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# The New Abortion Battleground

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## The New Abortion Battleground

David S. Cohen, Greer Donley & Rachel Rebouché\*

122 COLUMBIA LAW REVIEW (forthcoming 2022-23)

*This Article examines the paradigm shift that will occur if (and, likely, when) the Supreme Court overturns Roe v. Wade this coming summer. While most commentators are focusing on what a post-Roe world looks like within individual states, this Article examines the challenging legal issues that will arise across state borders and between the state and federal government. We emphasize how these issues intersect with innovations in the delivery of abortion, which can now occur entirely online and transcend state boundaries. The interjurisdictional abortion wars are coming, and this Article is the first to provide the roadmap for what lies ahead.*

*Judges and scholars have long claimed that abortion law will become simpler if Roe is overturned, but that is woefully naïve. Overturning Roe will create a novel world of complex, interjurisdictional legal conflicts over abortion. Some states will pass laws banning their citizens from out-of-state abortions while others will pass laws insulating their providers from out-of-state prosecutions. State legislatures are already introducing and drafting bills to this effect. The federal government will also stake a claim. Beyond promoting access to medication abortion, federal regulations may preempt state abortion bans and federal land could provide shelter for abortion services. Ultimately, once the constitutional protection for pre-viability abortion disappears, the impending battles over abortion access will transport the half-century war over Roe into a new arena, one that will make abortion jurisprudence more complex than ever before.*

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

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## INTRODUCTION

If the Supreme Court overturns *Roe v. Wade* this coming summer,<sup>1</sup> there will be a paradigm shift in abortion law and access. Borders and jurisdiction will become the central focus of the abortion battle. What has been, until now, a uniform national right<sup>2</sup> will devolve into a state-by-state patchwork. In this post-*Roe* world, states will attempt to impose their local abortion policies as widely as possible, even across state lines, and will battle one another over these choices; at the same time, the federal government may intervene to thwart state attempts to control abortion law. In other words, the interjurisdictional abortion wars are coming. This Article is the first to offer insights into this fast-approaching transformation of abortion rights, law, and access.

Though access to abortion is already scarce in many regions, for the past fifty years, the Supreme Court has held steadfast to the principle that the Constitution protects the right to pre-viability abortion everywhere in the country. The Court's decision to reconsider this holding in *Dobbs v. Jackson Women's Health Organization*—coupled with the new composition of the Supreme Court and the litigation surrounding Texas's near-total ban on abortion (SB8)—has left many legal scholars on both sides of the aisle predicting that the constitutional right to an abortion will not exist in any meaningful way in the near future.<sup>3</sup> If those scholars are correct and *Roe* is overturned,

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<sup>1</sup> In *Roe v. Wade*, the Supreme Court held that criminal laws banning abortion were an infringement of a constitutional right to privacy. 410 U.S. 113, 164 (1973). In *Planned Parenthood v. Casey*, the Court preserved constitutional protection for abortion, but gave states greater discretion to restrict access to abortion. 505 U.S. 833, 873 (1992). One of *Casey*'s central holdings is that a state cannot ban pre-viability abortions *Id.* at 872. This term, the Supreme Court will decide whether all pre-viability prohibitions on elective terminations are unconstitutional in *Dobbs v. Jackson Women's Health Organization*. 945 F.3d 265, 268 (5th Cir. 2019), *cert. granted*, 209 L. Ed. 2d 748 (2021). If the Court upholds the Mississippi law, as most suspect, it will at least minimally need to overturn that fundamental holding from *Casey*. Though it is possible for the Court to maintain, but radically change, the constitutional right to abortion while upholding the Mississippi law, the litigation surrounding Texas's six-week abortion ban has strongly suggested that the Court is not interested in protecting any abortion rights. See Mark Joseph Stern, *Sonia Sotomayor Knows Something About Roe We Don't*, SLATE (Jan. 20, 2022), <https://slate.com/news-and-politics/2022/01/sotomayor-dissent-abortion-roe-wade.html>. For these reasons, we believe that the most likely outcome in *Dobbs* is that the Court will overturn *Roe v. Wade*.

**To the editors:** This draft is written assuming *Roe* is overturned. Once *Dobbs* is decided, we will easily and quickly incorporate the holding and implications from the actual decision before publication.

<sup>2</sup> It is important to contrast the national *right* to the national reality of access. See DAVID S. COHEN & CAROLE JOFFE, OBSTACLE COURSE, THE EVERYDAY STRUGGLE TO GET AN ABORTION IN AMERICA (2021).

<sup>3</sup> See Reva B. Siegel, *Why Restrict Abortion? Expanding The Frame on June Medical*, 2020 SUP. CT. REV. 277 (describing the current Supreme Court and abortion); Sherif Girgis, *Two Obstacles to (Merely) Chipping Away at Roe in Dobbs*, SSRN (Aug. 19,

roughly half of the states—mostly in the South and Midwest—will ban abortion in all or almost all circumstances, while the remaining states—mostly along the coasts—will continue to offer legal abortion, regulated to varying degrees.<sup>4</sup>

Antiabortion jurists and advocates have long forecast that abortion law will become simpler if *Roe* is overturned. This claim has been a central part of their efforts to overturn *Roe*, claiming that it and *Planned Parenthood v. Casey*—the case that upheld *Roe*'s protection of pre-viability abortion—created an unworkably complex legal framework. In *Casey*, for instance, Justice Scalia argued, in dissent, that the undue burden test, which supplanted the trimester framework announced in *Roe*, was “inherently manipulable and will prove hopelessly unworkable in practice.”<sup>5</sup> Abortion law will become simpler, the argument continues, because states will be empowered to craft laws without the threat of constitutional litigation. Justice Scalia went so far as to suggest that overturning *Roe* and *Casey* will get the Court out of the “abortion-umpiring business” because doing so would “return this matter to the people” to determine “State by State, whether this practice should be allowed.”<sup>6</sup>

As we make clear in this Article, the opposite is true: overturning *Roe* and *Casey* will create a novel world of complicated, interjurisdictional legal conflicts over abortion. Instead of creating stability and certainty, it will lead to profound confusion because advocates on all sides of the abortion controversy will not stop at state borders in their efforts to apply their policies as broadly as possible. Antiabortion activists have made clear that overturning *Roe* is the first step toward their goal of making abortion illegal nationwide. To accomplish that goal, without *Roe*'s minimum protection, antiabortion jurisdictions not only will pass laws that criminalize in-state abortion, but also attempt to ban any abortion that has a relationship to their state. A recent Missouri bill, for instance, would apply Missouri's current abortion restrictions to out-of-state abortions performed on Missouri citizens.<sup>7</sup> After *Roe* is overturned, antiabortion jurisdictions will likely go further and try to prohibit their citizens from traveling to another state to obtain an abortion.<sup>8</sup> Seeking to protect and even extend abortion access in a post-*Roe* world, abortion-supportive states

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2021), [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=3907787](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3907787); Mary Ziegler, *The End of Roe Is Coming, and It Is Coming Soon*, N.Y. TIMES (Dec. 1, 2021), <https://www.nytimes.com/2021/12/01/opinion/supreme-court-abortion-mississippi-law.html>.

<sup>4</sup> *Abortion Policy in the Absence of Roe*, GUTTMACHER INST. (last updated Jan. 13, 2022), <https://www.guttmacher.org/state-policy/explore/abortion-policy-absence-ro>.

<sup>5</sup> *Casey*, 505 U.S. at 986 (Scalia, J., dissenting).

<sup>6</sup> *Id.*

<sup>7</sup> S.B. 603, 101st Gen. Assemb., Reg. Sess. (Mo. 2021).

<sup>8</sup> See *infra* Part II.A, B.

will seek to protect their providers from legal sanctions after helping out-of-state residents obtain care.<sup>9</sup>

*Roe*'s impending demise is just one part of the story behind the seismic shift in abortion law; the other is that abortion *practice* already has changed in ways that make borders less relevant. The rise of telehealth for medication abortion—abortion completed solely with medication during the first ten weeks of pregnancy—will make abortion access increasingly untethered to state borders.<sup>10</sup> Virtual clinics, offering remote medication abortion through telehealth, have begun to operate in greater numbers, and brick-and-mortar clinics have expanded their practice into virtual care as well. Early abortion care has, as a result, become more portable in the thirty-one states that permit telehealth for abortion.<sup>11</sup>

The portability of medication abortion will impact abortion access even in states that ban abortion after *Roe*. In those jurisdictions, people<sup>12</sup> will obtain this medication illegally through the mail—as we have seen in Texas.<sup>13</sup> Out-of-state, as well as out-of-country, providers could be guilty of state crimes by offering these telehealth services. In a post-*Roe* world, antiabortion states will struggle to establish jurisdiction over these out-of-state providers, while abortion-protective states will attempt to protect their providers from out-of-state prosecutions. The legal uncertainty in this newly-developing world of remote abortion will shape the actions of patients, providers, and the networks that support them in the years to come.

Interjurisdictional legal conflict will also arise because the federal government may play a more pronounced role in abortion law. A pro-choice President or Congress could deploy a variety of strategies to protect abortion rights, while an antiabortion President or Congress could do the opposite, as was evident by the various antiabortion

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<sup>9</sup> See *infra* Part II.D.

<sup>10</sup> The pandemic catapulted the idea of virtual abortion care from a distant dream to a new reality, revolutionizing how abortion care is offered. Rachel Rebouché, Greer Donley & David Cohen, *The FDA's Telehealth Safety Net for Abortion Only Stretches So Far*, THE HILL (Dec. 18, 2021), <https://thehill.com/opinion/healthcare/586329-the-fdas-telehealth-safety-net-for-abortion-only-stretches-so-far>.

<sup>11</sup> *Medication Abortion*, GUTTMACHER INST. (last updated Jan. 1, 2022), <https://www.guttmacher.org/state-policy/explore/medication-abortion>.

<sup>12</sup> Not every person capable of becoming pregnant is a woman; trans men and gender non-binary patients also need access to abortion and reproductive healthcare. There are also times, however, where gender's intersection with abortion is important and relevant. We do our best to thread that needle by using a variety of terms in our discussion. For more context, see Jessica Clarke, *They, Them, and Theirs*, 132 HARV. L. REV. 894 (2019); LORETTA ROSS & RICKIE SOLINGER, REPRODUCTIVE JUSTICE: AN INTRODUCTION 6-8 (1st ed. 2017).

<sup>13</sup> See *infra* Part I.B.

efforts of the Trump Administration.<sup>14</sup> Whatever the political agenda, federal action in this area will create jurisdictional conflict with state regulation of abortion. For example, the Food & Drug Administration (FDA) could attempt to use its power over drug regulation to preempt states from limiting access to abortion-inducing drugs, ensuring court battles between the agency and states that try to overregulate or ban the medication. Or the federal government could lease federal land in antiabortion states to abortion clinics in an attempt to insulate abortion provision from state bans, creating dueling abortion jurisdictions *within* states.

This Article tackles these tricky interjurisdictional issues while considering strategies to protect abortion access in a country without a constitutional right to abortion. We start by describing what a post-*Roe* country looks like if each state is free to ban abortion at any point in pregnancy. We highlight both the legal heterogeneity across states and how law is expected to alter the practice of abortion on the ground, paying attention to the possibility of remote abortion access across state lines and self-managed abortion.

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

We then highlight how the federal government, given the current Administration's commitments to reproductive rights, might protect abortion access in states that ban it. We argue that the supremacy of federal law provides a novel argument for chipping away at state abortion bans. For instance, because state law does not always apply on federal land, abortions provided on leased federal land within antiabortion states might not be subject to state abortion bans at all. Even more, the FDA has been exercising its authority over medication abortion since it was approved in 2000, and there is persuasive

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<sup>14</sup> See *Timeline of Attacks on Abortion: 2009–2021*, PLANNED PARENTHOOD (last visited Feb. 2, 2022), <https://www.plannedparenthoodaction.org/issues/abortion/abortion-central-history-reproductive-health-care-america/timeline-attacks-abortion>.

precedent to suggest that FDA regulation preempts contradictory state laws, essentially granting a right to medication abortion in all fifty states. We conclude by considering federal policy decisions that could promote access to medication abortion through telehealth and multi-state physician licensing, which could thwart antiabortion states' efforts to ban the procedure for their citizens.

Ultimately, once the constitutional right to abortion disappears, the coming battles over abortion access will move the half-century war over *Roe* into a new interjurisdictional arena. These conflicts will make abortion jurisprudence much more complex than before, in ways that test the principles underpinning our federalist system of government. But these conflicts also open the door to unexamined possibilities in a new era of abortion access—a future that is not tethered to constitutional rights. We conclude by highlighting how an abortion rights movement might pivot from defense to offense, from short game to long game and capitalize on the same strategies that led to the antiabortion movement's success.

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

Among the various arguments to overturn *Roe*, conservatives have long argued that *Roe* and its progeny created unworkable standards that have vexed lower courts. Their list of concerns includes that the undue burden standard—*Casey*'s constitutional test for vetting state abortion restrictions—is vague and difficult to apply,<sup>15</sup> that viability<sup>16</sup> is a moving target, and that a health-or-life exception<sup>17</sup> is malleable.<sup>18</sup> Abortion precedents should be overturned, in this vein of thinking, because the values underlying *stare decisis* fail in the face of unworkability.<sup>19</sup> The simpler, more workable alternative, they claim, would be to allow each state to decide its own abortion law. But they are wrong.

In this section, we explore a United States without any constitutional floor for abortion rights. Though states have regulated abortion to varying degrees, *Roe v. Wade*, as interpreted by *Planned Parenthood v. Casey*, established that no state may ban pre-viability

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<sup>15</sup> *Casey* held that states can regulate pre-viability abortions so long as the regulation did not create an undue burden. *Casey*, 505 U.S. at 874. Courts apply this standard differently.

<sup>16</sup> The Court has determined that viability starts when a fetus has “realistic possibility of maintaining and nourishing a life outside the womb.” *Id.* at 870. This point has changed over time.

<sup>17</sup> The Court has always required that abortion bans include an exception for the life or health of the mother, unless the court determines that the law does not harm the health or life of the mother. *See id.* at 846.

<sup>18</sup> Mary Ziegler, *Taming Unworkability Doctrine: Rethinking Stare Decisis*, 50 ARIZ. ST. L.J. 1215, 1218-39 (2018).

<sup>19</sup> *Id.* at 1218.



abortion.<sup>20</sup> In a post-*Roe* country, that will change. The legality of obtaining any abortion care will hinge on where you live.

The heterogeneity that characterized abortion regulation in the past will be nothing like the complexity in this fast-approaching future. This part outlines the myriad ways in which states will attempt to ban (or protect) in-state and cross-border services once *Roe* is overturned. We then explore how the right to abortion, or lack thereof, will affect access to abortion. We argue that due to innovations in abortion care, abortion access will not necessarily be tied to local abortion legality: people already can obtain abortion inducing drugs online and will continue to do so through telemedicine or other means. Thus, the coming post-*Roe* world looks very different than both the *Roe* and pre-*Roe* era.

#### A. *The Post-Roe Interjurisdictional Legal Landscape*

Without *Roe*, just over half the country (roughly twenty-six states) would make almost all abortion services illegal.<sup>21</sup> In some of these states, the laws already exist but have been enjoined as unconstitutional under *Roe* and *Casey*. If those cases are overturned or significantly modified, litigants could request that courts remove the injunctions so that the laws take effect. Other state laws will take effect immediately, however. Some states retained their pre-*Roe* bans but chose to never enforce them, thereby shielding them from injunctions; these laws could become immediately enforceable.<sup>22</sup> Twelve states have also passed so-called “trigger” laws, which would ban abortion automatically (or after minimal state action) if *Roe* is reversed. Other states have indicated an intention to prohibit abortion to the extent permitted by the U.S. Constitution, and still others have amended their constitutions to make clear that no state constitutional provision protects abortion. Overturning *Roe* will not only result in states criminalizing abortion; states also will be free to decree that life begins at conception, which could treat abortion as murder. Alabama already has such a law in place, though, under *Roe* and *Casey*, it is not in force.<sup>23</sup>

A 2019 study mapped what abortion provision would look like if *Roe* were overturned.<sup>24</sup> It found that “the average resident is expected to experience a 249-mile increase in travel distance, and the abortion rate is predicted to fall by 32.8%.”<sup>25</sup> Indeed, regional gaps in abortion access are already stark. Currently, six states have only one brick and

<sup>20</sup> *Casey*, 505 U.S. at 874.

<sup>21</sup> *Abortion Policy in the Absence of Roe*, *supra* note 4.

<sup>22</sup> Howard Wasserman, *Zombie Law*, 25 LEWIS & CLARK L. REV. 1047, 1064-65 (2022).

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

<sup>24</sup> Caitlin Myers et al., *Predicted Changes in Abortion Access and Incidence in a Post-Roe World*, 100 CONTRACEPTION 367, 369 (2019).

<sup>25</sup> *Id.* at 367.

mortar abortion provider,<sup>26</sup> and providers throughout the country are increasingly concentrated in urban areas, creating “abortion deserts,” mostly in the Midwest and South, in which there are no providers within one hundred miles of many of a state’s residents.<sup>27</sup> A post-*Roe* world in which twenty-six states ban abortion will expand the size of already-existing abortion deserts.

Abortion-supportive states will, of course, remain post-*Roe*. At present, fifteen states have passed laws to protect abortion rights on their own regardless of a federal constitutional right.<sup>28</sup> These statutes guarantee mostly unencumbered access to pre-viability abortion and access to post-viability abortion when necessary to protect the health or life of the pregnant person.<sup>29</sup> The remaining states will operate in a middle ground, where abortion is legal, but may be strictly regulated.<sup>30</sup> Providers in these abortion-supportive states will begin providing services to those traveling from states where abortion is banned, putting immense strain on their capacity to deliver services.<sup>31</sup>

Abortion travel will become an essential part of the post-*Roe* reality, but there will be attempts to criminalize it. The seeds of this strategy are apparent in one such proposed state law. In March 2021, a Missouri legislator introduced SB603, which would apply all Missouri abortion restrictions to conduct occurring “[p]artially within and partially outside this state” as well as conduct wholly outside the state when any one of the following conditions are met: the pregnant person resides in Missouri; there is a substantial connection with the pregnant person and Missouri; the “unborn child” is a resident of Missouri at the time of conception; the pregnant person intends to give birth in Missouri if the pregnancy is carried to term; the individual had sex in Missouri that “may have” conceived this pregnancy; or the patient sought prenatal care in Missouri during the pregnancy.<sup>32</sup> Bills like this could become a reality in a future with no constitutional right to

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<sup>26</sup> COMMUNITIES NEED CLINICS REPORT 2021, ABORTION CARE NETWORK, 5 (2021), <https://abortioncarenetwork.org/wp-content/uploads/2021/11/CommunitiesNeedClinics2021-1.pdf>.

