No. 15-274

IN THE
Supreme Court of the United States

WHOLE WOMAN'S HEALTH; AUSTIN WOMEN'S HEALTH CENTER; KILLEEN WOMEN'S HEALTH CENTER; NOVA HEALTH SYSTEMS D/B/A REPRODUCTIVE SERVICES; SHERWOOD C. LYNN, JR., M.D.; PAMELA J. RICHTER, D.O.; AND LENDOL L. DAVIS, M.D., on behalf of themselves and their patients,

Petitioners,

v.

KIRK COLE, M.D., Commissioner of the Texas Department of State Health Services; MARI ROBINSON, Executive Director of the Texas Medical Board, in their official capacities,

Respondents.

AMICI CURIAE BRIEF OF PUBLIC HEALTH DEANS, DEPARTMENT CHAIRS, AND FACULTY AND THE AMERICAN PUBLIC HEALTH ASSOCIATION IN SUPPORT OF PETITIONERS

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STATEMENT OF INTEREST OF *AMICI CURIAE*

Amici curiae Public Health Deans, Chairs, and Faculty and the American Public Health Association ("APHA") submit this brief in support of Petitioners Whole Woman's Health, Austin Women's Health Center, Killeen Women's Health Center, Nova Health Systems D/B/A Reproductive Services, Sherwood C. Lynn, Jr., M.D., Pamela J. Richter, D.O., and Lendol L. Davis, M.D. ("Petitioners").[1]

Amici curiae are deans, departmental chairs, and faculty members with expertise in public health and public health law from some of the leading schools of public health, nursing, law, business, public service, public policy, and medicine in the United States as listed in Appendix A. *Amici curiae* are engaged in the policy and science of protecting and improving the health of communities through education, promotion of healthy lifestyles, and research to reduce disease and prevent injury. *Amici* believe that the public's health will be adversely

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[1] The parties have consented to our intent to file an *amicus curiae* brief. Pursuant to Rule 37.6, undersigned counsel certify that: (1) no counsel for a party authored this brief in whole or in part; (2) no party or party's counsel contributed money that was intended to fund the preparation or submission of this brief; and (3) no person or entity—other than *amici curiae*, APHA members, and undersigned counsel—contributed money intended to fund the preparation or submission of this brief. *Amici* appear in their individual capacities; institutional affiliations are listed here for identification purposes only.

affected if the decision of the United States Court of Appeals for the Fifth Circuit is affirmed.

Amici curiae also includes APHA, an organization whose mission is to champion the health of all people and all communities, strengthen the profession of public health, share the latest research and information, promote best practices, and advocate for public health issues and policies grounded in research. APHA is the only organization that combines a 140-plus-year perspective, a broad-based member community, and the ability to influence federal policy to improve the public's health.

APHA has long recognized that access to the full range of reproductive health services, including abortion, is a fundamental right integral both to the health and well-being of individual women and to the broader public health. APHA opposes restrictions that deny, delay, and impede access to abortion services, increasing women's risk of injury or death, and that coerce women to carry unintended pregnancies to term. APHA opposes legislation that makes abortion services unnecessarily difficult to obtain, imposes physical or mental health risks on women seeking abortion services without valid medical reason, and impedes women's ability to access abortion services in a timely manner. This includes legislation that forces women to travel increased distances to reach quality abortion services and bear increased costs for services and that reduces the number of abortion providers and the availability of abortion services.

APHA has over 25,000 members nationwide, 1,057 of whom reside in Texas, and maintains a connection to the public health community in Texas through its affiliate, the Texas Public Health Association, which has provided over 90 years of public health service and has 417 members. APHA has previously been granted leave to appear as *amicus curiae* in various courts throughout the country on matters relating to reproductive health, including in the Fifth Circuit Court of Appeals and in the United States Supreme Court.

SUMMARY OF ARGUMENT

It is critical to the public health interests of the United States that all women have meaningful access to reproductive health services, including abortion. Texas House Bill No. 2 ("H.B. 2") imposes two harmful and medically unnecessary requirements on the provision of abortion: it requires physicians to have admitting privileges at a hospital within 30 miles of the location where the abortion is performed (the "Admitting-Privileges Requirement"), and it requires abortion facilities to qualify as ambulatory surgical centers ("ASCs" and the "ASC Requirement"). These requirements impose substantial and unconstitutional obstacles to the exercise of a constitutional right, as Petitioners argue, and create a grave risk to public health.

Legal abortion is extremely safe, and the requirements imposed by H.B. 2 will not make it safer. The two requirements at issue—that

providers in Texas have admitting privileges at local hospitals and that facilities meet standards designed for ASCs—impede and diminish access to reproductive care without making that care any safer for the few women who can still obtain it. H.B. 2 jeopardizes women's health and the collective public health of Texas by imposing requirements that force the vast majority of legal abortion providers in the state to close. By forcing the closure of abortion facilities and depriving women in Texas of safe, local reproductive care, H.B. 2 creates a substantial risk that women will seek later-term abortions with increased risk, face the serious mental and physical health risks of being forced to carry unwanted pregnancies to term, or resort to illegal abortions.

For these and the reasons set forth below, *amici* support Petitioners and urge the Court to reverse the Fifth Circuit Court of Appeals' decision upholding the constitutionality of the challenged provisions of H.B. 2 in substantial part.

ARGUMENT

I. Access to Reproductive Health Services, Including Abortion, is Critical to a Fully Functioning Public Health System.

The challenged provisions of H.B. 2 jeopardize the public health in Texas by imposing legislative constraints on access to safe and legal abortion with no public health or medical basis. Meaningful access to safe, legal abortion is essential to women's health and a necessary component of any public health

system. Without access to abortion, women of reproductive age face significantly increased risks to their health, including risks of major complications from childbirth and increased risks of death. Abortion is an essential component of comprehensive reproductive care.

APHA has recognized women's access to safe abortion services as a public health issue since 1967. Over 67 million women of reproductive age reside in the United States,[2] including approximately six million in the state of Texas.[3] APHA recognizes that protecting and promoting the health of women, and women's ability to make choices about their health and the medical care that they will receive, is essential to the health of the public overall. APHA has long recognized that access to affordable and acceptable reproductive health services, including abortion, is critical to a fully functioning public health system.

Meaningful access to reproductive care prevents disease, promotes health, and prolongs life among the population as a whole. Safe, legal

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[2] *National Reproductive Health Profile*, Guttmacher Institute, http://www.guttmacher.org/datacenter/profiles/US.jsp (last visited Dec. 28, 2015).

[3] *State Reproductive Health Profile: Texas*, Guttmacher Institute, http://www.guttmacher.org/datacenter/profiles/TX.jsp (last visited Dec. 28, 2015).

abortion is an important component of that care and helps avoid the adverse health consequences that may arise if women are forced to seek care from unauthorized providers—as in the pre-*Roe* era—or the proven health risks of carrying an unwanted pregnancy to term. Depriving women of that care by imposing superfluous requirements on those who provide it creates a "substantial obstacle" to the exercise of a substantive due process right, as demonstrated by Petitioners, and creates a severe, immediate, and concrete risk to public health.[4]

APHA is not alone in recognizing that meaningful access to abortion is essential to public health. It is joined in this brief by 59 signatories who are leading academics and practitioners in the field of public health and who join APHA in recognizing the centrality of the meaningful access to reproductive care to public health and the risk to public health posed by the H.B. 2 requirements.

