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.

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

BRIEF FOR RESPONDENTS

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QUESTIONS PRESENTED

Like other States, Texas responded to the Kermit Gosnell scandal by enacting laws to improve the standard of care for abortion patients. The Legislature heard testimony about the health benefits of requiring doctors to have admitting privileges at nearby hospitals and clinics to meet ambulatory-surgical-center standards. Evidence to the same effect was admitted at trial. Indeed, this Court upheld an ambulatory-surgical-center law for second-trimester abortions in *Simopoulos v. Virginia*, 462 U.S. 506 (1983), and the National Abortion Federation previously recommended that abortion doctors have local admitting privileges.

The Fifth Circuit upheld Texas's laws facially. Under its judgment, an abortion clinic will remain open in each area where one will close, meaning that over 90% of Texas women of reproductive age will live within 150 miles of an open abortion clinic. As the Fifth Circuit noted, petitioners advanced no proof that those clinics will lack capacity to meet abortion demand.

The questions presented are:

1.a. Whether the Court should overturn *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), and *Gonzales v. Carhart*, 550 U.S. 124 (2007), by allowing courts to override legislative determinations about disputed medical evidence, rather than adhering to the doctrine that an abortion regulation is valid if it has a rational basis and does not impose a substantial obstacle to abortion access.

1.b. Whether the challenged laws are invalid facially or as-applied to an abortion clinic in El Paso.

2. Whether res judicata bars petitioners' facial challenges.

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STATEMENT

I. Statutory And Regulatory Background

A. In the wake of the Kermit Gosnell scandal, Texas enacted House Bill 2 (HB2) to improve the standard of care for abortion patients. Act of July 12, 2013, 83d Leg., 2d C.S., ch. 1, 2013 Tex. Gen. Laws 5013; House Research Org., Bill Analysis at 10, Tex. H.B. 2, 83d Leg., 2d C.S. (July 9, 2013) (House Bill Analysis), http://www.hro.house.state.tx.us/pdf/ba832/hb0002.pdf (stating that higher standards will help prevent a "Kermit Gosnell" situation); *see Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 802-03 (7th Cir. 2013) (Manion, J., concurring in part and concurring in the judgment) (describing the "shocking revelation of terrible conditions and procedures at [Gosnell's] abortion clinic that received nationwide attention").

The Pennsylvania grand jury that indicted Gosnell for killing an abortion patient and three infants born alive specifically recommended that abortion clinics be held to the standards of ambulatory surgical centers:

> If oversight agencies expect to prevent future Dr. Gosnells, they must find the fortitude to enact and enforce the necessary regulations. Rules must be more than words on paper. . . . [A]bortion clinics . . . should be explicitly regulated as ambulatory surgical facilities, so that they are inspected annually and held to the same standards as all other outpatient procedure centers.

Grand Jury Rpt. at 16, *In re Cnty. Investigating Grand Jury XXIII*, No. 0009901-2008, 2011 WL 711902 (1st

Jud. Dist. Pa. Jan. 14, 2011), www.phila.gov/districtattorney/pdfs/grandjurywomensmedical.pdf.

Pennsylvania followed the grand jury's recommendation and enacted a law requiring abortion clinics to meet the standards of ambulatory surgical centers (ASCs). 35 Pa. Cons. Stat. § 448.806(h). Five other States increased their regulations of abortion clinics following the Gosnell scandal. App. 3a-4a. And nine States required abortion clinics to have doctors with admitting privileges at a nearby hospital, App. 1a-3a—thus following the prior advice of the National Abortion Federation that abortion patients should make sure that their doctor "'[i]n the case of emergency' can 'admit patients to a nearby hospital (no more than 20 minutes away).'" *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 748 F.3d 583, 595 (5th Cir. 2014) (*Abbott II*) (quoting National Abortion Federation, *Having an Abortion? Your Guide to Good Care* (2000)).

B. Texas was one of those States. In July 2013, the Texas Legislature passed HB2 to provide abortion patients with "the highest standard of health care." Senate Research Ctr., Bill Analysis at 2, Tex. H.B. 2, 83d Leg., 2d C.S. (July 11, 2013) (Senate Bill Analysis), http://www.capitol.state.tx.us/tlodocs/832/analysis/pdf/HB00002E.pdf; *see* House Bill Analysis at 9 (HB2 will "improve the standard of care"); Pet. App. 43a-44a, 202a. HB2 has four general provisions, two of which are implicated here. Pet. App. 181a-202a.

First is an ambulatory-surgical-center requirement. Preexisting Texas law, still in force, permits abortions to be performed at a licensed abortion facility, a licensed ambulatory surgical center, or a licensed hospital. Tex. Health & Safety Code §§ 245.003, 245.004; 25 Tex. Admin. Code § 139.1(b); *see also* 25 Tex. Admin. Code § 139.1(b)(1)(B)(iii) (additional exemption for certain

physician offices). Under HB2, "the minimum standards for an abortion facility must be equivalent to the minimum standards ... for ambulatory surgical centers." Tex. Health & Safety Code § 245.010(a). This requirement was to take effect September 1, 2014, more than 13 months after HB2's passage. Pet. App. 201a.

Second is an admitting-privileges requirement. Under HB2, abortion practitioners must "have active admitting privileges at a hospital that ... is located not further than 30 miles from the location at which the abortion is performed or induced." Tex. Health & Safety Code § 171.0031(a)(1). This was to take effect October 29, 2013, more than 100 days after HB2's passage. Pet. App. 202a. Texas law prohibits hospitals and health care facilities from discriminating against physicians on the basis that they perform abortions. Tex. Occ. Code § 103.002(b); *see also* 42 U.S.C. § 300a-7(c)(1).

HB2's provisions do not apply to abortions necessary to prevent the death or permanent physical impairment of a woman. Pet. App. 182a; Tex. Health & Safety Code § 245.016. And women who must travel more than 100 miles to an abortion facility remain exempt from the pre-existing 24-hour waiting period after informed consent; instead, only a 2-hour waiting period applies. Tex. Health & Safety Code § 171.012(a)(4).

C. Multiple abortion providers in Texas already operated as ASCs when HB2 was enacted. J.A. 231. For example, abortion providers opened four ASCs after Texas passed a law in 2003 requiring all abortions after 15 weeks' gestation to be performed in an ASC or hospital. Tex. Health & Safety Code § 171.004; J.A. 1121. The parties also stipulated that 433 total ASCs existed in Texas at the time of trial. J.A. 184.

HB2's implementing rules adopt abortion-facility minimum standards that largely track the minimum

standards for ASCs. *See* 25 Tex. Admin. Code § 139.40; 38 Tex. Reg. 9577, 9577-93 (2013). ASC standards fall into three general categories: (1) operating requirements, which cover topics such as staffing, nursing, training, patient safety, and sterilization procedures, 25 Tex. Admin. Code §§ 135.4-.17, 135.26-.27; (2) fire-prevention and general safety requirements, such as having a fire-extinguishing system and evacuation plan and properly storing inflammable materials, *id.* §§ 135.41-.43; and (3) physical-plant requirements regulating, for example, room size, floor coverings, and soap dispensers, *id.* §§ 135.51-.56. *See generally Simopoulos v. Virginia*, 462 U.S. 506, 515-16 (1983) (noting similar ASC standards when upholding Virginia's second-trimester ASC requirement).

Petitioners assert that the Texas agency implementing HB2 (the Department of State Health Services, or DSHS) did not repeal preexisting abortion-facility rules that were "more stringent" than the corresponding ASC rules. Pet. Br. 6 n.3 (cited as Br.). But the petitioner abortion clinics are or were licensed abortion facilities and therefore were presumably meeting those applicable licensing rules. Nor have petitioners alleged any substantial obstacle imposed by the differences, which only concern things like annual inspections of abortion facilities (as opposed to every three years for general ASCs) or stricter confidentiality provisions. *Compare, e.g.*, 25 Tex. Admin. Code §§ 135.21, 135.28, *with id.* §§ 139.31, 139.55.

Petitioners also incorrectly suggest that abortion clinics are subject to disparate treatment through ASC grandfathering and waiver provisions. Br. 7-8, 11, 60. As the court of appeals recognized, petitioners misunderstand the grandfathering and waiver regulations under Texas's general ASC law, which predates HB2.

Pet. App. 44a-45a. In 2009, the relevant Texas agency (DSHS) made certain modifications to the general ASC regulations. For example, it required soap dispensers at handwashing facilities and an additional 20 square feet in exam rooms. 34 Tex. Reg. 3948, 3949 (2009). These 2009 amendments included a grandfathering provision that permitted ASCs previously in compliance with ASC rules to remain licensed, including any ASCs that were performing abortions. 25 Tex. Admin. Code § 135.51(a)(1); Pet. App. 45a ("ASCs that provide abortions are treated no differently than any other ASC."). And the amendments included a waiver provision for "remodeling and additions," if they substantially complied with the updated ASC standards—that is, "if the intent of the requirement is met." 25 Tex. Admin. Code § 135.51(b). Petitioners do not allege that they met the previous ASC standards in 2009 or are in substantial compliance with existing ASC standards. Their request for disparately *favorable* treatment was accordingly denied. 38 Tex. Reg. 9583 (2013).

D. Both HB2 and its implementing rules include robust severability clauses, requiring courts to sever not only each textual provision but also each application of the law. Section 10(b) of HB2 states:

> [E]very provision, section, subsection, sentence, clause, phrase, or word in this Act, and every application of the provisions in this Act, are severable from each other. If any application of any provision in this Act to any person, group of persons, or circumstances is found by a court to be invalid, the remaining applications of that provision to all other persons and circumstances shall be severed and may not be affected.

Pet. App. 200a. Similarly, the implementing rules provide that "every provision, section, subsection, sentence, clause, phrase, or word in this chapter and each application of the provisions of this chapter remain severable." 25 Tex. Admin. Code § 139.9(b).

II. Petitioners' First Lawsuit

In September 2013, petitioners filed a lawsuit seeking facial invalidation of HB2's admitting-privileges requirement. Compl. ¶¶ 89-91, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 951 F. Supp. 2d 891 (W.D. Tex. 2013) (No. 1:13-cv-00862-LY), ECF No. 1 (*Abbott* Compl.). Joining petitioners as plaintiffs were multiple Planned Parenthood entities and several other abortion providers that did not join petitioners' instant lawsuit. *Id.* ¶¶ 9-21. Neither petitioners nor their co-plaintiffs challenged the ASC requirement. *Id.* at 3 n.2.

The district court held an expedited bench trial and facially enjoined the admitting-privileges requirement. 951 F. Supp. 2d at 901.[1] The court of appeals stayed the district court's order, allowing the admitting-privileges requirement to take effect on November 1, 2013. 734 F.3d 406, 416, 419 (5th Cir. 2013) (*Abbott I*). This Court denied petitioners' application to vacate the stay. 134 S. Ct. 506 (2013).

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[1] Petitioners agreed to an expedited bench trial on a written record but then objected to it one week before trial, after receiving the State's written declarations. *See* Advisory Regarding Trial Evid., *Abbott*, 951 F. Supp. 2d 891 (No. 1:13-cv-00862-LY), ECF No. 66. The district court allowed both parties to submit written testimony as originally agreed. 951 F. Supp. 2d at 896 n.3. Although petitioners now complain, Br. 10 n.6, they did not raise this issue on appeal in their first lawsuit or below here, thereby waiving any arguments about this procedure.

On the merits, the court of appeals held the admitting-privileges requirement facially constitutional, *Abbott II*, 748 F.3d at 599-600, and denied rehearing en banc, 769 F.3d 330 (2014). Petitioners did not seek certiorari review. Thus, their first lawsuit ended in a final judgment for the State.

III. Petitioners' Second Lawsuit

A. Six days after the court of appeals upheld the admitting-privileges requirement, petitioners filed this second lawsuit in the same district court. J.A. 125-67.