<sup>27</sup> See Lisa R. Pruitt & Marta R. Vanegas, *Urbanormativity, Spatial Privilege, and Judicial Blind Spots in Abortion Law*, 30 BERKELEY J. GENDER L. & JUST. 76, 79–80 (2015) (discussing the unique impacts antiabortion laws have on women living in rural areas).

<sup>28</sup> *Abortion Policy in the Absence of Roe*, *supra* note 4.

<sup>29</sup> Two states and the District of Columbia have codified the right to abortion throughout pregnancy without state interference. *Id.*

<sup>30</sup> *Id.*

<sup>31</sup> See Rachel Jones et al., *New Evidence: Texas Residents Have Obtained Abortions in at Least 12 States That Do Not Border Texas*, GUTTMACHER INST. (Nov. 9, 2021), <https://www.guttmacher.org/article/2021/11/new-evidence-texas-residents-have-obtained-abortions-least-12-states-do-not-border>; Mary Tuma, *Texas’ Abortion Ban is Having a ‘Domino Effect’ on Clinics across the U.S.*, TEX. OBSERVER (Nov. 18, 2021), <https://www.texasobserver.org/texas-abortion-ban-is-having-a-domino-effect-on-clinics-across-the-u-s/>.

<sup>32</sup> S.B. 603, 101st Gen. Assemb., Reg. Sess. (Mo. 2021).

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abortion. Missouri already has regulated in-state abortion to the point of near-extinction. According to state records, in 2020, only 167 abortions were performed in the state, down from over 6,000 a decade earlier.<sup>33</sup> If the proposed bill was enacted and enforced today, its impact could be considerable. Over 3,300 Missouri patients traveled to other states in 2020 to obtain an abortion, most of them to Illinois and Kansas.<sup>34</sup> A law like SB603 would call into question the legality of these abortions.

Abortion supportive states likewise will craft legislation in anticipation of increased demand for services and are considering how to protect providers who offer care to patients who live out of state. For example, California legislators, working with abortion providers, created a Future of Abortion Council. This group issued a series of recommendations in late 2021, several of which touch on interjurisdictional issues, including funding abortion-related travel.<sup>35</sup> Recognizing the risk of prosecutions from states where abortion is banned, the Council recommended “enact[ing] legal protections from civil and criminal liability as well as disciplinary action to the extent possible for [California] clinicians that provide abortions to patients, including to patients who reside in other states with hostile abortion laws.”<sup>36</sup> In Part II, we describe how states can enact what we call Abortion Provider Protection Acts to accomplish this goal.

Though the focus in the coming years will be on state efforts to outlaw or protect abortion access, the federal government will also enter the fray. It too has power, including on federal land and over medication abortion, that can influence abortion access not only in states that protect it but also in states that ban it. As we explain below, the federal government could assert its jurisdiction over federal land *within* antiabortion states to blunt the effects of state bans, opening up the possibility of abortion clinics legally operating within states that ban abortion. Furthermore, the FDA could use its jurisdiction over medication abortion to trump state laws. An antiabortion administration can impose additional barriers on accessing the drug; a pro-choice administration, on the other hand, could remove restrictions on the provision of medication abortion.<sup>37</sup> These

<sup>33</sup> Josh Mercant, *Nearly half of abortions in Kansas are for Missouri residents, but voters could end that*, KAN. CITY BEACON (Nov. 20, 2021), <https://www.kcur.org/news/2021-11-20/nearly-half-of-abortions-in-kansas-are-for-missouri-residents-but-voters-could-end-that>.

<sup>34</sup> *Id.*

<sup>35</sup> CALIFORNIA FUTURE OF ABORTION COUNCIL: RECOMMENDATIONS TO PROTECT, STRENGTHEN, AND EXPAND ABORTION CARE IN CALIFORNIA 6 (Dec. 2021), [https://www.plannedparenthoodaction.org/uploads/filer\\_public/d8/e1/d8e17825-72e0-4f6f-9c57-7549bb54261e/ca\\_fab\\_council\\_report\\_.pdf](https://www.plannedparenthoodaction.org/uploads/filer_public/d8/e1/d8e17825-72e0-4f6f-9c57-7549bb54261e/ca_fab_council_report_.pdf).

<sup>36</sup> *Id.* at 10.

<sup>37</sup> The Biden administration removed one of these restrictions in December 2021, explained in detail *infra* Part III.B, C.

regulations, which should preempt conflicting state abortion regulations and possibly even complete bans, will present federal courts with questions that test the relationship between state and federal law. Outside of courtroom battles, the federal government can play a key role in encouraging the uptake of telemedicine and interstate licensure, which could improve remote abortion access and help abortion-supportive states meet the needs of abortion travelers, with ripple effects deep into antiabortion jurisdictions. We discuss the legal complexities of these actions in depth in Part III.

With the antiabortion movement becoming more aggressive by the year and the abortion rights movement openly planning for how to protect providers who offer cross-border abortion provision, interjurisdictional abortion law will soon be a reality.

### B. *Beyond Legality: Accessing Abortion after Roe*

Abortion becoming illegal in half of the country will be devastating for people seeking abortion generally and disproportionately so for poor people and women of color.<sup>38</sup> But legal scholarship has not yet explored or developed what abortion care will actually look like in a post-*Roe* world.<sup>39</sup> Our country's pre-*Roe* history coupled with modern experience worldwide points to one thing, however: abortions will not stop occurring just because they are illegal.<sup>40</sup> One important difference between illegal abortion in the future and illegal abortion decades ago is that people will be able to safely terminate a pregnancy without leaving their homes.

In 2000, the FDA paved the way for abortion done solely with medication when it approved the first drug to end a pregnancy: mifepristone (previously known as RU-486).<sup>41</sup> Today, medication abortion in the United States is accomplished by consuming two drugs. The first, mifepristone, blocks the hormone progesterone, which is necessary for a pregnancy to continue.<sup>42</sup> The second drug, misoprostol, is taken 24 to 48 hours after mifepristone and causes uterine

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<sup>38</sup> Khaleda Rahman, *Roe v. Wade Being Overturned Will Harm Black Women the Most*, NEWSWEEK (Nov. 29, 2021), <https://www.newsweek.com/overturning-roe-harm-black-women-most-1653082>.

<sup>39</sup> *But see* Rachel Rebouché, *The Public Health Turn in Reproductive Rights*, 78 WASH. & LEE L. REV. 1355, 1416-28 (2021) (describing the abortion access in “without *Roe*”).

<sup>40</sup> Yvonne Lindgren, *When Patients Are Their Own Doctors: Roe v. Wade in An Era of Self-Managed Care*, 107 CORNELL L. REV. \_\_ (forthcoming 2022), [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=3793851](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3793851).

<sup>41</sup> Greer Donley, *Early Abortion Exceptionalism*, 107 CORNELL L. REV. \_\_, 10 (forthcoming 2022), [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=3795414](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3795414).

<sup>42</sup> *Mifeprex (mifepristone) Information*, U.S. FOOD & DRUG ADMIN., (last updated Dec. 16, 2021), <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information>.

contractions that expel the pregnancy from the uterus.<sup>43</sup> Misoprostol is not FDA-approved to terminate a pregnancy, but is used off label for this purpose.

As discussed more in depth below, the FDA has historically prevented mifepristone from being prescribed in the same manner as most other drugs. Until recently, the agency required patients to pick up the drug in person from a “certified provider,” which was almost always at an abortion clinic.<sup>44</sup> In December 2021, based on years of evidence showing the drug can be prescribed and used safely without such strict controls, the FDA removed the requirement that patients pick up the drug in person.<sup>45</sup> It nevertheless maintained other restrictions on medication abortion that continue to limit its access in ways that are unsupported by the evidence and are unlike other comparably-safe drugs.<sup>46</sup>

The removal of the in-person dispensing requirement opened the door for what will become a key part of abortion’s future: abortion untethered to a clinical space. Patients now can obtain a legal abortion after meeting via telehealth with an abortion provider who prescribes abortion medication that they then consume at the location of their choice.<sup>47</sup> Remote medication abortion became nationally available two years ago after a federal district court issued an injunction that temporarily suspended in-person collection during the COVID-19 pandemic.<sup>48</sup> Virtual abortion clinics opened and mailed medication abortion to their patients, typically partnering with online pharmacies.<sup>49</sup> For example, the first large-scale telehealth abortion service run by a U.S.-based provider, Abortion on Demand (AOD), launched in April

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<sup>43</sup> Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2014*, 49 PERSP. SEXUAL & REPROD. HEALTH 1, 6 (2017).

<sup>44</sup> Donley, *supra* note 41, at 15-21.

<sup>45</sup> *Mifeprex (mifepristone) Information*, *supra* note 42.

<sup>46</sup> Response Letter from FDA CDER to American Association of Pro-Life Obstetricians and Gynecologists and American College of Pediatricians (Dec. 16, 2022), <https://www.regulations.gov/document/FDA-2019-P-1534-0016>. [hereinafter FDA Letter]

<sup>47</sup> Rebouché, Donley & Cohen, *supra* note 10.

<sup>48</sup> During the pandemic, the Trump administration lifted the in-person requirements for most drugs but kept the restriction for mifepristone. The American College of Obstetricians and Gynecologists (ACOG) sued to remove the restriction for mifepristone. ACOG won a temporary injunction that was eventually reversed by the Supreme Court. When Biden became President, he suspended the mifepristone’s requirement for the duration of the pandemic. The FDA action in December 2021 made that decision permanent, even beyond the pandemic. Donley, *supra* note 41, at 51-55.

<sup>49</sup> Carrie N. Baker, *How Telemedicine Startups Are Revolutionizing Abortion Health Care in the U.S.*, MS. MAG. (Nov. 16, 2020), <https://msmagazine.com/2020/11/16/just-the-pill-choix-carafem-honeybee-health-how-telemedicine-startups-are-revolutionizing-abortion-health-care-in-the-u-s>.

2021 and operates in 23 states.<sup>50</sup> The AOD founder is a physician licensed in each of those 23 states. AOD prescribes medication abortion up to eight weeks of pregnancy, rather than ten weeks as allowed by the FDA, and only for those over eighteen in order to ensure compliance with parental involvement restrictions.<sup>51</sup> According to its founder, AOD is built for scale over scope, delivering medication abortion to patients who do not present complicated cases and adopting a patient protective strategy through a rigorous screening process.<sup>52</sup>

The platform used by AOD was built with telehealth regulations in mind: the process is designed to protect patient privacy and to comply with the privacy protections of the Health Insurance Portability and Accountability Act.<sup>53</sup> It is the same for every state in which AOD operates, even in states with 24-hour waiting periods.<sup>54</sup> The intake is asynchronous with informed consent delivered by a pre-recorded video; a video appointment with the physician follows. AOD works with an online pharmacy that then ships the medication directly to the patient with an option for express overnight shipping. The entire process—from counseling to receipt of abortion pills—takes between two to five days, depending on the state, and AOD charges \$239, which is around \$300 less than abortions offered by a clinic.<sup>55</sup> AOD hopes to expand to a total of 27 states in 2022.<sup>56</sup>

Even now with *Roe* intact and the in-person federal restriction jettisoned, remote abortion care is not available everywhere. Virtual providers can only operate in states that have not banned telemedicine for abortion or do not require in-person dispensation of abortion medication. For instance, nineteen states have their own laws prohibiting telemedicine for abortion.<sup>57</sup> AOD verifies that the patient is in a state permitting a virtual clinic to operate by tracking IP addresses to confirm location at patient intake. If the IP address indicates a location different than the location claimed by the patient, the patient is asked to provide an in-state identification.<sup>58</sup>

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<sup>50</sup> *Where is AOD Available?*, ABORTION ON DEMAND (last visited Jan. 30, 2022), <https://abortionondemand.org/>.

<sup>51</sup> *Id.* Other virtual clinics, such as Choix and Hey Jane, provide medication abortion through ten weeks of pregnancy. Baker, *supra* note 49.

<sup>52</sup> Telephone interview with AOD Founder, held by Rachel Rebouché (Aug. 3, 2021) (on file with author) [hereinafter AOD Interview].

<sup>53</sup> Health Insurance Portability and Accountability Act of 1996, 42 U.S.C.S. § 553-57.

<sup>54</sup> Counseling online is time stamped and shipment of medication abortion does not mail until 24 hours have passed. Patients' digital signatures have an audit trail with an email only the patient has access to. AOD Interview, *supra* note 52.

<sup>55</sup> Baker, *supra* note 49.

<sup>56</sup> *Where is AOD Available?*, *supra* note 52.

<sup>57</sup> *Medication Abortion*, *supra* note 11.

<sup>58</sup> This can happen when a patient is close to a border of a state with a law prohibiting telehealth for abortion. *Id.*

Nevertheless, there are three ways in which remote care can assist people in states that ban telehealth for abortion—or, after *Roe*, ban all abortion. First, patients traveling to a state that allows remote abortion care could travel just across the border to have their telehealth appointment, rather than travel further into the state to a brick-and-mortar clinic. This can mean the difference of hundreds of miles—and the extra cost of gas and time that come with it. Indeed, some providers are considering placing mobile clinics right next to antiabortion state borders to make telehealth visits easier.<sup>59</sup>

Second, some providers do not rely on IP addresses to assess a person's location; rather, they comply with the law by sending medication abortion to mailing addresses in states where it is lawful.<sup>60</sup> A person could use the mailing address of a friend or family member in a state allowing telabortion, who could then forward the medication once it arrives. Internet resources provide other ideas: one could rent a post office box in a state where telabortion is legal, and after the medication arrives, have it forwarded to one's true address.<sup>61</sup> How such measures would be policed raises additional questions.<sup>62</sup>

Virtual providers warn against trying to circumvent state law through, for example, VPNs or mail forwarding.<sup>63</sup> Extralegal strategies could have costs, particularly for those already vulnerable to state surveillance and punishment.<sup>64</sup> But the ability to receive abortion pills by mail in ways that defy detection is sure to encumber efforts to eliminate abortion in this country.

Third, people can (and do) circumvent legal requirements and access medication abortion online through other organizations, such as Aid Access, or by self-management. Even with the protections of *Roe*, gaining access to abortion is already challenging for many people, particularly those who live in rural areas or below the poverty level. Aid Access is an international non-profit that operates like AOD but serves people across the country, including those who live in states that ban telabortion.<sup>65</sup> It offers medication abortion to patients within the first 10 weeks of pregnancy and costs \$150. European-based physicians review the patients' consultation forms and prescribe them the medications, which are delivered by an India-based pharmacy within two weeks. Perhaps unsurprisingly, "the states with the highest requests for Aid Access's assistance were those with some of the most

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<sup>59</sup> See Melville House (@melvillehouse), TWITTER (Oct. 26, 2021, 1:45 PM), <https://twitter.com/melvillehouse/status/1453055176684748810>.

<sup>60</sup> Baker, *supra* note 49.

<sup>61</sup> *The Plan C Guide to Abortion Pills*, PLAN C (last visited Jan. 5, 2022), <https://www.plancpills.org/states/texas#results-anchor>.

<sup>62</sup> Jareb A. Gleckel & Sheryl L. Wulkan, *Abortion and Telemedicine: Looking Beyond COVID-19 and the Shadow Docket*, 54 U.C. DAVIS L. REV. ONLINE 105, 112 (2021).

<sup>63</sup> Donley, *supra* note 41, at 66; AOD Interview, *supra* note 52.

<sup>64</sup> Donley, *supra* note 41, at 32.

<sup>65</sup> *Consultation*, AID ACCESS (Sept. 14, 2021), <https://perma.cc/8BWQ-2WSQ>.

restrictive laws and with an acute scarcity of providers: Louisiana, Mississippi, Wyoming and Alabama.”<sup>66</sup> The organization has seen an increase in requests from Texans since SB8 went into effect.<sup>67</sup> And, “[a]t the county level, distance to an abortion clinic and living below the federal poverty level were associated with a higher rate of requests.”<sup>68</sup>

People seeking abortion also can self-manage their abortions—that is, buy the medication online without any involvement from a healthcare provider. Organizations like Plan C have a website that informs pregnant people how they can order abortion medication from foreign suppliers, even in states that view this action as illegal.<sup>69</sup> Although groups like Plan C offer detailed instructions about how to use the medication, the lack of a provider’s involvement may increase the abortion’s risks. But we know from studies conducted in this country and in others that people can safely and effectively end their own pregnancies by buying abortion medication online.<sup>70</sup> Unlike the back-alley abortions of generations ago, self-managed medication abortion early in pregnancy opens the door for continued and safe access even without legal permission. Thus, if *Roe* is overturned, people in the states that ban abortion will have access to remote abortion care, but at the potential, and significant, risk of acting outside of the law.

Though the emergence of online access to medication abortion can untether early abortion from abortion’s legality, there are some important caveats. As noted, even if medication abortion can be prescribed remotely in a safe way, there remain legal risks.<sup>71</sup> Historically, abortion bans have targeted providers, but the rise of telehealth and self-management, where the provider might be beyond the state’s reach or non-existent, suggests that enforcement of state abortion laws will target the people who seek abortion or those who assist them instead.<sup>72</sup> Poor people and people of color will be prosecuted disproportionately and face greater legal risks compared to those who are white or have wealth.<sup>73</sup>

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<sup>66</sup> AOD Interview, *supra* note 52.

<sup>67</sup> Tanya Basu, *Activists Are Helping Texans Get Access to Abortion Pills Online*, MIT TECH. R. (Sept. 15, 2021), <https://www.technologyreview.com/2021/09/15/1035790/abortion-pills-online-texas-sb8/>.

<sup>68</sup> *Id.*

<sup>69</sup> Patrick Adams, *Amid Covid-19, a Call for M.D.s to Mail the Abortion Pill*, N.Y. TIMES (May 12, 2020).

<sup>70</sup> Abigail R. A. Aiken et al., *Demand for Self-Managed Medication Abortion Through an Online Telemedicine Service in the United States*, 110 AM. J. PUB. HEALTH 90 (2020).

<sup>71</sup> Donley, *supra* note 41, at 31-33.

<sup>72</sup> Andrea Rowan, *Prosecuting Women for Self-Inducing Abortion: Counterproductive and Lacking Compassion*, 18 GUTTMACHER POL’Y REV. 70 (2015).

<sup>73</sup> MICHELE GOODWIN, *POLICING THE WOMB: INVISIBLE WOMEN AND THE CRIMINALIZATION OF MOTHERHOOD* (2020).



Moreover, medication abortion is only approved through the first trimester. (The FDA has approved it through the first ten weeks, but research suggests it can be safely used a few weeks beyond that and providers can prescribe it off-label through eleven weeks.<sup>74</sup>) This means that to safely access second or third trimester abortion, patients will need to travel to a state where clinics can operate.<sup>75</sup> As medication abortion becomes more prevalent, particularly as an online service at lower cost, the financial sustainability of brick-and-mortar clinics is under threat.<sup>76</sup> Many facilities already operate at a loss, due in no small part to the costs of complying with state restrictions.<sup>77</sup> A decreasing patient population due to more people accessing early abortion outside of the clinic setting may exacerbate that financial vulnerability.

