No. 19-2051

IN THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

WHOLE WOMAN'S HEALTH ALLIANCE, ALL-OPTIONS, INC., and JEFFREY GLAZER, M.D., Plaintiffs-Appellees, v. CURTIS T. HILL, in his official capacity as Attorney General of the State of Indiana; KRISTINA BOX, M.D.; JOHN STROBEL, M.D.; KENNETH P. COTTER; Defendants-Appellants.	)	Appeal from the United States District Court for the Southern District of Indiana No. 1:18-cv-01904-SEB-MJD The Honorable SARAH EVANS BARKER Judge Presiding.

BRIEF OF AMICI CURIAE ILLINOIS, CALIFORNIA, CONNECTICUT, DELAWARE, THE DISTRICT OF COLUMBIA, HAWAI'I, MAINE, MARYLAND, MASSACHUSETTS, NEVADA, NEW MEXICO, NEW YORK, OREGON, PENNSYLVANIA, VERMONT, AND WASHINGTON IN SUPPORT OF PLAINTIFFS-APPELLEES AND SEEKING AFFIRMANCE

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IDENTITY AND INTEREST OF AMICI STATES

The amici States of Illinois, California, Connecticut, Delaware, Hawai'i, Maine, Maryland, Massachusetts, Nevada, New Mexico, New York, Oregon, Pennsylvania, Vermont, and Washington and the District of Columbia 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 have a substantial interest in ensuring that courts strike a proper balance between respect for their policy judgments and substantive review of their abortion laws. The district court below held that defendants' regulatory regime was unconstitutional as applied to plaintiffs. On appeal, defendants argue that abortion regulations are subject to facial challenges only. But when a party is challenging the specific application of an abortion law—such as the denial of a licensing application for a single clinic—state interests are well served by as-applied review. This approach respects the States' legislative and policy judgments on how best to promote health and safety within their borders, yet also ensures that meaningful scrutiny is applied to the enforcement of abortion laws so that the right to abortion care is not unduly burdened.

The amici States also have a substantial interest in ensuring the health and safety of their residents 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 safety and accessibility of abortion

services without creating an undue burden on the right to terminate a pregnancy. States that enforce their regulatory schemes in a manner that unduly burdens access to abortion care create public health risks, interfere with reproductive autonomy, and place a strain on the healthcare systems of neighboring States, as some women 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

The preliminary injunction entered by the district court should be affirmed. The court weighed the marginal benefits of defendants' enforcement of Indiana's licensing law against plaintiffs, on the one hand, against the burden imposed on women seeking abortion services, on the other, and correctly concluded that defendants' enforcement of Indiana's licensing law in this instance "place[d] a substantial obstacle in the path of northern Indiana women seeking previability abortions." Dist. Ct. Doc. 116 at 71; *see also* 7th Cir. Doc. 10 at 2 (modifying the preliminary injunction). The amici States thus support affirmance of the decision below. They write separately, however, to explain the substantial state interests that will be served by affirmance of the district court's decision.

To begin, the district court's decision to assess plaintiffs' challenge under the as-applied framework serves the States' interest in appropriate deference to state healthcare laws. On appeal, defendants and their amici urge this Court to hold that as-applied challenges cannot be brought against laws that allegedly impose an undue burden on the right of women in a certain area to access abortion services. Appellants' Br. at 20-22; Tex. Br. at 17. This is incorrect. Although at times a statute or regulation may be amenable to a facial challenge, plaintiffs are not as a general rule foreclosed from bringing as-applied challenges to abortion laws. And when a party challenges the constitutionality of a state action taken under a state licensing statute or regulation against a single entity, the States have an interest in that narrow challenge proceeding on an as-applied basis, because if the challenge

results in an injunction, the law remains valid and enforceable in other contexts. This state interest is particularly acute when, as here, a district court issues a preliminary injunction affecting enforcement of the law while litigation is ongoing.

