IN THE
UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS, INDIANA

PLANNED PARENTHOOD OF INDIANA, INC., *et al*.,	)	
Plaintiffs,	)	
v.	)	No. 1:11-cv-0630-TWP-DKL
COMMISSIONER OF THE INDIANA STATE DEPARTMENT OF HEALTH, *et al*.,	)	
Defendants.	)	

DEFENDANTS' MEMORANDUM IN OPPOSITION
TO THE MOTION FOR PRELIMINARY INJUNCTION

FACTUAL BACKGROUND

1. Planned Parenthood of Indiana ("PPIN") provides many services to patients, including abortions, family planning, and cancer screenings. Compl. 2. Medicaid covers many such services, but not abortions. *See* Ind. Code § 16-34-1-2; Compl. 2, 7-8. Medicaid reimbursements for particular services or procedures are determined by the State, not by the allocation of specific costs to the provider for providing that service. *See* 405 Ind. Admin. Code 1-1-3. When there is no specific cost allocation model and no tracking of costs associated with reimbursable services, Medicaid funds inherently cover some portion of the costs of other services, such as abortion, which are not properly reimbursable under Medicaid laws and regulations. Exhibit A at 3 (Decl. of Martin J. Birr, CPA, CMA, CIA).

PPIN's audited financial statements for 2009 and 2010 give rise to a reasonable inference that it commingles Medicaid reimbursements with other revenues it receives. *See* Exhibit A-B at 21 (FY 2009 Audit); *see also* Exhibit A-C at 22 (FY 2010 Audit). Those financial statements

provide no record that PPIN makes any effort either to segregate Medicaid reimbursements from other unrestricted revenue sources or to allocate the costs of its various lines of business, whether abortion, family planning, cancer screenings, or other services. *See* Exhibit A at 3

In particular, note thirteen of the 2010 audit identifies seven sources of restricted federal funding by title or grant name, but does not mention Medicaid. *See* Exhibit A-C at 22, n.13 (FY 2010 Audit). Instead, Medicaid, as a revenue line, is shown with other unrestricted sources of income in the audit report's Consolidating Schedule–Statement of Activities Information, between patient fees and donations and net investment income. *Id*. at 22. This indicates that, while PPIN may not receive Medicaid reimbursements related directly to abortions (as federal and state laws generally prohibit), the Medicaid reimbursements it does receive for other services are pooled or commingled with other monies it receives and thus help pay for total operational costs, such as management, personnel, facilities, equipment, and other overhead. *See* Exhibit A at 3.

2. Multiple scientific studies support the view that a fetus can feel pain at or before twenty weeks post-fertilization. For example, according to Dr. Kanwaljeet S. Anand, M.B.B.S., D. Phil., "[t]he neural pathways for pain include sensory receptors in the skin connected to nerve fibers, which lead to pain processing in the dorsal horn of the spinal cord. Nerve tracts from these spinal cord areas transmit the signals of pain to supraspinal centers located primarily in the brainstem, thalamus, and cerebral cortex of the brain." *See* Exhibit B at 6 (Expert Report of Kanwaljeet S. Anand, M.B.B.S., D. Phil., *Carhart v. Ashcroft*, No. 4:03-cv-03385 (D. Neb. Jan. 19, 2004), Doc. 56-2). "The fetal neocortex is penetrated by the fibers from sensory thalamic nuclei *by 20 weeks*, whereas other fibers (not routed through the thalamus) have penetrated the sub-plate zone *by 13 weeks* and reached the cortical plate *by 16 weeks* of gestation, providing the

final anatomical link for inputs to reach the developing cortex." *Id.* at 7. (emphasis added). Thus, "[m]ultiple lines of scientific evidence converge to support the conclusion that the human fetus can experience pain from 20 weeks of gestation, and possibly as early as 16 weeks of gestation." *Id.* at 5. Dr. Anand's view is supported by Dr. Jean Wright, a pediatric anesthesiologist who has testified before Congress on fetal pain and has supplied a detailed affidavit accompanying this memorandum. *See* Exhibit G.

3. Objective scientific evidence establishes that, when a human ovum is fertilized by a human sperm, a biological life begins. Dr. Bruce Carlson, a leading expert on developmental biology, has declared unequivocally in expert testimony that "the embryo is a whole human being after fertilization as a matter of scientific and biological fact." Exhibit C at 2 (Decl. of Dr. Bruce M. Carlson, M.D., PH.D. in Opposition to Plaintiffs' Motion for Summary Judgment, *Planned Parenthood of Minnesota v. Rounds,* No. 05-4007 (D. S.D. July 10, 2006), Doc. 186). He noted that "[t]his biological fact should not be confused with value judgments or legal concepts concerning the legal or moral status of the human being during the gestational period" and emphasized that "[a]ttempts to confuse the simple biological term human being to take on meanings which include value judgments or legal concepts should be resisted." Exhibit D at 3,4 (Decl. of Dr. Bruce M. Carlson, M.D., PH.D. in Opposition to Temporary Restraining Order, *Rounds,* No. 05-4007 (D. S.D. June 24, 2005), Doc. 24). Dr. Carlson's view is supported by Dr. Maureen Condic, director of the University of Utah School of Medicine curriculum in Human Embryology, who has supplied a detailed affidavit accompanying this memorandum. *See* Exhibit H.

ARGUMENT

PLAINTIFFS ARE UNLIKELY TO SUCCEED ON THE MERITS

Part One: Count One – Defunding Provisions

I. Plaintiffs Are Unlikely To Succeed On Their Claim That HEA 1210's Defunding Provisions Violate Or Are Preempted By Federal Statutes

A. Plaintiffs have no cause of action to enforce the "freedom of choice" provision of the Medicaid Act or any other federal statutes they invoke

1. Plaintiffs have no cause of action under Medicaid, nor any Medicaid rights to enforce via 42 U.S.C. § 1983

PPIN is unlikely to succeed on this claim because it has failed to state a claim upon which relief can be granted. There is no private right of action under the Medicaid Act, *see Bertrand ex rel. Bertrand v. Maram*, 495 F.3d 452, 456 (7th Cir. 2007), and PPIN[1] cannot rely on 42 U.S.C. § 1983 because the Medicaid Act fails to establish an "unambiguously conferred right." *See Gonzaga Univ. v. Doe*, 536 U.S. 273, 283 (2002). Section 1983 applies only when State officials violate a plaintiff's federal *rights*; it does not provide a remedy for a mere violation of federal law. *Golden State Transit Corp. v. Los Angeles*, 493 U.S. 103, 106 (1989) ("Section 1983 speaks in terms of 'rights, privileges, or immunities,' not violations of federal law."). Nothing short of an "unambiguously conferred right" can support a cause of action under Section 1983. *Gonzaga*, 536 U.S. at 283.

The Medicaid statutes that PPIN invokes do not confer any federal "rights" on the plaintiffs, let alone an "unambiguously conferred" right. On the contrary, federal law permits Indiana to structure its Medicaid program however it sees fit. The Medicaid statutes impose legal obligations *only* on the Secretary of Health and Human Services, who may reimburse States for their Medicaid expenses only if she concludes that the State's Medicaid program satisfies the

[1] "PPIN" will hereafter be used to refer to the plaintiffs collectively unless otherwise noted.

criteria enumerated in federal statutes. Under the Medicaid statute, 42 U.S.C. § 1396c, only the Secretary of Health and Human Services is required to do anything, namely, to determine if a State is not in substantial compliance with its Medicaid plan, and to withhold funds if it is not.

