Nos. 21-2480 & 21-2573

IN THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

WHOLE WOMAN'S HEALTH ALLIANCE; ALL-OPTIONS, INC.; and JEFFREY GLAZER, M.D.,	)	Appeal from the United States District Court for the Southern District of Indiana
Plaintiffs-Appellees,	)	
v.	)	
	)	No. 1:18-cv-01904-SEB-MJD
TODD ROKITA, in his official capacity as Attorney General of the State of Indiana; KRISTINA BOX, M.D.; JOHN STROBEL, M.D.; and KENNETH P. COTTER,	)	The Honorable SARAH EVANS BARKER Judge Presiding.
Defendants-Appellants.	)	

BRIEF OF AMICI CURIAE ILLINOIS, CALIFORNIA, COLORADO, CONNECTICUT, DELAWARE, DISTRICT OF COLUMBIA, HAWAII, MAINE, MARYLAND, MASSACHUSETTS, MICHIGAN, NEVADA, NEW JERSEY, NEW MEXICO, NEW YORK, OREGON, PENNSYLVANIA, VERMONT, VIRGINIA, AND WASHINGTON IN SUPPORT OF PLAINTIFFS-APPELLEES AND SEEKING AFFIRMANCE

KWAME RAOUL
Attorney General
State of Illinois

SARAH A. HUNGER
Deputy Solicitor General
100 West Randolph Street
12th Floor
Chicago, Illinois 60601
(312) 814-5202
Sarah.Hunger@ilag.gov

JANE ELINOR NOTZ
Solicitor General

100 West Randolph Street
12th Floor
Chicago, Illinois 60601
(312) 814-3312

Attorneys for Amici States

(*Additional counsel on signature page)*

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Other Authorities

IDENTITY AND INTEREST OF AMICI STATES

The amici States of Illinois, California, Colorado, Connecticut, Delaware, the District of Columbia, Hawaii, Maine, Maryland, Massachusetts, Michigan, Nevada, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Vermont, Virginia, and Washington submit this brief in support of Plaintiffs-Appellees Whole Woman's Health Alliance ("WWHA"), All-Options, Inc., and Jeffrey Glazer pursuant to Federal Rule of Appellate Procedure 29(a)(2).

The amici States agree that "[t]he ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives." *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 856 (1992) (joint opinion of Justices O'Connor, Kennedy, and Souter).[1] The amici States thus have an interest in promoting the health and safety of all patients seeking abortion services by assuring the proper application of *Casey*'s undue-burden standard to prevent unwarranted burdens on the right to terminate a pregnancy.

Furthermore, the amici States have a substantial interest in ensuring the health and safety of their residents—who may need medical care while present as students, workers, or visitors in Indiana—through the enforcement of regulatory regimes that promote safe access to abortion services. Although the amici States have reached different conclusions on how best to regulate abortion care within their borders, they share an interest in promoting regulations that ensure the

[1] Unless otherwise indicated, all citations to *Casey* are to the joint opinion.

safety and accessibility of abortion services without creating an undue burden on the right to terminate a pregnancy. Regulatory schemes like Indiana's that unduly burden access to abortion care create public health risks, interfere with reproductive autonomy, and potentially place a strain on the healthcare systems of neighboring States, as some patients are likely to travel to seek the care that they need. The amici States thus have an interest in ensuring that state regulation of abortion advances public-health goals rather than unlawfully interferes with reproductive autonomy.

SUMMARY OF ARGUMENT

After conducting a seven-day trial, the district court determined that a number of Indiana statutory and regulatory provisions created an undue burden on access to abortion care and entered a permanent injunction against Defendants-Appellants Todd Rokita, Kristina Box, John Strobel, and Kenneth Cotter (hereinafter, "Indiana"). *See* Short Appendix ("SA") 156, SA159-61.[2] Specifically, the district court concluded that the following regulations were unconstitutional: (1) a limitation on the provision of first-trimester abortion to physicians as applied to medication abortions ("Physician-Only Law"); (2) a requirement that second-trimester abortions be performed in a hospital or an ambulatory surgical center ("Second Trimester Hospitalization/ASC Requirement"); (3) a requirement that all pre-abortion counseling be conducted in-person ("In-Person Counseling Requirement"); (4) a ban on the use of telemedicine to prescribe an "abortion inducing drug" ("Telemedicine Ban"); (5) a requirement that a medication abortion be preceded by an in-person examination ("In-Person Examination Requirement"); and (6) numerous structural requirements on clinic facilities that provide abortion services ("Facility Requirements"). SA156.

In reaching this decision, the district court faithfully applied *Casey*'s undue-burden standard by reviewing the evidence presented at trial, entering findings on

[2] The district court also concluded that certain mandatory disclosures "regarding fetal pain, the beginning of life, and the mental health risks of abortion . . . violate *Casey*'s truthful and non-misleading standard." SA156. Although the amici States support affirmance of that determination, this amicus brief focuses on the district court's undue-burden analysis.

the benefits and burdens of each regulation, and weighing the benefits against the burdens to determine whether the regulation imposed a substantial obstacle for patients seeking access to abortion care in Indiana. On the basis of the record presented in the district court, the amici States agree with plaintiffs that the district court's decision was correct, and that it should be affirmed by this court. They write separately, however, to highlight two aspects of the district court's undue-burden analysis that affect their state interests.