Additionally, the amici States have an interest in ensuring that abortion laws are enforced to protect the public health and safety of their residents, without unlawfully interfering with reproductive autonomy. States—including the amici States—have enacted a variety of licensing schemes that may be lawfully applied to protect these interests. However, where, as the district court held occurred here, a State's application of its regulatory regime unduly burdens the right to access abortion services, this application of state law increases public health risks and may strain the resources of neighboring States, because women must cross state lines to receive constitutionally guaranteed medical services.

ARGUMENT

I. The Preliminary Injunction Entered Here Strikes A Proper Balance Between Respect For State Policy Judgments And Meaningful Judicial Review Of Abortion Laws.

An abortion law is unconstitutional "if it imposes an 'undue burden' on a woman's ability to choose to have an abortion, meaning that it 'has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.'" *Planned Parenthood of Ind. & Ky., Inc. v. Comm'r of Ind. State Dep't of Health*, 896 F.3d 809, 816-17 (7th Cir. 2018) (quoting *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2324 (2016)). As this Court has recognized, the undue burden test is, by its nature, "context specific." *Id.* Under this test, "[a]n abortion

statute valid as to one set of facts and external circumstances can be invalid as to another." *Id.* For this reason, as Appellees explain, *see* Appellees' Br. at 18-19, 38-39, the undue burden test is well suited to as-applied challenges to the application of abortion laws.

Defendants and their amici disagree, arguing on appeal that United States Supreme Court precedent "does not authorize" such challenges. *See* Appellants' Br. at 20-22; Texas Br. at 17. But courts, including the Supreme Court and other federal circuit courts, have consistently recognized the validity of as-applied challenges to state laws that may burden the right to an abortion. *See, e.g.*, *Hellerstedt*, 136 S. Ct. at 2305 (*res judicata* did not bar challenge to Texas regulations "as applied to . . . clinics in McAllen and El Paso"); *Gonzales v. Carhart*, 550 U.S. 124, 168 (2007) ("The Act is open to a proper as-applied challenge in a discrete case."); *see also, e.g.*, *Jackson Women's Health Org. v. Currier*, 760 F.3d 448, 458 (5th Cir. 2014) (modifying preliminary injunction to limit application only to plaintiffs); *Women's Med. Prof'l Corp. v. Baird*, 438 F.3d 595, 603 (6th Cir. 2006) (rejecting argument that "[*Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992),] is only applicable to facial challenges to abortion regulations").

Moreover, limiting challenges to state abortion laws to facial challenges would impair the States' interest in ensuring the proper balance between deference to their valid regulatory choices and meaningful judicial review of laws that allegedly burden the right to access abortion services. But when these challenges are considered on an as-applied basis, as was done here, courts can provide a meaningful judicial check on

the validity of the State's asserted interests and the burdens that they impose on women seeking abortions without invalidating a law entirely. *See, e.g.*, *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 331 (2006) (finding that New Hampshire parental notification law placed undue burden on abortion in certain applications but that "lower courts need not have invalidated the law wholesale"). Successful as-applied challenges to state licensing statutes allow a State to continue to enforce those laws in a constitutional manner against other licensees while the litigation is pending. In contrast, nullifying a licensing law because it was not constitutionally applied in a particular circumstance frustrates the work of elected state legislatures. *See id.* An order enjoining a specific action gives States the opportunity to revise their approach before eliminating the regulation or law in its entirety.

For these reasons, the district court's evaluation of plaintiffs' challenge on an as-applied basis was not only correct but also consistent with the States' interest in preserving their legislative policy judgments while ensuring the protection of individual constitutional rights.

II. States Have An Interest In Ensuring Public Health And Safety Through Regulatory Schemes That Promote Safe Access To Abortion.