Two features of this statutory scheme have particular relevance for this litigation. First, the statute *permits* States to establish non-compliant programs that will not qualify for federal funds. Even after accepting federal funds, Section 1396c recognizes the State's continuing prerogative to alter its Medicaid program. Any State that administers a non-compliant program runs the risk that the Secretary will turn off the funding spigot, but this remains a lawful option for the State under the statute. Plaintiffs cannot possibly have a federally protected "right" to state Medicaid services when the statutes do nothing more than supply criteria for federal reimbursement. Second, the statute withdraws funding only after the *Secretary* has determined that a State's Medicaid program fails to satisfy the criteria in the federal Medicaid statutes. The Secretary—not a federal court—determines in the first instance whether a State's Medicaid program is worthy of federal funds. Of course, the Secretary's decision is subject to judicial review. *See Pharm. Researchers and Mfrs. of Am. v. Walsh*, 538 U.S. 644, 675 (2003) (Scalia, J., concurring).

The Supreme Court has permitted at least one provision of the federal Medicaid Act to be enforced under Section 1983. *See Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 524 (1990) (allowing hospitals to sue under Section 1983 to enforce the "Boren Amendment," which required participating States' Medicaid programs to reimburse providers at "reasonable and adequate" rates). However, *Gonzaga* limited *Wilder*'s holding to a provision in the Medicaid Act that "explicitly conferred specific *monetary* entitlements upon the plaintiffs." *Gonzaga*, 536 U.S. at 280 (emphasis added). The Court also noted that "more recent decisions . . . have rejected

attempts to infer enforceable rights from Spending Clause statutes." *Id*. at 281. And *Gonzaga* quoted with approval the following passage from the Court's earlier decision in *Pennhurst State School and Hospital v. Halderman*: "In legislation enacted pursuant to the spending power, the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State." *Gonzaga*, 536 U.S. at 280 (quoting *Pennhurst*, 451 U.S. 1, 28 (1981)). After *Gonzaga*, *Wilder* cannot stand for the proposition that *every* provision of the Medicaid Act can be enforced via Section 1983. If anything, *Gonzaga* indicates that *Wilder* and *Wright v. Roanoke Redevelopment and Housing Authority*, 479 U.S. 418 (1987), represent narrow exceptions to a rule that excludes spending legislation from judicial enforcement. *See Gonzaga*, 536 U.S. at 280 ("Since *Pennhurst*, only twice have we found spending legislation to give rise to enforceable rights.").

The Seventh Circuit has not ruled on whether 42 U.S.C. § 1396a(a)(23) can be enforced via Section 1983 by individual Medicaid beneficiaries such as Ms. Clemons and Ms. Grubbs. As far as the State can find, post-*Gonzaga*, the Seventh Circuit has reviewed only one subsection of §1396a(a) for purposes of determining whether it may be enforced through Section 1983. In *Bertrand*, 495 F.3d at 457-58, it assumed without deciding that (a)(8) could be so enforced, but expressly left the question for another day. *Id.* Quite plainly, this is an open question.

Notwithstanding this lack of controlling authority, Plaintiffs confidently assert that "[c]ourts have, with virtual unanimity, concluded that 42 U.S.C. § 1396a(a)(23)" confers a right of action "on individuals enrolled in the Medicaid program, such as Ms. Clemons and Ms. Jackson." PPIN Br. 14 n.7. They cite only two circuit court cases and two district court cases to support their assertion. *Id*. (citing *Ball v. Rodgers*, 492 F.3d 1094 (9th Cir. 2007); *Harris v.*

Olszewski, 442 F.3d 456 (6th Cir. 2006); *G. ex rel. K v. Hawaii Dep't of Human Resources*, 2009 WL 1322354 (D. Hawaii May 11, 2009); *Women's Hosp. Found. v. Townsend*, 2008 WL 2743284 (M.D. La. 2008)). They do not mention, however, that two other federal courts have rejected the ability of private plaintiffs to enforce (a)(23) through a Section 1983 cause of action: *Watson v. Weeks*, 436 F.3d 1152, 1162 (9th Cir. 2006) ("There is insufficient evidence of congressional intent to create a section 1983 right under [section 1396a(a)(17)]."); *M.A.C. v. Betit*, 284 F. Supp. 2d 1298, 1307 (D. Utah 2003) (concluding that "the freedom of choice provisions do not contain the unambiguous rights-creating language of *Gonzaga* ").

This is hardly a reliable body of authority establishing an individual right to enforce Section 1396a(a)(23), and the reasoning in PPIN's cases is not persuasive for the reasons stated above. Section 1396a(a) merely establishes conditions under which states receive federal funding, and those conditions are enforceable only by the federal government, not private plaintiffs and federal courts. It begins "[a] State plan for medical assistance must" and each subsection then delineates exactly what a state plan must provide or allow for. 42 U.S.C § 1396a(a). The purpose of the statute is therefore to establish requirements for participating States, not to establish an individual right to relief. Accordingly, the statute's focus is on "the person regulated rather than the individuals protected" and as such there is "no implication of an intent to confer rights on a particular class of persons." *Alexander v. Sandoval*, 532 U.S. 275, 289 (2001). Hence, Plaintiffs are unlikely to succeed with a Section 1983 cause of action.

2. The Preventive Health and Health Services Block Grant Program does not afford Plaintiffs a right of action

PPIN receives funding for the screening and treatment of sexually transmitted diseases through the federal Preventive Health and Health Services ("PHHS") Block Grant Program, 42 U.S.C. § 247c, *et seq*. PPIN Br. 6. This funding comes to PPIN via Disease Intervention Services

("DIS") grants administered by the Indiana State Department of Health. PPIN currently has two grant agreements with ISDH totaling $150,000 set to expire on December 31, 2011. *Id*.

The PHHS Block Grant Program, like Medicaid, does not afford PPIN a private right of action. PPIN cites no authority that would grant it a cause of action, presumably assuming that it has the right to challenge any law that harms it. The Supreme Court, however, disagrees. As discussed above, in order for PPIN to successfully challenge Indiana's decision to withhold grant money, it would have to point to an "unambiguously conferred right" provided by statute. *Gonzaga*, 536 U.S. at 283. It cannot do so.

3. The Supremacy Clause does not afford Plaintiffs a right of action

The only remaining plausible basis for a cause of action concerning the defunding provisions is the Supremacy Clause, but that theory is unlikely to succeed as well. Plaintiffs argue that, pursuant to the Supremacy Clause, the federal Medicaid statute preempts the defunding provision in HB 1210. While the Seventh Circuit has indicated that in some circumstances an independent cause of action is not necessary to assert federal preemption against state regulation, *Illinois Association of Mortgage Brokers v. Office of Banks and Real Estate*, 308 F.3d 762, 765 (7th Cir. 2002), that case did not address whether an independent cause of action is necessary to enforce federal laws enacted pursuant to the Spending Clause, where "the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State." *Pennhurst*, 451 U.S. at 28. To permit a free-standing claim of preemption where Spending Clause legislation affords no such cause of action would plainly undermine *Gonzaga* and antecedent cases. And, indeed, the State is aware of no Seventh Circuit

cases holding that there is a freestanding right of action to enforce federal Spending Clause statues against States under a theory of preemption.

As it happens, the Supreme Court is slated to consider this very issue during its upcoming October Term 2011. In *Maxwell-Jolly v. Independent Living Center of Southern California, Inc.*, 131 S. Ct. 992 (2011) (granting certiorari), the issue is whether a provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A), can be enforced via a preemption theory under a freestanding Supremacy Clause claim. Petition for Writ of Certiorari at i, *Maxwell-Jolly*, 2010 WL 599171 (Feb. 16, 2010) (No. 09-958).

And while the decision in that case is many months off, the Court's decision to consider the issue suggests skepticism of permitting such a claim to proceed. The Supreme Court has already acknowledged that "the Supremacy Clause, of its own force, does not create rights enforceable under §1983." *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 107 (1989) (internal citations omitted); *see also Chapman v. Houston Welfare Rights Org.*, 441 U.S. 600, 615 (1979) (holding that "an allegation of incompatibility between federal and state statutes and regulations does not, in itself, give rise to a claim 'secured by the Constitution' within the meaning of § 1343(3)"). It would seem to follow that the Supremacy Clause does not afford a freestanding right of action to bring preemption claims. Accordingly, PPIN is unlikely to succeed on the merits of its preemption claims.

