (Aug. 31, 2022), https://www.baynews9.com/fl/tampa/politics/2022/08/31/abortion-services-have-taken–emotional-toll–on-patients–advocates-say- [https://perma.cc/W7VY-6RDL] (describing how out-of-state patients are flooding abortion clinics in Colorado, Kansas, and New Mexico, including patients experiencing medical emergencies such as ectopic pregnancies).

402. Anjali Nambiar, Shivani Patel, Patricia Santiago-Munoz, Catherine Y. Spong & David B. Nelson, Maternal Morbidity and Fetal Outcomes Among Pregnant Women at 22 Weeks' Gestation or Less With Complications in 2 Texas Hospitals After Legislation on Abortion, 227 Am. J. Obstetrics & Gynecology 648, 649 (2022).

403. See Healy, supra note 56 (describing how patients in Tennessee, Texas, and Utah face medical risks due to these states' strict abortion bans); Carole Joffe & Jody Steinauer, Opinion, 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 (on file with the *Columbia Law Review*) (describing how about 700 women die each year from pregnancy complications and that this number is expected to increase in the aftermath of *Dobbs*).

Pregnant or Are Experiencing Pregnancy Loss."[404] The 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.[405] It specifically mentioned that ectopic pregnancy and complications from pregnancy loss would qualify as emergency medical conditions.[406] 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.[407]

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.[408] Instead it focused on people experiencing pregnancy loss.[409] 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.[410] 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

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404. Memorandum from Karen L. Tritz, Dir., Surv. & Operations Grp. & David R. Wright, Dir., Quality, Safety & Oversight Grp., to State Surv. Agency Dirs. (Sept. 17, 2021), https://www.cms.gov/files/document/qso-21-22-hospital.pdf [https://perma.cc/YK2B-3QSJ] [hereinafter CMS Memo].

405. Id. at 1, 3.

406. Id. at 4.

407. Press Release, HHS, HHS Secretary Xavier Becerra Announces Actions to Protect Patients and Providers in Response to Texas' SB 8 (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 [https://perma.cc/Q89T-B3B6].

408. See CMS Memo, supra note 404.

409. Id. at 4 (instructing that "[e]mergency medical conditions [include] . . . ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders" and that EMTALA requires that "all patients receive an appropriate medical screening, stabilizing treatment, and transfer, if necessary, irrespective of any state laws or mandates").

410. See Gabriela Weigel, Laurie Sobel & Alina Salganicoff, Understanding Pregnancy Loss in the Context of Abortion Restrictions and Fetal Harm Laws, Kaiser Fam. Found. (Dec. 4, 2019), https://www.kff.org/womens-health-policy/issue-brief/understanding-pregnancy-loss-in-the-context-of-abortion-restrictions-and-fetal-harm-laws/ [https://perma.cc/4VF2-7AWE] ("Under less common circumstances, however, fetal cardiac activity may be present during cases of miscarriage . . . . It is therefore possible that surgical bans on abortion may limit medical decision making in nuanced cases of pregnancy loss.").

stopped or a person's death was imminent.[411] 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.[412] 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.[413] 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.[414] Notably, because possible damage to an organ qualifies, EMTALA

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411. See, e.g., Lori R. Freedman, Uta Landy & Jody Steinauer, When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals, 98 Am. J. Pub. Health 1774, 1777 (2008) ("Physicians working in Catholic-owned hospitals in all 4 US regions of our study disclosed experiences of being barred from completing emergency uterine evacuation while fetal heart tones were present, even when medically indicated. As a result, they had to delay care or transfer patients to non-Catholic-owned facilities."); Lee A. Hasselbacher, Luciana E. Herbert, Yuan Liu & Debra B. Stulberg, "My Hands Are Tied": Abortion Restrictions and Providers' Experiences in Religious and Nonreligious Health Care Systems, 52 Persps. on Sexual Reprod. Health 107, 112 (2020) ("Many providers and nonproviders noted the delays in care that patients experience as a result of transfers, referrals and ethics committee deliberations at both Catholic and Protestant hospitals."). Though the ACLU attempted to sue a Catholic hospital system under EMTALA in 2016, the lawsuit was dismissed for lack of standing. ACLU v. Trinity Health Corp., 178 F. Supp. 3d 614, 618–21 (E.D. Mich. 2016). When an OBGYN was effectively fired for providing a medically necessary abortion, however, he sued arguing that he was obligated to provide the abortion to stabilize the patient under EMTALA. Ritten v. Lapeer Reg'l Med. Ctr., 611 F. Supp. 2d 696, 704, 709–10 (E.D. Mich. 2009). The court refused to dismiss the lawsuit and it settled before trial. Id. at 718; see also Stipulation and Order of Dismissal With Prejudice at 1–2, *Ritten*, 611 F. Supp. 2d 696 (No. 2:07-cv-10265).

412. Until recently, hospitals and hospital systems that were considering their obligations after *Dobbs* were not taking EMTALA into account. Compare, e.g., Lisa H. Harris, Navigating Loss of Abortion Services—A Large Academic Medical Center Prepares for the Overturn of *Roe v. Wade*, 386 New Eng. J. Med. 2061, 2061–64 (2022) (discussing a hospital's consideration of options for pregnant patients without a discussion of EMTALA), with Memorandum from Karen L. Tritz, Dir., Surv. & Operations Grp. & David R. Wright, Dir., Quality, Safety & Oversight Grp., to State Surv. Agency Dirs. (July 11, 2022), https://www.cms.gov/files/document/qso-22-22-hospitals.pdf [https://perma.cc/JXP4-M5K5] (reminding hospitals of their obligations under EMTALA to provide emergency abortion services).

413. 42 U.S.C. § 1395dd(e) (2018).

414. Donley & Chernoby, supra note 397. 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

would require abortion treatment that, if delayed, could damage the uterus and fallopian tubes, not just threaten a life.

Fortunately, the Biden Administration took 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, states that under EMTALA, a "hospital is required to provide you with the emergency care necessary to save your life, including abortion care."[415] And President Biden's 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."[416] Very soon after these actions were taken, the Texas 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."[417]

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 containing only a narrow life exception and no health exception.[418] This development is important—guidance documents mean nothing without corresponding action. In August 2022, district courts in Texas and Idaho issued conflicting decisions within one day of each other. The Texas court invalidated the HHS guidance for being procedurally defective and going beyond the EMTALA statute, which the court found "protects both mothers and unborn children."[419] The Idaho court, however, found that Idaho's abortion ban was partially preempted by EMTALA and enjoined it to the extent of a conflict, allowing the EMTALA standard to govern for emergency, hospital-based abortions.[420] These

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Treatment and Active Labor Act . . . ." Off. for Civ. Rts., HHS, Guidance on Nondiscrimination Protections Under the Church Amendments for Health Care Personnel 2 (Sept. 17, 2021), https://www.hhs.gov/sites/default/files/church-guidance.pdf [https://perma.cc/7PPZ-X75L].

