

THE PUBLIC HEALTH TURN IN REPRODUCTIVE RIGHTS

RACHEL REBOUCHÉ*

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 highlighted vividly 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 that patients collect in-person the first drug of a medication abortion – a two-drug regimen taken over two days – is an example.

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, out of necessity, and toward building capacity for delivering remote or virtual care. The confluence of regulation, funding, and evidence have helped facilitate telehealth for abortion as well as self-managed abortions, which can extend abortion access despite the evisceration of constitutional rights.

This Article argues that current developments in abortion law suggests a way forward that hinges neither on defending nor abandoning a right to an 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.

* Associate Dean for Research, James E. Beasley Professor of Law, Temple University School of Law. For helpful comments, I thank Aziza Ahmed, June Carbone, Doron Dorfman, Craig Green, Paul Gugliuzza, Jill Wieber Lens, Yvette Lindgren, Maya Manian, Linda McClain, Seema Mohapatra, Melissa Murray, Karen Rothenberg, Carol Sanger, Liz Sepper, Jocelyn Simonson, Lindsay Wiley, Megan Wright, Nina Varsava, Mary Ziegler, and the participants of the New York Area Family Law Workshop, Health Law Workshop, the Harvard Law School Workshop on Distribution, the Annual Health Law Professors Conference, and the Family Law Scholars and Teachers Workshop. For excellent research assistance, I thank Alexandria Bondy.

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INTRODUCTION

On his first day in office, President Biden signed 17 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* nodded toward the connection between abortion access and health, though the statement did not use the word "abortion" once.²

The silo of abortion within health and economic policy is the result of varied and complex factors.³ To name just a few: there is the tenacity of an adversarial model of abortion rights, pitting pregnant people against fetal personhood;⁴ there is a deep debate about the

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 One, Biden Moves to Undo Trump's Legacy*, N.Y. TIMES, Jan. 20, 2021, <https://www.nytimes.com/2021/01/20/us/politics/biden-executive-action.html>.

² "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." Press Release, *Statement from President Biden and Vice President Harris on the 48th Anniversary of Roe v. Wade*, Jan. 22, 2021, <https://www.whitehouse.gov/briefing-room/statements-releases/2021/01/22/statement-from-president-biden-and-vice-president-harris-on-the-48th-anniversary-of-roe-v-wade/>.

³ At the same time, the medicalization of abortion – a clinical service subject to the oversight of a physician – has also been subject of rich critique. See Nancy Ehrenreich, *The Colonization of the Womb*, 43 DUKE L.J. 492, 505 (1993); 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); KRISTIN LUKER, *ABORTION AND THE POLITICS OF MOTHERHOOD* 33 (1984); Ruth Bader Ginsburg, *Speaking in a Judicial Voice*, 67 N.Y.U. L. REV. 1185, 1199 (1992).

⁴ See, e.g., MARY ZIEGLER, *ABORTION AND THE LAW IN AMERICA: ROE V. WADE TO THE PRESENT* 1-20 (2020). Compare LAURENCE H. TRIBE, *ABORTION: THE CLASH OF ABSOLUTES* 45 (1990).

existence and nature of constitutional protection for abortion;⁵ and there is stigma and secrecy attached to reproductive decision-making, sex, and pregnancy.⁶ 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.”⁷

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 pregnancy is an inability to afford the costs of raising a child.⁸ This should not be not surprising, given the financial insecurity that marks the lives of an increasing number of people in the United States.⁹ Most abortion patients are also people of color.¹⁰ That, too, reflects broader disparities: race and income align because of the effects of institutional and structural racism.¹¹

When people cannot obtain abortion care, they incur social, financial, and physical costs that are difficult to bear.¹² Those costs have long-term effects that perpetuate cycles of disadvantage and subordination. The COVID-19 pandemic has amplified those costs through

⁵ See, e.g., Robin West, *From Choice to Reproductive Justice: De-constitutionalizing Abortion Rights*, 118 YALE L.J. 1394, 1409-10 (2009).

⁶ See CAROL SANGER, ABOUT ABORTION: TERMINATING PREGNANCY IN TWENTY-FIRST CENTURY AMERICA 47-52, 215-17 (2017); Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261 (1992).

⁷ See, e.g., DAVID COHEN & CAROLE JOFFE, OBSTACLE COURSE 8 (2020). See also Caitlin E. Borgmann, *Abortion Exceptionalism and Undue Burden Preemption*, 71 WASH. & LEE L. REV. 1047 (2014); Caroline Mala Corbin, *Abortion Distortions*, 71 WASH. & LEE L. REV. 1175, 1177 (2014); Maya Manian, *The Consequences of Abortion Restrictions for Women's Healthcare*, 71 WASH. LEE L. REV. 1317, 1371-20 (2014); B. Jessie Hill, *Essentially Elective: The Law and Ideology of Restricting Abortion During the COVID-19 Pandemic*, 106 VA. L. REV. ONLINE 99 (2020); Yvonne Lindgren, *The Rhetoric of Choice: Restoring Healthcare to the Abortion Right*, 64 HASTINGS L.J. 385 (2013). See Lori Freedman et al., *Obstacles to the Integration of Abortion into Obstetrics and Gynecology Practice*, 42 PERSP. SEXUAL & REPROD. HEALTH 146, 146 (2010).

⁸ JENNA JERMAN RACHEL K. JONES, & TSUYOSHI ONDA, CHARACTERISTICS OF U.S. ABORTION PATIENTS IN 2014 AND CHANGES SINCE 2008, GUTTMACHER INSTITUTE (2016) (“Nearly half (49%) of abortion patients in the United States are poor (living below the federal poverty level) and another 26% are low income (living at 100–199% of the federal poverty level).”); 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 3000 people seeking abortions and finding that “travel and procedure costs” were the most common reasons for delaying care).

⁹ See Jedediah Britton-Purdy, David Singh Grewal, Amy Kapczynski & Sabeel Rahman, *Building a Law-and-Political-Economy Framework: Beyond the Twentieth-Century Synthesis*, 129 YALE L.J. 1784, 1785 (2020); Thomas Piketty & Emmanuel Saez, *Inequality in the Long Run*, 344 SCIENCE 838, 838 (2014); THOMAS PIKETTY, CAPITAL IN THE TWENTY-FIRST CENTURY 1 (2014).

¹⁰ JERMAN ET AL., *supra* note 8, at 8 (“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.”).

¹¹ “[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.” Ruqaiyah Yearby, *Breaking the Cycle of “Unequal Treatment” with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias*, 44 U. CONN. L. REV. 1281, 1305-06 (2012) (describing the interpersonal, institutional, and structural racial bias that pervades U.S. healthcare).

¹² COHEN & JOFFE, *supra* note 7, at 9.

widespread unemployment, compounded caregiving responsibilities for families, and an already overstretched healthcare system.¹³

Public health research has highlighted the consequences of abortion restrictions for individuals' and the nation's health.¹⁴ Numerous studies, many generated in the past ten years, demonstrate the short-term, long-term, and cumulative health effects of anti-abortion laws.¹⁵ This research largely responds to state laws that target providers and facilities and frequently lead clinics to shut their doors.¹⁶ For example, quantitative and 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.¹⁷ Courts, including the U.S. Supreme Court, have cited this research in striking down facility and provider restrictions as unconstitutional.¹⁸

The type of evidence that courts cite has expanded to include abortion restrictions' impact on health disparities, which, historically, courts have ignored or minimized.¹⁹ 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.²⁰

¹³ See Ruqaiijah Yearby & Seema Mohapatra, *Systemic Racism, The Government's Pandemic Response, and Racial Inequities in COVID-19*, 70 EMORY L.J. ___, *7-9 (forthcoming 2021) (examining systemic racism in employment and healthcare that leads to higher infections and deaths from COVID-19 among people of color). See Amanda Fins, *Effects of COVID-19 Show Us Equal Pay is Critical for Mothers*, National Women's Law Center, May 2020, <https://nwlc-ciaw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2020/05/Moms-EPD-2020-v2.pdf> (reporting that although mothers with children under 18 are less than 16 percent of the working population, they constitute a large percentage of essential workers).

¹⁴ 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., COMM. FOR THE STUDY OF THE FUTURE OF PUBLIC HEALTH, THE FUTURE OF PUBLIC HEALTH 40 (1988). The field of public health is more nuanced than this definition suggests, but captures that public health encapsulates 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 the quality of life and targeted individual behaviors to curb unhealthy practices. 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 Lindsay F. Wiley, *Health Law as Social Justice*, 24 CORNELL J.L. & PUB. POL'Y 47 (2014). 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 "conduct 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 (2017).

¹⁵ See *infra* Part II.

¹⁶ 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. 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. 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. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits*, *supra* note 8, at 1692.

¹⁷ See *infra* Part II.A, II.B.

¹⁸ See *infra* Parts I.A, I.B.

¹⁹ See *infra* note 170 (describing court decisions that uphold state and federal bans on funding for abortion and resist that economic inequality is the fault of the state).

²⁰ See *infra* Parts I.B, II.A. The use of the term "patients" is deliberate though an imperfect choice. This Article attempts to avoid, when possible, describing individuals who seek abortion as "women" to acknowledge that people

American College of Obstetricians and Gynecologists v. U.S. Food and Drug Administration (ACOG v. FDA) illustrates the broader purposes health research serves.²¹

In that case, the U.S. District Court for the District of Maryland suspended, for the duration of the COVID-19 pandemic, an FDA policy requiring patients to pick up the first drug in a medication abortion from a health care facility.²² Medication abortion is a two-drug regimen taken over 24 to 48 hours before 10 weeks of pregnancy.²³ An immediate effect of the district court's ruling was to open new avenues for the remote delivery of abortion care. 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.²⁴ The court held that in-person collection of a demonstrably safe drug that patients take at home posed needless contraction risks and logistical hurdles. 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. In short, requiring in-person collection is irresponsible health policy.²⁵

Though the district court relied on extensive evidence and public health expertise, the Supreme Court was not persuaded by the same factual record. In January 2021, the Court stayed the district court's injunction pending appeal. 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."²⁶

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

who become pregnant do not all identify as women. See Jessica A. Clarke, *They, Them, and Theirs*, 132 HARV. L. REV. 894, 954 (2019). The choice to refer to "patients" is also to differentiate individualized burdens from those incurred by groups with common characteristics (populations) and from those affecting the healthcare system generally (the public's health). See *infra* Parts II.B, II.C.

²¹ *Am. Coll. of Obstetricians & Gynecologists v. Food & Drug Admin.*, No. CV TDC-20-1320, 2020 WL 7240396 (D. Md. Dec. 9, 2020).

²² Thirty-nine percent of the nation's abortions are medication abortions. Guttmacher Institute, Medication Abortion, Nov. 2019, <https://www.guttmacher.org/evidence-you-can-use/medication-abortion>.

²³ Kaiser Family Foundation, The Availability and Use of Medication Abortion, June 16, 2021, <https://www.kff.org/womens-health-policy/fact-sheet/the-availability-and-use-of-medication-abortion/>.

²⁴ See *infra* Part I.C.

²⁵ The National Academies of Science, Engineering, and Medicine concluded that abortion restrictions adversely affect the Institute of Medicine's six domains of quality of care: safety (avoiding harm), effectiveness (providing care grounded in science), efficiency (reducing waste), patient-centeredness (incorporating patient preferences), timeliness (avoiding delays), and equity (ensuring quality does not differ by patient characteristics). NATIONAL ACADEMIES OF SCIENCE, ENGINEERING, AND MEDICINE, ABORTION CARE THE SIX ATTRIBUTES OF QUALITY HEALTH CARE (2018), <https://www.nap.edu/resource/24950/03162018AbortionCareinsert.pdf>.

²⁶ *Food & Drug Admin. v. Am. Coll. of Obstetricians & Gynecologists*, 141 S.Ct. 578, 579, 583 (2021).

agency's regulation of the first drug in a medication abortion.²⁷ The FDA grounded this decision in evidence of medication abortion's safety and the efficacy of remote care.²⁸

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.²⁹ Public health evidence invites judges to develop factual records that account for the burdens on patients' health and lives. To be sure, Chief Justice Roberts's doctrinal formulation of what constitutes an undue burden in the recent case, *June Medical Services v. Russo*,³⁰ discounts whether an abortion restriction actually protects patient safety and defers to a state's reasons for passing a law.³¹ Yet even the Chief Justice's formulation of the undue burden test does not entirely abandon an assessment of whether a restriction imposes significant obstacles to services.

