Abortion in the Time of COVID-19: Telemedicine Restrictions and the Undue Burden Test

Katherine Fang and Rachel Perler†

ABSTRACT: During the COVID-19 pandemic, even while many traditional restrictions on telemedicine have been relaxed, few states have suspended existing regulatory restrictions on the remote provision of medication abortions (teleabortions). Simultaneously, an overlapping subset of states have cited the public health emergency as a reason to curtail access to surgical abortion. This Comment suggests that under the Fourteenth Amendment and Supreme Court precedent, these two actions, taken together, have the effect of posing an undue burden to abortion access, especially for women from disadvantaged backgrounds. It first describes the politicized regulatory landscape surrounding teleabortions and argues that expanded teleabortion is a safe alternative when states restrict access to surgical abortions due to a public health emergency. In light of the unique burdens of the pandemic, a failure to provide access to either constitutes an undue burden. Last, the results of select states' experimentation with teleabortion during the pandemic could provide additional data points in favor of integrating teleabortion into reproductive healthcare, even after the COVID-19 pandemic lapses.

ADDENDUM: The authors would like to note that this Comment's analysis makes reference to several authorities in ongoing litigation, many of which have developed during the editing process. Namely, we cite to *American College of Obstetricians & Gynecologists v. FDA*,[1] a federal district court decision enjoining the FDA's restriction on remote prescribing of the abortion

---

† Katherine Fang is a second-year student at Yale Law School. Rachel Perler is a second-year student at Yale Law School. The authors are grateful to Professor Reva Siegel for feedback, encouragement, and inspiration as we began writing this Comment. We also thank Emily Jo Coady for significant support in developing the piece. Lastly, this Comment would not have been possible without the careful editing of Ali Gali, Nina Oishi, B. Rey, Kataeya Wooten, Chelsea Thompson, and all of the people who helped in the brainstorming and editing process for this piece.

1. Am. Coll. of Obstetricians & Gynecologists v. FDA, No. TDC-20-1320, 2020 U.S. Dist. LEXIS 122017, at *113 (D. Md. July 13, 2020), *rev'd*, 208 L. Ed. 2d 155, *stay denied*, 2020 U.S. Dist. LEXIS 231387.

medication, mifepristone, during the COVID-19 pandemic. On January 12, 2021, the Supreme Court issued an unsigned order reinstating the FDA requirement.[2] Chief Justice Roberts explained that this result was a matter of agency deference. He wrote that the order addressed only the narrow question of whether the District Court properly overruled the agency's action based on "the court's own evaluation of the impact of the COVID-19 pandemic"[3]—not the constitutional question of "whether the requirements for dispensing mifepristone impose an undue burden on a woman's right to an abortion as a general matter."[4]

Our Comment addresses that constitutional question. Placing aside the question of agency deference, we argue that restrictions on remote prescribing of mifepristone constitute an undue burden in light of the unique circumstances of the COVID-19 pandemic. As Justice Sotomayor noted in her dissent, "patients' health vulnerabilities, public transportation risks, susceptible older family members at home, and clinic closures and reduced services pose substantial, sometimes insurmountable, obstacles for women seeking medication abortions during the COVID–19 pandemic."[5] Recognizing similar barriers, the FDA has suspended comparable restrictions, while leaving mifepristone restrictions in place. Thus, the question of whether specific rules and restrictions surrounding abortion access constitute an undue burden is very much a live one. Our Comment explores the safety of medication abortion, barriers to its availability, and its place in our constitutional landscape during a pandemic.

INTRODUCTION

The COVID-19 pandemic has disrupted the provision of health care and exacerbated existing health inequities.[6] Reproductive health care, in particular, has been a site of both disruption and political contention. For example, when the United States first imposed COVID-19 lockdown restrictions in March 2020, Congress stalled in passing emergency relief measures in part because Senate Republicans insisted on including language banning federal funding for abortions.[7] But most pandemic-era abortion restrictions have operated on the

2. FDA v. Am. Coll. Obstetricians & Gynecologists, No. 20A34, 2021 U.S. LEXIS 497 (Jan. 12, 2021).

3. *Id.* at *1-2.

4. *Id.* at *1.

5. *Id.* at *13 (Sotomayor, J., dissenting).

6. Even in pre-pandemic times, medical treatment was under-provisioned. In particular, women of color and women from under-resourced communities never enjoyed equitable access to health care resources. *See, e.g.*, Susan A. Cohen, *Abortion and Women of Color: The Bigger Picture*, 11 GUTTMACHER POL'Y REV. 1 (Aug. 6, 2008), https://www.guttmacher.org/gpr/2008/08/abortion-and-women-color-bigger-picture [https://perma.cc/JZ7J-3WLB]; Alexis Okeowo, *Fighting for Abortion Access in the South*, NEW YORKER (Oct. 7, 2019), https://www.newyorker.com/magazine/2019/10/14/fighting-for-abortion-access-in-the-south [https://perma.cc/67CG-6LY6].

7. Emily Cochrane, *Senate Cancels Recess as Democrats and White House Seek Virus Relief Deal*, N.Y. TIMES (Mar. 12, 2020), https://www.nytimes.com/2020/03/12/us/politics/trump-house-coronavirus-

state level. Governors have used executive action to curtail access to abortion clinics, while leaving restrictions on remote prescribing of abortion medication untouched. Much attention has been directed toward state executive orders classifying surgical abortions as "non-essential medical procedures" to be postponed during the public health emergency.[8] However, parallel state limitations on the provision of medication abortions via telemedicine (teleabortions) during the pandemic have received less attention. Though these latter constraints predate the pandemic, we argue that they have remained in place in a subset of states because of deliberate executive *inaction* while parallel restrictions on other telemedicine services have been suspended. Thus, this Comment critiques existing prohibitions on teleabortion and new surgical abortion limitations, to which we refer collectively as "pandemic-era restrictions."

In this Comment, we argue that restrictions on teleabortions do not pass constitutional muster during the COVID-19 pandemic. In Part I, we provide background on the safety considerations and the federal and state regulatory issues surrounding teleabortions. In Part II, we argue that barriers to teleabortions are an undue burden during the present crisis in states where access to surgical abortions has been suspended. In Part III, we conclude by asserting that teleabortion is a promising method for reducing health inequity, decreasing costs, and strengthening reproductive health infrastructure in the United States. We further contend that telemedicine is a reliable method for delivering reproductive health care, even after the pandemic lapses. The current public health crisis is a fertile ground for experimenting with new health care delivery models while normal services are disrupted. Innovations during the pandemic could advance health equity in the future.

