**Case Nos. 21-2480 & 21-2573**

# In the United States Court of Appeals for the Seventh Circuit

WHOLE WOMAN'S HEALTH ALLIANCE; *et al.*,

Plaintiffs-Appellees,

v.

TODD ROKITA, Attorney General of the State of Indiana, in his official capacity; *et al.*,

Defendants-Appellants.

On Appeal from the United States District Court
for the Southern District of Indiana
No. 1:18-CV-01904-SEB-MJD

## BRIEF OF APPELLEES

Kathrine D. Jack
JACK LAW OFFICE LLC
One Courthouse Plaza
P.O. Box 813
Greenfield, IN 46140

Rupali Sharma
LAWYERING PROJECT
113 Bonnybriar Rd.
South Portland, ME 04106
(908) 930-6445
rsharma@lawyeringproject.org

[Additional counsel listed on inside cover]

*Counsel for Plaintiffs-Appellees*

Additional counsel:

Juanluis Rodriguez
Sneha Shah
Stephanie Toti
LAWYERING PROJECT
41 Schermerhorn St., No. 1056
Brooklyn, NY 11201

Lara Flath
Mollie M. Kornreich
Michael M. Powell
Athanasia Charmani
One Manhattan West
New York, NY 10001

Melissa Shube
LAWYERING PROJECT
712 H St. NE, Ste. 1616
Washington, D.C. 20002

Amy Van Gelder
155 N. Wacker Dr., Ste. 2700
Chicago, IL 60606

*Counsel for Plaintiffs-Appellees*

**APPEARANCE & CIRCUIT RULE 26.1 DISCLOSURE STATEMENT**

Appellate Court No: 21-2480

Short Caption: Whole Woman's Health Alliance, et al. v. Todd Rokita, et al.

To enable the judges to determine whether recusal is necessary or appropriate, an attorney for a non-governmental party, amicus curiae, intervenor or a private attorney representing a government party, must furnish a disclosure statement providing the following information in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1.

The Court prefers that the disclosure statements be filed immediately following docketing; but, the disclosure statement must be filed within 21 days of docketing or upon the filing of a motion, response, petition, or answer in this court, whichever occurs first. Attorneys are required to file an amended statement to reflect any material changes in the required information. The text of the statement must also be included in the front of the table of contents of the party's main brief. **Counsel is required to complete the entire statement and to use N/A for any information that is not applicable if this form is used.**

☐ **PLEASE CHECK HERE IF ANY INFORMATION ON THIS FORM IS NEW OR REVISED AND INDICATE WHICH INFORMATION IS NEW OR REVISED.**

(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P. 26.1 by completing item #3):

Whole Woman's Health Alliance; All-Options, Inc.; Jeffrey Glazer, M.D.

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

Lawyering Project; Jack Law Office LLC; Skadden, Arps, Slate, Meagher & Flom LLP

(3) If the party, amicus or intervenor is a corporation:

i) Identify all its parent corporations, if any; and

N/A

ii) list any publicly held company that owns 10% or more of the party's, amicus' or intervenor's stock:

N/A

(4) Provide information required by FRAP 26.1(b) – Organizational Victims in Criminal Cases:

N/A

(5) Provide Debtor information required by FRAP 26.1 (c) 1 & 2:

N/A

---

Attorney's Signature: /s/ Thania Charmani Date: 9/8/21

Attorney's Printed Name: Thania Charmani

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ☐ **No** ☑

Address: One Manhattan West, New York, New York 10001

Phone Number: 212.735.3502 Fax Number: 917.777.3502

E-Mail Address: thania.charmani@probonolaw.com

**APPEARANCE & CIRCUIT RULE 26.1 DISCLOSURE STATEMENT**

Appellate Court No: 21-2480

Short Caption: Whole Woman's Health Alliance, et al. v. Todd Rokita, et al.

To enable the judges to determine whether recusal is necessary or appropriate, an attorney for a non-governmental party, amicus curiae, intervenor or a private attorney representing a government party, must furnish a disclosure statement providing the following information in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1.

The Court prefers that the disclosure statements be filed immediately following docketing; but, the disclosure statement must be filed within 21 days of docketing or upon the filing of a motion, response, petition, or answer in this court, whichever occurs first. Attorneys are required to file an amended statement to reflect any material changes in the required information. The text of the statement must also be included in the front of the table of contents of the party's main brief. **Counsel is required to complete the entire statement and to use N/A for any information that is not applicable if this form is used.**

☐ **PLEASE CHECK HERE IF ANY INFORMATION ON THIS FORM IS NEW OR REVISED AND INDICATE WHICH INFORMATION IS NEW OR REVISED.**

(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P. 26.1 by completing item #3):

Whole Woman's Health Alliance; All-Options, Inc.; Jeffrey Glazer, M.D.

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

Lawyering Project; Jack Law Office LLC; Skadden, Arps, Slate, Meagher & Flom LLP

(3) If the party, amicus or intervenor is a corporation:

i) Identify all its parent corporations, if any; and

N/A

ii) list any publicly held company that owns 10% or more of the party's, amicus' or intervenor's stock:

N/A

(4) Provide information required by FRAP 26.1(b) – Organizational Victims in Criminal Cases:

N/A

(5) Provide Debtor information required by FRAP 26.1 (c) 1 & 2:

N/A

---

Attorney's Signature: /s/ Lara Flath Date: 9/8/21

Attorney's Printed Name: Lara Flath

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ☐ **No** ☑

Address: One Manhattan West, New York, New York 10001

Phone Number: 212.735.3717 Fax Number: 917.777.3717

E-Mail Address: lara.flath@probonolaw.com

**APPEARANCE & CIRCUIT RULE 26.1 DISCLOSURE STATEMENT**

Appellate Court No: 21-2480

Short Caption: Whole Woman's Health Alliance, et al v. Rokita, et al

To enable the judges to determine whether recusal is necessary or appropriate, an attorney for a non-governmental party, amicus curiae, intervenor or a private attorney representing a government party, must furnish a disclosure statement providing the following information in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1.

The Court prefers that the disclosure statements be filed immediately following docketing; but, the disclosure statement must be filed within 21 days of docketing or upon the filing of a motion, response, petition, or answer in this court, whichever occurs first. Attorneys are required to file an amended statement to reflect any material changes in the required information. The text of the statement must also be included in the front of the table of contents of the party's main brief. **Counsel is required to complete the entire statement and to use N/A for any information that is not applicable if this form is used.**

☐ **PLEASE CHECK HERE IF ANY INFORMATION ON THIS FORM IS NEW OR REVISED AND INDICATE WHICH INFORMATION IS NEW OR REVISED.**

(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P. 26.1 by completing item #3):
WHOLE WOMAN'S HEALTH ALLIANCE, ALL-OPTIONS, INC., JEFFREY GLAZER, M.D.

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:
Lawyering Project, Jack Law Office LLC, Skadden, Arps, Slate, Meagher & Flom LLP

(3) If the party, amicus or intervenor is a corporation:

i) Identify all its parent corporations, if any; and
N/A

ii) list any publicly held company that owns 10% or more of the party's, amicus' or intervenor's stock:
N/A

(4) Provide information required by FRAP 26.1(b) – Organizational Victims in Criminal Cases:
N/A

(5) Provide Debtor information required by FRAP 26.1 (c) 1 & 2:
N/A

---

Attorney's Signature: /s/ Kathrine D. Jack Date: 9/10/21

Attorney's Printed Name: Kathrine D. Jack

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ☐ **No** ☑

Address: 1 Courthouse Plaza, Greenfield, IN 46140

Phone Number: 317-477-2300 Fax Number: 317-515-6377

E-Mail Address: kjack@jacklawoffice.com

**APPEARANCE & CIRCUIT RULE 26.1 DISCLOSURE STATEMENT**

Appellate Court No: 21-2480

Short Caption: Whole Woman's Health Alliance, et al. v. Todd Rokita, et al.

To enable the judges to determine whether recusal is necessary or appropriate, an attorney for a non-governmental party, amicus curiae, intervenor or a private attorney representing a government party, must furnish a disclosure statement providing the following information in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1.

The Court prefers that the disclosure statements be filed immediately following docketing; but, the disclosure statement must be filed within 21 days of docketing or upon the filing of a motion, response, petition, or answer in this court, whichever occurs first. Attorneys are required to file an amended statement to reflect any material changes in the required information. The text of the statement must also be included in the front of the table of contents of the party's main brief. **Counsel is required to complete the entire statement and to use N/A for any information that is not applicable if this form is used.**

☐ **PLEASE CHECK HERE IF ANY INFORMATION ON THIS FORM IS NEW OR REVISED AND INDICATE WHICH INFORMATION IS NEW OR REVISED.**

(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P. 26.1 by completing item #3):

Whole Woman's Health Alliance; All-Options, Inc.; Jeffrey Glazer, M.D.

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

Lawyering Project; Jack Law Office LLC; Skadden, Arps, Slate, Meagher & Flom LLP

(3) If the party, amicus or intervenor is a corporation:

i) Identify all its parent corporations, if any; and

N/A

ii) list any publicly held company that owns 10% or more of the party's, amicus' or intervenor's stock:

N/A

(4) Provide information required by FRAP 26.1(b) – Organizational Victims in Criminal Cases:

N/A

(5) Provide Debtor information required by FRAP 26.1 (c) 1 & 2:

N/A

---

Attorney's Signature: /s/ Mollie Kornreich Date: 9/8/21

Attorney's Printed Name: Mollie Kornreich

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ☐ **No** ☑

Address: One Manhattan West, New York, New York 10001

Phone Number: 212.735.2775 Fax Number: 917.777.2775

E-Mail Address: mollie.kornreich@probonolaw.com

rev. 12/19 AK

**APPEARANCE & CIRCUIT RULE 26.1 DISCLOSURE STATEMENT**

Appellate Court No: 21-2480

Short Caption: Whole Woman's Health Alliance, et al. v. Todd Rokita, et al.

To enable the judges to determine whether recusal is necessary or appropriate, an attorney for a non-governmental party, amicus curiae, intervenor or a private attorney representing a government party, must furnish a disclosure statement providing the following information in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1.

The Court prefers that the disclosure statements be filed immediately following docketing; but, the disclosure statement must be filed within 21 days of docketing or upon the filing of a motion, response, petition, or answer in this court, whichever occurs first. Attorneys are required to file an amended statement to reflect any material changes in the required information. The text of the statement must also be included in the front of the table of contents of the party's main brief. **Counsel is required to complete the entire statement and to use N/A for any information that is not applicable if this form is used.**

☐ **PLEASE CHECK HERE IF ANY INFORMATION ON THIS FORM IS NEW OR REVISED AND INDICATE WHICH INFORMATION IS NEW OR REVISED.**

(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P. 26.1 by completing item #3):

Whole Woman's Health Alliance; All-Options, Inc.; Jeffrey Glazer, M.D.

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

Lawyering Project; Jack Law Office LLC; Skadden, Arps, Slate, Meagher & Flom LLP

(3) If the party, amicus or intervenor is a corporation:

i) Identify all its parent corporations, if any; and

N/A

ii) list any publicly held company that owns 10% or more of the party's, amicus' or intervenor's stock:

N/A

(4) Provide information required by FRAP 26.1(b) – Organizational Victims in Criminal Cases:

N/A

(5) Provide Debtor information required by FRAP 26.1 (c) 1 & 2:

N/A

---

Attorney's Signature: /s/ Michael Powell Date: 9/8/21

Attorney's Printed Name: Michael Powell

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ☐ **No** ☑

Address: One Manhattan West, New York, New York 10001

Phone Number: 212.735.2908 Fax Number: 917.777.2908

E-Mail Address: michael.powell@probonolaw.com

**APPEARANCE & CIRCUIT RULE 26.1 DISCLOSURE STATEMENT**

Appellate Court No: 21-2480

Short Caption: Whole Woman's Health Alliance, et al. v. Todd Rokita, et al.

To enable the judges to determine whether recusal is necessary or appropriate, an attorney for a non-governmental party, amicus curiae, intervenor or a private attorney representing a government party, must furnish a disclosure statement providing the following information in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1.

The Court prefers that the disclosure statements be filed immediately following docketing; but, the disclosure statement must be filed within 21 days of docketing or upon the filing of a motion, response, petition, or answer in this court, whichever occurs first. Attorneys are required to file an amended statement to reflect any material changes in the required information. The text of the statement must also be included in the front of the table of contents of the party's main brief. **Counsel is required to complete the entire statement and to use N/A for any information that is not applicable if this form is used.**

☐ **PLEASE CHECK HERE IF ANY INFORMATION ON THIS FORM IS NEW OR REVISED AND INDICATE WHICH INFORMATION IS NEW OR REVISED.**

(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P. 26.1 by completing item #3):

Whole Woman's Health Alliance; All-Options, Inc.; Jeffrey Glazer, M.D.

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

Lawyering Project; Jack Law Office LLC; Skadden, Arps, Slate, Meagher & Flom LLP

(3) If the party, amicus or intervenor is a corporation:

i) Identify all its parent corporations, if any; and

Whole Woman's Health Alliance - N/A; All-Options, Inc. - N/A

ii) list any publicly held company that owns 10% or more of the party's, amicus' or intervenor's stock:

Whole Woman's Health Alliance - No; All-Options, Inc. - No

(4) Provide information required by FRAP 26.1(b) – Organizational Victims in Criminal Cases:

N/A

(5) Provide Debtor information required by FRAP 26.1 (c) 1 & 2:

N/A

---

Attorney's Signature: /s/ Juanluis Rodriguez Date: 10/25/21

Attorney's Printed Name: Juanluis Rodriguez

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ____ **No** ☑

Address: 41 Schermerhorn St., No. 1056; Brooklyn, NY 11201

Phone Number: 646-490-1080 Fax Number: 646-480-8756

E-Mail Address: prodriguez@lawyeringproject.org

**APPEARANCE & CIRCUIT RULE 26.1 DISCLOSURE STATEMENT**

Appellate Court No: 21-2480

Short Caption: Whole Woman's Health Alliance, et al. v. Todd Rokita, et al.

To enable the judges to determine whether recusal is necessary or appropriate, an attorney for a non-governmental party, amicus curiae, intervenor or a private attorney representing a government party, must furnish a disclosure statement providing the following information in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1.

The Court prefers that the disclosure statements be filed immediately following docketing; but, the disclosure statement must be filed within 21 days of docketing or upon the filing of a motion, response, petition, or answer in this court, whichever occurs first. Attorneys are required to file an amended statement to reflect any material changes in the required information. The text of the statement must also be included in the front of the table of contents of the party's main brief. **Counsel is required to complete the entire statement and to use N/A for any information that is not applicable if this form is used.**

☐ **PLEASE CHECK HERE IF ANY INFORMATION ON THIS FORM IS NEW OR REVISED AND INDICATE WHICH INFORMATION IS NEW OR REVISED.**

(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P. 26.1 by completing item #3):

Whole Woman's Health Alliance; All-Options, Inc.; Jeffrey Glazer, M.D.

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

Lawyering Project; Jack Law Office LLC; Skadden, Arps, Slate, Meagher & Flom LLP

(3) If the party, amicus or intervenor is a corporation:

i) Identify all its parent corporations, if any; and

Whole Woman's Health Alliance - N/A; All-Options, Inc. - N/A

ii) list any publicly held company that owns 10% or more of the party's, amicus' or intervenor's stock:

Whole Woman's Health Alliance - No; All-Options, Inc. - No

(4) Provide information required by FRAP 26.1(b) – Organizational Victims in Criminal Cases:

N/A

(5) Provide Debtor information required by FRAP 26.1 (c) 1 & 2:

N/A

---

Attorney's Signature: /s/ Sneha Shah Date: 10/27/21

Attorney's Printed Name: Sneha Shah

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ____ **No** ☑

Address: 41 Schermerhorn St., No. 1056; Brooklyn, NY 11201

Phone Number: 646-490-1225 Fax Number: 646-480-8852

E-Mail Address: sshah@lawyeringproject.org

**APPEARANCE & CIRCUIT RULE 26.1 DISCLOSURE STATEMENT**

Appellate Court No: 21-2480

Short Caption: Whole Woman's Health Alliance, et al. v. Todd Rokita, et al.

