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The Public Health Turn in Reproductive Rights

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Abstract

Over the last decade, public health research has demonstrated the short-term, long-term, and cumulative costs of delayed or denied abortion care. These costs are imposed on people who share common characteristics: abortion patients are predominantly low income and disproportionately people of color. Public health evidence, by establishing how law contributes to the scarcity of services and thereby entrenches health disparities, has vividly highlighted the connections between abortion access, race, and income. The contemporary attention to abortion law's relationship to inequality is no accident: researchers, lawyers, and advocates have built an infrastructure for generating credible empirical studies of abortion restrictions' effects.

What might surprise even close observers of abortion policy is how the federal courts, including the Supreme Court, have cited contemporary public health research. Recent litigation around the U.S. Food and Drug Administration's requirement

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that patients collect in-person the first drug of a medication abortion—a two-drug regimen taken over two days—is an example. The federal district court, in that litigation, drew heavily from public health research demonstrating the health consequences of denied or delayed abortion care.

Betting on courts to strike down abortion restrictions, however, is a risky wager, particularly given the current ambiguity about how the constitutional standard for evaluating abortion restrictions applies. This Article shows that abortion law is moving beyond constitutional litigation and toward building capacity for delivering remote or virtual care. The confluence of regulation, funding, and evidence has helped facilitate both telehealth for abortion and self-managed abortions, which can extend abortion access despite the evisceration of constitutional rights.

This Article argues that current developments in abortion law suggest a way forward that hinges neither on defending nor abandoning the constitutional right to abortion. Scholars in the field of reproductive justice have called for a move beyond constitutional doctrine for a long time. That shift, with its attention to structural and systemic inequalities, has never seemed more urgent—or more possible—than it is right now.

Table of Contents

INTRODUCTION

On his first day in office, President Biden signed seventeen executive orders, several of which addressed two pillars of the Administration's agenda: to reduce income inequality and root out racial discrimination.[1] Abortion access relates to both of those goals, though it is seldom described as an issue of economic and racial justice in public discourse. The Biden Administration's press release on the anniversary of *Roe v. Wade*[2] nodded toward the connection between abortion access and health, though the statement did not use the word "abortion" once.[3]

The silo of abortion within health and economic policy is the result of varied and complex factors.[4] To name just a few: there is the tenacity of an adversarial model of abortion rights, pitting pregnant people against fetal personhood;[5] there is a deep

1. These orders address the "converging crises" of "the pandemic, economic struggles, immigration and diversity issues, and the environment and climate change." Michael D. Shear, *On Day 1, Biden Moves to Undo Trump's Legacy*, N.Y. TIMES (Jan. 20, 2021), https://perma.cc/4U7L-KNSH (last updated Mar. 5, 2021).

2. 410 U.S. 113 (1973).

3. *See* Press Release, The White House, Statement from President Biden and Vice President Harris on the 48th Anniversary of *Roe v. Wade* (Jan. 22, 2021), https://perma.cc/6P5B-L2CK ("We are deeply committed to making sure everyone has access to care—including reproductive health care—regardless of income, race, zip code, health insurance status, or immigration status.").

4. *See* Nancy Ehrenreich, *The Colonization of the Womb*, 43 DUKE L.J. 492, 504–05 (1993) (critiquing the medicalization of abortion); Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451, 454–55 (2000) (discussing the "violation of the legal and ethical norms that govern doctor-patient relationships" when focusing on the maternal-fetal analysis); KRISTIN LUKER, ABORTION AND THE POLITICS OF MOTHERHOOD 33 (1984) (discussing physicians' opinions on medicalizing abortion and the potential for abuse in its practice); Ruth Bader Ginsburg, *Speaking in a Judicial Voice*, 67 N.Y.U. L. REV. 1185, 1199 (1992) ("The idea of the woman in control of her destiny and her place in society was less prominent in the *Roe* decision . . . .").

5. *See, e.g.*, MARY ZIEGLER, ABORTION AND THE LAW IN AMERICA: *ROE V. WADE* TO THE PRESENT 1–20 (2020) (discussing the history of the abortion debate and recent changes). *But see* LAURENCE H. TRIBE, ABORTION: THE CLASH

debate about the existence and nature of constitutional protection for abortion;[6] and there is stigma and secrecy attached to reproductive decision-making, sex, and pregnancy.[7] The result is what scholars have called "abortion exceptionalism" or, as defined by David Cohen and Carole Joffe, "the idea that abortion is treated uniquely compared to other medical procedures that are comparable to abortion in complexity and safety."[8]

Barriers to abortion services, however, create serious public health problems because they entrench economic and racial inequality. Three-fourths of people who terminate pregnancies are poor or low-income (as defined by federal poverty levels), and a majority of those people report their chief reason for ending a

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OF ABSOLUTES 45 (1990) (questioning "why it should be a matter of *medical* discretion at all").

6. *See, e.g.*, Robin West, *From Choice to Reproductive Justice: De-Constitutionalizing Abortion Rights*, 118 YALE L.J. 1394, 1409–10 (2009) (questioning the costs and dangers of the right to terminate a pregnancy).

7. *See* CAROL SANGER, ABOUT ABORTION: TERMINATING PREGNANCY IN TWENTY-FIRST CENTURY AMERICA 47–52, 215–17 (2017) (revealing that the stigma surrounding abortion often results in patients distancing themselves from the procedures by using an alias); Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 273–74 (1992) (highlighting the stigma and pathology attached to pregnancy and abortion).

8. DAVID COHEN & CAROLE JOFFE, OBSTACLE COURSE: THE EVERYDAY STRUGGLE TO GET AN ABORTION IN AMERICA 8 (2020); *see* Caitlin E. Borgmann, *Abortion Exceptionalism and Undue Burden Preemption*, 71 WASH. & LEE L. REV. 1047, 1048 (2014) (defining "[a]bortion exceptionalism" as the "tendency of legislatures and courts to subject abortion to unique, and uniquely burdensome, rules"); Caroline Mala Corbin, *Abortion Distortions*, 71 WASH. & LEE L. REV. 1175, 1176 (2014) (highlighting that, in abortion jurisprudence, "the normal doctrine does not apply" and "the rules are different when the claim involves abortion"); Maya Manian, *The Consequences of Abortion Restrictions for Women's Healthcare*, 71 WASH. & LEE L. REV. 1317, 1318–20 (2014) (rejecting the idea that abortion can be isolated from other women's healthcare issues); B. Jessie Hill, *Essentially Elective: The Law and Ideology of Restricting Abortion During the COVID-19 Pandemic*, 106 VA. L. REV. ONLINE 99, 99–100 (2020) (discussing the doctrine of abortion exceptionalism during the suspension of non-essential procedures during the pandemic); Yvonne Lindgren, *The Rhetoric of Choice: Restoring Healthcare to the Abortion Right*, 64 HASTINGS L.J. 385, 404–14 (2012) (tracing the litigation and legislation that has separated abortion from healthcare); Lori Freedman et al., *Obstacles to the Integration of Abortion into Obstetrics and Gynecology Practice*, 42 PERSPS. ON SEXUAL & REPROD. HEALTH 146, 146 (2010) (addressing the segregation of abortion services from other healthcare).

pregnancy is an inability to afford the costs of raising a child.[9] This should not be not surprising, given the financial insecurity that marks the lives of an increasing number of people in the United States.[10] Most abortion patients are also people of color.[11] That, too, reflects broader disparities: race and income align because of the effects of institutional and structural racism.[12]

When people cannot obtain abortion care, they incur social, financial, and physical costs that are difficult to bear.[13] Those costs have long-term effects that perpetuate cycles of disadvantage and subordination.[14] The COVID-19 pandemic has amplified those costs as made plain by widespread unemployment, compounded caregiving responsibilities for families, and an already overstretched healthcare system.[15]

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9. *See* GUTTMACHER INST., CHARACTERISTICS OF U.S. ABORTION PATIENTS IN 2014 AND CHANGES SINCE 2008, at 1 (2016), https://perma.cc/9H2V-3VVY (PDF) (finding that almost half of abortion patients in 2014 lived below the federal poverty level and an additional 26 percent were considered low income); Ushma D. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 AM. J. PUB. HEALTH 1687, 1689 (2014) (surveying over 3,000 people seeking abortions and finding that "travel and procedure costs" were the most common reasons for delaying care).

10. *See* Jedediah Britton-Purdy et al., *Building a Law-and-Political-Economy Framework: Beyond the Twentieth-Century Synthesis*, 129 YALE L.J. 1784, 1786 (2020) ("In the United States and across the world, income inequality has returned to the levels of the Gilded Age."); Thomas Piketty & Emmanuel Saez, *Inequality in the Long Run*, 344 SCIENCE 838, 839 (2014) (identifying the resurgence of income inequality in the United States beginning in the 1970s); THOMAS PIKETTY, CAPITAL IN THE TWENTY-FIRST CENTURY 1 (2014) (discussing how "capitalism automatically generates arbitrary and unsustainable inequalities").

11. *See* GUTTMACHER INST., *supra* note 9, at 1 ("Thirty-nine percent [of abortion patients] were white, 28% were black, 25% were Hispanic, 6% were Asian or Pacific Islander, and 3% were of some other race or ethnicity.").

12. *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) ("[S]tructural bias measures how non-race based factors, such as economic inequalities, indirectly affect racial minorities. . . . Those without privilege, such as minorities, who are disproportionately poor, have limited access to health care because they do not have health insurance and cannot afford to pay for it.").

13. *See* COHEN & JOFFE, *supra* note 8, at 9 (discussing "the everyday *consequences*" surrounding abortion).

14. *See id.* at 17 (noting that studies have found "that women who are denied wanted abortions are worse off in almost every aspect of their lives").

15. *See* Ruqaiijah Yearby & Seema Mohapatra, *Systemic Racism, the Government's Pandemic Response, and Racial Inequities in COVID-19*, 70

Public health research has highlighted the consequences of abortion restrictions for individuals' and the nation's health.[16] Numerous studies, many generated in the past ten years, demonstrate the short-term, long-term, and cumulative health effects of anti-abortion laws.[17] This research largely responds to state laws that target providers and facilities and frequently lead clinics to shut their doors.[18] For example, quantitative and

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EMORY L.J. 1419, 1426–28 (2021) (examining systemic racism in employment and healthcare that leads to higher infections and deaths from COVID-19 among people of color); AMANDA FINS, NAT'L WOMEN'S L. CTR, EFFECTS OF COVID-19 SHOW US EQUAL PAY IS CRITICAL FOR MOTHERS 1 (May 2020), https://perma.cc/TC2L-6MWH (PDF) (reporting that although mothers with children under eighteen are less than 16 percent of the working population, they constitute a large percentage of essential workers).

16. A classic definition of public health is "the fulfillment of society's interest in assuring the conditions in which people can be healthy." INST. OF MED., THE FUTURE OF PUBLIC HEALTH 40 (1988). The field of public health is more nuanced than this definition suggests, but the definition captures that public health includes the study of large-scale, collective health inequalities and disparities. For example, Lindsay Wiley argues that public health law historically focused on universal interventions to improve quality of life and, to that end, targeted individual behaviors to curb unhealthy practices. Lindsay F. Wiley, *Health Law as Social Justice*, 24 CORNELL J.L. & PUB. POL'Y 47, 88–100 (2014). But the field has changed dramatically since those beginnings and recent scholarship has focused increasingly on structural and institutional determinants that drive health disparities. *See id.* at 101–04 (discussing the modern conditions that create disparities and suggesting solutions to combat them). Public health researchers have applied a public health framework to abortion care, noting that an essential public health service, as defined by the Centers for Disease Control and Prevention, is to "[c]onduct research to attain new insights and innovative solutions to health problems." Sarah C. M. Roberts et al., *A 21st-Century Public Health Approach to Abortion*, 107 AM. J. PUB. HEALTH 1878, 1881 (2017).

17. *See infra* Part II.

18. *See, e.g.*, Caitlin Gerdts et al., *Impact of Clinic Closures on Women Obtaining Abortion Services After Implementation of a Restrictive Law in Texas*, 106 AM. J. PUB. HEALTH 857, 857 (2016). Generally, this Article uses the phrase "abortion restrictions" to mean state regulations, passed ostensibly to protect patient safety and health, that mandate abortion providers and facilities comply with rules on admitting privileges, ambulatory surgical space capacity, or the dimensions of clinical or recovery space, to list a few examples. *Id.* These laws—often referred to as the targeted regulation of abortion providers or TRAP laws—either require more from abortion providers than other providers offering office-based procedures of similar risk or impose rules that will be difficult for providers to meet, not because they fail to meet the relevant standard of care, but because the regulation is unnecessary given the nature of abortion care. *See* Bonnie S. Jones et al., *State Law Approaches to Facility Regulation of Abortion and Other Office Interventions*, 108 AM. J. PUB.

qualitative studies have measured the number of miles between remaining clinics after a legal restriction takes effect, and, in so doing, trace the ripple effects of increased cost and delay.[19] Courts, including the U.S. Supreme Court, have cited this research in striking down facility and provider restrictions as unconstitutional.[20]

The type of evidence that courts cite has expanded to include abortion restrictions' impact on health disparities, which courts have historically ignored or minimized.[21] An increasing number of courts, however, have looked beyond individual-level harms to identify health burdens on populations of patients and to analyze the lived experience of delayed or denied abortion care.[22] *American College of Obstetricians & Gynecologists v. FDA* (*ACOG v. FDA*)[23] illustrates the broader purposes health research serves.

In that case, the U.S. District Court for the District of Maryland suspended an FDA policy requiring patients to pick up the first drug in a medication abortion from a health care facility for the duration of the COVID-19 pandemic.[24]

HEALTH 486, 486–87 (2018). Other restrictions, such as waiting periods, gestational age limits, ultrasound, and counseling requirements, also make providing care expensive and time-consuming. *See* Upadhyay et al., *supra* note 9, at 1692 (concluding that financial support and referral programs must be strengthened to increase access).

19. *See infra* Part II.A–B.

20. *See infra* Part I.A–B.

21. *See infra* note 236.

22. *See* Am. Coll. of Obstetricians & Gynecologists v. FDA, 472 F. Supp. 3d 183, 210–11 (D. Md. 2020) (discussing both the size of the group of abortion-seeking patients affected as well as how types of evidence should be weighed); *see also infra* Parts I.B, II.A. The use of the term "patients" is a deliberate though imperfect choice. This Article attempts to avoid, when possible, describing individuals who seek abortion as "women" to acknowledge that people who become pregnant do not all identify as women. *See* Jessica A. Clarke, *They, Them, and Theirs*, 132 HARV. L. REV. 894, 954 (2019) ("Pregnancy is distinct from gender identity. People of all gender identities can be pregnant."). The choice to refer to "patients" is also to differentiate individualized burdens from those incurred by groups with common characteristics (populations) and from burdens affecting the healthcare system generally (the public's health). *See infra* Part II.B–C.

23. 472 F. Supp. 3d 183 (D. Md. 2020).

24. *Id.* at 232; *see Medication Abortion*, GUTTMACHER INST. (Feb. 2021), https://perma.cc/3RVU-K2RQ (reporting that 39 percent of the nation's abortions in 2017 were medication abortions).

Medication abortion is a two-drug regimen taken over twenty-four to forty-eight hours before ten weeks of pregnancy.[25] An immediate effect of the district court's ruling was to open new avenues for the remote delivery of abortion care.[26] The district court's opinion detailed various burdens of in-person dispensation, starting with the health risks for patients visiting a clinic in the midst of a pandemic.[27] The court held that in-person collection of a demonstrably safe drug that patients take at home posed needless risks of COVID-19 exposure and logistical hurdles.[28] Most significantly, the court's decision captured a core problem with the law: the FDA's rule penalizes people who already live with inadequate resources, and it exacerbates financial and other stress.[29] In short, requiring in-person collection is irresponsible health policy.

Though the district court relied on extensive evidence and public health expertise, the Supreme Court was not persuaded by the same factual record.[30] In January 2021, the Court stayed the district court's injunction pending appeal.[31] Justice Sotomayor wrote a strong dissent, which relied heavily on the district court's findings, calling the FDA's exceptional treatment of medication abortion "unnecessary, unjustifiable, irrational" and the effect of the rule "callous."[32]

The Supreme Court's order, however, did not prove to be a roadblock in the path forged by *ACOG v. FDA*. While the case

25. *See The Availability and Use of Medication Abortion*, KAISER FAM. FOUND. (June 16, 2021), https://perma.cc/94WD-T3PK (explaining what medication abortions are).

26. *See id.* ("[T]he federal district court ruled that the FDA was required to temporarily suspend the REMS in-person requirement during the pandemic emergency . . . .").

27. *See infra* Part I.C.

28. *Am. Coll. of Obstetricians & Gynecologists*, 472 F. Supp. 3d at 232.

29. *See* NAT'L ACADS. SCIS., ENG'G, & MED., ABORTION CARE AND THE SIX ATTRIBUTES OF QUALITY HEALTH CARE 1–2 (2018), https://perma.cc/C93P-DMSE (PDF) (concluding that abortion restrictions adversely affect the Institute of Medicine's six domains of quality of care: safety, effectiveness, efficiency, patient-centeredness, timeliness, and equity).

30. *See* FDA v. Am. Coll. of Obstetricians & Gynecologists, 141 S. Ct. 578, 578–79 (2021) (per curiam) (Roberts, C.J., concurring) (finding the record insufficient to "compel the FDA to alter the regimen for medical abortion").

31. *Id.* at 578 (per curiam opinion).

32. *Id.* at 579, 583 (Sotomayor, J., dissenting).

was before the U.S. Court of Appeals for the Fourth Circuit, the FDA suspended the in-person restriction for the life of the pandemic and announced it will reconsider the regulation of the first drug in a medication abortion.[33] The FDA grounded this decision in evidence of medication abortion's safety and the efficacy of remote care.[34]

Given the dozens of abortion cases working their way through the federal courts, judges will apply the constitutional test for abortion rights—the undue burden standard—for an unforeseeable (though potentially short) future.[35] Public health evidence invites judges to develop factual records that account for the burdens on patients' health and lives.[36] To be sure, Chief Justice Roberts's doctrinal formulation of the undue burden standard in the recent abortion case, *June Medical Services v. Russo*,[37] discounts whether an abortion restriction actually protects patient safety and defers to a state's reasons for passing a law.[38] Yet even the Chief Justice's formulation of the undue

33. *See* Motion for a 30-Day Extension of the Briefing Schedule and Postponement of Oral Argument at 2, Am. Coll. of Obstetricians & Gynecologists v. FDA, No. 20-1970 (4th Cir. Mar. 29, 2021) (requesting an extension to "allow new federal government officials to assess the issues in this case"); Joint Motion to Stay Case Pending Agency Review at 2, Chelius v. Becerra, No. 1:17-cv-00493 (D. Haw. May 7, 2021), ECF No. 148 (announcing the FDA's intention to review the safety restrictions on medication abortion).

34. Letter from Janet Woodcock, M.D., Acting Comm'r of Food & Drugs, to Maureen G. Phipps, M.D., Chief Exec. Officer, Am. Coll. of Obstetricians & Gynecologists and William Grobman, M.D., President, Soc'y for Maternal-Fetal Med. (Apr. 12, 2021), https://perma.cc/XGL5-X786 (PDF) (citing studies that "do not appear to show increases in serious safety concerns . . . occurring with medical abortion as a result of modifying the in-person dispensing requirement during the COVID-19 pandemic").

35. The Supreme Court might well strip constitutional protection from abortion. With the appointment of Justice Barrett, there are now six justices on the Supreme Court who appear willing to abandon constitutional protections for abortion rights. *See infra* Part III.A. On May 17, 2021, the Supreme Court granted certiorari in *Dobbs v. Jackson Women's Health Organization*, 141 S. Ct. 2619 (2021), taking up the question of whether all pre-viability prohibitions on elective abortions are unconstitutional. *Id.* at 2619–20.

36. *See* Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2310 (2016) (explaining that, when provided with factual findings, the Court retains the ability to establish its own interpretation).

37. 140 S. Ct. 2103 (2020).

38. *See infra* Part I.B.

burden test does not entirely abandon an assessment of whether a restriction imposes significant obstacles to services.[39]

As the *ACOG* case illustrates, lower courts have begun to cite evidence demonstrating the relationship between inaccessible abortion and the country's health disparities.[40] But drawing connections between law and health outcomes requires an understanding of the many ways that law entrenches inequality. This Article shows that the reasoning in *ACOG* draws on the social determinants of health—improving the conditions under which people live, work, and learn[41]—and emphasizes abortion's role in the health ecosystem. Indeed, framing abortion access as a public health issue, rather than only a right, becomes all the more pressing if the United States lacks a federal constitutional right to abortion, which could become a reality in 2022.[42]

A social-determinants framing invites on-the-ground interventions as well as federal and state policies that open avenues to care.[43] *ACOG v. FDA* underscores that people need not (and often do not) depend on traditional means of obtaining abortion services.[44] After the district court's decision in July 2020, providers and advocates mobilized quickly, as many sectors of the healthcare industry did, to provide care through telehealth.[45] By June 2021, telemedicine for abortion was

39. *See June Med. Servs. v. Russo*, 140 S. Ct. at 2135 (Roberts, C.J., concurring) (setting out the factors that should be assessed in applying the Court's abortion jurisprudence).

40. *See* Am. Coll. of Obstetricians & Gynecologists v. FDA, 472 F. Supp. 3d 183, 214–15 (D. Md. 2020) (discussing the impact of restricting abortions for disadvantaged social groups).

41. *See* WHO, A CONCEPTUAL FRAMEWORK FOR ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 6 (2010), https://perma.cc/NY5P-SMM2 (PDF) (defining the "social determinants of health inequities").

42. *See supra* note 35 and accompanying text.

43. *See* Britton-Purdy et al., *supra* note 10, at 1790 ("[In constitutional law,] questions of coercion and legitimacy remain central but are delimited to exclude economic power and other structural forms of inequality. Scrutiny in these fields tends to be restricted to narrowly defined differential treatment of individuals, especially by the state.").

44. *See Am. Coll. of Obstetricians & Gynecologists*, 472 F. Supp. 3d at 197 (discussing telehealth and alternative abortion options).

45. *See The Availability and Use of Medication Abortion*, *supra* note 25 (noting the use of telehealth to increase healthcare access in the pandemic).

offered in twenty-one states.[46] Permitting healthcare providers to administer care remotely or pregnant people to self-administer abortion with minimal professional intervention has changed the map of abortion access in ways that will outlast the pandemic.

The contribution of this Article is to highlight the role of public health research in shaping the future of abortion access and the role of abortion law in contributing to health disparities and inequalities.[47] It shows that strengthening the legal and practical infrastructure for teleabortion and self-managed care can respond to the challenges of navigating a country with divided and regionally-concentrated legal permission for abortion.

This Article is organized in three Parts. The first Part analyzes how recent court decisions have changed the undue burden test while relying on public health research. The second Part offers examples of public health research concerning abortion restrictions' effect on patients, populations, and the public at large, with the latter reflecting on how the pandemic has influenced the reception of that evidence. The last Part considers two scenarios—courts' application of a narrow undue burden test and the disappearance of constitutional abortion rights altogether. In conclusion, this Article explores the public health community's support for teleabortion and, to a different extent, self-managed abortion, which depends less on constitutional arguments and more on policy innovation, social movements, and political leadership.