I. TELEABORTION: BACKGROUND, SAFETY, AND REGULATORY ISSUES

Medication abortions have been common practice since 2000, when the United States Food and Drug Administration (FDA) first approved mifepristone, a medication that, when taken alongside the drug misoprostol during the first ten weeks of pregnancy, induces early-term abortion. By 2016, the proportion of early-term abortions that were medication abortions had risen to 41.9%.[9] By 2018, an estimated 3.7 million Americans had undergone a medication

relief-bill.html [https://perma.cc/T67R-7SPT] ("Republicans were insisting on inserting language into the emergency package to ban federal funding for most abortions.").

8. *See, e.g.*, Adams & Boyle, P.C. v. Slatery, 956 F.3d 913 (6th Cir. 2020) (resisting Tennessee's efforts to curtail abortions during the pandemic); *In re* Abbott, 956 F.3d 696 (5th Cir. 2020) (vacating a district court temporary restraining order on Governor's executive order effectively banning surgical abortions during the COVID-19 pandemic).

9. Tara C. Jatlaoui et al., *Abortion Surveillance—United States, 2016*, 68 MORBIDITY & MORTALITY WEEKLY REP. 1, 1 (2016), https://www.cdc.gov/mmwr/volumes/68/ss/ss6811a1.htm [https://perma.cc/3K2V-9MCW]. Early term abortions are defined as abortions at or below eight weeks gestation.

abortion.[10] There is "consensus within the medical and scientific communities that induced abortion is a safe and effective health care procedure."[11] The safety of the procedure does not appear to diminish when it is provided via telemedicine. A study of medication abortions in four states found that, whether medication abortion was provided in person or via telemedicine, clinical outcomes were similar.[12] Fewer than 0.5% of patients who take abortion-inducing medication experience major complications,[13] and the overall mortality rate associated with mifepristone is extremely low—the upper-bounds estimate is 0.65 deaths per 100,000 medical abortions.[14]

"Teleabortion" refers to the provision of medication abortions via telemedicine. Telemedicine includes remote health care services delivered using technology, most commonly by telephone or an internet-enabled device.[15] Ordinarily, a complex web of federal-state regulations substantially limits the services that can be rendered via telemedicine. Two aspects of this framework are particularly relevant to teleabortions: restrictions on remote prescribing of medications and geographic restrictions on telemedicine.

On the federal level, telemedicine is subject to an intricate regulatory framework developed by the FDA, the Federal Communications Commission (FCC), and the Office of the National Coordinator for Health Information Technology (ONC).[16] This framework ordinarily prohibits remote prescribing of certain medications, including abortion medications. Federal law also forbids remote prescribing of certain controlled substances without an initial in-person examination.[17] While mifepristone does not fall within this category, FDA

---

10. *Issue Brief: Analysis of Medication Abortion Risk and the FDA Report "Mifepristone U.S. Post-Marketing Adverse Events Summary Through 12/31/2018,"* ADVANCING NEW STANDARDS REPROD. HEALTH (2019) [hereinafter *Analysis of Medication Abortion Risk*] https://www.ansirh.org/sites/default/files/publications/files/mifepristone_safety_4-23-2019.pdf [https://perma.cc/DEC7-PLLT].

11. Julia E. Kohn et al., *Medication Abortion Provided Through Telemedicine in Four U.S. States*, 143 OBSTETRICS & GYNECOLOGY 343, 343 (2019).

12. *Id.*

13. *Analysis of Medication Abortion Risk*, *supra* note 10, at 1-2.

14. Because it is mandatory to report any deaths among persons who have taken mifepristone, this mortality estimate includes several deaths that may be unrelated to the medication. *See id.* at 1 (discussing how, of twenty-four deaths associated with mifepristone in the United States, eleven appear to be attributable to unrelated causes such as suicide, homicide, or natural causes).

15. *Using Telehealth Services*, CTRS. FOR DISEASE CONTROL & PREVENTION (last updated June 10, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/telehealth.html [https://perma.cc/5SK4-BNKJ]. "Telehealth" and "telemedicine" are sometimes used interchangeably, though telemedicine refers specifically to the provision of clinical care.

16. Rita M. Marcoux & F. Randy Vogenburg, *Telehealth: Applications from a Legal and Regulatory Perspective*, 41 PHARMACY & THERAPEUTICS 567 (2016). The FTC protects patients from deceptive practices, data breaches, or other violations of the Health Insurance Portability and Accountability Act (HIPAA). The FDA, together with the FCC and ONC, has the authority to promulgate federal regulations governing telemedicine.

17. 21 U.S.C. § 829(e) (2018). The statute contains an exception to the in-person examination requirement for certain DEA-registered medical providers practicing telemedicine. 21 U.S.C. § 829 (e)(3)(A) (2018).

regulations require that it be dispensed in person by a qualified provider.[18] Thus, patients seeking a medication abortion ordinarily must retrieve the pills in person, although no federal regulation bars prescribing mifepristone via telemedicine.

State laws and regulations supplement (and overlap with) the federal framework. The intricacy of this framework renders a comprehensive summary in this Comment impossible—however, this Part summarizes key characteristics relevant to our analysis. In every state, telemedicine is subject to licensing requirements that generally prevent patients from receiving telemedicine care from a provider who is not licensed to practice in the state where care originates and the state where care is received.[19] Further, in nineteen states, a clinician must be physically present when administering mifepristone.[20] A range of other regulatory issues complicate telehealth during non-pandemic times,[21] but this Comment focuses primarily on the subset of states with restrictions on remote prescribing of abortion medications. As mentioned, these limitations existed before the pandemic. But the subset of states with restrictions on teleabortions overlaps substantially with the subset of states that curtailed other means of abortion access at some point during the pandemic.[22] In fact, no state has affirmatively suspended teleabortion restrictions during the pandemic, despite waiving comparable restrictions in other areas of telemedicine. This inaction creates the regulatory hurdles that we characterize as an undue burden during the current public health crisis.

To contextualize this claim, we first survey the pandemic-era changes to the regulatory regime governing telemedicine writ large. Both federal and state officials have encouraged expanded telemedicine during the pandemic. On the federal level, the Centers for Disease Control (CDC) issued guidance to encourage the provision of care via telehealth "whenever possible" as "the best

18. *Mifeprex (Mifepristone) Information*, U.S. FOOD & DRUG ADMIN., https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information (describing the regulatory requirements imposed on prescription of mifepristone) [https://perma.cc/S6RH-E8JJ].

19. *See id.* at 3.

20. *Medication Abortion*, GUTTMACHER INST. (Jan. 2021), www.guttmacher.org/state-policy/explore/medication-abortion [https://perma.cc/J7RK-KLT5]. This requirement is slightly more restrictive than the federal regulations. On the federal level, a provider must dispense the medication in person, but the medication can be self-administered at home.

21. For example, the standard of care varies by state. Most states have laws determining that remote prescribing with no in-person visit does not meet the standard of care. *See generally* Nathaniel M. Lacktman, *Legal and Regulatory Issues*, in UNDERSTANDING TELEHEALTH (Karen Schulder Rheuban, Elizabeth A. Krupinski eds., 2020) (describing the legal and regulatory framework governing telehealth, including variations in the standard of care between states).