The American College of Obstetricians and Gynecologists supports the "availability of high-quality reproductive health services for all women and is committed to improving access to abortion"[5]

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[4] *See* Yvonne Lindgren, *The Rhetoric of Choice: Restoring Healthcare to the Abortion Right*, 64 Hastings L.J. 385, 404 (2013).

[5] *Committee Opinion No. 613—Increasing Access to Abortion*, Am. Coll. Obstetricians & Gynecologists, 1 (Nov. 2014), http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-

and supports Petitioners as *amicus curiae* in this case. The Association of Reproductive Health Professionals states that "[a]bortion care is a critical component of comprehensive reproductive health care" and thus "supports a woman's right to choose to have an abortion," recognizing that "[d]isparities in access to health care are a major public health failure . . . ."[6] The World Health Organization's ("WHO") Department of Reproductive Health and Research states that its "vision" is "the attainment by all peoples of the highest possible level of sexual and reproductive health," which requires eliminating unsafe abortion.[7] The WHO views hospital admitting-privileges laws "as structural barriers to equitable and safe abortion care" because they "seek to restrict the availability of abortion in an outpatient setting and are not grounded in evidence-based practices . . . ."[8] Like APHA, these

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Care-for-Underserved-Women/Increasing-Access-to-Abortion.

6 *Position Statements—Access to Reproductive Health Care,* Ass'n Reprod. Health Prof., (June 2012), http://www.arhp.org/about-us/position-statements#9.

7 *Our Vision*, World Health Org., Dep't Reprod. Health & Research, http://www.who.int/reproductivehealth/about_us/en/ (last visited Dec. 28, 2015).

8 *Policy Statement No. 20151—Opposition to Requirements for Hospital Admitting Privileges and Transfer Agreements for Abortion Providers*, Am. Pub. Health Ass'n, (Nov. 2015), http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-

organizations recognize safe, legal abortion as a critical component of reproductive health in particular and public health generally.

II. H.B. 2 Injures Public Health by Imposing Medically Unnecessary Barriers on Abortion Care.

The two challenged requirements of H.B. 2—the Admitting-Privileges Requirement and the ASC Requirement—seriously threaten public health in Texas by decreasing access to common and safe medical procedures. They limit an already vulnerable population's access to abortion without medical justification and not only fail to advance the public health, but endanger it.

A. The Admitting-Privileges and ASC Requirements Do Not Advance Any State Interest in Public Health.

H.B. 2 does not make abortion safer. The Admitting-Privileges Requirement and the ASC Requirement provide no meaningful medical benefit to the women of Texas. They simply make it far

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database/2015/12/14/11/04/opposition-to-requirements-for-hospital-admitting-privileges-for-abortion-providers [hereinafter "Am. Pub. Health Ass'n, *Policy Statement No. 20151*"] (describing *Safe Abortion: Technical and Policy Guidance for Health Systems,* World Health Organization (2012), http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf).

more difficult for women to obtain an abortion and, in doing so, put women's physical and mental health at risk by delaying abortions or forcing women to carry unwanted pregnancies to term. The H.B. 2 requirements impose substantial, additional, and medically unhelpful burdens on the provision of abortion care in Texas that translate directly into meaningful burdens on patients. Neither requirement advances patient care, and each imposes onerous obligations that will drastically limit reproductive care in Texas by reducing the number of places that provide it.[9]

Legal abortion is extremely safe. It is one of the "most common and safest gynecologic interventions in the United States."[10] Over 90 percent of U.S. abortions are performed in outpatient

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[9] *Policy Statement No. 20083—Need for State Legislation Protecting and Enhancing Women's Ability to Obtain Safe, Legal Abortion Services Without Delay or Government Interference,* Am. Pub. Health Ass'n, (Oct. 2008), http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/23/09/30/need-for-state-legislation-protecting-and-enhancing-womens-ability-to-obtain-safe-legal-abortion.

[10] *Policy Statement No. 20112—Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants,* Am. Pub. Health Ass'n, (Nov. 2011), http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/28/16/00/provision-of-abortion-care-by-advanced-practice-nurses-and-physician-assistants.

settings,[11] and hospitalization due to an abortion is exceedingly rare.[12]

In a medical abortion, the patient ingests oral medication at the facility, and the abortion itself typically takes place outside the facility. The "risks associated with taking [the oral medication are] similar to taking Tylenol."[13] Moreover, almost all post-abortion complications are treated on an outpatient basis.[14] Most women do not experience complications ***at all*** after a first-trimester abortion—whether medical or surgical—and serious complications, such as hospital admission, surgery,

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[11] Rachel Jones & Kathryn Kooistra, *Abortion Incidence and Access to Services in the United States, 2008*, 43 Persp. on Sexual & Reprod. Health 41, 46 (2011).

[12] *Safety of Abortion*, National Abortion Federation, (Dec. 2006), http://prochoice.org/wp-content/uploads/safety_of_abortion.pdf.

[13] *Abortion Restrictions in Context: Literature Review,* Texas Policy Evaluation Project, (July 2013), http://www.utexas.edu/cola/orgs/txpep/_files/pdf/AbortionRestrictionsinContext-LiteratureReview.pdf.

[14] *See, e.g.*, Tracy A. Weitz et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 Am. J. Pub. Health 454, 459 (2013) ("only 6 complications out of 11,487 [abortion] procedures required hospital-based care").

or a blood transfusion, occur in merely 0.23 percent of the patient population.[15]

Abortion-related deaths are extremely rare. Between 1998 and 2010, there was less than 1 death per 100,000 abortion procedures in the United States.[16] The Texas Department of State Health Services did not report a single abortion-related death from 2009 through 2013, the last year from which data is available,[17] and only five such deaths have been reported in Texas since 2002.[18]

In the rare event that complications arise after a legal abortion, they often occur at the patient's home, and the patient is treated at her local hospital by medical personnel, not back at the

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[15] Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications after Abortion*, 125 Obstetrics & Gynecology 175, 181 (2015).

[16] Suzanne Zane et al., *Abortion-Related Mortality in the United States: 1998-2010*, 126 Obstetrics & Gynecology 258 (2015).

[17] *Vital Statistics Annual Reports*, Tex. Dep't of St. Health Services, http://www.dshs.state.tx.us/chs/vstat/annrpts.shtm (last visited Dec. 28, 2015).