As smaller providers are driven out of business, large clinical centers will concentrate in the urban areas of states with supportive abortion laws.<sup>78</sup> Patients requiring abortions after the first trimester or who are not candidates for medication abortion (because of pre-existing conditions, for example) will have far fewer options located in only the most populous areas of certain states.<sup>79</sup> Desperate patients unable to afford the travel costs to get there might try to use medication abortion or other means to end later pregnancies, opening themselves up to greater medical and legal risks.<sup>80</sup> A recent study found that 25% of people seeking abortions attempt self-managed abortion first and the vast majority of them use an ineffective and potentially

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<sup>74</sup> Donley, *supra* note 41, at 63.

<sup>75</sup> Second trimester abortion is rare—only 6.2% of abortions occur in the second trimester. Third trimester abortions are extremely rare, less than 1%. But as abortion becomes more difficult to access, it is possible that the number of later abortions increase. *CDC's Abortion Surveillance System FAQs*, CTRS. DISEASE CONTROL (last reviewed Nov. 21, 2021), [https://www.cdc.gov/reproductivehealth/data\\_stats/abortion.htm](https://www.cdc.gov/reproductivehealth/data_stats/abortion.htm).

<sup>76</sup> AOD contributes 60 percent of all profits to the Save Our Clinics fund of the Abortion Care Network. Baker, *supra* note 49.

<sup>77</sup> Michelle L. McGowan et al., *Care Churn—Why Keeping Clinic Doors Open Isn't Enough to Ensure Access to Abortion*, 383 *NEW ENG. J. MED.* 508, 509 (2020).

<sup>78</sup> For instance, a Planned Parenthood designed as a regional hub recently opened in Illinois. Grace Hauck, *Planned Parenthood To Open Major Clinic In Illinois As 'Regional Haven' For Abortion Access*, USA TODAY (updated Oct. 3, 2019), <https://www.usatoday.com/story/news/nation/2019/10/02/illinois-planned-parenthood-mega-clinic-haven-abortion-access/3840714002/>.

<sup>79</sup> People taking certain kinds of blood thinners, for instance, are not candidates for medication abortion and are disproportionately people of color and people with low incomes. See Ruqaiyah Yearby, *Breaking the Cycle of "Unequal Treatment" with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias*, 44 *CONN. L. REV.* 1281, 1305-06 (2012).

<sup>80</sup> Medication abortions later in pregnancy induce labor. Many women in the United States who have tried to self-manage second and third trimester abortion with medication abortion have ended up in the hospital and then been prosecuted for the death of their fetus. See Donley, *supra* note 41, at 31.

dangerous method: 52% use supplements, herbs, or vitamins; 19% use many contraceptive pills; and 18% use physical trauma.<sup>81</sup>

Further, while online medication abortion may be increasingly available, it might be an option that has yet to become widely understood or embraced. In the same study described above, only 18% used medication abortion.<sup>82</sup> The response to SB8 in Texas provides an illustration. Although Aid Access has received a large increase in requests from Texans after SB8,<sup>83</sup> clinics across the country have also been inundated with demand from Texans.<sup>84</sup> Stories of Texans who have traveled to surrounding states in order to get abortions that are now prohibited in the state are everywhere.<sup>85</sup> The Guttmacher Institute reports that patients are going beyond those states that immediately border Texas, traveling instead to at least twelve other states.<sup>86</sup> While Aid Access may be significantly cheaper and more convenient than traveling for a legal abortion, it has not yet become mainstream.

In other words, given the need for abortion past ten weeks, the barriers to telehealth, and a lack of public familiarity, some abortion access still will depend on travel, particularly in the short term. Whether providers in other abortion-supportive states can handle the influx of demand is another question. Providers in Minnesota, a state that does not neighbor Texas, have reported that the increase of out-of-state abortion patients since SB8 went into effect has pushed them to the brink of their capacity.<sup>87</sup> California abortion providers already serve about 7,000 patients from other states; if the Court overturns *Roe*, one study estimates that California will see that number increase to over 200,000.<sup>88</sup> As a result, a coalition of state officials and medical care professionals is scaling up efforts to provide financial and logistical support to abortion travelers.<sup>89</sup>

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<sup>81</sup> *Explained: Barriers to Abortion and Attempted Self-Managed Abortion*, ADVANCING NEW STANDARDS IN REPROD. HEALTH (Oct. 26, 2021), <https://www.ansirh.org/research/infographic/explained-barriers-abortion-and-attempted-self-managed-abortion>.

<sup>82</sup> *Id.*

<sup>83</sup> Basu, *supra* note 67.

<sup>84</sup> Jones et al., *supra* note 31; Tuma, *supra* note 31.

<sup>85</sup> Shefali Luthra, *Abortion clinics north of Texas flooded with patients after severe state ban*, THE GUARDIAN (Sep. 21, 2021), <https://www.theguardian.com/world/2021/sep/21/abortion-clinics-bordering-texas-are-seeing-double-the-number-of-patients>.

<sup>86</sup> Jones et al., *supra* note 31.

<sup>87</sup> Ashley Hackett, *After Texas' abortion ban, some groups have seen increased demand for abortions in Minnesota*, MINNPOST (Nov. 19, 2021), <https://www.minnpost.com/health/2021/11/texas-abortion-ban-has-increased-demand-for-legal-abortions-in-minnesota-and-it-might-just-be-the-beginning/>.

<sup>88</sup> Rachel Bluth, *California makes plans to be the nation's abortion provider in post-Roe world*, KAISER HEALTH NEWS (Nov. 15, 2021), <https://www.latimes.com/california/story/2021-11-16/california-makes-plans-to-be-nations-abortion-provider>.

<sup>89</sup> *Id.*

A post-*Roe* country is a fractured legal landscape that necessitates time, resources, and tenacity to navigate. In the following parts, we set out the jurisdictional complications that will arise. The picture we paint is labyrinthine, and the ground we cover is largely unexplored: some states will assume roles as interstate abortion police, others will attempt to protect all abortion provision however they can, while the current federal government will have the opportunity to create new spaces, within and outside of hostile states, for abortion access.

## II. INTERSTATE BATTLES OVER CROSS-BORDER ABORTION

In the coming post-*Roe* world, state prosecutors and legislators will try to criminalize actions taken by their citizens who travel out of state to obtain an abortion. Though cross-border abortion prosecutions have been almost non-existent until this point,<sup>90</sup> we anticipate that antiabortion states will pursue them in a post-*Roe* future—perhaps going beyond criminalizing only abortion providers to also criminalizing anyone who seeks or helps a person seek an abortion out-of-state.<sup>91</sup> This future is hardly far-fetched: the antiabortion movement has been clear that the endgame is outlawing abortion nationwide. Amici in *Dobbs* argued, for instance, that the Court should overturn *Roe* by finding that fetuses are protected persons under the Fourteenth Amendment; doing so would likely have the effect of outlawing abortion everywhere.<sup>92</sup> Until that argument is accepted, the antiabortion movement will use state powers to stop as many abortions as possible, including outside state borders.

This section addresses the complex array of legal issues that arise from extraterritorial prosecution. We assess the possibilities of using already-existing criminal law to prosecute actions in another state, the possible constitutional objections to doing so, and specific laws that target extraterritorial abortion. We then address the complicated issues that would arise if an abortion-supportive state

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<sup>90</sup> In 1996, a Pennsylvania woman was prosecuted for taking a minor to New York for an abortion (with the minor's consent). *Woman Faces Trial For Taking 13-Year-Old To Outstate Abortion Clinic*, AP NEWS (Oct. 27, 1996)

<https://apnews.com/article/9d6313302114d7881dd2ecaa083f9b91>. Beyond that, there have been no publicized prosecutions for cross-border abortions. In theory, they could happen. Forty-three states ban abortion after a particular point in pregnancy, yet patients who need care later in pregnancy regularly travel to states where later abortion care is legal. To the best of our knowledge, none of these patients have been prosecuted for doing so.

<sup>91</sup> S.B. 8, 87th Leg., Reg. Sess. (Tex. 2021).

<sup>92</sup> Brief Amici Curiae for Scholars of Jurisprudence John M. Finnis and Robert P. George in Support of Petitioners, *Dobbs v. Jackson Women's Health Org.*, 141 S.Ct. 2619 (2021) (No. 19-1392).

were to attempt to protect its providers from extraterritorial investigations and prosecutions.

One important caveat to the analysis here is that even if courts permit these prosecutions and lawsuits to proceed, states may struggle to enforce their laws extraterritorially against providers who refuse to appear at a summons or participate in a lawsuit. There will be difficulties related to personal jurisdiction,<sup>93</sup> venue,<sup>94</sup> and problems of proof particular to interstate investigations.<sup>95</sup> It is for these reasons that antiabortion states, and even the federal government under the Trump Administration, have not been able to stop Aid Access from delivering illegal abortion in their states. Though we do not plumb these practical issues here, they will certainly add to the interjurisdictional concerns we explore in depth.

A. *Extraterritoriality in Abortion Law Precedent*

Only two cases decided after *Roe* have addressed whether states can penalize out-of-state conduct, and the modern application of those cases is unclear at best.<sup>96</sup> The first came in 1975 in a lesser-known Supreme Court abortion case, *Bigelow v. Virginia*.<sup>97</sup> That case concerned a Virginia statute prohibiting any publication from encouraging people to obtain an abortion.<sup>98</sup> In 1971, two years before *Roe*, a weekly newspaper distributed on the University of Virginia campus ran an advertisement for a New York City service that would refer people to an abortion provider in New York, where abortion had recently become legal.<sup>99</sup> The Virginia Supreme Court twice upheld the newspaper's conviction for violating the Virginia statute, both before and after *Roe* was decided.<sup>100</sup>

The U.S. Supreme Court disagreed. In finding that the statute infringed on the publisher's First Amendment rights, the Court made several statements casting doubt on the ability of states to legislate the

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<sup>93</sup> See *Int'l Shoe Co. v. Washington*, 326 U.S. 310 (1945).

<sup>94</sup> "In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial, by an impartial jury of the State and district wherein the crime shall have been committed" U.S. CONST. amend. VI.

<sup>95</sup> Susan F. Appleton, *Gender, Abortion, and Travel After Roe's End*, 51 ST. LOUIS U. L.J. (2007).

<sup>96</sup> *Roe's* companion case, *Doe v. Bolton*, 410 U.S. 179 (1973) addressed a provision of Georgia law that prohibited out-of-staters from getting an abortion in Georgia. This type of restriction seems far afield from extraterritorial application of abortion law we foresee if *Roe* is overturned, since it is hard to imagine in the current political climate that a state which continues to allow abortion within its borders would pass a new law also restricting it to state citizens. Thus, we are not including *Doe* in this line of precedent that has already addressed the issues we are covering here.

<sup>97</sup> *Bigelow v. Virginia*, 421 U.S. 809 (1975).

<sup>98</sup> *Id.* at 811.

<sup>99</sup> *Id.* at 811-12.

<sup>100</sup> *Id.* at 814-15.

behavior of their citizens when they travel to another state. The Court was concerned that Virginia, a state where abortion was illegal when the newspaper advertisement in question was published,<sup>101</sup> was infringing on its citizens' ability to travel to New York for an abortion.<sup>102</sup> In discussing these cross-border issues, the Court wrote that Virginia could not "prevent its residents from traveling to New York to obtain [abortion] services or, as the State conceded [at oral argument], prosecute them for going there."<sup>103</sup> Broadening this position to a more general statement about extraterritorial application of state law, the Court stated categorically that a "State does not acquire power or supervision over the internal affairs of another State merely because the welfare and health of its own citizens may be affected when they travel to that State."<sup>104</sup>

The other case comes from Missouri, and it relied on *Bigelow* to reach the same conclusion. In *Planned Parenthood of Kansas v. Nixon*,<sup>105</sup> the Missouri Supreme Court reviewed a Missouri law providing a civil cause of action against any person who causes, aids, or abets a minor obtaining an abortion without first getting parental consent or a judicial bypass.<sup>106</sup> As part of the lawsuit, the plaintiffs lodged a challenge to a unique provision of the Missouri law that effectively required Missouri minors who travel out of state for an abortion to follow Missouri's parental consent law, even if the other state has a different requirement for parental involvement or none whatsoever.<sup>107</sup>

In response to this argument, the Missouri Supreme Court reiterated the main points from *Bigelow*. Citing the U.S. Supreme Court, the court wrote that "it is beyond Missouri's authority to regulate conduct that occurs wholly outside of Missouri . . . Missouri simply does not have the authority to make lawful out-of-state conduct actionable here, for its laws do not have extraterritorial effect."<sup>108</sup> Because of this principle against extraterritorial application of the state's laws, the court held that the law was only valid as to conduct occurring in Missouri. Thus, the legality of an out-of-state abortion must be a defense to "wholly out-of-state conduct."<sup>109</sup>

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<sup>101</sup> *Id.* at 812-13.

<sup>102</sup> Bill Kovach, *Rockefeller, Signing Abortion Bill, Credits Women's Groups*, N.Y. TIMES (Apr. 12, 1970), <https://www.nytimes.com/1970/04/12/archives/rockefeller-signing-abortion-bill-credits-womens-groups.html>.

<sup>103</sup> *Bigelow*, 421 U.S. at 824; *see also id.* at 827 ("[The public interest] would not justify a Virginia statute that forbids Virginians from using in New York the then legal services of a local New York agency.").

<sup>104</sup> *Id.*

<sup>105</sup> *Planned Parenthood of Kansas v. Nixon*, 220 S.W.3d 732 (Mo. 2007).

<sup>106</sup> *Id.* at 736.

<sup>107</sup> *Id.* at 745.

<sup>108</sup> *Id.* at 742.

<sup>109</sup> *Id.* at 743.

Though these two precedents contain strong statements against the application of extraterritorial abortion law, there is no reason to count on them being the final say on the matter. The first is dated and concentrated on the First Amendment, and the second is applicable in Missouri only. The current U.S. Supreme Court, a Court we are assuming has overturned or eviscerated *Roe*, could easily revisit *Bigelow's* anti-extraterritoriality principle. Moreover, scholars have argued for decades about whether *Bigelow's* statements against extraterritorial application are mere dicta.<sup>110</sup>

This area of law is ripe for reassessment once interjurisdictional abortion prosecutions occur. Antiabortion states will not wait for the Court to give them permission to apply their laws extraterritorially; as the Missouri bill described above, and other pending legislation makes clear, they will just do it. It will take years before the litigation surrounding these cases reaches the Supreme Court, and in the meantime, states will proceed as if they have the power, waiting for courts to call their bluff. Indeed, litigation surrounding SB8 illustrates that some courts will exploit any legal uncertainty to uphold abortion restrictions. The Supreme Court may very well reaffirm its previous statements from *Bigelow*, but that is far from a foregone conclusion.

Amidst this less-than-certain legal backdrop, prosecutions related to extraterritorial conduct are on the horizon. There are two different questions that arise in the context of extraterritorial application of abortion law. The first, considered in Section B, is whether a state can apply its general abortion laws, by themselves or in conjunction with other non-abortion criminal laws, to out-of-state conduct even though they do not explicitly prohibit it. The second question, considered in Section C, is whether there are constitutional impediments to states passing and enforcing new laws that specifically target out-of-state conduct. Finally, in Section D, we explore whether abortion-supportive states can legislate in a way that protects their providers from out-of-state prosecutions.

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

If, say, Georgia bans all abortion following *Dobbs*, can the state apply that abortion ban, which says nothing about extraterritorial application, to a Georgia woman who travels to Illinois to obtain a legal abortion or to the Illinois provider who performs that abortion?

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<sup>110</sup> Compare Seth F. Kreimer, *The Law of Choice and Choice of Law: Abortion, the Right to Travel, and Extra Territorial Regulation in American Federalism*, 67 N.Y.U. L. REV. 451, 462-64, 487-519 (1992), with Mark D. Rosen, "Hard" or "Soft" Pluralism?: Positive, Normative, and Institutional Considerations of States' Extraterritorial Powers, 51 ST. LOUIS UNIV. L.J. 713, 714 (2007) [hereinafter Rosen, *Pluralism*]; Mark D. Rosen, *State Extraterritorial Powers Reconsidered*, 85 NOTRE DAME L. REV. 1133 (2010) [hereinafter Rosen, *State Powers*]; Mark D. Rosen, *Extraterritoriality and Political Heterogeneity in American Federalism*, 150 U. PENN. L. REV. 855 (2002) [hereinafter Rosen, *Heterogeneity*].

Or, could Georgia use its non-abortion conspiracy laws to charge the patient's friend who helps the patient travel to Illinois to obtain the out-of-state abortion? An aggressive prosecutor or other state official would not need any special law governing extraterritorial abortions if already-existing state law can be applied to legal abortions obtained in other states.

As a general matter, states cannot use ordinary criminal laws to prosecute people for crimes committed outside of their borders. This "general rule" is, according to the Massachusetts Supreme Judicial Court, "accepted as 'axiomatic' by the courts in this country."<sup>111</sup> However, this general rule against extraterritorial application of criminal law has enough gaps to allow prosecution of a wide variety of crimes that take place outside the jurisdiction of a state. It is beyond the scope of this Article to explore all the twists and turns of this rule, but a few examples suffice to support our general point here.

First, the "effects doctrine" allows states to prosecute someone for actions that take place outside the state that have detrimental effects in the state. The California Supreme Court has explained that "a state may exercise jurisdiction over criminal acts that take place outside of the state if the results of the crime are intended to, and do, cause harm within the state."<sup>112</sup> This doctrine could have a sweeping impact in a post-*Roe* world. Take Georgia's six-week abortion ban that was passed in 2019, and then enjoined as unconstitutional; in addition to banning abortion at six weeks, it also declared that "unborn children are a class of living, distinct person" who deserve "full legal protection."<sup>113</sup> The actions of a pregnant Georgian who crosses state lines to obtain a legal abortion outside Georgia would have the effect of killing a "living, distinct" Georgian deserving of "full legal protection."<sup>114</sup> An aggressive prosecutor could use this effects doctrine to argue that the out-of-state killing would have the in-state effect of removing a recognized member of the Georgia community from existence. While prosecutions for murders occurring in another state are rare under this doctrine, states seeking to enforce new criminal laws prohibiting abortion or protecting their new fetal persons have fresh reasons to deploy this legal strategy to the maximum extent possible.

This doctrine could apply even more broadly. Anyone involved with the killing of a "living, distinct" Georgian could be prosecuted for the effect of depriving the state of the good that comes from that now-recognized person's life. That would include anyone who worked at

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<sup>111</sup> *In re Vasquez*, 705 N.E.2d 606, 610 (Mass. 1999).