To enable the judges to determine whether recusal is necessary or appropriate, an attorney for a non-governmental party, amicus curiae, intervenor or a private attorney representing a government party, must furnish a disclosure statement providing the following information in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1.

The Court prefers that the disclosure statements be filed immediately following docketing; but, the disclosure statement must be filed within 21 days of docketing or upon the filing of a motion, response, petition, or answer in this court, whichever occurs first. Attorneys are required to file an amended statement to reflect any material changes in the required information. The text of the statement must also be included in the front of the table of contents of the party's main brief. **Counsel is required to complete the entire statement and to use N/A for any information that is not applicable if this form is used.**

☐ **PLEASE CHECK HERE IF ANY INFORMATION ON THIS FORM IS NEW OR REVISED AND INDICATE WHICH INFORMATION IS NEW OR REVISED.**

(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P. 26.1 by completing item #3):

Whole Woman's Health Alliance; All-Options, Inc.; Jeffrey Glazer, M.D.

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

Lawyering Project; Jack Law Office LLC; Skadden, Arps, Slate, Meagher & Flom LLP

(3) If the party, amicus or intervenor is a corporation:

i) Identify all its parent corporations, if any; and

Whole Woman's Health Alliance - N/A; All-Options, Inc. - N/A

ii) list any publicly held company that owns 10% or more of the party's, amicus' or intervenor's stock:

Whole Woman's Health Alliance - No; All-Options, Inc. - No

(4) Provide information required by FRAP 26.1(b) – Organizational Victims in Criminal Cases:

N/A

(5) Provide Debtor information required by FRAP 26.1 (c) 1 & 2:

N/A

---

Attorney's Signature: /s / Rupali Sharma Date: 8/23/21

Attorney's Printed Name: Rupali Sharma

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ☑ **No** ☐

Address: 197 Pine Street, Apt. 23

Portland, ME 04102

Phone Number: 908-930-6645 Fax Number: 646-480-8833

E-Mail Address: rsharma@lawyeringproject.org

**APPEARANCE & CIRCUIT RULE 26.1 DISCLOSURE STATEMENT**

Appellate Court No: 21-2573

Short Caption: Whole Woman's Health Alliance, et al. v. Todd Rokita, et al.

To enable the judges to determine whether recusal is necessary or appropriate, an attorney for a non-governmental party, amicus curiae, intervenor or a private attorney representing a government party, must furnish a disclosure statement providing the following information in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1.

The Court prefers that the disclosure statements be filed immediately following docketing; but, the disclosure statement must be filed within 21 days of docketing or upon the filing of a motion, response, petition, or answer in this court, whichever occurs first. Attorneys are required to file an amended statement to reflect any material changes in the required information. The text of the statement must also be included in the front of the table of contents of the party's main brief. **Counsel is required to complete the entire statement and to use N/A for any information that is not applicable if this form is used.**

☐ **PLEASE CHECK HERE IF ANY INFORMATION ON THIS FORM IS NEW OR REVISED AND INDICATE WHICH INFORMATION IS NEW OR REVISED.**

(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P. 26.1 by completing item #3):

Whole Woman's Health Alliance; All-Options, Inc.; Jeffrey Glazer, M.D.

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

Lawyering Project; Jack Law Office LLC; Skadden, Arps, Slate, Meagher & Flom LLP

(3) If the party, amicus or intervenor is a corporation:

i) Identify all its parent corporations, if any; and

Whole Woman's Health Alliance - N/A; All-Options, Inc. - N/A

ii) list any publicly held company that owns 10% or more of the party's, amicus' or intervenor's stock:

Whole Woman's Health Alliance - No; All-Options, Inc. - No

(4) Provide information required by FRAP 26.1(b) – Organizational Victims in Criminal Cases:

N/A

(5) Provide Debtor information required by FRAP 26.1 (c) 1 & 2:

N/A

---

Attorney's Signature: /s/ Melissa Shube Date: 8/30/21

Attorney's Printed Name: Melissa Shube

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ____ **No** ☑

Address: 712 H Street NE, Suite 1616

Washington, DC 20002

Phone Number: 646-480-8942 Fax Number: 646-402-5110

E-Mail Address: mshube@lawyeringproject.org

**APPEARANCE & CIRCUIT RULE 26.1 DISCLOSURE STATEMENT**

Appellate Court No: 21-2480

Short Caption: Whole Woman's Health Alliance, et al. v. Todd Rokita, et al.

To enable the judges to determine whether recusal is necessary or appropriate, an attorney for a non-governmental party, amicus curiae, intervenor or a private attorney representing a government party, must furnish a disclosure statement providing the following information in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1.

The Court prefers that the disclosure statements be filed immediately following docketing; but, the disclosure statement must be filed within 21 days of docketing or upon the filing of a motion, response, petition, or answer in this court, whichever occurs first. Attorneys are required to file an amended statement to reflect any material changes in the required information. The text of the statement must also be included in the front of the table of contents of the party's main brief. **Counsel is required to complete the entire statement and to use N/A for any information that is not applicable if this form is used.**

☐ **PLEASE CHECK HERE IF ANY INFORMATION ON THIS FORM IS NEW OR REVISED AND INDICATE WHICH INFORMATION IS NEW OR REVISED.**

(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P. 26.1 by completing item #3):

Whole Woman's Health Alliance; All-Options, Inc.; Jeffrey Glazer, M.D.

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

Lawyering Project; Jack Law Office LLC; Skadden, Arps, Slate, Meagher & Flom LLP

(3) If the party, amicus or intervenor is a corporation:

i) Identify all its parent corporations, if any; and

Whole Woman's Health Alliance - N/A; All-Options, Inc. - N/A

ii) list any publicly held company that owns 10% or more of the party's, amicus' or intervenor's stock:

Whole Woman's Health Alliance - No; All-Options, Inc. - No

(4) Provide information required by FRAP 26.1(b) – Organizational Victims in Criminal Cases:

N/A

(5) Provide Debtor information required by FRAP 26.1 (c) 1 & 2:

N/A

---

Attorney's Signature: /s/ Stephanie Toti Date: 8/23/21

Attorney's Printed Name: Stephanie Toti

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ____ **No** ☑

Address: 41 Schermerhorn St., No. 1056

Brooklyn, NY 11201

Phone Number: 646-490-1083 Fax Number: 646-480-8762

E-Mail Address: stoti@lawyeringproject.org

## TABLE OF CONTENTS

# TABLE OF AUTHORITIES

**Page(s)**

## CASES

**STATUTES**

**RULES AND REGULATIONS**

## JURISDICTIONAL STATEMENT

The information contained in Appellants' jurisdictional statement is correct. Appellees add that, on September 3, 2021, Plaintiffs filed a timely motion, under Federal Rule of Civil Procedure 59(e), to alter or amend the district court's judgment as to Indiana Code § 16-34-2-1.1(a)(5) ("Ultrasound Requirement"). Pls.' Mot. to Alter or Amend J. (ECF No. 444). That motion remains pending. Appellants do not challenge the portion of the district court's judgment concerning the Ultrasound Requirement, but they do rely on it to support some of their arguments concerning other laws. Appellees therefore bring the Rule 59(e) motion to the Court's attention in an excess of caution in light of *Griggs v. Provident Consumer Discount Company*, 459 U.S. 56, 61 (1982).

## INTRODUCTION

No one disputes that Indiana may engage in reasonable regulation of abortion care. It may not, however, single out abortion for medically unnecessary restrictions or use its regulatory power to impose an undue burden on abortion access. *See, e.g.*, *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309 (2016). As the record in this case demonstrates, the State has repeatedly flouted these constitutional parameters.

Plaintiffs asked the district court to strike down Indiana's unduly burdensome abortion laws, returning the State to a regime of reasonable and medically appropriate abortion regulation. Following a bench trial that included testimony from two dozen live witnesses, the district court issued a detailed set of findings of fact and conclusions of law that carefully weighed the evidence and credibility of witnesses.

Appellants' Required Short App. (7th Cir. ECF No. 48) ("Short App.") 1-158. It concluded that the following laws are unconstitutional and permanently enjoined their enforcement:

- the "Physician-Only Law," Ind. Code § 16-34-2-1(a)(1)(A), as applied to medication abortions;
- the "Second-Trimester Hospitalization Requirement," Ind. Code § 16-34-2-1(a)(2)(B);
- the "Telemedicine Ban," Ind. Code § 25-1-9.5-8(a)(4);
- the "In-Person Examination Requirement," Ind. Code § 16-34-2-1(a)(1);
- the "In-Person Counseling Requirement," Ind. Code § 16-34-2-1.1(a)(1), (a)(4), (b);
- "Facility Regulations" concerning the size of procedure rooms and hallways, and the type and location of sinks, 410 Ind. Admin. Code 26-17-2(d)(1), (d)(4), (e)(5); 410 Ind. Admin. Code 26.5-17-2(e)(1); and
- "Mandatory Disclosure Requirements" concerning when life begins, fetal pain, and mental health, Ind. Code § 16-34-2-1.1(a)(1)(E), (a)(1)(G), (b)(2).

Short App. at 156.

The State does not contest that these laws—which are based on outdated medical standards and prevent abortion providers from incorporating medical advancements into their practices—deny abortion patients the benefits of scientific progress. Instead, the State proclaims that the Constitution grants it the authority to halt innovation in abortion medicine indefinitely, so that patients can receive no better care than what was available in 1973. The State's position finds no support in the caselaw, however. *See infra* 35, 43-44.

Likewise, the State does not dispute that the laws at issue drastically and artificially limit the availability of abortion services in Indiana, causing weeks-long delays in access to care and inflating the cost of abortion to a degree that puts it out of reach for many patients. Instead, it argues that Plaintiffs' claims against many of the challenged laws are categorically barred by prior cases reviewing similar laws, even though the factual records in those cases are distinguishable from the factual record here. Indeed, the State ignores much of the relevant abortion jurisprudence from the past decade, which makes clear that courts applying the undue burden standard must undertake a fact intensive, record-based inquiry. *See June Med. Servs. L.L.C. v. Russo*, 140 S. Ct. 2103, 2121 (2020) (plurality); *id.* 2141 (Roberts, CJ., concurring); *Whole Woman's Health*, 136 S. Ct. at 2309-10; *Whole Woman's Health All. v. Hill*, 937 F.3d 864, 876 (7th Cir. 2019); *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 919-21 (7th Cir. 2015); *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 798 (7th Cir. 2013).

Here, as in *Whole Woman's Health*, 136 S. Ct. at 2310, the district court "did not simply substitute its own judgment for that of the legislature." To the contrary, "[i]t considered the evidence in the record—including expert evidence, presented in stipulations, depositions, and testimony." *Id.* "It then weighed the asserted benefits against the burdens." *Id.* "[I]n so doing, the District Court applied the correct legal standard." *Id.* For that reason, this Court should affirm the district court's judgment.

## STATEMENT OF THE CASE

### I. Indiana's Abortion Care Landscape

Few medical practices offer abortion care in Indiana. Only seven abortion clinics are currently operating in the State. Joint Stipulations of Fact (ECF No. 347) ("Stips.") ¶ 31. Of those, only five are legally authorized to provide aspiration abortions, *see id.* ¶¶ 32-44; *Whole Woman's Health All.*, 937 F.3d at 867-68, and none are legally authorized to provide abortion care after the first trimester of pregnancy, *see* Ind. Code § 16-34-2-1(a)(2)(B). Between 2015 and 2019, only five Indiana hospitals provided abortions, all within a twenty-mile radius of Indianapolis. Stips. ¶¶ 47, 49-53. These hospitals only provide abortions when maternal or fetal health indications are present. Tr. of Bench Trial (Phase I), Vol. 2 (ECF No. 379) ("Tr. I-2") at 32:12-32:19. Collectively, they provided only 210 abortions between 2015 and 2019, Stips. ¶ 48, representing just one-half of one percent of the 38,689 abortions provided in Indiana then, *see* Appellees' Suppl. App. ("Suppl. App.") 15. No Indiana ambulatory outpatient surgical centers ("ASCs") provided abortion care between 2015 and 2019. Stips. ¶ 55. In all, only five of Indiana's 92 counties currently have abortion providers. Suppl. App. 194. There are no Indiana abortion providers east of Indianapolis, an area that includes Fort Wayne, Indiana's second-largest city. Stips. ¶¶ 49-53, 58-59. Likewise, there are no Indiana abortion providers south of Bloomington, an area that includes Evansville, Indiana's third-largest city. Stips. ¶¶ 49-53, 61-62.

Despite the limited availability of abortion services in Indiana, demand for abortion care is significant. Between 2015 and 2019, an average of 7,738 abortions were performed annually in Indiana. *See* Suppl. App. 15. Individuals residing in every

Indiana county sought abortions during this period. *See* Suppl. App. 74, 111, 142, 172, 194.

People seek abortions for a variety of reasons that are often complex and intersecting, including their health, family size, relationship status, financial resources, age, and professional or educational goals. Tr. of Bench Trial (Phase I), Vol. 1 (ECF No. 378) ("Tr. I-1") at130:8-12; Tr. I-2 at 95:21-96:9, 187:6-187:9. Most abortion patients have prior experience with pregnancy and childbirth. Between 2015 and 2019, more than sixty percent of Indiana abortion patients had previously carried a pregnancy to term, and more than a third had carried two or more pregnancies to term. Suppl. App. 17. Approximately seventy-five percent of abortion patients in the U.S. are low-income. Tr. I-2 at 96:14-17. Nearly half of abortion patients live in households that are below the federal poverty level, and twenty-six percent live in households that earn 100%-200% of the federal poverty level. *Id.* 97:3-9. Most Indiana abortion patients must pay for their abortions out of pocket because of statutory limitations on health insurance coverage for abortion. Ind. Code §§ 16-34-1-2, 16-34-1-8, 27-8-13.4-2; *Humphreys v. Clinic for Women, Inc.*, 796 N.E.2d 247, 248-49 (Ind. 2003). Abortion funds such as the Hoosier Abortion Fund operated by Plaintiff All-Options are only able to provide their clients with funding sufficient to cover a small percentage of the cost of abortion care, and they are not able to assist every person in need. Tr. of Bench Trial (Phase I), Vol. 3 (ECF No. 380) ("Tr. I-3") at 18:19-19:18; Tr. of Bench Trial (Phase II), Vol. 1 (ECF No. 422) ("Tr. II-1") at 119:23-120:25; Short App. 29.

Abortion complications are exceedingly rare: nationwide, fewer than one-quarter of one percent of all abortion patients experience a complication requiring hospital admission, surgery, or blood transfusion. *Id.* 23:22-24; Short App. 12; *see generally Schimel*, 806 F.3d at 912 ("[C]omplications from an abortion are both rare and rarely dangerous."). Abortion-related deaths are even rarer: in the United States, there are roughly 0.7 deaths per 100,000 lawful abortions. Tr. I-2 at 29:10-11; Short App. 12-14. Indiana is not aware of a single death resulting from an abortion provided in the State in the past fifteen years. Stips. ¶ 75.

Carrying a pregnancy to term and delivering the baby is significantly riskier than abortion. *Id.* 26:16-20. The nationwide risk of maternal mortality associated with live birth is approximately fourteen times higher than that associated with induced abortion. *Id.* 26:18-20, 31:10-11. Moreover, every pregnancy-related complication is more common among those who give birth than among those having abortions. *Id.* 31:12-32:13. This is not surprising given that pregnancies ending in abortion are substantially shorter than those ending in childbirth and thus entail less time for pregnancy-related complications to occur; many serious pregnancy-related complications, such as pregnancy-related hypertension, occur later in pregnancy; and nearly one-third of U.S. births occur by cesarean delivery, a major abdominal surgery that entails significant risk. *Id.* 31:24-33:3. Further, while abortion does not increase a person's risk of mental illness, post-partum depression follows childbirth in at least fifteen percent of pregnancies. *Id.* 34:25-35:3, 36:16-25; 37:1-5; 38:09-12; Tr. of Bench Trial (Phase I), Vol. 4 (ECF No. 381) ("Tr. I-4") at 233:23-234:7, 237:6-10.