As the *ACOG* case illustrates, lower courts have begun to cite evidence demonstrating the relationship between inaccessible abortion and the country's health disparities. But drawing connections between law and health outcomes depends on understanding the many ways that law entrenches inequality. This Article shows that the reasoning in *ACOG* draws on policy work related to the social determinants of health – improving the conditions under which people live, work, and learn – and emphasizes abortion's role in the health ecosystem.³² 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 as soon as next year.³³

²⁷ On March 29, 2021, the FDA requested an extension for filing its brief before the Fourth Circuit to “allow new federal government officials to assess the issues in this case” and “evaluat[e] the scientific and regulatory issues raised in this appeal.” Motion for a 30-Day Extension of the Briefing Schedule and Postponement of Oral Argument, *Am. Coll. of Obstetricians & Gynecologists v. FDA*, No. 20-1784 (4th Cir. filed Mar. 29, 2021). In April 2021, the FDA exercised its enforcement discretion and effectively suspended the in-person dispensation requirement through the pandemic. Letter to Maureen G Phipps, Chief Executive Officer, ACOG and William Grobman, President, Society for Maternal-Fetal Medicine from Janet Woodcock, Acting Commissioner of Food and Drugs, April 12, 2021. In May 2021, the FDA announced its intention to review the safety restrictions on medication abortion discussed in Part II.C. Attorneys for Defendants Xavier Becerra, et al., Joint Motion To Stay Case Pending Agency Review, *Chelius v. Becerra*, CIV. NO. 1:17-00493 (D. Hawaii May 7, 2021).

²⁸ Letter to Maureen G Phipps, Chief Executive Officer, ACOG and William Grobman, President, Society for Maternal-Fetal Medicine from Janet Woodcock, Acting Commissioner of Food and Drugs, April 12, 2021 (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”).

²⁹ 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*, taking up the question of whether all pre-viability prohibitions on elective abortions are unconstitutional. *Dobbs v. Jackson Women's Health Organization*, 945 F.3d 265 (5th Cir. 2020), cert. granted, Docket No. 19-1392 (2021).

³⁰ *June Med. Servs. L.L.C. v. Russo*, 140 S. Ct. 2103, 2113 (2020).

³¹ See *infra* Parts I.B.

³² See WORLD HEALTH ORGANIZATION COMM'N ON THE SOCIAL DETERMINANTS OF HEALTH, A CONCEPTUAL FRAMEWORK FOR ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 9 (2010). The last part of this Article argues, in step with scholarship on the social determinants of health, that gaining access to healthcare services is important, but the larger problem of who funds and supports healthcare remains a central question for reform. See *infra* Part III.B.

³³ See *infra* note 29.

A social-determinants framing invites on-the-ground interventions as well as federal and state policies that open avenues to care.³⁴ *ACOG v. FDA* underscores that people need not depend (and often do not depend) on traditional means of obtaining abortion services. 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. By December 2020, telemedicine for abortion was offered in 21 states. Permitting health care providers to administer care remotely or permitting 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.³⁵ Strengthening the legal and practical infrastructure for teleabortion, as well as 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 abortion 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 lesser extent, self-managed abortion, which depend less on constitutional arguments and more on policy innovation, social movements, and political leadership.

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 v. Casey*.³⁶ Some courts have applied the balancing test in *Whole Woman's Health v. Hellerstedt*,³⁷ which weighs the benefits a law confers against the burdens it imposes on a person's access to abortion.³⁸ Other courts have applied Chief Justice Roberts's concurrence in *June Medical*

³⁴ “[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.” Britton-Purdy et al., *supra* note 9, at 1790.

³⁵ 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, Seema Mohapatra, Lindsay F. Wiley & Ruqaiyah Yearby, *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 present 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.

³⁶ *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833 (1992).

³⁷ *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016).

³⁸ 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. *Planned Parenthood of Wis. 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.”).

Services, which ignores abortion restrictions' benefits and focuses on the "substantial obstacles" erected by law.³⁹

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. This part concludes by analyzing the use of health evidence in *ACOG v. FDA*, in which a district court applied the version undue burden test established in *Whole Woman's Health* but more 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*, the case that established a constitutional right to abortion.⁴⁰ But the Court's scrutiny of abortion restrictions has changed as the test for constitutionality has evolved. In *Planned Parenthood of Se. Pennsylvania 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.⁴¹ 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."⁴²

The Court's decision in *Gonzales v. Carhart* captured the stakes of marshaling evidence to establish a law's burdens.⁴³ In *Carhart*, the Court upheld a federal law, the Partial Birth Abortion Ban Act, that barred physicians from using a particular procedure, intact dilation and extraction. The law made no exception for the procedure's use if indicated for a patient's health.⁴⁴ Relevant to this discussion, the Court deferred to legislative findings about the nature of and patient need

³⁹ See, e.g. *Hopkins v. Jegley*, 968 F. 3d 912 (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 Center v. Friedlander*, 978 F.3d 418 (6th Cir. 2020) (upholding hospital transfer-agreement requirement "[u]nder the Chief Justice's controlling opinion").

⁴⁰ In *Roe v. Wade*, the Supreme Court held that criminal laws banning abortion were an infringement of a constitutional right to privacy. Patients, in consultation with their physicians, could elect to have an abortion for any reason during the first trimester. In the second trimester, a state could "regulate the abortion procedure in ways that are reasonably related to maternal health." 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." 410 U.S. 113, 164-66 (1973). 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. *City of Akron v. Akron Ctr. for Reproductive Health*, 462 U.S. 416, 450-52 (1983).

⁴¹ 505 U.S. 833 (1992). The Court held that the state has an interest in protecting "women's health and in respecting fetal life" throughout a woman's pregnancy. 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. After viability, the state could proscribe abortion except when pregnancy threatened "the life or health of the mother." *Id.* at 846, 877-79.

⁴² *Id.* at 877.

⁴³ 550 U.S. 124 (2007).

⁴⁴ The Court emphasized "documented medical disagreement [about] whether the Act's prohibition would ever impose significant health risks on women." *Id.*

for the procedure, stating that “wide discretion” was warranted in “areas where there is medical and scientific uncertainty.”⁴⁵ *Carhart* signaled the Court’s willingness to defer to legislators even when the legislature offered scant or contradictory evidence of its claims.⁴⁶ And, specifically, the case underscored the heightened stakes of providing evidence on a law’s effects for patient health.⁴⁷

Almost a decade later, the Court scaled back deference to states and clarified the application of the undue burden test.⁴⁸ In 2016, the U.S. Supreme Court struck down Texas’s House Bill 2 (HB2), which required abortion providers to obtain admitting privileges at a hospital within 30 miles of their practice and mandated that abortion clinics must be outfitted as ambulatory surgical centers.⁴⁹ In applying *Casey*’s undue burden standard, the Court assessed and then balanced the purported benefits of the law against the burdens it imposed.⁵⁰ The Court held that HB2 did nothing to protect patient health; instead, by forcing clinics to close, the law threatened patients’ wellbeing.⁵¹

Balancing benefits against burdens allowed the Court to assess “women’s lived experience of exercising the right to abortion.”⁵² In that vein, the Court turned to public health expertise and common sense. Implementation of the law would have shuttered 11 facilities, leaving only 10 facilities to serve 5.4 million people of reproductive age.⁵³ Thousands of residents would have lived 150 or 200 miles away from the nearest abortion provider.⁵⁴ The Court cited evidence that clinic closures would mean “fewer doctors, longer waiting times, and increased crowding.”⁵⁵ The clinics remaining open, the Court held, could not have met the increased demand, resulting in wait

⁴⁵ *Id.* at 163 (“The Court has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty.”).

⁴⁶ 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.” *Carhart*, 550 U.S. at 159.

⁴⁷ ZIEGLER, *supra* note 4, at 169-170 (explaining how research-oriented hubs like ANSIRH, discussed *infra*, formed and built off the work of the Guttmacher Institute in reaction to Justice Kennedy’s opinion in *Gonzales v. Carhart*).

⁴⁸ SANGER, *supra* note 6, at 235-37 (“the 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 Litman, *Dignity and Civility, Reconsidered*, 70 HASTINGS L.J. 1225, 1231-32 (2019); Leah Litman, *Unduly Burdening Women’s Health: How Lower Courts are Undermining Whole Woman’s Health v. Hellerstedt*, MICH. L. REV. ONLINE 50, 57 (2017); 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, 161-62 (2016); Mary Ziegler, *Liberty: Whole Woman’s Health v. Hellerstedt and the Future of Abortion Law*, 2016 SUP. CT. REV. 77 (2016).

⁴⁸ *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2312 (2016).

⁴⁹ Targeted regulations of abortion providers or TRAP laws have been on some states’ books for decades, but different types of TRAP laws have proliferated along with an uptick of abortion regulations in general. For example, from 2011 through 2017, states enacted 401 abortion restrictions. Those 7 years accounted for 34% of the total number of restrictions enacted since *Roe v. Wade* was decided in 1973. Jones et al., *supra* note 16, at 486-87.

⁵⁰ *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 901 (1992).

⁵¹ 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).

⁵² Daniel Grossman, *The Use of Public Health Evidence in Whole Woman’s Health v. Hellerstedt*, J. AM. MED. ASS’N INT’L MED. e1 (2016). See Litman, *Unduly Burdening Women’s Health*, *supra* note 48, at 57.

⁵³ *Whole Woman’s Health v.*, 136 S. Ct. at 2312.

⁵⁴ After 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 . . . and the number of women living in a county more than 200 miles from a provider from approximately 10,000 to 290,000.” *Id.*

⁵⁵ *Id.* at 2313.

times for appointments, diminished quality of care, and increased need for second-trimester abortions.⁵⁶ “[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.⁵⁷

The Court relied on “direct testimony as well as plausible inferences to be drawn from the timing of the clinic closures.”⁵⁸ 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 HB2 would strain access.⁵⁹ Dr. Daniel Grossman is a professor and OB/GYN who has been a contributor to the public health research described in Part II.⁶⁰ The Court explained: “Dr. Grossman’s opinion rested upon his participation, along with other university researchers, in research that tracked ‘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.’”⁶¹

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.”⁶² 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.⁶³

⁵⁶ Caitlin Gerdt 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 (2016).

⁵⁷ *Whole Woman’s Health*, 136 S. Ct. at 2313.

⁵⁸ *Id.* at 2313.

⁵⁹ *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 or that HB2 caused various clinics to close. *Id.* at 2347-48, n. 21.

⁶⁰ University of California, San Francisco, Zuckerberg San Francisco General Obstetrics and Gynecology, About our Faculty, <https://obgyn.ucsf.edu/san-francisco-general-hospital/daniel-grossman-md>.

⁶¹ *Whole Woman’s Health*, 136 S. Ct. at 2316-17.

⁶² *Id.* at 2317.

⁶³ *Id.* at 2317-18.

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.”⁶⁴

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 to take full effect, and what distances people would have to travel to reach an open facility.⁶⁵ The invocation of common sense suggests that laws’ effects on health services are the subject of speculative intuition instead of measurable evidence.⁶⁶ In a subsequent Supreme Court decision, *June Medical Services*, both the plurality opinion and concurrence rely less on “common sense” and refer instead to evidence of the consequences of clinic closures.

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). The district court held that Act 620 “serve[d] no purpose other than to make abortions more difficult.”⁶⁷ Only one physician would have remained in practice, leaving 70 percent of Louisiana women without accessible abortion services.⁶⁸

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. Similar to the findings in *Whole Woman’s Health*, clinic closures would lead to longer driving and waiting times at the sole remaining facility. The district court concluded that many Louisiana patients would “face irreparable harms from the burdens associated with increased travel distances[, and these] burdens include the risks from delays in treatment including the increased risk of self-performed, unlicensed and unsafe abortions.”⁶⁹

⁶⁴ *Id.* at 2302.

⁶⁵ See *infra* Part II.A (describing the research studies cited in *Whole Woman’s Health*).

⁶⁶ Note the contestation by the state that the evidence offered by petitioners was accurate; Louisiana, for example, in *June Medical Services*, 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).

⁶⁷ *June Med. Servs. LLC v. Kliebert*, 250 F. Supp. 3d 27, 83 (M.D. La. 2017). Cary Franklin notes the immediate impact of *Whole Woman’s Health* on the district court’s injunction of Act 620: “the 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 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. 1, 80 (2019).

⁶⁸ *June Med. Servs.*, 140 S. Ct. at 2103. 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% of people seeking an abortion. 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. A fifth physician, Doe 3, testified that he would retire if the Act took effect due to fears for his safety. Louisiana would be left with only one provider and one clinic that could provide abortions. *Id.*

⁶⁹ *June Med. Servs. L.L.C. v. Kliebert*, 250 F. Supp. 3d 27, 83 (M.D. La. 2017).

