STATE OF INDIANA) MONROE COUNTY CIRCUIT COURT
) SS:
MONROE COUNTY) CAUSE NO. 53C06-2208-PL-001756

PLANNED PARENTHOOD GREAT NORTHWEST, HAWAI'I, ALASKA, INDIANA, KENTUCKY, INC., and ALL-OPTIONS, INC., on behalf of themselves, their staff, physicians, and patients; and AMY CALDWELL, M.D., on her own behalf and on behalf of her patients,

Plaintiffs,

v.

MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities; and the HENDRICKS COUNTY PROSECUTOR, LAKE COUNTY PROSECUTOR, MARION COUNTY PROSECUTOR, MONROE COUNTY PROSECUTOR, TIPPECANOE COUNTY PROSECUTOR, and the WARRICK COUNTY PROSECUTOR, in their official capacities,

Defendants.

ORDER DENYING MOTION FOR PERMANENT INJUNCTION

This matter comes before the Court on Plaintiffs' Motion for Permanent Injunction to enjoin Defendants from enforcing Senate Bill 1 ("S.B. 1"), as enacted in various sections of the Indiana Code. Plaintiffs appear by counsel Kenneth Falk, Stevie Pactor, and Gavin Rose of the ACLU of Indiana; Lori Martin, Alan Schoenfeld, Allyson Slater, Katherine Mackey, and Mikayla Foster of Wilmer Cutler

Pickering Hale and Dorr LLP; Catherine Peyton Humphreville and Melissa Shube of Planned Parenthood Federation of America; and Rupali Sharma and Allison Zimmer of The Lawyering Project. Defendants appear by Solicitor General James Barta, Deputy Solicitor General Jenna M. Lorence, Deputy Attorney General Katelyn E. Doering, and Gene Schaerr, Christopher Bartolomucci, Brian Field, Edward Trent, Justin Miller, and Miranda Sherrill of Schaerr Jaffe LLP.

PROCEDURAL HISTORY

On August 5, 2022, after a special legislative session, the Indiana General Assembly passed S.B. 1. S.B. 1 criminalizes abortion in Indiana, subject to limited exceptions including in the case of substantial and irreversible physical impairment of a major bodily function or death of the pregnant person (the "Health or Life Exception"). S.B. 1 also prohibits performing abortions at licensed clinics, and requires that abortions be performed at hospitals or ambulatory outpatient surgical centers that are majority-owned by a hospital (the "Hospital Requirement").

On August 31, 2022, Planned Parenthood Great Northwest, Hawai'i, Alaska, Indiana, Kentucky, Inc. ("PPGNHAIK"), Women's Med Group Professional Corporation, Whole Woman's Health Alliance, All-Options, Inc., and Dr. Amy Caldwell filed their initial challenge to S.B. 1. Plaintiffs claimed, among other things, that S.B. 1 violated Article 1, Section 1 of the Indiana Constitution. On September 22, 2022, this Court entered a preliminary injunction enjoining enforcement of the law, finding that Plaintiffs were likely to succeed on their claim that the statute violated Article 1, Section 1.

On June 30, 2023, the Indiana Supreme Court reversed this Court's preliminary injunction. *Members of Med. Licensing Bd. of Ind. v. Planned Parenthood Great Nw., Haw., Alaska, Ind., Ky., Inc.*, 211 N.E.3d 957 (Ind. 2023). The Supreme Court held that Plaintiffs have standing to challenge S.B. 1, both "because they believe it infringes on their patients' constitutional rights, but also because, if enforced, it places them in immediate danger of sustaining their own direct injury from criminal prosecution or regulatory enforcement." *Id.* at 966. The Supreme Court also concluded that Article 1, Section 1 is judicially enforceable, id. at 975, and "protects a woman's right to an abortion that is necessary to protect her life or to protect her from a serious health risk." *Id.* at 985. In so holding, the Supreme Court specifically noted that the rights within Article 1, Section 1 include the right to protect oneself against great bodily harm. *Id.* at 976. The Supreme Court additionally held that outside these circumstances, the General Assembly "otherwise retains broad legislative discretion for determining whether and the extent to which to prohibit abortions." *Id.* at 962. The Supreme Court did not conclude that Article 1, Section 1 confers a right to abortion where rape or incest victims are concerned. Because the law was not unconstitutional in all circumstances, the Court ruled, Plaintiffs' facial challenge to S.B. 1 failed, requiring reversal of the preliminary injunction. *Id.* Still, the Supreme Court stressed that:

> [b]y saying Senate Bill 1 is not unconstitutional in its entirety in all circumstances, we do not say the opposite either—that every single part of the law can be applied consistent with our Constitution in every conceivable set of circumstances. We do not prejudge those questions. So, while Plaintiffs' challenge to the entire statute fails, that does not preclude Plaintiffs with standing from pursuing a facial challenge to a particular part of the statute or an as-applied challenge to the State enforcing the law in a particular set of circumstances.

Id. at 984.

The Supreme Court subsequently denied Plaintiffs' request for rehearing of its decision. 214 N.E.3d 348 (2023) (mem.).

