Navigating the Post-Dobbs Landscape: A Roadmap for Interstate Abortion Care

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https://doi.org/10.38126/JSPG250105
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Keywords: Dobbs v. Jackson; abortion; maternal health; provider shield laws; telehealth; reproductive justice; healthcare infrastructure

Executive Summary: In June 2022, the Supreme Court issued an unprecedented ruling in the case of *Dobbs v. Jackson*, revoking the constitutional right to abortion for the first time in 50 years. To date, fourteen U.S. states have completely banned abortion. Consequently, individuals residing in states with restrictive legislation are forced to travel to neighboring states to access abortion care and other reproductive services. Extended travel time disproportionately affects individuals from communities of color, low-income patients, and rural residents, increasing the risk for maternal health complications and death. The United States holds the highest maternal mortality rate among developed nations, with 33 deaths per 100,000 births (Katella 2023). Alarmingly, 84% of these deaths are considered preventable (Katella 2023). Thus, it is imperative that state healthcare policymakers prioritize equitable access to comprehensive reproductive healthcare for all patients (Katella 2023). This care should incorporate strategies to decrease on-site patient volume, such as implementing shield laws to protect abortion providers treating out-of-state patients, enhancing telehealth services for abortion medication services, and incentivizing the establishment of physical infrastructure. For state officials in destination states, specifically the 23 governors of the non-partisan Reproductive Freedom Alliance, **we recommend immediately prioritizing the establishment and anticipated enforcement of provider shield laws.** To ensure widespread and equitable access to reproductive healthcare services, a more robust three-tiered approach is outlined herein, prioritizing: (1) shield laws, (2) telehealth services, and (3) physical infrastructure.

I. Introduction

The Supreme Court's decision on *Dobbs v. Jackson (2022)*, which overruled the constitutional right to abortion declared in *Roe v. Wade (1973)* and upheld in *Planned Parenthood v. Casey (1992)*, allowed states to enact legislation that has significantly restricted abortion access in certain states. As of April 2024, 14 states have enacted bans on abortion, with few or no exceptions (KFF 2024; Guttmacher 2024; Myers 2021). Currently, to access needed reproductive care many individuals are required to travel to "destination states", or states with less severe restrictions (e.g. Illinois, California and Virginia). For many, these restrictions have increased distances to reproductive care by as much as 600 miles. For example, the average travel time for patients in Texas grew from 15 minutes pre-*Dobbs* to 8 hours post-*Dobbs* (Myers 2021; Simmons-Duffin and Cheng 2023).

The dramatic increase in travel times disproportionately impacts low-income and rural patients who may not have the financial stability, work flexibility, or other resources required to travel (Thomsen et al. 2023). These restrictions also contain fundamental justice and equity implications as Black and Indigenous patients who already experience an increased likelihood of negative maternal health outcomes and are disproportionately impacted by poverty, lack of healthcare access, and racism in the healthcare system, are most affected by abortion and reproductive health restrictions (Myers 2021; Alfonseca 2022). For example, 61% of Black women who gave birth from November 2022 to November 2023 lived in states that had banned or were likely to ban abortion after the *Dobbs* ruling (Gray et al. 2023). This compares to 53% of white, non-Hispanic women and 50% of women overall (Gray et al. 2023). Such obstacles to accessing abortion services compel more individuals to pursue self-managed abortions, which fall outside of standard healthcare regulations (Grossman and Verma 2022) and, if performed using unsafe methods, can result in pelvic-organ injuries, hemorrhaging, clostridial infections, and sepsis (Harris and Grossman 2020).

The non-uniform and changing nature of abortion policy across states has also impacted healthcare providers. The influx of patients from other states has increased provider caseload; for example, New Mexico saw an increase in abortion numbers by 220% in the wake of neighboring states' restrictions and its own protectionist policies (Maddow-Zimet et al. 2023). This surge has overwhelmed clinics in destination states, increasing wait times to 2-3 weeks (Sanger-Katz, Miller and Katz 2022). Prolonged waiting periods increase the probability that patients may require more complex abortion procedures (Ungar 2023).

Though clinics and physicians have tried to overcome this demand by turning to telehealth and prescription delivery services to provide medication abortion, at least 19 states have restricted these practices (Price 2022; Guttmacher 2024). Consequently, many providers are wary of providing services for fear of legal action. The lawsuit against a Texas doctor for providing abortion services beyond the state's six-week limit demonstrates that legal action is not a mere hypothetical, but a tangible risk for healthcare providers in the current reproductive health landscape. (BBC 2021). Fear of legal repercussions could further result in a "medical brain drain" as clinicians leave or avoid working in states with restrictive reproductive healthcare laws. A recent survey of 2,000 medical doctors found that 76% would not apply to or work in states with abortion restrictions (Rovner 2023).