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46. The Kaiser Family Foundation reports, as of June 2021, that in twenty-two states and Washington, D.C. "the telehealth protocol could be used to provide medication abortion." Amrutha Ramaswamy et al., *Medication Abortion and Telemedicine: Innovations and Barriers During the COVID-19 Emergency*, KAISER FAM. FOUND. (June 16, 2021), https://perma.cc/8QN9-ZKB2.

47. Health justice is a framework that scholars have employed to advocate for "legal protections, financial supports, and accommodations" that can address health inequalities and reduce health disparities. Emily A. Benfer et al., *Health Justice Strategies to Combat the Pandemic: Eliminating Discrimination, Poverty, and Health Disparities During and After COVID-19*, 19 YALE J. HEALTH POL'Y L. & ETHICS 122, 138 (2020). Although scholarship on health justice has not engaged with the issue of abortion, one goal of this Article is to put movements for health justice and reproductive justice in conversation with each other.

I. THE EVIDENCE OF UNDUE BURDENS

The Supreme Court's 2020 decision, *June Medical Services v. Russo*, has sparked a debate among lower courts about how to apply the undue burden standard established in *Planned Parenthood of Southeast Pennsylvania v. Casey*.[48] Some courts have applied the balancing test described in *Whole Woman's Health v. Hellerstedt*,[49] which weighs the benefits a law confers against the burdens it imposes on a person's access to abortion.[50] Other courts have applied Chief Justice Roberts's concurrence in *June Medical Services*, which ignores abortion restrictions' benefits and focuses on the "substantial obstacles" erected by law.[51]

This Part describes the Court's application of the undue burden test in *Whole Woman's Health* and *June Medical Services*, concentrating on the role that patient-based and population-based burdens play in both opinions. Although Chief Justice Roberts's concurrence in *June Medical Services* portends a narrow application of the undue burden test, his opinion nonetheless recognized the distances that patients would have to travel as well as the various difficulties that come with travel, such as arranging transportation and child care.[52] This Part concludes by analyzing the use of health evidence in *ACOG v. FDA*, in which a district court applied the version of the undue burden test established in *Whole Woman's Health*, but more

48. 505 U.S. 833 (1992).

49. 136 S. Ct. 2292 (2016).

50. *See, e.g.*, Falls Church Med. Ctr., LLC v. Oliver, 412 F. Supp. 3d 668, 685 (E.D. Va. 2019) (following the *Hellerstedt* test). The roots of the balancing test described herein are in a case penned by Judge Posner on the U.S. Court of Appeals for the Seventh Circuit. *See* Planned Parenthood of Wis., Inc. v. Van Hollen, 738 F.3d 786, 798 (7th Cir. 2013) ("The feebler the medical grounds, the likelier the burden, even if slight, to be 'undue' in the sense of disproportionate or gratuitous.").

51. *See, e.g.*, Hopkins v. Jegley, 968 F.3d 912, 916 (8th Cir. 2020) (remanding "for reconsideration in light of Chief Justice Roberts's separate opinion in *June Medical*, which is controlling"); EMW Women's Surgical Ctr., P.S.C. v. Friedlander, 978 F.3d 418, 433–34 (6th Cir. 2020) (upholding a hospital transfer-agreement requirement "[u]nder the Chief Justice's controlling opinion").

52. *See* June Med. Servs. L.L.C. v. Russo, 140 S. Ct. 2103, 2140 (2020) (Roberts, C.J., concurring) (discussing the burdens identified by the district court's findings).

broadly described the health burdens for patients, populations, and the public.

A. Whole Woman's Health v. Hellerstedt

Laws regulating the delivery of abortion services have a life almost as long as *Roe v. Wade*,[53] the case that established a constitutional right to abortion.[54] But the Court's scrutiny of abortion restrictions has changed as the test for constitutionality has evolved. In *Planned Parenthood v. Casey*, the Court preserved constitutional protection for abortion, but rejected the trimester framework set out in *Roe*, according states greater discretion to restrict access to abortion.[55] A plurality of the Court held in *Casey* that states could restrict abortion before viability so long as "a state regulation [does not have] the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus."[56]

The Court's decision in *Gonzales v. Carhart*[57] captured the stakes of marshaling evidence to establish a law's burdens. In *Carhart*, the Court upheld a federal law, the Partial Birth

53. 410 U.S. 113 (1973).

54. In *Roe v. Wade*, the Supreme Court held that criminal laws banning abortion were an infringement of a constitutional right to privacy. *Roe*, 410 U.S. at 164. Patients, in consultation with their physicians, could elect to have an abortion for any reason during the first trimester. *Id.* In the second trimester, a state could "regulate the abortion procedure in ways that are reasonably related to maternal health." *Id*. In the third trimester, a state could "regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." *Id*. at 164–65. In 1983, for example, the Supreme Court reviewed and struck down the City of Akron's requirement that all second-trimester abortions occur in a hospital because of the obstacles to services the law erected. *See* City of Akron v. Akron Ctr. for Reprod. Health, Inc., 462 U.S. 416, 451–52 (1983) ("Because [the statute] fails to give a physician 'fair notice that his contemplated conduct is forbidden,' we agree that it violates the Due Process Clause." (internal citation omitted)).

55. *See Casey*, 505 U.S. at 873. The Court held that the state has an interest in protecting "the health of the woman and the life of the fetus" throughout a woman's pregnancy. *Id*. at 846. Pre-viability, the state has an interest in potential life and women's health, so long as restrictions do not impose an undue burden on the right to abortion. *Id*. After viability, the state could proscribe abortion except when pregnancy threatened "the life or health of the mother." *Id.* at 872.

56. *Id*. at 877.

57. 550 U.S. 124 (2007).

Abortion Ban Act,[58] that barred physicians from using a particular procedure, intact dilation and extraction.[59] The law made no exception for the procedure's use if indicated for a patient's health.[60] Relevant to this discussion, the Court deferred to legislative findings about the nature of and need for the procedure, stating that "wide discretion" was warranted in "areas where there is medical and scientific uncertainty."[61] *Carhart* signaled the Court's willingness to defer to legislators even when the legislature offered scant or contradictory evidence of its claims.[62] And, specifically, the case underscored the heightened stakes of providing evidence on a law's effects for patient health.[63]

Almost a decade later, the Court scaled back deference to states and clarified the application of the undue burden test.[64]

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58. 18 U.S.C. § 1531.

59. *See Carhart*, 550 U.S. at 167–68 (finding that the respondents had "not demonstrated that the Act would be unconstitutional in a large fraction of relevant cases").

60. The Court emphasized "documented medical disagreement [about] whether the Act's prohibition would ever impose significant health risks on women." *Id.* at 162.

61. *Id.* at 163.

62. Justice Kennedy wrote, "While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained." *Id.* at 159.

63. *See* ZIEGLER, *supra* note 5, at 169–70 (explaining how, in reaction to Justice Kennedy's opinion in *Gonzales v. Carhart*, research-oriented hubs formed and built off the work of the Guttmacher Institute).

64. *See* Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2312 (2016) (finding that the statute's admitting privileges requirement was a substantial obstacle); *see also* SANGER, *supra* note 7, at 235–37 ("[T]he Court explained why Texas cannot make patient care worse for women seeking abortions in the name of unproven claims about how it is making things better."); Leah M. Litman, *Dignity and Civility, Reconsidered*, 70 HASTINGS L.J. 1225, 1231 (2019) ("*Whole Woman's Health* later pointedly recognized that courts and legislatures cannot offer unsupported speculation as a basis for upholding a law that restricts in abortion."); Leah M. Litman, *Unduly Burdening Women's Health: How Lower Courts Are Undermining* Whole Woman's Health v. Hellerstedt, 116 MICH. L. REV. ONLINE 50, 57 (2017) [hereinafter, Litman, *Unduly Burdening Women's Health*] (explaining how *Whole Woman's Health* clarified and redirected courts' application of *Carhart's* holding); Linda Greenhouse & Reva B. Siegel, *The Difference A Whole Woman Makes: Protection for the Abortion Right after* Whole Woman's Health, 126 YALE L.J. F. 149, 161 (2016) ("In identifying the burdens imposed by the Texas law, the Court describes how enforcing the law would transform women's

In 2016, the U.S. Supreme Court struck down Texas's House Bill 2 (H.B. 2), which required abortion providers to obtain admitting privileges at a hospital within thirty miles of their practice and mandated that abortion clinics be outfitted as ambulatory surgical centers.[65] In applying *Casey*'s undue burden standard, the Court assessed and then balanced the purported benefits of the law against the burdens it imposed.[66] The Court held that H.B. 2 did nothing to protect patient health; instead, by forcing clinics to close, the law threatened patients' wellbeing.[67]

Balancing benefits against burdens allowed the Court to assess patients' lived experience of gaining access to abortion services.[68] In that vein, the Court turned to public health expertise and common sense.[69] Implementation of the law shuttered nineteen facilities, leaving around twenty facilities to

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experience of abortion, and treats these changes in the conditions of access as constitutionally cognizable harms to women."); Mary Ziegler, *Substantial Uncertainty:* Whole Woman's Health v. Hellerstedt *and the Future of Abortion Law*, 2016 SUP. CT. REV. 77, 78 (2016) ("*Whole Woman's Health* . . . put teeth in the undue-burden test first announced in *Planned Parenthood v Casey*.").

65. TRAP laws have been on some states' books for decades, but different types of TRAP laws have proliferated along with the general uptick of abortion regulations. For example, from 2011 through 2017, states enacted 401 abortion restrictions. Elizabeth Nash et al., *Policy Trends in the States, 2017*, GUTTMACHER INST. (Jan. 2, 2018), https://perma.cc/YK99-C6VX. Those seven years accounted for 34 percent of the total number of restrictions enacted since *Roe v. Wade* was decided in 1973. *Id*.

66. *See* Planned Parenthood of Se. Pa v. Casey, 505 U.S. 833, 900–01 (1992).

67. *See* Cary Franklin, Whole Woman's Health v. Hellerstedt *and What It Means to Protect Women*, *in* REPRODUCTIVE RIGHTS AND JUSTICE STORIES 241 (Melissa Murray et al. eds., 2019) (analyzing the repercussions of H.B. 2 on abortion-seeking patients and the Court's application of *Planned Parenthood v. Casey*).

68. *See* Daniel Grossman, *The Use of Public Health Evidence in* Whole Woman's Health v. Hellerstedt, 177 JAMA INTERNAL MED. 155, 156 (2016) (explaining the obstacles women seeking an abortion faced); *see* Litman, *Unduly Burdening Women's Health*, *supra* note 64, at 56 ("*Hellerstedt* rejected Texas's argument that courts could not consider evidence that a *plaintiff* offered to challenge an abortion restriction . . . .").

69. *See* Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2311 (2016) (relying on peer reviewed studies and expert testimony to conclude that Texas's abortion law did not solve any significant health-related problems).

serve 5.4 million people of reproductive age.[70] Thousands of residents would have lived 150 or 200 miles away from the nearest abortion provider.[71] The Court cited evidence that clinic closures would mean "fewer doctors, longer waiting times, and increased crowding."[72] The clinics remaining open, the Court held, could not have met increased demand, resulting in wait times for appointments, diminished quality of care, and increased need for second-trimester abortions.[73] "[T]hose increases are but one additional burden, which, when taken together with others that the closings brought about, and when viewed in light of the virtual absence of any health benefit," led the Court to conclude that the admitting-privileges requirement was an unconstitutional undue burden.[74]

The Court relied on "direct testimony as well as plausible inferences to be drawn from the timing of the clinic closures."[75] In terms of health expertise, the Court referred to the district court's evidentiary record, which "contain[ed] charts and oral testimony by Dr. Grossman" on how H.B. 2 would strain access.[76] Dr. Daniel Grossman is a professor and OB/GYN who has been a contributor to the public health research described in Part II.[77] The Court explained:

> Dr. Grossman's opinion rested upon his participation, along with other university researchers, in research that tracked

70. *See id.* at 2312 ("Eight abortion clinics closed in the months leading up to the requirement's effective date. . . . Eleven more closed on the day the admitting-privileges requirement took effect.").

71. *See id.* at 2313 ("[A]fter the admitting-privileges provision went into effect, the number of women of reproductive age living in a county . . . more than 150 miles from a provider increased from approximately 86,000 to 400,000 . . . ." (first omission in original) (internal quotation omitted)).

72. *Id.*

73. *Id.* at 2318; *see* Gerdts et al., *supra* note 18, at 863 (finding that closing abortion clinics can result in longer travel times and longer wait times, potentially inhibiting women from seeking abortion care).

74. *Whole Woman's Health*, 136 S. Ct. at 2313.

75. *Id.*

76. *Id.* at 2316. In his dissent, Justice Alito disputed the testimony of Dr. Grossman and the data on the availability of clinic services; he disagreed that clinics, under the law, would be stretched past capacity and that H.B. 2 caused various clinics to close. *Id.* at 2346 n.21 (Alito, J., dissenting).

77. *Daniel Grossman*, UCSF OBGYN&RS ZUCKERBERG S.F. GEN., https://perma.cc/83E3-VHD9.

> "the number of open facilities providing abortion care in the state by . . . requesting information from the Texas Department of State Health Services . . . [t]hrough interviews with clinic staff[,] and review of publicly available information."[78]

In addition to expert testimony and studies generated by university-based researchers, the Court opined that "common sense suggests that, more often than not, a physical facility that satisfies a certain physical demand will not be able to meet five times that demand without expanding or otherwise incurring significant costs."[79] Justice Breyer, writing for the majority, reasoned by analogy:

> Suppose that we know only that a certain grocery store serves 200 customers per week, that a certain apartment building provides apartments for 200 families, that a certain train station welcomes 200 trains per day. While it is conceivable that the store, the apartment building, or the train station could just as easily provide for 1,000 customers, families, or trains at no significant additional cost, crowding, or delay, most of us would find this possibility highly improbable. The dissent takes issue with this general, intuitive point by arguing that many places operate below capacity and that in any event, facilities could simply hire additional providers. We disagree that, according to common sense, medical facilities, well known for their wait times, operate below capacity as a general matter. . . . Healthcare facilities and medical professionals are not fungible commodities. Surgical centers attempting to accommodate sudden, vastly increased demand, may find that quality of care declines.[80]

The Court then expressed concern that a decreased quality of care, as well as the logistical difficulties of obtaining services, would fall hardest on "poor, rural, or disadvantaged women."[81]

Perhaps the Court did not need to rely on "common sense"; public health research had documented how many people would be turned away from the remaining clinics, were the Texas law

78. *Whole Woman's Health*, 136 S. Ct. at 2316–17 (majority opinion) (omissions in original) (internal citation omitted).

79. *Id.* at 2317.

80. *Id.* at 2317–18 (internal citations omitted).

81. *Id.* at 2302 (internal quotation omitted).

to take full effect, and what distances people would have to travel to reach an open facility.[82] The invocation of common sense suggests that laws' effects on health services are the subject of speculative intuition instead of measurable evidence.[83] In *June Medical Services*, decided by the Supreme Court after *Whole Women's Health*, both the plurality opinion and concurrence rely less on "common sense" and refer instead to evidence of the consequences of clinic closures.[84]

B. June Medical Services v. Russo

Shortly after the Court handed down *Whole Woman's Health*, the United States District Court of the Middle District of Louisiana struck down a nearly identical admitting-privileges requirement in the Louisiana Unsafe Abortion Protection Act (Act 620).[85] The district court held that Act 620 "would do little or nothing for women's health, but rather would create impediments to abortion, with especially high barriers set before poor, rural, and disadvantaged women."[86] Only one physician

82. *See id.* at 2317; *infra* Part II.A.

83. Note the contestation by the state that the evidence offered by petitioners was accurate; for example, in *June Medical Services*, Louisiana argued—and the Fifth Circuit agreed—that providers could comply with the privileges requirement but "sat on their hands," and thus clinic closures were the fault of providers and not the law. June Med. Servs. L.L.C. v. Gee, 905 F.3d 787, 807 (5th Cir. 2018).

84. *See* June Med. Servs. L.L.C. v. Russo, 140 S. Ct. 2103, 2129–30 (2020) (acknowledging that closures of abortion clinics would result in longer wait times, longer travel times, and a greater financial burden on poor women); *id.* at 2140 (Roberts, C.J., concurring) (deferring to the district court's findings that Louisiana's abortion law would be "particularly burdensome for women living in northern Louisiana . . . who once could access a clinic in their own area [and] will now have to travel approximately 320 miles to New Orleans" (internal quotation omitted)).

85. *See* June Med. Servs. L.L.C. v. Kliebert, 250 F. Supp. 3d 27, 88 (M.D. La. 2017) (finding that Louisiana's abortion law imposes an undue burden on women seeking an abortion).

86. *Id.* at 84. Cary Franklin notes the immediate impact of *Whole Woman's Health* on the district court's injunction of Act 620:

> [T]he class-related evidence the Louisiana court had previously refused to consider formed the centerpiece of its analysis. The court wrote extensively about the hardships that closing clinics would impose on low-income Louisianans, noting among other things that "[w]omen who cannot afford to pay the costs associated with travel, childcare, and time off from work may have to make sacrifices in

would have remained in practice, reducing the overall capacity to perform abortions in the state by up to 70 percent and rendering abortion services inaccessible to many pregnant people in Louisiana.[87]

Building a record based on the testimony and research of health experts, the district court determined that the minimal benefits of Act 620 were outweighed by the burdens caused by the legislation.[88] Similar to the findings in *Whole Woman's Health*, clinic closures would lead to longer driving and waiting times at the sole remaining facility.[89] The district court concluded that many Louisiana patients would "face irreparable harms from the burdens associated with increased travel distances,"[90] including delays in treatment and the increased risk of "self-performed, unlicensed and unsafe abortions."[91]

The U.S. Court of Appeals for the Fifth Circuit reversed, because the plaintiffs failed to prove "that a 'large fraction' of women of reproductive age in Louisiana [would] have a substantial obstacle to an abortion placed in their paths as a result of the challenged law."[92] The Fifth Circuit also disputed

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> other areas like food or rent expenses, rely on predatory lenders, or borrow money from family members of abusive partners or ex-partners, sacrificing their financial and personal security."

Cary Franklin, *The New Class Blindness*, 128 YALE L.J. 2, 80–81 (2018) (alteration in original) (quoting *June Med. Servs. v. Kliebert*, 250 F. Supp. 3d at 83).

87. *June Med. Servs. v. Russo*, 140 S. Ct. at 2115–16. The district court compared the number of patients that could receive an abortion before and after Act 620 took effect: abortion would be unavailable to 55 percent of people seeking an abortion. *Id.* at 2116. Four of the six physicians named in this suit—Doe 1, 2, 4, and 6—would have been unable to obtain admitting privileges and therefore would not have been able to perform abortions. *Id.* at 2115. A fifth physician, Doe 3, testified that he would retire if the Act took effect due to fears for his safety. *Id.* Louisiana would be left with only one provider and one clinic that could provide abortions. *Id*.

88. *See June Med. Servs. v. Kliebert*, 250 F. Supp. 3d at 88–89 ("The Act would create substantial obstacles for women seeking abortion in Louisiana without providing any demonstrated benefit to women's health or safety.").

89. *See id.* at 87–88 (detailing the burdens the Act imposed).

90. *Id.* at 89.

91. *Id.* at 88.

92. June Med. Servs. L.L.C. v. Kliebert, 158 F. Supp. 3d 473, 527 (M.D. La. 2016). In *Casey*, the state sought to preserve a spousal notification requirement by arguing that only 1 percent of patients would be affected because only 20 percent were married and 95 percent notify spouses in any

the effects of the law, holding that there is "[n]o evidence that Louisiana facilities will close from Act 620 . . . [and] an insufficient basis in the record to conclude that the law has prevented most of the doctors from gaining admitting privileges."[93]

The U.S. Supreme Court's ruling in *June Medical Services* was a highly-anticipated statement about the stability of the *Whole Woman's Health* balancing test and of abortion rights generally.[94] Justice Kavanaugh had replaced Justice Kennedy, who was one of five votes striking down H.B. 2 in *Whole Woman's Health*.[95] In a plurality decision, five members of the Court—including Chief Justice John Roberts, who dissented in *Whole Woman's Health*—held that the Louisiana statute was unconstitutional.[96] Rather than deferring to Louisiana's stated interest of protecting patient safety, five Justices agreed that the obstacles imposed by Act 620 were significant and created an undue burden on the right to abortion.[97]

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case. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 894 (1992). The *Casey* plurality held that the relevant group of patients was "those whose conduct [the law] affects" and the spousal-notification requirement would enact a substantial obstacle "in a large fraction of cases in which [the law] is relevant." *Id.* at 894–95. A law "must be judged by reference to those for whom it is an actual rather than an irrelevant restriction." *Id.* at 895. Since *Casey*, courts have applied the "large fraction" language in divergent ways. *See* Greenhouse & Siegel, *supra* note 64, at 154.

93. June Med. Servs. L.L.C. v. Gee, 905 F.3d 787, 810–11 (5th Cir. 2018); *see id.* at 807 ("[T]here is insufficient evidence to conclude that, had the doctors put forth a good-faith effort to comply with Act 620, they would have been able to obtain privileges. Instead . . . [they] sat on their hands, assuming that they would not qualify. Their inaction *severs the chain of causation*." (emphasis added)).

94. *See* Laurie Sobel & Alina Salganicoff, *Abortion Back at the Supreme Court:* June Medical Services LLC v. Russo, KAISER FAM. FOUND. (June 29, 2020), https://perma.cc/AK9Y-GV6N ("No matter how the Court rules, the decision will have far reaching impact . . . potentially determining how far other states can go in limiting access to abortion services.").

95. *See* Pete Williams, *New Justice on the Bench: Kavanaugh's First Supreme Court Cases*, NBC NEWS (Oct. 8, 2018, 12:11 PM), https://perma.cc/6YCC-EKYL.

96. June Med. Servs. L.L.C. v. Russo, 140 S. Ct. 2103, 2113 (2020).

97. *See id.* ("Given the facts found, we must also uphold the District Court's related factual and legal determinations. These include its determination that Louisiana's law poses a 'substantial obstacle' to women seeking an abortion . . . ."). Justice Clarence Thomas, joined by Justices

Justice Breyer penned an opinion joined by Justices Ginsburg, Sotomayor, and Kagan, which reiterated that residents in the northern part of Louisiana would have to travel over 300 miles to reach the state's sole provider.[98] Moreover, the state's requirement of an ultrasound and counseling session twenty-four hours before an abortion meant that many patients would either have to make two trips or pay for overnight accommodation.[99] Limiting the availability of services and increasing the distance between providers would result in "longer waiting times, and increased crowding."[100] Justice Breyer concluded, in agreement with "experts and laypersons . . . that the burdens of increased travel to distant clinics would fall disproportionately on poor women, who are least able to absorb them."[101] Notably, Justice Breyer's opinion

Samuel Alito, Neil Gorsuch, and Brett Kavanaugh dissented. *Id*. at 2142–82 (Thomas, J., dissenting).