Petitioners claimed that (i) HB2's admitting-privileges requirement is unconstitutional as applied to one abortion-performing doctor at Whole Woman's Health in McAllen and one such doctor at Reproductive Services in El Paso; (ii) the ASC requirement is facially unconstitutional; and (iii) the ASC requirement is unconstitutional as applied to the McAllen and El Paso clinics and to drug-induced abortions. J.A. 161-65. Petitioners did not raise a facial challenge to the admitting-privileges law, which was clearly barred by res judicata.

Before trial, the district court held that the admitting-privileges and ASC requirements are rationally related to patient health and safety. Pet. App. 176a. The court, however, denied respondents' motion to dismiss petitioners' claims as barred by res judicata. Pet. App. 170a.

B. After a bench trial, the district court held both the ASC and admitting-privileges requirements facially unconstitutional—even though petitioners had not requested facial invalidation of the admitting-privileges requirement, and even though binding Fifth Circuit precedent held that law facially constitutional. Pet. App. 132a, 154a. Alternatively, the district court enjoined the

challenged requirements as applied to the McAllen and El Paso clinics and doctors. Pet. App. 147a-48a, 158a.

C. Respondents appealed and moved for a stay, which the Fifth Circuit granted in substantial part. Pet. App. 118a-19a. This Court vacated part of that stay, while preserving the stay of the facial injunction against the admitting-privileges requirement. 135 S. Ct. 399 (2014).

D. On the merits, the court of appeals reversed in part and affirmed in part. Pet. App. 3a-4a. The court held that any facial attack on the admitting-privileges requirement was barred by res judicata and circuit precedent—and also forfeited. Pet. App. 35a-36a. The court then held that the facial challenge to the ASC requirement is barred by res judicata and meritless. Pet. App. 36a-59a.

The court affirmed as-applied relief for the McAllen clinic and physician, concluding that an undue burden arose from the challenged provisions' effect "*combined with*" petitioners' testimony about burdens and circumstances unique to women in that area. Pet. App. 67a; *see* Pet. App. 65a n.39, 142a. The court applied HB2's severability provision and enjoined the State only from enforcing the discrete ASC requirements that would cause the McAllen clinic to close. Pet. App. 68a-71a.

Lastly, the court reversed as-applied relief regarding El Paso, holding that women in that area faced no substantial obstacle to abortion access. A facility remained operational just one mile across the state line in Santa Teresa, New Mexico—less than twelve miles from the El Paso facility. J.A. 1059; Pet. App. 72a, 74a.

The court subsequently modified its judgment so that no ASC regulation would take effect in McAllen until October 29, 2015. Pet. App. 77a-78a. This Court stayed the mandate. 135 S. Ct. 2923 (2015).

IV. Petitioners' Factual Claims Are Unsupported And Improperly Rely On Evidence Outside The Record.

Petitioners' recitation of facts is inaccurate, is unsupported by record evidence and district-court fact-finding, and improperly relies on outside-the-record hearsay. Respondents deny petitioners' contentions, and they were not proved at trial with record evidence.

A. Petitioners have no record evidence for their representations that HB2 would "limit the capacity" of operating abortion facilities, Br. 25, or lead to a "shortage" of abortion providers to meet demand, Br. 56. Petitioners' trial expert, Grossman, asserted that existing ASCs will not be able to provide more abortions than they previously had. J.A. 238. But the court of appeals rightly held that "Grossman's opinion is *ipse dixit* and the record lacks any actual evidence regarding the current or future capacity of the [remaining] clinics." Pet. App. 56a. Petitioners' brief does not address that holding or the court of appeals' explanation that "Grossman based his opinion on a chain of unsupported inferences." Pet. App. 56a n.34.[2]

And the court's conclusion was correct. Grossman's testimony counted clinics, J.A. 228, but that does not reveal anything without evidence of capacity. Grossman did not conduct any research into the current or future capacity of existing ASC abortions clinics, or whether

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[2] In petitioners' first lawsuit, Grossman's research team predicted that "22,000 women in Texas would be unable to obtain abortions" because of the admitting-privileges requirement. Pet. App. 57a n.34. Grossman conceded both that this prediction was "inaccurate" and that he could not identify the admitting-privileges requirement as the cause of the decline in Texas abortions that he alleged. *Id.*

physicians from non-ASC abortion clinics would transfer to ASCs. Nor did petitioners even try to discover capacity evidence from most of the non-party abortion clinics.[3]

Petitioners' assertion regarding the McAllen abortion clinic's operations even with its as-applied relief also lacks citation of any supporting evidence. Br. 24. Petitioners did not attempt to show at trial that the McAllen clinic could not meet nurse-staffing ASC requirements, and they did not argue or demonstrate that this clinic served women outside the Rio Grande Valley or that Dr. Lynn could not handle the demand at the clinic. *See* J.A. 1438-41. Unsurprisingly, then, petitioners make no legal argument seeking expanded as-applied relief in McAllen. Br. 54-56 (seeking only "statewide invalidation").

Similarly, petitioners' claim of an "increase in the number of women seeking assistance after attempting self-abortion," Br. 26 (citing J.A. 721-22), rests on general hearsay accounts of incidents specific only to "the Rio Grande Valley," J.A. 721—where petitioners obtained as-applied relief in McAllen. Grossman, for his part, did not have any accounts of self-abortion and just speculated that this would follow from his unsupported

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[3] Petitioners also misrepresent that the State "stipulated that the ASC requirement would cause all of the licensed abortion facilities to close." Br. 6. Petitioners do not confront the Fifth Circuit's explanation that the State "did not stipulate that *only* eight abortion facilities would remain in Texas." Pet. App. 29a n.15. The parties stipulated that currently licensed abortion facilities (as opposed to licensed ASCs) would be unable to perform abortions at their current facility, J.A. 183-84—not that they would be unable to perform abortions by buying or leasing space at a licensed ASC or otherwise coming into compliance with ASC standards (as Planned Parenthood clinics have done). J.A. 183, 1121, 1437-38; Br. 24 n.13.

conclusion of "limited" facility access. J.A. 253. And of petitioners' three cited exhibits, Br. 27, two are in fact the same email chain with a single hearsay account and the third does not identify any alleged self-induced abortion at all. J.A. 589-93, 594-98, 599-602.

Finally, petitioners improperly try to buttress their capacity representations with outside-the-record evidence. Most egregious is their reliance on a post-trial report on abortion-clinic wait times, apparently prepared by Grossman.[4] Br. 25-26, 49. This is a "manifestly improper" litigation tactic, depriving respondents of their due-process right to discovery, cross-examination, and evidentiary objection. Stephen M. Shapiro et al., *Supreme Court Practice* 801 (10th ed. 2013) (collecting cases). Countenancing such efforts would excuse entirely petitioners' burden to prove, using evidence produced at trial, their claim that HB2 will impose a statewide undue burden on abortion access. *See infra* pp. 48-50.

B. In addition, petitioners make inaccurate representations about whether HB2 *caused* certain abortion clinics to close.

Petitioners' map (Br. App. 1) purports to show the "Impact of HB2" via a before-and-after depiction, but it inaccurately depicts numerous clinics as closed by HB2. For example, the map shows that HB2 closed the Abilene and Sugar Land clinics. *Id.* But not even petitioners' trial expert, Grossman, included those clinics in his

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[4] Grossman's involvement is apparent, as he is a lead investigator for the project behind the report (TexPEP), J.A. 408, whose press release directs questions and interviews to Grossman. Tex. Policy Eval. Proj., *Wait Time to Obtain an Abortion Is Increasing in Texas as Clinics Close*, Oct. 5, 2015, http://www.utexas.edu/cola/txpep/releases/wait-times-release.php.

analysis—as the Abilene and Sugar Land clinics closed before HB2 was even passed. *See* J.A. 229-30 (Grossman chart).

Petitioners also show a Lubbock abortion clinic on their map, as if HB2 caused its closure. Br. App. 1. But petitioners told this Court that this Planned Parenthood clinic "ha[d] withdrawn" from their first lawsuit and "abortion services will not be available in Lubbock even if this application [to block the admitting-privileges requirement] is granted." Emergency Appl. to Vacate Stay at 7 n.3, *Abbott*, 134 S. Ct. 506 (No. 13A452) (Emergency Appl.).

Petitioners also depict clinics in College Station, Midland, San Angelo, Stafford, and Waco as "impact[ed]" by HB2. Br. App. 1 (capitalization omitted). But petitioners' own expert, Grossman, concluded that those clinics closed before the admitting-privileges (or ASC) requirement took effect. J.A. 229-30 (chart). Petitioners did not offer any evidence of the reason these five clinics closed.

Notably, when petitioners previously argued in this Court that the admitting-privileges requirement would cause clinic closures, they did not identify Abilene, College Station, Lubbock, Midland, San Angelo, Sugar Land, or Stafford. *See* Emergency Appl. at 7-8. In short, petitioners cite no evidence for their insinuation that the admitting-privileges (or ASC) requirement caused any of the clinic closures in the area of West Texas between El Paso and San Antonio, Br. 24, 52, or the other areas just discussed. Yet they misleadingly show these clinics on their map.

Petitioners also represent that "more than half of [Texas abortion] facilities are currently closed because the admitting-privileges requirement is largely in effect." Br. 3; *accord* Br. 23. That was never proved or

found. Petitioners cite Pet. App. 138a, Br. 23, yet that is merely where the district court repeats Grossman's conclusions (J.A. 229-31) about how many clinics were performing abortions at certain dates. Grossman did not opine, and the district court did not find, that the cause of any closures was the admitting-privileges requirement. Pet. App. 138a; J.A. 232.

Indeed, Grossman gave no testimony on causation at all. He expressly stated that he was not offering any opinion on causation. J.A. 232. Grossman produced a list of clinics providing abortions at various dates. J.A. 229-30. But clinics may cease to offer abortions for any number of reasons. As with Lubbock, for example, a clinic may decline to provide abortions for reasons unrelated to HB2. Emergency Appl. at 7 n.3. Causation by HB2 is a factual question, on which petitioners had the burden of proof. Most of the State's abortion providers were not plaintiffs here, and petitioners sought no discovery from most of these non-parties on their decisions and plans. Petitioners cannot simply assert causation facts in their appellate briefing without record evidence presented for investigation and tested through the adversarial process. *See* Univ. Faculty Br. 7-18 (discussing in detail petitioners' unfounded representations).

Similarly, petitioners misleadingly represent that HB2 "would close more than 75% of Texas abortion facilities." Br. 3; *accord* Br. 25, 56. Again, petitioners cannot point to evidence, much less a finding, supporting this blanket causation assertion. *See* Br. 56 (citing only the Grossman declaration and district-court passage discussed above). Petitioners also imply causation when they say that "more than 40" abortion clinics were operating "[b]efore HB2." Br. 23. Of course, Grossman's declaration states that only 33 were operating when the admitting-privileges requirement took effect. J.A. 229-

30 (October 31, 2013 column). But, as noted, Grossman did not opine on causation in any event.

C. Finally, petitioners assert that the challenged requirements will have "no health benefit," Br. 17; *see* Br. 17-22, but that was not proved. Petitioners do not even acknowledge the record evidence showing a medical disagreement with their contention. Petitioners' own expert conceded the existence of such disagreement in the medical community. J.A. 526-28. And petitioners make no effort to address respondents' expert testimony explaining the medical justifications for the admitting-privileges and ASC requirements. *See infra* pp. 32-41; J.A. 846-55, 867-68, 873-99.

SUMMARY OF ARGUMENT

I. Petitioners' facial challenges are barred by res judicata. In their first lawsuit, petitioners litigated and lost their facial challenge to the admitting-privileges requirement. *Abbott II*, 748 F.3d at 599-600. Their facial challenge to the ASC requirement is barred, in turn, because it shares a common nucleus of operative fact with their first lawsuit and could have been raised there.

II. This Court's abortion precedents starting with *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), establish that States may regulate abortion, so long as the regulations have a rational basis and do not have the purpose or effect of creating a substantial obstacle to abortion access.

