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.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF OF *AMICUS CURIAE* AMERICAN PUBLIC HEALTH ASSOCIATION IN SUPPORT OF PETITIONERS

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STATEMENT OF INTEREST OF *AMICUS CURIAE*

The American Public Health Association ("APHA") submits this brief as *amicus curiae* in support of the petition for a writ of certiorari made by 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]

APHA's 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.

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[1] Pursuant to Supreme Court Rule 37.2, we have timely notified the parties of our intent to file an *amicus curiae* brief. The parties have consented. 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 *amicus curiae*, its members, and its counsel—contributed money intended to fund the preparation or submission of this brief.

It has been the longstanding position of APHA 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 legislation that makes abortion services unnecessarily difficult to obtain or imposes physical or mental health risks on women seeking abortion services without valid medical reason. APHA also opposes legislation that impedes women's ability to access abortion services in a timely manner. This includes legislation that forces women to navigate (1) increased travel distances to reach quality abortion services, (2) increased costs, (3) a reduced number of abortion providers, and (4) delays in accessing services overall.

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 ("TPHA"), 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 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 that abortion facilities qualify as ambulatory surgical centers (the "ASC Requirement"). These requirements not only pose substantial and unconstitutional obstacles to the exercise of a constitutional right, as Petitioners argue, but they also pose a grave risk to public health.

Legal abortion is extremely safe and the requirements imposed by H.B. 2 will not make it safer. Requiring providers in Texas to have admitting privileges at local hospitals or their facilities to meet standards designed for ambulatory surgical centers ("ASC") serves only to impede and diminish access to reproductive care. 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 providers and depriving women in Texas of safe, local reproductive care, H.B. 2 creates a substantial risk that women will seek later and riskier abortions, resort to illegal abortions, or face the serious mental and physical health risks of being forced to carry unwanted pregnancies to term.

For these and the reasons set forth below, APHA supports Petitioners' request for a writ of certiorari and urges the Court to review the Fifth

Circuit Court of Appeals' decision upholding H.B. 2 in substantial part.

ARGUMENT

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

H.B. 2 jeopardizes 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. APHA approaches abortion as a question of public health and 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 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 not only creates a "substantial obstacle" to the exercise of a substantive due process right and denies women equal protection of the laws, as demonstrated by Petitioners, but also creates a severe, immediate, and concrete risk to public health.[2]

APHA is not alone in recognizing that meaningful access to abortion is essential to public health. The American College of Obstetricians and Gynecologists ("ACOG") supports the "availability of reproductive health services for all women, including strategies to reduce unintended pregnancy and to improve access to safe abortion services"[3] 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

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

[3] Am. Coll. Obstetricians & Gynecologists, *Committee Opinion No. 424—Abortion Access and Training* 1 (Jan. 2009).

failure . . . ."[4] The World Health Organization's 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.[5] Like APHA, these organizations recognize safe, legal abortion as a critical component of reproductive health in particular and public health generally.

II. Public Health Is Suffering in Texas Due to Preexisting Abortion Restrictions and Lack of Family Planning.

Women in Texas are particularly vulnerable to the risk of serious negative health consequences from H.B. 2 because the state already has numerous laws that limit and delay access to abortion care. In Texas, a woman seeking to obtain an abortion must first participate in state-directed counseling that includes information designed to discourage her from having an abortion,[6] then wait at least 24 hours before undergoing the procedure.[7] She must

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

[5] *About Us*, WORLD HEALTH ORG., DEP'T REPROD. HEALTH & RESEARCH, http://www.who.int/reproductivehealth/about_us/en/.

[6] TEX. HEALTH & SAFETY CODE ANN. §§ 171.011–171.016 (WEST 2003).

[7] *Id.*

undergo a state-mandated ultrasound examination during which her doctor is required to show and describe the image of the fetus to her.[8] For women who live within 100 miles of the clinic, Texas law requires a preliminary trip to the clinic for the ultrasound examination at least 24 hours in advance of the abortion procedure.[9] The burden is even greater after 16 weeks of pregnancy, when women are required to travel to an ASC or hospital that is willing to provide abortion care[10]—only a handful of which exist in Texas.[11] And after 20 weeks of pregnancy, abortion is unavailable in Texas.[12]

Legislative restrictions on abortion access have a particularly meaningful impact on public health in Texas because of 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.[13] A year later, in 2011, the Texas

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8 TEX. HEALTH & SAFETY CODE ANN. § 171.012 (West 2003).