415. Know Your Rights: Reproductive Health Care, HHS, https://reproductiverights.org [https://perma.cc/8YSV-NT8T] (last visited Sept. 4, 2022); see also Press Release, HHS, Know Your Rights: Reproductive Health Care (June 25, 2022), https://www.hhs.gov/about/news/2022/06/25/know-your-rights-reproductive-health-care.html [https://perma.cc/KT6Q-D2UV] (announcing the launch of the reproductiverights.gov website).

416. Exec. Order No. 14,076, 87 Fed. Reg. 42,053, 42,054 (July 8, 2022).

417. State of Texas's Original Complaint at 1–2, Texas v. Becerra, No. 5:22-cv-185 (N.D. Tex. filed July 14, 2022), 2022 WL 2763763.

418. See Complaint at 2, 8, United States v. Idaho, No. 1:22-cv-329 (D. Idaho filed Aug. 8, 2022), 2022 WL 3137290 ("The *prima facie* criminal prohibition in Idaho's law does not contain any exceptions for when the pregnant patient's health or life is endangered.").

419. *Texas*, 2022 WL 3639525, at *1.

420. *Idaho*, 2022 WL 3692618, at *2.

decisions will likely be appealed to the Fifth and Ninth Circuits, setting up the first potential abortion-related circuit split of the post-*Dobbs* era.

HHS should also enforce the statute against specific hospitals that are accused of delaying care. Those enforcement actions, however, require patients to file complaints with the agency before the agency can act.[421] At the time of writing, the first EMTALA investigation against a hospital in Missouri that denied a patient emergency abortion care made headlines.[422] HHS should continue to spread awareness about the law and make the complaint filing system more user-friendly so that more complaints surface, and the agency can enforce the statute.[423]

A second federal law, the Health Insurance Portability and Accountability Act (HIPAA), preempts policies or actions that compromise the privacy of abortion seekers.[424] This law generally prohibits healthcare workers from disclosing people's private health information. Commentators have been quick to note that HIPAA is narrow: It does not protect personal healthcare data not in the possession of covered healthcare entities (e.g., a person's search histories, menstruation app information, location data), and it does not apply to nonhealthcare workers (e.g., friends and family or fake abortion clinic workers).[425] Nevertheless, it can be enforced against covered healthcare workers who report patients to law enforcement for suspected abortion unless one of the law enforcement exceptions are met.[426] A small number of people who use medication abortion without legal permission will seek medical care at

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421. See 42 U.S.C. § 1395dd(d) (2018) (providing enforcement mechanisms for EMTALA complaints against hospitals).

422. See Rudi Keller, Missouri Hospital the First Confirmed Federal Investigation of Denied Emergency Abortion, Mo. Independent (Nov. 2, 2022), https://missouriindependent.com/2022/11/02/missouri-hospital-the-first-confirmed-federal-investigation-of-denied-emergency-abortion/ [https://perma.cc/8XRL-MPAZ] ("[A Joplin, Missouri] hospital is apparently the first in the nation to be investigated for possibly violating federal law by telling a woman experiencing an emergency that she needed to terminate her pregnancy to protect her health but that the abortion could not take place in the state.").

423. Donley & Chernoby, supra note 397 ("But CMS can make its complaint process more user-friendly and do a better job spreading public awareness of how to file complaints, so that it can act.").

424. 42 U.S.C. §§ 1320d-6 to -7 (2018).

425. See Anya E.R. Prince, Reproductive Health Surveillance, 64 B.C. L. Rev. (forthcoming 2023) (manuscript at 12–13), https://ssrn.com/abstract=4176557 [https://perma.cc/77VG-43KM] (noting that the "siloed nature of [HIPAA] . . . means that the vast amount of health information existing outside of the [covered] healthcare space is not similarly protected").

426. See HIPAA Privacy Rule and Disclosures of Information Relating to Reproductive Health Care, HHS, https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/phi-reproductive-health/index.html [https://perma.cc/3EHQ-RLF8] [hereinafter HHS, Privacy Rule and Disclosures] (last updated June 29, 2022) (explaining that regulated providers cannot "use or disclose" protected health information unless it is "expressly permitted or required" by HIPAA).

a hospital. Past experience suggests that some hospital staff will report those they suspect of self-managed abortion.[427] These covered employees 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 covered employee is complying with a lawfully executed subpoena or similar document; (3) if the covered employee suspects a crime occurred involving the death of a person; (4) if the covered employee suspects child abuse; (5) if the covered employee acts to avert a serious threat to health or safety; or (6) if the covered employee suspects a crime occurred on hospital property.[428] These exceptions create many problems. First, states can get around HIPAA if they pass a law requiring healthcare providers to report suspected abortion. At time of publication, no state has such a law, but mandated disclosure could eventually come into play. Second, HIPAA is not violated if the covered employee is 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 HIPAA might permit a provider to report a patient to law enforcement on the premise that they suspect a crime occurred that involved 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.[429] To address this issue, the federal government could issue guidance that, under federal law, a fetus is not a person or a child, preempting state interpretations to the contrary under HIPAA.[430] Like the EMTALA discussion above, HHS would not only need to issue guidance but also to

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427. Carrie N. Baker, Texas Woman Lizelle Herrera's Arrest Foreshadows Post-*Roe* Future, Ms. Mag. (Apr. 16, 2022), https://msmagazine.com/2022/04/16/texas-woman-lizelle-herrera-arrest-murder-roe-v-wade-abortion/ [https://perma.cc/UNA5-4NSU] (describing how a Texas hospital's report of a woman's "self-induced abortion" led to her arrest and charge for murder).

428. 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 [https://perma.cc/WU7Z-BSQQ] (last visited Sept. 4, 2022).

429. See, e.g., Whitner v. South Carolina, 492 S.E.2d 777, 779 (S.C. 1997) ("South Carolina law has long recognized that viable fetuses are persons holding certain legal rights and privileges.").

430. Finally, a provider could argue that HIPAA does not apply in the context of self-managed abortion because a crime is occurring on the provider's 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.

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.[431] 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: "Where 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 by law' permission."[432] For the court order exception, the guidance stated: "If 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."[433] 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 (PHI) just because they believe such a disclosure would prevent harm to a fetus.[434] Specifically, the agency addressed the example where a patient tells a healthcare worker that they plan to obtain an abortion out of state. In this context, the healthcare workers may not share that with law enforcement absent a court-order document.[435]

Outside of issuing guidance, the Biden Administration could go further. All of the law enforcement exceptions are created by regulation,[436] 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. Though the composition of the current Supreme Court calls into question the likelihood of success on the more ambitious of these preemption arguments, some are less controversial, and lower courts could be amenable to all of them. This effort, along with more like it in the future,

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431. HHS, Privacy Rule and Disclosures, supra note 426.

