6

The Promise of Telehealth for Abortion

Greer Donley and Rachel Rebouché

I INTRODUCTION

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

Over the course of the COVID-19 pandemic, however, that changed. The pandemic's early days exposed how the FDA's in-person dispensing requirement facilitated virus transmission and hampered access to abortion without any medical benefits.[4] This realization created a fresh urgency to lift the FDA's unnecessary restrictions. Researchers and advocates worked in concert to highlight evidence undermining the need for the in-person dispensing requirement,[5] which culminated in the FDA permanently removing the requirement in December 2021.[6]

The result is an emerging new normal for abortion through ten weeks of pregnancy – telehealth – at least in the states that allow it.[7] Abortion by telehealth (what an early study dubbed "TelAbortion") generally involves a pregnant person meeting online with a health care professional, who evaluates whether the patient is a candidate for medication abortion, and, if so, whether the patient satisfies informed

[1] Greer Donley, Medication Abortion Exceptionalism, 107 Cornell L. Rev. 627, 647 (2022).

[2] Id. at 643–51.

[3] Id.

[4] Id. at 648–51; Rachel Rebouché, The Public Health Turn in Reproductive Rights, 78 Wash & Lee L. Rev. 1355, 1383–86 (2021).

[5] Rebouché, supra note 4, at 1383–86.

[6] Donley, supra note 1, at 648–51.

[7] Id. at 689–73.

https://doi.org/10.1017/9781009373234.009 Published online by Cambridge University Press

consent requirements.[8] Pills are then mailed directly to the patient, who can take them and complete an abortion at home. This innovation has made earlier-stage abortions cheaper, less burdensome, and more private, reducing some of the barriers that delay abortion and compromise access.[9]

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

II THE EARLY ABORTION CARE REVOLUTION

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

A *The Regulation of Medication Abortion*

In 2020, medication abortions comprised 54 percent of the nation's total abortions, which is a statistic that has steadily increased over the past two decades.[10] A medication abortion in the United States typically has involved taking two types of drugs, mifepristone and misoprostol, often 24 to 48 hours apart.[11] The first medication detaches the embryo from the uterus and the second induces uterine contractions to expel the tissue.[12] Medication abortion is approved by the FDA to end pregnancies through ten weeks of gestation, although some providers will prescribe its use off-label through twelve or thirteen weeks.[13]

[8] David Cohen, Greer Donley & Rachel Rebouché, The New Abortion Battleground, 123 Colum. L. Rev. 1, 9–13 (2023).

[9] Id.

[10] Rachel Jones et al., Abortion Incidence and Service Availability in the United States, Guttmacher Inst. (2022), www.guttmacher.org/article/2022/11/abortion-incidence-and-service-availability-united-states-2020.

[11] Donley, supra note 1, at 633.

[12] Id.

[13] Id.

https://doi.org/10.1017/9781009373234.009 Published online by Cambridge University Press

The FDA restricts mifepristone under a system intended to ensure the safety of particularly risky drugs – a Risk Evaluation and Mitigation Strategy (REMS).[14] The FDA can also issue a REMS with Elements to Assure Safe Use (ETASU), which can circumscribe distribution and limit who can prescribe a drug and under what conditions.[15] The FDA instituted a REMS with ETASU for mifepristone, the first drug in the medication abortion regimen, which historically mandated, among other requirements, that patients collect mifepristone in-person at a health care facility, such as a clinic or physician's office.[16] Thus, under the ETASU, certified providers could not dispense mifepristone through the mail or a pharmacy. Several states' laws impose their own restrictions on abortion medication in addition to the FDA's regulations, including mandating in-person pick-up, prohibiting telehealth for abortion, or banning the mailing of medication abortion; at the time of writing in 2023, most of those same states, save eight, ban almost all abortion, including medication abortion, from the earliest stages of pregnancy.[17]