Abortion bans also impact women's workforce participation (Jerman, Jones, and Onda 2016; McSwigan 2024). In states with abortion bans, new mothers are more likely to be the sole provider for their families, yet less likely to be in the labor force compared to those in states with abortion protections (Jerman, Jones, and Onda 2016; McSwigan 2024). The disparity in workforce participation between women in states with abortion bans and women in the rest of the country widens the economic gap between women in these two groups (Jerman, Jones and Onda 2016; McSwigan 2024). States with severe abortion restrictions consistently have lower workplace protections, lower minimum wages, and lower rates of social welfare program expansion (Banerjee 2023). Abortion bans exacerbate these negative workplace and social welfare policies by forcing women to take on the financial burden of childbirth. This burden perpetuates intergenerational poverty cycles that drain state resources through higher public assistance needs, diminished tax revenues, and overstressed social services (Banerjee 2023). Despite these negative outcomes, abortion policies in states with bans are unlikely to change, underscoring the growing need to provide policy recommendations surrounding abortion travel.

Furthermore, coordination among governors in the Reproductive Freedom Alliance, an interstate coalition committed to protecting reproductive rights, to establish realistic and prompt funding allocation and policies would ensure provider training adequately meets the increased caseload from out-of-state patient travel (Emmett 2023). The focus of this memo is to urge the 23 governors in the non-partisan Reproductive Freedom Alliance to take action to support and protect interstate abortion travel. Herein, we recommend **immediately prioritizing the establishment and anticipated enforcement of provider shield laws** and further outline additional policy options to alleviate burden

on providers, increase access to care, and sustain economic success at the patient and state levels. These options are: (1) the creation and reinforcement of shield laws for providers, (2) the expansion of telehealth services for medicated abortion, and (3) the revision of zoning laws to encourage the development of clinics near state borders.

II. Policy options

i. Option 1: Create and reinforce provider shield laws

Abortion shield laws protect healthcare providers, and other individuals who facilitate a patient's access to abortion, from criminal proceedings. Shield laws can be classified into three categories of protections: (1) preventing officials in abortion-restricted states from pursuing legal investigations in states where abortion access remains in place, (2) ensuring providers are protected from consequences related to medical licensure or malpractice insurance, and (3) protecting individuals receiving abortion care in states with access from having information about their medical record shared in legal proceedings against them or their provider (Seigel and Leiter 2023). The current implementation of shield laws by destination states with Governors in the Reproductive Freedom Alliance, such as Massachusetts, Washington, Colorado, New York and California has facilitated access to abortion for over 10,000 women residing in states with abortion bans or severe restrictions (Office of Governor Gavin Newsom 2023; Belluck 2024). However, enforcement of existing shield laws has yet to be tested in court.

Advantages

- Legal protections enable clinicians to offer essential care without concern for legal repercussions.
- Attract clinicians to destination states, bolstering those states' capacities to provide abortion healthcare services.
- Compared to infrastructure changes, there is minimal cost associated with this option, as any expenses would hinge on enforcement by the legal community

Disadvantages

- Not all states have the same laws or legal protections, leading to a complex environment of policies that patients and providers must navigate. Therefore, it is recommended that shield laws be periodically assessed and reevaluated (i.e. every year).
- Legislative approaches are often time-intensive, especially due to the partisan nature of abortion. Some legislative approaches have been challenged in courts, adding time before secure implementation or leading them to be stricken down (Cohen, Donely, and Rebouche 2023). For example, in Maryland the allocation of funds for provider training was delayed until the next gubernatorial administration because of a lack of cooperation between the former state governor and state lawmakers, who had already approved the funding (Nixon et al. 2023).
- If any changes in shield laws are not well communicated to providers, they may still be hesitant to provide services. Shield laws vary from state to state and accurate interpretation of the law may require the assistance of an attorney (Cohen, Donley, and Rebouche 2023).

ii. Option 2: Expand telehealth services for medication abortion

Telehealth, a remote healthcare service that allows for real-time communication between a patient and a healthcare provider, grew in prevalence during the COVID-19 pandemic and has maintained its value after the *Dobbs* decision. The number of abortions provided by virtual clinic providers increased by 137% between April and December 2022 (Society of Family Planning 2023). Telehealth for medical abortions is an option available up to 10 weeks gestation, encompassing the period during which over 81% of abortions take place (KFF 2024). Telehealth has extensively been used for medication abortion in the last several years, with research demonstrating it is as effective and safe as in-person medication abortions (Upadhyay et al. 2024). In general, telehealth care could substitute for up to $250 billion of the current US healthcare spending (National Committee for Quality Assurance 2020). However, in most cases telehealth is not allowed across state lines and currently, only five states (i.e.,

Arizona, Oregon, Texas and Florida) have adopted permanent policies detailing avenues for telehealth providers from other states to treat across state lines (Talington and CCHP 2024).

Advantages

- Telehealth is recommended by the World Health Organization (WHO), enhancing the probability of widespread acceptance and success.
- Estimates suggest that by 2029, telemedicine could save Medicare patients approximately $170 million in travel-related costs, with some reports projecting potential savings as high as $540 million (Department of Health and Human Services 2018). Furthermore, a one year study of medical abortion in a hospital setting found that mifepristone–misoprostol, the most common abortion medication prescribed via telehealth (KFF 2024), had a greater than 50% probability of being cost-effective than both surgical abortion and other options (Hunter et al 2021).
- 88% of physicians surveyed in one study reported that telehealth improved clinical outcomes and work efficiency, with 58.9% stating that it allowed them to complete tasks more quickly and effectively (Andino, Eyrich, and Boxer 2023).
- Telehealth increases equity in abortion access and ensures timely care for the most vulnerable patients. Younger patients, rural patients, and patients experiencing food insecurity are most likely to benefit from telehealth abortion services (Koenig et al. 2023).

