STATE OF INDIANA	)	MONROE COUNTY CIRCUIT COURT
	) SS:	
MONROE COUNTY	)	CAUSE NO. 53C06-2208-PL-001756

PLANNED PARENTHOOD GREAT NORTHWEST, HAWAI'I, ALASKA, INDIANA, KENTUCKY, INC., and ALL-OPTIONS, INC., on behalf of themselves, their staff, physicians, and patients; and AMY CALDWELL, M.D., on her own behalf and on behalf of her patients,

Plaintiffs,

v.

MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities; and the HENDRICKS COUNTY PROSECUTOR, LAKE COUNTY PROSECUTOR, MARION COUNTY PROSECUTOR, MONROE COUNTY PROSECUTOR, TIPPECANOE COUNTY PROSECUTOR, and the WARRICK COUNTY PROSECUTOR, in their official capacities,

Defendants.

ORDER DENYING MOTION FOR PERMANENT INJUNCTION

This matter comes before the Court on Plaintiffs' Motion for Permanent Injunction to enjoin Defendants from enforcing Senate Bill 1 ("S.B. 1"), as enacted in various sections of the Indiana Code. Plaintiffs appear by counsel Kenneth Falk, Stevie Pactor, and Gavin Rose of the ACLU of Indiana; Lori Martin, Alan Schoenfeld, Allyson Slater, Katherine Mackey, and Mikayla Foster of Wilmer Cutler

Pickering Hale and Dorr LLP; Catherine Peyton Humphreville and Melissa Shube of Planned Parenthood Federation of America; and Rupali Sharma and Allison Zimmer of The Lawyering Project. Defendants appear by Solicitor General James Barta, Deputy Solicitor General Jenna M. Lorence, Deputy Attorney General Katelyn E. Doering, and Gene Schaerr, Christopher Bartolomucci, Brian Field, Edward Trent, Justin Miller, and Miranda Sherrill of Schaerr Jaffe LLP.

PROCEDURAL HISTORY

On August 5, 2022, after a special legislative session, the Indiana General Assembly passed S.B. 1. S.B. 1 criminalizes abortion in Indiana, subject to limited exceptions including in the case of substantial and irreversible physical impairment of a major bodily function or death of the pregnant person (the "Health or Life Exception"). S.B. 1 also prohibits performing abortions at licensed clinics, and requires that abortions be performed at hospitals or ambulatory outpatient surgical centers that are majority-owned by a hospital (the "Hospital Requirement").

On August 31, 2022, Planned Parenthood Great Northwest, Hawai'i, Alaska, Indiana, Kentucky, Inc. ("PPGNHAIK"), Women's Med Group Professional Corporation, Whole Woman's Health Alliance, All-Options, Inc., and Dr. Amy Caldwell filed their initial challenge to S.B. 1. Plaintiffs claimed, among other things, that S.B. 1 violated Article 1, Section 1 of the Indiana Constitution. On September 22, 2022, this Court entered a preliminary injunction enjoining enforcement of the law,

finding that Plaintiffs were likely to succeed on their claim that the statute violated Article 1, Section 1.

On June 30, 2023, the Indiana Supreme Court reversed this Court's preliminary injunction. *Members of Med. Licensing Bd. of Ind. v. Planned Parenthood Great Nw., Haw., Alaska, Ind., Ky., Inc.*, 211 N.E.3d 957 (Ind. 2023). The Supreme Court held that Plaintiffs have standing to challenge S.B. 1, both "because they believe it infringes on their patients' constitutional rights, but also because, if enforced, it places them in immediate danger of sustaining their own direct injury from criminal prosecution or regulatory enforcement." *Id.* at 966. The Supreme Court also concluded that Article 1, Section 1 is judicially enforceable, id. at 975, and "protects a woman's right to an abortion that is necessary to protect her life or to protect her from a serious health risk." *Id.* at 985. In so holding, the Supreme Court specifically noted that the rights within Article 1, Section 1 include the right to protect oneself against great bodily harm. *Id.* at 976. The Supreme Court additionally held that outside these circumstances, the General Assembly "otherwise retains broad legislative discretion for determining whether and the extent to which to prohibit abortions." *Id.* at 962. The Supreme Court did not conclude that Article 1, Section 1 confers a right to abortion where rape or incest victims are concerned. Because the law was not unconstitutional in all circumstances, the Court ruled, Plaintiffs' facial challenge to S.B. 1 failed, requiring reversal of the preliminary injunction. *Id.* Still, the Supreme Court stressed that:

> [b]y saying Senate Bill 1 is not unconstitutional in its entirety in all circumstances, we do not say the opposite either—that every single part of the law can be applied consistent with our Constitution in every conceivable set of circumstances. We do not prejudge those questions. So, while Plaintiffs' challenge to the entire statute fails, that does not preclude Plaintiffs with standing from pursuing a facial challenge to a particular part of the statute or an as-applied challenge to the State enforcing the law in a particular set of circumstances.

Id. at 984.

The Supreme Court subsequently denied Plaintiffs' request for rehearing of its decision. 214 N.E.3d 348 (2023) (mem.).

On November 9, 2023, PPGNHAIK, Women's Med Group Professional Corporation, All-Options, Inc., and Dr. Amy Caldwell filed an Amended Complaint for Injunctive and Declaratory Relief (the "Amended Complaint"). Women's Med Group Professional Corporation was subsequently dismissed by agreement of the Parties. Plaintiffs alleged in the Amended Complaint that, as applied to Plaintiffs and their patients who present with serious physical or mental health risks that are not encompassed by the limited Health or Life Exception, the statute violates the constitutional right to abortion guaranteed by Article 1, Section 1, as found by the Indiana Supreme Court. Plaintiffs further alleged that the Hospital Requirement, which

prohibits abortions from occurring in the Indiana clinics where 98% of procedural abortions formerly occurred or where medications for abortion were dispensed, had created an insurmountable and medically unjustifiable barrier to abortion access for Hoosiers otherwise able to obtain abortions within the limited Health or Life Exception to S.B. 1, thus violating Article 1, Section 1.

Plaintiffs originally sought a preliminary injunction. However, on November 20, 2023, the Parties filed a Joint Motion to Consolidate the Trial with the Hearing on the Pending Preliminary Injunction, which the Court granted. As such, the Parties and the Court now treat Plaintiffs' request for a preliminary injunction as a request for a permanent injunction. On December 8, 2023, the Court granted the Parties' Stipulation providing "that any evidence received by the Court in the form of declarations, depositions, or other verified statements shall be admissible at the consolidated trial, subject to any objections to which in-person testimony is subject." (Order Granting Stipulation of the Parties Dec. 8, 2023).

The trial occurred from May 29 through May 31, 2024. In advance of trial, the Parties stipulated the admission of certain exhibits into the trial record. These include (1) all expert declarations and expert deposition transcripts, (2) all deposition transcripts of fact (i.e., non-expert) witnesses who did not testify at trial, (3) any deposition transcript of a party, and (4) any exhibit attached to any of the Parties' four legal briefs on the merits. Trial Tr. I at 4:23-6:3. The Court admitted certain additional exhibits at trial. The Parties also presented live testimony from

seven witnesses: Dr. Amy Caldwell, Dr. Steven Ralston, Parker Dockray, Dr. Leena Mittal, Dr. Elaine Cox, Dr. Aaron Kheriaty, and Dr. Monique Wubbenhorst.

With the benefit of a trial on the merits, extensive briefing, and additional time to consider the requested injunctive relief, and having considered the record of evidence, the text of the relevant provisions of the Indiana Constitution, the relevant case law, and the arguments and submissions of counsel for all Parties, the Court concludes that the evidentiary record does not support Plaintiffs' request for permanent injunction.

In support of this determination, the Court FINDS and CONCLUDES as follows:

FINDINGS OF FACT

I. PLAINTIFFS AND DEFENDANTS

1. Plaintiff PPGNHAIK is a not-for-profit corporation incorporated in Washington that operates eleven health centers throughout Indiana. Pls.' Ex. 1 (Gibron 8/29/2022 Decl.) ¶¶ 3, 7; Pls.' Ex.25 (Dudash Dep.) at 38:6; (Joint Statement of Undisputed Facts, Disputed Factual Issues, and Legal Issues to Be Decided May 24, 2024 ("Joint Statement") ¶ 1).

2. Before S.B. 1 went into effect, PPGNHAIK was "the largest provider of reproductive health services in Indiana." Pls.' Ex. 1 (Gibron 8/29/2022 Decl.) ¶ 7.

3. The Indiana Department of Health voided PPGNHAIK's abortion clinic licenses due to the Hospital Requirement, but PPGNHAIK's clinics in Indiana continue to provide non-abortion reproductive health services. Pls.' Ex. 1 (Gibron

8/29/2022 Decl.) ¶¶ 7, 9; Pls.' Ex. 25 (Dudash Dep.) at 39:10-12; (Joint Statement ¶ 1).

4. Plaintiffs contend that S.B. 1 seriously harms "PPGNHAIK's patients by depriving them of access to safe and legal abortions," and it leaves "many pregnant Hoosiers ... hundreds of miles from [an] abortion provider." Pls.' Ex. 1 (Gibron 8/29/2022 Decl.) ¶ 14; see Trial Tr. I at 51:25-52:8 (Caldwell)(discussing Indiana's "obstetric care deserts" and stating that patients now have to come from "all over the state" to Indianapolis to receive abortion care in a hospital setting).

5. "Most of PPGNHAIK's abortion patients are poor or have low incomes." Pls.' Ex. 1 (Gibron 8/29/2022 Decl.) ¶ 16.

6. PPGNHAIK would offer abortions at its clinics in Indiana if permitted by law. Pls.' Ex. 1 (Gibron 8/29/2022 Decl.) ¶ 19; Pls.' Ex. 25 (Dudash Dep.) at 30:21-31:7, 123:13-124:8, 151:23-152:6; Joint Statement ¶ 47.

