No. 15-274

In the Supreme Court of the United States

WHOLE WOMAN'S HEALTH, ET AL., PETITIONERS

v.

JOHN HELLERSTEDT, M.D., COMMISSIONER OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES, ET AL., RESPONDENTS

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF OF CITIZENLINK, CHARLOTTE LOZIER INSTITUTE AND STUDENTS FOR LIFE OF AMERICA, AMICI CURIAE SUPPORTING RESPONDENTS

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INTEREST OF AMICI CURIAE[1]

CitizenLink is a national organization working with allied state groups to promote public policy at the state level including health and safety for all Americans, including the unborn. After the tragedies at Kermit Gosnell's clinic in Philadelphia, many of its allied groups promoted legislation like that adopted by the Texas Legislature, in order to promote the health and safety of the women seeking abortion procedures as well as the babies born alive at such clinics.

Charlotte Lozier Institute is the education and research arm of the Susan B. Anthony List. Named after a 19th century feminist physician who, like Susan B. Anthony, championed women's rights without sacrificing either equal opportunity or the lives of the unborn, the Institute studies federal and state policies and their impact on women's health and on child and family well-being.

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[1] Pursuant to Supreme Court rule 37.6, counsel for amici represents that it authored this brief in its entirety and that none of the parties or their counsel, nor any other person or entity other than amici or their counsel, made a monetary contribution intended to fund the preparation or submission of this brief. Pursuant to Rule 37.3(a), counsel for amici represents that all parties have consented to the filing of this brief.

Students for Life of America is the nation's largest pro-life youth organization, consisting of more than 930 college and high school pro-life groups. Its mission is to create a culture where those most affected by abortion are empowered and equipped to recruit their peers to join this human rights movement, promote human life, lead local and national initiatives, and provide tangible resources to those facing an unplanned pregnancy. It submits this brief to inform the Court about changing attitudes among youth, which are contributing to the decrease in abortion nationwide.

SUMMARY OF ARGUMENT

Petitioners make much of the fact that there were 41 abortion clinics prior to the Texas Legislature's passage of House Bill 2 (HB2) in 2013, that there are about half that number currently, and that the number is anticipated to drop further once the ambulatory surgical center (ASC) requirements are fully in effect. Petitioners suppose the post-restriction environment will be static and meaningful access to abortions will decrease. Yet access is not determined by the percentage of closures or even the current geographic distribution of clinics.

While HB2 no doubt has had some effect on supply of clinics, other factors outside the control of any legislature have also been driving forces behind clinic owners deciding to cease operations. A considered analysis recognizes that 1) a decrease in demand for abortion services, 2) a maturing and consolidation of the abortion industry into bigger, more efficient entities, and 3) a loss of non-abortion

revenue due to the Affordable Care Act are megatrends that are affecting the number of clinics. Far from undermining supply, HB2 simply hastened the inevitable closure of marginal clinics.

Ultimately, supply and demand in markets, even in highly regulated markets like healthcare, equilibrate. If demand changes, market forces will adjust supply.[2] Demand may never again require 41 abortion clinics as existed at the time HB2 was passed. Demand may not even require the 33 that existed at the time the admitting privilege requirements went into effect or the 23 at the time the lawsuit was filed. J.A. 229-30 (chart); J.A. 401 (Killeen facility not taken into account on the chart when lawsuit was filed).[3] However, existing and relatively large ASC-compliant abortion clinics, which have sought to increase market share, new ASC-compliant abortion clinics like the ones opened during litigation, and other ASCs among the more than 400 ASCs operating across Texas are positioned to benefit by gaining market share in the new and safer regulatory environment.

While this brief is primarily intended to demonstrate how the long-term reduction in demand as well as changes in the industry largely explain the clinic closures and to show that the supply of abortion services will continue uninterrupted, this brief also touches on the critical importance of the health advances of HB2. Indeed, the Grand Jury in the Kermit Gosnell case recommended application of

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[2] N. Gregory Mankiw, *Principles of Economics* 83-84 (2d ed., Harcourt C. Pub. 2001) (explaining how supply adjusts to meet demand).

[3] These numbers only include clinics, not the additional hospital providers.

ASC standards to abortion clinics. *See* Grand Jury Rpt. 1, *In re Cnty. Investigating Grand Jury XXIII*, No. 0009901-2008, 2011 WL 711902 (1st Jud. Dist. Pa., filed Jan. 14, 2011) at 157-67. Rather than viewing additional standards as undermining this Court's legacy of abortion rights, the Court should view HB2 as largely closing a gap where the abortion industry was subject to fewer regulations—and thus women enjoyed fewer protections—than exist in similarly situated healthcare entities outside of the abortion context.