Disadvantages

- Increasing telehealth services for one clinic or healthcare office requires an estimated investment of $100,000 to $250,000 depending on factors such as the type of application used, staff training, the technical expertise needed by physicians, and compliance with telehealth standards, regulations, and insurance coverage (Shpachuk 2024). A comprehensive telehealth program also requires training for providers and IT support for both patients and providers. This initial investment may pose a hurdle, however, once set up, telehealth has long term benefits in terms of reduced costs, increased productivity (Snoswell et al 2020) and positive environmental impact (Ravindrane and Patel 2022).
- Adherence to HIPAA regulations and enhanced medical data security are necessary when patients and providers use an online platform.
- Effective telehealth programs rely on secure and reliable internet connectivity, which is frequently unavailable or unreliable for patients from low-income, rural, and/or marginalized groups. Because of this drawback, younger, rural, and food-insecure patients are less likely to seek out telehealth abortion services compared to wealthier patients who live in urban areas (Predmore and Rollison 2022).
- A quiet, confidential space for appointments may not be readily available for patients. This drawback is particularly important for patients who may be seeking an abortion without their family's or partner's awareness (Predmore and Rollison 2022).
- Differing state licensing regulations may impede out-of-state patients' access to treatment (Archambault, Nastasi and Perkins 2024).

iii. Option 3: Incentivize in-state independent healthcare providers and development of physical infrastructure near state borders

The increased demand on reproductive healthcare facilities providing abortion access cannot be fully alleviated by digital infrastructure alone. Enhancing physical infrastructure and expanding the provider workforce is imperative to reduce strain on current staff and curb rising wait times for both in-state and out-of-state patients. A comprehensive statewide zoning approach standardizing clinic classifications could reduce barriers to construction of facilities, by combating local or piecemeal zoning ordinances created to restrict the construction of abortion clinics independent from other healthcare facilities. This will also enable development of independent clinics near borders, reducing travel time for patients (Davis 2024). This approach was recently enacted in Alexandria, Virginia, where abortion clinics were newly classified as standard medical

offices (Carey 2023). This classification enabled clinics to operate in commercial zones, promoting the development of future clinics near state borders or airports.

Advantages

- Standardization of clinic classifications will reduce confusion and hesitancy regarding the legality of building and/or maintaining abortion clinics.
- Development of clinic infrastructure generates jobs and stimulates local economies.
- Boosting physical infrastructure near destination state borders will increase the likelihood of patients being closer to clinics near state lines, thereby reducing travel time for out-of-state patients.

Disadvantages

- Out-of-state patients residing in the central regions of their states may still need to travel a considerable distance.
- Statewide zoning law changes will override cities, but transitioning will take time.

III. Policy recommendation

We recommend governors in the Reproductive Freedom Alliance immediately pursue **Option 1**. Given the complexity of the issue, a tiered response is necessary and we still recommend working towards Options 2 and 3 as a long-term strategy. *Option 1* (creating and reinforcing provider shield laws) will ensure that clinicians and patients are protected from legal ramifications, allowing them to continue providing and receiving necessary medical care in the short-term. These safeguards will further strengthen trust in the overall healthcare system. While a critical first step, in isolation, policy *Option 1* will not address the overburdening of clinicians in destination states nor the inequities inherent in traveling to access reproductive care. Expanding telehealth services in destination states will reduce caseload burdens on providers and increase access to reproductive care for underserved or otherwise marginalized populations. *Options 1 and 2* allow for an immediate policy response to the current reproductive healthcare landscape. However, given the uncertain future of reproductive care in many states, we recommend destination states enact policy *Option 3* (incentivize in-state independent healthcare providers and development of physical infrastructure near state borders) as a long-term response. A standardized zoning classification for abortion clinics will spur the development of independent clinics near state borders, increasing long-term physical infrastructure capable of providing reproductive care, reducing travel time for patients and limiting caseload burdens on providers.

To implement this strategy, governors in the Reproductive Freedom Alliance will need to pursue state-level legislation. Specifically, Governors will collaborate to develop tailored yet consistent approaches across states, promoting replicability and efficient implementation. They will secure funding through state budgets and coordinate across government agencies. The process involves drafting bills, potentially including public referendums, and establishing oversight task forces. Once this legislation is passed, government agencies will enact the law through regulations and policies as well as enforce the law through litigation and with adjudicative authority (Columbus School of Law 2024). Governors will work closely with local and regional reproductive rights organizations to communicate policy changes to clinics, clinic developers, and the general public.

Consequences of Inaction: If no action is taken, the aforementioned issues will persist and we will continue to see negative maternal health outcomes, increases in self-managed abortion, and negative economic implications.

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