IN THE
UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No. 18-6161

EMW WOMEN'S SURGICAL CENTER, P.S.C., *et al.*,
Plaintiffs/Appellees,
v.
ADAM MEIER, in his official capacity as Secretary of Kentucky's Cabinet for Health and Family Services, *et al.*,
Defendants/Appellants.

On Appeal from the United States District Court for the Western District of Kentucky, No. 3:17-CV-00189-GNS, The Honorable Greg N. Stivers, Judge

BRIEF OF INDIANA, OHIO, AND 14 OTHER STATES AS *AMICUS CURIAE* IN SUPPORT OF APPELLANTS

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AMICI'S STATEMENT OF IDENTITY AND INTEREST

The States of Indiana, Ohio, Alabama, Arkansas, Idaho, Kansas, Louisiana, Missouri, Nebraska, North Dakota, Oklahoma, South Carolina, South Dakota, Texas, Utah, and West Virginia submit this brief as *amici curiae* in support of the appellants. Many States regulate outpatient surgical facilities—including but not limited to facilities that perform abortions—to protect patient health and safety. For example, following the lead of federal Medicare law, 42 C.F.R. § 416.41(b), many States require facilities performing outpatient surgery to have transfer agreements with a nearby hospital in case an emergency occurs. But the district court's decision below, if affirmed, would cast doubt on the constitutionality of these laws as applied to the abortion context. That would require States to facilitate abortion by creating exceptions so that abortion doctors are not subject to the same laws as anyone else. In hopes of stopping that from happening, the *amici* States are filing this brief under Rule 29(a)(2) of the Federal Rules of Appellate Procedure.

STATEMENT OF THE CASE

1. Physicians historically performed most surgeries, and they did so in hospitals. But outpatient surgery has grown rapidly in the United States since the 1980s. *See* G.D. Durant & C.J. Battaglia, *The Growth of Ambulatory Surgery Centres in the United States*, Ambulatory Surgery at 83-85 (June 1993). So too have

regulations concerning outpatient surgery. For instance, many federal and state regulations require formal arrangements between outpatient surgical facilities and local hospitals, allowing patients to be transferred and cared for quickly if an emergency occurs during outpatient surgery. To take but one real-world example, federal regulations require outpatient surgery centers that participate in Medicare to have either "a written transfer agreement" with a local hospital or "[e]nsure that all physicians in the [facility] have admitting privileges" at a local hospital. 42 C.F.R. § 416.41(b). The federal government imposed this regulation after receiving public comment from the medical community about the circumstances necessary to perform outpatient surgery safely. *See* 46 Fed. Reg. 28013 (May 22, 1981). After considering the issue, it concluded that this regulation would "ensure that patients have immediate access to needed emergency or medical treatment in a hospital," consistent with its "goal of assuring that [Medicare] beneficiaries receive quality care." 47 Fed. Reg. 34082-01 (Aug. 5, 1982).

States have followed the federal government's lead, requiring outpatient surgical facilities to have transfer agreements (many States accept admitting privileges as an alternative). *See, e.g.*, Ala. Admin. Code r. 560-X-38-.05; Alaska Admin. Code tit. 7, § 12.910(d); Cal. Health & Safety Code § 1248.15(a)(2)(C); Conn. Agencies Regs. § 19-13-D56(e)(7)(B); Haw. Code R. § 11-95-31; Ill. Admin. Code tit. 77, § 205.540(d); 410 Ind. Admin. Code 15-2.4-1(e); Kan. Admin. Regs. § 28-34-52b(g);

Md. Code Regs. 10.05.05.09; 130 Mass. Code Regs. 423.404; Mo. Code Regs. tit. 19, § 30-30.020(1)(B); Mich. Comp. L. Servs. § 333.20821; Code Miss. R. 15-16-1:42.10; Nev. Admin. Code § 449.996; Ohio Rev. Code § 3702.303(A) (also Ohio Admin. Code 3701-83-19(E)); Okla Stat. tit. 63, § 2666; 28 Pa. Code § 555.23(e); 216 R.I. Code R. § 40-10-5.5.7; S.D. Admin. R. 44:76:04:12; Tenn. Comp. R. & Reg. 1200-08-10-.05(6); 25 Tex. Admin. Code § 135.4(c)(11); Utah Admin. Code r. 432-500-12; 12 Va. Admin. Code §5-410-1240; Wash. Admin. Code §70-230-060; 048-0026-5 Wyo. Code R. § 7(g).