ARGUMENT

I. HB2 Accelerated Inevitable Clinic Closures.

Petitioners argue that the common-sense health requirements of HB2 are unconstitutional because some clinics in Texas have chosen to close instead of complying with the health standards, allegedly making it difficult to obtain an abortion. However, this Court has recognized that the "fact that a law which serves a valid purpose, one not designed to strike at the right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it." *Gonzales v. Carhart*, 127 S. Ct. 1610, 1633 (2007) (quoting *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 874 (1992)). "Only where state regulation imposes an undue burden on a woman's ability to make this decision does the power of the State reach into the heart of the liberty protected by the Due Process Clause." *Casey*, 505 U.S. at 874.

Still, Petitioners claim that the closures, which they suggest undermine supply of abortion services

and therefore access, renders the law unconstitutional. Even under that logic, petitioners mistakenly attribute the bulk of these closures to HB2 when instead there has been a steady decrease both in the number of abortions and abortion clinics nationally, even in states with few laws impacting abortion, evidencing a nationwide decrease in demand for abortion. Likewise, the abortion industry itself has been undergoing maturation, resulting in the opening of so-called mega-clinics and closure of various smaller clinics due to decreased demand for abortion as well as non-abortion services.

Following passage of HB2, every clinic was faced with the choice of investing in meeting the health and safety standards required by HB2 or not investing and closing. But other significant trends have been in play: a long-term reduction in demand coupled with a strategy on the part of America's largest abortion business, Planned Parenthood, of building larger, urban clinics and amassing a greater market share. From the standpoint of a marginal provider that recognizes it will eventually have to close due to countless other reasons, such as profitability, such a provider will choose to do so in the face of these requirements rather than making an investment in a business that is unsustainable over the long term.

A. Demand For Abortion Services Has Been Declining Significantly And Steadily For Decades, Resulting In The Closure Of Clinics.

Petitioners suggest that the supply of abortion clinics is solely the result of government forces and,

despite the lack of record evidence, that demand is not being met. On the contrary, the present market conditions must be understood in the context of very significant trends: a long-term reduction in demand in regulated and non-regulated states alike that has resulted in a reduction in clinics. In short, *the decrease in demand resulted in a decreased need for supply, not a decreased supply proving unable to meet demand.*

The number of abortions, abortion rates, and even the sheer number of clinics have been in decline for decades in nearly every state. Total abortions nationwide in 1990 were 1,608,600 million but steadily fell to 1,058,490 million in 2011.[4] Texas' numbers mirror those nationally, with 110,110 abortions in 1981 falling to 73,200 in 2011.[5] These trends are consistent with the fact that a smaller percentage of women facing unintended pregnancies have obtained an abortion. This number fell from 54 percent nationally in 1994 to 40 percent in 2008.[6]

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[4] Stanley K. Henshaw and Jennifer Van Vort, *Abortion Services in the United States 1991 and 1992*, 26 FAM. PLAN. PERSP. 100-106, 112 (1994); Guttmacher Institute, *Get trend data*, GUTTMACHER.ORG, http://tinyurl.com/h7rdm7o (follow "Abortion" hyperlink; then follow "Abortions by state of residence" hyperlink; then follow "Number of abortions" hyperlink) (*last visited Jan. 30, 2016*).

[5] Rachel K. Jones and Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2011*, 46 PERSP. ON SEXUAL AND REPROD. HEALTH at 7 (2014); Guttmacher Institute, *supra*.

[6] Lawrence B. Finer & Mia R. Zolna, *Shifts in Intended and Unintended Pregnancies in the United States*, *2001–2008*, 104 AM. J. PUB. HEALTH S43, S45–S46 (2014); Stanley K. Henshaw, *Unintended Pregnancy in the United States*, 30 FAM. PLAN. PERSP. 24, 28 (1998).

Likewise, the U.S. abortion rate and the Texas abortion rate have steadily fallen from 29.3 and 30.0 respectfully in 1980 to 16.9 and 13.5 in 2011.[7]

As a natural result of the decrease in demand, the supply of clinics has gone down. A record number of abortion providers existed in the early 1980s: 2,908 nationally and 134 in Texas. Those numbers dropped to 1,720 nationally and 62 in Texas according to the latest readily available data.[8] Of those 62 Texas providers in 2011, 46 of those were clinics, defined to include both abortion clinics and ASCs. *See* Jones & Jerman, *supra* at 9.