First, the district court's decision to assess plaintiffs' challenges based on facts presented in this case was correct as a matter of law. As the court rightly determined, and contrary to the assertions otherwise by Indiana and its amici, the undue-burden standard requires that courts undertake a holistic review of the record and assess whether the restrictions at issue burden access to care based on the evidence presented in each case. Not only is this approach consistent with precedent from the Supreme Court and this court, but it also allows for consideration of state-specific evidence and important medical and technological advancements.

Second, the district court properly considered a wide range of burdens when conducting its analysis, including how the regulations limited or prevented access to care in Indiana, increased travel time and costs, imposed additional delays, and affected low-income women, for whom it is more difficult to cover costs, take time off from work, and make childcare and travel arrangements. It is not the case, as Indiana and its amici suggest, that the only constitutionally relevant burdens are

those that completely prevent women from accessing abortion care. Instead, there are many types of burdens, including the burdens discussed by the district court, that can impact access to abortion care. For these reasons and those articulated by plaintiffs, the amici States urge this court to affirm the district court's judgment.

ARGUMENT

I. The Undue-Burden Standard Requires Independent Judicial Review Of The Evidence Presented In Each Case.

A State's regulation of abortion care violates the Constitution if it "has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Casey*, 505 U.S. at 877; *accord Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2310 (2016). Under *Casey*, courts must "consider the burdens a law imposes on abortion access together with the benefits th[e] law[] confer[s]." *Hellerstedt*, 136 S. Ct. at 2309. And in *Planned Parenthood of Indiana & Kentucky v. Box, Inc.*, 991 F.3d 740, 752 (7th Cir. 2021), this court noted that the *Hellerstedt* balancing test remains the governing standard notwithstanding questions that have been raised by other courts on that issue as a result of the Roberts concurrence in *June Medical Services LLC v. Russo*, 140 S. Ct. 2103 (2020). If a law fails to confer benefits "sufficient to justify [its] burdens," then it is unconstitutional. *Hellerstedt*, 136 S. Ct. at 2300.

The district court here heard seven days of testimony about the impact of the challenged Indiana restrictions on women seeking abortions. Based on that testimony, the court found that the above-referenced regulations imposed an undue burden on women seeking abortion care in Indiana. SA11, SA156. The district

court's holding, and the factual findings underlying it, were well supported and fully consistent with opinions issued by the Supreme Court and this court, as explained by plaintiffs. *See* WWHA Br. 35-60.

Indiana and its amici, however, argue that the district court erred in conducting fact-finding in its undue-burden analysis on five of the challenged restrictions—the Physician-Only Law, Second Trimester Hospitalization/ASC Requirement, In-Person Counseling Requirement, In-Person Examination Requirement, and Telemedicine Ban—because challenges to those restrictions are purportedly foreclosed by binding precedent. *See* Ind. Br. 22-26; Tex. Br. 4-10. According to Indiana and its amici, only the Supreme Court can "revisit its decisions based on any 'new' facts." Tex. Br. 10; *see also* Ind. Br. 22-26 (arguing that binding precedent bars these challenges). That argument is incorrect.

To begin, this position conflicts with a central component of the undue-burden standard: the duty to review and weigh the evidence in the record. As this court has observed, "the undue-burden inquiry requires a holistic, rigorous, and independent judicial examination of the facts of a case to determine whether the burdens are undue in light of the benefits the state is permitted to pursue." *Whole Woman's Health Alliance v. Hill*, 937 F.3d 864, 876-77 (7th Cir. 2019), *cert. denied*, 141 S. Ct. 189 (2020). Courts are thus "instructed to use a balancing test, with careful heed to the record." *Id.*; *see also, e.g.*, *Planned Parenthood of Indiana & Kentucky, Inc. v. Comm'r of Indiana State Dep't of Health*, 896 F.3d 809, 818 (7th Cir. 2018) (explaining that under *Casey*, "[t]he proper standard is for courts to

consider the evidence in the record"), *cert. granted, judgment vacated, and case remanded for future consideration by* 141 S. Ct. 184 (2020).

Although this court concluded at the stay application stage that "existing precedents provide strong grounds for concluding that Indiana is likely to prevail," it did not foreclose further review of the issues based on the evidence presented in this case. *Whole Woman's Health Alliance v. Rokita*, 13 F.4th 595, 598 (7th Cir. 2021) ("We leave the merits for resolution after full briefing and argument"). And in prior decisions, this court has rejected the notion that challenges to abortion regulations under the undue-burden standard are off-limits if an analogous law has previously been found constitutional. *Karlin v. Foust*, 188 F.3d 446, 484 (7th Cir. 1999) (acknowledging that litigants could challenge "similar abortion restrictions in other state abortion statutes that were modeled after the Pennsylvania provisions found constitutional in *Casey*"); *see also, e.g.*, *A Woman's Choice-E. Side Women's Clinic v. Newman*, 305 F.3d 684, 688 (7th Cir. 2002) (in cases involving adjudicative facts, "[f]indings based on new evidence could produce a new understanding, and thus a different legal outcome; the plurality implied this in *Casey,* as did we in *Karlin*").