These laws are consistent with the guidelines issued by medical and accreditation organizations. One prominent accrediting organization requires that facilities seeking accreditation have "a written transfer agreement" with a local hospital or that operating surgeons have admitting privileges. Am. Ass'n for Accreditation of Ambulatory Surgery Facilities, 2017 Checklist at 48, *available at* https://www.aaaasf.org/wp-content/uploads/2019/01/Standards-and-Checklist-Manual-V14.5-01072019.pdf.

Similarly, among the American College of Surgeons' core principles are that physicians performing office-based surgeries "have admitting privileges at a nearby hospital, or a transfer agreement with another physician who has admitting privileges at a nearby hospital, or maintain an emergency transfer agreement with a nearby hospital." American College of Surgeons, *Patient Safety Principles for Office-Based*

Surgery, https://www.facs.org/education/patient-education/patient-safety/office-based-surgery (last visited Feb. 4, 2019). The Federation of State Medical Boards' 2002 model guidelines likewise recommend that doctors performing office-based surgery have a transfer agreement or admitting privileges. Federation of State Medical Boards, *Report of the Special Committee on Outpatient (Office-Based) Surgery*, https://www.fsmb.org/siteassets/advocacy/policies/outpatient-office-based-surgery.pdf (guideline 2G).

And tellingly, the National Abortion Federation's 2018 clinical guidelines also recommend that clinics "consider developing a transfer agreement with a hospital outlining the means of communication and transport and the protocol for emergent transfer of care." National Abortion Federation, 2018 Clinical Policy Guidelines at 54, *available at* https://prochoice.org/education-and-advocacy/cpg/.

2. This case involves application of these commonplace regulations to abortion clinics. Some States have included abortion clinics within neutral health and safety regulations that apply to all outpatient surgical facilities. Ohio, as one example, has long regulated abortion clinics in the same manner as all other ambulatory surgical facilities. *See Women's Med. Prof'l Corp. v. Baird*, 438 F.3d 595 (6th Cir. 2006). This Court has upheld the constitutionality of those laws. *Id.* at 602–10.

Kentucky has decided to hold abortion clinics to *lesser* standards than other outpatient surgical facilities. Its regulations place detailed requirements on the facilities, operations, and services of other outpatient surgical facilities. 902 Ky. Admin. Regs. 20:101, 20:106 (setting standards for "ambulatory surgical centers"). Those regulations require in part that every "ambulatory surgical center" "have a physician on the medical staff with admitting privileges in a nearby hospital who is responsible for admitting patients in need of inpatient care." 902 Ky. Admin. Regs. 20:106 § (2)(6). Kentucky's State Health Plan further requires license applicants to "have a transfer agreement for the proposed [ambulatory surgical center] with at least one (1) acute care hospital that is located within twenty (20) minutes normal driving time." 2018 Update to the 2017–2019 Kentucky State Health Plan (July 2018), *available at* https://chfs.ky.gov/agencies/os/oig/dcn/Documents/2017_2019_StateHealthPlan_Emergency_SB123_CLEAN_7318.pdf.

In the late 1990s, the Kentucky General Assembly took up the question of how to regulate abortion clinics. As the district court noted, the Kentucky General Assembly at that time was "appalled by the conditions in some abortion clinics in Kentucky—especially a facility run by a notorious abortion provider named Dr. Ronachai Banchongmanie," whose hygienic practices were so poor that patients could find their way "to the patient recovery room by following the bloody footprints from the surgery room." Trial Or. 2, R.168, PageID#6816.