States have enacted a wide variety of regulatory schemes that apply to abortion clinics. For example, although the majority of States do not have specific

licensing requirements for medication-only abortion clinics,[1] several States, including Indiana, require all abortion clinics to obtain licenses, even if the services provided are limited to medication abortion.[2] Additionally, most States require all abortions to be performed by licensed healthcare professionals.[3] And healthcare professionals are

[1] *See*, *e.g.*, Cal. Health & Safety Code §§ 1200, 1204; Del. Code Ann. tit. 16, §§ 1003, 1103; Haw. Rev. Stat. §§ 321-14.5, 14.8; Idaho Code Ann. § 18-608(1); Idaho Admin. Code r. 16.03.02.003, 16.03.14.100; Ill. Pub. Act 101-13, § 910-25 (eff. June 12, 2019) (adding 210 ILCS 5/3(A)(6)); Iowa Code §§ 135C.1(7), (14), 135C.6; 105 Code Mass. Regs. §§ 140.020, 140.101; Me. Rev. Stat. Ann. tit. 22, § 1812-E; Md. Code Regs. 10.12.01.02(A); Mich. Admin. Code §§ 325.3802(d), 325.3811(1); Nev. Rev. Stat. ch. 449; N.H. Rev. Stat. Ann. § 151:1; N.M. Stat. §§ 24-1-2(F), 24-1-5(A); N.Y. Pub. Health Law § 2599-bb; N.D. Admin. Code § 33-07-01.1-01(1); Ohio Rev. Code § 3702.30(A)(1); Or. Rev. Stat. §§ 441.015, 442.015(12); 216 R.I. Code R. § 20-10-6.3.1(B)-(D); Tenn. Code Ann. §§ 68-11-201(3), 68-11-202(a)(1); Vt. Stat. Ann. tit. 18, §§ 1902(1), 1903; Wash. Rev. Code §§ 18.46.010(1), 18.46.020, 18.51.010(3), 18.51.030, 70.41.020(7), 70.41.090(1), 71.12.455(2), 71.12.460; W. Va. Code R. §§ 64-12-2.13, 64-12-3.1.a, 64-12-17, 64-31-4.2, 64-31-5.1.1; Wis. Stat. § 253.10; Wis. Admin. Code, MED. § 11.04; Wyo. Stat. Ann. §§ 35-2-901(a)(x), 35-2-902.

[2] *See* Ala. Code §§ 22-21-20, 22-21-22; Ariz. Rev. Stat. § 36-449.02; Ark. Code § 20-9-302(a); Conn. Gen. Stat. § 19a-493c(a); Conn. Agencies Reg. § 19a-116-1; Fla. Admin. Code Ann. r. 59A-9.020; Ind. Code § 16-21-2-10; Kan. Stat. §§ 65-4a01(g), 65-4a02(a); Ky. Rev. Stat. § 216; La. Rev. Stat. § 2175.4; Miss. Code § 41-75-5; Neb. Rev. Stat. § 71-416; 175 Neb. Admin. Code § 7-003; N.J. Stat. § 26:2H-14; N.J. Admin. Code § 8:43A-1.3; N.C. Gen. Stat. § 14-45.1(a); 10A N.C. Admin. Code 14E.0107; Okla. Stat. tit. 63, § 1-748(J); 28 Pa. Code § 29.43; S.C. Code Ann. Regs. 61-12.102; S.D. Codified Laws § 34-23; Tex. Health & Safety Code § 245.010(a); Utah Code § 26-21-6.5; 12 Va. Admin. Code § 5-412-20.