B. The Medicaid Act expressly recognizes state authority to determine what constitutes a "qualified" provider, and the "freedom of choice" provision does not override that authority

States enjoy considerable freedom to design and implement their own Medicaid administration programs. Each State creates its own plan and has the option to cover "medically needy" residents in addition to its required coverage of "categorically needy" residents. *Walsh*,

538 U.S. at 650-51; *see also id.* at 686 (O'Connor, J., concurring in part and dissenting in part) ("Congress has afforded States broad flexibility in tailoring the scope and coverage of their Medicaid programs"). A plaintiff arguing that a state law is preempted by the federal Medicaid statute has the burden of showing that the state law does not serve any "Medicaid-related goal or purpose." *Id.* at 662 (plurality opinion). Furthermore, "[t]he fact that a State's decision to curtail Medicaid benefits may have been motivated by a state policy unrelated to the Medicaid Act does not limit the scope of its broad discretion to define the package of benefits it will finance." *Id.* at 666. Given that States have broad discretion to regulate Medicaid providers as they see fit, a new state regulation having the effect of disqualifying a provider does not create a freedom of choice issue, whether the matter is cast in terms of "violating" Medicaid or in terms of preemption.

The Medicaid Act provides that "[i]n addition to any other authority, a State may exclude any individual or entity [from participating in its Medicaid program] for any reason for which the Secretary [of the Department of Health and Human Services] could exclude the individual or entity from participation in [Medicare]." 42 U.S.C. § 1396a(p)(1). The First Circuit has held that "this 'any other authority' language was intended to permit a state to exclude an entity from its Medicaid program for *any* reason established by state law." *First Medical Health Plan v. Vega-Ramos*, 479 F.3d 46, 53 (1st Cir. 2007) (emphasis in original). The court noted that its interpretation was derived directly from the legislative history of 42 U.S.C. § 1396a:

> The Committee bill clarifies current Medicaid Law by expressly granting States the authority to exclude individuals or entities from participation in their Medicaid programs for any reason that constitutes a basis for an exclusion from Medicare. . . *This provision is not intended to preclude a State from establishing, under State law, any other bases for excluding individuals or entities from its Medicaid program.*

Id. (emphasis in original). Accordingly, the court held that Puerto Rico could exclude providers that owned Medicare-eligible facilities from participation in its dual-eligible Medicare/Medicaid

program (Medicare Platino). *Id*. This exclusion was not based on quality of care, but rather was a policy decision meant to "protect the integrity of the Puerto Rico Medicaid system. *Id*. at 52; *see also Senape v. Constantio*, 936 F.2d 687, 691 (2d Cir. 1991) (recognizing State officials' "broad discretion in selecting providers").

Plaintiffs rely on the Medicaid Act's provision stating that, under a proper State plan, "any individual eligible for medical assistance . . . may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide him such services." 42 U.S.C. § 1396a(a)(23). Yet the Supreme Court has stated that this right applies only so long as the provider "continues to be qualified." *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 785 (1980). That is to say, the Medicaid Act "clearly does not confer a right on a recipient to enter an unqualified [provider] and demand a hearing to certify it, nor does it confer a right on a recipient to continue to receive benefits for care [from a provider] that has been decertified." *Id*.[2]

The Seventh Circuit has held that Medicaid's freedom of choice provision is meant "to give the recipient a choice among available facilities, not to require the creation or authorization of new facilities." *Bruggeman ex rel. Bruggeman v. Blagojevich*, 324 F.3d 906, 911 (7th Cir. 2003). In reaching this conclusion, the court adopted the Second Circuit's interpretation of *O'Bannon* that beneficiaries have freedom of choice only within the universe of providers that are both "*qualified* and *participating* in the Medicaid program." *Kelly Kare, Ltd. v. O'Rourke*, 930 F.2d 170, 178 (2d Cir. 1991) (emphasis added). Thus, in *Kelly Kare*, the State of New York

[2] Plaintiffs cite for support a fiscal impact by the Indiana Legislative Services Agency concerning HEA1210. PPIN Br. 14. The fiscal impact statement cites information from someone at FSSA concerning potentially relevant portions of Medicaid. First, of course, an unidentified (perhaps non-lawyer) FSSA employee does not set forth the legal views of the State. Second, the LSA memo neither provides any legal conclusions nor attributes any to FSSA. So, it is not clear in what way this supposed "interpretation" from FSSA "supports" PPIN's "reading" of the law.

had the right to unilaterally end a contract with a Medicaid provider without cause. *Id.* The court held that, upon the termination of this contract, the class of beneficiaries that had previously utilized the services of the provider suffered only an incidental burden on their freedom of choice. *Id*.

These cases are clearly different from the cases cited by PPIN in which States have been found to violate a beneficiary's freedom of choice. Legislative schemes that have been held to violate that right are those in which the State forced a beneficiary to utilize the services of one provider over another provider *within* the universe of accepted providers. For instance, the State of Louisiana was not allowed to force school-aged children to seek services at their respective schools, as opposed to a private Medicaid provider. *Chisholm v. Hood*, 110 F. Supp. 2d 499, 506 (E.D. La. 2000). In another instance, the City of New York attempted to establish a program by which Medicaid eligible providers bid for exclusive contracts to serve a borough of the city. *Bay Ridge Diagnostic Lab. Inc. v. Dumpson*, 400 F. Supp. 1104, 1105 (E.D.N.Y. 1975). The program would have created only one provider for each borough and beneficiaries in those boroughs were forbidden from seeking services from any other provider. *Id.* This restriction was held to violate beneficiaries' freedom of choice. *Id.* at 1108.

Nor do Plaintiffs' cited cases hold that provider qualifications offend Medicaid's freedom of choice rule. Their cases have only to do with the ability of States to add qualifications to a single government program—the Title X grant program, which is a program that PPIN does not even allege it participates in or that the State administers. *See Planned Parenthood of Billings, Inc. v. State of Montana*, 648 F. Supp. 47, 51 (D. Mont. 1986) (holding that a state law banning co-location of Title X eligible clinics with abortion providers was an additional eligibility requirement not authorized by the statute); *Valley Family Planning v. State of North Dakota*, 661

F.2d 99, 100-02 (8th Cir. 1981) (holding that a law banning use of state or federal funds to any provider that "performs . . . or encourages" abortion was unconstitutional because Title X funds could be used for abortion referrals in limited circumstances); *Planned Parenthood Ass'n of Utah v. Matheson*, 582 F. Supp. 1001, 1005-07 (D. Utah 1983) (holding that a parental consent law impermissibly interfered with Title X's specific provision of funding for sexually active minors). These Title X cases are not analogous to the case at bar because Title X's text specifically identifies the qualifications of a Title X grant recipient, and by implication precludes any additional qualifications. *See Planned Parenthood of Houston & Southeastern Texas v. Sanchez*, 403 F.3d 324, 340-41 (5th Cir. 2005).

Furthermore, *O'Bannon* cannot support Plaintiffs' argument for absolute veto power over state provider qualifications. While the Court recognized a right to choose a provider, it also said that right is limited to those providers that are actively participating in the Medicaid program. *O'Bannon*, 447 U.S. at 786. The fact that a provider exits the program involuntarily is irrelevant. Nothing supports the claim that provider disqualification amounts to a violation of freedom of choice. Under PPIN's argument, *any* action by the State that operated to disqualify a previously qualified provider would constitute a violation of a beneficiary's freedom of choice. The State would be unable, for example, to disqualify providers based on illegal conduct unrelated to quality of care; billing or claims fraud; the natural termination of a provider contract; or to prevent self-dealing amongst providers and plans.[3] HEA 1210 is itself a Medicaid provider qualification, so it is fully consonant with the Medicaid freedom of choice protection.