The 46 clinics in 2011 declined to 41 clinics *before the passage* of HB2 and to 33 *prior to the effective date* of either provision in question. J.A. 229-30. The correcting of the regulatory imbalance of substandard regulations for abortion providers as opposed to other healthcare providers certainly has had an effect. "The impact of the new regime in which states no longer indirectly subsidize abortion practice by withholding regulatory mandates that would have otherwise applied to them" has resulted in clinic closures, but "*demand for abortion has also dropped precipitously*."[9] While the decision to no

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[7] Guttmacher Institute, *supra*, (follow "Abortion" hyperlink; then follow "Abortions by state of residence" hyperlink; then follow "Abortion rate" hyperlink).

[8] Jones & Jerman, *supra* at 9; Rachel K. Jones and Kathryn Kooistra, *Abortion Incidence and Access to Services in the United States, 2008*, 43 PERSP. ON SEXUAL AND REPROD. HEALTH at 45 (2011); Guttmacher Institute, *supra* (follow "Abortion" hyperlink; then follow "Abortion providers" hyperlink; then follow "Number of providers" hyperlink).

[9] Steven H. Aden, *Driving Out Bad Medicine: How State Regulation Impacts the Supply and Demand of Abortion*, 8 U.

longer "subsidize" the industry by withholding regulations applicable to other healthcare providers had a hastening effect, it is the conjunction of demand as explained here and other market forces set forth in the following section that better account for the closures. Ultimately closures are normal in the abortion industry, and especially in times of reduced demand "when a provider leaves a market, it is generally not replaced"—suggesting that reentry into the exited market is not worthwhile.[10]

The reduction in abortion demand and clinic closures nationally are not the result of governmental health standards. The Guttmacher Institute observed that laws passed prior to 2011 "were far from sufficient to explain the significant drop that spanned almost all states and every major region of the country."[11] Between 2010 and the most recent data available from 2013 and 2014, abortions have dropped another twelve percent nationally.[12] Interestingly, some of the biggest declines occurred in states with few restrictions, such as Hawaii with a 30 percent decrease, New Mexico with a 24 percent decrease, and Nevada with a 22 percent decrease.

ST. THOMAS J.L. & PUB. POL'Y at 18 (2014), available at http://tinyurl.com/h2542l2 (emphasis added).

[10] *Id.* at 19 (citing Andrew Beauchamp, *Abortion Supplier Dynamics* 40 (revised March 2010) (unpublished manuscript) (on file with Boston College) available at http://tinyurl.com/zkj9973).

[11] Joerg Dreweke, *U.S. Abortion Rate Continues to Decline While Debate over Means to the End Escalates*, 17 GUTTMACHER POL'Y REV. at 3 (NO. 2, 2014).

[12] David Crary, *Abortions declining greatly across most of US: Changes in laws do not appear to affect trend*, ASSOCIATED PRESS, June 8, 2015, http://tinyurl.com/gvxfon8 (last visited Jan. 30, 2016).

See id. Texas' decline exactly matched the national average of 12 percent. *See id.* This is consistent with the longer-term trends in Texas with a 42.3 percent reduction in the abortion rate since 1980 in comparison with Oregon and New Mexico, both states with few abortion restrictions, experiencing a 50.2 percent and 51.9 percent abortion rate decline respectively during the same period.[13]

During the three-year period leading up to 2011, the date of the last full dataset, total providers nationally fell four percent and total clinics fell one percent. *See* Jones & Jerman, *supra* at 9. Some states had steeper clinic reductions, such as New Jersey at 15 percent, Maine at 17 percent, and Vermont at 25 percent. *See id.* Clearly a reduction in demand for abortion services is not directly proportional to the reduction in the number of clinics. As with any business, a significant loss in revenue will move that business from strong profitability to marginal profitability or even loss. Such a business may hobble along for a time in hopes that revenues will increase. And typically such businesses trapped by loss of cash flow will eventually need to close, especially when faced with an event that requires additional cash infusion. Therefore, though the long-term sustainability of many clinics nationally is in question, they do not necessarily close their doors immediately unless standing at a crossroads. Such a situation will hasten the inevitable. Consistent with the non-

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[13] Guttmacher Institute, *supra*, (follow "Abortion" hyperlink; then follow "Abortions by state of residence" hyperlink; then follow "Abortion rate" hyperlink).

immediate effect, recent research indicated that between 2010 and 2013 or 2014 alone, more than 70 clinics nationally have now shut their doors. *See* Crary, *supra*.

