IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE, *et al*., Plaintiffs, v. GREG ABBOTT, in his official capacity as Governor of Texas, *et al*., Defendants.	No. 1:20-cv-00323-LY

SUPPLEMENTAL MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

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INTRODUCTION

Plaintiffs (collectively, "Providers") submit this supplemental memorandum of law in support of their motion for a preliminary injunction. On April 17, 2020, Governor Greg Abbott issued Executive Order GA-15, "Relating to hospital capacity during the COVID-19 disaster," which supersedes the prior Executive Order as of 11:59 P.M. on April 21, 2020. *See* Ex. 21, attached hereto. Executive Order GA-15 largely incorporates the terms of Executive Order GA-09,[1] which Defendants have interpreted to prohibit virtually all abortion in Texas for the Order's duration. However, GA-15 establishes the following exception:

> any surgery or procedure performed in a licensed health care facility that has certified in writing to the Texas Health and Human Services Commission both: (1) that it will reserve at least 25% of its hospital capacity for treatment of COVID-19 patients, accounting for the range of clinical severity of COVID-l9 patients; and (2) that it will not request any personal protective equipment from any public source, whether federal, state, or local, for the duration of the COVID 19 disaster.

Providers believe that they meet this exception, and therefore that Executive Order GA-15 has no application to them. Providers' licensed health care facilities do not have any hospital capacity, and Providers do not intend to request personal protective equipment ("PPE") from any public source for the duration of the COVID-19 disaster. Providers will submit certifications to the Texas Health and Human Services Commission to that effect.

[1] The Texas Medical Board's amendment to 22 Tex. Admin. Code § 187.57 incorporates the terms of GA-09 and remains in effect through July 20, 2020. Plaintiffs' Motion for a Preliminary Injunction challenges that rule together with GA-09. To the extent Defendants intend to interpret and enforce the rule consistent with their interpretation of GA-09 and inconsistent with GA-15's new exception, Plaintiffs maintain their request for a preliminary injunction against that enforcement. Throughout this brief, references to the "Executive Orders" include the rule.

Providers have attempted to meet and confer with counsel for Defendants to confirm that their licensed facilities qualify for this exception by emails to Defendants yesterday and today, but do not have a response that clarifies Defendants' position.[2] Accordingly, the need for preliminary injunctive relief persists as long as Defendants continue their efforts to ban nearly all abortions during the COVID-19 pandemic through application of Governor Abbott's March 22, 2020, Executive Order GA-09 and GA-15 (collectively, "Executive Orders"). A preliminary injunction is urgently needed: every day that the Executive Orders prevent Texas residents from obtaining in-state abortion care, Providers, their patients, and the public health suffer irreparable harm.

STATEMENT OF FACTS[3]

A. Provision of Abortion Care in Texas.

Twenty-four outpatient facilities in Texas were providing abortion before the pandemic. White Decl. ¶ 12. Sixteen are licensed abortion facilities ("clinics"), and eight are ambulatory surgical centers ("ASCs"). *Id.* The clinics are located in or near Austin; Dallas; Fort Worth; El Paso; Houston; McAllen; San Antonio; and Waco. *Id.* ¶ 13. Only six of the eight ASCs—those in Austin, Dallas, Houston, and San Antonio—provide abortion after eighteen weeks LMP. *Id.* ¶¶ 16–

[2] Defendants' response states in relevant part "OAG has no role in receiving, processing, or ruling upon certifications submitted under GA-15 and cannot confirm...whether any specific facility complies with GA-15's certification requirement." *See* Ex. 22, attached hereto. This response provides no information on the position of Defendant Wilson, Acting Executive Commissioner of the Texas Health and Human Services Commission, to which the required submissions must be submitted, or of the other Defendants charged with enforcement of the Executive Orders.

Providers respectfully request the opportunity to supplement these filings with additional argument and evidence if Defendants take the position that GA-15's exception does not apply to Provider Plaintiffs' facilities, as this would implicate additional issues not addressed herein.

[3] A complete list of all testimony and briefing that Providers are designating is set forth in Appendix A, attached hereto.

17. In the most recent year for which data are available, only two-tenths of a percent (0.2%) of Texas abortions were performed in hospitals. *See* Ex. 40, attached hereto.

After ten weeks of pregnancy as measured from the first day of their last menstrual period ("LMP"), patients are not eligible for medication abortion in Texas; but must have procedural abortions. *See* Tex. Health & Safety Code § 171.063(a)(2). Early procedural abortions are performed using aspiration. Starting around twelve to thirteen weeks LMP, abortion requires same-day cervical preparation, which requires several hours in the health center. Schutt-Aine 2d Decl. ¶ 30. Beginning at fourteen to sixteen weeks LMP, procedural abortion is provided by D&E rather than aspiration. *Id.* ¶¶ 16, 39. Between approximately fifteen and eighteen weeks LMP, patients must have two-day rather than single-day D&E procedures. Braid Decl. ¶ 9; Schutt-Aine 2d Decl. ¶ 34. At eighteen weeks LMP, patients must seek abortion care at ambulatory surgical centers ("ASCs") or hospitals. *See* Tex. Health & Safety Code § 171.004. Texas prohibits abortion, absent exceptional circumstances, beginning at twenty-two weeks LMP. *See* Tex. Health & Safety Code § 171.044.

B. Burdens on Abortion Access Imposed by the Executive Orders.

As interpreted by Defendants, the Executive Orders function as a six-week long abortion ban. As a result, Texas residents with means to travel are leaving the State in droves to obtain abortion care. *See* Boyd Decl. ¶¶ 6, 8–9; Doe Decl. ¶¶ 15–22; Ferrigno 2d Decl. ¶¶ 5–6; Hagstrom Miller 2d Decl. ¶ 6; Johnson Decl. ¶¶ 8–10; Jones Decl. ¶ 15; Lamunyon Sanford Decl. ¶¶ 16–18; Moe Decl. ¶ 18; Nguyen Decl. ¶ 17; Schalit Decl. ¶¶ 15–16; Ward Decl. ¶¶ 12–14. Those unable to travel out of state are forced to wait as their pregnancies progress.

Texas abortion providers expect to have substantial backlogs when the Executive Orders expire. *See, e.g.*, Dewitt-Dick 2d Decl. ¶ 9 (one-month cessation will result in a backlog of approximately 800 patients); *id.* ¶ 11 (it will take two months to resolve backlog, pushing

additional patients past the legal limit in Texas); *see also* Ferrigno Decl. ¶ 29; Hagstrom Miller Decl. ¶ 29; Johnson Decl. ¶ 12; Nguyen Decl. ¶ 23; White Decl. ¶¶ 21, 27. Combined with social-distancing policies that reduce patient volume, *see* Ferrigno 2d Decl. ¶ 4; Hagstrom Miller 2d Decl. ¶ 4; Schutt-Aine Decl. ¶ 30, and Texas laws that delay abortion access during normal times,[4] those backlogs will inevitably prevent some people from obtaining an abortion in Texas for at least another one to two weeks. Clinics in neighboring states are experiencing long wait-times for appointments due to the influx of Texas patients. Boyd Decl. ¶ 9.

The Executive Orders impose heavy burdens both on those who are able to travel out of state to access abortion and those who must wait in Texas until the ban is lifted. These burdens generally fall into the following categories: (1) increased health risks; (2) physical discomfort, emotional distress and loss of privacy; (3) travel-related burdens; (4) economic costs; (5) increased safety risks; and (6) forced childbirth. Many of these burdens compound one another.

1. *Increased health risks.*

Those who must wait weeks to access abortion care face increased health risks, whether they remain pregnant or are able to have a later abortion. The risks of pregnancy and abortion increase with gestational age. Macones Decl. ¶ 8; Schutt-Aine Decl. ¶ 22. Similarly, while very low, risk of major complications—those requiring hospital admission, surgery, or blood transfusion—from abortion is approximately 2.5 times greater in the second trimester than in the first. Schutt-Aine 2d Decl. ¶¶ 26–27. Some people unable to access abortion in a healthcare setting will turn to unsafe methods to end their pregnancies. Levison Decl. ¶ 11; Roe ¶ 15.

[4] Texas' mandatory waiting period law, Tex. Health & Safety Code § 171.012(a)(4), (b), for example, delays abortion access for many Texans. Jones Decl. ¶ 12.

Those who must travel long distances to obtain abortion care also face increased health risks—they are at higher risk of contracting and spreading COVID-19. Bassett Decl. ¶¶ 7–8; Schutt-Aine ¶ 37; Sharfstein 2d. Decl. ¶ 10. One woman approaching the gestational limit for medication abortion described making a hazardous twelve-hour drive from Arlington, Texas, to Denver, Colorado, to access that care. Doe Decl. ¶¶ 12, 15–16; *see also id.* at ¶ 25.

2. *Physical discomfort, emotional distress, and loss of privacy.*

Individuals denied access to abortion must continue to cope with pregnancy-related physical symptoms, such as severe nausea and vomiting, shortness of breath, frequent urination and dizziness, and conditions exacerbated by pregnancy, such as hypertension, diabetes, kidney disease, autoimmune disorders, and asthma. Schutt-Aine 2d Decl. ¶¶ 6, 8; Bennett Decl. ¶ 25; Hagstrom Miller Decl. ¶ 33. They must also endure not knowing when—or if—they will be able to obtain an abortion, which is "devastat[ing]," Hagstrom Miller 2d Decl. ¶ 6. *See also* Bennett Decl. ¶ 22; Nguyen Decl. ¶ 13. Those who want to keep their pregnancy private must struggle to conceal their pregnancies for a longer period of time. Doe Decl. ¶ 6 (individual did not want prospective employers to know she was pregnant); Ferrigno 2d. Decl. ¶ 6. Revealing a pregnancy may also put individuals with abusive partners or family at risk of harm. *See infra* at 8–9.

3. *Travel-related burdens.*

The need to travel to access abortion is itself a burden, Lamunyon Sanford Decl. ¶ 10, and Texas residents with means are currently traveling long distances to reach out-of-state abortion providers. *See* Ward Decl. ¶ 12 ("average distance traveled . . . jumped from 158 miles in 2019 to 734 miles" since the Executive Orders); Gomez Decl. ¶ 14 (Texans traveling to Arizona, Kentucky, Louisiana, Mississippi, New Mexico, Oklahoma, and Virginia); Schalit Decl. ¶¶ 15–16 (Texans traveling to New Mexico, Kansas, and Illinois). Some have taken lengthy road trips and others have had to fly. Lamunyon Decl. ¶ 11 (describing travel of up to 860 miles, one way); Ward

Decl. ¶ 14 (most clients are flying "because the health risks involved in air travel have made it much more affordable").

Long-distance travel is expensive, prohibitively so for some. *See* Ward Decl. ¶¶ 6, 8; Moe Decl. ¶¶ 14, 19; Bennett ¶¶ 9, 11. It is also fraught with logistical challenges, including the need to secure lodging and childcare, take time off from work, and explain one's whereabouts to family members or others. *See* Bennett Decl. ¶¶ 2, 8–9; Gomez Decl. ¶¶ 1, 9; Jones Decl. ¶¶ 8, 12; Lamunyon Sanford Decl. ¶¶ 8, 10, 12; Moe Decl. ¶¶ 14, 18; Schalit Decl. ¶¶ 1, 4; Ward Decl. ¶ 10. Organizations that assist people with abortion access can mitigate some of these burdens but cannot alleviate them completely. *See* Bennett Decl. ¶ 16; Conner Decl. ¶ 7; Gomez Decl. ¶ 16; Moe Decl. ¶ 8, 12; Ward Decl. ¶¶ 1, 4, 8. In addition, the need to travel often delays access to abortion because, for many, it takes time to make arrangements and raise the necessary money. Bennett Decl. ¶ 11; Heflin Decl. ¶¶ 51–61; Jones Decl. ¶ 12; Lamunyon Sanford Decl. ¶¶ 10, 12–13; Moe Decl. ¶ 14; Ward Decl. ¶ 7; *see also* Schalit Decl. ¶¶ 1, 4–5.

The COVID-19 pandemic makes travel "increasingly fraught, and even dangerous." Lamunyon Sanford Decl. ¶¶ 11–13; *see also* Moe Decl. ¶ 21 (reductions in flights; common delays and cancellations); Gomez Decl. ¶¶ 9-13 (difficulty finding local transportation and hotels; confusion due to state rules for out-of-state travelers during pandemic); Conner Decl. ¶ 11 (increased difficulty securing childcare); Ward Decl. ¶ 10 (delays caused by greater logistical barriers during pandemic); *infra* pp. 11–12 (travel increases risk of contagion).

4. *Economic costs*.

Delays can drive up the cost of an abortion, which increases with gestational age together with the duration and complexity of the procedure. Jones Decl. ¶ 15 (cost of a client's abortion increased about $1,500 due to two-week delay); Dewitt-Dick Decl. ¶ 22; Ferrigno Decl. ¶ 36; Hagstrom Miller 2d Decl. ¶¶ 7–10; Moe Decl. ¶ 8; Ward Decl. ¶ 6; White Decl. ¶ 25. For example,

a medication abortion at one Texas clinic costs $725. Hagstrom Miller 2d Decl. ¶ 8. A procedural abortion at that clinic costs $750 before twelve weeks LMP, and increases by $100 every week thereafter, reaching $1,350 by eighteen weeks LMP. *Id*. An abortion at a Texas ASC at 21–22 weeks LMP costs at least $3,000. *Id*. ¶ 10. Most patients will need to pay these costs out-of-pocket because Texas generally bars coverage of abortion in public *and* private insurance plans.[5] And as discussed above, the need to travel also adds to the cost of an abortion. *Supra* p. 6–7.

Even in normal times, roughly 75% of people seeking abortion are poor or low-income. Heflin Decl. ¶ 37. The pandemic has profoundly impacted people's financial resources. Between March 15th and April 4th, 2020, 760,000 Texans filed for unemployment, exceeding the roughly 700,000 claims filed in all of 2019. Heflin Decl. ¶ 10; *see also, e.g.*, *id.* ¶¶ 13–14 (record number of Texans applying for SNAP benefits and relying on food pantries); Moe Decl. ¶ 15 (callers "struggling with loss of work, income, employer-sponsored health insurance, and childcare" and "finding it difficult to pay their rents, mortgages, and bills"); Ward Decl. ¶ 10 ("One client recently worked to raise money for her abortion care for weeks only to have to use it for rent."); Doe Decl. ¶¶ 5–6 (patient lost job at restaurant right as she discovered she was pregnant).

5. *Forced childbirth.*

Those who are delayed past twenty-two weeks LMP and who cannot travel out of state for an abortion will be forced to give birth. *See* Gomez Decl. ¶ 18. Even before their duration was extended by the GA-15, the record demonstrated that the Orders would push many individuals past Texas's gestational age limit. Hagstrom Miller ¶ 27; Ward ¶ 12; Conner Decl. ¶ 10; Johnson ¶ 10; Moe Decl. ¶ 19. Further, obtaining abortion care in other states is becoming increasingly difficult because abortion clinics do not have capacity to see the large volume of Texas patients now seeking

[5] Guttmacher Inst., *Regulating Insurance Coverage of Abortion* (Apr. 1, 2020), https://www. guttmacher.org/state-policy/explore/regulating-insurance-coverage-abortion.

their services. Boyd Decl. ¶ 13 (New Mexico clinic is "simply overwhelmed with requests from Texas women and often unable to meet the sudden increase in need for timely care"); Moe Decl. ¶ 18 (by April 1, New Mexico clinic was scheduling appointments for Texas patients between April 8–24 though that clinic is "generally able to see our callers within a week of being contacted"); Conner Decl. ¶ 11; Johnson Decl. ¶ 9.

6. *Increased risks of abuse.*

Patients who have been victims of intimate partner violence ("IPV") and minors with abusive parents are at particular risk of harm from forced delays in access to abortion, and of being unable to access abortion altogether after the Executive Orders end. Stay-at-home guidelines have heightened the frequency and severity of IPV.[6] Even before the pandemic, pregnancy was associated with increased and more severe violence in abusive relationships.[7] To avoid further harm, including being denied abortion, a pregnant person may need to keep their pregnancy and abortion decision confidential, *see* Moe Decl. ¶ 19; Gomez Decl. ¶ 13, which is more difficult as access is delayed, Bennett Decl. ¶ 10; Moe Decl. ¶ 19.

For minors who have obtained a judicial bypass due to abuse or other hardships, *see* Northcutt Decl. ¶¶ 3–6, delay likewise threatens their health and safety and may prevent their access to abortion entirely. A judge has already determined that these minors should obtain an abortion promptly because, for example, any delay "increases the risk to the applicant's health." Nguyen Decl. ¶ 18 & Ex. A. And abortion access may be necessary to prevent further hardship imposed by a minor's parents. Northcutt Decl. ¶ 5 (describing potential homelessness if parent

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[6] *See* Amanda Taub, *A New Covid-19 Crisis: Domestic Abuse Worldwide*, N.Y. Times (Apr. 14, 2020), https://www.nytimes.com/2020/04/06/world/coronavirus-domestic-violence.html; Am. Psychological Ass'n, *How COVID-19 May Increase Domestic Violence and Child Abuse* (Apr. 8, 2020), https://www.apa.org/topics/covid-19/domestic-violence-child-abuse.

[7] Julie A. Gazmararian et al., *Prevalence of Violence Against Pregnant Women*, 275 JAMA 1915, 1918 (1996).

discovered pregnancy). Minors in these circumstances are having appointments cancelled because of the Executive Orders, further increasing the risks and other burdens. Northcutt Decl. ¶¶ 5–6; Nguyen Decl. ¶¶ 18–19. Most lack the financial, social, and familial resources to travel out of state to obtain abortion care. Northcutt Decl. ¶¶ 4, 7; Nguyen Decl. ¶¶ 18–19.

C. Asserted State Interests.

Defendants assert three interests supporting the Executive Orders: (1) conserving PPE; (2) conserving hospital capacity; and (3) preventing COVID-19's spread. None is advanced by banning and forcibly delaying abortion.

1. *Conserving PPE during the pandemic.*

The State's asserted interest in conserving PPE is not served by banning or forcibly delaying abortion for at least three reasons. **First**, individuals with ongoing pregnancies require more interactions with the healthcare system, involving more PPE, than individuals who obtain abortions. Levison Decl. ¶¶ 12–14; Macones Decl. ¶ 20; Schutt-Aine Decl. ¶ 26; Rosenfeld Decl. ¶ 15. Pregnant people must have regular, in-person medical visits to safeguard their own health, even if they intend to have an abortion. Chang Decl. ¶ 8; *see also* Levison Decl. ¶¶ 18–19. Pregnancy poses significant health risks, which are heightened for people with underlying conditions such as diabetes, high-blood pressure, and obesity. Schutt-Aine 2d Decl. ¶¶ 6–8. The Executive Orders impose no limits on routine pregnancy-related care, including physical examinations, ultrasounds, and laboratory tests. Macones Decl. ¶ 12; Levison Decl. ¶ 19; Chang Decl. ¶¶ 8–9. Doctors are continuing to provide such care during the pandemic, even while reducing other in-person visits. Levison Decl. ¶ 18; Macones Decl. ¶¶ 10–12. High-risk patients and patients in their second and third trimesters have more frequent in-person visits. Macones Decl. ¶¶ 10, 12. PPE used for prenatal care varies by provider, but at minimum, providers use gloves for physical examinations, vaginal ultrasounds, and laboratory testing, and wear masks and

other PPE whenever a patient has symptoms of COVID-19 or is at high risk of contracting the virus. Levison ¶¶ 13, 17; Chang ¶ 15, 25; Macones Decl. ¶ 17. Some OB/GYNs wear masks for all patient interactions and give patients the option of wearing masks. Wood Decl. ¶ 16.

In contrast, providing abortion care requires little or no PPE. Medication abortion requires a single, in-person visit without physical contact between doctor and patient, and no PPE is needed. *See* Schutt-Aine 2d Decl. ¶ 38. Aspiration abortion likewise requires a single, in-person visit during which minimal PPE is used. *See, e.g.*, Barraza Decl. ¶ 7; Ferrigno Decl. ¶¶ 10, 12; Klier Decl. ¶ 11; Schutt-Aine Decl. ¶¶ 25; Wallace Decl. ¶ 12. D&E abortion requires one or two in-person visits, depending on gestational age, during which minimal PPE is used. Abortion providers generally do not use N95 masks. Only one physician associated with Plaintiffs has used an N95 mask since the pandemic began, and that physician has been reusing the same mask. *See, e.g.*, Barraza Decl. ¶ 8; Hagstrom Miller Decl. ¶ 16; Schutt-Aine Decl. ¶ 27. Plaintiffs are not treating patients with COVID-19 symptoms. *See, e.g.*, Ferrigno Decl. ¶ 17; Lambrecht Decl. ¶ 16; Schutt-Aine Decl. ¶ 31. They screen those patients in advance and refer them for treatment. *Id*.