[18] *Id.*; Brooks Egerton, *Abortion in Texas: Facts, Figures, Questions and Answers*, The Dallas Morning News (July 3, 2013), http://watchdogblog.dallasnews.com/2013/07/abortion-in-texas-facts-figures-questions-and-answers.html/.

abortion facility.[19] The universe of patients with serious complications requiring hospitalization or surgical care is ***less than one-quarter of one percent*** of the patient population,[20] and the very few patients who need such care may be "hundreds of miles away from the facility at which they obtained [abortion] services and its affiliated hospital" by the time they experience any complications.[21] Seeking care from an unaffiliated hospital is consistent with modern medical practice and poses no harm to patients; they receive appropriate treatment and cannot be turned away or denied care.[22]

Forcing women to carry pregnancies to term by depriving them of access to abortion care is not a neutral act when it comes to women's health; by restricting access to abortion, H.B. 2 materially endangers maternal health and well-being. The risks to maternal health associated with unintended pregnancy are substantial. All pregnancies involve risks of both physical and psychological complications.[23] Some of these risks can be fatal,

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19 *See* Upadhyay et al., *supra* note 15, at 181–82; Weitz et al., *supra* note 14, at 459.

20 *See* Upadhyay et al., *supra* note 15, at 181–82.

21 Am. Pub. Health Ass'n, *Policy Statement No. 20151*, *supra* note 8.

22 *Id.*

23 *See Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors,* World Health Org., (2000),

while others, such as depression, persist even after childbirth.[24] Women who undergo unintended childbirth experience increased risk of maternal depression.[25] Additionally, births following unintended pregnancy carry increased risks of congenital anomalies, premature delivery, and low birth weight.[26] The risk of death during childbirth is far greater than the risk of death from legal abortion—and is a risk that H.B. 2 would force women in Texas to bear.[27]

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http://www.iawg.net/resources/RH%20Kit%2011%20-%20Complications%20of%20pregnancy%20and%20childbirth_midwives%20and%20doctors.pdf.

[24] *See id.*; *Pregnancy Complications*, Centers for Disease Control and Prevention, (Sept. 2015) http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregcomplications.htm.

[25] Jessica D. Gipson et al., *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature*, 39 Stud. Fam. Plan. 18, 28 (2008).

[26] *Id.* at 24.

[27] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119(2) Obstetrics & Gynecology 215, 217 (2012) ("Legal abortion in the United States remains much safer than childbirth. The difference in risk of death is approximately 14-fold.").

B. The Admitting-Privileges Requirement Imposes a Substantial Burden on Patients and Providers and Does Not Advance Any State Interest in Public Health.

The Admitting-Privileges Requirement limits women's access to legal abortion without providing any corresponding public health benefit. "Admitting privileges" refers to the right to admit patients to a particular hospital without the approval of hospital personnel. The Admitting-Privileges Requirement requires a physician who performs an abortion in Texas—even if that abortion is a medical procedure with no surgical component—to have admitting privileges at a hospital within 30 miles of the location where the abortion is performed. Requiring doctors who provide abortion care at clinics or doctors' offices to directly admit patients to a hospital does nothing to improve the health of their patients and is directly at odds with modern medical practice.

In contemporary medical practice, a woman experiencing a rare complication from abortion—as with any other medical procedure—will receive care for that complication from a trained emergency room physician or on-call specialist at the nearest hospital.[28] The transfer of care from an outpatient

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[28] Texas Hospital Association's Statement of Opposition to Sec. 2 of the Committee Substitute for Senate Bill 5 by Glenn Hegar, *Relating to the Regulation of Abortion Procedures, Providers, and Facilities; Providing Penalties*

provider to an emergency room physician is consistent with the developments dividing ambulatory and hospital care and is standard medical practice.[29] Continuity of care is achieved not by a single doctor following the patient to the hospital, but through communication and collaboration among specialized health care providers, wherever they are. Requiring a woman's abortion provider to have admitting privileges at a nearby hospital—which may or may not be near her home, and may or may not be the hospital where she would receive care in an emergency—does not guarantee that physician will be available if complications arise later and does not affect the care the patient is likely to receive from the emergency staff and specialists who will see her upon admission.

The Admitting-Privileges Requirement makes abortion highly burdensome for doctors to provide and women to obtain. It has drastically reduced the number of abortion providers in Texas. Prior to H.B. 2, over 40 licensed abortion facilities provided

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(Texas Hospital Association, 2013), http://www.tha.org/HealthCareProviders/Advocacy/CommentLetters/THA%20Testimony%20in%20opposition%20to%20SB%205%20(special%20session).pdf.

[29] *See* Christine Dehlendorf & Tracy Weitz, *Access to Abortion Services: A Neglected Health Disparity*, 22 J. Health Care for Poor & Underserved 415, 417 (2011).

abortion services in Texas.[30] That number decreased "***by almost half*** leading up to and in the wake of enforcement of the admitting-privileges requirement."[31] Access to abortion services became extremely limited. The state's abortion rate decreased by 13 percent compared to the year before the law went into effect, "which was likely associated with the state's clinic closures."[32] Texas women of reproductive age "living 100 miles or more from an abortion provider increased . . . from 417,000 to over . . . 1,000,000 from May 2013 to April 2014," and in areas like the lower Rio Grande Valley of Texas, where more than 275,000 women of reproductive age live—many at or below the federal poverty level—clinic closures "leave many women without an abortion provider for 150-250 miles."[33]

The clinic closure rate is likely to increase because of the burdens that the challenged sections of H.B. 2 place on hospitals and physicians. As the Texas Hospital Association has recognized, H.B. 2 puts the onus on hospitals to extend admitting

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[30] *Whole Woman's Health v. Lakey*, 46 F. Supp. 3d 673, 681 (W.D. Tex. 2014), *aff'd in part, vacated in part, rev'd in part sub nom. Whole Woman's Health v. Cole*, 790 F.3d 563 (5th Cir. 2015), *modified*, 790 F.3d 598 (5th Cir. 2015).

[31] *Id.*

[32] Am. Pub. Health Ass'n, *Policy Statement No. 20151*, supra note 8.

[33] *Id.*

privileges to physicians who do not practice there.[34] That is a time-consuming and expensive process that hospitals (through the decisions of their medical staff) are being asked to undertake on behalf of physicians whose practices are primarily elsewhere and who will not, typically, be providing services for the hospital in return. The disconnect between the *requirement* that physicians who provide abortion obtain admitting privileges at a hospital and the *fact* that their practices take place almost exclusively outside the hospital setting, poses practical challenges and raises public health concerns. It does not serve the purpose for which admitting privileges are intended,[35] and hospitals may be disinclined to support it.

For those hospitals willing to entertain privileges applications, the requirements vary widely. Each hospital's medical staff may weigh multiple factors and develop its own standards; many require doctors to admit a minimum number of patients each year, while others require physicians to live a minimum distance from the hospital. Privileges decisions may be driven by the hospital's business and staffing plans or by contracts

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[34] Hegar, *supra* note 28.

[35] *Id.*

awarding exclusivity to designated ob/gyn practice groups.[36]

Doctors applying to meet these various standards face substantial challenges, including time away from their patients to navigate the hospital requirements and to complete the often lengthy application process. Even then, they may find that some hospitals—on religious grounds[37] or in an attempt to avoid entanglement in abortion politics—simply deny privileges to doctors who perform abortions.[38] Indeed, no state has laws

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[36] See, e.g., Pl. Exh. 059 at 3.2.3 (Record 3377, 3378) (discussing reserving admitting privileges pursuant to a "staff development plan"); Pl. Exh. 076 at 3.2.2 (Record 3377, 3378) (discussing reserving admitting privileges to those who belong to chosen practice groups that enter into exclusive hospital contracts).