[3] *See e.g., Plaza Health Laboratories, Inc. v. Perales*, 878 F.2d 577, 582-83 (2d Cir. 1989) (upholding the State's right to disqualify a laboratory from its Medicaid program for allegedly illegally dumping waste in a river); *Guzman v. Shewry*, 552 F.3d 941, 950 (9th Cir. 2009) (upholding the temporary suspension of a provider from the State Medicaid program pending an investigation of allegations that it fraudulently sought reimbursement for non-FDA approved devices); *Geriatrics, Inc. v. Harris*, 640 F.2d 262, 265 (10th Cir. 1981) (holding that provider was not entitled to a pre-termination hearing after the State declined to renew its provider agreement); *First Med. Health*

C. The Hyde Amendment does not require States to deem abortion clinics to be qualified Medicaid providers

PPIN suggests that the Hyde Amendment, which prohibits federal Medicaid funding for abortions except in cases where the pregnancy results from rape or incest or where the life of the mother is at stake, somehow preempts HEA 1210. PPIN Br. 19. PPIN neither has established standing to make this argument nor can it show any likelihood that this argument will succeed.

1. First, to be able to make this argument, PPIN (or one of the medical professional plaintiffs) must establish that it regularly performs abortions covered by the Hyde Amendment, *i.e.*, abortions in cases of rape or incest or where the pregnant woman's life is at stake. *See S.D. Myers, Inc. v. City & County of San Francisco*, 253 F.3d 461, 476 (9th Cir. 2001), *cert. denied*, 541 U.S. 936 (2004) (holding that plaintiff had no standing to argue that city ordinance, which barred him from receiving municipal contracts, was preempted by ERISA because plaintiff failed to allege that he would be eligible for the contracts if the ordinance were struck down). It has not done this. All PPIN has alleged is that it regularly performs first trimester abortions. *See* Compl. 11 ("PPIN only provides abortion services to women who are in their first trimester of pregnancy.").

2. HEA 1210 does not, in fact, preclude Hyde Amendment-covered abortions in Indiana. HEA 1210 precludes state contracts only with *abortion clinics*—a subcategory of all medical procedure facilities that is distinguished by its regular provision of abortion services. It does *not* preclude state contracts with *all* facilities that might perform abortions. In particular, it exempts hospitals and ambulatory surgical centers—medical procedure facilities that historically perform only occasional abortions, and that are not understood to offer abortions as a central

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Plan, Inc. v. Vega-Ramos, 479 F.3d 46, 53 (1st Cir. 2007) (upholding a Puerto Rico statute that excluded providers who could engage in "self-dealing" from participating in its Medicaid program).

portion of their business. So, Medicaid-eligible women who seek abortions covered by the Hyde Amendment may yet obtain such abortions at hospitals and ambulatory surgical centers. In fact, abortions that take place where the life of the mother is at stake would self-evidently occur in a hospital setting anyway, likely in an emergency, not by way of a planned, routine procedure at PPIN or other abortion clinics.

Finally, even to the extent that HEA 1210 might preclude government funding of a few abortions that would otherwise be covered by Medicaid, that does not require facial invalidation of the statute. Statutes are not to be declared facially invalid unless they are invalid in *all* applications. *See Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 328-30 (2006). The Hyde Amendment certainly cannot be said to preempt all state abortion funding laws. At most, it preempts by way of a very limited conflict in a narrow category of cases. Any preemption declared by the court could be no broader than for abortions funded by the Hyde Amendment. *See Dalton v. Little Rock Family Planning*, 516 U.S. 474, 476-78 (1996) (holding that Arkansas statute stating "No public funds shall be used to pay for any abortion, except to save the mother's life" could only be enjoined from being enforced against Medicaid-funded abortions covered by the Hyde Amendment). That is, even if the State can be required to pay an abortion clinic for Hyde Amendment abortions, it must still be permitted to preclude all other state government contracts for other services at abortion clinics.

D. HEA 1210 does not conflict with DIS program requirements

The federal PHHS Block Grant Program, 42 U.S.C. § 247c, does not restrict how States may regulate recipients of funding under the program, and Plaintiffs cite no cases holding that States may not create qualifications for receiving DIS grants.

Again, all the preemption cases that Plaintiffs cite relate to the preemptive effect of Title X, which contains specific text delineating exactly who is eligible for Title X grants. Plaintiffs cite no similar language in the DIS act, and there is no general rule presuming federal preemption of state laws. In fact, the presumptions run in the opposition direction—against preemption. *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1997); *see also Sanchez*, 403 F.3d at 336-37 ("We start with 'a presumption that the state statute is valid, and ask whether petitioner has shouldered the burden of overcoming that presumption.'" (quoting *Walsh*, 538 U.S. at 661-62)). "[M]ere differences between state and federal regulation of the same subject are not conclusive of preemption." *Aux Sable Liquid Products v. Murphy*, 526 F.3d 1028, 1034 (7th Cir. 2008) (quoting *Frank Bros. v. Wisc. Dep't of Transp.*, 409 F.3d 880, 894 (7th Cir. 2005)). Without specific federal statutory text expressly preempting or conflicting with state enactments, there can be no preemption, and Plaintiffs have cited none here.

II. HEA 1210 is Not an Unconstitutional Impairment of PPIN's Contracts

Neither the Medicaid provider agreements nor the DIS grants at issue in this case are substantially impaired by HEA 1210 because, even prior to the enactment of that legislation, the State enjoyed the right to cancel the agreements for any reason. And even apart from being terminable upon the State's notice, these agreements do not represent commercial or vendor contracts that implicate Contract Clause concerns. Rather, they are the means of carrying out government programs intended to benefit the poor and disadvantaged, not PPIN. That is a crucial distinction in Contract Clause analysis.

A. Because PPIN's Medicaid provider agreements and DIS grant agreements are terminable by the State at any time, they are not substantially impaired

"To establish a contractual relationship subject to the Contract Clause, the party must demonstrate that the contract gave her a vested interest, not merely an expectation." *Allstate Life*

Ins. Co. v. Hanson, 200 F. Supp. 2d 1012, 1018 (E.D. Wis. 2002) (citing *Dodge v. Bd. of Educ.*, 302 U.S. 74, 77-79 (1937); *Larsen v. Senate*, 154 F.3d 82, 89-90 (3d Cir. 1998); *Ace Cycle World, Inc. v. Am. Honda Motor Co., Inc.*, 788 F.2d 1225, 1228 (7th Cir. 1986)).

PPIN has no vested contractual rights in either its Medicaid provider agreements or DIS grants because both agreements are terminable-at-will by the State. All Medicaid provider agreements, including PPIN's, contain provisions stating that they may be terminated either "[b]y IFSSA or its fiscal agent for Provider's breach of any provision of this Agreement as determined by IFSSA," *or* "[b]y IFSSA or its fiscal agent, or by Provider, upon 60 days written notice." Compl. Ex. 1 at 6. Likewise, PPIN's two DIS agreements—which, exclusive of the amendments specifying the amount of each grant, are textually identical—are also terminable-at-will by the State. *See* Compl. Ex. 2-1, 2-2. Section 18 of the DIS agreements (entitled "Termination for Convenience") states: "This Grant Agreement may be terminated, in whole or in part, by the State whenever, for any reason, the State determines that such termination is in the best interest of the State." *Id*. In addition, the DIS agreements provide that "[t]he enactment or modification of any applicable state or federal statute or the promulgation of rules or regulations thereunder after execution of this Grant shall be reviewed by the State and the Grantee to determine whether the provisions of this Grant require formal modification." *Id*. at § 10A. Along these lines, the agreements state that "[w]hen the Director of the State Budget Agency makes a written determination that funds are not appropriate or otherwise available to support continuation of performance of this Grant Agreement, it shall be canceled." *Id*. at § 12. Such a determination "shall be final and conclusive." *Id.*

Thus, both the Medicaid and DIS agreements allow the State to cancel the agreements for any reason. A party can claim no vested interest in an agreement that is terminable-at-will. For

example, in *Hanson*, the court held that an ex-wife—the named beneficiary in her former husband's life insurance policy—did not have a vested interest in the policy benefit because the husband "expressly reserved the right to change the beneficiary" and therefore she had only a "revocable expectancy." *Hanson*, 200 F. Supp. 2d at 1019 (internal quotations and citations omitted). Furthermore, she failed to show that "she could reasonably have expected her beneficiary status to continue." *Id*. Thus, the court held that because she had no vested interest, she therefore had no contractual relationship that was subject to the Contract Clause. *Id*.