7. Until August 1, 2023, PPGNHAIK offered medication abortion through 10 weeks from last menstrual period (LMP) at its Lafayette health center, and both medication abortion up to 10 weeks LMP and procedural abortion (also known as surgical abortion) up to 13 weeks and 6 days LMP at its Bloomington, Merrillville, and Georgetown Road health centers. Pls.' Ex.1 (Gibron 8/29/2022 Decl.) ¶ 9; (Joint Statement ¶ 1).

8. PPGNHAIK brings this action on behalf of itself, its staff, its physicians, and its patients.

9. Plaintiffs submitted testimony of PPGNHAIK's 30(b)(6) witness, Sharon Dudash. *See* Pls.' Ex.25 (Dudash Dep.).

10. Plaintiffs submitted testimony from PPGNHAIK's Chief Executive Officer, Rebecca Gibron. *See* Pls.' Ex.1 (Gibron 8/29/2022 Decl.).

11. Dr. Amy Caldwell is an obstetrician/gynecologist ("OB/GYN") physician licensed to practice medicine in Indiana and Illinois. Pls.' Ex.4 (Caldwell 11/1/23 Decl.) ¶ 1; Trial Tr. I at 11:6 (Caldwell); (Joint Statement ¶ 4).

12. Dr. Caldwell is currently an assistant clinical professor at Indiana University ("IU") School of Medicine, where she is also a practicing OB/GYN. Trial Tr. I at 8:7-9 (Caldwell); Pls.' Ex.4 (Caldwell 11/1/23 Decl.) ¶¶ 1, 6; (Joint Statement ¶ 4).

13. Before S.B. 1 took effect, Dr. Caldwell performed abortions up to 13 weeks and 6 days LMP at PPGNHAIK's clinics in Indiana. Trial Tr. I at 15:1-12 (Caldwell). She no longer provides abortion care at PPGNHAIK's clinics in Indiana because of the Hospital Requirement but would if allowed to do so. Trial Tr. I at 14:20-25, 16:11-14 (Caldwell); Pls.' Ex.4 (Caldwell 11/1/23 Decl.) ¶¶ 1, 8.

14. Dr. Caldwell has performed some abortions in Indiana since S.B. 1 took effect but, due to fear of prosecution under S.B. 1, has been unable to perform abortions for other patients even when she believed, in her reasonable medical judgment, that those abortions were medically necessary. *See* Trial Tr. I at 40:11-16, 44:14-15, 51:1-4; Pls.' Ex. 12 (Caldwell 2/15/24 Decl.) ¶ 7; Pls.' Ex. 23 (Caldwell Dep.) at 12:5-9, 112:4-12, 189:5-9; (Joint Statement ¶ 5).

15. When Dr. Caldwell has provided abortions pursuant to the Health or Life Exception, at least one other physician employed by the hospital where she performed the abortion has agreed the abortion was permitted under S.B. 1. Pls.' Ex. 12 (Caldwell 2/15/24 Decl.) ¶ 34; Pls.' Ex. 23 (Caldwell Dep.) at 113:17-114:12; (*see* Joint Statement ¶ 6).

16. Dr. Caldwell brings this action on her own behalf and on behalf of her patients.

17. Plaintiffs submitted the testimony of Dr. Amy Caldwell. *See* Trial Tr. I at 5:10-12, 6:25; Pls.' Ex.4 (Caldwell 11/1/23 Decl.); Pls.' Ex.12 (Caldwell 2/15/24 Decl.); Pls.' Ex.23 (Caldwell Dep.).

18. All-Options, Inc. is a not-for-profit corporation incorporated in Oregon that operates a Pregnancy Resource Center in Bloomington. Trial Tr. I at 162:6-8 (Dockray); Pls.' Ex. 7 (Dockray 11/8/23 Decl.) ¶ 1; (Joint Statement ¶ 2).

19. All-Options' Pregnancy Resource Center's Hoosier Abortion Fund provides financial assistance to Indiana residents who need help paying for abortions. Trial Tr. I at 162:10-13 (Dockray); Pls.' Ex. 7 (Dockray 11/8/23 Decl.) ¶¶ 1, 5, 16; (Joint Statement ¶ 2). All-Options provides funding to contribute to the cost of patients' abortions, whether performed in Indiana hospitals or out of state. Pls.' Ex. 7 (Dockray 11/8/23 Decl.) ¶ 16; Pls.' Ex. 19 (Dockray Dep.) at 23:25-24:10, 27:24-28:2, 52:11-18, 133:15-17; (Joint Statement ¶ 3).

20. The Hoosier Abortion Fund receives about one hundred calls per month and maintains records on the number of callers and other information related to the fund's operations. Trial Tr. I at 166:20-167:10 (Dockray).

21. Approximately 5-10% of the callers to the Hoosier Abortion Fund seek an abortion because of a medical condition. Trial Tr. I at 189:14-17 (Dockray). The clinical severity of any health conditions/concerns of these patients is not clear from the record. There is no requirement that a women suffer from any health impairment to access support from the Hoosier Abortion Fund and All-Options has no requirement that women provide the reason they are seeking an abortion; All-Options does not request or require documentation of medical issues from patients before providing Hoosier Abortion Fund support. Trial Tr. I at 188:12-25; 189:1-17 (Dockray).

22. Plaintiffs allege that S.B. 1 has severely hindered All-Options' ability to carry out its mission of providing unconditional, judgment-free support for people navigating pregnancy, parenting, abortion, and adoption and forced the Hoosier Abortion Fund to expend significantly more per client to help Indiana patients obtain care. Pls.' Ex. 7 (Dockray 11/8/23 Decl.) ¶ 15.

23. Since S.B. 1 went into effect, one person who has received financial assistance from the Hoosier Abortion Fund was able to obtain an abortion in Indiana. Trial Tr. I at 180:14-18 (Dockray). All other patients who have received financial assistance from the Hoosier Abortion Fund have traveled out of state to access abortion care. Trial Tr. I at 180:21-180:25 (Dockray). This has nearly doubled All Options' per-person pledge amount (i.e., the amount of funding All Options pledges to each

individual seeking an abortion) and increased the amount of time All-Options' employees spend assisting patients seeking abortions. Trial Tr. I at 183:2-8 (Dockray).

24. All-Options does not have enough funding to provide grants to support every patient who contacts the organization seeking financial support from the Hoosier Abortion Fund. Trial Tr. I at 170:22-171:12 (Dockray). All-Options prioritizes grants for patients over nine-weeks' gestation because those patients tend to have greater difficulty finding a clinic to obtain an abortion. Trial Tr. I at 173:1-2 (Dockray). All-Options received significant additional funding for the Hoosier Abortion Fund following the leak of the *Dobbs* decision and—to a lesser degree—with the passage of S.B. 1. Trial Tr. I at 172:13-24 (Dockray).

25. Before S.B. 1 took effect, All-Options' average pledge was $225 per person, and now it is approximately $450 per person. Trial Tr. I at 183:18-20 (Dockray); Joint Statement ¶ 48. Although the cost of individual pledges has increased, the number of women All-Options has had to turn away has decreased slightly because of fundraising increases post-*Dobbs*. 191:1-18 (Dockray).

26. Hoosiers who rely on the Hoosier Abortion Fund are often low-income, unemployed, and/or uninsured. They often do not have reliable transportation or childcare and face additional financial barriers. Trial Tr. I at 169:7-20 (Dockray).

27. All-Options brings this action on behalf of itself, its staff, and its clients.

28. Plaintiffs submitted testimony of All-Options through Jennifer Parker Dockray, its executive director. Trial Tr. I at 161:20-21 (Dockray); Pls.' Ex. 7 (Dockray 11/8/23 Decl.); Pls.' Ex. 19 (Dockray Dep.).

29. Defendants Members of the Medical Licensing Board of Indiana serve on Indiana's Medical Licensing Board, a state agency responsible for licensing and disciplining certain medical practitioners, including physicians. Ind. Code §§ 25-0.5-3-7, 25-0.5-8-11, 25-0.5-10-17, 25-0.5-11-5, 25-22.5-2-1, 25-22.5-8-6; (*see* Joint Statement ¶ 7).

30. In their official capacities, Members of the Medical Licensing Board of Indiana have the authority to regulate the practice of medicine in Indiana pursuant to Indiana Code § 25-22.5-2-7. This includes the revocation of the medical licenses of physicians who perform abortions in violation of S.B. 1.

31. Defendants County Prosecutors from Hendricks, Lake, Marion, Monroe, Tippecanoe, and Warrick Counties ("Prosecutor Defendants") have the power to enforce S.B. 1's criminal penalties, which include one to six years' imprisonment, as well as fines of up to $10,000 and revocation of physicians' medical licenses. Ind. Code §§ 16-34-2-7; 25-22.5-8-6(b)(2); 35-50-2-6(b).

32. Prosecutor Defendants all have a statutory duty to prosecute felonies and misdemeanors within their respective jurisdictions, including the prosecution of medical providers who perform abortions that Prosecutor Defendants conclude are not permitted under S.B. 1.

II. PLAINTIFFS' CHALLENGE

33. After S.B. 1 was enacted, Plaintiffs challenged the law. Compl. (Aug. 31, 2022). They raised three claims: (1) S.B. 1 violated Article 1, Section 1, because it

violated a substantive due process right to privacy by limiting abortion access; (2) S.B. 1 violated Article 1, Section 23 of the Indiana Constitution because it discriminated against abortion clinics in favor of hospitals; and (3) the gestational age limit in the Health or Life exception was unconstitutionally vague in violation of Article 1, Section 12. *Id.* ¶¶ 58–66.

34. This court granted Plaintiffs a preliminary injunction for their first claim—that S.B. 1 violated Article 1, Section 1 of the Indiana Constitution, because its "restriction of personal autonomy offends the liberty guarantees of the Indiana Constitution." (Order Sept. 22, 2022). It denied Plaintiffs' motion on the second claim and noted that Plaintiffs had withdrawn their third claim. *Id.* at 13.

35. The Indiana Supreme Court granted transfer. (Order Oct. 12, 2022). In June 2023, it held that S.B. 1 did not facially violate a right to abortion protected by Article 1, Section 1. *Planned Parenthood*, 211 N.E.3d at 985.