98. *See id.* at 2130 (discussing the potential necessity for a patient to drive from Shreveport to New Orleans because of the law, a distance of over 300 miles). Louisiana also asked the Court to decide whether abortion providers had third-party standing to bring constitutional challenges. *See* Brief for the Respondent/Cross Petitioner at 48–53, June Med. Servs. L.L.C. v. Russo, 140 S. Ct. 2103 (2020) (Nos. 18-1323, 18-1460), 2019 WL 7372920 (arguing for the Court to dismiss Plaintiffs' claims for a lack of third-party standing). The Court recognized standing for abortion providers in *Singleton v. Wulff*, 428 U.S. 106 (1976), and applied that case, citing stare decisis. *See June Med. Servs. v. Russo*, 140 S. Ct. at 2117–20 (majority opinion) ("We have long permitted abortion providers to invoke the rights of their actual or potential patients in challenges to abortion-related regulations."). Dissenting Justices mounted attacks on *Singleton v. Wulff* as unsettled and unconvincing precedent. *See id.* at 2147–48 (Thomas, J., dissenting) (arguing that *Singleton* was decided on very narrow grounds, with facts inapplicable to *June Medical Services*); *id.* at 2170 (Alito, J., dissenting) (stating that the Court's jurisprudence on standing has changed since *Singleton*).

99. *June Med. Servs. v. Russo*, 140 S. Ct. at 2130 (majority opinion).

100. *Id.* at 2130 (quoting Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2298 (2016)).

101. *Id.* at 2130. Although *June Medical Services* made no mention of race, as noted below, people of color comprise two-thirds of abortion patients in Louisiana. *See* Brief *Amici Curiae* for Organizations and Individuals Dedicated to the Fight for Reproductive Justice—Women with a Vision et al.—in Support of Petitioners at 23–24, June Med. Servs. L.L.C. v. Russo, 140 S. Ct. 2103 (2020) (Nos. 18-1323, 18-1460), 2019 WL 6727087. The role of gender inequality passed unmentioned. *See infra* Part II.C.

de-emphasized the "common sense" of supply and demand that was prominent in *Whole Woman's Health*.[102]

Because the Court struck down an almost identical law in *Whole Woman's Health*, Chief Justice Roberts's concurrence emphasized respect for stare decisis.[103] He wrote separately to dispute Justice Breyer's application of the undue burden test.[104] Per the Chief Justice's opinion, under *Casey*, the Court did not need to consider whether a law conferred any health benefits; the only question to answer was whether a law erects a "substantial obstacle" to services.[105] Chief Justice Roberts's approach abandons a balancing test of the law's benefits (protecting patient safety, for example) against the burdens imposed.[106]

Although the Chief Justice was the fifth vote invalidating the Louisiana law, his concurrence neither shields constitutional abortion rights from future attacks, nor signals a willingness to strike down other abortion restrictions under

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102. *See June Med. Servs. v. Russo*, 140 S. Ct. at 2131–32 (relying on expert and lay testimony to decide that the district court's factual findings were not clearly erroneous).

103. For a discussion of the treatment of stare decisis in *June Medical Services*, see Melissa Murray, *The Symbiosis of Abortion and Precedent*, 134 HARV. L. REV. 308, 322–27 (2020).

104. *See June Med. Servs. v. Russo*, 140 S. Ct. at 2136 (Roberts, C.J., concurring) (stating that the Court, while assessing an abortion regulation, should focus on the presence of substantial obstacles rather than weighing its costs and benefits).

105. *See id.*

> Nothing about *Casey* suggested that a weighing of costs and benefits of an abortion regulation was a job for the courts. On the contrary, we have explained that the "traditional rule" that "state and federal legislatures [have] wide discretion to pass legislation in areas where there is medical and scientific uncertainty" is "consistent with *Casey*." *Casey* instead focuses on the existence of a substantial obstacle, the sort of inquiry familiar to judges across a variety of contexts. (quoting Gonzales v. Carhart, 550 U.S. 124, 163 (2007)).

106. *See id.* (stating that objectively weighing the "the State's interests in protecting the potentiality of human life and the health of the woman . . . against the woman's liberty interest in defining her own concept of existence, of meaning, of the universe, and of the mystery of human life" is implausible (internal quotations omitted)).

different facts.[107] Yet the Chief Justice's concurrence accepted the district court's depiction of what the landscape of abortion care would look like if the law had taken effect.[108] Despite his allegiance to precedent and his ambivalence about assessing the law's ostensible benefits, his concurrence considered the law's operation in the real world.[109] As Justice Breyer cited evidence of the financial, social, and practical burdens of delayed or denied abortion care, Chief Justice Roberts acknowledged evidence-based claims that clinic closures lead to increased burdens for pregnant people:

> The [district] court found that Louisiana women already "have difficulty affording or arranging for transportation and childcare on the days of their clinic visits" and that "[i]ncreased travel distance" would exacerbate this difficulty. The law would prove "particularly burdensome for women living in northern Louisiana . . . who once could access a clinic in their own area [and] will now have to travel approximately 320 miles to New Orleans."[110]

As Melissa Murray has demonstrated, this passage responds to the dissents penned by Justices Alito and Gorsuch, who criticized the Chief Justice for expressing solicitude for precedent while reinterpreting *Whole Woman's Health*.[111] But, even if reiterating the burdens erected by the Louisiana law attempted to support his application of stare decisis, the Chief Justice could have written about precedent without repeating evidence about the

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107. *See id.* at 2141–42 ("*Stare decisis* instructs us to treat like cases alike. The result in this case is controlled by our decision four years ago invalidating a nearly identical Texas law.").

108. *See id.* at 2140 (showing deference to the district court by accepting their findings).

109. *See id.* (finding similarities between Louisiana's abortion law and Texas's abortion law in *Whole Woman's Health*).

110. *Id.* at 2140 (alterations and omission in original).

111. *See* Murray, *supra* note 103, at 325–36 (comparing Chief Justice Roberts's decision in *Whole Woman's Health* to a "legal version of Dorian Gray's portrait"); June Med. Servs. L.L.C. v. Russo, 140 S. Ct. 2103, 2153 (2020) (Alito, J., dissenting) ("The Chief Justice stresses the importance of *stare decisis* and thinks that precedent, namely *Whole Woman's Health,* dooms the Louisiana law. But at the same time, he votes to overrule *Whole Woman*'s *Health* insofar as it changed the *Casey* test."); *id.* at 2180–81 (Gorsuch, J., dissenting) (arguing that the concurrence ignored the doctrine of stare decisis when it applied the "substantial obstacle" standard from *Whole Woman's Health*).

nature of the obstacles imposed.[112] That is not to argue that the Chief Justice is a champion of abortion rights, but rather to highlight the evidence of law's lived effects that five Justices found credible.[113]

Given its current composition, the Supreme Court may be unlikely to apply a balancing approach moving forward.[114] Indeed, the question the Court will decide in 2022 is whether all pre-viability bans are unconstitutional.[115] Yet the evidentiary record in *June Medical Services* showcases litigators' and public health researchers' coordinated efforts to generate empirical evidence about the costs of navigating state restrictions.[116] Courts cannot know such facts without research to support them. The point here, however, is not to celebrate the production of evidence.[117] As Aziza Ahmed has shown, evidence-based strategies are susceptible to manipulation by either end of the ideological spectrum.[118] The point is to underscore the reach of

112. *See June Med. Servs. v. Russo*, 140 S. Ct. at 2139 (Roberts, C.J., concurring) (reiterating the district court's finding that Louisiana's abortion law would impose several obstacles for women seeking an abortion).

113. *See* Reva Siegel, *Why Restrict Abortion? Expanding the Frame on* June Medical, 20 SUP. CT. REV. (forthcoming 2021) (manuscript at 6–7), https://perma.cc/46CT-4QF9

> Justices who denounce balancing as legislative rather than judicial are directing judges to defer to state claims about health. This adds the courts' imprimatur to modern forms of protectionism that inflict physical and dignitary injuries on poor women. The Justices who denounce balancing as legislative rather than judicial are engaged in a political project at the very moment they claim to be avoiding entanglement in politics.

114. Justice Kavanaugh wrote in dissent, "Today, five Members of the Court reject the *Whole Woman's Health* cost-benefit standard." *June Med. Servs. v. Russo*, 140 S. Ct. at 2182 (Kavanaugh, J., dissenting).

115. *See* Jackson Women's Health Org. v. Dobbs, 945 F.3d 265, 268 (5th Cir. 2019), *cert. granted in part*, 141 S. Ct. 216 (2021) ("The central question before us is whether [Mississippi's abortion] law is an unconstitutional ban on pre-viability abortions.").

116. *See June Med. Servs. v. Russo*, 140 S. Ct. at 2115–16 (majority opinion) (discussing the evidentiary record).

117. *See* Aziza Ahmed, *Medical Evidence and Expertise in Abortion Jurisprudence*, 41 AM. J.L. & MED. 85, 110 (2015) (noting courts' distinctions between ideology and fact when upholding abortion restrictions and warning that generating expertise in abortion law also has advanced "a conservative political project").

118. *See id.* at 86–87 (explaining how judges have viewed medical evidence and expertise through the lens of ideology).

public health research on the unequal distribution of health resources, as *ACOG v. FDA* illustrates.

C. ACOG v. FDA

ACOG v. FDA is distinct from *Whole Woman's Health* and *June Medical Services* in that it concerns a federal rule, not a state law, and rulemaking by an agency, not state legislators.[119] Nevertheless, at the heart of the case is an analysis of the undue burden standard, under which the court adopted evidence of the multi-level burdens imposed by law.[120]

The case concerns the FDA's restrictions on mifepristone, which is the first drug ingested in a medication abortion.[121] The second drug, misoprostol, is taken twenty-four to forty-eight hours after mifepristone and it is not subject to the same restrictions.[122] The FDA applies a drug safety program—a Risk Evaluation and Mitigation Strategy or REMS—to mifepristone.[123] The FDA issues a REMS for drugs it deems potentially risky and in need of monitoring.[124] With a REMS, the FDA can issue an Elements to Assure Safe Use (ETASU), which can limit distribution and set the terms of who can prescribe a

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119. *See* Am. Coll. of Obstetricians & Gynecologists v. FDA, 506 F. Supp. 3d 328, 333–36 (D. Md. 2020).

120. *See id.* at 339 (noting that COVID-19 has impacted individuals' access to abortion clinics).

121. *Id.* at 331. Almost all medication abortions are completed through a mifepristone-misoprostol regimen. *See* Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2014*, 49 PERSPS. ON SEXUAL & REPRO. HEALTH 17, 22 (2017) ("While other drugs can be administered in early medication abortion, the overwhelming majority—97%—were done with mifepristone.").

122. *See Questions and Answers on Mifeprex*, FDA, https://perma.cc/87ZR-PXB7 (last updated Apr. 13, 2021) ("Mifeprex (mifepristone) is a drug that blocks a hormone called progesterone that is needed for a pregnancy to continue. Mifeprex, when used together with another medicine called misoprostol, is used to end an early pregnancy (70 days or less since the first day of the last menstrual period)."); *The Availability and Use of Medication Abortion*, *supra* note 25 (stating that misoprostol, taken twenty-four to forty-eight hours after mifepristone, empties the uterus by causing cramping).

123. *See* FDA, MIFEPREX RISK EVALUATION AND MITIGATION STRATEGIES 1 (2016), https://perma.cc/SHF2-2P5R (PDF) (stating the goals of the REMS).

124. *See Risk Evaluation and Mitigation Strategies*, FDA, https://perma.cc/98TD-DUMY (last updated Aug. 8, 2019) (explaining what a REMS is).

drug and under what conditions.[125] Modified in 2016, FDA's mifepristone REMS includes an ETASU with several parts; relevant here is the requirement that patients collect mifepristone at a healthcare facility—a hospital, clinic, or medical office.[126] The effect of in-person collection has been to prohibit retail pharmacies and mail-order prescription services from distributing mifepristone, though some commentators dispute whether such a prohibition follows from the ETASU's language.[127] The ETASU does not mandate that the provider be physically present when the drug regimen is collected or taken by the patient.[128] Thus, mifepristone (and misoprostol) can be self-administered outside of a healthcare setting.[129]

The American College of Obstetricians and Gynecologists (ACOG), the leading professional organization in the field, brought suit with four other parties to enjoin the in-person

125. *See ETASU Explained*, AIMED ALL. (2020), https://perma.cc/2DCD-NSRV ("ETASU are carefully planned safety systems that control how a medication is administered by health professionals and taken by patient.").

126. *See* FDA, *supra* note 123, at 1. In 2016, the FDA approved use of mifepristone from forty-nine days to seventy days from the first day of the last menstrual period, lowered the dose regimen, permitted non-physician providers to apply for certification to prescribe mifepristone, and allowed patients to take mifepristone outside a healthcare facility even though the drug had to be dispensed at a health care facility. *See* Rachel K. Jones & Heather Boonstra, *The Public Health Implications of the FDA's Update to the Medication Abortion Label*, HEALTH AFFS. (June 30, 2016), https://perma.cc/9PTP-CKQR. *See generally* GOV'T ACCOUNTABILITY OFF., INFORMATION ON MIFEPREX LABELING CHANGES AND ONGOING MONITORING EFFORTS (Mar. 2018), https://perma.cc/73LN-K9DL (PDF). For certification under the ETASU, providers must submit a form to the drug sponsor attesting that they can "assess the duration of pregnancy accurately," "diagnose ectopic pregnancies," and "provide surgical intervention" or "have made plans to provide such care through others." FDA, *supra* note 123, at 7. Patients must receive a Medication Guide and sign a Patient Agreement Form; providers agree to report any adverse events. *Id.* The Patient Agreement Form outlines the drug's risks and benefits, and it emphasizes the need to follow up with a provider seven to fourteen days after completing the drug regimen. *Id.*

127. *See infra* Part III.B; Manian, *supra* note 8, at 1331–33 (describing longstanding efforts to restrict medication abortion).

128. *See* FDA, *supra* note 123, at 1.

129. *See id.* Misoprostol may be mailed to patients, but a medication abortion regimen includes both drugs, so both are delivered together. *See* Manian, *supra* note 8, at 1331 (describing the protocol).

ETASU during the pandemic.[130] ACOG argued that applying the in-person ETASU contradicts substantial evidence of the drug's safety and is ineffectual in protecting patients.[131] Indeed, the FDA's management of mifepristone stands out among other drugs. Of the 20,000 drugs regulated by the FDA, and the seventeen with the same ETASU, mifepristone is the only one that patients must retrieve at a medical center but may take without physician supervision.[132] In fact, the FDA permits mailing to patients' homes the exact same drug compound as mifepristone, in higher doses and larger quantities, for treatment of other conditions—but not for abortion or miscarriage.[133] Moreover, retrieving mifepristone at a healthcare facility does not reduce the likelihood of a complication; usually, a provider is not present when the abortion begins and a patient is not at a healthcare facility.[134] Complications, which are very rare, typically occur where the

130. *See* Am. Coll. of Obstetricians & Gynecologists v. FDA, 506 F. Supp. 3d 328, 331 (D. Md. 2020). The other named plaintiffs are the Council of University Chairs of Obstetrics and Gynecology, the New York State Academy of Family Physicians, SisterSong Women of Color Reproductive Justice Collective, and Dr. Honor Macnaughton. *Id.* SisterSong is a non-profit organization that has been the leader and a founder of the reproductive justice movement. *See* JENNIFER NELSON, MORE THAN MEDICINE: A HISTORY OF THE FEMINIST WOMEN'S HEALTH MOVEMENT 167–92 (2015) (describing the leadership of women of color in advocating for reproductive justice).

131. *See* Plaintiffs-Appellees' Principal and Response Brief at 2, Am. Coll. of Obstetricians & Gynecologist v. FDA, 506 F. Supp. 3d 328 (D. Md. 2020) (Nos. 20-1824, 20-1784, 20-1970), 2021 WL 424851 ("There is no medical content to this visit: Defendants do not require any clinical services or counseling when patients pick up their pill, and permit patients to swallow the pill later, unsupervised, at the location of their choice."). Mifepristone and misoprostol are over 96 percent effective in completing a termination and only 0.1 percent of medication abortions result in serious adverse events. NAT'L ACADS. SCI., ENG'G, & MED., THE SAFETY AND QUALITY OF ABORTION CARE IN THE UNITED STATES 53–55 (2018), https://perma.cc/M7WR-L4XC (PDF).

132. Plaintiffs-Appellees' Principal and Response Brief, *supra* note 131, at 2.

133. *See* Complaint at 32, Am. Coll. of Obstetricians & Gynecologists v. FDA, 506 F. Supp. 3d 328 (D. Md. 2020) (No. 8:20-cv-01320-TDC), 2020 WL 2771735 (offering the example of endogenous Cushing's syndrome, a condition that the same drug compound as mifepristone treats).

134. *See id.* at 15–16 (describing the steps that a patient takes to use mifepristone).

patient ingests the medicine, which is usually at the patient's home.[135]

ACOG further highlighted that in-person dispensation for mifepristone contradicts the FDA's (and other federal agencies') encouragement of telemedicine to reduce patient-provider contact during the pandemic.[136] Along with the Centers for Disease Control and Prevention (CDC), the FDA has urged providers to reduce patient contact as much as possible.[137] To this end, the FDA suspended REMS for other drugs, such as certain opioids, that pose far greater risks to patient safety.[138]

In addition to arguments about mifepristone's safety and the FDA's exceptional treatment of medication abortion, ACOG emphasized the many ways in which the in-person requirement exacerbates burdens that are already shouldered by people who work essential jobs or are unemployed, have lost health insurance, live in multi-generational homes, and lack

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135. The U.S. Government Accountability Office found that between 2000 and 2017, over 3 million people terminated pregnancies with medication abortion and only 4,200 adverse events occurred; of those, only 0.01 to 0.7 percent required hospitalization. GOV'T ACCOUNTABILITY OFF., *supra* note 126, at 21.

136. *See* Complaint, *supra* note 133, at 25–30. The district court detailed the FDA's pandemic-based approach on remote drug delivery:

> In March and April 2020, FDA informed drug sponsors for two specific drugs, Spravato and Tysabri, that during the pandemic it would not enforce the associated ETASU C requirement that a drug be administered or dispensed only at a hospital, clinic, or medical office—the same limitation imposed on mifepristone—even though both still must be administered in-person by a physician.

Am. Coll. of Obstetricians & Gynecologists v. FDA, 472 F. Supp. 3d 183, 194 (D. Md. 2020).

137. *See* FDA, POLICY FOR CERTAIN REMS REQUIREMENTS DURING THE COVID-19 PUBLIC HEALTH EMERGENCY 7 (Mar. 2020), https://perma.cc/MJ9S-VBGF (PDF) (recommending that providers be cognizant of patients' desires to avoid in-person contact); *Secretary Azar Announces Historic Expansion of Telehealth Access to Combat COVID-19*, U.S. DEP'T OF HEALTH & HUM. SERVS. (Mar. 17, 2020), https://perma.cc/94GM-EFEW (announcing that HHS would waive potential HIPAA violations to promote telemedicine over in-person visits).

138. *See* FDA, *supra* note 137, at 7 ("Although all REMS requirements remain in effect, FDA does not intend to take enforcement action against sponsors or others for accommodations made . . . during the PHE . . . provided that such accommodations were made based on the judgment of a health care professional.").

transportation.[139] ACOG relied on evidence that low-income patients and people of color are more likely to become ill, to have inadequate resources to respond to illness, and to have worse health outcomes as a result of existing health inequalities.[140]

In July 2020, the U.S. District Court for the District of Maryland issued a nationwide injunction of the in-person requirement for the duration of the COVID-19 national emergency.[141] The court held that the ETASU was an undue burden because requiring travel to a hospital, clinic, or medical office to pick up a drug that can be taken at home offers no medical benefit.[142] And any possible benefit was outweighed by the burdens that the ETASU imposed, such as increased risk of exposure to COVID-19.[143]

After the district court's decision, more providers began to counsel patients through telehealth, mailing mifepristone to patients through a supervised delivery service or through online (but not retail) pharmacies.[144] Well before the July decision, an ongoing national study of "TelAbortion" had demonstrated the

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139. *See Am. Coll. of Obstetricians & Gynecologists*, 472 F. Supp. 3d at 224 (noting that COVID-19 disproportionately impacts marginalized populations).

140. *Id.*

141. *See id.* at 232.

142. *See id.* at 220 (finding that telemedicine is an acceptable alternative to the requirement that patients take mifepristone in-person).

143. *See id.* at 221.

144. *See* Elizabeth Raymond et al., *TelAbortion: Evaluation of a Direct to Patient Telemedicine Abortion Service in the United States*, 100 CONTRACEPTION 173, 174 (2019) (discussing several studies focused on teleabortion); *Evaluation of Telemedicine in Iowa,* ANSIRH, https://perma.cc/275K-99YC

> The first telemedicine abortion program began in Iowa in 2008. Between 2008 and 2015, Planned Parenthood clinics in the state performed 8,765 medication abortions via telemedicine, all following the same protocol. A patient came into the clinic for an intake appointment, including an ultrasound, and a provider reviewed her images and medical history remotely. The provider spoke with the patient via videoconference, after which the provider entered a password to unlock a drawer in front of the patient, where the medication abortion pills were held. The patient took the first pill, mifepristone, in front of the provider via videoconference, and the second pill at home. Within two weeks, the patient returned to the clinic for a follow-up to ensure the abortion was complete.

effectiveness and safety of remote care.[145] In 2016, Gynuity Health Projects received an Investigational New Drug Approval to deliver medication abortion without the in-person collection requirement.[146] Providers counseled patients through videoconferencing, and patients confirmed gestational age with blood tests and ultrasounds at a location of their choosing.[147] During the pandemic, study participants who were at low risk of complications did not have to undergo an ultrasound or have a blood test; rather, gestational age was assessed by home pregnancy tests and questions about the date of the patient's last menstrual period.[148] The Gynuity provider then mailed the medication abortion regimen directly to the patient and requested to meet the patient online seven to fourteen days after.[149] Other ETASU requirements, such as receiving the Medication Guide or signing the Patient Agreement form, also occurred virtually.[150]

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145. *See* Daniel Grossman & Kate Grindlay, *Safety of Medical Abortion Through Telemedicine Compared with In Person*, 130 OBSTETRICS & GYNECOLOGY 778, 778 (2017) (concluding that "[a]dverse events are rare with medical abortion, and telemedicine provision is noninferior to in-person provision with regard to clinically significant adverse events").

146. The Gynuity project started with five states and now includes eighteen states and Washington, D.C. *See infra* Part III.B. An Investigational New Drug Approval allows research on an approved drug, but for a non-approved use. Raymond et al., *supra* note 144, at 174.

147. *See* Raymond et al., *supra* note 144, at 174 (outlining the screening and intake process for participants). The protocol adopted by Gynuity reflects FDA counseling and informational requirements. Also, ultrasounds and blood tests to confirm pregnancy can be covered by insurance or Medicaid. *Id.* at 174.

148. *See* Hillary Bracken et al., *Alternatives to Routine Ultrasound for Eligibility Assessment Prior to Early Termination of Pregnancy with Mifepristone-Misoprostol*, 118 BJOG 17–23 (2011) (concluding that using the last menstrual period and physical examination alone are highly effective in determining a woman's eligibility for early termination of pregnancy); Ushma D. Upadhyay & Daniel Grossman, *Telemedicine for Medication Abortion*, 100 CONTRACEPTION 351, 352 (2019) (describing research, which assesses no-touch protocols and demonstrates 95 percent accuracy in identifying patients within the eligible gestational limit for medication abortion).

149. *See* Raymond et al., *supra* note 144, at 174 (explaining that a follow-up is scheduled with the participant seven to fourteen days after the package containing the medicine was mailed).