Likewise, PPIN has no vested interest in either the Medicaid provider agreements or the DIS grant agreements. The agreements create no contractual relationship between PPIN and the State because the State has always enjoyed the right to cancel them. Furthermore, with respect to the provider agreement, it is important to note that Medicaid is a pay-as-you-go reimbursement system for services rendered. When a provider agreement is terminated, nothing more is owed the provider—there is no commitment to pay for all future services to patients.

The State has exercised its right to terminate these agreements, as it is contractually and constitutionally entitled to do. And even if one assumes that these agreements could nonetheless give rise to a contractual relationship, HEA 1210 works no substantial impairment upon that relationship. Rather, it merely acts upon the termination rights the State has always enjoyed.

B. Contract Clause doctrine concerns itself with commercial contracts, not with agreements that execute government policy subject to change at any time

Even if this Court finds that HEA 1210 imposes a substantial impairment on contractual obligations, the statute is still valid if "the State has a legitimate and significant public purpose behind the law." *Energy Reserves Group, Inc. v. Kansas Power & Light Co.*, 459 U.S. 400, 411 (1983). Prior contracts notwithstanding, the State possesses the police power to protect the general welfare of its people. *City of El Paso v. Simmons*, 379 U.S. 497, 508, 516 (1965). HEA

1210 serves the important and legitimate public purpose of preventing government funds from indirectly subsidizing abortions. The State's interest in preventing the subsidization of abortion stems from its "important and legitimate interest in protecting the potentiality of human life." *Roe v. Wade*, 410 U.S. 113, 162 (1973). Thus, States are free to make policy decisions and enact laws expressing a preference for childbirth over abortion, so long as those laws do not impose an undue burden on a woman's right to obtain an abortion. *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 872-73 (1992).

PPIN contends that "because the State is the direct party to the contracts at issue" it is not free to impair those contracts regardless of any public interest it might have in doing so. *See* PPIN Br. 12. Thus, according to PPIN, the State "may not avoid its financial obligations by passing legislation that declares its avoidance of its own financial obligations." *Id*.

Neither the Medicaid nor DIS agreements create "financial obligations" on the part of the State. They are not "debt contracts" of the type routinely enforced by courts against the States. *See U.S. Trust Co. of New York v. New Jersey*, 431 U.S. 1, 24 (1977) (collecting cases). As over one hundred years of Supreme Court precedent makes clear, the Contract Clause applies where States have created a financial obligation to the holder of some form of security and then subsequently passed a law that circumvents that obligation. *See, e.g., W.B. Worthen Co. v. Kavanaugh*, 295 U.S. 56, 59 (1935) (striking down Arkansas statute that modified procedures by which municipal bondholder and trustee could collect delinquencies); *State ex rel. S. Bank v. Pilsbury*, 105 U.S. 278, 299 (1881) (striking down Louisiana legislation interfering with state bond initiative to fund the consolidation of New Orleans with surrounding areas); *Murray v. City of Charleston*, 96 U.S. 432, 447 (1877) (striking down Charleston ordinance levying assessment

on interest of city-issued bonds, finding that the assessment essentially decreased the contractual interest rate).

These types of contracts create debt obligations on the part of the State resulting from the State's conscious decision to enter a financial market. *See Energy Reserves Group*, 459 U.S. at 411 ("When a State itself enters into a contract, it cannot simply walk away from its financial obligations. In almost every case the Court has held a governmental unit to its contractual obligations when it enters financial or other markets.").

The State does not enter "financial or other markets" by entering into a Medicaid provider agreement or a DIS grant agreement. Rather, the State enters into these agreements as a means of carrying out the regulatory and welfare schemes established by the Medicaid Act and the PHHS Block Grant Program. PPIN cites no cases precluding governmental policy changes under a Contract Clause theory. It cannot be the case that by entering into these agreements, the State forfeits its ability to make policy decisions regarding its implementation of these programs to the extent those decisions impact current welfare distribution arrangements.

III. HEA 1210 Does Not Impose An Unconstitutional Condition On PPIN's Receipt Of Government Funds

A. Physicians have no independent constitutional right to perform abortions or to receive an indirect subsidy for abortions

The Supreme Court has held that "[n]either Congress nor the States may condition the granting of government funds on the forfeiture of constitutional rights." *Planned Parenthood of Mid-Missouri & E. Kansas, Inc. v. Dempsey*, 167 F.3d 458, 461 (8th Cir. 1999) (citing *Perry v. Sindermann*, 408 U.S. 593, 597 (1972); *Shapiro v. Thompson*, 394 U.S. 618, 634-35 (1969); *Speiser v. Randall*, 357 U.S. 513, 518-19 (1958)). PPIN argues that HEA 1210 imposes an

unconstitutional condition on its government funding by requiring it to forfeit its constitutional right to perform abortions. PPIN Br. 22. No such right exists.

As PPIN concedes, the Supreme Court has never held that providers or physicians have an independent constitutional right to perform abortions or any other medical procedure. *See* PPIN Br. 23. In fact, the Court has expressly declined to decide whether a physician has a "constitutional right[] to practice medicine." *Singleton v. Wulff*, 428 U.S. 106, 113 (1976) (plurality opinion) (citation and internal quotation omitted). What is clear is that "the practice of medicine," including the performance of abortions, is "subject to reasonable licensing and regulation by the State." *Casey*, 505 U.S. at 884; *see also Lambert v. Yellowley*, 272 U.S. 581, 596 (1926) ("there is no right to practice medicine which is not subordinate to the police power of the States").

Any right of physicians to perform abortions is entirely derivative of, dependent upon, and no broader than the pregnant woman's rights. *See Casey*, 505 U.S. at 884 ("[w]hatever constitutional status the doctor-patient relation may have as a general matter, in the present context it is derivative of the woman's position"); *Harris v. McRae*, 448 U.S. at 318 n.21 ("[T]he constitutional entitlement of a physician who administers medical care to an indigent woman is no broader than that of his patient."). Thus, while the Supreme Court has held that it is "generally appropriate" for physicians to stand in the shoes of their patients in abortion cases, they have standing only to the extent that the challenged governmental action allegedly "interfere[s] with the abortion decision." *Singleton*, 428 U.S. at 118.

HEA 1210 does not interfere with a woman's right to obtain an abortion, and PPIN makes no claim that it does. PPIN is already prohibited from using public funds to perform most abortions. *See* Ind. Code § 16-34-1-2. HEA 1210 simply carries to full effect the Indiana

legislature's decision to prevent taxpayer subsidy of abortions; it "places no obstacles—absolute or otherwise—in the pregnant woman's path to an abortion" because she "continues as before to be dependent on private sources for the service she desires." *Maher v. Roe*, 432 U.S. 464, 474 (1977) (upholding Medicaid for childbirth but not for non-therapeutic abortions). And like the law upheld in *Webster*, HEA 1210 does not prohibit women from seeking abortions from other non-publicly funded facilities. *Webster v. Reproductive Health Servs.*, 492 U.S. 490, 509 (1989) (upholding Missouri law prohibiting the use of public facilities for abortions because the law "leaves a pregnant woman with the same choices as if the State had chosen not to operate any public hospitals at all.").