On November 9, 2023, PPGNHAIK, Women's Med Group Professional Corporation, All-Options, Inc., and Dr. Amy Caldwell filed an Amended Complaint for Injunctive and Declaratory Relief (the "Amended Complaint"). Women's Med Group Professional Corporation was subsequently dismissed by agreement of the Parties. Plaintiffs alleged in the Amended Complaint that, as applied to Plaintiffs and their patients who present with serious physical or mental health risks that are not encompassed by the limited Health or Life Exception, the statute violates the constitutional right to abortion guaranteed by Article 1, Section 1, as found by the Indiana Supreme Court. Plaintiffs further alleged that the Hospital Requirement, which prohibits abortions from occurring in the Indiana clinics where 98% of procedural abortions formerly occurred or where medications for abortion were dispensed, had created an insurmountable and medically unjustifiable barrier to abortion access for Hoosiers otherwise able to obtain abortions within the limited Health or Life Exception to S.B. 1, thus violating Article 1, Section 1.

Plaintiffs originally sought a preliminary injunction. However, on November 20, 2023, the Parties filed a Joint Motion to Consolidate the Trial with the Hearing on the Pending Preliminary Injunction, which the Court granted. As such, the Parties and the Court now treat Plaintiffs' request for a preliminary injunction as a request for a permanent injunction. On December 8, 2023, the Court granted the Parties' Stipulation providing "that any evidence received by the Court in the form of declarations, depositions, or other verified statements shall be admissible at the consolidated trial, subject to any objections to which in-person testimony is subject." (Order Granting Stipulation of the Parties Dec. 8, 2023).

The trial occurred from May 29 through May 31, 2024. In advance of trial, the Parties stipulated the admission of certain exhibits into the trial record. These include (1) all expert declarations and expert deposition transcripts, (2) all deposition transcripts of fact (i.e., non-expert) witnesses who did not testify at trial, (3) any deposition transcript of a party, and (4) any exhibit attached to any of the Parties' four legal briefs on the merits. Trial Tr. I at 4:23-6:3. The Court admitted certain additional exhibits at trial. The Parties also presented live testimony from seven witnesses: Dr. Amy Caldwell, Dr. Steven Ralston, Parker Dockray, Dr. Leena Mittal, Dr. Elaine Cox, Dr. Aaron Kheriaty, and Dr. Monique Wubbenhorst.

With the benefit of a trial on the merits, extensive briefing, and additional time to consider the requested injunctive relief, and having considered the record of evidence, the text of the relevant provisions of the Indiana Constitution, the relevant case law, and the arguments and submissions of counsel for all Parties, the Court concludes that the evidentiary record does not support Plaintiffs' request for permanent injunction.

In support of this determination, the Court FINDS and CONCLUDES as follows:

FINDINGS OF FACT

I. PLAINTIFFS AND DEFENDANTS

1. Plaintiff PPGNHAIK is a not-for-profit corporation incorporated in Washington that operates eleven health centers throughout Indiana. Pls.' Ex. 1 (Gibron 8/29/2022 Decl.) ¶¶ 3, 7; Pls.' Ex.25 (Dudash Dep.) at 38:6; (Joint Statement of Undisputed Facts, Disputed Factual Issues, and Legal Issues to Be Decided May 24, 2024 ("Joint Statement") ¶ 1).

2. Before S.B. 1 went into effect, PPGNHAIK was "the largest provider of reproductive health services in Indiana." Pls.' Ex. 1 (Gibron 8/29/2022 Decl.) ¶ 7.

3. The Indiana Department of Health voided PPGNHAIK's abortion clinic licenses due to the Hospital Requirement, but PPGNHAIK's clinics in Indiana continue to provide non-abortion reproductive health services. Pls.' Ex. 1 (Gibron

8/29/2022 Decl.) ¶¶ 7, 9; Pls.' Ex. 25 (Dudash Dep.) at 39:10-12; (Joint Statement ¶ 1).

4. Plaintiffs contend that S.B. 1 seriously harms "PPGNHAIK's patients by depriving them of access to safe and legal abortions," and it leaves "many pregnant Hoosiers ... hundreds of miles from [an] abortion provider." Pls.' Ex. 1 (Gibron 8/29/2022 Decl.) ¶ 14; see Trial Tr. I at 51:25-52:8 (Caldwell)(discussing Indiana's "obstetric care deserts" and stating that patients now have to come from "all over the state" to Indianapolis to receive abortion care in a hospital setting).

5. "Most of PPGNHAIK's abortion patients are poor or have low incomes." Pls.' Ex. 1 (Gibron 8/29/2022 Decl.) ¶ 16.

6. PPGNHAIK would offer abortions at its clinics in Indiana if permitted by law. Pls.' Ex. 1 (Gibron 8/29/2022 Decl.) ¶ 19; Pls.' Ex. 25 (Dudash Dep.) at 30:21-31:7, 123:13-124:8, 151:23-152:6; Joint Statement ¶ 47.

7. Until August 1, 2023, PPGNHAIK offered medication abortion through 10 weeks from last menstrual period (LMP) at its Lafayette health center, and both medication abortion up to 10 weeks LMP and procedural abortion (also known as surgical abortion) up to 13 weeks and 6 days LMP at its Bloomington, Merrillville, and Georgetown Road health centers. Pls.' Ex.1 (Gibron 8/29/2022 Decl.) ¶ 9; (Joint Statement ¶ 1).