[37] *See, e.g., Ethical and Religious Directives for Catholic Health Care,* United States Conference of Catholic Bishops, (5th Ed. Nov. 17, 2009) at 26, http://www.usccb.org/about/doctrine/ethical-and-religious-directives/index.cfm (ethical standards to which Catholic hospitals are required to adhere, including that "Abortion . . . is never permitted" and that "Catholic health care institutions need to be concerned about the danger of scandal in any association with abortion providers.").

[38] Sandhya Somashekhar, *Admitting-Privileges Laws Have Created High Hurdle for Abortion Providers to Clear*, The Washington Post (Aug. 10, 2014), http://www.washingtonpost.com/national/2014/08/10/62554324-1d88-11e4-82f9-2cd6fa8da5c4_story.html. *See also Robinson v. UGHS Dallas Hospitals, Inc.*, No. DC-14-04101 (Dallas Cnty. Ct. Apr. 17, 2014), in which the court granted a temporary injunction against a Dallas hospital

"governing how hospitals . . . implement a fair and objective process of admitting privileges," so a hospital is "free to deny admitting privileges to any health care provider via a process that is vulnerable to political interference and may not be based on patient safety or evidence[-]based standards of care."[39] For example, in 2014, one Texas physician's privileges were revoked because the physician was providing abortions outside the hospital, which the hospital claimed would be "disruptive to [its] business and reputation . . . ."[40]

Because abortion is an extremely safe procedure that is largely performed on an out-patient basis without complication or hospitalization, doctors who provide abortion may not have the kind of hospital-based practice that may be required to qualify for admitting privileges. For example, so few abortion patients require

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that, in a rare admission, openly stated in its revocation letters that it was revoking physicians' privileges on the illegal basis of their provision of abortions at other, unrelated facilities. *See* Tex. Occ. Code § 103.002(b) (West 1999).

39 Am. Pub. Health Ass'n, *Policy Statement No. 20151*, *supra* note 8.

40 *Robinson v. UGHS Dallas Hospitals, Inc.*, No. DC-14-04101 (Dallas Cnty. Ct. Apr. 17, 2014) (citing Letter from Chuck Schuetz, CEO, University General Hospital, to Dr. Lamar Robinson (Mar. 31, 2014), http://rhrealitycheck.wpengine.netdna-cdn.com/wp-content/uploads/2014/04/UGHD-Letter.pdf.).

hospitalization that a doctor whose primary practice involves the provision of outpatient abortion care is unlikely to have admitted enough patients to a hospital in a given to year satisfy the minimum annual patient admission requirements that are a common criterion in granting admitting privileges.[41] A physician's record for providing "safe, quality care actually limits [his or her] ability to obtain admitting privileges."[42] That physicians who can meet minimum admission requirements have "a clearer path to obtaining privileges[] strongly suggest[s] that admitting privileges are less about ensuring safe care for abortion patients, and more about restricting women's ability to access legal abortion care."[43]

Hospitals in general are reluctant to give admitting privileges to physicians who practice exclusively in an outpatient setting, regardless of their specialty, because the hospital cannot monitor the quality of care of a physician whose practice it neither sees nor controls. Moreover, hospitals face

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41 Somashekhar, *supra* note 38; Am. Pub. Health Ass'n, *Policy Statement No. 20151*, *supra* note 8 ("Many hospitals require physicians to maintain an annual minimum of patient admissions, a requirement that the vast majority of abortion providers cannot meet owing to the very low risk of complications.").

42 Am. Pub. Health Ass'n, *Policy Statement No. 20151*, *supra* note 8.

43 *Id.*

legal and financial disincentives to granting admitting privileges to unknown physicians since a hospital's board can be liable for its medical staff's decisions on who receives privileges. For both reasons, protecting the public health actually militates against granting privileges to physicians who never practice in a hospital. Thus, the Admitting-Privileges Requirement obligates clinic physicians to meet an impossible and unwise criterion: obtain admitting privileges that hospitals should not grant—and in practice will not grant—to any outpatient physician.

In short, the Admitting-Privileges Requirement forces both hospitals and physicians to divert time, effort, and resources from patient care to a process for granting privileges to doctors whose practice takes place entirely outside the hospital and can exist safely and independently without it.

C. The ASC Requirement Imposes a Medically Unnecessary Barrier to Abortion Access.

The ASC Requirement of H.B. 2 is detrimental to the public health since it imposes additional costs on and barriers to the provision of abortion with no medical benefit.

Historically, the overwhelming majority of abortions in Texas—87 percent in 2010—are performed on an outpatient basis in clinics or

physicians' offices.[44] These facilities are extremely safe places to obtain an abortion. From 2009 to 2013, the last year in which data is available, Texas did not have a single reported abortion-related death.[45] The vast majority—83 percent—of abortions performed in Texas during that time were in outpatient clinics and physicians' offices, not in ASCs or hospitals.[46] From 2001 to 2012, 92 percent of abortions were performed in abortion facilities or physicians' offices. Texas statistics reflected an exceedingly low mortality rate of .00054 percent during that time.[47] Scientific literature suggests that the safety of abortions performed in an office setting is equivalent to those performed in a hospital setting.[48]

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44 Direct Test. of Elizabeth Gray Raymond, M.D, M.P.H 3, ECF 162, [hereinafter "Direct Testimony of Elizabeth Gray Raymond"].

45 *See Vital Statistics Annual Reports*, Texas Department of State Health Services, http://www.dshs.state.tx.us/chs/vstat/annrpts.shtm (last visited Dec. 28, 2015).

46 *Id.*

47 *Id.*

48 *See, e.g.*, David A. Grimes, *Every Third Woman in America: How Legal Abortion Transformed Our Nation* 31-32 (2014) ("[C]ontrary to conventional wisdom, abortions performed in freestanding clinics proved safer than those provided in hospitals."); David A. Grimes et al., *Abortion Facilities and the Risk of Death*, 13 Fam. Plan. Persp. 30, 31 (1981); David A. Grimes et al., *Comparative Risk of Death from Legally Induced Abortion in Hospitals*

Despite this safety record, the ASC Requirement eliminates the option of obtaining an abortion at a clinic or physician's office by forcing each facility that provides abortions of any type—including early-stage and medical abortions—to meet the costly standards required of a surgical center. But ASC standards are inappropriate and unattainable for most clinics.

ASC standards include hospital-like requirements for physical plant and fire prevention and safety.[49] To satisfy these, clinics must make transformative and expensive renovations that have

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and Nonhospital Facilities, 51 Obstetrics & Gynecology 323, 324 (1978); *Fact Sheet: Ambulatory Surgical Center Laws and the Provision of First-Trimester Abortion Care,* Texas Policy Evaluation Project (July 6, 2015), http://www.utexas.edu/cola/txpep/_files/pdf/TxPEP_FactSheet_Ambulatory_Surgical_Center_Laws_and_FirstTrimesterAbortion_June2015.pdf (percentage of abortions resulting in major complications was similar for office-based clinics, ASCs, and hospital-based clinics).