PPIN makes much of the Court's speculation in *Webster* that the case "might [] be different if the State barred doctors who performed abortions in private facilities from the use of public facilities for any purpose." *Id*. at 510 n.8; PPIN Br. 24. But there, injury would be sustained by the doctors essentially as punishment for performing abortions, not as an incidental effect of the State's legitimate efforts to preclude public support of the abortions themselves. HEA 1210 is no different from the actual law upheld in *Webster*—it merely carries out the state's prerogative not to support, even indirectly, abortion procedures. *See Webster*, 492 U.S. at 509.

PPIN's reliance on similar dicta in *Harris* is likewise unavailing. The *Harris* Court hypothesized that "[a] substantial constitutional question would arise if Congress had attempted to withhold all Medicaid benefits from an otherwise eligible candidate simply because that candidate exercised her constitutionally protected freedom to terminate her pregnancy by abortion." *Harris*, 448 U.S. at 317 n.19. "This," PPIN argues "would be an unconstitutional condition." PPIN Br. 24. It is not entirely clear what point PPIN is attempting to make. While such an action may, indeed, constitute an unconstitutional condition on the woman's receipt of

Medicaid benefits, HEA 1210 is not such an action. Again, the woman's rights to obtain an abortion and to receive Medicaid benefits are completely unaltered. She can simply seek out another provider. All the new law does is ensure that, indeed, taxpayer funds do not indirectly subsidize abortions. The Supreme Court rejected the theory that government must subsidize abortions in *Webster*, *Maher* and *Harris*.

B. If for no other reason, HEA 1210 does not impose an unconstitutional condition because PPIN can still receive federal funding if it establishes independent, unsubsidized affiliates to perform abortions

Yet another reason HEA 1210 does not rise to the level of an unconstitutional condition is that it permits some level of affiliation between Medicaid providers and abortion clinics—as long as there is no cross-subsidy of abortion. In *Planned Parenthood of Mid-Missouri and Eastern Kansas, Inc. v. Dempsey*, 167 F.3d 458 (8th Cir. 2008), the Eighth Circuit held that a Missouri law similar to HEA 1210 did not impose an unconstitutional condition on PPIN's receipt of Title X family-planning funds because it allowed potential recipients of funds "to exercise their constitutionally protected rights through independent affiliates." *Id.* at 463. While this allowance is not constitutionally required, HEA 1210 also leaves PPIN with this option and therefore is unquestionably constitutional.

The Missouri law at issue in *Dempsey* prohibited Title X family-planning funds from being used to "perform, assist, encourage, or make direct referrals for abortions." *Dempsey*, 167 F.3d at 461. The law also provided that "organizations or affiliates of organizations that provide or promote abortions are not eligible for family-planning funds." *Id.* (internal quotations and citation omitted). The *Dempsey* court held, however, that "nothing in [the law] prohibits grantees from maintaining an affiliation with an abortion service provider, so long as the affiliated abortion service provider does not directly or indirectly receive State family-planning funds." *Id.*

at 463. Thus, the court found the law "facially ambiguous regarding whether an organization that receives State funds may be affiliated with an abortion service provider." *Id*. Because the law would be an unconstitutional condition if the court interpreted it to prohibit such affiliation, the court instead construed the law "to allow a grantee to maintain an affiliation with an abortion service provider, so long as that affiliation does not include direct referrals for abortion." *Id*.

HEA 1210 provides that "[a]n agency of the state may not enter into a contract with or make a grant to any entity that performs abortions or operates a facility where abortions are performed that involves the expenditure of state funds or federal funds administered by the state." Ind. Code § 5-22-17-5.5(b). There is nothing in this language that would prohibit PPIN from forming independent affiliates for the provision of abortion services. This construction of HEA 1210 is entirely consistent with the purpose of the legislation. HEA 1210 was not intended to stop PPIN from performing abortions altogether; rather, it was intended to stop the indirect subsidization of abortion with state funds. As set forth in the statement of background facts, PPIN's audited financial statements indicate that it commingles Medicaid funds with other sources of income and does not allocate costs for abortions versus other services. It necessarily follows that Medicaid indirectly subsidizes costs PPIN incurs when performing abortions. *See* Exhibit A at 3. Allowing PPIN to restructure its operations so that a Medicaid provider can affiliate with an abortion service provider can achieve the goal of preventing such cross-subsidization so long as the affiliates are sufficiently separate from PPIN to prevent indirect taxpayer subsidization.

Part Two: Count Two – Informed Consent Provisions

I. The Informed Consent Provisions Should Be Upheld As They Require Truthful, Non-Misleading Information

The Supreme Court has routinely upheld informed consent provisions in abortion statutes against First Amendment challenges. *See Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 884 (1992) (plurality opinion). *Casey* acknowledged that "a requirement that a doctor give a woman certain information as part of obtaining her consent to an abortion" implicates a physician's First Amendment right not to speak, "but only as part of the practice of medicine, subject to reasonable licensing and regulation by the State." *Id.* Any such regulation that the state chooses to adopt may be based on the State's "permi[ssible and] legitimate goal of protecting the life of the unborn by enacting legislation aimed at ensuring a decision that is mature and informed, even when in so doing the State expresses a preference for childbirth over abortion." *Id*. at 883. Thus, a physician's right not to speak is not violated where the physician is required to give "truthful, nonmisleading information" relevant to the patient's decision to have an abortion. *Id.* at 882. The *Casey* plurality found that such relevant information included facts about the procedure's medical risks, information relating to the father's child support obligations, and information about adoption and other "alternatives to abortion." *Id.* at 881. This information "furthers the legitimate purpose of reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed." *Id.* at 882. The statements required by Indiana law are neither false nor misleading nor irrelevant and are, therefore, permissible state regulations of the practice of medicine.

A. Objective scientific information evidences fetal pain at or before twenty weeks

Indiana Code section 16-34-2-1.1(a)(1)(G) (effective July 1, 2011) requires that physicians inform a patient who is seeking an abortion that "objective scientific information

shows that a fetus can feel pain at or before twenty (20) weeks of postfertilization age[.]" "Objective scientific information" as used in the statute, is defined as "data that have been reasonably derived from scientific literature and verified or supported by research in compliance with scientific methods." Ind. Code § 16-18-2-254.2 (effective July 1, 2011). This requirement is based on legislative findings enacted as part of the bill. In section six of the Act, the legislature found as follows:

> (1) There is substantial medical evidence that a fetus at twenty (20) weeks of postfertilization age has the physical structures necessary to experience pain.
> (2) There is substantial medical evidence that a fetus of at least twenty (20) weeks of postfertilization age seeks to evade certain stimuli in a manner similar to an infant's or adult's response to pain.
> (3) Anesthesia is routinely administered to a fetus of at least twenty (20) weeks of postfertilization age when prenatal surgery is performed.
> (4) A fetus has been observed to exhibit hormonal stress responses to painful stimuli earlier than at twenty (20) weeks of postfertilization age.

2011 Ind. Legis. Serv. P.L. 193-2011, Sec. 6. The Act further states that "Indiana asserts a compelling state interest in protecting the life of a fetus from the state at which substantial medical evidence indicates that the fetus is capable of feeling pain." *Id.*

PPIN challenges the fetal-pain informed-consent statement as "false, misleading and irrelevant[,]" and yet, it specifically acknowledges that "the minority scientific opinion [is] that conscious pain perception is possible at the end of the second trimester, from about 20-22 weeks gestation[.]" PPIN Br. 28, 29 n.13. For a statement to be "objective scientific information" it need not be the "majority" position on an issue, whatever that means. It must only be "supported by research in compliance with scientific methods." Ind. Code § 16-18-2-254.2 (effective July 1, 2011). PPIN cannot demonstrate that the statement regarding fetal pain fails this criterion.