In Indiana, as nationwide, abortion is generally performed by one of the following methods: medication abortion, aspiration abortion, or dilation and evacuation ("D&E").[1] Tr. I-2 at 17:21-18:4. Medication abortion may be used to end a pregnancy up to seventy days (*i.e.*, ten weeks) LMP. Stips. ¶ 63. It involves terminating a pregnancy through a combination of two medications: mifepristone and misoprostol. Stips. ¶ 65. Mifepristone works by blocking the hormone progesterone, which is necessary to maintain pregnancy. Tr. I-2 at 18:6-11. Misoprostol then causes the cervix to open and the uterus to contract and expel its contents, generally within hours, thereby completing the abortion. *Id.* 18:12-16. Medication abortion requires no anesthesia or sedation; pain is typically managed using oral medications. *Id.* 39:2-39:12.

The current drug label for Mifeprex—the brand name for mifepristone— was approved by the U.S. Food and Drug Administration ("FDA") in 2016. Stips. ¶ 67. It sets forth the following regimen for medication abortion, which is generally known as the "evidence-based regimen": On day one, the patient takes 200 milligrams of mifepristone orally; twenty-four to forty-eight hours later, the patient takes 800 micrograms of misoprostol buccally (in the cheek pouch); seven to fourteen days later, the patient follows up with a healthcare provider to confirm that the pregnancy has been terminated. Stips. ¶ 68; Suppl. App. 20-21.

[1] In addition, a small percentage of second-trimester abortions are performed using a method called "induction," which entails administering medications to induce labor and delivery of a previablilty fetus, generally after sixteen weeks of pregnancy, as measured from the first day of a patient's last menstrual period ("LMP"). Stips. ¶ 72.

Medication abortion is highly effective. Tr. I-2 at 56:7-16; 57:5-22. The FDA-approved Mifeprex label, which aggregates data from seven U.S. clinical trials totaling over 16,000 medication abortions, indicates that 97.4% of medication abortions using the evidence-based regimen are successful. Suppl. App. 29, 30 tbl.3; Tr. I-2 at 57:7-22. In rare cases when medication abortion is unsuccessful, the patient has the option of taking an additional dose of misoprostol or having an aspiration procedure. Tr. I-2 at 58:16-21.

Medication abortion is also highly safe. *Id.* 55:17-19. Serious complications occur in only a fraction of a percent of patients. *Id.* 55:17-24. A 2017 study of over 19,000 medication abortion patients, including both patients treated in person and patients treated via telemedicine, found that only 0.26% experienced a major complication requiring treatment in a hospital emergency department, hospital admission, or blood transfusion. *Id.* 60:19-62:13. This finding accords with earlier clinical studies. *Id.* 61:21-62:3; 62:18-64:24; Suppl. App. 24. Notably, complications from medication abortion occur only after the patient has left the abortion facility because the medications take time to exert their effects. Tr. I-2 at 65:1-9.

Practitioners routinely prescribe or dispense medications that entail equal or greater risk than mifepristone and misoprostol. *Id.* 66:8-16. For example, penicillin, a type of antibiotic, causes a fatal reaction at a rate several times higher than the risk of death associated with medication abortion. *Id.* 66:11-15. Tylenol (acetaminophen) and Viagra (sildenafil citrate) also have higher mortality rates than medication abortion. *Id.* 66:15-16. Further, the evidence-based regimen of mifepristone and

misoprostol used to induce medication abortions is also commonly used to treat incomplete miscarriages. *Id.* 67:12-69:5. The regimen's risks are no greater when used to induce a medication abortion than when used for miscarriage management. *Id.* 69:6-10.

Aspiration abortion, also referred to as suction curettage, entails the use of suction to empty the contents of the uterus. *Id.* 18:17-19:4. Although aspiration abortion is sometimes described as a surgery, it does not require making an incision in the patient's body, and is more properly classified as a "procedure." Stips. ¶ 70; Tr. of Bench Trial (Phase II), Vol. 3 (ECF No. 424) ("Tr. II-3") at 42:24-44:1, 46:2-47:2. A hollow curette is inserted into the uterus, and a hand-held syringe or electric device is applied to create suction and remove the products of conception from the uterus. Tr. I-2 at 19:1-4. The procedure typically takes less than ten minutes. *Id.* 19:5-8. This abortion method is used in the first and early second trimester of pregnancy. *Id.* 19:9-15.

Aspiration abortions rarely result in complications. *Id.* 69:19-22; Tr. II-1 at 185:17-19. A study published in 2015 found that only fifty-seven of almost 35,000 patients (0.16%) experienced a major complication requiring hospital admission, surgery, or blood transfusion. Tr. I-2 at 70:1-4.

With respect to risk, complexity, and duration of the procedure, aspiration abortion is comparable to other common procedures, such as diagnostic hysteroscopy (to visualize the inside of the uterus) and endometrial biopsy (to take a small tissue sample from the uterine lining). *Id.* 71:3-72:5. Aspiration abortion is nearly identical to

dilation and curettage ("D&C"), a procedure used to evacuate the uterus following an incomplete miscarriage. *Id.* 70:10-24. The risks of aspiration abortion are therefore no greater than the risks of D&C for miscarriage management. *Id.* 70:10-71:2.

D&E is a method of abortion used in the second trimester of pregnancy. Stips. ¶ 71. It entails the use of both suction and medical instruments to empty the contents of the uterus. Tr. I-2 at 19:18-24. Like aspiration abortion, D&E does not require making an incision in the patient's body. *Id.* 20:8-9. First, the cervix is dilated using osmotic dilators and/or medications. *Id.* 19:18-21. Depending on gestational age, it may take up to forty-eight hours to achieve the necessary degree of dilation. *Id.* 19:25-20:4. After the cervix is dilated, a combination of suction and forceps is used to empty the uterus. *Id.* 19:16-24. This part of the procedure typically takes five to ten minutes. *Id.* 20:5-7. Like other contemporary abortion methods, D&E presents minimal risks. *Id.* 23:3-5; Tr. II-1 at 191:12-22. Complication rates reported in the medical literature range from 0.05% to 4% of cases. Tr. II-1 at 191:16-22.

Although abortion is safe throughout pregnancy, the medical risks of both pregnancy and abortion increase with gestational age. Stips. ¶¶ 73-74; *supra* 6. Consequently, delayed access to abortion poses risks to patient health. In addition, delayed access to abortion means that patients must cope with the physical symptoms of pregnancy for longer and will have a harder time concealing their pregnancies. Tr. I-1 at 136:23-138:15,144:22-147:18,151:16-152:11; Tr. I-2 at 98:14-100:3, 187:14-189:12. This, in turn, increases patients' levels of stress and anxiety. Tr. I-1 at 138:16-23; Tr. I-2 at 99:14-23; 190:13-:21; Tr. I-3 at 28:21-31:6, 32:7-20, 41:19-42:1. Patients with

abusive partners or family members will face an increased risk of abuse or interference. Tr. I-2 at 108:12-22; Tr. I-3 at 35:20-36:19; Tr. II-1 at 118:1-22. Further, patients who are delayed past ten weeks LMP will no longer have the option of medication abortion, and they will not be able to obtain care at the abortion clinics in South Bend or Lafayette. Stips. ¶¶ 35, 64. Patients delayed past the first trimester will not be able to obtain an abortion at any Indiana abortion clinic. Ind. Code § 16-34-2-1(a)(2). Patients delayed past twenty-two weeks LMP are prohibited from obtaining an abortion in Indiana absent exceptional circumstances. *Id.* § 16-34-2-1(a)(3).

## II. The Challenged Laws

### A. Physician-Only Law

Indiana's Physician-Only Law limits the provision of first-trimester abortions—including medication abortions—to physicians. Ind. Code § 16-34-2-1(a)(1)(A). In so doing, it prevents duly licensed and qualified advanced practice clinicians ("APCs"), such as physician assistants, nurse practitioners, and certified nurse midwives, from providing abortion care that would otherwise fall within their scope of practice.[2] Short App. 60-61, 64-65. Enacted in 1973, *see* Pub. L. No. 322-1973, § 2, 1973 Ind. Acts 1741-46, nearly three decades before medication abortion was approved for use in the U.S., Stips. ¶ 66, the law is out of step with contemporary medical practice, Short App. 107.

[2] Absent the Physician-Only Law, generally applicable laws concerning APCs' scope of practice and professional standards would govern their provision of medication abortion care. *See* Ind. Code §§ 25-22.5-1-1.1(i)(1), 25-23-1-1, 25-23-1-19.4; 844 Ind. Admin. Code 2.2-1.1-13, 2.2-1.1-16, 2.2-2-6; 848 Ind. Admin. Code 3-1-1, 3-1-2, 4-1-4, 4-2-1; Short App. 64-65.

The record demonstrates that leading medical and public health associations, including the American College of Obstetricians and Gynecologists ("ACOG"), the American Public Health Association, and the World Health Association, have endorsed APCs' ability to provide medication abortion care, and one third of states currently permit APCs to provide medication abortions. Tr. II-1 at 152:16-155:1; Short App. 58. When the FDA updated the labeling for Mifeprex in 2016, it removed language specifying that the prescriber should be a physician; any qualified clinician may now prescribe medication abortion in accordance with the label. Suppl. App. 18; Tr. II-1 at 157:8-23; Tr. of Bench Trial (Phase II), Vol. 2 (ECF No. 423) ("Tr. II-2") at 122:8-123:19; Short App. 57-58. In addition, research shows that APCs are well-qualified to provide medication abortion. Tr. II-1 at 156:11-157:22; 162:22-165:21; Short App. 59-60. Notably, a recent analysis of abortion care in the U.S. by the National Academies of Sciences, Engineering, and Medicine ("National Academies"), which is "widely recognized as an authoritative source on the safety and quality of abortion care throughout the United States," Short App. 12, concluded that APCs provide medication abortions safely and effectively. Tr. II-1 at 156:14-25; Short App. 59.

In Indiana, APCs routinely provide medical care that is comparable or greater in risk than medication abortion. This includes treatment of incomplete miscarriage, which is associated with the same types of complications as medication abortion. Tr. I-2 at 69:6-10; Tr. II-1 at 165:24-166:5, 167:12-18. It likewise includes prescription of hormonal contraceptives and controlled substances, such as opioids. Tr. II-1 at 165:24-166:4; Short App. 60.

Based on this evidence, the district court found that, as applied to medication abortion, the Physician-Only Law does not advance "the State's interest in the safety of maternal and fetal health"; it "is out of sync with contemporary medical practice standards"; and its benefits are "*de minimis*." Short App. 103, 107-108. In addition, the court found no justification for the State's differential treatment of patients seeking medication abortion and patients seeking treatment for miscarriage, given that the "medical and physiological effects of these procedures are identical." Short App. 103.

The district court credited testimony from Plaintiffs' chief medical expert, Dr. Grossman, concerning the benefits of the Physician-Only Law, finding that Dr. Grossman's opinions were well grounded in his clinical experience, research findings, and knowledge of the medical literature, and consistent with the positions taken by major medical and public health organizations. Short App. 101-102. In contrast, the district court gave little weight to the testimony of the State's experts because they "drew on *no* medical literature" and offered opinions that were "not supported by or consistent with medical research findings." Short App. 102. The district court also found that the value of the testimony by the State's medical expert, Dr. Calhoun, "was substantially diminished by certain errors and other shortcomings," including that he was unaware of the 2016 changes to the Mifeprex label. Short App. 63-64 n.39.

With respect to burdens, the district court found that "Plaintiffs' evidence establishes that limited physician availability is a real and significant barrier to abortion access in Indiana . . . causing limited capacities and long wait times often upward of

two weeks" Short App at. 105. But for the Physician-Only Law, APCs "would dramatically expand the availability of abortion services," Short App. 106, enabling clinics to double or triple the number of days each week that they offer abortion services, Tr. II-1 at 12:22-13:3; 67:2-11; 75:3-9; 78:18-79:4; Short App. 66, 106. In addition, because APCs are more cost-effective providers of abortion care than physicians, permitting them to provide abortions would reduce the cost of medication abortion for patients. Short App. 66-67, 107. The district court found that even a forty-dollar cost savings "may make the difference as to whether or not [some patients] can afford an abortion." Short App. 107. It therefore concluded that "the Physician-Only law . . . places concrete and significant burdens on Indiana women attempting to access medication abortion services." Short App. 106.

**B. Second-Trimester Hospitalization Requirement**

The Second-Trimester Hospitalization Requirement provides that "after the first trimester of pregnancy," an abortion may only be "performed in a hospital or [ASC]." Ind. Code § 16-34-2-1(a)(2)(B). It therefore prohibits Indiana's abortion clinics from providing any second-trimester abortion care.

When abortion was first legalized in the United States, most second-trimester abortions were performed using a procedure called instillation, which required injecting medications directly into the uterine cavity to induce labor. Tr. II-1 at 189:9-18. It was medically appropriate to provide this procedure, which entailed a high risk of complications, in hospitals, where patients could be closely monitored during the labor and delivery process. *Id.* 189:18-20. In the late 1970s and 1980s, doctors developed the D&E procedure, which greatly reduced the risk of complications from

second-trimester abortions and could be safely performed in outpatient settings. *Id.* 189:21-24. Since then, technological advancements have made D&E even safer. *Id.* 189:25-190:5; Short App. 67-68, 112.

Today, outside Indiana, D&E is routinely performed in abortion clinics. Tr. II-1 at 16:2-7, 52:2-8, 92:11-18, 123:12-22, 195:25-196:2; Short App. 68, 71-72. The safety of D&E is not enhanced when the procedure is performed in hospitals or ASCs. Tr. II-1 at 192:7-9; Short App. 69, 112-14. Those facilities are subject to heightened construction and staffing requirements to maintain a sterile operating environment for surgical procedures that require an incision into sterile body tissue. Tr. II-1 at 192:10-24; Short App. 68-69, 112-13. Such requirements provide no health or safety benefits for second-trimester abortion patients because neither aspiration nor D&E requires cutting into sterile tissue. Tr. II-1 at 187:15-17, 188:6-12, 192:10-24; Short App. 68-69, 112-13. Moreover, in the rare event that a serious complication occurs, a D&E patient in an abortion clinic is similarly situated to a D&E patient in an ASC; both would require transfer to a hospital for care by an appropriate specialist. Tr. II-1 at 192:25-193:14; Short App, at 69, 114.

Multiple studies, including one published in the *Journal of the American Medical Association* in 2018, demonstrate that second-trimester abortions performed in abortion clinics are as safe and effective as those performed in ASCs. Tr. II-1 at 194:15-195:24; Short App. 70. The National Academies Report concluded that D&Es can be safely provided in abortion clinics, as long as clinics have the equipment needed to manage complications associated with the method of sedation that is used. Tr. II-1

at 175:15-177:7; Short App. 69-70. Likewise, consensus guidelines for facilities performing outpatient procedures, published in 2019 by leading professional associations including ACOG and the American College of Physicians, concluded that no scientific evidence justifies subjecting clinics that provide aspiration and D&E abortions to heightened facilities standards; these procedures do not differ from others performed in outpatient clinics and doctor's offices in any way that warrants different building standards. Tr. II-1 at 177:14-178:15; Short App. 69-70.