Casey and subsequent cases clarify two points crucial to this case. First, legislatures have "wide discretion to pass legislation in areas where there is medical and scientific uncertainty," so a "facial attack" cannot be sustained where there is medical disagreement. *Gonzales v. Carhart*, 550 U.S. 124, 163, 164 (2007). Second, the undue-burden test analyzes the degree of an abortion law's burden to determine whether it imposes a substantial obstacle to abortion access; it does not reweigh the the medical justifications for a law by balancing them against the law's burdens. *Id.* at 166.

Petitioners seek to upend *Casey*'s undue-burden test. They ask the Court to choose a version of the disputed medical evidence and then to try to balance that view of a law's medical benefits against the law's burdens. This would effectively revive the strict-scrutiny framework rejected in *Casey* and overrule multiple decisions. For example, the Court would have to overturn *Mazurek v. Armstrong*, which upheld a requirement that only doctors could perform abortions; the only study in the record there found that physician-assistants could perform abortions without additional complications. 520 U.S. 968, 973 (1997) (per curiam). The Court would also have to overrule *Casey*'s holding that States may require that doctors have to give informed-consent information. 505 U.S. at 881-83.[5] And the Court would have to overturn *Gonzales*'s holding that facial challenges cannot succeed when the medical evidence is in dispute. 550 U.S. at 164.

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[5] *Casey* citations are to the controlling joint opinion. *See Gonzales*, 550 U.S. at 156 (accepting that opinion's principles as controlling).

III. HB2's challenged provisions are facially valid.

The facially apparent and expressly stated purpose of the challenged provisions is to ensure patient safety and raise standards of care, which are legitimate state interests. Reacting to the Gosnell scandal, Texas joined other States in adding new abortion-patient protections.

Petitioners have nothing close to the clearest proof needed to show that the Legislature's stated purpose is a sham. They argue that the nature of the requirements means they could only be pretext. But this Court in *Simopoulos* upheld a second-trimester ASC requirement even under *Roe*'s strict-scrutiny framework, recognizing that it furthered the legitimate state interest in ensuring patient health. 462 U.S. at 519. And the National Abortion Federation has recommended that women use abortion doctors with admitting privileges at a nearby hospital.

The State also presented trial evidence explaining the medical benefits from requiring local admitting privileges and ASC-standard compliance. Petitioners offered competing medical evidence, but even petitioners' expert conceded the existence of medical disagreement. As *Gonzales* held, where the medical evidence is in dispute, legislatures have "wide discretion" to enact medical regulations. 550 U.S. at 163. *Gonzales* does not permit a district court to choose one version of the disputed medical evidence, under the guise of making witness-credibility determinations, and use that disputed view to find abortion laws unconstitutional.

Nor do the challenged provisions have the effect of presenting a facial, statewide substantial obstacle to abortion access. Petitioners do not dispute that at least one abortion clinic will remain open in every metropolitan area in Texas that currently has one if the Court

affirms. Over 90% of Texas women of reproductive age live within 150 miles of an operational clinic.

Petitioners did not even attempt to offer evidence regarding the capacity of remaining abortion clinics to meet the demand for abortion. Their belated capacity argument, relying on a study released online long after trial, is a manifestly improper ploy to fill critical gaps in their trial evidence. In any event, that study does not show a lack of capacity and cannot establish a statewide substantial obstacle.

IV. Petitioners' as-applied challenge regarding El Paso is without merit. The undue-burden test examines access to abortion. Crossing a short distance over state lines is not a burden that denies a woman the ultimate decision of whether to have an abortion.

ARGUMENT

I. Res Judicata Bars Petitioners' Facial Attacks.

"A final judgment on the merits of an action precludes the parties or their privies from relitigating issues that were or could have been raised in that action." *Federated Dep't Stores, Inc. v. Moitie*, 452 U.S. 394, 398 (1981). Petitioners concede that they were parties to the first HB2 lawsuit and that it reached a final judgment. Pet. App. 109a n.20. Res judicata bars their facial challenges here.

A. *Admitting-privileges requirement.* Petitioners' claim that the admitting-privileges requirement is facially unconstitutional was raised, litigated, and lost in their first lawsuit. *Abbott* Compl. ¶ 90 (claiming that the admitting-privileges law is a "medically unwarranted health regulation[]" that "impose[s] an undue burden on women seeking abortions"); *Abbott II*, 748 F.3d at 599-600. They cannot now relitigate that facial challenge—especially for the first time on appeal. Pet. App. 35a

("By facially invalidating the admitting privileges requirement, the district court granted more relief than anyone requested . . . .").

To resurrect their facial claim, petitioners at a minimum needed evidence of a previously unknown statewide burden caused by the admitting-privileges requirement. They could not possibly have such evidence regarding legislative purpose. And although petitioners mention "newly-developed facts," Br. 57, they cite only evidence regarding their McAllen and El Paso as-applied challenges. Br. 57 (citing court of appeals' discussion of that as-applied evidence at Pet. App. 60a). If that allows petitioners to reinstate their facial challenge, claim preclusion will never apply in abortion litigation. Any time a doctor retires or moves, or a clinic closes, a new facial challenge could be launched no matter how many times it has been rejected before.

Petitioners also cannot avoid res judicata by invoking *Citizens United v. FEC*, 558 U.S. 310, 330-31 (2010), which did not involve a party who had previously litigated and lost a facial challenge. *Cf.* Br. 54-55, 57-58. Res judicata enforces principles of judgment finality and conservation of resources, which were not implicated there. Moreover, *Citizens United* addressed concerns about a chill on political speech from granting only as-applied relief; that is a concern animating the free-speech overbreadth doctrine. 558 U.S. at 333-36. No such doctrine exists in the abortion context. *Gonzales*, 550 U.S. at 167.

B. *ASC requirement.* Res judicata extinguishes claims that (i) could have been brought in a prior lawsuit and (ii) arise from a common nucleus of operative fact. *See Brown v. Felsen*, 442 U.S. 127, 131 (1979) ("Res judicata prevents litigation of all grounds for, or defense to, recovery that were previously available to the parties, regardless of whether they were asserted

or determined in the prior proceeding."). Both are true as to the facial attack on the ASC requirement.

First, a facial challenge to the ASC requirement would not have been premature in the first suit. The point of a facial challenge is to examine the "statute on its face." *United States v. Raines*, 362 U.S. 17, 20 (1960). HB2 unambiguously required all abortion facilities to meet the ASC standards by September 1, 2014. Pet. App. 194a. Regulations for licensed ASCs were already codified at 25 Texas Administrative Code §§ 135.1-.56. And HB2 made no allowance for waivers or grandfathering. Pet. App. 194a.

Second, although petitioners link together both of their facial challenges in this Court, Br. 33-55, they contend that the challenges do not arise from a "common nucleus of operative fact." Br. 59. Yet petitioners do not attack any of the court of appeals' reasons for finding a common nucleus. The court did not hold that all portions of an omnibus statute must be challenged at the same time. *Cf.* Br. 58-61. It held that the sharing of legal theories, governing standards, witnesses, and evidence shows a common nucleus of operative fact. Pet. App. 36a-42a. Petitioners' proof is not of a "different" character, Br. 59, when their facial challenges in both cases hinged on allegations of increased driving distances and of lack of capacity among remaining abortion providers. Pet. App. 36a-42a; *see Abbott II*, 748 F.3d at 597-98. Res judicata bars petitioners' splitting of these claims.

II. *Casey*'s Undue-Burden Test Allows Legislatures To Resolve Medical Disputes About The Benefits Of Abortion Regulations And Prevents Courts From Redoing Such Balancing Judgments.

In replacing *Roe*'s strict-scrutiny framework with the undue-burden test, *Casey* and subsequent cases recognized two points crucial here.

First, "[t]he Court has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty." *Gonzales*, 550 U.S. at 163 (collecting cases). Thus, when evidence "demonstrates both sides have medical support for their position," *id.* at 161, that is "a sufficient basis to conclude in [a] facial attack that the Act does not impose an undue burden," *id.* at 164.

Second, the undue-burden test analyzes the degree of a law's burden on abortion patients—whether the burden is so severe as to take away the "ultimate decision" to have an abortion. *Casey*, 505 U.S. at 879. That is an inquiry about abortion access, not about reweighing medical justifications or the "balance of risks." *Gonzales*, 550 U.S. at 166.

Petitioners seek to upend *Casey*'s undue-burden test. They would have this Court "serve as the country's *ex officio* medical board with powers to approve or disapprove medical and operative practices and standards throughout the United States," *id.* at 164, by second-guessing legislative judgments supported by medical evidence. But the Court has made clear that such decisions belong to legislatures. *Id.*

A. Beginning in *Akron I*, Justice O'Connor advocated for the undue-burden test to replace the strict-scrutiny trimester framework of *Roe v. Wade*, 410 U.S. 113 (1973). *City of Akron v. Akron Ctr. for Reprod.*

Health, Inc., 462 U.S. 416, 455-56 (1983) (*Akron I*) (O'Connor, J., dissenting), *overruled in part by Casey*, 505 U.S. at 882. Most relevant here, Justice O'Connor in *Simopoulos* would have applied the undue-burden test to uphold an abortion ASC requirement—regardless of trimester. *See* 462 U.S. at 520 (O'Connor, J., concurring) (stating that ASC requirement's constitutionality was not "contingent in any way on the trimester in which it is imposed"); *accord Akron I*, 462 U.S. at 466-67 (O'Connor, J., dissenting) (stating that requiring abortions to be performed in hospitals, regardless of trimester, is not facially an undue burden).

B. *Casey* replaced *Roe*'s strict-scrutiny framework with the undue-burden test. 505 U.S. at 878; *see Stenberg v. Carhart*, 530 U.S. 914, 960, 976 (2000) (Kennedy, J., dissenting) (*Casey* "rejected a strict scrutiny standard of review" and "disavows strict scrutiny review"). In doing so, *Casey* "struck a balance" that was "central to its holding." *Gonzales*, 550 U.S. at 146. In that balance, a "central premise was that the States retain a critical and legitimate role in legislating on the subject of abortion." *Stenberg*, 530 U.S. at 956-57 (Kennedy, J., dissenting).

Accordingly, a State may regulate abortion so long as it "has a rational basis to act, and it does not impose an undue burden." *Gonzales*, 550 U.S. at 158; *see Casey*, 505 U.S. at 877. The rational-basis test examines whether a law has a "rational relationship" with "some legitimate governmental purpose." *Heller v. Doe*, 509 U.S. 312, 319-20 (1993). The undue-burden test then asks whether the regulation has the "purpose or effect of placing a substantial obstacle in the path of a woman" seeking a pre-viability abortion. *Casey*, 505 U.S. at 877. *Casey* noted that "[n]umerous forms of state regulation might have the incidental effect of increasing the cost or

decreasing the availability of medical care, whether for abortion or any other medical procedure." *Id.* at 874. But the Court clarified that this derivative effect—of "making it more difficult or more expensive to procure an abortion"—does not render a law unconstitutional so long as the effect is not a substantial obstacle to abortion access. *Id.*

Applying the undue-burden test, *Casey* upheld various abortion regulations that did not outright ban or displace a woman's ultimate decision to abort a pregnancy. For instance, *Casey* upheld a requirement that only a doctor could give the mandated informed-consent information to an abortion patient. *Id.* at 881-83. In so ruling, *Casey* dispensed with the need to litigate whether the State's regulations track some medical organization's view of accepted practice. *Id.* at 884-85 (partially overruling *Akron I* and noting that the Constitution "gives the States broad latitude to decide that particular functions may be performed only by licensed professionals, even if an objective assessment might suggest that those same tasks could be performed by others").

Casey also upheld a 24-hour waiting period for abortion, despite district-court findings that it would burden patients with additional travel, overnight stays, and lost wages. *Id.* at 886-87; *Planned Parenthood of Se. Pa. v. Casey*, 744 F. Supp. 1323, 1352 (E.D. Pa. 1990). Regarding travel, the *Casey* district court found that over 40% of women in Pennsylvania would have to travel over one hour and sometimes over three hours to reach the nearest provider. 744 F. Supp. at 1352. Although this Court "d[id] not doubt that ... the waiting period has the effect of increasing the cost and risk of delay of abortions," that effect did not rise to the level of a facial substantial obstacle. 505 U.S. at 886-87.