<sup>112</sup> *People v. Betts*, 103 P.3d 883, 887 (Cal. 2005). The Massachusetts Supreme Judicial Court criticized the doctrine as a fiction of "punishing the cause of the harm as if he had been present at the effect." *Vasquez*, 705 N.E. 2d at 611.

<sup>113</sup> *Sistersong Women of Color Reprod. Just. Collective v. Kemp*, 472 F. Supp. 3d 1297 (N.D. Ga. 2020).

<sup>114</sup> O.C.G.A. §§ 16-12-141(c)(1)(A-B).

the out-of-state abortion clinic and anyone who helped the patient travel to the clinic. Once a state declares a fetus a separate life, the effects doctrine could result in almost endless criminal prosecutions related to out-of-state abortions. Whether courts are willing to give in-state, antiabortion prosecutors this much authority over otherwise-lawful out-of-state activity would be a complicated and politicized issue that state and possibly federal courts would confront in a *Roe*-less future.<sup>115</sup>

Second, most states already have criminal jurisdictional provisions that offer avenues for extraterritorial application of abortion law. For instance, borrowing what Professor Gabriel Chin calls the “reasonably representative” jurisdictional statute from Pennsylvania,<sup>116</sup> the complexities become obvious. The Pennsylvania statute provides jurisdiction over any person when any of the following occur in the state: an element of the offense; an attempt to commit an offense; a conspiracy, attempted conspiracy, solicitation of a conspiracy, or overt act; or an omission of a legal duty.<sup>117</sup> The statute also provides that any Pennsylvania law specifically applying outside its borders creates jurisdiction if “the conduct bears a reasonable relation to a legitimate interest of [Pennsylvania] and the actor knows or should know that his conduct is likely to affect that interest.”<sup>118</sup>

Provisions like these create opportunities for chaos in application of criminal laws to extraterritorial conduct. The scenarios outlined above with respect to Georgia’s personhood law are illustrative. Would a conspiracy between two people to obtain an abortion out of state be chargeable in Georgia if the agreement and travel taking place in state is considered an “overt act” in furtherance of the conspiracy to murder the fetus (a person under Georgia law)? Would obtaining assistance with funding while in state be an act that provides sufficient jurisdiction to criminalize the out of state abortion? How about a neighbor watching an abortion-seeker’s children while she travels to another state? Or, in the world of telemedicine, would a Georgia resident who receives abortion medication by mail at a friend’s house over the border in North Carolina but takes the pills in her home state or completes the abortion only when she returns to Georgia be guilty of homicide because the “unborn child” is in Georgia? These questions would be answered state-by-state and case-by-case, all but ensuring disparate results even within a state.

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<sup>115</sup> These kinds of complicated legal questions have doomed antiabortion efforts in the past (see Frank James, *Mississippi Voters Reject Personhood Amendment by Wide Margin*, NPR (Nov. 8, 2011)), but there is no reason to be confident that would be the case in the future, especially with an energized antiabortion movement once *Roe* is overturned.

<sup>116</sup> Gabriel J. Chin, *Policy, Preemption, and Pot: Extra-Territorial Citizen Jurisdiction*, 58 B.C. L. REV. 929, 933 (2017).

<sup>117</sup> 18 Pa. C.S.A. § 102.

<sup>118</sup> *Id.* at § 102(a).



## DO NOT QUOTE WITHOUT AUTHOR PERMISSION

Third, even if a court found that the in-state conduct was sufficient to establish jurisdiction, a related point of contention would be whether a state can criminalize a conspiracy to commit an act that is legal in the destination state but illegal in the home state.<sup>119</sup> As Chin points out, statutes like Pennsylvania's generally "require that the offense be criminalized in the out-of-state jurisdiction."<sup>120</sup> However, Chin argues that it is "not clear" whether this is universally applied or constitutionally mandated.<sup>121</sup> The California Supreme Court stated similarly: "We reserve for another day the issue whether a conspiracy in state to commit an act criminalized in this state but not in the jurisdiction in which the act is committed, also may be punished under California law."<sup>122</sup>

This wrinkle becomes even more visible in the context of medication abortion. If a California abortion provider provides care via telehealth to a Georgia resident and then mails pills to Georgia, the question of whether Georgia can have jurisdiction over the California provider is more complex than if the Georgia resident had traveled to California. The California provider, in mailing the pills, is doing something that is legal in California, but the person receiving the pills is not in California. Would the illegal act, as Georgia views it, be the provider's actions that occurred in California or the patient's actions in Georgia? Would Georgia have jurisdiction over anyone helping its resident for conspiring to violate Georgia law? That the provider and the patient can be in two different jurisdictions in the age of teleabortion creates a messy situation for extraterritorial jurisdiction.

Even without new statutes that specifically target out-of-state abortions, antiabortion prosecutors could use already existing tools to try to limit or completely prohibit people in their state from going elsewhere to obtain legal abortions. And state court judges would be put in the position of deciding which of these applications of already-existing law are within the bounds of state jurisdiction principles and which exceed those limits.

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<sup>119</sup> Generally, a conspiracy exists when two people intend to promote or facilitate the commission of a crime. *See, e.g.*, 18 Pa. C.S.A. § 903.

<sup>120</sup> Chin, *supra* note 116, at 951-52.

<sup>121</sup> *Id.* at 952.

<sup>122</sup> *People v. Morante*, 975 P.2d 1071, 1086 (Cal. 1999). Alabama is an example of a state that has a statute that leaves out the requirement that the crime be punishable in the destination state. The provision states: "A conspiracy formed in this state to do an act beyond the state, which, if done in this state, would be a criminal offense, is indictable and punishable in this state in all respects if such conspiracy had been to do such act in this state." This law has not appeared in any reported decisions, so it would be ripe for testing from an aggressive antiabortion prosecutor trying to stop people in the state from working with others to obtain an out-of-state abortion if *Roe* were overturned. Ala. St. 13A-4-4.

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

Separate from whether ordinary criminal abortion law applies extraterritorially is the constitutionality of laws that specifically target extraterritorial abortions. For example, the Georgia legislature could pass a law that specifically targets out-of-state abortion activity instead of using existing state law to prosecute out-of-state abortions. Much like the introduced Missouri bill discussed above, such a law could make it a crime for anyone with sufficient ties to Georgia to obtain an abortion anywhere, not just in the state. Or, the law could make it a crime for anyone to perform or aid and abet the performance of an abortion on a person with sufficient ties to Georgia. Georgia might also target abortion travel, passing a law that prohibits anyone from traveling out of state to get an abortion or for aiding or abetting someone in traveling out of state to get an abortion.

Without established doctrine or caselaw, a small number of scholars have attempted to parse these issues in the past, and they fall largely into three different camps: those who believe that extraterritorial application of abortion law would violate various provisions of the Constitution; those who believe it would not; and those who believe that it would raise complicated and unanswered issues of constitutional law that would throw the Court into bitter disputes about foundational issues of federalism. We agree with the third position: the constitutional uncertainty, combined with the new realities of abortion provision, will keep the Court mired in difficult abortion controversies long after *Roe*'s destruction.

In the first camp, scholars have relied on a right to travel, conflict of laws, and the dormant commerce clause to cast doubt on states' extraterritorial reach. Professor Seth Kreimer provided the most developed explanation of the position in the early 1990s. In two different articles, he developed both an originalist and a normative argument against extraterritorial application of abortion laws. In the originalist argument, he explained that the Constitution's framers, as evidenced by the Commerce Clause, Article IV's Privileges and Immunities Clause, and the citizenship clause of the Fourteenth Amendment, had a strong commitment to a legal system in which state sovereignty was limited to application within its own borders and to a conception of national citizenship that protected a strong right to travel to other states.<sup>123</sup> He argued that the right to travel to other states and take advantage of their laws is an essential component of liberty,<sup>124</sup> and that to further the Constitution's goal of "establishing a single national identity," there is value in people having the same privileges and responsibilities when located within a state, whether as a visitor or

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<sup>123</sup> Seth F. Kreimer, *supra* note 110, at 487-519 (1992).

<sup>124</sup> Seth F. Kreimer, "But Whoever Treasures Freedom . . .": *The Right to Travel and Extraterritorial Abortions*, 91 MICH. L. REV. 907, 914-15 (1993).

a resident.<sup>125</sup> His ultimate conclusion is that “citizens who reside in each of the states of the Union have the right to travel to any of the other states in order to follow their consciences, and they are entitled to do so within the frameworks of law and morality that those sister states provide.”<sup>126</sup>

A small group of scholars have agreed with Kreimer. Professor Lea Brilmayer, applying conflict-of-laws principles, argued that the policy of the “territorial state” should trump the state of residence because states that permit abortion have a strong interest in regulating what happens within their state.<sup>127</sup> Taking a different approach, Professor Susan Lorde Martin, though touching on abortion only passingly, opined that the modern Dormant Commerce Clause doctrine prohibits extraterritorial application of a state’s laws; indeed, she called this principle a “bedrock of a federalist system.”<sup>128</sup>

At the other end of the spectrum lie those scholars who have analyzed the same doctrines and concluded that there is nothing in the Constitution that prohibits states from enforcing laws targeting out-of-state abortions or abortion travel. Professor Mark Rosen has provided perhaps the most detailed analysis, concluding that none of the previously identified constitutional doctrines prohibit states from applying their criminal laws outside state borders.<sup>129</sup> According to Rosen, the Supreme Court, state courts, and model codes have long supported states regulating out-of-state activity.<sup>130</sup> Rosen recognizes that the Constitution places some limits on extraterritorial application of state law but argues that those narrow doctrines have no applicability when one state applies its criminal law to its own citizens acting in another state.<sup>131</sup> Allowing states to determine the reach of their own powers, according to Rosen, is normatively preferable in order to prevent people picking and choosing which state policies to follow and to ensure actual political heterogeneity among the states.<sup>132</sup>

Rosen has developed the most sustained defense of extraterritorial enforcement of criminal abortion law, but he is not alone. Professor Donald Regan argued that the “reality and

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<sup>125</sup> *Id.* at 919-921. (“[A] system in which my opportunities upon entering California remain subject to the moral demands of Pennsylvania undercuts this sense of national unity.”).

<sup>126</sup> *Id.* at 938.

<sup>127</sup> Lea Brilmayer, *Interstate Preemption: The Right to Travel, the Right to Life, and the Right to Die*, 91 MICH. L. REV. 873, 884-90 (1993); see also Katherine Florey, *State Courts, State Territory, State Power: Reflections on the Extraterritoriality Principle in Choice of Law and Legislation*, 84 NOTRE DAME L. REV. 1057 (2009).

<sup>128</sup> Susan Lorde Martin, *The Extraterritoriality Doctrine of the Dormant Commerce Clause Is Not Dead*, 100 MARQ. L. REV. 497, 526 (2016).

<sup>129</sup> Rosen, *Pluralism*, *supra* note 110, at 714; Rosen, *State Powers*, *supra* note 110; Rosen, *Heterogeneity*, *supra* note 110.

<sup>130</sup> Rosen, *Pluralism*, *supra* note 110, at 719-23.

<sup>131</sup> *Id.* at 733-40.

<sup>132</sup> Rosen, *Heterogeneity*, *supra* note 110, at 883-891.

significance of state citizenship” includes states having an interest in controlling their citizens’ conduct no matter where they are.<sup>133</sup> Professor William Van Alstyne similarly contended that there is no constitutional right to “evade” your home state’s criminal law by traveling to another state,<sup>134</sup> and Professor Joseph Dellapenna maintained that states can apply their own law extraterritorially because people always have the option of moving to a different state if they want to take advantage of more permissive abortion laws.<sup>135</sup>

The third camp straddles these two positions. Professor Richard Fallon took this approach: if *Roe* were overturned, “very serious constitutional questions would arise—and, somewhat ironically, a central issue for the Supreme Court would likely be whether the states’ interest in preserving fetal life is weighty enough to justify them in regulating abortions that occur outside their borders.”<sup>136</sup> After surveying the issues, Fallon explained that he had no basis to “pronounce a confident judgment” on the issue but had “no hesitation in concluding that this question would be a difficult one that is not clearly resolved” by Supreme Court precedent.<sup>137</sup> Professor Susan Appleton agreed with Fallon, arguing that choice of law doctrine would make any prosecution of out-of-state individuals (like the abortion provider or the clinic worker) a highly contentious matter, presenting courts with “excruciatingly challenging constitutional issues.”<sup>138</sup>

While we find the first camp convincing both doctrinally and normatively, we find Professors Fallon’s and Professor Appleton’s position a better prediction of what the future holds for four reasons.

First, constitutional doctrines related to extraterritoriality are notoriously underdeveloped. For instance, the Fourteenth Amendment’s Privileges or Immunities Clause was given very limited application early in its history when the Court ruled that only a very narrow set of national privileges or immunities were protected against state intrusion.<sup>139</sup> Only once since has the Court used the clause to

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<sup>133</sup> Donald H. Regan, *Siamese Essays: (I) CTS Corp. v. Dynamics Corp. of America and Dormant Commerce Clause Doctrine; (II) Extraterritorial State Legislation*, 85 MICH. L. REV. 1865, 1908-12 (1987).

<sup>134</sup> William W. Van Alstyne, *Closing the Circle of Constitutional Review from Griswold v. Connecticut to Roe v. Wade: An Outline of Decision Merely Overruling Roe*, 1989 DUKE L.J. 1677, 1684-85 (1989).

<sup>135</sup> Joseph W. Dellapenna, *Abortion Across State Lines*, 2008 BYU L. REV. 1651, 1694 (2008); cf. Reva B. Siegel, *Prochoicelife: Asking Who Protects Life and How--And Why It Matters in Law and Politics*, 93 INDIANA L.J. 207 (2018)

<sup>136</sup> Richard H. Fallon Jr., *If Roe Were Overruled: Abortion and the Constitution in a Post-Roe World*, 51 ST. LOUIS. UNIV. L.J. 611, 613 (2007).

<sup>137</sup> *Id.* at 632.

<sup>138</sup> Appleton, *supra* note 95, at 682-83.

<sup>139</sup> Slaughter-House Cases, 83 U.S. 36 (1872).

strike down a state law.<sup>140</sup> Since then, the Court has not taken any opportunity to further develop the clause’s jurisprudence.<sup>141</sup>

The same can be said of the Dormant Commerce Clause and the Citizenship Clause in this context. Before he became a Supreme Court Justice, Tenth Circuit Judge Neil Gorsuch called the extraterritorial principle “the least understood of the Court’s three strands of dormant commerce clause jurisprudence.”<sup>142</sup> Unable to resist the pun, Judge Gorsuch continued that this strand is “certainly the most dormant” considering the Court has used it to strike down only three state laws.<sup>143</sup> Yet, the principle continues to appear in lower court opinions from time to time as the basis for striking down the occasional law.<sup>144</sup> Commentators have noted the confusion this underdeveloped principle has created, calling it “all but clear”<sup>145</sup> and bemoaning its “difficulty of application [resulting in] courts struggl[ing] to define the extraterritorial principle’s precise scope.”<sup>146</sup> Similarly, outside of debates about birthright citizenship, the Citizenship Clause’s implications for federal identity has long been “neglected by courts and scholars.”<sup>147</sup>

That leaves the Due Process Clause as the most likely basis for vetting the extraterritorial application of abortion law. While that clause has certainly been developed more than the other three, in a world in which *Roe* is overturned or seriously eroded, substantive due process would be in flux, especially since it has long been a controversial area of law. After all, without *Roe*, one of the foundational cases establishing substantive due process, the whole

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<sup>140</sup> *Saenz v. Roe*, 526 U.S. 489 (1999).

<sup>141</sup> *Saenz* has been cited only six times by the Court, and only once in a majority opinion. See *Alden v. Maine*, 527 U.S. 706, 751 (1999) (citing *Saenz* merely for a general quote about federalism).

<sup>142</sup> *Energy & Env’t Legal Inst. v. Epel*, 793 F.3d 1169, 1172 (10th Cir. 2015).

<sup>143</sup> *Id.*; see also *Am. Beverage Ass’n v. Snyder*, 735 F.3d 362, 378–79 (6th Cir. 2013) (Sutton, J., concurring) (calling the doctrine “a relic of the old world with no useful role to play in the new”).

<sup>144</sup> See *Ass’n for Accessible Med. v. Frosh*, 887 F.3d 664, 670 (4th Cir. 2018) (striking a Maryland price gouging law because “the Act controls the prices of transactions that occur outside the state”).

<sup>145</sup> Tyler L. Shearer, *Locating Extraterritoriality: Association for Accessible Medicines and the Reach of State Power*, 100 B.U. L. Rev. 1501, 1504 (2020).

<sup>146</sup> *Dormant Commerce Clause—Extraterritoriality Doctrine—Fourth Circuit Invalidates Maryland Statute Regulating Price Gouging in the Sale of Generic Drugs*, 132 HARV. L. REV. 1748, 1748 (2019), available at [https://harvardlawreview.org/wp-content/uploads/2019/04/1748-1755\\_Online.pdf](https://harvardlawreview.org/wp-content/uploads/2019/04/1748-1755_Online.pdf); Brannon P. Denning, *Extraterritoriality and the Dormant Commerce Clause: A Doctrinal Post-Mortem*, 73 L.A. L. REV. 979, 990-92 (2013) (arguing that *PbRMA v. Walsh* marked the Court’s abandonment of a freestanding rule against extraterritorial regulation under the dormant Commerce Clause doctrine).

<sup>147</sup> Rebecca E. Zietlow, *Belonging, Protection and Equality: The Neglected Citizenship Clause and the Limits of Federalism*, 62 PITT. L. REV. 281, 283 (2000).

doctrine might crumble.<sup>148</sup> Moreover, the due process extraterritoriality doctrine the Court has developed, which exists in the context of punitive damages for a defendant's out-of-state actions, has not been expanded.<sup>149</sup> This leaves the clause ripe for bitter dispute in how it should be applied to extraterritorial abortion law.

Similarly, other legal doctrines outside of constitutional law, like conflicts-of-law jurisprudence, are just as indeterminate. Professor Appleton has explained that “criminal law has customarily remained immune from scrutiny through a choice-of-law lens.”<sup>150</sup> And Professor Dellapenna wrote, despite forcefully arguing that conflicts doctrine allows extraterritorial application of abortion restrictions, that “[t]his domain is notoriously unstable and contested.”<sup>151</sup>

Second, determining the legality of extraterritorial application of abortion law would involve resolving claims of competing fundamental constitutional values. Among these values are, on the side of allowing extraterritorial application, local experimentation, preventing the proverbial “race to the bottom,” and judicial restraint. On the side of prohibiting extraterritorial application are the constitutional values of national citizenship, liberty of travel, and freedom of choice. And the interest in state sovereignty cuts both ways, as both restrictive and permissive states want their local policy choices to have the broadest possible reach. Having competing constitutional values would in no way be unique to this particular issue, as this is standard fare for most high-profile constitutional disputes. However, because these constitutional values, which are in theory separate from the values underlying the abortion debate, will become proxies for the abortion debate, the conflict of fundamental values will become even more difficult for courts to resolve.<sup>152</sup>

Third, as the short sampling of scholarly treatment of the constitutional issues that extraterritorial application of state abortion law shows, any solution to the constitutional question here implicates not only competing constitutional foundational principles but also competing notions of constitutional interpretation. Historical disputes about the original understanding of the different clauses at issue will lead the Court to pick among different versions of complex history, which the Court does regularly.<sup>153</sup> However, when the Court is put in a position of having to choose among different versions of history, the ever-present criticisms of the Court as deciding cases based on Justices'

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<sup>148</sup> Brief of Texas Right to Life as Amicus Curiae in Support of the Petitioners at 22-23, *Dobbs v. Jackson Women's Health Org.*, No. 19-1392 (2021).