But rather than subject abortion clinics to the same standard as all other facilities, legislators in the Bluegrass State settled on a more moderate position: they regulated abortion clinics, but subjected them to standards that are easier to meet than those applicable to other outpatient surgical facilities. *See id.* For example, Kentucky enacted the transfer-and-transport agreement laws still applicable today, requiring that clinics enter into transfer agreements to prepare for potential complications and emergencies. Ky. Rev. Stat. 216B.0435. It imposes analogous requirements on other healthcare facilities. Trial Tr. Vol.2a 54:24-55:10, 84:11-20, R..115, PageID#4183-84, 4213; *see also* Trial Or. 2, R.168, PageID#6816 (recognizing Kentucky's intent to place a "lower" regulatory standard on abortion clinics than other comparable facilities). But it *did not* require abortion clinics to have a physician on staff with admitting privileges at a nearby hospital—even though that is exactly what it would require of other surgical facilities.

3. For nineteen years, Kentucky's transfer-and-transport requirement "appears to have been merely an item on the checklist of licensure requirements," which abortion clinics had little difficulty meeting. Trial Or. 3–4, R.168, PageID#6817–18. That changed in recent years, when hospitals began refusing to reach transfer-and-transport agreements with then-existing abortion clinics, all of which were located in the Louisville area. Those clinics sued, alleging that Kentucky's law—the same

law that the General Assembly passed with the "intent" of holding "abortion facilities to a *lower standard*" than other outpatient surgical centers, *id*. at 2 (emphasis added)—unconstitutionally restricted the right to abortion. The district court agreed, holding that the hospitals' independent decisions not to contract with any then-practicing abortion doctors turned a valid health-and-safety regulation into an unconstitutional undue burden.

SUMMARY OF THE ARGUMENT

1. This brief emphasizes two points that should be critical to this Court's undue-burden analysis.

First, the undue-burden test requires courts to consider the *general* benefits of *generally applicable* laws—they must not home in on only the benefits applicable in the abortion context. States are free to regulate abortion, so long as they do not impose an "undue" burden." *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992). In 2016, the Supreme Court held for the first time that the question whether a burden is "undue" requires consideration of "the burdens [the] law imposes on abortion access together with the benefits [it] confer[s]." *Whole Woman's Health v. Hellerstedt*, 136 S.Ct. 2292, 2309 (2016). When a generally applicable law creates generally applicable benefits the question is whether the burden is undue in light of *all* those benefits, not just the benefits unique to the abortion context. Any other

interpretation would obligate the State to affirmatively facilitate abortions by exempting abortion clinics from the same laws that apply to everyone else. That is not, and never has been, the law. Insofar as Kentucky's transfer-and-transport requirement is generally applicable, the district court erred by failing to consider its generally applicable benefits.

Second, and owing to the "fact-intensive nature of" the undue-burden test, *Comprehensive Health of Planned Parenthood Great Plains v. Hawley*, 903 F.3d 750, 755 (8th Cir. 2018), the Court should be careful to avoid any broad pronouncements on transfer agreements generally. As *Whole Woman's Health* and *Baird* jointly illustrate, whether a law imposes on undue burden depends upon the precise effects of a law in any given case. This means the same law may be constitutional in one State even if it imposes an undue burden in another. The Court should be careful to avoid pre-deciding any cases not before it; it should avoid adopting bright-line rules pertaining to transfer agreements.

2. Even if *Whole Woman's Health* does apply to laws requiring transfer-and-transport agreements, the district court confused the standards for facial and as-applied challenges. The proper standard for a facial challenge is whether the restriction imposes an undue burden on a woman's ability to obtain an abortion in a large fraction of cases in which the restriction is relevant. But the district court never made this finding. Instead, it quotes (but does not actually apply) the *Salerno* "no set

of circumstances" standard, and then goes on to apply the *Ayotte* test for fashioning judicial remedies.