Texas law requires an ultrasound and in-person consultation before every abortion. Tex. Health & Safety Code §171.012(a)(4), (b). For patients living within 100 miles of the facility, the consultation must occur at least twenty-four hours before the abortion. *Id.* A pre-abortion ultrasound requires no more PPE than an ultrasound performed for prenatal care. *Compare* Ferrigno Decl. ¶ 11, *and* Hagstrom Miller Decl. ¶ 14, *with* Macones Decl. ¶ 14. When laboratory testing is required along with an abortion, technicians use only non-sterile gloves, just as with laboratory tests for prenatal care. *Compare* Hagstrom Miller Decl. ¶ 14 *with* Macones Decl. ¶ 14.

Notably, in addition to routine prenatal care, doctors continue to offer other obstetrical and gynecological care comparable to abortion in PPE use and time-sensitivity. *See* Chang Decl. ¶ 24;

Levison Decl. ¶ 18; Macones Decl. ¶ 19. Doctors also continue to prescribe or recommend oral medications comparable to the medications used to induce an abortion. Schutt-Aine 2d Decl. ¶ 47.

Second, abortion becomes more complex as pregnancy progresses, in turn requiring more PPE. Medication abortion, available in Texas to ten weeks LMP, requires no PPE. *See* Tex. Health & Safety Code § 171.063(a)(2); Barraza Decl. ¶ 7; Dewitt-Dick Decl. ¶ 19; Schutt-Aine Decl. ¶ 25. After ten weeks LMP abortion involves an aspiration procedure and limited PPE, such as gloves, a surgical mask, and a disposable or washable gown. Barraza Decl. ¶ 7; Dewitt-Dick Decl. ¶ 19; Ferrigno Decl. ¶¶ 10, 12; Hagstrom Miller Decl. ¶¶ 13, 15; Klier Decl. ¶ 11; Lambrecht Decl. ¶ 12; Rosenfeld Decl. ¶ 11; Schutt-Aine Decl. ¶ 25; Wallace Decl. ¶ 12. Around fourteen to sixteen weeks LMP the provider generally must use instruments to complete the procedure, usually requiring additional dilation and possibly additional staff and PPE. Ferrigno Decl. ¶ 35; Hagstrom Miller Decl. ¶ 34; Lambrecht Decl. ¶ 18; Schutt-Aine Decl. ¶¶ 16, 35; Schutt-Aine 2d Decl. ¶ 31. Beginning approximately fifteen to eighteen weeks LMP the dilation process must begin the day before the procedure, requiring two separate trips to the health center and an additional visit's worth of PPE. Schutt-Aine Decl. ¶¶ 16, 39; Schutt-Aine 2d Decl. ¶¶ 32, 34. Moreover, as detailed below, while abortion remains safe throughout pregnancy (and safer than childbirth), risks increase with gestational age, Schutt-Aine Decl. ¶ 22, and accordingly so does the risk that PPE may be needed to treat any complications that do arise (such treatment generally occurs at the health center where the abortion was provided).

Finally, forcing patients to attempt travel for care they could otherwise obtain locally results in no net savings of PPE, but rather increases contagion risks for both the patient and others. Bassett Decl. ¶¶ 6–8; Sharfstein 2d Decl. ¶¶ 9–11. If anything, such travel may increase the amount of PPE used because a patient forced to travel out-of-state will likely be delayed in doing so, and

may therefore require a more complex procedure involving more PPE. Schutt-Aine Decl. ¶¶ 16, 35, 39; Sharfstein 2d Decl. ¶ 11.

2. *Conserving hospital capacity during the pandemic.*

Likewise, preventing people from accessing abortion care during the pandemic will not conserve hospital capacity. As discussed above, nearly all abortions are provided in outpatient facilities rather than hospitals. *See supra* p. 2. Major complications occur in less than one-quarter of one percent (0.23%) of all abortion cases: in 0.31% of medication abortion cases, in 0.16% of first-trimester procedural abortion cases, and in 0.41% of procedural cases in the second trimester or later. Schutt-Aine Decl. ¶ 12. Abortion-related emergency room visits constitute just 0.01% of all emergency room visits in the United States. *Id.* Individuals with ongoing pregnancies are far more likely to seek treatment in a hospital (including in an emergency department) than individuals who have pre-viability abortions. Levison Decl. ¶¶ 8–11; Loe Decl. ¶¶ 14, 16; Macones Decl. ¶ 19; Roe Decl. ¶¶ 10–13; Schutt-Aine Decl. ¶ 26; Schutt-Aine 2d Decl. ¶¶ 9, 11, 13, 19. And as discussed below, forcing patients with the means to do so to travel long distances to attempt to obtain care increases contagion risks, including the risk that those patients or their close contacts will develop symptoms of COVID-19 requiring hospital care.

3. *Reducing the spread of COVID-19.*

As explained above, people denied access to abortion will still require regular, in-person visits with medical practitioners. *Supra* pp. 9–11. Accordingly, banning abortion will not reduce the risk of COVID-19 transmission in healthcare settings. In fact, because the Executive Orders are causing many Texas residents to travel out of state for abortion care, they are actually *increasing* the risk of COVID-19 transmission. *Supra* pp. 11–12.

D. Procedural History.

On March 25, 2020, Providers moved for a temporary restraining order ("TRO"), ECF No. 7, which this Court granted "as applied to medication abortions and procedural abortions." Order Granting Pls.' Req. for TRO at 8, ECF No. 40. Defendants petitioned the Fifth Circuit for a writ of mandamus to vacate the TRO. A divided panel of the Fifth Circuit administratively stayed the TRO, *In re Abbott*, No. 20-50264 (5th Cir. Mar. 31, 2020) (per curiam), and then granted the mandamus petition, *In re Abbott*, No. 20-50264, 2020 WL 1685929, at *1 (5th Cir. Apr. 7, 2020).

The panel majority concluded that mandamus was appropriate for three reasons. First, it held that this Court erred by not applying *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11 (1905), under which this Court "was empowered to decide only whether GA-09 lacks a 'real or substantial relation' to the public health crisis or whether it is 'beyond all question, a plain, palpable invasion' of the right to abortion." *In re Abbott*, 2020 WL 1685929, at *8 (citing *Jacobson*, 197 U.S. at 31). Second, the panel rejected Providers' argument that the Executive Orders operate as an "outright [abortion] ban." *Id.* at *10. Because it concluded the first Order did not impose a ban, the panel held that the undue-burden balancing test in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), applies. *Id.* at *10–12. Given the overlay of *Jacobson*, the panel held that "*certain applications* of GA-09 may constitute an undue burden under *Casey*," where Providers can show, "'beyond question,' GA-09's burdens outweigh its benefits in those situations." *Id.* at *9 (quoting *Jacobson*, 197 U.S. at 31) (emphasis added). Third, the majority held that any determination whether the TRO served the public interest should "weigh the potential injury to the public health" from enjoining enforcement of the first Order. *Id.* at *12. Critically, the panel emphasized that it was not expressing an opinion as to "whether an injunction narrowly tailored to particular circumstances would pass muster under the *Jacobson* framework." *Id.* It explained that "[t]hese are issues that the parties may pursue at the preliminary injunction stage,

where [Providers] will bear the burden to prove, 'by a clear showing,' that they are entitled to relief." *Id.*

On remand, Providers filed a second TRO motion, seeking more limited relief. ECF No. 56. The Court granted the motion on April 9, 2020, temporarily restraining Defendants from enforcing the first Order as a categorical ban on all abortions; against medication abortions; against procedural abortion for any patient who, based on the treating physician's medical judgment, would be more than eighteen weeks LMP on April 22, 2020, and likely unable to reach an ASC in Texas or to obtain abortion care; and against procedural abortion for any patient who, based on the treating physician's medical judgment, would be past the legal limit for an abortion in Texas—22 weeks LMP—on April 22, 2020. Order Granting Pls.' Second Mot. for TRO at 15, ECF No. 63. The TRO was set to expire on April 19, 2020, at 4:25 p.m., unless "extended for good cause, pursuant to Federal Rule of Civil Procedure 65." *Id.*

Defendants filed another mandamus petition and motion to stay the TRO. On April 10, 2020, the Fifth Circuit administratively stayed the second TRO "EXCEPT that part of the TRO applying to 'any patient who, based on the treating physician's medical judgment, would be past the legal limit for an abortion in Texas" by the Order's expiration. *In re Abbott*, No. 20-50296, slip op. at 4 (5th Cir. Apr. 10, 2020) (per curiam). Following additional briefing by the parties and Plaintiffs' application to the U.S. Supreme Court to vacate a portion of the Fifth Circuit's stay, the Fifth Circuit dissolved the administrative stay and denied Defendants' motion to stay the TRO as to medication abortion. *In re Abbott*, No. 20-50296, 2020 WL 1866010 (5th Cir. Apr. 13, 2020).

On April 14, 2020, this Court set a preliminary injunction hearing for April 29, 2020; entered a briefing schedule; and extended the TRO, as modified by the Court of Appeals, until May 1, 2020, at 5 p.m. Order Extending Order Granting Pls.' Second Mot. for TRO & Scheduling

Order for Pls.' Mot. for Prelim. Inj. at 2–4, ECF No. 82. The next day, despite their pending mandamus petition, Defendants filed an interlocutory appeal from the TRO as well as a motion for stay pending appeal. Appellants' Opposed Emergency Mot. to Stay Pending Appeal and, Alternatively, for a Temp. Administrative Stay, *Planned Parenthood Ctr. for Choice v. Abbott*, No. 20-50314 (5th Cir. Apr. 15, 2020). All remain pending.

ARGUMENT

Providers are entitled to a preliminary injunction because the record demonstrates that (1) they have a substantial likelihood of success on the merits; (2) their patients are experiencing irreparable injury; (3) that injury outweighs any harm to Defendants; and (4) granting the injunction will not disserve the public interest. *Jackson Women's Health Org. v. Currier*, 760 F.3d 448, 452 (5th Cir. 2014); *Janvey v. Alguire*, 647 F.3d 585, 595 (5th Cir. 2011).[8]

I. PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS.

The right to end a pregnancy is a fundamental component of the liberty protected by the Due Process Clause. *See, e.g.*, *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309–10 (2016); *Casey*, 505 U.S. at 851–53 (1992); *Roe v. Wade*, 410 U.S. 113, 152–54 (1973). Laws that infringe on this right are subject to the undue-burden standard set forth in *Casey*, which "requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer." *Whole Woman's Health*, 136 S. Ct. at 2309. Where the burdens are disproportionate to the benefits, the law is unconstitutional. *See id.* at 2300, 2309–10.

The undue burden standard is a form of heightened scrutiny. *Id.* at 2309–10. To satisfy it, the State cannot merely assert that a challenged law is rationally related to a valid state interest. *Id.*

[8] For the reasons set forth in Plaintiffs' Mot. for TRO and/or Prelim. Inj. at 27–28, ECF No. 7, which is hereby designated by Providers, the Court should waive the bond requirement in Federal Rule of Civil Procedure 65(c).

at 2309. Instead, the State must demonstrate that the law actually advances the asserted interest—and that it does so to an extent sufficient to justify the burdens that it imposes on abortion access. *Id.* at 2300, 2309–10 ("[T]he 'Court retains an independent constitutional duty to review factual findings where constitutional rights are at stake.'" (quoting *Gonzales v. Carhart*, 550 U.S. 124, 165 (2007))).

The Fifth Circuit directed this Court to apply the undue-burden standard in tandem with the principles set forth in *Jacobson*, which it views as providing "the framework governing emergency public health measures like [the Executive Orders]." *In re Abbott*, 2020 WL 1685929, at *1. This Court must ask "whether [the Executive Orders] impose burdens on abortion that 'beyond question' exceed its benefits in combating the epidemic Texas now faces." *Id.* at *11 (quoting *Jacobson*, 197 U.S. at 31). This inquiry is fact-specific, "requiring careful parsing of the evidence." *Id.*[9]

The Executive Orders fail to satisfy the constitutional standard set forth by the Fifth Circuit. The burdens imposed by these laws are unwarranted as to all people seeking abortions, and especially as to (1) patients seeking medication abortions; (2) patients seeking procedural abortions after ten weeks LMP, including patients who, by the Executive Orders' expiration, (a) will likely be ineligible for aspiration abortion; (b) will likely be ineligible for a single-day D&E abortion; (c) will likely be ineligible for abortion in a clinic setting; or (d) will likely be past the gestational age limit for abortion in Texas; and (3) patients experiencing IPV and minors who have obtained judicial bypasses.

[9] Plaintiffs reassert and preserve for appeal their arguments that the Executive Orders as applied to provision of abortion care are unconstitutional because (1) they impose an outright ban on previability abortion, *see Roe* and *Casey*, and (2) they impose an undue burden under the test described in *Casey*, which is not modified during a public health emergency, by *Jacobson* or otherwise.

A. The Executive Orders Impose Unconstitutional Burdens on Texas Residents Seeking Medication Abortions.

Applying the Executive Orders to medication abortion beyond question fails to serve Defendants' asserted interests in conserving PPE and hospital capacity or limiting the spread of COVID-19. The record shows that medication abortion requires *no PPE*. *Supra* p. 10. Although Texas requires an in-person consultation and ultrasound examination before a medication abortion, *see* Tex. Health & Safety Code § 171.012(a)(4), (b), the Texas Medical Board has issued guidance indicating that those services—whether provided in the context of abortion care or prenatal care—do not fall within the scope of the Executive Orders' prohibitions.[10] In any event, these pre-abortion visits require little or no PPE. *Supra* p. 10. Moreover, banning medication abortion fails to serve Defendants' interest in conserving PPE because individuals with ongoing pregnancies will require more in-person healthcare, including ultrasounds, physical examinations, and lab tests, during the pandemic than individuals who have medication abortions. *Supra* pp. 9–11.

Further, virtually all medication abortions are provided in outpatient facilities rather than hospitals, and complications associated with medication abortion, including any requiring hospital care, are exceedingly rare. *Supra* pp. 11–12. Delaying or denying abortion access does not conserve hospital capacity because patients with continuing pregnancies are far more likely to seek hospital care than patients who terminate a pregnancy before viability. *Supra* p. 12; Levison Decl. ¶ 10 (testifying that at least twenty percent of pregnant patients will visit a hospital at some point prior to delivery, some on multiple occasions).

[10] Tex. Med. Bd., Texas Medical Board (TMB) Frequently Asked Questions (FAQs) Regarding Non-Urgent Elective Surgeries and Procedures During Texas Disaster Declaration for COVID-19 Pandemic (Mar. 29, 2020), Ex. A to Schutt-Aine 2d Decl. While Defendants characterize these services as part of a single, multi-step medication abortion "procedure," if this were so, it would be impossible to comply with Texas's law requiring the ultrasound to occur "at least 24 hours *before* the abortion." Tex. Health & Safety Code §171.012(a)(4) (emphasis added).

The Executive Orders' application to medication abortion also undermines Defendants' asserted interest in thwarting the spread of COVID-19. As discussed above, it has increased the risk that patients will contract and transmit the virus by forcing them to travel extensive distances to obtain a medication abortion. *See* Bassett Decl. ¶ 7; Doe Decl. ¶ 18.

In these ways, Defendants' threats to enforce the Executive Orders against those who provide medication abortions lack any "real or substantial relation" to the public health objectives offered to justify them, contravening *Jacobson*, 197 U.S. at 31.

The Executive Orders' failure to further Defendants' interests is plainly outweighed by their profound burdens on medication abortion patients—which will continue without injunctive relief. They have already forced Providers to cancel hundreds of appointments, including for medication abortion, thus delaying patient care. *See, e.g.*, Dewitt-Dick Decl. ¶ 8; Johnson Decl. ¶ 4; Klier Decl. ¶ 17; Nguyen Decl. ¶ 8; Wallace Decl. ¶ 9; Rosenfeld Decl. ¶ 9. Delayed abortion access subjects patients to increased health risks, *supra* pp. 4–5, greater financial burdens, *supra* pp. 6–7, and other harms, ranging from the physical and psychological impact of unwanted pregnancy to fear that an abusive partner or family member will learn of the pregnancy or intended abortion, *supra* pp. 5, 8–9. Moreover, the Executive Orders have compelled patients to travel long distances out of state during a pandemic to obtain pills that they could take at home. *See, e.g.*, Doe Decl. ¶¶ 9, 19–22. These burdens are "beyond question" undue in relation to the illusory benefits of applying the Executive Orders to medication abortion. *In re Abbott*, 2020 WL 1685929, at *9 (citing *Jacobson*, 197 U.S. at 31); *see also Whole Woman's Health*, 136 S. Ct. at 2300, 2309–10.

Enforcing the Executive Orders as to medication abortion is also at odds with the Fifth Circuit's standard because it singles out medication abortion for disfavored treatment without justification. *In re Abbott*, 2020 WL 1685929, at *19 (citing *Jacobson*'s prohibition on states

exercising their authority to "safeguard the public health" in an "arbitrary, unreasonable manner"). Defendants have yet to identify another oral medication they consider banned by the Executive Orders, which on their face apply only to "surgeries and procedures." *Supra* p. 11. Indeed, the record shows that the Executive Orders exempt treatments comparable to medication abortion and the care accompanying it. *See, e.g.*, Levison Decl. ¶¶ 13, 18–19 (noting that most prenatal care, which includes ultrasounds, physical exams, and blood tests, is continuing during the pandemic).

B. The Executive Orders Impose Unconstitutional Burdens on Texas Residents Seeking Procedural Abortions.

The Executive Orders also impose unwarranted burdens on people seeking procedural abortions. For the reasons explained above, the Executive Orders fail to advance Defendants' asserted public health interests in any material way. *See supra* pp. 9–12 (continuing a pregnancy conserves no PPE because it requires more in-person healthcare at each stage of pregnancy than obtaining a previability abortion; abortions later in pregnancy use more PPE; and forcing patients to travel results in contagion risks that deplete rather than conserve PPE); *supra* p. 12 (patients with continuing pregnancies are far more likely to seek hospital care than patients who terminate a pregnancy before viability; abortion later in pregnancy, while safe, carries more risk of complications than earlier abortions; and forced travel results in contagion risks that increase the chances of hospital-based care); *supra* pp. 11–12 (out-of-state travel heightens the risk that abortion patients will contract and transmit the COVID-19 virus to others).

On the other hand, the Executive Orders impose heavy burdens on people seeking procedural abortions. These burdens, detailed above, include increased health risks, *supra* pp. 4–5; physical discomfort, emotional distress and loss of privacy, *supra* p. 5; travel-related burdens, *supra* pp. 5–6; economic costs, *supra* pp. 6–7; forced childbirth, *supra* pp. 7–8; and increased risk of abuse by a partner or family member, *supra* pp. 8–9.

Because these burdens are outweighed by any possible benefit and lack any "real or substantial relation" to the state's interest, they cannot be applied abortion procedures, but these burdens are most severe and unjustified in the following categories:

1. *Individuals seeking procedural abortions after ten weeks LMP.*

Texas law prohibits medication abortion after ten weeks LMP, so individuals turned away from procedural abortion will either lose all access in Texas or be forced to wait until they are at a later stage of pregnancy when their procedure will involve more PPE. Further, the risks of pregnancy, Macones Decl. ¶ 8, and abortion, Schutt-Aine Decl. ¶ 22, increase with gestational age. Also, after twelve weeks LMP, the abortion costs increases significantly each week as the length and complexity of the procedure increases. Hagstrom Miller 2d Decl. ¶ 8. This increased cost leads to further delay. Heflin Decl. ¶¶ 41–43, 48, 50–52. For these reasons, being delayed past ten weeks LMP, or forced to seek care elsewhere, imposes substantial burdens on Texas residents. And such delays or forced travel *increase* use of PPE, hospital resources, and contagion risks, and thus lack any "real or substantial relation" to the state's interests. *Jacobson*, 197 U.S. at 31.

2. *Individuals who will likely be ineligible for aspiration abortion by the time the Executive Orders expire.*

Beginning around fourteen to sixteen weeks LMP, abortion patients must have a D&E abortion, which is a lengthier, more complex, and more expensive procedure than aspiration; it also uses more PPE and requires more time at the health center, and (while very safe) carries higher risks of complications. Ferrigno Decl. ¶¶ 35–36; Hagstrom Miller Decl. ¶¶ 34–35; Schutt-Aine Decl. ¶¶ 16, 39; Schutt-Aine 2d Decl. ¶¶ 32–34. Thus, being delayed past fourteen weeks LMP can impose significant burdens on abortion patients, and further undermine any "real or substantial relation" to the state's interests.