8. PPGNHAIK brings this action on behalf of itself, its staff, its physicians, and its patients.

9. Plaintiffs submitted testimony of PPGNHAIK's 30(b)(6) witness, Sharon Dudash. *See* Pls.' Ex.25 (Dudash Dep.).

10. Plaintiffs submitted testimony from PPGNHAIK's Chief Executive Officer, Rebecca Gibron. *See* Pls.' Ex.1 (Gibron 8/29/2022 Decl.).

11. Dr. Amy Caldwell is an obstetrician/gynecologist ("OB/GYN") physician licensed to practice medicine in Indiana and Illinois. Pls.' Ex.4 (Caldwell 11/1/23 Decl.) ¶ 1; Trial Tr. I at 11:6 (Caldwell); (Joint Statement ¶ 4).

12. Dr. Caldwell is currently an assistant clinical professor at Indiana University ("IU") School of Medicine, where she is also a practicing OB/GYN. Trial Tr. I at 8:7-9 (Caldwell); Pls.' Ex.4 (Caldwell 11/1/23 Decl.) ¶¶ 1, 6; (Joint Statement ¶ 4).

13. Before S.B. 1 took effect, Dr. Caldwell performed abortions up to 13 weeks and 6 days LMP at PPGNHAIK's clinics in Indiana. Trial Tr. I at 15:1-12 (Caldwell). She no longer provides abortion care at PPGNHAIK's clinics in Indiana because of the Hospital Requirement but would if allowed to do so. Trial Tr. I at 14:20-25, 16:11-14 (Caldwell); Pls.' Ex.4 (Caldwell 11/1/23 Decl.) ¶¶ 1, 8.

14. Dr. Caldwell has performed some abortions in Indiana since S.B. 1 took effect but, due to fear of prosecution under S.B. 1, has been unable to perform abortions for other patients even when she believed, in her reasonable medical judgment, that those abortions were medically necessary. *See* Trial Tr. I at 40:11-16, 44:14-15, 51:1-4; Pls.' Ex. 12 (Caldwell 2/15/24 Decl.) ¶ 7; Pls.' Ex. 23 (Caldwell Dep.) at 12:5-9, 112:4-12, 189:5-9; (Joint Statement ¶ 5).

15. When Dr. Caldwell has provided abortions pursuant to the Health or Life Exception, at least one other physician employed by the hospital where she performed the abortion has agreed the abortion was permitted under S.B. 1. Pls.' Ex. 12 (Caldwell 2/15/24 Decl.) ¶ 34; Pls.' Ex. 23 (Caldwell Dep.) at 113:17-114:12; (*see* Joint Statement ¶ 6).

16. Dr. Caldwell brings this action on her own behalf and on behalf of her patients.

17. Plaintiffs submitted the testimony of Dr. Amy Caldwell. *See* Trial Tr. I at 5:10-12, 6:25; Pls.' Ex.4 (Caldwell 11/1/23 Decl.); Pls.' Ex.12 (Caldwell 2/15/24 Decl.); Pls.' Ex.23 (Caldwell Dep.).

18. All-Options, Inc. is a not-for-profit corporation incorporated in Oregon that operates a Pregnancy Resource Center in Bloomington. Trial Tr. I at 162:6-8 (Dockray); Pls.' Ex. 7 (Dockray 11/8/23 Decl.) ¶ 1; (Joint Statement ¶ 2).

19. All-Options' Pregnancy Resource Center's Hoosier Abortion Fund provides financial assistance to Indiana residents who need help paying for abortions. Trial Tr. I at 162:10-13 (Dockray); Pls.' Ex. 7 (Dockray 11/8/23 Decl.) ¶¶ 1, 5, 16; (Joint Statement ¶ 2). All-Options provides funding to contribute to the cost of patients' abortions, whether performed in Indiana hospitals or out of state. Pls.' Ex. 7 (Dockray 11/8/23 Decl.) ¶ 16; Pls.' Ex. 19 (Dockray Dep.) at 23:25-24:10, 27:24-28:2, 52:11-18, 133:15-17; (Joint Statement ¶ 3).

20. The Hoosier Abortion Fund receives about one hundred calls per month and maintains records on the number of callers and other information related to the fund's operations. Trial Tr. I at 166:20-167:10 (Dockray).

21. Approximately 5-10% of the callers to the Hoosier Abortion Fund seek an abortion because of a medical condition. Trial Tr. I at 189:14-17 (Dockray). The clinical severity of any health conditions/concerns of these patients is not clear from the record. There is no requirement that a women suffer from any health impairment to access support from the Hoosier Abortion Fund and All-Options has no requirement that women provide the reason they are seeking an abortion; All-Options does not request or require documentation of medical issues from patients before providing Hoosier Abortion Fund support. Trial Tr. I at 188:12-25; 189:1-17 (Dockray).

22. Plaintiffs allege that S.B. 1 has severely hindered All-Options' ability to carry out its mission of providing unconditional, judgment-free support for people navigating pregnancy, parenting, abortion, and adoption and forced the Hoosier Abortion Fund to expend significantly more per client to help Indiana patients obtain care. Pls.' Ex. 7 (Dockray 11/8/23 Decl.) ¶ 15.

23. Since S.B. 1 went into effect, one person who has received financial assistance from the Hoosier Abortion Fund was able to obtain an abortion in Indiana. Trial Tr. I at 180:14-18 (Dockray). All other patients who have received financial assistance from the Hoosier Abortion Fund have traveled out of state to access abortion care. Trial Tr. I at 180:21-180:25 (Dockray). This has nearly doubled All Options' per-person pledge amount (i.e., the amount of funding All Options pledges to each

individual seeking an abortion) and increased the amount of time All-Options' employees spend assisting patients seeking abortions. Trial Tr. I at 183:2-8 (Dockray).