After noting that Plaintiffs' key evidence on this issue went unrefuted, Short App. 112-14, and that the State offered no explanation for the differential treatment of second-trimester abortion and other medical procedures with equal or greater risk, *id.* 115, the district court concluded that the Second-Trimester Hospitalization Requirement "does not provide benefits that support or advance Indiana's interest in promoting the health and safety of women," *id.*

With respect to burdens, the district court found that "[t]here is no dispute that the Second-Trimester Hospitalization Requirement increases the cost and reduces the availability of second-trimester abortion care." Short App. 73. No ASCs provide abortion care in Indiana, Stips. ¶ 55, and it would be prohibitively expensive for abortion clinics to transform themselves into ASCs, which would require "adding space to satisfy the larger square footage requirements and installing expanded HVAC systems," among other things. Short App. 73, 115. Indeed, one clinic owner's undisputed testimony put the cost of retrofitting at over $2 million. Tr. II-1 at 51:10-19; Short App. 73. Further, few hospitals in Indiana provide abortion care; none provide

abortion care absent maternal or fetal health indications; and it costs tens of thousands of dollars to have a second-trimester abortion in a hospital, compared to $800 to $1,500 at an abortion clinic. Tr. II-1 at 32:12-33:15, 33:24-34:1, 92:19-25; *supra* 4; Short App. 73, 75. The limited availability of second-trimester abortion care in Indiana "force[s] most Indiana women to travel out of state to receive second-trimester abortions." Short App. 116; *accord id.* 73-74; Tr. II-1 at 34:2-10, 34:20-22,52:2-16,115:22-116:15,127:15-19. But for the Second-Trimester Hospitalization Requirement, however, several Indiana abortion clinics would offer second-trimester care. Tr. II-1 at 34:2-10, 34:20-22, 52:2-16, 115:22-116:15, 127:15-19.

This undisputed evidence led the district court to conclude that there was "no serious dispute regarding the substantial obstacles imposed by this restriction," Short App. 115, and that the Second-Trimester Hospitalization Requirement "substantially curtails the constitutional right to an abortion by effectively foreclosing access to second-trimester abortions within the state," *id.* 116.

### C. Telemedicine Ban and In-Person Examination Requirement

The Telemedicine Ban prohibits healthcare providers from using telemedicine to prescribe "an abortion inducing drug." Ind. Code § 25-1-9.5-8(a)(4). The In-Person Examination Requirement acts as a de facto telemedicine ban, providing that "[a] physician shall examine a pregnant woman in person before prescribing or dispensing an abortion inducing drug." Ind. Code § 16-34-2-1(a)(1). For purposes of this requirement, "in person" expressly excludes the use of telemedicine. *See id.*

Providing medication abortion through telemedicine is as safe and effective as in-person treatment. Tr. I-2 at 60:23-62:3, 90:24-91:2; 91:7-15, 92:12-93:14; Short App.

135. Screening patients for contraindications and eligibility, providing counseling, and dispensing medications can be done with equal safety regardless of whether the practitioner is physically present in the room with the patient. Tr. I-2 at 76:16-77:6, 77:14-22,78:14-80:25; 81:11-25; 82:1-83:20; 85:11-21. Moreover, an in-person examination is not part of the standard of care for providing medication abortion and does not enhance the safety or efficacy of the intervention. Tr. I-2 at 53:25-54:20; Short App. 43, 135.

Research shows that telemedicine is a safe and effective means of providing medication abortion. A 2011 study of medication abortion in Iowa found that the success rates for telemedicine patients and in-person patients were similar: 99% for telemedicine patients and 97% for in-person patients. Tr. I-2 at 91:7-93-2. Likewise, there was no significant difference in the occurrence of adverse events among telemedicine patients compared to in-person patients. Tr. I-2 at 93:3-14. A subsequent study, published in 2017, compared the safety of in-person and telemedicine medication abortion in Iowa over a seven-year period. Tr. I-2 at 60:19-61:14. The study encompassed more than 19,000 medication abortions—nearly 9,000 performed via telemedicine and about 10,400 performed in person. Tr. I-2 at 61:15-19. Like the 2011 study, it found no significant difference in the prevalence of adverse events between telemedicine and in-person patients. Tr. I-2 at 61:20-62:3. A 2019 systematic review of evidence regarding the use of telemedicine to provide medication abortion similarly found that the practice is safe and complication rates are low. Tr. I-2 at 94:5-21.

Given the clear and substantial scientific evidence, ACOG has concluded that telemedicine is a safe and effective means of providing medication abortion. Tr. I-2 at 94:22-95:3. Likewise, the National Academies has concluded that there is no evidence that the dispensing or taking of mifepristone tablets requires the physical presence of a clinician. Tr. I-2 at 85:11-19.

Outside the abortion context, Indiana has authorized a dramatic expansion in the use of telemedicine in recent years. *See* Stips. ¶ 76. In 2015, Indiana enacted a law requiring health insurance policies to provide coverage for telemedicine services on the same terms as they provide coverage for healthcare services delivered in person. *See* Pub. L. No. 185-2015, §§ 25-27, 2015 Ind. Acts 2102-04 (codified at Ind. Code §§ 27-8-34-1 to 27-8-34-7, 27-13-1-34, 27-13-7-22). In 2016, Indiana enacted a law broadly authorizing healthcare providers to use telemedicine to treat patients and prescribe medications. *See* Pub. L. No. 78-2016, § 2, 2016 Ind. Acts 711-15 (codified at Ind. Code §§ 25-1-9.5-1 to 25-1-9.5-12). In 2017, Indiana enacted a law authorizing practitioners to prescribe controlled substances via telemedicine. *See* Pub. L. No. 150-2017, § 7, 2017 Ind. Acts 1430-31 (codified in relevant part at Ind. Code § 25-1-9.5-8). Apart from abortion-inducing drugs and certain opioids, Indiana law does not prohibit practitioners from prescribing any medications via telemedicine, Ind. Code § 25-1-9.5-8, and it does not prohibit practitioners from prescribing mifepristone and misoprostol for purposes other than inducing an abortion, *see* Ind. Code § 16-18-2-1.6.

Today, healthcare providers throughout Indiana utilize telemedicine to deliver services to patients, including services that are far more complex than medication

abortion. Suppl. App. 202-203. Notably, Indiana practitioners provide a broad range of reproductive healthcare via telemedicine. Planned Parenthood health centers, for example, provide birth control, testing for sexually transmitted infections, and other services via telemedicine. Tr. I-1 at 46:23-47:5; Short App. 33. Similarly, one of Defendants' medical experts uses telemedicine "extensively" in treating patients with infertility or recurrent pregnancy loss. Tr. I-3 at 209:20-210:4.

The district court ultimately concluded that the Telemedicine Ban and In-Person Examination Requirement "accomplish little more than to impose unjustifiable restrictions on the use of telemedicine in abortion care," Short App. 137, characterizing the laws' benefits as "unidentifiable," *id.* 138. It further concluded that the "State's attempt to explain its basis for excluding the far-reaching benefits of telemedicine from [abortion] patients is feeble at best, especially given the widespread use of telemedicine throughout Indiana as well as the overall safety of medication abortions." *Id.* 139. In reaching these conclusions, the district court found that Plaintiffs' evidence about the safety and efficacy of using telemedicine to provide medication abortion "went unrebutted by the State's experts," *id.* 135, and those experts' testimony about the purported benefits of an in-person examination for medication abortion patients was internally inconsistent, unsupported by medical research, and in some instances, speculative, *id.* 135-137.

With respect to the burdens imposed by the Telemedicine Ban and In-Person Examination Requirement, the record evidence demonstrates that these laws significantly delay to patients' access to abortion care. Representatives of several Indiana

abortion clinics testified that that their respective clinics would be able to dramatically increase their capacity absent the Telemedicine Ban and In-Person Examination Requirement. Short App. 38-41, 138. Planned Parenthood, for example, would be able to offer abortion services five days per week at all of its Indiana abortion clinics, rather than one or two days per week as is the case at most of its clinics currently. Tr. I-1 at 60:25-61:4, 64:3-10; Short App. 38. The same is true for the Women's Med clinic in Indianapolis. Tr. I-1 at 206:15-20; Short App. 41. WWHA's South Bend Clinic would likewise be able to offer abortion care four to five days per week, up from three to four days per month, currently. Tr. I-1 at 109:15-110:13, 121:7-20; Short App. 40. Telemedicine would also reduce the cost of care at the South Bend Clinic because travel reimbursement for physicians residing outside Indiana is currently a significant overhead expense. Tr. I-1 at 111:5-10; Short App. 40.

The district court found that "[i]ncorporating telemedicine into healthcare services generally has resulted in well-documented, widely accepted benefits in the form of reduced costs of care and expanded access thereto." Short App. 137. This is true even with respect to site-to-site telemedicine, in which a patient reports to a health center and uses a telemedicine platform to communicate with a practitioner who is offsite. *Id.* 137-38. "Site-to-site telemedicine would allow Indiana's abortion clinics to dramatically expand the availability of appointments and reduce delays in care," *id.* 138, which would be "highly significant" in alleviating the burdens that delay imposes, especially on economically disadvantaged abortion patients, *id.*; *see also id.* 24-30.

### D. In-Person Counseling Requirement

Indiana's "Mandatory Disclosure and Delay Law" provides that "consent to an abortion is voluntary and informed only if" abortion providers satisfy certain requirements, which include providing certain information to abortion patients orally and in writing at least eighteen hours before the abortion. Ind. Code § 16-34-2-1.1(a). The In-Person Counseling Requirement is a component of the Mandatory Disclosure and Delay Law. It requires that a patient be "in the . . . presence" of the person providing certain information, thus prohibiting oral information from being communicated via video-conference and written information from being transmitted electronically. Ind. Code § 16-34-2-1.1(a)(1), (a)(4), (b).

Practitioners can provide a patient with information and obtain their informed consent just as effectively when using telemedicine as when meeting with the patient in-person. *Id.*; Tr. I-1 at 141:16-142:7; Short App. 127-28. That is because today's telemedicine technology permits direct, face-to-face communication between a practitioner and patient via video-conference. Tr. I-1 at 50:16-20; Tr. I-2 at 77:20-22; Short App. 127-28. Telemedicine platforms like the one currently utilized by Planned Parenthood enable secure oral and written communications, and they also enable patients to review and sign documents. Tr. I-1 at 50:6-51:5; Short App. 45.

The weight of the evidence shows that practitioners engaging with patients through telemedicine are able to assess a patient's capacity to give voluntary and informed consent in the same way and to the same extent as providers meeting with patients in person. Tr. I-2 at 82:18-21; Short App. 127-28. Practitioners using telemedicine are also able to effectively screen their patients for intimate partner

violence. Tr. I-1 at 154:21-25, 155:1-12; Tr. I-2 at 83:10-85:2; Short App. 47-48, 128-29. Research has found that both abortion patients and abortion providers have a high level of satisfaction with using telemedicine for preabortion counseling. Tr. I-2 at 78:11-82:17; Short App. 46-47, 128. In fact, patients are significantly more likely to feel comfortable asking questions with a telemedicine visit as compared to an in-person visit. Tr. I-2 at 81:23-25.

Indiana does not impose comparable in-person counseling requirements on any other health care intervention. As explained above, Indiana broadly permits the use of telemedicine, including for counseling related to contraceptives, fertility treatments, and other obstetrical and gynecological care. *See* Ind. Code §§ 25-1-9.5-1 to 25-1-9.5-13; *supra* 19-20.

The district court found that, "given the broad-based societal advancements to telemedicine technology and the successful incorporation of videoconferencing into preabortion counseling care elsewhere, . . . the benefits imposed by [the In-Person Counseling Requirement are] at best slight. Short App. 130. It further found that, since "no other aspect of healthcare is restricted in its ability to utilize telemedicine, . . . there appears to be little to no justification for excluding abortion patients from the benefits of telemedicine." *Id.* In reaching these conclusions, the district court gave substantial weight to the testimony of Plaintiffs' witnesses, "who have had extensive experience providing and receiving abortion care and researching the effectiveness of telemedicine in this setting," *id.* , while noting that the testimony of the State's witnesses ignored "significant research and testimonials" concerning the

effectiveness and utility of using telemedicine platforms for preabortion counseling, *id.* 129.

The record demonstrates that the In-Person Counseling Requirement imposes significant burdens on abortion access, particularly for low-income patients, by requiring them to make an additional trip to an abortion clinic. Short App. 51, 131-32. It forces patients "to take additional time off work (which, for some, threatens the loss of their jobs) and arrange and pay for extra child care." *Id.* 131. Those who do not live near one of Indiana's few abortion clinics "must choose between expending their resources either to travel on two separate days or to secure overnight lodging, which is simply unaffordable for some women, who therefore must resort to sleeping in their cars outside of clinics." *Id.*

These hardships cause a significant number of patients "to delay their second appointment for an additional week or two," *id.*, which exposes them to greater health risks, causes their pregnant bodies to experience additional physical discomfort, exacerbates the stress and anxiety of their unwanted pregnancies, puts them at greater risk of violence from abusive partners, increases the cost of obtaining abortion care, and decreases their options with respect to abortion method and provider. Short App. 131; *supra* 10-11. The district court ultimately concluded that the burdens imposed on abortion patients by the In-Person Counseling Requirement are "clearly excessive" and "would be ameliorated by telemedicine delivered services." Short App. 132.

### E. Facility Regulations

#### 1. Aspiration abortion regulations

Pursuant to a statutory directive, Ind. Code § 16-21-2-2.5(a),(c)(1), Defendant Indiana State Department of Health ("Health Department") has promulgated regulations that aspiration abortion clinics must satisfy to obtain and maintain licensure. The following regulations are at issue in this appeal:

- a requirement that procedure rooms be at least 120 square feet for procedures utilizing local analgesia or nitrous oxide, 410 Ind. Admin. Code 26-17-2(d)(1);
- a requirement that scrub facilities be provided near the entrance of procedure rooms, 410 Ind. Admin. Code 26-17-2(d)(4); and
- a requirement that corridors be at least forty-four inches wide, 410 Ind. Admin. Code 26-17-2(e)(5).

These regulations do not enhance the safety of aspiration abortion. *Supra* 16.

Indiana does not impose heightened building standards on healthcare facilities that provide medical procedures comparable to aspiration abortion. For instance, Dr. Clark, an OB-GYN in private practice in South Bend, routinely performs procedures similar in risk and complexity to aspiration abortion, such as IUD insertions, colposcopies, and endometrial biopsies, in an office-based setting. Tr. II-1 at 105:23-106:3.; Short App. 80-81. As the Court noted, D&Cs for miscarriage management, which are nearly identical to aspiration abortion, *supra* 9-10, are not subject to heightened facility requirements. Tr. II-1 at 179:16-24; 180:9-20; Short App. 121.

The district court credited Dr. Grossman's testimony concerning the Aspiration Abortion Regulations, observing that his opinions are "reliable and informed." *Id.* 119-21. In contrast, Dr. Calhoun's testimony about the 120-square-foot requirement

was "not supported by any medical research" and is inconsistent with the medical literature. Short App. 120. The district court observed that the State did not provide *any* evidence to rebut Dr. Grossman's opinion that forty-four-inch corridors are not medically necessary. *Id.* Finally, the district court declined to credit Dr. Stroud's testimony that practitioners should use a scrub facility before performing a D&C because Indiana does not require scrub facilities for D&Cs or similar procedures. Short App. 121. The district court ultimately concluded that, since "no medical or patient related safety benefits flow from these required structural, facility-based specifications for abortion care clinics," and "Indiana does not interpose similar restrictions on facilities providing other similar medical services," the Aspiration Abortion Regulations "do not achieve any purpose beyond unnecessarily restricting who can provide abortion care and, in turn, limiting access to abortion services." Short App. 122.

As to burdens, the Aspiration Abortion Regulations prevent properly equipped clinics, including WWHA's South Bend Clinic, from providing aspiration abortions. Tr. II-1 at 83:17-87:20; Short App. 81, 121-22. Unrebutted testimony demonstrated that it would be difficult, if not impossible, for the South Bend Clinic to satisfy the regulations. For instance, increasing the size of the exam rooms or adding scrub facilities would require reducing the size of the corridors below the required minimum width, blocking required exits, or moving walls and adding plumbing. Tr. II-1 at 83:17-87:20; Short App. 81. And even if compliance were physically possible, construction would be prohibitively expensive. Tr. II-1 at 83:1-5, 87:14-20

Consequently, the Aspiration Abortion Regulations force patients in the South Bend region seeking aspiration abortions to travel to Merrillville, Indianapolis, Chicago, or farther. Tr. II-1 at 82:22-84:24, 87:14-88:13; Short App. 81, 121-22. Given the hardships associated with such travel, particularly for low-income patients, the regulations impose "significant burdens" on patients seeking aspiration abortions. Short App. 122.