It makes good sense that this court has applied the undue-burden standard to the facts before it rather than deriving broad holdings from the decisions cited by Indiana and its amici. *E.g.*, *Hill*, 937 F.3d at 875. As the Supreme Court has repeatedly explained, "[c]onstitutional questions are not to be dealt with abstractly," but instead "dealt with only as they are appropriately raised upon a record" before a

court. *Local No. 8-6, Oil, Chem. & Atomic Workers Int'l Union, AFL-CIO v. Missouri*, 361 U.S. 363, 370 (1960) (cleaned up); *see Cohens v. Virginia*, 19 U.S. 264, 399 (1821) (Marshall, C.J.) ("[G]eneral expressions, in every opinion, are to be taken in connection with the case in which those expressions are used.").

That approach, moreover, permits States to tailor regulations to the needs of their jurisdictions. *See Hillsborough Cnty. v. Automated Med. Labs., Inc.*, 471 U.S. 707, 719 (1985) (regulation of medicine is a "matter of local concern"). And it also permits courts to review the facts and circumstances on the ground to analyze whether States have, in practice, infringed constitutional rights. *See Hellerstedt*, 136 S. Ct. at 2310 (explaining that "the Court, when determining the constitutionality of laws regulating abortion procedures, has placed considerable weight upon evidence and argument presented in judicial proceedings").

The approach urged by Indiana and its amici, by contrast, would undermine these fundamental principles by eliminating a court's ability to undertake a review of a law's benefits and burdens, as is required under *Casey*. In practice, States would be able to avoid judicial scrutiny of abortion regulations, so long as the text of the challenged regulation mirrored a law that had survived a constitutional challenge at any point during the past 50 years. In other words, the constitutionality of certain abortion regulations would be set in stone under the undue-burden standard, regardless of their current real-world impact on residents or medical and technological advancements in abortion care.

When applied to the facts of this case, the consequences of Indiana's proposed standard become clear. As one example, Indiana and its amici argue that the Physician-Only Law should be upheld at the threshold because the Supreme Court upheld Montana's physician-only law in *Mazurek v. Armstrong*, 520 U.S. 968 (1997), and because no other state physician-only law has been enjoined on federal constitutional grounds. Ind. Br. 23-24. The district court, however, differentiated Indiana's law from those that have been upheld in the past based on the evidence presented at trial. SA99-100. Indeed, as plaintiffs explain in further detail, the burdens created by Indiana's law were not explored, let alone established, in *Mazurek* or in any of the other cases cited by Indiana or its amici. *See* WWHA Br. 38-39. Nor could they have been. The district court heard evidence specific to Indiana's Physician-Only Law that demonstrated how its regulatory scheme placed a substantial obstacle in the path of its affected residents.

For instance, the district court found that Indiana faces a "shortage of available physicians" that is a "real and significant barrier to abortion access in Indiana." SA105; SA22 (describing testimony on shortages). The court reviewed evidence demonstrating that as a result of this shortage, Indiana clinics are only able to schedule appointments one or two days a week or once every other week, which causes "limited capacities" and "long wait times." SA105. Against that backdrop, the court found that delaying abortion care for the periods caused by the Physician-Only Law leads to later term abortion methods and "increased risks for maternal health." *Id.* These clinics, however, already employ "dozens" of nurse

practitioners or physician assistants (also called Advanced Practice Clinicians), SA99, who "would and could provide abortion services, if permitted by law to do so," SA106. With those additional resources, "abortion clinics in Indiana would expand to provide services five days a week," which would result in reduced wait times and additional access to care. *Id.*

Compounding these burdens, the district court found, is the fact that reduction in appointment availability caused by the Physician-Only requirement especially impacts low-income women in Indiana "who struggle to arrange transportation, child care, and time off work, which are essential to accessing care." SA105. In Indiana, the travel distances for many are significant, as no "abortion clinics are located east of Indianapolis or south of Bloomington." SA23. This "deprives residents living in Indiana's second-largest and third-largest cities, Fort Wayne and Evansville, . . . from convenient geographic access to these services." *Id.* Women living in the Fort Wayne and Evansville areas must "travel 250 miles round trip to obtain abortion care in Indiana." *Id.* The district court further found that the majority of women impacted by these shortages in Indiana "are low-income individuals, living in households at or below 200% of the federal poverty line." *Id.* And, the court noted, most women seeking abortion care from these Indiana clinics "are employed in the service or labor sectors" and report that missing work creates "negative job consequences, such as termination." SA25.