As recounted in the statement of background facts, *supra*, Kanwaljeet S. Anand, M.B.B.S., D. Phil., among others, has provided the objective science necessary to support this

provision. Dr. Anand is perhaps the world's leading expert on fetal pain. *See, e.g.*, PPIN's Attach. 6 at 2. Yet Plaintiffs dispute the sufficiency of his science based on nothing more than what they refer to as "the majority view" that a fetus does not feel pain until 29 weeks. *Id.*

One central point of scientific contention between Dr. Anand's studies and the views of PPIN's experts has to do with what anatomical growth is necessary to feel pain. PPIN's experts essentially contend that a fetus is a "little adult" that can be expected to feel pain only through the same neural pathways as fully formed people. Dr. Anand disputes that assumption. According to Dr. Anand, "the structures and mechanisms used for pain processing during fetal or neonatal life are unique and completely different from those used by adults, and . . . many of these structures/mechanisms are not maintained beyond specific periods of early development." Exhibit E at 2 (*A Scientific Appraisal of Fetal Pain and Conscious Sensory Perception: Hearing on H.R. 356 Before the U.S. House Committee on the Judiciary*, 109th Cong. 2 (2005) (written statement of K. J. S. Anand, MBBS, D.Phil., FAAP, FCCM, FRCPCH)). The lack of cerebral cortex development does not answer the question of fetal pain, Dr. Anand says, because "[t]he immature pain system . . . plays a signaling role during each stage of development and may use the neural elements available at that time to fulfill this role." *Id.* Furthermore, even in adults, "[p]ain is now viewed as a homeostatic emotion, with the thalamus playing a central role in pain processing and regulating the spinal-brainstem-spinal loops that mediate descending facilitation or inhibition depending on the context of pain. Fetal development of the thalamus occurs much earlier than the sensory cortex." *Id.* at 3. And because it "is likely . . . that thalamic nuclei play a central role in conscious pain perception," the substrate and mechanisms for conscious pain perception" are developed in a fetus "well before the third trimester of human gestation." *Id.* at 6.

Other prominent pediatric and gestational scientists agree with Dr. Anand. Jean A. Wright, MD MBA, Vice President and Chief Medical Officer for two of the hospitals in the Carolinas Healthcare System, which is the third largest public healthcare system in the United States, explains that "by 20 weeks, and perhaps even earlier, all the essential components of anatomy, physiology, and neurobiology exist to transmit painful sensations from the skin to the spinal cord and to the brain." Exhibit F at 3 (*Testimony, Hearing on H.R. 356 Before the U.S. House Committee on the Judiciary*, 109th Cong. 1 (2005) (statement of Jean A. Wright MD MBA)). Accordingly, in her expert opinion, "the statement relating to fetal pain and the findings upon which the General Assembly based that statement, are substantially based in scientific fact." Exhibit G at 3 (Decl. of Jean A. Wright). In particular, Dr. Wright observes that the growing science concerning fetal surgery supports the inference that fetal pain occurs before 20 weeks. She recites "preliminary evidence for a therapeutic response in Opioid (pain) receptors of fetuses at 16-21 weeks on the administration of intravenous sedation/anesthesia in the maternal patient as compared with those that did not receive anesthesia; the infants of mothers who received anesthesia were less stressed by the procedure." *Id.* at 6. This sort of "stress," she explains, is indicative of fetal pain. *Id.* Now, "[a]nesthesia for the pre-born child is a planned part of these surgical procedures, and every effort is made to prevent the pre-born child from experiencing noxious stimuli with the hormonal and physiologic changes that accompany the surgery." *Id.* at 7.

Both Dr. Anand and Dr. Wright, as well as many others, *see, e.g.*, http://www.doctorsonfetalpain.com, have come to the conclusion, through scientific research, that a fetus can feel pain at or before twenty weeks. PPIN's experts obviously disagree, but fortunately the Court is not required to decide who is right. The Indiana General Assembly is

permitted to choose which objective scientific studies to rely on, regardless whether they represent the "majority" view. *See Gonzales v. Carhart*, 550 U.S. 124, 163 (2007)*; see also Jones v. United States*, 463 U.S. 354, 370 (1983) (when a legislature "undertakes to act in areas fraught with medical and scientific uncertainties, legislative options must be especially broad and courts should be cautious not to rewrite legislation.") (internal quotation marks and citation omitted).

Indiana's fetal pain informed consent requirement is also relevant to the abortion decision. Exhibit G at 3. If a pregnant woman understands that a fetus can feel pain, the information may influence her views about the nature of fetal life and about the abortion procedure. Indeed, even if the purpose of the regulation "do[es] no more than create a structural mechanism by which the State . . . may express profound respect for the life of the unborn," the law is permissible because it does not present "a substantial obstacle to the woman's exercise of the right to choose." *Casey*, 505 U.S. at 877. At the very least, even if a woman does not change her mind about the procedure when confronted with this information, she will be making her decision based on more complete information and avoid a situation where she later learns about fetal pain and comes to regret her decision in light of it. *See Gonzales*, 550 U.S. at 159-60 ("It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know").

PPIN claims, without evidentiary substantiation, that the required statement about fetal pain will "certainly" cause all women to believe that even in the first trimester, at or before 12 weeks, the fetus might feel pain. PPIN Br. 29. The argument that proceeds from this unsupported assertion is that the fetal pain information is "misleading" to first-trimester patients. *Id.* But this

argument oddly depends on the assumption that the abortion doctor will, when delivering the required truthful information, abandon the duty to patients to advise them regarding their particular circumstances. The law does not preclude or even discourage the doctor (or delegate) from informing a first-trimester patient whether scientific evidence shows fetal pain at that stage of pregnancy. Exhibit G at 7. Indeed, a physician (or delegate) who disagrees with the science evidencing fetal pain at or before 20 weeks can share that view with the patient.

This ability of the physician to disassociate from the state's message neutralizes any potentially misleading applications of the statute, and only underscores the statute's validity. For example, in *Fargo Women's Health Organization v. Schafer*, 18 F.3d 526, 533-34 (8th Cir. 1994), the court upheld an abortion informed-consent requirement that could in some circumstances be misleading based on the ability of physicians to comment on it and disassociate themselves from it. *See also Planned Parenthood Minnesota v. Rounds*, 530 F.3d 724, 736-37 (8th Cir. 2008) (*en banc*) (acknowledging the same principle).

Moreover, because the science of fetal pain is highly dynamic, requiring information that may not directly speak to every patient's situation, while permitting the physician to provide further clarification on the spot based on the latest science, is a sound approach. For example, Dr. Wright, in her congressional testimony, noted how, when she began practicing medicine in 1980, fetal pain was not something doctors knew much about. Exhibit F at 1. Since then, however, emerging surgical technologies have permitted surgeons to observe fetal responses to in-utero procedures, which observations have then provided data supporting conclusions about fetal pain. *Id.* As a consequence, scientific understanding of fetal pain has grown rapidly, and will only continue to grow. Exhibit G at 6. An open-ended statement that a fetus can feel pain at or before twenty weeks is not only literally true, but it prompts physicians to start a discussion with

patients about what the latest science shows. This way the legislature is not required to revisit the issue with every new study regarding fetal pain.

Finally, even if it is somehow misleading to tell a first-trimester patient that her fetus would feel pain at or before twenty weeks, the Court may not enjoin application of the provision in its entirety. Facial invalidation is disfavored, even in abortion-regulation cases. *See Ayotte v. Planned Parenthood of Northern New Eng.*, 546 U.S. 320, 328-29 (2006). "[F]acial challenges threaten to short circuit the democratic process by preventing laws embodying the will of the people from being implemented in a manner consistent with the Constitution." *Washington State Grange v. Washington State Republican Party*, 552 U.S. 442, 451 (2008) ("We must keep in mind that '[a] ruling of unconstitutionality frustrates the intent of the elected representatives of the people.'") (quoting *Ayotte*, 546 U.S. at 329); *cf. Yazoo & Mississippi Valley R. Co. v. Jackson Vinegar Co.*, 226 U.S. 217, 220 (1912) ("How the state court may apply [a statute] to other cases, whether its general words may be treated as more or less restrained, and how far parts of it may be sustained if others fail are matters upon which we need not speculate now"). In fact, PPIN brings only an as-applied challenge to the fetal pain language because it does not perform abortions after the first trimester. Compl. 15. Accordingly, at most the Court could enjoin the enforcement of Indiana Code section 16-34-2-1.1(a)(1)(G) as applied to first-trimester abortions.