In July 2020, a federal district court in *American College of Obstetricians & Gynecologists (ACOG)* v. *FDA* temporarily suspended the in-person dispensing requirement and opened the door to the broader adoption of telehealth for abortion during the course of the pandemic.[18] Well before this case, in 2016, the non-profit organization, Gynuity, received an Investigational New Drug Approval to study the efficacy of providing medication abortion care by videoconference and mail.[19] In the study, "TelAbortion," providers counselled patients online, and patients confirmed the gestational age with blood tests and ultrasounds at a location of their choosing.[20] As the pandemic took hold, patients who were not at risk for medical complications, were less than eight weeks pregnant, and had regular menstrual cycles could forgo ultrasounds and blood tests, and rely on home pregnancy tests and a self-report of the first day of their last menstrual period. The results of the study indicated that a "direct-to-patient telemedicine abortion service was safe, effective, efficient, and satisfactory."[21] Since Gynuity's study, additional research has

[14] Id. at 637–43.

[15] Id.

[16] Id.

[17] Nineteen states mandate that the prescribing physician be physically present during an abortion or require patient-physician contact, such as mandatory pre-termination ultrasounds and in-person counseling. Five of these states also explicitly prohibit the mailing of abortion-inducing drugs (Arizona, Arkansas, Montana, Oklahoma, and Texas). Nine states have banned telehealth for abortion. Medication Abortion, *Abortion Law Project*, Ctr. for Pub. Health L. Rsch. (December 2021), http://lawatlas.org/datasets/medication-abortion-requirements. Of these states, currently only Alabama, Arizona, Indiana, Kansas, Montana, Nebraska, North Carolina, and Wisconsin have laws that preclude telehealth for abortion, but otherwise have not banned abortion before ten weeks.

[18] Order for Preliminary Injunction, *ACOG* v. *FDA*, No. 8:20-cv-01320-TDC 80 (D. Md. July 13, 2020).

[19] See Elizabeth Raymond et al., TelAbortion: Evaluation of a Direct to Patient Telemedicine Abortion Service in the United States, 100 Contraception 173, 174 (2019).

[20] Id.

[21] Id.

https://doi.org/10.1017/9781009373234.009 Published online by Cambridge University Press

demonstrated that abortion medication can be taken safely and effectively without in-person oversight.[22]

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

The FDA appealed the district court's decision to the US Court of Appeals for the Fourth Circuit and petitioned the Supreme Court for a stay of the injunction in October and again in December 2020. The briefs filed by the Trump Administration's solicitor general and ten states contested that the in-person dispensing requirement presented heightened COVID-19 risks for patients.[26] Indeed, some of the same states that had suspended abortion as a purported means to protect people from COVID-19 now argued that the pandemic posed little threat for people seeking abortion care.[27] ACOG highlighted the absurdity of the government's position. The FDA could not produce evidence that any patient had been harmed by the removal of the in-person dispensing requirement, whereas, in terms of COVID-19 risk, "the day Defendants filed their motion, approximately 100,000 people in the United States were diagnosed with COVID-19 – a new global record – and nearly 1,000 people died from it."[28]

The Supreme Court was not persuaded by ACOG's arguments. In January 2021, the Court stayed the district court's injunction pending appeal with scant analysis.[29] Chief Justice Roberts, in a concurrence, argued that the Court must defer to "politically accountable entities with the background, competence, and expertise to assess

[22] Hillary Bracken, Alternatives to Routine Ultrasound for Eligibility Assessment Prior to Early Termination of Pregnancy with Mifepristone-Misoprostol, 118 BJOG 17–23 (2011).

[23] *Am. Coll. of Obstetricians and Gynecologists* v. *US Food and Drug Admin.*, No. TDC-20-1320, 2020 WL 8167535 at 210–11 (D. Md. August 19, 2020).

[24] Id.

[25] Donley, supra note 1, at 631.

[26] Solicitor General Brief to US District Court for the District of Maryland, Case 8:20-cv-01320-TDC, November 11, 2020.

[27] Rebouché, supra note 4, at 1383–89; Greer Donley, Beatrice A. Chen & Sonya Borrero, The Legal and Medical Necessity of Abortion Care Amid the COVID-19 Pandemic, 7 J.L. & Biosciences 1, 13 (2020).

[28] Plaintiff Brief in Opposition to Defendants' Renewed Motion to Stay the Preliminary Injunction, at 1, No. 20-1320-Tdc, November 13, 2020.