The significant reductions in numbers of abortions and thus decline in clinics are precisely what one would expect based on cultural trends. Americans, particularly young Americans, are increasingly pro-life. In 1991, 36 percent of 18 to 29 year-olds believed abortion should be legal in all circumstances. That number dropped to 24 percent by 2009.[14] And regardless of their views on the legality of abortion, a 2013 study revealed that 49 percent of Americans believe abortion is morally wrong in contrast to 15 percent who believe it is morally acceptable.[15] Naturally someone who believes the procedure is immoral will be less likely to have an abortion even if she believes it should be legal for others.

It is far from surprising that the younger generation in particular is increasingly pro-life. They have grown up seeing ultrasound photos and videos of their unborn siblings and friends' siblings showing them yawning, blinking and sucking their thumbs inside their mothers' wombs. As they get older and may find themselves with an unexpected pregnancy, they are more likely to want to keep the baby. Women ages 18 to 29 are much more likely than previous generations to view three to four children as an ideal family size, and thus unexpected

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[14] Lydia Saad, *Generational Differences on Abortion Narrow*, GALLUP, Mar. 12, 2010.

[15] Pew Research Center, *Abortion Viewed in Moral Terms: Fewer See Stem Cell Research and IVF as Moral Issues* at 2 (August 15, 2013).

pregnancies are viewed as an opportunity rather than a constraint.[16] This generation of women is also less likely to see motherhood as a constraint to working outside the home. *See id*. Likewise, those growing up in an environment where single motherhood is common are less likely to believe that single motherhood is a reason to have an abortion. *See id* at 141.

Owners of abortion clinics observe these trends. And as the current 18 to 29 year-old cohort becomes the 30 to 44 year-old generation, which is currently more pro-choice, the pro-life trend in attitudes as well as decrease in abortion demand will continue. *See id* at 124 ("If this trend continues, generational replacement will no longer offset trends toward more conservative [pro-life] attitudes—it will instead reinforce it."). With their eyes on these demographics, it is no surprise that marginal providers would choose now as the time to throw in the towel instead of investing in meeting health and safety standards required by law.

One of the most significant factors in the reduction of abortions is a decrease in the teen abortion rate from 40.3 abortions per thousand 15 to 19 year-old females in 1990 to 11.8 abortions per thousand in 2010.[17] This trend does not result from

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[16] Clyde Wilcox and Patrick Carr, *The Puzzling Case of the Abortion Attitudes of the Millennial Generation*, UNDERSTANDING PUB. OPINION 128-29 (Barbara Norrander and Clyde Wilcox eds., 3d ed., Wash., DC: Cong. Q. Press 2009), available at http://tinyurl.com/hrh6juy (last visited Jan. 30, 2016).

[17] Susan Wills, *The Overlooked Key to the Drop in U.S. Abortions*, CHARLOTTE LOZIER INSTITUTE at 4 (May

an inability of teens to get an abortion. Instead, the pregnancy rate is down from 77 per thousand 15 to 17 year-old females and 168 per thousand 18 to 19 year-old females in 1990 to 37 per thousand and 107 per thousand respectively in 2009. *See id*. at 5. This, in turn, is explained by, among other things, a significantly lower rate of sexual activity among teens. 73 percent of 15 to 17 year-old females and 36 percent of 18 to 19 year-old females reported never having had sex based on data from 2006-2010, up from 61 percent and 29 percent, respectively. *See id*. at 7.

With lower rates of sexual activity among teens, and with pregnancy rates of those who are sexually active declining as well, abortions are declining. Even among those teens and young women who get pregnant, the scientific advances, the social acceptance of single parenting, desires for larger families, and changed attitudes protecting working parents have all contributed to a decreased desire for abortion. With abortions on the decline, especially among the young, *see id*. at 4 (revealing a 71 percent decrease in the abortion rates of teenagers and a 52 percent decrease in abortion rates in 20 to 24 year-old women from 1990 to 2010), one can only expect that the abortion rate will continue to decline as this generation ages and replaces those of older childbearing years who are less pro-life. These trends not only have had but will continue to have an effect on the abortion industry.

2014), available at http://tinyurl.com/z2pko9j (last visited Jan. 30, 2016).