[49] *See, e.g.*, *Whole Woman's Health v. Lakey*, 46 F. Supp. 3d 673, 682 (W.D. Tex. 2014), *aff'd in part, vacated in part, rev'd in part sub nom. Whole Woman's Health v. Cole*, 790 F.3d 563 (5th Cir. 2015), *modified*, 790 F.3d 598 (5th Cir. 2015) (noting that clinics forced to make renovations to comply with H.B. 2 will undergo "significant" costs); *see also* Tara Culp-Ressler, *Texas Clinics Won't Be Able to Give out the Abortion Pill without Hospital-Like Facilities*, Think Progress (June 10 2015 4:30PM), http://thinkprogress.org/health/2015/06/10/3668277/texas-surgical-center-abortion-law.

little or nothing to do with the patient services they provide. For example, clinics must replace patient rooms with wholly unnecessary full operating suites. But given that an increasingly large percentage of abortions are medical, no designated procedure space is required since the protocol involves taking pills to induce pregnancy termination, which then typically occurs at home.[50] Under the ASC Requirement, abortion clinics must also build standard janitors' closets and install sophisticated air filtration systems,[51] neither of which provides any additional medical benefit for their patients.[52]

By imposing additional costs on the provision of abortion with no medical benefit, and by forcing noncompliant clinics and physicians' offices to cease performing any abortion procedures despite these facilities' excellent safety records, the ASC

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[50] *See Practice Bulletin Number 143: Medical Management of First-Trimester Abortion*, Am. Coll. of Obstetricians & Gynecologists (2014), http://www.acog.org/Resources-And-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Medical-Management-of-First-Trimester-Abortion.

[51] Culp-Ressler, *supra* note 49 ("In practice, this means the state of Texas will require abortion clinics to make hospital-style upgrades to their buildings to legally allow their patients to swallow pills.").

[52] *Abortion Restrictions in Context*, *supra* note 13 ("The physical plant upgrades and staffing requirements for an ASC are not warranted for abortion performed up to 18 weeks.").

Requirement of H.B. 2 is detrimental to the public health.

III. By Substantially Reducing Abortion Care, H.B. 2 Jeopardizes the Public Health in Texas.

Together, the Admitting-Privileges Requirement and the ASC Requirement have forced and will continue to force dozens of abortion clinics throughout Texas to close.[53] When clinics close and doctors can no longer practice, women are left with significantly fewer options to obtain a safe and legal abortion. The existing ASCs are likely insufficient to provide care for the large number of patients who seek abortions in Texas each year, leaving the population without essential reproductive health care.[54] By forcing reproductive care facilities to close their doors throughout the state, H.B. 2 increases the likelihood that delays due to limited capacity and burdensome travel will cause women in Texas to resort to illegal and unsafe procedures, obtain abortions later at relatively greater risk, or face the mental and physical health risks of being forced to carry unwanted pregnancies to term, all of which pose serious threats to their health. The challenged sections of H.B. 2 will have particularly devastating

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[53] *Whole Woman's Health v. Cole*, 790 F.3d 563, (5th Cir. 2015), *petition for cert. filed,* No. 15-274 (filed Sept. 2, 2015).

[54] Direct Test. of Daniel Grossman, M.D. 11, ECF 161 [hereinafter "Direct Testimony of Daniel Grossman"].

effects on the health and safety of low-income and rural women, who already face considerable barriers to critical health care.

A. Public Health in Texas is Highly Vulnerable to H.B. 2's Restrictions Due to Preexisting Abortion Restrictions and a Lack of Support for Family Planning.

The population of Texas is particularly vulnerable to increased restrictions on abortion because the state already severely burdens abortion care through existing regulations while providing inadequate support for family planning and maternal health.

Texas requires a woman who would like to terminate a pregnancy to participate in state-directed counseling that includes information designed to discourage her from having an abortion[55] and to wait at least 24 hours after that counseling before proceeding with an abortion.[56] She must undergo a state-mandated ultrasound examination during which her doctor is required to show and describe the image of the fetus to her—regardless of whether she has requested that examination or

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[55] Tex. Health & Safety Code Ann. §§ 171.011–171.012 (West 2003) (amended 2015).

[56] *Id.*

wishes to hear the description or see the images.[57] Women who live within 100 miles of the clinic must make their preliminary trip to the clinic for the ultrasound examination at least 24 hours in advance of the abortion procedure,[58] then return later for the procedure itself. After 15 weeks of pregnancy, Texas requires women to travel to one of the few ASCs or hospitals that will provide abortion care[59]—only nine of which exist in Texas.[60] And after 19 weeks of pregnancy, abortion is largely unavailable in Texas.[61]

By restricting access to abortion, Texas has already damaged the public health and the health of the individual women and children who live in the state. Texas, with 12 codified restrictions on abortion, is tied with Alabama for 40th among the 50 states in terms of women's and children's well-being, far behind less restrictive states like Vermont and New Hampshire, which have few or no restrictions

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57 Tex. Health & Safety Code Ann. § 171.012 (West 2003) (amended 2015).

58 *Id.*

59 Tex. Health & Safety Code Ann. § 171.004 (West 2003).

60 Silvie Colman & Ted Joyce, *Regulating Abortion: Impact on Patients and Providers in Texas*, 30 J. Pol'y Analysis & Mgmt. 775 (2011).

61 Tex. Health & Safety Code Ann. § 171.044 (West 2013).

on abortion access and are ranked in the top two states overall in women's and children's well-being.[62]

The public health impact of Texas's legislative restrictions on abortion access is compounded by the state's high rate of unintended pregnancy and lack of support for family planning services or birth control. In 2010 alone, 300,000 women in Texas had unintended pregnancies.[63] A year later, in 2011, the Texas legislature cut funding for family planning by 66 percent, causing at least 150,000 women to lose access to preventive care and birth control.[64] Although the legislature recently increased funding for women's health, that increase was insufficient "to match the growing demand for publicly supported family planning services and supplies."[65] By

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[62] Am. Pub. Health Ass'n, *Policy Statement No. 20152* (citing Marshall Medoff, *Pro-Choice Versus Pro-Life: The Relationship Between State Abortion Policy and Child Well-Being*, Health Care for Women Int'l, 1, 1–12 (2013)).

[63] *Facts on Publicly Funded Family Planning Services: Texas,* Guttmacher Institute (2014), http://www.guttmacher.org/statecenter/family-planning/TX.html.

[64] Crystal Conde, *A Steep Price: Physicians Worry about Women's Access to Care*, 108 Tex. Med. no. 7, 18–25 (2012).