36. The Supreme Court concluded that Article 1, Section 1 protects certain judicially enforceable rights. *Planned Parenthood*, 211 N.E.3d at 968. To determine what it protects, courts must describe a putative right with an "appropriate level of particularity" and determine "whether the founding generation would have considered the right fundamental. *Id.* at 969. Courts "cannot supplant what the framers and ratifiers believed they were agreeing to with [their] own notions of which aspects of liberty ought to be off limits." *Id.* at 977.

37. Examining "Indiana's long history of generally prohibiting abortion as a criminal act," the Supreme Court held that it was the "common understanding among

Article 1, Section 1's framers and ratifiers" that the General Assembly was "left . . . with legislative discretion to regulate or limit abortion." *Planned Parenthood*, 211 N.E.3d at 978; *see id.* at 981. It explained that "the State's broad authority to protect the public's health, welfare, and safety extends to protecting pre-natal life." *Id.* at 961.

38. The Supreme Court also stated that Indiana law generally permits persons to protect their "own life . . . against imminent death" and "against 'great bodily harm.'" *Planned Parenthood*, 211 N.E.3d at 976. Additionally, the Court held that "Senate Bill 1 is not facially invalid as interfering with a woman's access to care that is necessary to protect her life or health." *Id.* at 977. Any claim that the law infringes a right to abortion "necessary to protect [a woman's] life or to protect her from a serious health risk" in a "particular set of circumstances," the Supreme Court explained, must be resolved in "an as-applied challenge." *Id.* at 976.

39. In vacating the preliminary injunction, the Supreme Court did not reach the "claim that Senate Bill 1's hospital requirements for performing abortions" violate "Article 1, Section 23's Equal Privileges and Immunities Clause." *Planned Parenthood*, 211 N.E.3d at 984. It also did not preclude "Plaintiffs with standing" from pursuing "an as-applied challenge to the State enforcing the law in a particular set of circumstances." *Id.* It remanded for further proceedings consistent with its opinion. *Id.* at 985.

40. Plaintiffs filed an amended complaint on November 9, 2023.[1] This complaint alleges that S.B. 1 violates Article 1, Section 1 of the Indiana Constitution in two ways. First, the amended complaint alleges that S.B. 1 "unnecessarily restricts access to abortion care" because women may want abortions for health reasons "that may not meet the limited exception for serious health risks set out in S.B. 1." (Amend. Compl. ¶¶ 40–41). Second, Plaintiffs allege that the Hospital Requirement increases the cost of abortion and may reduce access to abortion. *Id.* at ¶ 48.

41. Plaintiffs do not allege that any specific patient is or was unable to obtain an abortion under S.B. 1 that was necessary to avert a serious health risk as defined in S.B. 1. However, Plaintiffs present evidence regarding various classes of conditions that they contend constitute serious health risks necessitating abortions that fall outside S.B. 1's exceptions.

42. Plaintiffs moved for a preliminary injunction. *Id.* at 23. This Court consolidated consideration of that motion with a trial on the merits. (*See* Order Dec. 8, 2023); Ind. Tr. R. 65(A)(2). Discovery, briefing, and a three-day bench trial followed.

III. PREGNANCY & MEDICAL TREATMENT

43. Although pregnancy significantly impacts a child's mother, pregnancy is "not a disease." Pls.' Ex. 8 (Wubbenhorst Decl. ¶ 194). It is "a developmental stage

[1] Since the amended complaint was filed, Whole Woman's Health Alliance and Women's Med Group Professional Corporation were voluntarily dismissed as Plaintiffs. *See* Joint Stipulation of Dismissal of Plaintiff Whole Woman's Health Alliance (June 5, 2023); Order (June 6, 2023); Plaintiffs' Motion to Dismiss Women's Med Group Professional Corporation (Feb. 2, 2024); Order (Feb. 5, 2024).

in the continuum of human life." *Id.* Pregnant women's bodies undergo changes, such as a "faster heartbeat," "changes in lung volume," and changes in "blood volume." *Id.* ¶ 100. These changes "are part of pregnancy" and do not require corrective interventions; rather, they "are largely adaptive," designed to ensure a healthy pregnancy and delivery and "are not pathologic in healthy women." *Id.* ¶¶ 98, 100.

44. "[G]enerally speaking," pregnancy "is safe." But it is not as safe as not being pregnant. Tr. Vol. 1, 17:10–12 (Caldwell). Unfortunately, pregnant women can face a variety of health conditions and complications, many of which are directly related to—or significantly exacerbated by—their pregnancy. Tr. Vol. 1, 17:14–20 (Caldwell).

45. Women can suffer from "health conditions that cause extended and debilitating symptoms during the course of a pregnancy; health conditions that may worsen over the course of the pregnancy to eventually become life-threatening; health conditions that may significantly increase the patient's health risks if they remain pregnant or that may significantly increase the patient's future health risk, even after giving birth; and health conditions requiring treatment that would endanger the fetus, meaning that continuing the pregnancy could require forgoing needed treatment." (Am. Compl. ¶ 41); *see* Trial Tr. I at 17:20, 33:5 (Caldwell); Trial Tr. I at 84:15-33, 117:1-23, 119:1-11 (Ralston).

46. The complexity of women's perinatal healthcare cannot be overstated. The range of symptoms, health risks, and treatments for a given disease can vary significantly from patient to patient.

47. Hyperemesis gravidarum is a severe form of nausea and vomiting brought on by pregnancy. Trial Tr. I at 24:12-17 (Caldwell); Trial Tr. I at 117:1-17 (Ralston); Pls.' Ex. 6 (Ralston 11/3/23 Decl.) ¶ 20; Pls.' Ex.23 (Caldwell Dep.) at 84:6-85:1; Pls.' Ex. 8(Wubbenhorst 1/15/24 Decl.) ¶ 163; (Joint Statement ¶¶ 13, 20). The most commonly cited diagnostic criteria for the disease are persistent vomiting not related to other causes, a measure of acute starvation (usually large ketonuria), and some discrete measure of weight loss, most often at least 5% of pre-pregnancy weight. Defs.' Ex. 66 (ACOG Practice Bulletin No. 189) at 1.

48. Hyperemesis gravidarum is the most common indication for admission to the hospital during the first part of pregnancy and is second only to preterm labor as the most common reason for hospitalization during pregnancy. *Id.* at 2.

49. Hyperemesis gravidarum is typically confined to the first trimester but it can occasionally extend into the second trimester, and rarely into the third trimester. Pls.' Ex.22 (Ralston Dep.) at 82:1-3.

50. Hyperemesis gravidarum presents with different degrees of severity in different pregnant patients, and, although rare, it can become life-threatening. Trial Tr. I at 24:18-22 (Caldwell); (Joint Statement ¶¶ 15, 21). Some patients are unable to eat or drink for weeks, if not months, on end, severely limiting their nutritional intake. Trial Tr. I at 24:16-17 (Caldwell); Trial Tr. I at 118:5-7 (Ralston). Severe hyperemesis can cause significant electrolyte abnormalities, cardiac arrhythmias and heart attack, kidney failure, liver damage, and even death. Trial Tr. I at

24:18-22 (Caldwell); Pls.' Ex. 23 (Caldwell Dep.) at 84:6-85:1, 87:21-88:5; (Joint Statement ¶ 21).

51. Patients with hyperemesis gravidarum are at high risk of early delivery and are at risk of infections and blood clots. Trial Tr. I at 118:10-13 (Ralston).

52. The impact of hyperemesis gravidarum on women can be devastating not only physically but also socially and emotionally. Trial Tr. I at 25:15-23 (Caldwell). Although not typically life-threatening, patients with hyperemesis gravidarum may need to be admitted to hospitals for multiple days or weeks. *Id.* (Caldwell). (Joint Statement ¶ 21).

53. Treatments for hyperemesis gravidarum symptoms can vary significantly and can include nonpharmacologic options, pharmacotherapy, hospitalization, tube-feeding, and/or catheterization. Defs.' Ex. 66 (ACOG Practice Bulletin) at 11.

54. Given the significant range of clinical possibilities, it is possible that different patients suffering from hyperemesis gravidarum could qualify for a legal abortion under S.B. 1, a constitutionally protected abortion under the Supreme Court's ruling in *Planned Parenthood*, both, or neither.

55. Deep vein thrombosis is a condition in which potentially dangerous blood clots form in a patient's veins. Pls.' Ex. 22 (Ralston Dep.) at 83:21-84:22. The condition can have different levels of severity, including pulmonary failure and death from thromboembolism. Pls.' Ex. 22 (Ralston Dep.) at 83:21-84:22; Pls. Ex. 17 (Wubbenhorst Dep.) at 249:17-18; (Joint Statement ¶ 26).

56. Pregnancy is a risk factor for deep vein thrombosis. Pls.' Ex. 22 (Ralston Dep.) at 84:1-14; Pls. Ex. 8 (Wubbenhorst Decl.) ¶¶ 165-66; Pls.' Ex. 17 (Wubbenhorst Dep.) at 249:6-8. As Dr. Ralston testified in his deposition, "[i]f you are predisposed to having deep vein thrombosis, being pregnant is going to put you at higher risk." Pls.' Ex.22 (Ralston Dep.) at 84:4-6; see Pls.' Ex.6 (Ralston 11/3/23 Decl.) ¶ 19.

57. Doctors regularly expectantly manage a pregnant patient's deep vein thrombosis through anticoagulation medication (i.e., blood thinners). Pls.' Ex. 22 (Ralston Dep.) at 85:3-6. Most patients with deep vein thrombosis have mild disease that can be managed but a small subset of women suffer from severe embolic disease during pregnancy or in the postpartum period. *Id.* at 88:14-25.

58. Neither induced abortion nor termination of pregnancy are mentioned as a management strategy for deep vein thrombosis in the American College of Obstetricians and Gynecologist's Practice Bulletin on Thromboembolism in Pregnancy. Pls. Ex. 8 (Wubbenhorst 1/15/24 Decl.) ¶¶ 166.