B. Due To Market Forces, Many Clinics Were Bound To Close.

A significantly declining abortion market, coupled with a decline in many non-abortion services, a reallocation of non-abortion funding streams for some clinics that had become dependent on these funds, and a new business model by America's largest abortion provider of building mega-clinics in urban areas, made it inevitable that many clinics nationally would close. The abortion industry grew quickly from the time of *Roe v. Wade* until the 1980s. Since that time, this industry has behaved like many others, where an industry reaches capacity or even declines, large providers grow, and smaller providers get squeezed out.

Unfortunately for the industry, demand not only decreased for abortions themselves, but clinics have far fewer clients for their other services. Partially because of the Affordable Care Act, women who formerly received reproductive healthcare services at an abortion provider now go to medical providers within their insurance network. As a result, Planned Parenthood lost six percent of its patients the year the Affordable Care Act went into full effect. Certain other providers declined even further.[18] This effect

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[18] Jillian Mincer, Planned Parenthood faces unexpected challenge from Obamacare, REUTERS, Sep. 8, 2015, http://tinyurl.com/zl3dkxa (last visited Jan. 30, 2016); Kaiser Family Foundation, Women and Health Care in the Early Years of the Affordable Care Act: Key Findings from the 2013 Kaiser Women's Health Survey at 3, 5, available at http://tinyurl.com/j7463jr (last visited Jan. 30, 2016) (recognizing the shift to private providers under the ACA).

was compounded by the reliance of many clinics nationally on governmental funding. As state legislatures have been faced with limited resources, some have reallocated funding streams for non-abortion services, which certain clinics took for granted. *See* Mincer, *supra*. This was a particularly difficult adjustment for clinics where client revenue was only a small fraction of the budget.[19] This adjustment in income for non-abortion services caused by the increased use of network providers under the Affordable Care Act to obtain non-abortion services and more direct subsidies for non-abortion services being directed to comprehensive health care service providers created a perfect storm nationally to make profitable clinics marginal, and marginal clinics no longer sustainable.

But the adverse market conditions for clinics did not stop there. Instead, America's largest abortion provider has been steadily eating market share. In 1993, fewer than ten percent of abortions in America were done in Planned Parenthood facilities. Planned Parenthood's market share increased to 32 percent by 2011. *See* Aden, *supra*, at 19. This recent market share expansion can easily be attributed to the building of mega-clinics. In Houston in 2010, Planned Parenthood built the largest administrative and medical abortion facility in the nation, stating

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[19] Kate Clark, *Testimony on the Proposed FY2016 State Budget*, FAMILY PLANNING ASSOCIATION OF NEW JERSEY, March 24, 2015, available at http://tinyurl.com/hsleb9h (last visited Jan. 30, 2016) (stating that more than ten percent of New Jersey's family planning clinics closed after budget cuts in that state).

that one of the four goals was "room to grow."[20] By opening this clinic Planned Parenthood sought to service 30,000 more clients annually. *See id*. This is merely one of 21 mega-clinics opened or planned nationally since 2004, and three of these were in Texas, *including two after the passage of HB2*.[21]

This increased capacity affects the competition no less than when a Lowe's or Home Depot moves into an area and the local hardware store closes or when the so-called "Walmartization" of America occurs, where smaller, locally run stores are unable to compete with the national box-store giant. Furthermore, local hardware stores have trouble competing even if demand for hardware remains the same or is increasing. The effects would be much worse if demand were decreasing, as it is in the abortion industry. The co-founder of a clinic that closed in Washington State said, "We would not be closing today if Planned Parenthood had not started providing abortion services in the same town."[22] This criticism is not unique. Clinic operator Amy Hagstrom-Miller stated, "This is not the Planned Parenthood we all grew up with . . . they now have more of a business approach, much more

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[20] Cindy George, *Planned Parenthood debuts new building*, HOUSTON CHRONICLE, May 21, 2010, http://tinyurl.com/znzadgj (last visited Jan. 30, 2016).

[21] Americans United for Life, *The New Leviathan: The Mega-Center Report - How Planned Parenthood Has Become Abortion, Inc.* at 9 (2015), available at http://tinyurl.com/hzuu8dy (last visited Jan. 30, 2016).

[22] Amie Newman, *Feminist Health Center Closes After Thirty Years. What Does it Mean for Women?* RH REALITY CHECK, November 18, 2010, http://tinyurl.com/zngzyoh (last visited Jan. 30, 2016).

aggressive."[23] As stated by the Wall Street Journal, "Ms. Hagstrom-Miller competes with Planned Parenthood for abortion patients—and finds it deeply frustrating. She does not receive the government grants or tax-deductible contributions that bolster Planned Parenthood, and says she can't match the nonprofit's budget for advertising or clinic upgrades." *Id*. Hagstrom-Miller explains that "[t]hey're not unlike other big national chains. . . . They put local independent businesses in a tough situation." *Id*.