Petitioners and the federal government misdescribe *Casey*. First, they repeatedly take out of context *Casey*'s single use of the word "unnecessary" and assert incorrectly that a court must assess medical necessity to uphold an abortion law. Br. 2, 34, 45; U.S. Br. 11, 12, 16, 17, 19, 23-25. The cited sentence summarized the undue-burden test as follows: "Unnecessary health regulations *that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion* impose an undue burden on the right." *Casey*, 505 U.S. at 878 (emphasis added). This sentence cuts against petitioners' position by describing an additional threshold for invalidity: even if a law has the purpose or effect of creating a substantial obstacle, invalidation requires a separate determination that the law is "unnecessary." *Id.* Regardless, the Court has never used the phrase "unnecessary health regulations" in any other abortion case, and the undue-burden test is articulated in multiple passages in *Casey* as well as later decisions. *See, e.g.*, *Gonzales*, 550 U.S. at 145, 146, 156, 161. Changing the focus from abortion access to medical justification would return courts to assessing "accepted" medical practice, which *Casey* rejects. 505 U.S. at 884-85.

Petitioners deploy the same strategy by citing *Casey*'s quotation of *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972), which referred to an "*unwarranted* governmental intrusion" on the decision to bear a child. Br. 44-45 (emphasis by petitioners); *see* U.S. Br. 15, 24. *Casey* did not turn that statement into a constitutional cost–benefit analysis; an intrusion is "unwarranted" if it lacks a rational basis or presents a substantial obstacle to abortion access. *Casey*, 505 U.S. at 877.

Second, petitioners contend that *Casey*'s only doctrinal change was giving weight to the State's interest in fetal life, implying that *Casey* did not change the gov-

erning test in cases implicating the State's interest in patient health. Br. 38 n.18. But *Casey* affirmed that the State has an interest in safeguarding "the health of the woman," 505 U.S. at 871, and held that the State may adopt rational regulations furthering that end if they do not impose an undue burden, *id.* at 878. Petitioners claim that the *Roe* strict-scrutiny test used in *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976), still applies. Br. 38 & n.18. But the *Danforth* "principles" that *Casey* preserved were only about the dynamics of spousal-notification laws. 505 U.S. at 897. *Casey* did not approve *Danforth*'s use of the *Roe* strict-scrutiny test, *see id.*, and the Court has never suggested that the undue-burden test covers only *some* abortion regulations. That would be unworkable, as it is not always possible to neatly categorize the interests animating a law. For example, measures aimed at ensuring high levels of professionalism among abortion providers protect not only patient health but also fetal life, by screening out individuals like Gosnell.

C. Post-*Casey* decisions confirm that the undue-burden test does not balance a court's selected version of the medical evidence against a regulation's burdens.

Mazurek upheld a requirement that only physicians could perform abortions, even though "the only extant study comparing the complication rates for first-trimester abortions . . . found no significant difference" between abortions performed by physicians versus physician-assistants. 520 U.S. at 973.[6] Although the only

[6] This was in accord with the Court's guidance in *Connecticut v. Menillo*, 423 U.S. 9, 11 (1975) (per curiam), that "[e]ven during the first trimester of pregnancy, [prohibitions of] abortions conducted by nonphysicians infringe upon no realm of personal privacy secured by the Constitution against state interference."

medical evidence showed that the law was unnecessary, the Court found no substantial obstacle to abortion access and held that *Casey* "squarely foreclosed" a judicial attempt at weighing the law's burdens against its medical justifications. *Id.*; *contra* U.S. Br. 24 (wrongly portraying *Mazurek* as based on a judicial finding of the regulation's likely benefits).

Similarly, *Gonzales* upheld a ban on partial-birth abortion even though the medical evidence was disputed. 550 U.S. at 161, 166-67. Applying the undue-burden test, the Court explained that legislatures have "wide discretion to pass legislation in areas where there is medical and scientific uncertainty." *Id.* at 163; *accord id.* at 161 (recognizing that "both sides have medical support for their position"). Rather than try to resolve such matters, the Court held that "[t]he medical uncertainty over whether the Act's prohibition creates significant health risks provides a sufficient basis to conclude in this facial attack that the Act does not impose an undue burden." *Id.* at 164 ("Medical uncertainty does not foreclose the exercise of legislative power in the abortion context any more than it does in other contexts.").[7] *Gonzales* confirmed that the balancing of risks and benefits is left to legislatures: "Considerations of marginal safety, *including the balance of risks*, are *within the legislative competence* when the regulation

[7] Petitioners note that the Court "retains an independent constitutional duty to review [legislative] findings where constitutional rights are at stake." Br. 47 (quoting *Gonzales*, 550 U.S. at 165). Thus, a court need not accept legislative findings that are "superseded" or "factually incorrect." 550 U.S. at 165. But this does not instruct courts, under the rubric of judicial fact-finding, to resolve debates over medical uncertainty by elevating one view of a law's medical merits and calling the other not "credible." *Id.* at 164, 166.

is rational and in pursuit of legitimate ends." *Id.* at 166 (emphases added).

The federal government wrongly criticizes the court of appeals for failing to "move beyond a rational basis analysis and examine the regulation's actual benefits." U.S. Br. 23. Moving beyond a rational-basis analysis does not mean second-guessing legislative resolution of medical disagreement about a law's benefits. Rather, the next step is examining any alleged substantial obstacle to abortion access. The court of appeals did just that, explaining that under *Gonzales* "medical uncertainty underlying a statute is for resolution by legislatures, not the courts." Pet. App. 51a ("the district court erred by substituting its own judgment for that of the legislature, albeit this time in the name of the undue burden inquiry").

D. Petitioners' articulation of controlling legal principles would require overruling *Casey* and effectively reverting back to *Roe*'s strict-scrutiny framework.

Petitioners ask this Court to choose their version of the disputed medical evidence about HB2's justification, Br. 39, 51, and then balance that judicially-chosen view of the medical evidence against the alleged burdens, Br. 44-48. Petitioners also want a return to the era when this Court's abortion doctrine scrutinized "the strength of a state's interest." Br. 31, 44, 45, 46, 48, 52. But *Casey* rejected *Roe*'s strict-scrutiny framework, which had asked whether an abortion regulation is "drawn in narrow terms to further a compelling state interest." 505 U.S. at 871.

Petitioners' goal is apparent when they argue that any law reasonably designed to enhance abortion safety must "focus on eliminating barriers to early abortion access, not erecting additional ones." Br. 39 n.19. This sounds like a call to reestablish *Roe*'s trimester frame-

work, under which governments largely could not regulate first-trimester abortions. *Roe*, 410 U.S. at 164. *Casey*, of course, held that this is not the constitutional test. 505 U.S. at 878. The Court also recognized that while virtually all abortion regulations will create some additional burdens, this does not render them unconstitutional. *Id.* at 874.

Petitioners repeatedly invoke the phrase "reasonably designed." Br. 30, 31, 34, 36-39, 52. They seek to infuse that rational-basis language with strict-scrutiny meaning, requiring a judicial reweighing of legislative judgments about the strength of a law's medical benefits. Br. 36-37. Yet the portion of *Casey* that petitioners quote simply observed that an informed-consent requirement "furthers [a] legitimate purpose." 505 U.S. at 882. The undue-burden test does not reevaluate policy judgments or choose between competing testimony of medical professionals. *Cf.* Br. 39, 45, 46.

Petitioners' test would require overruling multiple precedents. It conflicts with cases upholding laws directing that only doctors may perform abortions (*Mazurek*) and give required informed-consent information (*Casey*). The Court had no evidence before it that those tasks could not be performed by physician-assistants with the same efficacy. *Mazurek*, 520 U.S. at 973; *Casey*, 505 U.S. at 885.

Petitioners' view would also require reevaluating *Gonzales*, as the Court would have to "credit" one version of the disputed medical evidence regarding partial-birth abortion and reweigh the legislature's balance of policy interests. 550 U.S. at 164. The federal government now argues that a judge's "credibility" determinations can erase a legislature's judgment about a law's disputed policy merit. U.S. Br. 6, 17, 25-26. But *Gonzales* rejected that argument, 550 U.S. at 162-64—and so

did the federal government when it prevailed in *Gonzales*. Pet. Br. 39, *Gonzales*, 550 U.S. 124 (No. 05-380), 2006 WL 1436690 ("no basis" to overrule the legislature's findings "simply because the *district court* may have disagreed with [the legislature] and concluded that the physicians who testified against the Act were more credible"); Pet. Reply Br. 11, *Gonzales*, 550 U.S. 124 (Nos. 05-380, 05-1382), 2006 WL 3043976 ("The constitutionality of nationwide legislation properly depends on the credibility judgments of [the legislature], not those of individual district court judges, which of course can vary.").

Petitioners' position here would even overrule pre-*Casey* holdings. *Simopoulos* upheld (under *Roe*'s strict-scrutiny framework) a restriction of second-trimester abortions to ASCs or hospitals. 462 U.S. at 519. Yet petitioners contend that "ASC standards were designed for surgeries that are more complex than abortion" and cannot "reasonably" be required for abortion facilities. Br. 39. Also in doubt would be *Ashcroft*'s holding that a State may constitutionally require a pathologist, rather than just a physician, to examine remaining fetal tissue after an abortion. *Planned Parenthood Ass'n of Kan. City, Mo., Inc. v. Ashcroft*, 462 U.S. 476, 488-90 (1983). The "medical opinion differ[ed] widely" on whether that practice should be used, *id.* at 489, and there was "no showing that tissue examinations by a pathologist do more to protect health than examinations by a nonpathologist physician," *id.* at 497 (Blackmun, J., dissenting).[8]

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[8] Respondents tailored their factual presentation at trial to binding Fifth Circuit precedent, which followed this Court's rulings that the undue-burden test does not scrutinize disputed medical evidence and balance medical merits against burdens. *Abbott II*, 748 F.3d at 590. If this Court changes its abortion doctrine, respond-

III. The Admitting-Privileges And Ambulatory-Surgical-Center Requirements Are Facially Valid.

Petitioners have waived any argument that the challenged requirements fail rational-basis review. The district court found a rational basis, Pet. App. 176a, and petitioners did not challenge that correct conclusion in the court of appeals, J.A. 1423-24, or here.

Casey's undue-burden test then asks whether the challenged laws have the "purpose or effect of placing a substantial obstacle in the path of a woman" seeking a previability abortion. 505 U.S. at 877.[9] Even if petitioners could establish some undue burden, they cannot secure facial invalidation unless they prove, at an absolute minimum, that the law imposes a substantial obstacle "in a large fraction of relevant cases." *Gonzales*, 550 U.S. at 167-68. But the Court prefers as-applied challenges involving "discrete and well-defined" applications, which "are the basic building blocks of constitutional adjudication." *Id.* at 168. Petitioners' facial challenges here fail, as the admitting-privileges and ASC requirements do not impose a substantial obstacle in a large fraction of cases.

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ents would be entitled to a remand to show—under this Court's newly announced standard—that the challenged laws are constitutional.

[9] The court of appeals did not insist that its role "is limited to conducting rational basis review in its most deferential form," as petitioners say. Br. 46-47. The court conducted undue-burden review, Pet. App. 43a-58a, after rational-basis review, Pet. App. 42a-43a.

A. Facial Challenges Require a Demanding Showing.

Plaintiffs raising a facial challenge have a "heavy burden." *Gonzales*, 550 U.S. at 167. The unique, free-speech overbreadth doctrine does not apply in abortion cases. *Id.* ("The latitude given facial challenges in the First Amendment context is inapplicable here.").

Petitioners acknowledge that, at a minimum, they must prove that HB2's requirements will impose an undue burden in a "large fraction of the cases in which they are relevant." Br. 55.[10] And the relevant denominator is the number of Texas women of reproductive age, as the court of appeals held. Pet. App. 54a-55a (holding that figure appropriate "[b]ecause H.B. 2 applies to all abortion providers and facilities in Texas, and the Plaintiffs argued that abortion clinics all across the state would likely be required to close"); *see also Gonzales*, 550 U.S. at 168 (rejecting a denominator-shrinking argument). Petitioners have not disputed the court of appeals' holding on the denominator point, *see* Br. 55-56, and have thus waived any argument to the contrary.