[3] *See Overview of Abortion Laws*, Guttmacher Inst., https://www.guttmacher.org/state-policy/explore/overview-abortion-laws (41 States require an abortion to be performed by a physician) (visited Aug. 21, 2019); Taylor, *et al.*, *Advancing Scope of Practice to Include Abortion Care*, The APC Toolkit, http://apctoolkit.org/wp-content/themes/apctoolkit/section3a.html (although almost all States have enacted physician-only abortion laws, some allow abortions to be performed by licensed advanced-practice clinicians) (visited Aug. 21, 2019); *see also, e.g.*, Ill. Pub. Act 101-13, §§ 1-10, 1-25(a) (eff. June 12, 2019) (allowing physician, advanced practice registered nurse, or physician assistant to perform abortion); Ind. Code § 16-34-2-

subject to regulation by the State, independent of any applicable clinic licensure requirements. As part of their regulatory authority, States may discipline licensed healthcare professionals as necessary, including by suspending or revoking their licenses.[4]

Regardless of the approach, however, these licensing and regulatory schemes are always subject to review for constitutionality when the right to abortion is at stake. *See Gonzales*, 550 U.S. at 165 (courts "retain[ ] an independent constitutional duty to review factual findings"). Although States may use medical licensing to achieve their valid interests in "maximum safety" for women receiving an abortion, they cannot impose or enforce unnecessary requirements when they "'have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion.'" *Hellerstedt*, 136 S. Ct. at 2309 (quoting *Casey*, 505 U.S. at 878). Thus, when reviewing abortion laws, courts must determine whether the State has shown that its regulation furthers a valid state interest. *See id.* at 2309-10. Defendants' actions here, however, do not satisfy that standard. On the contrary, on the facts of this case, defendants' application of Indiana's licensing law increases public health

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1(a)(1)(A) (only physician may perform abortion); Mont. Code Ann. § 50-20-109(a) (only "physician or physician assistant" may perform abortion).

[4] *See, e.g.,* Ala. Code § 34-24-360 (discipline up to revocation of medical license); Fla. Stat. § 458.331 (same); Ind. Code § 25-22.5-8-6 (same); N.Y. Educ. Law § 6530, N.Y. Pub. Health Law § 230-a (same); Tenn. Code § 63-6-214 (same); Tex. Occupations Code § 51.356 (same); *see also* 225 ILCS 60/40, 65/70-5(a), 95/21(a) (disciplinary provisions for physicians, advanced practice registered nurses, physician assistants); *see also* Ind. Code § 16-34-2-7 (discipline against medical license for performing unlawful abortion); Fla. Admin. Code Ann. r. 64B8-8.001 (same).

risks and strains the resources of neighboring States, as women must often cross state lines when constitutionally guaranteed medical services are unavailable near their home.

A. Abortion Is A Safe Medical Procedure.

Defendants and their amici argue that the regulatory actions challenged by plaintiffs are necessary to protect the health and safety of women seeking abortions. Appellants' Br. at 23-26; Texas Br. at 6-9. But defendants and their amici overlook the overwhelming evidence that abortion is a highly safe medical procedure. *See Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 912 (7th Cir. 2015) ("[C]omplications from an abortion are both rare and rarely dangerous."). Only a fraction of a percent of abortions, whether performed by medication or surgery, cause major health complications.[5]

And, as this Court has recognized, medication abortion, the only type of abortion WWHA seeks to administer in South Bend, is even safer. *See Schimel*, 806 F.3d at 913. 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."[6] In trials of the drugs

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[5] *See* Upadhyay, *et al.*, *Incidence of Emergency Department Visits and Complications after Abortion*, 125 Obstet. Gynecol. 175, 181 (Jan. 2015), https://journals.lww.com/greenjournal/Fulltext/2015/01000/Incidence_of_Emergency_Department_Visits_and.29.aspx.

[6] Nat'l Acads. of Scis., Eng'g, & Med., The Safety and Quality of Abortion Care in the United States 55 (2018), https://www.nap.edu/read/24950/chapter/1.

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."[7] Another study of more than 230,000 medication-abortion patients found that just 0.65 percent of patients experienced any complications at all. Dist. Ct. Doc. 116 at 4; Dist. Ct. Doc. 104-2 at 2.