<sup>149</sup> *BMW of N. Am. v. Gore*, 517 U.S. 559 (1996).

<sup>150</sup> Appleton, *supra* note 95, at 667.

<sup>151</sup> Dellapenna, *supra* note 135, at 1654.

<sup>152</sup> Fallon, *supra* note 136.

<sup>153</sup> For instance, compare the majority and dissenting opinion uses of history in *McDonald v. Chicago*, 561 U.S. 742 (2010), and *District of Columbia v. Heller*, 554 U.S. 570 (2008).

own preferred outcomes become more salient.<sup>154</sup> Appeals to other modes of constitutional interpretation, such as relying on tradition or contemporary normative concerns, face similar challenges and criticism.<sup>155</sup>

Fourth, and finally, given the various ways that states might attempt to restrict extraterritorial abortions, especially in an era of telaboration, courts will parse cases based on different facts and thus render different outcomes based on differing in-state and out-of-state activities. This will subject courts to the same criticism leveled at *Planned Parenthood v. Casey*: any resulting standard is not workable. Imagine different situations based on the abortion patient's ties to her home state where abortion is illegal (does she live in the state where she is a citizen or live temporarily elsewhere?), the doctor's ties to the state where abortion is illegal (is she licensed in that state but practicing elsewhere or does she have no connection to that state at all?), the type of assistance someone else provides the patient (does a friend drive the patient across state lines or does she deliver her pills from a state where they are legal to a state where they are not?), or for medication abortion, where the abortion pills are taken and the abortion completed (does she take the pills out of state but expel the pregnancy tissue in state?). Now combine these various scenarios and even more permutations arise.

It is possible that in a post-*Roe* country the Supreme Court and lower federal courts reach a consistent rule despite these varying interests and hold that these laws are always permissible or always prohibited. But it is much more likely that some combination of the scenarios listed above would strike some federal judges as appropriate and others as going too far, whether because of a sense of fundamental fairness,<sup>156</sup> the constitutional theories already discussed in this section,<sup>157</sup> or other constitutional concerns.<sup>158</sup> Given the underdeveloped and contested jurisprudence, the competing fundamental constitutional principles involved, and the complex web of factual scenarios that could possibly arise, the post-*Roe* judiciary will soon be mired in interjurisdictional complexities that will make the workability of the previous era look simple in comparison.

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<sup>154</sup> Justice John Paul Stevens, *Originalism and History*, 48 GA. L. REV. 691 (2014); Saul Cornell, *Originalism on Trial: The Use and Abuse of History in District of Columbia v. Heller*, 69 OHIO. ST. L.J. 625 (2008).

<sup>155</sup> Compare Kreimer, *supra* note 110, with Rosen, *Pluralism*, *supra* note 110.

<sup>156</sup> *Lassiter v. Dep't of Soc. Serv. of Durham Cnty.*, 452 U.S. 18, 24-25 (1981).

<sup>157</sup> See *supra* notes 110.

<sup>158</sup> This might include concerns over minimum contacts from personal jurisdiction doctrine, see *Int'l Shoe*, 326 U.S. at 310, or other the impact on other areas of law. See Brief of Firearms Policy Coalition as *Amicus Curiae* in Support of Granting Certiorari, *Whole Woman's Health v. Jackson*, \_\_ F.Supp.3d \_\_ (W.D. Tex. 2021) (No. 21-463), 2021 WL 3821062.

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

So far, we have explored the difficult legal issues that arise when antiabortion states attempt to apply their laws beyond state borders. However, antiabortion states are not alone in thinking about extraterritoriality after *Roe* falls. An abortion-supportive state could try to thwart antiabortion states from applying their law to their providers. California has already recognized this possibility, though without yet providing any specifics.<sup>159</sup> This section explores several avenues by which California and other abortion-supportive states might try to blunt the force of antiabortion states' extraterritorial reach. Importantly, each of these interventions would strike at the heart of one of the basic, fundamental principles of law—interstate comity.

An abortion-supportive state might think first about protecting its providers' licenses and malpractice insurance. Ever since SB8 went into effect in September 2021, many have questioned why Texas abortion providers have not engaged in civil disobedience and provided abortions after six weeks despite what the law says.<sup>160</sup> The answer is not just the risk of being forced to pay the \$10,000 (or more) bounty. Texas abortion providers, many of whom also practice other areas of medicine or provide abortions in other states, also fear losing their medical licenses and malpractice insurance.<sup>161</sup> Physicians must report all lawsuits and complaints in which they are named as defendants to their licensing bodies and insurers. Being named as a defendant too many times, or being subject to a disciplinary investigation, even if the provider ultimately prevails, could result in licensure suspension, prohibitively high malpractice insurance costs, and reputational damage, given that lawsuits are publicly available and figure into ratings of physician competence.<sup>162</sup>

Providers from abortion-supportive states may face similar concerns, but their home states could protect them. If, to go back to the examples used earlier, an Illinois provider performs an abortion on a patient from Georgia (whether in Illinois or via telemedicine), Georgia might try to prosecute the Illinois provider or a private citizen might file a complaint or civil lawsuit. Illinois could prohibit its medical boards and in-state malpractice insurance companies from taking any adverse action against providers who assist out-of-state patients. This would not be a blanket immunity for abortion providers but rather a targeted protection applicable to out-of-state lawsuits or prosecutions

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<sup>159</sup> See discussion *infra* Part I.B.

<sup>160</sup> Alexi Pfeffer-Gillett, *Civil Disobedience in the Face of Texas's Abortion Ban*, 106 MINN. L. REV. 203 (2021).

<sup>161</sup> Complaint, *United States v. Texas*, \_\_\_ F. Supp.3d \_\_\_, 2021 WL 4593319 (W.D. Tex. 2021).

<sup>162</sup> See *U.S. Medical Licensing and Disciplinary Data*, FEDERATION OF STATE MEDICAL BOARDS (last visited Feb. 3, 2022), <https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/u.s.-medical-licensing-and-disciplinary-data/>.



arising from abortions performed in compliance with Illinois law. States could further insulate providers by removing any statutory or regulatory requirements to ask for a patient's residence or location. Providers would presume that any patient who scheduled an appointment with them was in their state and would therefore not be knowingly violating Georgia law.

Abortion-supportive states might further thwart interstate investigations, both civil and criminal. On the civil side, most states have enacted some form of the Uniform Interstate Depositions and Discovery Act which simplifies the process for litigants to take depositions and engage in discovery with people from another state.<sup>163</sup> The Act streamlines the process for an out-of-state court to enforce the original state's subpoena. On the criminal side, the Uniform Act to Secure the Attendance of Witnesses from Without a State in Criminal Proceedings, a version of which every state has enacted, accomplishes the same goal for witness subpoenas.<sup>164</sup> And even before witnesses are called, police departments usually work with one another across state lines via formal and informal cooperation agreements.<sup>165</sup>

States could protect their providers from antiabortion state investigations by passing a law exempting abortion providers from the interstate discovery and interstate witness subpoena laws while also prohibiting state and local law enforcement agencies from cooperating with antiabortion states' investigations. As with the license and malpractice exemption above, this would not be for any and all abortions. Rather, it would apply only to abortions that are otherwise legal in the provider's state. A state passing such an exemption or waiver would not protect the provider if she ever traveled to the antiabortion state, where she would then be subject to that state's laws. However, doing so would prevent the courts of the provider's home state from enforcing these out-of-state subpoenas and discovery requests and the law enforcement agencies of the provider's home state from becoming a cooperating arm of the antiabortion state's investigation apparatus.

Finally, the abortion-supportive state could exempt abortion providers from the state's extradition law (again, not for all abortions, just those that would otherwise be legal in the provider's home state). The Constitution requires states to extradite an accused criminal who flees to that state.<sup>166</sup> Thus, for instance, Illinois cannot constitutionally

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<sup>163</sup> Uniform Interstate Depositions and Discovery Act, S.B. 79, 42 PA.CON.S.TAT.ANN. § 5335 (2013).

<sup>164</sup> Uniform Act to Secure the Attendance of Witnesses from Within or Without a State in Criminal Proceedings (1936), *available at* [https://www.hrw.org/legacy/pub/2006/Uniform\\_Act\\_to\\_Secure\\_the\\_Attendence\\_of\\_Witnesses.pdf](https://www.hrw.org/legacy/pub/2006/Uniform_Act_to_Secure_the_Attendence_of_Witnesses.pdf).

<sup>165</sup> Bridget A. Fahey, *Federalism By Contract*, 129 YALE L.J. 2326 (2020).

<sup>166</sup> U.S. CONST. art. IV, § 2, cl. 2.

refuse to extradite an Illinois provider who travels to Georgia, performs an illegal abortion there, and then goes back to Illinois. However, the Constitution's extradition clause does not cover extradition of people who did not flee, meaning a state is not constitutionally required to extradite an Illinois provider who never leaves Illinois but mails abortion medication to a Georgia resident in Georgia.<sup>167</sup> Nonetheless, some states have provisions in their own extradition laws that obligate the state to extradite accused criminals, even if they have never been in the other state and thus have not fled.<sup>168</sup> An abortion-supportive state seeking to fully protect its providers could exempt them from these provisions so that the provider could perform abortions in their home state to out-of-state patients—whether physically in the provider's home state or by telemedicine to the patient's home state—without fear of being extradited.

An abortion-supportive state could bundle all of these suggestions together into what we suggest calling an Abortion Provider Protection Act. New Jersey and California already protect abortion providers' home address from public discovery out of concern that they will be targeted by antiabortion extremists.<sup>169</sup> The act proposed here could include such protection, but would go much further, protecting providers from adverse actions from licensing bodies and malpractice insurers, from out-of-state civil discovery, from in state law enforcement agencies cooperating with antiabortion state investigations, from out-of-state criminal subpoenas, and from extradition.

Other than the constitutional floor of extradition for fleeing accused criminals, none of these approaches would likely raise issues that could be challenged in the courts. However, each would threaten basic principles of comity between states, possibly resulting in retaliation. After all, if Illinois refuses to extradite an abortion provider to Georgia, will Georgia retaliate and refuse to extradite a gun dealer to Illinois? A state passing some version of an Abortion Provider Protection Act would go a long way to protecting its providers in a post-*Roe* world, but would also intensify interstate conflict in a way that could have unintended consequences for other areas of law. As we argue throughout this Article, these are the inevitable effects of overturning *Roe*.

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<sup>167</sup> *Hyatt v. People of State of N.Y. ex rel. Corkran*, 188 U.S. 691, 709–13.

<sup>168</sup> CONN. STAT. § 54-162 (“even though the accused was not in that state at the time of the commission of the crime and has not fled therefrom”).

<sup>169</sup> See CAL. GOV'T CODE § 6215 (West 2003); N.J. REV. STAT. § 47:4-2 (2019).

### III. FEDERAL INTERVENTIONS: LAND, PREEMPTION, HEALTH POLICY

Interstate issues are not the only area that will cause deep confusion: interaction between federal and state law will also be complicated and in flux. Right now, for instance, the Biden administration has used some of its power to protect abortion rights.<sup>170</sup> But more could be done. This section will explore how possible federal actions taken in the wake of *Dobbs* interact with—and possibly preempt—state laws to the contrary.<sup>171</sup> As with everything described already in this Article, each move will face legal uncertainty and depend on political mobilization. But if *Roe* is overturned, the Biden presidency will face increasing pressure to use its power, however untested, to protect abortion rights—and we offer creative avenues for how it can do so.

The federal government can improve abortion access on its own, even without the currently-stalemated legislative proposals. One of the main tools at its disposal is through the FDA—an executive agency with primary regulatory authority over abortion-inducing drugs. The FDA could remove the unnecessary regulations it has imposed on mifepristone, as it started to do this December. These regulations should preempt state laws that overregulate medication abortion or *de facto* ban them in a post-*Roe* country, setting up a federal-state conflict that could force all states to allow medication abortions up to ten weeks. The executive branch could also encourage investment in telehealth and the adoption of interstate compacts that will improve abortion care throughout the country. And, taking a bold and novel approach, the federal government could use its jurisdiction over federal land within antiabortion states to insulate providers who offer abortion care on that land, infiltrating even the most antiabortion state's boundaries. We begin with the example of federal land and highlight how the scope of federal power—especially as it impacts antiabortion states—will become critical to future abortion debates.

#### A. Federal Land

There is neither a general federal prohibition on abortion, nor, for purposes of this section, a prohibition on abortions being performed on federal land. There is, as most people are familiar with, a prohibition on federal dollars being used to perform abortions that

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<sup>170</sup> We have publicly argued it should be done more. David S. Cohen, Greer Donley, & Rachel Rebouché, *Joe Biden Can't Save Roe v. Wade Alone. But He Can Do This*, N.Y. TIMES (Dec. 30, 2021), <https://www.nytimes.com/2021/12/30/opinion/abortion-pills-biden.html>.

<sup>171</sup> Though our article focuses on FDA law's possible preemption of state abortion laws, there are other federal laws that might poke additional holes in state abortion bans. See Greer Donley, Rachel Rebouché, & David Cohen, *Existing Federal Laws Could Protect Abortion Rights Even if Roe Is Overturned*, TIME (Jan. 24, 2022), <https://time.com/6141517/abortion-federal-law-preemption-roe-v-wade/>.

do not fall within any of the Hyde Amendment exceptions,<sup>172</sup> but that leaves space for the federal government to lease space on federal land to some private entity to perform abortions there. Those providers would have a reasonable—though certainly controversial—argument that state criminal and civil abortion bans do not apply on federal land, and they are therefore free to lawfully provide abortions there, even if the state within which the federal land is situated has otherwise banned abortion.

The key to this legal analysis is the Assimilative Crimes Act (ACA).<sup>173</sup> This relatively little-known federal law is the mechanism by which the federal government bans criminal activity on federal land<sup>174</sup> without passing specific laws to do so. When someone engages in behavior on federal land for which there is no crime “punishable by any enactment of Congress,” this Act makes it a federal crime if that behavior “would be punishable if committed or omitted within the jurisdiction of the State, Territory, Possession, or District in which [the federal land] is situated.”<sup>175</sup> Someone falling under this provision is “guilty of a like offense and subject to a like punishment.”<sup>176</sup>

At first blush, it may seem that state laws criminalizing abortion would be actionable under the ACA. But there are a few pieces of the ACA that are important to understand for our argument. First, someone who engages in behavior on federal land that is punishable as a crime under state law is not prosecuted by the state. Rather, the ACA incorporates the state crime into federal law so that technically the person has violated the ACA, not the state law.<sup>177</sup> That means that crimes are prosecuted by federal prosecutors in federal court, not by state prosecutors in state court.<sup>178</sup> Prochoice federal prosecutors could exercise enforcement discretion on federal land, and antiabortion state prosecutors would have no ability to prosecute on their own.

Second, the ACA does not incorporate all state criminal law. The Supreme Court has explained that “normally” and “presumably”

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<sup>172</sup> Consolidated Appropriations Act, 134 Stat. 1182, div. H, §§ 506–07 (Pub. L. No. 116260, Dec. 27, 2020).

<sup>173</sup> 18 U.S.C.A. § 13.

<sup>174</sup> 18 U.S.C.A. § 7(3) defines federal land as “Any lands reserved or acquired for the use of the United States, and under the exclusive or concurrent jurisdiction thereof, or any place purchased or otherwise acquired by the United States by consent of the legislature of the State in which the same shall be, for the erection of a fort, magazine, arsenal, dockyard, or other needful building.”

<sup>175</sup> 18 U.S.C.A. § 13(a).

<sup>176</sup> *Id.*

<sup>177</sup> “Prosecution under the ACA is not for enforcement of state law but for enforcement of federal law assimilating a state statute.” *United States v. Brown*, 608 F.2d 551, 553 (5th Cir. 1979).

<sup>178</sup> *United States v. Ware*, 190 F. Supp. 645, 659 (N.D. Cal. 1960), *affirmed in part, vacated in part*, *Paul v. United States*, 371 U.S. 245 (1963). *Paul* reaffirmed the principle that Congressional regulation of federal land “bars state regulation without specific congressional action.” *Id.* at 263.

the ACA assimilates a state statute if no enactment of Congress punishes the conduct in question.<sup>179</sup> However, the Court offered several important considerations that go into a determination whether a state statute is assimilated: whether application of state law would “interfere with the achievement of a federal policy,” if application of the state law would “rewrite an offense definition Congress carefully considered,” or when Congress has “occup[ie]d so much of a field as would exclude use of the particular state statute at issue.”<sup>180</sup> When state criminal law is inconsistent with aspects of federal law, state law does not apply on federal land. Precedent has been uniform that, to determine whether there is an absence of federal law such that state law applies, the ACA looks not only to laws passed by Congress but also to federal regulations.<sup>181</sup>

Providers who want to avoid state abortion bans post-*Roe* (or in Texas right now) should appeal to the federal government for permission to operate on federal land, such as by attempting to lease space from the federal agencies or programs. Providers who do so would have several arguments at their disposal, many of which dovetail with the preemption arguments described above. Federal regulations constitute a body of federal law under the ACA, so a federal regulation clearly stating that state abortion law does not apply on federal lands could help protect providers and patients.

The FDA or its parent, HHS, could assist this effort by issuing such a regulation regarding the abortion medication regime. As described earlier, the FDA already regulates this medication.<sup>182</sup> If the FDA issued a new statement, either generally proclaiming its authority to make final decisions on a drug’s safety and availability or a specific statement about FDA authority on federal land, providers would have a strong argument that they could prescribe and distribute abortion medication without fear of legal punishment while on federal land. This would not mean that people on federal land had access to

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<sup>179</sup> *Lewis v. United States*, 523 U.S. 155, 164 (1998).

<sup>180</sup> *Id.* at 164-65. The Court listed these considerations as part of its discussion of determining whether state law is assimilated when a federal enactment punishes the same conduct yet cited with approval precedent that looked to these considerations even if there is no such federal enactment. *Id.* (citing *Johnson v. Yellow Cab Transit Co.*, 321 U.S. 383, 389-90 (1944)). Given the Court’s use of the words “normally” and “presumably” to couch the assimilation determination when there is no federal enactment punishing the same conduct, it would be reasonable to use these same factors in assessing whether this normal presumption should not apply. *See generally* *James Stewart & Co. v. Sadrakula*, 309 U.S. 94, 103-04 (1940) (“Where enforcement of the state law would handicap efforts to carry out the plans of the United States, the state enactment must, of course, give way.”).