Based on that evidence, which pertained specifically to Indiana and how its regulation affected women there seeking abortion care, the district court concluded

that "the Physician-Only Law, to the extent it restricts the provision of first-trimester medication abortion care to physicians only, is unduly burdensome." SA110. To be sure, as demonstrated by *Mazurek* and other cases, States can (and do) impose laws regulating who may perform abortions in a constitutional manner. But the existence of such laws does not obviate the need for independent judicial scrutiny of any regulatory regime with similar provisions. *See Hill*, 937 F.3d at 875 (explaining that although the Constitution gives States broad latitude to require that only licensed physicians may perform an abortion, it is not the case that "every licensing regime, no matter how burdensome or arbitrary, passes constitutional muster"). Instead, each regime must be scrutinized against the record evidence to determine whether its provisions unduly burden access to abortion care within the context of its State.

Another consequence of the approach to the undue-burden analysis set forth by Indiana and its amici is that it disregards advancements in medical care and technology. *E.g.*, *Rokita*, 13 F.4th at 603 (Wood, J., dissenting). Nowhere is this more evident than in the context of medication abortion. Indiana and its amici argue that the constitutionality of physician-only laws as applied to the provision of medication abortion was decided in 1997 by *Mazurek*. Ind. Br. 23; *see also* Tex Br. 5. But, as the district court noted, medication abortion did not exist at the time of that decision. SA99-100. Accordingly, the Supreme Court could not have passed on the constitutionality of laws restricting who may prescribe medication abortion or assessed how the undue-burden standard would apply in such circumstances.

Given the fact-specific nature of the undue-burden standard, it is appropriate for a court to consider medical advancements when determining whether a physician-only law is constitutional with respect to first-trimester medication abortions. And, as this court has recognized, the overwhelming evidence confirms that medication abortion is a highly safe medical procedure. *Planned Parenthood of Wisconsin, Inc. v. Schimel*, 806 F.3d 908, 913 (7th Cir. 2015). The National Academies of Sciences, Engineering, and Medicine have explained that "[c]omplications after medication abortion, such as hemorrhage, hospitalization, persistent pain, infection, or prolonged heavy bleeding, are rare—occurring in no more than a fraction of a percent of patients."[3] In trials of the drugs used for medication abortion (mifepristone and misoprostol), including more than 45,000 women conducted over nearly two decades, "[s]erious complications requiring hospitalization or transfusion occurred in less than 0.4% of patients."[4]

Medication abortion, moreover, is safe regardless of whether it is performed by a physician or an Advanced Practice Clinician. SA59-60 (collecting studies and discussing expert testimony). Indeed, many States have long allowed Advanced Practice Clinicians to conduct medication abortions, beginning with regulatory and statutory approval in California and Rhode Island, respectively, in 2002. Cal. S.B. 1301 (Reproductive Privacy Act) (approved Sept. 5, 2002); 216 R.I. Code R. § 20-10-

---

[3] Nat'l Acads. of Scis., Eng'g, & Med., The Safety and Quality of Abortion Care in the United States 55 (2018), https://bit.ly/3F0AmTP.

[4] Raymond, *et al.*, *First-Trimester Medical Abortion with Mifepristone 200 mg and Misoprostol*, 87 Contraception 26, 30 (2013), https://bit.ly/3EXmf1y.

6.3.4(a); *see also, e.g.*, Ill. Attorney General Opinion 09-002 (Mar. 5, 2009); Wash. Attorney General Opinion, AGO No. 1 2004 (Jan. 5, 2004). Now, 18 States, including many of the amici States, authorize Advanced Practice Clinicians to administer medication abortion.[5]

The Second Trimester Hospitalization/ASC Requirement provides another example where the district court correctly found on the basis of the record before it that "medical advancements . . . have developed substantially," SA112, since the cases cited by Indiana as dispositive were decided, SA110-11 (discussing *Gary-Northwest Indiana Women's Services, Inc. v. Bowen*, 496 F. Supp. 894 (N.D. Ind. 1980), *aff'd*, 451 U.S. 934 (1981), and *Simopolous v. Virginia*, 462 U.S. 506 (1983)). Undisputed record evidence showed, for instance, that osmotic dilators were not introduced into the provision of second-trimester Dilation and Evacuation ("D&E") services until the 1990s. SA112. Osmotic dilators "simplified" the D&E procedure and "increased their safety" because, among other reasons, they "do not necessitate a sterile operating room" or "the use of general anesthesia." SA113. Accordingly, it is safe to perform second-trimester abortions in "out-patient, office-based settings." *Id.* For that reason, "numerous" States, including many amici States, do not impose hospitalization requirements. *Id.*[6]

---

[5] *See* Guttmacher Inst., An Overview of Abortion Laws (Oct. 1, 2021), https://bit.ly/3qxwTrZ (California, Colorado, Connecticut, the District of Columbia, Hawaii, Illinois, Maine, Massachusetts, Montana, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, Vermont, Virginia, and West Virginia).

[6] *See also, e.g.*, Guttmacher Inst., *supra* note 5.