3. *Individuals who will likely be ineligible for a single-day D&E abortion by the time the Executive Orders expire.*

D&E abortions are usually performed as two-day procedures beginning between fifteen to eighteen weeks LMP, depending on the individual patient and physician judgment. Schutt-Aine 2d Decl. ¶ 32. Thus, most abortion patients who require a two-day D&E procedure must make three rather than two trips to an abortion provider to terminate their pregnancy. *See* Tex. Health & Safety Code § 171.012(a)(4), (b). Multiple trips present many of the same logistical challenges as long-distance travel to obtain abortion care. Bennett Decl. ¶ 9; Jones Decl. ¶ 12; Moe Decl. ¶ 14. A two-day procedure involves more PPE and medical staff, as well as more time at the health center and trips back-and-forth, thus increasing risks of contagion and complication. Accordingly, the Executive Orders' application to this category of patients lacks any "real or substantial relation" to the State's interests.

4. *Individuals who will likely be ineligible to have an abortion in a clinic setting by the time the Executive Orders expire.*

Texas law requires abortion patients who exceed eighteen weeks LMP to obtain their care at an ASC rather than a licensed abortion facility. Tex. Health & Safety Code § 171.004. But just six of the ASCs in Texas (in only four cities) offer abortion care after eighteen weeks LMP. White Decl. ¶¶ 16–17. Long-distance travel is expensive, *supra* pp. 5–6, the cost of an abortion increases significantly with gestational age, *supra* at pp. 6–7, and about 75% of women seeking an abortion in the U.S. are poor or low-income. Heflin Decl. ¶ 37; *see* Ward Decl. ¶ 6. As a result, many Texas residents delayed past eighteen weeks LMP may be unable to access abortion and forced to carry to term. *See* Sanford Decl. ¶ 9. Patients delayed in or foreclosed from accessing abortion care will require more PPE and be exposed to higher health-related risks, again undermining any "real or substantial relation" to the state's interests.

5. *Individuals who will likely be past the gestational age limit for abortion in Texas by the time the Executive Orders expire.*

Texas law prohibits abortion after twenty-two weeks LMP absent exceptional circumstances. Tex. Health & Safety Code § 171.044. Thus, delay past that gestational age forces Texans to carry their pregnancy to term or, for those with means, to leave the state to seek abortion care. *See, e.g.*, Ward Decl. ¶ 12; Moe Decl. ¶ 18; Bennett Decl. ¶ 24; Johnson Decl. ¶ 10. As this Court has held, application of the Executive Orders to procedural abortion patients in these circumstances at minimum unduly burdens their right to access a previability abortion. Order Granting Pls.' Second Mot. for TRO at 13, ECF No. 63; *see Casey*, 505 U.S. at 877. Those who manage to access care out of state obtain the care later in their pregnancies than they otherwise would—and suffer attendant health risks, financial burdens, and emotional costs. Thus, on this record, it is beyond question that the Executive Orders impose burdens that exceed any public health benefits. *See Jacobson*, 197 U.S. at 31; *Whole Woman's Health*, 136 S. Ct. at 2300, 2309–10.

6. *Patients experiencing IPV and minors who have obtained judicial bypass.*

Patients experiencing IPV and minors who have obtained a judicial bypass are at particular risk of harm from forced delays in access to abortion, including of being unable to access an abortion altogether even after the Executive Orders' expiration. *Supra* at pp. 8–9. Because of these heightened harms, Defendants' interpretation of the Executive Orders to flatly bar abortions for this group again imposes burdens that exceed any public health benefit.

C. Arbitrary and Unreasonable Treatment of Patients Seeking Procedural Abortion.

As with medication abortion, applying the Executive Orders to procedural abortion is also unconstitutional because it singles out abortion care for disfavored treatment in an "arbitrary, unreasonable manner." *Jacobson*, 197 U.S. at 26. Texas physicians continue to provide obstetrical

and gynecological procedures comparable to procedural abortion in PPE use and time-sensitivity based on their professional medical judgment. Chang Decl. ¶ 22; Levison Decl. ¶ 18.[11] Indeed, all physicians other than abortion providers are permitted to exercise professional judgment as to whether a procedure can safely be postponed, and to rely on the guidance of leading professional organizations in so doing. Schutt-Aine 2d Decl. ¶¶ 48–50, 53–54. The Medical Board and Texas Medical Association agree that such judgment and reliance are appropriate. *Id*. Providers simply seek the same ability to care for their patients. *Cf. Robinson v. Marshall*, No. 2:19cv365-MHT, 2020 WL 1659700, at *3 (M.D. Ala. Apr. 3, 2020) (ordering that "[t]he reasonable medical judgment of abortion providers will be treated with the same respect and deference as the judgments of other medical providers" and that "decisions will not be singled out for adverse consequences because the services in question are abortions or abortion-related").

D. Defendants' Arguments That This Court Lacks Authority to Enter an Injunction Are Meritless.

The Fifth Circuit has already held that "a justiciable controversy exists as to the [Defendant] health officials." *In re Abbott*, 2020 WL 1685929, at *5 n.17. It has further held that Providers "have standing to sue on their own behalf because the [Executive Orders] 'directly operates against them,'" *id.* (quoting *Planned Parenthood of Cen. Mo. v. Danforth*, 428 U.S. 52, 62 (1976), and that consideration of Providers' third-party standing may be deferred, *id.*

Defendants' remaining jurisdictional argument—that sovereign immunity bars Providers' claims against the Governor and Attorney General—is meritless. Providers' claims against the Governor are proper because he may modify, amend, rescind, or supersede the Executive Orders

[11] The singling out of abortion providers is further underscored by the fact that crisis pregnancy centers—which provide ultrasounds of no medical or diagnostic value—are advertising on their websites that they are providing ultrasounds during the COVID-19 pandemic. Nguyen 2d Decl. ¶¶ 16–17.

pursuant to their terms, Tex. Exec. Order No. GA-09 (Mar. 22, 2020) at 2, ECF No. 1-2; Tex. Exec. Order No. GA-15 (Apr. 17, 2020) at 2, Ex. 21, and his statutory authority, Tex. Gov't Code Ann. § 418.012. By exercising his authority to implement one Executive Order after another, the Governor has directly and continuously injured Providers and their patients. *See City of Austin v. Paxton*, 943 F.3d 993, 998, 1000, 1002 (5th Cir. 2019) (holding that the requirements of *Ex parte Young* are satisfied when a state official has the ability to "compel or constrain" plaintiffs' actions).

Similarly, the Attorney General has authority to prosecute Providers and their agents at the request of local prosecutors for alleged violations of the Executive Orders. Tex. Gov't Code Ann. § 402.028(a). His public threat to do so "with the full force of the law," ECF No. 1-1, directly caused Providers to cancel hundreds of abortion appointments and cease providing nearly all abortion care, Pls.' Second Mot. for TRO at 3, ECF No. 56. *Cf. City of Austin*, 943 F.3d at 1001 (noting that *Ex Parte Young* applied where Attorney General sent plaintiff letters threatening to enforce a statute and thus constrained plaintiff's conduct).

II. PLAINTIFFS' PATIENTS WILL SUFFER IRREPARABLE HARM ABSENT A PRELIMINARY INJUNCTION.

Plaintiffs' patients will suffer severe and irreparable harm in the absence of a preliminary injunction. The Executive Orders violate their constitutional right to end a pregnancy. It is well settled that, where a plaintiff establishes a constitutional violation, no further showing of irreparable injury is necessary. *See Elrod v. Burns*, 427 U.S. 347, 373 (1976); *Opulent Life Church v. City of Holly Springs*, 697 F.3d 279, 295 (5th Cir. 2012); *Deerfield Med. Ctr. v. City of Deerfield Beach*, 661 F.2d 328, 338 (5th Cir. Unit B Nov. 1981). Moreover, the Executive Orders expose Providers' patients to increased health and safety risks, *supra* pp. 4–5, and cause them to suffer physical discomfort, emotional distress, and loss of privacy, *supra* p. 5, as a consequence of having to continue unintended pregnancies. This "disruption or denial of . . . patients' health care cannot

be undone after a trial on the merits." *Planned Parenthood of Kan. & Mid-Mo. v. Andersen*, 882 F.3d 1205, 1236 (10th Cir. 2018) (internal quotation marks omitted), *cert. denied sub nom. Andersen v. Planned Parenthood of Kan. & Mid-Mo.*, 139 S. Ct. 638 (Mem.) (2018); *accord Planned Parenthood of Ariz., Inc. v. Humble*, 753 F.3d 905, 911 (9th Cir. 2014); *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 796 (7th Cir. 2013).

III. THE BALANCE OF HARMS AND PUBLIC INTEREST SUPPORT PRELIMINARY INJUNCTIVE RELIEF.

As explained above, Providers' patients will continue to experience severe and irreparable harm in the absence of a preliminary injunction. *Supra* pp. 3–9, 19–23. Defendants, on the other hand, will suffer no harm from such an injunction because the Executive Orders' application to abortion fails to actually serve Defendants' asserted public health interests. *Supra* pp. 9–12, 19–22. Thus, the balance of harms weighs in favor of a preliminary injunction. Likewise, the Fifth Circuit has made clear that "the grant of an injunction will not disserve the public interest" where, as here, the "injunction is designed to avoid constitutional deprivations." *Jackson Women's Health Org.*, 940 F. Supp. 2d at 424; *see also Ingebretsen v. Jackson Pub. Sch. Dist.*, 88 F.3d 274, 280 (5th Cir. 1996). Finally, preserving abortion access will actually aid the response to COVID-19. *See supra* pp. 9–12.

CONCLUSION

For the foregoing reasons and those set forth in prior filings designated by Plaintiffs, this Court should grant Plaintiffs' motion for a preliminary injunction.

Dated: April 18, 2020

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on this 18th day of April, 2020, I filed a copy of the foregoing with this Court's CM/ECF system, which will serve a copy on the following individuals:

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APPENDIX A

Exhibits to Supplemental Memorandum of Law in Support of Plaintiffs' Motion for a Preliminary Injunction

Short Name	Document
GA-15	Ex. 21, Governor Greg Abbott, Texas Executive Order GA-15 (Apr. 17, 2020), *available at* https://tinyurl.com/EOGA15.
N/A	Ex. 22, Email correspondence between counsel for State Defendants and counsel for Plaintiffs
Bennett Decl.	Ex. 23, Declaration of Amanda Bennett
Boyd Decl.	Ex. 24, Declaration of Curtis Boyd
Dewitt-Dick 2d Decl.	Ex. 25, Second Declaration of Alicia Dewitt-Dick
Ferrigno 2d Decl.	Ex. 26, Second Declaration of Andrea Ferrigno
Gomez Decl.	Ex. 27, Declaration of Stephanie Gomez
Hagstrom Miller 2d Decl.	Ex. 28, Second Declaration of Amy Hagstrom Miller
Heflin Decl.	Ex. 29, Declaration of Colleen Heflin, Ph.D.
Jones Decl.	Ex. 30, Declaration of Marsha Jones
Lamunyon Sanford Decl.	Ex. 31, Declaration of Joan Lamunyon Sanford
Loe Decl.	Ex. 32, Declaration of Alma Loe, M.D.
Moe Decl.	Ex. 33, Declaration of Alex Moe
Nguyen 2d Decl.	Ex. 34, Second Declaration of Tram Nguyen
Roe Decl.	Ex. 35, Declaration of Mary Roe, M.D.
Schalit Decl.	Ex. 36, Declaration of Odile Schalit
Schutt-Aine 2d Decl.	Ex. 37, Second Declaration of Ann Schutt-Aine, M.D.
Sharfstein 2d Decl.	Ex. 38, Second Declaration of Joshua Sharfstein, M.D.
White Decl.	Ex. 39, Declaration of Kari White, Ph.D.
N/A	Ex. 40, Texas Department of State Health Services, 2017 Induced Terminations of Pregnancy by Post-Fertilization Age and Procedure, *available at* https://tinyurl.com/ya4xwwpm.

APPENDIX A

Other Declarations in the Record

Short Name	Document
Barraza Decl.	Ex. 1, Declaration of Polin C. Barraza (ECF No. 7-1)
Bassett Decl.	Ex. 12, Declaration of Mary Travis Bassett (ECF No. 49-2)
Braid Decl.	Declaration of Alan Braid (ECF No. 87-1)
Chang Decl.	Ex. 16, Declaration of Stephanie Chang, M.D. (ECF No. 49-6)
Conner Decl.	Ex. 9, Declaration of Kamyon Conner, M.S.W. (ECF No. 7-9)
Dewitt-Dick Decl.	Ex. 2, Declaration of Alicia Dewitt-Dick (ECF No. 7-2)
Doe Decl.	Ex. 10, Declaration of Jane Doe (ECF No. 29-1)
Ferrigno Decl.	Ex. 3, Declaration of Andrea Ferrigno (ECF No. 7-3)
Hagstrom Miller Decl.	Ex. 4, Declaration of Amy Hagstrom Miller (ECF No. 7-4)
Johnson Decl.	Ex. 14, Declaration of Clora Johnson (ECF No. 49-4)
Klier Decl.	Ex. 5, Declaration of Jessica Klier (ECF No. 7-5)
Lambrecht Decl.	Ex. 6, Declaration of Ken Lambrecht (ECF No. 7-6)
Levison Decl.	Ex. 17, Declaration of Judy Levison, M.D., M.P.H. (ECF No. 49-7)
Macones Decl.	Ex. 19, Declaration of George A. Macones, M.D., M.S.C.E. (ECF No. 49-9)
Nguyen Decl.	Ex. 15, Declaration of Tram Nguyen (ECF No. 49-5)
Northcutt Decl.	Ex. 13, Declaration of Frances Northcutt (ECF No. 49-3)
Rosenfeld Decl.	Declaration of Dr. Bernard Rosenfeld (ECF No. 79-1)
Schutt-Aine Decl.	Ex. 7, Declaration of Ann Schutt-Aine, M.D. (ECF No. 7-7)
Sharfstein Decl.	Ex. 11, Declaration of Joshua Sharfstein, M.D. (ECF No.)
Wallace Decl.	Ex. 8, Declaration of Robin Wallace, M.D. (ECF No. 7-8)
Ward Decl.	Ex. 20, Declaration of Rashae Ward (ECF No. 56-1)
Wood Decl.	Ex. 18, Declaration of Rita Golikeri Wood, D.O. (ECF No. 49-8)

EXHIBIT 21

GOVERNOR GREG ABBOTT

April 17, 2020

FILED IN THE OFFICE OF THE
SECRETARY OF STATE
11:40AM O'CLOCK

APR 17 2020

Secretary of State

The Honorable Ruth R. Hughs
Secretary of State
State Capitol Room 1E.8
Austin, Texas 78701

Dear Secretary Hughs:

Pursuant to his powers as Governor of the State of Texas, Greg Abbott has issued the following:

> Executive Order No. GA-15 relating to hospital capacity during the COVID-19 disaster.

The original executive order is attached to this letter of transmittal.

Respectfully submitted,

Gregory S. Davidson
Executive Clerk to the Governor

GSD/gsd

Attachment

Executive Order

BY THE
GOVERNOR OF THE STATE OF TEXAS

Executive Department
Austin, Texas
April 17, 2020

EXECUTIVE ORDER
GA 15

Relating to hospital capacity during the COVID-19 disaster.

WHEREAS, I, Greg Abbott, Governor of Texas, issued a disaster proclamation on March 13, 2020, certifying under Section 418.014 of the Texas Government Code that the novel coronavirus (COVID-19) poses an imminent threat of disaster for all counties in the State of Texas; and

WHEREAS, on April 12, 2020, I issued a proclamation renewing the disaster declaration for all counties in Texas; and

WHEREAS, the Commissioner of the Texas Department of State Health Services, Dr. John Hellerstedt, has determined that COVID-19 represents a public health disaster within the meaning of Chapter 81 of the Texas Health and Safety Code; and

WHEREAS, I have issued numerous executive orders and suspensions of Texas laws in response to COVID-19, aimed at protecting the health and safety of Texans and ensuring an effective response to this disaster; and

WHEREAS, a shortage of hospital capacity or personal protective equipment would hinder efforts to cope with the COVID-19 disaster; and

WHEREAS, hospital capacity and personal protective equipment were being depleted by surgeries and procedures that were not medically necessary to correct a serious medical condition or to preserve the life of a patient, contrary to recommendations from the President's Coronavirus Task Force, the Centers for Disease Control and Prevention, the U.S. Surgeon General, and the Centers for Medicare and Medicaid Services; and

WHEREAS, various hospital licensing requirements would stand in the way of implementing increased occupancy in the event of surge needs for hospital capacity due to COVID-19; and

WHEREAS, I issued Executive Order GA-09 on March 22, 2020, in an effort to avoid a shortage of hospital capacity or personal protective equipment, and it is subject to expiration at 11:59 p.m. on April 21, 2020, absent further action by the governor; and

WHEREAS, the "governor is responsible for meeting … the dangers to the state and people presented by disasters" under Section 418.011 of the Texas Government Code, and the legislature has given the governor broad authority to fulfill that responsibility; and

FILED IN THE OFFICE OF THE
SECRETARY OF STATE
11:40 AM O'CLOCK

APR 17 2020

WHEREAS, under Section 418.012, the "governor may issue executive orders … hav[ing] the force and effect of law;" and

WHEREAS, under Section 418.016(a), the "governor may suspend the provisions of any regulatory statute prescribing the procedures for conduct of state business or the orders or rules of a state agency if strict compliance with the provisions, orders, or rules would in any way prevent, hinder, or delay necessary action in coping with a disaster;" and

WHEREAS, under Section 418.173, failure to comply with any executive order issued during the COVID-19 disaster is an offense punishable by a fine not to exceed $1,000, confinement in jail for a term not to exceed 180 days, or both fine and confinement.

NOW, THEREFORE, I, Greg Abbott, Governor of Texas, by virtue of the power and authority vested in me by the Constitution and laws of the State of Texas, do hereby order the following on a statewide basis beginning at 11:59 p.m. on April 21, 2020, and continuing until 11:59 p.m. on May 8, 2020:

All licensed health care professionals and all licensed health care facilities shall postpone all surgeries and procedures that are not medically necessary to diagnose or correct a serious medical condition of, or to preserve the life of, a patient who without timely performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician; provided, however, that this prohibition shall not apply to either of the following:

- any procedure that, if performed in accordance with the commonly accepted standard of clinical practice, would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 disaster; or

- any surgery or procedure performed in a licensed health care facility that has certified in writing to the Texas Health and Human Services Commission both: (1) that it will reserve at least 25% of its hospital capacity for treatment of COVID-19 patients, accounting for the range of clinical severity of COVID-19 patients; and (2) that it will not request any personal protective equipment from any public source, whether federal, state, or local, for the duration of the COVID-19 disaster.

I hereby continue the suspension of the following provisions to the extent necessary to implement increased occupancy in the event of surge needs for hospital capacity due to COVID-19:

25 TAC Sec. 133.162(d)(4)(A)(iii)(I);
25 TAC Sec. 133.163(f)(1)(A)(i)(II)–(III);
25 TAC Sec. 133.163(f)(1)(B)(i)(III)–(IV);
25 TAC Sec. 133.163(m)(1)(B)(ii);
25 TAC Sec. 133.163(t)(1)(B)(iii)–(iv);
25 TAC Sec. 133.163(t)(1)(C);
25 TAC Sec. 133.163(t)(5)(B)–(C); and
Any other pertinent regulations or statutes, upon written approval of the Office of the Governor.

This executive order shall remain in effect and in full force until 11:59 p.m. on May 8, 2020, unless it is modified, amended, rescinded, or superseded by the governor.

FILED IN THE OFFICE OF THE
SECRETARY OF STATE
11:40 AM O'CLOCK

APR 17 2020

Given under my hand this the 17th day of April, 2020.

GREG ABBOTT
Governor

ATTESTED BY:

RUTH R. HUGHS
Secretary of State

FILED IN THE OFFICE OF THE
SECRETARY OF STATE
11:40 AM O'CLOCK

APR 17 2020

EXHIBIT 22

Subject: Re: re GA-15
Date: Saturday, April 18, 2020 at 3:55:01 PM Eastern Daylight Time
From: Stephens, Andrew <Andrew.Stephens@oag.texas.gov>
To: Sandman, Jennifer <jennifer.sandman@ppfa.org>
CC: Hacker, Heather <Heather.Hacker@oag.texas.gov>, Walton, Benjamin <Benjamin.Walton@oag.texas.gov>

Jennifer,

GA-15 applies to all "licensed health care professionals" and all "licensed health care facilities." GA-15 states that a licensed health care facility may perform surgeries or procedures if it certifies in writing to HHSC that it complies with certain conditions set forth in GA-15. Facilities that cannot make that certification may not perform surgeries or procedures unless they meet the other requirements of GA-15. OAG has no role in receiving, processing, or ruling upon certifications submitted under GA-15 and cannot confirm, as a factual matter, whether any specific facility complies with GA-15's certification requirement as it lacks the information and authority to make that determination. Finally, we would stress that all licensed facilities remain subject to GA-09's requirements until they expire on April 21.

