IN THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MISSOURI
CENTRAL DIVISION

COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, et al. Plaintiffs, v. DR. RANDALL WILLIAMS, et al., Defendants.	)	Case No. 2:16-cv-04313-HFS

STATE DEFENDANT'S SUGGESTIONS IN OPPOSITION TO PLAINTIFFS' THIRD MOTION FOR PRELIMINARY INJUNCTION

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INTRODUCTION

Plaintiffs' third motion for preliminary injunction, Doc. 152, should be denied. Plaintiffs' claim for relief at the Columbia facility fails as a matter of law for several reasons. First, Plaintiffs cannot establish that the hospital-privileges requirement imposes a substantial obstacle on a "large fraction" of affected Missouri women. The fraction that Plaintiffs themselves provide—22 percent—is not a "large fraction" under controlling case law. Second, Plaintiffs rely solely on increased driving distances to posit a "substantial obstacle," but the Supreme Court's case make clear that increased travel distances alone do not constitute a "substantial obstacle." Third, the hospital-privileges requirement is not unduly difficult to satisfy in Columbia, Missouri, which has many OB/GYNs and multiple hospitals. If Plaintiffs cannot satisfy the requirement, that is because of the refusal or unwillingness of doctors with hospital privileges to perform abortions, and it is not due to any action of the State. As the Jackson County Circuit Court recently held, "the issue of abortion provider scarcity is not one of the state's making and, therefore, should not be considered by this Court in consideration of the undue-burden analysis." Fourth, Plaintiffs lack standing and their claim is unripe because they have presented no evidence of any recent efforts to comply with the hospital-privileges requirement in Columbia—their only evidence is two years old. Fifth, Plaintiffs gravely underestimate the health risks of abortion in Missouri, and abundant evidence in the record demonstrates that those risks are far greater than Plaintiffs' expert predicts. Sixth, Plaintiffs ignore or mischaracterize the evident health benefits of the requirement, which include ensuring continuity of care for patients and ensuring that a qualified physician takes responsibility for patients experiencing post-abortion complications. Seventh, Plaintiffs greatly exaggerate the supposed burdens on women from the hospital-privileges requirement, and their methodologically flawed analysis overestimates the number of women impacted.

The State Defendants hereby incorporate by reference the evidence and arguments in their prior filings in this case, including but not limited to their Response in Opposition to Plaintiffs' Second Motion for Temporary Restraining Order, ECF No. 141, and Exhibits thereto.

ARGUMENT

Preliminary injunctive relief is "an extraordinary remedy," and "the burden of establishing the propriety of an injunction is on the movant." *Watkins Inc. v. Lewis*, 346 F.3d 841, 44 (8th Cir. 2003). The Court considers four factors in determining whether to grant a temporary injunction: "(1) the likelihood of the movant's success on the merits; (2) the threat of irreparable harm to the movant in the absence of relief; (3) the balance between that harm and the harm that the relief would cause to other litigants; and (4) the public interest." *Id.* (citing *Dataphase Sys., Inc. v. C.L. Sys., Inc.*, 640 F.2d 109, 114 (8th Cir. 1981) (en banc)).

I. Plaintiffs Are Not Likely to Succeed on the Merits.

Plaintiffs are not likely to succeed on the merits because their claim of an undue burden for women seeking abortions at the Columbia facility suffers from numerous fatal deficiencies.

A. Plaintiffs' claim fails because 22 percent is not a "large fraction."

First, Plaintiffs' claims fail as a matter of law because 22 percent is not a "large fraction" of Missouri women seeking abortions for whom the Columbia clinic is the closest clinic. Thus, even if Plaintiffs' predictions of impact on the abortion rate were correct (which they are not, *see infra*), and even if Plaintiffs had identified the correct denominator (which they have not),[1] their claims would still fail as a matter of law.

[1] As the State Defendants previously argued, Doc. 141, at 20-21, the correct denominator is not the number of women seeking abortions for whom the Columbia facility is the closest, but the number of women seeking abortions throughout Missouri, because the regulation affects all Missouri abortion facilities and it is thus "relevant" for all Missouri women. *See* Doc. 141, at 20-21; *Planned Parenthood of Arkansas & E. Oklahoma v. Jegley*, 864 F.3d 953, 953 (8th Cir. 2017)

The Supreme Court in *Casey* identified two threshold elements for any undue-burden challenge to an abortion regulation: the challenged regulation must impose (1) a "substantial obstacle" to (2) a "large fraction" of women for whom the restriction is relevant. *See Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 894-95 (1992) (holding that an abortion regulation is invalid if, "in a *large fraction* of the cases in which [the statute] is relevant, it will operate as a *substantial obstacle* to a woman's choice to undergo an abortion") (emphases added); *see also June Med. Servs. L.L.C. v. Gee*, 905 F.3d 787, 803 (5th Cir. 2018) ("[W]e must weigh the benefits and burdens of [the statute] to determine whether it places a *substantial obstacle* in the path of a *large fraction* of women seeking abortions in Louisiana") (emphases added).

Here, Plaintiffs purport to seek relief on behalf of all Missouri women "for whom the Columbia health center is the closest [abortion] provider." Doc. 153, at 25; *see also id.* at 17, 18, 23 n.23, 24. They predict that the hospital-privileges requirement will prevent 22 percent of those women, for whom the Columbia facility is the closest in-state abortion facility, from obtaining an abortion who otherwise would have obtained one. *Id.* at 3, 17, 19, 20; *see also* Doc. 133-3 (Lindo Declaration).

As the State Defendants have previously argued, Doc. 141, at 5-8, the law is clear that 22 percent is not a "large fraction" under *Casey*. Just a few months ago, the Fifth Circuit held that 30 percent is not a "large fraction." *June Medical*, 905 F.3d at 814 (holding that the large-fraction requirement was not met where "only 30% (or, less than one-third) of women seeking an abortion

("Because the [challenged] requirement only applies to medication-abortion providers, the 'relevant denominator' here is women seeking abortions in Arkansas."); *June Medical*, 905 F.3d at 802 ("Here, too, the relevant denominator to determine a "large fraction" is all women seeking abortions in Louisiana, as [the statute] applies to providers of both medication and surgical abortions."); *Whole Woman's Health v. Lakey*, 769 F.3d 285, 299 (5th Cir. 2014) ("*Casey* itself counsels that the denominator should encompass all women 'for whom the law is a restriction.'").

would face even a potential burden of increased wait times"); *id.* at 815 ("Bearing a burden of 30% compared to the typical burden of 100% is not large. To conclude otherwise eviscerates the restrictions on a successful facial challenge."). The Fifth Circuit had already held that 17 percent is "nowhere near a 'large fraction.'" *Whole Women's Health v. Lakey*, 769 F.3d 285, 298 (5th Cir. 2014) (holding that 16.7 percent is "nowhere near a 'large fraction' . . . We decline to interpret *Casey* as changing the threshold for facial challenges from 100% to 17%."). Last year, the Eighth Circuit stated in *Jegley* that 12 percent is not a "large fraction." *Planned Parenthood of Arkansas & E. Oklahoma v. Jegley*, 864 F.3d 953, 959 n.8 (8th Cir. 2017) (citing with approval the Sixth Circuit's holding that "12 percent does not constitute a 'large fraction'"). Both the Eighth Circuit and the Fifth Circuit cited with approval the Sixth Circuit case holding that 12 percent is not a "large fraction." *Cincinnati Women's Services, Inc. v. Taft*, 468 F.3d 361, 374 (6th Cir. 2006) ("[T]he term 'large fraction' . . . envisions something more than the 12 out of 100 women identified here").[2]