<sup>181</sup> *See, e.g.*, *United States v. Hall*, 979 F.2d 320, 322 (3d Cir. 1992) (“We agree with those courts that have concluded that a federal regulation does qualify as ‘an enactment of Congress.’”); *United States v. Palmer*, 956 F.2d 189, 191 (9th Cir. 1992).

<sup>182</sup> *See supra* Part II.B.

abortion in the same manner as before *Roe* was overturned because abortion medication is, at this time, only FDA-approved for terminating pregnancies up to ten weeks of gestation.<sup>183</sup> However, it would mean that for people terminating up to ten weeks gestation, abortion access would remain in a post-*Roe* world—even in states where abortion is illegal—as long as the medication was distributed on federal land.

There is also an argument that federal law, as it currently exists, *already* precludes the application of state law regarding abortion on federal land. This argument could take several different forms. For instance, providers could argue that even in the absence of an agency statement, the FDA’s approval of the medication abortion regimen along with its strong statements about the safety of the drug protocol<sup>184</sup> is not merely permission from the federal government for providers to perform abortions in this manner, but is the policy of the federal government. There is precedent for this line of argument under the ACA from multiple lower courts that have refused to apply state bans on union shop agreements on federal land because federal law “expressly permits union shop agreements.”<sup>185</sup> That the FDA has expressly permitted the use of medication abortion could mean that state bans on the use of this protocol—whether through specific bans on medication abortion or general bans on abortion—should not be applicable on federal lands under the ACA. Although these are lower court cases, they are consistent with the Supreme Court’s statements about the ACA’s goals.<sup>186</sup>

Taking this argument further, providers could argue that the federal government’s regulation of abortion has already occupied the field with respect to the matter. In addition to FDA regulation, Congress has also prohibited so-called “partial-birth abortion”<sup>187</sup> and outlawed acts that cause the death of an “unborn child.”<sup>188</sup> Every year, Congress renews the Hyde Amendment, which prohibits federal dollars from being spent on abortion.<sup>189</sup> Under the Affordable Care Act, Congress bans abortion from being part of the insurance options offered on Obamacare exchanges,<sup>190</sup> and there are many different provisions protecting freedom of conscience with respect to abortion

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<sup>183</sup> *Id.*

<sup>184</sup> *See infra* Part III.C.

<sup>185</sup> *King v. Gemini Food Serv., Inc.*, 438 F. Supp. 964, 966 (E.D. Va. 1976); *Lord v. Local Union No. 2088*, 646 F.2d 1057, 1061-62 (5th Cir. 1981); *Vincent v. Gen. Dynamics Corp.*, 427 F. Supp. 786, 800 (N.D. Tex. 1977).

<sup>186</sup> *Sadrakula*, 309 U.S. at 103-04 (“But the authority of state laws or their administration may not interfere with the carrying out of a national purpose. Where enforcement of the state law would handicap efforts to carry out the plans of the United States, the state enactment must, of course, give way.”).

<sup>187</sup> 18 U.S.C. § 1531.

<sup>188</sup> 1 U.S.C. § 8.

<sup>189</sup> Consolidated Appropriations Act (2021), *supra* note 172.

<sup>190</sup> 42 U.S.C. § 18023

provision and refusal.<sup>191</sup> These different laws, taken together, could be seen as the set of laws that Congress has chosen to adopt for purposes of federal abortion law, making anything that is not explicitly illegal, legal on federal lands. While we acknowledge this argument is a bold one, the Supreme Court has made clear that “through the comprehensiveness of its regulation,” Congress can occupy the field and thus preclude the application of state law through the ACA.<sup>192</sup> This argument would posit that these federal abortion laws and regulations do just that with respect to how the federal government wants to treat abortion within its own laws, meaning on federal lands.<sup>193</sup>

Although the ACA concerns whether criminal abortion law applies on federal land, states have passed abortion laws that are civil in nature—most famously, Texas’s SB8. For civil law on federal land, there is no law comparable to the ACA that wholesale incorporates non-conflicting state civil law. Rather, there are individual statutes that incorporate some specific state civil laws, such as wrongful death or personal injury.<sup>194</sup> For other civil actions, “[w]hen federal law neither addresses the civil law question nor assimilates pertinent state law, the applicable law is the state law that was in effect at the time that the state ceded jurisdiction to the United States.”<sup>195</sup> Because Texas’s SB8 and any copycat laws from other states are of such recent vintage, they would be precluded from being incorporated on federal land and thus escaping liability under the law.<sup>196</sup> Abortion providers *would* have to deal with the possibility of a wrongful death lawsuit if allowed under state law in a post-*Roe* world. The risk of such a lawsuit might be an insurmountable barrier for some providers. Abortion providers concerned about this liability, however, could require patients—and possibly others related to the patient—to sign waivers from suing under state wrongful death provisions.

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<sup>191</sup> For a thorough list of federal laws relating to abortion refusal, see SECRETARIAT OF PRO-LIFE ACTIVITIES, CURRENT FEDERAL LAWS PROTECTING CONSCIENCE RIGHTS (May 2019), <https://www.usccb.org/issues-and-action/religious-liberty/conscience-protection/upload/Federal-Conscience-Laws-Fact-Sheet.pdf>.

<sup>192</sup> *Lewis*, 523 U.S. at 165 (citing *Wis. Pub. Intervenor v. Mortier*, 501 U.S. 597, 604-05 (1991)).

<sup>193</sup> Providers might even claim that because the United States already prohibits one form of abortion, so-called “partial-birth abortion,” other forms of abortion are presumed to be lawful under federal law and that this presumption should preclude the application of state law to the contrary. *United States v. Butler*, 541 F.2d 730, 737 (8th Cir. 1976) (“[T]he fact that the federal statutes are narrower in scope does not allow the federal government to use state law to broaden the definition of a federal crime.”).

<sup>194</sup> 28 U.S.C.A. § 5001.

<sup>195</sup> JAMES RASBAND, JAMES SALZMAN, & MARK SQUILLACE, PUBLIC NATURAL RESOURCES LAW § 3:8 (2d ed. 2009) (using *Arlington Hotel Co. v. Fant*, 278 U.S. 439 (1929) as an illustrative example of this point).

<sup>196</sup> See, e.g., *Balderrama v. Pride Indus., Inc.*, 963 F. Supp. 2d 646, 656 (W.D. Tex. 2013).

Other than the argument that SB8 would not apply on federal land, we recognize that the other arguments put forth here are based on legally uncertain interpretations of the law that raise serious questions about the relationship between the federal government and the states. These questions are not well covered in scholarship or federal court decisions, as “relatively few published decisions have engaged the ACA, and even fewer scholars have done so. As a result, the ACA has received little analytical treatment.”<sup>197</sup> Beyond that, there is an important preliminary issue under the ACA of what types of federal land are covered by its provisions. The statute differentiates between federal land that is considered an exclusive enclave, which would mean it is covered by the ACA, and federal land over which the state reserved jurisdiction when it transferred the land to the federal government, which would put it outside the coverage of the ACA. This determination can involve intense factual dispute relying on dated documents and contested history.<sup>198</sup>

The point here is the same as with the other issues covered in this Article: reliance on the ACA to shield abortion provision on federal land from the application of state abortion bans, particularly in states banning abortion post-*Roe*, would raise unexplored interjurisdictional legal issues that have previously been unaddressed in the long history of abortion conflict.

### B. Federal Preemption

The federal government could also create conflict with antiabortion states through preemption related to medication abortion. As noted, the FDA approved medication abortion in 2000, but used its authority to restrict access to the drug in a variety of ways. The FDA’s current regulation of mifepristone—the first medication in the two-medication regimen for medical abortions—includes a Risk Evaluation and Mitigation System (REMS). The imposition of a REMS is a rare action that by statute can only be imposed if a REMS is necessary to ensure that the drug’s benefits outweigh its risks.<sup>199</sup> Scholars have argued that the FDA’s use of the REMS is unnecessary and unduly burdensome.<sup>200</sup>

The FDA’s current REMS, which will soon reflect its recent decision to allow virtual care, has the following requirements: (1) only certified providers can prescribe the drug, (2) patients must sign a Patient Agreement Form, and (3) only certified providers or certified pharmacies can dispense the drug.<sup>201</sup> In the process of revising the

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<sup>197</sup> Nihkil Bhagat, *Filling the Gap? Non-Abrogation Provisions and the Assimilative Crimes Act*, 111 COLUM. L. REV. 77, 80 (2011).

<sup>198</sup> *Paul*, 371 U.S. 245.

<sup>199</sup> Donley, *supra* note 41, at 22-36.

<sup>200</sup> *Id.*; Rebouché, Donley & Cohen, *supra* note 10.

<sup>201</sup> *Mifeprex (mifepristone) Information*, *supra* note 42.



REMS numerous times over the past decade, the FDA has made specific scientific findings about the drug's safety and efficacy. For instance, in 2016, the agency removed its earlier requirements that patients consume the drug in-person, allowing patients to swallow their pills at home,<sup>202</sup> and that physicians alone could prescribe the drug, allowing physician assistants and nurse practitioners to prescribe as well.<sup>203</sup> The agency also found medication abortion safe and effective through the tenth week of pregnancy (not the seventh, as it had previously determined).<sup>204</sup> In December 2021, the agency abandoned the REMS provision that forced patients to pick up the medication at a healthcare facility, finding that remote provision of medication abortion is safe and effective.<sup>205</sup>

Many states laws conflict with these determinations. Nineteen states require a physician to be present upon delivery of medication abortion, thus rendering completely remote abortion impossible.<sup>206</sup> State legislation that requires in-person visits for counseling or ultrasounds further restrict the reach of online services. Current state laws also burden medication abortion in other ways that are inconsistent with the FDA's mifepristone regulation: thirty-two states, for instance, only allow physicians to prescribe medication abortion, even though the FDA found it safe for non-physician providers to prescribe it. Many states, like Mississippi, also require patients to consume the drug in the presence of a provider—i.e., they cannot take the drug at home. And Texas recently enacted a law making it illegal to use medication abortion after the first seven weeks of pregnancy, even though the drug has been approved for used through the tenth week of pregnancy.<sup>207</sup> Because the antiabortion movement understands how medication abortion poses an almost existential threat to their cause,<sup>208</sup> there is great enthusiasm in antiabortion states for even greater

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<sup>202</sup> CENTER FOR DRUG EVALUATION & RESEARCH, APPLICATION NUMBER 020687ORIG1S020, SUMMARY REVIEW FOR REGULATORY ACTION 17 (Mar. 29, 2016), [https://www.accessdata.fda.gov/drugsatfda\\_docs/nda/2016/020687Orig1s020SumR.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020SumR.pdf).

<sup>203</sup> *Id.*

<sup>204</sup> *Id.*

<sup>205</sup> *Mifeprex (mifepristone) Information*, *supra* note 42.

<sup>206</sup> *Medication Abortion*, *supra* note 11. Ten states also have statutes that explicitly ban the use of telemedicine for abortion even though existing in-person requirements accomplish the same end; state courts in two of those states have enjoined the in-person requirement. *See* Planned Parenthood of the Heartland v. Iowa Bd. of Med., 865 N.W.2d 252, 269 (Iowa 2015); Carrie N. Baker, *Advocates Cheer FDA Review of Abortion Pill Restrictions*, MS. MAG., May 11, 2021 (describing the Ohio law and state court injunction).

<sup>207</sup> *See* S.B. 4, Sess. 87(2) (Tex. 2021).

<sup>208</sup> *See, e.g.,* Cheryl Sullenger, *The Status of American Abortion Facilities: Telemedicine's Impact in 2021*, OPERATION RESCUE (Jan. 11, 2022), <https://www.operationrescue.org/archives/the-status-of-american-abortion-facilities-telemedicines-impact-in-2021>.

restrictions against telemedicine. Indeed, South Dakota recently passed a law requiring patients to visit an abortion clinic four times to access medication abortion: to obtain consent, to pick up mifepristone, to pick up misoprostol, and to confirm the abortion's completion.<sup>209</sup>

There is a strong, though legally uncertain, argument that federal law preempts these state restrictions. The U.S. Constitution's Supremacy Clause establishes that when state and federal laws conflict, the federal law will preempt state law.<sup>210</sup> For this reason, if Congress were to pass the Women's Health Protection Act, or a similar law that created a federal right to abortion and limited state restrictions, there would be little question that these state abortion laws would be preempted. However, given the current, seemingly hopeless stalemate in the Senate, the prospects of a new federal law protecting abortion rights are slim to none in the short term.

Nonetheless, the FDA's regulation of medication abortion might already preempt these laws. Even more generally, the FDA's regulation might partially preempt general state abortion bans in a post-*Roe* world by preventing them from banning medication abortion in their state. This would force states to allow medication abortion, maintaining access to early abortion in all fifty states. The crux of any preemption argument is Congressional purpose, which "is the ultimate touchstone in every preemption case."<sup>211</sup> Congress can express this preemptive purpose explicitly or implicitly, but in the context of federal preemption of state drug law, plaintiffs must rely on implied preemption theories. The Supreme Court has noted that Congress expressly preempted state law when it created legislation that governed medical devices, but never did so for pharmaceuticals.<sup>212</sup>

Implied preemption of state law occurs in a few contexts: when it is impossible to comply with both state and federal law (impossibility preemption),<sup>213</sup> when a state law would frustrate the purpose underlying federal law (obstacle preemption),<sup>214</sup> or when federal law entirely occupies a field (field preemption).<sup>215</sup> The former two types of implied preemption—impossibility and obstacle preemption, together considered conflict preemption—are more commonly relied upon to prove preemption in the context of federal drug law.<sup>216</sup> The Supreme

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<sup>209</sup> See, e.g., Veronica Stracqualursi, *South Dakota Places Further Restrictions on Medication Abortions*, CNN (Jan. 8, 2022), <https://www.cnn.com/2022/01/08/politics/south-dakota-medication-abortions/index.html>.

<sup>210</sup> U.S. CONST. art. VI, cl. 2.

<sup>211</sup> *Wyeth v. Levine*, 555 U.S. 555, 565 (2009).

<sup>212</sup> *Wyeth*, 555 U.S. at 567; Patricia J. Zettler, *Pharmaceutical Federalism*, 92 IND. L.J. 845, 862 (2017).

<sup>213</sup> *English v. Gen. Elec. Co.*, 496 U.S. 72, 79 (1990).

<sup>214</sup> *Id.*

<sup>215</sup> *Id.* at 78.

<sup>216</sup> Because the Food, Drug & Cosmetic Act (FDCA) does not disrupt the states' ability to regulate drugs in certain confined contexts, like tort law or the practice of

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Court has considered whether the Food, Drug, and Cosmetic Act (FDCA), and the regulatory scheme implementing it, preempts state law a few times in the past decade—all using conflict preemption theories. Recent decisions increasingly have accepted the FDA’s preemption power.

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

For a preemption challenge to the existing laws that regulate mifepristone more harshly than the FDA—laws that still might be controlling in purple states after *Roe*—the third purpose is most relevant because the states’ laws directly conflict with the FDA’s determinations under the REMS. Indeed, it is the FDA’s imposition of a REMS—and the extra control that comes with it—that strengthens the preemption argument. When Congress created the REMS program in 2007, it gave the FDA the ability to impose additional controls on certain approved drugs, but in doing so, required the agency to use the least restrictive means of protecting the public.<sup>217</sup> The statute specifically said that the REMS may “not be unduly burdensome on patient access to the drug . . .”<sup>218</sup> Thus, in imposing a REMS for mifepristone, the FDA has chosen to exercise more control over the drug than it does for the 95% of approved drugs that are not subject to a REMS.<sup>219</sup> And in exercising that control, it has

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medicine, the FDA may not presumptively occupy the entire field. Zettler, *supra* note 212, at 859-62.

<sup>217</sup> The statute requires that the ETASU be “commensurate with the specific serious risk listed in the labeling of the drug,” “not be unduly burdensome on patient access to the drug, considering in particular . . . patients who have difficulty accessing health care (such as patients in rural or medically underserved areas),” and “conform with elements to assure safe use for other drugs with similar, serious risks.” 21 U.S.C. § 355-1(f)(2). The statute also required the agency “to the extent practicable . . . minimize the burden on the healthcare delivery system.” 21 U.S.C. § 355-1(f)(2).

<sup>218</sup> 21 U.S.C. § 355-1(f)(2).

<sup>219</sup> Donley, *supra* note 41, at 31.

had to justify its decisions with evidence that balanced safety and efficacy with access.

State laws that overregulate medication abortion purport to reach scientific conclusions that are directly at odds with those that Congress required the FDA to make when issuing a REMS. As noted, the FDA has specifically considered and rendered judgment about whether medication abortion can be safely and effectively (1) prescribed by non-physician providers;<sup>220</sup> (2) used through ten weeks of pregnancy;<sup>221</sup> (3) consumed at home;<sup>222</sup> and (4) dispensed by mail or certified pharmacy.<sup>223</sup> Thus, state laws that require physician prescribing, limit the length of use, require in-person pick up or consumption, ban the use of telehealth, or prohibit mailing medication abortion conflict directly with the agency's evidence-based conclusions required by the REMS statute.<sup>224</sup> In a similar context, courts have preempted state laws that are directly at odds with the FDA's determinations. For instance, state tort laws are preempted when they require risk disclosures that the FDA has specifically considered and rejected as not necessary.<sup>225</sup>

There is also case law suggesting that states cannot regulate FDA-approved drugs in a way that would make them less accessible. One such case in the District of Massachusetts invalidated a state's attempt to regulate a newly approved and controversial opioid, Zohydro, more harshly than the FDA.<sup>226</sup> Of particular concern was the

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<sup>220</sup> CENTER FOR DRUG EVALUATION & RESEARCH, *supra* note 202, at 17. (“healthcare providers other than physicians can effectively and safely provide abortion services, provided that they meet the requirements for certification described in the REMS.”).

<sup>221</sup> *Id.* at 9 (“the data and information reviewed constitute substantial evidence to support the proposed dosing regimen . . . for pregnancy termination through 70 days [or ten weeks] gestation.”).

<sup>222</sup> *Id.* at 15 (“there is no clinical reason to restrict the location in which misoprostol may be taken. . . . Given the fact that the onset of cramping and bleeding occurs rapidly (i.e., generally within 2 hours) after misoprostol dosing, allowing dosing at home increases the chance that the woman will be in an appropriate and safe location when the process begins.”).

<sup>223</sup> FDA Letter, *supra* note 46 (“We have concluded that mifepristone will remain safe and effective for medical abortion if the in- person dispensing requirement is removed, provided all the other requirements of the REMS are met and pharmacy certification is added.”).