As to the Emergency Rule, it will be interpreted in accordance with its text until such time that it is modified or replaced.

Andrew

From: Sandman, Jennifer <jennifer.sandman@ppfa.org>
Sent: Friday, April 17, 2020 2:58 PM
To: Stephens, Andrew <Andrew.Stephens@oag.texas.gov>
Cc: Stephanie Toti <stoti@lawyeringproject.org>; Molly Duane <MDuane@reprorights.org>; Brigitte Amiri <bamiri@aclu.org>
Subject: re GA-15

Andrew,

As I'm sure you know, Governor Abbott's new executive order (GA-15) provides that as of 11:59 P.M. on April 21, the requirement that licensed health care professionals and licensed health care facilities postpone surgeries or procedures that are not medically necessary to diagnose or correct a serious medical condition of, or to preserve the life of, a patient who without timely performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician, will no longer apply to:

"Any surgery or procedure performed in a licensed health care facility that has cer ified in wri ing to the Texas Health and Human Services Commission both: (1) that it will reserve at least 25% of its hospital capacity for treatment of COVID-19 patients, accounting for the range of clinical severity of COVID-l9 patients; and (2) that it will not request any personal protective equipment from any public source, whether federal, state, or local, for the duration of the COVID 19 disaster."

Provider Plaintiffs do not have hospital capacity and do not intend to request personal protective equipment from any public source for the duration of the COVID-19 disaster, and intend to shortly provide certifications to the Texas Health and Human Services Commission to that effect. Accordingly, Provider Plaintiffs believe that as of April 22, their services will not be affected by either GA-09 (which will have expired) or GA-15 (which does not apply to entities that have made the required certifications).

Can you confirm that you share this understanding?

Given the discrepancy between the terms of GA-15 and the Texas Medical Board's emergency amendment to 22 Tex. Admin Code §187.57, which took effect March 23, 2020, and expires July 20, 2020, Plaintiffs further request confirmation from your clients that the Emergency Rule will be interpreted and enforced consistent with the terms of EO-15 from the time that Order takes effect.

Finally, Plaintiffs do not believe that it makes sense to file their preliminary injunction brief (currently due today) without clarification of the State's position regarding GA-15's application to their services. Accordingly, Plaintiffs plan to email chambers to respectfully request that the time for their brief to be filed be extended by 24 hours, and that this Court convene a status conference to discuss next steps.

Regards,
Jennifer

Jennifer Sandman
Deputy Director
Public Policy Litigation & Law
Planned Parenthood Federation of America
(212) 261-4584
jennifer.sandman@ppfa.org

EXHIBIT 23

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE; *et al.*,	)	
	)	CIVIL ACTION
Plaintiffs,	)	
	)	CASE NO. 1:20-cv-323-LY
v.	)	
	)	
GREG ABBOTT, in his official capacity as Governor; *et al.*,	)	
	)	
Defendants.	)	

DECLARATION OF AMANDA BENNETT IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

AMANDA BENNETT, hereby declares under penalty of perjury that the following statements are true and correct:

1. I am a member of the non-hierarchical Board of Directors ("core member") of the Bridge Collective—an Austin-based nonprofit organization that provides practical support to Texas residents who want to end a pregnancy but face practical and logistical difficulties accessing care.

2. Founded in 2012, Bridge Collective started as a team of full-spectrum doulas providing educational, emotional, and physical support to pregnant people seeking abortion, during childbirth, and soon after they gave birth. After Texas House Bill 2 shuttered abortion clinics across the state in 2014, client needs shifted. People did not need an abortion doula if they could not get to one of the few remaining in-state clinics. We accordingly shifted our focus and resources to supporting people seeking abortion care, specifically by providing rides. Today, we are an all-volunteer practical support collective providing information, rides, childcare, accommodation, and doula services to Texans seeking abortion care in the Austin-area.

3. I first joined Bridge Collective as a volunteer in the spring of 2016; last summer, I became a core member. Over the years, I have served as an intake coordinator and volunteer providing rides, accommodation, and emotional support. I also help recruit and train volunteers. I regularly speak with volunteers about our clients' needs concerning abortion access. I also speak directly with clients about their needs on a regular basis. In addition, I speak with other organizations providing financial and practical support to Texans seeking abortion care.

4. I provide the following testimony based on personal knowledge acquired through my service at Bridge Collective and review of the organization's business records.

Challenges Accessing Abortion Care in Texas

5. Bridge Collective operates a hotline and online intake system for people seeking assistance overcoming barriers to abortion care. Callers contact us and leave a message explaining their needs. An intake coordinator calls them back, usually within twenty-four hours. Currently, we have six intake coordinators who rotate daily. After identifying a caller's needs, the intake coordinator reaches out to our network of forty active volunteers to inquire about whether they are available to assist the caller. If so, the intake coordinator connects the volunteer with the caller.

6. Unfortunately, we are not always able to find a volunteer to help, especially for callers seeking rides or childcare who live outside of Austin. Generally, our callers have abortion appointments during work hours on weekdays, and it can be difficult to find available volunteers, most of whom also work during the day on weekdays. If we are unable to assist a caller, we do our best to connect them to another organization for assistance.

7. During the intake process, we assess the caller's needs, including whether they have an appointment scheduled, and if so, where; how far along in their pregnancy they are; whether they need a ride and if so, how many; and whether the caller needs accommodations, and if so, for

how many nights. We also inquire about whether the caller needs financial assistance. Although we do not have the resources to provide money to our callers, we do our best to help callers secure funds from other organizations. Ultimately, we work closely with our callers to develop a plan for accessing abortion care.

8. Our callers face many challenges to accessing abortion care in Texas. These challenges include lack of abortion providers, lack of access to reliable transportation, need for childcare, lack of emotional support for their abortion decision, an inability to take time off from work or school, and difficulty affording the cost of care.

9. Texas requires most abortion patients to make at least two trips to obtain care, which exacerbates the barriers that people seeking abortion care in Texas face. For example, forcing people to make two trips requires some people to travel long distances to an abortion provider twice, which increases the cost of travel and makes it harder to secure transportation and childcare. Some people opt to stay in Austin overnight rather than make multiple long-distance trips to a provider. That is not an option available to all clients, however. Some clients without childcare, for example, must return home to put their children to bed at night.

10. Delay can also make it harder for people to keep their pregnancies or abortion confidential. Callers seek to keep their pregnancy confidential for a variety of reasons. For example, callers have sought to keep their pregnancy or abortion decision confidential from an abusive partner or parent. Some callers want to keep their pregnancy or abortion decision confidential because no one in their network supports their decision and they fear judgment or irreparable damage to their relationships with family or friends.

11. It is not uncommon for our clients to miss an appointment or delay care because of difficulty overcoming barriers to care.

12. In 2019, over 314 Texans contacted Bridge Collective seeking assistance accessing abortion care.

13. The vast majority of our callers request rides to and from appointments. We provide rides to people located within 100 miles of Austin, and occasionally have helped clients who live even farther away. We routinely travel to Killeen, which is 70 miles away, one way, where there is a military base. In 2019, our volunteers provided 205 rides.

14. Our volunteers also regularly provide accommodation at their homes for clients who need a place to stay before or after their appointments, childcare during their appointments, company during their appointments, and emotional support during the rides to and from their appointments. We train all our volunteers to be supportive, non-judgmental listeners.

Abortion Access in Texas Since the Executive Order

15. The COVID-19 outbreak has impacted Texans' day-to-day lives, including the lives of our callers. For example, a client who I recently provided a ride to lost her job after Governor Abbott's stay-at-home order closed the restaurant at which she worked.

16. The COVID-19 outbreak has also adversely impacted Bridge Collective's ability to assist callers. For example, callers sometimes desire someone to accompany them to the clinic to provide emotional support, including while they are in the waiting room. Some callers must bring their children with them to the clinic and need someone to watch them during their appointment. Prior to the COVID-19 outbreak, our volunteers routinely accompanied clients to their appointments to provide emotional support, childcare, or both. Unfortunately, because of the need for COVID-19 related social distancing, we are unable to offer these services to our clients. Last month, I personally had to decline help to a caller who asked if someone could accompany her to her abortion appointment.

17. I understand that Texas has threatened to enforce an Executive Order by Governor Abbott as a ban on abortion care (the "Executive Order"), which has made abortion care virtually unavailable in Texas.

18. Most callers are referred to us by an abortion clinic after they make their appointments, though sometimes callers find out about us from another source (e.g., another organization providing financial or practical support to Texans seeking abortion care or through an online search). As a result, the vast majority of our callers already have an abortion appointment when they contact us.

19. In March, prior to the Executive Order, thirteen people had contacted us seeking assistance. Since March 23, we have received only five calls, which is far less than we would normally expect to receive. I believe our caller volume has dramatically declined because the Executive Order caused most doctors in Texas to stop providing abortions.

20. We referred two of the five callers since March 23 to other organizations for assistance because they were out of our service area (i.e., more than 100 miles from Austin). Because the Executive Order made most abortion care unavailable in Texas, one of those callers was seeking to travel to Oklahoma to access care.

21. Our volunteers attempted to help the other three callers obtain abortion care. Unfortunately, because of the Executive Order and related judicial decisions, each of their appointments was cancelled. To my knowledge, only one of these callers has been able to obtain an abortion to date.

22. One caller (who was driven by a volunteer to her state-manded pre-abortion appointment a week earlier) requested a ride to and from her medication abortion appointment. The volunteer drove the caller from her home to the closest abortion clinic, which was in Austin—

an approximately three-hour roundtrip drive. The caller had to make three appointments before she was able to obtain care—the first two appointments were cancelled because of the Executive Order and an interim court ruling. The client told us that she experienced a great deal of stress and anxiety throughout the process. She strongly desired an early abortion and the thought of having to delay her abortion to later in pregnancy was very upsetting to her. She preferred a medication abortion because, among other things, it felt more natural to her than a procedural abortion. In addition, because of COVID-19-related social distancing policies, her partner and child would not have been able to accompany her to a procedural abortion appointment. A medication abortion would allow the caller to pass her pregnancy at home, surrounded by her loved ones.

23. The Executive Order gave rise to uncertainty about how, when, and even whether, the caller would obtain an abortion, which caused her a great deal of distress. The possibility that she might be delayed to a point at which she would no longer be able to obtain a medication abortion in Texas was very stressful for her. The Executive Order made the client feel like she was doing something wrong, which exacerbated her stress and anxiety. She described contending with these challenges as the "worst day of [her] life." The client was ultimately able to obtain a medication abortion. However, any additional delay would have pushed her past the gestational limit for obtaining a medication abortion in Texas.

24. Another caller who was eighteen weeks pregnant, as measured from the first day of the last menstrual period ("lmp"), called us seeking assistance accessing a dilation and evacuation abortion. The caller planned to travel from out of town to Austin and stay overnight at a hotel. She would be unable to drive herself to and from the clinic, however, because she would be sedated. She requested that we provide her rides between the clinic and her hotel. Her appointment was cancelled just after the Executive Order went into effect. After the court issued

a temporary restraining order, she made a second appointment. Her second appointment was canceled after the court of appeals allowed the Executive Order to go back into effect. With assistance from another organization, the caller now plans to travel to New Mexico, where she has an appointment at an abortion clinic later this month. Traveling out of state to New Mexico has always been difficult for our callers, but it is even harder now due to COVID-19. For example, this caller worried about whether it is safe to travel to New Mexico, and she struggled to understand New Mexico's rules concerning out-of-state travelers.

25. Another caller who past the gestational limit for medication abortion in Texas contacted us seeking a ride to an aspiration abortion appointment. Like many of our callers, her pregnancy was causing severe nausea. This happens so often that we ask every caller about it and recommend that our drivers keep nausea bags in their cars during the rides. Unfortunately, her March 25 appointment was cancelled due to the Executive Order.

26. The Executive Order has significantly and adversely impacted our callers. It has created confusion, uncertainty, and unnecessary delay. It has forced our callers to stay pregnant when they do not want to be. It has exacerbated the stress of dealing with an unwanted pregnancy and seeking abortion care in Texas.

Dated: April 15, 2020

/S/ Amanda Bennett
Amanda Bennett

EXHIBIT 24

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE, et al., Plaintiffs, v. GREG ABBOTT, in his official capacity as Governor of Texas, et al., Defendants.	No. 1:20-cv-00323

DECLARATION OF CURTIS BOYD IN SUPPORT OF
PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, CURTIS BOYD, declare as follows:

1. I am an owner of Southwestern Women's Surgery Center ("Southwestern") in Dallas, a plaintiff in this lawsuit. I also own Southwestern Women's Options ("Women's Options"), a healthcare facility in Albuquerque, New Mexico that provides abortion care. I submit this declaration in support of Plaintiffs' request for a preliminary injunction, which seeks to enjoin the March 22, 2019 Executive Order No. GA-09 as interpreted by the Texas Attorney General on March 23, 2020 to ban all previability abortion procedures in the state except where immediately necessary to protect the life or health of a patient.

2. Since the Executive Order was interpreted to bar most abortion services in Texas on March 23, abortion care has been inaccessible to many patients in Texas. Given how many patients seek abortion in Texas, thousands of patients have been thrown into uncertainty by the Order. At times, since the Order went into effect, abortion has only been available in Texas in medical emergencies; at other times, medication abortion and/or procedural abortion in certain circumstances where a patient is on the cusp of the legal limit in Texas have also been allowed.

3. Southwestern provides abortion services through 21 weeks, 6 days of pregnancy. It has a well-equipped facility, expert staff, and, presently, patients desperate for care, which we are forbidden to provide.

4. Because we routinely provide individual counseling for all patients, we are privy to their thoughts and feelings as they decide to continue or end a pregnancy. Our patients take the responsibilities of parenthood seriously. The majority already have one or more children, so they consider the welfare of their existing family in making decisions about their current pregnancy. Those who do not yet have children hope to one day—but not now. They may believe they are too young to parent, not yet independent from their own parents, not in a stable relationship, or not financially able to support themselves and a child at this time. Whatever their reason, their choice is valid and essential to their ability to chart their own course in life.

5. Our patients have almost uniformly given the decision to have an abortion extensive, careful thought. Most have talked their situation over with the important people in their life—whether a husband, partner, parent(s), close relative(s), or friend(s).

6. Since March 23, due to the extraordinary number of patients who cannot be seen in Texas under the Executive Order, Women's Options has received unprecedented demand for care from patients traveling from Texas. It is hard to adequately describe the desperation of these Texas patients.

7. It is not unusual for Women's Options to provide services to patients traveling from other states, including Texas. We also receive referrals from providers in Texas for patients who cannot be seen in Texas for one reason or another.

8. Since March 23, we have seen more than double our typical amount of Texas patients, either referred to us by a physician or calling independently because of the Executive Order.

9. At this time of year, our clinic typically has a one week wait time between a patient calling or being referred to the clinic, and the patient's appointment for an abortion. As of April 13, 2020, given the influx of patients from other states, including Texas, the wait time for an abortion appointment at the Albuquerque facility is at least 4 weeks.

10. We are scheduling appointments for Texas patients who, after desperately trying to get in to see us for care, are ultimately unable to navigate the challenges of traveling to us during the pandemic. Each time Texas shuts down abortion services, Southwestern refers patients out of state. Only a small percentage of those women are ultimately able to take time away from work, find childcare, have transportation to make the trip, and access to money to pay the additional costs of travel. Most of our patients face these challenges under the best of circumstances, but these challenges are exponentially increased during the COVID-19 pandemic.

11. In the face of COVID-19 and its associated, additional health and financial risks for all people, and pregnant women in particular, our patients are in even greater need of safe, timely abortion care. They are experiencing high levels of stress and fear around traveling during the pandemic, caring for their families given that so many people are out of work and relying on dwindling resources, and being forced to remain pregnant against their wishes during this public health emergency.

12. To deny patients care, to force them to travel out of state, or to needlessly delay care, especially in this uncertain time, is simply cruel.

13. We are trying to accommodate as many of these Texas patients in Albuquerque as possible. But, we can only see a small fraction. The clinics to which Southwestern refers, including Women's Options, are simply overwhelmed with requests from Texas women and often unable to meet the sudden increase in need for timely care.

14. The Texas women we do see at Women's Options are incredibly grateful. They express that we "saved" them or families; that they don't know "what they would have done" if we hadn't helped them. We are incredibly disheartened about the circumstances that these patients have had to navigate during this already difficult public health crisis. I do not understand how forcing patients to remain pregnant during this time in any way helps to reduce people traveling from home, observe COVID-19 guidance, or preserve capacity of the healthcare system. Rather, it seems that the Order actually undermines all of those goals. Women who remain pregnant only require increasingly involved healthcare, to say nothing of the incredible harm done to women forced to continue pregnancies against their will during the pandemic.

I declare under penalty of perjury that the foregoing is true and correct.

Curtis Boyd

Executed April 15, 2020

EXHIBIT 25

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE, et al., Plaintiffs, v. GREG ABBOTT, in his official capacity as Governor of Texas, et al., Defendants.	No. 1:20-cv-00323

SECOND DECLARATION OF ALICIA DEWITT-DICK IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, ALICIA DEWITT-DICK, declare as follows:

1. I am the administrator of Plaintiff Southwestern Women's Surgery Center ("Southwestern").

2. Southwestern operates a licensed ambulatory surgical center in Dallas. Southwestern provides medication abortion up to 10 weeks as measured from the first day of the woman's last menstrual period ("LMP") and procedural abortions through 21.6 weeks LMP, as well as miscarriage management and contraceptive services. Southwestern provides care to approximately 9000 patients a year.

3. As administrator, I oversee operations at the clinic and am familiar with all aspects of our policies and practices. The facts I state here are based on my experience, my review of Southwestern's business records, information obtained in the course of my duties at Southwestern, and personal knowledge that I have acquired through my service at Southwestern.

4. I submit this declaration in further support of Plaintiffs' request for a preliminary injunction, which seeks to enjoin the March 22, 2019 Executive Order No. GA-09 as interpreted

by the Texas Attorney General on March 23, 2020 to ban all previability abortion procedures in the state except where immediately necessary to protect the life or health of a patient.

5. Each day that we are prevented from providing time-sensitive abortion care, the eventual backlog of patients that the clinic will face after the expiration of the Executive Order increases. The Executive Order is currently effective until 11:59 p.m. on April 21, 2020, but may be extended.

6. Since March 23, when the Texas Attorney General threatened to interpret the Executive Order to bar abortion in most circumstances, Southwestern has cancelled appointments for 483 patients.

7. Prior to March 23, Southwestern was experiencing exceptionally high demand for appointments. During the first quarter of this year, patients were waiting 2-3 weeks to come in for their first counseling and ultrasound visit. Because of Texas's mandatory 24-hour waiting period following counseling, and constraints of physician staffing, patients were typically waiting 1-5 days between their initial counseling visit, and their second visit to receive their abortion, depending on availability.

8. Small independently owned medical providers like Southwestern cannot easily turn their services off and on.

9. Prior to March 23, Southwestern was typically providing 180-200 abortions each week, around 26 % of which were medication abortions, and approximately 2.3 % of which were abortions at 20 weeks gestation and above. A one-month cessation of providing abortion care—which is what the Executive Order causes—would, therefore, result in a backlog of approximately 800 patients.

10. Many of our physicians live out of state and travel to provide care at Southwestern. Our physicians rotate monthly. Due to the COVID-19 pandemic, many of our physicians have had difficulty traveling in and out of Texas.

11. By providing our full range of services 5-6 days per week, we would be able to push our capacity to around 250-300 abortions per week to address the backlog. Operating at this expanded capacity, for each counseling period, we would likely need 12-13 dedicated staff, which would mean around 16 total staff. For each period providing abortions, we would likely need 19-20 dedicated staff, which would mean around 30 total staff members. Operating at this level, therefore, we would need to have around 46 staff members at a minimum. Our staff typically work 4 days a week, and we have 42 total staff, so we would initially need to employ and train 5 additional staff members. But, even operating at this level, based on a sample one-month cessation resulting in a backlog of approximately 800 patients, it would take the clinic a minimum of two months to resolve the backlog. It is likely that even in the most optimistic scenario, there will inevitably be patients we simply cannot see before they are beyond the legal limit in Texas. Unfortunately, every day we are unable to provide our full services, we face increasing difficulty in maintaining our current staff. And, without even our regular amount of staff, the clinic will take many more months to return to its typical practice.

12. Patients cannot wait indefinitely to access abortion care; their need for services only becomes more urgent because abortion increases in complexity with advancing gestational age and it is accessible only up to 22 weeks LMP in Texas.