[29] *Food and Drug Admin.* v. *Am. Coll. of Obstetricians and Gynecologists*, 141 S.Ct. 578 (2021).

https://doi.org/10.1017/9781009373234.009 Published online by Cambridge University Press

public health."[30] Justice Sotomayor dissented, citing the district court's findings and characterizing the reimposition of the in-person dispensing requirement as "unnecessary, unjustifiable, irrational" and "callous."[31]

The impact of the Supreme Court's order, however, was short-lived. In April 2021, the FDA suspended the enforcement of the requirement throughout the course of the pandemic and announced that it would reconsider aspects of the REMS.[32] In December 2021, the FDA announced that it would permanently lift the in-person dispensing requirement.

Other aspects of the mifepristone REMS, however, have not changed. The FDA still mandates that only certified providers who have registered with the drug manufacturer may prescribe the drug (the "certified provider requirement"), which imposes an unnecessary administrative burden that reduces the number of abortion providers.[33] An additional informed consent requirement – the FDA-required Patient Agreement Form, which patients sign before beginning a medication abortion – also remains in place despite repeating what providers already communicate to patients.[34] The FDA also added a new ETASU requiring that only certified pharmacies can dispense mifepristone.[35] The details of pharmacy certification were announced in January 2023; among other requirements, a pharmacy must agree to particular record-keeping, reporting, and medication tracking efforts, as well as designate a representative to ensure compliance.[36] This requirement, as it is implemented, could mirror the burdens associated with the certified provider requirement, perpetuating the FDA's unusual treatment of this safe and effective drug.[37]

Despite these restrictions, permission for providers and, at present, two online pharmacies to mail medication abortion has allowed virtual abortion clinics to proliferate in states that permit telehealth for abortion.[38] As explored below, this change has the potential to dramatically increase access to early abortion care, but there are obstacles that can limit such growth.

[30] Id. (Roberts, J., concurring); Rebouché, supra note 4, at 1389.

[31] *FDA* v. *ACOG*, 141 S.Ct. at 583 (Sotomayor, J, dissenting).

[32] Joint Motion to Stay Case Pending Agency Review at 2, *Chelius* v. *Wright*, no. 17-cv-493 (D. Haw. May 7, 2021), ECF no. 148.

[33] Donley, supra note 1, at 643–48.

[34] Id.

[35] Id.

[36] Mifepristone REMS, US Food and Drug Admin., www.accessdata.fda.gov/drugsatfda_docs/rems/Mifepristone_2023_01_03_REMS_Full.pdf.

[37] Donley, supra note 1, at 643–48.

[38] Rachel Rebouché, Remote Reproductive Rights, 48 Am. J. L. & Med. __(in press, 2023). The FDA granted permission to two online pharmacies to dispense abortion medication while it determined the process for certification. Abagail Abrams, Meet the Pharmacist Expanding Access to Abortion Pills Across the US, *Time* (June 13, 2022), https://time.com/6183395/abortion-pills-honeybee-health-online-pharmacy/.

https://doi.org/10.1017/9781009373234.009 Published online by Cambridge University Press

B *Telehealth for Abortion*

A new model for distributing medication abortion is quickly gaining traction across the country: Certified providers partnering with online pharmacies to mail abortion medication to patients after online intake and counseling.[39] For example, the virtual clinic, Choix, prescribes medication abortion to patients up to ten weeks of pregnancy in Maine, New Mexico, Colorado, Illinois, and California.[40] The founders describe how Choix's asynchronous telehealth platform works:

> Patients first sign up on our website and fill out an initial questionnaire, then we review their history and follow up via text with any questions. Once patients are approved to proceed, they're able to complete the consent online. We send our video and educational handouts electronically and make them available via our patient portal. We're always accessible via phone for patients.[41]

The entire process, from intake to receipt of pills, takes between two to five days and the cost is $289, which is significantly cheaper than medication abortions offered by brick-and-mortar clinics.[42] Advice on taking the medication abortion and possible complications is available through a provider-supported hotline.[43] Choix is just one of many virtual clinics. Another virtual clinic, Abortion on Demand, provides medication abortion services to twenty-two states.[44] Many virtual clinics translate their webpages into Spanish but do not offer services in Spanish or other languages, although a few are planning to incorporate non-English services.[45]