22. For a catalogue of the types of anti-abortion measures in place across the various states, see *Bans on Specific Abortion Methods After the First Trimester*, GUTTMACHER INST. (Dec. 2020), https://www.guttmacher.org/state-policy/explore/bans-specific-abortion-methods-used-after-first-trimester [https://perma.cc/3MEJ-XQAF].

way to protect patients and staff from COVID-19."[23] Congress acted quickly to expand telemedicine—on March 6, 2020, the Coronavirus Preparedness and Response Appropriations Act became law.[24] The law gave authority to the Secretary of the Department of Health and Human Services (HHS) to waive certain regulations on telemedicine during a declared public health emergency. Under this authority, the Secretary temporarily suspended geographic restrictions, device type restrictions, and limitations on forms of care traditionally available via telemedicine.[25] Also, the United States Drug Enforcement Agency (DEA) temporarily lifted restrictions on remote prescription of controlled substances without a prior in-person examination during the pandemic.[26] Finally, in June 2020, a federal district court issued a nationwide injunction on the enforcement of an FDA requirement that abortion medications be dispensed in person.[27] The court reasoned that the requirement constitutes an undue burden in light of the public health emergency.[28] Together, these changes removed federal barriers to fully remote teleabortions.

States took similar actions to expand telemedicine, but existing legal and regulatory barriers to teleabortion remained in place. State actions to expand telemedicine primarily occurred via two avenues: state medical boards and executive actions. As mentioned, licensing requirements normally prevent the provision of telemedicine across state lines. During the COVID-19 pandemic, however, many state medical boards temporarily waived these restrictions to permit providers licensed in other states to expand their telemedicine practice.[29] Most states also suspended in-person requirements for prescribing most oral

---

23. *Prepare Your Practice for COVID-19*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/hcp/preparedness-resources.html [https://perma.cc/RFH2-9CX5].

24. Pub. L. No. 116-123 (Mar. 6, 2020). Additionally, the Centers for Medicare and Medicaid Services issued multiple waivers to increase the flexibility of telehealth reimbursement during the pandemic. *See Using Telehealth to Expand Access to Essential Health Services During the COVID-19 Pandemic*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/hcp/telehealth.html [https://perma.cc/NN7E-GX2V].

25. *Id.* HHS also announced that it would waive penalties for good faith privacy violations by health care providers using standard online communications platforms. *OCR Announces Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency*, U.S. DEPT. HEALTH & HUMAN SERVS. (Mar. 17, 2020), https://www.hhs.gov/about/news/2020/03/17/ocr-announces-notification-of-enforcement-discretion-for-telehealth-remote-communications-during-the-covid-19.html [https://perma.cc/V7Q2-SJZP].

26. *COVID-19 Information Page*, U.S. DRUG ENF'T AGENCY DIVERSION CONTROL UNIT (Oct. 6, 2020) https://www.deadiversion.usdoj.gov/coronavirus.html [https://perma.cc/V3UK-DLBX].

27. Am. Coll. of Obstetricians & Gynecologists v. FDA, No. TDC-20-1320, 2020 U.S. Dist. LEXIS 122017, at *81 (D. Md. July 13, 2020) ("In light of the convergence of all of these factors stemming from the COVID-19 pandemic, the Court finds that the In-Person Requirements impose a substantial obstacle to abortion patients seeking medication abortion care.").

28. *Id.*

29. *See generally U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19,* FED'N STATE MED. BOARDS, https://www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf (last updated Jan. 22, 2021) (summarizing state medical board waivers of telehealth regulations as of December 30, 2020) [https://perma.cc/H5P2-SX4X].

medications.[30] With respect to executive action, governors in many states invoked their emergency powers to further dissolve regulatory barriers to telemedicine.[31] In Indiana, for example, the governor issued an executive order specifically authorizing the remote prescription of opioids.[32] In Texas, the state attorney general interpreted a March 2020 executive order banning nonessential medical procedures to apply to both surgical and medication abortions, singling out medication abortion as the only oral medication included in the ban.[33] Medication abortions were later allowed to proceed by a Fifth Circuit order,[34] but the state's requirement that the medications be administered in person remained in place. In fact, despite legal challenges to teleabortion restrictions,[35] none of the nineteen states with extant restrictions on the remote provision of medication abortions has modified those restrictions during the COVID-19 pandemic.[36]

A pattern of COVID-era teleabortion restrictions has emerged: states that already had substantial barriers to abortion access have ratcheted up restrictions on surgical abortions during the pandemic, often via executive orders classifying them as "non-essential" medical procedures subject to temporary suspension.[37] Simultaneously, many of the same states have left regulatory barriers to teleabortions untouched while medical boards have lifted limitations on many other facets of telemedicine, including remote prescribing of nearly all other oral medications.[38] The result of these dual processes is that teleabortions remain out

---

30. *Id.*

31. For a catalogue of the current status of emergency state action on telehealth, see *COVID-19 Related State Actions*, CTR. FOR CONNECTED HEALTH POL'Y, https://www.cchpca.org/covid-19-related-state-actions [https://perma.cc/UHM2-3KVA].

32. *See* Exec. Order No. 20-12, IND. ADMIN. CODE 10-14-3 (2020); *see also* Bradley S. Davidson, *New State Laws Allow Telehealth Prescriptions for Controlled Substances; Yet, Regulatory Obstacles Still Remain*, HEALTH L. ADVISOR (Jan. 22, 2018), https://www.healthlawadvisor.com/2018/01/22/new-state-laws-allow-telehealth-prescriptions-for-controlled-substances-yet-regulatory-obstacles-still-remain [https://perma.cc/98U5-YG25].

33. Tex. Exec. Order No. Ga-09 (Mar. 22, 2020), https://lrl.texas.gov/scanned/govdocs/Greg%20Abbott/2020/GA-09.pdf [https://perma.cc/3FZL-AZT3]; *see also* Raga Justin, *No Abortions in Texas Unless the Mother's Life is in Danger, Texas Attorney General Says as Coronavirus Spreads*, TEX. TRIB. (Mar. 23, 2020), https://www.texastribune.org/2020/03/23/texas-stops-most-abortions-during-coronavirus-outbreak/ [https://perma.cc/6KGH-RXMA].

34. *In re* Abbott, 809 F. App'x 200 (5th Cir. 2020).

35. For example, the Kansas Court of Appeals rejected a challenge to regulations on medication abortion delivery requiring in-person delivery of services. *See* Press Release, Attorney General Derek Schmidt: Court of Appeals Rejects 'Opportunistic' Attempt to Lift Abortion Restrictions Because of COVID-19 Crisis (Apr. 10, 2020), https://ag.ks.gov/media-center/news-releases/2020/04/10/ag-derek-schmidt-court-of-appeals-rejects-opportunistic-attempt-to-lift-abortion-restrictions-because-of-covid-19-crisis [https://perma.cc/M4JH-SGNJ].