59. Thromboembolic disease is potentially life threatening and accounts for 9% of pregnancy-related deaths. Pls.' Ex.70 (CDC Newsroom Article) at 1.

60. Given the significant range of clinical possibilities, it is possible that different patients suffering from thromboembolic disease could qualify for a legal abortion under S.B. 1, a constitutionally protected abortion under the Supreme Court's ruling in *Planned Parenthood*, both, or neither.

61. Preeclampsia is a disorder of pregnancy associated with new-onset hypertension, which occurs most often after twenty weeks gestation and frequently near term. Defs. Ex. 69 (ACOG Practice Bulletin Number 222) at 1.

62. Preeclampsia presents with different degrees of severity in different women. If untreated, preeclampsia can develop into its more serious form, Hemolysis, Elevated Liver Enzymes and Low Platelets ("HELLP") syndrome and can cause organ damage, stroke, seizures, and death. Trial Tr. I at 30:3-6 (Caldwell); Pls.' Ex. 6 (Ralston 11/3/23 Decl.) ¶ 13; see also Defs. Ex. 69; (Joint Statement ¶¶ 15, 24).

63. Preemclapsia is a progressive disease, and it can be difficult for physicians to predict when the risks presented by preeclampsia may become an emergency. Trial Tr. I at 31:4-11 (Caldwell); Trial Tr. I at 114:14-115:1 (Ralston); see Trial Tr. III at 47:21-23 (Wubbenhorst). Thus, it is consistent with best practices to manage preeclampsia as soon as it is detected, regardless of its severity at the time. Pls.' Ex. 6 (Ralston 11/3/23 Decl.) ¶ 13. Optimal management strategies for preeclampsia can be different depending on clinical maternal and fetal evaluation and gestational age. Defs.' Ex. 69 (ACOG Practice Bulletin Number 222) at 7.

64. Before 37 weeks LMP, doctors may try to manage preeclampsia symptoms by, for example, managing a pregnant person's blood pressure and monitoring for signs and symptoms of worsening disease. Trial Tr. I at 115:2-10 (Ralston); Pls.' Ex. 6 (Ralston 11/3/23 Decl.) ¶ 13; Pls.' Ex. 11 (Ralston 2/15/24 Decl.) ¶ 21; Pls.' Ex. 22 (Ralston Dep.) at 57:16-58:2; Pls.' Ex. 23 (Caldwell Dep.) at 94:13-95:9; DX-1 (Wubbenhorst 1/15/24 Decl.) ¶¶ 139-140, 142-143.

65. Because preeclampsia is a progressive disease, the longer a patient remains pregnant, the worse the preeclampsia will get. Trial Tr. I at 30:7-12 (Caldwell); Trial Tr. I at 114:7-13 (Ralston). As such, expectant management of preeclampsia is not always the safest option. Trial Tr. I at 115:9-21 (Ralston); Pls.' Ex. 11 (Ralston 2/15/24 Decl.) ¶ 21; Pls.' Ex. 22 (Ralston Dep.) at 58:13-22; Pls.' Ex. 8 (Wubbenhorst 1/15/24 Decl.) ¶ 140.

66. When preeclampsia occurs prior to viability, expectant management may not be recommended as a treatment option because it can pose a higher risk to the patient's health and the fetus may be unlikely to survive. Trial Tr. I at 115:9-116:8 (Ralston); Pls.' Ex. 22 (Ralston Dep.) at 58:13-59:4; (Wubbenhorst 1/15/24 Decl.) ¶¶ 139-140, 142-143.

67. Because expectant management is intended to provide neonatal benefit at the expense of maternal risk, expectant management is not advised when neonatal survival is not anticipated. Defs.' Ex. 69 (ACOG Practice Bulletin) at 7.

68. The decision whether to manage a preeclamptic patient expectantly versus moving toward delivery is nuanced. Pls.' Ex. 8 (Wubbenhorst 1/15/24 Decl.) ¶146.

69. Given the significant range of clinical possibilities, it is possible that different patients suffering from preeclampsia could qualify for a legal abortion under S.B. 1, a constitutionally protected abortion under the Supreme Court's ruling in *Planned Parenthood*, both, or neither.

70. Preterm premature rupture of the membranes ("PPROM") occurs when the sac (or amniotic membrane) surrounding the fetus ruptures before the pregnancy is full-term. Pls.' Ex. 6 (Ralston 11/3/23 Decl.) ¶ 16; (Joint Statement ¶ 27); *see also* Defs.' Ex. 68 (ACOG Practice Bulletin). It is a serious condition that places the pregnant woman at increased risk of infection, including "clinically evident intraamniotic infection," which occurs in 15-35% of cases. Pls.' Ex. 6 (Ralston 11/3/23 Decl.) ¶ 16; Pls.' Ex. 11 (Ralston 2/15/24 Decl.) ¶ 23; *see also* Defs.' Ex. 68. If the infection progresses to sepsis (infection in the bloodstream), the risk of severe morbidity (loss of fingers, toes, limbs, or neurologic injury), need for hysterectomy, or mortality becomes quite high. Pls.' Ex. 6 (Ralston 11/3/23 Decl.) ¶ 16.

71. PPROM occurs in approximately 2% to 3% of pregnancies in the United States. Pls.' Ex. 6 (Ralston 11/3/23 Decl.) ¶ 16; *see also* Defs.' Ex. 68 (ACOG Practice Bulletin).

72. Management decisions for PPROM depend on gestational age and evaluation of the relative risks of delivery versus the risks of expectant management when pregnancy is allowed to progress to a later gestational age. Pls.' Ex. 11 (Ralston 2/15/24 Decl.) ¶ 23; *see also* Defs.' Ex. 68. While expectant management is one option for patients with PPROM, it has significant maternal risks. Pls.' Ex.11 (Ralston 2/15/24 Decl.) ¶ 23; *see also* DX-68.

73. The risks of PPROM are especially difficult to manage in the mid-trimester—especially before 24 weeks LMP—because the prognosis for the fetus if the pregnancy continues is usually poor, and, even in the best of circumstances,

uncertain. Trial Tr. I at 48:18-22 (Caldwell); Trial Tr. I at 107:19-108:18, 145:2-10 (Ralston); Pls.' Ex. 6 (Ralston 11/3/23 Decl.) ¶ 16.

74. Delaying treatment when a patient has mid-trimester PPROM can have grave consequences, including maternal sepsis and death. Pls.' Ex. 6 (Ralston 11/3/23 Decl.) ¶ 17.

75. IU Health and Eskenazi hospital systems have provided guidance to their physicians that performing abortion care in certain instances of PPROM fits within the Health or Life Exception and abortions have been provided under these circumstances. Dr. Caldwell has treated patients with PPROM that were transferred from other hospitals that were unable or unwilling to provide abortion care. Pls.' Ex. 4 (Caldwell 11/1/23 Decl.) ¶ 31; Pls.' Ex. 12 (Caldwell 2/15/24 Decl.) ¶ 38.

76. Given the significant range of clinical possibilities, it is possible that different patients suffering from PPROM could qualify for a legal abortion under S.B. 1, a constitutionally protected abortion under the Supreme Court's ruling in *Planned Parenthood*, both, or neither.

77. Plaintiffs present additional evidence regarding a range of other illnesses that they contend implicate constitutionally protected abortions that are prevented by S.B.1. These included but were not limited to diabetes (gestational and preexisting), kidney disease, cancer, cardiovascular disease, molar pregnancy, autoimmune disorders, and obstructive sleep apnea.

78. Sometimes ending a pregnancy is necessary to protect a woman from a serious health risk or from a threat to her life. Tr. Vol. 1, 17:23–18:9 (Caldwell); Tr.

Vol. 3, 17:19–18:10 (Wubbenhorst). There are, however, "very, very few" conditions for which pregnancy is "contraindicated." Caldwell Dep. 69:1–3; Tr. Vol. 1, 23:15–16 (Caldwell). And even for those conditions, both sides' experts agree that abortion is not the only way to manage the condition or even to terminate the pregnancy; early delivery is another option. Pls.' Ex. 23 (Caldwell Dep.) 84:6–24, 86:12–14 (hyperemesis gravidarum); *id.* at 94:24–95:9 (preeclampsia); *id.* at 96:6–11 (peripartum cardiomyopathy); *see also* Tr. Vol. 3, 22:22–23:7 (Wubbenhorst) (describing the American College of Obstetricians and Gynecologists suggested treatments for hyperemesis gravidarum that do not include abortion); Pls.' Ex. 8 (Wubbenhorst Decl.) ¶¶ 137–146 (preeclampsia).

79. In addition to physical health conditions, pregnant patients may face a variety of mental health conditions. Tr. Vol. 2, 11:9–12 (Mittal). These include mood disorders, anxiety disorders, trauma related disorders, substance use disorders, or psychotic disorders. *Id.*

80. Biological, psychosocial, and genetic factors can all affect mental health during pregnancy. *Id.* at 17:2–8 (Mittal); 121:5–7 (Kheriaty).

81. Suicidal ideation "is a symptom that can occur as part of many psychiatric conditions." *Id.* at 13:6–9 (Mittal).

82. Pregnancy is a complex and dynamic time that can impact mental health in a variety of ways, both biologically and psychosocially. Trial Tr. II at 17:1-8 (Mittal).

83. These biological and psychosocial factors can cause new mental health conditions to emerge in pregnant patients, can cause recurrences or exacerbations of previously experienced or current mental health conditions, and can force pregnant patients who take teratogenic medications to manage mental health conditions to face the decision to stop or adjust that medication or to change medications. Trial Tr. II at 17:14-18:4 (Mittal); see also Pls.' Ex.13 (Mittal 2/15/24 Decl.) ¶¶ 11, 15.

84. Pregnant patients may experience a range of severe and debilitating mental health conditions, including anxiety, depressive, and psychotic disorders. See Trial Tr. II at 11:16-18, 13:5-13 (Mittal). The specific symptoms and consequences of these conditions vary by both condition and between specific patients with similar diagnoses. See Trial Tr. II at 18:21-23, 29:1-3 (Mittal).