As compared to brick-and-mortar clinics, virtual clinics and online pharmacies provide care that costs less, offers more privacy, increases convenience, and reduces delays without compromising the efficacy or quality of care.[46] Patients no longer need to drive long distances to pick up safe and effective medications before driving back home to take them. In short, mailed pills can untether early-stage abortion from a physical place.[47]

[39] Carrie N. Baker, How Telemedicine Startups Are Revolutionizing Abortion Health Care in the US, *Ms. Mag.*, November 16, 2020.

[40] Id.

[41] Carrie Baker, Online Abortion Providers Cindy Adam and Lauren Dubey of Choix: "We're Really Excited about the Future of Abortion Care," *Ms. Mag.* (April 14, 2022).

[42] Id. Choix also offers a sliding scale of cost, starting at $175, for patients with financial need. Choix, Learn, *FAQ*, https://choixhealth.com/faq/.

[43] Choix, Learn, *FAQ*, https://choixhealth.com/faq/.

[44] Carrie Baker, Abortion on Demand Offers Telemedicine Abortion in 20+ States and Counting: "I Didn't Know I Could Do This!," *Ms. Mag.* (June 7, 2021), https://msmagazine.com/2021/06/07/abortion-on-demand-telemedicine-abortion-fda-rems-abortion-at-home/.

[45] Ushma Upadhyay, *Provision of Medication Abortion via Telehealth after Dobbs* (draft presentation on file with the authors).

[46] Donley, supra note 1, at 690–92.

[47] Id.

https://doi.org/10.1017/9781009373234.009 Published online by Cambridge University Press

Telehealth for abortion, however, has clear and significant limitations. As noted above, laws in about half of the country prohibit, explicitly or indirectly, telemedicine for abortion. And telemedicine depends on people having internet connections and computers or smartphones, which is a barrier for low-income communities.[48] Even with a telehealth-compliant device, "[patients] may live in communities that lack access to technological infrastructure, like high-speed internet, necessary to use many dominant tele-health services, such as virtual video visits."[49] Finally, the FDA has approved medication abortion only through ten weeks of gestation.

These barriers, imposed by law and in practice, will test how far telehealth for abortion can reach. As discussed below, the portability of medication abortion opens avenues that strain the bounds of legality, facilitated in no small part by the networks of advocates that have mobilized to make pills available to people across the country.[50] But extralegal strategies could have serious costs, particularly for those already vulnerable to state surveillance and punishment.[51] And attempts to bypass state laws could have serious consequences for providers, who are subject to professional, civil, and criminal penalties, as well as those who assist providers and patients.[52]

III THE FUTURE OF ABORTION CARE

The COVID-19 pandemic transformed abortion care, but the benefits were limited to those living in states that did not have laws requiring in-person care or prohibiting the mailing of abortion medication.[53] This widened a disparity in abortion access that has been growing for years between red and blue states.[54]

On June 24, 2022, the Supreme Court issued its decision in *Dobbs* v. *Jackson Women's Health Organization*, upholding Mississippi's fifteen-week abortion ban and overturning *Roe* v. *Wade*.[55] Twenty-four states have attempted to ban almost all abortions, although ten of those bans have been halted by courts.[56] At the time of writing, pregnant people in the remaining fourteen states face limited options: Continue a pregnancy against their will, travel out of state to obtain a legal abortion,

[48] David Simon & Carmel Shachar, Telehealth to Address Health Disparities: Potential, Pitfalls, and Paths, 49 J. L. Med. & Ethics 415 (2022).

[49] Id.

[50] Jareb A. Gleckel & Sheryl L. Wulkan, Abortion and Telemedicine: Looking Beyond COVID-19 and the Shadow Docket, 54 U.C. Davis L. Rev. Online 105, 112, 119–20 (2021).

[51] Carrie N. Baker, Texas Woman Lizelle Herrera's Arrest Foreshadows Post-Roe Future, *Ms. Mag* (April 16, 2022), https://msmagazine.com/2022/04/16/texas-woman-lizelle-herrera-arrest-murder-roe-v-wade-abortion/.