13. Although we refer patients out of state, we have only been able to refer out a small fraction of the patients that need care.

I declare under penalty of perjury that the foregoing is true and correct.

Alicia Dewitt-Dick

Executed April 15, 2020

EXHIBIT 26

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE; *et al.*,	)	
	)	CIVIL ACTION
Plaintiffs,	)	
	)	CASE NO. 1:20-cv-323-LY
v.	)	
	)	
GREG ABBOTT, in his official capacity as Governor; *et al.*,	)	
	)	
Defendants.	)	

SECOND DECLARATION OF ANDREA FERRIGNO IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

ANDREA FERRIGNO hereby declares under penalty of perjury that the following statements are true and correct:

1. I am the Corporate Vice-President with Whole Woman's Health ("WWH"), a plaintiff in this case.

2. I am providing this declaration to supplement the declaration that I submitted on March 25, 2020.

3. The following testimony is based on personal knowledge, interactions with WWH's staff members and patients, and review of WWH's business records.

4. As I explained in my prior declaration, WWH has adopted policies to protect its patients and staff members from exposure to the virus. Those policies limit the number of patients that we permit in our clinics at any given time and thereby reduce our overall capacity to treat patients.

5. As a result of the Governor's March 22, 2020, Executive Order, WWH has had to turn away more than a hundred patients seeking abortion care. We have helped some of these

patients secure appointments at abortion clinics in other states, including Colorado, Kansas, New Mexico, and Virginia.

6. One patient, pregnant with twins, was very anxious to have an abortion. She was 12 weeks LMP when she contacted our Fort Worth clinic to make an appointment, but we could not treat her there because of the Executive Order. It was very important to her to have an abortion before her pregnancy progressed further and became visible to others. We helped her obtain an appointment at an abortion clinic in Virginia and raised money for her to travel there. She had never flown on an airplane before and was so afraid of flying that she threw up at the airport. She would not have had to make such a long and frightening trip if it wasn't for the Executive Order.

7. As I mentioned in my prior declaration, the cost of abortion care increases with gestational age. The reason is that the duration and complexity of an abortion increases as pregnancy advances, making later abortion care more expensive to provide.

8. The price of an abortion at a given gestational age differs at our Fort Worth and McAllen clinics based on market conditions, but at each clinic, the price remains constant up to 12 weeks LMP and steadily increases each week thereafter. In Fort Worth, the price of a medication abortion or a procedural abortion before 12 weeks LMP is $750, including the pre-abortion consultation. The price increases to $870 at 13-14 weeks LMP; $1,000 at 15-16 weeks LMP; and $1,100 at 17-18 weeks LMP. In McAllen, the price of a medication abortion or a procedural abortion before 12 weeks LMP is $800, including the pre-abortion consultation. The price increases to $1,075 at 13-14 weeks LMP; $1,250 at 15-16 weeks LMP; and $1,550 at 17-18 weeks LMP.

9. WWH used to operate an ambulatory surgical center in San Antonio. That facility closed in 2016. Just prior to its closure, we charged $2,100 for abortion services—including pre-

abortion care and ultrasound—at 18-19 weeks LMP; $2,400 for abortion services at 19-20 weeks LMP; $2,900 for abortion services at 20-21 weeks LMP; and $3,100 for abortion services at 22-23 weeks LMP.

Dated: April 17, 2020

/S/Andrea Ferrigno
Andrea Ferrigno

EXHIBIT 27

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE; *et al.*,	)	
	)	CIVIL ACTION
Plaintiffs,	)	
	)	CASE NO. 1:20-cv-323-LY
v.	)	
	)	
GREG ABBOTT, in his official capacity as Governor; *et al.*,	)	
	)	
Defendants.	)	

DECLARATION OF STEPHANIE GOMEZ IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

STEPHANIE GOMEZ hereby declares under penalty of perjury that the following statements are true and correct:

1. I am a member of the Board of Directors of Fund Texas Choice ("FTC"), a Texas nonprofit corporation that provides financial assistance to Texas residents who must travel to access abortion care to cover the cost of transportation and accommodations. Currently, FTC employs 2 staff members. Our statewide Board and small staff work intentionally and thoughtfully to help ensure abortion access for all Texans.

2. As a Board member, I help shape FTC's mission and direct its strategy based on our clients' experiences. Along with the other Board members, I supervise FTC's staff, which includes a program coordinator. I also serve as the Board's Program Chair and Secretary. In that role, among other things, I am responsible for overseeing FTC's programmatic work and supporting FTC's program coordinator.

3. I provide the following testimony based on personal knowledge acquired through my service at FTC and review of the organization's business records.

FTC Background

4. FTC's clients primarily contact us through our online intake form. Some clients are referred to us from abortion providers or other organizations supporting Texas residents seeking abortion care. We accept intakes until we have exhausted our weekly budget.

5. Every Thursday, we review caller requests for assistance and contact each caller to assess their needs and develop a plan for accessing care. FTC offers travel assistance to clients who already have appointments and covers one hundred percent of their travel costs. We pay for the cost of transportation (i.e., bus fare, gas money, rideshares, or airfare), as well as the cost of lodging. We also help clients schedule appointments if they do not already have one. If a client needs assistance to pay for their abortion, we help that client secure funding from another organization.

6. It is not uncommon for a client to request assistance from multiple organizations to secure the financial and practical resources needed to access care. We regularly work with other organizations supporting Texas residents seeking abortion care.

7. In 2019, FTC assisted 289 Texas residents seeking abortion care.

The Impact of the Governor's Executive Order on Texans Seeking Abortion Care

8. I understand that the State has threatened to enforce an Executive Order by Governor Abbott as a ban on abortion care (the "EO"), which made abortion care virtually unavailable in Texas.

9. Because of COVID-19 and Governor Abbott's stay-at-home Executive Order, clients now struggle with reduced job hours, layoffs, loss of childcare, and even greater difficulty traveling. For example, clients who lack a reliable car have even greater difficulty finding someone

in their network to drive them to appointments. Now more often than before, flights are delayed, which results in longer stays at the airport, or are cancelled, which can require multiple trips to the airport. In addition, clients who must travel out of state for care must contend with different states' rules regarding out-of-state travelers, which can be confusing and make the experience more stressful. For example, although New Mexico requires out-of-state air travelers to self-isolate for a period and recommends that people traveling there by other means do so, it permits all out-of-state travelers to leave their hotels to obtain medical care.

10. Clients are also confused by Texas' conflicting messages about COVID-19. On the one hand, Texas has told them to stay at home to avoid becoming infected by COVID-19. On the other hand, Texas is forcing them to leave the state to access abortion care that should be available in-state. It has been reported that the Texas Department of Safety is ramping up enforcement of the Governor's proclamation requiring travelers from Louisiana to quarantine. One client driving back from Louisiana was stopped by the Department of Safety.

11. Clients traveling out of state also worry about becoming infected with COVID-19 and exposing their family members, children, or housemates after returning home.

12. The COVID-19 outbreak has also made it harder to find lodging for our clients because some hotels have limited their occupancy.

13. In addition, some clients find it harder to keep their pregnancy or abortion decision confidential. One client sheltered at home with her abuser feared her partner would physically harm her if he discovered she was pregnant.

14. As a result of the EO, the vast majority of our clients have been unable to access abortion care in Texas. With assistance from FTC, clients have or plan to travel to Arizona, Colorado, Kentucky, Louisiana, Mississippi, New Mexico, Oklahoma, and Virginia to access care.

Clients sometimes travel to states that are farther away if there is someone in their network there that will provide emotional support to them while they access care in an unfamiliar place. Our clients have limited financial means, and many have never left their communities or traveled by air; because of the EO, they are forced to do so for the first time during a global pandemic.

15. In February, we assisted 24 Texas residents access abortion care, most obtained care in-state.

16. After the Governor issued the EO, FTC had to twice close intake because requests for assistance far exceeded our resources.

17. Since March 23, 44 Texas residents contacted us seeking assistance accessing abortion forced to travel out of state to access abortion care as a result of the EO. Twenty-nine people were less than 11 weeks pregnant, as measured from the first day of their last menstrual period (lmp), and at least one had her appointment for medication abortion cancelled as a result of the EO; we very rarely help clients at this gestational age travel out of state for care. Fifteen of the clients we assisted go out of state for care were between 11-22 weeks lmp. We were able to assist 37 of these clients.

18. Not all clients are able to travel out of state to obtain care. One client who could not obtain an abortion in Texas as a result of the EO was too scared to travel by air or to drive by herself to obtain care. She did not have anyone in her network who would her over ten hours, one-way to the nearest out of state abortion clinic. She still has not obtained her abortion and feels forced to give birth.

19. Until recently, our weekly budget was $1500. Last month, we increased our budget to $2500 to meet increased client need during the COVID-19 outbreak. For the last 2 weeks, we exceeded our weekly budget due to client need.

20. Even before the current public health crisis and the EO, Texas made abortion difficult to access. Abortion providers are scarce, and some patients must travel long distances to their appointments, usually more than once. The COVID-19 outbreak exacerbated existing barriers to care. Now, the EO banning most abortion care has put our clients in crisis mode.

21. Forcing clients to remain pregnant when they do not want to be significantly and adversely impacts their physical and mental well-being and exacerbates the difficulties they face in the current public health crisis.

Dated: April 16, 2020

/S/ Stephanie Gomez
STEPHANIE GOMEZ

EXHIBIT 28

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE; *et al.*,	)	
	)	CIVIL ACTION
Plaintiffs,	)	
	)	CASE NO. 1:20-CV-00323-LY
v.	)	
	)	
GREG ABBOTT, in his official capacity as Governor; *et al.*,	)	
	)	
Defendants.	)	

SECOND DECLARATION OF AMY HAGSTROM MILLER
IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

AMY HAGSTROM MILLER hereby declares under penalty of perjury that the following statements are true and correct:

1. I am the President and Chief Executive Officer ("CEO") of Whole Woman's Health Alliance ("WWHA"), a plaintiff in this case.

2. I am providing this declaration to supplement the declaration that I previously submitted on March 25, 2020.

3. The following testimony is based on my personal knowledge, interactions with WWHA staff and patients, and review of WWHA's business records.

4. As I explained in my prior declaration, WWHA has adopted policies to protect its patients and staff members from exposure to the virus. These policies include social-distancing measures that limit patient volume at our Austin clinic. As a result of these policies, we are not able to provide care to the same number of patients that we would otherwise treat in a given day. Our social-distancing policies reduce our overall capacity.

5. We continue to have to deny care to dozens of patients each week, many of whom find themselves in dire circumstances. For example, we had a patient who was referred to the Austin clinic from a local hospital, where she had been admitted with influenza and pneumonia. The patient, in her second-trimester, is homeless, has few financial resources, and no car. She knew that she wanted to have an abortion, so we helped her raise the necessary funds. We scheduled her appointment at the clinic to coincide with her discharge from the hospital, but we ultimately had to cancel it because of the Executive Order. The patient's pregnancy is now past 18 weeks LMP, so we can no longer provide her abortion care at the Austin clinic. The patient does not have the means to travel out of state for an abortion, and must instead just wait as her pregnancy progresses and the cost of an abortion becomes more expensive. I am concerned that she will be forced to give birth, even though that's not what she wants.

6. Another patient, who was fourteen years old, came to the clinic with her mom. She was nearly 15 weeks LMP. We were not able to provide her abortion because of the Executive Order. Both the patient and her mother were devastated. We offered to assist them in making arrangements to go to an abortion clinic in another state. The earliest appointment we were able to secure was for two weeks later at a clinic in New Mexico. The family was very concerned about the additional expenses that they would incur to obtain abortion care in New Mexico because the mom is the only person in the household who is currently working.

7. As I mentioned in my prior declaration, the cost of abortion care increases with gestational age. This is because, as a pregnancy advances, the amount of time, personnel, supplies and equipment needed to perform an abortion increase.

8. Currently, at our Austin clinic, the price of a medication abortion, including the required pre-abortion consultation, is $725. Up to 12 weeks LMP, the price of a procedural

abortion is $750. After that, the price of a procedural abortion increases by $100 each week. By 18 weeks LMP, the price of a procedural abortion is $1,350.

9. The price of an abortion varies across clinics and cities based on market factors that affect the cost of providing care. But, based on market research that WWHA has conducted, I am aware that abortion clinics throughout Texas have a price structure that is comparable to that of WWHA's Austin clinic.

10. I am also aware that the cost of having an abortion at a Texas ASC at 22 weeks LMP is at least $3,000.

Dated: April 17, 2020

Amy Hagstrom Miller

AMY HAGSTROM MILLER

EXHIBIT 29

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE, *et al*.,

Plaintiffs,

v.

GREG ABBOTT, in his official capacity as Governor of Texas, *et al*.,

Defendants.

No. 1:20-cv-00323-LY

DECLARATION OF COLLEEN HEFLIN, PH.D., IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

COLLEEN HEFLIN, PH.D., hereby declares under penalty of perjury that the following statements are true and correct:

My Professional Background and Qualifications

1. I am a Professor of Public Administration and International Affairs at the Maxwell School of Citizenship and Public Affairs at Syracuse University. At the Maxwell School, I also serve as a Senior Research Associate at the Center for Policy Studies and as a Research Affiliate at the Aging Studies Center. My areas of expertise include poverty policy, social policy, and family and child policy in the United States. My C.V. is attached as Exhibit A.

2. I have been a faculty member at Syracuse University since 2017. Prior to that, I was a Professor at the Harry S. Truman School of Public Affairs at the University of Missouri, where I held various positions, including Co-Director of the Population, Education, and Health Center, and Co-Director of the University of Missouri Research Data Center. I earned my B.A. in social sciences and my master's in public policy from the University of Michigan. I also received my

Ph.D. in sociology, with an emphasis on social demography and population studies, from the University of Michigan, a program that was ranked in the top three in the country at that time.

3. For the past twenty years, my research has focused on the study of social and poverty policy, with a special emphasis on low-income households' inability to meet basic needs and on the evaluation of federal and state social programs available to low-income and poor households. I have taught research methods and program evaluation courses for more than fifteen years to master's students in public affairs. In addition, I regularly teach courses in social or poverty policy at the undergraduate, master's, and doctoral levels.

4. I have conducted research at the national level documenting the vulnerability of low-income households to material hardship. In a recent study, for example, I analyzed how specific shocks to family stability, such as unemployment or becoming disabled, were associated with particular types of material hardship.[1] In another study, with coauthors Jim Ziliak and Samuel Ingram, I examined how participation in the Supplemental Nutrition Assistance Program ("SNAP," commonly known as food stamps) leads to a one- to two-percentage point reduction in population mortality.[2] In other recent projects, I have examined how the population using food stamps and the unemployment insurance program changed with the Great Recession (coauthored work with Peter Mueser);[3] how physical health problems associated with different types of disability are associated with household food insecurity (coauthored with Claire Altman and Laura

[1] Colleen Heflin, *Family Instability and Material Hardship: Results from the 2008 Survey of Income and Program Participation*, 37 J. Fam. and Econ. Issues 359 (2016), doi: 10.1007/s10834-016-9503-6.

[2] Colleen Heflin, Samual Ingram & James P. Ziliak, *The Effects of the Supplemental Nutrition Assistance Program on Mortality*, Health Affairs (forthcoming).

[3] Colleen Heflin & Peter Mueser, *UI and SNAP Receipt in the Sun: The Great Recession and Its Aftermath in Florida* in Helping Together: Unemployment Insurance, Supplemental Nutrition Assistance, and the Great Recession (David Stevens & Michael Wiseman eds., 2019.; Colleen Heflin & Peter Mueser, *Program Participation in the Show Me State: Missouri Responds to the Great Recession*, *in* Helping Together: Unemployment Insurance, Supplemental Nutrition Assistance, and the Great Recession (David Stevens & Michael Wiseman eds., 2019).

Rodriguez);[4] and the later-life consequences for adolescent exposure to household food insecurity (with Rajeev Darolia and Sharon Acevedo).[5] Additionally, I have conducted research on the impacts of government programs and policies on specific populations. For example, in a 2015 study with Andrew London, I examined the use of SNAP benefits by active-duty military, veterans, and reservists.[6]

5. In addition to my research focused on national-level data, I also routinely analyze the impact of social and poverty policies at the state- or community-level. I have worked with states as part of this research, either through data sharing or more active collaboration. For example, I have examined the transition from welfare to work for Temporary Assistance for Needy Families ("TANF") recipients in one county in Michigan,[7] the barriers to accessing SNAP benefits in Florida,[8] and the health care-utilization patterns of SNAP participants in Missouri.[9] I am currently studying the redesign of the recertification process for SNAP benefits in a Minnesota

[4] Colleen Heflin, Claire Altman & Laura Rodriguez, *Food Insecurity and Disability in the United States*, 12 Disability and Health J. 220 (2019), https://doi.org/10.1016/j.dhjo.2018.09.006.

[5] Colleen Heflin, Sharon Kukla-Acevedo & Rajeev Darolia, *Adolescent Food Insecurity and Risky Behaviors and Mental Health During the Transition to Adulthood*, 105 Child. and Youth Servs. Rev. 104416 (2019), https://doi.org/10.1016/j.childyouth.2019.104416.

[6] Andrew London & Colleen Heflin, *Supplemental Nutrition Assistance Program (SNAP) Use among Active-Duty Military Personnel, Veterans, and Reservists*, 34 Population Res. and Pol'y Rev. 805.

[7] Sheldon Danziger, Colleen Heflin, Mary Corcoran, Elizabeth Oeltmans & Hui-Chen Wang, *Does It Pay to Move From Welfare to Work?*, 21 J. Pol'y Analysis and Mgmt. 671 (2002). Reprinted in J. Pol'y Analysis and Magmt. classic volume on "Poverty and Welfare."

[8] Colleen Heflin, Andrew London & Peter Mueser, *Clients' Perspectives on a Technology-Based Food Assistance Application System,* 43 Am. Rev. Pub. Admin. 658 (2013), doi: 10.1177/0275074012455454.

[9] Colleen Heflin, Irma Arteaga, Leslie Hodges, Jean Felix Ndashiyme & Matthew P. Rabbitt, *SNAP Benefits and Childhood Asthma,* 220 Soc. Sci. & Med. 203–11 (2019), https://doi.org/10.1016/j.socscimed.2018.11.001; Chinnedum Ojinnaka & Colleen Heflin, *Supplemental Nutrition Assistance Program Size and Timing and Hypertension-Related Emergency Department Claims Among Medicaid Enrollees*, 12 J. Am. Soc'y of Hypertension e27–e34 (2018), https://doi.org/10.1016/j.jash.2018.10.001; Irma Arteaga, Colleen Heflin & Leslie Hodges, *SNAP Benefits and Pregnancy-Related Emergency Room Visits*, 37 Population Res. and Pol'y Rev., 1031 (2018), http://doi.org/10.1007/s11113-01809481-5.

county,[10] as well as the effects of children's TANF and SNAP participation during the early childhood period on kindergarten-readiness in Virginia.[11]

6. Over the course of my career, I have published more than fifty articles in peer-reviewed academic journals. According to Google Scholar, my research has been cited more than 3,800 times by other academic researchers. In addition, I am regularly asked to lecture to international audiences on the subject of poverty and social policy in the United States.

7. I have received competitive national grants from the United States Department of Agriculture, the United States Department of Health and Human Services, the National Institutes of Health, and the National Science Foundation to support my research.

8. Additionally, I am regularly called on to review the scientific merit of academic research and grant proposals submitted by others. This review typically involves carefully analyzing the data and research methods used, determining if they meet scientific standards in the field, and evaluating whether authors provide a rigorous analysis and interpretation of their research findings.

9. The following testimony is based on my personal knowledge, professional experience, original research, and knowledge of the relevant professional literature.

COVID-19 and Poverty

10. As a consequence of social-distancing requirements and "Stay at Home" orders limiting travel except where necessary to provide or obtain essential services, the United States is facing job losses at truly historic levels. While Texas boasted state unemployment rates at historic

[10] Colleen Heflin & Len Lopoo, *Creating Evidenced-Based Strategies to Address Administrative Churn in SNAP,* Econ. Research Serv., U.S. Dep't of Agric. (forthcoming).