Finally, the district court rightly concluded that advancements in telemedicine are relevant to the constitutional analysis in this case. *E.g.*, SA37-39, SA127-28. When this court upheld the constitutionality of Indiana's In-Person Counseling Requirement in 2002—a case that Indiana cites as dispositive here of the In-Person Counseling Requirement, the In-Person Examination Requirement, and the Telemedicine Ban, Ind. Br. 25-26—the question presented was whether information must "be supplied 'in the presence of the pregnant woman'—rather than by printed brochure, telephone, or website . . . ," *Newman*, 305 F.3d at 685.

Since that time, technology has advanced to allow for secure videoconferencing between patients and healthcare providers. In fact, Indiana recently amended its statutory code to recognize these advancements, defining telehealth as "'the delivery of health care services using interactive electronic communications and information technology, . . . including: (1) secure videoconferencing; (2) store and forward technology; or (3) remote patient monitoring technology . . . .'" SA31 n.17 (quoting Ind. Code § 25-1-9.5-6(a)). As the district court rightly concluded, with this new technology, "the personal interactions between providers and patients are enabled to a degree that the same quality and kind of communications occurs with patients as would have occurred in person." SA126.

In addition to improvements to the technology itself, the use of telemedicine has become more widespread, as the district court noted. SA36-37. In Indiana, for example, providers who practice in non-abortion contexts may use telemedicine to

treat patients and prescribe controlled substances, SA37 (citing Ind. Code §§ 25-1-9.5-1 to 25-1-9.5-12), and insurance policies must cover telemedicine services on the same terms as in-person services, *id.* (citing Ind. Code §§ 27-8-34-1 to 27-8-34-7, 27-13-1-34, 27-13-7-22). Moreover, telemedicine has increased in prevalence (and likely will continue to do so) because, in response to the Covid-19 pandemic, many States expanded the scope of authorized telemedicine to promote access to care and conserve healthcare resources.[7] For example, some States suspended rules governing when individuals may access telemedicine, including rules prohibiting the use of telemedicine for new conditions and rules requiring an existing patient-provider relationship before telemedicine is authorized.[8] Others suspended

[7] *E.g.*, Cal. Exec. Dep't, Executive Order N-43-20 (Apr. 3, 2020), https://bit.ly/3bWLX9G; Del. Office of the Governor, Second Modification: Declaration of a State of Emergency (Mar. 18, 2020), https://bit.ly/3wr2goQ; Haw. Office of the Governor, Exec. Order 20-02 (Mar. 29, 2020), https://bit.ly/3CRJPvX; Ill. Executive Order, 2020-09 (Mar. 19, 2020), https://bit.ly/3qmHSEi; Md. Office of the Governor, Exec. Order 20-04-01-1 (Apr. 1, 2020), https://bit.ly/3qjWq7S; Minn. Office of the Governor, Emergency Exec. Order 20-28 (April 6, 2020), https://bit.ly/31xL7yk; Ch. 3, 2020 N.J. Laws (Mar. 19, 2020) (A3860); N.Y. Office of the Governor, Exec. Order No. 202.1, 9 N.Y.C.R.R. § 8.202.1 (2020); N.Y. Dep't of Health, New York State Medicaid Update - Vol. 37, No. 7, Telehealth (June 2021); R.I. Office of the Governor, Exec. Order 20-06 (Mar. 18, 2020), https://bit.ly/3o6lsod; Vt. Exec. Dep't, Exec. Order No. 01-20, https://bit.ly/3EUHkJL; Va. Office of the Governor, Exec. Order No. 57 (Apr. 17, 2020), https://bit.ly/3kkSEXR.

[8] *See, e.g.*, Del. Office of the Governor, Eighth Modification: Declaration of a State of Emergency (Mar. 30, 2020), https://bit.ly/302CJqp; Haw. Office of the Governor, Exec. Order 20-02, *supra* note 7; Md. Office of the Governor, Order No. 20-04-01-01, *supra* note 7; Mass. Bd. of Registration in Med., Policy 2020-01, Policy on Telemedicine in the Commonwealth (June 25, 2020), https://bit.ly/3CWsgLh.

provisions prohibiting the use of telemedicine for prescribing certain categories of regulated drugs.[9]

As the district court noted, telemedicine offers patients a safe and effective way to access healthcare, including early abortion care. *E.g.*, SA33-34. Providers are able to effectively conduct counseling, evaluate a patient's suitability for an abortion, identify potential risk factors, and prescribe medication. SA33. When medically appropriate, the use of telemedicine also lessens the burdens associated with in-person appointments, such as travel costs, requesting time off work, and securing childcare. SA35-36, SA39. Finally, telemedicine allows providers to conserve resources and see more patients, including women in underserved or rural areas who may otherwise find it challenging to secure abortion care. SA38-39. The district court correctly reviewed these considerations, *e.g.*, SA128-30, in determining that Indiana's refusal to allow the provision of any services related to abortion through telemedicine, as reflected in the In-Person Counseling Requirement, the In-Person Examination Requirement, and the Telemedicine Ban, violates the Constitution.