Regardless which standard applies, the law cannot be facially invalid because it was in place without incident for nineteen years. The as-applied burden rests entirely on the inability of plaintiff clinics to obtain transfer agreements with Louisville hospitals. But the court did not consider how the law might be applied constitutionally to a clinic in Lexington. Because the University of Kentucky hospital has offered to sign a transfer agreement with the clinics, the law could be constitutionally applied to a clinic in Lexington. The potential for constitutional application shows that it is not the statute, but the business decisions of the clinics and the Louisville hospitals, that imposes the alleged burdens. Therefore, the law is not facially unconstitutional.

ARGUMENT

I. Courts Applying the Undue-Burden Analysis to Generally Applicable Laws Must Consider the Laws' Generally Applicable Benefits in Applying the Undue-Burden Test

Under *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 877 (1992), laws regulating abortion are unconstitutional if they have "the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." To assess whether a burden is "undue," courts must "consider the burdens a law imposes on abortion access together with the benefits those laws confer." *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309

(2016). *Amici* States write to alert the Court to important considerations relevant to both sides of this balance.

A. Courts presented with generally applicable laws should consider the generally applicable benefits those laws bestow

The Sixth Circuit has held that the undue-burden analysis applies even to generally applicable laws with the unintended and incidental effect of making it hard to obtain an abortion. That is wrong. But the error is ameliorated by *Whole Woman's Health*, which established that whether a burden is "undue" turns on a balancing of the benefits and burdens the law imposes. *Id*. When a law is generally applicable, this means considering *all* the benefits the law confers—not just the benefits it confers in the abortion context particularly. Whatever the Court does in this case, it should not cast doubt on generally applicable laws by ignoring this principle.

1. The undue-burden test and generally applicable laws

The Supreme Court has held that women have a constitutional right to obtain an abortion before viability. *See Casey*, 505 U.S. 833. But it has never held that States must *facilitate* the provision of abortions. For example, States are under no obligation to pay for abortions by those who cannot otherwise obtain them. *Rust v. Sullivan*, 500 U.S. 173, 201 (1991). Neither should they be obligated to facilitate abortions by carving out exceptions to generally applicable health-and-safety regulations. It follows, then, that States do not run afoul of *Casey* by permitting abortion

clinics to operate under the same transfer-and-transport requirements as everyone else.

These principles are not unique to abortion law. The First Amendment protects the freedom of the press. But it does not violate the First Amendment to subject newspaper publishers to the same property taxes as all other business owners. *See Minneapolis Star & Tribune Co. v. Minnesota Comm'r of Revenue*, 460 U.S. 575, 581 (1983) ("It is beyond dispute that the States and the Federal Government can subject newspapers to generally applicable economic regulations without creating constitutional problems."). And nothing about the analysis would change if, due to changing market conditions, no newspapers in the State could afford the tax.

The Constitution also guarantees a right to the free exercise of religion. But in that context, "rational-basis review applies to neutral, generally applicable laws" that "act neutrally toward religion or among religions." *Am. Atheists, Inc. v. City of Detroit Downtown Dev. Auth.*, 567 F.3d 278, 302 (6th Cir. 2009). In America, our rights generally consist of negative liberties, not positive rights to special treatment.

The flip side of this is that laws receive heightened scrutiny when they *target* protected rights or classes, rather than burdening them incidentally. In *Casey*, a plurality of the Supreme Court applied the undue-burden test to a series of abortion-*specific* laws that required women to satisfy certain prerequisites before receiving an abortion. *See generally* 505 U.S. 833. At the same time, however, it overruled earlier

cases suggesting that heightened scrutiny applied to any law "touching" abortion. *Id*. at 871–72.