[11] Colleen Heflin & Michah Rothbart, *SNAP Uptake and School Readiness in Virginia*, Econ. Research Serv., U.S. Dep't of Agric. (forthcoming).

lows of 3.5% in February 2020, 760,000 Texans filed for unemployment between March 15th and April 4th, 2020, exceeding the roughly 700,000 claims filed in all of 2019.[12] Ultimately, analysts expect more than 1 million Texans to be jobless,[13] while an official from the Federal Reserve Bank predicted that the national level of unemployment may exceed 30% by June.[14] Nationally, the U.S. Chamber of Commerce reports that half of all small businesses have shut down or expect to shut down in the coming weeks.[15] As of early April, 4 out of 10 Americans already report lost income or a job loss as a result of the COVID crisis, including nearly half of all parents with children under age 18, 54% of part-time workers and 45% of those paid hourly or by the job.[16]

11. One of the unique features of this economic downtown is how quickly the collapse is occurring. While in previous recessions, workers were laid off in waves, often separated by weeks or months, here the process is accelerated, with employers closing down and laying off their entire workforce until the "Stay at Home" orders are lifted. As a consequence, workers have had little advance notice that might have allowed them to cut back on expenses for a few months in order to build a small cushion of savings.

12. Most Americans live paycheck-to-paycheck and short disruptions in pay can lead to an inability to cover basic needs. In a University of Chicago survey conducted a year ago, most

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[12] Mitchell Ferman, Anna Novak & Clare Proctor, *More Texans Filed for Unemployment in the Last 4 Weeks Than All of 2019*, Tex. Tribune (Apr. 9, 2020), https://www.texastribune.org/2020/04/09/761262-texans-filed -unemployment-claims-first-month-coronavirus/.

[13] *Id.*

[14] Andrew Soergel, *Fed Official Warns of 30% Unemployment*, U.S. News (Mar. 23, 2020), https://www.usnews.com/news/economy/articles/2020-03-23/fed-official-unemployment-could-hit-30-as-coronavirus-slams-economy.

[15] MetLife & U.S. Chamber of Commerce, *Special Report on Coronavirus and Small Business* (Apr. 3, 2020), https://www.uschamber.com/report/special-report-coronavirus-and-small-business.

[16] Kaiser Family Found., *Poll: 4 in 10 Americans Report Losing Their Jobs or Work-Related Income Due to the Coronavirus Crisis, Including More Than Half of Part-Time Workers* (Apr. 2, 2020), https://www kff.org/health- reform/press-release/poll-4-in-10-americans-report-losing-jobs-or-income-due-to-coronavirus-crisis-including-more-than-half-part-time-workers.

households (51%) indicated that they would not be able to cover basic necessities after missing one paycheck and this number increased by another 15% after missing two paychecks.[17]

13. As a consequence of the economic disruption caused by COVID-19, Texans are applying for SNAP benefits, commonly known as food stamps, in record numbers in order to feed their families. In March 2020, Texas received twice the number of SNAP applications as in March of the prior year.[18] However, many states, including Texas, have been slow to implement federal changes that would allow applications to move more quickly through the SNAP eligibility process, which, as of this filing, has kept many people from applying and being approved for benefits for which they are eligible.

14. The economic crisis is so dire that Texans are turning to food pantries in record numbers, even though food pantries are often the last resort for households accustomed to supporting themselves. In Austin, over 3,000 cars stood in line for food on April 4th[19]; as of April 10th, the North Texas Food Bank in Dallas announced that it was running out of money to buy food.[20] The U.S. National Guard has been assigned to the East Texas Food Bank to help provide food to the twenty-six-county region it serves. Families across Texas are facing severe economic hardship on an unprecedented scale.

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[17] NORC at the Univ. of Chi., *Most Working Americans Would Face Economic Hardship If They Missed More than One Paycheck* (May. 16, 2020), https://www norc.org/NewsEventsPublications/PressReleases/Pages/most-working-americans-would-face-economic-hardship-if-they-missed-more-than-one-paycheck.aspx.

[18] Stacy Fernández, *230,000 Texas Families Filed for SNAP Food Assistance in March, Twice as Many as Same Month Last Year,* Tex. Tribune (Apr. 13, 2020), https://www.texastribune.org/2020/04/13/texas-snap-applications-coronavirus/.

[19] Stacy Fernández, *Food Banks Rely on Donations from Grocery Stores. But as Texans Rush Stores, Grocers Have Less to Give.*, Tex. Tribune (Apr. 8, 2020), https://www.texastribune.org/2020/04/08/texas-food- banks-low-supplies-volunteers-during-coronavirus-pandemic/.

[20] Natalie Solis, *North Texas Food Bank Running Out of Money as Demand Continues to Grow Due to COVID-19 Pandemic* (Apr. 10, 2020), https://www.fox4news.com/news/north-texas-food-bank-running-out-of-money-as-demand-continues-to-grow-due-to-covid-19-pandemic.

15. Additionally, when jobs are lost, often private health insurance is lost as well. This is particularly harmful during a public health emergency like this one, when individuals are likely to incur medical costs associated with treatment for COVID-19. According to one estimate, approximately 7.3 million workers (along with their family members) are likely to lose health insurance coverage by the end of June, with losses more heavily concentrated in states, such as Texas, which have not expanded Medicaid.[21] As of this filing, current federal legislation has not provided support in the form of health care subsidies or coverage for these workers and their families.

16. The economic consequences of COVID-19 provide an important backdrop to the observations made here. While poor and low-income women face obstacles to receiving abortion services under normal conditions, the financial and logistical hurdles that must be overcome to access abortion have grown in ways that are difficult to document given the recency of the crisis. Although I have attempted to use the most recent data possible, given how quickly the pandemic has unfolded, public data that would fully document the extent to which and exactly how poor and low-income women in Texas are being impacted is largely not yet available. Most of the analysis provided below likely grossly understates the hurdles COVID-19 has created for poor and low-income women in obtaining abortion services in Texas.

Texas Governor Greg Abbott's Executive Order GA-09

17. I understand that on March 22, 2020, Texas Governor Greg Abbott issued Executive Order GA-09 ("Executive Order") stating that all surgeries and procedures that are not medically necessary to correct a serious medical condition or to preserve the life of a patient should

[21] Steffie Woolhandler & David U. Himmelstein, *Intersecting U.S. Epidemics: COVID-19 and Lack of Health Insurance*, Annals of Internal Med. (Apr. 7, 2020), https://annals.org/aim/fullarticle/2764415/intersecting -u-s-epidemics-covid-19-lack-health-insurance.

be postponed because of the COVID-19 pandemic.[22] I understand that the Executive Order is in effect until 11:59 p.m. on April 21, 2020, but that it may be extended.

18. I further understand that in a press release on March 23, 2020,[23] Texas Attorney General Ken Paxton declared that, as a result of the Executive Order, abortion providers must postpone "any type of abortion that is not medically necessary to preserve the life or health of the mother." I understand that, under the Attorney General's interpretation, the Executive Order prohibits the provision of almost all abortion at any gestational point in pregnancy.

19. I have reviewed the statutes that establish gestational age limits for different categories of abortion in Texas. Based on those statutes, I understand that, in Texas, medication abortion is available up to ten weeks LMP,[24] procedural abortion after eighteen weeks LMP must be performed in an ambulatory surgical center ("ASC"),[25] and abortion is illegal after twenty-two weeks LMP except in limited circumstances.[26]

20. I have also reviewed the declaration of Kari White. Based on that declaration, I understand that all of the ASCs that provide abortions after eighteen weeks LMP are located in Austin, Dallas, Houston, or San Antonio.

21. In this declaration, I describe the challenges that poor and low-income women, including those in Texas, already face when coping with an unexpected situation, such as unwanted pregnancy, and the additional hardship that the Executive Order will create for Texas women if it

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[22] Tex. Exec. Order No. GA-09 (Mar. 22, 2020), https://gov.texas.gov/uploads/files/press/EO-GA_09_COVID-19_hospital_capacity_IMAGE_03-22-2020.pdf.

[23] Press Release, Ken Paxton, Att'y Gen. of Tex., Health Care Pro-fes-sion-als and Facil-i-ties, Includ-ing Abor-tion Providers, Must Imme-di-ate-ly Stop All Med-ical-ly Unnec-es-sary Surg-eries and Pro-ce-dures to Pre-serve Resources to Fight COVID-19 Pandemic (Mar. 23, 2020), https://www.texasattorneygeneral.gov/news/releases/ health-care-professionals-and-facilities-including-abortion-providersmust-immediately-stop-all.

[24] Tex. Health & Safety Code § 171.063(a)(2).

[25] Tex. Health & Safety Code § 171.004.

[26] Tex. Health & Safety Code § 171.044.

is used to delay access to abortion, thus making abortion and the logistics required to access it more expensive.

22. The opinions detailed below are based on my own research, my professional experience, and my familiarity with the relevant literature in my field, as applied to my understanding of the facts in this case.

Impact of Executive Order GA-09 on Abortion Access

23. Even before the COVID-19 pandemic and the Executive Order, low-income and poor women in Texas faced substantial costs associated with obtaining abortion services related to the medical costs of the procedure, travel costs to get to a provider, as well as lost wages and childcare expenses. These expenses created significant barriers to care for low-income and poor women in Texas, who lack the flexibility in their finances to cover unexpected medical and transportation costs. To navigate these barriers related to abortion services, low-income and poor women have had to forgo essential expenses, making them and their existing children vulnerable to food insecurity, homelessness, utility shut-offs, and health care crises, and potentially starting a cascade of negative life events from which national evidence shows it is difficult to return to equilibrium.

24. The economic reality faced by low-income and poor women in Texas creates a series of obstacles (cost of procedure, transportation, missed work, child care, etc.) that must be overcome when navigating unexpected medical expenses, such as the need for abortion services. These logistical and financial challenges delay access to abortion services for low-income and poor women and prevent some women from accessing abortion altogether.[27]

[27] Lawrence B. Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 Contraception 334 (2006); Ushma D. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 Am. J. Pub. Health 1687 (2014).

25. As discussed above, the COVID-19 pandemic has only exacerbated economic insecurity for families in Texas, meaning that more families are facing economic hardship with fewer resources to support them, with the consequence that barriers to accessing health care are higher than ever. By delaying access to abortion for weeks (even assuming it is not extended beyond April 21, 2020), the Executive Order requires patients to get an abortion later in pregnancy than they otherwise would, when procedures are more expensive and available at fewer locations in Texas. Given this increased expense and logistical complexity, combined with the financial instability caused by the pandemic, it will be extremely difficult for poor and low-income people to access abortion immediately once the Executive Order is lifted.

Background on Poor and Low-Income Households in Texas

26. A person is defined by the U.S. Census Bureau as being "poor" if she lives in a household whose total annual income is below the federal poverty level ("FPL") for her family size. For example, a household with one adult and one child is defined as poor in 2020 if the household's annual household income falls at or below $17,240, or $1,437 per month. For a woman living alone, the federal poverty level is $12,760 annually, or $1,063 per month.[28]

27. In Texas, 14.9% of residents—or more than 4.1 million people—were poor in 2018, the most recent year that data is available and a point when the Texas economy was strong. The child poverty rate in Texas is even higher: in 2018, 21.1%, or 1.5 million, Texas children aged 0–17 years old lived in households with incomes below the federal poverty level.[29]

[28] U.S. Dep't of Health and Human Servs., *HHS Poverty Guidelines for 2020* (Apr. 15, 2020), https://aspe.hhs.gov/2020-poverty-guidelines.

[29] U.S. Census Bureau, *Poverty Status in the Past 12 Months: Texas* https://data.census.gov/cedsci/all?q=poverty%20texas&g=0400000US48&hidePreview=false&tid=ACSST1Y2018.S1701&t=Poverty&vintage=2018&layer=VT_2018_040_00_PY_D1&cid=S1701_C01_001E/ (last visited Apr. 15, 2020).

28. State level poverty data for 2020 in Texas will not be available until fall 2021 at the earliest. As a consequence, the statistics cited herein to document the reach and depth of poverty in Texas grossly understate the size of the population that is currently poor and low-income as a result of COVID-19. The actual number of women in Texas who will be burdened by the Executive Order could easily be more than twice the size indicated by 2018 statistics.

29. Poverty in Texas tends to be widespread and geographically dispersed. According to the 2018 Small Area Income and Poverty Estimates, out of the 254 counties in Texas, there are 212 counties in Texas with poverty rates above the national average of 11.8%. However, even in a high-poverty state like Texas, six counties stand out as having particularly high levels of poverty—over 30%. These counties are Hidalgo, Brooks, Zavala, Zapata, Starr and Willacy, which are generally located along the Mexican border.[30] Women in these high-poverty counties are more likely to face higher barriers to receiving abortion services.

30. The risk of poverty in Texas is concentrated among particular demographic groups. According to American Community Survey 2018 data, a nationally representative survey collected by the U.S. Census Bureau, women in Texas are more likely to be poor than men (16.3% versus 13.4%), and, among adults, the poverty rate is highest among Texans of reproductive age—18-34 years, when the rate rises to 16.2%.[31] In addition, Texans of Hispanic or Latino origin are more likely than other racial and ethnic groups to be poor (20.9%), followed by those who identify as Black or African American (19.6%), and American Indian or Alaska Native (15.6%).[32]

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[30] Index Mundi, *Texas Poverty Rate by County*, https://www.indexmundi.com/facts/united-states/quick - facts/texas/percent-of-people-of-all-ages-in-poverty#table (last visited Apr. 16, 2020).

[31] U.S. Census Bureau, *Poverty Status in the Past 12 Months: Texas, supra* note 29.

[32] *Id.*

31. Poverty experts widely acknowledge that the federal-poverty-level measure no longer accurately reflects the income required to meet basic needs. This poverty measure was originally designed in the 1960s by taking the average amount of money required to support a modest diet and multiplying that number by three, since food comprised a third of a household's monthly expenses at that time. The standard for determining the federal poverty level has been adjusted for inflation, but no other changes have been made since its creation. Currently, however, food purchases constitute about one-eighth of household consumption; other costs, such as housing and transportation, have increased as a share of household expenses. Additionally, new categories of spending have emerged that did not exist in the 1960s, such as cell phones, computers, and internet coverage. Furthermore, the federal poverty level does not account for work-related, childcare, or medical-care expenses that are mandatory and not discretionary. The impact of these expenses in calling into question the FPL standard is somewhat offset by the fact that the definition of household income used for calculating the federal poverty level does not include the value of near-cash transfers, such as food stamps, housing assistance, and the Earned Income Tax Credit, as well as regional differences in the cost of living.[33] However, poverty experts still widely acknowledge that, on balance, the federal-poverty-level measure underestimates the number of households that struggle to make ends meet.

32. Households with incomes up to 200% of the poverty line, although not technically "poor," are considered "low-income" households, as that term is used in the literature. In Texas, 34% of all individuals (over 9.5 million Texans) survived on incomes below 200% of the federal poverty level, according to data from the American Community Survey.[34] According to the

[33] John Iceland, Poverty in America: A Handbook (2d ed. 2006).

[34] Kaiser Family Found., *Distribution of the Total Population by Federal Poverty Level* https://www kff.org/other/state-indicator/distribution-by-fpl/?currentTimeframe=0&selectedDistributions=under-100percent--100-199percent--200-

National Center for Children in Poverty, 48% of all children in Texas in 2016 (3,375,666 children) lived in low-income families.[35]

33. Our federal social policy acknowledges that families with incomes above the federal poverty level still need assistance in meeting basic needs. For example, in the SNAP program, federal eligibility is set at 130% of the federal poverty level, and states have the option of extending income eligibility—as many do, including Texas—up to 185% of the federal poverty level.[36] Similarly, income eligibility for subsidized school meals extends to 185% of the federal poverty level,[37] as does income eligibility for the Women, Infants and Children Program ("WIC").[38] Under federal law, states also have the flexibility to set an income eligibility threshold for the Low-Income Home Energy Assistance Program between 100% and 150% of the federal poverty level.[39] Finally, Medicaid, which provides public health insurance for the poor, can, at state option, extend up to 300% of the federal poverty level in some cases.[40]

34. Before the onset of COVID-19, at the national level, among low-income households in which one member was employed but did not work full-time, year-round, two out of five households reported housing insecurity and two out of five households reported food

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399percent&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited Apr. 15, 2020).

[35] Nat'l Ctr. for Children in Poverty, *Texas Demographics of Low-Income Children* (Nov. 19, 2018), http://www.nccp.org/profiles/TX_profile_6.html.

[36] U.S. Dep't of Agric., Supplemental Nutrition Assistance Program (SNAP) Fiscal Year (FY) 2019 *Income Eligibility Standards (Oct. 1, 2018)*, https://fns-prod.azureedge.net/sites/default/files/snap/FY19-Income-Eligibility-Standards.pdf; U.S. Dep't of Agric., State Options Report (May 31, 2018), https://fns-prod.azureedge.net/sites/default/files/snap/14-State-Options.pdf.

[37] Child Nutrition Programs: Income Eligibility Guidelines, 84 Fed. Reg. 10,295 (March 20, 2019).

[38] U.S. Dep't of Agric., Special Supplemental Nutrition Program for Women, Infants and Children (WIC): 2018/2019 Income Eligibility Guidelines, 83 Fed. Reg. 14,240 (Apr. 3, 2018).

[39] U.S. Dep't of Health & Human Servs., *LIHEAP Assistance Eligibility* (Jan. 11, 2016), http://www.acf.hhs.gov/ocs/resource/liheap-eligibility-criteria.

[40] Ctrs. for Medicare & Medicaid Servs., *Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels* (Apr. 1, 2019), https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels/index.html.

insecurity. Even among low-income households in which one adult worked full-time, full-year one in four reported housing insecurity and one in four reported food insecurity.[41]

The Intersection of Poverty and Abortion Care

35. Poverty levels among women and children in Texas and across the nation are relevant to abortion access because poor and low-income women face higher odds of having an unintended pregnancy and abortion.[42]

36. Among women who are poor, 60% of pregnancies are unintended, and among low-income women (i.e., those with household incomes below 200% of the federal poverty level), 52% of pregnancies are unintended.[43] The rate of unintended pregnancies for low-income women is five times higher than it is for more affluent women, who—according to nationally representative data from the National Survey of Family Growth—are likely to have better access to health care services and contraception than low-income women.[44]

37. Approximately one-half of all women seeking abortion in the United States are poor, which—as noted above—means that they live in households with incomes below the federal poverty level for their family size. Additionally, another quarter of all women seeking abortion nationally live in low-income households, meaning that their household earns below 200% of the federal poverty level.[45] Thus, roughly 75% of all women seeking abortion in the United States are either poor or low-income.

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[41] Gregory Acs & Pamela Loprest, Urban Inst., Who Are Low-Income Working Families? 8 (Sept. 2015), http://www.urban.org/sites/default/files/publication/51726/311242-who-are-low-income-working-families-.pdf.

[42] Lawrence B. Finer & Mia R. Zolna, *Declines in Unintended Pregnancy in the United States 2008-2011*, 374 New Eng. J. Med. 843 (2016).

[43] *Id.*

[44] *Id.*

[45] Jenna Jerman, Rachel K. Jones & Tsuyoshi Onda, Guttmacher Inst., Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008, at 7 (2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.

38. To better conceptualize the impact of poverty on Texas abortion patients, it is helpful to know the household composition of women seeking abortion in the state. According to data provided in the Texas Department of Health and Human Service's Induced Termination of Pregnancy Reports, 52,669 residents of Texas received abortions in 2017 (52,103 of which were for performed within Texas). Less than one-fifth (18%) of Texas residents who obtained abortions were married, while 82% were unmarried (i.e., divorced, widowed, or never-married), with the remaining women (n=14) not providing marital status.[46] About 61% of Texas residents who received abortions in 2017 had at least one prior live birth.[47]

39. These data suggest that it is common for women seeking abortion in Texas to live in a single-parent household with at least one child. If an unmarried woman in Texas with one child is working full-time, year-round, at the current prevailing minimum wage of $7.25,[48] her annual gross household income would be $15,080, or $1,256 per month. Since her income is below the federal poverty level for a two-person family of $17,210, she and her child are considered poor. If she earns more than $17,210 but less than $34,420 annually—between 100% and 200% of the federal poverty level for a two-person family—she and her child would be considered low-income.

40. Alternatively, a woman without children who worked full-time, year-round at minimum wage and lived alone would be considered low-income: her annual gross household income of $15,080 is equivalent to 118% of the federal poverty level for a one-person household.

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[46] Texas Dep't of Health and Human Servs., *ITOP Report 2017* (2019), https://hhs.texas.gov/about-hhs/records-statistics/data-statistics/itop-statistics (last visited Apr. 15, 2020).

[47] Texas Dep't of Health and Human Servs., *2017 ITOP Narrative Texas Residents* (2019), https://hhs.texas.gov/sites/default/files/documents/about-hhs/records-statistics/research-statistics/itop/2017/2017-itop-narrative-texas-residents.pdf (last visited Apr. 15, 2020).

[48] U.S. Dep't of Labor, *Consolidated State Minimum Wage Update Table* (Jan. 1, 2020), https://www.dol.gov/agencies/whd/mw-consolidated.