In sum, the district court made findings of fact regarding the impact of the challenged regulations on women in Indiana based on the extensive record compiled by the parties, and carefully applied *Casey*'s undue-burden standard to those

[9] *See* Cal. Dep't of Health Care Servs., Behavioral Health Information Notice No. 20-009 (updated May 20, 2020), https://bit.ly/3qiS2pr; Haw. Office of the Governor, Eighth Supplementary Proclamation Related to the COVID-19 Emergency (May 18, 2020), https://bit.ly/30eakgV.

findings. The request by Indiana and its amici that this court bypass the district court's findings should be rejected.

II. The District Court Correctly Considered A Wide Range Of Burdens In Its Analysis.

As explained, the undue-burden standard requires courts to assess whether the benefits of the challenged regulations outweigh the burdens that they impose on women seeking access to abortion care. *E.g.*, *Box*, 991 F.3d at 752. The district court adhered to that standard: it entered detailed findings on the benefits and burdens of each of the enjoined regulations and explained why the many burdens demonstrated by the record—such as limited access to care, cost, travel, and delay—amounted to a substantial obstacle, rendering the regulations unconstitutional. SA99-108 (Physician-Only Law), SA110-17 (Second Trimester Hospitalization/ASC Requirement), SA117-22 (Facility Requirements), SA126-33 (In-Person Counseling Requirement), SA133-39 (Telemedicine Ban and In-Person Examination Requirements).

One of the grounds upon which Indiana and its amici seek reversal is an alleged lack of record evidence showing "that Indiana's abortion laws have decreased the overall number of women able to obtain an abortion in Indiana." Ind. Br. 27; Tex. Br. 10-11. They argue that the district court's analysis instead improperly relied only on evidence that the challenged restrictions "delay[ ] or increase[ ] the cost of an abortion." Ind. Br. 29; *see also* Tex. Br. 11. Those burdens, they assert, are legally insufficient to establish a substantial obstacle to abortion access. Ind. Br. 29; Tex. Br. 12-14. This argument is unfounded.

At the threshold, Indiana and its amici misconstrue the district court's findings. The district court specifically addressed and rejected the argument that Indiana's "abortion regulations do not prevent women from accessing abortion in Indiana." SA30. Indeed, the court found that plaintiffs "have presented at this trial substantial, highly persuasive evidence to the contrary, demonstrating that under Indiana's onerous requirements, Indiana women who must contend [ ] with the above-referenced burdens, either struggle or ultimately fail to overcome them, causing them to travel to neighboring states." *Id.*; *see also, e.g.*, SA74 ("The evidence reflects that it is not uncommon for women in Indiana to need second-trimester care but be unable to access it. Dr. Bernard testified that she encounters at least one patient a month whom she must refer out of state for second-trimester services."); SA105 ("Plaintiffs' evidence establishes that limited physician availability is a real and significant barrier to abortion access in Indiana."). As this court has explained, requiring an individual to seek care from another jurisdiction is the equivalent of denying them access to care. *Schimel*, 806 F.3d at 918.

The district court, moreover, detailed how the challenged regulations limit access to care in Indiana. For instance, with respect to the Second Trimester Hospitalization/ASC Requirement, the court found, based on the evidence presented, that no abortion clinic in Indiana "provides abortion services after the first trimester." SA21. The court further found "that, without this law, Indiana's abortion clinics in Merrillville, Indianapolis, and Bloomington . . . would provide second-trimester abortion care." SA116. And although five hospitals in the State

provide second-trimester services, they are all located in or near Indianapolis and will only perform a second-trimester abortion "if a maternal or fetal indication has presented." SA22-23. Because abortion care is usually not covered by insurance, women who fit within those categories—and thus are able to receive treatment at an Indiana hospital—often pay upwards of $20,000 for a second-trimester abortion. SA75, SA115. At clinics, however, second-trimester abortions typically cost between $800 and $2,400. SA75. The "sparse availability of facilities," combined with the increased cost, the district court concluded, "force most Indiana women to travel out of state to receive second-trimester abortions." SA116.

Indeed, the district court found, based on the evidence presented at trial, that women from Indiana regularly travel to Illinois, Ohio, or Kentucky to obtain abortions. SA73-74. For example, one Illinois-based practitioner testified that "approximately one out of nine second-trimester patients for whom she provides care . . . has traveled to her Chicago facility from Indiana" because of an inability "to access abortion care in Indiana." SA74. Similarly, Indiana-based practitioners testified that they regularly refer patients to out-of-state clinics to receive abortion care that they cannot access in Indiana. *Id.*

It is thus untrue, as Indiana and its amici assert, that the district court failed to consider whether the challenged restrictions prevented Indiana women from accessing abortion care. *See also, e.g.*, SA105 (finding, in context of Physician-Only Law, that the "evidence clearly establishes that delays of this nature and for these reasons regularly affect the availability of abortion care services for which a woman

may be eligible"); SA122 ("these facility restrictions do not achieve any purpose beyond unnecessarily restricting who can provide abortion care and, in turn, limiting access to abortion services"); SA139 (finding, in context of Telemedicine Ban and In-Person Examination Requirement, that the "burdens imposed by such laws which include a reduction in access to care with no offsetting medical benefits cannot be deemed anything other than undue").