The U.S. Court of Appeals for the Fifth Circuit reversed, holding that 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.”⁷⁰ The Fifth Circuit also disputed 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.”⁷¹

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. Justice Kavanaugh had replaced Justice Kennedy, who was one of five votes striking down HB2 in *Whole Woman’s Health*. 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. Rather than deferring to the 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.⁷²

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.⁷³ Moreover, the state’s requirement of an ultrasound and counseling session 24 hours before an abortion meant that many patients either would have to make two trips or pay for overnight accommodation.⁷⁴ Limiting the availability of services and increasing the distance between providers would result in “longer wait times for appointments [and] increased crowding.”⁷⁵ Justice Breyer concluded, in agreement with “experts and laypersons,” “that the burdens of this increased travel would fall disproportionately on poor women, who are least able to absorb them.”⁷⁶ Notably, Justice Breyer’s opinion de-emphasized the “common sense” of the supply and demand that was prominent in *Whole Woman’s Health*.

⁷⁰ *June Med. Servs. L.L.C. v. Gee*, 905 F.3d 787, 807 (5th Cir. 2018) (citing *Whole Woman’s Health v. Cole*, 790 F.3d 563, 588-589 (5th Cir. 2015)). In *Casey*, the state sought to preserve a spousal notification requirement by arguing that only 1% of patients would be affected because only 20% were married and 95% notify spouses in any case. 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.” A law “must be judged by reference to those for whom it is an actual rather than an irrelevant restriction.” *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 894 (1992). Since *Casey*, courts have applied the “large fraction” language in divergent ways. Siegel, *supra* note 6, at 1707-32; Greenhouse & Siegel, *supra* note 48, at 1150.

⁷¹ *June Med. Servs., L.L.C. v. Gee*, 905 F.3d 787, 807 (5th Cir. 2018). “There 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[...], the vast majority largely sat on their hands, assuming that they would not qualify. Their inaction *severs the chain of causation*.” *Id.* (emphasis added).

⁷² Justices Clarence Thomas, Samuel Alito, Neil Gorsuch, and Brett Kavanaugh dissented. *June Med. Servs. L.L.C. v. Russo*, 140 S. Ct. 2103 (2020).

⁷³ Louisiana also asked the Court to decide whether abortion providers had third-party standing to bring constitutional challenges. The Court recognized standing for abortion providers in *Singleton v. Wulff*, 428 U.S. 106 (1976), and applied that case, citing *stare decisis*. *Id.* at 2118-2120. Dissenting justices mounted attacks on *Singleton v. Wulff* as unsettled and unconvincing precedent. *Id.* at 2147 (Thomas, J., dissenting); *id.* at 2170 (Alito, J., dissenting).

⁷⁴ *Id.* at 2130.

⁷⁵ *Id.* at 2130-31.

⁷⁶ *Id.* Although *June Medical Services* made no mention of race, as noted below, people of color comprise two thirds of abortion patients in Louisiana. The pervasiveness of gender inequality passed unmentioned. See *infra* Part II.C.

Because the Court had struck down an almost identical law in *Whole Woman's Health*, Chief Justice Roberts's concurrence emphasized respect for stare decisis.⁷⁷ He wrote separately to dispute Justice Breyer's application of the undue burden test. 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.⁷⁸ Chief Justice Roberts's approach would abandon a balancing test of the law's benefits (protecting patient safety, for example) against the burdens imposed.⁷⁹

Although the Chief Justice was the fifth vote in striking down the Louisiana law, his concurrence neither shields constitutional abortion rights from future attacks, nor signals a willingness to strike down other abortion restrictions under different facts. Yet the Roberts's concurrence accepted the district court's depiction of what the landscape of abortion care would look like if the law had taken effect. 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. Just 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."⁸⁰

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*.⁸¹ But, even if reiterating the burdens erected by the Louisiana law served only to bolster his application of stare decisis, the Chief Justice could have written about precedent without repeating evidence about the nature of the obstacles imposed. This is not to argue

⁷⁷ For *June Medical Services's* treatment of stare decisis, see Melissa Murray, *The Symbiosis of Abortion and Precedent*, 134 HARV. L. REV. 308, 322-27 (2020).

⁷⁸ "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." *June Med. Servs.*, 140 S. Ct. at 2136 (Roberts, C.J., concurring).

⁷⁹ "In this context, courts applying a balancing test would be asked in essence to weigh the State's interests in 'protecting the potentiality of human life' and the health of the woman, on the one hand, 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' on the other. There is no plausible sense in which anyone, let alone this Court, could objectively assign weight to such imponderable values and no meaningful way to compare them if there were." *Id.* at 2136.

⁸⁰ *Id.* at 2140.

⁸¹ See Murray, *Symbiosis*, *supra* note 77, at 325-36. See *June Med. Servs.*, 140 S. Ct. at 2153 (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).

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.⁸²

Given the current composition of the Court, the Supreme Court may be unlikely to apply a balancing approach moving forward.⁸³ Indeed, the question the Court will decide in 2022 is whether all pre-viability bans are unconstitutional.⁸⁴ 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. Courts cannot know such facts without research to support them. The point here, however, is not to celebrate the generation of evidence.⁸⁵ As Aziza Ahmed has shown, evidence-based strategies are susceptible to manipulation by either end of the ideological spectrum.⁸⁶ The point is to highlight the reach of public health research on the unequal distribution of health resources, as *ACOG v. FDA* illustrates next.

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. 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.

The case concerns the FDA's restrictions on mifepristone, which is the first drug ingested in a medication abortion.⁸⁷ The second drug, misoprostol, is taken 24 to 48 hours after mifepristone and it is not subject to the same restrictions.⁸⁸ The FDA applies a drug safety program – a Risk Evaluation and Mitigation Strategy or REMS – to mifepristone.⁸⁹ The FDA issues a REMS for

⁸² See Reva Siegel, *Why Restrict Abortion? Expanding the Frame on June Medical*, 20 SUP. CT. REV. __, *5 (forthcoming 2021) (“Justices who denounce balancing as legislative rather than judicial are directing judges to defer to state claims about health, and so add 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.”)

⁸³ Justice Kavanaugh wrote in dissent, “Today, five Members of the Court reject the *Whole Woman's Health* cost-benefit standard.” *June Med. Servs.*, 140 S. Ct. at 2182 (Kavanaugh, J., dissenting).

⁸⁴ See *Dobbs v. Jackson Women's Health Organization*, 945 F.3d 265 (5th Cir. 2020), *cert. granted*, Docket No. 19-1392 (2021).

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

⁸⁶ *Id.*

⁸⁷ *Am. Coll. of Obstetricians & Gynecologists v. United States Food & Drug Admin.*, No. CV TDC-20-1320, 2020 WL 7240396 at 6 (D. Md. Dec. 9, 2020). Almost all medication abortions are completed through a mifepristone-misoprostol regimen. Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States*, 2014, 49 PERSP. SEXUAL & REPRO. HEALTH 1, 6 (2017).

⁸⁸ “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).” Misoprostol, taken 24-48 hours after mifepristone, empties the uterus by causing cramping. Questions and Answers on Mifeprex, U.S. Food & Drug Administration, Apr. 12, 2019, <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifeprex>.

⁸⁹ Risk Evaluation and Mitigation Strategies, U.S. Food & Drug Admin., NDA 20-687 Mifeprex, *available at* https://www.accessdata.fda.gov/drugsatfda_docs/remis/Mifeprex_2011-06-08_Full.pdf.

drugs it deems potentially risky and in need of monitoring.⁹⁰ In addition to 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 drug and under what conditions.⁹¹ Modified in 2016, FDA's mifepristone REMS includes an ETASU with several requirements; relevant here is the requirement that patients collect mifepristone at a healthcare facility – a hospital, clinic, or medical office.⁹² The effect of the FDA's in-person restriction has been to prohibit retail pharmacies and mail order prescription services from distributing mifepristone, though some commentators dispute whether such a prohibition is actually required by the ETASU's language.⁹³ The ETASU does not mandate that the provider be physically present when the drug regimen is collected or taken by the patient. Thus, mifepristone and misoprostol can be self-administered outside of a healthcare setting.⁹⁴

The American College of Obstetricians and Gynecologists, the leading professional organization in the field, brought suit with four other parties to enjoin the in-person ETASU during the pandemic.⁹⁵ ACOG argued that applying the in-person requirement contradicts substantial evidence of the drug's safety and is ineffectual in protecting patients.⁹⁶ Indeed, the FDA's management of mifepristone stands out among other drugs. Of the 20,000 drugs regulated by the FDA, and the 17 with the same ETASU, mifepristone is the only one that patients must retrieve at a medical center but may take without physician supervision. In fact, the FDA permits mailing to patients' homes the exact same drug compound as mifepristone, in higher doses and larger

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² In 2016, the FDA approved use of mifepristone from 49 days to 70 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. 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.” Questions and Answers on Mifeprex, U.S. Food & Drug Administration, Apr. 2019, <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifeprex>. Patients must receive a Medication Guide and sign a Patient Agreement Form; providers agree to report any adverse events. The Patient Agreement Form outlines the drug's risks and benefits, and the emphasizes the need to follow-up with a provider seven to fourteen days after completing the drug regimen. GOVERNMENT ACCOUNTABILITY OFFICE, FOOD AND DRUG ADMINISTRATION: INFORMATION OF MIFEPREX LABELING CHANGES AND ONGOING MONITORING EFFORTS 7-8 (2018).

⁹³ See *infra* Part III.B (noting that the non-profit organization, Plan C, disputes that in-person collection is required by the language of the FDA's REMS). Manian, *supra* note 7, at 1331-33 (describing longstanding efforts to target medication abortion).

⁹⁴ Questions and Answers on Mifeprex, U.S. Food & Drug Administration, Apr. 12, 2019, <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifeprex>. Misoprostol may be mailed to patients, but because a medication abortion regimen includes both drugs, and both are delivered together. Manian, *supra* note 7, at 1331.

⁹⁵ 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. SisterSong is a non-profit organization that has been the leader and a founder of the reproductive justice movement. JENNIFER NELSON, MORE THAN MEDICINE: A HISTORY OF THE FEMINIST WOMEN'S HEALTH MOVEMENT 167-92 (2015).

⁹⁶ Brief of Plaintiffs American College of Obstetricians and Gynecologists et al., No. CV TDC-20-1320, 2020 WL 2771735 at 4-10 (2020). Mifepristone and misoprostol are over 96% effective in completing a termination and only .1% of serious adverse events. NATIONAL ACADEMIES OF SCIENCE, ENGINEERING, AND MEDICINE, THE SAFETY AND QUALITY OF ABORTION CARE IN THE UNITED STATES (2018).

quantities, for treatment of other conditions but not for abortion or miscarriage.⁹⁷ 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. Any complication, which is very rare, would occur where the patient ingests the medicine, which is typically the patient's home.⁹⁸

ACOG further highlighted that the in-person requirement for mifepristone contradicts the FDA's (and other federal agencies') encouragement of telemedicine to reduce patient-provider contact during the pandemic.⁹⁹ Along with the Centers for Disease Control and Prevention (CDC), the FDA has urged providers to reduce patient contact as much as possible.¹⁰⁰ To this end, the FDA suspended REMS requirements for other drugs that pose far greater patient safety risks, such as certain opioids.¹⁰¹

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 transportation.¹⁰² 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.¹⁰³

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 COVID-19 national emergency.¹⁰⁴ 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. And any possible benefit was outweighed by the burdens that the ETASU imposed, such as increased risk of exposure to COVID-19.¹⁰⁵

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

⁹⁷ ACOG, No. CV TDC-20-1320 at 5 (offering the example of endogenous Cushing's syndrome, a condition that the same drug compound as mifepristone treats).

⁹⁸ 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 .01 to .7% required hospitalization. GOVERNMENT ACCOUNTABILITY OFFICE, FOOD AND DRUG ADMINISTRATION: INFORMATION OF MIFEPREX LABELING CHANGES AND ONGOING MONITORING EFFORTS 7-8 (2018), <https://www.gao.gov/assets/700/690914.pdf>.

⁹⁹ 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." ACOG, No. CV TDC-20-1320 at 10-11 (also citing guidance from HHS and CDC).

¹⁰⁰ FDA, Policy for Certain REMS Requirements During the COVID-19 Public Health Emergency: Guidance for Industry and Health Care Professionals 7 (Mar. 2020); Dept. of Health & Human Servs., Secretary Azar Announces Historic Expansion of Telehealth Access To Combat COVID-19 (Mar. 17, 2020).

¹⁰¹ *Id.* at 29-30.

¹⁰² ACOG Brief, *supra* note 96, at 4, 33-37.

¹⁰³ *Id.*

¹⁰⁴ ACOG, No. CV TDC-20-132 at 19

¹⁰⁵ ACOG, No. CV TDC-20-1320 at 25.