150. The district court clarified that patients and providers were permitted to sign or give verbal consent to the terms of the Patient Agreement form (required by the ETASU) during a telehealth session. *See* Order, Am. Coll. of

Based in part on studies demonstrating the safety and efficacy of remote abortion care,[151] the district court in *ACOG v. FDA* enjoined the in-person requirement as an undue burden, drawing from health research demonstrating patients' experiences, effects on particular populations, and the broader consequences for public health.[152] The district court rejected Chief Justice Roberts's version of the undue burden test in *June Medical Services*.[153] Instead, the district court applied *Whole Woman's Health*'s balancing test because the "common denominator" of the *June Medical Services* plurality was "that a 'substantial obstacle' based solely on consideration of burdens is *sufficient* to satisfy the undue burden standard, [but] not that it is *necessary*."[154] Because five Supreme Court justices agreed

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Obstetricians & Gynecologists v. FDA, No. 20-1320 (D. Md. Aug. 19, 2020) 2020 WL 8167535.

151. In a study of the first thirty-two months of the Gynuity program, two of 217 participants reported serious adverse events but "neither event would have been averted had the abortion medications been provided in person." Raymond et al., *supra* note 144, at 176. Participants were either satisfied (20 percent) or very satisfied (80 percent) with their experiences. *Id*.

152. Note that the district court, while framing the decision in terms of public health, referred to the common sense of what obstacles abortion restrictions impose: "the extensive evidence relating to the burdens of the In-Person Requirements during the COVID-19 pandemic supports the 'commonsense inference' that they present a substantial obstacle to a large fraction of the women for whom the In-Person Requirements are relevant." Am. Coll. of Obstetricians & Gynecologists v. FDA, 472 F. Supp. 3d 183, 224 (D. Md. 2020) (citing *Whole Woman's Health* for its "holding that courts may draw 'commonsense inferences' from the evidence in assessing whether an undue burden exists").

153. *See id*. at 209 (noting that "the holding of *June Medical Services* is fairly limited to the reasoning that represents a 'common denominator' that he shared with the plurality").

154. *Id*. The Supreme Court has held that "[w]hen a fragmented Court decides a case and no single rationale explaining the result enjoys the assent of five Justices, 'the holding of the Court may be viewed as that position taken by those Members who concurred in the judgments on the narrowest grounds.'" Marks v. United States, 430 U.S. 188, 193 (1977) (quoting Gregg v. Georgia, 428 U.S. 153, 169 n.15 (1976)). Applying the *Marks* test differently, the Eighth Circuit asked a district court to reconsider its injunction against four Arkansas abortion restrictions because *June Medical Services* eliminated the *Whole Woman's Health* balancing test and required only assessment of burdens caused by law. *See* Hopkins v. Jegley, 968 F.3d 912, 916 (8th Cir. 2020) (vacating the district court's preliminary injunction). Under the Eighth Circuit's reasoning, the narrowest ground for *June Medical Services* is the test

that Act 620 erected a substantial obstacle, "*June Medical Services* is appropriately considered to have been decided without the need to apply or reaffirm the balancing test of *Whole Woman's Health*," leaving no reason to believe "that *Whole Woman's Health* and its balancing test have been overruled."[155]

In applying the undue burden test, the district court detailed the cumulative effects of abortion restrictions based on expert testimony and evidence introduced by ACOG, finding that the "combination of such barriers can establish a substantial obstacle."[156] After holding that the government had not proved any of the ETASU's alleged benefits, the district court developed a strong factual case for the harm caused by the in-person restriction.[157] The practical and economic strains on providers during the pandemic have caused clinics to scale back operating hours or close altogether, creating long wait lists to collect the drug regimen.[158] At the population level, the court opined that "abortion patients generally face more significant health risks arising from traveling to a medical facility during the pandemic . . . . 60 percent of women who have abortions are people of color, and 75 percent are poor or low-income," and those populations are more likely to have preexisting medical conditions.[159] They are also less likely to have access to medical care, which puts a significant number of abortion patients at higher risk of illness and death if infected with COVID-19.[160]

For almost all patients, the pandemic has made arranging childcare, housing, transport, or time off work difficult. But the decision highlighted that the majority of people seeking abortions—low-income patients and people of color—shoulder

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offered by Chief Justice Roberts, and courts therefore should consider only burdens, not benefits, imposed by abortion restrictions. *See id*.

155. *Am. Coll. of Obstetricians & Gynecologists*, 472 F. Supp. 3d at 209. On appeal, the FDA asked the U.S. Court of Appeals for the Fourth Circuit to apply Chief Justice Roberts's concurrence in *June Medical Services*. *See* Defendants-Appellants/Cross-Appellees' Opening Brief at 33, Am. Coll. of Obstetricians & Gynecologists v. FDA, Nos. 20-1784, 20-1824, 20-1970 (4th Cir. Oct. 26, 2020), 2020 WL 6319261 (arguing that the district court misapplied the *Marks* test).

156. *Am. Coll. of Obstetricians & Gynecologists*, 472 F. Supp. 3d at 216.

157. *See id.* at 212–16.

158. *See id.* at 214.

159. *Id.* at 214–15.

160. *Id.* at 215.

these hardships disproportionately.[161] To take the example of travel, the district court cited the testimony of providers who recounted that many of their patients do not own a car, cannot afford private transportation, and should avoid public transportation if possible.[162] The court summarized that the combination of barriers—from inflexible work hours to the lack of childcare—delayed individuals from receiving a medication abortion, "which can either increase the health risk to them or, in light of the ten-week limit . . . prevent them from receiving a medication abortion at all."[163]

The district court's suspension lasted six months.[164] The FDA appealed the case to the Fourth Circuit,[165] and asked the Supreme Court to stay the injunction.[166] In October 2020, the Supreme Court denied the government's request, instructing the FDA to return to the district court and for the district court to revise or to suspend its ruling if conditions had changed.[167] The district court declined to lift its order, prompting a second petition for a stay, which the Court granted on January 12, 2021.[168]

Although the FDA has taken a different course under the Biden Administration,[169] the arguments defending the ETASU, particularly in the first stay petitions, elucidate opposing approaches to health evidence. Briefs filed in October 2020 by ten states and the solicitor general (on behalf of the FDA) contested that in-person dispensation imposes any heightened

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161. *Id.*

162. *Id.*

163. *Id.* at 216.

164. *Id.* at 233.

165. Notice of Appeal to the Fourth Circuit at 1, Am. Coll. of Obstetricians & Gynecologists v. FDA, 472 F. Supp. 3d 183 (D. Md. 2020) (No. 20-1320), ECF No. 95.

166. Application for a Stay of the Injunction Issued by the United States District Court for the District of Maryland at 9, FDA v. Am. Coll. of Obstetricians & Gynecologists, 141 S. Ct. 578 (2021) (No. 20A34), ECF No. 1.

167. On Application for Stay at 1, *Am. Coll. of Obstetricians & Gynecologists*, 141 S. Ct. 578 (No. 20A34), ECF No. 19.

168. *Am. Coll. of Obstetricians & Gynecologists*, 141 S. Ct. at 578.

169. *See* Abigail Abrams, *Why Abortion Pills Are the Next Frontier in the Battle Over Reproductive Rights*, TIME (Apr. 13, 2021, 9:00 PM), https://perma.cc/YAU8-ZHL6 (discussing how the Biden Administration reversed the Trump Administration's policy on mailing abortion medication).

risks for patients.[170] For example, the brief submitted by ten states asserted:

> As States have reopened with the benefit of public health precautions, a one-time visit to medical facilities presents no greater risk than engaging in a variety of other public activities that state public health officials have judged safe to resume. And women now have a greater range of safe, affordable childcare and transportation options than earlier in the pandemic.[171]

States such as Arkansas, which suspended abortion in March 2020 purportedly to protect people from COVID-19, claimed that the pandemic posed only a minimal threat for people who need abortion care.[172] In the same vein, the solicitor general argued that mask mandates, increased testing, and better treatment have "mitigated or resolved" any burdens on travel, finances, or childcare.[173] In other words, medication abortion presents a health and safety risk, but potential COVID-19 contraction does not.

ACOG replied that on "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."[174] ACOG further showed that in the

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170. Brief of Intervenors-Appellants at 48, Am. Coll. of Obstetricians & Gynecologists v. FDA, Nos. 20-1784, 20-1824, 20-1970 (4th Cir. Oct. 26, 2020), ECF No. 45; Defendants-Appellants/Cross-Appellees' Opening Brief, *supra* note 155 at 43. Indiana, Louisiana, Alabama, Arkansas, Idaho, Kentucky, Mississippi, Missouri, Nebraska, and Oklahoma (collectively, "the States") moved to intervene on June 28, 2020. Brief of Intervenors-Appellants, *supra*, at 2. On June 15, 2020, the district court denied the States' motion to intervene. *Id.* The States then filed a motion to reconsider, which the district court denied on July 13, 2020. *Id.*

171. Defendants' Memorandum in Support of Their Renewed Motion to Stay the Preliminary Injunction and for an Indicative Ruling Dissolving the Preliminary Injunction at 1, Am. Coll. of Obstetricians & Gynecologists v. FDA, 472 F. Supp. 3d 183 (D. Md. 2020) (No. 20-1320), ECF No. 141-2 [hereinafter Defendant's Memorandum in Support].

172. *See* Brief of Intervenors-Appellants, *supra* note 170, at 53 (stating that "nothing supports a conclusion that abortion patients would be irreparably harmed" by attending in-person appointments).

173. *See* Defendants' Memorandum in Support, *supra* note 171, at 5 (asserting that the burdens imposed by COVID-19 are no longer obstacles).

174. Plaintiffs' Brief in Opposition to Defendants' Renewed Motion to Stay the Preliminary Injunction at 1, Am. Coll. of Obstetricians & Gynecologists v.

intervening months since the district court's ruling, the FDA had not produced any evidence that the injunction had caused harm to any patient.[175]

At the heart of the case was a battle between deference to policymakers versus public health evidence—evidence that undermined granting deference to government actors. While defending the lawsuit, the FDA's repeated a theme of pandemic-related litigation: legislators "should not be subject to second-guessing by an 'unelected federal judiciary,' which lacks the background, competence, and expertise to assess public health."[176] By contrast, ACOG endeavored to prove that delaying and denying abortion exacerbates health inequalities and contributes to a health-care crisis now and beyond the pandemic.[177] When people do not have access to local abortion services, they will travel far distances, self-induce terminations, or carry unwanted pregnancies to term.[178] Each of those options can have short-term and long-term costs, as public health research proves.[179]

The parties made similar arguments between deference and evidence in December 2020, when the FDA again asked the Supreme Court to stay the injunction.[180] However, the government, in the face of COVID-19 surges, revised its contention that the risks of the pandemic had abated. Instead, it pointed to two states, Nebraska and Indiana, in which state

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FDA, 472 F. Supp. 3d 183 (D. Md. 2020) (20-1320), ECF No. 142 [hereinafter Plaintiffs' Brief in Opposition].

175. *See id.* at 3 ("Defendants concede that they cannot identify any harm resulting from the injunction over the past four months.").

176. S. Bay United Pentecostal Church v. Newsom, 140 S. Ct. 1613, 1614 (2020) (Roberts, C.J., concurring).

177. *See* Plaintiffs' Brief in Opposition, *supra* note 174, at 18 (contending that requiring in-person appointments, which are now more scarce, will delay or block access for patients who are unable to arrange them).

178. *See* Nina Bai, *As More States Restrict Abortions, Research Points to Negative Health Outcomes for Women, Families,* UCSF (May 22, 2019), https://perma.cc/3N4B-EZWF (detailing the effects that abortion restrictions will have on women seeking access).

179. *See id.* (finding large differences in economic outcomes between women who were denied abortion access and those who were not).

180. Defendants' Renewed Motion to Stay the Preliminary Injunction and for an Indicative Ruling Dissolving the Preliminary Injunction at 1, Am. Coll. of Obstetricians & Gynecologists v. FDA, 472 F. Supp. 3d 183 (D. Md. 2020) (No. 20-1320), ECF No. 141.

law requires in-person collection of medication abortion and had seen increases in abortion rates from 2019 to 2020.[181] ACOG highlighted that abortion rates from two states for a one-year period did not mean that the pandemic had no effect on abortion access.[182] And it again noted the gaps in evidence offered by the government: the solicitor general did not introduce one statement from the FDA or CDC or any other health agency; it produced no evidence from any health expert.[183] ACOG, on the other hand, relied on statements from four leading public health experts and epidemiologists.[184]

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181. *See* Defendants' Memorandum in Support, *supra* note 171, at 13–14 (citing to a declaration stating that the number of abortions in Nebraska and Indiana during the pandemic exceeded numbers for the same period the year prior).

182. *See* Plaintiffs' Brief in Opposition, *supra* note 174, at 18 n.13 (stating that the argument around the increase in abortions in Indiana and Nebraska ignores evidence that abortion demand is up). The abortion rates took account of all abortions, not just medication abortions, and did not compare rates in states in which restrictions had been suspended. *See* Declaration of Matthew Foster at 3–5, Am. Coll. of Obstetricians & Gynecologists v. FDA, 472 F. Supp. 3d 183 (D. Md. 2020), ECF No. 141-7 (detailing the data for both medication and surgical abortions). Additionally, the data only compared two years and failed to account for changes in contraceptive access and use or an increase in unwanted pregnancies *because of* the pandemic. *See id*. (reporting only the abortion numbers for 2019 and 2020). As Justice Sotomayor stated in her dissent to the Court's stay, "[r]eading the Government's statistically insignificant, cherry-picked data is no more informative than reading tea leaves." FDA v. Am. Coll. of Obstetricians & Gynecologists, 141 S. Ct. 578, 584 (2021) (Sotomayor, J., dissenting).

183. *See* Plaintiffs' Brief in Opposition, *supra* note 174, at 19 (noting that the defendants had not produced a declaration from an HHS or FDA expert regarding COVID-19 risks with travel and in-person activities); *id*. at 18 n.13 (asserting that the defendants' argument lacked scientific rigor).

184. *See* Second Declaration of Arthur L. Reingold, M.D., in Opposition to Defendants' Renewed Motion to Stay the Preliminary Injunction and for an Indicative Ruling Dissolving the Preliminary Injunction, Am. Coll. of Obstetricians & Gynecologists v. FDA, 472 F. Supp. 3d 183 (D. Md. 2020) (No. 20-1320), ECF No. 142-1; Declaration of Mary Travis Bassett, M.D., M.P.H., Am. Coll. of Obstetricians & Gynecologists v. FDA, 472 F. Supp. 3d 183 (D. Md. 2020) (No. 20-1320), ECF No. 142-2; Declaration of Honor MacNaughton, M.D., Am. Coll. of Obstetricians & Gynecologists v. FDA, 472 F. Supp. 3d 183 (D. Md. 2020) (No. 20-1320), ECF No. 142-3; Declaration of Trevon D. Logan, Ph.D., Am. Coll. of Obstetricians & Gynecologists v. FDA, 472 F. Supp. 3d 183 (D. Md. 2020) (No. 20-1320), ECF No. 142-5. That evidence confirmed what ACOG had demonstrated throughout the litigation: the burdens of the law and of the pandemic fall heaviest on low-income patients and people of color, who comprise the majority of abortion seekers and have been disproportionately

The Supreme Court issued a stay without explanation.[185] In a short concurrence, Chief Justice Roberts relied on pandemic-related caselaw: "Here as in related contexts concerning government responses to the pandemic, my view is that courts owe significant deference to the politically accountable entities with the 'background, competence, and expertise to assess public health.'"[186] In a powerful dissent that affirmed many of ACOG's arguments, Justice Sotomayor, joined by Justice Kagan, qualified what kind of deference the Court owes the agency:

> The Government has not submitted a single declaration from an FDA or HHS official explaining why the Government believes women must continue to pick up mifepristone in person, even though it has exempted many other drugs from such a requirement given the health risks of COVID-19. There simply is no reasoned decision here to which this Court can defer.[187]

When and whether courts should defer to agencies or legislatures during a pandemic is not a question this Article attempts to answer, particularly given the Supreme Court's mixed messages on the subject.[188] But the lack of clarity as to when deference is warranted will have at least one consequence for abortion litigation: deference invites those bringing constitutional challenges to continue to amass evidence of the

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harmed by COVID-19. *See* Plaintiffs' Brief in Opposition, *supra* note 174, at 18–19; *see generally* Catherine Powell, *Color of COVID and Gender of COVID: Essential Workers, Not Disposable People*, 33 YALE J.L. & FEMINISM 1 (2021)

185. *See* FDA v. Am. Coll. of Obstetricians & Gynecologists, 141 S. Ct. 578, 578 (2021) (per curiam).

186. *Id.* at 579 (Roberts, C.J., concurring) (quoting S. Bay United Pentecostal Church v. Newsom, 140 S. Ct. 1613, 1614 (2020)).

187. *Id.* at 584–85 (Sotomayor, J., dissenting); *see id.* at 584 ("Together, patients' health vulnerabilities, public transportation risks, susceptible older family members at home, and clinic closures and reduced services pose substantial, sometimes insurmountable, obstacles for women seeking medication abortions during the COVID-19 pandemic.").

188. *Compare* S. Bay United Pentecostal Church v. Newsom, 140 S. Ct. 1613, 1613 (2020) (denying an application for injunctive relief on an order limiting attendance at places of worship), *with* Roman Catholic Diocese of Brooklyn v. Cuomo, 141 S. Ct. 63, 65 (2020) (granting in part an application for injunctive relief from the Governor's emergency Executive Order that imposed occupancy restrictions on places of worship).

burdens restrictions impose.[189] In this vein, the Court's invocation of deference during the pandemic may do the same work that factual "uncertainty" did after *Gonzales*.[190]

The FDA's review of the mifepristone REMS will turn on the public health research that helped ACOG make its case. The next Part illustrates the work of research centers that have generated studies on the effects of abortion restrictions. As the last section argues, the value of research on abortion law is not just the possibility of producing evidence that convinces courts; indeed, the Court's stay in *ACOG* suggests that not much may convince the highest Court of the country. Rather, the collaboration among researchers, academics, advocates, and lawyers has created an infrastructure for abortion delivery rooted in community and political engagement.

II. THE EVOLVING ROLE OF PUBLIC HEALTH RESEARCH

Abortion debates have long been waged on the terrain of contested expertise and facts, and health-based arguments have been marshalled by both sides since *Roe* was decided.[191]

189. *See* Leah Litman, *The Supreme Court Won't Explain Why It Just Greenlit New Abortion Restrictions*, SLATE (Jan. 14, 2021, 11:15 AM), https://perma.cc/S3K8-UU6E (noting that, without explanation of the stay, the Court "may have instead arrived at their own independent conclusion that the in-person requirement is constitutional, which would signal that the court has significantly watered down of the legal test governing abortion restrictions behind the scenes").

190. *See infra* Part III.A; Lindsay F. Wiley & Stephen I. Vladeck, *Coronavirus, Civil Liberties, and the Courts: The Case Against "Suspending" Judicial Review*, 133 HARV. L. REV. F. 179, 190–91 (2020) (arguing that *Jacobson v. Massachusetts* encourages judicial review by suggesting a balancing test for emergency health measures); Wendy E. Parmet, *Rediscovering* Jacobson *in the Era of COVID-19*, 100 B.U. L. REV. ONLINE 117, 130–31 (2020) (disputing that *Jacobson v. Massachusetts* is the apt framework for legislative deference).

191. Abortion opponents have also sought to generate evidence that abortion correlates with negative health effects, suggesting that abortion leads to breast cancer or mental health problems. ZIEGLER, *supra* note 5, at 124; *Myths About Abortion and Breast Cancer*, PLANNED PARENTHOOD at 1 (Mar. 2013), https://perma.cc/HS3T-8C9B (PDF). Those efforts have been dwarfed by the research supportive of abortion access, in part because of better funding but also because of stronger alliances with respected academics and reliance on credible research methods. ZIEGLER, *supra* note 5, at 199. Mary Ziegler points out that,

Although research on the health consequences of abortion restrictions is not new, in recent years, there has been a shift in the scope and kind of evidence generated.[192] An impetus for this shift is the substantial investment in rigorous research on the regulation of abortion facilities and providers.[193] This investment has yielded an increasing number of experts and organizations that study the health and social consequences of abortion restrictions.[194] Research teams at the University of

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> [s]ince 2007, abortion opponents had tried to expand their capacity for research. In 2011, the Susan B. Anthony List founded the Charlotte Lozier Institute as an alternative to abortion-rights research groups. Texas and pro-life organizations cited evidence collected by sympathetic researchers, but as many abortion opponents realized, supporters of abortion-rights had an advantage in research funding and access to data.

Id.

192. The Guttmacher Institute, which was founded originally as the Center for Family Planning Program and Development, has been generating research on the effects of abortion restrictions on individual and population health since 1968. *The History of the Guttmacher Institute*, GUTTMACHER INST., https://perma.cc/BB4R-SXTA. The Institute's work is not spotlighted in Part II, but it is the clear leader in producing studies on abortion law by demographers, social scientists, and public policy analysts. *Id.*

193. The investment in research hubs is a product of concentrated, coordinated funding by one of the largest private foundations in the country. *See* Nina Martin, *How One Abortion Research Megadonor Forced the Supreme Court's Hand*, MOTHER JONES (July 14, 2016), https://perma.cc/2XXF-FP9L (reporting that private donors poured at least 200 million dollars into the research Justice Breyer cited in *Whole Woman's Health*); Kelsey Piper, *How Billionaire Philanthropy Provides Reproductive Health Care When Politicians Won't*, VOX (Sept. 17, 2019, 8:10 AM), https://perma.cc/B4EH-SMUB (stating that reproductive health care "would suffer greatly if billionaire philanthropy was reduced in scale or ceased to exist tomorrow"); GUTTMACHER INST., ANNUAL REPORT 2019, https://perma.cc/YN92-G9TM (PDF) (showing that 65 percent of the organization's funding is from private U.S. foundations, and listing "anonymous" and the Gates Foundation as foundation-based donors).

194. *See* ZIEGLER, *supra* note 5, at 199

> Abortion-rights supporters relied on studies completed by the Texas Policy Evaluation Project, organized in 2011 at the University of Texas-Austin by doctors, demographers, and public health experts. The project received financial support from the Susan Thompson Buffett Foundation, a major donor to abortion-rights causes, and its members included Daniel Grossman, the new head of Advancing New Standards in Reproductive Health, a leading research center supportive of abortion-rights.

ANSIRH was founded in 2002 but began to expand operations between 2009 and 2012. *See About*, ANSIRH, https://perma.cc/SU58-UD5E. TxPEP "began

Texas and the University of California, San Francisco (UCSF), for example, have investigated what happens to people who seek abortions when clinics close and providers are forced out of practice.[195] Indeed, a new generation of peer reviewed studies (as well as the longstanding work of the Guttmacher Institute) helped shape the application of the undue burden test established in *Whole Woman's Health* and conferred credibility and certainty in the aftermath of *Gonzales v. Carhart*.[196]

A recurring challenge, however, has been to convince courts that abortion restrictions correlate with individual and community health outcomes.[197] A number of courts have accepted states' arguments that the difficulties clinics experience in implementing regulations, such as an admitting-privileges requirement, reflect "neutral, pre-existing states of affairs unrelated to the legislation itself."[198] Take, for example, Justice Alito's dissenting opinion in *Whole Woman's Health v. Hellerstedt*, in which he argued that clinic closures were not caused by a privileges law; instead, clinic closures were the result of provider shortages and an overall decreasing rate

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in the fall of 2011 with the purpose of documenting and evaluating the impact of reproductive health legislation passed by the 82nd Texas Legislature." *TxPEP Fact Sheet*, UNIV. OF TEX. AT AUSTIN, https://perma.cc/V34S-RYMF.