B. A substantial scientific basis exists for the General Assembly's conclusion that human physical life begins at fertilization

Indiana Code section 16-34-2-1.1(a)(1)(E) (effective July 1, 2011) requires that physicians inform a patient who is seeking an abortion that "human physical life begins when a human ovum is fertilized by a human sperm." PPIN attempts to turn this biological truism into "a moral, theological, and philosophical" issue relating to "when life begins[.]" PPIN Br. 30. The term "human physical life," however, refers only to biology. A similar informed consent

requirement was upheld by the *en banc* Eighth Circuit in *Rounds*. 530 F.3d at 736-37. There, the plaintiffs challenged a North Dakota statute that required a physician to tell patients "[t]hat the abortion will terminate the life of a whole, separate, unique, living human being," where "human being" was defined as "an individual living member of the species of Homo sapiens . . . during [its] embryonic [or] fetal age[.]" *Id.* at 735-36. The court found that "evidence suggests that the biological sense in which the embryo or fetus is whole, separate, unique and living should be clear in context to a physician[.]" *Id.* at 736.

Indeed, as set forth in the Factual Background, *supra*, objective scientific evidence plainly establishes that, when a human ovum is fertilized by a human sperm, a biological life begins. Maureen L. Condic, Ph.D., Associate Professor of Neurobiology and Anatomy at the University of Utah School of Medicine and director of the University of Utah School of Medicine course in Human Embryology, agrees that the statement "human physical life begins when a human ovum is fertilized by a human sperm" is "substantially based in scientific fact." Exhibit H at 2 (Decl. of Maureen L. Condic). In her expert view, "[b]ased on a scientific description of fertilization, fusion of sperm and egg generates a new human cell, the zygote, with composition and behavior distinct from that of either gamete. Moreover, this cell is not merely a unique human cell, but a cell with all the properties of a fully complete (albeit immature) human organism; it is 'an individual constituted to carry on the activities of life by means of organs separate in function but mutually dependent: a living being.'" *Id.* at 5. This conclusion, she says, "is objective, based on the universally accepted scientific method of distinguishing different cell types from each other, and consistent with the factual evidence. It is entirely independent of any specific ethical, moral, political, or religious view of human life or of human embryos." *Id.*

In response to Dr. Silver, Dr. Condic says that "the scientific community has a clear set of criteria for distinguishing one cell type from another, and human cells from human organisms. By these criteria, it is a matter of objective, scientific fact that a full and complete, albeit developmentally immature, human organism comes into existence at the fusion of sperm and egg, and that the resulting zygote is indeed a 'human physical life.'" *Id.* In response to Dr. Orentlicher, Dr. Condic says that "religious views and personal opinions are irrelevant to the scientific facts of human embryology" which strongly support the conclusion that "a new cell (the zygote), that is distinct from the gametes that gave rise to it both in terms of molecular composition and behavior, comes into existence at the scientifically well defined 'moment' of sperm-egg fusion, an event that occurs in less than a second." *Id.* at 2-3.

The legislature has chosen to require that women seeking abortions be told that biological, physical life is created when an ovum is fertilized. This statement is not false, misleading or irrelevant. While it "certainly may be read to make a point in the debate about the ethics of abortion[,]" a state is permitted under *Casey* and *Gonzales* to "use its regulatory authority to require a physician to provide truthful, non-misleading information relevant to a patient's decision to have an abortion, even if that information might also encourage the patient to choose childbirth over abortion." *Rounds*, 530 F.3d at 734-35. As in *Rounds*, PPIN has not proven that "in practice, the patient will not receive or understand the narrow, species-based" statement regarding human physical life. *Id.* at 735.

PLAINTIFFS HAVE NOT DEMONSTRATED IRREPARABLE HARM

In order to prevail on a motion for a preliminary injunction, Plaintiffs must establish that the denial of such an injunction will result in irreparable harm. *Winter v. Natural Resources Defense Council, Inc.*, 555 U.S. 7 (2008). "'Irreparable' in the injunction context means not

rectifiable by the entry of a final judgment." *Walgreen Co. v. Sara Creek Property Co.*, 966 F.2d 273, 275 (7th Cir. 1992) (citations omitted). Here, the Plaintiff-patients are not harmed because they may receive family planning services from any Medicaid provider that is not an abortion clinic. Indeed, they may receive such services at PPIN. PPIN, however, may not bill Medicaid for the services. But even if the funding qualifications of the Act are later held invalid, PPIN will have up to a year from the date of services to bill Medicaid. 405 Ind. Admin. Code § 1-1-3(a). Accordingly, neither PPIN nor the patients will lack a remedy if the abortion qualification provisions are ultimately invalidated.

What is more, PPIN has not established that its cash flow needs presuppose a particular Medicaid payment timetable. The mere long-term need for Medicaid funding does not establish that PPIN depends on receiving payment for services within any particular time from the date of service. Accordingly, PPIN has established no particular urgency that would warrant the issuance of such extraordinary relief as a preliminary injunction.

PUBLIC POLICY AND THE BALANCE OF EQUITIES FAVORS THE STATE

To prevail on a motion for a preliminary injunction, a plaintiff must show "that the probability of success on the merits is sufficiently high—or the injury from the enforcement of the order sufficiently great—to warrant a conclusion that the balance of error costs tilts in favor of relief." *Illinois Bell Telephone Co. v. Worldcom Technologies, Inc.*, 157 F.3d 500, 503 (7th Cir. 1998). When the party opposing the motion for a preliminary injunction is a political branch of government, the restraint for issuing such an injunction is particularly high due to public policy considerations, as "the court must consider that all judicial interference with a public program has the cost of diminishing the scope of democratic governance." *Id.*

Indiana public policy highly values fetal life. In state law, "childbirth is preferred, encouraged, and supported over abortion," Ind. Code § 16-34-1-1, and the legislature accordingly has enacted a comprehensive abortion regulatory scheme, including informed consent components and a waiting period. *See* Ind. Code §§ 16-34-2-1(a); 16-34-2-4; 12-15-5-1(3), 12-15-5-1 (17), 12-15-5-2, 16-34-1-2, 16-34-2-1.1. The citizens of Indiana have a strong interest in the implementation of the laws passed by their duly elected representatives. *United States v. Rural Elec. Convenience Co-op. Co.*, 922 F.2d 429, 440 (7th Cir. 1991) (holding that "the government's interest is in large part presumed to be the public's interest"); *see also Fargo Women's Health Organization v. Schafer*, 819 F. Supp. 865, 867 (D. N.D. 1993) (denying motion for stay and injunction pending appeal of abortion statute and reasoning that "the public interest lies in enforcement of statutes enacted by the people's legislature.").

HEA 1210 serves the public interest in three ways. First, the funding qualification provision prevents taxpayer dollars from indirectly funding abortions, as happened at PPIN prior to enactment. *See* Exhibit A at 3. Second, it advances the State's goal of encouraging women to choose childbirth instead of abortion by removing any appearance of State support for abortion. *See Casey*, 505 U.S. at 883 (holding that it is constitutionally permissible for a State to enact policies that "express[] a preference for childbirth over abortion"). Third, the informed-consent requirements ensure that women who choose abortion have all the information necessary to make an informed and voluntary decision. *Casey*, 505 U.S. at 882 (holding that the State has an interest in "reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed."). Therefore, enforcement of HEA 1210 pending a final decision in the merits is in the public interest, and the law should not be preliminarily enjoined.

Respectfully submitted,

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