[65] *Nuestro Texas: An Analysis of the 84th Texas Legislative Session* (Aug. 2015), http://www.nuestrotexas.org/wp-content/uploads/2015/08/Nuestro-Texas_An-Analysis-of-the-84th-Texas-Legislative-Session_EN-FINAL.pdf; Kari White et al., *The Impact of Reproductive Health Legislation on Family Planning Clinic Services in Texas*,

stripping the state's public health system of publicly supported family planning services and underfunding those few women's services which the state does provide, the Texas legislature has created an even greater likelihood of high rates of unintended pregnancy and a correspondingly greater need for comprehensive reproductive care, including abortion.[66]

B. By Substantially Reducing and Geographically Concentrating Abortion Care, the H.B. 2 Restrictions Jeopardize Public Health in Texas.

Reproductive care in Texas cannot withstand still further onerous restrictions. If the challenged portions of H.B. 2 take effect, the only abortion facilities that would be able to provide abortion care on a regular basis are those in or around Texas's four largest metropolitan areas: Dallas-Fort Worth, Houston, San Antonio, and Austin.[67] The rest of the

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Am. J. Pub. Health (Dec. 10, 2014), http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2014.302515; *Barriers to Family Planning Access in Texas: Evidence from a Statewide Representative Survey*, Texas Policy Evaluation Project (May 2015), http://www.utexas.edu/cola/txpep/_files/pdf/TxPEP-ResearchBrief_Barriers-to-Family-Planning-Access-in-Texas_May2015.pdf.

66 *Facts on Publicly Funded Family Planning Services: Texas*, *supra* note 63.

67 Direct Testimony of Daniel Grossman, *supra* note 54, at 13.

state will face greatly diminished access to care. Women who previously had access to nearby abortion facilities will be forced to undertake arduous and expensive travel in order to obtain an abortion—if they can do so at all—and patients who are able to locate and travel to a legal abortion facility may be forced to wait longer or find there is no capacity to care for them at all.

By substantially reducing and geographically concentrating abortion care, the H.B. 2 restrictions pose a serious threat to public health in Texas, in numerous ways.

First, the reduction and geographic concentration of abortion providers in Texas will force women to wait longer and travel farther to obtain abortion services, almost inevitably delaying the timing of the procedure until later in the pregnancy, when it is more dangerous to the woman's health.[68] While abortion remains a safe procedure throughout pregnancy, abortions performed later in a pregnancy carry more risk than those performed earlier in the pregnancy, and women should not be forced to have a later abortion when they wish to have one at an earlier stage in their pregnancy.

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[68] *See* Direct Testimony of Elizabeth Gray Raymond 263–71 (discussing the risks associated with abortion).

By forcing the closure and geographic concentration of abortion providers in Texas, the challenged restrictions of H.B. 2 compound the difficulties that patients already face. If the challenged H.B. 2 restrictions take effect, women in Texas will find it even more difficult to secure an appointment at one of the state's few remaining abortion facilities, traverse hundreds of miles to get there, and raise enough money to fund all of the costs of travel—including transportation, overnight lodging, child care, and other attendant costs[69]—on top of the cost of the abortion itself.[70] In addition, a woman seeking an abortion in Texas must ascertain and abide by Texas's counseling and waiting periods

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[69] Bonnie Scott Jones & Tracy Weitz, *Legal Barriers to Second-Trimester Abortion Provision and Public Health Consequences*, 99 Am. J. Pub. Health 623, 624 (2009).

[70] Abortion in Texas can cost between $450 and $3,000, depending on the nature and timing of the procedure, with costs increasing substantially after the first trimester. Carolyn Jones, *Need an Abortion in Texas? Don't be Poor*, Texas Observer, (May 8, 2013), http://www.texasobserver.org/need-an-abortion-in-texas-dont-be-poor/. The average cost of an abortion at 10 weeks is $543, while an abortion at 20 weeks costs an average of $1,562. *See* Ushma D. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 Am. J. Pub. Health 1687, 1687 (Sept. 2014) (time spent raising money to pay for an abortion and transportation represents a primary cause of delay in obtaining an abortion). For many women, depending on the circumstances, neither federal nor state Medicaid will cover the cost of an abortion.

and arrange the required number of visits,[71] all within the 20 week gestational limit that applies to the vast majority of cases under Texas law.[72] As a result, by the time many low-income women have saved enough money for an abortion to be performed at an early gestational age, their pregnancies have advanced, and the procedure is pushed into the second trimester.[73] Some women may be prevented from obtaining an abortion at all, be forced to carry an unwanted pregnancy to term, and experience the physical and mental burdens of pregnancy and childbirth. The overall detrimental impact on public health exacerbates medical inequality.[74]

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71 *See Texas Abortion Laws*, Planned Parenthood, https://www.plannedparenthood.org/planned-parenthood-center-for-choice/texas-abortion-laws (last visited Dec. 28, 2015).

72 This rule applies unless "there exists a condition that, in the physician's reasonable medical judgment, so complicates the medical condition of the woman that [an abortion is necessary] to avert the woman's death or a serious risk of substantial and irreversible physical impairment of a major bodily function, other than a psychological condition." Tx. Health & Safety Code § 171.046 (West 2013).

73 *See, e.g.*, Jones & Weitz, *supra* note 69, at 623 (discussing the need for abortion care in the second trimester).

74 Christine Dehlendorf et al., *Disparities in Abortion Rates: A Public Health Approach*, 103 Am. J. Pub. Health 1775, 1776 (Oct. 2013); Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstetrics & Gynecology 729, 735–36 (2004).

The effects of the challenged portions of H.B. 2 may be particularly acute for low-income women in places like South Texas, which is home to the two poorest cities in the nation, Brownsville and McAllen.[75] The U.S. Census reports that nearly a quarter (23.3 percent) of residents in El Paso County, Texas have incomes below the federal poverty line.[76] In the Corpus Christi metro area, a fifth of the population lives at or below the federal poverty level.[77] For patients whose annual family income is at or below the poverty level—just $15,930 for a family of two[78]—the out-of-pocket cost of the abortion procedure alone is substantial, and the additional costs, challenges, and requirements may be prohibitive.[79]

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[75] Craig Hlavaty, *Brownsville Named the Poorest City in America*, Chron (Oct. 31, 2013), http://www.chron.com/news/houstontexas/texas/article/Brownsville-named-the-poorest-city-in-America-4939821.php.

[76] *Quick Facts*, U.S. Census Bureau, http://quickfacts.census.gov/qfd/states/48/48141.html (last visited Dec. 28, 2015).

[77] Danielle Kurtzleben, *10 Metro Areas with the Highest Poverty Levels*, U.S. News (Oct. 7, 2011), http://www.usnews.com/news/slideshows/10-metro-areas-with-the-highest-poverty-levels/3.

[78] Office of the Assistant Secretary for Planning and Evaluation, *2015 Poverty Guidelines* (Sept. 3, 2015), https://aspe.hhs.gov/2015-poverty-guidelines.

[79] Even researching and planning for an abortion procedure can be a challenge for those who lack internet access—

The challenges facing women in Lubbock and Corpus Christi illustrate just some of the issues women in typical mid-sized Texas cities will face if the Fifth Circuit's decision is affirmed. Each city had a single abortion facility which has been forced to close as a result of H.B. 2—and that closure will require local residents to overcome substantial obstacles in order to obtain abortion care.