**2. Medication abortion regulation**

The Health Department has also adopted regulations applicable to licensed abortion clinics providing medication abortion. *See generally* 410 Ind. Admin Code 26.5-1-1 to 26.5-20-1. At issue here is a requirement that such clinics maintain a housekeeping room with a service sink and storage. 410 Ind. Admin. Code 26.5-17-2(e)(1).

The record demonstrates that the housekeeping room requirement does not enhance the safety of medication abortion care, which involves no instruments or other items that would need to be cleaned in a housekeeping room. Tr. II-1 at 184:25-185:12; Short App. 76, 117. The National Academies Report concluded that no specific facility requirements are needed for the provision of medication abortion. Tr. II-1 176:16-19; Short App. 76. Further, Indiana does not impose a housekeeping room and sink requirement on outpatient facilities providing healthcare comparable to medication abortion. Tr. II-1 at 179:16-24; 180:9-20; Short App. 76.

Notably, Planned Parenthood's Evansville health center does not have a housekeeping room with a sink, and the record demonstrates that it does not need one. Tr. II-1 at 20:17-22:19. It contracts with a janitorial service that uses mostly disposable

supplies. *Id.* Moreover, the health center has a designated "dirty" sink in a laboratory area that can be used for cleaning soiled items. *Id.*; Short App. 76-77.

The district court found there are no benefits associated with the housekeeping room requirement. Short App. 77. At the same time, it found that the requirement imposes "clearly excessive" burdens on abortion patients by preventing Planned Parenthood's Evansville health center from providing medication abortions in a vastly underserved part of the state. Tr. II-1 at 20:8-21; Short App. 76-77. As a result, abortion patients in that region must travel at least as far as Bloomington, which is a 250-mile round trip, to obtain abortion care. Tr. II-1 at 23:13-16; Short App. 76-77. The district court found that "[s]uch travel . . . extracts incredible investments of time and money, which are clearly and obviously burdensome for those who . . . have limited means and lack reliable or accessible transportation." Short App. 118.

### F. Mandatory Disclosure Requirements

As noted above, Indiana's "Mandatory Disclosure and Delay Law" requires abortion providers to make certain oral and written disclosures to their patients at least eighteen hours before an abortion. Ind. Code § 16-34-2-1.1(a). Two specific disclosures are at issue here. The first requires abortion providers to tell their patients that "human physical life begins when a human ovum is fertilized by a human sperm." Ind. Code § 16-34-2-1.1(a)(1)(E). The second requires abortion providers to tell their patients that "objective scientific information shows that a fetus can feel pain at or before twenty (20) weeks of postfertilization age." Ind. Code § 16-34-2-1.1(a)(1)(G).

With respect to the required disclosure about when life begins, a nurse practitioner who conducts preabortion counseling testified that most of her patients become confused and angry when she reads this statement to them. Tr. II-1 at 67:22-68:4; Short App. 83. The district court found that there is no scientific or medical consensus on when human life begins, and the phrase "human physical life" is not "a medical term that is defined in any extant medical literature." Short App. 83, 148. It rejected "the State's efforts to neutralize the import of this statement by declaring it medically accurate, scientifically uncontroversial, and not ideologically charged," *Id.* 148, holding instead that the statement cannot properly be characterized as "truthful and non-misleading," *Id.* 149.

With respect to the required disclosure about fetal pain, the district court found that it "appear[s] to represent a 'fringe view' within the medical community," one that conflicts with the findings of leading medical organizations. Short App. 145. Both ACOG, which represents 90% of licensed OB-GYNs in the U.S., and the Royal College of Obstetricians and Gynaecologists ("RCOG"), the leading OB-GYN society in the U.K., reject the contention that a fetus can feel pain at or before twenty weeks' post-fertilization age (twenty-two weeks LMP), finding instead that a developing fetus cannot feel pain until at least twenty-four weeks LMP, when a connection is established between its thalamus and cerebral cortex. *Id.* 84, 144-45. No major medical association has endorsed a contrary view. *Id.* 84.

Although the State's expert witness disputed the validity of the scientific conclusions drawn by ACOG and RCOG based on her own review of the relevant research,

*id.* 144, the district court held that the dispute was largely beside the point, *id.* 145. It concluded that the required disclosure was misleading because it suggests that the information it conveys is uncontroversial and widely accepted in the scientific community, when in fact, it represents a minority view. *Id.* 145-46.

## SUMMARY OF ARGUMENT

Under Federal Rule of Civil Procedure 52(a)(6), clear error review applies to the district court's findings of fact. Consequently, this Court must accord substantial deference to those findings. *Infra* 31-32.

The undue burden standard, which governs most of Plaintiffs' claims, is fact-dependent, and its application turns on the evidentiary record in a particular case. *Infra* 32-35. The district court was not bound by factual determinations made in past cases reviewing similar laws, as the State contends. *Infra* 32-35. To the contrary, it was obligated to assess the constitutionality of the challenged laws based on the evidence in the record before it. *Infra* 32-35.

The district court properly held that each of the laws at issue in this appeal violated the Due Process Clause of the Fourteenth Amendment by imposing an undue burden on previability abortion access. *Infra* 35-64. With respect to the challenged Physician-Only Law; Second-Trimester Hospitalization Requirement; Telemedicine Ban; In-Person Examination Requirement; In-Person Counseling Requirement; and Facilities Regulations, the district court correctly concluded that these laws impose burdens on abortion access that are disproportionate to their respective benefits. *Infra* 38-60. Likewise, the district court correctly concluded that these laws violate the

Equal Protection Clause because they draw classifications between abortion and other medical interventions that unduly burden abortion access. *Infra* 67-68.

The district court properly held that the challenged Mandatory Disclosure Requirements violate abortion patients' due process rights because the required disclosures are misleading. *Infra* 60-64. In addition, these requirements violate abortion providers' free speech rights. *Infra* 64-67. The Supreme Court has explained that preabortion disclosure requirements should be treated as regulations of conduct that incidentally burden speech. *Infra* 64. Such regulations are subject to the test set forth in *United States v. O'Brien*, 391 U.S. 367, 377 (1968). *Infra* 64-65. Neither challenged disclosure requirement satisfies this test. *Infra* 65-67.

## ARGUMENT

### I. Standard of Review

Contrary to the State's assertion, there is no *sui generis* standard of review for abortion cases. As with all judgments following a bench trial, this Court must review the district court's factual findings for clear error and its legal conclusions *de novo*. *Consumer Fin. Prot. Bureau v. Consumer First Legal Grp., LLC*, 6 F.4th 694, 704 (7th Cir. 2021). Clear error review also applies to the district court's applications of law to facts. *Id.*

The clear error standard is prescribed by Federal Rule of Civil Procedure 52(a)(6), which provides that, following a bench trial, "[f]indings of fact, whether based on oral or other evidence, must not be set aside unless clearly erroneous, and the reviewing court must give due regard to the trial court's opportunity to judge the witnesses' credibility." "This standard plainly does not entitle a reviewing court to reverse the

finding of the trier of fact simply because it is convinced that it would have decided the case differently." *Anderson v. City of Bessemer City*, 470 U.S. 564, 573 (1985). "If the district court's account of the evidence is plausible in light of the record viewed in its entirety, the court of appeals may not reverse it even though convinced that had it been sitting as the trier of fact, it would have weighed the evidence differently." *Id.* at 573-74. "Where there are two permissible views of the evidence, the factfinder's choice between them cannot be clearly erroneous." *Id.* at 574. "When a fact-finder bases her finding on a decision to credit a witness's testimony, that finding 'can virtually never be clear error' as long as the testimony is 'coherent and facially plausible,' 'not internally inconsistent,' and 'not contradicted by extrinsic evidence.'" *Estrada-Martinez v. Lynch*, 809 F.3d 886, 895 (7th Cir. 2015) (quoting *Anderson*, 470 U.S. at 575).

## II. Plaintiffs' Claims Against the Challenged Laws Are Not Barred.

The State's contention that prior, fact-bound decisions by this Court and the Supreme Court categorically bar Plaintiffs' undue burden claims against the challenged laws is incorrect. *See* Appellants' Br. 22-26. Controlling precedent could not make any clearer that the undue burden standard is fact dependent, and its application turns on the evidentiary record in a given case. *See, e.g.*, *Whole Woman's Health*, 136 S. Ct. at 2310-13 (detailing the record evidence supporting the district court's conclusion); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 887 (1992) (upholding an abortion restriction "on the record before us"); *A Woman's Choice-East Side Woman's Clinic v. Newman*, 305 F.3d 684, 688 (7th Cir. 2002) ("Findings based on new evidence could produce a new understanding, and thus a different legal outcome . . . ."). As the

Eighth Circuit recently explained, "[t]he [undue burden] standard is so intertwined with underlying facts that 'later, concrete factual developments' can affect whether or not the *same* law violates the undue burden standard." *Comprehensive Health of Planned Parenthood Great Plains v. Hawley*, 903 F.3d 750, 756 (8th Cir. 2018) (citations omitted).

At an earlier stage of this case, this Court explained that, under Supreme Court precedent, "the undue-burden inquiry requires a holistic, rigorous, and independent judicial examination of the facts of a case to determine whether the burdens are undue in light of the benefits the state is permitted to pursue." *Whole Woman's Health All.*, 937 F.3d at 876. The State is wrong to assert that the district court erred by undertaking this very inquiry in its post-trial decision. *Cf. Whole Woman's Health*, 136 S. Ct. at 2310.

The State is also wrong to assert that the district court lacked authority to distinguish prior caselaw based on differences in material facts. *See* Appellants' Br. 22 (citing *Whole Woman's Health All. v. Rokita*, 13 F.4th 595, 598 (7th Cir. 2021)).[3] In *June Medical*, the Supreme Court considered the constitutionality of a Louisiana law requiring hospital admitting privileges for abortion providers that was "almost word-for-word identical" to a Texas law that it had struck down just four years earlier. 140 S. Ct. at 2112 (plurality). If the State's argument were correct, then *Whole Woman's*

[3] A merits panel is authorized to reexamine a ruling made by a motions panel. *Hor v. Gonzales*, 421 F.3d 497, 498 (7th Cir. 2005); *Johnson v. Burken*, 930 F.2d 1202, 1205 (7th Cir. 1991) ("Decisions by motions panels are summary in character, made often on a scanty record, and not entitled to the weight of a decision made after plenary submission.").

*Health* would have controlled the outcome in *June Medical* without regard to the factual record in the later case. But both the plurality and concurring opinions in *June Medical* analyzed the factual record in painstaking detail, affording deference to the district court's factual findings under the clear error standard and concluding that the factual similarities in the respective cases warranted the same result. *See id.* at 2113 (plurality) ("We have examined the extensive record carefully and conclude that it supports the District Court's findings of fact. Those findings mirror those made in *Whole Woman's Health* in every relevant respect and require the same result."); *id.* at 2141 (Roberts, C.J., concurring) ("In my view, the District Court's work reveals no . . . clear error, for the reasons the plurality explains. The District Court findings therefore bind us in this case." (citation omitted)).

This Court's decision in *Newman* does not support the State's position. There, in upholding an abortion restriction in the context of a pre-enforcement challenge, the Court expressly acknowledged that subsequent factual developments might lead to a different result in later cases. *Newman*, 305 F.3d at 688. Although the Court posited in dicta that "constitutionality must be assessed at the level of legislative fact, rather than adjudicative fact determined by more than 650 district judges," it ultimately concluded that "the Supreme Court ha[d] not made this point explicit . . . and . . . the undue-burden approach d[id] not prescribe a choice between the legislative-fact and adjudicative-fact approaches." *Id.* If, however, this Court interprets *Newman* to bar district courts from engaging in the fact-specific, record-based analysis required by *Whole Woman's Health* and *June Medical*, it must treat *Newman* as abrogated by

those subsequent Supreme Court decisions, which now make clear that the undue burden standard requires an adjudicative-fact approach.

Moreover, barring district courts from considering changed factual circumstances when reviewing regulations of medical practice would lead to absurd and oppressive results given that medical standards evolve over time. The Supreme Court has never sanctioned this approach to reviewing abortion laws. To the contrary, it has evaluated such laws based on "present medical knowledge," *City of Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 437 (1983) (citation omitted), *overruled in part on other grounds by Casey*, 505 U.S. at 870, and "accepted medical practice," *Simopoulous v. Virginia*, 462 U.S. 506, 516 (1983); *accord Whole Woman's Health All.*, 937 F.3d at 875.

## III. The District Court Correctly Held That the Challenged Laws Violate the Due Process Clause.

Laws that burden previability abortion access must satisfy the undue burden standard, which specifies that a law is unconstitutional if it "has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Casey*, 505 U.S. at 887. This rule "requires that courts consider the burdens a law imposes on abortion access together with the benefits th[e] law[] confer[s]," specifically whether the benefits are "sufficient to justify the . . . burdens." *Whole Woman's Health*, 136 S. Ct. at 2300, 2309.

First, courts must determine whether the challenged law is reasonably related to a legitimate state interest, such that it actually furthers that interest. *See June Med.*, 140 S. Ct. at 2138 (2020) (Roberts, CJ., concurring) (describing this step as a

"threshold requirement" set forth in *Casey*). This inquiry is more exacting than mere rational basis review. *See Whole Woman's Health*, 136 S. Ct. at 2309 (holding that the court of appeals was wrong to apply "the less strict review applicable where . . . economic legislation is at issue" while purporting to examine whether abortion restrictions were "reasonably related to (or designed to further) a legitimate state interest."). As this Court has explained, "a statute that curtails the constitutional right to an abortion . . . cannot survive challenge without evidence that the curtailment is justifiable by reference to the benefits conferred by the statute." *Schimel*, 806 F.3d at 921. "The statute may not be irrational, yet may still impose an undue burden." *Id.* Second, courts must next determine whether the law imposes burdens on abortion access that substantially outweigh its benefits— i.e., the extent to which the law actually furthers a legitimate state interest.[4]

Contrary to the State's assertions, plaintiffs challenging an abortion law need not show that it has "prevented" a large fraction of abortion patients from obtaining an abortion. Appellants' Br. 26. Both the Supreme Court and this Court have recognized a wide range of burdens as constitutionally significant, including decreased capacity and increased crowding at abortion clinics, delays in obtaining abortion care, loss of treatment options, elevated medical risks, increased travel distances, compromised patient-practitioner relationships, and exposure to violence or other forms of abuse.

[4] In *June Medical*, the plurality and concurring opinions disagreed on the proper formulation of the second step of the undue burden test. *Compare* 140 S. Ct. at 2120 (plurality), *with id.* at 2138-39 (Roberts, CJ., concurring). This Court has correctly held that "[b]ecause a majority of Justices of the Supreme Court has not held otherwise, the balancing test from *Whole Woman's Health* remains binding precedent." *Planned Parenthood of Ind. & Ky., Inc. v. Box*, 991 F.3d 740, 752 (7th Cir. 2021), *petition for cert. docketed*, No. 20-1375 (U.S. Apr. 1, 2021).

*See, e.g.*, *Whole Woman's Health*, 136 S. Ct. at 2313; *Schimel*, 806 F.3d at 919; *Van Hollen*, 738 F.3d at 795-96.

Importantly, the Supreme Court has placed vulnerable patients at the center of the undue burden analysis, focusing the "constitutional inquiry [on] the group for whom the law is a restriction, not the group for whom the law is irrelevant." *Casey*, 505 U.S. at 894. This requires examining the impact of a challenged law on people struggling with unreliable employment, a lack of savings, limited health insurance, geographic isolation, intimate partner violence, and similar hardships. In *Casey*, for example, the Court evaluated the burdens of a spousal notification requirement by focusing on "victims of regular physical and psychological abuse" rather than women in "well-functioning marriages." *Id.* at 892-93. Likewise, in *Whole Woman's Health*, the Court noted that the challenged abortion restrictions "erect[ed] a particularly high barrier for poor, rural, or disadvantaged women." 136 S. Ct. at 2302 (citation omitted); *see also June Med.*, 140 S. Ct. at 2140 (Roberts, CJ., concurring) (considering how increased travel distances imposed by the challenged law "would exacerbate th[e] difficulty" "Louisiana women already 'have . . . affording or arranging for transportation and childcare'" (citation omitted)).