[2] Plaintiffs argue in a footnote that the Eighth Circuit has suggested that 18 percent is a "large fraction," Doc. 153, at 26 n.27 (citing *Planned Parenthood, Sioux Falls Clinic v. Miller*, 63 F.3d 1452, 1462 n.10 (1995)), but they plainly misconstrue that case. *Miller* held that a parental-notice statute that lacked a judicial-bypass provision was unconstitutional. *Miller* explicitly stated that "requiring parental notice . . . is *not* an undue burden on immature minors who cannot show that an abortion would be in their best interests." *Miller*, 63 F.3d at 1459. *Miller* held that: "The State runs afoul of the Constitution, however, when it attempts to give that same power to parents of mature daughters capable of making their own informed choices." *Id.* at 1460. In other words, *Miller* concluded that the parental notice-requirement constituted a substantial obstacle for all the minors for whom it was relevant—*i.e.* those who were sufficiently mature to make their own decision or for whom an abortion was in the best interest. *Id.* The "large fraction" in *Miller* was thus 100 percent, not 18 percent. *See id.* (holding that the "requirement . . . places a substantial obstacle in the way of a mature or best-interests minor's right to choose"). *Miller* referred to the 18 percent figure only in a footnote, in rejecting the argument that South Dakota's alternative abuse-and-neglect bypass procedure was insufficient. That footnote stated in passing: "Roughly eighteen per cent. of South Dakota's minors live in single-parent homes; many of them, as a practical matter, have only one parent to notify." *Id.* at 1462. Nothing in the reasoning or holding of *Miller*, therefore, even remotely suggests that 18 percent is a "large fraction" under *Casey*.

Moreover, the Sixth Circuit case, which both the Eighth Circuit and the Fifth Circuit cited with approval, holds that a "large fraction" must be substantially more than 50 percent, and likely much closer to 100 percent—*i.e.*, "practically all of the affected women." *Id.* at 373 ("Other circuits that have applied the large fraction test to facial challenges to abortion regulations have, likewise, only found a large fraction when *practically all* of the affected women would face a substantial obstacle in obtaining an abortion.") (emphasis added). The Fifth Circuit, likewise, has held that a "large fraction" must comprise the "vast majority" of women affected by the regulation. *Planned Parenthood of Greater Texas Surgical Health Services v. Abbott*, 748 F.3d 583, 600 (5th Cir. 2014) (holding that the "large fraction" test was not met because "the burden does not fall on the *vast majority* of Texas women seeking abortions") (emphasis added).

This holding that a "large fraction" is much closer to 100 percent than 50 percent follows directly from the reasoning of the Supreme Court's abortion decisions. Outside of the abortion context, the default rule for facial challenges is that 100 percent of the challenged statute's applications have to be invalid. *Washington State Grange v. Washington State Republican Party*, 552 U.S. 442, 449 (2008); *United States v. Salerno*, 481 U.S. 739, 745 (1987). In adopting the "large fraction" test in *Casey*, the Supreme Court relaxed the *Salerno* standard somewhat, but did not purport to abolish it entirely. *See June Medical*, 905 F.3d at 815 ("The shift from the usual [*Salerno*] standard to the large-fraction standard was intended to ease the burden on abortion plaintiffs relative to plaintiffs who bring challenges to other sorts of laws. There is a difference, however, between cracking the door and holding it wide open."). For this reason, the Supreme Court has explicitly stated that the "large fraction" test is *more* exacting, and thus requires a *bigger* fraction, than the "substantial overbreadth" test of the First Amendment, which requires something more than 50 percent. *See Gonzales v. Carhart*, 550 U.S. 124, 167 (2007) ("The latitude given

facial challenges in the First Amendment context [substantial overbreadth] is inapplicable here. Broad challenges of this type impose 'a heavy burden' upon the parties maintaining the suit."). To argue that 22 percent is a "large fraction" directly contradicts the reasoning and holding of *Gonzales*.

Plaintiffs' arguments to the contrary have no merit. First, Plaintiffs argue that the "large fraction" test does not apply *at all*, because they claim they have asserted an "as-applied" challenge. This argument is plainly meritless. As the State Defendants have previously pointed out, Doc. 141, at 4-5, the "large fraction" test does not apply to "as applied" challenges only when the challenge is brought *on behalf of a single, individual woman seeking an abortion*. This is because the "large fraction" test makes no sense to apply to a challenge brought by a single individual—the numerator and denominator are both one, leading to a fraction of 100 percent in every case where a substantial obstacle is found (or zero percent if one is not found). But Plaintiffs do not seek relief on behalf of an individual patient. Rather, their motion seeks sweeping relief on behalf of all women for whom the Columbia facility is the closest in-state abortion facility, which includes many thousands of Missouri women of reproductive age in much of central and Western Missouri—in fact, because Plaintiffs discount out-state facilities, it may include more than half of Missouri's female population, including the entire western half of the State. As the State Defendants have previously argued, this is not an "as applied" challenge at all, but a modified facial challenge. Doc. 141, at 4-5. The Supreme Court has clearly held that an "as applied" challenge, in the abortion context, relates to the "discrete case" of an individual patient seeking an abortion. *Gonzales*, 550 U.S. at 168 (describing "as applied" challenges, in the abortion context, as one which presents "a discrete case" of an individual woman's personal health risk, and holding

that "for this reason, as-applied challenges are the basic building blocks of constitutional adjudication"). There is nothing "discrete" about the sweeping relief sought here.

In any event, regardless of whether the relief sought in Plaintiffs' motion is described as "facial" or "as-applied," they seek relief that would prevent enforcement of the law on behalf of a large geographical and demographic swath of Missouri. By Plaintiffs' logic, they would be entitled to an injunction against enforcement of the law at the Columbia facility if they could demonstrate that it imposed a substantial obstacle on *a single woman* in mid-Missouri, which is directly contrary to the reasoning and holding of both *Casey* and *Gonzales*. *Casey*, 550 U.S. at 894-95; *Gonzales*, 550 U.S. at 168. Plaintiffs cite no authority that supports this counterintuitive and absurd conclusion.

Plaintiffs also argue that their estimate of 22 percent is less than the total fraction of women facing a substantial obstacle, because that number reflects the women who are prevented from having an abortion, while an indeterminate number of additional women are *delayed* before having an abortion. Even if a mere delay of indeterminate length could constitute a "substantial obstacle," which it does not, the Eighth Circuit's opinion in *Jegley* forecloses this argument. In *Jegley*, the Eighth Circuit held that a plaintiff who argues that women will experience delay before having an abortion must provide evidence supporting an estimate of "the number of women who would postpone their abortions," to allow for meaningful application of the "large fraction" test. *Jegley*, 864 F.3d at 959-60. Here, Plaintiffs provide no numerical evidence of "the number of women who would postpone their abortions," other than vague speculation. *Id.* Because the "large fraction" test is "not entirely freewheeling," *id.* at 960, this speculation is insufficient to carry their burden.