Additionally, courts prefer "to enjoin only the unconstitutional applications of a statute while leaving other applications in force, or to sever its problematic portions while leaving the remainder intact." *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 328-29 (2006) (citation omitted). This is particularly true

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[10] Respondents assume arguendo that the "large fraction" test applies and do not need any stricter test to prevail. Should the Court address the issue, the "no set of circumstances" test should govern facial invalidity, as previously explained by the federal government. *E.g.*, U.S. Br. 9-18, *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320 (2006) (No. 04-1144), 2005 WL 1900328.

where the statute contains a severability clause. *Id.* at 331. And HB2 requires courts to sever every provision and every application of it or its implementing rules. Pet. App. 182a, 200a; 25 Tex. Admin. Code § 139.9(b).

B. Petitioners Failed to Prove that the Challenged Requirements Have the Purpose of Imposing a Substantial Obstacle to Abortion Access.

Constitutional analysis of a statute's purpose is highly deferential. *E.g.*, *McCleskey v. Kemp*, 481 U.S. 279, 298-99 (1987) (where "there [are] legitimate reasons" for a law, courts "will not infer a discriminatory purpose"). Courts "ordinarily defer to the legislature's stated intent," and "only the clearest proof will suffice to override" that consideration. *Smith v. Doe*, 538 U.S. 84, 92 (2003) (internal quotation marks omitted); *accord Kansas v. Hendricks*, 521 U.S. 346, 361 (1997); *Flemming v. Nestor*, 363 U.S. 603, 617 (1960).[11]

Nothing close to clear proof of an unconstitutional purpose exists. In the wake of the Gosnell scandal, HB2 was enacted to "increase the health and safety" of abortion patients and provide them with "the highest standard of health care." Pet. App. 43a-44a & n.26 (quoting Senate Bill Analysis at 1-2). These are undoubtedly legitimate purposes. *E.g.*, *Roe*, 410 U.S. at 150 (noting a legitimate goal to "insure maximum safety for the patient"); *id.* (permitting regulations extending "to the performing physician and his staff, to the facility in-

[11] The Court has suggested that purpose, without the effect of an undue burden, may not render a law unconstitutional. *See Mazurek*, 520 U.S. at 972 ("assuming" it does); *cf. Tenney v. Brandhove*, 341 U.S. 367, 377 (1951) (it is "not consonant with our scheme of government for a court to inquire into the motives of legislators").

volved, to the availability of after-care, and to adequate provision for any complication or emergency that might arise"). Likewise legitimate is the State's interest in "the integrity and ethics of the medical profession." *Gonzales*, 550 U.S. at 157.

Petitioners do not cite anything from HB2's legislative history to corroborate their claim (Br. 35-44) that the Legislature's stated objectives were pretextual. Neither did the district court. *Cf. Edwards v. Aguillard*, 482 U.S. 578, 586-89 (1987) (rejecting a statute's stated purpose based on contrary statements by legislative sponsor). Instead, petitioners make three arguments, all of which fall far short of the clearest proof of unconstitutional purpose.

1. Petitioners ignore substantial evidence about the laws' justification.

Petitioners' first argument (Br. 36-40) is that no purpose other than creating a substantial obstacle could exist because the challenged provisions "utterly fail" (Br. 40) to advance any beneficial end. In so arguing, petitioners ignore the evidence admitted at trial that the admitting-privileges and ASC requirements would increase patient health and safety and promote physician professionalism.

To be sure, petitioners' expert witnesses and the district judge held a different view of the law's efficacy. But a district judge's view about disputed medical evidence does not retroactively determine the legislature's view or override the "wide discretion" of legislatures to act on medical uncertainty. *Gonzales*, 550 U.S. at 163.

a. *Admitting-privileges requirement.* Petitioners did not even raise in the district court a facial challenge to the admitting-privileges requirement. J.A. 161-64. Regardless, that requirement was enacted for multiple

valid reasons: evaluating physician competency, ensuring continuity of care, reducing miscommunications between doctors, and preventing patient abandonment. *Abbott II*, 748 F.3d at 592, 595; *see, e.g.*, *Greenville Women's Clinic v. Comm'r, S.C. Dep't of Health & Envtl. Control*, 317 F.3d 357, 363 (4th Cir. 2002) ("requirements of having admitting privileges at local hospitals and referral arrangements with local experts are . . . obviously beneficial to patients").

Medical evidence admitted at trial established that this requirement furthers patient health. Dr. James Anderson testified that the admitting-privileges requirement ensures "the rigorous scrutiny of both a doctor's qualifications and his/her technical skills required for surgical procedures." J.A. 867-68.[12] The requirement ensures additional examination of the physician's abilities and record. J.A. 877-78; *see* J.A. 527-28 (petitioners' expert agreeing that admitting privileges ensure clinical competence).

Anderson also testified that the admitting-privileges requirement "improves doctor-patient continuity of care because hospital staff privileges mandate standards of accessibility and availability of the doctor." J.A. 868. For example, if an abortion patient experiences compli-

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[12] Petitioners attack this and other evidence, which the district court admitted, based on the involvement of respondents' litigation consultant, Vincent Rue. Br. 13-14; Pet. App. 132a-33a n.1; J.A. 169. Rue helped find and prepare expert witnesses and suggested ways to word experts' views for presentation. J.A. 936, 975-76; *e.g.*, J.A. 1075-86 (example of communication between Rue and expert). The experts all testified that their opinions were theirs alone. J.A. 963, 971-72, 1150, 1280-81. And the alleged "efforts" to "obscure" Rue's work, Br. 14, consisted of asserting privilege over his communications. J.A. 168-79, 929-30, 979.

cations and arrives at an emergency room on her own, the emergency-room physician will not have access to her medical records or history and may not be able to contact her abortion provider. J.A. 887-88. As a study quoted by Anderson explained: "Treating patients without complete information poses an important challenge to patient safety, increasing the likelihood of medical errors, adverse events, duplication of laboratory tests and procedures, and increased health care costs." J.A. 892-93.

Petitioners have never disputed that the Legislature heard evidence of these benefits when abortion doctors have admitting privileges at a nearby hospital. *See* House Bill Analysis at 10-11 (summarizing supporter testimony). For example, Dr. Ingrid Skop testified: "[I]t's useful in terms of getting records. In my experience a lot of these young girls, they're scared. They come away from the abortion. They don't know what procedure they had and they don't know who the doctor was. And so it's very, very difficult to get a good history out of them."[13] Dr. Jim Mauldin stated: "Without hospital privileges, other physicians are left to take care of an abortion provider's most serious complications. By requiring privileges, not only would there be continuity of care but the peer review processes of the hospital would be brought to bear and ensure quality."[14]

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[13] Hearing on H.B. 2816 Before the H. Comm. on State Affairs, 83d Leg., R.S. at 2:46:56-2:47:12 (Mar. 27, 2013) (Skop testimony on prior version of HB2), http://tlchouse.granicus.com/MediaPlayer.php?clip_id=6765.

[14] Hearing on S.B. 1 Before the S. Comm. on Health & Human Servs., 83d Leg., 2d C.S. at 7:03:11-7:03:27 (July 8, 2013) (Mauldin testimony on Senate version of HB2), http://tlcsenate.granicus.com/MediaPlayer.php?clip_id=495.

Abortion complications presented the Legislature with a real concern. Abortion can entail hemorrhage, infection, uterine perforation, anesthesia complications, incomplete abortion, and embolism, some of which can lead to hysterectomy or death. J.A. 277, 850. Statistics indicate that multiple Texas women each week suffer abortion complications, even using figures relied on by petitioners' experts. *See, e.g.*, J.A. 266-67 (noting a University of California study showing a "major complication" rate of 0.23%, which translates to 2-3 women every week assuming 60,000 abortions annually in Texas); *see also Abbott II*, 748 F.3d at 591, 595 (noting expert testimony on major complications and that "Planned Parenthood conceded that at least 210 women in Texas annually must be hospitalized after seeking an abortion"); J.A. 267 (indicating that 0.87% of abortion patients, which translates to ten per week in Texas, visit an emergency department to receive post-abortion care); J.A. 640-700 (Whole Woman's Health logs showing at least 20 patients sent or transferred to a hospital with complications ranging from bleeding to infection to uterine perforation).

Moreover, every reason exists to believe these complication rates are understated. Many States have no mandated abortion-reporting system, and facilities have incentives not to report complications. J.A. 844, 870-72. In fact, significant discrepancies exist between petitioner Whole Woman's Health's forms reporting complications to the State and its internal complication logs. *Compare* J.A. 640-46, 652-57, 680-87, 689-700 (2013-2014 logs), *with* J.A. 606-639 (2013-2014 complication reports that fail to report numerous complications noted internally and lack forms for several months and for San Antonio and McAllen facilities altogether).

All of this evidence refutes petitioners' claim of unconstitutional purpose. Were there any doubt, it would be dispelled by the National Abortion Federation's own prior recommendation that abortion patients use a doctor who "'[i]n the case of emergency' can 'admit patients to a nearby hospital (no more than 20 minutes away).'" *Abbott II*, 748 F.3d at 595 (quoting National Abortion Federation, *Having an Abortion? Your Guide to Good Care* (2000)). The Federation's amicus brief here does not even acknowledge its previous recommendation.

Other organizations have also recognized that admitting privileges at a nearby hospital promote patient safety. In 2004, the American College of Obstetricians and Gynecologists (ACOG) and the American Medical Association joined a patient-safety statement; it announced the "core principle" that "[p]hysicians performing office-based surgery must have *admitting privileges at a nearby hospital*, a transfer agreement with another physician who has admitting privileges at a nearby hospital, or maintain an emergency transfer agreement with a nearby hospital." *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 928 & n.3 (7th Cir. 2015) (Manion, J., dissenting) (quoting statement) (emphasis added). Transfer agreements were listed as alternatives, *see* ACOG Br. 21 n.50 (so noting), but the statement confirms that local admitting privileges have a direct relationship with patient care.

These amici now opine that admitting-privileges requirements are unnecessary. But state medical regulations are not unconstitutional for failing to track "accepted practice" decreed by certain medical organizations. *See Gonzales*, 550 U.S. at 166 (refusing to "strike down legitimate abortion regulations, like the present one, if some part of the medical community were disinclined to follow the proscription"); *Akron I*,

462 U.S. at 456 (O'Connor, J., dissenting) (stating that, under the undue-burden test, the validity of abortion regulations did not depend on "accepted medical practice" or change "every time the American College of Obstetricians and Gynecologists (ACOG) or similar group revises its views").

b. *Ambulatory-surgical-center requirement*. Petitioners fare no better in their parallel contention about the purpose of HB2's ambulatory-surgical-center requirement. Br. 39. On petitioners' reasoning, Pennsylvania and the other States that enacted ASC abortion standards after the Gosnell scandal also acted with an unconstitutional purpose. *See supra* p. 2. Furthermore, petitioners have not questioned the constitutionality of Texas's preexisting ASC requirement for abortions after 15 weeks' gestation. Tex. Health & Safety Code § 171.004.

Simopoulos readily dispels the notion that the ASC requirement was enacted for an improper purpose: this Court upheld (under *Roe*'s strict-scrutiny framework) Virginia's requirement that non-hospital second-trimester abortions be performed in "ambulatory surgical facilities." 462 U.S. at 517. The Court noted that this ASC requirement was a valid means of "furthering the State's compelling interest in 'protecting the woman's own health and safety.'" *Id.* at 519 (quoting *Roe*, 410 U.S. at 150). Justice O'Connor's concurrence would have applied the undue-burden test to find that ASC requirement facially constitutional regardless of trimester. *Id.* at 520.