The Court's later jurisprudence is of a piece. Take, for example, *Whole Woman's Health*, 136 S. Ct. 2292. That case applied the undue-burden test to adjudge the constitutionality of Texas laws that imposed more stringent requirements on abortion clinics than other facilities. True, the challenged laws in those cases required abortion clinics to satisfy standards applicable to other ambulatory surgical facilities. *Id*. at 2300. But through a grandfather clause, Texas partly or wholly waived requirement for most facilities. *Id.* at 2315. It provided no similar waiver to abortion clinics. *Id.* Texas thereby engaged in a "targeted regulation of abortion providers." *Id.* at 2321 (Ginsburg, J., concurring).

In addition to the fact that the Supreme Court has never applied the undue-burden test to a generally applicable law, applying the undue-burden framework to neutral laws would lead to absurd results. Abortion clinics could claim exemptions from any number of regulations merely because enforcement might affect abortion access. It could avoid paying the same burdensome taxes that would put the aforementioned newspaper out of business—leading to the oddity that the indirect-beneficiaries of the right to an abortion (abortion doctors) get more protection than the intended beneficiaries (the press) of a right enumerated in the First Amendment. At a minimum, a state or local government would have to endure a costly and fact-

specific trial before it could apply its neutral law. The better answer is not that such laws should survive undue-burden analysis because their benefits outweigh their burdens, but that such laws should not even be subject to that framework.

2. The general benefits of generally applicable laws

This Court's precedent forecloses holding that the undue-burden analysis is wholly inapplicable to neutral laws. *See Baird*, 438 F.3d at 603. But the same precedent, coupled with *Whole Woman's Health*, points the way toward a resolution of the question of how to weigh the benefits and burdens of a generally applicable state law.

In *Baird*, this Court considered the constitutionality of Ohio's transfer-agreement regulation, which applied then (and applies now) to all outpatient surgical facilities. *Id.* at 602–10. The Court assessed the law's validity under the undue-burden analysis, but it *upheld* the law, reasoning that the law "affect[ed] all medical facilities equally," and that this weighed heavily in Ohio's favor. *Id.* at 607. These regulations, the Court held, "serve a valid purpose; they ensure that any [surgical facility], and not just those providing abortion services, has a license to operate and meets certain minimum standards." *Id.* The Court thus recognized that the law's neutrality weighed heavily in favor of its validity.

After *Whole Woman's Health*, the Court can now easily give the neutrality of state law the weight it is due. Once again, the Court in that case held that the undue-

burden analysis mandates a weighing of benefits and burdens. *See* 136 S. Ct. at 2309. And, as explained above, it went on to scrutinize the benefits of the abortion-specific regulations before it. *Id*. at 2310–2312. But when it comes to generally applicable laws, courts should consider the law's benefits as applied to outpatient services *generally*—and they certainly should not closely scrutinize the law's abortion-specific benefits, as the district court did below. *See* Trial Or. 26-27, R.168, PageID#6840-41.

This rule makes legal sense because, as explained above, States have no duty to facilitate abortions by carving out exceptions to generally applicable laws. So if the benefits of the law in all its applications justify the burden on abortion rights in particular, it has no obligation to make an exception to that law.

The rule makes practical sense as well. There is often far more evidence of the law's benefits generally than there is of the law's benefits to abortion in particular, if only because the number of outpatient surgery centers is larger than the small subset of abortion providers. To focus entirely on the effects on abortion, as the district court did here, means ignoring valuable evidence of a law's purpose. In addition, that the legislature deemed something important enough to require generally is good evidence that it really does advance health and safety.

3. The district court ignored the general benefits of Kentucky's law

The district court in this case failed to consider the *general* benefits of Kentucky's transfer-and-transport law, focusing instead on the law's abortion-specific applications. If Kentucky is right that its provisions are generally applicable, the district court erred by failing to consider the generally applicable benefits. And various aspects of its opinion help highlight the problems with its approach.