432. Id. (emphasis omitted).

433. Id. (emphasis omitted).

434. Id.

435. Id.

436. See, e.g., 45 C.F.R. § 164.512 (2021) (allowing disclosure of health information without authorization for law enforcement matters).

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. About 28% of the United States' land mass is owned by the federal government—in such forms as national parks, wilderness preserves, military bases, and more.[437] State abortion bans might be inapplicable on these lands. For example, located forty-five miles from Jackson, Mississippi, is the federally owned Bienville National Forest,[438] and the federal government may lease land it owns in urban areas, such as decommissioned military facilities.[439] Traveling to such sites to receive care—travel that could be much less burdensome than traveling out of state—would help abortion seekers in states with bans, as long as those bans did not apply on 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 the use of federal dollars to perform abortions that do not fall within the provision's exceptions for life, incest, or rape.[440] However, that leaves room for the federal government to lease space on federal land or otherwise permit some private entity to perform abortions there.[441] Those providers

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437. See Carol Hardy Vincent, Laura A. Hanson & Lucas F. Bermejo, Cong. Rsch. Serv., R42346, Federal Land Ownership: Overview and Data 1–3 (2020), https://sgp.fas.org/crs/misc/R42346.pdf [https://perma.cc/H6YA-5476]. Title 18 of the U.S. Code 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.

18 U.S.C. § 7(3) (2018).

438. See Bienville National Forest, Miss. State Parks, https://stateparks.com/bienville_national_forest_in_mississippi.html [https://perma.cc/AL7B-ZX7A] (last visited Oct. 17, 2022); see also Federal Land Policy in Mississippi, Ballotpedia, https://ballotpedia.org/Federal_land_policy_in_Mississippi [https://perma.cc/2EBN-2W4Z] (last visited Oct. 31, 2022).

439. See Org. for Econ. Coop. & Dev., The Governance of Land Use: Country Fact Sheet United States (2017), https://www.oecd.org/regional/regional-policy/land-use-United-States.pdf [https://perma.cc/X74U-A5TB].

440. Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, §§ 506–507, 134 Stat. 1182, 1622, div. H (2022).

441. 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 a Popeye's chicken restaurant. See Peoples v. Puget Sound's Best

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).[442] This relatively little-known federal law is the mechanism by which the federal government bans criminal activity on federal land 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."[443] Someone falling under this provision is "guilty of a like offense and subject to a like punishment."[444]

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 outside the coverage of the ACA.[445] Unfortunately, there is no easy or publicly accessible way to categorize federal land, as this determination involves intense factual analysis relying on dated documents and often contested history.[446] Thus, as a preliminary matter, discerning exactly where the ACA applies and where it does not is a difficult hurdle.[447]

Chicken!, Inc., 345 P.3d 811, 812 (Wash. Ct. App. 2015) (noting that defendants operated a fast-food restaurant leased on what was federal-enclave land and devoting little analytical space to this issue, assuming it to present little analytical difficulty). 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). Knowing that the Biden Administration supports this option, however, would be a prerequisite to a provider considering exploring this possibility because of the role the DOJ has in directing enforcement of federal law and the President has in issuing pardons. See infra notes 450–451 and accompanying text. So far, the Biden Administration has shown little interest in this option despite other Democrats urging the President to try. See Platoff, supra note 66 (noting the Biden Administration has resisted exploring use of federal lands).

442. 18 U.S.C. § 13.

443. Id. § 13(a).

444. Id.

445. It is estimated that just 6% of federal land is considered a federal enclave. John D. Leshy, Robert L. Fischman & Sarah A. Krakoff, Coggins & Wilkinson's Federal Public Land and Resources Law 142 (8th ed. 2022).

446. See Paul v. United States, 371 U.S. 245, 268–69 (1963) (looking deeply into the history of state laws governing transfers of land from the state to the federal government).

447. National parks are federal enclaves, 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, 1144 (S.D. Cal. 2007) (noting the uncontested fact that a federal nuclear generating station is a federal enclave). But federal properties located on

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 the 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.[448] Rather, the ACA incorporates the state crime into federal law so that, technically, the person has violated the federal ACA, not the state law.[449] That means that federal prosecutors prosecute these crimes in federal court, not state prosecutors in state court.[450] 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.[451] 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.[452] Abortion provision in the future, however, would be vulnerable.

Second, the ACA does not incorporate all state criminal law. In *Lewis v. United States*, the Court laid out a two-step test for determining if the ACA assimilates state criminal law.[453] 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, "[t]he ACA presumably would assimilate the [state] statute."[454] Lower courts have made clear that this inquiry includes exploring whether federal

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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 W. River Elec. Ass'n, Inc. v. Black Hills Power & Light Co., 719 F. Supp. 1489, 1499 (D.S.D. 1989).

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

449. See id.

450. United States v. Warne, 190 F. Supp. 645, 659 (N.D. Cal. 1960), aff'd in part, vacated in part sub nom. *Paul*, 371 U.S. 245. *Paul* reaffirmed the principle that congressional regulation of federal land "bars state regulation without specific congressional action." 371 U.S. at 263.

451. Cf. Ex parte Garland, 71 U.S. (4 Wall.) 333, 351 (1866) (recognizing the President's constitutional grant of an "unlimited power in respect to pardon, save only in cases of impeachment"—a power "not merely to take away the penalty, but to forgive and obliterate the offence").

452. Lydia Wheeler, Progressives Look to Pardon Power as Abortion Access Fix, Bloomberg L. (July 12, 2022), https://news.bloomberglaw.com/us-law-week/progressives-look-to-pardon-power-as-abortion-access-fix [https://perma.cc/B9SS-WFT7].

453. 523 U.S. 155, 164 (1998).

454. Id.

regulations cover the conduct.[455] 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 conflict with a federal law occupying the field.[456] 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.[457]

The Court in *Lewis*, however, 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. There is a strong argument—though untested post-*Lewis*—that state abortion law does not apply despite the fact that there is no federal law prohibiting abortion. 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.[458] *Lewis* makes less sense for actions that are not universally prohibited. 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.[459] 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."[460] Although these lower court cases about federal law permitting behavior predate *Lewis* and

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455. 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.'" (quoting language used by multiple lower courts)); United States v. Palmer, 956 F.2d 189, 191 (9th Cir. 1992) (considering the extent to which a federal regulation concerning drunk driving on federal land adopts state law crimes' substance and attendant penalties).