[52] Cohen, Donley & Rebouché, supra note 8, at 12.

[53] See Section II.

[54] Donley, supra note 1, at 694.

[55] *Dobbs* v. *Jackson Women's Health Organization*, 142 S. Ct. 2228, 2242 (2022).

[56] Tracking States Where Abortion is Now Banned, *The New York Times* (November 8, 2022), www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html.

https://doi.org/10.1017/9781009373234.009 Published online by Cambridge University Press

or self-manage their abortion in their home state.[57] Data from Texas, where the SB8 legislation[58] effectively banned abortion after roughly six weeks of pregnancy months before *Dobbs*, suggests that only a small percentage of people will choose the first option – the number of abortions Texans received dropped by only 10–15 percent as a result of travel and self-management.[59] Evidence from other countries and the United States's own pre-*Roe* history also demonstrate that abortion bans do not stop abortions from happening.[60]

Traveling to a state where abortion is legal, however, is not an option for many people.[61] Yet unlike the pre-*Roe* era, there is another means to safely end a pregnancy – one that threatens the antiabortion movement's ultimate goal of ending abortion nationwide:[62] Self-managed abortion with medication. Self-managed abortion generally refers to abortion obtained outside of the formal health care system.[63] Thus, self-managed abortion can include a pregnant person buying medication abortion online directly from an international pharmacy (sometimes called self-sourced abortion) and a pregnant person interacting with an international or out-of-state provider via telemedicine, who ships them abortion medication or calls a prescription into an international pharmacy on their behalf.[64]

Because many states have heavily restricted abortion for years, self-managed abortion is not new. The non-profit organization Aid Access started providing medication abortion to patients in the United States in 2017.[65] Each year, the number of

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

58 S.B. 8, 87th Gen. Assemb., Reg. Sess. (Tex. 2021) (codified as amended at Tex. Health & Safety Code Ann. §§ 171.201–.212 (West 2023)).

59 See Margot Sanger-Katz, Claire Cain Miller & Quoctrung Bui, Most Women Denied Abortions by Texas Law Got Them Another Way, *The New York Times* (March 6, 2022), www.nytimes.com/2022/03/06/upshot/texas-abortion-women-data.html.

60 Yvonne Lindgren, When Patients Are Their Own Doctors: Roe v. Wade in An Era of Self-Managed Care, 107 Cornell L. Rev. 151, 169 (2022).

61 Three quarters of abortion patients are of low income, Abortion Patients are Disproportionately Poor and Low Income, *Guttmacher Inst*. (May 19, 2016), www.guttmacher.org/infographic/2016/abortion-patients-are-disproportionately-poor-and-low-income and the cost and time associated with in-person abortion care delayed and thwarted abortion access when a ban on pre-viability abortion was constitutionally prohibited under *Roe* v. *Wade*, Ushma D. Upadhyay, et al., Denial of Abortion Because of Provider Gestational Age Limits in the United States, 104 Am. J. Public Health 1687, 1689–91 (2014).

62 Interview by Terry Gross with Mary Ziegler, Fresh Air, *Nat'l Pub. Radio* (June 23, 2022), www.npr.org/2022/06/23/1106922050/why-overturning-roe-isnt-the-final-goal-of-the-anti-abortion-movement.

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

64 See Donley, supra note 1, at 697; Jennifer Conti, The Complicated Reality of Buying Abortion Pills Online, *Self Mag*. (April 9, 2019), www.self.com/story/buying-abortion-pills-online.

65 Jones & Donovan, supra note 62. When this chapter was drafted, Aid Access was serviced by international providers, but as this chapter was going to press, Aid Access began working with U.S.-based

https://doi.org/10.1017/9781009373234.009 Published online by Cambridge University Press

US patients they have served has grown.[66] Once Texas's SB8 became effective, Aid Access saw demand for their services increase 1,180 percent, levelling out to 245 percent of the pre-SB8 demand a month later.[67] Similarly, after *Dobbs*, the demand for Aid Access doubled, tripled, or even quadrupled in states with abortion bans.[68] There are advantages to self-managed abortion: The price is affordable (roughly only $105 for use of foreign providers and pharmacy) and the pregnant person can have an abortion at home.[69] The disadvantage is that receiving the pills can take one to three weeks (when shipped internationally) and comes with the legal risks explored below.