For example, consider the district court's consideration of expert testimony regarding the benefits of Kentucky's law. Kentucky's expert, Dr. Hamilton, is an expert in emergency medicine with roughly 20 years of clinical experience. Trial Tr. Vol.3a 88:3-90:17, R.126, PageID#4557-59. He was the only emergency-medicine physician who testified in the case. *See* Trial Or. 20–21, R.168, PageID#6834–35. Dr. Hamilton testified that patient transfers are "a daily part of [his] practice," Trial Tr. Vol.3a 90:17, R.126, PageID#4559, and that in his clinical experience he receives "more complete information" with a transfer agreement in place, Trial Tr. Vol.3a 95:17-96:3, R.126, PageID#4564-65. But the court discounted his testimony based on his lack of experience with abortion in particular. According to the court, he "[a]t best" testified that "transfer agreements would theoretically help achieve optimal patient care in the abstract." Trial Or. 21, R.168, PageID#6835.

This makes little sense. For one thing, the question whether the burdens that Kentucky law imposes are "undue" should naturally turn on *all* the law's benefits,

not simply those that arise in the abortion context. *See supra* 14–16. Again, the States have no obligation to affirmatively facilitate abortions by exempting abortion clinics from the laws that govern everyone else.

In addition, the district court's call for medical experts with experience in the field of abortion all but assures that the only experts deemed reliable will be those who perform or assist in abortions. This guarantees a biased pool of experts. It also misses that the benefits of emergency-transfer requirements apply *across* different medical procedures. *Cf. Baird*, 438 F.3d at 598 n.1 (recognizing that regulation of outpatient surgery reaches a variety of medical procedures from "cosmetic and laser surgery, plastic surgery, abortion, dermatology, digestive endoscopy, gastroenterology, lithotripsy, urology, and orthopedics"). Preparing for foreseeable medical emergencies—even uncommon ones—is a good thing. Outpatient surgeries are generally safe, so physicians can perform them outside the hospital setting. But things can go wrong. When they do, it is important to quickly transfer the patient to a hospital. That requires coordination between the outpatient facility, the transportation service, and the receiving hospital. And the more time-sensitive the emergency, the more important is effective communications. Thus, it makes sense to require outpatient facilities to have agreements already in place before performing surgeries. And all this is true without regard to whether the outpatient surgery involves abortion or

something else. Even assuming abortion is relatively safe for women (other outpatient procedures are as well), it cannot seriously be disputed that problems can, and do, sometimes arise. There is no reason that lessons learned in other outpatient contexts cannot be meaningfully applied to the context of abortion procedures.

It is worth noting that *Whole Woman's Health* and *Baird* both recognized the very real benefits of transfer agreements. *Whole Woman's Health* compared Texas's new law, which required abortion providers to have admitting privileges, to Texas's pre-existing law, which required abortion providers to have working relationships with physicians who had admitting privileges. *Whole Woman's Health*, 136 S. Ct. at 2310. That earlier Texas law, by requiring an existing relationship as a means to ensure that patients could be admitted to a hospital, resembled transfer-agreement requirements like Kentucky's. The Court cast no doubt on the benefits of Texas's prior law—it simply held that the new law conferred no *new* benefits. *See id.* at 2311 ("[N]othing in Texas' record evidence that shows that, *compared to prior law* . . . the new law advanced Texas' legitimate interest in protecting women's health.") (emphasis added); *id.* at 2314 ("The record contains nothing to suggest that H. B. 2 *would be more effective than pre-existing Texas law* at deterring wrongdoers like Gosnell from criminal behavior.") (emphasis added). The Court thus implicitly recognized the benefits that transfer agreements confer, including specifically with respect to abortions.