B. Increased driving distances alone do not constitute a "substantial obstacle."

Second, Plaintiffs' claims fail as a matter of law because the only increased burden on women that they identify is increased driving distances (and the incidental burdens that necessarily follow from travel, such as transportation costs, costs of child care while traveling, and costs of taking time off work to travel). Such increased travel distances do not constitute a "substantial obstacle" under the holding of *Casey*, because *Casey* itself held that increased driving distances very similar to those asserted here—up to three hours of travel for 42 percent of women in Pennsylvania—did not constitute a substantial obstacle. *Casey*, 505 U.S. at 886-87; *see also Planned Parenthood of Southeastern Pa. v. Casey*, 744 F. Supp. 1323, 1352 (E.D. Pa 1990).

Because of *Casey*'s holding that such increased driving distances did not constitute a substantial obstacle, subsequent cases have carefully specified that other burdens in addition to and independent of increased driving distances must be included as well to constitute a undue burden. For example, *Whole Woman's Health v. Hellerstedt* explicitly "recognize[d] that increased distances do not always constitute an 'undue burden,'" and treated them as "one additional burden" to be "taken together with others that the closings brought about," such as massive congestion at Texas abortion facilities, long waiting periods before obtaining an abortion, and similar burdens. 136 S. Ct. 2292, 2313 (2016). In *Hellerstedt*, "the Court identified four obstacles erected by Texas's requirement of admitting privileges: closure of facilities, difficulty in obtaining privileges, driving distances, and clinic capacities. The Court decided not that any burden individually was sufficient but that the four dominoed to constitute a substantial burden." *June Medical*, 905 F.3d at 807. *Hellerstedt* thus concluded that there was a substantial obstacle only by "stacking that burden [of driving distances] on top of the others." *Id.* at 804.

Here, by contrast, Plaintiffs do not identify any burdens other than increased driving distances and inconveniences that flow directly from increased driving distances, and they provide no evidence of increased congestion or long wait times at Missouri clinics. "The Court in [*Hellerstedt*] found unduly burdensome the expectation that 8 clinics could absorb the work of 40. Each remaining Texas abortion provider would have had to increase his capacity by a factor of 5." *June Medical*, 905 F.3d at 812 (citing *Hellerstedt*, 136 S. Ct. at 2317). In Missouri, the St. Louis facility is much larger and performs many times more procedures than the Columbia facility. The operation of the Columbia facility will have no discernible impact on congestion at the St. Louis facility—and Plaintiffs have submitted no evidence to suggest otherwise. Accordingly, this case differs starkly from *Hellerstedt*, and *Casey*'s holding directly controls.

C. Plaintiffs' claims fail because they incorrectly attribute to the State burdens that are attributable to third parties outside the State's control.

In addition, Plaintiffs' claim fails as a matter of law because they repeatedly, and erroneously, attribute to the State alleged burdens on access to abortion that are caused by the independent actions of third parties outside the State's control.

As the Supreme Court has repeatedly held, "[a]lthough government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those obstacles not of its own creation." *Harris v. McRae*, 448 U.S. 297, 316 (1980); *see also Maher v. Roe*, 432 U.S. 464, 474 (1977). Despite this holding, Plaintiffs repeatedly attribute to the State issues relating to abortion access that are caused by the actions of third parties outside the State's control. For example, Plaintiffs repeatedly complain that Missouri's informed-consent law requires women to travel to the abortion facility "twice," supposedly doubling the requisite driving distance. Doc. 153, at 2, 4, 17, 18, 21, 23, 24. But Missouri's informed-consent law does not

require two trips to the abortion facility to complete the informed-consent process. The informed consent may occur at another facility, such as the Columbia facility, regardless of whether the abortion is performed there. The reason the informed-consent process does not happen in Columbia is that Plaintiffs' physicians are unwilling to travel to Columbia to meet women before they have abortions, because they contend that they are simply too busy with other matters, and/or that there are too few physicians willing to perform this role. The Jackson County Circuit Court, in denying a TRO to these same plaintiffs in a recent case challenging this very aspect of the informed-consent law, held as follows: "the issue of abortion provider scarcity is not one of the state's making and, therefore, should not be considered by this Court in consideration of the undue-burden analysis." *See* Judgment/Order Denying TRO, *Comprehensive Health of Planned Parenthood Great Plains, et al. v. Hawley*, No. 1716-CV24109 (Jackson Cty. Cir. Ct.) (Oct. 23, 2017), at 8 (filed as Doc. 141-5).

The same reasoning undermines Plaintiffs' entire theory of undue burden in this case. Plaintiffs contend that the hospital-privileges requirement prevents the Columbia facility from performing abortions, because the sole doctor willing to perform abortions there is based in St. Louis and cannot obtain hospital privileges in Columbia. But there are many OB/GYNs in the Columbia area who are able to obtain hospital privileges in the area, which contains at least two major hospitals. Unlike the situation in Texas, *see June Medical*, 905 F.3d at 804, there is no evidence that it is unduly difficult for doctors who reside and practice in the Columbia area to obtain hospital privileges in Columbia. Rather, Plaintiffs' difficulty is that, for reasons entirely outside the State's control, they have failed to recruit any of the many qualified OB/GYNs or other physicians with hospital privileges in the Columbia area to perform abortions at their Columbia facility. If it is true that no qualified physicians in the Columbia area are willing to perform

abortions at the Columbia facility, *but see infra* Part I.D, that fact is not caused by the State, but it is caused by the independent choices and actions of parties outside the State's control. The Constitution simply does not obligate the State to recruit and produce willing abortion providers for the Columbia facility.[3] As the Fifth Circuit squarely held in *June Medical*, the "inaction" and "personal choice" of abortion providers not to perform abortions "cannot be legally attributed to" the challenged statute. *June Medical*, 905 F.3d at 811. And as Judge Burnett held, "the issue of abortion provider scarcity is not one of the state's making and . . . should not be considered by this Court in consideration of the undue-burden analysis." Doc. 141-5, at 8.

D. Plaintiffs have not submitted sufficient evidence to establish standing and ripeness for their claim.

For related reasons, Plaintiffs have not submitted evidence to establish standing and ripeness for their current request for relief. Obviously, the hospital-privileges requirement imposes no obstacle to women in the Columbia area if Plaintiffs can comply with it—*i.e.*, if they can recruit a physician with hospital privileges who is willing to perform abortions at the Columbia facility. Over two years ago, in late 2016, Plaintiffs presented evidence that they were unable either to recruit a physician with such privileges or to obtain privileges for the physician(s) who are willing to perform abortions there. *See* Doc. 15-1. But Plaintiffs have submitted no evidence of any efforts to recruit a physician with privileges in Columbia, or to obtain privileges for their physicians in Columbia, in the intervening two years. Neither the motion they filed in September 2018, nor their current renewed motion filed in December 2018, cited or provided any such evidence. In fact,

[3] For the same reason, Plaintiffs' argument that the undue-burden analysis should not take into account abortion facilities in neighboring States that Missouri women frequently use—such as the facility in Overland Park, Kansas, which is in the Kansas City metropolitan area—is meritless. The Supreme Court's abortion cases do not require the States to take affirmative steps to guarantee the existence of abortion providers within their borders. Those cases only prohibit the States from imposing undue burdens on access to the abortion providers who are available.