Petitioners and the federal government have no answer for *Simopoulos*. The federal government does not even acknowledge that *Simopoulos* involved an ASC requirement. U.S. Br. 25 n.8. Petitioners at least concede that it did, but imply that *Simopoulos* turned

on "the ability of facilities to seek waivers and grandfathering." Br. 60 n.25. Not so. In explaining the background of how Virginia's ASC regulations operated, the Court noted that "deviations" from the "second category" of requirements (construction standards) could be "approved" if "'the purposes of the minimum requirement have been fulfilled.'" 462 U.S. at 515 (quoting Va. Regs. § 50.2.1). This fact did not play any role in the Court's subsequent analysis. *See id.* at 516-19. Moreover, this quoted regulation is a substantial-compliance provision—not a grandfathering or waiver provision that categorically absolved a facility of the need to comply with the purpose of ASC requirements. Petitioners make no claim that certain abortion facilities in Texas will have to close even though they are in substantial compliance with HB2's ASC requirements.

Trial evidence corroborates *Simopoulos*'s point that ASC standards ensure that abortions providers "can provide the highest quality of care and safety." Pet. App. 45a. Dr. Mayra Jimenez Thompson explained:

- "The pregnant uterus with higher risks should only be treated in an ASC or hospital setting where the necessary additional testing or surgery to assess and treat for complications can be safely accomplished." J.A. 849.
- "In an ASC or hospital setting, the patient is monitored by a licensed medical practitioner and nursing staff who are trained to recognize these risks and complications." J.A. 850.
- "ASCs are monitored for quality assurance, patient safety, and staff and facility compliance via their own internal administrative policies and requirements, as well as by three external mechanisms: state licensure, certification by the

> federal Center for Medicare Services, and/or accreditation by professional ASC associations or regulatory bodies, including the Joint Commission." J.A. 852.

And petitioner Whole Woman's Health acknowledged that its ASC clinic offers "more robust pain management options" for abortions than do non-ASC clinics. *See* J.A. 807-08.

Even more notably, one of petitioners' experts conceded that the benefits of an ASC requirement are a matter of disagreement in the medical community. She admitted that "there are at least some health care providers who believe requiring a clinic to be an ASC benefits the health and safety of a woman choosing to undergo an abortion." J.A. 528. This confirms at least "medical and scientific uncertainty" regarding the merits of the requirement. *Gonzales*, 550 U.S. at 163. That is precisely when legislatures have "wide discretion" to regulate abortions under *Gonzales*. *Id.*

Petitioners have never disputed that the Legislature heard evidence of the ASC requirement's medical benefits. *See* House Bill Analysis at 10-11 (summarizing supporter testimony). For example, Dr. Pat Nunnelly explained that the ASC requirement "hold[s] abortion providers to the same standard of care that I am held to when I do a D&C or multiple other surgical procedures in the hospital."[15] And Dr. Linda Flower stated that the ASC requirements are designed "to keep the patients safe" and that "simple things like physical plant re-

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[15] Hearing on S.B. 5 and 24 Before the S. Comm. on Health & Human Servs., 83d Leg., 1st C.S. at 3:20:25-3:20:40 (June 13, 2013) (Nunnelly testimony on prior version of HB2), http://tlcsenate.granicus.com/MediaPlayer.php?clip_id=525.

quirements to have a generator in case the power goes out [and] CPR training" are important "in case there's a complication."[16]

Petitioners insist that surgical abortions do not require the sterile environment provided by ASC standards because the "vagina . . . is not sterile." Br. 18. But the Legislature could conclude differently: the cervix and intra-uterine cavity are sterile, and actively opening the cervix breaks the sterile barrier. J.A. 847. As described by one of the State's experts, a surgical abortion is similar to the performance of a dilation and curettage (D&C), and D&C's are traditionally performed in an ASC or hospital setting. J.A. 848-50. During a D&C, the patient is anesthetized, washed, and covered with sterile drapes to limit contamination. J.A. 848. After performing a pelvic exam, the surgeon uses an instrument to assess the opening of the cervix. *Id.* If it is not open, the surgeon must dilate the cervix with metal dilators. *Id.* Dilation can be extremely painful, and the patient often requires more than local anesthetics. *Id.* Once the cervix is sufficiently open, the surgeon inserts a probe to measure the length of the uterus, and dilation continues until the cervix opening is large enough to insert the curette. *Id.* The surgeon uses the curette to remove tissue within the uterus, inspects the uterus for bleeding, and removes the instruments. J.A. 848-49. Accompanying the surgeon are a circulating nurse, either a scrub nurse or technician, the anesthesia team, and sometimes a medical student. J.A. 848.

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[16] Hearing on S.B. 537 Before the S. Comm. on Health & Human Servs., 83d Leg., R.S. at 1:28:20-1:28:54 (Mar. 19, 2013) (Flower testimony on prior version of HB2), http://tlcsenate.granicus.com/MediaPlayer.php?clip_id=842.

The district court also invalidated the ASC requirement as applied to drug-induced abortions, but petitioners failed below to defend that portion of the district court's judgment. Pet. App. 58a-59a. Any argument on that point is therefore waived. Additionally, no petitioner testified that it sought to provide only drug-induced abortions, and petitioners would lack standing to request as-applied relief for other facilities. Regardless, evidence showed that incomplete drug-induced abortions require surgical abortions. J.A. 278; *see Abbott II*, 748 F.3d at 602. And drug-induced abortions present a greater complication rate (5.0%-8.0%) and a hospitalization rate of 0.3%. 38 Tex. Reg. 9586 (2013); J.A. 201.

Petitioners lastly argue that the ASC requirement can have only an invalid purpose absent proof that ASCs produce better patient "outcomes." Br. 5, 18, 31.[17] That is not the constitutional standard. *See, e.g.*, *Mazurek*, 520 U.S. at 973. Petitioners may dispute the degree of medical benefits from the ASC requirement. Br. 19-22, 39. But when evidence "demonstrates both sides have medical support for their position," that is "a sufficient basis to conclude in [a] facial attack that the Act does not impose an undue burden." *Gonzales*, 550 U.S. at 161, 164.[18]

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[17] Petitioners reference a "study" in which their expert, Grossman, compared complications at just three Whole Woman's Health non-ASC facilities with the Whole Woman's Health ASC and found no significant difference in outcomes. Br. 18. Comparing only a subset of facilities within a single corporate entity cannot produce statistically relevant results, much less prove a law's facial invalidity.

[18] Petitioners' reliance (Br. 37) on *Sorrell v. IMS Health Inc.*, 131 S. Ct. 2653 (2011), is misplaced. *Sorrell* concerned heightened scrutiny of a content-based speech restriction, not a medical regulation involving disputed medical evidence.

2. Petitioners wrongly treat a law's effect of closing noncompliant facilities as proof of unconstitutional purpose.

Petitioners are wrong to say that HB2's "undisputed and predictable effect" is to close abortion clinics, and they are wrong to call this evidence of unconstitutional purpose. Br. 40-41. There is no evidence or finding that the admitting-privileges requirement has caused half of the State's abortion clinics to close. *See supra* pp. 12-13. Much less is there evidence substantiating petitioners' claim that remaining abortion clinics will lack capacity to meet the demand for abortion. *See supra* pp. 9-11. Abortion providers have been able to comply with both the admitting-privileges and ASC requirements, J.A. 182-83, 1435-36, and the Legislature gave abortion clinics over 13 months to conform to the ASC requirement, Pet. App. 25a. The Legislature would not have provided this allowance if its purpose had been to close clinics. Whether clinics would close rather than comply with these requirements was not "predictable" when the Legislature enacted HB2.

In all events, this Court "do[es] not assume unconstitutional legislative intent even when statutes produce harmful results." *Mazurek*, 520 U.S. at 972. An "awareness of consequences" is not sufficient to demonstrate an unconstitutional purpose. *Pers. Adm'r of Mass. v. Feeney*, 442 U.S. 256, 279 (1979). In any industry, businesses that do not meet governing regulations may not be able to operate, and a legislature may be well aware of that fact. But that does not prove a legislative purpose to produce whatever effects may flow from closing a business, rather than to achieve the public-welfare benefits of the regulations.

Finally, HB2's severability clause refutes any claim of unconstitutional legislative purpose. The Legislature specifically provided that HB2 would be enforced only in situations where the law would not impose an "undue burden" on abortion patients. Pet. App. 200a-01a. The Texas Legislature could not have had the "purpose" of imposing an undue burden when the statute specifically requires the non-enforcement of any applications that would result in an undue burden.

3. Petitioners incorrectly assert that abortion cannot be regulated differently than other procedures.

This Court has long rejected petitioners' claim that governments cannot regulate abortion differently from other medical procedures. *See, e.g.*, *Gonzales*, 550 U.S. at 159; *Casey*, 505 U.S. at 852 ("Abortion is a unique act."); *Harris v. McRae*, 448 U.S. 297, 325 (1980) ("[a]bortion is inherently different from other medical procedures"); *Danforth*, 428 U.S. at 66-67 (upholding written-consent requirement that applied only to abortion); *see also Akron I*, 462 U.S. at 464 n.9 (O'Connor, J., dissenting) ("the Court . . . has expressly rejected the view that differential treatment of abortion requires invalidation of regulations").

Contrary to petitioners' sweeping theory about "singl[ing] out abortion," Br. 43, the Constitution does not require a State to reform all of its medical regulations or none at all. The Legislature did not have an unconstitutional purpose in enacting abortion-facility reform, a topic of public attention after the Gosnell scandal.

Moreover, while abortion practice may be regulated differently, petitioners' assertion that Texas "explicitly authorizes" physicians to perform "major outpatient

surgeries" in their offices is without support. Br. 42. Texas requires physicians who use certain types of anesthesia to register with the State and meet certain equipment and safety standards. 22 Tex. Admin. Code §§ 192.1-.6. That many physicians have done so does not mean they are performing "major outpatient surgeries." J.A. 1225-26 (stating only that physicians may use anesthesia, but not describing the types of surgeries provided).

Petitioners ultimately appear to acknowledge that abortion may be regulated differently, but they assert without any citation that any regulation must be "aimed at an aspect of abortion that is unique." Br. 43. The Court's decisions have not imposed any such restriction. For example, *Mazurek* allowed States to prohibit non-physicians from performing abortions, 520 U.S. at 973, without discussing whether abortion was uniquely more risky than other services that non-physicians may perform. Petitioners' argument only highlights that they want the Court to abandon a quarter-century of abortion precedent.

C. Petitioners Failed to Prove that the Challenged Requirements' Effects Warrant Facial Invalidation.

Petitioners' claims for statewide invalidation based on HB2's "effects" (Br. 44-52, 54-56) fail for multiple independent reasons.

First, an abortion law cannot be facially invalidated unless a plaintiff proves, at an absolute minimum, that it imposes an undue burden "in a large fraction of relevant cases." *Gonzales*, 550 U.S. at 167-68. Petitioners cannot satisfy this "heavy burden," *id.* at 167, because an abortion clinic will remain operational in each metropolitan area where petitioners allege one would close

if the Court affirms. J.A. 1430-31, 1435-36. Over 90% of Texas women of reproductive age will live within 150 miles of an operational abortion clinic. J.A. 921-22.

Second, HB2's severability clause requires the Court to preserve every valid application of HB2. At the very least, the ASC requirements are constitutional as applied to second-trimester abortions under *Simopoulos*.

Third, each of the discrete ASC rules is also severable, and petitioners do not even argue (let alone prove) that each specific requirement in the ASC rules will cause a clinic to close or impose an undue burden.

1. Petitioners failed to prove that the challenged requirements will impose a substantial obstacle in a large fraction of cases.

A central premise of petitioners' facial challenge is that travel distances to abortion providers constitute or contribute to a statewide substantial obstacle to abortion access. *See* Br. 49-52. But petitioners proved no statewide substantial obstacle from travel distances.