24. All-Options does not have enough funding to provide grants to support every patient who contacts the organization seeking financial support from the Hoosier Abortion Fund. Trial Tr. I at 170:22-171:12 (Dockray). All-Options prioritizes grants for patients over nine-weeks' gestation because those patients tend to have greater difficulty finding a clinic to obtain an abortion. Trial Tr. I at 173:1-2 (Dockray). All-Options received significant additional funding for the Hoosier Abortion Fund following the leak of the *Dobbs* decision and—to a lesser degree—with the passage of S.B. 1. Trial Tr. I at 172:13-24 (Dockray).

25. Before S.B. 1 took effect, All-Options' average pledge was $225 per person, and now it is approximately $450 per person. Trial Tr. I at 183:18-20 (Dockray); Joint Statement ¶ 48. Although the cost of individual pledges has increased, the number of women All-Options has had to turn away has decreased slightly because of fundraising increases post-*Dobbs*. 191:1-18 (Dockray).

26. Hoosiers who rely on the Hoosier Abortion Fund are often low-income, unemployed, and/or uninsured. They often do not have reliable transportation or childcare and face additional financial barriers. Trial Tr. I at 169:7-20 (Dockray).

27. All-Options brings this action on behalf of itself, its staff, and its clients.

28. Plaintiffs submitted testimony of All-Options through Jennifer Parker Dockray, its executive director. Trial Tr. I at 161:20-21 (Dockray); Pls.' Ex. 7 (Dockray 11/8/23 Decl.); Pls.' Ex. 19 (Dockray Dep.).

29. Defendants Members of the Medical Licensing Board of Indiana serve on Indiana's Medical Licensing Board, a state agency responsible for licensing and disciplining certain medical practitioners, including physicians. Ind. Code §§ 25-0.5-3-7, 25-0.5-8-11, 25-0.5-10-17, 25-0.5-11-5, 25-22.5-2-1, 25-22.5-8-6; (*see* Joint Statement ¶ 7).

30. In their official capacities, Members of the Medical Licensing Board of Indiana have the authority to regulate the practice of medicine in Indiana pursuant to Indiana Code § 25-22.5-2-7. This includes the revocation of the medical licenses of physicians who perform abortions in violation of S.B. 1.

31. Defendants County Prosecutors from Hendricks, Lake, Marion, Monroe, Tippecanoe, and Warrick Counties ("Prosecutor Defendants") have the power to enforce S.B. 1's criminal penalties, which include one to six years' imprisonment, as well as fines of up to $10,000 and revocation of physicians' medical licenses. Ind. Code §§ 16-34-2-7; 25-22.5-8-6(b)(2); 35-50-2-6(b).

32. Prosecutor Defendants all have a statutory duty to prosecute felonies and misdemeanors within their respective jurisdictions, including the prosecution of medical providers who perform abortions that Prosecutor Defendants conclude are not permitted under S.B. 1.

II. PLAINTIFFS' CHALLENGE

33. After S.B. 1 was enacted, Plaintiffs challenged the law. Compl. (Aug. 31, 2022). They raised three claims: (1) S.B. 1 violated Article 1, Section 1, because it

violated a substantive due process right to privacy by limiting abortion access; (2) S.B. 1 violated Article 1, Section 23 of the Indiana Constitution because it discriminated against abortion clinics in favor of hospitals; and (3) the gestational age limit in the Health or Life exception was unconstitutionally vague in violation of Article 1, Section 12. *Id.* ¶¶ 58–66.

34. This court granted Plaintiffs a preliminary injunction for their first claim—that S.B. 1 violated Article 1, Section 1 of the Indiana Constitution, because its "restriction of personal autonomy offends the liberty guarantees of the Indiana Constitution." (Order Sept. 22, 2022). It denied Plaintiffs' motion on the second claim and noted that Plaintiffs had withdrawn their third claim. *Id.* at 13.

35. The Indiana Supreme Court granted transfer. (Order Oct. 12, 2022). In June 2023, it held that S.B. 1 did not facially violate a right to abortion protected by Article 1, Section 1. *Planned Parenthood*, 211 N.E.3d at 985.

36. The Supreme Court concluded that Article 1, Section 1 protects certain judicially enforceable rights. *Planned Parenthood,* 211 N.E.3d at 968. To determine what it protects, courts must describe a putative right with an "appropriate level of particularity" and determine "whether the founding generation would have considered the right fundamental. *Id.* at 969. Courts "cannot supplant what the framers and ratifiers believed they were agreeing to with [their] own notions of which aspects of liberty ought to be off limits." *Id.* at 977.

37. Examining "Indiana's long history of generally prohibiting abortion as a criminal act," the Supreme Court held that it was the "common understanding among

Article 1, Section 1's framers and ratifiers" that the General Assembly was "left . . . with legislative discretion to regulate or limit abortion." *Planned Parenthood*, 211 N.E.3d at 978; *see id.* at 981. It explained that "the State's broad authority to protect the public's health, welfare, and safety extends to protecting prenatal life." *Id.* at 961.