Likewise, in *Baird*, this Court recognized that Ohio's transfer-agreement regulation was "a legitimate measure put into place to protect the health of patients." 438 F.3d at 609. In stark contrast to this authority, the district court concluded that transfer-and-transport requirements have zero to little value. *See* Trial Or. 1-2, 31-32, R.168, PageID#6815-16, 6845-56. That contradicts *Baird*. While a fact-specific distinction between this case and *Baird* on the *burdens* of the law is one thing, *but see infra* Part I.B, it is hard to square how Ohio's transfer-agreement requirement is a "legitimate measure" in *Baird* with the district court's dismissing Kentucky's law as worthless.

* * *

In sum, *Casey* permits States to regulate abortion practices for health and safety purposes, provided States do not impose an "undue burden." *Whole Woman's Health* shows that whether a burden is "undue" depends on a balancing of the law's benefits and burdens. When the law is generally applicable, the question should be whether the burdens are justified by the benefits *generally*—not by the benefits in the abortion context specifically.

B. The Court should recognize the fact-bound nature of the "burden" side of the undue-burden balancing

Because this is an undue-burden case, the Court has to assess the burdens before weighing them against the law's benefits. Kentucky's own brief adequately illustrates the absence of a substantial burden—including by pointing to the lack of

evidence that other clinics will be unable to set up. *Amici* stress that the "fact-intensive nature of" the undue-burden test, *Comprehensive Health*, 903 F.3d at 755, which counsels against adopting any bright-line rules as to what constitutes a "substantial burden." In all undue-burden cases, the nature of the burden must be assessed with regard to the particular facts on the ground. Effects that constitute a substantial burden in one setting might not in another, and identical laws with different effects in different States may amount to substantial burdens in some States but not others.

To illustrate this point, contrast *Whole Woman's Health* and *Baird*. In the first of these cases, the Supreme Court held that Texas's admitting-privileges law imposed an undue burden. In assessing the extent of the burden the law imposed, the Court looked to the facts on the ground in Texas. It found that, after the law went into effect, "the 'number of women of reproductive age living in a county . . . more than 150 miles from a provider increased from approximately 86,000 to 400,000 . . . and the number of women living in a county more than 200 miles from a provider from approximately 10,000 to 290,000.'" 136 S.Ct. at 2313. It recognized that "increased driving distances do not always constitute an 'undue burden.'" *Id*. (citing *Casey*, 505 U.S. at 885–87). But the increases in Texas were "but one additional burden, which, when taken together with others that the closings brought about, and when viewed in light of the virtual absence of any health benefit," amounted to an undue burden. *Id*. In other words, *Whole Woman's Health* did not broadly announce

any *per se* rules relevant to the burden at issue—driving distances. Nor did it say that courts must adhere rigidly to state borders (or otherwise ignore a State's specific geography and population). Instead, it closely scrutinized the challenged law's on-the-ground effect, being careful to note that the effects amounted to an undue burden in the case before it.

Baird is consistent with this. That case considered whether Ohio's transfer-agreement requirement created an undue burden on women living in and around Dayton, since it would have had the effect of closing the only local abortion clinic. 438 F.3d at 604. This Court held that it did not. It first explained that "the binding and persuasive authority of other courts [did] not firmly establish when distance becomes an undue burden." *Id*. at 605. *Baird* sided with those courts, eschewing bright-line rules for a fact-intensive look at the record. It stressed that women in the Dayton area could still obtain abortions in at least four other cities, including one clinic just 45 to 55 miles from the Dayton clinic. *Id*. With "no evidence suggesting that a large fraction of" women in the Dayton area "would be unable to travel," it upheld Ohio's law.

Whole Woman's Health and *Baird* reflect the fact-bound nature of the undue-burden analysis. Both stand for the proposition that the real-world facts matter when assessing the impact of the burden. This Court should adhere to that approach, and

avoid announcing any bright-line rules that would pre-decide the legality of abortion laws not before the Court.