9 *Id.*

10 TEX. HEALTH & SAFETY CODE ANN. § 171.004 (West 2003).

11 *See* ROA.2370; Silvie Colman & Ted Joyce, *Regulating Abortion: Impact on Patients and Providers in Texas*, 30 J. Pol'y Analysis & Mgmt. 775 (2011).

12 TEX. HEALTH & SAFETY CODE ANN. § 171.044 (West 2003).

13 Guttmacher Institute, *State Facts On Public Funding: Texas* 1 (2014), https://www.guttmacher.org/statecenter/

legislature cut funding for family planning by 66%, causing at least 150,000 women to lose access to preventive care and birth control.[14] By stripping the state's public health system of publicly supported family planning services, 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.[15]

III. 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—pose a serious threat to 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.

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family-planning/TX.html; H.B. 1 82ND LEG., REG. SESS. (Tex. 2011).

[14] Crystal Condle, *Physicians Worry About Women's Access to Care*, 108 TEX. MED. no. 7, 18–25 (2012).

[15] Guttmacher Institute, *State Facts On Public Funding: Texas* 3 (2014), https://www.guttmacher.org/statecenter/family-planning/TX.html.

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 two requirements at issue—the Admitting Privileges Requirement and the ASC Requirement—provide no meaningful medical benefit. Instead, by making abortion care far more difficult to obtain, they impose the meaningful risks to physical and mental health associated with delaying abortions or forcing women to carry unwanted pregnancies to term. Each requirement imposes 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.[16]

Legal abortion is extremely safe. It is one of the "most common and safest gynecologic

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[16] Am. Pub. Health Ass'n, *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* (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.

interventions in the United States."[17] Over 90% of U.S. abortions are performed in outpatient settings,[18] and hospitalization due to an abortion is exceedingly rare.[19] In a medical abortion, the patient ingests oral medication at the facility, and typically the abortion itself takes place outside the facility. The "risks associated with taking [the oral medication are] similar to taking Tylenol."[20] Moreover, almost all post-abortion complications are treated on an outpatient basis.[21] Most women do not

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17 Am. Pub. Health Ass'n, *Policy Statement No. 20122—Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants* (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.

18 Rachel Jones & Kathryn Kooistra, *Abortion Incidence and Access to Services in the United States, 2008*, 43 PERSP. ON SEXUAL & REPROD. HEALTH 41, 46 (2011).

19 National Abortion Federation, Safety of Abortion, http://prochoice.org/wp-content/uploads/safety_of_abortion.pdf.

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

21 *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").

experience complications ***at all*** after a first-trimester abortion, and serious complications, such as hospital admission, surgery, or a blood transfusion, occur in merely 0.23% of the patient population.[22] In the rare event that complications arise, they occur most often at the patient's home, and the patient is treated at her local hospital by emergency medical personnel, not at the abortion facility.

From 2009 through 2012 (the last year data is available), the Texas Department of State Health Services did not report a single abortion-related death;[23] only five such deaths have been reported in Texas since 2002.[24] The risk of death during childbirth is far greater than in connection with legal abortion.[25] So few abortion patients require

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[22] Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 OBSTETRICS & GYNECOLOGY 175, 181 (2015).

[23] *Selected Characteristics of Induced Terminations of Pregnancy Texas Residence*, TEX. DEP'T OF ST. HEALTH SERVICES, http://www.dshs.state.tx.us/chs/vstat/vs12/t33.shtm.

[24] Brooks Egerton, *Abortion in Texas: Facts, Figures, Questions and Answers*, THE DALLAS MORNING NEWS (2013), *http://watchdogblog.dallasnews.com/2013/07/abortion-in-texas-facts-figures-questions-and-answers.html/.*

[25] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119(2) OBSTETRICS & GYNECOLOGY 5, 7 (2012) ("Legal abortion in the United

hospitalization that a doctor whose primary practice involves the provision of outpatient abortion care who seeks hospital admitting privileges is unlikely to satisfy minimum annual patient admission requirements—a common criterion in granting admitting privileges.[26]

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 further limits women's access to legal abortion while providing no 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

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States remains much safer than childbirth. The difference in risk of death is approximately 14-fold.").

[26] Sandhya Somashekhar, *Admitting-Privileges Laws Have Created High Hurdle or 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.

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[27]—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 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

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27 Upadhyay et al. at 181.

28 Glenn Hegar, *Relating to the regulation of abortion procedures, providers, and facilities; providing penalties: Statement of Opposition to Sec. 2 of the Committee Substitute for Senate Bill 5*, *Texas Hospital Association*.