The district court performed this analysis correctly, focusing its inquiry on the challenged laws' impact on abortion patients with "limited financial means and/or those dealing with a lack of means for travel." Short App. 27. It also centered on "women experiencing intimate partner violence, who often face the necessity of hiding their pregnancies from their perpetrators." *Id.* at 28. Although this analysis is often

referred to as the "large fraction test," it does not, as the State contends, require courts to quantify the number of people burdened by an abortion restriction or perform any mathematical calculations. *Compare* Appellants' Br. 30-33, *with Whole Woman's Health*, 136 S. Ct. at 2320 (rejecting the State's argument that the undue burden standard requires a plaintiff to show that an abortion restriction poses a substantial obstacle to a large fraction of reproductive-age women).

### A. Physician-Only Law

The State's central argument for reversing the district court's deliberate and factually grounded decision concerning the Physician-Only Law is that *Mazurek v. Armstrong*, 520 U.S. 968, 973 (1997) (per curiam), barred all subsequent challenges to such laws. This is incorrect.

The only question that *Mazurek* decided was whether plaintiffs had presented sufficient evidence to establish that the Montana legislature had an "unlawful motive," namely creating a substantial obstacle to abortion access, for restricting the performance of abortions to licensed physicians. 520 U.S. at 972-74. The Court answered in the negative given record evidence that "only a single practitioner [wa]s affected" by the Montana law. *Id.* at 973.

*Mazurek*, it is true, quoted *Casey*'s statement that "the Constitution gives the States broad latitude to decide that particular functions may be performed only by licensed professionals, *even if an objective assessment might suggest that those same tasks could be performed by others.*" 520 U.S. at 973 (quoting Casey, 505 U.S. at 885)). But APCs are licensed professionals, subject to rigorous professional standards, as the district court correctly noted. *See* Short App. 27, 42-43, 69. *Mazurek* also cited

statements from three Supreme Court opinions from the period 1973-1983 that the performance of abortions "may be restricted to physicians," but those statements were dicta. *Mazurek*, 520 U.S. at 974-75. None of the cases considered whether a state could bar properly trained and licensed APCs—as opposed to lay people—from providing abortions. *See Roe v. Wade*, 410 U.S. 113, 164-65 (1973); *Connecticut v. Menillo*, 423 U.S. 9, 9-11 (1975); *City of Akron*, 462 U.S. at 447-48. The last case in the line, *Akron*, noted that States could mandate that only physicians perform abortions "to ensure the safety of the abortion procedure." *Mazurek*, 520 U.S. at 974-75 (quoting *Akron*, 462 U.S. at 447). It did not comment on whether, if confronted with conclusive evidence that APCs can perform abortions as safely and effectively as physicians, states could still restrict the provision of abortion care to physicians only. Nor did *Mazurek* itself confront this question. A summary decision, it considered only whether the health evidence in the record—consisting of a single study—was sufficient to establish that the legislature's motive must have been improper. *Id.* at 973.

This case differs from *Mazurek* in a critical way: the district court held the Physician-Only Law unconstitutional as applied to medication abortion, which did not exist when *Mazurek* was decided. Short App. 99-100. This medical advancement, first approved for use in the U.S. in 2000, Stips. ¶ 66, did not factor into the Supreme Court's 1997 decision. *Id.* ("[I]t was not possible for the *Mazurek* court, or those that came before it, to consider whether restricting medication abortion care to physicians-only ensures the safety of the procedure."); *see also Planned Parenthood of the Great Nw. & the Hawaiian Islands v. Wasden*, 406 F. Supp. 3d 922, 929 (D. Idaho 2019)

("[T]he calculation of state interest in protecting the health of the mother has . . . changed substantially since *Mazurek*.").

The State criticizes the district court's opinion for finding that the "the reach of Indiana's physician-only statute is substantially broader than Montana's statute in *Mazurek*" because the text of the respective statutes is "materially identical." Appellants' Br. 24 (quoting Short App. 99). But the district court was comparing the statutes' impact, not their text. It explained that, "[i]n *Mazurek*, the record reflected that only one non-physician was impacted by the new Montana statute"; whereas, in this case, "Plaintiffs have identified dozens of APCs already working in licensed abortion facilities who would provide abortion care but for the prohibitions imposed by Indiana's Physician-Only Law." Short App. 99.

The State's arguments are likewise flawed in other important ways. First, the State disregards the substantial deference owed to the district court's factual findings, *see supra* 31-32, and seeks to re-try the case in this Court. For instance, it points to testimony by one of its medical experts comparing the abilities of APCs and physicians. *See* Appellants' Br. 34. But the district court, which is uniquely suited to assess the credibility of witnesses, gave little weight to the testimony because it drew on no medical literature, and the experts lacked any experience providing medication abortion. *See* Short App. 135-136.

Second, ignoring the Supreme Court's explicit holding in *Whole Woman's Health*, Indiana claims that the district court committed error by failing to apply the rational basis standard set forth in *Williamson v. Lee Optical of Okla., Inc.*, 348 U.S. 483, 489

(1955). Appellants' Br. 35. Of course, in *Whole Woman's Health*, the Supreme Court said that applying this standard in abortion cases would be the error. 136 S. Ct. at 2309 (citing *Williamson*, 348 U.S. at 491, with disapproval). The Supreme Court further explained that singling out abortion for regulations not imposed on medical treatments of equal or greater risk undermines a state's claim that the regulations serve a legitimate health and safety interest. *Id.* at 2315; *accord Schimel*, 806 F.3d at 914.

Third, the State's effort to manufacture "medical uncertainty" misses the mark. Appellants' Br. 35 (quoting *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007)). In *Gonzales*, the district court's respective findings included a "division of opinion among highly qualified experts regarding the necessity or safety" of a banned abortion procedure and the federal government's "expert witnesses reasonably and effectively refuted [the plaintiffs'] proffered bases for the opinion that [the banned procedure] has safety advantages." *Id.* at 162 (internal quotation marks omitted). Here, by contrast, the district court credited Dr. Grossman's testimony, made adverse credibility findings about the State's medical experts, and unequivocally concluded "there is no advancement of the State's interest in the safety of maternal and fetal health derived from restricting the provision of medication abortion care to physicians only." Short App. 103. Thus, there is no medical uncertainty in this case.

Fourth, the State is unable to effectively contest the district court's well-supported factual findings on the substantial obstacles created by the Physician-Only Law. These include a significant reduction in the already scarce pool of abortion providers

in Indiana and thus "long wait times often upwards of two weeks," which can deprive patients of the ability to obtain a medication abortion, increase the medical risks to patients, prolong the physical and emotional stress of an unwanted pregnancy; and increase costs to patients as much as $70. Short App. 105, 107. Instead, the State creates out of whole cloth a standard disqualifying any burden from amounting to a substantial obstacle except being altogether prevented from obtaining an abortion. *See* Appellants' Br. 35. By the State's calculus, every other burden is mere inconvenience. *Id.*

Nevertheless, the district court properly looked not only to evidence of the nature of the burdens imposed by the Physician-Only Law, but to evidence of how those burdens function as substantial obstacles in the lives of Indiana's most disadvantaged residents. *Supra* 36-37. For example, the court credited the testimony of Plaintiffs' public health expert that people living in poverty already forgo or delay healthcare to afford basic necessities. Short App. 24. The court noted that the testimony was consistent with the first-hand experience of an All-Options' employee responsible for providing financial assistance to low-income abortion patients. *Id.* 24-25. That witness testified that she had never encountered a salaried client. *Id.* 25. For people in these circumstances, a cost increase of $70 certainly poses a substantial obstacle, even if they are ultimately able to overcome it by skipping a rent payment or taking a similarly perilous action. *See id.* at 28; *cf. Schimel,* 806 F.3d at 919 ("[A] 90–mile trip is no big deal for persons who own a car or can afford an Amtrak or Greyhound

ticket. But more than 50 percent of Wisconsin women seeking abortions have incomes below the federal poverty line . . . .").[5]

In distorting the undue burden standard and erasing the hardships of its most disadvantaged residents, Indiana enables the very health and safety risks that it purports to be minimizing by enforcing the Physician-Only Law. *See supra* 10. On one hand, it argues for the ability to preserve an alleged, incremental benefit from limiting the screening and treatment of complications associated with medication abortion to physicians, *see* Appellants' Br. 34, while dismissing significant delays to abortion care and extended unwanted pregnancy as negligible byproducts, *id.* 35; *see* Short App. 29 (finding that delays in accessing abortion care "increases the likelihood that a woman will face physical complications from her pregnancy or her abortion" and "force women to endure longer the physical symptoms associated with pregnancy"); Stips. ¶ 73.

### B. Second-Trimester Hospitalization Requirement

Contrary to the State's arguments, the Supreme Court's prior decisions involving second-trimester hospitalization requirements support the conclusion that Indiana's law fails the undue burden test.

In *City of Akron*, the Supreme Court invalidated a law that required second-trimester abortions to be performed in a hospital because the law was not reasonably

[5] The record includes a recent report published by the Board of Governors of the Federal Reserve System, which found that 37% of adults in the U.S. do not have enough cash on hand to pay for an unexpected expense of $400, Suppl. App. 228, and that "[o]ut-of-pocket spending for health care is a common unexpected expense that can be a substantial hardship for those without a financial cushion," *id.* 23.

designed to further the State's interest in patient health, 462 U.S. 416, 437 (1983), and it posed a substantial obstacle to abortion access, *id.* at 438. The Supreme Court noted that the law departed from accepted medical practice because the widespread use of the D&E procedure, including in outpatient facilities, had dramatically increased the safety of second-trimester abortions and led major medical associations to abandon their recommendations that such abortions be provided in a hospital. *Id.* at 435-37. The Supreme Court held that the law substantially interfered with abortion access because second-trimester abortions were rarely performed in hospitals, and abortions cost twice as much in hospitals as in outpatient facilities. *Id.* at 434-35. Thus, the law would force patients to travel out of state for care. *Id.* at 435, 438-39. In a companion case, the Court invalidated on identical grounds a requirement that abortions be performed in a hospital after twelve weeks' gestation. *Planned Parenthood Ass'n of Kansas City, Inc. v. Ashcroft*, 462 U.S. 476, 479, 481-82 (1983).

*Simopoulos v. Virginia*, yet another companion case, upheld a requirement that second-trimester abortions be performed in a hospital or ASC. 462 U.S. 506, 519 (1983). But it is distinguishable from this case in two fundamental ways. First, the Supreme Court emphasized that it saw "no reason to doubt that an adequately equipped clinic could, upon proper application, obtain an outpatient hospital license permitting the performance of second-trimester abortions." *Id.* at 518-19. By contrast, the record here shows that licensed abortion clinics could not obtain an ASC license without undertaking prohibitively expensive renovations. *Supra* 16.

Second, the plaintiff in *Simopoulos* did "not attack[] [the requirement] as being insufficiently related to the State's interest in protecting health." *Simopoulos*,462 U.S. 506, 517 (1983); *see Whole Woman's Health*, 136 S. Ct. at 2320 ("[T]he Court in *Simopoulos* found that the petitioner in that case . . . had waived any argument that the regulation did not significantly help protect women's health."). Here, Plaintiffs have not only attacked the Second-Trimester Hospitalization Requirement as insufficiently related to the State's interest in health, but they have presented conclusive evidence on the issue. *Supra* 14-16.

Critically, the Supreme Court's decisions in *City of Akron*, *Ashcroft*, and *Simopoulos* abrogated *Gary-Northwest Indiana Women's Services, Inc. v. Bowen*, 496 F. Supp. 894, 899 (N.D. Ind. 1980), a*ff'd sub nom. Gary-Northwest Indiana Women's Services, Inc. v. Orr*, 451 U.S. 934 (1981), which held that it is constitutional *per se* to restrict second-trimester abortion care to hospitals. *Bowen* is no longer good law, and the State's reliance on it is misplaced.

As with the Physician-Only Law, the State attempts to re-try the case in this Court rather than demonstrate that the district court's detailed factual findings concerning the Second-Trimester Hospitalization Requirement are clearly erroneous. For example, Indiana cites Dr. Calhoun's testimony that deep sedation is necessary for second-trimester abortions and offered only in hospitals and ASCs. Appellants' Br. 37-38. But, in a reasonable exercise of its discretion as fact finder, the district court accorded little weight to that testimony because it was not grounded in medical research or literature, and the witness' personal experience with second-trimester

abortions was limited to ten to fifteen procedures performed decades ago.[6] *See* Short App. 70-71.

Indiana belittles the burdens on abortion patients from the Second-Trimester Hospitalization Requirement, portraying them as incidental effects that simply make it more difficult or expensive to obtain an abortion. The district court's meticulous factual findings, however, demonstrate "no serious dispute regarding the substantial obstacles imposed by this restriction." Short App. 115. The court found that no ASCs provide abortion care in Indiana; "only four Indiana hospitals, all located in and around Indianapolis, perform second-trimester abortions, and only if a fetal or maternal indication has been identified"; and the cost of obtaining a second-trimester abortion at a hospital is "upwards of $20,000" even though most patients lack health insurance coverage for abortion. *Id.*

The district court found that these burdens "force most Indiana women to travel out of state to receive second-trimester abortions." *Id.* 116. Contrary to Indiana's attempts to downplay the impact of the Second-Trimester Hospitalization Requirement, being forced out of state for abortion care is, in and of itself, a substantial obstacle. *See Schimel*, 806 F.3d at 918-19 ("[T]he proposition that 'the harm to a

[6] Citing Dr. Calhoun's testimony, the State claims that "the leading professional organization of American surgeons recognizes second-trimester abortions as surgeries and considers it necessary for surgeons to be accredited by a licensed hospital or ASC." Appellants' Br. 37. But the cited testimony concerns the Physician-Only Law, not the Second-Trimester Hospitalization Requirement, it does not reference second-trimester abortions at all, and it does not contend that any professional association recognizes second-trimester abortion as surgery. Tr. II-2 at 99:19-21, 100:16-22. On the other hand, Dr. Grossman testified that, based on ACOG's classification system, both aspiration abortion and D&E are considered procedures rather surgeries. Tr. II-3 at 42:18-44:1.

constitutional right [can be] measured by the extent to which it can be exercised in another jurisdiction . . . [is] a profoundly mistaken assumption.'"(citation omitted)). In any event, the district court found that the Second-Trimester Hospitalization Requirement subjects low-income patients to cost and travel burdens that routinely result in indignities and risks to their personal safety, such as having to sleep in their cars or in bus stations. Short App. 74-75.

Indiana tries to evade responsibility for these harms by recasting them as "circumstances outside the State's control." Appellants' Br. 39. The State lays the blame for ASCs not offering abortion care partly at the feet of abortion providers for not converting their licensed clinics to ASCs. As the district court found, however, existing providers would need to spend millions of dollars to comply with Indiana's standards for ASCs. Short App. 73. The undue burden standard requires courts to assess the burdens and benefits of an abortion restriction in the real-world context in which it operates. *Planned Parenthood of Ind. & Ky., Inc. v. Adams*, 937 F.3d 973, 986 (7th Cir. 2019) ("We must . . . recognize that any particular obstacle to exercising the right to choose to end a pregnancy does not exist in a vacuum."), *cert. granted, judgment vacated, and case remanded for further consideration sub nom. Box v. Planned Parenthood of Ind. & Ky., Inc.*, 141 S. Ct. 187 (2020), *reasoning readopted by* 991 F.3d 740 (7th Cir. 2021), *petition for cert. docketed*, No. 20-1375 (U.S. Apr. 4, 2021).

Poverty is a complicated phenomenon with many causes, but it has nonetheless been a critical consideration in determining whether a challenged law poses a substantial obstacle to abortion access. *See, e.g.*, *Schimel,* 806 F.3d at 919 (discussing

the increased hardships that poor people face in making a ninety-mile trip as compared to people with greater financial resources). By focusing its analysis of burdens on abortion patients who are economically disadvantaged, the district court was faithful to precedent. *Supra* 36-37.