Plaintiffs are currently refusing to respond to the State Defendants' preliminary-injunction-related discovery requests, which ask for this very information. *See, e.g.,* Doc. 155-4, at 6 (Interrogatories 1 and 2).

Another District Judge in this Circuit recently denied temporary injunctive relief to these same Plaintiffs, raising similar claims, for exactly the same reason. In *Comprehensive Health of Planned Parenthood Great Plains v. Williams*, No. 17-4207-CV-C-BP, Judge Phillips denied Plaintiffs' request for a temporary restraining order against Missouri's complication-plan requirement because Plaintiffs had not "identified efforts made to comply with the regulation." Order and Opinion Denying Plaintiffs' Motion for Temporary Restraining Order, *Comprehensive Health of Planned Parenthood Great Plains v. Williams*, No. 17-4207-CV-C-BP, Doc. 26, at 6 (Nov. 3, 2017) (attached as Exhibit 1). This Court held that Plaintiffs had not submitted evidence to show that they were unable to recruit a backup physician with admitting privileges in the Columbia area, because their only efforts to do so were two years old: "Moreover, even if admitting privileges are required, Plaintiffs have not attempted to find a qualifying OB/GYN who will contract with the Columbia clinic. They last sought doctors to contract with in 2015, which was two years ago. This does not establish that Plaintiffs could not *today* find an OB/GYN who will satisfy the regulation's requirements." *Id.* at 7 (emphasis in original). For this reason, the Court concluded that "[a]t present, Plaintiffs have not demonstrated that they cannot comply with the regulation." *Id.*

So also here, Plaintiffs have not submitted evidence to demonstrate their inability to recruit a doctor with hospital privileges to perform abortions at the Columbia facility since late 2016, "which was two years ago." *Id.* "This does not establish that Plaintiffs could not *today* find an OB/GYN who will satisfy the [statute's] requirements." *Id.* (emphasis in original).

In the absence of current evidence demonstrating that they cannot satisfy the hospital-privileges requirement through reasonable efforts, Plaintiffs lack Article III standing and their claims are unripe. Standing requires "that the alleged injury is not too speculative for Article III purposes—that the injury is *certainly* impending." *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 409 (2013) (citation omitted). Article III standing is lacking where "the dispute is purely hypothetical and the injury is speculative." *Thomas v. Anchorage Equal Rights Comm'n*, 220 F.3d 1134, 1137 (9th Cir. 2000) (en banc).

The ripeness doctrine "prevent[s] courts, through avoidance of premature adjudication, from entangling themselves in abstract disagreements over administrative policies, and also to protect the agencies from judicial interference until an administrative decision has been formalized and its effects felt in a concrete way by the challenging parties." *Abbott Labs. v. Gardner*, 387 U.S. 136, 148-49 (1967), *abrogated on other grounds by Califano v. Sanders*, 430 U.S. 99 (1977). Thus, "the ripeness doctrine is 'drawn from both Article III limitations on judicial power and from prudential reasons for refusing to exercise jurisdiction.'" *Nat'l Park Hospitality Ass'n v. Dep't of Interior*, 538 U.S. 803, 808 (2003) (quoting *Reno v. Catholic Social Servs., Inc.*, 509 U.S. 43, 57 n.18 (1993)).

The burden is on the party invoking the court's jurisdiction to prove that its injuries are not speculative and hypothetical, and that its claims are ripe. *Nebraska Pub. Power Dist. v. MidAmerican Energy Co*., 234 F.3d 1032, 1039 (8th Cir. 2000). This burden requires a showing both that the issues have crystallized to the point of being fit for review, and that there would be hardship to the parties from withholding court consideration. *Parrish v. Dayton*, 761 F.3d 873, 875 (8th Cir. 2014). Because Plaintiffs have submitted no evidence in over two years to

demonstrate that they are not currently able to satisfy the hospital-privileges requirement at the Columbia facility, they lack standing and their claim is unripe.

E. Plaintiffs gravely underestimate the health risks of abortion in Missouri.

In addition, Plaintiffs gravely underestimate the health risks of abortion in Missouri. As the State Defendants have established through previous filings, the record demonstrates that abortion complications are far more frequent and more severe than Plaintiffs predict.

1. Plaintiffs ignore strong evidence of systematic underreporting of abortion complications.

The evidence in the record indicates that there are four "layers," so to speak, of abortion complications. First, there are the abortion complications that are known to the abortion providers and reported to the States. Plaintiffs' predictions of abortion complication rates are entirely rooted in this first "layer," and they ignore the impact of the other three layers of complications. And even relying on this first "layer" alone, Plaintiffs gravely underestimate the frequency and severity of complications. *See* Coleman Decl., Ex. 2, ¶¶ 55-61. The abortion complication reports filed with the State since May 2017 indicate that this first "layer" alone is far more severe than Plaintiffs admit, for the reasons discussed below. *See infra* Part I.E.2.

Second, there are complications that are known to abortion providers but that they fail to report to the States. For decades prior to 2017, this "layer" comprised virtually *all* complications in Missouri, as Plaintiffs and other abortion providers systematically ignored their legal obligation to provide abortion-complication reports, as mandated by Mo. Rev. Stat. § 188.052.2. Plaintiffs do not dispute that they never filed any mandatory abortion complication reports at any time prior to May 2017, though the statutory obligation has been in effect for decades.

Third, there are the abortion complications that neither the abortion providers nor the State ever know about, because the patients seek treatment elsewhere, do not notify the health care

provider that the complications arose from an abortion, and/or the patient is "lost to follow-up" for any number of other reasons. These are major issues leading to significant underreporting of abortion complications, as Plaintiffs have effectively conceded in a related case. *See, e.g.,* Eisenberg Dep. 235-36 (attached as Exhibit 3) (testifying that "it's a regular occurrence" that women seeking post-abortion treatment fail to disclose to doctors that they had an abortion); McNicholas Testimony Tr. 265 (attached as Exhibit 4) (agreeing that "many women who seek treatment for post-abortion complications may not tell the [provider treating the complication] that they had an abortion"). And a practice bulletin of the American College of Obstetricians and Gynecologists reports "loss-to-follow rates as high as 45% in clinical settings" for post-abortion treatment of medication abortion patients. ACOG Practice Bulletin No. 143, at 9 (2014).

Fourth, there are the abortion complications that would have occurred but did not, because since 2007 Missouri has imposed reasonable regulations on abortion facilities designed to promote women's health and safety. In claiming that the St. Louis facility has a strong safety record (which it does not), Plaintiffs overlook that, for the entire relevant time period, the St. Louis facility complied with both the ASC requirements and the hospital-privileges requirement that have been challenged in this case. Even more complications, and more severe complications, would undoubtedly have occurred if abortion facilities had been radically deregulated as Plaintiffs wish. This point is especially important because the hospital-privileges requirement and other regulations are not directed only to Plaintiffs, or only to the Columbia facility. Rather, they are *statewide* requirements that prevent abuses and promote safety not just at Plaintiffs' facilities, but also for "the shoddiest operators" and "the worst providers." Doc. 84, at 1 (quoting Megan Twohey, *State Abortion Records Full of Gaps*, CHICAGO TRIBUNE, at 5 (June 16, 2011) (filed as Doc. 84-1)).