36. *See Medication Abortion*, *supra* note 20.

37. *See* Jessie Hill, *Essentially Elective: The Law and Ideology of Restricting Abortion During the COVID-19 Pandemic*, 106 VA. L. REV. ONLINE 99 (2020).

38. For a timeline of abortion bans during the pandemic, see Laurie Sobel, et al., *State Action to Limit Abortion Access During the COVID-19 Pandemic*, KAISER FAMILY FOUND. (Aug. 10, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/state-action-to-limit-abortion-access-during-the-covid-19-pandemic/ [https://perma.cc/83U3-KJWP].

of reach in many of the states where surgical abortions are also restricted.[39] In the next Part, we will argue that states' failure to extend emergency deregulation to teleabortions constitutes an undue burden on patients seeking abortions.

II. TELEABORTION AND THE UNDUE BURDEN STANDARD

Restrictions on teleabortions do not pass constitutional muster during the COVID-19 pandemic. In a non-pandemic context, teleabortion restrictions would withstand scrutiny since the burdens they pose—normally, a requirement to travel to an abortion clinic in person—may not be substantial enough for the constitutional standard. However, in the context of a global health emergency with its attendant economic and public health destruction, months of government shutdowns, and substantial curtailment of in-person health services, the burdens posed by teleabortion restrictions have grown in severity. In this Part, we contend that the states' effective bans on teleabortion create an undue burden for patients with unwanted pregnancies, particularly in states where surgical abortions have also been suspended.

The constitutional right to seek an abortion was first recognized in *Roe v. Wade*, in which the Court held that the right of personal privacy "is broad enough to encompass a woman's decision whether or not to terminate her pregnancy."[40] In *Planned Parenthood v. Casey*, the Court established the "undue burden" standard to determine if a state regulation on abortion conflicts with the Constitution.[41] A regulation that has "the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion" is an undue burden and an unconstitutional infringement of the fundamental right to privacy.[42] The Supreme Court affirmed and clarified the "undue burden" standard in *Whole Woman's Health v. Hellerstedt*, explaining that the undue burden standard enumerated in *Casey* "requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer."[43]

The first step in determining whether teleabortion restrictions are unduly burdensome is to assess the burdens that the restrictions pose to patients. As the Supreme Court reaffirmed in *June Medical*, "[u]nnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman

---

39. It is noteworthy that, of the nineteen states that submitted an amicus brief on behalf of the Texas governor's emergency order restricting surgical abortions, thirteen prohibit teleabortions via requirements that a prescribing physician be in the physical presence of a patient. Those states are Alabama, Arkansas, Indiana, Kentucky, Louisiana, Mississippi, Missouri, Nebraska, Oklahoma, South Dakota, South Carolina, Tennessee, and West Virginia. *See* Brief of 19 States as Amici Curiae, *In re* Abbott, 809 F. App'x 200 (5th Cir. 2020).

40. 410 U.S. 113, 153 (1973).

41. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992).

42. *Id.* at 877.

43. 136 S. Ct. 2292, 2309 (2016). *See also* June Med. Servs. L.L.C. v. Russo, 140 S. Ct. 2103, 2112 (2020) (affirming the standard advanced in *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016)).

seeking an abortion impose an undue burden on the right."[44] Courts have considered a range of factors in assessing the burdens posed by an abortion restriction, including the travel distance to an abortion facility, difficulties securing transportation to a facility, the need for childcare during visits, additional costs, and other practical considerations.[45] During the COVID-19 pandemic, travel to medical facilities carries a significant health risk for patients. For those who rely on public transportation, these requirements also expose patients to COVID-19 risk due to crowding in enclosed public transportation spaces.[46] Further, they disproportionately burden mothers, especially those of color, who, because of the pandemic, bear a greater burden of childcare responsibilities.[47] Finally, the federal government's actions in encouraging closure of nonessential medical offices and waiving restrictions on telemedicine demonstrates an acknowledgment that travel to medical offices poses a burden to patients, providers, and the broader community during the pandemic.[48] In light of all of these factors, we argue that the current bans have the effect of placing a substantial obstacle to abortion in the path of all patients.

The second step in assessing whether teleabortion restrictions constitute an undue burden is to consider the alleged benefits of the restrictions. As discussed earlier,[49] abortion medications are considered to be safe and effective, whether administered in person or remotely. The FDA implicitly acknowledged the safety of medication abortions when it rescinded a 2016 requirement that abortion medications be administered in person. Since 2016, FDA regulations merely require that a patient pick up the medications from a pharmacy in person; in states which lack additional restrictions, abortion medications can be taken at home, unsupervised.[50] Yet, in June 2020, a federal district court in Maryland determined that even this requirement was too burdensome during the COVID-19 pandemic. In *American College of Obstetricians*, the court held that the

---

44. June Med. Servs. L.L.C., 140 S. Ct. at 2112 (quoting *Whole Woman's Health*, 136 S. Ct. at 2309).

45. *See, e.g.*, *Whole Woman's Health*, 136 S. Ct. at 2317-18 (considering cost and travel time for women to visit abortion facilities); Planned Parenthood Ariz., Inc. v. Humble, 753 F.3d 905, 915-16 (considering "practical considerations, such as the frequency with which clinics can see patients and the difficulties women face in obtaining time off from work or transportation to a clinic" as well as the "cost of [an] extra dosage of medicine," the need for an additional clinic visit, and "increase[d] costs to the patient for transportation, gas, [and] lodging").

46. *See* Kim Schive, *How Safe Is Public Transportation?*, MIT MED. (Sept. 29, 2020) (suggesting that various factors, including rate of community infection, affect the safety of public transit during the pandemic), https://medical.mit.edu/covid-19-updates/2020/09/how-safe-public-transportation [https://perma.cc/C32A-QX53].

47. *See* Misty L. Heggeness & Jason M. Fields, *Parents Juggle Work and Child Care During the Pandemic*, U.S. CENSUS BUREAU (Aug. 18, 2020), https://www.census.gov/library/stories/2020/08/parents-juggle-work-and-child-care-during-pandemic.html [https://perma.cc/7MZ4-MWW6]; Eleanor Mueller, *'Crashing Down': How the Child Care Crisis is Magnifying Racial Disparities*, POLITICO (July 21, 2020), https://www.politico.com/news/2020/07/22/coronavirus-child-care-racial-disparities-377058 [https://perma.cc/9KAQ-SMJH].

48. *See generally Prepare Your Practice for COVID-19*, *supra* note 23 (promoting the use of telemedicine wherever possible to limit in-person contact with healthcare providers).

49. *See supra* Part I.

50. *Mifeprex (Mifepristone) Information*, *supra* note 18.