If the Fifth Circuit's judgment is affirmed, abortion clinics will be operating in at least the metropolitan areas of Austin, Dallas (2 clinics), Fort Worth, Houston (2 clinics), San Antonio (3 clinics), El Paso (in Santa Teresa, New Mexico), and McAllen (with as-applied relief). *See* J.A. 1435-36, 1441. Trial evidence showed that, if HB2 takes full effect, at least 86.6% of reproductive-age Texas women would live within 150 miles of an operating abortion clinic; that number rises to 92.8% given the as-applied relief to the McAllen facility.[19]

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[19] The State's expert testified that 83.3% of women of reproductive age in Texas live within 150 miles of an existing Texas abortion ASC (located in Austin, Dallas, Fort Worth, Houston, and San Antonio). J.A. 921-22. Petitioners' expert, Grossman, arrived at a

With over 85% of reproductive-age Texas women living within 150 miles of an abortion clinic remaining open under HB2, the statute cannot be facially invalidated on the premise that travel distances to clinics create a "substantial obstacle" to abortion access in a large fraction of cases. *See Casey*, 505 U.S. at 885-87 (no substantial obstacle from traveling over one hour and sometimes over three hours to reach the nearest provider, when that trip "often" must be made twice because of a 24-hour waiting period); *cf.* Tex. Health & Safety Code § 171.012(a)(4) (reducing the 24-hour waiting period to 2 hours for women who travel over 100 miles).

In addition, petitioners fall well short in demonstrating that the travel distances they label a statewide substantial obstacle were caused by the challenged laws. Petitioners did not even attempt to prove that the nonparty clinic closures they show on their map (Br. App. 1) were caused by HB2's admitting-privileges requirement, *see supra* pp. 12-13—no doubt because petitioners did not raise a facial challenge to that requirement in district court. Nor will most Texas women see a material travel-distance change due to the ASC requirement, as illustrated at page 5a of this brief's appendix. The first map there shows the cities in which abortion providers operated at the time of the Fifth Circuit's *Abbott II* ruling, several months after the admitting-

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similar result of 82.5%. *See* J.A. 242, 244. The State's expert further testified that 3.3% live within 150 miles of the Santa Teresa, New Mexico facility, and another 6.2% live within 150 miles of the McAllen facility. J.A. 921-22.

privileges law took effect. J.A. 145, 229-30, 401-03, 1124. The second map shows cities in which abortion providers will be operating under the Fifth Circuit's judgment here. J.A. 1435-36, 1441. This confirms that the six most populous metropolitan areas in Texas (Houston, San Antonio, Dallas, Austin, Fort Worth, and El Paso)—plus McAllen—will still have an operational abortion clinic if the Court affirms.[20]

Given the flaws in petitioners' travel-distance argument for facial invalidation, they have suggested that operational clinics will lack capacity to meet the demand for abortion. Br. 25-26. But they lack any record evidence for that claim.

Petitioners' expert, Grossman, supplied no such evidence. Petitioners' brief never denies that Grossman's "opinion" on the capacity of Texas abortion clinics "is *ipse dixit*" that was based on "a chain of unsupported inferences," nor does their brief deny that "the record lacks any actual evidence regarding the current or future capacity of the [remaining] clinics." Pet. App. 56a & n.34; Pet. App. 105a-06a. Nevertheless, petitioners cite Grossman's discredited capacity opinion for support of their assertions that HB2 reduces access to

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[20] The only cities that had an abortion provider after *Abbott II* but would lack one if the Fifth Circuit's judgment is affirmed (at least immediately after) are Corpus Christi and Killeen. App. 5a. But the Corpus Christi facility closed before trial, and there is no proof of the closure's cause or that the facility would reopen if petitioners prevail in this lawsuit. *See* J.A. 737-38, 1433 (noting that the facility's owner moved to San Antonio and opened an ASC there). As for Killeen, petitioners did not seek as-applied relief, Pet. App. 2a; *see* J.A. 339-40, 403, or explain how any additional travel distance to the next closest facility (about 70 miles away in Austin) justifies facial invalidation of the ASC requirement.

abortion. Br. 23-25, 56 (citing J.A. 229-31, 234-35, 237-38, 241, 248-49). Petitioners cannot possibly demonstrate an undue burden in a "large fraction" of cases when this claim turns on their capacity argument and they fail to contest the court of appeals' conclusions regarding Grossman's testimony. Pet. App. 47a-58a.

Petitioners believe they can satisfy the "large fraction" test by asserting that a "shortage of abortion providers would prevent some women from obtaining abortions and make it much harder for others to do so." Br. 56. This statement about clinic capacity limitations and HB2's causation of those limitations is unsupported by the record evidence. *See supra* pp. 9-14. Even if there were evidence of some undue burden, petitioners still must show that this harm would apply to a "large fraction" of Texas women of reproductive age. A plaintiff cannot establish a "large fraction" just by announcing—without citing any evidence—that "some" patients or "others" will encounter substantial obstacles. Br. 56.

Petitioners note that the number of abortions in Texas has decreased since the admitting-privileges requirement went into effect. Br. 25. But petitioners failed to introduce any analysis of causation that controls for other factors that could produce that result, such as the decreasing abortion rate nationwide. J.A. 1117-18. A decrease in total abortions hardly shows that HB2 imposed a substantial obstacle, much less in a "large fraction" of circumstances.

Petitioners' capacity claims about HB2's ASC requirement are equally meritless. Every metropolitan area in Texas with an abortion clinic today will still have at least one if the Court affirms. J.A. 1430-31, 1435-36. Petitioners did not even try to offer evidence that those clinics (or others that may open) lack capacity to meet abortion demand, much less that this is true for a "large

fraction" of potential abortion patients statewide. *See supra* pp. 9-11.

Unable to point to trial testimony demonstrating a lack of capacity, petitioners have now turned to a post-trial internet release of a study that appears to have been conducted by their trial expert Grossman or at his direction. Br. 25-26. This source belatedly makes factual assertions, which respondents deny, and it obviously was not admitted as evidence at trial or tested through the adversarial process of cross-examination and competing expert testimony. It cannot be considered by this Court, certainly not consistent with due process. *E.g.*, *Witters v. Wash. Dep't of Servs. for the Blind*, 474 U.S. 481, 486 n.3 (1986) ("Nor is it appropriate . . . for us to consider claims that have not been the subject of factual development in earlier proceedings."); *New Haven Inclusion Cases*, 399 U.S. 392, 450 n.66 (1970) ("None of this is record evidence, and we do not consider it."). This source is extra-record evidence not limited to "indisputable facts subject to judicial notice or 'legislative' facts," and it is "manifestly improper to bring such facts to the Court's attention." *Supreme Court Practice* 800-01.

If this internet report had been offered as evidence, respondents would have likely argued and proved that, even on its own terms, the report does not establish that remaining abortion clinics in Texas will lack capacity to meet abortion demand. Based on "mystery" calls to abortion clinics, the report suggests that capacity is lacking on the premise that wait times for abortions have increased. Tex. Policy Eval. Proj., Abortion Wait Times in Texas, Oct. 5, 2015, https://utexas.app.box.com/AbortionWaitTimeBrief (TexPEP Rpt.). But the report's own measures do not show a lack of capacity—statewide or in individual cities. It found (1) no increase in wait times in Houston, (2) a one-day wait time in El

Paso with only one clinic, (3) a wait time between one and eight days in McAllen, and (4) wait times as little as a week or less in Austin. *Id.* at 2-3. The report also concluded that the ASC requirement would not affect wait times in San Antonio. *Id.* at 4. It purported to find an increase in wait times in Dallas and Fort Worth during the last two to three months it examined, which it claimed may be attributable to the closure of a Dallas clinic in June 2015. *Id.* Yet the report's analysis ended before allowing any opinion on whether the Dallas and Fort Worth clinics would be able to adjust and lower wait times. *Id.*[21]

2. The statute's severability clause precludes facial invalidation.

This Court applies severability clauses in state laws. *See Leavitt v. Jane L.*, 518 U.S. 137, 139 (1996) (per curiam) ("Severability is of course a matter of state law."); *see also Wyoming v. Oklahoma*, 502 U.S. 437, 460-61

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[21] Had respondents been able to take discovery and conduct cross-examination on this report, they might also have learned what Grossman chose not to disclose—namely whether the report concluded that certain clinic closures in November 2013 had any effect on wait times. As the report indicates, "monthly mystery calls" began in "November 2013"—that is, the same month that the admitting-privileges requirement took effect, and four months *before* this lawsuit was filed on April 2, 2014. TexPEP Rpt. at 6; *accord id.* at 1. Yet although the report presents data by month, it only presents results "since November 2014" and does not state wait times it allegedly found from November 2013 to October 2014. *Id.* at 2. Petitioners did not offer any information from this report at trial in August 2014—even though Grossman would have had at least nine months of data at that point. This silence is reason to question whether Grossman may not have revealed data that did not support petitioners' position.

(1992) ("Severability clauses may easily be written to provide that if application of a statute to some classes is found unconstitutional, severance of those classes permits application to the acceptable classes."). HB2 has a "comprehensive and careful severability provision" requiring courts to sever and preserve any applications of HB2's provisions that do not constitute an undue burden. *Abbott II*, 748 F.3d at 589; Pet. App. 200a. The Fifth Circuit concluded that HB2's severability provision must be given force, Pet. App. 68a, and petitioners have waived any argument otherwise by failing to make it here. Their brief does not even mention the word "sever" or "severability."

Although petitioners ignore HB2's severability clause, it precludes statewide facial invalidation. *See, e.g.*, *Brockett v. Spokane Arcades, Inc.*, 472 U.S. 491, 506 n.14 (1985) (enforcing a requirement to sever applications of a law, even in a First Amendment overbreadth case). The ASC requirement is undoubtedly constitutional as applied to second-trimester abortions, for petitioners have not asked this Court to overrule *Simopoulos*. And both the ASC and admitting-privileges requirements are constitutional as applied to clinics in any Texas city that will have an abortion ASC. Petitioners stipulated that abortion ASCs will remain in Austin, Fort Worth, Dallas, Houston, and San Antonio after HB2 takes full effect, J.A. 182-83, and they produced no evidence that those clinics would be unable to meet demand, Pet. App. 56a.

At the very least, the State should be able to apply the ASC requirement to any new abortion facilities and existing ASC-compliant facilities that perform abortions, as even the district court found would be permissible if the ASC requirement were severed and viewed in isolation. Pet. App. 157a. Petitioners cannot complain about

this aspect of the district court's judgment, as they do not claim they intend to open new, non-ASC abortion facilities in Texas and cannot raise such claims on behalf of nonparties. *Kowalski v. Tesmer*, 543 U.S. 125, 129 (2004).

3. Each discrete ambulatory-surgical-center regulation is severable, and petitioners have not attempted to prove that each violates the Constitution.

The ASC abortion rules cannot be invalidated in full because each discrete provision is severable from the others. *See* 25 Tex. Admin. Code § 139.9(b). Many of the requirements cannot possibly be regarded as undue burdens on abortion access. *See, e.g.*, *id.* § 135.5(a) ("Patients shall be treated with respect, consideration, and dignity."); *id.* § 135.5(c) (protections for patient medical records); *id.* § 135.5(g) ("Marketing or advertising regarding the competence and/or capabilities of the organization shall not be misleading to patients."); *id.* § 135.10(c) ("Facilities shall be clean and properly maintained.").

Petitioners' trial brief explained that "[i]t is the construction and nursing requirements that form the basis of Plaintiffs' challenge." R.2590.[22] In other words, they did not challenge any of the operating standards (25 Tex. Admin. Code §§ 135.4-.17, 135.26-.27) except the nursing requirements at section 135.15(a), or any of the general safety standards (*id.* §§ 135.41-.43) except the fire-prevention standards at section 135.41. *See* Pet. App. 68a-70a. Petitioners even admitted that most of the remaining ASC standards were "comparable to" or

[22] The court of appeals' electronic record is cited as "R."

less stringent than existing abortion-clinic regulations. R.2589-90. At a minimum, these unchallenged ASC requirements cannot be invalidated in light of HB2's severability clause. Pet. App. 25a; *see Leavitt*, 518 U.S. at 138.