2. Complication reports filed since May 2017 reflect a much higher complication rate than Plaintiffs contend.

Plaintiffs contend that "the record shows that abortion complication rates in Missouri are entirely consistent with the rates reported in the national literature." Doc. 153, at 5. On the contrary, the existing evidence from recent complication reports suggests that abortion complication rates in Missouri are much higher than the national rates predicted by Dr. Eisenberg and the Upadhyay study on which he relies. *See* Doc. 153, at 5 n.4. As discussed in the State Defendants' motion for preliminary-injunction-related discovery, Doc. 155, at 6-7, "the complication reports filed since May 2017 directly undermine the Plaintiffs' contentions regarding the safety of abortion procedures in Missouri." *Id.* at 6. Between June 2017 and October 2018, the Department received 193 complication reports and 4,669 abortion reports, implying an overall complication rate of 4.13 percent (193/4,669).[4] *See* Affidavit of Lori Brenneke, attached as Exhibit 5 & atts. (attachments to be filed separately as an Exhibit under seal upon leave of Court). Again, this ratio is almost double the national complication rate of 2.1 percent predicted by Plaintiffs' expert and the Upadhyay study. *See* Doc. 153, at 5. Those 193 complication reports reflect 28 incidents that Plaintiffs and Upadhyay et al. would classify as "major" complications, involving hospital treatment, blood transfusions, and problems of similar severity. *See, e.g.,* Ex. 5 & att. at 29, 30, 32, 47-52, 54, 83, 84, 92, 102, 103, 105, 107, 123, 143, 149, 150, 157, 159, 160, 161, 162, 169, 172, 175, 178, 180, 182, 194 (complication reports reflecting major complications). This implies an overall rate of major complications of 0.60 percent (28/4,669)—again, much higher

[4] These numbers are updated from the numbers reported in the State Defendants' Motion for Preliminary-Injunction-Related Discovery, Doc. 155, at 5-7, because the Department received additional complication reports and abortion reports for October 2018 since that filing on December 28, 2018. As they did previously, the State Defendants are filing with this response a motion for leave to file the additional complication reports under seal and to disclose them to Plaintiff's counsel pursuant to the protective order.

than the major-complication rate predicted for Missouri by Dr. Eisenberg. These major complications include grave and life-threatening scenarios such as septic abortion, cervical laceration, uterine perforation, significant hemorrhages, pyrexia, and other conditions. *See id.*

To be sure, any complication rate drawn from the complication reports is inexact because (1) the complication reports include many cases of treatment in Missouri for abortions performed outside Missouri, and (2) they do not include cases for treatment provided outside Missouri for abortions performed in Missouri. *Id.* Also, the complication reports are almost certainly greatly underinclusive. Given that health care providers failed to file such reports for decades, failing to file such reports almost certainly continues. Furthermore, the complication reports cannot capture instances where women sought treatment for complications without telling the physician that the complications resulted from an abortion, which Plaintiffs' physicians have admitted in another case is a significant source of underreporting. *See* Eisenberg Dep. 235-236 (Ex. 3); McNicholas Tr. 265 (Ex. 4); ACOG Practice Bulletin No. 143, at 9.[5]

Plaintiffs repeatedly contend that "DHSS did not *request or collect* complication reports from abortion providers or any other medical providers" prior to May 2017. Doc. 153, at 7 (emphasis added); *see also* Doc. 153-2, ¶ 7. But the statute does not require the Department to "request or collect" complication reports. The statute places the affirmative duty on *the providers* to file the reports: "An individual abortion complication report for any post-abortion care performed upon a woman shall be completed *by the physician* providing such post-abortion care."

[5] Plaintiffs contend that the complication reports filed since May 2017 provide no evidence of poor communication between abortion providers and physicians treating complications from the abortions. On the contrary, numerous complication reports indicate that the doctor treating the complication did not even know where the abortion was performed. *See, e.g.*, Ex. 5 & att. at 49, 79, 80, 83, 91, 95, 100, 156, 174. In some cases, there had obviously been no communication *at all* between the abortion provider and the physician treating the complication. *See also* Doc. 28-4, at 6.

Mo. Rev. Stat. § 188.052.2. "All complication reports shall be signed by the physician providing the post-abortion care and submitted to the department of health and senior services within forty-five days from the date of the post-abortion care." Mo. Rev. Stat. § 188.052.3. Moreover, the very same statutory section requires the filing of abortion reports, *see id.*, and Plaintiffs filed many thousands of abortion reports during the same time period. Plaintiffs have never explained why they complied with the requirement of filing abortion reports while systematically ignoring the requirement of filing complication reports, which is found in the very same statutory section—and again, they are currently refusing to respond to the State Defendants' discovery requests, which ask these very questions.[6] Docs. 155-3, 155-4 (Interrogatories 5, 6, 7).

Plaintiffs contend that their failure to file mandatory complication reports for decades should be excused because they were supposedly "complying with the state-mandated quality assurance process overseen by DHSS." Doc. 153, at 7. On the contrary, Plaintiffs' facilities were frequently cited for failing to comply with quality-assurance procedures during this period. *See infra* Part I.E.3. In any event, establishing a quality-assurance process is not a substitute for filing complication reports, because it does not create reliable statistical data for abortion complications in Missouri, and does not allow off-site scrutiny of the health-and-safety records of the facilities.

3. Plaintiffs' own facilities have a troubling history of substandard health-and-safety practices.

Moreover, the health-and-safety records of Plaintiffs' own abortion facilities highlight the problems in abortion safety in Missouri. Most recently, on September 26, 2018, black mold and bodily fluid were discovered in the tubing of the suction aspiration machine used on patients in the

[6] Plaintiffs also claim that the Department failed to publish complication data in annual reports. Doc. 153, at 7. Because Plaintiffs and other providers were not filing complication reports, it is hard to see what data Plaintiffs think the Department should have been publishing, but was not.

Columbia facility at issue here. *See* Doc. 141-1 (Declaration of William Koebel); *see also* Declaration of William Koebel ¶¶ 2-8 (attached as Exhibit 6). Plaintiffs argue that the State's claim that black mold and bodily fluid were discovered in the suction aspiration machine is "inflammatory and false," but Plaintiffs never actually dispute any of the critical facts: (1) a black substance was clearly visible in one portion of tubing, and a reddish fluid was clearly visible in another portion of tubing; (2) Plaintiff's own Health Center Manager identified the substances and mold and bodily fluid during the inspection; and (3) the machine had been used on at least one patient while it was in that unsanitary, substandard condition. *See id.*

While it is particularly shocking, this most recent health-and-safety violation at the Columbia facility is only the tip of the iceberg. The Columbia facility has a history of troubling inspection deficiencies regarding cleanliness, treatment, and reporting. In 2013, the facility was found deficient because it failed to ensure clean linens were stored separately from soiled linens. *See* Ex. A to Affidavit of William Koebel (attached as Exhibit 7), Statement (June 11, 2013). In 2015, the facility was cited for failing to demonstrate compliance with its own infection prevention program, including failing to maintain a sterilization log and failing to stock the supplies necessary to disinfect its vaginal ultrasound probes properly. *See* Ex. B to Ex. 7, Findings Letter (Apr. 3, 2015). In addition, the Department has repeatedly cited the facility for not having a properly equipped emergency tray. For instance, its Automated External Defibrillator did not have working batteries in 2013. *See* Ex. A to Ex. 7. In 2016, the facility lacked medications and supplies that state law says must be "immediately available" to a physician on the emergency tray. *See* Ex. C to Ex. 7, Statement (Nov. 2, 2016). In 2013, 2015, and 2016, the facility did not have certifications to administer controlled substances from the Drug Enforcement Administration and Bureau of Narcotics and Dangerous Drugs (although it was not licensed at all for some or all of this time).