FDA's in-person requirements "cause an undue burden in violation of the Constitution, imposing a substantial obstacle on a large fraction of the relevant women seeking a medication abortion."[51] The court also noted that telemedicine was not common practice in 2016, when FDA regulations were last modified. Consequently, deference to the agency's regulations should be tempered by consideration of the contemporary context, in which telemedicine is widely available and in-person visits to clinics pose significant risks and delays.[52] This analysis suggests restrictions in states that also ban surgical abortions may be vulnerable to constitutional challenges, as well. A state restriction should not stand while a weaker federal restriction is enjoined for being unduly burdensome.[53]

It is important to note that teleabortion restrictions would almost certainly withstand scrutiny in a non-pandemic context. Regulations requiring that a patient be examined in person by a doctor or visit a clinic to sign forms when retrieving abortion medications may be burdensome to patients who lack reliable childcare or need to request time off work. But these burdens are unlikely to constitute the "substantial obstacle" requirement for an "undue burden" explained in *Casey*.[54] And though abortion medications are considered safe and effective by most medical professionals, the regulations to which they are subject during ordinary times arguably carry the benefit of ensuring that patients receive sound clinical guidance within a high standard of care. However modest this benefit may be, the prescription of all controlled substances via telemedicine operates within roughly the same framework on the federal and state level. As a result, it would be difficult to argue that regulations on teleabortions are too burdensome to withstand constitutional challenge during ordinary times.

But these are not ordinary times. In 2020, twenty million people in the United States contracted COVID-19 and 344,030 have died as of this writing.[55] Throughout the country, states have entered prolonged lockdown periods marked by closures of schools, places of worship, restaurants, nonessential businesses, and other public spaces. Fifteen percent of Americans report that they lost their

---

51. Am. Coll. of Obstetricians & Gynecologists v. FDA, No. TDC-20-1320, 2020 U.S. Dist. LEXIS 122017, at *113 (D. Md. July 13, 2020), *rev'd by* 2020 U.S. LEXIS 4833 (per curiam), *stay denied*, U.S. Dist. LEXIS 231387.

52. *See id.* at *90-91.

53. Following the issuance of a preliminary injunction on the FDA regulation, the Government petitioned the Supreme Court for a stay. In an unusual move, the Court declined to issue a stay, and instead remanded the case to the District Court to reconsider the Government's motion, "including on the ground that relevant circumstances have changed." FDA v. Am. Coll. of Obstetricians & Gynecologists, No. 20A34, 2020 U.S. LEXIS 4833, at *1 (Oct. 8, 2020) (per curiam).

54. *Casey* further explains that the question is whether a challenged restriction affects "a large fraction" of women for whom it is "an actual rather than an irrelevant restriction." Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 895 (1992). *See also* Whole Woman's Health v. Hellerstedt, 126 S. Ct. 2292, 2320 (2016).

55. *CDC COVID Data Tracker*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://covid.cdc.gov/covid-data-tracker [https://perma.cc/RD4X-2LF4].

job during the pandemic.[56] As of July 2020, around 30 million individuals were collecting unemployment benefits.[57] Women, especially low-income women of color, have been especially impacted by COVID-19.[58] Following school closures and transitions to online schooling, working mothers have taken on the brunt of increased childcare responsibilities. Women have also been more likely than men to lose their job during the pandemic.[59] Within this context, states have pushed bans on surgical abortions and left regulatory barriers to teleabortions in place.[60]

Despite admonitions to stay home, pregnant women impacted by the bans are already traveling far from home to states where the practice has not been banned,[61] risking contracting COVID-19 or spreading it to others. As the death toll continues to mount, states' moves to restrict abortion access have arguably given rise to another public health crisis.[62] Ohio's ban would have required

---

56. Kim Parker, Rachel Minkin & Jesse Bennet, *Economic Fallout from COVID-19 Continues to Hit Lower-Income Americans the Hardest,* PEW RES. CTR. (Sept. 24, 2020), https://www.pewsocialtrends.org/2020/09/24/economic-fallout-from-covid-19-continues-to-hit-lower-income-americans-the-hardest/ [https://perma.cc/4CX4-HZN6].

57. *About 30 Million Workers Are Collecting Jobless Benefits*, N.Y. TIMES (July 24, 2020), https://www.nytimes.com/live/2020/07/23/business/stock-market-today-coronavirus/roughly-one-in-five-workers-are-collecting-unemployment-benefits [https://perma.cc/6MXN-C8Y6].

58. Nicole Bateman & Martha Ross, *Why Has COVID-19 Been Especially Harmful for Women?*, BROOKINGS INST. (Oct. 2020), https://www.brookings.edu/essay/why-has-covid-19-been-especially-harmful-for-working-women/ [https://perma.cc/2SNC-GE5H].

59. *Id.*

60. *See supra*, Part I. Proponents of these bans have cited the need to preserve person protective equipment (PPE) for doctors treating patients with COVID-19. *See, e.g.*, Tony Cook & Chris Sikich*, What a Coronavirus Executive Order Means for Abortion in Indiana*, INDYSTAR (Mar. 31, 2020), https://www.indystar.com/story/news/politics/2020/03/31/coronavirus-indiana-what-executive-order-means-abortions/5096617002/ [https://perma.cc/5QUZ-U6AB] (describing the stated purpose of Indiana Governor Eric Holcomb's executive order classifying abortions as elective as preserving medical equipment and masks).

61. Paige Alexandria, *Paying for an Abortion Was Already Hard. The COVID-19 Economic Downturn Has Made It Even Harder*, REWIRE NEWS (Mar. 27, 2020), https://rewire.news/article/2020/03/27/paying-for-an-abortion-was-already-hard-the-covid-19-economic-downturn-has-made-it-even-harder [https://perma.cc/6RXN-RU2M].