195. *See, e.g.*, Grossman, *supra* note 68, at 155 (describing the increased number of women who lived more than one hundred miles from an abortion facility and the increase in wait times at these facilities following facility closure in Texas due to H.B. 2). The research teams based at universities include demographers, social epidemiologists, social scientists, or public health academics. *See, e.g.*, *Investigators & Staff*, ANSIRH, https://perma.cc/5FDR-RWQZ.

196. *See* Martin, *supra* note 193 (demonstrating that the purpose of funding centers and studies like those identified in this Part was to provide evidence offering courts certainty in the aftermath of *Gonzales v. Carhart*); B. Jessie Hill, *The Geography of Abortion Rights*, 109 GEO. L.J. 1081, 1112 (2021)

> Some courts and scholars have begun to recognize, however, that the geographical disparities that result from facility regulation are a direct result of state policies. In *Whole Woman's Health*, the Court recognized for the first time the disproportionate impact of facility regulations on poor and rural women and used this fact as a reason in support of its decision.

197. *See* Hill, *supra* note 196, at 1111–12 (explaining that courts do not consider how various laws reduce abortion access).

198. *Id.* at 1111; *see* ZIEGLER, *supra* note 5, at 122 ("Abortion foes had promoted incremental restrictions and often defended them by emphasizing claims about the costs of abortion.").

of abortion.[199] Studies of people's health and financial well-being after they have sought out and failed to obtain abortions because of service scarcity attempt to substantiate explanations about the negative impact of restrictive abortion laws.[200]

The subparts that follow offer examples of research that advances the health case against abortion restrictions. Again, this Article's purpose is not to extoll the inherent value of evidence or suggest that all research is of the same quality or significance. The purpose is to spotlight how research has advanced more nuanced understandings of abortion laws' health effects, and to locate that work as contributing to a movement for abortion access. To that end, this Part will track how abortion law research has shifted from a focus on patients to assessments of the burdens that abortion restrictions impose on populations and on the general public. Here, "populations" refers to groups that share characteristics, such as income level or race. "Public health" includes the study of populations, but, in this account, concerns the health disparities that characterize the healthcare system and perpetuate inequality. This Part concludes by describing a shared political project among abortion-supportive researchers, advocates, and lawyers and how that collaboration draws from scholarship on the social determinants of health.

A. *Patients*

Research on the patient-level effects of facility closures has been the most visible in contemporary litigation of restrictions on providers and facilities. Petitioners in *Whole Woman's Health* urged that *Casey* required courts to assess evidence of the benefits and burdens of a restriction, and to resist reliance on

199. *See* Mary Ziegler, *The Jurisprudence of Uncertainty: Knowledge, Science, and Abortion*, 2018 WIS. L. REV. 317, 355, 357 (2018) (noting that *Whole Woman's Health* turned on a question about the Texas statute's causal effects).

200. *See The Turnaway Study*, ANSIRH, https://perma.cc/M8H2-9G62 (finding that women denied abortions are four times more likely to live in poverty and are more likely to experience serious health complications from pregnancy).

the state's proffered reasons for regulating.[201] Consider the genesis of the studies cited in *Whole Woman's Health*. The Texas Policy Evaluation Project (TxPEP), housed at the University of Texas at Austin Population Research Center, is "a collaborative group of university-based investigators who evaluate the impact of legislation in Texas related to women's reproductive health."[202] Before H.B. 2 was implemented in the fall of 2013, TxPEP researchers contacted the forty-one abortion providers open in Texas at the end of 2012 (including those that subsequently closed) and obtained information on the services provided through April 2014.[203] Comparing the first six months of enforcement with the previous year, studies documented a 13 percent reduction in abortion procedures.[204] There was also a statistically significant increase in the number of abortions performed after twelve weeks of gestation.[205]

In addition, TxPEP studied the barriers to services after clinics closed and left remaining providers concentrated in the state's larger cities.[206] When H.B. 2 took effect, the number of

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201. *See* Ziegler, *supra* note 199, at 359 (explaining that *Casey* "involve[d] two important considerations, the government's interest in protecting fetal life and a woman's constitutional liberty and equality").

202. *TxPEP*, UNIV. OF TEX. AT AUSTIN, https://perma.cc/RQY3-TLNE. TxPEP collaborates with Advancing New Standards in Reproductive Health (ANSIRH), the work of which is detailed in Part II.B. The director of ANSIRH, Dr. Daniel Grossman, is also an investigator for TxPEP and Part I.A notes the influence of his research on the decision in *Whole Woman's Health*. *Texas Policy Evaluation Project (TxPEP)*, ANSIRH, https://perma.cc/K89E-K8UL

> In 2011, and again in 2013, the Texas Legislature passed sweeping legislation impacting reproductive health in Texas, which has a population of 5.4 million women of reproductive age. . . . ANSIRH's Director, Dr. Dan Grossman, co-leads the Texas Policy Evaluation Project (TxPEP), a collaborative effort to analyze and document the effects of these measures on Texas women and their families.

203. *See* Liza Fuentes et al., *Women's Experiences Seeking Abortion Care Shortly After the Closure of Clinics Due to A Restrictive Law in Texas*, 93 CONTRACEPTION 292, 293 n.1 (2016) (discussing the dwindling number of facilities that were open throughout the time period).

204. *See* Daniel Grossman et al., *Change in Abortion Services After Implementation of a Restrictive Law in Texas*, 90 CONTRACEPTION 496, 499 (2014) (describing how the decline resulted in about 9,200 fewer abortions).

205. *See* Gerdts et al., *supra* note 18, at 862 (showing an increase in abortion rates from 10.2 percent to 14.6 percent after the nearest clinic closed in 2014).

206. *See Abortion Wait Times in Texas: The Shrinking Capacity of Facilities and the Potential Impact of Closing Non-ASC Clinics*, TEX. POL'Y

women of reproductive age that lived over 100 miles from the nearest provider increased from 400,000 to 1,000,000.[207] Wait times for appointments increased: in the Dallas metropolitan area, the wait time increased from five days to twenty-one days or longer.[208]

TxPEP researchers conducted extensive interviews with abortion patients about clinic closures' impact on costs and travel.[209] The data collected showed that "women whose nearest clinic had closed traveled four times farther to obtain an abortion—eighty-five miles on average each way—compared with those whose nearest clinic remained open. In addition, more women whose nearest clinic closed had out-of-pocket expenditures greater than $100 (32% v. 20%)."[210]

EVALUATION PROJECT (Oct. 5, 2015), https://perma.cc/D8RZ-635L (PDF) (assessing wait times at open facilities in large Texas cities after closures due to H.B. 2).

207. *See* Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2298 (2016) (citing the district court's factual findings, which relied on TxPEP research). Additional studies have examined the relationship between abortion rates and increased travel distance to the nearest provider. Even short travel increases can correlate with lower abortion incidence:

> Our econometric analysis indicates that travel distance has a substantial and non-linear effect on abortion rates. If the nearest clinic is 0 miles away, we estimate that a 25 mile increase in distance reduces the abortion rate by close to 10 percent. If the nearest clinic is farther away, the effect of additional increases in distance are smaller. At the point that the nearest clinic is 200 miles away, we no longer detect statistically significant reductions in abortion caused by further increases in distance. In addition to finding that even modest initial increases in distance have substantial effects on abortion rates, we find that abortion clinic closures affect abortion rates through congestion, as measured by the number of women served per clinic in a region.

Jason M. Lindo et al., *How Far Is Too Far? New Evidence on Abortion Clinic Closures, Access, and Abortions* 2 (Nat'l Bureau of Econ. Rsch., Working Paper No. 23366, 2018), https://perma.cc/4MMX-BW53 (PDF); *see* Jonathan M. Bearak et al., *Disparities and Change Over Time in Distance Women Would Need to Travel to Have an Abortion in the USA: A Spatial Analysis*, 2 LANCET PUB. HEALTH e493, e495, e499 (2017) (discussing the barriers that increased distance to clinics imposes and how travel to clinics in Texas increased about fifty-six miles during the studied time period).

208. *See* Grossman, *supra* note 68, at 155 (describing the increased wait times resulting from facility closures).

209. *Id.* at 156.

210. *Id.*

Numerous factors dictate clinic capacity and patients' access to abortion services. Michelle McGowan and her co-investigators describe how physician training and availability, clinics' financial sustainability, and staffing and ownership arrangements, all of which can appear relatively distinct from legal restrictions, determine the accessibility of services.[211] But financial and personnel arrangements are made with the legal landscape in view:

> [A]bortion facilities must expend considerable financial and human capital in order to comply with restrictions such as targeted regulations of abortion provider laws, in-person visits for state-mandated counseling and other onerous administrative requirements. These laws and regulations can require institutional and personnel adaptations that may divert financial resources and staff time away from providing care.[212]

Abortion providers' isolation from other healthcare makes them easy regulatory targets. Jessie Hill argues that this isolation, in tandem with the "concentration of hospitals in urban areas," "the refusal of most hospitals to perform abortions," "industry norms," and "the widespread religious affiliation of hospitals," allows states to claim that barriers to access are not within legislators' control.[213] Hill writes, "[t]he legal rule, which does not appear to be aimed at advancing moral goals (such as reducing abortions), relies upon realities on the ground to achieve precisely those goals."[214]

To capture the "realities on the ground" of restrictive legal environments, another vein of abortion research interrogates

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211. *See* Michelle L. McGowan et al., *Care Churn—Why Keeping Clinic Doors Open Isn't Enough to Ensure Access to Abortion*, 383 NEW ENG. J. MED. 508, 509 (2020) (describing factors separate from legislation that affect abortion care access).

212. Elizabeth Witwer et al., *Abortion Service Delivery in Clinics by State Policy Climate in 2017*, 2 CONTRACEPTION: X 1, 4 (2020).

213. Hill, *supra* note 196, at 1111.

214. *Id.* It is beyond the scope of this Article to engage with the rich literature on state action and state neutrality generally. In the abortion context, refuting state action as a "cause" of poverty has been the justification for upholding state funding bans. *See infra* note 220 and accompanying text.

the disproportionate impact of law on specific populations.[215] Research on populations that are collectively and consistently affected by abortion restrictions, as the Court has recognized for poor and rural patients, seeks to demonstrate a predictable relationship between facility or provider regulations and material, physical and mental wellbeing.[216] The litigation strategy in *June Medical Services* provides an illustration.

B. *Populations*

In *June Medical Services*, several amicus briefs described the demographics of abortion patients.[217] For instance, the National Health Law Program (N-HELP), a national non-profit organization, explained:

> [T]he harmful effects of the requirement will be felt exponentially by low-income Louisianans—many of whom will not be able to access abortion care should the law be implemented. . . . Communities of color, survivors of intimate partner violence, and LGBTQ-GNC people are even

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215. For the role of "population" and the population perspective in public health, see WENDY E. PARMET, POPULATIONS, PUBLIC HEALTH, AND THE LAW 2 (2009)

> [B]y placing populations at the center of the legal stage while emphasizing the importance of empirical evidence and probabilistic thinking, population-based legal analysis can enrich and expand legal discourse, offering an alternative to the individualism and formalism that is excessive in much of contemporary American law, especially contemporary constitutional law.

See also Lindsay F. Wiley, *The Struggle for the Soul of Public Health*, 41 J. HEALTH POL., POL'Y, & L. 1083, 1083 (2016) ("The population perspective—which emphasizes the social determinants of health, collective action to create healthier communities, and communitarian rationales for prioritizing health—is as important to public health problem-solving as the prevention orientation.").

216. *See* GUTTMACHER INST., *supra* note 9 (reporting that 75 percent of abortion patients are low income and disproportionately affected by regulations that increase closures of clinics and therefore increase delays and costs to obtain abortion care).

217. *See* Brief *Amici Curiae* for Organizations and Individuals Dedicated to the Fight for Reproductive Justice, *supra* note 101, at 7 (discussing marginalized communities' unequal access to reproductive healthcare); Brief of *Amici Curiae* Reproductive Justice Scholars Supporting Petitioners-Cross-Respondents at 10, June Med. Servs. L.L.C. v. Russo, 140 S. Ct. 2103 (2020) (No. 18-1323), 2019 WL 6609232 (addressing how Act 620 will burden marginalized communities).

> more likely to live in poverty—and, thus, more likely to experience Act 620 as a practical ban on their right to have an abortion.[218]

The N-HELP brief draws from multiple studies documenting common characteristics of people seeking abortion, both nationally and in Louisiana.[219] As noted above, almost half of the nation's abortion patients live below the federal poverty level,[220] and the depth of patients' economic insecurity is particularly salient in Louisiana. Louisiana ranks as the third poorest state in the United States, with one in five residents living in poverty.[221] Like three dozen states, Louisiana does not permit state funding for abortion services, and, like almost a dozen states, it restricts abortion coverage in health care insurance plans.[222]

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218. Brief of *Amici Curiae* National Health Law Program and National Network of Abortion Funds Supporting Petitioners-Cross-Respondents at 2, June Med. Servs. v. Russo, 140 S. Ct. 2103 (2020) (No. 18-1323), 2019 WL 6698205.

219. *See id.* at 7, 9, 13–14, 27.

220. *See* GUTTMACHER INST., *supra* note 9 (finding that 49 percent of abortion patients had family incomes below the federal poverty level). Additional studies draw a correlation between income and unintended pregnancy. *See* Lawrence B. Finer & Mia R. Zolna, *Unintended Pregnancy in the United States: Incidence and Disparities, 2006*, 84 CONTRACEPTION 478, 483 (2011) ("Poor and low-income women also experienced some of the greatest increases and highest rates of unintended pregnancy."). Moreover, the reasons for terminating a pregnancy are overwhelmingly related to existing financial stressors and the costs of parenting existing children. *See* Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 PERSPS. SEXUAL & REPROD. HEALTH 110, 117 (2005) ("Nearly three-quarters of respondents indicated that they could not afford to have a child now . . . ."); M. Antonia Biggs et al., *Understanding Why Women Seek Abortions in the U.S.*, 13 BMC WOMEN'S HEALTH 29, 33 (2013) (reporting that financial reasons were the most frequently cited reason for an abortion).

221. *See* David Gray & Monica Bergeron, *Louisiana's Poverty and Child Poverty Rates Remain High*, LA. BUDGET PROJECT (Sept. 18, 2014), https://perma.cc/A5VP-EBK5 (finding that 19.8 percent of Louisiana's population lives below the federal poverty line).

222. According to the Guttmacher Institute,

> 33 states and the District of Columbia follow the federal standard [under the Hyde Amendment] and provide abortions in cases of life endangerment, rape and incest. 4 of these states also provide state funds for abortions in cases of fetal impairment. 4 of these states also provide state funds for abortions that are necessary to prevent grave, long-lasting damage to the person's physical health.

National surveys speak to the relationship between race and income.[223] According to 2018 census estimates, 22.5 percent of Black and 18.8 percent of Latinx individuals live below the federal poverty level, compared with only 9.5 percent of whites.[224] As the N-HELP brief described, in Louisiana, 32.9 percent of Black residents live below the federal poverty line in comparison to 12.1 percent of white Louisianans.[225] *Whole Woman's Health*, at least by remarking on the burdens shouldered by rural and low-income people, recognized that longstanding economic and social vulnerability compounds the consequences of abortion restrictions.[226] Like TxPEP, studies generated by a team of researchers attempt to demonstrate that point.[227]

The work of social scientists and legal epidemiologists at Advancing New Standards in Reproductive Health (ANSIRH), which is based at the UCSF Gynecology & Reproductive Sciences, offers an example.[228] ANSIRH collected the first

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State Funding of Abortion Under Medicaid, GUTTMACHER INST. (July 1, 2021), https://perma.cc/TSF3-RN4C. Further, "11 states have laws in effect restricting insurance coverage of abortion in all private insurance plans written in the state, including those offered through health insurance exchanges established under the ACA." *Regulating Insurance Coverage of Abortion*, GUTTMACHER INST. (Sept. 1, 2021), https://perma.cc/2WC3-FYDN. For the first time since 1976, the 2022 House Labor-HHS-Education funding bill does not include the Hyde Amendment, which prohibits federal funding for abortion except in cases of rape, incest or to protect the life of the woman. *See* Sandhya Raman, *Hyde Amendment Fight Just the First Step in Changing Abortion Coverage*, ROLL CALL (July 21, 2021, 6:45 AM), https://perma.cc/9RZE-27PK.

223. *See* GUTTMACHER INST., *supra* note 9 (demonstrating that, in 2014, 75 percent of abortion patients were low income).

224. U.S. CENSUS BUREAU, POVERTY STATUS IN THE LAST 12 MONTHS (2018), https://perma.cc/BF8Z-UUB5 (PDF).

225. *Poverty in Louisiana*, WELFARE INFO, https://perma.cc/K85C-CTC5.

226. Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2302 (2016) (noting the disproportionate impact of restrictions on poor and rural patients).

227. *See* DIANA GREENE FOSTER, THE TURNAWAY STUDY: TEN YEARS, A THOUSAND WOMEN, AND THE CONSEQUENCES OF HAVING—OR BEING DENIED—AN ABORTION 15 (2020) (describing Foster's team's efforts to "study the outcomes of both birth and abortion for women with unwanted pregnancies").

228. *See The Turnaway Study*, *supra* note 200 ("The Turnaway Study is ANSIRH's prospective longitudinal study examining the effects of unwanted pregnancy on women's lives.").

longitudinal data on individuals who sought but could not obtain an abortion.[229] ANSIRH, working with thirty abortion facilities around the country, recruited over 1,000 participants, and conducted over 8,000 telephone interviews over five years.[230] Participants fell into three study groups.[231] The "turnaway" group were people who sought, but did not receive, an abortion because their pregnancies exceeded the facility's gestational age limit.[232] Two groups were included for comparison to the "turnaway" group: the first group of patients terminated their pregnancies within the first thirteen weeks while the second group was comprised of patients who terminated a pregnancy within two weeks of a gestational age cutoff.[233]

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229. *Id.* A series of articles resulted from the Turnaway study, and the findings have recently been published as a book. *See* FOSTER, *supra* note 227, at 13 ("Laying out the findings of the largest study of women's experiences with abortion in the United States this book represents the first time that the results of our in-depth ten-year investigation have been collected in one place."); M. Antonia Biggs et al., *Women's Mental Health and Well-Being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*, 74 JAMA PSYCHIATRY 169, 169 (2017) ("This study presents data from the Turnaway Study, a prospective longitudinal study with a quasi-experimental design."); Diana Greene Foster et al., *Comparison of Health, Development, Maternal Bonding, and Poverty Among Children Born After Denial of Abortion vs. After Pregnancies Subsequent to an Abortion*, 172 JAMA PEDIATRICS 1053, 1054–55 (2018) (describing the use of data from the Turnaway Study); Ushma D. Upadhyay et al., *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, 15 BMC WOMEN'S HEALTH 102, 102 (2015) ("Data are from the Turnaway Study, a prospective cohort study of women recruited from 30 abortion facilities across the US."); Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 AM. J. PUB. HEALTH 407, 407 (2018) ("We used data from the Turnaway Study, a 5-year, longitudinal study of women who presented for abortion care at 1 of 30 facilities throughout the United States between 2008 and 2010.").

230. *See The Turnaway Study*, *supra* note 200 ("[W]e recruited from 30 abortion facilities around the country . . . to select about 1,000 women who sought abortions . . . . We conducted nearly 8,000 interviews over the course of the project, and the stories that women shared with us about their lives are fascinating."). For more information on the design of the Turnaway Study, see generally Loren M. Dobkin et al., *Implementing a Prospective Study of Women Seeking Abortion in the United States: Understanding and Overcoming Barriers to Recruitment,* 24 WOMEN'S HEALTH ISSUES e115 (2014).

231. *Id.* at e116.

232. *Id.*

233. FOSTER, *supra* note 227, at 16.

ANSIRH's Turnaway Study asked participants about a number of topics, such as their physical and mental health, employment and educational attainment, relationship status, contraceptive use, and emotions attached to pregnancy and abortion.[234] The most common reason given for seeking an abortion was an inability to afford raising a child.[235] Participants also reported that their timing for seeking abortions depended on collecting funds to cover the cost of travel and the procedure.[236] The study's authors concluded:

> Evidence from surveys indicates that women who were denied versus received wanted abortions experienced worse health, higher poverty rates, and higher levels of public assistance receipt over the next five years. Newly linked administrative data [e.g., credit reports, bankruptcies, tax liens] shows that women who were denied abortions experienced large and persistent increases in markers of financial distress, even when accounting for pre-existing differences in the characteristics of women seeking an abortion at later gestational ages.[237]

The claim here is not that abortion is the solution for lifting people out of poverty; the cycle of poverty is too complicated and pernicious for a singular answer. But what the Turnaway Study poignantly illustrates is how abortion denial compounds

234. *See id.* ("We interviewed these women by phone twice a year for up to five years—through both easy and difficult recoveries from abortion and birth. We asked about their emotions and mental health, their physical health, their life goals and financial well-being, and the health and development of their children.").

235. The majority of abortion patients (59 percent) have given birth at least once. *See* GUTTMACHER INST., *supra* note 9.

236. Consider the cost of abortion services. The mean price of an aspiration abortion in the first trimester is $508 and the mean price for a medication abortion is $535; the median price for an abortion at 20 weeks is $1,195. *See* Rachel K. Jones et al., *Differences in Abortion Service Delivery in Hostile, Middle-ground, and Supportive States in 2014*, 28 WOMEN'S HEALTH ISSUES 212, 216–17 (2018). In Louisiana, the average cost of a first-trimester abortion is about $500; a second-trimester abortion is approximately $850. *Abortion Information and Resources*, LIFT LA., https://perma.cc/72QC-BBV6.

237. Sarah Miller et al., *What Happens After an Abortion Denial? A Review of Results from the Turnaway Study*, 110 AEA PAPERS & PROC. 226, 230 (2020).

financial hardships with effects for people's long-term wellbeing.[238]

Law plays a key role in obstructing or delaying abortion care. For one, state gestational time-limits will keep some from state-approved terminations.[239] But it is the web of legal restrictions—from cumbersome and unnecessary facility requirements to waiting periods—that increase the cost of providing services and make every step in the process a challenge.[240] When those challenges are insurmountable, the Turnaway Study identified the economic and health consequences that follow for populations already living without sufficient resources.[241]

The following subpart considers the present trajectory for public health research that connects unaffordable and inaccessible abortion to the inequalities that characterize U.S. health care. The next subpart shows how that research draws from scholarship on the social determinants of health, which interrogates why and how health disparities and inequalities are perpetuated.

C. *The Public's Health*

Although both *June Medical Services* and *Whole Woman's Health* interpreted the undue burden standard in light of the

238. *See* FOSTER, *supra* 227, at 175 ("It took four years for women who were turned away and gave birth to catch up to the level of employment experienced by women just under the limit who received their abortion.").