See Exs. A, B, C to Ex. 7. In 2016, the program was cited for a deficient quality assurance program. *See* Ex. C to Ex. 7.

The August 2018 report found that the facility had failed to maintain an adequate infection control program, including proper hand hygiene practices. *See* Ex. D to Ex 7, Statement (Aug. 14, 2018). The suction machine cabinet had numerous spots of rust. *See id.* The exam rooms were not clean or sanitary. *Id*. Patient medical records were incomplete: they did not include discharge instructions; they showed that medication orders were not properly marked with the date and time or were not signed by medical staff; and several files did not include physician notes documenting abortion counseling. *Id*.

As noted above, the September 26, 2018 inspection noted several significant deficiencies. *See* Ex. E to Ex. 7, Statement (Sept. 26, 2018). The facility had failed to dispose of used, soiled single-use suction tubing filled with "reddish fluid," which (as noted above) was identified as human bodily fluid. *Id.* A reusable glass suction bottle had "a layer of dried black substance in the bottom." *Id.* The suction machine had a "dried brown spill" down one side. *Id.* A reusable series of connecting hose had a "blackish-gray substance on the inside of the length of the tubing," which (as noted above) was identified as mold. *Id*. Staff said they had identified this mold problem "a couple of months previously" but had "continued to use the machine" with the hose anyway. *Id*.

Plaintiffs' St. Louis facility has a troubled history of health-and-safety violations as well. Inspection reports show that the St. Louis facility has a longstanding problem of not complying with regulations designed to prevent infections and maintain a clean environment. *See* Ex. F. to Ex. 7, Statement (Apr. 5, 2001). A 2013 inspection found rust in what were supposed to be sanitary environments—including a rusted stool, oxygen tank, suction machine, and the base of a procedure

table. *See* Ex. G to Ex. 7, Statement (Jan. 31, 2013). In 2015, the facility was cited for an examination table with multiple tears in the pad, exposing the uncleanable, non-sterile foam underneath. *See* Ex. H to Ex. 7, Statement (Mar. 31, 2015). The same 2015 report noted a "layer of dust" on shelving where IV tubing was stored and on the frame of an "often" used wheelchair. *Id*. A "[b]rownish residue" was found in a cabinet and on the floor in the sterilization room. *Id*. Dust and strands of hair were found in the laboratory refrigerator. *Id*. In 2016, the facility was cited for failing to clean its sterilizer machines. *See* Ex. I to Ex. 7, Statement (Mar. 16, 2016). The manual cautioned that "dirt and debris will build up and clog the tubing" if not cleaned, and the inspection in fact showed discoloring "with shades of brown spots." *Id*. The 2016 inspection also found "white flecks" and dust in the sterilization room on the peel pouches used to store instruments after sterilization. *Id*. The facility was also cited in 2016 for failing to provide ongoing staff education regarding infection control. *Id*. Both the 2017 and 2018 inspection reports noted that staff followed poor hand hygiene practices. *See* Ex. J to Ex. 7, Statement (May 25, 2017); Ex. K to Ex. 7, Statement (Mar. 7, 2018). The 2017 inspector noted that the oxygen tanks in the procedure rooms "were soiled" and dirt was actually "stuck on the tanks." *See* Ex. J to Ex. 7.

The St. Louis facility has also been found deficient for its poor handling of controlled substances and medical supplies. A 2013 report found the facility did not dispose of single-use medication vials, including the dangerous opioid Fentanyl, but instead used the open vial for multiple patients. *See* Ex. G to Ex. 7. The same inspection found a range of expired medication and products, including valium, that had not been discarded. *Id*. A 2015 inspection again found expired medications that had not been discarded, this time including Fentanyl. *See* Ex. H to Ex. 7. In 2016, the facility was again cited for administering single-dose vials to multiple patients, and again cited for not disposing of expired medical supplies. *See* Ex. I to Ex. 7. The facility had also

failed to ensure the temperature of its medication refrigerator was stable. *Id.* The log showed unsafe temperatures on 15 of 27 recorded days, including seven days below freezing, and showed no one had recorded the temperature at all on many other days. *Id*. The facility was also cited for using a single-patient blood glucose monitoring system on multiple patients even thought it was not approved for such use. *Id*. And heating pads were used by recovering patients that were marked "household use only" and specifically not recommended for those sedated or medicated because of burn risks. *Id*.

The facility's "quality assurance" (QA) program has also consistently been deficient. The 2001 report noted the facility's QA program did not measure up to regulatory requirements. *See* Ex. F to Ex. 7. The 2013 licensing report found the facility failed to maintain an adequate quality assurance program that correctly tracked cases and documented the responsive actions taken. *See* Ex. G to Ex. 7. The facility also did not inform patients in writing that complaints could be reported directly to DHSS. *Id*. A 2016 inspection report found the facility failed to follow its own protocols for post-operative patient monitoring to track stability and vital signs during recovery. *See* Ex. I to Ex. 7. The same report noted that patient medical records were often incomplete. *Id.* In 2017, the facility was cited for failing to submit complication reports after a review of an internal log showed complications that had not been reported to the Department. *See* Ex. J to Ex. 7. The facility's Quality Assurance Manual showed it had "no policy specific to the submission of post-abortion complication reports." *Id*. Staff acknowledged that they had known for "several months" that complication reports need to be made but still "had not sent in any." *Id.* The quality assurance program had still not been corrected by March 2018. *See* Ex. K to Ex. 7. For example, the facility had no method to track length of stay, and the facility did not review results on a quarterly basis as required. *Id*. Finally, the facility gave inadequate warnings about short and long-term risks,

telling patients there was "no medical evidence" to support the statement of risks required by state law. *Id.*

The troubled health-and-safety histories of Plaintiffs' own facilities contradict their arguments that abortion is supposedly "safe" and that abortion facilities should be radically deregulated. Requirements like the hospital-privileges requirement work to prevent such problems by ensuring that a qualified physician with ties to the local medical community is present and has ultimate responsibility for the quality of care provided by the facility. As Dr. Steele opined, "itinerant surgery violates the ethical relations between surgeon and patient." Doc. 28-4, at 5. And as Dr. Williams has frequently opined, requirements like the hospital-privileges requirement ensure that a qualified physician "owns" both the patient and the abortion facility, taking ultimate responsibility for the quality of care provided. *See* Doc. 141-2. The fact that Plaintiffs have frequently fallen short in their responsibility to maintain clean, safe facilities for providing medical care is not an argument that they should be protected from further regulation—quite the contrary, the opposite is true.