The outdated and isolated examples of "dangerous clinics" cited by defendants and their amici do not call these studies into question. Tex. Br. at 8. Three of the five examples are more than 20 years old, *see* Tex. Br. at 6-9, and predate the existence of medication abortion in the United States, *see* Dist. Ct. Doc. 116 at 3. The other two examples, *see* Appellants' Br. at 9, 23; Tex. Br. at 8-9, involved physicians convicted of criminal acts. They hardly compare to the abortions that are regularly performed by licensed, regulated healthcare professionals appropriately exercising their professional judgment.

Defendants and their amici also point to regulatory violations identified at Whole Woman's Health and WWHA clinics performing surgical abortions in Texas and Illinois. Appellants' Br. at 23-24; Tex. Br. at 9-17. Defendants and their amici fail to mention, however, that none of these violations were cause for revocation or suspension of the license of any Whole Woman's Health or WWHA clinic; to the

[7] Raymond, *et al.*, *First-Trimester Medical Abortion with Mifepristone 200 mg and Misoprostol*, 87 Contraception 26, 30 (2013), https://www.contraceptionjournal.org/article/S0010-7824(12)00643-9/pdf.

contrary, in each instance the clinic took appropriate corrective action to address the violation. These examples show that when state regulations are applied properly, regulators are able to work effectively with clinics to correct deficiencies without precluding them from providing access to abortion care. This corrective-action process is thus no different from how the States regulate the provision of any other type of healthcare.

This conclusion is underscored by the fact that Whole Woman's Health and WWHA have operated clinics in other States for years without incident. For example, Whole Woman's Health manages a clinic in Baltimore, Maryland that has been licensed as a surgical abortion facility since 2012. The clinic has successfully applied for two renewals, state regulators have never received a credible complaint against the clinic, and its license has never been suspended.

In short, despite the handful of examples cited by defendants and their amici, they cannot overcome the body of scientific evidence showing that abortions—and, in particular, the non-surgical abortions at issue here—are both safe and amenable to effective regulation without unduly burdening constitutional rights.

B. When Licensing Regimes Are Enforced In A Way That Deprives Women Of Access To Abortion Care, It Increases Public Health Risks.

When licensing schemes prevent new clinics from opening in areas with inadequate abortion services, public health problems arise. By contrast, regulatory mechanisms that facilitate access to safe abortion services promote public health and

safety. Accordingly, States have an interest in ensuring that abortion licensing schemes are enforced in a way that promotes access to safe care.

To begin, preventing a clinic from operating in an underserved area may cause women to seek abortions from wholly unregulated sources, exposing them to unscrupulous practitioners or the dangers of self-administered abortions. *See Hellerstedt*, 136 S. Ct. at 2321 (Ginsburg, J., concurring) ("When a State severely limits access to safe and legal procedures, women in desperate circumstances may resort to unlicensed rogue practitioners, *faute de mieux*, at great risk to their health and safety.").[8] Rather than ensuring that women seek abortions from regulated facilities and professionals, defendants' actions are more likely to drive women to the type of unregulated, "dangerous clinics" defendants and their amici claim to seek to eliminate. *See* Tex. Br. at 8.

Additionally, depriving women of access to abortion care in their community may force women who want an abortion to delay seeking one. And women who delay obtaining abortions face a higher risk of medical complications than women with unobstructed access to care.[9] One study showed that, while still very low, the risk of

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[8] *See also* Grossman, *et al.*, *The Public Health Threat of Anti-Abortion Legislation*, 89(2) Contraception 73-74 (Feb. 2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4418533/pdf/nihms681634.pdf (citing evidence from other countries showing that restricting access to abortion "makes unsafe abortion more common").