85. Pregnant patients experiencing severe anxiety disorders may be unable to work or care for themselves or their families and may require in-patient hospitalization. Trial Tr. II at 20:3-7 (Mittal).

86. Pregnant patients experiencing post-traumatic stress disorder ("PTSD") may suffer from nightmares, states of fear, and flashbacks, causing these patients to withdraw from daily life and relationships and possibly engage in self-harm. Trial Tr. II at 20:9-14 (Mittal).

87. Pregnant patients experiencing severe depressive disorder may be unable to function—for example, by being unable to eat or to care for themselves—and can suffer from escalating suicidal ideation, which increases the risk for self-harm and may require hospitalization. Trial Tr. II at 19:18-20:1 (Mittal).

88. Pregnant patients experiencing severe bipolar disorder can experience an exacerbation in the manic pole, causing the patient to become extremely agitated with excess energy, to feel decreased need for sleep, and to engage in very risky behavior that can evolve into psychosis and require psychiatric hospitalization. Trial Tr. II at 19:4-9 (Mittal). Pregnant patients with severe bipolar disorder may also experience an exacerbation of the depressive pole, the risks of which are similar to those for patients experiencing severe depressive disorder. Trial Tr. II at 19:18-20:1 (Mittal).

89. Pregnant patients experiencing severe schizophrenia can experience psychosis characterized by delusions, paranoia, and auditory hallucinations, which can tell the patient to do highly risky things, leading to psychiatric hospitalization and/or increased medication for the patient's safety. Trial Tr. II at 19:11-16 (Mittal).

90. If the aforementioned mental health conditions go untreated, they can significantly worsen throughout pregnancy, and can require psychiatric hospitalization. Trial Tr. II at 21:1-3 (Mittal).

91. Suicidal ideation, which can present alongside any of the aforementioned mental health conditions, can present as thoughts of ending one's life, developing active, specific plans to end one's life, and gathering means to end one's life. Trial Tr. II at 20:16-21 (Mittal).

92. Mental health conditions can also emerge or worsen during the postpartum period, which is a period complicated by many physiologic and biological changes, including abrupt hormonal changes, sleep disturbance, pain, recovery from delivery,

and additional psychosocial changes. Trial Tr. II at 21:13-19 (Mittal); (Joint Statement ¶ 39).

93. Postpartum depression is a major depressive episode in the postpartum period. Trial Tr. II at 21:22-22:2 (Mittal). Symptoms of postpartum depression can emerge during pregnancy and persist into or worsen during the postpartum period. Trial Tr. II at 22:1-5 (Mittal); Pls.' Ex. 5 (Mittal 11/4/23 Decl.) ¶ 11.

94. Individuals experiencing postpartum depression can engage in suicidal or self-harming behavior. Trial Tr. II at 22:11-12 (Mittal). Symptoms such as apathy, low motivation, decreased appetite, and low energy may also significantly impact the individual's ability to care for themselves or others. Trial Tr. II at 22:12-16 (Mittal).

95. Another condition that can emerge in the postpartum period is postpartum psychosis, which is characterized by a confusional state, delusions, paranoia, breaks with reality, potentially dangerous behavior, and can lead to infanticide and suicide. Trial Tr. II at 22:18-22 (Mittal); Pls.' Ex. 5 (Mittal 11/4/23 Decl.) ¶ 14.

96. Patients who have experienced postpartum psychosis in a previous pregnancy face a 20 to 50% chance that it will recur in a future pregnancy. Pls.' Ex. 5 (Mittal 11/4/23 Decl.) ¶ 14; Pls.' Ex. 13 (Mittal 2/15/24 Decl.) ¶ 22; see also Pls.' Ex. 99 at 1791.

97. The risk factors for postpartum mental health conditions include previous mental health conditions (including a perinatal mental health condition from a previous pregnancy), a family history of mental health conditions and adverse perinatal mental health conditions, substance use disorders, and exposure to trauma and

violent relationships. Trial Tr. II at 23:1-7 (Mittal); Trial Tr. II at 125:24-126:4 (Kheriaty); Defs. Ex. 107; *see also* Pls.' Ex. 114 (Royal Colleges Study).

98. Postpartum depression and psychosis pose serious risks to a patient's health, such as self-harm, including suicide, as well as risks to others, including a patient's newborn or other children. Pls.' Ex.5 (Mittal 11/4/23 Decl.) ¶ 32. Pls.' Ex. 5 (Mittal 11/4/23 Decl.) ¶¶ 30, 32.

99. Certain medications can pose developmental risks for an embryo or fetus. Tr. Vol. 2, 23:11–14 (Mittal). These teratogenic medications are sometimes used to manage mental health disorders during pregnancy. *Id.* at 17:23–18:4 (Mittal). Teratogenic medications are not the only way to manage certain mental health conditions during pregnancy. *Id.* at 111:4–13 (Kheriaty). Most doctors avoid teratogenic medications for women of childbearing age, whether or not they are pregnant. *Id.* at 112:20–113:7 (Kheriaty).

100. Doctors routinely adjust patients' medications for a variety of reasons, and this can occur during pregnancy as well. Pls.' Ex. 9 (Kheriaty Decl.) ¶ 14; *see also* Tr. Vol. 2, 113:8–115:6 (Kheriaty) ("[A]lmost every day there's reasons to, to make adjustments to medications . . . . [I]n the vast majority of cases that can be done in a way that's, that's safe.").

101. Due to ethical limitations on study design and the extreme difficulty in controlling for the innumerable confounding factors impacting a person's mental health, the scientific literature presented on the mental health impacts of abortion

does not support definitive factual conclusions regarding abortion's mental health effects for a particular patient or class of patients.

102. The current scientific consensus is that abortion is not a direct treatment for mental health conditions. *Id.* at 109:3–24 (Kheriaty); *see* Pls.' Ex. 28 (Mittal Dep.) 30:22–23.

103. The American College of Obstetricians and Gynecologists has asserted that it is impossible to create an inclusive list of what constitutes a medical emergency, and that creating a finite list is dangerous. Pls.' Ex. 184 (Ruhman Article) at 6.

104. Since S.B. 1's passage, physicians have faced challenges in applying its legal standards and terminology to their practice of medicine. *See* Pls.' Ex.4 (Caldwell 11/1/23 Decl.); Pls.' Ex.12 (Caldwell 2/15/24 Decl.); Pls.' Ex.20 (Ferris-Rowe Depo.) at 34; Pls.' Ex.184 (Ruhman Article).

IV. ABORTION FACILITIES

105. Until S.B. 1 went into effect, clinics performed the vast majority of abortions in Indiana, and they did so in accordance with State law and with minimal complications. *See* Trial Tr. I at 51:15-17 (Caldwell); Pls.' Ex. 113 (National Academies Study) at 23 ("Most abortions can be provided safely in office-based settings."); Pls.' Ex. 167 at 17-18; Pls.' Ex. 168 at 3, 7; Pls.' Ex. 169 at 19; Pls.' Ex. 173 at 4.

106. Complications from medically uncomplex abortion care are rare and can typically be treated in clinics. Trial Tr. I at 97:22-25 (Ralston); Pls.' Ex. 11 (Ralston

2/15/24 Decl.) ¶ 27; Pls.' Ex. 23 (Caldwell Dep.) at 57:1-58:15; Pls.' Ex. 25 (Dudash Dep.) at 144:7-146:12; Pls.' Ex. 45 at 46-47.

107. Prior to S.B. 1, clinics had policies and procedures to safely refer or transfer patients needing higher levels of care. Trial Tr. I at 53:15-20 (Caldwell); Pls.' Ex. 29; Pls.' Ex. 32; Pls.' Ex. 25 (Dudash Dep.) at 73:13-74:8, 109:14-19, 144:7-146:12.

108. Before S.B. 1 went into effect, and consistent with Indiana law, PPGNHAIK provided procedural abortions until 13 weeks and 6 days LMP, using oral medications and local pain medications, not anesthesia. Trial Tr. I at 15:1-17 (Caldwell). Anesthesia is not required to provide abortion care, and, before S.B. 1, patients needing anesthesia to complete a procedural abortion were transferred to hospitals as needed. See Trial Tr. I at 15:13-17, 59:12-17 (Caldwell).

109. Because of the legal limitations on abortions in Indiana, the likelihood that an abortion will be performed at a later gestational age and on a more medically complex patient has increased. *See* Pls.' Ex. 172 (IDOH Terminated Pregnancy Report, Oct. 1-Dec. 31, 2023)(25 of 46 abortions performed this quarter were surgical and 27 (58.6%) were at gestational age of 14 weeks or more; six were conducted utilizing intracardiac injections) *compare* Pls.' Ex. 167 (IDOH Terminated Pregnancy Report 2021)(98.75% of abortions were performed at a gestational age of 13 weeks or less).

110. Hospitals and ambulatory surgical centers are better equipped than clinics to address complications arising from a constitutionally protected abortion implicating a serious health risk. Pls.'s Ex. 8 (Wubbenhorst Decl. ¶ 78); Pls.' Ex. 26 (Cox

Dep. Vol. 2)71:6–24; Pls.' Ex. 20 (Ferries-Rowe Dep.)14:7–15:19. "[W]hile clinics . . . may have plenty of staff who . . . know a lot about what . . . care they provide, they don't have the same type of emergency equipment that a . . . full-fledged hospital would have." Tr. Vol. 2, 91:7–10 (Cox). For example, code carts, which have necessary equipment "for cardiopulmonary resuscitation," *id.* at 91:12–13, are "required in . . . a hospital," but not in a clinic. *Id.* at 91:21–25. This is in part because ambulatory surgical centers and hospitals can perform "more complicated" procedures, including those requiring sedation or anesthesia. *Id.* at 90:9.

111. Similarly, for an abortion in the case of a lethal fetal anomaly, hospitals are more likely than clinics to have genetic counseling, perinatal hospice and/or bereavement counseling services following abortion. Tr. Vol. 3, 36:23–37:25 (Wubbenhorst); Pls.' Ex. 24 (Cox Depo) at 42. And for abortions in the case of rape or incest, hospitals employ trained Sexual Assault Nurse Examiners who can investigate the circumstances leading to the abortion and help women avoid potentially abusive situations. Tr. Vol. 3, 38:4–11 (Wubbenhorst).