4. Published literature does not support Plaintiffs' conclusions regarding the safety of abortion procedures.

As the State Defendants have previously discussed at great length, the published literature on abortion complications does not support Plaintiffs' sweeping claims regarding the "safety" of abortion. *See, e.g.,* Doc. 54-2. Plaintiffs' most recent submissions do not cure this deficiency. Dr. Eisenberg engages in selective overview of literature that lacks a critical review of study methodology. Coleman Decl., Ex. 2, ¶ 55-61. Studies employing rigorous methodologies and more complete follow-up rates with patients reflect complication rates that are much higher than predicted by Plaintiffs. *See id.* ¶ 58. As a result, "abortion-related morbidity and mortality [are] far greater than the estimates provided by the Plaintiffs' experts." *Id.* ¶ 61. "A careful examination

of the data . . . relying on the most complete data sources with the most reliable diagnostic information, suggested that abortion-related physical complication rates [are] considerably greater than Plaintiffs' experts contend." *Id.*

Plaintiffs argue that statistics regarding medication-abortion complications are irrelevant because "the Columbia health center does not seek to provide medication abortions at this time." Doc. 153, at 6. This is incorrect. The hospital-privileges requirement, which applies to providers of both surgical and medication abortion, is a statewide policy that addresses a statewide problem with a statewide justification. Moreover, the fact that the Columbia facility is not *currently* providing medication abortion does not mean it will not attempt to do so in the future. As the Eighth Circuit stated in *Jegley*, "Planned Parenthood could unilaterally decide" to change its practices, so the State has an interest in establishing standards of care irrespective of their current practices. *Jegley*, 864 F.3d at 860 n.9. "While we elect not to quantify it at this time, we certainly see some benefit for patients where the State mandates continuity-of-care standards—especially in the face of known complications and where there previously had been no state requirements." *Id.* In any event, the safety problems are much greater than predicted by Plaintiffs even if one focuses solely on risks from surgical abortion. *See, e.g.,* Coleman Decl., Ex. 2, ¶¶ 55-61.

F. Plaintiffs misconstrue and ignore the significant health benefits of the hospital-privileges requirement.

Plaintiffs alternatively mischaracterize and ignore the significant health benefits from the hospital-privileges requirement. The State Defendants previously demonstrated that the regulation provides significant benefits to women's health. *See* Doc. 141, at 13-17; Doc. 141-2 (Declaration of Randall Williams). These benefits include (1) ensuring continuity of care for abortion patients; (2) ensuring that each patient has greater access to a physician qualified to treat her; (3) ensuring that the patient experiencing a complication has greater access to the physician with knowledge of

the procedure; (4) reducing the likelihood that abortion patients receive unnecessary treatment; (5) fostering effective communication between the physician who performed the abortion and the treating physician; (6) ensuring that physicians performing abortions are well-credentialed and "meet standards for training and skill," Steele Decl., Doc. 28-4, at 3; and (7) improving the tracking and accurate reporting of abortion complications. Doc. 141, at 13-17.

Plaintiffs fail to meaningfully address or undermine these benefits of the hospital-privileges requirement. Most fundamentally, "it is the Department's contention that there should not be two standards of care applied just because a surgical or medical procedure is deemed 'safe' when physicians have a duty to provide standard care for their patients in the event that complications arise from elective procedures." Rebuttal Declaration of Randall W. Williams, MD, FACOG, ¶ 15 (attached as Exhibit 8). It is consistent with standard care for other elective procedures with similar risks of complications to provide continuous coverage by a physician with hospital privileges in the community. *Id.* ¶ 16. "For elective gynecological procedures, the standard by which physicians are trained and then held to is that they have a duty to provide care for elective procedures prior, during and after procedures as a component of providing standard care." *Id.* ¶ 16. The hospital-privileges requirement directly implements and advances this fundamental principle of standard care. *Id.* ¶ 23. "It is not standard practice to have a consulting OB-GYN from another practice who is covering unassigned call for the Emergency Room to see a patient of another physician who had hospital privileges who has performed an elective procedure on the patient and chooses not to follow their patient into the Emergency Room because he or she deemed the procedure 'safe' and therefore thought that somebody else should be responsible." *Id.* ¶ 23. In fact, Missouri imposes similar regulatory requirements on many similar facilities and procedures.

In the unique context of abortion, however, the State is aware of a push by providers to address the issue of provider scarcity by attempting to dilute the standard of care. Ex. 8 (Williams Rebuttal Decl.) ¶ 19 ("[P]laintiffs have held themselves out to a different standard because of their perceived safety of the procedure."); *id.* ("In my years of practice and review, I am unaware of a similar procedure in gynecology in which physicians have stated that due to the argument that the procedure is 'safe' they are not responsible for being able to treat complications."). Indeed, Dr. Eisenberg's "admission that abortion care sees itself as 'set aside' lends credence to a concern that abortion providers in their view do not have to follow those same standards." *Id.* ¶ 24. "In my 30 years of experience taking care of patients as an obstetrician-gynecologist, I saw firsthand the importance of ensuring patient safety by taking care of my patients by having hospital privileges or prearranging to have someone with hospital privileges to take care of my patients when I was not available to do so." *Id.* "[T]here is no reason why abortion patients should not receive the benefit of these same types of arrangements, which are standard in the practice of medicine." *Id.*

The hospital-privileges requirement is part of a comprehensive regulatory scheme designed to address this unique problem of attempts to "dilute" the standard of care in the abortion context, and to ensure that abortion patients are not provided substandard care just because fewer physicians are willing to perform abortions than other elective procedures, or because abortion providers think abortion is so "safe" that standard care should not apply. *Id.* ¶¶ 16, 23.

G. Plaintiffs greatly overstate the burdens on abortion access from the hospital-privileges requirement.

To draw their conclusion that 22 percent of women in the Columbia area will be prevented from having an abortion, Plaintiffs rely heavily on the analysis of Dr. Lindo, which relies heavily on the analysis of abortion rates in Texas in the unpublished "LMSC" study. *See* Lindo Decl. (citing Lindo, Myers, Schlosser, and Cunningham, *How Far Is Too Far? New Evidence on*

Abortion Clinic Closures, Access, and Abortions?). But Dr. Lindo's analysis suffers from several fatal deficiencies. *See* Coleman Decl., Ex. 2, ¶¶ 8-29; Solanky Decl., Ex. 9, ¶¶ 4-18, 20-22. The LMSC study is unpublished and has never been peer-reviewed. Coleman Decl., Ex. 2, ¶ 9. Dr. Lindo's analysis overlooks the significant limitations of his "differences-in-differences" methodology, which are well-established in the peer-reviewed literature. *Id.* ¶¶ 10-17. The LMSC study fails adequately to account for the effects of several empirical factors that undermine confidence in its results. Solanky Decl., Ex. 9, ¶ 7(a)-(d). Properly controlling for these empirical factors would demonstrate that the impact of abortion-facility restrictions on the abortion rate was much smaller in Texas than the LMSC study concludes. *Id.* ¶ 8.