(but not retail) pharmacies.¹⁰⁶ Well before the July decision, an on-going national study of “TelAbortion” demonstrated the effectiveness and safety of remote care.¹⁰⁷ In 2016, Gynuity Health Projects received an Investigational New Drug Approval to deliver medication abortion without the in-person collection requirement.¹⁰⁸ Providers counseled patients through videoconferencing, and patients confirmed gestational age with blood tests and ultrasounds at a location of their choosing.¹⁰⁹ 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.¹¹⁰ 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. Other REMS requirements, such as receiving the Medication Guide or signing the Patient Agreement form, also occurred virtually.¹¹¹

Based, in part, on studies demonstrating the safety and efficacy of remote abortion care,¹¹² the district court 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.¹¹³

¹⁰⁶ The Gynuity project is not the first study of teleabortion: “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.” Elizabeth Raymond et al., *Telabortion: Evaluation of a Direct to Patient Telemedicine Abortion Service in the United States*, 100 *CONTRACEPTION* 173, 174 (2019).

¹⁰⁷ Daniel Grossman & Kate Grindlay, *Safety of Medical Abortion Through Telemedicine Compared with In Person*, 130 *OBSTETRICS & GYNECOLOGY* 1 (2017).

¹⁰⁸ The Gynuity project started with 5 states and now includes 15 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 106, at 174.

¹⁰⁹ 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. Raymond et al., *supra* note 106, at 174.

¹¹⁰ Hillary Bracken, *Alternatives to Routine Ultrasound for Eligibility Assessment Prior to Early Termination of Pregnancy with Mifepristone-misoprostol*, 118 *BJOG* 17-23 (2011). Research assessing no-touch protocols demonstrates 98% accuracy in identifying patients within the eligible gestational limit for medication abortion. Ushma D. Upadhyay & Daniel Grossman, *Telemedicine for Medication Abortion*, 100 *CONTRACEPTION* 351 (2019).

¹¹¹ 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. Order Clarifying July 13 Memorandum Opinion, *Am. Coll. of Obstetricians & Gynecologists v. U.S. Food & Drug Admin.*, No. TDC-20-1320, 2020 WL 8167535 (D. Md. Aug. 19, 2020).

¹¹² In a study of the first 32 months of Gynuity program, two participants 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 106, at 176. Participants were either satisfied (20%) or very satisfied (80%) with their experience. *Id.*

¹¹³ 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.” *ACOG*, No. CV TDC-20-1320 at 63 (citing *Whole Woman’s Health* for the “holding that courts may draw ‘commonsense inferences’ from the evidence in assessing whether an undue burden exists”).

The district court rejected Chief Justice Roberts's version of the undue burden test in *June Medical Services*. 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."¹¹⁴ Because five Supreme Court justices agreed 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."¹¹⁵

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."¹¹⁶ 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. 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.¹¹⁷ 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. They are also less likely to have access to medical care, which put a significant number of abortion patients at higher risk of illness and death if infected with COVID-19.¹¹⁸

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 these hardships disproportionately.¹¹⁹ 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. 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."¹²⁰

¹¹⁴ 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. Under the Eighth Circuit's reasoning, the narrowest ground for *June Medical Services* is the test offered by Chief Justice Roberts, and courts therefore should consider only burdens, not benefits, imposed by abortion restrictions. *Hopkins v. Jegley*, 968 F.3d 912, 916 (8th Cir. 2020).

¹¹⁵ *ACOG*, No. CV TDC-20-1320 at 37. On appeal, the FDA has asked the U.S. Court of Appeals for the Fourth Circuit to apply Chief Justice Roberts's concurrence in *June Medical Services*.

¹¹⁶ *Id.*

¹¹⁷ *Id.* at 40.

¹¹⁸ *Id.* at 46.

¹¹⁹ *Id.*

¹²⁰ *Id.*

The district court's suspension lasted six months. The FDA appealed the case to the Fourth Circuit, and asked the Supreme Court to stay the injunction. 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. The district declined to lift its order, prompting a second petition for a stay, which the Court granted on January 12, 2021.

Although FDA has taken a different course under the Biden Administration, the arguments defending the ETASU, particularly in the first stay petitions, elucidate opposing approaches health evidence. Briefs filed in October 2020 by 10 states and the solicitor general (on behalf of the FDA) contested that in-person dispensation imposes any heightened risks for patients.¹²¹ For example, the brief submitted by 10 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.¹²²

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.¹²³ The solicitor general, in the same vein, argued that mask mandates, increased testing, and better treatment have “mitigated or resolved” any burdens on travel, finances, or childcare.¹²⁴

In other words, medication abortion presents a health and safety risk, but 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.”¹²⁵ ACOG further showed that in the intervening months since the district court's ruling, the FDA had not produced any evidence that the injunction had caused harm to any patient.¹²⁶

At the heart of the case was a battle between deference to policymakers versus public health evidence – evidence that undermines granting deference to government actors. While defending the lawsuit, the FDA's response was to repeat 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.”¹²⁷ By contrast, ACOG endeavored to prove that delaying and denying abortion exacerbates health inequalities and contributes to a

¹²¹ On June 8, 2020, the States of Indiana, Louisiana, Alabama, Arkansas, Idaho, Kentucky, Mississippi, Missouri, Nebraska, and Oklahoma (collectively, “the States”) moved to intervene. States Brief to Fourth Circuit Nos. 20-1784, 20-1824, 20-1970 (8:20-cv-01320-TDC). The district court denied the States' motion to intervene on June 15, 2020. The States then filed a motion to reconsider, which the district court denied on July 13, 2020. *ACOG*, No. CV TDC-20-132 at 19.

¹²² *Id.* FDA Brief to Fourth Circuit Nos. 20-1784, 20-1824, 20-1970 (8:20-cv-01320-TDC).

¹²³ States Brief to Fourth Circuit Nos. 20-1784, 20-1824, 20-1970 (8:20-cv-01320-TDC).

¹²⁴ FDA Brief to Fourth Circuit Nos. 20-1784, 20-1824, 20-1970 (8:20-cv-01320-TDC).

¹²⁵ Plaintiffs' Brief in Opposition to Defendants' Renewed Motion to Stay the Preliminary Injunction, at 1, No. 20-1320-Tdc (Nov. 13, 2020).

¹²⁶ *Id.*

¹²⁷ *South Bay United Pentecostal Church v. Newsom*, 140 S. Ct. 1613, 1614 (2020) (Roberts, C.J., concurring).

health-care crisis now and beyond the pandemic. When people do not have access to local abortion services, they will travel far distances, self-induce terminations, or carry unwanted pregnancies to term. Each of those options can have short-term and long-term costs, and public health research has offered the proof.

Similar arguments between deference and evidence were made by the parties in December 2020, when the FDA again asked for the Supreme Court to stay the injunction. 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 law requires in-person collection of medication abortion and had seen increases in abortion rates from 2019 to 2020. 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.¹²⁸ 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. ACOG, on the other hand, relied on evidence from four leading public health experts and epidemiologists.¹²⁹

Seeming to ignore this imbalance in evidence, the Supreme Court issued the stay without explanation. 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.’”¹³⁰ In a powerful dissent that affirms 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.¹³¹

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

¹²⁸ The abortion rates took account of all abortions, not just medical abortions, and did not compare rates in states in which restrictions had been suspended. For another, 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. As Justice Sotomayor stated in her dissent to the Court’s stay, “Reading the Government’s statistically insignificant, cherry-picked data is no more informative than reading tea leaves.” Food & Drug Admin., 141 S.Ct. at 584.

¹²⁹ 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 harmed by COVID-19. *Id.* See also Catherine Powell, *The Color of COVID and Gender of COVID*, 32 YALE J.L. & FEM. ____ (forthcoming 2021).

¹³⁰ Food & Drug Admin v. Am. Coll. of Obstetricians & Gynecologists, 141 S.Ct. 578, 579 (2021) (Roberts, C.J.) (citing *South Bay United Pentecostal Church v. Newsom*, 140 S.Ct. 1613, 590 U.S. ____ (2020)).

¹³¹ Food & Drug Admin, 141 S.Ct. at 584-85. Justice Sotomayor also concluded: “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.” *Id.* at 584.

on the subject.¹³² The lack of clarity as to when deference is invited those bringing constitutional challenges to continue to amass evidence of the burdens restrictions impose.¹³³ In this vein, the Court's invocation of deference during the pandemic may do the same work that factual "uncertainty" did after *Gonzales*.¹³⁴

The FDA's review will turn on the public health research that helped ACOG make its case. The next part illustrates the work of research centers that, in the context of abortion law, have generated studies on the effects of abortion restrictions. As the last section argues, the value of research on reproductive health is not just the possibility of producing evidence that convinces courts; indeed, the Court's stay in *ACOG* suggests 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.¹³⁵ 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.¹³⁶ An impetus for this shift is the substantial investment in rigorous research on the regulation of abortion facilities and providers.¹³⁷ This

¹³² Compare *South Bay United Pentecostal Church v. Newsom*, 140 S.Ct. 1613, 590 U.S. ___ (2020) and *Roman Catholic Diocese of Brooklyn v. Cuomo*, 141 S.Ct. 63 (2020).

¹³³ Leah Litman, *The Supreme Court Won't Explain Why it Just Greenlit New Abortion Restrictions*, SLATE, Jan. 14, 2021, <https://slate.com/news-and-politics/2021/01/the-supreme-court-abortion-pill-order.html> (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").

¹³⁴ See *infra* Part III.A (noting two courts' deference to legislatures suspending abortion care during the pandemic by relying on *Jacobson v. Massachusetts*). See also Lindsay F. Wiley & Stephen Vladeck, *Coronavirus, Civil Liberties, and the Courts: The Case Against "Suspending" Judicial Review*, 133 HARV. L. REV. F. 179, 190 (2020) (arguing that *Jacobson v. Massachusetts* encourages judicial review by suggesting a balancing test for emergency health measures); Wendy Parmet, *Rediscovering Jacobson in the Era of COVID-19*, 100 BU L. REV. ONLINE 117, 130 (2020) (disputing that *Jacobson v. Massachusetts* is the apt framework for legislative deference).

¹³⁵ 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. Those efforts have been dwarfed by the research activism of abortion supporters, in part because of better funding but also because of stronger alliances with respected academics and reliance on credible research methods. ZIEGLER, *supra* note 4, at 199 ("Since 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.").

¹³⁶ The Guttmacher Institute, which was founded originally as the Center for Family Planning Program and Development in 1968, has been generating research on the effects of abortion restrictions on individual and population health for decades. 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, public policy analysts. Guttmacher Institute, *The History of the Guttmacher Institute*, <https://www.guttmacher.org/about/history>.

¹³⁷ The investment in research hubs is a product of concentrated, coordinated funding by one of the largest private foundations in the country. Nina Martin, *How One Abortion Research Megadonor Forced the Supreme Court's Hand*, MOTHER JONES, July 14, 2016, <https://www.motherjones.com/politics/2016/07/abortion-research-buffett/>; Kelsey Piper *How Billionaire Philanthropy Provides Reproductive Health Care When Politicians Won't*, Vox, Sep 17, 2019, <https://www.vox.com/future-perfect/2019/9/17/20754970/billionaire-philanthropy-reproductive-health->

investment has yielded an increasing number of experts and organizations that study the health and social consequences of abortion restrictions.¹³⁸ Research teams at the University of 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.¹³⁹ 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, in the aftermath of *Gonzales v. Carhart*, conferred credibility and certainty.¹⁴⁰

A recurring challenge, however, has been to convince courts that abortion restrictions correlate with individual and community health outcomes.¹⁴¹ 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."¹⁴² 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 of abortion.¹⁴³ 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.

The sections 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 importance. The purpose is to spotlight the work research has done to advance nuanced understandings of abortion laws' health effects, and

care-politics. See also Guttmacher Institute, Annual Report 2019, https://www.guttmacher.org/sites/default/files/page_files/guttmacher_2019_annual_report.pdf (showing that 65% of the organization's funding is from private U.S. foundations; listing "anonymous" and the Gates Foundation as foundation-based donors).

¹³⁸ ANSIRH was founded in 2002 but began to expand operations between 2009 and 2012. ANSIRH, University of California, San Francisco, About Us, <https://www.ansirh.org/about/history>. TxPEP "began in the fall of 2011 with the purpose of documenting and evaluating the impact of reproductive health legislation passed by the 82nd Texas Legislature." The University of Texas at Austin, Texas Policy Evaluation Project, About TxPEP, <https://liberalarts.utexas.edu/txpep/about.php>. ZIEGLER, *supra* note 4, 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.").

¹³⁹ See, e.g. Grossman, *supra* note 52, at e1. The research teams based at universities include demographers, social epidemiologists, social scientists or public health academics.

¹⁴⁰ Martin, *supra* note 137, at 1 (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*). See 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.").