112. The cost difference between abortion treatment in a clinic versus a hospital is a significant one. Tr. Vol. 1, 52:21–53:3 (Caldwell). It is unclear from the record what portion of the cost differential—if any—is related to the potentially increased complexity of hospital-based procedures and/or additional services provided in a hospital.

113. Some patients cannot "safely access abortion" in an outpatient setting. Tr. Vol. 1, 56:21–22 (Caldwell). This can include high-risk patients or patients with certain complications. *Id.* at 56:25–58:2 (Caldwell).

114. Abortions performed at higher gestational ages may pose higher risks of complications or require sedation. Tr. Vol. 3, 28:21–25; 32:22–25 (Wubbenhorst). Both Plaintiffs' and Defendants' experts agree that these abortions are more safely performed in a hospital setting. Tr. Vol. 1, 53:6–10 (Caldwell) (sedation); Tr. Vol. 3 36:23–37:8 (Wubbenhorst) (higher gestational age).

115. Hospitals like IU Health and Eskenazi provide physicians with extensive guidance regarding compliance with Indiana abortion laws, including S.B. 1. *See, e.g.*, Defs.' Ex.139, Ex. 141-142, Ex. 149 (documents explaining hospital policies regarding S.B. 1). For example, IU Health provides its physicians with a document that has "frequently asked questions" regarding S.B.1. Tr. Vol. 2, 76:21–77:14 (Cox). IU Health has also put together a "rapid response team" to "deal with urgent [provider] questions regarding . . . termination of pregnancy" under the health or life exception. Tr. Vol. 2, 81:7–10 (Cox). This team has "a clinical expert," "an ethical expert," and "a legal expert," reachable by "a phone number you can call twenty-four seven." Tr. Vol. 2, 81:10–13 (Cox). The hospital encourages physicians to consult its S.B. 1 compliance resources and will defend its physicians against any legal action under S.B. 1 if they follow the hospital's protocols. Tr. Vol. 1, 71:7–8 (Caldwell); Tr. Vol. 2, 77:15–23 (Cox). Though abortions have been performed there since S.B. 1 went into effect, no civil or

criminal actions have been brough against an IU Health physician regarding whether an abortion was legally performed under S.B. 1. Tr. Vol. 2, 78:2–17 (Cox).

CONCLUSIONS OF LAW

I. ABORTION REGULATION & THE LAW OF THE CASE

1. "For all of Indiana's history, abortion has been the subject of state law-making, and to the extent federal courts interpreting the Federal Constitution have permitted, the legislature has generally prohibited abortions except for pregnancies that threaten a woman's life." *Members of Med. Licensing Bd. of Ind. v. Planned Parenthood Great Nw. Haw., Alaska, Ind., Ky., Inc.*, 211 N.E.3d 957, 962 (Ind. 2023), *reh'g denied*, 214 N.E.3d 348 (Ind. 2023)(hereinafter referred to as "*Planned Parenthood*").

2. Indiana's prohibition on abortion originated with its adoption of common law. *Planned Parenthood*, 211 N.E.3d at 962. In 1835, "the General Assembly passed its own statute criminalizing abortion, making it a crime to 'wilfully administer to any pregnant woman, any medicine, drug, substance or thing whatever, or . . . use or employ any instrument or other means whatever, . . . to procure the miscarriage of any such woman, unless the same shall have been necessary to preserve the life of such woman.'" *Id.* (quoting Act of Feb. 7, 1835, ch. XLVII, § 3, 1835 Ind. Acts 66, 66). Shortly after the 1851 Constitution's adoption, "[t]he General Assembly expanded the law . . . by prohibiting a 'druggist, apothecary, physician, or other person selling medicine' from selling any 'medicine . . . known to be capable of producing abortion or

miscarriage, with [the] intent to produce abortion.'" *Id.* (quoting Act of Mar. 5, 1859, ch. LXXXI, § 2, 1859 Ind. Acts 130, 131). In 1881, the General Assembly raised the penalty from a misdemeanor to a felony. *Id.* (citing Act of Apr. 14, 1881, ch. XXXVII, § 22, 1881 Ind. Acts 174, 177). And "[i]n 1905, the legislature enacted a new criminal code and incorporated the 1881 statute." *Id.* at 962–63 (citing Act of Mar. 10, 1905, ch. CXLIX, §§ 367, 368, 1905 Ind. Acts 584, 663–64).

3. After the U.S. Supreme Court declared a federal constitutional right to abortion in *Roe v. Wade*, 410 U.S. 113 (1973), the Indiana General Assembly, "under protest," "revised [state] abortion laws only to comply with 'recent U.S. Supreme Court decisions.'" *Planned Parenthood*, 211 N.E.3d at 963. Indiana's 1973 law allowed abortion at any point during pregnancy when, in a doctor's "professional, medical judgment," an "abortion is necessary to prevent a substantial permanent impairment of the life or physical health of the pregnant woman." Pub. L. No. 322, § 2(c)(2), 1973 Ind. Acts 1740, 1743. In enacting that statute, however, the State "disclaim[ed] any 'constitutional right to abortion on demand' or approval of 'abortion, except to save the life of the mother.'" *Planned Parenthood*, 211 N.E.3d at 963 (quoting Pub. L. No. 322, § 2(c)(2), 1973 Ind. Acts 1740,1740).

4. During the time that federal law limited state authority over abortion, Indiana continued to regulate it to the extent permitted. *Planned Parenthood*, 211 N.E.3d at 963. Those laws included definitions for medical emergencies warranting an abortion and criminal penalties for violating the abortion code. Pub. L. No. 187-1995, 1995 Ind. Acts, pp. 3327–29. Indiana also enacted a prohibition on

"dismemberment abortion[s]" unless reasonable medical judgment dictates that "performing the dismemberment abortion is necessary to prevent any serious health risk to the mother or to save the mother's life." Pub. L. 93-2019, 2019 Ind. Acts 830, 832 (cleaned up) (codified at Ind. Code § 16-34-2-1(c)); *see* Pub. L. No. 93-2019, 2019 Ind. Acts. 830, 830–31 (adding definition of "[s]erious health risk" codified at Ind. Code § 16-18-2-327.9). The General Assembly permitted abortion when, in a doctor's "professional, medical judgment," an "abortion is necessary to prevent a substantial permanent impairment of the life or physical health of the pregnant woman." Pub. L. No. 193-2011, 2011 Ind. Acts, 2776, 2479.

5. In June 2022, the U.S. Supreme Court held that the federal constitution did not confer a right to abortion, overruling *Roe*. *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 231 (2022). Shortly thereafter, the General Assembly enacted S.B. 1. That law, like Indiana's pre-*Roe* statutes, makes abortion a "criminal act" except in certain defined circumstances. Ind. Code § 16-34-2-1(a). Under S.B. 1, abortion is permitted in three circumstances:

6. First, S.B. 1 permits abortions "before the earlier of viability of the fetus or twenty (20) weeks postfertilization age of the fetus" where (i) "reasonable medical judgment dictates that performing the abortion is necessary to prevent any serious health risk to the pregnant woman or to save the pregnant woman's life" or (ii) "the fetus is diagnosed with a lethal fetal anomaly." Ind. Code § 16-34-2-1(a)(1). A "serious health risk" is one "that has complicated the mother's medical condition and necessitates an abortion to prevent death or a serious risk of substantial and irreversible

physical impairment of a major bodily function," but "does not include psychological or emotional conditions." § 16-18-2-327.9. Only hospitals and ambulatory surgical centers may perform abortions under that exception. § 16-34-2-1(a)(1)(B).

7. Second, S.B. 1 permits abortions "at the earlier of viability of the fetus or twenty (20) weeks of postfertilization age and any time after" where "necessary to prevent any serious health risk to the pregnant woman or to save the pregnant woman's life." Ind. Code § 16-34-2-1(a)(3). Because those abortions are performed later in the pregnancy, S.B. 1 imposes some additional requirements. Those include that the abortion be "performed in a hospital" and be "performed in compliance with" Indiana Code § 16-34-2-3. § 16-34-2-1(a)(3)(C)–(D). Indiana Code § 16-34-2-3, in turn, requires the presence of a second physician who is prepared to provide care for any "child born alive as a result of the abortion." § 16-34-2-3(b); *see* § 16-34-2-3(a), (c)–(d).

8. Third, S.B. 1 permits abortions "during the first ten (10) weeks of post-fertilization age" where the pregnancy arose from rape or incest. Ind. Code § 16-34-2-1(a)(2). Only hospitals and ambulatory surgical centers may perform those abortions. § 16-34-2-1(a)(2)(C).

9. Physicians who perform abortions that do not fall within the exceptions of S.B. 1 are subject to prosecution. Performing an abortion outside S.B. 1's exceptions constitutes a Level 5 felony punishable by one to six years' imprisonment, as well as a fine of up to $10,000 and revocation of the physician's medical license. Ind. Code §§ 16-34-2-7; 25-22.5-8-6(b)(2); 35-50-2-6(a), (b).

10. Physicians are also subject to mandatory license revocation absent a criminal prosecution if, "after appropriate notice and an opportunity for a hearing, the attorney general proves by a preponderance of the evidence that the physician performed" an unlawful abortion "with the intent to avoid the requirements of" providing a legal abortion under the law. Ind. Code § 25-22.5-8-6(b)(2).

II. COUNT I—CONSTITUTIONALITY OF HEALTH OR LIFE EXCEPTION AS APPLIED TO PLAINTIFFS & THEIR PATIENTS

11. Plaintiffs have requested that the Court grant pre-enforcement injunctive relief for themselves and their patients suffering from a non-exhaustive list of illnesses that fit into broad general categories. Although the Plaintiffs have identified numerous serious diseases (including serious mental illnesses) that present a huge range of hypothetical clinical scenarios, Plaintiffs have not identified a situation in which S.B. 1 would prohibit an abortion protected by Article 1, Section 1 of the Indiana Constitution and accordingly, injunctive relief is not appropriate.