Two critical problems with Dr. Lindo's analysis vividly illustrate this problem, and they are merely illustrative of other deficiencies that wholly undermine his conclusions. *See* Solanky Decl., Ex. 9, ¶¶ 4-18, 20-22. First, as Dr. Coleman points out, "Dr. Lindo struggled to understand why his observed reduction in abortion rates was not mirrored by an increase in births. Clearly the methodology was flawed, rendering the quantitative estimates unreliable and/or unmeasured variables were the sources of the differences." Coleman Decl., Ex. 2, ¶ 17. Though the LMSC study concluded that there were "missing abortions" after Texas passed restrictions that limited the number of abortions, the LMSC study did *not* find a corresponding increase in live births that reflected the "missing" abortions. *Id.* ¶¶ 22-23. The study speculated that, among other possibilities, "some women responded to the reduction in access to abortion facilities by decreasing risky sexual behaviors and, as a result, unintended pregnancies." *Id.* ¶ 23. This concession undermines Plaintiffs' entire theory of undue burden in this case. If women respond to clinic closures by decreasing risky behaviors that lead to unintended pregnancy, and thus *never have any reason to seek an abortion*, the clinic closures impose no possible "undue burden" on

those women's right to abortion—they never need to have one. *See id.* Dr. Lindo concedes that this is a significant likelihood, but he makes no attempt to quantify it. *Id.*

Second, Dr. Lindo's attempt to extrapolate from Texas to Missouri's unique situation is similarly flawed and unconvincing. Coleman Decl., Ex. 2, ¶ 27-28. Dr. Lindo attempts to extrapolate from the observed differences in abortion rates in Texas counties to draw conclusions regarding abortion rates in Missouri, yet his own analysis in the LMSC paper (of which he is the lead author) states: "Introducing additional data from other states where abortion rates are evolving differently over time would invalidate the study." Solanky Decl., Ex. 9, at 9 (quoting Lindo Supp. Decl. ¶ 9). Dr. Lindo's extrapolation from the Texas data to mid-Missouri is based on other unjustified or faulty assumptions as well. *Id.* ¶¶ 12-16.

In short, Dr. Lindo's reliance on Texas to draw causal conclusions about Missouri is deeply flawed. As Dr. Solanky notes, "Texas is a rather unique state which shares borders with Mexico and two states, Louisiana and New Mexico, which changed their out-of-state abortion reporting starting in 2013. . . . [T]he counties which are impacted by these missing/unreliable reporting of abortions have impacted the conclusions derived by the LMSC study." *Id.* ¶ 22. "Also, the Texas counties which account for the vast majority of abortions in Texas, over 90%, who have complete/reliable data, merely saw a 3% additional drop in abortions over a two-year period after [Texas's] HB2." *Id.* "Apart from the inaccuracies of the LMSC model, the applicability of the Texas based study in predicting abortions in Missouri is scientifically incorrect." *Id.*

Independent peer-reviewed research that uses more rigorous methodology and examines larger trends also contradicts Dr. Lindo's conclusions. According to the "largest, most comprehensive and sophisticated analysis" of the impact of health-and-safety regulations of abortion facilities on abortion rates, Coleman Decl., Ex. 2, ¶ 34, such regulations "failed to show

a discernible impact on the abortion rate." *Id.* ¶ 36. Other peer-reviewed studies came to similar conclusions. *Id.* ¶¶ 38-39, 41-46. Perhaps most notably, during the period from 2011 to 2014, Missouri had one of the two largest proportional reductions of the number of abortion facilities of any State in the nation, yet during that time period, Missouri "experienced declines in the abortion rate that were comparable to the national average." *Id.* ¶ 42 (quoting Jones and Jerman (2017)). Dr. Solanky likewise notes recent research that has "analyzed abortion data from all 50 states and the District of Columbia" and has concluded that "the evidence suggests that contraception and fewer unintended pregnancies played a larger role in these most recent declines than new abortion restrictions." Solanky Decl., Ex. 9, ¶ 19. Thus, "the relationship between abortion access, as measured by the number of clinics, and abortion rates is not straightforward." *Id.*

II. The Other Three Dataphase Factors Weigh Heavily Against Granting a Preliminary Injunction.

The remaining *Dataphase* factors include "(2) the threat of irreparable harm to the movant in the absence of relief; (3) the balance between that harm and the harm that the relief would cause to the other litigants; and (4) the public interest." *Watkins*, 346 F.3d at 844 (citing *Dataphase*, 640 F.2d at 114). All these factors weigh against Plaintiffs' request for relief.

First, as many courts have recognized, an order that prevents the State from enforcing its duly enacted laws is heavily disfavored and inflicts *per se* irreparable injury on the State. *See, e.g., 1-800-411-Pain Referral Service, LLC v. Otto*, 744 F.3d 1045, 1053-54 (8th Cir. 2014) (holding that, "because Plaintiffs seek to enjoin enforcement of a validly enacted statute," they must meet "a more rigorous threshold showing than th[e] ordinary preliminary injunction test"). "Any time a State is enjoined by a court from effectuating statutes enacted by representatives of its people, it suffers a form of irreparable injury." *Maryland v. King*, 567 U.S. 1301, 1303 (2012) (Roberts, C.J., in chambers) (citation omitted). "When a statute is enjoined, the State necessarily suffers the

irreparable harm of denying the public interest in the enforcement of its law." *Planned Parenthood of Greater Texas Surgical Health Servs. v. Abbott*, 734 F.3d 406, 419 (5th Cir. 2013). Thus, "a state suffers irreparable injury whenever an enactment of its people or their representatives is enjoined." *Coalition for Economic Equity v. Wilson*, 122 F.3d 718, 719 (9th Cir. 1997).

Second, for the reasons discussed in detail above, an order blocking enforcement of the Privileges Requirement will impose significant irreparable harm on women seeking abortions by permitting Plaintiffs to pursue substandard practices. *See supra* Part I.

Third, in assessing the public interest, the actions of Missouri's legislature, Governor, and state officials provide decisive evidence of where the public interest lies. Where the party opposing equitable relief is the government, consideration of the public interest "merge[s]" with consideration of harm to the government. *Nken v. Holder*, 556 U.S. 418, 435 (2009); *see also, e.g.*, *Drakes Bay Oyster Co. v. Jewell*, 747 F.3d 1073, 1092 (9th Cir. 2014). A statute "is in itself a declaration of public interest and policy." *Virginian Ry. Co. v. Sys. Fed'n No. 40*, 300 U.S. 515, 552 (1937). Thus, the public has a strong interest in the enforcement of duly enacted laws and validly promulgated regulations. *Peterson v. Village of Downers Grove*, No. 14-C-09851, 2016 WL 427566, at *5 (N.D. Ill. Feb. 4, 2016); *Abbott*, 734 F.3d at 419. Courts should not "ignore the judgment" of the legislature "deliberately expressed in legislation," and "override [the legislature's] policy choice, articulated in a statute, as to what behavior should be prohibited." *United States v. Oakland Cannabis Buyers' Coop.*, 532 U.S. 483, 497 (2001).

CONCLUSION

Plaintiffs third motion for preliminary injunction, Doc. 152, should be denied.

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Respectfully submitted,

ERIC S. SCHMITT
Attorney General

/s/ D. John Sauer
D. John Sauer, Mo. Bar No. 58721
Solicitor General
Emily A. Dodge
Assistant Attorney General
P.O. Box 899
Jefferson City, MO 65102
Phone No. (573) 751-8870
Fax No. (573) 751-9456

Attorneys for the State Defendants

CERTIFICATE OF SERVICE

I hereby certify that on January 11, 2019, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which sent electronic notification to all counsel of record.

/s/ D. John Sauer