### C. Telemedicine Ban and In-Person Examination Requirement

The State makes no attempt whatsoever to establish that the Telemedicine Ban is reasonably related to a legitimate state interest, nor could it given the overwhelming evidence in the record about the safety and efficacy of using telemedicine to provide medication abortion and the State's efforts to expand and facilitate the use of telemedicine in all areas of medicine besides abortion care. *See supra* 17-20; Short App. 34-38, 42. Instead, the State contends that the district court's findings concerning the In-Person Examination Requirement are clearly erroneous, Appellants' Br. 43, but it fails to make the showing required by the clear error standard—namely, that the district court's account of the evidence is implausible in light of the record viewed in its entirety. *See supra* 31-32. The district court is not required, as the State suggests, to cite specific evidence refuting every point made by the State's witnesses. *Compare* Appellants' Br. 43-44, *with Anderson*, 470 U.S. at 573; *Estrada-Martinez*, 809 F.3d at 895.

In particular, the State highlights testimony by some of its witnesses contending that the In-Person Examination Requirement provides certain health-related benefits. Appellants' Br. 43-45. The district court considered this testimony, *see* Short App. 43-44, and gave greater weight to contrary testimony and documentary evidence presented by Plaintiffs, *id.* 136. "When a fact-finder bases her finding on a decision

to credit a witness's testimony, that finding 'can virtually never be clear error' as long as the testimony is 'coherent and facially plausible,' 'not internally inconsistent,' and 'not contradicted by extrinsic evidence.'" *Estrada-Martinez*, 809 F.3d at 895 (citation omitted). The State does not establish—or even allege—that the testimony credited by the district court suffers from any of these flaws.

As in *Whole Woman's Health*, "[b]y refusing to defer to a state's purported justifications, and instead carefully evaluating the facts," the district court "ensured that in conducting its balancing analysis, pretextual purposes d[id] not receive any weight on the 'benefits' side of the ledger." *Whole Woman's Health All.*, 937 F.3d at 877. As this Court has acknowledged, "[o]pponents of abortion reveal their true objectives when they procure legislation limited to . . . abortion," even though "other medical procedures are far more dangerous to the patient than abortion." *Schimel*, 806 F.3d at 921. Here, the State has utterly failed to justify through competent evidence why it singles out abortion patients from all other medical patients for a ban on the use of telemedicine to obtain treatment.

The record as a whole and the district court's well-supported factual findings demonstrate that the State failed to satisfy its burden of proving that the Telemedicine Ban and In-Person Examination Requirement are reasonably related to the State's interest in patient health or any other legitimate state interest. *See supra* 17-20; Short App. 133-39. The district court's judgment with respect to those laws should be affirmed on that basis alone.

In addition, the district court correctly concluded that "[t]he burdens imposed by [the Telemedicine Ban and In-Person Examination Requirement] which include a reduction in access to care with no offsetting medical benefits cannot be deemed anything other than undue." Short App. 139; *accord Schimel*, 806 F.3d at 919-20. The State offers only a single argument in response to this holding: that denying abortion patients the benefits of medical progress should not be construed as a burden. Appellants' Br. 45. In the State's view, because telemedicine did not exist in 1973, when abortion was first legalized, it cannot be unconstitutional to deny abortion patients access to telemedicine in 2021, no matter how much the technology would increase the availability of abortion care, decrease delays in obtaining abortion and associated medical risks, or reduce cost and travel burdens on low-income and rural patients.

This is plainly inconsistent with the Supreme Court's jurisprudence, which has maintained that abortion regulations must be consistent with contemporary medical standards. For example, as discussed above, in 1983, the Supreme Court struck down a second-trimester hospitalization requirement, even though, at the time *Roe* was decided, such laws were widely considered "reasonable health regulation[s]." *City of Akron*, 462 U.S. at 435. It did so because, in the decade following *Roe*, "the safety of second-trimester abortions . . . increased dramatically" as a result of the development of the D&E procedure, which was a medical advancement. *Id.* at 435-36. In a companion case, the Supreme Court explained that states lack "discretion . . . to adopt abortion regulations that depart from accepted medical practice," *Simopoulos*, 462

U.S. at 516, a rule incompatible with denying abortion patients the benefits of medical progress.

Contrary to the State's assertion, the Telemedicine Ban and In-Person Examination Requirement do not "prevent the diversion of abortion-inducing drugs and painkillers," Appellants' Br. 45, because neither requires an abortion patient to consume such medications before leaving an abortion clinic or hospital. *See* Ind. Code § 25-1-9.5-8(a)(4). Rather, under the challenged laws, patients are free to take the medications home with them and initiate their abortion at a time of their choosing. *Id.*[7] Further, under generally applicable Indiana law, nearly all pain medications, including controlled substances, may be prescribed via telemedicine, indicating a lack of any real concern that telemedicine increases the risk of drug diversion. *See* Ind. Code § 25-1-9.5-8(b).

**D. In-Person Counseling Requirement**

Based on the trial testimony of medical experts, counselors, and abortion patients, the district court found that "providers utilizing telemedicine are able to obtain informed consent as effectively as if the participants were present in person." Short App. 127. It further found that "[t]hrough advancements in videoconferencing technology, the personal interactions between providers and patients are enabled to a degree that the same quality and kind of communications occurs with patients as

[7] Indiana enacted a new law in 2021 that, for the first time, requires that "[a] physician must dispense the abortion inducing drug in person and have the pregnant woman consume the drug in the presence of the physician." Pub. L. 218-2021, § 4(a)(1), 2021 Ind. Acts ___ (codified at Ind. Code § 16034-2-1(a)(1)). This law is being challenged in a separate lawsuit. Compl. (ECF No. 1) ¶¶ 5, 57-60, *All-Options, Inc. v. Att'y Gen. of Ind.*, No. 1:21-CV-1231 (S.D. Ind. May 18, 2021).

would have occurred in person." *Id.* 128. In addition, the district court found that "intimate partner violence can be effectively screened for via telemedicine through a series of oral and written communications," and that "intimate partner violence is frequently screened for via telemedicine in other aspects of healthcare." *Id.* 128-29.

The State's selective quotations from the district court's opinion present a misleading account of its findings. For example, the State contends that the district court found that some of its claims concerning the benefits of in-person counseling were "true in a general sense." Appellants' Br. 41 (quoting Short App. 129). But what the district court actually found was that, "[t]hough these opinions may be true in a general sense, they ignore the significant research and testimonials reflecting the perspective of abortion patients and providers which show that these individuals—those actually involved in the process—typically find the interactions to be just as meaningful when delivered through videoconferencing and, in fact, would prefer that this option be available." Short App. 129-30.

The district court gave little weight to the testimony of the State's experts because they lacked relevant personal experience and, unlike Plaintiffs' experts, had not conducted or cited research concerning the effectiveness of telemedicine in abortion counseling. *Id.* 130. The district court also cited Indiana's "vast expansion of telemedicine in other healthcare settings" as a factor that undermined the State's claim that the In-Person Counseling Requirement was beneficial to patients. *Id.* Notably, the State presented no evidence concerning why obtaining informed consent through telemedicine is safe and effective for all medical interventions besides abortion. *Cf. Whole*

*Woman's Health*, 136 S. Ct. at 2315 (finding that a challenged abortion restriction "imposes 'a requirement that simply is not based on differences' between abortion and other surgical procedures 'that are reasonably related to' . . . the asserted 'purpos[e] of the Act.'" (alteration in original) (citations omitted)); *Schimel*, 806 F.3d at 914 ("Wisconsin appears to be indifferent to complications of any other outpatient procedures, even when they are far more likely to produce complications than abortions are."). The State has not demonstrated—nor even contended—that any of the district court's factual findings concerning the In-Person Counseling Requirement are clearly erroneous. As a result, this Court should not disturb those findings. *Supra* 31-32.

Contrary to the State's assertions, the district court correctly held that the burdens imposed by the In-Person Counseling Requirement are "substantially disproportionate" to its benefits. Short App. 132. Unlike in *Casey*, where "the District Court did not conclude that the waiting period is [a substantial] obstacle even for the women who are most burdened by it," 505 U.S. at 887, here, the district court's factual findings clearly support its conclusion that the In-Person Counseling Requirement unduly burdens those patients for whom it is relevant. *See* Short App. 23-30, 50-52, 131-32. In particular, the district court found that "[t]he majority of women impacted most severely" by Indiana's abortion restrictions are "low-income individuals, living in households at or below 200% of the federal poverty line." *Id.* 23. "[I]ndividuals living in poverty forego or delay all healthcare services because other costs, such as those related to securing the basic necessities of food and housing, are prioritized." *Id.* 24. "In addition, low-wage workers often tend to have inflexible, unpredictable

work schedules that do not provide them either with paid or unpaid time off or sick leave." *Id.* "For women of limited financial means and/or those dealing with a lack of means for travel—which is the majority of Indiana women seeking abortion services—the burdens imposed by Indiana's expansive abortion regulations . . . seriously exacerbate their [] inability to receive this care." *Id.* 27-28. "These burdens intensify for women experiencing intimate partner violence, who often face the necessity of hiding their pregnancies from their perpetrators." *Id.* 28.

A careful examination of the way in which the In-Person Counseling Requirement exacerbates the obstacles that low-income individuals and those experiencing intimate partner violence must overcome to access abortion care led the district court to conclude that the burdens imposed by the statute are not mere inconveniences, as the State insists; rather, they are "significant" and, in some cases, prohibitive obstacles. *Id.* 131; *supra* 24.

Moreover, the State's claim that the In-Person Counseling Requirement imposes no burdens on Indiana abortion patients beyond those imposed by the "Ultrasound Requirement," Ind. Code § 16-34-2-1.1(a)(5), is incorrect.[8] Appellants' Br. 42. As the district court explained, absent the In-Person Counseling Requirement, a patient could present to a nearby health center to satisfy the Ultrasound Requirement regardless of whether a physician or APC were on site, which would substantially increase flexibility in scheduling the necessary appointment. Short App. 57, 133. That

[8] As noted above, Plaintiffs filed a timely motion asking the district court to reconsider its judgment as to the Ultrasound Requirement, and that motion remains pending. *Supra* 1.

increased flexibility would, in turn, "significantly mitigate at least some of th[e] burdens established by Plaintiffs." *Id.* 133.

As explained above, the State is wrong in arguing that *Newman* forecloses any and all challenges to the In-Person Counseling Requirement. *See supra* 34-35. In *Newman*, the Court rejected a pre-enforcement challenge to the In-Person Counseling Requirement because it viewed the evidence that the plaintiffs relied on as speculative. 305 F.3d at 687 ("Plaintiffs rely on predictions about what is likely to happen if Indiana's law were enforced as written."). Here, in contrast, Plaintiffs presented detailed evidence about the actual, ongoing impact of the law on Indiana abortion patients. *See* Short App. 50-52.

### E. Facility Regulations

#### 1. Aspiration abortion regulations

The district court's factual findings regarding the benefits and burdens of the challenged aspiration abortion regulations are well supported by the record, *see* Short App. 78-82, 119-22, which precludes a finding that they are clearly erroneous, *see Anderson*, 470 U.S. at 573; *Estrada-Martinez*, 809 F.3d at 895. These findings accord with findings made by the Supreme Court in *Whole Woman's Health*. 136 S. Ct. at 2315. There, the Court noted that "many surgical-center requirements are inappropriate as applied to surgical abortions," and it cited "scrub facilities" as a specific example. *Id.* The State fails to offer any evidence or argument explaining why a different result is warranted here than in *Whole Woman's Health*.

The State incorrectly asserts that the district court "disregarded" the testimony of its experts concerning the aspiration abortion regulations because of their lack of

experience providing abortion care. Appellants' Br. 47. The portion of the opinion from which the State quotes—selectively and misleadingly—concerns the regulation pertaining to medication abortion facilities, not the regulations pertaining to aspiration abortion facilities.[9] *Compare id.*, *with* Short App. 117-18. The district court did not cite lack of relevant experience as a factor relevant to its assessment of testimony concerning the latter regulations. *See* Short App. 78-80, 120-21.

With respect to the requirement that procedure rooms be a minimum of 120 square feet, 410 Ind. Admin. Code 26-17-2(d)(1), the district court gave little weight to the testimony of the State's expert, Dr. Calhoun, because "he did not rebut" testimony by Plaintiffs' expert "that a standard procedure room suffices to provide safe and effective first-trimester aspiration abortion care," and "his opinion is not supported by any medical research and is inconsistent with the findings of . . . medical literature," Short App. 120. This was not clear error. *See Anderson*, 470 U.S. at 573; *Estrada-Martinez*, 809 F.3d at 895.

With respect to the requirement that corridors be a minimum of forty-four inches wide, 410 Ind. Admin. Code 26-17-2(e)(5), the State does not dispute the district court's finding that "no evidence was proffered by the State to rebut [Plaintiffs' expert's] assertion that no accommodations for passing wheelchairs or gurneys are

[9] Lack of relevant personal experience is one of many factors that informed the district court's decision about how much weight to give the testimony of the State's experts concerning the medication abortion regulation. Short App. 117-18. The full quotation from the district court's opinion states: "As discussed previously in our Findings of Fact, both Dr. Stroud's and Dr. Calhoun's testimony on this issue was largely irrelevant, omitted a direct response to the issues presented, and lacked any basis in their personal experiences in this area of medical practice or their review of any relevant medical research." *Id.*

necessary in the context of first-trimester aspiration abortion care," Short App. 120, which is the rationale for imposing the requirement on hospitals and surgical centers, *Id.* 79.[10]

With respect to the requirement that abortion clinics have "scrub facilities," 410 Ind. Admin. Code 26-17-2(d)(4), in addition to "hand washing station[s]," 410 Ind. Admin. Code 26-17-2(d)(3), the district court gave little weight to the testimony of the State's experts that these specialized sinks are necessary wherever intrauterine procedures are performed. That is because Indiana imposes the requirement only on facilities providing abortion procedures, while "other facilities in Indiana, such as Dr. Allen Clark's office in South[] Bend," provide intrauterine procedures without having such sinks.[11] Short App. 80; *accord id.* 121. This was not clear error. *See Anderson*, 470 U.S. at 573; *Estrada-Martinez*, 809 F.3d at 895.

That all of these regulations target abortion clinics for requirements that are not imposed on doctor's offices and clinics that provide procedures of comparable or greater risk undermines the State's claim that the regulations serve an important

[10] Although the South Bend Clinic currently complies with the corridor width requirement, because of the physical footprint of the building, the clinic faces a trade-off between maintaining compliance with that requirement and achieving compliance with the procedure room square footage requirement. Tr. II-1 at 83:19-84:3.

[11] The State contends that the district court erred by asking whether the scrub facilities regulation is necessary. Appellants' Br. 52. But *Casey* prohibits "[u]nnecessary health regulations" that burden abortion access, 505 U.S. at 878, and subsequent decisions by the Supreme Court and this Court have evaluated the necessity of such regulations, *see, e.g.*, *Whole Woman's Health*, 136 S. Ct. at 2316 ("The record evidence thus supports the ultimate legal conclusion that the surgical-center requirement is not *necessary*." (emphasis added)); *Schimel*, 806 F.3d at 919-20 ("If a burden significantly exceeds what is *necessary* to advance the state's interests, it is 'undue,' which is to say unconstitutional." (emphasis added) (citation omitted)).

health or safety interest. *See Whole Woman's Health*, 136 S. Ct. at 2315; *Schimel*, 806 F.3d at 921.

The State's repeated assertion that the regulation of abortion facilities is within the discretion of the State and not subject to constitutional review ignores the Supreme Court's decision in *Whole Woman's Health*, which struck down a requirement that abortion clinics satisfy facility requirements designed for surgical centers. 136 S. Ct. at 2314-15. There, as here, the record showed that the challenged requirements "provide[] few, if any, health benefits for women, pose[] a substantial obstacle to women seeking abortions, and constitute[] an 'undue burden' on their constitutional right to do so. *Id.* at 2318.