456. *Lewis*, 523 U.S. at 164.

457. One exception is found in § 1531, which prohibits a particular abortion procedure Congress dubbed "partial-birth abortion." 18 U.S.C. § 1531 (2018).

458. *Lewis*, 523 U.S. at 166.

459. Cf. Joseph R. Biden, President, United States, 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/ [https://perma.cc/462U-JHRN] (expressing President Biden's desire that the Justice Department "do everything in [its] power to protect . . . women seeking to invoke their right [to abortion]").

460. King v. Gemini Food Servs., Inc., 438 F. Supp. 964, 966 (E.D. Va. 1976); see also Lord v. Local Union No. 2088, 646 F.2d 1057, 1061–62 (5th Cir. 1981) (holding that because "union security agreements are not illegal under federal law," it would be inconsistent to apply state law to the contrary); Vincent v. Gen. Dynamics Corp., 427 F. Supp. 786, 800 (N.D. Tex. 1977) ("[S]ince federal labor policy favors union security agreements, the criminal provisions of the Texas 'right-to-work' laws are not incorporated into federal criminal law by 18 U.S.C. § 13.").

its focus on federal laws that criminalize behavior, they are consistent with the Supreme Court's statements about the ACA's goals.[461]

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.[462] Because federal regulations can be the source of federal law under the ACA,[463] 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.[464] 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.[465] Early abortion access would, however, 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.[466]

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461. James Stewart & Co. v. Sadrakula, 309 U.S. 94, 103–04 (1940) ("[T]he 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.").

462. In many ways, these arguments dovetail with the preemption arguments described above. 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 and its case law. The preemption argument in section III.A of this Article is similar in that it looks to conflict between state and federal law. Moreover, the general preemption argument would apply beyond federal land and in all parts of a state. Thus, if a general preemption argument prevailed, there would be no need for a federal lands argument.

However, if a general preemption argument were not to succeed, the federal lands argument could still prevail if courts perceive the unique ACA language and case law to apply when the preemption case law does not. For instance, a court might find the comparison to the ACA union shop cases convincing but might not be convinced by a comparison to preemption jurisprudence. Cf. *Lord*, 646 F.2d at 1061; *Vincent*, 427 F. Supp. at 800; *King*, 438 F. Supp. at 966. Moreover, a court might feel less concerned about the interjurisdictional implications of allowing abortion on federal enclaves within a state as opposed to finding that federal law preempts state law throughout the entirety of the state.

463. See United States v. Hall, 979 F.2d 320, 322 (3d Cir. 1992).

464. See supra section I.B.

465. See supra section I.B.

466. 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. See supra note 90 and accompanying text noting that the standard of care typically is determined by

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 regimen's safety,[467] represents not merely permission from the federal government to perform abortions in this manner; rather, such approval constitutes an affirmative 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.[468] 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"[469] and outlawed acts that cause the death of an "unborn child."[470] Every year, Congress renews the Hyde Amendment, which prohibits federal dollars from being spent on abortion.[471] Under the Affordable Care Act, Congress bans abortion from being part of the insurance options offered through exchanges,[472] and there are many different provisions protecting freedom of conscience with respect to abortion provision and refusal.[473] 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 legal anything that is not explicitly illegal on federal lands. This interpretation would permit

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where the patient is located. For this reason, it might be safer to require the patient to consume the drugs on federal land as well.

467. See supra section III.A.

468. See supra notes 460–461 and accompanying text explaining that the federal government's approval of union shops amounted to a national policy that barred assimilation through the ACA of state right-to-work laws.

469. See 18 U.S.C. § 1531 (2018).

470. See id. § 1841(a)(1).

471. See, e.g., Consolidated Appropriations Act, 2022, Pub. L. No. 117-103, §§ 201–203, 136 Stat. 49, 131 (2020) ("None of the funds appropriated by this title shall be available to pay for an abortion, except where the life of the mother would be endangered if the fetus were carried to term, or in the case of rape or incest."); Consolidated Appropriations Act, 2021, Pub. L. No. 116-120, 134 Stat. 1182, 1263 §§ 201–203 (2021) (utilizing the same language).

472. 42 U.S.C. § 18023 (2018).

473. For a thorough list of federal laws relating to abortion refusal, see Secretariat of Pro-Life Activities, Current Federal Laws Protecting Conscience Rights (2019), https://www.usccb.org/issues-and-action/religious-liberty/conscience-protection/upload/Federal-Conscience-Laws-Fact-Sheet.pdf [https://perma.cc/VZA6-YCTU].

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.[474] 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.[475]

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 SB 8.[476] For civil law on federal land, there is no law comparable to the ACA that wholesale incorporates nonconflicting state civil law. Rather, there are individual statutes that incorporate some specific state civil laws, such as wrongful death or personal injury.[477] 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."[478] Because Texas's SB 8 and any copycat laws from other states are of such recent vintage, they would be precluded from being incorporated on federal land.[479] Abortion providers, however, 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.[480]

It is important to note that the ACA analysis here is limited to the legal risk people will face while on federal land. Once those people—whether

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474. Lewis v. United States, 523 U.S. 155, 164 (1998) (citing Wis. Pub. Intervenor v. Mortier, 501 U.S. 597, 604–05 (1991)).

475. 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.").

476. S.B. 8, 87th Gen. Assemb., Reg. Sess. (Tex. 2021) (codified as amended at Tex. Health & Safety Code Ann. §§ 171.201–.212 (West 2022)).

477. See 28 U.S.C. § 5001 (2018) (providing that state law shall govern the rights of parties in civil actions for death or personal injury in a place subject to exclusive jurisdiction of the United States).

478. George Cameron Coggins & Robert L. Glicksman, 1 Pub. Nat. Res. L. § 3:8 (2d ed. 2009) (using Arlington Hotel Co. v. Fant, 278 U.S. 439 (1929), as an illustrative example of this point).

479. Cf. Balderrama v. Pride Indus., Inc., 963 F. Supp. 2d 646, 656 (W.D. Tex. 2013) (stating that "laws of the state adopted after the cession are without any force or effect on the federal enclave").

480. Abortion providers concerned about this liability, however, could require patients—and possibly other persons related to the patient—to sign waivers from suing under state wrongful death provisions.

provider, patient, or helper—travel 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,[481] 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.[482] 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 privileges or immunities of their federal government should apply to conducting any federally approved business on federal land.

The authors 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."[483] 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 has the potential to increase abortion access in antiabortion states while simultaneously raising unexplored interjurisdictional legal issues previously unaddressed in the long history of abortion conflict.[484]

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481. This is due to all of the complications discussed above in Part II regarding states punishing abortion travel or extraterritorial abortion.