The market forces in the abortion industry are akin to the consolidations occurring in multiple industries, including the healthcare industry itself.[24] For better or for worse, the massive national leader in the abortion business is creating conditions that make it difficult if not impossible for other smaller providers to survive, especially with fewer abortions being demanded, more non-abortion related services being provided by health network providers, and correspondingly fewer governmental subsidies for these non-abortion services.

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[23] Stephanie Simon, *Planned Parenthood Hits Suburbia*, WALL STREET JOURNAL ONLINE (June 23, 2008), http://tinyurl.com/gwrdhhr (last visited Jan. 29, 2016).

[24] Deloitte, *The great consolidation: The potential for rapid consolidation of health systems* (2014), available at http://tinyurl.com/zolznzr (last visited Jan. 29, 2016) (stating that the healthcare industry is beginning a consolidation not unlike what we see in the banking, retail, and airline industries).

II. Texas Women Will Still Have Adequate Access To Abortion Services In A Post-HB2 Environment.

The demographic and market forces discussed above naturally resulted in a market consolidation and the closure of marginally profitable clinics that were unwilling, in the face of daunting market forces in the years ahead, to make the investment in modern and safe medicine. These closures in no way suggest that women will be unable to access abortions. There is no evidence of record that the ASC-compliant providers lack capacity to service demand. Besides, demand is always a driver of supply, so if there were any indication that additional supply were necessary, current providers could begin providing abortions at one of the 400 ASCs in the state.

There are no insurmountable barriers to entry for abortion providers. This is not a situation where a state is prohibiting supply from either continuing or being created. Instead, the state is simply requiring those in the abortion business to meet certain standards that are not significantly different from those required of similarly situated healthcare providers.

By way of example, in 1999 there were fewer than 3,000 ASCs nationally.[25] By 2011, there were more than 6,000.[26] Despite the costs of such

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[25] Ambulatory Surgery Center Association, *Ambulatory Surgery Centers: A Positive Trend in Healthcare.*

[26] Carrie Pallardy and Scott Becker, *50 Things to Know About the Ambulatory Surgery Center Industry*, BECKER'S ASC REVIEW, July 30, 2013.

facilities, the demand for affordable, high-quality healthcare quickly transformed the marketplace.

The same is no less true for abortion services. Two ASC-compliant clinics were built in Texas *following* passage of HB2. J.A. 737-38; J.A. 1433.[27] Clearly, if demand warrants the investment, more will be built. If providers would choose to obtain space at one of the existing 400 ASCs in Texas, such ready-to-go facilities would allow operation to begin promptly.

Since capacity will not ultimately be an issue, petitioners complain about the geographical distribution of clinics. While governmental regulations cannot be used to deny access, there is no prohibition on providing abortions in West Texas. Government is not responsible to ensure that private actors evenly distribute clinics throughout the state.

The fact remains that it was the choice of abortion providers to no longer provide abortions in this region. Despite petitioners' map, Abilene closed before passage of HB2. J.A. 229-30. Midland and San Angelo closed prior to the admitting privilege requirements going into effect. *Id*. Petitioners argue that clinics closed because of the registration fees, *see* Pet'rs' Br. at 23, n.12, which indicates that the businesses were not sufficiently profitable to cover these fees, hardly a big price tag by any standard since they were designed to simply cover costs, *see* 25 TEX. ADMIN. CODE § 139.22(g). The ability to adequately handle patient safety is also called into question in clinics with those types of financial

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[27] Melissa Stoeltje, *Planned Parenthood will expand services with new center*, SAN ANTONIO EXPRESS-NEWS, Oct. 11, 2014, http://tinyurl.com/jh8oq4j (last visited Jan. 30, 2016).

constraints. Clearly these clinics had significant problems quite apart from HB2. This is confirmed by Planned Parenthood's closure of a location in Lubbock, regardless of the outcome of the admitting privileges dispute. *See* Emergency Appl. to Vacate Stay, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 134 S. CT. 506 at 7 n.3 (2013) (NO. 13A452). Thus the absence of clinics between El Paso on the west and San Antonio and Fort Worth to the east is explained by market forces, not ultimately by HB2. Therefore, it is fair to say that 93 percent of Texas women of reproductive age will live within 150 miles of an abortion facility whether or not the Fifth Circuit decision is allowed to stand because the remaining seven percent would not otherwise have lived within 150 miles of an abortion facility. *See* Resp'ts' Br. at 45-46 (citing J.A. 242, 244, 921-22). Those slated to close are within already serviced regions.