[9] Gemzell-Danielsson, *et al.*, *Second Trimester Medical Abortion with Mifepristone-Misoprostol and Misoprostol Alone: A Review of Methods and Management*, 16 Reproductive Health Matters 162, 165 (2008), https://www.tandfonline.com/doi/full/10.1016/S0968-8080(08)31371-8; *see also Schimel*, 806 F.3d at 920 ("For abortions performed in the first trimester the rate of major complications is 0.05–0.06 percent (that is, between five one-hundredths of 1 percent and six one-

mortality more than doubles for women who obtain an abortion more than 18 weeks after gestation, as compared to those who obtain an abortion 14 to 17 weeks after gestation.[10] Indeed, although abortions are associated with an "extremely low risk of mortality," that risk "increases gradually with each week of gestation."[11]

Indeed, women who carry pregnancies to term as a result of inadequate access to abortion services face significantly higher health risks.[12] For example, one study found that women who were turned away from an abortion clinic were more than four times more likely to develop potentially life-threatening health conditions than those who had access to an abortion.[13] In addition, women who are forced to give birth after being denied an abortion are more likely to face a risk of physical violence from the man involved in the pregnancy.[14] Women who have a baby with an abusive

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hundredths of 1 percent). It is 1.3 percent for second-trimester abortions—between 22 and 26 times higher.").

[10] Zane, *et al.*, *Abortion-Related Mortality in the United States 1998-2010*, 126(2) Obstet. Gynecol. 258, fig. 2 (Aug. 2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4554338/pdf/nihms718534.pdf.

[11] Gerdts, *et al.*, *Side Effects, Physical Health Consequences, & Mortality Associated with Abortion and Birth after an Unwanted Pregnancy*, 26-1 Women's Health Issues 55, 58 (2016), https://www.whijournal.com/article/S1049-3867(15)00158-9/pdf.

[12] *Id.* at 59.

[13] *Id.* at 58, tab. 2.

[14] *See* Roberts, *et al.*, *Risk of Violence from the Man Involved in the Pregnancy after Receiving or Being Denied an Abortion*, BMC Medicine 12:144 (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4182793/pdf/12916_2014_Article_144.pdf.

man are less likely to leave the abusive relationship, whereas women who have access to an abortion tend to leave such relationships more quickly.[15]

Finally, the States' interest in promoting access to safe abortion care is underscored here, as the northern Indiana community affected by the defendants' actions includes many of the amici States' residents who attend the universities located in the South Bend area.[16] Although these students may have temporarily left the amici States to pursue their education, the States retain an interest in ensuring that they are spared the "stress, anxiety, shame, and financial hardship" associated with not having access to constitutionally protected medical care. Dist. Ct. Doc. 76-6 at 2 (Dec. of Prof. Lidinsky of Indiana University South Bend).

C. When A State Imposes Unconstitutional Burdens On Women Seeking Abortions, It May Strain The Resources Of Neighboring States.

If women cannot access abortion services in their home State, they must travel to other States to receive care. As detailed by Appellees, making these travel arrangements is difficult for residents of northern Indiana, especially for women who rely on public transit, lack disposable income, or provide care to children or other dependents. *See* Appellees' Br. at 2-4; *see also* Dist. Ct. Doc. 116 at 6-11. Moreover,

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[15] *Id.* at 5.

[16] *See* Caroline Torie, *Notre Dame Is Now the Most "National" University in the Country*, WSBT 22 (May 30, 2018), https://wsbt.com/news/local/notre-dae-is-now-the-most-national-university-in-the-country (noting that Notre Dame's class of 2022 includes students from 49 states and that two-thirds of the class come from outside the Midwest); Indiana Univ. South Bend, IU South Bend Fast Facts, https://www.iusb. edu/fast-facts/index.html (visited Aug. 21, 2019) (student body includes out-of-state residents).

requiring women to cross state lines to seek abortion care can strain the healthcare systems in neighboring States. Here, for example, the evidence shows that women from Indiana regularly travel to Chicago to obtain abortions. *See* Dist. Ct. Doc. 76-1, ¶ 35; Dist. Ct. Doc. 76-6, ¶ 9.