482. Slaughter-House Cases, 83 U.S. (16 Wall.) 36, 79–80 (1873) ("It is said to be the right of the citizen of this great country . . . 'to come to the seat of government . . . to transact any business [he or she] may have with it . . . .'" (quoting Crandall v. Nevada, 73 U.S. (6 Wall.) 35, 44 (1867))).

483. Nikhil Bhagat, Filling the Gap? Non-Abrogation Provisions and the Assimilative Crimes Act, 111 Colum. L. Rev. 77, 80 (2011).

484. Interjurisdictional issues would also arise with abortion provision on Native land, though this Article does not address that complex topic here. See generally Heidi L. Guzmán, *Roe* on the Rez: The Case for Expanding Abortion Access on Tribal Land, 9 Colum. J. Race & L. 95 (2019) (setting out how and why tribal land could support abortion provision); Lauren van Schilfgaarde, Aila Hoss, Sarah Deer, Ann E. Tweedy & Stacy Leeds, The Indian Country Abortion Safe Harbor Fallacy, LPE Project (June 6, 2022), https://lpeproject.org/blog/the-indian-country-abortion-safe-harbor-fallacy/ [https://perma.cc/9AZ4-G8AY] (arguing that "the possibility of an abortion 'safe harbor' on tribal lands . . . overlooks important legal, financial, political, and ethical considerations that . . . make the possibility of abortion safe harbors highly unlikely"). Importantly, the authors 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

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. With these policy changes, medication abortion would 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 mifepristone that make the drug harder to access across the country.[485] The first two REMS requirements—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.[486] The certification process requires providers to register with the drug manufacturer, affirming that they can identify and treat mifepristone's rare adverse effects.[487] 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.[488] This process also disincentivizes general obstetricians and primary care providers from offering medication abortion as part of their practices.[489] In the same vein,

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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, slip op. at 22 (U.S. June 29, 2022) ("[N]o federal law preempts the State's exercise of jurisdiction over crimes committed by non-Indians against Indians in Indian country. And principles of tribal self-government likewise do not preempt state jurisdiction here."). For comprehensive treatment of the issue, see generally Lauren van Schilfgaarde, Alia Hoss, Ann E. Tweedy, Sarah Deer & Stacy Leeds, Tribal Nations and Abortion Access: A Path Forward, 46 Harv. J.L. & Gender (forthcoming 2023), https://ssrn.com/abstract=4190492 [https://perma.cc/NT4X-JGDT] (exploring the challenges, and ethical problems, of utilizing tribal lands for abortion travel).

485. See supra notes 280–288. The FDA could also permit medication abortion through twelve weeks of pregnancy, which is supported by evidence of the drug's effectiveness through that time. The FDA has done this previously, in 2016, when it approved mifepristone use through ten, rather than seven, weeks. Donley, supra note 70, at 641.

486. Donley, supra note 70, at 638.

487. Id. at 641–42 n.104.

488. See generally David S. Cohen & Krysten Connon, Living in the Crosshairs: The Untold Stories of Anti-Abortion Terrorism (2015) (chronicling the ways in which abortion providers are targeted by antiabortion extremists).

489. 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/ [https://perma.cc/ZQ27-GS5Q].

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.[490]

As discussed in the previous Parts, 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.[491] The first is through the mail, supervised by a certified provider, which was a practice over most of the pandemic.[492] The second is new: dispensation by a pharmacy.[493] The FDA, however, added a new REMS element that pharmacies also must seek certification to dispense mifepristone.[494] 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.[495] For example, the 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.[496] Other requirements

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490. Rachel Rebouché, Greer Donley & David S. Cohen, Opinion, 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/ (on file with the *Columbia Law Review*).

491. FDA, Questions and Answers, supra note 71.

492. Id.

493. Id.

494. FDA, Cavazzoni Letter, supra note 76, at 6–7.

495. Other drugs are subject to pharmacy certification under a REMS, and those requirements vary in what additional dispensation and administrative restrictions they impose. See, e.g., FDA, NDA 22-405 Caprelsa (Vandetanib): Risk Evaluation and Mitigation Strategy 1–4 (2017), https://www.accessdata.fda.gov/drugsatfda_docs/rems/Caprelsa_2017-05-16_REMS_Document.pdf [https://perma.cc/U892-WULJ] (describing the certification requirements for healthcare facilities dispensing Capresla, a medication used to treat medullary thyroid cancer); FDA, Risk Evaluation and Mitigation Strategy (REMS) Document: Adasuve (Loxapine) REMS Program 2 (2022), https://www.accessdata.fda.gov/drugsatfda_docs/rems/Adasuve_2022_01_27_REMS_Document.pdf [https://perma.cc/6HPS-U45V] (describing the certification requirements for healthcare facilities dispensing Adasuve, an antipsychotic medication).

496. Cf. FDA, Risk Evaluation and Mitigation Strategy (REMS) Document: Pomalyst (Pomalidomide) REMS Program 1–3 (2021), https://www.accessdata.fda.gov/drugsatfda_docs/rems/Pomalyst_2021_08_05_REMS_Document%20.pdf [https://perma.cc/8P6T-MQJ3] (describing limitations on pharmacists' fulfilment of prescriptions of Pomalyst, a birth-control medication). 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 abortion, the availability of which could vary by state law. See 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. 4, 2022),

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.

If the FDA wants to expand abortion access, it can ensure that the yet-to-be-determined pharmacy certification process reflects mifepristone's safety and imposes minimal requirements. As is true for provider certification, overly burdensome obligations on pharmacies will discourage them from carrying mifepristone.[497] 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.

For mailed medication abortion, 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.[498] 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."[499] 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.[500] At the moment, there are few signs that retail pharmacies are eager to dispense mifepristone.[501] In June 2022, the five largest pharmacy companies declined to comment on whether they would seek certification. CVS indicated it would assess future

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https://msmagazine.com/2022/01/04/online-abortion-pills-provider-robin-tucker-virginia-maryland-maine/ [https://perma.cc/4VNX-ECX4] (highlighting a current obstacle in obtaining advance provision abortion pills).

497. Rebouché, Remote Reproductive Rights, supra note 34, at 8 (noting how pharmacy certification, depending on the process, could deter pharmacies from carrying mifepristone).

498. 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/ [https://perma.cc/T9VU-AM3T].

499. Id.

500. 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: "Given what is at stake, business leaders need to make their voices heard." Emma Goldberg, These Companies Will Cover Travel Expenses for Employee Abortions, N.Y. Times (Aug. 19, 2022), https://www.nytimes.com/article/abortion-companies-travel-expenses.html (on file with the *Columbia Law Review*).