239. *See* THEODORE J. JOYCE ET AL., THE IMPACT OF STATE MANDATORY COUNSELING AND WAITING PERIOD LAWS ON ABORTION: A LITERATURE REVIEW 15 (2009), https://perma.cc/2WCR-VNT8 (PDF) ("We conclude that mandatory counseling and waiting period laws that require an additional in-person visit before the procedure likely increase both the personal and the financial costs of obtaining an abortion, thereby preventing some women from accessing abortion services.").

240. *See id.* (surveying the literature on mandatory counseling and waiting periods for abortion and concluding that such laws likely increase the cost of abortion services); FOSTER, *supra* note 227, at 47 ("Mandatory waiting periods are one of those laws that sound good (everyone should get time to think about such a critical decision) but have unintended consequences in raising the cost and causing abortions to happen later in pregnancy than women want them.").

241. *See* Foster et al., *Socioeconomic Outcomes*, *supra* note 229, at 411–12 ("Many women seeking abortion face economic hardship; half live below the [federal poverty line] and three quarters struggle to pay for food, housing, and transportation. Denial of abortion services exacerbates this hardship.").

burdens imposed on low-income people, neither opinion mentions race (or gender) discrimination.[242] By contrast, the *ACOG* decision takes up race and social position explicitly.[243] ACOG offered evidence, which the district court endorsed, that health resources are distributed along lines of race, class, and location. Moreover, material deprivation and social subordination have damaging health effects that accumulate over time.[244] ACOG's brief, for instance, argued that existing health disparities and inequalities, made worse by the pandemic, are part of an undue burden analysis:

> Significantly, COVID-19's harms have not been borne equally. The available data show a particularly high prevalence of infection in areas with lower average incomes, which often overlap with areas where a higher percentage of people of color live. . . . People with fewer resources are also more likely to live in crowded housing, without extra space that might allow isolation of a family member sick with COVID-19; more likely to rely on public transportation; and generally lack the resources available in wealthier communities to mitigate the risk of contagion. In addition, due to longstanding inequities in access to and quality of care and structural racism, low-income people and people of color

242. *See* June Med. Servs. L.L.C. v. Russo, 140 S. Ct. 2103, 2130 (2020) ("As the District Court stated, both experts and laypersons testified that the burdens of this increased travel [due to closed abortion clinics] would fall disproportionately on poor women, who are least able to absorb them."); Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2298 (2016) ("The dramatic drop in the number of clinics means fewer doctors, longer waiting times, and increased crowding.").

243. *See* Am. Coll. of Obstetricians & Gynecologists v. FDA, 506 F. Supp. 3d 328, 344 (D. Md. 2020) ("As particularly relevant to the demographic groups comprising the majority of women seeking a medication abortion, the Black unemployment rate remains over 10 percent, and 80 percent of all exits from the labor force in September 2020 consisted of women."). Cary Franklin demonstrated how research on health disparities and inequalities was important to petitioners' arguments in *Whole Woman's Health*. Franklin, *supra* note 67, at 241.

244. *See Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity*, CDC, https://perma.cc/8UE8-SE5Q (last updated July 16, 2021) (demonstrating that Black, Hispanic or Latino, and American Indian individuals are more likely than white individuals to contract COVID-19); Ruqaiijah Yearby & Seema Mohapatra, *Law, Structural Racism, and the COVID-19 Pandemic*, 7 J.L. & BIOSCI. 1, 2 (2020) ("Racial and ethnic minorities are disproportionately impacted during pandemics, not due to any biological difference between races, but rather as a result of social factors.").

> are more likely to suffer from certain preexisting medical conditions, such as diabetes, obesity, and hypertension, that make them high risk for severe COVID-19 illness and fatality.[245]

The burden of in-person collection is not just the imposition of logistical difficulties. The problem is also that those complications compound for people who already have inadequate resources, and those stressors have long-term health costs for individuals, communities, and the collective welfare.[246] To repeat the point, people of color contract COVID-19 at higher rates than whites and Black, Native Americans, and Latinx COVID-19 patients are almost five times as likely to be hospitalized—and two-to-three times as likely to die—as white patients.[247] The FDA's policy perpetuates the disparities that, as Ruqaiijah Yearby and Seema Mohapatra demonstrate, stem from historic and current racism that cause and exacerbate disparities in health care and health status.[248]

The ACOG brief invoked the social determinants of health by emphasizing how inflexible workplaces, limited transportation options, overcrowded housing, and pre-existing

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245. Plaintiffs' Amended and Corrected Memorandum of Law in Support of Motion for Preliminary Injunction at 17, Am. Coll. of Obstetricians & Gynecologists v. FDA, 506 F. Supp. 3d 328 (D. Md. 2020) (No. 20-1320), 2020 WL 5700818.

246. *See* Paula Braveman et al., *The Social Determinants of Health: Coming of Age*, 32 ANN. REV. PUB. HEALTH 381, 388 (2011)

> Coping with daily challenges can be particularly stressful when one's financial and social resources are limited. Recent evidence implicates chronic stress in the causal pathways linking multiple upstream social determinants with health, through neuroendocrine, inflammatory, immune, and/or vascular mechanisms. Stressful experiences—such as those associated with social disadvantage, including economic hardship and racial discrimination—may trigger the release of cortisol, cytokines, and other substances that can damage immune defenses, vital organs, and physiologic systems.

247. *See supra* note 244 and accompanying text; *cf.* Eona Harrison & Ebonie Megibow, *Three Ways COVID-19 is Further Jeopardizing Black Maternal Health*, URBAN INST. (July 30, 2020), https://perma.cc/D2TA-27TH.

248. *See* Yearby & Mohapatra, *Systemic Racism*, *supra* note 15, at 1422 ("Historically, the federal and state government's legal and policy response to pandemics has ignored these racial inequalities in employment and health care, which are linked to racial inequities in infection and death.").

health conditions exacerbate longstanding inequalities.[249] Social determinants are the conditions that mediate the extent to which people are exposed to health stressors and are able to withstand them.[250] Quality health care is one of the resources that helps determine health, but the environments in which people live, work, and learn also shape physical and mental health.[251] Determinants include limited education or nutrition, preventable disease, unsafe water or work, poor sanitation,

249. *See, e.g.,* Plaintiffs' Amended and Corrected Memorandum of Law, *supra* note 245, at 22–23 (citing public health studies on racial disparities); Cary P. Gross et al., *Racial and Ethnic Disparities in Population-Level Covid-19 Mortality*, 35 J. GEN. INTERNAL MED. 3097, 3097–98 (2020) (reporting racial disparities in COVID-19 mortality rates); *Racial Data Transparency*, JOHNS HOPKINS UNIV., https://perma.cc/9TL5-CD34 (last updated Mar. 12, 2021, 10:05 AM) ("Existing racial disparities in the rates of chronic medical conditions increase the risk among ethnic minorities for serious complications of the novel coronavirus and resulting higher death rates.").

250. *See* Braveman et al., *supra* note 246, at 387–88 (linking education attainment with social support which "may buffer the health-damaging effects of stress" and also linking economic hardship and racial discrimination with health-damaging stress); Bruce G. Link & Jo Phelan, *Social Conditions as Fundamental Causes of Disease*, 35 J. HEALTH & SOC. BEHAV. 80, 81 (1995) ("[S]ome social conditions may be 'fundamental causes' of disease. A fundamental cause involves access to resources, resources that help individuals avoid diseases and their negative consequences through a variety of mechanisms."). See also Martha Fineman's work on vulnerability theory, Martha Albertson Fineman, *The Vulnerable Subject: Anchoring Equality in the Human Condition*, 20 YALE J.L. & FEMINISM 1, 9 (2008)

> Vulnerability initially should be understood as arising from our embodiment, which carries with it the ever-present possibility of harm, injury, and misfortune from mildly adverse to catastrophically devastating events, whether accidental, intentional, or otherwise. Individuals can attempt to lessen the risk or mitigate the impact of such events, but they cannot eliminate their possibility. Understanding vulnerability begins with the realization that many such events are ultimately beyond human control.

251. *See* Lindsay F. Wiley, *From Patient Rights to Health Justice: Securing the Public's Interest in Affordable, High-Quality Health Care*, 37 CARDOZO L. REV. 833, 879 (2016) ("From a socially-situated, population health perspective, access to health care is not an end in itself, but rather a means to improved health at the individual—as well as at the population—level."). Social determinants are the "cultural, social economic, ecological, and physical circumstances that affect our health by shaping where and how we live, work, learn, and play." Angela P. Harris & Aysha Pamukcu, *The Civil Rights of Health: A New Approach to Challenging Structural Inequality*, 67 UCLA L. REV. 758, 768 (2020).

inadequate income or access to health care, and substandard housing, all of which correlate with shorter life expectancies and poor health.[252] Past and present discrimination and subordination shape the social determinants of health that in turn reproduce health disparities.[253]

Law is also a determinant that maintains and mediates the social, economic, and physical structures shaping who suffers and who thrives[254] and distributing who has access to economic and social resources.[255] For instance, tax provisions, welfare, and public assistance programs that strengthen economic security are correlated with longer and healthier lives.[256] Yet,

252. *Social Determinants of Health: Key Concepts*, WHO (May 7, 2013), https://perma.cc/MU6K-WFN8; *see* Scott Burris, *From Health Care Law to the Social Determinants of Health: A Public Health Law Research Perspective*, 159 U. PA. L. REV. 1649, 1651 (2011) (exploring the importance of the social determinants of health).

253. *See generally* INST. OF MED., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE (2003) (finding that even with equal access to health care, people of color continue to have poor health outcomes across a range of indicators). Legal and de-facto racial segregation, for example, force some populations of color to live in communities that have significant problems with sanitation systems, exposure to toxins, or limited access to nutritious foods. Carolette R. Norwood, *Mapping the Intersections of Violence on Black Women's Sexual Health Within the Jim Crow Geographies of Cincinnati Neighborhoods*, 39 FRONTIERS 97, 97–98 (2018).

254. *See* Scott Burris et al., *Integrating Law and Social Epidemiology*, 30 J.L. MED. & ETHICS 510, 510 (describing how law is a social determinant of health).

255. *See* O. B. K. Dingake, Letter to the Editor, *The Rule of Law as a Social Determinant of Health*, 19 HEALTH HUM. RTS. 295, 297 (2017) ("The structural determinants [including the governing process and legal policies] affect whether the resources necessary for health are distributed equally in society, or whether they are unjustly distributed according to race, gender, social class, geography, sexual identity, or another socially defined group of people.").

256. *See* Leonard E. Burman, *Taxes and Inequality*, 66 TAX L. REV. 563, 589–90 (2013) ("[T]he single most effective program at reducing poverty in 2010 was the EITC [Earned Income Tax Credit]. It reduced overall poverty rates by 2 percentage points and the child poverty rate by 4.2 percentage points. Overall, this single program cut child poverty by more than 20%."); Hilary W. Hoynes et al., *Income, the Earned Income Tax Credit, and Infant Health* 30 (Nat'l Bureau of Econ. Rsch., Working Paper No. 18206, 2012) ("We believe that these effects are largely due to the sizeable increase in income [due to the Earned Income Tax Credit] for eligible families."); Rachel Rebouché & Scott Burris, *The Social Determinants of Health*, *in* OXFORD HANDBOOK OF U.S. HEALTH LAW 1097, 1104 (I. Glenn Cohen et al. eds., 2016) ("Research on the effects of tax credits indicates that the expansion of the earned income tax

often courts have overlooked social determinants by reasoning that law (and the state) did not create poverty, or that the relationship between law and health disparities is too attenuated.[257] That limited view of law "reinscribes underlying inequalities, while appearing to act neutrally and without reference to categories of race, sex, or poverty."[258] By contrast, the *ACOG* litigation highlights the impact of law when it constricts abortion services, not only on patients and populations of patients, but also for the broader project of dismantling systemic inequalities.[259] In the same vein, a social determinants approach recognizes that addressing health inequalities requires structural and institutional change.[260]

The *ACOG* case suggests one way to frame abortion restrictions as threats to public health and the healthcare system, both with respect to COVID-19 and chronic

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credit (EITC) correlates with better overall health behaviors and lower rates of depression among mothers and children that are EITC beneficiaries.").

257. Supreme Court cases that uphold bans on abortion funding are examples. *See* Harris v. McRae, 448 U.S. 297, 298 (1980) ("Although government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation, and indigency falls within the latter category."); Maher v. Roe, 432 U.S. 464, 474 (1977) (stating that Connecticut's law banning Medicaid funding for elective abortion did not cause poverty and thus was not the reason low-income people could not afford abortion); *see also* Khiara Bridges, *Elision and Erasure: Race, Class, and Gender in* Harris v. McRae, *in* REPRODUCTIVE RIGHTS & JUSTICE STORIES 127 (Melissa Murray et al. eds., 2019) ("[A]lthough concerns about race, class, and gender drove much of the debate about Medicaid funding for abortion, precedent (and politics) counseled those who challenged the Hyde Amendment to downplay or ignore these elements in their legal arguments. And in its opinion, the Court also elided these issues.").

258. Hill, *supra* note 196, at 1125.

259. *See supra* Part II.C.

260. *See* Daphne McGee & Drew Stevens, *Law as a Social Determinant of Health and the Pursuit of Health Justice*, AM. HEALTH LAW ASS'N (Aug. 21, 2020), https://perma.cc/99VQ-FSDC ("[T]he health law community should also prioritize a 'Health in *All* Policies' approach . . . . [which] is defined as an approach to public policies and governance across *all* sectors to 'systematically address the health and health-system implications of decisions, seek synergies, and avoid harmful health impacts.'" (internal citations omitted)); Raj C. Shah & Sarah R. Kamensky, *Health in All Policies for Government: Promise, Progress, and Pitfalls to Achieving Health Equity*, 69 DEPAUL L. REV. 757, 763 (2020) (stating that the "Health in All Policies" framework includes "creating structural or procedural change on how government works by embedding health and equity into all levels of government decision-making").

disparities.[261] But relying on courts is fraught terrain as the Supreme Court made clear in its order in *ACOG*.[262] The next Part discusses how abortion rights have come under pressure with the Supreme Court poised to overrule or reinterpret *Planned Parenthood v. Casey*. Notwithstanding the precarious future of constitutional abortion rights, the next generation of abortion policy may have less to do with courts and more to do with political action that advances innovative practices and technologies in the pursuit of abortion access.

III. A POST-*ROE* COUNTRY

The first subpart of this Part considers an imminent future when federal constitutional rights to abortion have been further eviscerated. The second subpart contemplates two ways by which the delivery of care is evolving, with or without constitutional rights to abortion—remote abortion care and self-managed abortion. The Article concludes by assessing potential strategies that movements for reproductive justice and health justice might advance to ensure abortion access.

A. *With* Roe: *Betting on Burdens*

The constitutional right to abortion has been under siege for decades.[263] However, *Roe v. Wade* and *Planned Parenthood v. Casey* have stood even though numerous cases and laws have chipped away at their legal force.[264] The constitutional right to abortion will continue to exist for some indeterminate period,

261. *See supra* Part II.C.

262. *See supra* notes 164–170 and accompanying text.

263. *See* Mary Ziegler, *What's Next for Abortion Law?*, BOSTON REV. (Sept. 1, 2020), https://perma.cc/6HPM-35GK (detailing the unraveling of abortion rights since *Roe v. Wade*); Elizabeth Nash & Lauren Cross, *2021 Is on Track to Become the Most Devastating Antiabortion State Legislative Session in Decades*, GUTTMACHER INST. (Apr. 30, 2021), https://perma.cc/PWY4-9JPL (last updated June 14, 2021) ("Due to the numbing effect from the onslaught of abortion restrictions enacted over the past 10 years, the level of damage to abortion rights and access may not be immediately apparent.").

264. This Part refers to a "post-*Roe*" country, even though the Court would reverse *Casey*, because the phrase tracks popular writing and public perception.

and, for the time being, the application of the undue burden test is unclear.[265]

Amid doctrinal uncertainty, the present choice for state courts remains between evidence that demonstrates the multilevel burdens imposed by law, or deference to the legislature.[266] Some states are counting on the latter. As one state representative from South Carolina put it, "[a] lot of what state legislatures do on the issue of abortion is guided by what federal courts have allowed . . . [a]nd it seems like the envelope has been pushed a little further."[267]

The implications of taking one path versus the other are considerable. To take an example, the same week that the Supreme Court handed down *June Medical Services*, it ordered the U.S. Court of Appeals for the Seventh Circuit to reconsider appellate decisions that invalidated two abortion restrictions from Indiana.[268] One of the laws required patients to wait eighteen hours between having a state-mandated ultrasound and an abortion procedure.[269]

In its 2018 decision, the Seventh Circuit employed a "context specific" analysis of the law's effects and purposes based on "the evidence in the record—including expert evidence."[270] The court described the costs imposed by making

265. *See supra* Part I.

266. This Article does not argue that either path—evidence or deference—is apolitical or neutral. These are strategies that reflect the larger legal, social context in which evidence is generated. *See* Ahmed, *Medical Evidence and Expertise, supra* note 117, at 118 (calling for a critique of evidence and expertise in health law advocacy because "progressive lawyers cannot presuppose the stability of public health, scientific, and medical expertise and evidence as a foundation for pro-choice activism").

267. Scott S. Greenberger, *Trump-Appointed Judges Fuel Abortion Debate in the States*, PEW (Jan. 25, 2021), https://perma.cc/HCF4-RPYM (quoting Republican State Senator Larry Grooms of South Carolina).

268. Rachel Rebouché, Opinion, *Abortion Restrictions After* June Medical Services, REG. REV. (Aug. 4, 2020), https://perma.cc/45ZY-HE8J.

269. Planned Parenthood of Ind. & Ky., Inc. v. Comm'r of the Ind. State Dep't of Health, 896 F.3d 809, 812–13 (7th Cir. 2018) (describing the statutory requirements). The other law required parental notice of minors' abortion decisions—even if the minor had received a judicial order circumventing parental involvement—unless such notice was contrary to the minor's best interests. Planned Parenthood of Ind. & Ky., Inc. v. Box, 991 F.3d 740, 742 (7th Cir. 2021).

270. *Comm'r of the Ind. State Dep't of Health*, 896 F.3d at 818.

two trips to the handful of clinics located across the state that perform ultrasounds and abortions.[271] The ultrasound waiting period would result in "additional travel expenses, child-care costs, loss of entire days' wages, risk of losing jobs, and potential danger from an abusive partner," all of which represent significant burdens on individuals who are seeking abortion.[272] The Seventh Circuit specifically recounted expert testimony from the district court record that explained "the impact of the new law on these interconnected stressors and on the already precarious financial lives of poor women seeking an abortion."[273]

The Seventh Circuit found no credible evidence that the waiting period was medically necessary or created opportunities for patients' meaningful reflection.[274] The State of Indiana offered only one study claiming that abortion correlated with "moderate to highly increased psychological problems," a study the Seventh Circuit described as "controversial and much maligned."[275] The Seventh Circuit ultimately did not reconsider the case; the court remanded the case to the district court but the parties settled in the fall of 2020 after Planned Parenthood acquired additional ultrasound equipment.[276]

An undue burden standard (or any standard that replaces it) that accords states wide discretion to enact laws with no health benefits has implications for legislative responses to the

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271. *Id*. at 815, 817.

272. *Id*. at 827.

273. *Id*. at 819. The court noted the incomes of Indiana's abortion patients: 56 percent had incomes below 200 percent of the federal poverty line. *Id*. at 815.

274. *See id.* at 828 (stating that the state's argument that the waiting-period "gives women time for deeper reflection" is unsupported by the evidence).

275. *Id*. at 826.

276. The Seventh Circuit remanded the case to the district court on September 30, 2020. *See* Planned Parenthood of Ind. & Ky., Inc. v. Comm'r of the Ind. Dep't of Health, 823 F. App'x 440, 441 (7th Cir. 2020); Kyra Howard, *Indiana Pre-Abortion Ultrasound Law Goes Into Effect After Four-Year Wait*, STATEHOUSE FILE (Jan. 22, 2021), https://perma.cc/UPU6-RQFW

> Planned Parenthood agreed to drop the lawsuit challenging the Indiana bill in August 2020, allowing the bill to come into effect in January 2021. . . . One possible reason Planned Parenthood ended the lawsuit is because it obtained new ultrasound equipment at the Fort Wayne clinic. The group also cited 'events' over the last three years but did not go into detail.

pandemic and beyond.[277] In the spring of 2020, five federal courts of appeal reviewed state actions that suspended abortion care by deeming it a nonessential medical service.[278] Those decisions produced mixed results: two appellate courts deferred to the states and three struck down the suspensions.[279] The U.S. Court of Appeals for the Fifth Circuit upheld the Texas executive order barring all abortion, including medication abortion.[280] Citing a Supreme Court case decided in 1905, *Jacobson v. Massachusetts*,[281] the Fifth Circuit held that a court may not "second-guess" any state's regulatory response to a public health emergency.[282] The Eighth Circuit, repeating the Fifth Circuit's reasoning, upheld Arkansas's abortion suspension and rejected evidence that the order failed to conserve health resources or impede the spread of COVID-19.[283] Both circuit courts dismissed arguments about the short-term and long-term costs to individuals and the healthcare system as mere "policy" considerations.[284]

One lesson from the suspensions and courts' debate over the application of *June Medical Services* is that location continues to matter a great deal. Depending on the circuit, some courts

277. *See* Rachel Rebouché, *Abortion Opportunism,* 7 J.L. & BIOSCI. 1, 2–6 (2020) (explaining the implications of *In re* Abbott, which include unnecessary and extraneous use of medical resources by people unable to induce abortion remotely).

278. *See id*. at 2–9 (discussing opinions from the Fifth, Sixth, Seventh, Eighth, and Eleventh Circuit Courts of Appeal).

279. For appellate courts deferring to states, see *In re* Abbott, 954 F.3d 772, 777–79 (5th Cir. 2020); *In re* Rutledge, 956 F.3d 1018, 1030–32 (8th Cir. 2020). For appellate courts striking down abortion suspensions, see Adams & Boyle, P.C. v. Slatery, 956 F.3d 913, 929 (6th Cir. 2020); Robinson v. Att'y Gen., 957 F.3d 1171, 1183–84 (11th Cir. 2020); Planned Parenthood of Ind. & Ky., Inc. v. Box, 991 F.3d 740, 751–52 (7th Cir. 2021).

280. *See* Rebouché, *Abortion Opportunism*, *supra* note 277, at 2–3 (discussing *In re* Abbott).

281. 197 U.S. 11 (1905). The Supreme Court in *Jacobson* wrote that legislators can choose the means by which they exercise emergency health authority unless the "regulations [are] so arbitrary and oppressive . . . as to justify the interference of the courts to prevent wrong and oppression." *Id*. at 38.

282. *In re Abbott*, 954 F.3d at 777–79. In January 2021, the Supreme Court vacated the Fifth Circuit's decision as moot. Planned Parenthood Ctr. for Choice v. Abbott, 141 S. Ct. 1261 (2021).

283. *In re Rutledge*, 956 F.3d at 1030–32.

284. *In re Abbott*, 954 F.3d at 784; *In re Rutledge*, 956 F.3d at 1028–29.

will affirm the multitude of ways that abortion restrictions exacerbate existing health disparities and inequalities.[285] Others will not.[286] If courts apply Chief Justice Roberts's approach moving forward, some abortion regulations could fall whenever legal restrictions put abortion services too far out of reach for an undetermined number of patients—matters of degree and determined by the facts.[287] Other anti-abortion statutes that do not shut clinic doors or excessively increase travel distances for patients may stand.[288]

Another take away from the abortion suspensions early in the pandemic, however, is the unexpected malleability of state

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285. *See supra* notes 270–275 and accompanying text.