29 *See* Christine Dehlendorf & Tracy Weitz, *Access to Abortion Services: A Neglected Health Disparity*, 22 J. HEALTH CARE FOR POOR & UNDERSERVED 415, 417 (2011).

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 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] The closure rate is likely to increase because of the burdens H.B. 2 places on both hospitals and physicians. As the Texas Hospital Association has recognized, H.B. 2 puts the burden on hospitals to extend admitting privileges to physicians who do not practice there.[32] That is a time-consuming and expensive process that hospitals 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. It does not serve the purpose for

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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] *Id.*

which privileges were intended,[33] and hospitals may be disinclined to support it.

For those hospitals willing to entertain privileges applications, the requirements vary widely. Each hospital 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. Doctors applying to meet these standards also face substantial challenges, including time away from their patients to navigate the hospital requirements and to complete the often lengthy application process. Even then, some hospitals—on religious grounds or in an attempt to avoid entanglement in abortion politics—deny privileges to doctors who perform abortions.[34] The Admitting Privileges Requirement forces both providers and hospitals 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.

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[33] *Id.*

[34] Somashekhar, *supra* note 26; *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 that revoked the plaintiff physicians' admitting privileges. The hospital admitted in its revocation letters that it was revoking the physicians' privileges on the illegal basis of their provision of abortions at other, unrelated facilities. *See* TEX. OCC. CODE § 103.002(b) (WEST 1999).

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

The ASC Requirement of H.B. 2 is at odds with medical standards and the public health. Historically, the overwhelming majority of abortions in Texas—87% in 2010—are not surgical and are performed on an outpatient basis in clinics or physicians' offices.[35] The ASC requirement eliminates those options by forcing each facility that provides abortions of any type—including early-stage and medical abortions—to meet the costly standards required of an ambulatory surgical center. But that requirement does not benefit the public because legal abortion is a safe procedure and is not made safer by being performed in an ASC.[36]

ASC standards are inappropriate and unattainable for most abortion clinics. They are far

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[35] Direct Testimony of Elizabeth Gray Raymond at 3, *Whole Woman's Health v. Lakey*, 46 F. Supp. 3d 673 (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).

[36] Texas Policy Evaluation Project, *Fact Sheet: Ambulatory Surgical Center Laws and the Provision of First-Trimester Abortion Care* (July 6, 2015), http://www.utexas.edu/cola/orgs/txpep/_files/pdf/ASC%20fact%20sheet%20updated%20July%206.pdf. (percentage of abortions resulting in major complications was similar for office-based clinics, ASCs, and hospital-based clinics).

more analogous to those of a hospital than a doctor's office. ASC standards include hospital-like requirements for operations (record systems, patient rights, quality assurance, staffing, and cleanliness), fire prevention and safety, and physical plant (location, physical construction, electrical, plumbing, *et cetera*).[37] To satisfy these, clinics must make transformative and expensive renovations that have little or nothing to do with the patient services they provide. For example, a clinic that provides only medically-induced early-stage abortion—which, in Texas, involves on-site pill ingestion—must replace patient rooms with wholly unnecessary full operating suites, build standard janitors' closets, and install sophisticated air filtration systems,[38] none of

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[37] *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.

[38] Tara Culp-Ressler, *Texas Clinics Won't Be Able To Give Out The Abortion Pill Without Hospital-Like Facilities*, THINK PROGRESS (June 10, 2015), http://thinkprogress.org/health/2015/06/10/3668277/texas-surgical-center-abortion-law ("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.").

which provide any additional medical benefit for their patients.[39]

IV. 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.[40] When clinics close and doctors can no longer practice, women are left with significantly fewer locations to obtain a safe and legal abortion. The existing ASCs are unlikely to be able to provide care for the large number of patients who seek abortions in Texas each year, leaving the population without essential reproductive health care.[41] By forcing reproductive care facilities to close

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[39] Texas Policy Evaluation Project, *Abortion Restrictions in Context* (July 2013), http://www.utexas.edu/cola/orgs/txpep/_files/pdf/AbortionRestrictionsinContext-LiteratureReview.pdf ("The physical plant upgrades and staffing requirements for an ASC are not warranted for abortion performed up to 18 weeks . . .").

[40] Petition for a Writ of Certiorari at 10, *Whole Woman's Health v. Cole*, No. 15-274 (filed Sept. 2, 2015).

[41] Direct Testimony of Daniel Grossman at 11, *Whole Woman's Health v. Lakey*, 46 F. Supp. 3d 673 (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) [hereinafter "Direct Testimony of Daniel Grossman"].