38. The Supreme Court also stated that Indiana law generally permits persons to protect their "own life . . . against imminent death" and "against 'great bodily harm.'" *Planned Parenthood*, 211 N.E.3d at 976. Additionally, the Court held that "Senate Bill 1 is not facially invalid as interfering with a woman's access to care that is necessary to protect her life or health." *Id.* at 977. Any claim that the law infringes a right to abortion "necessary to protect [a woman's] life or to protect her from a serious health risk" in a "particular set of circumstances," the Supreme Court explained, must be resolved in "an as-applied challenge." *Id.* at 976.

39. In vacating the preliminary injunction, the Supreme Court did not reach the "claim that Senate Bill 1's hospital requirements for performing abortions" violate "Article 1, Section 23's Equal Privileges and Immunities Clause." *Planned Parenthood*, 211 N.E.3d at 984. It also did not preclude "Plaintiffs with standing" from pursuing "an as-applied challenge to the State enforcing the law in a particular set of circumstances." *Id.* It remanded for further proceedings consistent with its opinion. *Id.* at 985.

40. Plaintiffs filed an amended complaint on November 9, 2023.[1] This complaint alleges that S.B. 1 violates Article 1, Section 1 of the Indiana Constitution in two ways. First, the amended complaint alleges that S.B. 1 "unnecessarily restricts access to abortion care" because women may want abortions for health reasons "that may not meet the limited exception for serious health risks set out in S.B. 1." (Amend. Compl. ¶¶ 40–41). Second, Plaintiffs allege that the Hospital Requirement increases the cost of abortion and may reduce access to abortion. *Id.* at ¶ 48.

41. Plaintiffs do not allege that any specific patient is or was unable to obtain an abortion under S.B. 1 that was necessary to avert a serious health risk as defined in S.B. 1. However, Plaintiffs present evidence regarding various classes of conditions that they contend constitute serious health risks necessitating abortions that fall outside S.B. 1's exceptions.

42. Plaintiffs moved for a preliminary injunction. *Id.* at 23. This Court consolidated consideration of that motion with a trial on the merits. (*See* Order Dec. 8, 2023); Ind. Tr. R. 65(A)(2). Discovery, briefing, and a three-day bench trial followed.

III. PREGNANCY & MEDICAL TREATMENT

43. Although pregnancy significantly impacts a child's mother, pregnancy is "not a disease." Pls.' Ex. 8 (Wubbenhorst Decl. ¶ 194). It is "a developmental stage

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[1] Since the amended complaint was filed, Whole Woman's Health Alliance and Women's Med Group Professional Corporation were voluntarily dismissed as Plaintiffs. *See* Joint Stipulation of Dismissal of Plaintiff Whole Woman's Health Alliance (June 5, 2023); Order (June 6, 2023); Plaintiffs' Motion to Dismiss Women's Med Group Professional Corporation (Feb. 2, 2024); Order (Feb. 5, 2024).

in the continuum of human life." *Id.* Pregnant women's bodies undergo changes, such as a "faster heartbeat," "changes in lung volume," and changes in "blood volume." *Id.* ¶ 100. These changes "are part of pregnancy" and do not require corrective interventions; rather, they "are largely adaptive," designed to ensure a healthy pregnancy and delivery and "are not pathologic in healthy women." *Id.* ¶¶ 98, 100.

44. "[G]enerally speaking," pregnancy "is safe." But it is not as safe as not being pregnant. Tr. Vol. 1, 17:10–12 (Caldwell). Unfortunately, pregnant women can face a variety of health conditions and complications, many of which are directly related to—or significantly exacerbated by—their pregnancy. Tr. Vol. 1, 17:14–20 (Caldwell).

45. Women can suffer from "health conditions that cause extended and debilitating symptoms during the course of a pregnancy; health conditions that may worsen over the course of the pregnancy to eventually become life-threatening; health conditions that may significantly increase the patient's health risks if they remain pregnant or that may significantly increase the patient's future health risk, even after giving birth; and health conditions requiring treatment that would endanger the fetus, meaning that continuing the pregnancy could require forgoing needed treatment." (Am. Compl. ¶ 41); *see* Trial Tr. I at 17:20, 33:5 (Caldwell); Trial Tr. I at 84:15-33, 117:1-23, 119:1-11 (Ralston).

46. The complexity of women's perinatal healthcare cannot be overstated. The range of symptoms, health risks, and treatments for a given disease can vary significantly from patient to patient.

47. Hyperemesis gravidarum is a severe form of nausea and vomiting brought on by pregnancy. Trial Tr. I at 24:12-17 (Caldwell); Trial Tr. I at 117:1-17 (Ralston); Pls.' Ex. 6 (Ralston 11/3/23 Decl.) ¶ 20; Pls.' Ex.23 (Caldwell Dep.) at 84:6-85:1; Pls.' Ex. 8(Wubbenhorst 1/15/24 Decl.) ¶ 163; (Joint Statement ¶¶ 13, 20). The most commonly cited diagnostic criteria for the disease are persistent vomiting not related to other causes, a measure of acute starvation (usually large ketonuria), and some discrete measure of weight loss, most often at least 5% of pre-pregnancy weight. Defs.' Ex. 66 (ACOG Practice Bulletin No. 189) at 1.

48. Hyperemesis gravidarum is the most common indication for admission to the hospital during the first part of pregnancy and is second only to preterm labor as the most common reason for hospitalization during pregnancy. *Id.* at 2.