From Lubbock, the 11th most populous city in Texas,[80] the nearest remaining clinics are those in Fort Worth, Texas; Albuquerque, New Mexico; and Oklahoma City, Oklahoma.[81] Not a single clinic is within 300 miles of Lubbock, and the closest is over 320 miles away. That may be a daunting and time-consuming drive even for those with cars—but in Lubbock, as in many cities in Texas, one in 20

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which cannot be assumed, particularly for low-income women in Texas, which is the 41st ranked state in the U.S. in terms of Internet connectivity. Ria Misra, *Which State Has the Worst Internet Access in the Nation?*, Gizmodo, http://io9.gizmodo.com/which-state-has-the-best-internet-access-in-the-nation-1658816647 (last visited Dec. 28, 2015).

[80] *U.S. Cities: Texas*, TOGETHER We Teach, http://www.togetherweteach.com/TWTIC/uscityinfo/43tx/txpopr/43txpr.htm (last visited Dec. 28, 2015).

[81] *Texas Abortion Clinic Map*, Fund Texas Women, http://fundtexaschoice.org/resources/texas-abortion-clinic-map/#list.

residents lives in a household without access to a vehicle.[82]

Taking public transportation from Lubbock to the closest abortion facilities—hundreds of miles away—is not easy. The bus routes from Lubbock to Fort Worth, Albuquerque, and Oklahoma City, are long, slow, expensive, and infrequent on many routes. Trips from Lubbock to Fort Worth by bus take roughly six to eight hours and cost from nearly $80 to $180 round-trip,[83] with one-way taxi fares to and from the bus station to the clinic ranging from nearly $20 to over $30.[84] A trip by train is impossible, since the nearest Amtrak station is over 250 miles away, in New Mexico.[85] Lubbock Preston Smith International Airport offers nonstop flights to

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[82] Alan Berube et al., *Socioeconomic Differences in Household Automobile Ownership Rates: Implications for Evacuation Policy* (June 2006), http://socrates.berkeley.edu/~raphael/BerubeDeakenRaphael.pdf.

[83] Greyhound, https://www.greyhound.com/ (last visited Dec. 28, 2015).

[84] *Dallas, TX*, Taxi Fare Finder, http://www.taxifarefinder.com/main.php?city=Dallas&from=Greyhound-Trailways%2C+Commerce+Street%2C+Fort+Worth%2C+TX%2C+United+States&to=6464+John+Ryan+Dr+Fort+Worth%2C+TX+76132&fromCoord=32.752222,-97.328125 (last visited Dec. 28, 2015).

[85] *Destinations*, Amtrak, https://www.amtrak.com/find-train-bus-stations-train-routes (last visited Dec. 28, 2015).

Dallas-Fort Worth International Airport, but a round-trip ticket costs $181, based on a recent search,[86] and upon landing, the 20 mile trip by taxi to the closest abortion clinic can cost over $60.[87]

Travel from Corpus Christi is also challenging. The nearest abortion provider is in San Antonio, Texas, over 135 miles away. Roughly one in fourteen residents of Corpus Christi lives in a household without access to a car,[88] and public transportation can be expensive and time-consuming. Bus routes from Corpus Christi to San Antonio can take from two and a half to four and a half hours, with one-way fares ranging from $16 to $43[89] and one-way taxi fares from the San Antonio bus station to the clinic costing between $15 and $24.[90] Travel to Houston, Texas, takes roughly four

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86 Kayak, http://www.kayak.com/flights/LBB-DFW/2016-01-12-flexible/2016-01-15-flexible (last visited Dec. 28, 2015).

87 *Dallas, TX*, Taxi Fare Finder, http://www.taxifarefinder.com/main.php?city=Dallas&from=Dallas+Fort-Worth+Airport+(DFW)&to=8616+Greenville+Ave+%23101%2C+Dallas%2C+TX+75243 (last visited Dec. 28, 2015).

88 Alan Berube et al., *Socioeconomic Differences in Household Automobile Ownership Rates: Implications for Evacuation Policy* (June 2006), http://socrates.berkeley.edu/~raphael/BerubeDeakenRaphael.pdf.

89 Greyhound, *supra* note 83.

90 *San Antonio, TX*, Taxi Fare Finder, http://www.taxifarefinder.com/main.php?city=San-

or five hours by bus, with one-way fares ranging from $21 to $40[91] and one-way taxi fares to the clinic costing between $11.25 and $18.14.[92] Amtrak is not an option since the nearest Amtrak station is about 130 miles away, in San Antonio.[93]

Looking just at transportation from two mid-sized cities—without even beginning to consider additional costs such as child care, missed work, or overnight stays, or the additional difficulties of traveling from smaller or more remote locations—suggests that by concentrating abortion facilities in just a few cities, the challenged restrictions of H.B. 2 will leave women across the state with formidable challenges to overcome to get basic, safe, reproductive care.

Antonio-TX&from=Greyhound+Lines%2C+San+Antonio%2C+TX%2C+United+States&to=104+Babcock+Road%2C+San+Antonio%2C+TX%2C+United+States&fromCoord=29.42894679999999,-98.4910673&toCoord=29.4718262,-98.5349923 (last visited Dec. 28, 2015).

91 Greyhound, *supra* note 83.

92 *Houston, TX*, Taxi Fare Finder, http://www.taxifarefinder.com/main.php?city=Houston&from=Greyhound%2C+Main+Street%2C+Houston%2C+TX%2C+United+States&to=4600+Gulf+Freeway%2C+Houston%2C+TX%2C+United+States&fromCoord=29.7481028,-95.37136799999996&toCoord=29.7256613,-95.33479569999997 (last visited Dec. 28, 2015).

93 *See Destinations*, Amtrak, https://www.amtrak.com/find-train-bus-stations-train-routes (last visited Dec. 28, 2015).

Second, with limited access to abortion services, women are more likely to carry an unwanted pregnancy to term, which in itself is dangerous to the mother's health. All pregnancies involve risks of both physical and psychological complications.[94] Some of these risks can be fatal, while others, such as depression, persist even after childbirth.[95] The risks associated with unwanted pregnancies are particularly troubling. Women who undergo unintended childbirth experience increased risk of maternal depression,[96] and unwanted births carry increased risks of congenital anomalies, premature delivery, and low birth weight.[97]

Texas is particularly vulnerable to the risks associated with unwanted pregnancy because the state has a high rate of maternal mortality,[98] and

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94 *See Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors*, World Health Org. (2000), http://apps.who.int/iris/bitstream/10665/43972/1/9241545879_eng.pdf.

95 *See id.*; *Pregnancy Complications*, Centers for Disease Control and Prevention (last updated Sept. 29. 2015), http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregcomplications.htm.

96 Jessica D. Gipson et al., *supra* note 25, at 28.

97 *Id.* at 24.