In addition to preventing women in Indiana from accessing abortion care, the district court properly concluded that the enjoined regulations burden Indiana women in a number of other meaningful ways. To start, the court entered detailed findings on how restricting in-state care affects Indiana women. For many, making the necessary travel arrangements to obtain abortion care in other States can be difficult, especially for women who rely on public transit, lack disposable income, or provide care to children or other dependents. *E.g.*, SA28, SA74-75. To access out-of-state care, "women will scrape together every penny they have to pay" for the travel and lodging expenses and, often, that is not enough. SA74-75 (cleaned up). As the district court found, "[m]any women sleep in their cars or bus stations," SA75, and others forego timely payments on rent and utility bills, take out payday loans, or pawn their belongings, SA28. In addition to those financial costs, many women face exacerbated stress levels when trying to "maintain their employment relationships and secure adequate child care for other children." SA75.

The district court also discussed how the enjoined regulations impose similar burdens on women who manage to access care in Indiana, such as significant

additional costs, lengthier distances to obtain care, and limited capacity at the few clinics in Indiana that provide abortion care. SA105, SA115, SA118, SA131, SA137. And, the court further found, the regulations cause women to receive delayed treatment, which, in turn, exposes them to elevated medical risks and forces them to endure the physical and emotional aspects of pregnancy for an extended period of time. SA105, SA131, SA138. These burdens are felt to an even greater extent among low-income women "who struggle to arrange transportation, child care, and time off work, which are essential to accessing care." SA105; *see also* SA115, SA118, SA131.

Indiana and its amici incorrectly argue that the district court should not have relied on these findings because burdens short of total deprivation of abortion access cannot, as a matter of law, amount to an unconstitutional undue burden. Ind. Br. 29; Tex. Br. 12-13. They assert that courts have only ever credited burdens that completely prevent women from accessing abortion, specifically: (1) "[s]hutting down so many clinics that women cannot obtain abortions"; (2) "[p]reventing so many doctors from performing abortions that women cannot obtain abortions"; and (3) "[r]equiring spousal-notice such that women may be precluded from obtaining abortions by their husbands." Tex. Br. 13. This position finds no support in relevant precedent. *E.g.*, *June Medical Servs. LLC*, 140 S. Ct. at 2133 (rejecting State's argument that undue-burden analysis requires evidence that it is "nearly impossible" to obtain an abortion and noting that "[s]ince *Casey*, we have repeatedly reiterated that the plaintiff's burden in a challenge to an abortion regulation is to

show that the regulation's purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus") (cleaned up).

On the contrary, both the Supreme Court and this court have recognized that the undue-burden analysis includes, where relevant, consideration of burdens beyond complete inability to access care, such as additional travel, increased cost, elevated medical risk, decreased capacity at abortion clinics, and delayed access to treatment. *E.g.*, *Hellerstedt*, 136 S. Ct. at 2313; *Schimel*, 806 F.3d at 919-20. To be sure, there are cases in which some or all of those burdens did not create a substantial obstacle. *E.g.*, *Casey*, 505 U.S. at 886 ("We do not doubt that, as the District Court held, the waiting period has the effect of increasing the cost and risk of delay of abortions, but the District Court did not conclude that the increased costs and potential delays amount to substantial obstacles.") (cleaned up). But, as explained, *see supra* Section I, those decisions do not foreclose review of these burdens in other cases or obviate the need to conduct an undue-burden analysis in each case.

In *Hellerstedt*, for example, the Court's conclusion that the admitting-privileges requirement at issue was unconstitutional rested in part on its finding that the requirement resulted in "fewer doctors, longer waiting times, and increased crowding." 136 S. Ct. at 2313; *see also June Med. Servs.*, 140 S. Ct. at 2129 (discussing longer waiting times and increased crowding). It also recognized that after the requirement went into effect, women faced "increased driving distances" of more than 200 miles. *Hellerstedt*, 136 S. Ct. at 2313*; see also June Medical Servs.*,

140 S. Ct. at 2130 (noting that women would face "increased driving distances" of up to five hours); *Planned Parenthood of Indiana & Kentucky, Inc.*, 896 F.3d at 832 (finding "the burden imposed by the double travel requirement" to be "great").

Courts have also considered the many ways in which abortion regulations that delay access to care can burden women. For instance, the Supreme Court has recognized, in the context of finding a law to be unconstitutional, that delayed receipt of care can cause an increased risk "that a woman will experience complications from the procedure." *June Med. Servs.*, 140 S. Ct. at 2130. It has also taken into account how delayed care near the end of the first trimester can make it "impossible" for women "to choose a noninvasive medication abortion." *Id.*; *see also, e.g.*, *Schimel*, 806 F.3d at 918 (relying on findings that, as a result of delays, "[s]ome women would have to forgo first-trimester abortions and instead get second-trimester ones, which are more expensive and present greater health risks," and "[o]ther women would be unable to obtain any abortion, because the delay would push them past" the deadline for obtaining an abortion in Wisconsin).