Even the total removal of nearly every abortion regulation cannot ensure a uniform distribution of abortion providers. Economics Professor Andrew Beauchamp simulated what would happen if state abortion restrictions were removed. He determined that the number of large providers would remain the same and small providers would increase by eleven percent. He concluded that additional small providers would not generally serve new markets but would seek the benefits of already served, populous markets. *See* Aden, *supra*, at 31-32 (citing Beauchamp, *supra, at* 38-39).

This has been Planned Parenthood's model as well. It could have chosen to continue to locate in West Texas. Instead, it seems to have recognized what this model predicts, that existing markets are

the most fruitful, perhaps because women in a region accustomed to travel for even mundane reasons will also do so for an abortion. Certainly the State of Texas should not be faulted for abortion providers making logical choices based on market forces.

III. HB2 Is A Legitimate Response To Serious Health Concerns.

A. The Gosnell Grand Jury Specifically Recommended Adoption Of ASC Standards.

In passing HB2, the Texas Legislature required abortion clinics to meet ASC and hospital admitting privilege requirements. Texas' law and the passage of similar laws in other states occurred after the investigation of Kermit Gosnell's abortion clinic in Philadelphia where at least two women died, numerous others were harmed by unsanitary conditions, and children born alive were killed. *See* Grand Jury Rpt. 1, *supra*.

The Grand Jury made clear that its members ran the spectrum regarding support for abortion, but it sought to "recommend[] measures to prevent anything like this from ever happening again." *Id*. at 1. Among those recommendations was the application of ASC requirements to abortion providers, *see id*. at 157-67, since surgical abortions done at clinics were within the same category of surgeries that the ASC law was meant to address, *see id*. at 158-59 (discussing the fact that endoscopy, plastic surgery, and eye surgery centers—among others—were required to comply with the law).

Up until this point Texas, like many other states, had a two-tiered system of health standards: a robust standard protected the health of patients in every context except abortion and, in contrast, a far inferior standard applied to abortion patients.[28] In response to the Gosnell crisis, the Texas Legislature, like other state legislatures, recognized the irresponsibility of this two-tiered system and passed regulations to increase professionalism. Through passage of HB2, Texas required abortion clinics to meet the same standards as others providing ambulatory surgical care and required those performing abortions to have admitting privileges in a hospital.

While petitioners would attempt to characterize HB2 as a burden targeted at the abortion industry, the law eliminates a gap in care that had long been detrimental to women's health. We assume that

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[28] This substandard level of regulation and oversight resulted in evidence of numerous poorly run, unprofessional abortion clinics across the country. *See, e.g.,* Wendy Saltzman, *Delaware abortion clinic facing charges of unsafe and unsanitary conditions*, 6ABC ACTION NEWS, July 24, 2013, http://6abc.com/archive/9059172/ (last visited Jan. 30, 2016) (stating that nurses at Planned Parenthood of Delaware claimed the clinic was engaged in "a meat-market style of assembly-line abortions"); Brian Rogers, *Houston doctor accused of illegal abortion*s, HOUSTON CHRONICLE, May 17, 2013, http://tinyurl.com/hkholf3 (last visited Jan. 30, 2016) (regarding allegations of late-term abortions and "appalling sanitary conditions" at Aaron Women's Clinic in Houston); Tom Jackman, *Fairfax City abortion clinic, busiest in Virginia, closes*, THE WASHINGTON POST, July 24, 2013, http://tinyurl.com/huglunc (last visited Jan. 30, 2016) (according to a lawsuit, the Nova Women's Health Center in Falls Church, Virginia regularly had patients "lying down in corridors…and, in some instances, even vomiting").

everyone should have access to safe healthcare and that government is preventing unsafe providers. *Caveat emptor* should not apply to healthcare.

B. To Allow Lower Standards In The Abortion Context Amounts To Subsidization Of Inferior Care.

To give substandard abortion providers a pass when it comes to basic healthcare—simply to make it easier for such providers to enter and remain in the market—is *nothing more than state subsidization of inferior care rather than a well-considered public policy approach to abortion services*. Stated another way, the lack of regulation was "artificially elevating the number of providers and lowering barriers to entry for substandard practitioners." Aden, *supra* 14, 17. The state should not be "subsidizing weaker competitors to the detriment of consumers." *Id*. at 17.