501. Donley, supra note 70, at 646–47.

facts once permitted to dispense mifepristone, and Walgreens implied that it will not seek pharmacy certification.[502]

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 part of the FDA's ordinary functions, the agency would not need to rely on any novel legal theories to act.[503] Any challenge to the agency's action here, which would inevitably come, would face legal obstacles.[504]

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.[505] 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.[506] Despite this growth, there remains unequal access to telehealth, mirroring broader disparities in the distribution of health resources.[507] Most abortion patients live at or 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.[508] Those same patients need access to a telehealth-

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502. Cynthia Koons, The Abortion Pill Is Safer Than Tylenol and Almost Impossible to Get, Bloomberg (Feb. 17, 2022), https://www.bloomberg.com/news/features/2022-02-17/abortion-pill-mifepristone-is-safer-than-tylenol-and-almost-impossible-to-get?leadSource=uverify%20wall (on file with the *Columbia Law Review*) (last updated May 3, 2022).

503. Ironically, if the FDA removed the entire REMS, this might undercut the preemption argument made in this Part's first section, see supra section III.A, but it would nevertheless provide broader access to everyone.

504. Donley, supra note 70, at 688–89 (noting that any move by the FDA to remove or relax mifepristone's REMS would face administrative law challenges that would be "unlikely to succeed" because "[t]he FDA's decision would be realigning mifepristone with its treatment of similar drugs," insulating it from an arbitrary and capricious challenge).

505. White House, Protecting Access, supra note 26.

506. See Cason D. Schmit, Johnathan Schwitzer, Kevin Survance, Megan Barbre, Yeka Nmadu & Carly McCord, Telehealth in the COVID-19 Pandemic, *in* Assessing Legal Responses to COVID-19, at 123, 128 (Scott Burris, Sarah de Guia, Lance Gable, Donna E. Levin, Wendy E. Parmet & Nicolas P. Terry eds., 2020) ("Fifteen states expanded the authority to provide telehealth across state lines.").

507. See id. at 123 (noting that "[t]echnology access, digital literacy, and reliable internet coverage are major barriers to telehealth . . . experienced disproportionately among . . . the elderly, persons of color, and individuals with low socioeconomic status"); see also David A. Hoffman, Increasing Access to Care: Telehealth During COVID-19, 7 J.L. & Bioscis. 1, 2 (2020) (describing similar barriers to telehealth).

508. See Guttmacher Inst., Abortion Patients, supra note 52 ("Nearly half of abortion patients in the United States are poor and another 26% are low income.").

capable device, high-speed data transmission, and digital literacy. Take for instance unequal access to broadband internet service.[509] 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.[510] Most telehealth services are available only in English, though an increasing number of providers deliver care in Spanish, and people with visual or cognitive difficulties or other disabilities may have trouble interfacing via video.[511] 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.[512] The ripple effects of doing so would benefit those seeking abortion via telehealth.

These efforts depend on state cooperation, however, and here the federal government would have to play an advocacy role in promoting permissive state telehealth policies.[513] During the pandemic, with the assistance of federal agencies like HHS, 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.[514] Also with federal

509. See Betsy Lawton, COVID-19 Illustrates Need to Close the Digital Divide, *in* 2 COVID-19 Policy Playbook: Legal Recommendations for a Safer, More Equitable Future 198, 198 (Scott Burris, Sarah de Guia, Lance Gable, Donna E. Levin, Wendy E. Parmet & Nicolas P. Terry eds., 2021).

510. See Alexandra Thompson, Dipti Singh, Adrienne R. Ghorashi, Megan K. Donovan, Jenny Ma & Julie Rikelman, The Disproportionate Burdens of the Mifepristone REMS, 104 Contraception 16, 18 (2021).

511. Jorge A. Rodriguez, Altaf Saadi, Lee H. Schwamm, David W. Bates & Lipika Samal, Disparities in Telehealth Use Among California Patients With Limited English Proficiency, 40 Health Affs. 487, 490 (2021); Daniel Young & Elizabeth Edwards, Telehealth and Disability: Challenges and Opportunities for Care, Nat'l Health L. Program (May 6, 2020), https://healthlaw.org/telehealth-and-disability-challenges-and-opportunities-for-care/ [https://perma.cc/8ZPN-VKN8] ("A provider may be inclined to visually examine patients with a videoconference, but the movements and positioning often necessary for a physical exam may be hard for people with mobility and sensory disabilities to perform.").

512. See, e.g., Devin Coldewey, FCC Enacts $200M Telehealth Initiative to Ease COVID-19 Burden on Hospitals, TechCrunch (Apr. 2, 2020), https://techcrunch.com/2020/04/02/fcc-enacts-200m-telehealth-initiative-to-ease-covid-19-burden-on-hospitals/ [https://perma.cc/2L3X-UC5G] (discussing program to help "eligible health care providers purchase telecommunications services, information services, and devices necessary to provide critical connected care services" during the pandemic).

513. Cf. Hudson Worthy, The New Norm in Healthcare: Telehealth, 15 Charleston L. Rev. 549, 550, 555–58 (2020) (noting that with the pandemic "our country was forced to adopt telehealth" but that the currently governing regime suffers from a "lack of uniformity in the regulations and laws of each state").

514. See Kyle Y. Faget, Telehealth in the Wake of COVID-19, 22 J. Health Care Compliance 5, 7 (2020) (discussing federal and state action to expand available telehealth modalities, including through HHS efforts); Schmit et al., supra note 506, at 125–29 (discussing federal measures to recognize additional telehealth modalities and surveying states that have done so).

guidance, and with federal protection from liability, many states waived and some states repealed rules limiting the reach of telehealth, such as rules regulating how patient–provider relationships are established and rules limiting the ability of out-of-state providers to practice in state.[515] 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*, at the time of writing, the Administration has not taken this step but is evaluating statutes that grant the President such powers and considering the challenges that any public health declaration would certainly face in courts.[516]

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.[517] Although most pandemic-related waivers of state telehealth restrictions have expired,[518] the

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515. See Faget, supra note 514, at 7–9.

516. 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 [https://perma.cc/F5MJ-DXEU]. Under this approach, the Biden Administration could declare a public health emergency under a statute like the Public Readiness and Emergency Preparedness (PREP) Act. See 42 U.S.C. § 247d-6d to -6e (2018). 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. Public Readiness and Emergency Preparedness (PREP) Act, HHS, https://aspr.hhs.gov/legal/PREPact/Pages/default.aspx (on file with the *Columbia Law Review*) (last visited Sept. 4, 2022). Countermeasures are approved products that assist in fighting an epidemic or pandemic, which can include material assistance and drugs. See 42 U.S.C. § 247d-6d(i)(1)(A), (i)(7). 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, Opinion, Biden Must Declare a Public Health Emergency for Abortion—Immediately, Wash. Post (June 30, 2022), https://www.washingtonpost.com/opinions/2022/06/30/declare-abortion-public-health-emergency (on file with the *Columbia Law Review*). 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 many people. See Jennifer L. Piatt, Summer Ghaith & Madisyn Puchebner, The Network for Pub. Health L., Abortion Access: A Post-*Roe* Public Health Emergency 4 (2022), https://www.networkforphl.org/wp-content/uploads/2022/06/Western-Region-Memo-Abortion-and-Public-Health-Emergencies.pdf [https://perma.cc/83FW-XNAX].