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 obtain later, riskier abortions; resort to illegal and unsafe procedures; 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. H.B. 2 will have particularly devastating effects on the health and safety of low-income and rural women, who already face considerable barriers to critical health care.

If H.B. 2 takes effect, abortion services in Texas will be geographically concentrated and drastically reduced, with fewer facilities and physicians available to serve the same population. In fact, 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.[42] The rest of the 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, and patients may be forced to wait longer for care or find there is no capacity for such care.

By substantially reducing abortion care, H.B. 2 poses a serious threat to public health in Texas, in numerous ways.

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[42] Direct Testimony of Daniel Grossman at 13.

First, limited access to abortion services means that some women are unlikely to be able to obtain safe and legal abortion care[43] and will 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.[44] Instead, when access to abortion is compromised, some women will attempt to obtain abortions from unauthorized providers or through self-treatment.[45] These abortions, unlike abortions

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[43] *See* Silvie Colman & Ted Joyce at 777–79; *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.").

[44] 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); Guttmacher Institute, *Facts on Induced Abortion Worldwide* (Jan. 2012), http://www.guttmacher.org/pubs/fb_IAW.html#r15a (lack of access to abortion, such as in developing countries, does not diminish need for abortion).

[45] Heather Boonstra & Adam Sonfield, Guttmacher Institute, *Rights Without Access: Revisiting Public Funding of Abortion for Poor Women* 10 (2000), http://www.guttmacher.org/pubs/tgr/03/2/gr030208.html; Daniel Grossman et al., *The Public Health Threat of Anti-Abortion Legislation*, 89 CONTRACEPTION 73 (2014) (7% of Texas women who were required to make an extra visit to

performed by skilled providers, may pose higher risks of health complications and death.[46]

Illegal abortion was a major cause of death and injury for pregnant women in the pre-*Roe* era[47] and is likely to be again in Texas if H.B.2 takes effect. Self-induction has already become more common in Texas in the locations affected by H.B. 2,[48] 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

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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% of abortion patients nationwide who reported ever attempting to self-induce a medical abortion).

[46] Gilda Sedgh et al. (listing reasons for higher risks of health complications, including delay in seeking an abortion and lack of appropriate post-abortion care).

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

[48] Direct Testimony of Daniel Grossman at 5; *see also* Daniel Grossman et al., *The Public Health Threat of Anti-Abortion Legislation*, 89 CONTRACEPTION 73, 73 (2014) (rate of attempted self-medicated abortion even higher for women near the Mexican border, 12% of whom reported trying to end their own pregnancy).

knowledge of methods of self-induction, and relatively easy access to misoprostol across the border in Mexico."[49] Women without access to safe, legal abortion care may also resort to more traumatic methods of self-induction including intravaginal or external manipulation.[50]

Second, 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.[51] Abortions performed later in a pregnancy carry more risk, and women should not be forced to have a later-term abortion with its associated health risks when they wish to have one at an earlier stage in their pregnancy.

Delays in seeking abortion services stem from both the time required to traverse hundreds of miles to the nearest abortion clinic and the time required to raise enough money to fund transportation, overnight lodging, child care, and other attendant

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[49] Direct Testimony of Daniel Grossman at 6.

[50] *Id.* at 5.

[51] *See* Sharon A. Dobie et al., *Abortion Services in Rural Washington State, 1983–1984 to 1993–1994: Availability and Outcomes*, 31 FAMILY PLANNING PERSP. 241, 244–45 (1999), https://www.guttmacher.org/pubs/journals/3124199.html.

costs of travel,[52] as well as the time to secure an appointment if services are reduced. Women who would prefer to have an earlier abortion are often forced to delay the procedure due to lack of funds and transportation costs.[53] 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.[54] In addition, the cost of abortion rises proportionately with the length of pregnancy,[55] so

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

[53] Lawrence B. Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 CONTRACEPTION 334, 341–44 (2006); Aida Torres & Jacqueline Darroch Forrest, *Why Do Women Have Abortions?*, 20 FAMILY PLANNING PERSP. 169, 175–76 (1988); *see* Rachel K. Jones & Jenna Jerman, *How Far Did US Women Travel for Abortion Services in 2008?*, 22 J. WOMEN'S HEALTH 706, 706 (2013).

[54] *See, e.g.*, Jones & Weitz at 623 (discussing the need for abortion care in the second trimester).