Existing Poverty-Related Barriers That Delay Women's Access to Health Care, Including Abortion

41. Poor and low-income women, many of whom already have children, face higher barriers to accessing health care, including abortion services, than their more affluent counterparts even during normal times in which there is not a state of emergency.[49] These barriers help explain why some women experience delays in obtaining abortions and why it would be so difficult currently, during a national pandemic, to secure care quickly once the Executive Order expires.

(1) Procedure Costs

42. The need to pull together financial resources to pay for abortion services is one of the reasons most frequently cited by women who would have preferred to have had their abortion earlier.[50] These financial pressures intensify in the second trimester of pregnancy because the cost of abortion increases with gestational age.[51]

43. Research based on a survey of abortion providers in 2014 indicates that at that time, in states (including Texas) that the authors categorized as hostile to abortion rights, the mean cost for a surgical abortion at 10 weeks of pregnancy was $442 and was $479 for a medication abortion (both adjusted for cost of living). By twenty weeks, the mean cost of an abortion in these states was $1,350 (adjusted for cost of living).[52] For a woman working full-time and earning the minimum wage, the cost of an abortion at ten weeks represents between 35% and 38% of her gross monthly income; for a woman seeking an abortion at twenty weeks the full cost of the procedure

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[49] Finer & Zolna, *supra* note 42.

[50] Finer et al., *supra* note 27; Upadhyay et al., *supra* note 27.

[51] Stanley K. Henshaw & Lawrence B. Finer, *The Accessibility of Abortion Services in the United States, 2001*, 35 Persp. on Sexual & Reprod. Health 16 (2003), https://www.guttmacher.org/journals/psrh/2003/01/accessibility-abortion-services-united-states-2001.

[52] Rachel K. Jones, Meghan Ingerick & Jenna Jerman, *Differences in Abortion Service Delivery in Hostile, Middle-ground, and Supportive States in 2014*, 28 Women's Health Issues 212, 216 (2018).

alone is more than she earns in an entire month. For women who are barely able to make ends meet, scraping together the costs for abortion procedures that were even half these amounts would represent a substantial financial burden.

44. While middle-class women may be able to rely upon savings, credit cards, or other financial services to cover unexpected medical expenses, poor and low-income households have fewer options. Recent research documents that 40% of Americans lack the savings required to cover an unexpected $400 expense and that 3 in 10 adults would be unable to pay their bills if faced with a $400 unexpected expense.[53] 22% of Americans are unbanked or under-banked, relying upon nonstandard banking options such as check-cashing services, pawn shops, and payday lenders that charge higher fees for financial services than traditional banking options; the use of these nonstandard banking options is much higher among the low-income and poor.[54] Additionally, low-income households are much more likely to have their credit applications denied, and while nearly 100% of households with incomes over $100,000 have at least one credit card, for households with incomes below $40,000 this drops to 60%.[55] Thus, poor and low-income families do not have access to the same types of financial strategies that middle-class families can use to mitigate the hardship that an unexpected expense creates.

45. Accordingly, in order to afford an unexpected medical expense such as abortion, poor and low-income women make trade-offs among basic needs. For example, one study of women in Arizona reported that "the majority of women seeking abortion services had to forgo or

[53] Bd. of Governors of the Fed. Reserve Sys., Report on the Economic Well-Being of U.S. Households in 2018, at 21 (May 2019), https://www.federalreserve.gov/publications/files/2018-report-economic-well-being-us-households-201905.pdf.

[54] *Id.*

[55] *Id.*

delay food, rent, childcare, or another important cost to finance their abortion."[56] In some cases, however, the timing of abortion care will need to be juggled alongside other mandatory expenses. For example, recent evidence based on bank transaction data demonstrates that "consumers increase health care spending by 60% in the week after receiving a tax refund, and the majority of these payments are made in person—likely for care received on that day . . . . The findings suggest that many consumers make decisions about when to pay for and receive health care based on whether they have the cash on hand."[57]

46. Evidence documenting what is known in the literature as the "eat or treat" phenomenon further supports my view that women will make trade-offs among basic needs to afford an abortion. The "eat or treat" phenomenon refers to a dynamic in which individuals faced with an unexpected medical expense—particularly one for which insurance coverage is not available—may be forced to decide whether to obtain food or medical care. For example, nationally representative data establish that one in three chronically ill individuals are unable to afford food, medication, or both, and that having public health insurance, such as Medicaid, reduces levels of food insecurity and medication underuse.[58]

47. Similarly, in my own research using data from Missouri and working with a set of coauthors, I examined the relationship between emergency room ("ER") visits for pregnancy-related causes and the timing of SNAP benefit receipt. Pregnant women are very sensitive to fluctuations in the quantity and quality of food consumed, and research suggests that households

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[56] Deborah Karasek, S.C.M. Roberts & Tracey A. Weitz, *Abortion Patients' Experience and Perception of Waiting Periods: Survey Evidence Before Arizona's Two-Visit 24-Hour Mandatory Waiting Period Law*, Women's 26 Health Issues 60, 64 (2016).

[57] Diana Farrell, Fiona Greig & Amar Hamoudi, *Cash Flow Dynamics and Family Health Care Spending: Evidence From Banking Data*, Health Affairs Health Policy Brief, Dec. 13, 2018, DOI:10.1377/hpb20181105.26180.

[58] Seth A. Berkowitz et al., *Treat or Eat: Food Insecurity, Cost-Related Medication Underuse, and Unmet Needs*, 127 Am. J. Med. 303 (2014); Dena Herman et al., *Food Insecurity and Cost- Related Medication Underuse Among Nonelderly Adults in a Nationally Representative Sample*, 105 Am. J. Pub. Health e48 (2015).

tend to spend their SNAP benefits soon after receiving them, and, as a consequence, consume fewer calories at the end of the month.[59] Given that non-SNAP sources of income tend to be received early in the month and exhausted in the latter part of the month, and that SNAP benefits in Missouri are distributed based on the household head's birth month and last name over the first twenty-two days of the month, I explored the relationship between the within-month SNAP benefit timing and pregnancy-related ER claims against the backdrop of a late-in-month scarcity of non-SNAP resources. I found that among Missouri women aged seventeen to forty-five who were of childbearing age and on SNAP and Medicaid, women who received SNAP benefits later in the month were less likely to go to the ER for pregnancy-related causes in the weeks after they received their benefits—that is, in the latter part of the month—compared to those who received their SNAP benefits earlier in the month. This finding suggests that receiving SNAP at different points in the month helped pregnant women distribute their food consumption more evenly and maintain their health.[60]

48. My research suggests that the financial burden of having to pay for and travel to access abortion services is likely to act as a barrier to care, result in other basic needs not being met, or both. Those women for whom the expense of an abortion is infeasible given other basic needs may experience a delay in accessing abortion care, if they are able to access it at all. As the Board of Governors of the Federal Reserve System recently recognized: "There is a strong relationship between family income and individuals' likelihood of receiving medical care. Among those with family income less than $40,000, 36% went without some medical treatment in 2018,

[59] Parke E. Wilde & Christine K. Ranney, *The Monthly Food Stamp Cycle: Shopping Frequency and Food Intake Decisions in an Endogenous Switching Regression Framework*, 82 Am. J. of Agric. Economics, 200 (2000).

[60] Colleen Heflin, The Mediating Effects of SNAP on Health Outcomes for Low Income Households, Address at the Ctr. for Research on Inequalities and the Life Course Seminar, Yale Univ. (Apr. 27, 2016).

down from 39% in 2017. This share falls to 24% of those with incomes between $40,000 and $100,000 and 8% of those making over $100,000."[61]

49. It is unlikely that women seeking abortion can overcome insufficient financial resources by relying on financial help from family and friends alone. First, low-income households are likely to be embedded in family and friend networks that are also struggling economically.[62] What little empirical evidence there is around financial transfers between family members suggests that such transfers are uncommon and tend to be of low monetary value.[63] Second, while some women may receive financial assistance, it is not enough to ensure that women avoid making trade-offs in essential expenses. Surveys of women who have received abortion services suggest that despite receiving financial assistance, many report experiencing financial hardships.[64]

50. Given the level of economic uncertainty created by the COVID-19 crisis, the increased procedure costs associated with abortion care later in pregnancy once the Executive Order is lifted itself represents a substantial economic burden on poor and low-income women in Texas. Many poor and low-income women will delay care as they try to pull together the resources to cover the costs, most will experience financial hardship as a result, and some will be prevented from securing abortion services at all.

(2) Travel-Related Costs

51. Women seeking abortions in Texas must also consider how they will pay for associated travel costs, which may further delay the timing of an abortion. Before the COVID

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[61] Bd. of Governors of the Fed. Reserve Sys., *supra* note 53, at 23.

[62] Colleen Heflin & Mary Pattillo, *Poverty in the Family: Race, Siblings and Socioeconomic Heterogeneity*, 25 Social Sci. Res. 804 (2006).

[63] Kathleen McGarry & Robert F. Schoeni, *Transfer Behavior in the Health and Retirement Study: Measurement and the Redistribution of Resources within the Family*, 30 J. Human Res. S184 (1995).

[64] Karasek, Roberts & Weitz, *supra* note 56, at 64.

crisis and the Executive Order prohibiting most abortion in Texas, almost half of Texas counties were over 100 miles from the nearest U.S. facility that provided abortion services. If Texas residents are all forced to travel out of the state to receive abortion services, this will substantially increase the already high distance that women are forced to travel to access care: 94% of Texas counties are 100 miles or more from a U.S. facility and 72% are over 200 miles away.[65]

52. As the distance increases, so do the series of obstacles that women in Texas must overcome in order to obtain abortion services. "With distance comes increased travel time, increased costs of transportation and child care, lost wages, need to take time off of work or school, the need to disclose the abortion to more people than desired, and overall delays in care."[66]

53. These travel-related obstacles fall particularly hard on women with low incomes. "Lower-income women who are unable to access a car or money for gas may have to travel by bus, train, or other forms of transportation, which also becomes more difficult the farther they have to travel. Delays in care due to distance or transportation can push women seeking abortion to later gestations and are likely to disproportionately affect low-income women, who may struggle to cover the cost of transport."[67] Thus, transportation creates its own hurdle for abortion services for low-income women due to both distance and cost in Texas.

54. For women without access to a reliable car (and without a friend or family member able to drive them), travel by public transportation involves more logistical complexity, in addition to cost.

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[65] Kari White et al., *The Potential Impacts of Texas' Executive Order on Patients' Access to Abortion Care*, Tex. Policy Evaluation Project (Mar. 2020), http://sites.utexas.edu/txpep/files/2020/03/TxPEP-Research-Brief-Executive-Order-3-31-20.pdf.

[66] Alice F. Cartwright et al., *Identifying National Availability of Abortion Care and Distance from Major U.S. Cities: Systematic Online Search*, 20 J. Med. Internet Res. e186 (2018), http://www.jmir.org/2018/5/e186/pdf.

[67] *Id.* at 9.

55. In the middle of the COVID pandemic, relying upon either public transportation or a friend or family member to drive them potentially exposes women to the risk of infection. The Center for Disease Control has taken the unusual step of issuing guidance for precautions to take when traveling within the United States.[68]

56. If a woman can successfully negotiate the financial and logistical hurdles in traveling out of state to obtain abortion services, she may need to contend with a 14-day quarantine required upon her return to Texas, per other executive orders issued by Governor Abbott.[69] During a quarantine, according to CDC guidelines, she must be physically isolated from family members and friends and refrain from working.

57. The cost of travel itself—for example, gas money or the price of a bus ticket—does not include other related costs, such as meals, local transportation, and additional nights of hotel stays. Those hotel costs could be significant, particularly beginning at approximately eighteen weeks of pregnancy: at that gestational age, an abortion generally takes two consecutive days, the first to prepare a patient's cervix, and the second to perform the actual abortion procedure. Women who need abortions at this gestational age must either make two trips to the clinic—thereby doubling travel time and costs—or stay overnight near the clinic for at least one night between clinic visits, maybe longer depending on the distance to the woman's home and whether and when she is able to drive after the procedure.

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[68] Ctrs. for Disease Control & Prevention, *Coronavirus and Travel in the United States* (Apr. 13, 2020), https://www.cdc.gov/coronavirus/2019-ncov/travelers/travel-in-the-us html.

[69] *See* Governor Greg Abbott, Executive Order GA-11, "Relating to airport screening and self-quarantine during the COVID-19 disaster" (March 26, 2020), *available at* https://gov.texas.gov/uploads/files/ press/EO-GA-11_airport_travel_reporting_COVID-19_IMAGE_03-26-2020.pdf; Governor Greg Abbott, Executive Order GA-12, "Relating to roadway screening and self-quarantine during the COVID-19 disaster" (March 29, 2020), *available at* https://gov.texas.gov/uploads/files/press/EO-GA-12_roadway_quarantine_for_COVID-19_IMAGE_03-29-2020.pdf.

58. Travel for medical care imposes other, less tangible costs in addition to the financial costs of the procedure and necessary transportation. Low-wage jobs have several characteristics that make an unexpected medical expense particularly burdensome, separate from the low wages themselves. First, while almost 3 out of 4 of all workers have access to paid sick leave, in the service industries, where many low-wage workers are employed, 39% of workers lack access to paid sick leave.[70] In the bottom 10% of the wage distribution, that rate rises to 69%.[71] Without sick leave, women in low-wage jobs are very likely to need to take uncompensated time off work to deal with medical issues, making it even harder to pay for the medical expense. Some employers also require workers to disclose why they are taking time off, jeopardizing women's confidentiality. Second, low-wage workers are likely to have unpredictable work schedules, with last-minute changes to the posted schedule and the total hours worked.[72] This adds to household income instability and makes it difficult to plan ahead to schedule a doctor's appointment. Additionally, women may be risking their job security by turning down work hours offered by an employer, a particularly important concern at a time when so many low-wage workers are losing their jobs. Finally, 15% of all employed workers hold more than one job at a time, making it even harder to plan ahead for time off work for a doctor's appointment.[73] Thus, low-wage work itself creates barriers for women navigating unexpected needs for medical care, such as abortion.

59. The work-related difficulties associated with out-of-state travel for abortion services are increased during the COVID-19 crisis. Particularly in light of travel-related quarantine

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[70] U.S. Dep't of Labor, Bureau of Labor Statistics, News Release: Employee Benefits in the United States—March 2019, at 16, https://www.bls.gov/news.release/pdf/ebs2.pdf (Sept. 19, 2019).

[71] *Id.*

[72] Bd. of Governors of the Fed. Reserve Sys., Report on the Economic Well-Being of U.S. Households in 2016 (May 2017), https://www.federalreserve.gov/publications/files/2016-report-economic-well-being-us-households-201705.pdf.

[73] *Id.*

recommendations, the work disruption is likely to be quite significant, potentially resulting in the loss of over two weeks' pay.

60. In addition, arranging and paying for child care presents another logistical barrier for women seeking abortion. Even as a one-day trip with a personal car, the trip could be very long and might extend beyond normal childcare hours. A woman would therefore be required to find a family or friend to drop off and/or pick up her child from childcare and to care for the child during the additional hours she is away, or find a family member or friend to provide childcare for the entire trip. An overnight stay for one or more days to obtain an abortion would further compound these logistical barriers. Standard childcare arrangements are not available for overnight care. Once again, women must rely upon family and friends to help care for their child while they seek health care. In order to make such an arrangement, a woman must likely disclose the reason for her trip, resulting in a further loss of confidentiality.

61. As should be clear from the picture provided above of the challenges that poor and low-income women face in obtaining abortion services in Texas, even when the county is not facing a national pandemic, financial and logistical challenges often delay women's access to abortion even after women are aware of their pregnancy and have made the decision to have an abortion. The suggestion that patients can obtain abortions immediately once the Executive Order is lifted ignores the reality of poor and low-income women's lived experience and the added layer of difficulty women are facing during the COVID-19 crisis.

Additional Burdens That The Executive Order Would Impose on Poor and Low-Income Women

62. It is my opinion that, as applied to prohibit abortion for its duration, the Executive Order would exacerbate existing financial and logistical barriers to abortion access among poor and low-income women. These women would be forced to forgo other essential needs in order to

access abortion in other states while the Executive Order is in effect, or in order to access abortion in Texas at a later point in pregnancy (when abortion is more expensive) once the Executive Order is lifted. Some will be forced to forgo abortion care altogether.

63. To the extent that poor or low-income women could afford travel to another state to obtain an abortion, or could afford the increased cost of an abortion later in pregnancy once the Executive Order is lifted, I expect that the burden would force even greater trade-offs in terms of meeting basic needs. Given the documented monthly instability among low-income households in both income (resources flowing in) and expenses (resources flowing out), it is widely acknowledged that many households come up short each month and, as a consequence, experience material hardship. In my own research, I have documented that 15% of American households were unable to pay essential expenses, 12% were unable to see a doctor or dentist when they needed to because of their inability to pay, 11% were food insecure, and 7% could not pay their rent or mortgage.[74] More recent evidence from a nationally representative survey conducted in late 2017 suggests rates of material hardship that are even higher—with 10.2% of American families missing a rent or mortgage payment, 13% missing a utility payment and 4.3% experiencing a utility shut-off, 18% reporting problems paying family medical bills, and 17.8% indicating that they had an unmet need for medical care due to cost.[75] Furthermore, according to data from the 2014 Hunger in America Survey from Feeding America, among clients receiving informal food assistance, who are likely to be low-income, approximately 2 out of 3 reported having to choose between food and

[74] Heflin, *supra* note 1, at 359.

[75] Michael Karpman et al., Urban Inst., Material Hardship Among Nonelderly Adults and Their Families in 2017, at 7 (Aug. 2018), https://www.urban.org/sites/default/files/publication/98918/material_hardship_among_nonelderly_adults_and_their_families_in_2017.pdf.

paying for medical care, between food and utilities, or between food and transportation, and 3 out of 5 reported making trade-offs between food and housing.[76]

64. Women who use their rent money to pay for abortion services can be evicted from their home, leaving them and their families homeless. Those who use money they had allocated for their phone, water, gas, or electricity bill to pay their travel expenses risk having their utilities disconnected, forcing them to go without water, heat, or light until they can pay a reconnection fee on top of their original bill in order to re-establish services with the utility company. In my own research, for example, I have documented how utility shut-offs impact the entire family:

> They could interfere with children's ability to complete homework, and extended non-payment can mean legal consequences, involvement of a collection agency, and damage to an individual's credit rating. Telephone terminations, in contrast, occurred more frequently. For some women, telephone disconnection caused emotional distress because they were unable to maintain contact with their children while they were at work and they worried about being unable to telephone for help in the case of an emergency.[77]

65. Other women may forgo transportation costs (gas, car insurance, car payment, or repairs), making it impossible for them to get to work and putting them at risk of losing their job. However, in the face of an unexpected medical expense such as an abortion, most low-income households will decide to forgo food in order to keep their cars running.[78]

66. If a woman decides to pay for her abortion services by forgoing other basic expenses and she already has children, as most women who seek abortion services in Texas do, there could be dire consequences for the children as well. Children who are exposed to food

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[76] Nancy S. Weinfield et al., Feeding America, Hunger in America 2014: National Report 135 (Aug. 2014), http://help feedingamerica.org/HungerInAmerica/hunger-in-america-2014-full-report.pdf.

[77] Colleen Heflin, Andrew S. London & Ellen K. Scott, *Mitigating Material Hardship: The Strategies Low-Income Families Employ To Reduce the Consequences of Poverty*, 81 Soc. Inquiry 223, 232 (2011).

[78] Kathryn Edin et al., U.S. Dep't of Agriculture, SNAP Food Security In-Depth Interview Study: Final Report 21–22 (2013).

insecurity face a number of negative consequences ranging from poor cognitive outcomes, physical and mental health consequences, and behavioral consequences.[79] Ultimately, the stress of living in conditions of material hardship has been shown to negatively alter the socio-emotional environment in the home and cause further harm to children.[80]

67. Not obtaining an abortion can have financial consequences, too. There is good evidence that a woman forced to forgo abortion care to meet other basic needs suffers negative economic consequences. The Turnaway Study, a nationwide study conducted by researchers at the University of California San Francisco, documents that women who were unable to obtain an abortion were three times more likely to be unemployed six months later, four times more likely to have fallen below 100% of the federal poverty level, more likely to be receiving public assistance benefits, and more likely to be raising children alone, as compared to women who were able to obtain an abortion. Furthermore, the negative consequences to economic well-being were shown to persist four years later compared to women who were able to obtain an abortion.[81]

CONCLUSION

68. The costs of an abortion procedure, associated transportation, and other related expenses already impose a significant burden on poor and low-income women in Texas. The COVID-19 pandemic makes these burdens worse. These costs, along with logistical hurdles such as inflexible work schedules for low-wage workers, are part of the reason that some Texas women are unable travel out of state to access abortion, or will be unable to obtain abortions in Texas

[79] Linda Weinreb et al., *Hunger: Its Impact on Children's Health and Mental Health*, 110 Pediatrics e41 (2002), https://pediatrics.aappublications.org/content/pediatrics/110/4/e41.full-text.pdf.