62. Though aggregated statistics of the number of women affected by pandemic restrictions on abortion are difficult to locate, extensive reporting has unearthed domestic and global diminutions in reproductive freedoms. *See, e.g.*, Anonymous, *I Don't Regret My Abortion. But the Coronavirus Lockdown Made It a Guilty Secret*, GUARDIAN (Aug. 18, 2020), https://www.theguardian.com/world/2020/aug/18/coronavirus-pandemic-abortion-terminating-pregnancy-lockdown-shaming-sex [https://perma.cc/LV7X-7CEE] (recounting one perspective on the negative effects of a state abortion ban); Anonymous Mother in Tennessee, *What Happened When I Needed an Abortion During the Pandemic*, AM. CIV. LIBERTIES UNION (May 1, 2020) https://www.aclu.org/news/reproductive-freedom/what-happened-when-i-needed-an-abortion-during-the-pandemic/ [https://perma.cc/T3PN-NFZE] (same); Glenna Gordon, *She Tried to Get an Abortion During the Pandemic. Her State Wouldn't Allow It.,* CNN (2020), https://www.cnn.com/interactive/2020/06/health/abortion-access-coronavirus-cnnphotos/ [https://perma.cc/275N-XAG7] (explaining that for "many weeks" as the pandemic worsened, "women were left in limbo"); Isabella Gomez Sarmiento, *The Pandemic and Legal Abortion: What Happens When Access is Limited?* NPR (June 8, 2020), https://www.npr.org/sections/goatsandsoda/2020/06/08/864970278/lockdown-limits-access-to-legal-abortion-in-colombia-telemedicine-is-now-an-opti [https://perma.cc/2G9D-8E3Y]. In May, the United States requested removal of programs targeting "sexual and reproductive health" in the United Nations' COVID-19 response plan. John Barsa, *Acting Administrator John Barsa Letter to U.N. Secretary General Guterres*, USAID (May 18, 2020), https://www.usaid.gov/news-information/press-releases/may-18-2020-acting-administrator-john-barsa-un-secretary-general-antonio-guterres [https://perma.cc/P7VF-JYU9].

women to travel a distance 713% greater to receive an abortion.[63] Oklahoma's ban would have increased median driving distance by 1200%, and Texas's pandemic restrictions subjected abortion-seekers to a 3,625% longer journey.[64] Thus, the limitations states sought to impose were hardly narrowly tailored. They carried profound, "actual" consequences for "a large fraction" of women.[65] Many of these same states had already imposed limitations on surgical abortions before the pandemic. For example, states restrict the number of weeks into a pregnancy for which an abortion might be available; require the operation be performed by two physicians, or in a hospital; impose waiting periods; and withhold public funding for even medically necessary abortions.[66]

In recognition of the extraordinary burdens caused by the COVID-19 pandemic, federal and state governments have taken dramatic actions to promote telemedicine in place of in-person medical visits. States with regulations prohibiting remote prescribing of controlled substances have largely lifted these restrictions. On the federal and state level, remote prescribing of opioids has been allowed to proceed via telemedicine, although up to 29% of people in the United States who are prescribed opioids misuse them.[67] Opioid misuse costs the United States an estimated $78.5 billion per year.[68] Still, regulators and health officials have determined that the public health benefits of reducing travel to clinics outweigh the risks of deregulation of telemedicine. Yet, in nineteen states, teleabortion bans remain in place as the sole restriction on remote prescription of oral medications.

Combating the unprecedented spread of COVID-19 requires the federal and state governments to take creative measures. Proponents of the teleabortion bans during the crisis may argue that the pandemic warrants heightened emergency powers and authorizes curtailing certain constitutional rights. During the pandemic, several circuits have explained that states' police power to enact laws intended to preserve public health is expansive, even, apparently, when those laws conflict with the Fourteenth Amendment.[69] But that power cannot run

---

63. Jonathan Bearak et al., *COVID-19 Abortion Bans Would Greatly Increase Driving Distance for Those Seeking Care*, GUTTMACHER INST. (Apr. 2020), https://www.guttmacher.org/article/2020/04/covid-19-abortion-bans-would-greatly-increase-driving-distances-those-seeking-care [https://perma.cc/Z7CB-BR8L].

64. *Id.*

65. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 895 (1992).

66. *See Bans on Specific Abortion Methods*, *supra* note 22; *An Overview of Abortion Laws*, GUTTMACHER INST. (Dec. 9, 2020), https://www.guttmacher.org/state-policy/explore/overview-abortion-laws [https://perma.cc/M8MQ-9RE4].

67. *Opioid Overdose Crisis*, NAT'L INST. OF HEALTH (May 27, 2020), https://www.drugabuse.gov/drug-topics/opioids/opioid-overdose-crisis [https://perma.cc/547E-HEB9] (explaining that 128 people died per day in 2018 due to opioid overdose, and 80% of heroin users first misused prescribed opioids).

68. *Id.*

69. *See, e.g.*, *In re* Abbott, 956 F.3d 696, 784 (5th Cir. 2020) (quoting Jacobson v. Massachusetts, 197 U.S. 11, 31 (1905)) ("[W]hen faced with a society-threatening epidemic, a state may implement emergency measures that curtail constitutional rights so long as the measures have at least some 'real or substantial relation' to the public health crisis and are not 'beyond all question, a plain, palpable invasion of rights secured by the fundamental law.'"). It is important to note that courts continue to wrangle about

unchecked, especially when restrictions have neither the purpose nor the effect of improving the general welfare of the people. Rather, public health justifications are subject to strict scrutiny when they interfere with a constitutionally safeguarded liberty.[70] When such a liberty is burdened, the state must use the "least restrictive alternative" to achieve its ends.[71] In fact, in *Roman Catholic Diocese of Brooklyn v. Cuomo*, the Supreme Court held that that restrictions to religious services in the name of public health during a pandemic would "cause irreparable harm" in light of the guarantees of the First Amendment.[72] Arguably, Fourteenth Amendment protections merit as much safeguarding as First Amendment ones, especially because religious services might result in community spread,[73] but the greater availability of medication abortions would limit the need for unnecessary travel or in-person contact between physicians and patients. A wholesale ban on remote prescription of abortion medications during a global pandemic when the option to provide teleabortions exists, in conjunction with certain state bans on surgical abortions in early and mid-2020, unnecessarily obstructs women's right to healthcare.

III. THE SUSTAINABILITY OF TELEABORTION

We have argued thus far that teleabortion restrictions during the COVID-19 pandemic are an unconstitutional burden on the right to abortion. But even after the pandemic resolves, making teleabortion more accessible could increase access to reproductive healthcare in the long term, particularly for patients located in states with few abortion providers. In this Part, we advance three normative arguments for why teleabortion should remain accessible after the pandemic. Teleabortion can 1) improve health equity; 2) reduce costs associated with seeking an abortion; and 3) create a stronger reproductive health infrastructure.

First, expanded teleabortion access will promote reproductive health equity. Although abortion is a common procedure, access to abortion is not uniform throughout the United States. Women of color, lower income patients, and those who live in rural areas face barriers to accessing abortion.[74] These barriers are

---

Jacobson's application in the pandemic context. This spring, the Sixth Circuit rejected an argument from the state of Tennessee asserting that *Jacobson* supports its statewide abortion ban. Adams & Boyle, P.C. v. Slatery, 956 F.3d 913, 925-26 (6th Cir. 2020).

70. Lawrence O. Gostin, *The Future of Public Health Law*, 12 AM. J.L. & MED. 461, 469-70 (1986).

71. *Id.*

72. 141 S. Ct. 63, 67 (2020).

73. *See Considerations for Communities of Faith*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 30, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/faith-based.html [https://perma.cc/4V2D-2APA] ("[G]atherings present a risk for increasing spread of COVID-19 during this [p]ublic [h]ealth [e]mergency."); *but see Roman Catholic Diocese*, 141 S. Ct. at 66 ("[T]he State has not claimed that attendance at the applicants' services has resulted in the spread of the disease.").