286. As noted above, many of the same states defending the FDA's in-person requirement for mifepristone have expanded telemedicine across numerous health care sectors. *See supra* notes 138–140 and accompanying text. Justice Sotomayor emphasized a similar point in her dissent from the Court's *ACOG* order. *See* FDA v. Am. Coll. of Obstetricians & Gynecologists, 141 S. Ct. 578, 580 (2021) (Sotomayor, J., dissenting)

> The Government has thus recognized that in-person healthcare during the COVID-19 pandemic poses a significant risk to patients' health, and it has acted to help patients 'access healthcare they need from their home, without worrying about putting themselves or others at risk during the COVID-19 outbreak.' Yet the Government has refused to extend that same grace to women seeking medication abortion.

287. *See* June Med. Servs. L.L.C. v. Russo, 140 S. Ct. 2103, 2138 (2020) (Roberts, C.J., concurring) ("*Casey* discussed benefits in considering the threshold requirement that the State have a 'legitimate purpose' and that the law be 'reasonably related to that goal.'" (quoting Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 878 (1992))).

288. Consider so-called fetal discrimination statutes, which ban abortions that are motivated by the fetus's sex, race, or prenatal diagnosis (for example, Down syndrome). *See, e.g.*, N.D. CENT. CODE § 14-02.1-04.1 (2021) (barring physicians from performing abortions if they have knowledge that their patient is seeking an abortion based on the fetus's sex or a prenatal diagnosis). Laws that attempt to restrict the reason for abortion are increasingly popular, and although reason-based bans do not drive providers out of business, they can deter people from seeking services or chill the care offered by providers—in the name of respecting potential life, not protecting patient health. *See* Rachel Rebouché, *Testing Sex*, 49 U. RICH. L. REV. 519, 521 (2015) ("Before 2011, only two states prohibited sex-selective abortion. Six states have since passed sex-selective abortion bans and almost half of the country's state legislatures have considered similar bills."). The Sixth Circuit upheld an Ohio law that prohibits providers from terminating pregnancies because of a fetal diagnosis of Down syndrome. *See* Preterm-Cleveland v. McCloud, 994 F.3d 512, 535 (6th Cir. 2021).

policy.[289] The state suspensions undermined the typical argument that abortion is different from all other healthcare services—in twelve states, an overly-regulated procedure became a non-essential service, like cosmetic surgery.[290] Distinctions between essential and non-essential care, including abortion, ceased to matter when states like Texas sought to reopen businesses, essential or not, in the spring of 2020.[291] Even given the exceptional circumstances, the course of pandemic suspensions illustrate that states will bend to political pressure or compromise anti-abortion stances for other legislative priorities, which are policy decisions that do not hinge on constitutional rights.

The proposal to decenter constitutional arguments is not new.[292] Yet the intersection of developments in legal doctrine, judicial personnel, public health evidence, and social activism has yielded new research-based, politically-focused action with respect to abortion access. In that vein, the next subpart explores the growth of and obstacles to teleabortion and self-managed abortion. Again, public health evidence has played

289. *See* B. Jessie Hill, *What Is the Meaning of Health? Constitutional Implications of Defining "Medical Necessity" and "Essential Health Benefits" Under the Affordable Care Act*, 38 AM. J.L. & MED. 445, 446–47 (2012) (discussing the political and legal issues surrounding the definitions of essential health care and medical necessity).

290. *See* Rebouché, *Abortion Opportunism*, *supra* note 277, at 9 ("Contradictory treatment of abortion compared to other outpatient services existed long before COVID-19 . . . . Abortion restrictions are 'more numerous and more stringent' than regulations of other types of office-based procedures." (internal citation omitted)).

291. *See* Patrick Svitek, *Gov. Greg Abbott to Let Restaurants, Movie Theaters and Malls Open with Limited Capacity Friday*, TEXAS TRIB. (Apr. 27, 2020), https://perma.cc/A645-FL4Z (last updated Apr. 28, 2020) (describing the re-opening of nonessential businesses in Texas).

292. The reproductive justice movement has called for reproductive rights advocates to focus less on litigating a right to an abortion and to retrain their sights on community and political engagement, both for abortion access and for a range of reproductive and sexual services. *See* Zakiya Luna & Kristin Luker, *Reproductive Justice*, 9 ANN. REV. L. & SOC. SCI. 327, 341–43 (2013) (stating that the reproductive justice strategies include advocacy for reducing racial and class disparities in criminal sentencing and healthcare); Rachel Rebouché, *Reproducing Rights: The Intersection of Reproductive Justice and Human Rights*, 7 U.C. IRVINE L. REV. 579, 595 (2017) ("[R]ather than focusing on litigating privacy rights, reproductive justice prioritizes community engagement with vulnerable populations of women, and focuses on the experiences of those living under abortion laws.").

a role, investigating and confirming the safety and efficacy of teleabortion and self-managed abortion.[293] Studies generated by TxPEP and ANSIRH, to take Part II's examples, have been at the forefront of this research, not just to support the expansion of abortion services, but also to promote cultural acceptance of and investment in reproductive healthcare.[294]

B. *Without* Roe: *From Rights to Resources*

Even though *Roe* has survived for decades, its reversal seems more possible than at any other time. Already in 2021, nine states have passed laws prohibiting abortion for almost all reasons and well before viability; all but one of those laws are not in effect at the time of writing.[295] As noted, the Supreme Court will decide whether all pre-viable prohibitions on elective terminations are unconstitutional in *Dobbs v. Jackson Women's*

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293. Take the work of Plan C and Gynuity as examples. *See* Patrick Adams, Opinion, *Amid Covid-19, a Call for M.D.s to Mail the Abortion Pill*, N.Y. TIMES (May 12, 2020), https://perma.cc/E8Z2-SRCK

> When they started Plan C in 2016, Ms. Wells and Ms. Coeytaux—who in the late 1990s were instrumental in making emergency contraception available over the counter—set out to raise awareness about self-managed abortion through a grass-roots approach. They held meetings in their homes, trained groups of millennial "ambassadors," and put out a report card ranking the various vendors offering pills online. While Plan C was getting the word out, the nonprofit research group Gynuity Health Projects was gathering evidence for advocacy efforts aimed at removing the regulation.

294. *See* SANGER, *supra* note 7, at 230–33 (arguing that technology, such as telemedicine, and "current events," or "the unexpected vagaries of modern life that sometimes cause people to reconsider a position," can "normalize" and support abortion care).

295. Nash & Cross, *supra* note 263. Texas passed a so-called "heartbeat statute," which prohibits abortion after a provider detects fetal cardiac activity or approximately six weeks after the first day of the patient's last menstrual period. TEX. HEALTH & SAFETY CODE ANN. § 171.204 (West 2021). The statute is unique in that it places the law's enforcement in the hands of private citizens, who can sue providers and all who aid and abet an abortion in violation of the law, rather than state officials. *Id.* § 171.201. The law took effect on September 1, 2021, and has been the subject of multiple state and federal lawsuits. Mary Ziegler & Rachel Rebouché, *The Federal Suit Against Texas's Abortion Law May Fail. It's Still Worthwhile*, WASH. POST, https://perma.cc/52JL-UEQR (Sept. 11, 2021, 6:00 AM); Ashley Lopez, *Federal Appeals Court Temporarily Reinstates Texas's 6-Week Abortion Ban*, NPR (Oct. 8, 2021, 10:06 PM), https://perma.cc/YCH5-P2J4.

Health Organization.[296] If the Court upholds Mississippi's fifteen-week ban and permits some or all pre-viability restrictions, there may be little left of the constitutional right to abortion as set out in *Roe* and *Casey*.

The picture of abortion access, however, is already stark. Currently, six states have one abortion provider.[297] In addition, providers are increasingly concentrated in urban areas, creating "abortion deserts," mostly in the Midwest and South, in which there are no providers within one hundred miles of many of a state's residents.[298] The Guttmacher Institute found that of the "808 clinic facilities that provided 95% of abortions in 2017" only 26 percent of abortion facilities are in hostile states.[299] But "58% of American women of reproductive age lived in a state considered either hostile or extremely hostile to abortion rights" and "[o]nly 30% of women lived in a state supportive of abortion rights."[300] The critical shortage of abortion services in many parts of the country will worsen if constitutional rights to abortion disappear.[301] If the Court abandons *Casey,* twenty-one states have laws in place or plan to pass laws that would make

296. 141 S. Ct. 2619 (2021).

297. Holly Yan, *These 6 States Have Only 1 Abortion Clinic Left. Missouri Could Become the First with Zero*, CNN (June 21, 2019, 12:48 PM), https://perma.cc/JG7R-57Q5.

298. *See* Raymond et al., *supra* note 144, at 174 ("27 cities with populations of 50,000 or more had no abortion clinic within a 100 mile radius."); 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 anti-abortion laws have on women living in rural areas).

299. Witwer et al., *supra* note 212, at 4.

300. Elizabeth Nash et al., *Policy Trends in the States, 2017*, GUTTMACHER INST. (Feb. 1, 2018), https://perma.cc/TTH7-5QBS. The Guttmacher Institute defined "hostile" and "supportive": "A state is considered supportive of abortion rights if it has no more than one [abortion] restriction[], a middle-ground state if it has 2–3, a hostile state if it has 4–5 and an extremely hostile state if it has 6–10." *Id*. Six states were coded as hostile and twenty-three states as extremely hostile; twelve states as supportive; and nine as middle ground. *Id.* The types of laws analyzed included waiting periods, mandatory ultrasounds, parental involvement requirements, gestational limits, and reason-based bans, to name several. *Id.*

301. *See* COHEN & JOFFE, *supra* note 8, at 54–68 (detailing the scarcity of providers and clinics and documenting the hardships both impose on patients).

abortion a crime with limited exceptions.[302] A study mapped what abortion provision would look like if states likely to ban abortion post-*Roe* did so.[303] Caitlin Myers, Rachel Jones, and Ushma Upadhyay 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%."[304] Travel is and will remain necessary for the majority of people seeking abortion care unless care becomes untethered to place.[305]

The remote delivery of medication abortion, though far from a perfect solution, has expanded the geographical reach of abortion care.[306] Over half of the country's states permit or have no law restricting telemedicine for abortion.[307] The Supreme Court's stay in *ACOG* thwarted some efforts to expand remote

302. *Abortion Policy in the Absence of* Roe, GUTTMACHER INST., https://perma.cc/Y44P-58Q9 (last updated July 1, 2021).

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

304. *Id.* at 367. Myers's study found an increase from a national average of twenty-five miles to 122 miles to a provider if *Roe* were overruled because 26 percent of people would live further than 200 miles from a clinic, and the most affected people would be those living in urban Southern or Midwestern areas who would be thirty miles away from a provider instead of five miles away. *Id.* at 372. The study predicts that abortion rates would decline as much as 40 percent in urban areas. *Id.*

305. Touching on a longstanding debate among legal academics, there are mixed views about whether states could limit residents from seeking abortion outside of state lines. *See* Richard H. Fallon, Jr., *If* Roe *Were Overruled: Abortion and the Constitution in a Post-*Roe *World*, 51 ST. LOUIS U. L.J. 611, 627 (2007) (hypothesizing that state statutes criminalizing the procurement of out-of-state abortion by residents would be unconstitutional); Susan Frelich Appleton, *Gender, Abortion, and Travel after* Roe*'s End*, 51 ST. LOUIS U. L.J. 655, 655–57 (2007) (arguing that Fallon's analysis "would prove highly problematic" and that states could instead use civil remedies as a deterrent for out-of-state abortions); Seth F. Kreimer, *"But Whoever Treasures Freedom . . .": The Right to Travel and Extraterritorial Abortions*, 91 MICH. L. REV. 907, 914–21 (1993) (arguing that out-of-state abortion restrictions could be deemed unconstitutional because they violate the Privileges and Immunities or the Due Process clauses).

306. *See* Yvonne Lindgren, *The Doctor Requirement: Griswold, Privacy, and At-Home Reproductive Care*, 32 CONST. COMMENT. 341, 346 (2017) (arguing that people "living in poverty, of color, or with compromised immigration status" may be more likely to self-induce abortion at home).

307. *See Medication Abortion*, *supra* note 24 (explaining that in-person requirements "effectively ban[] telemedicine provision of medication abortion despite clinical evidence that this practice is appropriate and safe").

care from January to April 2021.[308] But the FDA's decision to suspend enforcement of the in-person ETASU until the end of the COVID-19 emergency, just as the agency has done for other drugs and while the FDA reviews the REMS, allowed virtual clinics to resume operation.[309]

The Gynuity study, which was established before the pandemic, as described in Part I, offers teleabortion services in eighteen states and Washington, D.C.[310] The first large-scale

308. *See* Rachel Rebouché & Ushma Upadhyay, Opinion, *Online Clinics Show Abortion Access Can Survive State Restrictions and* Roe v. Wade *Threat*, USA TODAY (Apr. 12, 2021, 5:01 AM), https://perma.cc/6AAL-FDUM ("At the moment, these virtual clinics cannot use mail-order pharmacies to deliver medications to their patients. That's because in January, the Supreme Court reinstated the FDA rule while litigation is ongoing."); Rachel Rebouché, *The Supreme Court Doesn't Hold All the Power When It Comes to Abortion Rights. Here Are 2 Things the Biden Administration Can Do to Extend Access*, TIME (Dec. 22, 2020, 9:00 AM), https://perma.cc/8DUS-A3D5 (arguing that the Biden Administration could remove FDA restrictions on teleabortion); Carrie N. Baker, *SCOTUS Blocks Access to Abortion Pill by Mail During Pandemic. Advocates Look to Biden Administration to Reverse Trump Policy*, MS. MAG. (Jan. 13, 2021), https://perma.cc/T8VJ-JWGV (last updated Jan. 23, 2021) (detailing the negative impacts of the FDA's medication abortion regulation enacted during the Trump Administration).

309. *See supra* note 33 and accompanying text.

310. *See supra* note 144. Those states are Colorado, Georgia, Hawaii, Illinois, Iowa, Maine, Maryland, Massachusetts, Minnesota, Montana, Nevada, New Jersey, New Mexico, New York, Oregon, Virginia, Washington, and Washington, D.C. *TelAbortion: Get Started,* GYNUITY HEALTH PROJECTS, https://perma.cc/5V7M-VV5L. Note that Montana's teleabortion services may be impacted by a 2021 law requiring in-person dispensation. Eric Wicklund, *Planned Parenthood Challenges Montana's Ban on Telemedicine Abortions*, MHEALTH INTELLIGENCE (Aug. 17, 2021), https://perma.cc/M3HB-AF6V. In 2019, Gynuity partnered with carafem, which operates a telehealth program for abortion, as well as four health centers in Georgia, Illinois, Maryland, and Washington, D.C. *See* CARAFEM, 2020 ANNUAL REPORT 1 (2020), https://perma.cc/9YJF-NKP2 (PDF). Like ANSIRH and TxPEP, Gynuity received substantial financial support from a large, private foundation. *See* ZIEGLER, *supra* note 5, at 169 ("The Buffett Foundation alone provided $40 million to the Guttmacher Foundation and nearly $30 million to Gynuity Health Projects."). In addition to the states that Gynuity serves, Abortion on Demand (AOD) offers virtual services in California, Connecticut, Delaware, Rhode Island, and Vermont. Carrie N. 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://perma.cc/L7GT-7QGZ (describing how Abortion On Demand operates). The AOD website has announced expansion to Hawaii, Idaho, Wyoming, Michigan, Pennsylvania, and New Hampshire. *Where is AOD Available*?, ABORTION ON DEMAND, https://perma.cc/FV43-J752. AOD prescribes medication abortion up to eight weeks of pregnancy, rather

virtual clinic, Abortion on Demand, launched in April 2021 and now operates in twenty states with plans to expand to twenty-seven states in 2021.[311] Virtual clinics like Abortion on Demand are able to charge much less than brick-and-mortar clinics[312] and contract with online pharmacies to mail medication abortion prescribed by licensed physicians.[313] Another organization, Aid Access, works with physicians certified to prescribe medication abortion and willing to mail the regimen directly to patients. Aid Access operates in six states, bringing the current number of states with teleabortion services to twenty-three.[314] Patient satisfaction surveys suggest that the value of remote abortion care is what one could have predicted—effective care with privacy, convenience, and reduced delay and cost.[315]

Growth of virtual clinics appears to continue, not least because of the FDA's reconsideration of the REMS. The FDA will base its decision on research provided in a supplemental new drug application by the drug manufacturer and evidence from published studies.[316] The research centers described in this

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than ten as allowed by the FDA, and only for people aged eighteen and older, in order to avoid parental involvement restrictions. *Id.*

311. Other start-up clinics include Choix, Hey Jane, and Just the Pill. *See* Rebouché & Upadhyay, *supra* note 308 (explaining the resiliency of abortion rights as exampled by the new-wave of virtual abortion clinics, which may be undeterred by "[n]ear-total bans on abortion"); Telephone Interview with Jamie Phifer, Founder, Abortion on Demand (Aug. 3, 2021).

312. *See* Carrie N. Baker, *How Telemedicine Startups Are Revolutionizing Abortion Health Care in the U.S.*, MS. MAG. (Nov. 16, 2020), https://perma.cc/Q9MS-KNRH (discussing the cost of abortions at virtual clinics). Carrie Baker details how abortion funds help patients cover the cost of medication abortion and several clinics use sliding scales for payment based on patient income. *See id.*

313. *See id.* (noting that a district court judge "temporarily suspended an FDA restriction" that allowed providers to send abortion pills through the mail for a short time).

314. Aid Access offers its telemedicine services for abortion, in addition to the states covered by Gynuity and carafem, to Arkansas, Connecticut, Indiana, New Jersey, Nevada, and Vermont. *Where We Operate*, *FAQs*, AID ACCESS, https://perma.cc/8BWQ-2WSQ.

315. *See* Rebouché & Upadhyay, *supra* note 308 (reporting that an ongoing study has suggested that virtual clinic patients were "overwhelmingly satisfied with [the] service" they received).

316. 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.

Article have been, and will be, the main source of those studies.[317] That research, moreover, contributes to the work of advocates and lawyers who disseminate information about how remote medication abortion works.[318] Plan C, a non-profit organization, has been a hub for connecting patients with providers.[319] And Plan C disputes the dominant interpretation of the in-person ETASU and argues that in-person collection is not required because the FDA does not specify how mifepristone should be dispensed.[320] Even before the *ACOG* case, Plan C organizers recruited physicians who received certification required by the FDA and then interpreted the provision as allowing supervised direct mail of mifepristone and misoprostol.[321]

The landscape of abortion has shifted in ways that many thought unimaginable ten years before—that is, early terminations without a visit to a clinic.[322] But telemedicine for abortion has clear limitations. The current regulation of telemedicine for abortion mirrors the map of abortion access in a post-*Roe* country. Laws in about half of the country limit, explicitly or implicitly, telemedicine for abortion.[323] For instance, twenty states require a physician to be present upon

317. The work of ANSIRH, noted in Part II, is significant in establishing the safety and efficacy of remote care. *See Telemedicine for Abortion*, ANSIRH, https://perma.cc/HR4B-J67Y (providing accessible information regarding abortion).

318. *See* Amna A. Akbar et al., *Movement Law*, 73 STAN. L. REV. 821, 847 (2021) (calling for legal scholars writing about law, justice, and social change to co-generate ideas with social movements).

319. *See* Adams, *supra* note 293 ("[T]he pandemic has also shone a spotlight on what's known as 'medication abortion,' or the use of pills to terminate an early pregnancy. And Ms. Coeytaux and Ms. Wells, [the creators of Plan C], say that has only broadened support for their efforts to make the medicines available by mail.").

320. *See The Plan C Guide to Getting Abortion Pills*, PLAN C, https://perma.cc/N62H-J28S (offering in-depth information on the process of receiving and using medication abortion).

321. *See* Adams, *supra* note 293 (describing Plan C's efforts to encourage doctors to mail mifepristone to patients).

322. *See* Carole Joffe, *A Rare Expansion in Abortion Access Because of COVID-19*, TIME (Sept. 28, 2020, 3:29 PM), https://perma.cc/Q47E-2K87.

323. *See Medication Abortion*, *supra* note 24. The *ACOG* decision did not suspend the operation of state law and applied, in any case, through and for thirty days after the COVID-19 national emergency. FDA v. Am. Coll. of Obstetricians & Gynecologists, 141 S. Ct. 578, 580 (2021) (per curiam).

delivery of medication abortion.[324] Ten states ban the use of telemedicine for abortion even though existing in-person requirements would accomplish the same end; state courts in two states have enjoined those in-person requirements.[325]

Moreover, patients need access to technology to make teleabortion work. Based on the statistics about laptop and tablet use, most abortion patients would likely use a smartphone for remote care.[326] Rules that require people to log on from certain locations from specific devices, which is dependent on broadband or wireless internet, may encumber participation in telehealth visits.[327]

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324. *Medication Abortion Requirements*, POL'Y SURVEILLANCE PROGRAM (Dec. 1, 2018), https://perma.cc/H4ZW-DCQV (last updated Mar. 1, 2021). Montana passed legislation in May 2021 requiring in-person dispensation and Ohio and Iowa state courts have enjoined the in-person requirement. *See infra* note 325 and accompanying text.

325. *See Medication Abortion Requirements*, *supra* note 324 (noting that Arizona, Texas, Arkansas, Iowa, Indiana, Kentucky, West Virginia, and South Carolina have banned the use of telemedicine for medication abortion). West Virginia has an exception for physicians with an existing relationship established through an in-person encounter. *See* W. VA. CODE §§ 30-3-13a, 30-14-12d (2020). Iowa has a ban on telemedicine for abortion, but its regulation of medication abortion, such as in-person administration, has been enjoined by the Supreme Court of Iowa. *See* Planned Parenthood of the Heartland, Inc. v. Iowa Bd. of Med., 865 N.W.2d 252, 269 (Iowa 2015). Montana and Ohio recently passed telemedicine bans for abortion, but as of May 2021, a state court temporarily enjoined the Ohio law. Iris Samuels, *Montana Governor Signs 3 Bills Restricting Abortion Access*, AP NEWS (Apr. 26, 2021), https://perma.cc/2T77-Z62R; Carrie N. Baker, *Advocates Cheer FDA Review of Abortion Pill Restrictions*, MS. MAG. (May 11, 2021), https://perma.cc/5M8P-WPY5 (describing the Ohio law and state court injunction).

326. carafem, a provider that operates a virtual clinic in addition to physical locations in Atlanta, Nashville, Chicago, and Washington, DC, designed an app, "Cara," that helps schedule appointments, answers questions, and provides a hotline to a healthcare provider. Mallory Hackett, *carafem Develops Text-Based Virtual Assistant for Patients Taking Abortion Pill at Home*, MOBI HEALTH NEWS (Apr. 14, 2021, 2:28 PM), https://perma.cc/7PSQ-XVFD.

327. In addition, there are issues of privacy and "telefraud." *See* Nathaniel M. Lacktman et al., *Top 5 Telehealth Law Predictions for 2021*, NAT'L L. REV. (Jan. 12, 2021), https://perma.cc/3FTY-L9BW ("HHS OIG and DOJ will continue its [sic] takedown of companies engaged in 'telefraud . . . ."'). Parity in reimbursement is a significant issue, especially for Medicaid coverage of telehealth. *Id.* The application of the Hyde Amendment and state restrictions on funding for abortion services, however, complicate the issue for abortion care.