The portability of abortion medication, combined with the uptake of telehealth, poses an existential crisis for the antiabortion movement. Just as it achieved its decades-long goal of overturning *Roe*, the nature of abortion care has shifted and decentralized, making it difficult to police and control.[70] Before the advent of abortion medication, pregnant people depended on the help of a provider to end their pregnancies.[71] They could not do it alone. As a result, states would threaten providers' livelihood and freedom, driving providers out of business and leaving patients with few options.[72] Many turned to unqualified providers who offered unsafe abortions that lead to illness, infertility, and death.[73] But abortion medication created *safe* alternatives for patients that their predecessors lacked. Because abortion medication makes the involvement of providers no longer necessary to terminate early pregnancies, the classic abortion ban, which targets providers, will not have the same effect.[74] And out-of-country providers who help patients self-manage abortions remain outside of a state's reach.[75]

The antiabortion movement is aware of this shifting reality. Indeed, antiabortion state legislators are introducing and enacting laws specifically targeting abortion medication – laws that would ban it entirely, ban its shipment through

providers to prescribe and to mail medication abortion across the country. For additional information, see David S. Cohen, Greer Donley & Rachel Rebouché, Abortion Pills, 76 Stan. L. Rev. (forthcoming 2024), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4335735.

66 Donley, supra note 1, at 660.

67 Abigail R. A. Aiken et al, Association of Texas Senate Bill 8 With Requests for Self-managed Medication Abortion, 5 JAMA Netw. Open e221122 (2022).

68 Abigail R. A. Aiken et al, Requests for Self-managed Medication Abortion Provided Using Online Telemedicine in 30 US States Before and After the Dobbs v Jackson Women's Health Organization Decision, 328 J. Am. Med. Assn. 1768 (2022).

69 Cohen, Donley & Rebouché, supra note 8, n.98.

70 See id.

71 Lindgren, supra note 59, at 5–6.

72 See Meghan K. Donovan, Self-Managed Medication Abortion: Expanding the Available Options for U.S. Abortion Care, *Guttmacher Inst.* (October 17, 2018), www.guttmacher.org/gpr/2018/10/self-managed-medication-abortion-expanding-available-options-us-abortion-care.

73 Rachel Benson Gold, Lessons from Before Roe: Will Past be Prologue?, *Guttmacher Inst.* (March 1, 2003), www.guttmacher.org/gpr/2003/03/lessons-roe-will-past-be-prologue.

74 Greer Donley & Jill Wieber Lens, Subjective Fetal Personhood, 75 Vand. L. Rev. 1649, 1705–06 (2022).

75 Id.

https://doi.org/10.1017/9781009373234.009 Published online by Cambridge University Press

the mail, or otherwise burden its dispensation.[76] Nevertheless, it is unclear how states will enforce these laws. Most mail goes in and out of states without inspection.[77]

This is not to suggest that self-management will solve the post-*Roe* abortion crisis. For one, self-managed abortion medication is generally not recommended beyond the first trimester, meaning later-stage abortion patients, who comprise less than 10 percent of the patient population, will either need to travel to obtain an abortion or face the higher medical risks associated with self-management.[78] Moreover, pregnant patients may face legal risks in self-managing an abortion in an antiabortion state.[79] Historically, legislators were unwilling to target abortion patients themselves, but patients and their in-state helpers may become more vulnerable as legislatures and prosecutors reckon with the inability to target in-state providers. These types of prosecutions may occur in a few ways.

First, even if shipments of abortion medication largely go undetected, a small percentage of patients will experience side effects or complications that lead them to seek treatment in a hospital.[80] Self-managed abortions mimic miscarriage, which will aid some people in evading abortion laws, although some patients may reveal to a health care professional that their miscarriage was induced with abortion medication.[81] And even with federal protection for patient health information,[82] hospital employees could report those they *suspect* of abortion-related crimes.[83] This will lead to an increase in the investigation and criminalization of both pregnancy loss and abortion.[84]

[76] Caroline Kitchener, Kevin Schaul & Daniela Santamariña, Tracking New Action on Abortion Legislation Across the States, *Washington Post* (last updated April 14, 2022), www.washingtonpost.com/nation/interactive/2022/abortion-rights-protections-restrictions-tracker/.