[55] The average cost of an abortion at 10 weeks is $543, while an abortion at 20 weeks costs an average of $1,562. 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 (Aug. 15, 2013) (time spent raising money to pay for an abortion and transportation represents a primary cause of delay in obtaining an abortion).

women who struggle to raise the funds for travel are faced with a vicious cycle of compounding costs and increasing delay.[56] Having had to delay care to raise the funds required for an earlier procedure, they may find themselves pushed to a later, more expensive option, which requires even more fundraising and more delay. The impact is harshest for low-income women—who 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—and the overall detrimental impact on public health exacerbates medical inequality.[57]

Third, with limited access to abortion services, women are more likely to carry an unwanted pregnancy to term, which in itself is dangerous to their health. All pregnancies involve risks of both physical and psychological complications.[58] Some of these risks can be fatal, while others, such as

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[56] Jones & Weitz at 623.

[57] Christine Dehlendorf et al., *Disparities in Abortion Rates: A Public Health Approach*, 103 AM. J. PUB. HEALTH 1772, 1776, 1775 (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).

[58] *See Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors* (2000), WORLD HEALTH ORG., http://whqlibdoc.who.int/publications/2007/9241545879_eng.pdf.

depression, persist even after childbirth.[59] The risks associated with unwanted pregnancies are particularly troubling. Women who undergo unintended childbirth experience increased risk of maternal depression,[60] and unwanted births carry increased risks of congenital anomalies, premature delivery, and low birth weight.[61]

Texas is particularly vulnerable to the risks associated with unwanted pregnancy because the state has a high rate of maternal mortality,[62] and

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[59] *See id.*; *Pregnancy Complications*, CENTERS FOR DISEASE CONTROL AND PREVENTION (last updated Jan. 22, 2014), http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregcomplications.htm.

[60] 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).

[61] *Id.* at 24.

[62] Rita Henley Jensen, *Pregnant? Watch Your Risks in Great State of Texas*, (Feb. 13, 2011), http://womensenews.org/story/sisterspace/130208/pregnant-watch-your-risks-in-great-state-texas#.Vg3efVLluUl ("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; *see also Maternal Mortality and Morbidity Task Force Report*, TEX. DEP'T OF STATE HEALTH SERVICES*,* (Sept. 2014), https://www.dshs.state.tx.us/legislative/2014/Attachment1-MMMTF-LegReport-FCHS-1-081214.pdf; *see also* June Hanke, *Maternal Mortality and Morbidity Review*,

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,[63] low-income women have more unintended pregnancies and higher abortion rates than women with higher incomes.[64] The U.S. Census reports that nearly a quarter (23.3%) of residents in El Paso County, Texas have incomes below the federal poverty line[65] of $15,930 for a family of 2[66]—and the two poorest cities in the nation are Brownsville and McAllen, in Southern

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http://www.marchofdimes.org/pdf/texas/TX_VPN_Maternal_Mortality_Morbidity_Review_-_Hanke.pdf.

63 *See, e.g.*, Guttmacher Institute, *Contraceptive Use in the United States*, 1 (July 2015), http://www.guttmacher.org/pubs/fb_contr_use.html; Dehlendorf et al., at 1772; Carole Joffe, Roe v. Wade *and Beyond: Forty Years of Legal Abortion in the United States*, Dissent (Winter 2013).

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

65 U.S. Census Bureau, Quick Facts, http://quickfacts.census.gov/qfd/states/48/48141.html.

66 Office of the Assistant Secretary for Planning and Evaluation, *2015 Poverty Guidelines*, http://aspe.hhs.gov/2015-poverty-guidelines.

Texas.[67] In the Corpus Christie metro area, 20.5 percent of the population, or 87,784 people, live at or below the federal poverty level.[68] The list goes on. For women living in Texas at or below the poverty level, abortion can cost between $450 and $3,000 dollars,[69] and costs increase after the first trimester.[70] For many women, depending on the circumstances, neither federal nor state Medicaid will cover the cost of an abortion. The risks to public health caused by restricted access to abortion services are even more severe for this already vulnerable population.

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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67 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.

68 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.

69 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/.

70 Dehlendorf et al.; *see also* Lawrence B. Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 CONTRACEPTION 334, 334 (2006).

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

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. H.B. 2 not only places a substantial—and unconstitutional—burden on the exercise of a fundamental right, but it also threatens to significantly harm the State's public health and welfare.

For these and the foregoing reasons, *amicus curiae* APHA joins Petitioners in petitioning this Court for certiorari.

Respectfully submitted,

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