12. In *Planned Parenthood*, our Indiana Supreme Court enshrined constitutional protection under Article 1, Section 1 for abortions "necessary" to "protect a woman's life or to protect her from a serious health risk." *Planned Parenthood*, 211 N.E. 3d at 976–77.

13. The Supreme Court did not "establish the precise contours" of this protection nor did it determine a specific test under which to assess the availability of constitutionally protected abortion. In essence, the amount of health risk the Indiana General Assembly may constitutionally require women in Indiana to tolerate in

pregnancy and childbirth remains an open question subject to review through as-applied challenges. *Planned Parenthood*, 211 N.E.3d at 976. However, the decision does make that clear that to enjoy constitutional protection, an abortion must be "necessary" to protect life or health of the woman and the health risk posed to the woman must be either life-threatening or "serious." *Id.* The Court also provided that in asking whether an abortion is "necessary" or a health risk is "serious," we cannot simply ask what these terms mean "in a colloquial sense." *Id.* at 978. "Rather, [this Court's] task is to discern the contours of constitutionally protected liberty as Section 1's framers and ratifiers understood them." *Id.*

14. Plaintiffs have not shown that the Health or Life Exception prohibits any constitutionally protected abortion. On its face, S.B. 1 allows abortion whenever "reasonable medical judgment dictates that performing the abortion is necessary to prevent any serious health risk to the pregnant woman or to save the pregnant woman's life." Ind. Code § 16-34-2-1-(a)(1)(A)(i). It defines a "serious health risk" as situations where an issue "has complicated the mother's medical condition and necessitates an abortion to prevent death or a serious risk of substantial and irreversible physical impairment of a major bodily function." § 16-18-2-327.9.

15. The statutory definition of "serious health risk" has presented significant challenges for physicians who have been in the incredibly unenviable position of providing exigent obstetrical care in a politically charged environment and under a new statutory regime that includes potential criminal liability and license revocation. However, this definition does not require physicians to wait until a woman is

clinically unstable to provide care. S.B.1's Health or Life Exception permits abortion where the treating physician's "reasonable medical judgment" is that a woman would face a serious risk within the meaning of S.B. 1.

16. Plaintiffs understandably argue there could be situations in which a physician might want to perform an abortion that falls outside of the Health or Life Exception. But they have not identified a specific situation in which the abortion would *both* fall outside any of S.B. 1's exceptions *and* be "necessary" to guard against a serious health risk protected under *Planned Parenthood*. Tr. Vol. 1, 64:6–11 (Caldwell); *see also* Tr. Vol. 2, 13:23–24 (Mittal); Tr. Vol. 3, 18:18–20.

17. Consider the conditions discussed at trial. Depending on a patient's situation, hyperemesis gravidarum may be treated with dietary changes, ginger supplements, or oral anti-nausea medications. Tr. Vol. 1, 25:1–14 (Caldwell). Defs.' Ex. 66 (ACOG Practice Bulletin No. 189) at 6, 9-10. Preeclampsia can be treated with anti-heparin medications, frequent blood tests, and/or expectant management. Tr. Vol. 1 at 115:7–16 (Caldwell). Gestational diabetes may be treated with nutrition therapy, exercise therapy, or medications. *Id.* at 32:12–16. However, some patients may require more significant medical interventions, and if so, Indiana doctors are not limited to these options if a woman's life is at risk or if she faces a serious health risk "that has complicated [her] medical condition and necessitates an abortion to prevent death or a serious risk of substantial and irreversible physical impairment of a major bodily function." Ind. Code § 16-18-2-327.9. In these circumstances, doctors may perform abortions.

18. The only types of conditions that are categorically excluded under S.B. 1's exceptions are mental and emotional conditions. Plaintiffs have presented compelling evidence regarding the serious nature of mental illness for perinatal women, but they have not shown that these conditions constitute serious health risks implicating a constitutionally protected abortion right as established by *Planned Parenthood* or that abortion is a "necessary" treatment for mental and emotional conditions.

19. Plaintiffs have not shown that there is a single mental health concern that must be treated with abortion. Plaintiffs' own witnesses explained that mental health conditions during pregnancy vary widely in kind and severity, Pls.' Ex. 28 (Mittal Dep.) 72:5–6, and can be treated in a variety of ways. *See* Pls.' Ex. 23 (Caldwell Dep.) 140:17–141:16, 143:21–144:2 (explaining non-abortion treatments for mental health concerns); Pls.' Ex. 28 (Mittal Dep.) 173:15–17 (treatments for certain bipolar disorders "can be provided with monitoring and vigilance around the emergence of risk" to pregnant women). But Plaintiffs have not identified a specific scenario where abortion would be necessary to treat a serious mental health condition.

20. Plaintiffs' own expert testified that the treatment for acute mental health concerns (like suicidal ideation) is "acute psychiatric treatment," not abortion. Pls.' Ex. 28 (Mittal Dep.) 183:15–16. In her own clinical practice, Mittal "never proactively recommends abortion as a treatment for mental health issues." Tr. Vol. 2, 38:8–9. Mittal "can't be sure that [a] person's [mental] health situation would have been different if she had had an abortion." Tr. Vol. 2, 48:7–9 (Mittal).

21. Plaintiffs also argue that the exclusion of mental health from S.B. 1's definition of "serious health risk" means that women will be unable to take certain teratogenic medications. S.B. 1 does not categorically ban teratogenic medications for pregnant women. Plaintiffs' and Defendants' experts agree that "scenarios are very individualized and unique to a particular patient and their clinical context," Tr. Vol. 2, 59:22–60:2 (Mittal); *see also id.* at 110:22–111:13 (Kheriaty) (discussing alternatives to teratogenic medication); 158:12–25 (discussing treatment options other than teratogenic medication and how to reduce risk from using teratogenic medications during pregnancy).

22. Plaintiffs presented significant compelling evidence regarding the state of healthcare for women in Indiana. This evidence included concerning data about healthcare deserts (women in a large swath of Indiana have no birthing care within a thirty-minute drive) Pls.' Ex. 170 (IDOH Maternal Mortality Annual Report) at 16; and the fear and frustration Hoosier OBGYNs have expressed regarding S.B. 1's impacts on patient care and their own ability to practice medicine. Pls.' Ex.184 (WFYI Article) at 3-6; Tr. Vol. 1, 37:1–43:3 (Caldwell). Although compelling, the Court is not tasked with determining the wisdom of S.B. 1. Rather, the Court limits its analysis to whether S.B. 1 prevents patients from exercising a constitutional right to protect themselves against serious health risks by materially burdening access to abortions necessary to address that risk. Plaintiffs have not shown that S.B. 1 does so as to any individual patient or in any well-defined instance sufficient to support an as-applied challenge.

23. As part of their claim under Article 1, Section 1, Plaintiffs additionally argue that S.B. 1's definition of "serious health risk" is "uncertain" or "vague" and "chills" access to abortion. (Pls.' Br. at 23–24, Nov. 9, 2023); *see also* Tr. Vol. 1, 74:13–20 (Caldwell) (describing situations where it "wasn't clear that [the patient] was absolutely covered"); *id.* at 111:10–12 (Ralston) ("I find the language to be vague"). But this argument is insufficient to enjoin enforcement of S.B. 1 for several reasons.

24. First, in the Amended Complaint, Plaintiffs did not bring a claim that S.B. 1 violates the Due Course of Law Clause or notions of due process because of its vagueness. Plaintiffs only alleged a violation of Article 1, Section 1. (Amend. Compl. 23–24). But Plaintiffs do not attempt to show how Article 1, Section 1 prohibits against laws that "chill" conduct.

25. Outside the First Amendment context, vagueness principles only require a statute to provide "'fair warning' as to what conduct will subject a person to liability." *Karlin v. Foust*, 188 F.3d 446, 458 (7th Cir. 1999); *see Morales v. Rust*, 228 N.E.3d 1025, 1049 (Ind. 2024). This means that a court need not "worr[y] about the periphery" of a statute; it need only ask whether the statute has a "substantial, understandable core." *Trustees of Ind. Univ. v. Curry*, 918 F.3d 537, 540 (7th Cir. 2019). One party's "uncertain[ty]" about what a law means, even if there are multiple "permissible readings," cannot make a law unconstitutionally vague if the courts can discern its meaning. *Pulsifer v. United States*, 601 U.S. 124, 152 (2024).

26. S.B. 1's text has a core. It prohibits abortion unless, in a doctor's "reasonable medical judgment, a condition exists that has complicated the mother's

medical condition and necessitates an abortion to prevent death or a serious risk of substantial and irreversible physical impairment of a major bodily function." Ind. Code 16-18-2-327.9; *see* § 16-34-2-1(a). Practitioners regularly use the "reasonable medical judgment" standard. Tr. Vol. 1, 43:7–14 (Caldwell) (uses reasonable medical judgment "every day"); *id.* at 111:19–20 (Ralston) ("[E]very day I deal with doctors who are using reasonable medical judgment"). And while Plaintiffs assert that it is not always clear what meets the exception, that does not demonstrate a core is absent. *See Planned Parenthood of Ind. & Ky., Inc. v. Marion Cnty. Prosecutor*, 7 F.4th 594, 604 (7th Cir. 2021).

27. Secondly, Plaintiffs have previously performed abortions under definitions similar to S.B. 1's life and health exception. S.B. 1's exception is borrowed from other statutes that predated its enactment. From 1993 to 2022, Indiana law permitted abortions post-viability if, "in the attending physicians' professional, medical judgment" the abortion was "necessary to prevent a substantial permanent impairment of the life or physical health of the pregnant woman." Ind. Code 16-34-2-1(3)(C) (1993). Doctors, including a Plaintiff in this case, performed abortions under that standard, Pls.' Ex. 23 (Caldwell Dep.) 40:3–18; *see also* Tr. Vol. 1, 72:8–74:3 (Caldwell). Similarly, prior to S.B. 1, Indiana prohibited "dismemberment abortion[s] unless reasonable medical judgment dictates that performing the dismemberment abortion is necessary to prevent any serious health risk to the mother or to save the mother's life." Pub. L. 93-2019, 2019 Ind. Acts p. 832. Doctors in Indiana have performed abortions under that exception too. *See* Tr. Vol. 1, 72:8–74:3 (Caldwell).