<sup>224</sup> It is worth noting that the FDA reviewed and reiterated its scientific conclusions from 2016 in 2021. *Id.*

<sup>225</sup> *See e.g.*, *Seufert v. Merck Sharp & Dohme Corp.*, 187 F. Supp. 3d 1163, 1175-77 (S.D. Cal. 2016) (finding that a state duty-to-warn case was preempted because the manufacturer could not have been required to warn patients of a risk that the FDA has specifically concluded did not exist); *In re Zofran (Ondansetron) Prod. Liab. Litig.*, No. 1:15-MD-2657-FDS, 2021 WL 2209871, at \*33 (D. Mass. June 1, 2021) (same).

<sup>226</sup> Its own advisory committee had recommended against approving Zohydro on the ground that there was no “need for a new form of one of most widely abused

state requirement that a prescribing physician verify “that other pain management treatments have failed.”<sup>227</sup> The court evaluated “whether the regulations prevent the accomplishment of the FDA’s objective that safe and effective drugs be available to the public.”<sup>228</sup> The judge preliminarily enjoined the regulation as preempted on the basis that “if the Commonwealth interprets its regulation to make Zohydro a last-resort opioid, it undeniably makes Zohydro less available.”<sup>229</sup> When the state thereafter changed the requirement to only require a showing that other pain-management treatments were “inadequate,” mimicking the FDA-approved label, the court upheld the law.<sup>230</sup> Based on this reasoning, a state law that makes a drug less accessible than the FDA frustrates Congress’s purpose in ensuring the accessibility of safe and effective drugs.

Some scholars have been skeptical that one of Congress’s purposes in creating the national drug review system was to make approved drugs accessible (instead of just safe and effective).<sup>231</sup> However, this accessibility purpose is clearly incorporated into the REMS statute, suggesting that congressional purpose would be frustrated if states attempt to ban a drug that the FDA regulates through the REMS process. Professor Patti Zettler agrees that in the context of a REMS, the preemption argument is stronger because “Congress has arguably required the FDA to do a complex balancing of numerous considerations, both in determining whether a REMS is necessary at all, and in determining what to include in a REMS when one is needed.”<sup>232</sup> As a result, any additional restrictions might “pose an obstacle to the FDA’s responsibility to satisfy these Congressional objectives.”<sup>233</sup> Recently, Zettler and Ameet Sarpatwari applied this line of reasoning to medication abortion:

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

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prescription drugs in the United States,” but the FDA nevertheless approved it. *In re Zofran*, at 3, n.9.

<sup>227</sup> *Zogenix, Inc. v. Patrick*, No. CIV.A. 14-11689-RWZ, 2014 WL 3339610, at \*1 (D. Mass. July 8, 2014), *vacated in part*, No. CIV.A. 14-11689-RWZ, 2014 WL 4273251 (D. Mass. Aug. 28, 2014).

<sup>228</sup> *Id.* at \*4.

<sup>229</sup> *Id.*

<sup>230</sup> *Zogenix, Inc.*, 2014 WL 3339610, at \*3.

<sup>231</sup> See Lars Noah, *State Affronts to Federal Primacy in the Licensure of Pharmaceutical Products*, 2016 MICH. ST. L. REV. 1, 8-12 (2016).

<sup>232</sup> Zettler, *supra* note 212, at 875.

<sup>233</sup> *Id.*

when it imposes a REMS like the one for mifepristone.<sup>234</sup>

She notes that these laws are particularly troubling when they are “are grounded in drug-safety arguments,” because they encroach on FDA’s clear authority.<sup>235</sup>

One effort to test this theory has already begun. Mifepristone’s generic manufacturer, GenBioPro, recently sued Mississippi on preemption grounds. Mississippi law requires physicians to physically examine a patient prior to offering medication abortion and for patients to ingest the medication “in the same room and in the physical presence of the physician who gave, sold, dispensed or otherwise provided or prescribed the drug or chemical to the patient.”<sup>236</sup> GenBioPro argues that Mississippi’s law, which is far stricter than the current REMS, is preempted because it is “an impermissible effort by Mississippi to establish its own drug approval policy and directly regulate the availability of drugs within the state.”<sup>237</sup> In short, the FDA’s actions preempt state efforts to restrict dispensation of the drug.<sup>238</sup> Thus far, the FDA has not weighed in, but in a *Roe*-less future, the FDA could not only support the plaintiffs lodging preemption challenges as *amici*, but also work with the Department of Justice to sue states itself.<sup>239</sup>

Antiabortion states will vehemently oppose these efforts, and one of their primary arguments against them will be that states have the sole authority to regulate the practice of medicine, which includes provider prescribing.<sup>240</sup> As scholars have explained, “courts, lawmakers, and the FDA itself have long opined that state jurisdiction is reserved for medical practice—the activities of physicians and other health care professionals—and federal jurisdiction for medical products, including drugs.”<sup>241</sup> However, the practice-of-medicine

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<sup>234</sup> Patricia J. Zettler & Ameet Sarpatwari, *State Restrictions on Mifepristone Access—The Case for Federal Preemption*, NEW ENG. J. MED. (Jan. 12, 2022), <https://www.nejm.org/doi/full/10.1056/NEJMp2118696>.

<sup>235</sup> *Id.*

<sup>236</sup> Miss. Code Ann. § 41-41-107(2)-(3).

<sup>237</sup> Brief of Plaintiffs GenBioPro at 27, *Genbiopro, Inc. v. Dobbs*, (No. CV TDC-20-652), 2020 WL 2771735 (S.D. Miss. Oct. 9, 2020).

<sup>238</sup> *Id.* at 28. In addition, GenBioPro argues that the Mississippi statute is a “significant burden on interstate commerce because [it] interferes with the FDA’s national and uniform system of regulation,” in violation of the Commerce Clause.

<sup>239</sup> See Press Release, Dept. of Just., Justice Department Files Preemption Lawsuit Against the State of California to Stop Interference with Federal Immigration Authorities (Mar. 7, 2018), <https://www.justice.gov/opa/pr/justice-department-files-preemption-lawsuit-against-state-california-stop-interference> (describing a lawsuit filed to invalidate a state law that the federal government viewed as preempted).

<sup>240</sup> Zettler, *supra* note 212, at 869 n.160.

<sup>241</sup> *Id.* at 849.

defense was raised and rejected in the Zohydro litigation.<sup>242</sup> Professor Zettler contends that the Zohydro litigation is one of many recent examples showing that “the distinction between regulating medical practice and medical products is nebulous” and “the FDA’s preemptive reach can extend into medical practice regulation in certain circumstances.”<sup>243</sup> Zettler suggests that if the state is attempting to regulate drugs—even if it does so through the smokescreen of provider conduct—it is attempting to displace federal law and frustrate congressional purpose.<sup>244</sup>

In a post-*Roe* world, however, most state laws burdening medication abortion will essentially become moot: most of the states that have them will move to ban all abortion. But there is reason to think the preemption argument still has merit in the face of general state abortion bans. Returning to the purpose of the FDA, it is important to remember that the agency acts as a gatekeeper. To earn the right to sell a drug product, manufacturers must produce years, if not decades, of expensive, high-quality research proving that the drug is safe and effective.<sup>245</sup> If they are successful, they can sell their product in every state; if unsuccessful, they cannot sell their product anywhere.<sup>246</sup> If a state were to ban abortion, it would in effect ban the sale of an FDA-approved drug. And whether a state has the authority to do that has been considered peripherally by the Supreme Court and directly by a lower court in a series of cases.

In 2009, the Court held in *Wyeth v. Levine* that the FDA’s regulatory scheme did not preempt state tort laws that would have required greater drug warnings than those required by the FDA.<sup>247</sup> The Court rejected the impossibility preemption theory because it was not impossible for the brand name manufacturer to comply with both state and federal law—FDA regulation allowed the manufacturer to unilaterally change their drug labels to be *more* protective, though not less.<sup>248</sup> The Court also rejected an obstacle preemption argument, finding that Congress’s “silence on the issue, coupled with its awareness of the prevalence of state tort litigation, is powerful evidence that Congress did not intend FDA oversight to be the

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<sup>242</sup> *Id.* at 872.

<sup>243</sup> *Id.* at 886.

<sup>244</sup> *Id.* at 887.

<sup>245</sup> See *Cost of Clinical Trials For New Drug FDA Approval*, JOHNS HOPKINS (Sept. 24, 2018), <https://publichealth.jhu.edu/2018/cost-of-clinical-trials-for-new-drug-fda-approval-are-fraction-of-total-tab> (noting that the cost of developing an individual drug is only around \$19 million on average, but that number balloons to over a billion dollars when taking into account failed drugs).

<sup>246</sup> See *FDA Activities to Remove Unapproved Drugs from the Market*, FOOD & DRUG ADMIN. (last updated June 2, 2021), <https://www.fda.gov/drugs/enforcement-activities-fda/fda-activities-remove-unapproved-drugs-market>.

<sup>247</sup> *Wyeth*, 555 U.S. at 569.

<sup>248</sup> *Id.* at 569-72.

exclusive means of ensuring drug safety and effectiveness.”<sup>249</sup> Though the agency had stated its view that its labeling regulations preempted state tort laws, the Court refused to defer to an agency’s conclusions regarding preemption because its determination was conclusory, procedurally defective, and contrary to its past position.<sup>250</sup>

But two years later, the Court distinguished *Wyeth* in the context of generic drugs. In *PLIVA v. Mensing*, the Court held that because generic drugs are required to adhere to the brand drug’s labeling—and companies are therefore unable to make a drug’s label more stringent—it would be impossible for a generic drug company to change their labels to avoid a failure-to-warn tort action, while also remaining compliant with FDA law.<sup>251</sup> In this case, a plurality of the Court seemed to shift their understanding of preemption doctrine to recognize *implied* invalidation of state law, concluding that courts “should not distort federal law to accommodate conflicting state law.”<sup>252</sup> Thus, in a case with very similar facts to *Wyeth*, the Court found that federal drug law preempted state failure-to-warn tort actions against generic manufacturers.<sup>253</sup> Then, in *Mut. Pharm. Co. v. Bartlett*, in 2013, the Supreme Court reiterated that conclusion by preempting a design defect tort action against a generic manufacturer on the ground that a generic manufacturer similarly cannot alter the composition of a drug.<sup>254</sup>

Importantly, in both *Mensing* and *Bartlett*, which relied on impossibility preemption, the plaintiffs argued that the manufacturer could comply with both state and federal law by refusing to sell their product in those states. The Court rejected this argument explicitly in *Bartlett*: “We reject this ‘stop-selling’ rationale as incompatible with our pre-emption jurisprudence. Our pre-emption cases presume that an actor seeking to satisfy both his federal- and state-law obligations is not required to cease acting altogether in order to avoid liability.”<sup>255</sup> In fact, the Court went so far as to say that requiring a manufacturer to remove a product from a state market would render the entire doctrine of impossibility preemption meaningless.<sup>256</sup> Thus, the Supreme Court suggested in *Mensing* and *Barrett* that states cannot ban FDA-approved drugs: “if the relatively more attenuated command of design defect scrutiny in tort law created an actual conflict with federal law governing FDA-approved drugs, then surely an outright sales prohibition imposed by state officials would do so.”<sup>257</sup>

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<sup>249</sup> *Id.* at 575.

<sup>250</sup> *Id.* at 576-79.

<sup>251</sup> *PLIVA Inc. v. Mensing*, 564 U.S. 604, 604 (2011).

<sup>252</sup> *Id.* at 622.

<sup>253</sup> *Id.*

<sup>254</sup> *Mut. Pharm. Co. v. Bartlett*, 570 U.S. 472, 475 (2013).

<sup>255</sup> *Id.* at 487.

<sup>256</sup> *Id.* at 488.

<sup>257</sup> Noah, *supra* note 231, at 35.



There is very little case law directly evaluating whether a state can ban an FDA-approved drug, mainly because states rarely attempt it. The most analogous case to date is an earlier iteration of the same District of Massachusetts case discussed above. Before Massachusetts crafted extra restrictions for Zohydro, it first banned the drug entirely, and the court considered whether that ban was invalid under an obstacle preemption theory.<sup>258</sup> In issuing a preliminary injunction, the District of Massachusetts concluded that the state's ban would frustrate congressional purpose in ensuring that drugs are not only safe and effective, but also accessible: "If the Commonwealth were able to countermand the FDA's determinations [on safety and efficacy] and substitute its own requirements, it would undermine the FDA's ability to make drugs available to promote and protect the public health."<sup>259</sup> The court distinguished *Wyeth* by noting that there, the Supreme Court "assumed the availability of the drug at issue."<sup>260</sup>

Though many FDA law scholars agree that a state ban of an FDA-approved drug would be preempted,<sup>261</sup> some have disagreed with the district court's reasoning, which emphasized that one of FDA's purposes was to ensure that drugs are accessible.<sup>262</sup> Though there is certainly some statutory support for the proposition that Congress wanted the FDA to safeguard drug safety, efficacy, *and* access, the agency's primary role as a gatekeeper cuts against this view. Professor Lars Noah has argued, for instance, that the agency typically has no say over whether pharmaceutical companies charge reasonable prices or remove important, but unprofitable drugs from the market—both of which impede access.<sup>263</sup> To the extent the FDA has any role in promoting access to drugs, it is secondary to its role in protecting patients from unsafe or ineffective drugs. Instead, Noah suggests that a state ban on an FDA-approved drug likely frustrates a different Congressional purpose: the creation of a uniform, national, definitive judgment about drug safety and efficacy. When seen through this lens, a state ban is problematic because it frustrates the uniformity promised

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<sup>258</sup> *Zogenix, Inc. v. Patrick*, No. 14-11689-RWZ, 2014 WL 1454696, at \*2 (D. Mass. Apr. 15, 2014). The manufacturer also brought a Dormant Commerce Clause challenge, which the judge rejected. *Zogenix, Inc. v. Baker*, No. CIV.A. 14-11689-RWZ, 2015 WL 1206354, at \*7 (D. Mass. Mar. 17, 2015). The court found that the state interest in "promoting public health and safety" outweighed these interstate commerce effects: "It does not contravene the dormant commerce clause for a state merely to regulate the distribution within its borders of a product that travels in interstate commerce." *Id.* The court did admit that "Zohydro's theory about national pharmacies refusing to dispense Zohydro may be sufficient to show a burden on interstate commerce," but found the plaintiff's allegations too speculative. *Id.*

<sup>259</sup> *Zogenix, Inc.*, 2014 WL 1454696, at \*2.

<sup>260</sup> *Id.*

<sup>261</sup> See Noah, *supra* note 231, at 8-12; Zettler, *supra* note 212, at 870-78.

<sup>262</sup> Noah, *supra* note 231, at 8-12.

<sup>263</sup> *Id.*

by a national drug review system; it revokes the promise of a national market for drugs that meet the demands of an onerous review process.

Consumer safety is often offered as a reason to oppose preemption in the context of state efforts to regulate drugs.<sup>264</sup> But medication abortion's excellent safety record nullifies this critique.<sup>265</sup> Indeed, though the dissenters in *Bartlett* focused on the state interest in protecting patients, they made clear that the particulars of the drug at issue matter. For instance, Justice Breyer's dissent, which was joined by Justice Kagan, noted that "the more medically valuable the drug, the less likely Congress intended to permit a State to drive it from the marketplace."<sup>266</sup> And Justice Sotomayor's dissent suggested that an obstacle preemption framework, instead of impossibility preemption, would help the Court better account for safety by "allow[ing] the Court to consider evidence about whether Congress intended the FDA to make an optimal safety determination and set a maximum safety standard (in which case state tort law would undermine the purpose) rather than a minimal safety threshold (in which case state tort law could supplement it)."<sup>267</sup> Justice Sotomayor's comments are particularly relevant in the context of the REMS program, where the statute clearly envisions not just a regulatory floor, but a ceiling that accounts for patient access.<sup>268</sup> Again, mifepristone's strong safety profile makes the preemptions arguments stronger than past cases, and easy to distinguish from good-faith state efforts to protect patient safety.<sup>269</sup>

States will likely oppose these preemption challenges with even more vibrato.<sup>270</sup> First, states will argue that their laws do not ban medication abortion drugs entirely because they could be sold and used

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<sup>264</sup> For years, liberal scholars have opposed preemption challenges based on food and drug law because they were often brought by pharmaceutical and tobacco companies who were attempting to invalidate state efforts to require additional warnings or impose stricter safety regulations.

<sup>265</sup> Donley, *supra* note 41, at 14-22.

<sup>266</sup> *Mensing*, 564 U.S. at 494 (Beyer, J., dissenting).

<sup>267</sup> *Id.* at 514-15 (Sotomayor, J., dissenting).

<sup>268</sup> Of note, the mifepristone REMS required the FDA to make an on-the-record agency determination related to risk, benefit, and access that the Court found missing in *Wyeth*. Jennifer L. Bragg & Maya P. Florence, *Life with A Rems: Challenges and Opportunities*, 13 J. HEALTH CARE L. & POL'Y 269, 278 (2010).

<sup>269</sup> Zettler & Sarpatwari, *supra* note 234, at 3 ("preemption challenges to state mifepristone restrictions should not be understood as risking the future viability of public health federalism more broadly.").

<sup>270</sup> One challenge not mentioned above is that though the practice-product distinction may be less stark than previously assumed, courts might also be more willing to find that a state's regulation or prohibition of all abortion (even procedure-based abortion) to more obviously fit a practice-of-medicine regulation reserved for the states than a ban on an FDA-approved product. This might be the case, but the preemption challenge would not be to the whole law, but to the law's application over medication abortion.

for other uses.<sup>271</sup> Misoprostol, in particular, is used for a variety of obstetric purposes, including inducing labor and treating miscarriage. Thus, states could argue that the ban would not be on a drug, but on a use of the drug.

This distinction may be less important than it initially appears. The FDA has approved mifepristone only for abortion, and its manufacturers are only legally allowed to market it for that one use.<sup>272</sup> And though providers, as distinct from manufacturers, are generally allowed to prescribe drugs off label, the REMS has made it almost impossible for them to do so with mifepristone—again suggesting that this is a *de facto* ban.<sup>273</sup> Recall that the payoff at the end of the long, expensive drug approval process is an assurance that manufacturers can sell their drug throughout the country. Without that assurance, manufacturers would never invest the time and money to complete the drug review process. In this way, FDA approval “represent[s] more than simply federal permission to market a pharmaceutical product; [it] amount[s] to licenses, which qualify as a form of intangible property entitled to constitutional recognition.”<sup>274</sup> When a state bans the only use of an approved drug, that state has thwarted the purpose of the FDA approval process.