517. See Kate Nelson, "To Infinity and Beyond": A Limitless Approach to Telemedicine Beyond State Borders, 85 Brook. L. Rev. 1017, 1024–27 (2020).

518. See Juan J. Andino, Ziwei Zhu, Mihir Surapaneni, Rodney L. Dunn & Chad Ellimoottil, Interstate Telehealth Use by Medicare Beneficiaries Before and After COVID-19 Licensure Waivers, 2017–20, 41 Health Affs. 838, 839 (2022); Katherine Fang & Rachel

growing acceptance of telehealth across state lines has prompted calls for uniform policy, particularly as related to physician licensure.[519] Thirty-four states are currently members of the Interstate Medical Licensure Compact (IMLC), which "offers a voluntary, expedited pathway to licensure for physicians who qualify."[520] Three additional states have legislation pending.[521] The IMLC utilizes a "mutual recognition" model that aims to increase access to healthcare for patients in rural and underserved areas.[522] The IMLC does not grant automatic cross-border licensure but makes the process of obtaining practice permission in another state easier.[523] 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."[524] Reiterating a theme of this Article, polarized approaches to abortion regulation could undermine the emerging consensus 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

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Perler, Comment, Abortion in the Time of COVID-19: Telemedicine Restrictions and the Undue Burden Test, 32 Yale J.L. & Feminism 134, 135 (2021); Kerri Pinchuk, Note, 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, 277 (2021).

519. Nathaniel M. Lacktman, Alexis Finkelberg Bortniker, Thomas B. Ferrante, Aaron T. Maguregui & Jennifer J. Hennessy, Top 5 Telehealth Law Predictions for 2021, Nat'l L. Rev. (Jan. 12, 2021), https://www.natlawreview.com/article/top-5-telehealth-law-predictions-2021 [https://perma.cc/6G7G-XH22] ("The status quo (i.e., profession-specific interstate compacts and state-by-state patchwork legislative efforts) has left many digital health stakeholders unimpressed, frustrated, and increasingly searching for an alternate solution.").

520. A Faster Pathway to Physician Licensure, Interstate Med. Licensure Compact, https://www.imlcc.org/a-faster-pathway-to-physician-licensure/ [https://perma.cc/ZB3F-9KJF] (last visited Sept. 4, 2022); see also Eli Y. Adashi, I. Glenn Cohen & Winston L. McCormick, The Interstate Medical Licensure Compact: Attending to the Underserved, 325 J. Am. Med. Ass'n 1607, 1607–08 (2021) (discussing the benefits of the IMLC's overhaul of the interstate licensure process for telemedicine).

521. See Participating States, Interstate Med. Licensure Compact, https://www.imlcc.org/participating-states/ [https://perma.cc/6FS6-Q338] (last visited Sept. 4, 2022).

522. Nelson, supra note 517, at 1038.

523. See id. at 1037–38.

524. Id. 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.

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 will likely see more patients traveling from antiabortion states. Thus, if Illinois experiences an increase in patients due to its proximity to Kentucky (or other antiabortion states), 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 abortion providers in Kentucky are now unable to perform abortions in Kentucky, they could become licensed in other states that permit telehealth for abortion and provide abortions to patients scattered throughout abortion-supportive states, even if they remain in Kentucky.[525]

In July 2022, the Uniform Law Commission (ULC) approved a model act on telehealth for states to adopt.[526] The model act creates a registration process for out-of-state practitioners seeking to practice telehealth in a patient's resident state. Under this process, 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 "a practitioner-patient relationship with the patient."[527] The scope of care is broadly defined under the draft act: "A practitioner may provide telehealth services to a patient located in this state if the services are consistent with the practitioner's scope of practice in this state, applicable professional practice standards in this state, and requirements and limitations of federal law and law of this state."[528]

A few aspects of the ULC's model act 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 model act tracks the currently governing 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"[529] and other

525. 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. Section II.D and the remainder of this section discuss the ramifications of disciplinary actions for licensure and malpractice insurance.

526. Unif. Telehealth Act (Unif. L. Comm'n 2022).

527. Id. § 6(a)(3)(A). In addition, an out-of-state physician may provide telehealth services "pursuant to a previously established practitioner-patient relationship" so long as the services are provided within one year of the last time the doctor provided healthcare to the patient. Id. § 6(a)(3)(C). The commentary explains this provision allows out-of-state practitioners to provide "follow-up care" to patients through remote means. Id. § 6 cmt. 5.

528. Id. § 4(a).

529. See discussion supra section II.D.

jurisdictions may follow suit or define 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 healthcare, precluding "provision of health care otherwise regulated by federal law or law of this state."[530] 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 model 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.)[531] In addition, the model 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 shield laws that seek to protect providers from in-state repercussions of disciplinary actions taken in other states.

There is a similar conflict between shield laws and the IMLC. The IMLC, when enacted by a state, currently requires that state to recognize and act on the disciplinary actions taken by other member states.[532] Although those provisions are currently under review by the IMLC Commission,[533] member states agree when becoming part of the IMLC

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530. Unif. Telehealth Act § 4(b). A previous, now deleted, comment to this section listed abortion restrictions as a relevant example. The comment stated: "[S]tate statutes restricting or prohibiting the prescription of abortion-inducing medications or other controlled substances through telehealth will continue to apply." Unif. Telehealth Act § 4 cmt. (Unif. L. Comm'n, Draft June 28, 2021).

531. See Unif. Telehealth Act § 6 cmt. 5 (Unif. L. Comm'n 2022) ("Out-of-state practitioners must be mindful . . . that under section 4(a), any requirements with respect to the delivery of health care within this state will apply, including . . . limitations on the prescription of controlled substances.").

532. See Interstate Med. Licensure Compact §§ 8–10 (Interstate Med. Licensure Compact Comm'n 2015) (providing, for example, in Section 10(b) that "[i]f a license . . . in the state of principal license is revoked . . . then all [member board] licenses . . . shall automatically be placed, without further action necessary by any member board, on the same status").