¹⁴¹ Hill, *supra* note 140, at 1111-12.

¹⁴² *Id.* See ZIEGLER, *supra* note 4, at 442 (arguing that anti-abortion legislators contend that "the burden created by a law resulted not from the statute itself but rather from economic and political circumstances over which the government had no control").

¹⁴³ Mary Ziegler, *The Jurisprudence of Uncertainty*, 2018 WISC. L. REV. 317, 355, 357 (noting that *Whole Woman's Health* turned on a question about the Texas statute's causal effects).

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” refer 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 the shared political project among 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 the state’s proffered reasons for regulating.¹⁴⁴ 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.”¹⁴⁵ Before HB2 was implemented in the fall of 2013, TxPEP researchers contacted the 41 abortion providers open in Texas at the end of 2012 (including those that subsequently closed) and obtained information on the services provided through April 2014.¹⁴⁶ Comparing the first 6 months of enforcement with the previous year, studies documented a 13% reduction in abortions.¹⁴⁷ There was also a statistically significant increase in the number of abortions performed after 12 weeks of gestation.¹⁴⁸

In addition, TxPEP studied the barriers to services after clinics closed and left remaining providers concentrated in the state’s larger cities. When HB2 took effect, “the number of women of reproductive age that lived over 100 miles from the nearest provider increased from 400,000 to

¹⁴⁴ *Id.*

¹⁴⁵ TEXAS POLICY EVALUATION PROJECT, ASSESSING THE IMPACT OF REPRODUCTIVE HEALTH LEGISLATION, <https://liberalarts.utexas.edu/txpep/>. 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 expertise on work on the decision in *Whole Woman’s Health*. ANSIRH, Texas Policy Evaluation Project, <https://www.ansirh.org/research/ongoing/texas-policy-evaluation-project-txpep> (“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.”).

¹⁴⁶ 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 (2016).

¹⁴⁷ Daniel Grossman et al., *Change in Abortion Services after Implementation of a Restrictive Law in Texas*, 90 CONTRACEPTION 496 (2014).

¹⁴⁸ Caitlin Gerds, Liza Fuentes, & Daniel Grossman, *Impact of Clinic Closures on Women Obtaining Abortion Services after Implementation of a Restrictive Law in Texas*, 106 AM. J. PUB. HEALTH 857 (2016).

1,000,000.”¹⁴⁹ Wait times for appointments increased: in the Dallas metropolitan area, the wait time increased from 5 days to 21 days or longer.¹⁵⁰

TxPEP researchers conducted extensive interviews with abortion patients about clinic closures’ impact on costs and travel.¹⁵¹ The data collected showed that “women whose nearest clinic had closed traveled 4 times farther to obtain an abortion – 85 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%).”¹⁵²

Numerous factors dictate clinic capacity and patients’ ability to receive abortion services. Michelle McGowan and her co-investigators describe how the accessibility of services is determined partly by physician training and availability, clinics’ financial sustainability, or staffing and ownership arrangements, all of which can appear relatively distinct from legal restrictions.¹⁵³ 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.¹⁵⁴

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.¹⁵⁵ Hill writes, “The legal rule, which does not appear to be aimed at advancing moral aims

¹⁴⁹ *Id.* Additional studies examine 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, Caitlin Myers, Andrea Schlosser, & Scott Cunningham, *How Far Is Too Far? New Evidence on Abortion Clinic Closures, Access, and Abortions*, NAT’L BUREAU OF ECON. RES. Aug. 2018, available at <http://www.nber.org/papers/w23366>. See also Jonathan M. Bearak, Kristen Lagasse Burke & Rachel K. Jones, *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).

¹⁵⁰ Gerdtz, Fuentes, & Grossman, *supra* note 148, at 857.

¹⁵¹ *Id.*

¹⁵² *Id.* See also Grossman, *supra* note 52, at e1.

¹⁵³ Michelle L. McGowan, Alison H. Norris & Danielle Bessett, *Care Churn – Why Keeping Clinic Doors Open Isn’t Enough to Ensure Access to Abortion*, 383 NEW ENG. J. MED. 508, 509 (2020).

¹⁵⁴ Elizabeth Witwer, *Abortion Service Delivery in Clinics by State Policy Climate in 2017*, 2 CONTRACEPTION 1, 4 (2020).

¹⁵⁵ Hill, *supra* note 140, at 1111.

(such as reducing abortions), relies upon realities on the ground to achieve precisely those goals.”¹⁵⁶

To capture the “realities on the ground” of restrictive legal environments, another vein of abortion research interrogates the disproportionate impact of law on specific populations.¹⁵⁷ 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. 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. 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 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.¹⁵⁸

The N-HELP brief draws from multiple studies documenting common characteristics of people seeking abortion, both nationally and in Louisiana. As noted above, almost half of the nation’s abortion patients live below the federal poverty level,¹⁵⁹ and the depth of patients’ economic insecurity is particularly salient in Louisiana. Louisiana ranks as the third poorest state in the

¹⁵⁶ *Id.* It is beyond the scope of this Article to engage with the rich literature on state action and state neutrality generally. In abortion context, refuting state action is a “cause” of poverty has been the justification for upholding state funding bans. See *infra* note 160.

¹⁵⁷ For the role of “population” and the population perspective in public health, see WENDY PARMET, POPULATIONS, PUBLIC HEALTH, AND THE LAW 3 (2009) (“by 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”); Lindsay F. Wiley, *The Struggle for the Soul of Public Health*, 41 J. HEALTH, POL’Y & L. 1147, 1148 (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.”).

¹⁵⁸ Brief of Amici Curiae National Health Law Program and National Network of Abortion Funds Supporting Petitioners-Cross-Respondents at 4-10, *June Med. Servs. v. Russo*, 591 U.S. __ (2020) (No. 18-1323).

¹⁵⁹ JERMAN ET AL., *supra* note 8, at 5. Additional studies draw a correlation between income and unintended pregnancy. Lawrence B. Finer & Mia R. Zolna, *Unintended Pregnancy in the United States: Incidence and Disparities*, 2006, 84 CONTRACEPTION 478, 483 (2011). Moreover, the reasons for terminating a pregnancy are overwhelmingly related to existing financial stressors and the costs of parenting existing children. Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 PERS. SEXUAL & REPRO. HEALTH 110 (2005); see also M. Antonia Biggs et al., *Understanding Why Women Seek Abortions in the U.S.*, 13 BMC WOMEN’S HEALTH 29 (2013).

United States, with one in five residents living in poverty.¹⁶⁰ 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.¹⁶¹

National surveys speak to the relationship between race and income.¹⁶² 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.¹⁶³ As the N-HELP brief described, in Louisiana, 32.9 percent of Black residents live below the federal poverty line in comparison to 12.5 percent of white Louisianans.¹⁶⁴ *June Medical Services*, 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.¹⁶⁵ Like TxPEP, studies generated by a team of researchers attempt to demonstrate that point.

The work of social scientists and legal epidemiologists at Advancing New Standards in Reproductive Health (ANSIRH), based at the UCSF Gynecology & Reproductive Sciences, provides an example. ANSIRH collected the first longitudinal data on individuals who sought but could not obtain an abortion.¹⁶⁶ ANSIRH, working with 30 abortion facilities around the country, recruited over 1,000 participants, and conducted over 8,000 telephone interviews over five years. Participants fell into three study groups. The “turnaway” group were people who sought, but did not receive, an abortion because their pregnancies exceeded the facility’s gestational age limit.

¹⁶⁰ See LA. BUDGET PROJECT, LOUISIANA’S POVERTY AND CHILD POVERTY RATES REMAIN HIGH, Sept. 18, 2014, <https://www.labudget.org/2014/09/louisianas-poverty-and-child-poverty-rates-remain-high/>.

¹⁶¹ “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 woman’s physical health.” Guttmacher Institute, *State Funding of Abortion Under Medicaid*, Feb. 1, 2021, <https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicaid>. “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.” Guttmacher Institute, *Regulating Insurance Coverage of Abortion*, Feb. 1, 2021, <https://www.guttmacher.org/state-policy/explore/regulating-insurance-coverage-abortion>. 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. Sandhya Raman, *Hyde Amendment Fight Just the First Step in Changing Abortion Coverage*, ROLL CALL, July 21, 2021, <https://www.rollcall.com/2021/07/21/hyde-amendment-fight-just-the-first-step-in-changing-abortion-coverage/>.

¹⁶² JERMAN ET AL., *supra* note 8, 6.

¹⁶³ U.S. CENSUS BUREAU, POVERTY STATUS IN THE LAST 12 MONTHS, <https://data.census.gov/cedsci/>.

¹⁶⁴ WELFARE INFO, LOUISIANA POVERTY RATE BY RACE (2017), *available at* <https://welfareinfo.org/poverty-rate/louisiana/#by-race>.

¹⁶⁵ *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2302 (2016) (noting disproportionate impact on poor and rural patients).

¹⁶⁶ A series of articles resulted from the Turnaway study, and the findings have recently been published as a book. See DIANA GREENE FOSTER, *THE TURNAWAY STUDY: TEN YEARS, A THOUSAND WOMEN, AND THE CONSEQUENCES OF HAVING – OR BEING DENIED – AN ABORTION* (2020); 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 J. AM. MED. ASS’N PSYCHIATRY 169 (2017); Diana G. 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 J. AM. MED. ASS’N PEDIATRICS 1053 (2018); Ushma D. Upadhyay, M. Antonia Biggs, & Diana G. Foster, *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, 15 BMC WOMEN’S HEALTH 102 (2015); Diana G. 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 (2018).

Two groups were included for comparison to the “turnaway” group – the “First Trimester” group (patients terminating pregnancies within 13 weeks) and a “Near Limit” group, comprised of patients who terminated a pregnancy within 2 weeks of a gestational age cutoff.¹⁶⁷

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. The most common reason given for seeking an abortion was an inability to afford raising a child.¹⁶⁸ Participants also reported that their timing for seeking abortions depended on collecting funds to cover the cost of travel and the procedure.¹⁶⁹ 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.¹⁷⁰

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 financial hardships with effects for people’s long-term wellbeing.

Law plays a key role in obstructing or delaying abortion care: for one, state gestational time-limits will keep some from state-approved terminations. 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. When those challenges are insurmountable, the Turnaway Study identified the economic and health consequences that follow for populations already living without sufficient resources.

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

¹⁶⁷ FOSTER, *supra* note 166, at 1-5.

¹⁶⁸ The majority of abortion patients (59%) have given birth at least once. JERMAN ET AL., *supra* note 8, at 7.

¹⁶⁹ 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. 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. LIFT LOUISIANA, ABORTION INFORMATION AND RESOURCES, <https://liftlouisiana.org/content/abortion-information-and-resources>.

¹⁷⁰ Sarah Miller, Laura R. Wherry & Diana Greene Foster, *What Happens After an Abortion Denial? A Review of Results from the Turnaway Study*, 110 AEA PAPERS & PROCEEDINGS 226, 226-30 (2020).

C. The Public's Health

Although both *June Medical Services* and *Whole Woman's Health* interpreted the undue burden standard in light of the burdens imposed on low-income people, neither opinion mentions race (or gender) discrimination. By contrast, the ACOG decision takes up race and social position explicitly.¹⁷¹ 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 especially damaging health effects that accumulate over time.¹⁷² 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 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.¹⁷³

The burden of the in-person requirement 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 collective welfare. To repeat the point, people of color contract COVID-19 at higher rates than whites and Black, Native Americans, and Latinx patients are almost five times as likely to be hospitalized as white patients as well as two to three times as likely to die.¹⁷⁴ The FDA's policy perpetuates the disparities that, as Ruqaiijah Yearby and Seema Mohapatra demonstrate, "are a result of historical and current practices of racism that cause disparities in exposure, susceptibility, and treatment as of historical and current practices of racism that cause disparities in exposure, susceptibility, and treatment."¹⁷⁵

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

¹⁷¹ Brief for ACOG *supra* note 96, at 7-8. Cary Franklin demonstrated how research on health disparities and inequalities was important to petitioners' arguments in *Whole Woman's Health*. Franklin, *supra* note 51, at 240-45.

¹⁷² See CENTERS FOR DISEASE CONTROL AND PREVENTION, COVID-19 HOSPITALIZATION AND DEATH BY RACE/ETHNICITY, <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html>. See also Ruqaiijah Yearby & Seema Mohapatra, *Law, Structural Racism, and the COVID-19 Pandemic*, 7 J. L. & BIOSCIENCES 1, 1 (2020).

¹⁷³ ACOG, No. CV TDC-20-1320 at 23-24.