49. Hyperemesis gravidarum is typically confined to the first trimester but it can occasionally extend into the second trimester, and rarely into the third trimester. Pls.' Ex.22 (Ralston Dep.) at 82:1-3.

50. Hyperemesis gravidarum presents with different degrees of severity in different pregnant patients, and, although rare, it can become life-threatening. Trial Tr. I at 24:18-22 (Caldwell); (Joint Statement ¶¶ 15, 21). Some patients are unable to eat or drink for weeks, if not months, on end, severely limiting their nutritional intake. Trial Tr. I at 24:16-17 (Caldwell); Trial Tr. I at 118:5-7 (Ralston). Severe hyperemesis can cause significant electrolyte abnormalities, cardiac arrhythmias and heart attack, kidney failure, liver damage, and even death. Trial Tr. I at

24:18-22 (Caldwell); Pls.' Ex. 23 (Caldwell Dep.) at 84:6-85:1, 87:21-88:5; (Joint Statement ¶ 21).

51. Patients with hyperemesis gravidarum are at high risk of early delivery and are at risk of infections and blood clots. Trial Tr. I at 118:10-13 (Ralston).

52. The impact of hyperemesis gravidarum on women can be devastating not only physically but also socially and emotionally. Trial Tr. I at 25:15-23 (Caldwell). Although not typically life-threatening, patients with hyperemesis gravidarum may need to be admitted to hospitals for multiple days or weeks. *Id.* (Caldwell). (Joint Statement ¶ 21).

53. Treatments for hyperemesis gravidarum symptoms can vary significantly and can include nonpharmacologic options, pharmacotherapy, hospitalization, tube-feeding, and/or catheterization. Defs.' Ex. 66 (ACOG Practice Bulletin) at 11.

54. Given the significant range of clinical possibilities, it is possible that different patients suffering from hyperemesis gravidarum could qualify for a legal abortion under S.B. 1, a constitutionally protected abortion under the Supreme Court's ruling in *Planned Parenthood*, both, or neither.

55. Deep vein thrombosis is a condition in which potentially dangerous blood clots form in a patient's veins. Pls.' Ex. 22 (Ralston Dep.) at 83:21-84:22. The condition can have different levels of severity, including pulmonary failure and death from thromboembolism. Pls.' Ex. 22 (Ralston Dep.) at 83:21-84:22; Pls. Ex. 17 (Wubbenhorst Dep.) at 249:17-18; (Joint Statement ¶ 26).

56. Pregnancy is a risk factor for deep vein thrombosis. Pls.' Ex. 22 (Ralston Dep.) at 84:1-14; Pls. Ex. 8 (Wubbenhorst Decl.) ¶¶ 165-66; Pls.' Ex. 17 (Wubbenhorst Dep.) at 249:6-8. As Dr. Ralston testified in his deposition, "[i]f you are predisposed to having deep vein thrombosis, being pregnant is going to put you at higher risk." Pls.' Ex.22 (Ralston Dep.) at 84:4-6; see Pls.' Ex.6 (Ralston 11/3/23 Decl.) ¶ 19.

57. Doctors regularly expectantly manage a pregnant patient's deep vein thrombosis through anticoagulation medication (i.e., blood thinners). Pls.' Ex. 22 (Ralston Dep.) at 85:3-6. Most patients with deep vein thrombosis have mild disease that can be managed but a small subset of women suffer from severe embolic disease during pregnancy or in the postpartum period. *Id.* at 88:14-25.

58. Neither induced abortion nor termination of pregnancy are mentioned as a management strategy for deep vein thrombosis in the American College of Obstetricians and Gynecologist's Practice Bulletin on Thromboembolism in Pregnancy. Pls. Ex. 8 (Wubbenhorst 1/15/24 Decl.) ¶¶ 166.

59. Thromboembolic disease is potentially life threatening and accounts for 9% of pregnancy-related deaths. Pls.' Ex.70 (CDC Newsroom Article) at 1.

60. Given the significant range of clinical possibilities, it is possible that different patients suffering from thromboembolic disease could qualify for a legal abortion under S.B. 1, a constitutionally protected abortion under the Supreme Court's ruling in *Planned Parenthood*, both, or neither.

61. Preeclampsia is a disorder of pregnancy associated with new-onset hypertension, which occurs most often after twenty weeks gestation and frequently near term. Defs. Ex. 69 (ACOG Practice Bulletin Number 222) at 1.

62. Preeclampsia presents with different degrees of severity in different women. If untreated, preeclampsia can develop into its more serious form, Hemolysis, Elevated Liver Enzymes and Low Platelets ("HELLP") syndrome and can cause organ damage, stroke, seizures, and death. Trial Tr. I at 30:3-6 (Caldwell); Pls.' Ex. 6 (Ralston 11/3/23 Decl.) ¶ 13; see also Defs. Ex. 69; (Joint Statement ¶¶ 15, 24).

63. Preemclapsia is a progressive disease, and it can be difficult for physicians to predict when the risks presented by preeclampsia may become an emergency. Trial Tr. I at 31:4-11 (Caldwell); Trial Tr. I at 114:14-115:1 (Ralston); see Trial Tr. III at 47:21-23 (Wubbenhorst). Thus, it is consistent with best practices to manage preeclampsia as soon as it is detected, regardless of its severity at the time. Pls.' Ex. 6 (Ralston 11/3/23 Decl.) ¶ 13. Optimal management strategies for preeclampsia can be different depending on clinical maternal and fetal evaluation and gestational age. Defs.' Ex. 69 (ACOG Practice Bulletin Number 222) at 7.