Petitioners make cursory reference to the ASC nursing-staff requirements. Br. 7, 24. But as the court of appeals correctly noted, petitioners have no "record evidence that complying with the nursing requirements would cause the closure of abortion facilities," and they "admitted that the remaining operational requirements were comparable to the standards with which abortion facilities were already required to comply." Pet. App. 70a; *see also* Pet. App. 120a (Judge Higginson's opinion agreeing with a stay of the injunction to "allow enforcement of the operational requirements," as only the "physical plant requirements" were addressed by the district court).

IV. The Challenged Requirements Are Not Unconstitutional As Applied In El Paso.

The El Paso petitioners' as-applied challenge is based on the premise that all El Paso abortion facilities will close rather than comply with HB2. This will allegedly cause women to face the "substantial obstacle" of traveling short distances across the state line to a Santa Teresa, New Mexico abortion facility within the El Paso metropolitan area. Br. 52-53.

This challenge to the *admitting-privileges requirement* as applied in El Paso cannot succeed. There is an abortion doctor with sufficient admitting privileges currently performing abortions in El Paso. J.A. 1110-11.

As to the *ASC requirement*, while no ASC abortion clinic currently exists in El Paso, merely crossing state lines is not a "substantial obstacle" tantamount to pre-

venting the "ultimate decision" to abort a pregnancy. *Casey*, 505 U.S. at 879. An abortion clinic will remain operational in Santa Teresa, New Mexico—just one mile across the Texas border and only twelve miles from the facility currently operating in El Paso. J.A. 1059; Pet. App. 72a. The record confirms that women in El Paso often used the Santa Teresa clinic to obtain abortions. Pet. App. 74a.

Casey's effects inquiry analyzes abortion access by asking whether a law imposes a "substantial obstacle to the woman's effective right to elect the procedure." 505 U.S. at 846. When an abortion facility remains operational in the same metropolitan area, the fact that a patient must cross state lines does not substantially interfere with her ability to access abortion. The issue could be different if it involved crossing international borders with onerous burdens; but there are no checkpoints or other barriers to cross state lines.

Rather than confront the simplicity of crossing state lines, petitioners advocate a new abortion doctrine: courts may not examine the ease of obtaining an abortion outside the State whose law is challenged. Petitioners cite (Br. 53) *Missouri ex rel. Gaines v. Canada*, 305 U.S. 337 (1938). But *Gaines*'s equal-protection holding has no application here, as the instant case involves the substantive component of the Due Process Clause. *Casey*, 505 U.S. at 846. In *Gaines*, the State had an affirmative equal-protection duty to admit students without regard to race once it opened and operated a law school. 305 U.S. at 351. In contrast, the State here has no due-process (or equal-protection) obligation to affirmatively subsidize abortion. *See, e.g.*, *Rust v. Sullivan*, 500 U.S. 173, 193 (1991); *Harris*, 448 U.S. at 316-17. Under *Casey*, the State must refrain from imposing a substantial obstacle that takes away a woman's

"ultimate decision" about whether to have an abortion. 505 U.S. at 879. But that negative prohibition does not require any affirmative act. *See Jackson Women's Health Org. v. Currier*, 760 F.3d 448, 463 (5th Cir. 2014) (Garza, J., dissenting) (stating that the "duty not to unduly burden the abortion right" "does not require a state to *take* any action, but rather to *refrain* from taking unconstitutional actions").

Women in the El Paso area face no materially different travel distances because the Santa Teresa clinic will remain operational. So the effect of the ASC requirement in El Paso does not impose a substantial obstacle to abortion access.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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Appendix

APPENDIX

Admitting-Privileges Laws Enacted in 2011 or Later

Alabama – Ala. Code § 26-23E-4(c) ("Every physician referenced in this section shall have staff privileges at an acute care hospital within the same standard metropolitan statistical area as the facility is located that permit him or her to perform dilation and curettage, laparotomy procedures, hysterectomy, and any other procedures reasonably necessary to treat abortion-related complications."), added by 2013 Ala. Laws Act 2013-79, § 4.

Arizona – Ariz. Rev. Stat. Ann. § 36-449.03(C) ("The director shall adopt rules relating to abortion clinic personnel. At a minimum these rules shall require that: . . . (3) A physician is available: (a) For a surgical abortion who has admitting privileges at a health care institution that is classified by the director as a hospital pursuant to § 36-405, subsection B and that is within thirty miles of the abortion clinic. (b) For a medication abortion who has admitting privileges at a health care institution that is classified by the director as a hospital pursuant to § 36-405, subsection B."), amended by 2012 Ariz. Legis. Serv. ch. 250, § 2.

Kansas – Kan. Stat. Ann. § 65-4a08(b) ("It shall be unlawful for a person to perform or induce an abortion in a facility unless such person is a physician, with clinical privileges at a hospital located within 30 miles of the facility, with no requirement of culpable mental state."), added by 2011 Kan. Sess. Laws ch. 82, § 8.

Louisiana – La. Stat. Ann. § 40:1061.10(A)(2) ("On the date the abortion is performed or induced, a physician performing or inducing an abortion shall: (a) Have active admitting privileges at a hospital that is located not further than thirty miles from the location at which the abortion is performed or induced and that provides obstetrical or gynecological health care services."), added by 2014 La. Sess. Law Serv. Act 620, § 1 (originally section 40:1299.35.2(A)(2)).

Mississippi – Miss. Code Ann. § 41-75-1(f) ("All physicians associated with the abortion facility must have admitting privileges at a local hospital and staff privileges to replace local hospital on-staff physicians."), amended by 2012 Miss. Laws ch. 331, § 1.

North Dakota – N.D. Cent. Code § 14-02.1-04(1) ("All physicians performing abortion procedures must have admitting privileges at a hospital located within thirty miles [42.28 kilometers] of the abortion facility and staff privileges to replace hospital on-staff physicians at that hospital."), amended by 2013 N.D. Laws ch. 118, § 1.

Tennessee – Tenn. Code Ann. § 39-15-202(j)(1) ("A physician may not perform an abortion unless the physician has admitting privileges at a hospital licensed under title 68 that is located: (A) In the county in which the abortion is performed; or (B) In a county adjacent to the county in which the abortion is performed."), amended by 2012 Tenn. Pub. Acts ch. 1008, § 2 (originally subsection (h)(1)).

Texas – Tex. Health & Safety Code § 171.0031(a) ("A physician performing or inducing an abortion: (1) must,

on the date the abortion is performed or induced, have active admitting privileges at a hospital that: (A) is located not further than 30 miles from the location at which the abortion is performed or induced; and (B) provides obstetrical or gynecological health care services."), added by Act of July 12, 2013, 83d Leg., 2d C.S., ch. 1, § 2, 2013 Tex. Gen. Laws 5013, 5013-14.

Wisconsin – Wis. Stat. § 253.095(2) ("No physician may perform an abortion, as defined in s. 253.10(2)(a), unless he or she has admitting privileges in a hospital within 30 miles of the location where the abortion is to be performed."), added by 2013-14 Wis. Legis. Serv. Act 37, § 1.

Abortion-Clinic Laws Enacted in 2011 or Later

Alabama – Ala. Code § 26-23E-9 (providing that "abortion or reproductive health center shall be classified as ambulatory health care occupancy and shall meet all standards in the NFPA 101 Life Safety Code 2000 edition"), added by 2013 Ala. Laws Act 2013-79, § 9.

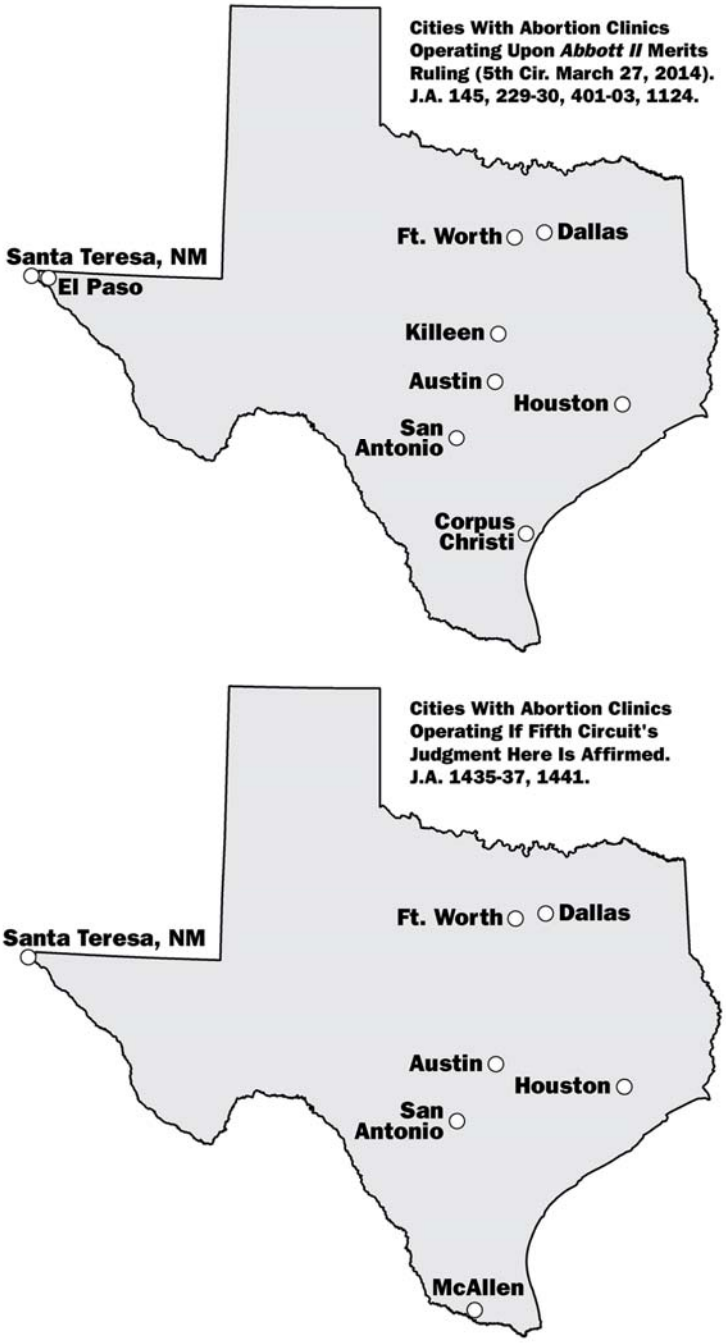
Kansas – Kan. Stat. Ann. § 65-4a09 (requiring the Secretary of the Department of Health and Environment to adopt rules and regulations for licensing abortion facilities and providing minimum standards for those rules), added by 2011 Kan. Sess. Laws ch. 82, § 9.

Pennsylvania – 35 Pa. Cons. Stat. § 448.806(h) (requiring Department of Health to apply the same regulations to abortion facilities that are applied to ambulatory surgical facilities), added by 2011 Pa. Legis. Serv. Act 2011-122, § 2.

Tennessee – Tenn. Code Ann. § 68-11-201(3) (requiring offices of private physicians to be licensed as ambulatory surgical treatment centers if they perform more than fifty abortions in any calendar year), amended by 2015 Tenn. Pub. Acts ch. 419, § 1.

Texas – Tex. Health & Safety Code § 245.010(a) (requiring the minimum standards for an abortion facility to be equivalent to the minimum standards for an ambulatory surgical center), amended by Act of July 12, 2013, 83d Leg., 2d C.S., ch. 1, § 4, 2013 Tex. Gen. Laws 5013, 5017.

Virginia – Va. Code Ann. § 32.1-127(B)(1) (classifying facilities in which five or more first trimester abortions per month are performed as hospitals), amended by 2011 Va. Acts ch. 670.


Cities With Abortion Clinics
Operating Upon *Abbott II* Merits
Ruling (5th Cir. March 27, 2014).
J.A. 145, 229-30, 401-03, 1124.
Ft. Worth
Dallas
Santa Teresa, NM
El Paso
Killeen
Austin
Houston
San
Antonio
Corpus
Christi
Cities With Abortion Clinics
Operating If Fifth Circuit's
Judgment Here Is Affirmed.
J.A. 1435-37, 1441.
Ft. Worth
Dallas
Santa Teresa, NM
Austin
Houston
San
Antonio
McAllen