[77] The Justice Department issued an opinion in December 2022 reaffirming the mailability of abortion medication in accordance with a general prohibition on postal agency inspections of packages containing prescription drugs. Application of the Comstock Act to the Mailing of Prescription Drugs That Can Be Used for Abortions, 46 Op. O.L.C. 1, 2 (2022).

[78] The FDA has approved abortion medication through the first ten weeks, but the protocol is the same through twelve weeks. Later Abortion Initiative, *Can Misoprostol and Mifepristone be Used for Medical Management of Abortion after the First Trimester?* (2019), www.ibisreproductivehealth.org/sites/default/files/files/publications/lai_medication_abortion_0.pdf. After that, patients typically need a higher dose for an effective abortion, which takes place in a clinical facility. In a post-Dobbs world, however, some patients will attempt to self-manage second trimester abortions. Id.

[79] Donley & Lens, supra note 73, at 39–43.

[80] Id. Or people might seek after-abortion care if they are unfamiliar with how misoprostol works and believe they are experiencing complications when they likely are not.

[81] Id.

[82] Cohen, Donley & Rebouché, supra note 8, at 77 (discussing how the Health Insurance Portability and Accountability Act (HIPAA) prohibits covered health care employees from reporting health information to law enforcement unless an exception is met). The HIPAA's protections might not be a sufficient deterrent for motivated individuals who want to report suspected abortion crimes, especially if the Biden Administration is not aggressive in enforcing the statute.

[83] Donley & Lens, supra note 73, at 39–43.

[84] Id.

https://doi.org/10.1017/9781009373234.009 Published online by Cambridge University Press

This is how many people have become targets of criminal prosecution in other countries that ban abortion.[85]

Second, the new terrain of digital surveillance will play an important role. Any time the state is notified of someone who could be charged for an abortion-related crime, the police will be able to obtain a warrant to search their digital life if they have sufficient probable cause. Anya Prince has explained the breadth of the reproductive health data ecosystem, in which advertisers and period tracking apps can easily capture when a person is pregnant.[86] The proliferation of "digital diagnostics" (for instance, wearables that track and assess health data) could become capable of diagnosing a possible pregnancy based on physiologic signals, such as temperature and heart rate, perhaps without the user's knowledge. As Prince notes, this type of information is largely unprotected by privacy laws and companies may sell it to state entities.[87] Technology that indicates that a person went from "possibly pregnant" to "not pregnant" without a documented birth could signal an abortion worthy of investigation. Alternatively, pregnancy data combined with search histories regarding abortion options, geofencing data of out-of-state trips, and text histories with friends could be used to support abortion prosecutions.[88] Antiabortion organizations could also set up fake virtual clinics – crisis pregnancy centers for the digital age – to identify potential abortion patients and leak their information to the police.[89]

These technologies will test conceptions of privacy as people voluntarily offer health data that can be used against them.[90] Law enforcement will, as they have with search engine requests and electronic receipts, use this digital information against people self-managing abortions.[91] And, almost certainly, low-income people and women of color will be targets of pregnancy surveillance and criminalization.[92] This is already true – even though drug use in pregnancy is the same in white and populations of color – Black women are ten times more likely to be reported to

[85] Id.; Michelle Oberman, Abortion Bans, Doctors, and the Criminalization of Patients, 48 Hastings Ctr. Rep. 5 (2018).

[86] Anya E.R. Prince, Reproductive Health Surveillance, *B.C. L. Rev.* (in press, 2023), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4176557.

[87] Id.

[88] Id.

[89] See Leslie Reagan, Abortion Access in Post-Roe America vs. Pre-Roe America, *The New York Times* (December 10, 2021), www.nytimes.com/2021/12/10/opinion/supreme-court-abortion-roe.html.

[90] David Cohen, Greer Donley & Rachel Rebouché, *Abortion Pills*, 59–65 (on file with the authors), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4335735 (describing impending efforts to surveil pregnancies).