¹⁷⁴ Eona Harrison & Ebonie Megibow, *Three Ways COVID-19 is Further Jeopardizing Black Maternal Health*, URBAN INSTITUTE, Jan. 5, 2021, <https://www.urban.org/urban-wire/three-ways-covid-19-further-jeopardizing-black-maternal-health>.

¹⁷⁵ Yearby & Mohapatra, *Systemic Racism*, *supra* note 13, at 1.

conditions deepen existing and exacerbate longstanding inequalities.¹⁷⁶ Social determinants are the conditions that mediate the extent to which people are exposed to health stressors and are able to withstand them.¹⁷⁷ Quality healthcare 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.¹⁷⁸ Determinants include limited education or nutrition, preventable disease, unsafe water or work, poor sanitation, inadequate income or access to health care, and substandard housing, all of which correlate with shorter life expectancies and poor health.¹⁷⁹ Past and present discrimination shape the social determinants of health that in turn reproduce health disparities.¹⁸⁰

Law too is a determinant that maintains and mediates the social, economic, and physical structures that shape who suffers and who thrives. Law directly distributes who has access to economic and social resources. Tax provisions and public assistance programs, for instance, that strengthen economic security are correlated with longer and healthier lives.¹⁸¹ Yet often courts have overlooked social determinants by reasoning that law (and the state) did not create poverty, or that the relationship between law and larger health disparities is too attenuated.¹⁸² That limited

¹⁷⁶ See, e.g., ACOG Brief, *supra* note 96, at 22-23, nn. 23, 24 (citing public health studies on racial disparities, Cary P. Gross, Utibe R. Essien, Saamir Pasha, Jacob R. Gross, Shi-yi Wang & Marcella Nunez-Smith, Racial and Ethnic Disparities in Population Level Covid-19 Mortality, medRxiv, <https://doi.org/10.1101/2020.05.07.20094250>; Racial Data Transparency, Johns Hopkins Univ., <https://coronavirus.jhu.edu/data/racial-datatransparency>).

¹⁷⁷ Paula Braveman, Susan Egerter, & David R. Williams, *The Social Determinants of Health: Coming of Age*, 32 ANN. REV. PUB. HEALTH 381, 382 (2011); Bruce G. Link & Jo Phelan, *Social Conditions as Fundamental Causes of Disease*, 35 J. HEALTH & SOC. BEHAV. 80, 81 (1995). See also the work of Martha Fineman on vulnerability theory, Martha A. Fineman, *The Vulnerable Subject: Anchoring Equality in the Human Condition*, 20 YALE J.L. & FEMINISM 1 (2008) (“Vulnerability theory understands human beings as embodied creatures who are inexorably embedded in social relationships and institutions.”).

¹⁷⁸ Lindsay F. Wiley, *From Patient Rights to Health Justice: Securing the Public’s Interest in Affordable, High-Quality Health Care*, 37 CARDOZO LAW REVIEW 833, 856 (2016). 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, 762 (2020) (citing ELIZABETH TOBIN-TYLER & JOEL B. TEITELBAUM, ESSENTIALS OF HEALTH JUSTICE: A PRIMER (2018)).

¹⁷⁹ WORLD HEALTH ORGANIZATION, SOCIAL DETERMINANTS OF HEALTH: KEY CONCEPTS 1, http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/; 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).

¹⁸⁰ INSTITUTE OF MEDICINE, UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE (2002) (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).

¹⁸¹ Leonard E. Burman, *Taxes and Inequality*, 66 TAX L. REV. 563, 589-90 (2013); Hilary W. Hoynes, Douglas L. Miller, & David Simon, *Income, the Earned Income Tax Credit, and Infant Health*, National Bureau of Economic Research, Working Paper Series 18206 (2012). Rachel Rebouché & Scott Burris, *The Social Determinants of Health*, in OXFORD HANDBOOK OF U.S. HEALTH LAW (I. Glenn Cohen et al. eds., 2016) (“Laws administering tax credits, for example, indicate that expanding the Earned Income Tax Credit (EITC) correlates with better health behavior and lower depression rates for beneficiary mothers and their children.”).

¹⁸² 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, 473 (1977) (stating that Connecticut’s law, in banning Medicaid funding for elective abortion, was not the cause of poverty and thus has not been the reason low income people could not afford abortion). See also *Khiara*

view of law “reinscribes underlying inequalities, while appearing to act neutrally and without reference to categories of race, sex, or poverty.”¹⁸³ 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. A social determinants approach recognizes that addressing health inequalities requires structural and institutional change.

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 disparities. But relying on courts is fraught terrain as the Supreme Court made clear in its order in *ACOG*. The next part discusses how abortion rights have come under pressure with a Supreme Court that is 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 section of this part considers an imminent future when federal constitutional rights to abortion have been further eviscerated. The second section 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. However, *Roe v. Wade* and *Planned Parenthood v. Casey* have stood even though numerous cases and laws have chipped away at their legal force.¹⁸⁴ The constitutional right to abortion will continue to exist for some indeterminate period, and, for the time being, the application of the undue burden test is unclear.

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.¹⁸⁵ Some states are counting on the latter. As one state representative from South Carolina put it, “[a]lot of

Bridges, *Elision and Erasure: Race, Class, and Gender in Harris v. McRae*, in *REPRODUCTIVE RIGHTS AND 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.”).

¹⁸³ Hill, *supra* note 140, at 1125.

¹⁸⁴ This part refers to a “post-*Roe*” country, even though the Court would reverse *Casey*, because the phrase tracks popular writing and the relevant research studies.

¹⁸⁵ This Article does not argue that either path – evidence or deference – is apolitical or neutral. These are strategies reflect the larger legal, social context in which evidence is generated. See Ahmed, *Medical Evidence and Expertise*, *supra* note 85, 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”).

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.”¹⁸⁶

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.¹⁸⁷ One of the laws required patients to wait 18 hours between having a state-mandated ultrasound and an abortion procedure.¹⁸⁸

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.”¹⁸⁹ The court described the costs imposed by making two trips to the handful of clinics located across the state that perform ultrasounds and abortions.¹⁹⁰ 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.¹⁹¹ 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.”¹⁹²

The Seventh Circuit previously found no credible evidence that the waiting period was medically necessary or created opportunities for patients’ meaningful reflection.¹⁹³ 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.”¹⁹⁴ The Seventh Circuit ultimately did not reconsider the case; the court remanded the case to the district court but the parties settled in fall 2020 after Planned Parenthood acquired additional ultrasound equipment.¹⁹⁵

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

¹⁸⁶ Scott Greenberger, *Trump-Appointed Judges Fuel Abortion Debate in the States*, PEW, Jan. 25, 2021, <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2021/01/25/trump-appointed-judges-fuel-abortion-debate-in-the-states> (quoting Republican State Senator Larry Grooms of South Carolina).

¹⁸⁷ Rachel Rebouché, *Abortion Restrictions after June Medical Services*, REG. REV., Aug. 4, 2020, <https://www.theregreview.org/2020/08/04/rebouche-abortion-restrictions-june-medical/>.

¹⁸⁸ The first 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 Indiana and Kentucky v. Commissioner*, 896 F.3d 809 (7th Cir. 2018).

¹⁸⁹ *Id.* at 815.

¹⁹⁰ *Id.* at 815, 817.

¹⁹¹ *Id.* at 827.

¹⁹² *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.

¹⁹³ *Planned Parenthood of Indiana and Kentucky*, 896 F.3d at 828.

¹⁹⁴ *Id.* at 826.

¹⁹⁵ The Seventh Circuit court remanded to the district court on Sept. 20, 2020. *Planned Parenthood of Indiana v. Commissioner of the Indiana, et al*, Docket No.17-01883 (7th Cir. Apr 27, 2017). “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.” Kyra Howard, *Indiana Pre-abortion Ultrasound Law Goes into Effect after Four Year Wait*, THE STATEHOUSE FILE, Jan. 22, 2021, <http://thestatehousefile.com/indiana-pre-abortion-ultrasound-law-goes-effect-four-year-wait/>.

pandemic and beyond.¹⁹⁶ In the spring of 2020, five federal courts of appeals reviewed state actions that suspended abortion care by deeming it a nonessential medical service.¹⁹⁷ Those decisions produced mixed results; two appellate courts deferred to the states, and three struck down the suspensions. The U.S. Court of Appeals for the Fifth Circuit upheld the Texas executive order barring all abortion, including medication abortion. Citing a Supreme Court case decided in 1905, *Jacobson v. Massachusetts*, the Fifth Circuit held that a court may not “second guess” any state’s regulatory response to a public health emergency.¹⁹⁸ 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. Both circuit courts dismissed arguments about the short-term and long-term costs to individuals and the healthcare system as mere “policy” considerations.¹⁹⁹

One lesson from the suspensions and courts’ debate over the application of *June Medical Services* is that place continues to matter a great deal. Depending on the circuit, some courts will affirm the multitude of ways that abortion restrictions exacerbate existing health disparities and inequalities. Others will not.²⁰⁰ 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. Other anti-abortion statutes that do not shut clinic doors or excessively increase travel distances for patients may stand.²⁰¹

Another take away from the abortion suspensions early in the pandemic, however, is the unexpected malleability of state policy.²⁰² The state suspensions undermined the typical argument that abortion is different from all other healthcare services – in 12 states, an overly-regulated procedure became a non-essential service, like cosmetic surgery.²⁰³ Distinctions between essential and non-essential care, including abortion, ceased to matter when states like Texas sought to

¹⁹⁶ Rachel Rebouché, *Abortion Opportunism*, 7 J. L. & BIOSCIENCES 1 (2020).

¹⁹⁷ *Id.* at 9.

¹⁹⁸ 197 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. In January 2021, the Supreme Court vacated the Fifth Circuit’s decision as moot. *See infra* note 117.

¹⁹⁹ *In re Abbott*, 954 F.3d 772 (5th Cir. 2020); *In re Rutledge*, 956 F.3d 1018 (8th Cir. 2020).

²⁰⁰ 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. Justice Sotomayor emphasized a similar point in her dissent from the Court’s *ACOG* order: “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.” Food & Drug Admin., 141 S.Ct. at 580.

²⁰¹ 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). 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 (2015). The Sixth Circuit upheld an Ohio law that prohibits providers from terminating pregnancies because of a fetal diagnosis of Down syndrome. *Preterm-Cleveland v. McCloud*, 2021 WL 1377279 (6th Cir. Apr. 13, 2021).

²⁰² *See also* 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 (2012) (discussing the political and legal issues around what counts as essential health care and medical necessity).

²⁰³ Rebouché, *Abortion Opportunism*, *supra* 196, note at 9–10.

reopen businesses, essential or not, in the spring of 2020. Even given the exceptional circumstances, the course of pandemic suspensions illustrate that states will bend to political pressure or will 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.²⁰⁴ Yet the intersection of developments in legal doctrine, judicial personnel, public health research, and social activism has yielded new research-based, politically-focused action with respect to abortion access. In that vein, the next section explores the growth of and obstacles to teleabortion and self-managed abortion. Again, public health evidence has played a role, investigating and confirming the safety and efficacy of teleabortion and self-managed abortion.²⁰⁵ 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.²⁰⁶

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, 9 states have passed laws prohibiting abortion for almost all reasons and well before viability.²⁰⁷ As noted, the Supreme Court will decide whether all pre-viable prohibitions on elective terminations are unconstitutional in *Dobbs v. Jackson Women's Health Organization*.²⁰⁸ 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 is already stark. Currently, 6 states have one abortion provider.²⁰⁹ 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 100 miles of

²⁰⁴ 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, for abortion access but also for a range of reproductive and sexual services. Zakiya Luna & Kristin Luker, *Reproductive Justice*, 9 ANN. REV. L. SOC. SCI. 327, 341-43 (2013); See Rachel Rebouché, *Reproducing Rights*, 6 UC IRVINE L. REV. 579, 597 (2018).

²⁰⁵ Take the work of Plan C and Gynuity: "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." Adams, *supra* note at 1.

²⁰⁶ Sanger, *supra* note 6, 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).

²⁰⁷ Elizabeth Nash & Lauren Cross, *2021 is on Track to Become the Most Devastating Antiabortion State Legislative Session in Decades*, GUTTMACHER INSTITUTE, May 18, 2021, <https://www.guttmacher.org/article/2021/04/2021-track-become-most-devastating-antiabortion-state-legislative-session-decades>.

²⁰⁸ *Dobbs v. Jackson Women's Health Organization*, 945 F.3d 265 (5th Cir. 2020), *cert. granted*, Docket No. 19-1392 (2021).