Finally, the Supreme Court and this court have discussed the disproportionate effects of abortion regulations on low-income women when determining the constitutionality of such regulations. *E.g.*, *June Med. Servs.*, 140 S. Ct. at 2130 ("both experts and laypersons testified that the burdens of this increased travel would fall disproportionately on poor women, who are least able to absorb them"); *Planned Parenthood of Indiana & Kentucky, Inc.*, 896 F.3d at 832 (noting that the law "creates significant financial and other burdens on . . . patients,

particularly low-income women in Indiana who face lengthy travel"). As one example, this court in *Schimel* relied on its findings that the challenged abortion regulations disproportionately burdened low-income women. The court noted, in the course of deeming Wisconsin regulations unconstitutional, that "more than 50 percent of Wisconsin women seeking abortions have incomes below the federal poverty line," and recognized that for such women the cost of travel and an overnight stay "may be prohibitively expensive." *Schimel*, 806 F.3d at 919. Furthermore, it might not be feasible for them "to take the time required for the round trip away from their work or the care of their children." *Id.*

In short, the district court properly considered a wide range of burdens, such as inaccessible care, travel, cost, and delay, as well as the impact of those burdens on low-income women, when conducting its analysis in this case.

CONCLUSION

For these reasons, this court should affirm the district court's judgment.

Respectfully submitted,

KWAME RAOUL
Attorney General
State of Illinois

JANE ELINOR NOTZ
Solicitor General

100 West Randolph Street
12th Floor
Chicago, Illinois 60601
(312) 814-3312

/s/ Sarah A. Hunger
SARAH A. HUNGER
Deputy Solicitor General
100 West Randolph Street
12th Floor
Chicago, Illinois 60601
(312) 814-5202
Sarah.Hunger@ilag.gov

ROB BONTA
Attorney General
State of California
1300 I Street
Sacramento, CA 95814

WILLIAM TONG
Attorney General
State of Connecticut
165 Capitol Avenue
Hartford, CT 06106

KARL A. RACINE
Attorney General
District of Columbia
400 6th Street, NW, Suite 8100
Washington, D.C. 20001

AARON M. FREY
Attorney General
State of Maine
6 State House Station
Augusta, ME 04333

MAURA HEALEY
Attorney General
Commonwealth of Massachusetts
One Ashburton Place
Boston, MA 02108

AARON D. FORD
Attorney General
State of Nevada
100 North Carson St.
Carson City, NV 89701

HECTOR BALDERAS
Attorney General
State of New Mexico
Post Office Drawer 1508
Santa Fe, NM 87504

PHILIP J. WEISER
Attorney General
State of Colorado
1300 Broadway, 10th Floor
Denver, CO 80203

KATHLEEN JENNINGS
Attorney General
State of Delaware
820 North French Street
Wilmington, DE 19801

CLARE E. CONNORS
Attorney General
State of Hawaii
425 Queen Street
Honolulu, HI 96813

BRIAN E. FROSH
Attorney General
State of Maryland
200 Saint Paul Place
Baltimore, MD 21202

DANA NESSEL
Attorney General
State of Michigan
P.O. Box 30212
Lansing, MI 48909

ANDREW J. BRUCK
Acting Attorney General
State of New Jersey
25 Market Street
Trenton, NJ 08625

LETITIA JAMES
Attorney General
State of New York
The Capitol
Albany, NY 12224

ELLEN F. ROSENBLUM
Attorney General
State of Oregon
1162 Court Street NE
Salem, OR 97301

THOMAS J. DONOVAN, JR.
Attorney General
State of Vermont
109 State Street
Montpelier, VT 05609

ROBERT W. FERGUSON
Attorney General
State of Washington
1125 Washington St. SE
Olympia, WA 98504

JOSH SHAPIRO
Attorney General
Commonwealth of Pennsylvania
Strawberry Square
Harrisburg, PA 17120

MARK R. HERRING
Attorney General
Commonwealth of Virginia
202 North 9th Street
Richmond, VA 23219

CERTIFICATE OF COMPLIANCE WITH CIRCUIT RULE 29

I certify that this brief complies with the type volume limitations set forth in Circuit Rule 29, in that the text of the brief, including headings, footnotes, and quotations, but excluding the cover page, the table of contents, the table of authorities, the signature block, and this certificate and the certificate of service, contains 5,966 words. In preparing this certificate, I relied on the word count of the Microsoft Word 2021 word processing system used to prepare this brief.

/s/ Sarah A. Hunger
SARAH A. HUNGER
Deputy Solicitor General
100 West Randolph Street
12th Floor
Chicago, Illinois 60601
(312) 814-5202
Sarah.Hunger@ilag.gov

CERTIFICATE OF FILING AND SERVICE

I hereby certify that on November 8, 2021, I electronically filed the foregoing Brief of Amici Curiae Illinois, *et al.*, with the Clerk of the Court for the United States Court of Appeals for the Seventh Circuit by using the CM/ECF system. I further certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

/s/ Sarah A. Hunger
SARAH A. HUNGER
Deputy Solicitor General
100 West Randolph Street
12th Floor
Chicago, Illinois 60601
(312) 814-5202
Sarah.Hunger@ilag.gov