[91] Data collected on people's iPads and Google searches have been used in criminal prosecutions. See Laura Huss, Farah Diaz-Tello, & Goleen Samari, Self-Care, Criminalized: August 2022 Preliminary Findings, *If/When/How* (2022), www.ifwhenhow.org/resources/self-care-criminalized-preliminary-findings/.

[92] In her book, *Policing the Womb*, Michelle Goodwin explains in great detail how the state particularly targets Black women and women of color during pregnancy. Michele Goodwin, Policing the Womb: Invisible Women and the Criminalization of Motherhood 21 (2020).

https://doi.org/10.1017/9781009373234.009 Published online by Cambridge University Press

authorities.[93] And because low-income women and women of color are more likely to seek abortion and less likely to have early prenatal care, any pregnancy complications may be viewed suspiciously.[94]

State legislatures and the federal government can help to protect providers and patients in the coming era of abortion care, although their actions may have a limited reach.[95] At the federal level, the FDA could assert that its regulation of medication abortion preempts contradictory state laws, potentially creating a nationwide, abortion-medication exception to state abortion bans.[96] The federal government could also use federal laws and regulations that govern emergency care, medical privacy, and Medicare and Medicaid reimbursement to preempt state abortion laws and reduce hospital-based investigations, though the impact of such laws and regulations would be more limited.[97] As this chapter goes to press in 2023, the Biden Administration is undertaking some of these actions.[98]

State policies in jurisdictions supportive of abortion rights can also improve access for patients traveling to them. States can invest in telehealth generally to continue to loosen restrictions on telemedicine, as many states have done in response to the pandemic, reducing demand at brick-and-mortar abortion clinics and disparities in technology access.[99] They can also join interstate licensure compacts, which could extend the reach of telehealth for abortion in the states that permit the practice and allow providers to pool resources and provide care across state lines.[100] States can also pass abortion shield laws to insulate their providers who care for out-of-state residents by refusing to cooperate in out-of-state investigations, lawsuits, prosecutions, or extradition requests for abortion-related lawsuits.[101] All of these efforts will help reduce, but by no means stop, the sea change to abortion law and access moving forward. And none of these efforts protect the patients or those that assist them in states that ban abortion.

IV CONCLUSION

A post-*Dobbs* country will be messy. A right that generations took for granted – even though for some, abortion was inaccessible – disappeared in half of the country. The present landscape, however, is not like the pre-*Roe* era. Innovations in

[93] Id.

[94] Donley & Lens, supra note 73, at 41.

[95] Id.

[96] Cohen, Donley & Rebouché, supra note 8, at 52–79.

[97] Greer Donley, Rachel Rebouché & David Cohen, Existing Federal Laws Could Protect Abortion Rights Even if Roe Is Overturned, *Time* (January 24, 2023), https://time.com/6141517/abortion-federal-law-preemption-roe-v-wade/.

[98] Cohen, Donley & Rebouché, supra note 8, at 71–79.

[99] Id. at 65–74.

[100] Id.

[101] Id. at 31.

https://doi.org/10.1017/9781009373234.009 Published online by Cambridge University Press

medical care and telehealth have changed abortion care, thwarting the antiabortion movement's ability to control abortion, just as it gained the ability to ban it. Unlike patients in past generations, patients now will be able to access safe abortions, even in states in which it is illegal. But they will also face legal risks that were uncommon previously, given the new ways for the state to investigate and criminalize them.

As courts and lawmakers tackle the changing reality of abortion rights, we should not be surprised by surprises – unlikely allies and opponents may coalesce on both sides of the abortion debate. Laws that seek to punish abortion will become harder to enforce as mailed abortion pills proliferate. This will create urgency for some antiabortion states to find creative ways to chill abortion, while other states will be content to ban abortion in law, understanding that it continues in practice. *Who* states seek to punish will shift, with authorities targeting not only providers, but also patients, and with the most marginalized patients being the most vulnerable.[102]

[102] See Goodwin, supra note 91, at 12–26.

https://doi.org/10.1017/9781009373234.009 Published online by Cambridge University Press