Admitting privileges are a sensible improvement as even the National Abortion Federation previously suggested. *See Planned Parenthood of Greater Texas v. Abbott*, 748 F.3d 583, 595 (5th Cir. 2014) (citing National Abortion Federation, *Having an Abortion? Your Guide to Good Care* (2000), http://tinyurl.com/j54svq4). In fact, Alabama, Kentucky, and South Carolina all require admitting privileges for physicians at ASCs.[29] Numerous other states require admitting privileges for ASC

[29] ALA. ADMIN. CODE r. 560-X-38-.05 (2015); 902 KY. ADMIN. REGS. 20:106 (2015); 61-91 S.C. CODE REGS. 504 (2014).

physicians in the absence of a transfer agreement.[30] Admitting privileges make particular sense in the abortion environment where women sometimes report to the emergency room following complications with abortions.[31] Though the frequency is low, the numbers are significant considering that more than 60,000 abortions are performed in Texas every year.

Likewise, to treat abortion providers like ASCs is certainly reasonable and beneficial because abortions are within the same category of procedures for which ASC requirements were designed. *See* Grand Jury Rpt. 1, *supra* at 158-59 (observing that all free-standing abortion clinics are by definition ambulatory surgical facilities); TEX. HEALTH & SAFETY CODE § 243.002 (defining "[a]mbulatory surgical center" as "a facility that operates primarily to provide surgical services to patients who do not require overnight hospital care"); Pallardy, *supra* (stating that the most typical procedures at ASCs

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[30] 6 COLO. CODE REGS. § 1011-1 Ch. 20 (2015); GA REG. 111-2-2-.40 (2015); IL ADMIN. CODE 77.205.540 (2015); 844 IND. ADMIN. CODE 5-5-22 (2015); KAN. ADMIN. REGS. § 28-34-52b (2015); 10 144 ME. CODE R. Ch. 125 § 4 (2015); MD. REGS. CODE § 10.05.05.09 (2015); 130 MASS. CODE REGS. 423.404 (2015); 175 NEB. ADMIN. CODE. Ch. 07 § 006 (2015); N.H. CODE ADMIN. R. HE-HEA 1903.03 (2015); OKLA. ADMIN. CODE § 310:615-5-1 (2016); UTAH ADMIN. CODE R432-500 (2015); WY. REGS. Ch. 5 § 7 (2015).

[31] Ushma D. Upadhyay *et al.*, *Incidence of Emergency Department Visits and Complications After Abortion*, 125 OBSTETRICS & GYNECOLOGY, (No. 2, Jan. 2015) http://tinyurl.com/j6ghf75 (last visited Jan. 30, 2016) (stating that one of every 115 abortions sends a woman with an abortion-related complication to an emergency room, and one of every 436 involves a major complication).

are cataract surgery, upper GI endoscopy, colonoscopy, and spinal injections). Besides, ASC regulations are designed to create both a cost-effective and safe environment. *See* Ambulatory Surgery Center Association, *supra* at 2.

Petitioners argue for special treatment, even though application of objective standards is how government ensures good healthcare in every other context. This law does what it was designed to do: protect women's health by preventing substandard treatment of patients, not to mention preventing the kind of public health horrors that such special treatment produces, like the Gosnell clinic crisis.

CONCLUSION

Multiple abortion clinics closed their doors in Texas. While HB2 may have been the final straw or a decision point at which certain clinics needed to choose whether to stay in business, their closure is more attributable to decreased demand and a myriad of market challenges than to any insurmountable health standard. The business model of America's largest abortion provider has resulted in large clinics and the closure of small competitors—the same phenomenon witnessed in other industries. Small clinics have also been impacted by the reduction of secondary services due in part to the Affordable Care Act giving those seeking non-abortion services provided by these clinics other options and, simultaneously, by a reduction in government subsidy for these non-abortion services.

While some clinics decided it was time to close, other ASC-compliant abortion clinics opened after

passage of HB2. There will continue to be demand for abortion services, and this dynamic market has many means of ensuring that supply continues to meet that demand. Women's access will not suffer.

Finally, it was beneficial for the Texas Legislature to implement appropriate healthcare standards for the industry, particularly in light of the Gosnell Grand Jury's plea that ASC requirements apply to abortion providers to avoid the substandard medical care that was provided at Kermit Gosnell's clinic. Therefore, the judgment of the Fifth Circuit should be affirmed.

Respectfully submitted,

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