II. The District Court Misapplied the Standard for Facial Challenges and Improperly Afforded Constitutional Protection to EMW's Business Plan

The district court facially invalidated the statute, but in doing so stated that "[i]n a facial challenge, the challenging party is asserting that 'no application of the statute could be constitutional . . . .'" Trial. Or. 55, R.168, PageID#6869 (quoting *Sabri v. United States*, 541 U.S. 600, 609 (2004)); *see also Sabri*, 541 U.S. at 604; *United States v. Salerno*, 481 U.S. 739 (1987). If that standard actually applied, however, the Kentucky statute would survive, as the uncontested evidence demonstrates that Kentucky required transfer-and-transport agreements for nineteen years with no problems. In other words, it shows that *some* applications of the statute are constitutional.

As it happens, the district court did not actually apply the "no set of circumstances" test, but it also did not apply the proper standard for a facial challenge to an abortion statute, which is whether the restriction acts as an undue burden on a woman's ability to obtain an abortion in a large fraction of cases in which the law is relevant. *See Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309, 2320 (2016); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 878, 894 (1992).

The district court here never made that finding. Instead, citing *Ayotte v. Planned Parenthood of Northern New England*, 546 U.S. 320 (2006), it facially invalidated the law because it found an undue burden as applied to the particular plaintiffs *in this case*. Trial Or. 55, R.168, PageID#6869 (noting that "the evidence establishes that the laws are unconstitutional as applied to EMW Plaintiffs and Planned Parenthood," but making no separate finding of undue burden as facially applied). But in *Ayotte*, the Court concluded that facial invalidation was too blunt a remedy because "[o]nly a few applications of New Hampshire's parental notification statute would present a constitutional problem." 546 U.S. at 331. The same is true here. Even if no Louisville hospital will sign a transfer agreement with EMW or Planned Parenthood, at least one hospital in Lexington would sign an agreement with an abortion clinic there, if only EMW or Planned Parenthood would open one. Facial invalidation is therefore inappropriate.

The fundamental problem with the district court's analysis is that the undue burden standard does not protect abortion clinics—it protects women seeking abortions. *See Casey*, 505 U.S. at 874 (explaining the undue burden standard in terms of "an undue burden on a *woman's* ability to make [the abortion] decision" (emphasis added)). Because the district court improperly treated the plaintiff clinics as an absolute proxy for all women seeking abortions in Louisville, it ultimately protected its business decisions as a matter of constitutional law. For while EMW and Planned

Parenthood are unable to obtain a transfer agreement with a Louisville hospital, the University of Kentucky hospital in Lexington has signed transfer agreements with both clinics. While Lexington is too far for these agreements to comply with the requirements for the Louisville clinics, there is nothing preventing EMW, Planned Parenthood, or anyone else from opening an abortion clinic in Lexington. If a clinic were to open in Lexington, it would alleviate any potential undue burden on the right to abortion occasioned by the closing of EMW's Louisville clinic. Because the law does not prevent the opening of a Lexington clinic, it is not the law that imposes a burden on Kentucky women.

But the district court essentially deferred to EMW's and Planned Parenthood's business decisions to open a clinic in Louisville rather than in Lexington. Such a rule, in effect, constitutionalizes the static business models of current abortion providers and negates any need to take account of how both women and the market can adapt to changing circumstances. The practical effect of this rule is to transform a woman's personal right to privacy in making the abortion decision into an abortion provider's right to protected business practices.

Because the Kentucky statute was applied constitutionally for nineteen years and because it may still be applied constitutionally in some instances, *Amici* urge this Court to reverse the district court and to hold that the requirement that abortion clinics have transfer-and-transport agreements is facially valid.

CONCLUSION

The Court should reverse the decision below.

Respectfully submitted,

s/ Thomas M. Fisher

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CERTIFICATE OF WORD COUNT

I verify that this brief, including footnotes and issues presented, but excluding certificates, contains 5,315 words according to the word-count function of Microsoft Word, the word-processing program used to prepare this brief.

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CERTIFICATE OF SERVICE

I hereby certify that on February 6, 2018, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Sixth Circuit using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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