**2. Medication abortion regulation**

The State's argument that WWHA lacks standing to challenge the regulation requiring medication abortion clinics to maintain a discrete housekeeping room with a service sink, 410 Ind. Admin. Code 26.5-17-2(e)(1), ignores that there are two other Plaintiffs in this case: Dr. Glazer and All-Options. Dr. Glazer has standing to challenge the regulation on behalf of his abortion patients who would be able to obtain abortion care in Evansville but for it, *see June Med.*, 140 S. Ct. at 2118-20 (plurality); *id.* at 2139 n.4 (Roberts, J., concurring),[12] and All-Options has standing to challenge the regulation because it requires the nonprofit organization to divert resources from

[12] The district court addressed Dr. Glazer's standing to challenge the facility regulations at an earlier stage of the case. *See Whole Woman's Health All. v. Hill*, 377 F. Supp. 3d 924, 934 (S.D. Ind. 2019) ("[T]he complaint adequately alleges that new abortion clinics, which would operate in Indiana but for the challenged licensing regulations, would reduce the severity of the burdens on obtaining abortions for Glazer's patients and allow Glazer to expand his professional practice.").

other programming to assist people in Evansville with travel to other parts of Indiana—or other states—to obtain abortion care, *see Havens Realty Corp. v. Coleman*, 455 U.S. 363, 379 (1982). It is well settled that, where at least one plaintiff has standing, courts need not inquire into the standing of other plaintiffs seeking the same relief. *See Ezell v. City of Chicago*, 651 F.3d 684, 696 n.7 (7th Cir. 2011). Accordingly, the Court need not determine whether WWHA has standing.

The State has failed to demonstrate that the challenged medication abortion facility regulation is reasonably related to the State's interest in patient health and safety. As with the other challenged laws, the State simply engages in selective quotation from its witnesses' testimony without demonstrating—or even attempting to demonstrate—that the record as a whole fails to support the district court's detailed findings. Appellants' Br. 56-57; Short App. 75-78, 117-19; *Anderson*, 470 U.S. at 573; *Estrada-Martinez*, 809 F.3d at 895. Given that the State imposes the housekeeping room requirement only on medication abortion facilities and not on outpatient facilities providing other kinds of healthcare, the district court was correct to view with skepticism the State's claim that the requirement provides important health or safety benefits to patients receiving outpatient medical care. *See Whole Woman's Health*, 136 S. Ct. at 2315; *Schimel*, 806 F.3d at 921. The State failed to offer any evidence to justify this differential treatment. Short App. 118.

Nor does the State contest the district court's finding that, by preventing Planned Parenthood from offering medication abortion at its Evansville health center, the challenged regulation requires abortion patients living in the Evansville area to

travel an additional 250 miles round-trip to obtain care. Appellants' Br. 57. Instead, the State argues that the fact that no one has challenged the regulation in the past should preclude Plaintiffs from challenging it now. *Id.* Apparently, in the State's view, both prior cases and the absence of prior cases should bar challenges to its abortion laws, but the State cites no legal authority to support this position. Moreover, *Whole Woman's Health* undermines the State's suggestion that Plaintiffs are required to seek as-applied relief from the regulation before bringing a facial challenge. *See* 136 S. Ct. at 2300 (invalidating, in the context of a pre-enforcement facial challenge, a requirement that abortion clinics comply with certain facility regulations).

### F. Mandatory Disclosure Requirements

In *Casey*, the Supreme Court explained that, "as with any medical procedure, the State may require a woman to give her written informed consent to an abortion," but it recognized that preabortion disclosure requirements implicate a patient's fundamental right to abortion. 505 U.S. at 881-84. The Court held that, for a preabortion disclosure requirement to satisfy the Due Process Clause, the required disclosure must, at a minimum, be truthful and not misleading. *Id.* at 882 ("If the information the State requires to be made available to the woman is truthful and not misleading, the requirement may be permissible."). The Mandatory Disclosures at issue here fail that to satisfy those criteria.[13]

[13] The State does not appeal the district court's judgment invalidating the requirement that abortion providers distribute a "perinatal hospice brochure" to certain patients, Ind. Code § 16-34-2-1.1(b)(2), insofar as the brochure contains an inaccurate statement about abortion and mental health. *See* Appellants' Br. 58; Short App. 141-43.

### 1. The Mandatory Disclosure Requirement Concerning When Life Begins is Misleading.

The first Mandatory Disclosure Requirement at issue requires abortion providers to tell their patients that "human physical life begins when a human ovum is fertilized by a human sperm." Ind. Code § 16-34-2-1.1(a)(1)(E). It violates abortion patients' due process rights because the required statement is misleading, *see Casey*, 505 U.S. at 882, presenting as settled fact a proposition that is actually a hotly contested matter of ideology and religious belief. The Supreme Court has long recognized that "those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus" concerning "the difficult question of when life begins." *Roe*, 410 U.S. at 159.

The State's attempt to save the requirement with a semantic argument—that the prescribed statement conveys only biological trivia rather than a message about the personhood status of a fertilized egg—falls flat. The biological trivia—that a fertilized egg is alive in the same way that an amoeba or bacterium is alive—is not material to a person's decision to have an abortion. What is material is whether a fertilized egg constitutes meaningful human life that is morally or ethically distinguishable from an amoeba or bacterium. As a result, the average patient participating in preabortion counseling is not likely to comprehend the prescribed statement about when human life begins as an ideologically neutral refresher on middle school biology, but rather,

as a message about the personhood status of a fertilized egg.[14] Indeed, the record indicates that many abortion patients "become confused and angry when they are provided with this disclosure." Short App. 83.

The State again mischaracterizes the district court's assessment of its expert's testimony. The district court did not "discount[]" Dr. Curlin's opinions because of his personal belief that "abortion is the killing of an innocent human life." Appellants' Br. 59. Rather, the district court rejected Dr. Curlin's view that the required disclosure "is critical to the informed consent process because the woman considering the abortion needs to understand that the procedure will 'kill a living human being.'" Short App. 84 (quoting Tr. Vol. 2-2, 12:25). The district court correctly viewed Dr. Curlin's understanding of the required statement as conveying a moral judgment about abortion rather than an uncontroversial fact. Short App. 148. In assigning weight to the conflicting expert testimony concerning the required disclosure, the district court also found relevant that Dr. Curlin did not dispute the testimony of Plaintiffs' expert that "human physical life" is not a medical term and is not defined in any medical literature. *Id.*

In sum, the district court's conclusion that "this mandatory disclosure does not communicate truthful and non-misleading information" is correct in all respects and requires invalidation of the disclosure requirement. *Id.* 149.

[14] The Eighth Circuit's contrary reasoning is unsound, and this Court should not adopt it. *See Planned Parenthood Minn., N.D., S.D. v. Rounds*, 530 F.3d 724, 735-36 (8th Cir. 2008) (en banc).

### 2. The Mandatory Disclosure Requirement Concerning Fetal Pain is Misleading.

The next Mandatory Disclosure Requirement at issue requires abortion providers to tell their patients that "objective scientific information shows that a fetus can feel pain at or before twenty (20) weeks of postfertilization age." Ind. Code § 16-34-2-1.1(a)(1)(G). Leading medical associations, however, including ACOG and RCOG have reviewed the available evidence and concluded that a human fetus does not have the capacity to experience pain until at least twenty-four weeks LMP. Short App. 84, 144; *see* Suppl. App. 204. The contention that a fetus can feel pain at earlier gestational ages reflects a fringe view that is far outside mainstream medical consensus. Short App. 85, 145.

The disclosure requirement is misleading because it presents as settled science a fringe view that has been rejected by leading medical associations. An abortion patient who hears or reads the prescribed statement is likely to be left with the impression that the ability of a fetus to feel pain is an uncontroversial fact that is widely accepted in the medical community and would have no idea that the leading OB-GYN societies in both the U.S. and U.K. have concluded that a fetus lacks the capacity to experience pain until at least twenty-four weeks LMP.

Although the State's expert on fetal pain criticizes the conclusions of ACOG and RCOG, she did not and could not dispute that they are the leading organizations of OB-GYNs in their respective nations. Short App. 84. Indeed, ACOG represents more than 90% of the OB-GYNs in the U.S. *Id.* Nor could the State's expert identify any

major medical organization that agreed with her interpretation of the scientific evidence concerning fetal pain. *Id.* 84, 144.

Accordingly, the district court correctly concluded that disclosure requirement concerning fetal pain fails under *Casey* because it is misleading. Short App. 146; *see Casey*, 505 U.S. at 882.

## IV. The First Amendment Provides an Alternative Basis for Affirming the District Court's Judgment Concerning the Mandatory Disclosure Requirements.

Abortion patients' due process rights and abortion providers' free speech rights are governed by distinct legal standards. *Casey* held that "the physician's First Amendment rights not to speak are implicated" by preabortion disclosure requirements, but they are moderated, to some extent, by the government's authority to regulate "the practice of medicine." 505 U.S. at 884 (citations omitted). The Supreme Court later clarified that, to the extent that such requirements relate to physicians' informed consent obligations, they regulate physicians' *conduct* in providing medical care while incidentally burdening their speech. *See Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2372-73 (2018) (discussing *Casey*). The standard of review applicable to regulations of conduct that incidentally burden speech is set forth in *O'Brien*: such a regulation is permissible only if (1) "it is within the constitutional power of the Government"; (2) "it furthers an important or substantial governmental interest"; (3) "the governmental interest is unrelated to the suppression of free expression"; and (4) "the incidental restriction on alleged First Amendment freedoms is no greater than is essential to the furtherance of that interest." 391 U.S. at

377 (1968); *accord Hodgkins ex rel. Hodgkins v. Peterson*, 355 F.3d 1048, 1059 (7th Cir. 2004).

The Mandatory Disclosure concerning when human life begins fails the *O'Brien* test. It fails the second prong of the test because the State does not have an important or substantial governmental interest in elevating one set of beliefs about when human life begins over others. *See O'Brien*, 391 U.S. at 377. To the contrary, the Supreme Court has repeatedly held that it is improper for states to enforce an official viewpoint on such contested ideological matters. *See, e.g.*, *Becerra*, 138 S. Ct. at 2375 ("'[T]he best test of truth is the power of the thought to get itself accepted in the competition of the market,' and the people lose when the government is the one deciding which ideas should prevail.") (alteration in original) (citation omitted); *Casey*, 505 U.S. at 851 ("At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State."); *W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624, 642 (1943) ("If there is any fixed star in our constitutional constellation, it is that no official, high or petty, can prescribe what shall be orthodox in politics, nationalism, religion, or other matters of opinion . . . ."). Although the State may express a preference for childbirth over abortion through the dissemination of objective, factual information "relating to the consequences to the fetus," *Casey*, 505 U.S. at 882, it may not enforce an official view of when life begins, *id.* at 851.

In addition, the requirement fails the fourth prong of the *O'Brien* test because it is greater than necessary to further the State's interest. *See O'Brien*, 391 U.S. at 377. Even if the Court were to conclude that the prescribed statement merely conveys objective, factual information about embryonic and fetal development, it would still violate abortion providers' free speech rights because it is greater than necessary to further the State's interest in providing factual information about that subject. Independently of this challenged requirement, Indiana law requires abortion providers to distribute a color copy of the State's Abortion Informed Consent Brochure to their patients. *See* Ind. Code § 16-34-2-1.1(a)(4). The Abortion Informed Consent Brochure contains detailed descriptions of the embryonic and fetal development process that are illustrated by computer-generated images. Suppl. App. 37-43. The challenged disclosure requirement does not further the State's interest in informing abortion patients about embryonic and fetal development to a greater extent than the Abortion Informed Consent Brochure; it merely requires duplication of certain information using ideologically charged language about when "life begins." *Compare id.*, *with* Ind. Code § 16-34-2-1.1(a)(1)(E).

The Mandatory Disclosure concerning fetal pain violates the second prong of the *O'Brien* test. *See* 391 U.S. at 377. Although the State may, in certain circumstances, have an important or substantial interest in informing patients that certain medical information is subject to debate, it does not have an important or substantial interest in promoting fringe beliefs without acknowledging their status within the medical community. The district court correctly found that the required statement concerning

fetal pain reflects a "'fringe view' within the medical community" that has been rejected by leading medical associations in both the U.S. and U.K. Short App. 145.

Accordingly, the First Amendment provides an alternative basis for affirming the district court's judgment concerning the Mandatory Disclosure Requirements.

## V. The Equal Protection Clause Provides an Alternative Basis for Affirming the Remainder of the District Court's Judgment.

The Equal Protection Clause "commands that no State shall 'deny to any person within its jurisdiction the equal protection of the laws', which is essentially a direction that all persons similarly situated should be treated alike." *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 439 (1985) (citation omitted). It prohibits classifications that burden the exercise of fundamental rights without adequate justification. *See, e.g.*, *Williams v. Rhodes*, 393 U.S. 23, 30-31 (1968); *Loving v. Virginia*, 388 U.S. 1, 11-12 (1967).

Under the Supreme Court's equal protection precedent, such classifications "must be closely scrutinized and carefully confined." *Harper v. Va. State Bd. of Elections*, 383 U.S. 663, 670 (1966). The district court determined that the undue burden standard provides the proper level of scrutiny for Plaintiffs' equal protection claims because it mirrors the level of scrutiny that the abortion right is provided in the due process context. Short App. 94-96. To apply the undue burden standard to Plaintiffs' equal protection claims, this Court must first determine whether the *classification* drawn by the challenged law is reasonably related to a legitimate state interest, such that it actually furthers that interest. *Cf. supra* 35-36. Then the court must determine

whether the *classification* imposes burdens on abortion access that substantially outweigh its benefits. *Cf. supra* 36.

As discussed previously, the district court made extensive factual findings indicating that none of the classifications drawn by the challenged laws advance the State's valid interests in health, safety, or potential life even as they create substantial obstacles to abortion access. *Supra* 12, 13, 16, 20, 26-28. Indeed, in most cases, the State failed to offer any evidence whatsoever to justify its differential treatment of abortion. *Supra* 12,16,19-20,23, 25-26. Consequently, the challenged laws violate the Equal Protection Clause, which provides an alternative basis for affirming the district court's judgment.

## CONCLUSION

For the reasons set forth above, this Court should affirm the district court's judgment.

Dated: November 1, 2021

Respectfully submitted,

*/s/ Rupali Sharma*

Rupali Sharma
rsharma@lawyeringproject.org
LAWYERING PROJECT
113 Bonnybriar Rd.
South Portland, ME 04106
(908) 930-6645

Juanluis Rodriguez
prodriguez@lawyeringproject.org
Sneha Shah
sshah@lawyeringproject.org
Stephanie Toti
stoti@lawyeringproject.org
LAWYERING PROJECT
41 Schermerhorn St., No. 1056
Brooklyn, NY 11201
(646) 490-1083

Melissa Shube
mshube@lawyeringproject.org
LAWYERING PROJECT
712 H St. NE, Ste. 1616
Washington, D.C. 20002
(646) 480-8942

Kathrine D. Jack
kjack@jacklawoffice.com
JACK LAW OFFICE LLC
One Courthouse Plaza
P.O. Box 813
Greenfield, IN 46140
(317) 477-2300

Lara Flath
lara.flath@probonolaw.com
Mollie M. Kornreich
mollie.kornreich@probonolaw.com
Michael M. Powell
michael.powell@probonolaw.com
Athanasia Charmani
thania.charmani@probonolaw.com
One Manhattan West
New York, NY 10001
(212) 735-3000

Amy Van Gelder
amy.vangelder@probonolaw.com
155 N. Wacker Dr., Ste. 2700
Chicago, IL 60606
(312) 407-0700

*Attorneys for Plaintiffs-Appellees*

## CERTIFICATE OF COMPLIANCE

1. This document complies with the Court's Order dated September 23, 2021, because—excluding the parts of the document exempted by Federal Rule of Appellate Procedure 32(f)—it contains 17,999 words.

2. This document complies with the typeface requirements of Circuit Rule 32(b) and the type-style requirements of Federal Rule of Appellate Procedure 32(a)(6) because it has been prepared in a proportionally spaced typeface, Century Schoolbook, that is 12 points in the body of the brief and 11 points in the footnotes.

**CERTIFICATE OF SERVICE**

I hereby certify that, on November 1, 2021, the foregoing document was served on all counsel of record via the Court's CM/ECF system.

*/s/ Rupali Sharma*
Rupali Sharma