²⁰⁹ Holly Yan, *These 6 States Have Only 1 Abortion Clinic Left. Missouri Could Become the First With Zero*, CNN, June 21, 2019, <https://www.cnn.com/2019/05/29/health/six-states-with-1-abortion-clinic-map-trnd/index.html>.

many of a state's residents.²¹⁰ 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.²¹¹ 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."²¹² The critical shortage of abortion services in numerous parts of the country will worsen if constitutional rights to abortion disappear.²¹³ If the Court abandons *Casey*, 21 states have laws or plan to pass laws that would make abortion a crime with limited exceptions.²¹⁴ A study mapped what abortion provision would look like if states likely to ban abortion, post-*Casey*, did so. 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%."²¹⁵ Travel is and will remain necessary for the majority of people seeking abortion care unless care becomes untethered to place.²¹⁶

The remote delivery of medication abortion, though far from a perfect solution, has expanded the reach of abortion care.²¹⁷ Over half of the country's states permit or have no law restricting telemedicine for abortion. The Supreme Court's stay in *ACOG* thwarted some efforts to expand remote care from January to April 2021.²¹⁸ But the FDA's decision to suspend

²¹⁰ Raymond et al., *supra* note 106, at 174 ("27 cities with populations of 50,000 or more had no abortion clinic within a 100 mile radius"). See also Lisa R. Pruitt & Marta R. Vanegas, *Urbanormativity, Spatial Privilege, and Judicial Blind Spots in Abortion Law*, 30 BERKELEY J. GENDER, L. & J. 76 (2015).

²¹¹ Witwer et al., *supra* note 154, at 4.

²¹² Guttmacher defined "hostile" versus "supportive" states: "A state is considered supportive of abortion rights if it has no more than one [abortion] restrictions, 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." Six states were coded as hostile and 23 states as extremely hostile; 12 states as supportive and 9 as middle ground. The types of laws analyzed included waiting periods, mandatory ultrasounds, parental involvement requirements, gestational limits, and reason-based bans, to name several. Elizabeth Nash et al., *Policy Trends in the States, 2017*, GUTTMACHER INSTITUTE, Feb. 1, 2018, <https://www.guttmacher.org/print/article/2018/01/policy-trends-states-2017>.

²¹³ COHEN & JOFFE, *supra* note 7, at 54–83 (detailing the scarcity of providers and clinics and documenting the hardships both impose on patients).

²¹⁴ Public Policy Office, Guttmacher Institute, *Abortion Policy in the Absence of Roe*, Nov. 1, 2020, <https://www.guttmacher.org/state-policy/explore/abortion-policy-absence-roe>.

²¹⁵ Caitlin Myers, Rachel Jones, & Ushma Upadhyay, *Predicted Changes in Abortion Access and Incidence in a Post-Roe World*, 100 CONTRACEPTION 367 (2019). Myers's study found an increase from a national average of 25 miles to 122 miles to a provider if *Roe* were overruled because 26% 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 30 miles away from a provider instead of 5 miles away. *Id.* at 373. The study predicts that abortion rates would decline as much as 40% in urban areas. *Id.* at 372.

²¹⁶ 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 Susan Frelich Appleton, *Gender, Abortion, and Travel after Roe's End*, 51 ST. LOUIS UNIV. L.J. 655 (2007); Richard H. Fallon, Jr., *If Roe Were Overruled: Abortion and the Constitution in a Post-Roe World*, 51 ST. LOUIS U. L.J. 611 (2007); Seth F. Kreimer, "But Whoever Treasures Freedom...": *The Right to Travel and Extraterritorial Abortions*, 91 MICH. L. REV. 907 (1993).

²¹⁷ See Yvonne Lindgren, *The Doctor Requirement: Griswold, Privacy, and At-Home Reproductive Care*, 32 CONST. COMM. 341, 346 (2017).

²¹⁸ See Rachel Rebouché & Ushma Upadhyay, *Online clinics show abortion access can survive state restrictions and Roe v. Wade threat*, USA TODAY, Apr. 12, 2021, <https://www.usatoday.com/story/opinion/2021/04/12/medication-abortion-rights-protected-online-clinics-column/7106777002/>. See also Rachel Rebouché, *The Supreme Court Doesn't Hold All the Power When It Comes to Abortion Rights*, TIME MAG., Dec. 22, 2020, <https://time.com/5922555/medication-abortion-joe-biden/>; Carrie Baker, *SCOTUS Blocks Access to Abortion Pill By Mail During Pandemic*, MS. MAG., Jan. 1, 2021, <https://msmagazine.com/2021/01/13/supreme-court-abortion-pill-trump-biden/>.

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.²¹⁹

The Gynuity study, which was established before the pandemic, as described in Part I, offers teleabortion services in 18 states and Washington, D.C.²²⁰ The first large-scale virtual clinic, Abortion on Demand, launched in April 2021 and now operates in 20 states with plans expand to 27 states in 2021.²²¹ Virtual clinics like Abortion on Demand are able to charge much less than brick-and-mortar clinics²²² and contract with online pharmacies to mail medication abortion prescribed by licensed, physicians.²²³ 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 6 additional states, bringing the current number of states with teleabortion services to 23 states.²²⁴ 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.²²⁵

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.²²⁶ The research hubs described in this Article have been and will be the main source of those studies.²²⁷

²¹⁹ See *infra* note 27.

²²⁰ Those states are Colorado, DC, Georgia, Hawaii, Illinois, Iowa, Maine, Maryland, Massachusetts, Minnesota, Montana, Nevada, New Jersey, New Mexico, New York, Oregon, Virginia and Washington. TelAbortion, Get Started, <https://telabortion.org/get-started>. Note that Montana's teleabortion services may be impacted by 2021 law requiring in-person dispensation. In 2019, Gynuity partnered with carafem, with operates a telehealth program for abortion as well as four health centers in Georgia, Illinois, Maryland, DC. carafem, About Us, <https://carafem.org/wp-content/uploads/2020/08/2020-Annual-Report.pdf>. Like ANSIRH and TxPEP, Gynuity received substantial financial support from a large, private foundation. ZIEGLER, *supra* note 4, 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. The AOD website has announced expansion to Hawaii, Idaho, Wyoming, Michigan, Pennsylvania, and New Hampshire. AOD prescribes medication abortion up to 8 weeks of pregnancy, rather than 10 as allowed by the FDA, and only for people age 18 and older, in order avoid parental involvement restrictions. Abortion on Demand, Where is AOD Available?, <https://abortionondemand.org/>.
²²¹ Other start-up clinics include Choix, Hey Jane, and Just the Pill. See Rachel Rebouche & Ushma Upadhyay, *Online clinics show abortion access can survive state restrictions and Roe v. Wade threat*, USA TODAY, Apr. 12, 2021, <https://www.usatoday.com/story/opinion/2021/04/12/medication-abortion-rights-protected-online-clinics-column/7106777002/>. Call with Jamie Phifer, founder of Abortion on Demand, August 3, 2021.

²²² *Id.* 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. *Id.*

²²³ Carrie N. Baker, *How Telemedicine Startups Are Revolutionizing Abortion Health Care in the U.S.*, MS. MAG., Nov. 16, 2020.

²²⁴ 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, Vermont. Aid Access, Where We Operate, FAQs, <https://aidaccess.org/en/i-need-an-abortion>.

²²⁵ Rachel Rebouche & Ushma Upadhyay, *Online Clinics Show Abortion Access Can Survive State Restrictions and Roe v. Wade Threat*, USA TODAY, Apr. 12, 2021, <https://www.usatoday.com/story/opinion/2021/04/12/medication-abortion-rights-protected-online-clinics-column/7106777002/>.

²²⁶ Order Granting Joint Motion to Stay Case Pending Agency Review, *Chelius v. Wright*, Docket No. 1:17-cv-00493 (D. Haw. May 7, 2021).

²²⁷ The work of ANSIRH, noted in Part II, is significant in establishing the safety and efficacy of remote care. See ANSIRH, *Telemedicine for Abortion*, <https://www.ansirh.org/abortion/medication-abortion/telemedicine>.

That research, moreover, contributes to the work of advocates and lawyers who disseminate information about how remote medication abortion works.²²⁸ Plan C, a non-profit organization, has been a hub for connecting patients with providers.²²⁹ 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.²³⁰ Even before the *ACOG* case and the FDA's enforcement suspension, Plan C organizers recruited physicians, who after receiving certification required by the FDA, interpreted the provision as allowing supervised direct mail of mifepristone and misoprostol.²³¹

The landscape of abortion provision has shifted in ways that many thought unimaginable ten years before – early terminations without a visit to clinical space.²³² 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 indirectly, telemedicine for abortion.²³³ For instance, 20 states require a physician to be present upon delivery of medication abortion.²³⁴ Ten of those states further ban the use of telemedicine for abortion even though existing in-person requirements accomplish the same end; state courts in two states have enjoined the in-person requirement.²³⁵

Moreover, patients need access to technology. Most abortion patients, based on the statistics about laptop and tablet use, likely would use a smartphone for remote care.²³⁶ Rules that require people to logon from certain locations from specific devices, which is dependent on

²²⁸ See Amna Akbar, Sameer Ashar, & Jocelyn Simonson, *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).

²²⁹ Patrick Adams, *Amid Covid-19, a Call for M.D.s to Mail the Abortion Pill*, N.Y. TIMES, May 12, 2020.

²³⁰ Plan C, FAQs, How to Get Abortion Pills, <https://www.plancpills.org/guide-how-to-get-abortion-pills#faq>.

²³¹ Adams, *supra* note 229, at 1.

²³² See Carole Joffe, *A Rare Expansion in Abortion Access Because of COVID-19*, TIME Mag., Sept. 28, 2020, <https://time.com/5893969/covid-19-medication-abortion/>.

²³³ 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. *Food & Drug Admin. v. Am. Coll. of Obstetricians & Gynecologists*, 141 S.Ct. 578, 580 (2021).

²³⁴ Medication Abortion, Abortion Law Project, Center for Public Health Law Research, Dec. 2020, <http://lawatlas.org/datasets/medication-abortion-requirements>. 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 235.

²³⁵ Medication Abortion, Abortion Law Project, Center for Public Health Law Research, Dec. 2020, <http://lawatlas.org/datasets/medication-abortion-requirements> (Arizona, Texas, Arkansas, Iowa, Indiana, Kentucky, West Virginia, South Carolina). West Virginia has an exception for physicians with an existing relationship established through an in-person encounter. W. Va. Code § 30-3-13a; W. Va. Code § 30-14-12d. 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. *Planned Parenthood of the Heartland v. Iowa Bd. of Med.*, 865 N.W.2d 252, 269 (Iowa 2015) (“[A]s we read *Casey*, it turned on the evidence and record in that case, including a recognition that the informed consent requirement served a ‘substantial government interest,’ including the ‘psychological well-being’ of the woman. As we have discussed already, this record, which is based on 2013 medical standards and practices in Iowa, reveals only minimal medical justification for the challenged aspects of the rule.”). Montana and Ohio recently passed telemedicine bans for abortion, though, as of May 2021, a state court temporarily enjoined the Ohio law. Iris Samuels, *Montana Governor Signs Three Bills Restricting Abortion Access*, ASSOCIATED PRESS, Apr. 26, 2021; Carrie N. Baker, *Advocates Cheer FDA Review of Abortion Pill Restrictions*, MS. MAG., May 11, 2021 (describing the Ohio law and state court injunction).

²³⁶ 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. carafem, About Us, <https://carafem.org/about/>.

broadband or wireless, may encumber participation in telehealth visits.²³⁷ 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.²³⁸ 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.²³⁹ Under a licensure waiver or interstate compact, an out-of-state practitioner can counsel patients and prescribe medication abortion online or over the telephone if not otherwise prohibited by state law.²⁴⁰

Patients must also 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. People of color and low income people are more likely to have pregnancy complications and to have poorer health generally, reducing the chance that they can be candidates for teleabortion.²⁴¹ Moreover, childbirth

²³⁷ In addition, there are issues of privacy and “tele-fraud.” Nathaniel M. Lacktman et al., *Top 5 Telehealth Law Predictions for 2021*, 11 NAT’L L. REV. 1, 1-4 (2020). Parity in reimbursement is a significant issue, especially for Medicaid coverage of telehealth. The application of the Hyde Amendment and state restrictions on funding for abortion services, however, complicate the issue for abortion care.

²³⁸ Osub Ahmed, *States Must Expand Telehealth to Improve Access to Sexual and Reproductive Health Care*, CENTER FOR AMERICAN PROGRESS, May 21, 2020, <https://www.americanprogress.org/issues/women/reports/2020/05/21/485297/states-must-expand-telehealth-improve-access-sexual-reproductive-health-care/>. 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. Licensure compacts also allow physicians to prescribe medication to out-of-state residents. See Eli Y. Adashi, I. Glenn Cohen, Winston L. McCormick, *The Interstate Medical Licensure Compact*, 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.”).