Although not the subject of this Article, state regulation can ease or impede telehealth generally by allowing out-of-state providers to offer telehealth services or by permitting the patient-provider relationship to be established online or over the telephone, to name two examples.[328] Taking the former example, over the course of the pandemic, numerous states relaxed licensure requirements that normally restrict physicians from practicing only in the state in which they offer services.[329] Under a licensure waiver or an interstate compact, an out-of-state practitioner can counsel patients and prescribe medication abortion online or over the phone if not otherwise prohibited by state law.[330]

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328. *See* OSUB AHMED, CTR. FOR AM. PROGRESS, STATES MUST EXPAND TELEHEALTH TO IMPROVE ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH CARE 2 (2020), https://perma.cc/Q4ZK-4WTC (PDF) ("Regardless of the modality, telehealth technology is critical to overcoming the geographical, financial, and logistical barriers that many people face when trying to access [sexual and reproductive health] care in person."). As happened over the course of the pandemic, states may waive licensure requirements to permit providers in good standing in another state to practice within the state's jurisdiction. *See* Eli Y. Adashi et al., *The Interstate Medical Licensure Compact: Attending to the Underserved*, 325 JAMA 1607, 1607 (2021) ("Telemedicine, which is likely to become an enduring legacy of the COVID-19 pandemic, invariably is in conflict with the interstate physician licensing process. This obstacle is being progressively overcome by the Interstate Medical Licensure Compact (IMLC), which has been rapidly gaining ground since . . . 2017."). Licensure compacts also allow physicians to prescribe medication to out-of-state residents. *Prescribing Controlled Substances via Telehealth*, HEATH RES. & SERVS. ADMIN., https://perma.cc/97K2-RBEG (last updated Jan. 28, 2021).

329. *See* Cason D. Schmit et al., *Telehealth in the COVID-19 Pandemic, in* ASSESSING LEGAL RESPONSES TO COVID-19 123, 128 (Scott Burris et al. eds., 2020), https://perma.cc/QMR8-K7FW (PDF); Kyle Faget, *Telehealth in the Wake of COVID-19*, 22 J. HEALTH CARE COMPLIANCE 5, 8–9 (2020).

330. *See* Lacktman et al., *supra* note 327

> In an effort to balance workload nationally and expand access to health care practitioners during the Public Health Emergency (PHE), many states temporarily suspended medical licensing requirements. As these temporary waivers begin to sunset, some state legislatures will seek to make the waivers permanent, allowing practitioners licensed in other states to deliver telehealth services across state lines, provided the out-of-state practitioner follows local state practice standards. While this may be a topic of discussion among policy shops, we expect few states will actually enact such changes in 2021.

The Uniform Law Commission presently is drafting a Telehealth Act for state adoption, which would create a national registry for out-of-state practitioners

Patients also must meet the medical criteria for remote services. Medication abortion is not recommended for people at risk of an ectopic pregnancy, taking blood thinners or certain steroids, and with blood disorders, pelvic inflammatory disease, or severe anemia.[331] People of color and low-income people are more likely to have pregnancy complications and to have poorer health, thereby reducing the chance, overall, that they can be candidates for teleabortion.[332] These are not only challenges for remote care, but also mirror the disparities in U.S. healthcare.[333]

Finally, medication abortion will not serve those seeking to terminate pregnancies after ten weeks of pregnancy.[334] Presently, almost 60 percent of abortion patients use non-medication methods.[335] Those procedures are tethered to

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offering telehealth services. TELEHEALTH ACT (UNIF. L. COMM'N, Draft June 28, 2021), https://perma.cc/GD5R-QBHW. The draft Act, however, provides that practitioners may offer services "not otherwise prohibited by law," *id*. § 4, and contemplates exclusion of abortion services in the Comment: "For example, state statutes restricting or prohibiting the prescription of abortion-inducing medications or other controlled substances through telehealth will continue to apply." *Id*. § 4 cmt.

331. *See Medical Abortion*, MAYO CLINIC, https://perma.cc/78AQ-J793.

332. *See* Harrison & Megibow, *supra* note 247 (describing the heightened risks associated with pregnancy for Black people).

333. *See Infant Health Mortality and African Americans*, U.S. DEP'T OF HEALTH & HUM. SERVS. OFF. OF MINORITY HEALTH, https://perma.cc/UP95-W4HH (finding the infant mortality rate among non-Hispanic Blacks/African Americans to be 2.3 times the infant mortality rate among non-Hispanic whites); NAT'L ACADS. OF SCI., ENG'G, & MED., METRICS THAT MATTER FOR POPULATION HEALTH ACTION 54 (2016) (noting that there are pervasive health inequities in the United States); Khiara M. Bridges, *Racial Disparities in Maternal Mortality*, 95 N.Y.U. L. REV. 1229, 1257–65, 1308–16 (2020) (providing an overview of racial disparities in maternal mortality and calling for policy changes that address the structural and institutional forces that result in maternal deaths).

334. *See Medication Abortion Up to 70 Days of Gestation*, 136 ACOG PRAC. BULL. e31, e32 (2020), https://perma.cc/B4E3-MTRU (PDF) ("Most patients at 70 days of gestation or less who desire abortion are eligible for a medication abortion.").

335. Ninety-two percent of abortions occur before thirteen weeks of pregnancy and over 60 percent of all terminations are performed by removing pregnancy tissue in the uterus by suction. PLANNED PARENTHOOD, ABORTION AFTER THE FIRST TRIMESTER 1 (2014), https://perma.cc/93ZY-ZC6W (PDF); *see Surgical Abortion (First Trimester)*, UCSF HEALTH, https://perma.cc/L6TY-87M9.

clinical spaces, access to which becomes increasingly complicated if a Supreme Court ruling permits states to ban most abortions at any point in pregnancy.[336]

Self-managed abortion is another avenue for abortion care, which also has been the subject of intensive study. An individual self-manages abortion when they terminate a pregnancy without direct health care provider supervision. Typically, the two-drug regimen (or, sometimes, misoprostol only) is ordered online from companies or organizations headquartered in other countries.[337] People report preferring self-managed abortion because it provides more privacy and autonomy than abortions conducted at a health facility.[338] Substantial research has shown that self-administration of medication abortion with proper instruction is effective and comparably as safe as care administered by professionals in clinical settings.[339]

Like teleabortion, research networks have produced studies that support the expansion of self-managed abortions.[340] Although the prevalence of self-managed abortion is challenging to measure, surveys of health care providers and patients note

336. *See* Jill Wieber Lens, *Miscarriage, Stillbirth, and Reproductive Justice*, 98 WASH. U. L. REV. 1059, 1081 ("Some women, especially marginalized women, may 'choose' to get an abortion, but that does not mean that they can access one.").

337. Chloe Murtagh et al., *Exploring the Feasibility of Obtaining Mifepristone and Misoprostol from the Internet*, 97 CONTRACEPTION 287, 289 (2018). Aid Access offers U.S. residents an online consultation with a physician residing in another country who, if the physician deems it safe to do so, prescribes a regimen that a pharmacy, typically in India, fills and mails to the patient. *Consultation*, AID ACCESS, https://perma.cc/9FZF-YYGE. In 2019, 21,000 U.S. women requested Aid Access's help, and at least one-third were served. *Who Are We*, AID ACCESS, https://perma.cc/6TG6-TP6L; *see* Hannah Devlin, *Revealed: 21,000 US Women Order Abortion Pills Online in Past Year*, GUARDIAN, https://perma.cc/FJY8-H6RR (May 22, 2019, 2:00 PM) (asserting that Aid Access, in 2019, assisted between one-third and one-half of people who requested help).

338. Mariana Prandini Assis & Sara Larrea, *Why Self-Managed Abortion Is So Much More than a Provisional Solution for Times of Pandemic*, 28 SEXUAL & REPROD. HEALTH MATTERS 2, 38 (2020).

339. *See id.* (comparing self-administration of medication abortion to medication abortion "administered by professionals in health facilities").

340. *See* Abigail R. A. Aiken et al., *Factors Associated with Use of an Online Telemedicine Service to Access Self-Managed Medical Abortion in the US,* 4 JAMA NETWORK OPEN 1, 1 (2021) (finding that increased access to medication abortion might have the potential to expand access for those living below the federal poverty level).

that the practice has increased in recent years, specifically in areas of the United States in which abortion access is heavily circumscribed.[341] Aid Access, which, as noted, provides telehealth for abortion, also assists individuals to self-induce abortion.[342] Aid Access is directed by a physician, Rebecca Gomperts, trained in the Netherlands, who has spearheaded previous initiatives to deliver abortion services across the world in the face of restrictive country laws.[343] The organization offers information about administering medication abortion and procures prescriptions from U.S. or European healthcare providers.[344]

Wider introduction of self-managed abortion faces considerable obstacles too. For one, although self-managed abortion is increasingly understood to be safe, concerns remain that people underestimate their stage of pregnancy.[345] For another, and more significantly, providers and patients can be

341. *See, e.g.*, Fuentes et al., *supra* note 203, at 205 (explaining that five of the participants interviewed considered self-inducing abortion but did not attempt it).

342. *See supra* note 314 and accompanying text.

343. *See Rebecca Gomperts (Born 1966 in Vlissingen, Holland)*, MUSEUM OF CONTRACEPTION & ABORTION (2020), https://perma.cc/4AR3-XY87 (highlighting Gomperts's initiatives to combat restrictive abortion laws). The FDA sent Aid Access a warning letter indicating that the organization may be in violation of the Food, Drug & Cosmetic Act. Letter from the FDA to Aidaccess.org (Mar. 8, 2019), https://perma.cc/5EMU-EGFG.

344. *See* Carrie N. Baker, *Why Order Abortion Pills Online? Affordability, Privacy and Convenience, Says New Study*, MS. MAG. (May 27, 2021), https://perma.cc/B346-SYUY

> Individuals make requests to Aid Access by filling out an online consultation form. If patients live in Alaska, California, Connecticut, Idaho, Massachusetts, New Hampshire, New York, New Jersey, New Mexico, Nevada, Vermont and Washington, Aid Access refers patients to doctors in their state. These patients pay $150 and receive the medication within a few days. For patients living in the remaining states, European-based physicians review the consultation forms and provide medication to eligible patients via an India-based pharmacy that mails the pills within two weeks for a cost of $105. The Aid Access help desk is available to users at any time during and after an abortion.

345. *See* Megan K. Donovan, *Self-Managed Medication Abortion: Expanding the Available Options for U.S. Abortion Care*, 21 GUTTMACHER POL'Y REV. 41, 44 (2018), https://perma.cc/J9UX-QAZF (PDF) (noting that the "patients' ability to self-assess eligibility" needs more evidence).

punished under a variety of state laws.[346] Six states have laws that attempt to criminalize self-managed abortions and several states have so-called fetal endangerment laws.[347] Per the latter, fetal endangerment laws originally targeted drug use by pregnant people, but have been applied to a range of activities including terminating a pregnancy.[348] In states that do not have

346. *See* Aziza Ahmed, *Floating Lungs: Forensic Science in Self-Induced Abortion Prosecutions*, 100 B.U. L. REV. 1111, 1116, 1121, 1124 (2020) (analyzing the "intersection of pregnancy, abortion, and the carceral state in the context of the broader critique of policing and mass incarceration"). Aziza Ahmed has shown that prosecution of self-managed abortion depends on "racialized and gendered assumptions that shape decision-making in the court in finding that a woman ought to be punished for her behavior during or after pregnancy." *Id*. at 1137. It is beyond the scope of this Article to describe the myriad ways in which pregnant individuals' behavior is policed and punished. But important scholarship describes how criminal law has been used to surveil and punish providers and patients for their reproductive choices. *See* MICHELE GOODWIN, POLICING THE WOMB: INVISIBLE WOMEN AND THE CRIMINALIZATION OF MOTHERHOOD 12–26 (2020) (discussing ways in which the law is harnessed to punish reproductive behavior and choices).

347. *See* Farah Diaz-Tello, Roe *Remains for Now . . . Will It Be Enough*?, ABA (Sept. 7, 2020), https://perma.cc/RC4E-CAN9 (discussing the Alabama Supreme Court's reinterpretation of a child endangerment law). For more information on the legal landscape for self-managed abortion, see THE SIA LEGAL TEAM, *ROE*'S UNFINISHED PROMISE: DECRIMINALIZING ABORTION ONCE AND FOR ALL (2018), https://perma.cc/H635-B5BX (PDF). Fetal protection laws promote the view that fetal life deserves protection separate from the pregnant person. *Id.* at 5. Michele Goodwin writes that this "is significant as it normalizes treating the unborn as if they had been born at the time of injury, which not only implicates abortion policy, but also criminal law and other constitutional interests." Michele Goodwin, *Fetal Protection Laws: Moral Panic and the New Constitutional Battlefront*, 102 CAL. L. REV. 791, 794 (2014).

348. *See* Lynn M. Paltrow & Jeanne Flavin, *Arrests and Forced Interventions of Pregnant Women in the United States 1973-2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POLS., POL'Y & L. 299, 315 (2013). Megan Boone and Benjamin McMichael recently demonstrated that fetal protection laws have had a statistically significant negative impact on fetal and infant health:

> Though ostensibly passed to protect fetuses (and later, infants) from harm, this law does no such thing. In 2015 alone, the empirical analysis shows that the law resulted in twenty fetal deaths and sixty infant deaths. And the empirical results suggest a well-defined mechanism by which these deaths occurred. Mothers forego prenatal care when this law is in place—indeed, the chilling effect of such law on pregnant mothers lasts past the time the law lapses—which places them and their fetuses at higher risk.

Meghan M. Boone & Benjamin J. McMichael, *State Created Fetal Harm*, 109 GEO. L.J. 475, 507 (2021).

fetal endangerment laws, police and prosecutors could apply other criminal laws to target people who self-manage abortion.[349] Feticide or solicitation of murder laws, for example, have been applied to punish self-managed abortion, although the frequency of such prosecutions is hard to gauge.[350]

The barriers to remote care are significant, but not insurmountable. While there are obstacles to telehealth for abortion care and self-managed abortion, there has also been support for pro-abortion policies. On the federal level, the Biden Administration has expressed a "commit[ment] to codifying *Roe v. Wade*."[351] The proposed Women's Health Protection Act[352] offers one option, which the House of Representatives passed on September 24, 2021.[353] The Act protects providers' right to offer services and patients' right to receive care; the bill also would limit what restrictions states can pass.[354] Specifically, the Act preempts state restrictions on telemedicine, unless the restriction is generally applicable, as well as in-person requirements unless the in-person visit is medically necessary.[355]

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349. *See* Diaz-Tello, *supra* note 347 (describing individuals being "charged with felonies like concealment of a birth, practicing pharmacy without a license, or even homicide").

350. Ahmed, *supra* note 346, at 1123. By one account, twenty-one people over the last twenty years have been prosecuted for self-managed abortion, although commentators suspect that is a vast underestimate. *See* Diaz-Tello, *supra* note 347 (highlighting that legally, abortion has become riskier as people in the United States have been arrested and charged with felonies for ending pregnancy on their own).

351. *See* Press Release, *supra* note 3 ("We are deeply committed to making sure everyone has access to . . . reproductive healthcare—regardless of income, race, zip code, health insurance status, or immigration status."); Kate Smith, *Biden Pledged to Make* Roe v. Wade "*The Law of the Land*," CBS NEWS (Oct. 6, 2020, 4:55 PM), https://perma.cc/NNG4-GG5Q (noting that, during the election, the Biden campaign promised to codify *Roe* if the Supreme Court abandoned abortion rights).

352. Women's Health Protection Act of 2019, H.R. 2975, 116th Cong. (2019).

353. Daniella Diaz et al., *House Passes Bill Preserving the Right to Abortion*, CNN (Sept. 24, 2021, 1:01 PM), https://perma.cc/E7N8-8W7S.

354. H.R. 2975, § 4(a)–(b).

355. *Id.* § 4(a)(5), (7). *But see* Teleabortion Prevention Act of 2019, H.R. 4935, 116th Cong. (2019) (requiring in-person administration of medication abortion).

On the state level, legislation can ensure abortion rights within a jurisdiction.[356] Massachusetts passed the ROE Act, which provides a state right to abortion for any reason before twenty-four weeks of pregnancy, and for reason of life, health, or lethal fetal anomaly after twenty-four weeks.[357] Virginia, once a state with only anti-abortion laws, repealed its ban on abortion coverage in private health care plans offered through the state's health insurance exchange.[358]

Changing state law depends on political organizing. The lawyers, advocates, and researchers described here have supported increased abortion access through the political process, but not just for the sake of protecting an individual choice or defending an abstract right.[359] Rather, their work is in conversation with networks that seek abortion access as an issue of economic and racial justice.[360] Those networks are committed to principles grounded in reproductive justice and health justice, which share commitments to empowering communities and to the fairer redistribution of resources.[361]

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356. *See, e.g.*, ROE Act, MASS. GEN. LAWS ch. 112, §§ 12F, K–U (2021); *id.* ch. 118E, § 10E.

357. *Id.* As noted, Massachusetts is not the first state to enact legislation to protect abortion rights. Fourteen states and the District of Columbia have laws that protect the right to abortion, either throughout pregnancy (D.C., Oregon, and Vermont) or prior to viability (and then after when necessary to protect the life or health of the pregnant person) (California, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Nevada, New York, Rhode Island, Washington). *See Abortion Policy in the Absence of* Roe, *supra* note 302.

358. VA. CODE ANN. § 38.2-3451 (2021).

359. Research studies described herein are models of "participatory action research," or using the "tools of social science to treat movement actors and activists as research partners in the generation of questions and answers about the world." Akbar et al., *supra* note 318, at 863 n.176. In a similar vein, and in the context of reproductive justice, Zakiya Luna and Kristin Luker have called for interviews and participatory techniques in research "from design to execution to publication to evaluation." Luna & Luker, *supra* note 292, at 344.

360. "What would it look like to design a policy around the idea that no one should have to choose abortion because she is too poor to have a child? It would cost billions of dollars. Yet, we routinely spend such sums on the war over abortion's legality." MICHELLE OBERMAN, HER BODY, OUR LAWS: ON THE FRONT LINES OF THE ABORTION WAR, FROM EL SALVADOR TO OKLAHOMA 141 (2018).

361. Angela P. Harris and Aysha Pamukcu note three commitments shared among social justice movements: "(1) a commitment to acknowledging the centrality and complexity of subordination; (2) an understanding of the necessity yet insufficiency of legal advocacy and technical knowledge alone to

Health justice and reproductive justice, however, are not always in conversation with one another.

Health justice is a framework that "addresses the social determinants of health that result in poor health for individuals and consequential negative outcomes for society at large."[362] And health justice scholarship emphasizes collective action as key to dismantling disparities and inequalities.[363] Angela Harris and Aysha Pamukcu described the likeminded goals of reproductive justice:

> The reproductive justice movement was similarly founded as a response to the reproductive rights . . . . [and] its focus on protecting the individual right to abortion, [which] failed to challenge racially and financially differentiated access to reproductive health . . . . Reproductive justice advocates thus defined their mission around the need to identify the institutional and structural forms of discrimination that prevent all women from equally enjoying the right to bear and raise healthy children, in addition to the right to choose not to have a child.[364]

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redress subordination; and (3) a commitment to, through social movement organizing, centering state and market governance around broadly-articulated 'life rights.'" Harris & Pamukcu, *supra* note 251, at 806, 808 (internal citation omitted).

362. Emily Benfer, *Health Justice: A Framework (and Call to Action) for the Elimination of Health Inequity and Social Injustice*, 65 AM. U. L. REV. 275, 278 (2015).

363. Lindsay Wiley proposes four key commitments for health justice:

> First, the health justice model asserts the importance of collective interests, alongside individual interests, in decisions about medical treatment. Second, the health justice model emphasizes that universal access to affordable health care protects collective, as well as individual, interests. Third, because "upstream" prevention strategies have greater population-level impact, the health justice model prioritizes prevention and integration of health care with public health. Fourth, the health justice model asserts the role of collective oversight through democratic governance—much in the same way that the market power model champions the role of private payers and market dynamics—in managing resources and securing common goods.

Wiley, *supra* note 251, at 833.

364. Harris & Pamukcu, *supra* note 251, at 809. Harris and Pamukcu call for a health justice framework that combines public health expertise on the social determinants of health, civil rights, legal principles on equality and

Synthesizing the work of various social justice campaigns, Harris and Pamukcu call for a convergence of civil rights, social determinants, and health justice to work toward "a world in which your wealth, your social status, your access to power, and your zip code are irrelevant to your life expectancy or vulnerability to illness."[365] In other words, where people live should not dictate whether they can obtain abortion care.

Health justice and reproductive justice emphasize the limitations of strategies concerned only with the right to buy a service and support policies that lower or eliminate the costs of care, make child rearing more affordable, and address the country's tattered healthcare system.[366] Such measures would include, but also go beyond, those specifically designed to expand abortion services.[367] So in addition to lifting funding bans or providing financial support for abortion facilities in underserved areas, for example,[368] responsive policy reform would mean support for higher wages, accessible healthcare, secure housing, and other interventions that upend inequality. In short, health justice and reproductive justice share a commitment to advancing policies that respond to the social determinants of health.

CONCLUSION

U.S. abortion law, politics, and practice are approaching an important pivot point that could affect the reproductive health and wellbeing of the next generation or more. It is unclear how things will work out in the terrain of national politics, given the

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liberty, and a social movement focus on challenging power structures. *Id.* at 806.

365. *Id.* at 766.

366. The proposed Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act would require coverage for abortion care through public health insurance programs (such as Medicaid) and for federal employees. Equal Access to Abortion Coverage (EACH) Act of 2021, S. 1021, 117th Cong. § 2. The bill also mandates that federally supported healthcare facilities provide care for eligible individuals and prohibits the federal government from inhibiting state, local or private insurance plans from covering abortion services. *Id.* § 4.

367. *Id.*

368. *See* Upadhyay et al., *supra* note 9, at 1692 (finding that "[e]xpanding the number of abortion facilities in underserved areas" would "reduce out-of-pocket costs").

new Biden Administration, and in judicial decisions, given the confirmation of Justice Barrett.[369] But something equally important is also happening. A new emphasis on public health evidence has reinforced essential links among abortion access, race, and class.[370] Some evidence of this transformation can be seen in events leading up to the FDA's review of the restrictions on medication abortion. One can already see the influence of new regulatory contexts and new categories of supportive evidence—even sometimes with respect to decisions of the Supreme Court and in the factual records of district courts.[371]

The attention to the links between abortion access and inequality has been supported by the work of political activists, public health researchers, and practicing lawyers.[372] Though not blind to the obstacles and opposition ahead, this Article endeavored to tell how those connections have been made visible and why they can inspire legislative and community change. The future of abortion discourse and practice is unclear, but, this Article argues, abortion care will survive despite the decisions of the Supreme Court and the formidable anti-abortion energies of many states.

369. *See* Smith, *supra* note 351 (noting that the confirmation of Justice Barrett creates uncertainty).

370. *See* Yearby, *supra* note 12, at 1284 (documenting that the "persistence of racial bias" is "evident in the health care system").

371. *See supra* note 152 and accompanying text.

372. *See supra* note 359 and accompanying text.