74. *See* Charles R. Lawrence III, *The Id, the Ego, and Equal Protection: Reckoning with Unconscious Racism*, 39 STAN. L. REV. 317, 377 (1987) ("[The Supreme Court case *Harris v.*] *McCrae* involved the

especially steep in states that have enacted laws and policies that are hostile to abortions. For example, patients living in states with mandatory waiting periods are more likely to travel longer distances to get an abortion.[75] Given that most abortion patients are low-income, additional barriers to accessing abortion, including travel costs, lost wages, childcare expenses, transportation, and accommodations, may result in significant inequities in access.[76] A survey of three of the five abortion clinics in Louisiana in 2015 revealed that "[h]alf (53%) of women who had an abortion had no education beyond high school, most were black (62%) . . . and most (89%) were having a first-trimester abortion. [79%] resided in Louisiana and 15% in Texas."[77] If states committed to removing regulatory restrictions on interstate telemedicine even after the pandemic resolves, teleabortion could overcome geographic barriers to abortion access. But even operating under the current regulations limiting telemedicine to patients and providers residing in the same state, teleabortion could remove many of the barriers that contribute to racial and socioeconomic inequities in abortion access. Justice Breyer, writing for the plurality in *June Medical*, noted that "both experts and laypersons testified that the burdens of . . . increased travel" that would result from imposing upon abortion providers a requirement that they obtain admitting privileges within thirty miles of their clinic "would fall disproportionately on poor women, who are least able to absorb them."[78] Likewise, during the pandemic, as clinics become less accessible to women, the impact will be felt mostly by low-income women and women of color.

Next, teleabortion has the potential to reduce the costs of medication abortion for both patients and providers. A medication abortion can cost as much as $1,000, not including the costs of transportation, lost wages, childcare, and other incidental costs.[79] For low-income patients who either lack insurance or whose insurance coverage does not reimburse the cost of abortions, these expenses can be prohibitive.[80] While telemedicine will not remove the costs of

---

exclusion of certain abortions from coverage under a federal medicaid act. Blacks and Mexican-Americans were disproportionately represented in each of the disfavored groups, but without proof of racial animus, the Court considered their disparate burden irrelevant to the statutes' constitutionality."); Okeowo, *supra* note 6.

75. Jenna Jerman et al., *Barriers to Abortion Care and Their Consequences for Patients Traveling for Services: Qualitative Findings from Two States*, 49 PERSPS. ON SEXUAL & REPROD. HEALTH 2, 95-102 (2017).

76. *Id.*

77. S.C.M. Roberts, et al.**,** *Implications for Women of Louisiana's Law Requiring Abortion Providers to Have Hospital Admitting Privileges*, 91 CONTRACEPTION 368, 368 (2015), https://ibisreproductivehealth.org/publications/implications-women-louisiana%E2%80%99s-law-requiring-abortion-providers-have-hospital-admitting [https://perma.cc/DF27-ML9X].

78. June Med. Servs. L.L.C. v. Russo, 140 S. Ct. 2103, 2130 (2020).

79. *How Do I Get the Abortion Pill?,* PLANNED PARENTHOOD (2020), https://www.plannedparenthood.org/learn/abortion/the-abortion-pill/how-do-i-get-the-abortion-pill [https://perma.cc/D7BB-3KR2].

80. Insurance providers are not required to cover abortions. Additionally, many of the lowest income Americans get their insurance through Medicaid; the federal Hyde Amendment prohibits the use of federal Medicaid dollars to fund abortions, with very narrow exceptions. *See Medicaid Funding of Abortion*,

the abortion medication itself, it may allow patients to forego clinical fees, travel costs, and lost wages from taking time off work.[81] For providers, it may allow clinics to accommodate a high volume of cases without depleting supplies, and to accommodate a greater number of patients who require in-person services. Entities as authoritative as the World Health Organization (WHO) have long urged that teleabortion with a licensed nurse practitioner is both safe and cost effective.[82] Clinical surveys have borne out the idea that teleabortions are safe.[83]

Ultimately, teleabortion can improve the U.S. reproductive health care infrastructure in the long term. The unprecedented public health emergency necessitated the expansion of innovative at-home care via telemedicine. While federal and state regulations prevented patients from accessing truly remote abortions prior to the COVID-19 pandemic, temporary deregulation has allowed teleabortions to proceed in many states alongside other telemedicine services. As a result, providers and healthcare systems have built capacity to deliver telemedicine on a large scale after the pandemic ends. This real-time experiment may give us the evidence we need to conclude that the WHO is correct—that teleabortion is both safe and cost-effective for patients and providers.

As a final note, we situate our normative claims within a broader discussion of the political climate surrounding our current crisis. Throughout his administration, President Trump took actions to make even in-clinic abortion access more difficult. His gag order on Title X of the Public Health Service Act,[84] for example, reduced the Title X national family planning network by half, endangering reproductive care for at least 1.6 million women.[85] It was during his administration and in front of a Supreme Court with two Trump appointees that the state of Louisiana advanced abortion-restrictive claims duplicative of settled law under *Whole Woman's Health*.[86] It is unsurprising, therefore, that the FDA under the Trump administration attempted to constrain teleabortion access during the COVID-19 pandemic. Nor is it surprising that there has been legislative backlash to deregulation—Louisiana Senator Bill Cassidy introduced a bill that would prohibit medication abortions from taking place without the

---

GUTTMACHER INST. (2020), https://www.guttmacher.org/evidence-you-can-use/medicaid-funding-abortion [https://perma.cc/PQ43-37KC].

81. *How Do I Get the Abortion Pill?*, *supra* note 79.

82. *Health Worker Roles in Providing Safe Abortion Care and Post-Abortion Contraception*, WORLD HEALTH ORG. (2015), https://apps.who.int/iris/bitstream/handle/10665/181041/9789241549264_eng.pdf [https://perma.cc/X5D8-29EH].

83. Kohn et al., *supra* note 11, at 343 n.2.

84. 42 U.S.C. § 300 *et seq.*; 42 C.F.R. § 59 (2019).

85. Ruth Dawson, *Trump Administration's Domestic Gag Rule Has Slashed the Title X Network's Capacity by Half*, GUTTMACHER INST. (Feb. 5, 2020), https://www.guttmacher.org/article/2020/02/trump-administrations-domestic-gag-rule-has-slashed-title-x-networks-capacity-half [https://perma.cc/FL69-885Q].