²³⁹ See Cason Schmit et al., *Telehealth in the COVID-19 Pandemic*, in ASSESSING LEGAL RESPONSES TO COVID-19 (Scott Burris et al. eds., 2020). See also Kyle Faget, *Telehealth in the Wake of COVID-19*, 22 J. HEALTH CARE COMPLIANCE, 5, 8 (2020).

²⁴⁰ “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.” Lacktman et al., *supra* note 237, at 12. The Uniform Law Commission is presently drafting Telehealth Act for state adoption, which would create a national registry for out-of-state practitioners offering telehealth services. Uniform Law Commission, Telehealth Act, Draft, <https://www.uniformlaws.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=3a9c23ee-3def-f7f5-bf6e-bf335dfac73c&forceDialog=0>. The draft Act, however, provides that practitioners may offer services “not otherwise prohibited by law” 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.

²⁴¹ Harrison & Megibow, *supra* note at 1.

has steep costs and health risks for low-income people and people of color specifically.²⁴² These are not only challenges for remote care, but also mirror the disparities in U.S. healthcare.²⁴³

Finally, medication abortion will not serve those seeking to terminate pregnancies after ten weeks of pregnancy. Presently, almost 60% of abortion patients use non-medication methods.²⁴⁴ Those patients' needs are tethered to clinical spaces, access to which becomes increasingly complicated if a Supreme Court ruling permits states to ban most abortions at any point in pregnancy.²⁴⁵

Self-managed abortion is another avenue for abortion care, which also has been the subject of intensive study. An individual self-manages abortion when terminating 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.²⁴⁶ People report preferring self-managed abortion because it provides more privacy and autonomy than abortions conducted at a health facility.²⁴⁷ Substantial research has shown that self-administration of medication abortion with proper instruction is effective and comparably as safe to care administered by professionals in clinical settings.²⁴⁸

Like teleabortion, research networks have produced studies that support the expansion of self-managed abortions.²⁴⁹ Although the prevalence of self-managed abortion is challenging to measure, surveys of health care providers and patients note that the practice has increased in recent years, specifically in areas of the United States in which abortion access is heavily circumscribed.²⁵⁰ Aid Access, which, as noted, provides telehealth for abortion, also assists individuals to self-induce abortion. Aid Access is directed by a physician, Rebecca Gromperts, trained in the Netherlands, who has spearheaded previous initiatives to deliver abortion services

²⁴² The United States has the worst maternal mortality rate in comparison to countries similarly situated; Black individuals are four times as likely to die in childbirth than white individuals. Foster et al., *Socioeconomic Outcomes*, *supra* note at 407-13.

²⁴³ See U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF MINORITY HEALTH, INFANT HEALTH MORTALITY AND AFRICAN AMERICANS, <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=23>; NATIONAL ACADEMIES OF SCIENCE, ENGINEERING, AND MEDICINE, METRICS THAT MATTER FOR POPULATION HEALTH ACCESS (2016). See Khiara Bridges, *Racial Disparities in Maternal Mortality*, 95 NYU L. REV. 1229, 1257-65, 1308-1316 (2020) (overviewing racial disparities in maternal mortality and calling for policy changes that address the structural and institutional forces that result in maternal deaths).

²⁴⁴ Almost 91% of abortions occur before 14 weeks of pregnancy, though just over 60% of those terminations are performed by removing pregnancy tissue in the uterus by suction. UCSF Health, Surgical Abortion (First Trimester), <https://www.ucsfhealth.org/treatments/surgical-abortion-first-trimester>.

²⁴⁵ See Jill Wieber Lens, *Miscarriage, Stillbirth, and Reproductive Justice*, 98 WASH. U. L. REV. 1, 22 (forthcoming 2021) (noting that second-trimester abortion is a “poster child of a right without resources; the right exists now, but there are very little resources to help women exercise that right”).

²⁴⁶ Chloe Murtagh et al., *Exploring the Feasibility of Obtaining Mifepristone and Misoprostol from the Internet*, 97 CONTRACEPTION 287-91 (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. In 2019, 21,000 U.S. women requested Aid Access's help, and one third were served. Aid Access, *Who Are We*, <https://aidaccess.org/en/page/561>.

²⁴⁷ 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 (2020).

²⁴⁸ *Id.*

²⁴⁹ Abigail R. A. Aiken et al., *Factors Associated with Use of an Online Telemedicine Service to Access Self-Managed in the US*, 4 JAMA 1, 1 (2021).

²⁵⁰ See, e.g., Fuentes et al., *supra* note at 1.

across the world in the face of restrictive country laws.²⁵¹ The organization offers information about administering medication abortion and procures prescriptions from U.S. or European healthcare providers.²⁵²

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.²⁵³ For another, and more significantly, providers and patients can be punished under a variety of state laws.²⁵⁴ Six states have laws that attempt to criminalize self-managed abortions and several states have so-called fetal endangerment laws.²⁵⁵ Per the later, fetal endangerment laws originally targeted drug use by pregnant people, but have been applied to a range of activities including terminating a pregnancy.²⁵⁶ In states that do not have a fetal endangerment law on the books, “politically-motivated police and prosecutors may try to misuse other criminal laws to target people who self-manage abortion.”²⁵⁷ Criminal laws, such as

²⁵¹ The FDA sent Aid Access a warning letter indicating that the organization may be in violation of the Food, Drug & Cosmetic Act. Food & Drug Admin., *Warning Letter to Aid Access*, Mar. 8, 2019, <https://www.fda.gov/inspections-compliance-enforcement-and-criminal-investigations/warning-letters/aidaccessorg-575658-03082019>.

²⁵² “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.” Aiken et al., *supra* note at 2.

²⁵³ Megan K. Donovan, *Self-Managed Medication Abortion: Expanding the Available Options for U.S. Abortion Care*, 21 GUTTMACHER POL’Y REV. 41 (2018).

²⁵⁴ See Aziza Ahmed, *Floating Lungs: Forensic Science in Self-Induced Abortion Prosecutions*, 100 BU L. REV. 1111, 1121, 1124 (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 a robust literature 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, 46 (2020).

²⁵⁵ Farah Diaz-Tello, *Roe Remains for Now...Will it be Enough?*, 45 HUM. RTS. 14, 15 (2020). For more information on the legal landscape for self-managed abortion, see THE SIA LEGAL TEAM, *ROE’S UNFINISHED PROMISE* (2017), <https://www.ifwhenhow.org/resources/roes-unfinished-promise/>. Fetal protection laws promote the view that fetal life deserves protection separate from the pregnant person. 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).

²⁵⁶ Lynn M. Paltrow & Jeanne Flavin, *Arrests and Forced Interventions of Pregnant Women in the United States*, 38 J. HEALTH POL. 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).

²⁵⁷ Diaz-Tello, *supra* note at 15 (describing individuals being “charged with felonies like concealment of a birth, practicing pharmacy without a license, or even homicide”).

feticide or solicitation of murder, have been applied to punish self-managed abortion, although the frequency of such prosecutions is hard to gauge.²⁵⁸

The barriers to remote care are significant but not insurmountable. At the same time that there are obstacles to remote abortion care and self-managed abortion, there has been support for pro-abortion policies. On the federal level, the Biden Administration has expressed a “commit[ment] to codifying *Roe v. Wade*.”²⁵⁹ The proposed Women’s Health Protection Act offers one option. The Act protects providers’ right to offer services and patients’ right to receive care; the bill also would limit what restrictions states can pass. 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.²⁶⁰ On the state level, legislation ensures abortion rights within the jurisdiction. Massachusetts recently passed the ROE Act, which provides a state right to abortion for any reason before 24 weeks of pregnancy, and for reason of life, health or lethal fetal anomaly after 24 weeks.²⁶¹ Virginia, once a state with only anti-abortion laws, recently repealed its ban on abortion coverage in private health care plans offered through the state’s health insurance exchange.²⁶²

Changing state law depends on collective, political organizing. The lawyers, advocates, and researchers described here seek increased abortion access, but not just for the sake of protecting an individual choice or defending an abstract right.²⁶³ Rather, their work is in conversation with networks that advance abortion access as an issue of economic and racial justice.²⁶⁴ Those networks are committed to principles grounded in reproductive justice and health

²⁵⁸ Ahmed, *supra* note at 1123. By one account, 21 people over the last twenty years have been prosecuted for self-managed abortion, although commentators suspect that is a vast underestimate. Diaz-Tello, *supra* note at 15.

²⁵⁹ Press Release, *Statement from President Biden and Vice President Harris on the 48th Anniversary of Roe v. Wade*, Jan. 22, 2021, <https://www.whitehouse.gov/briefing-room/statements-releases/2021/01/22/statement-from-president-biden-and-vice-president-harris-on-the-48th-anniversary-of-roe-v-wade/>. See also Kate Smith, *Biden Pledged to Make Roe v. Wade “The Law of the Land,”* CBS NEWS, Oct. 6, 2020, <https://www.cbsnews.com/news/biden-roe-v-wade-law-land-supreme-court-supporters/> (noting that, during the election, the Biden campaign promised to codify *Roe* if the Supreme Court abandoned abortion rights).

²⁶⁰ Women’s Health Protection Act §§ 4(a)(5), (7). But see Teleabortion Prevention Act of 2019 (a bill introduced in Congress that would require in-person administration of medication abortion).

²⁶¹ An Act to Remove Obstacles and Expand Abortion Access (ROE Act), <https://www.mass.gov/info-details/massachusetts-law-about-abortion#massachusetts-laws->. 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 (DC, 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). Guttmacher Institute, *Abortion Policy in the Absence of Roe*, Feb. 1, 2021, <https://www.guttmacher.org/state-policy/explore/abortion-policy-absence-roe>.

²⁶² Virginia Senate Bill No. 1275, January 13, 2021, <https://lis.virginia.gov/cgi-bin/legp604.exe?211+ful+SB1276>.

²⁶³ Research studies described here 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, Ashar, & Simonson, *supra* note 228, at n.176. “With participatory action research, legal scholars can use tools of social science to treat movement actors and activists as equal research partners in the generation of questions and answers about the world—for example, in seeking to answer the question of what public safety means for their community.” *Id.* at n.863. In a similar vein, and in the context of reproductive justice, Zakiya Luna and Kristin Luker have called for “best practices” in research, such as interviews and participatory techniques “from design to execution to publication to evaluation.” Luna & Luker, *supra* note 204, at 344.

²⁶⁴ “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

justice, which share commitments to empowering communities and to the fairer redistribution of resources.²⁶⁵ 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.”²⁶⁶ And health justice scholarship emphasizes collective action as key to dismantling disparities and inequalities.²⁶⁷ 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.²⁶⁸

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.”²⁶⁹ In other words, where one lives should not dictate whether you 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 failing health infrastructure.²⁷⁰ Such

abortion’s legality.” MICHELLE OBERMAN, *HER BODY, OUR LAWS: ON THE FRONT LINES OF THE ABORTION WAR* 141 (2018).

²⁶⁵ Harris & Pamukcu, *supra* note 178, at 806, 808 (noting 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 redress subordination; and (3) a commitment to, through social movement organizing, centering state and market governance around broadly-articulated ‘life rights’”).

²⁶⁶ Emily Benfer, *Health Justice: A Framework (and Call to Action) for the Elimination of Health Inequity and Social Injustice*, 65 AM. UNIV. L. REV. 275, 278 (2015).

²⁶⁷ 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 178, at 833.

²⁶⁸ Harris & Pamukcu, *supra* note 178, 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 liberty, and a social movement focus on challenging power structures. *Id.*

²⁶⁹ *Id.* at 766.

²⁷⁰ 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. The bill also mandates that federally supported healthcare facilities provide care for eligible individuals and

measures would include but also go beyond those specifically designed to expand abortion services. So in addition to financial support for abortion facilities in underserved areas or lifting funding bans, for example,²⁷¹ responsive policy reform would provide meaningful state support for higher wages, accessible healthcare, secure housing, and interventions that upend inequality. They are 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 familiar terrain of national politics, given the new Biden Administration, and judicial decisions, given the confirmation of Justice Barrett. But something equally important is also happening. A new emphasis on public health evidence has reinforced essential links among abortion access, race, and class. 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.

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. This Article endeavored to tell how those connections have been made visible and why they can inspire legislative and community change, though it is not blind to the obstacles and opposition ahead. Although the future of abortion discourse and practice is unclear, abortion care will survive despite the decisions of the Supreme Court and the formidable anti-abortion energies of many states.

prohibits the federal government from inhibiting state, local or private insurance plans from covering abortion services. S.1021 Equal Access to Abortion Coverage in Health Insurance Act of 2021, <https://www.congress.gov/bill/117th-congress/senate-bill/1021/text>.

²⁷¹ Upadhyay et al., *Denial of Abortion Because of Gestational Limits*, *supra* note 8, at 1692.