28. Lastly, the record in this case demonstrates that medical professionals have proven themselves able to understand and apply the Health and Life Exception's requirements. Since S.B. 1 took effect, Caldwell performed abortions for reasons related to life and health. Pls.' Ex. 23 (Caldwell Dep.) 114:3–115:5; 127:22–24; Tr. Vol. 1, 50:15–18 (Caldwell). Indiana hospitals have developed guidance, procedures, and appropriate consultations to ensure that doctors can perform abortions permitted by S.B. 1. Tr. Vol. 1, 41:8–11 (Caldwell)(describing IU hospital review system); Tr. Vol. 2, 83:10 (Cox) (same); *see also* Defs. Exs. 139, 141, 142, 149 (documents explaining hospital policies regarding S.B. 1). And in every situation in which Caldwell has performed an abortion permitted by S.B. 1, at least one other Maternal Fetal Medicine Specialist agreed it was appropriate. Tr. Vol. 1, 70:7–10, 71:13–16 (Caldwell).

29. The Court acknowledges the Provider Plaintiffs' concerns about applying the statute in the clinical setting and the apprehension S.B. 1's penalty provision causes. The most significant challenge physicians seem to face in applying the Health or Life Exception of S.B. 1, is the legislation's failure to account for the individual risk tolerance of physicians and patients, which would be a usual consideration in medical decision making. However, Plaintiffs provide no sufficiently specific clinical situation for the Court to analyze. Indiana precedent further supports the conclusion that an as-applied vagueness challenge pointing to hypothetical clinical situations of unknown, unidentified patients with insufficient detail surrounding the circumstances and diagnoses will not support a conclusion that a statute is unduly vague. *See*

Duncan v. State, 975 N.E.2d 838, 845 (Ind. Ct. App. 2012); *Price v. State*, 911 N.E.2d 716, 720 (Ind. Ct. App. 2009).

30. Based upon the foregoing, the evidence presented does not support permanent injunctive relief as to Plaintiffs' as-applied, Article 1, Section 1 challenge to the Health or Life Exception.

III. COUNT II—CONSTITUTIONALITY OF THE HOSPITAL REQUIREMENT

A. Article, Section 1 Material Burden Analysis

31. Plaintiffs' second claim is that S.B. 1's requirement that abortions be performed in hospitals and ambulatory surgical centers violates Article 1, Section 1 by erecting barriers to abortion. (Amend. Compl. at ¶ 4).

32. Legislative enactment or government regulation is unconstitutional if it imposes a material burden on a fundamental right that constitutes a core constitutional value. *Clinic for Women v. Brizzi*, 837 N.E.2d 972, 983 (Ind. 2005).

33. Plaintiffs have not shown that the Hospital Requirement has "materially burden[ed] one of the core values which [the Constitution] embodies." *Price v. State*, 622 N.E.2d 954, 960 (Ind. 1993). The Supreme Court has previously held that, even if a broad right to abortion exists, that right is not materially burdened by a state law that may adversely affect "some unknown number of women" by causing them to "(i) delay obtaining abortions, (ii) travel to other states to obtain abortions, (iii) carry pregnancies to term, or (iv) seek alternatives to legal abortions." *Brizzi*, 837 N.E.2d at 981; *see also State v. Economic Freedom Fund*, 959 N.E.2d 794, 807 (Ind. 2011) (additional costs did not create a substantial obstacle to "engag[ing] in political

expression"). Consistent with Supreme Court precedent, the Court concludes that increased cost of care or travel on an unknown or hypothetical patient does not constitute a material burden on seeking abortion care. *See Brizzi*, 837 N.E.2d at 981.

34. To succeed on their facial challenge, Plaintiffs must prove there is *no* instance in which the Hospital Requirement is constitutional. In other words, Plaintiffs must show that in every instance, the Hospital Requirement materially burdens the core constitutional right of women to seek abortion when it is necessary to prevent death or a serious health risk. *Planned Parenthood*, 211 N.E.3d at 965. Plaintiffs acknowledge that women who have a variety of medical complications could require hospital-based care. Caldwell Dep. 51:14–19. Plaintiffs also acknowledge there are women who categorically cannot "safely access abortion care in the outpatient setting." Tr. Vol. 1, 56:21–22 (Caldwell); *see also id.* at 53:6–10, 56:25–58:2 (Caldwell) (any abortion requiring sedation should be performed in a hospital). The record contains evidence of many classes of patients for whom the Hospital Requirement does not materially burden their right to seek abortion and accordingly a facial challenge is defeated.

35. As to their as-applied Article 1, Section 1 challenge to the Hospital Requirement, Plaintiffs have not shown that the Hospital Requirement has prevented or materially burdened any woman, or class of women, in obtaining an abortion necessary to save her life or protect her from a serious health risk. *See Planned Parenthood*, 211 N.E.3d at 976.

36. Material burden analysis does not involve weighing nor is it influenced by the social utility of the state action at issue. *City Chapel Evangelical Free, Inc. v. City of South Bend*, 744 N.E.2d 443, 447 (Ind. 2001)(citing *Price*, 622 N.E.2d at 960). We look only at the magnitude of the impairment. If the right, as impaired, would no longer serve the purpose for which it was designed, it has been materially impaired. *Brizzi*, 837 N.E.2d at 983.

37. Here, the core constitutional value at stake under our Article 1, Section 1 analysis, is a woman's ability to access an abortion when she faces death or a serious health risk. The Hospital Requirement is constitutionally impermissible if it imposes a material burden on a woman's ability to do so. Plaintiffs allege increased costs and travel associated with the Hospital Requirement create substantial barrier to constitutionally protected abortion access for women facing serious health risks.

38. The evidence does not support this contention. As mentioned, the Court has no well-defined class of women or clinical circumstances to consider, but even with that limitation, the evidence demonstrates that many women receiving abortion care when they are seriously ill or at risk of becoming seriously ill will likely be receiving in-hospital care irrespective of the Hospital Requirement. Many of the serious diseases caused by pregnancy present mid or late-term when abortion care becomes more invasive and complex. Requiring a procedure to occur at a medical facility where it would be likely to occur absent the legislation is not substantial obstacle.

39. The record shows that the Hospital Requirement clearly increases the cost, and the potential travel required for abortion care. Tr. Vol. 1, 186:14–23

(Dockray). But that is not enough to show that the Hospital Requirement is impermissibly burdensome to a core constitutional value. Even assuming all women seeking abortion care will face economic hardship in doing so, a law does not violate the Constitution solely because it directly or indirectly results in economic hardship. *Brizzi*, 837 N.E.2d at 981.

B. Rational Basis Analysis as to Rape, Incest, & Lethal Fetal Anomaly Hospital Requirement

40. S.B. 1 also allows abortion in cases of rape, incest, and lethal fetal anomalies. Plaintiffs do not assert there is a stand-alone constitutional right to abortion in those situations and none was identified by the Indiana Supreme Court in *Planned Parenthood*. As such, the legislature may limit these procedures in any fashion that is rationally related to a legitimate governmental purpose. *See Hawkins v. State*, 973 N.E.2d 619, 622 (Ind. Ct. App. 2012).

41. The Hospital Requirement is not arbitrary and bears a rational relationship to the legitimate governmental objectives of protecting maternal health and preserving fetal life. As mentioned above, Plaintiffs concede many women have health conditions and complications that necessitate hospital-based abortion care and that there are women who cannot "safely access abortion care in the outpatient setting" due to complications. Tr. Vol. 1, 56:21–22; 51:14–19 (Caldwell). It is likely that many of the legal abortions sought under S.B. 1's exceptions will be in these higher risk situations in which hospital-based care is necessary.

42. It is reasonable to require women seeking abortions for lethal fetal anomalies to do so at a hospital because those procedures are often done at a higher gestational age and carry a greater risk for complications. Tr. Vol. 3, 37:1–8 (Wubbenhorst). Hospitals are prepared to provide the counseling and bereavement care some women desire when undergoing an abortion procedure because of a lethal fetal anomaly. *Id.* at 37:8–12 (Wubbenhorst). It is also reasonable to require abortions in instances of rape and incest to take place in a hospital because hospitals have specially trained staff members who can investigate the circumstances leading to the abortion and help women avoid potentially abusive situations. *Id.* at 38:7–11 (Wubbenhorst).

43. Finally, as this Court has previously observed, it is rational for the legislature to require abortions to be performed in hospitals and ambulatory surgical centers because the Indiana Department of Health must separately monitor and inspect Indiana abortion clinics. Order at 12–13 (Sept. 22, 2022). Ending this increased burden on the State (of "maintaining a separate licensing and inspection regime") is "a legitimate and reasonable rationale" for the Hospital Requirement. *Id.* at 13.

44. For all these reasons, the Hospital Requirement survives the less exacting scrutiny of rational basis review.

III. CONCLUSION

45. To summarize, Plaintiffs have not shown a that S.B. 1 materially burdens the rights of any specific patient or well-defined class of patients to access constitutionally protected abortion care. Significant and compelling evidence regarding

the policy implications of S.B. 1—and its effect on medical professionals in particular—was presented. However, the Court cannot substitute its own policy preferences for that of the Indiana General Assembly and the Court limits its examination to the General Assembly's constitutional authority post-*Planned Parenthood*. Plaintiffs have not shown an instance where an abortion is *necessary* to treat a serious health risk but would also fall outside of the Health and Life Exception. Additionally, Plaintiffs have not demonstrated that the Hospital Requirement is materially burdensome to constitutionally protected abortion access, nor that it fails rational basis review as to statutorily authorized (but not constitutionally protected) abortions.

IT IS THEREFORE ORDERED that Plaintiffs' motion for permanent injunction is DENIED and judgment is entered for Defendants.

Dated: 9/11/2024

Hon. Kelsey B. Hanlon, Special Judge
Monroe Circuit Court

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