86. *See* June Med. Servs. L.L.C. v. Russo, 140 S. Ct. 2013, 2112-13 (2020) (describing the Louisiana law as "word-for-word identical to Texas' admitting-privileges law" contemplated in *Whole Woman's Health* and suggesting the district court's finding in this case "mirror those made in *Whole Woman's Health* in every relevant respect and require the same result").

physical presence of a healthcare provider.[87] Meanwhile, various scholars and activists have linked deregulation to greater accessibility to underserved communities.[88]

But the pandemic context demonstrates that, while regulatory barriers complicate teleabortion access, these barriers are not insurmountable. Coordinated efforts to simplify telemedicine regulations, and to update them based on the best available scientific and technological evidence, are needed. Evidence that telemedicine can facilitate abortion care safely during the pandemic supports the idea that sustained, scaled-up use of teleabortion services should outlast the crisis. These innovations will have the secondary effects of increasing stability and predictability of abortion access, both of which are essential promises of the rule of law.[89] These aims are especially important in the uncertain immediate aftermath of the pandemic. The economic devastation caused by COVID-19 could result in permanent clinic closures, creating new burdens on abortion access that last beyond the duration of the crisis.[90] Making teleabortion accessible nationwide would alleviate these burdens for at least some patients.

IV. CONCLUSION

This Comment argues that pandemic-era restrictions[91] on teleabortion create an undue burden during the unique circumstances of the COVID-19 pandemic. In the subset of states with existing teleabortion restrictions, those restrictions have remained in places while comparable federal restrictions have been enjoined as unduly burdensome.[92] Additionally, nine of the nineteen states with teleabortion restrictions have attempted to curtail or entirely suspend access to abortion entirely during the pandemic.[93] Although courts have disallowed

87. S. 3252, 116th Cong. (2020).

88. *See, e.g.*, Megan Donovan, *Improving Access to Abortion via Telehealth*, 22 GUTTMACHER POL'Y REV. 23 (2019); Sarah J. Betstadt et. al., *Telemedicine for Medication Abortion: The Time is Now*, 9 CURRENT OBSTETRICS & GYNECOLOGY REP. 66 (2020).

89. *See* Stefanie A. Lindquist & Frank C. Cross, *Stability, Predictability, and the Rule of Law:* Stare Decisis *as Reciprocity Norm* (2010), https://law.utexas.edu/conferences/measuring/The%20Papers/Rule%20of%20Law%20Conference.crosslindquist.pdf [https://perma.cc/52Y6-6FUU].

90. Abigail Abrams, *COVID-19 Could Permanently Make Abortions Harder to Access Nationwide*, TIME (Apr. 7, 2020), https://time.com/5816530/coronavirus-abortion-clinics-access [https://perma.cc/F48Y-6EW5].

91. As mentioned in the Introduction, we characterize these restrictions broadly, as the functional result of states' affirmative action to restrict access to abortion clinics combined with targeted *inaction* leaving regulatory hurdles to telehealth abortion in place.

92. For a list of the nineteen states with restrictions on teleabortion that predate the pandemic, *see Medication Abortion*, *supra* note 20. Federal restrictions on remote prescription of mifepristone were enjoined in *Am. Coll. Obstetricians & Gynecologists v. FDA*, No. TDC-20-1320, 2020 U.S. Dist. LEXIS 122017, at *113 (D. Md. July 13, 2020), *rev'd*, 208 L. Ed. 2d 155, *stay denied*, 2020 U.S. Dist. LEXIS 231387.

93. For a map of state action to curtail abortion during the pandemic, see Sobel et al., *supra* note 38.

complete bans on abortion during the pandemic,[94] many women still face extraordinary burdens when seeking an abortion—from additional expenses to potential exposure to COVID-19. These burdens are especially onerous in low-income communities and communities of color, in which women are more likely to experience difficulties accessing reproductive care.[95] In light of the extraordinary circumstances of the COVID-19 pandemic, targeted restrictions on teleabortion do not pass constitutional muster.

A targeted critique of the regulatory regime surrounding teleabortions is especially timely, as teleabortion will likely garner substantial debate in the coming years. Commentators estimate that telehealth will occupy a much more substantial role in health care provision after the COVID-19 pandemic.[96] And an increasing number of women are availing themselves of medication abortions. The rate of "abortion pill" use relative to the total number of abortions in the first eight weeks of gestation is 41.9%[97] and growing.[98] While teleabortion was not widespread before the pandemic, preliminary clinical research suggests that medication abortion is just as safe when administered remotely.[99] During the pandemic, providers in many states will observe the clinical outcomes of teleabortion firsthand. This record will provide rich information about the sustainability, safety, and health equity impacts of teleabortion in the future.

Finally, we argue that teleabortion is a promising health care innovation during and outside of public health emergencies. And during the COVID-19 pandemic, restrictions do not withstand scrutiny. States are prohibited from imposing "undue burdens" to abortions. When they proscribe visits to an abortion clinic in the name of public health, teleabortions can fill the gap left behind. Justice Kavanaugh put it best in a dissenting opinion attached to the stay order in *June Medical*, before a hearing on the merits of Louisiana's abortion law. In that case, he urged a "good faith" effort "to reach a definitive conclusion" about whether a law mandating admitting privileges for abortion providers would indeed impose an "undue burden."[100] He suggested allowing the state law to go into effect would resolve the empirical debate about whether it was restrictive, because then the Court could observe whether the number of abortion

94. *Id.*

95. Cohen, *supra* note 6, at 3, tbls. 12-13.

96. Tanya Albert Henry, *After COVID-19, $250 Billion in Care Could Shift to Telehealth*, AMA (June 18, 2020) https://www.ama-assn.org/practice-management/digital/after-covid-19-250-billion-care-could-shift-telehealth [https://perma.cc/4682-B8WS].

97. Jatlaoui et al., *supra* note 9.

98. Cristina Yunzal-Butler, Judith Sackoff & Wenhui Li, *Medication Abortions Among New York City Residents, 2001-2008*, 43 PERSP. ON SEXUAL & REPROD. HEALTH 218 (2011), https://pubmed.ncbi.nlm.nih.gov/22151508/ [https://perma.cc/676A-QCPT]. Medication abortion is effective up to eleven weeks into a pregnancy. *The Abortion Pill*, PLANNED PARENTHOOD, https://www.plannedparenthood.org/learn/abortion/the-abortion-pill [https://perma.cc/3DWD-HNAD].

99. *See* Kohn et al., *supra* note 11.

100. June Med. Servs. L.L.C. v. Gee, 139 S. Ct. 663, 664 (2019) (Kavanaugh, J., dissenting).

providers in Louisiana shrank as a result of the legislation.[101] In the unusual times we find ourselves, Justice Kavanaugh's admonition might be uniquely instructive: with pandemic disruptions circumscribing surgical abortions, the country has a chance to empirically observe teleabortion's safety and impact on health equity. If it proves safe, effective, and accessible in our current moment of crisis, states and the federal government should take coordinated actions to permit teleabortion services to continue, in light of the reproductive justice and health equity values at stake.

101. *Id.*