533. Proposed amendments to the IMLC law would replace mandatory language with permissive language—language that allows, but does not require, a member medical board to act when the state of principal license or another member state has revoked, surrendered, suspended, or relinquished a license. See Interstate Med. Licensure Compact Comm'n, Rule on Coordinated Information System, Joint Investigations and Disciplinary Actions 7 (2022), https://www.imlcc.org/wp-content/uploads/2022/10/IMLCC-Rule-Chapter-6-Coordinated-Information-System-Joint-Investigations-and-Disciplinary-Actions-Adopted-November-16-2018-Rulemaking-Hearing-Draft-11-8-2022.pdf [https://perma.cc/3TER-WTAX] (featuring proposed language that a state "may terminate, reverse, or rescind such automatic action" as is triggered under § 10(b) or § 10(d) of the Compact whereby disciplinary action against a physician in one member state can automatically effect or authorize the same discipline in another member state). The American Medical Association requested that the IMLC Commission provide further amendments addressing potential

that "[a]ny disciplinary action taken by any member board against a physician licensed through the Compact shall be deemed unprofessional conduct which may be subject to discipline by other member boards . . . ."[534] Thus, providers with licenses under the IMLC open themselves up to discipline by all member states' boards. Reciprocity of disciplinary actions, of course, helps member states to police bad or negligent behavior of physicians who cross state lines. But whereas there has traditionally been alignment among state medical practice acts, after *Dobbs*, states vary widely on abortion's legality and on exceptions to abortion criminalization.[535] Medical boards in states that ban abortion might, under very broad language of what constitutes unethical conduct, seek to penalize a provider with an in-state license for care that is provided legally out of state.[536] Shield laws attempt to protect those providers, but the current provisions of the IMLC might undermine shield laws, especially when compacts seek to preempt conflicting state laws.

The ULC's model act and the IMLC spotlight the complexities inherent in mapping abortion care onto policies that govern telehealth, licensure, and 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.[537] And any travel outside the state may be high risk. For example, Kentucky courts could hear a civil suit and enter a default judgment against a provider, though evidence would be difficult to amass if the shield laws operate as expected and no one agrees to cooperate. For reasons discussed in Part II, pulling a nonresident 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.

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conflicts among member states with differing abortion laws so "that each state has the authority over the practice of medicine within its borders and does not have the authority to regulate the practice of medicine in other states." Letter from James L. Madara, Chief Exec. Officer, Am. Med. Ass'n, to Marschall S. Smith, Exec. Dir., Interstate Med. Licensure Compact Comm'n 2 (Sept. 19, 2022), https://www.imlcc.org/wp-content/uploads/2022/09/Comments-Rule-Chapter-6-American-Medical-Association.pdf [https://perma.cc/H4BT-J2VG].

534. Interstate Med. Licensure Compact § 10(a).

535. See supra Part I.

536. Some states have provisions in their licensure laws that allow medical boards to discipline a provider for broad reasons and/or for actions in another state regardless of whether those actions are legal in the state in which they occurred. See, e.g., W. Va. Code Ann. § 11-1A-12.1.j (LexisNexis 2022) (providing grounds for discipline for "any act contrary to honesty, justice or good morals, whether the same is committed in the course of his or her practice or otherwise and whether committed within or without this State").

537. See supra section II.D.

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 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.[538] 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.[539] 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.[540] Senators Elizabeth Warren, Patti Murray, and many others urged the Administration in a June 2022 letter to secure material support for travel and related expenses: "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."[541] Because these measures do not fund abortion services, they fall outside of the Hyde Amendment's reach. Other resources, marshaled through federal agencies with varying powers and expertise, could be used to attempt to soften the material consequences for abortion patients after *Dobbs*.[542] Any efforts to streamline care, remove barriers, and increase the number of abortion providers will help all patients.

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538. See supra notes 259–264 and accompanying text.

539. See 18B Charles Alan Wright, Arthur R. Miller & Edward H. Cooper, Federal Practice and Procedure § 4467 n.14 (3d ed. 2022).

540. See David S. Cohen, Greer Donley & Rachel Rebouché, Opinion, 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 (on file with the *Columbia Law Review*) (noting that "[a]bortion providers also will need protection from threats to their medical licenses and insurance status").

541. See Senate Letter, supra note 26, at 2.

542. For example, the Centers for Medicare & Medicaid Services could ensure, as a condition of participation, that Hyde-compliant abortions are performed at participating

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 antiabortion states, regardless of their opposition. As early abortion access becomes more portable, it will be easier to obtain for everyone. Patients who travel from antiabortion 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.[543] And yet others who want to remain in antiabortion states might find more options to explore, including mail forwarding and "doctors of conscience,"[544] 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

This Article identifies 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 lie opportunities to untether abortion access to the pronouncement of constitutional abortion 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 telabortion through licensure and telemedicine infrastructure.

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hospitals and other facilities in every state. Medicare Coverage Database: Abortion, Ctrs. for Medicare & Medicaid Servs., https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=127&ncdver=2&bc=AAAAgA [https://perma.cc/X3RS-AMDQ] (last visited Sept. 4, 2022) (stating that abortions are covered Medicare procedures in cases of rape or incest and when "a woman suffers from a physical disorder, physical injury, or physical illness . . . that would, as certified by a physician, place the woman in danger of death unless an abortion is performed").

543. Jamie Ducharme, New Abortion Clinics Are Opening Near Airports and State Borders, TIME (June 9, 2022), https://time.com/6185519/abortion-clinics-travel-state-borders/ [https://perma.cc/M23N-8KYA].

544. Carole Joffe, Doctors of Conscience: The Struggle to Provide Abortion Before and After *Roe v. Wade* (1995) (exploring the stories of "doctors of conscience"—physicians motivated by their conscience to perform or facilitate abortion care).

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;[545] other options involve risks and collateral consequences that people may not be willing to take. But thinking about interjurisdictional approaches to abortion access is important now more than ever because the abortion debate, and the conflicts it inspires, are in the process of fundamentally changing. 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,[546] 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 years[547]—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 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.

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545. 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 discussed throughout this Article, no matter how well established.

546. See David S. Cohen, Chaos and the United States Supreme Court, LEX, 2021, at 35, https://issuu.com/drexelkline/docs/lex4_full_magazine_r6 (on file with the *Columbia Law Review*) (reviewing the randomness of Supreme Court vacancies).

547. See generally David S. Cohen, Greer Donley & Rachel Rebouché, Re-Thinking Strategy After *Dobbs*, 75 Stan. L. Rev. Online 1, 14 (2022) ("A model suited for 2022 and beyond will require a big tent that capitalizes on novel yet varied approaches from all of the existing organizations and welcomes newcomers into the fold, even if they disagree and even if there is no guarantee of success.").