64. Before 37 weeks LMP, doctors may try to manage preeclampsia symptoms by, for example, managing a pregnant person's blood pressure and monitoring for signs and symptoms of worsening disease. Trial Tr. I at 115:2-10 (Ralston); Pls.' Ex. 6 (Ralston 11/3/23 Decl.) ¶ 13; Pls.' Ex. 11 (Ralston 2/15/24 Decl.) ¶ 21; Pls.' Ex. 22 (Ralston Dep.) at 57:16-58:2; Pls.' Ex. 23 (Caldwell Dep.) at 94:13-95:9; DX-1 (Wubbenhorst 1/15/24 Decl.) ¶¶ 139-140, 142-143.

65. Because preeclampsia is a progressive disease, the longer a patient remains pregnant, the worse the preeclampsia will get. Trial Tr. I at 30:7-12 (Caldwell); Trial Tr. I at 114:7-13 (Ralston). As such, expectant management of preeclampsia is not always the safest option. Trial Tr. I at 115:9-21 (Ralston); Pls.' Ex. 11 (Ralston 2/15/24 Decl.) ¶ 21; Pls.' Ex. 22 (Ralston Dep.) at 58:13-22; Pls.' Ex. 8 (Wubbenhorst 1/15/24 Decl.) ¶ 140.

66. When preeclampsia occurs prior to viability, expectant management may not be recommended as a treatment option because it can pose a higher risk to the patient's health and the fetus may be unlikely to survive. Trial Tr. I at 115:9-116:8 (Ralston); Pls.' Ex. 22 (Ralston Dep.) at 58:13-59:4; (Wubbenhorst 1/15/24 Decl.) ¶¶ 139-140, 142-143.

67. Because expectant management is intended to provide neonatal benefit at the expense of maternal risk, expectant management is not advised when neonatal survival is not anticipated. Defs.' Ex. 69 (ACOG Practice Bulletin) at 7.

68. The decision whether to manage a preeclamptic patient expectantly versus moving toward delivery is nuanced. Pls.' Ex. 8 (Wubbenhorst 1/15/24 Decl.) ¶146.

69. Given the significant range of clinical possibilities, it is possible that different patients suffering from preeclampsia could qualify for a legal abortion under S.B. 1, a constitutionally protected abortion under the Supreme Court's ruling in *Planned Parenthood*, both, or neither.

70. Preterm premature rupture of the membranes ("PPROM") occurs when the sac (or amniotic membrane) surrounding the fetus ruptures before the pregnancy is full-term. Pls.' Ex. 6 (Ralston 11/3/23 Decl.) ¶ 16; (Joint Statement ¶ 27); *see also* Defs.' Ex. 68 (ACOG Practice Bulletin). It is a serious condition that places the pregnant woman at increased risk of infection, including "clinically evident intraamniotic infection," which occurs in 15-35% of cases. Pls.' Ex. 6 (Ralston 11/3/23 Decl.) ¶ 16; Pls.' Ex. 11 (Ralston 2/15/24 Decl.) ¶ 23; *see also* Defs.' Ex. 68. If the infection progresses to sepsis (infection in the bloodstream), the risk of severe morbidity (loss of fingers, toes, limbs, or neurologic injury), need for hysterectomy, or mortality becomes quite high. Pls.' Ex. 6 (Ralston 11/3/23 Decl.) ¶ 16.

71. PPROM occurs in approximately 2% to 3% of pregnancies in the United States. Pls.' Ex. 6 (Ralston 11/3/23 Decl.) ¶ 16; *see also* Defs.' Ex. 68 (ACOG Practice Bulletin).

72. Management decisions for PPROM depend on gestational age and evaluation of the relative risks of delivery versus the risks of expectant management when pregnancy is allowed to progress to a later gestational age. Pls.' Ex. 11 (Ralston 2/15/24 Decl.) ¶ 23; *see also* Defs.' Ex. 68. While expectant management is one option for patients with PPROM, it has significant maternal risks. Pls.' Ex.11 (Ralston 2/15/24 Decl.) ¶ 23; *see also* DX-68.

73. The risks of PPROM are especially difficult to manage in the mid-trimester—especially before 24 weeks LMP—because the prognosis for the fetus if the pregnancy continues is usually poor, and, even in the best of circumstances,

uncertain. Trial Tr. I at 48:18-22 (Caldwell); Trial Tr. I at 107:19-108:18, 145:2-10 (Ralston); Pls.' Ex. 6 (Ralston 11/3/23 Decl.) ¶ 16.

74. Delaying treatment when a patient has mid-trimester PPROM can have grave consequences, including maternal sepsis and death. Pls.' Ex. 6 (Ralston 11/3/23 Decl.) ¶ 17.

75. IU Health and Eskenazi hospital systems have provided guidance to their physicians that performing abortion care in certain instances of PPROM fits within the Health or Life Exception and abortions have been provided under these circumstances. Dr. Caldwell has treated patients with PPROM that were transferred from other hospitals that were unable or unwilling to provide abortion care. Pls.' Ex. 4 (Caldwell 11/1/23 Decl.) ¶ 31; Pls.' Ex. 12 (Caldwell 2/15/24 Decl.) ¶ 38.