Second, states will argue that Congress’s purpose in creating a federal drug approval system does not empower the FDA to second guess state policies purported to protect the welfare of its citizens, especially when Congress has been silent on the matter. For instance, when the FDA attempted to regulate tobacco products by claiming that nicotine met the definition of a drug and that a cigarette was therefore a drug delivery device, the Supreme Court in *Brown & Williamson* rejected that interpretation. The Court held that “we are confident that Congress could not have intended to delegate a decision of such economic and political significance to an agency in so cryptic a fashion.”<sup>275</sup> *Brown & Williamson* is often pinpointed for the emergence of the “no-elephants-in-mouseholes” doctrine—the concept that Congress does not hide huge, politically-relevant policy decisions in the interstices of a statute.<sup>276</sup> The Court found it anomalous that the FDCA could be interpreted to regulate (maybe even ban) a product, cigarettes, that were so politically and economically important to states when Congress had never considered or debated that possibility when it passed the statute. One could imagine the same type of analysis in

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<sup>271</sup> Donley, *supra* note 41, at 32-33.

<sup>272</sup> 86 Fed. Reg. 41383 (Aug. 2, 2021) (2021 Final Rule), <https://www.govinfo.gov/app/details/FR-2021-08-02/2021-15980/summary>.

<sup>273</sup> *Id.*

<sup>274</sup> Noah, *supra* note 231, at 32.

<sup>275</sup> Food & Drug Admin. v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 159-60 (2000).

<sup>276</sup> Jacob Loshin & Aaron Nielson, *Hiding Nondelegation in Mouseholes*, 62 ADMIN. L. REV. 19 (2010).

the case of mifepristone. If Congress wants to prevent states from banning medication abortion, the argument goes, they must say so explicitly.

Unlike the tobacco regulation in the *Brown & Williamson* era,<sup>277</sup> however, the FDA clearly has authority to regulate mifepristone and has been closely regulating it for decades. Indeed, *Brown & Williamson* relied on the fact that the FDA previously had denounced its ability to regulate tobacco products, while, in the meantime, Congress had assumed that role.<sup>278</sup> The opposite is true in the case of medication abortion: the FDA has exercised sustained control over drugs like mifepristone, and Congress has done nothing to stop the agency from doing so. Moreover, the plaintiffs in a preemption challenge would concede that, if successful, their win would not invalidate the state's entire abortion ban—only its application to an FDA-approved drug. In other words, the ban would still prohibit all procedure-based abortions and medication abortions beyond ten weeks.

As the arguments for and against preemption make clear, the stakes are high for federal agencies and for states deploying what they consider to be their police powers to ban abortion. The uncertainty of the result is perhaps why preemption has not been litigated by abortion supporters until now. What we believe has changed is the willingness of litigants like GenBioPro to push the envelope in anticipation of *Roe's* demise. This effort, along with more like it in the future, will spark new debates about the balance of state-federal power in abortion law.

C. *Federal Policies on Medication Abortion, Telehealth, and Licensure*

The federal government, as well as abortion-supportive states, can apply various policies to remove obstacles to medication abortion, telehealth, and interstate provision of healthcare. If they attempt to do so, medication abortion will become more accessible everywhere, including in states that ban abortion. Attempting to control this influx will lead to additional fights as states try to regulate this new abortion frontier. Nevertheless, federal action, particularly as related to improving access to medication abortion, relies on strong policy justifications that likely half the country will accept, and half will reject. The more access to medication abortion these federal policies create, the more likely state bans will be thwarted in practice.

First, the FDA could lift the remaining restrictions on the dispensation of mifepristone that make the drug harder to access across the country. When the FDA re-evaluated the mifepristone REMS in December 2021, the agency created two additional ways that

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<sup>277</sup> The FDA gained authority to regulate tobacco by statute decades later. *See* Family Smoking Prevention and Tobacco Control Act, H.R. 1256 (Pub. L. No. 111–31, June 22, 2009).

<sup>278</sup> *Brown & Williamson*, 529 U.S. at 157-60.

patients can receive mifepristone. The first is through the mail, sometimes supervised by a certified provider, which was a practice the FDA allowed over the course of the pandemic. The second is new—dispensation by a certified pharmacy. Though this is an important step forward, the path ahead for pharmacies is not clear. The FDA has not yet defined the process of pharmacy certification. Based on the pharmacy certification requirements for other drugs, a range of requirements could be enacted.<sup>279</sup>

At a minimum, pharmacies may have to attest to compliance with safety standards. To do so, they might be required to submit a Pharmacy Enrollment Form to the drug sponsors or the FDA (or both), apply for an authorization number that marks the prescription as valid for a certain period of time, or limit the number of times that a drug is dispensed to an individual.<sup>280</sup> Other requirements might be imposed as well, such as requiring a system that documents compliance with the REMS, ongoing education and training for pharmacists, and counseling for patients.

In addition to barriers imposed by pharmacy certification, other aspects of the mifepristone REMS that have not changed continue to impede access. Providers must register with the drug manufacturer, affirming that they can identify and treat mifepristone's rare adverse effects.<sup>281</sup> Doing so might expose providers to boycotts, protests, and violence if their status becomes known to the public.<sup>282</sup> And the FDA's additional informed consent requirement—the Patient Agreement Form, which patients sign before beginning a medication abortion—remains in place despite duplicating what providers already communicate to patients.<sup>283</sup>

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<sup>279</sup> Other drugs are subject to pharmacy certification under a REMS, and those requirements vary in what additional dispensation and administrative restrictions they impose. FOOD & DRUG ADMIN., REMS DISPENSER CERTIFICATION REQUIREMENTS (June 1, 2013), <https://www.fda.gov/files/about%20fda/published/REMS-Dispenser-Certification-Requirements.pdf>.

<sup>280</sup> This rule might attempt to stop a pregnant abortion rights supporter from obtaining multiple prescriptions with the purpose of sending the drugs to people in other states. It could also impede advance provision of medication pills, the availability of which could vary by state law. Carrie N. Baker, *Online Abortion Provider Robin Tucker: 'I'm Trying to Remove Barriers. ... It Feels Great To Be Able To Help People This Way'*, MS. MAG. (Jan. 1, 2022), <https://msmagazine.com/2022/01/04/online-abortion-pills-provider-robin-tucker-virginia-maryland-maine/>.

<sup>281</sup> Donley, *supra* note 41, at 11.

<sup>282</sup> See generally DAVID S. COHEN & KRISTEN CONNOR, LIVING IN THE CROSSHAIRS: THE UNTOLD STORIES OF ANTI-ABORTION TERRORISM (2015).

<sup>283</sup> Rachel Rebouché, Greer Donley, David S. Cohen, *Progress In The Bid To Make Abortion Pills More Widely Available*, BOS. GLOBE (Dec. 22, 2021), <https://www.bostonglobe.com/2021/12/22/opinion/progress-bid-make-abortion-pills-more-widely-available/>.

The FDA could remove these unnecessary restrictions on mifepristone, or, at least, ensure that the yet-to-be-determined pharmacy certification process is reflective of mifepristone's safety, and imposes minimal requirements. For instance, mandating that healthcare providers identify as an abortion provider disincentivizes general obstetricians and primary care providers from offering medication abortion as part of their practices.<sup>284</sup> Overly burdensome obligations on pharmacies will discourage them from carrying mifepristone. Though some specialty and mail-order pharmacies will be undeterred, it remains an unanswered question whether the retail pharmacy chains most Americans rely on will obtain certification.<sup>285</sup> If the FDA were to lessen these restrictions and make pharmacy certification easier, it would further increase access to mifepristone via telehealth for patients everywhere.

Second, there are general barriers to telehealth that impede access to remote abortion care, which the federal government can work to improve. With the pandemic, telehealth exploded across many healthcare sectors and nationally.<sup>286</sup> Yet there remains unequal access to telehealth, mirroring broader disparities in the distribution of health resources.<sup>287</sup> Most abortion patients live below the federal poverty line and indicate that their chief reason for terminating a pregnancy is the inability to afford the costs of raising a child.<sup>288</sup> Those same patients need access to a telehealth-capable device, high-speed data transmission, and digital literacy. Take for instance unequal access to broadband internet service.<sup>289</sup> The “digital divide” disproportionately affects communities of color and low-income individuals as well as rural populations that lack the infrastructure that can make telehealth methods broadly available.<sup>290</sup> Non-English speakers have additional barriers for navigating telehealth, and people with cognitive difficulties

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<sup>284</sup> Carrie N. Baker, *Online Abortion Provider and “Activist Physician” Michele Gomez Is Expanding Early Abortion Options Into Primary Care*, MS. MAG. (Jan. 19, 2022), <https://msmagazine.com/2022/01/19/online-abortion-primary-care-doctor-michele-gomez-mya-network/>.

<sup>285</sup> The FDA could also permit medication abortion through 12 weeks of pregnancy, which is supported by evidence of the drug's effectiveness through that time. The FDA has done this previously, in 2016, when it approved mifepristone use through 10, rather than 7, weeks. Donley, *supra* note 41, at 14.

<sup>286</sup> David Hoffman, *Increasing Access to Care: Telehealth During COVID-19*, 7 J. L. & BIOSCIENCES 1, 2 (2020).

<sup>287</sup> Cason Schmit et al., *Telehealth in the COVID-19 Pandemic*, in ASSESSING LEGAL RESPONSES TO COVID-19, at 102 (Scott Burris et al. eds., 2020).

<sup>288</sup> See DIANA GREENE FOSTER, *THE TURNAWAY STUDY: TEN YEARS, A THOUSAND WOMEN, AND THE CONSEQUENCES OF HAVING – OR BEING DENIED – AN ABORTION* (2020).

<sup>289</sup> See Betsy Lawton, *COVID-19 Illustrates Need to Close the Digital Divide*, in ASSESSING LEGAL RESPONSES TO COVID-19, *supra* note 287, at 191.

<sup>290</sup> Alexandra Thompson et al., *The Disproportionate Burdens of the Mifepristone REMS*, 20 CONTRACEPTION 1, 3 (2021).

also may have trouble interacting via video.<sup>291</sup> The federal government could use its spending power, as it did during the pandemic, to invest in the infrastructure that makes telemedicine work. The ripple effects of doing so would benefit all seeking abortion via telehealth.

These efforts, however, depend on state cooperation, and, here, the federal government would have to play an advocacy role in promoting permissive state telehealth policies.<sup>292</sup> During the pandemic, with the strong encouragement of federal agencies like the HHS, DOJ, CDC, states began to recognize various modes of telehealth delivery, such as over the telephone, thereby removing the requirement of a video link.<sup>293</sup> Also with federal support (and guidance), many states waived and some states repealed rules limiting the reach of telehealth, such as how a patient-provider relationship is established or permitting out-of-state providers to practice in state.<sup>294</sup>

Third, the federal government, along with supportive states, can work to improve the national distribution of abortion providers by making interstate licensure easier. Although some waivers of state telehealth restrictions have expired,<sup>295</sup> the growing acceptance of telemedicine across state lines has prompted calls for uniformity in telehealth policy, particularly as related to physician licensure.<sup>296</sup> Over the last two years, an increasing number of states permitted physicians to treat out-of-state patients, using telemedicine, if providers were in good standing in their home jurisdiction and registered with state boards.<sup>297</sup> Thirty states are currently members of the Interstate Medical Licensure Compact (IMLC), which “offers a voluntary, expedited pathway to licensure for physicians who qualify.”<sup>298</sup> Three additional

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<sup>291</sup> Jorge A. Rodriguez et al., *Disparities in Telehealth Use among California Patients with Limited English Proficiency*, 40 HEALTH AFF. 487 (Mar. 2021), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00823>.

<sup>292</sup> Hudson Worthy, *The New Norm in Healthcare: Telehealth*, 15 CHARLESTON L. REV. 549, 550 (2020).

<sup>293</sup> See Schmit et al., *supra* note 287.

<sup>294</sup> See Kyle Faget, *Telehealth in the Wake of COVID-19*, 22 J. HEALTH CARE COMPLIANCE 5, 6 (2020).

<sup>295</sup> See also Kerri Pinchuk, *California Policy Recommendations for Realizing the Promise of Medication Abortion: How the Covid-19 Public Health Emergency Offers a Unique Lens for Catalyzing Change*, 18 HASTINGS RACE & POVERTY L.J. 265 (2021); Katherine Fang & Rachel Perler, *Abortion in the Time of COVID-19: Telemedicine Restrictions and the Undue Burden Test*, 32 YALE J.L. & FEMINISM 134, 135 (2021).

<sup>296</sup> Nathaniel M. Lacketman et al., *Top 5 Telehealth Law Predictions for 2021*, 11 NAT'L L. REV. 12 (2020).

<sup>297</sup> Kate Nelson, *“To Infinity and Beyond”: A Limitless Approach to Telemedicine Beyond State Borders*, 85 BROOK. L. REV. \_ (2020).

<sup>298</sup> *Introduction*, INTERSTATE MEDICAL LICENSURE COMPACT (last visited Dec. 8, 2021), <https://www.imlcc.org/a-faster-pathway-to-physician-licensure/>; Eli Y. Adashi, et. al., *The Interstate Medical Licensure Compact: Attending to the Underserved*, 325 J. AM. MED. ASS'N, 1607, 1607 (2021).

states have legislation pending.<sup>299</sup> The IMLC utilizes a “mutual recognition” model that aims to increase access to health care for patients in rural and underserved areas. The IMLC does not grant automatic cross-border licensure but makes the process of obtaining practice permission in another state easier. However, professionals obtaining licensure through the IMLC “still face in-state barriers because approval ultimately remains within the individual state medical board’s discretion and physicians still need to retain a license in every state they practice in.”<sup>300</sup>

In response to enthusiasm for telemedicine, the Uniform Law Commission is drafting a model act on telehealth for states to adopt. The draft act creates a registration process for out-of-state practitioners seeking to practice telehealth in a patient’s resident state; registered out-of-state physicians would have the same privileges as in-state physicians, as would physicians who are subject to an interstate compact or consulting with a practitioner who has “established a practitioner-patient relationship with the patient.”<sup>301</sup>

The scope of care is broadly defined under the draft Act: “A practitioner may provide a telehealth service to a patient located in this state if to do so is consistent with the practitioner’s scope of practice in this state, the applicable professional practice standard in this state, and the requirements of federal law and law of this state.”<sup>302</sup> There is an exception, however. The Act precludes “provision of a health care service otherwise prohibited by federal law or the law of this state,” and the comment to this section lists abortion restrictions as a relevant example.<sup>303</sup> The comment states: “a state might prohibit the prescription of abortion-inducing medications or other controlled substances through telehealth.”<sup>304</sup>

Certainly, advocates can lobby to remove this language. But even if unsuccessful, license compacts could improve interstate abortion provision, blunting the effect of state laws and thus state borders. For instance, abortion friendly states could create a pool of providers across states to better handle unpredictable demand in their

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<sup>299</sup> *Compact State Map – Participating States*, INTERSTATE MEDICAL LICENSURE COMPACT, <https://www.imlcc.org/participating-states/>.

<sup>300</sup> Nelson, *supra* note 297, at 1038. Additionally, only physicians belonging to the American Board of Medical Specialties or the American Osteopathic Association’s Bureau of Osteopathic Specialists are eligible for IMLC. *Id.*

<sup>301</sup> Uniform Law Commission, Telehealth Act, § 5(a) (Draft, Nov. 2021). In addition, an out-of-state physician may provide “follow-up care to treatment provided in the state in which the out-of-state practitioner is licensed, certified, or otherwise authorized by law to provide the treatment; and the follow-up care is infrequent or episodic and occurs not later than [one year] after the previously provided in-person treatment.” *Id.* § 5(a)(4)(A)-(B).

<sup>302</sup> *Id.* § 3(a).

<sup>303</sup> *Id.* § 3(b).

<sup>304</sup> *Id.* Comment to Section 3.



home states. This pooling of resources would reduce pressure on individual abortion providers, especially those in states immediately abutting antiabortion states, who, as a result, will likely experience much higher demands. Thus, if New Mexico experiences an increase in patients due to its proximity to antiabortion states, providers in Maine could help by offering early abortions by telemedicine to those in the first ten weeks, freeing the New Mexico providers to focus their attention on the procedural abortions after ten weeks. It will also improve flexibility. If an abortion provider in Texas is now unable to practice, she would be able to travel to any state permitting telaboration and provide abortions to patients scattered throughout abortion-supportive states, including those who have traveled from states with abortion bans.

The federal government acting in the ways explained here will do more than just improve access to medication abortion and telehealth for abortion in states that continue to allow abortion post-*Roe*; it will also have broad impact on anti-abortion states, regardless of their opposition. As early abortion access becomes more portable, it will be easier to obtain for everyone. Patients who travel from anti-abortion states to obtain an abortion at a brick-and-mortar clinic will find providers with greater capacity. Others who cross state lines to access abortion will have an easier time doing so because they can use telemedicine just over the border instead of traveling to a clinic much further away. And yet others who want to remain in their antiabortion state and test the waters of obtaining medication illegally might find more options to explore, including “doctors of conscience”<sup>305</sup> willing to provide care despite the procedure’s illegality. As a result, the interstate conflicts described here will intensify as antiabortion states’ policies are thwarted by the efforts of the federal government and abortion-supportive states.

### CONCLUSION

In this Article, we have identified the seismic shifts in abortion law and practice that are coming once the Supreme Court abandons *Roe*. The future will be one of interjurisdictional conflict, in all the ways identified here (and in ways we have yet to consider). But within these identified conflicts lies opportunities to untether abortion access to the pronouncement of constitutional abortion rights. As discussed throughout this Article, these opportunities include shielding out-of-state conduct from in-state punishment, protecting abortion providers in abortion-supportive states from being investigated by states that restrict abortion, preempting state laws that contradict FDA rules, further loosening federal restrictions on medication abortion,

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<sup>305</sup> CAROLE JOFFE, *DOCTORS OF CONSCIENCE: THE STRUGGLE TO PROVIDE ABORTION BEFORE AND AFTER ROE V. WADE* (1996).

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advancing telaboration through licensure and telemedicine infrastructure, and providing abortion services on federal land.

There is no guarantee that all, or even any, of these strategies will work, especially because some of them will rely on courts that might be hostile to abortion rights. But thinking about interjurisdictional approaches to abortion access is important now more than ever because the abortion debate, and the conflicts it inspires, is going to fundamentally change. For half a century, the antiabortion movement has thrown whatever it can muster against the wall, hoping something will stick and without fear of defeat. They have lost many of their battles over the years, but have also had significant victories. They have learned lessons, relied on lower court and dissenting opinions, lobbied state legislators, influenced federal policy, and continued to press their novel, often legally tenuous, approaches. This steely-headed approach, coupled with the luck of Supreme Court vacancies, has put them in the position to usher in a post-*Roe* era. Without the protection of *Roe*, the abortion rights movement will be forced to emulate at least some parts of this approach and press their own novel strategies in the coming years—strategies that will rely less on respecting borders and more on invading them on federal land, preempting them with federal laws, or ignoring them altogether.

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