Illinois is not the only State that has experienced increased pressure on its healthcare system when needs for abortion care are unmet in a neighboring State. Shortly after New York amended its abortion laws in 1970, nearly 350,000 women traveled to New York from other States to access abortion services. *See* Rachel Benson Gold, *Abortion and Women's Health: A Turning Point for America?* 3 (1990). And after abortion clinics were forced to close in Texas, Mississippi, and Ohio, abortions performed in neighboring Louisiana and Michigan between 2010 and 2014 rose 12 percent and 18.5 percent, respectively.[17] Similarly, Kansas reported that nearly half of the abortions performed at clinics within its borders in 2018 were provided to residents of Missouri, which, as of 2017, had only one abortion clinic still operating.[18]

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[17] David Crary, *Abortions Declining in Nearly All States*, Associated Press, (June 7, 2015), https://www.apnews.com/0aae4e73500142e5b8745d681c7de270.

[18] Kansas Dep't of Health & Env't, Abortions in Kansas, 2018 at 5, 7 (Apr. 2019), http://www.kdheks.gov/phi/abortion_sum/2018_Preliminary_Abortion_Report.pdf; Haksgaard, *Rural Women & Developments in the Undue Burden Analysis*, 65 Drake L. Rev. 663, 709 (2017); *see also*, *e.g.*, *EMW Women's Surgical Ctr.. P.S.C. v. Glisson*, No. 3:17-cv-00189-GNS, 2018 WL 6444391, at *9 (W.D. Ky. Sept. 28, 2018) ("Because Kentucky permitted later-term abortions compared to other states . . . , residents of the neighboring states of Indiana, Ohio, Tennessee, and West Virginia have traveled to [Kentucky] to have an abortion.").

Forcing women to seek healthcare in neighboring States requires providers in those States to take on additional patients and places additional pressure on state regulators to monitor the services provided. For example, when one of Missouri's remaining two clinics closed in 2017, an Illinois abortion clinic near the Missouri border hired two doctors to accommodate the increased demand from Missouri residents.[19] But it is not always possible for clinics to accept new patients. As this Court has recognized, an expansion of "staff and facilities to accommodate such an influx . . . would be costly and could even be impossible given the difficulty of recruiting abortion doctors." *Schimel*, 806 F.3d at 918. And when clinics are faced with levels of demand that they cannot satisfy, women may be unable to obtain the abortion care that they need. *Id.* In short, the repercussions of defendants' unlawful actions are not limited to their State or the women who live there. The amici States

[19] Marie Solis, *Neighboring States Are Bracing for an Influx of Missouri Abortion Patients*, Vice (June 7, 2019), https://www.vice.com/en_us/article/a3xydk/states-preparing-for-missouri-s-last-abortion-clinic-to-close; *see also* Angie Leventis Lourgos, *Inside the Illinois Abortion Clinic that Could Become the Nearest Option for Women in St. Louis and Beyond*, Chicago Tribune (June 10, 2019), https://www.chicagotribune.com/news/ct-met-abortion-clinic-last-option-20190531-story.html (reporting that, since Missouri closed all but one of its clinics, 55% of patients who received abortion at Hope Clinic for Women in Granite City, Illinois, came from Missouri and total number of patients increased 30%, requiring clinic to hire and train new staff); Molly Hennessy-Fiske, *Crossing the "Abortion Desert": Women Increasingly Travel Out of Their States for the Procedure*, Los Angeles Times (June 2, 2016), https://www.latimes.com/nation/la-na-adv-abortion-traveler-20160530-snap-story.html (reporting that, as clinics in some states closed in response to onerous regulations, clinics in other States had to fly in doctors to keep up with increased demand).

thus have a strong interest in ensuring that women in neighboring States are not unconstitutionally denied access to abortion care within their home State.

CONCLUSION

For these reasons, this Court should affirm the district court's May 31, 2019, preliminary injunction order.

Respectfully submitted,

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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 4,250 words. In preparing this certificate, I relied on the word count of the Microsoft Word 2016 word processing system used to prepare this brief.

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CERTIFICATE OF FILING AND SERVICE

I hereby certify that on August 21, 2019, 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.

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