98 Rita Henley Jensen, *Pregnant? Watch Your Risks in Great State of Texas*, (Feb. 11, 2013),

many women live at or near the poverty level. Due to a combination of factors, including lack of access to medical services and difficulty accessing and affording contraceptives,[99] low-income women have more unintended pregnancies and higher abortion rates than women with higher incomes.[100] Depriving

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http://womensenews.org/story/sisterspace/130208/pregnant-watch-your-risks-in-great-state-texas ("The maternal mortality rate for Texas has quadrupled over the last 15 years to 24.6 out of 100,000 births in 2010); *see also 2013 Mortality*, Tex. Dep't of State Health Services, http://www.dshs.state.tx.us/chs/vstat/vs13/nmortal.aspx (last updated Sept. 4, 2015); *see also Maternal Mortality and Morbidity Task Force Report*, Tex. Dep't of State Health Services (last updated Feb. 19, 2015), http://www.dshs.state.tx.us/layouts/contentpage.aspx?pageid=29479&id=8589979757&terms=maternal+mortality; *see also* June Hanke, *Maternal Mortality and Morbidity Review*, http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwiey-jVnf_JAhWJQSYKHV6aC8sQFggdMAA&url=http%3A%2F%2Fwww.marchofdimes.org%2Fpdf%2Ftexas%2FTX_VPN_Maternal_Mortality_Morbidity_Review_-_Hanke.pdf&usg=AFQjCNGw0Ed6siiQZ4qM0l_TXUxR4lMJwg (last visited Dec. 28, 2015).

99 Dehlendorf et al. *supra* note 74, at 1772; Carole Joffe, Roe v. Wade *and Beyond: Forty Years of Legal Abortion in the United States*, Dissent (Winter 2013).

100 The rate of unintended pregnancy among women with incomes below the federal poverty line in 2008 was 137 per 1,000 women aged 15 to 44, more than five times the rate among higher-income women (26 per 1,000). *Unintended Pregnancy in the United States*, Guttmacher Institute (July 2015), http://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html.

this already vulnerable group of women of access to safe, local abortion care effectively forces them to bear the substantial and serious health consequences of unintended pregnancy and childbirth.

Third, limited access to abortion services means that some women are unlikely to be able to obtain safe and legal abortion care[101] and may turn to unsafe, illegal methods to terminate their pregnancies. Limiting access to legal abortion providers does not substantially lower pregnancy rates, nor does it eliminate the need for abortion services.[102] Instead, when access to abortion is compromised, some women will attempt to obtain abortions from unauthorized providers or through self-treatment.[103] These abortions, unlike abortions

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[101] *See* Colman & Joyce, *supra* note 60, at 777; *see also* Stanley K. Henshaw, *Factors Hindering Access to Abortion Services*, 27 Family Planning Persp. 54, 54 (1995) ("The greater the distance a woman lives from an abortion provider, the less likely she is able to use the provider's services.").

[102] Gilda Sedgh et al., *Induced Abortion: Incidence and Trends Worldwide from 1995 to 2008*, 379 The Lancet 625, 625–26 (2012) (concluding that restrictive abortion laws are not associated with lower abortion rates); *Facts on Induced Abortion Worldwide*, Guttmacher Institute (Jan. 2012), https://www.guttmacher.org/pubs/fb_IAW.html (lack of access to abortion, such as in developing countries, does not diminish need for abortion).

[103] Daniel Grossman et al., *The Public Health Threat of Anti-Abortion Legislation*, 89 Contraception 73 (2014) (seven percent of Texas women who were required to make an

performed by skilled providers, may pose higher risks of health complications and death.[104]

Self-induction has already become more common in Texas in the locations affected by H.B. 2,[105] and as clinics continue to close, it is likely that self-induction in Texas will become even more prevalent, "particularly in places like the Lower Rio Grande Valley, where . . . there is a significant population of immigrants from Latin America with knowledge of methods of self-induction and relatively easy access to misoprostol across the border in Mexico."[106] Women without access to safe,

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extra visit to undergo an ultrasound and listen to a description of its images at least 24 hours before an abortion reported self-medicating in order to attempt to end their pregnancy before visiting an abortion clinic, compared to only 2.6 percent of abortion patients nationwide who reported ever attempting to self-induce a medical abortion).

104 Gilda Sedgh et al., *supra* note 102, at 625–27 (listing reasons for higher risks of health complications associated with illegal and unsafe abortions, including delay in seeking an abortion and lack of appropriate post-abortion care).

105 Direct Testimony of Daniel Grossman, *supra* note 54, at 5; *see also* Grossman et al., *supra* note 103, 89 Contraception 73, 73 (2014) (rate of attempted self-medicated abortion even higher for women near the Mexican border, 12 percent of whom reported trying to end their own pregnancy).

106 Direct Testimony of Daniel Grossman, *supra* note 54, at 6.

legal abortion care may also resort to more traumatic methods of self-induction, including intravaginal or external manipulation.[107] A November 2015 study by the Texas Policy Evaluation Project concluded that at least 100,000 Texas women age 18 to 49—estimated to be 1.7 percent of Texas women of reproductive age—have ever attempted to end a pregnancy on their own without medical assistance.[108] Illegal abortion was a major cause of death and injury for pregnant women in the pre-*Roe* era.[109] If the challenged portions of H.B. 2 are allowed to take effect and legal abortion becomes increasingly unavailable, illegal abortion rates in Texas could rise, and with them, the attendant increased risks of death and injury.

Making abortion more difficult to obtain—with fewer facilities and doctors providing services in only a handful of Texas cities—imperils the health of women by delaying abortion until later in pregnancy,

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107 *Id.* at 5.

108 Daniel Grossman et al., *Knowledge, Opinion and Experience Related to Abortion Self-induction in Texas*, Texas Policy Evaluation Project Research Brief (Nov. 17, 2015), https://utexas.app.box.com/KOESelfInductionResearchBrief.

109 *Lessons from Before Roe: Will Past Be Prologue?*, (Mar. 2003), Guttmacher Institute, https://www.guttmacher.org/pubs/tgr/06/1/gr060108.html (noting that the death toll was one "stark indication" that illegal abortions were common).

causing some women to carry unwanted pregnancies to term, with all of the attendant serious risks to health, and increasing the incidence of unsafe, illegal abortion.

CONCLUSION

Promoting health and safety is a central rationale for states' authority to regulate health care facilities. In discharging its public health duty to promote health and safety, a state should support women and families in their choice to have children at the time that is right for them. It should not impose on abortion clinics and providers medically unnecessary restrictions that are out of touch with the modern practice of medicine and provide no benefit to public health. H.B. 2's requirements of admitting privileges for physicians and ASC standards for clinics harm women's health in Texas, particularly against the backdrop of Texas's existing abortion restrictions and lack of funding for family planning. The challenged portions of H.B. 2 not only place a substantial—and unconstitutional—burden on the exercise of a fundamental right, but threaten to significantly harm the state's public health and welfare.

For these and the foregoing reasons, *amici curiae* APHA and the signatories hereto support Petitioners and urge the Court to reverse the Fifth Circuit Court of Appeals' decision upholding the constitutionality of H.B. 2 in substantial part.

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