76. Given the significant range of clinical possibilities, it is possible that different patients suffering from PPROM could qualify for a legal abortion under S.B. 1, a constitutionally protected abortion under the Supreme Court's ruling in *Planned Parenthood*, both, or neither.

77. Plaintiffs present additional evidence regarding a range of other illnesses that they contend implicate constitutionally protected abortions that are prevented by S.B.1. These included but were not limited to diabetes (gestational and preexisting), kidney disease, cancer, cardiovascular disease, molar pregnancy, autoimmune disorders, and obstructive sleep apnea.

78. Sometimes ending a pregnancy is necessary to protect a woman from a serious health risk or from a threat to her life. Tr. Vol. 1, 17:23–18:9 (Caldwell); Tr.

Vol. 3, 17:19–18:10 (Wubbenhorst). There are, however, "very, very few" conditions for which pregnancy is "contraindicated." Caldwell Dep. 69:1–3; Tr. Vol. 1, 23:15–16 (Caldwell). And even for those conditions, both sides' experts agree that abortion is not the only way to manage the condition or even to terminate the pregnancy; early delivery is another option. Pls.' Ex. 23 (Caldwell Dep.) 84:6–24, 86:12–14 (hyperemesis gravidarum); *id.* at 94:24–95:9 (preeclampsia); *id.* at 96:6–11 (peripartum cardiomyopathy); *see also* Tr. Vol. 3, 22:22–23:7 (Wubbenhorst) (describing the American College of Obstetricians and Gynecologists suggested treatments for hyperemesis gravidarum that do not include abortion); Pls.' Ex. 8 (Wubbenhorst Decl.) ¶¶ 137–146 (preeclampsia).

79. In addition to physical health conditions, pregnant patients may face a variety of mental health conditions. Tr. Vol. 2, 11:9–12 (Mittal). These include mood disorders, anxiety disorders, trauma related disorders, substance use disorders, or psychotic disorders. *Id.*

80. Biological, psychosocial, and genetic factors can all affect mental health during pregnancy. *Id.* at 17:2–8 (Mittal); 121:5–7 (Kheriaty).

81. Suicidal ideation "is a symptom that can occur as part of many psychiatric conditions." *Id.* at 13:6–9 (Mittal).

82. Pregnancy is a complex and dynamic time that can impact mental health in a variety of ways, both biologically and psychosocially. Trial Tr. II at 17:1-8 (Mittal).

83. These biological and psychosocial factors can cause new mental health conditions to emerge in pregnant patients, can cause recurrences or exacerbations of previously experienced or current mental health conditions, and can force pregnant patients who take teratogenic medications to manage mental health conditions to face the decision to stop or adjust that medication or to change medications. Trial Tr. II at 17:14-18:4 (Mittal); see also Pls.' Ex.13 (Mittal 2/15/24 Decl.) ¶¶ 11, 15.

84. Pregnant patients may experience a range of severe and debilitating mental health conditions, including anxiety, depressive, and psychotic disorders. See Trial Tr. II at 11:16-18, 13:5-13 (Mittal). The specific symptoms and consequences of these conditions vary by both condition and between specific patients with similar diagnoses. See Trial Tr. II at 18:21-23, 29:1-3 (Mittal).

85. Pregnant patients experiencing severe anxiety disorders may be unable to work or care for themselves or their families and may require in-patient hospitalization. Trial Tr. II at 20:3-7 (Mittal).

86. Pregnant patients experiencing post-traumatic stress disorder ("PTSD") may suffer from nightmares, states of fear, and flashbacks, causing these patients to withdraw from daily life and relationships and possibly engage in self-harm. Trial Tr. II at 20:9-14 (Mittal).

87. Pregnant patients experiencing severe depressive disorder may be unable to function—for example, by being unable to eat or to care for themselves—and can suffer from escalating suicidal ideation, which increases the risk for self-harm and may require hospitalization. Trial Tr. II at 19:18-20:1 (Mittal).

88. Pregnant patients experiencing severe bipolar disorder can experience an exacerbation in the manic pole, causing the patient to become extremely agitated with excess energy, to feel decreased need for sleep, and to engage in very risky behavior that can evolve into psychosis and require psychiatric hospitalization. Trial Tr. II at 19:4-9 (Mittal). Pregnant patients with severe bipolar disorder may also experience an exacerbation of the depressive pole, the risks of which are similar to those for patients experiencing severe depressive disorder. Trial Tr. II at 19:18-20:1 (Mittal).

89. Pregnant patients experiencing severe schizophrenia can experience psychosis characterized by delusions, paranoia, and auditory hallucinations, which can tell the patient to do highly risky things, leading to psychiatric hospitalization and/or increased medication for the patient's safety. Trial Tr. II at 19:11-16 (Mittal).

90. If the aforementioned mental health conditions go untreated, they can significantly worsen throughout pregnancy, and can require psychiatric hospitalization. Trial Tr. II at 21:1-3 (Mittal).

91. Suicidal ideation, which can present alongside any of the aforementioned mental health conditions, can present as thoughts of ending one's life, developing active, specific plans to end one's life, and gathering means to end one's life. Trial Tr. II at 20:16-21 (Mittal).

92. Mental health conditions can also emerge or worsen during the postpartum period, which is a period complicated by many physiologic and biological changes, including abrupt hormonal changes, sleep disturbance, pain, recovery from delivery,