[80] Elizabeth T. Gershoff, et al., *Income Is Not Enough: Incorporating Material Hardship Into Models of Income Associations With Parenting and Child Development*, 78 Child Dev. 70 (2007).

[81] Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 Am. J. Pub. Health 407 (2018).

immediately or at all once the Executive Order is lifted. For these reasons, the theory that patients would be able to obtain abortion quickly after the Executive Order is lifted in time to avoid Texas's twenty-two-week LMP gestational age cut-off, such that the Executive Order simply "postpones" abortion access, ignores the reality of the lives of poor and low-income patients.

69. I know from my own research, and based on the extensive literature on the subject, that in order to afford additional, unexpected costs like those required for travel out of state or within state to obtain an abortion, particularly later in pregnancy, poor and low-income women are forced to make trade-offs in their monthly budgets and to forgo basic necessities including food, jeopardizing their own health and well-being and that of their families, if they are able to obtain the abortion at all.

Dated: April ___, 2020

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Colleen M. Heflin, Ph.D.

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Dated: April 10, 2020

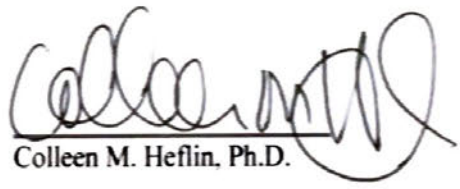

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EXHIBIT A

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RESEARCH AND TEACHING INTERESTS

Social policy, food and nutrition policy, social demography

EDUCATION

2002 Ph.D. in Sociology, University of Michigan
1995 Master of Public Policy, Gerald Ford School of Public Policy, University of Michigan
1992 Bachelor of Arts with Honors in Social Sciences, University of Michigan

EMPLOYMENT

2017–present	Professor, Public Administration and International Affairs, Maxwell School of Citizenship and Public Affairs, Syracuse University
2017–present	Senior Research Associate, Center for Policy Research, Syracuse University
2018-present	Research Affiliate, University of Kentucky Center for Poverty Research
2014–present	Member of External Review Board, *Social Service Review*
2016–2017	Professor, Harry S Truman School of Public Affairs, University of Missouri
2014–2017	Co-Director of Population, Education and Health Center
2014–2017	Co-Director of the University of Missouri Research Data Center
2008–2017	Research Affiliate, Institute for Public Policy, University of Missouri
2013–2016	Member of the External Review Board, Southern Rural Development Center RIDGE Program, Purdue University
2010–2016	Associate Professor, Harry S Truman School of Public Affairs, University of Missouri
2007–2010	Assistant Professor, Harry S Truman School of Public Affairs, University of Missouri
2005–2014	Research Affiliate, National Poverty Center, University of Michigan
2002–2007	Assistant Professor, Martin School of Public Policy, University of Kentucky
2002–2007	Executive Board Member, University of Kentucky Center for Poverty Research
1997–2002	Senior Research Associate, Michigan Poverty Research and Training Center, University of Michigan

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Meckstroth, Alicia, Andrew Burwick, Quinn Moore, Colleen Heflin, Jonathan McCay, and Michael Ponza. 2016. "The Effects of an Intensive Life Skills Education and Home Visiting Program on the Employment, Earnings, and Well-Being of At-Risk Families." Mathematica Policy Research Working Paper.

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Heflin, Colleen. April 2017. "The Great Recession and the Rise in Material Hardship." Family Self-Sufficiency and Stability Research Consortium, 2013-2018. Office of Planning, Research & Evaluation, Office of the Administration for Children & Families.

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Dabson, Brian, Colleen Heflin and Kathleen Miller. February 2012. "Regional Resilence: Research and Policy Brief." RUPRI Rural Futures Lab, University of Missouri.

Heflin, Colleen and Kathleen Miller. June 2011. Geography of Need: Identifying Human Service Needs in Rural America." RUPRI White Paper.

Rysavy, Matt and Heflin, Colleen. August 2009. **"**Food Insecurity, Food Stamp Participation and Poverty: The Paradox of Missouri." Institute of Public Policy, University of Missouri.

Heflin, Colleen and James Ziliak**.** December 2008. **"**Food Insufficiency, Food Stamp Participation and Mental Health." Policy Brief. Institute of Public Policy, University of Missouri.

RESEARCH GRANTS RECEIVED

Co-Investigator. *"*Food insecurity and chronic diseases in low-income older Americans: The role of SNAP receipt in medication underuse" University of Kentucky Center for Poverty Research. 02/25/2020 – 02/24/2022 $249,888 with Irma Arteaga (Principle Investigator), Leslie Hodges (Co-Investigator) and Chinedum Ojinnaka (Co-Investigator).

Principle Investigator. "Changing Patterns of Eligibility and Take up in SNAP and the Roles of Out of Pocket Medical Expense" University of Kentucky Center for Poverty Research. 02/25/2020 – 02/24/2021 $49,888 with Dongmei Zuo, Co-Investigator.

Principle Investigator. "Hunger SNAPs: Food Insecurity among Older Adults." Russell Sage Foundation. 5/1/2020-4/30/22. $35,000.

Principle Investigator. "Advancing understanding of the conditions of parents' employment on access to and maintenance of child care and child-care subsidies." Robert Wood Johnson Foundation. 1/15/2020-1/14/21. ($74,986). with Taryn Morrissey, Co-Investigator.

Principle Investigator. "SNAP Uptake and School Readiness in Virginia." Economic Research Service, United States Department of Agriculture. 8/14/18-9/14/20 ($100,000) with Michah Rothbart, Co-Investigator.

Principle Investigator. "Creating Evidenced-Based Strategies to Address Administrative Churn in SNAP." Economic Research Service, United States Department of Agriculture. 8/1/2018-7/30/2020. ($120,101) with Len Lopoo, Co-Investigator.

Principle Investigator. "Does Child Support Increase Self-Sufficiency?: Evidence from Virginia". National Institute for Health through the Institute for Research on Poverty (IRP)'s Extramural Small Grants program for Research. 3/1/18-2/28/19. ($24,847) with Len Lopoo, Co-Principal Investigator.

Principal Investigator. "SNAP and Child Health: Evidence from Missouri Administrative Data." Economic Research Service, United States Department of Agriculture. 8/25/2016–8/1/2018 ($99,997). With Peter Mueser and Irma Arteaga, Co-Investigators.

Co-Principal Investigator. "Understanding SNAP and Food Security among Low-Income Households." University of Kentucky Center for Poverty Research; Economic Research Service, United States Department of Agriculture. 4/30/2015–6/30/2018 ($400,000). With James P. Ziliak, Co-Principal Investigator.

Principal Investigator. "Community Eligibility and Child Well-Being." Research Innovation and Development Grants in Economics (RIDGE) Center for Targeted Studies at the Southern Rural Development Center, Mississippi State University. 8/1/2015–12/31/2016 ($34,987). With Daniel P. Miller, Co-Principal Investigator.

Co-Principal Investigator. "Design Flaws: The Effect of the Coverage Gap in Food Assistance Programs on Child's Well-Being." University of Wisconsin–Madison, Institute for Research on Poverty, RIDGE Center for National Food and Nutrition Assistance Research. 7/1/2015–12/31/2016 ($39,962). With Irma Arteaga, Co-Principal Investigator.

Principal Investigator. "Family Self-Sufficiency and Stability and Material Hardship: The Role for Public Policy after the Great Recession." US Department of Health and Human Services, Administration for Children and Families. 9/30/13–9/29/18 ($500,000).

Co-Principal Investigator. "Census Research Data Center." National Science Foundation. 8/15/2014–7/31/2017 ($0).

Principal Investigator. "The Mediating Effects of SNAP on Health Outcomes for Low-Income Households." Cooperative Research Agreement. Economic Research Service, United

States Department of Agriculture. 7/1/2014–6/30/2016 (in no-cost time extension; $100,000).

Principal Investigator. "Secondary Analyses of Strengthening Families Datasets: Economic Strain and Family Formation." US Department of Health and Human Services, Administration for Children and Families. 9/30/14–8/1/16 ($99,343).

Principal Investigator, "Understanding the Rates, Causes and Costs of Churning in SNAP." Urban Institute. 8/1/2013–7/15/2014 ($32,561). With Peter Mueser, Co-Investigator.

Principal Investigator, "Participation in the National School Lunch Program and Food Security: A Regression Discontinuity Design Analysis of Transitions into Kindergarten." Southern Rural Development Center RIDGE Program. 7/1/2012–12/31/2013 ($34,934). With Irma Arteaga, Co-Investigator.

Principal Investigator. "Joint Participation in SNAP and UI in Florida" USDA-FANRP Economic Research Service. 4/15/2010-5/14/2020 ($242,830). With Peter Mueser, Co-Investigator.

Co-Investigator. "The Intersection of Veteran's Benefits Programs and Disability Insurance among Veterans: A Synthetic Cohort Approach Using the Survey of Income and Program Participation (SIPP)." Boston College/Social Security Administration. 10/1/2011–9/30/2012 ($85,817). With Janet Wilmoth and Andrew London, Co-Investigators.

Principal Investigator. "Families with Hungry Children and the Transition from Preschool to Kindergarten." University of Kentucky Center for Poverty Research; Economic Research Service, United States Department of Agriculture. 7/1/2011–9/30/2012 ($45,000). With Irma Arteaga and Sara Gable, Co-Investigators.

Co-Investigator. "A Food Systems Approach to Addressing Obesity Among Food Pantry Clients in Missouri." USDA-AFRI Human Nutrition and Obesity Program. 1/01/2010–4/30/2013 ($432,171).

Principal Investigator. "Veteran Status, Disability, Poverty, and Material Hardship." National Center for Poverty Research at the University of Michigan/US Census Bureau. 2010 ($20,000).

Principal Investigator. "Localizing Estimates of Hunger: Creating County-level Estimates of Food Insecurity." Research Council Fellowship, University of Missouri. 2010 ($7,000).

Principal Investigator. "Assessing the Impact of On-Line Applications in Florida's Food Stamp Caseload." Regional Small Grant Program, University of Kentucky Center for Poverty Research. 2008-2009 ($20,000)

Principal Investigator. "Assessing the Impact of On-Line Applications in Florida's Food Stamp Caseload." 2008 RIDGE Program sponsored by the Southern Rural Development Center in partnership with the Economic Research Service, U.S. Department Agriculture. 2008-2009 ($35,000).

Principal Investigator, "The Impact of Improving Access to Benefits for Low-Income Families on Caseload Characteristics and Dynamics." Research Board Fellowship, University of Missouri. 2008-2009 ($33,498).

Principal Investigator, "Do Middle Class Members Take on Debt in Order to Help Their Poor Siblings Weather Shocks?" Summer Research Fellowship Competition, University of Missouri. 2008-2009 ($7,000).

Principal Investigator, "State-Level Variation in Material Hardship Among Households with Children." West Coast Poverty Center. 2007–2008 ($15,000).

Principal Investigator, "Does the Size of the Check Matter? New Results on the Effects of Welfare Receipt on Early Childhood Cognitive Scores." Spencer Foundation. 2006-2007 ($39,840).

Principal Investigator, "Social Capital and Race Inequality." Research Support Grant, University of Kentucky. 2005–2006 ($19,204).

Principal Investigator, "Does Variation in Transfer Program Participation and Generosity at the State Level Explain Variation in Mental Health?" University of Kentucky Center for Poverty Research. 2005 ($19,124).

Summer Faculty Research Fellowship, University of Kentucky. 2005 ($6,000).

Principal Investigator, "Determinants of Different Forms of Material Hardship in the Women's Employment Survey." Small Grant Program, Institute for Research on Poverty, University of Wisconsin-Madison. 2004–2005 ($34,913).

Principal Investigator, "Does Food Stamp Receipt Mediate the Relationship Between Food Insecurity and Mental Health?" The National Poverty Center. 2003-–2004 ($19,783). With James Ziliak, Co-Investigator.

Principal Investigator, "Household Food Insecurity and the Physical and Mental Health of Low-Income Men and Women." NSAF Small Research Grants Program, Association for Public Policy and Analysis and Management (funded by Annie E. Casey Foundation). 2003-2004 ($20,000).

Principal Investigator, "An Individual-Level Analysis of Food Stamp Dynamics." Small Grant Program, Institute for Research on Poverty, University of Wisconsin-Madison. 2002-–2003 ($31,922).

Co-Principal Investigator, "Do Women's Wages Depreciate While on Welfare?" U.S. Census Bureau/Joint Center for Research on Poverty. 2002–2003 ($29,966). With Mary Noonan, Principal Investigator.

Co-Principal Investigator, "Barriers to Work Among Housing Assistance Recipients on Welfare." United States Department of Housing and Urban Development. 1999–2001 ($49,870). With Mary Corcoran, Principal Investigator.

Collaborator. "Causes and Consequences of Food Insufficiency and Material Hardships as Welfare Recipients Move from Welfare to Work." Economic Research Service, U.S. Department of Agriculture. 1999–2000 ($200,354). With Kristine Siefert and Mary Corcoran, Principal Investigators.

Collaborator. "Food Insecurity and Welfare Reform." Institute for Research on Poverty, University of Wisconsin-Madison. 1999–2000 ($49,704). With Mary Corcoran and Kristine Siefert, Principal Investigators.

CONTRACTS

Consultant. "Feeding America SNAP Program Evaluation Multi-Site Case Study." Feeding America. June 2013–November 2014.

Consultant. "Evaluation of Missouri PREP Program." Missouri Department of Health and Senior Services. June 2011–May 2015.

INVITED PRESENTATIONS

"The Value and Limits of Linking Administrative Data" Invited speaker at the National Academy of Sciences Committee on National Statistics Panel on Improving USDA's Consumer Data for Food and Nutrition Policy Research. September 21, 2018. Washington, DC.

"Household Instability and Material Hardship." Invited speaker at the 2016 MU Extension Summit, University of Missouri. October 26, 2016. Columbia, MO.

"The Mediating Effects of SNAP on Health Outcomes for Low Income Households." Invited speaker in Center for Research on Inequalities and the Life Course Seminar, Yale University. April 27, 2016. New Haven, CT.

"Community and Systematic Approaches to Hunger: Social Protections." Invited speaker at the Hunger Summit hosted by Universities Fighting World Hunger (partnership of the United Nations World Food Program and Auburn University). February 26, 2016. Columbia, MO.

"Reflecting on 20 years of Measuring Household Food Security," Invited speaker at the US Department of Agriculture - Economic Research Service, October 21, 2015. Washington, DC.

"The Mediating Effects of SNAP on Health Outcomes for Low Income Households." Invited speaker in the West Virginia University Public Health Dialogues. October 2, 2015. Morgantown, WV.

"In Tandem: Pairing Public and Private Nonprofit Assistance to Make Ends Meet." Invited speaker at The School of Public Affairs at American University and Feeding America, July, 2015. Washington, DC.

"Hot Topics for Program Evaluation." Invited speaker at Feeding America's 2014 Agency Capacity, Programs and Nutrition Annual Conference. October 30, 2014. Chicago, IL.

"Using Program Evaluation to Drive Decision-Making." Invited speaker at Feeding America's 2014 Agency Capacity, Programs and Nutrition Annual Conference. October 30, 2014. Chicago, IL.

"The War on Poverty: 50 Years Later and the Battle Continues" Invited speaker at a congressional briefing hosted by the Population Association of America and the Association of Population Centers in conjunction with Congressman Mike Honda. June 9, 2014. Washington, D.C.

"Household Instability and Material Hardship." Invited speaker at Poverty, Policy and People: 25 Years of Research and Training at the University of Michigan. April 10, 2014. Ann Arbor, MI.

"Material hardship and the case for measurement." Invited speaker at the Presidential Plenary: Poverty Measurement and Implications for Policy. Southern Sociological Society. April 3, 2014. Charleston, NC.

"Individual and Family Coping Responses to Hunger." Invited speaker at the Workshop on Research Gaps and Opportunities in Child Hunger and Food Insecurity at the Committee on National Statistics. National Academy of Sciences, Food and Nutrition Board, Institute of Medicine. April, 2013.

"Short-Term Dynamics of Food Insecurity and Obesity." Invited speaker at Institute of Medicine Workshop on Understanding the Relationship Between Food Insecurity and Obesity. November 16-19, 2010. Washington, D.C.

OTHER PRESENTATIONS AND CONFERENCES

Heflin, Colleen, Leonard Lopoo, and Mattie Mackenzie-Liu, "*When States Coordinate between Social Welfare Programs: Considering the Child Support Income Exclusion".* Fall Research Conference of the Association for Public Policy Analysis and Management. November 7-9, 2019. Denver, CO.

Bullinger, L.R., Heflin, C.M., & Raissian, K.M. "*SNAP and Child Maltreatment*" Fall Research Conference of the Association for Public Policy Analysis and Management. November 7-9, 2019. Denver, CO.

Heflin, Colleen, Leonard Lopoo, and Mattie Mackenzie-Liu, "*When States Coordinate between Social Welfare Programs: Considering the Child Support Income Exclusion"* Increasing Family Income through Child Support: Lessons from Recent Research. Institute for Research on Poverty, University of Wisconsin-Madison and Assistant Secretary for Planning and Evaluation, US. Dept. of Health and Human Services. September 18, 2019. Washington, DC.

Heflin, Colleen. "Food and Nutrition Policy across the Life Course." American Sociological Association." August 13, 2019. New York, NY.

Sharon Kukla-Acevedo and Colleen Heflin. "Adolescent Food Insecurity and the Transition to Adulthood." Research on Food Security Using the Panel Study of Income Dynamics, September 20, 2018. Washington, DC.

Colleen Heflin, Rajeev Darolia, and Sharon Kukla-Acevedo. "Exposure to Food Insecurity during Adolescence and the Educational Consequences." Fall Research Conference of the Association for Public Policy Analysis and Management. November 1-4, 2017. Chicago, IL.

Claire Altman, Chaeyung Jun and Colleen Heflin. "Hardships of Undocumented Immigrants in the United States: Evidence from the 1996-2008 SIPP." Fall Research Conference of the Association for Public Policy Analysis and Management. November 1-4, 2017. Chicago, IL.

Colleen Heflin, Sharon Kukla-Acevedo, and Rajeev Darolia. "Risky Adolescent Behaviors and the Role of Food Insecurity." Fall Research Conference of the Association for Public Policy Analysis and Management. November 1-4, 2017. Chicago, IL.

Altman, Claire, Colleen Heflin, and Chaegyung Jun. "The Many Hardships of Undocumented Immigrants in the United States: Evidence from SIPP 1996-2008." 2017 American Sociological Association Annual Meeting. August 12-15, 2017. Montreal, Quebec, Canada.

Altman, Claire, Colleen Heflin, and Chaegyung Jun. "The Many Hardships of Undocumented Immigrants in the United States: Evidence from SIPP 1996-2008" (poster presentation). 2017 Population Association of America Annual Meeting. April 27-29, 2017. Chicago, IL.

Arteaga, Irma, Heflin, Colleen, Leslie Hodges and Peter Mueser. "Does the Timing Matter for SNAP Benefits and Pregnancy-Related Emergency Room Visits?" Fall Research Conference of the Association for Public Policy Analysis and Management. November 3-5, 2016. Washington, DC.

Heflin, Colleen. "Social Program Participation and Material Hardship." Fall Research Conference of the Association for Public Policy Analysis and Management. November 3-5, 2016. Washington, DC.

Arteaga, Irma, Colleen Heflin and Sarah Parsons. "The Coverage Gap." Annual meeting of the Population Association of America. March 31, 2016. Washington, DC.

Mueser, Peter, Colleen Heflin and Leslie Hodges. "The Mediating Effects of SNAP on Health Outcomes for Low-Income Households." Annual meeting of the Association of Public Policy & Management. November 12-14, 2015. Miami, FL.

Huang, Ying, Stephanie Potochnick and Colleen Heflin. "Household Food Insecurity and Young Immigrant Children's Health and Development Outcomes." Annual meeting of the Association of Public Policy & Management. November 12-14, 2015. Miami, FL.

Mueser, Peter and Colleen Heflin. "Aid to Jobless Workers in the Face of the Great Recession: The Interaction of Unemployment Insurance and the Supplemental Nutritional Assistance Program." Annual meeting of the Association of Public Policy & Management. November 12-14, 2015. Miami, FL.

Huang, Ying, Stephanie Potochnik and Colleen Heflin. "Household Food Insecurity and Young Immigrant Children's Health and Developmental Outcomes" (poster presentation). Annual meeting of the Population Association of America. April 30-May 2, 2015. San Diego, CA.

Olson, Kate and Colleen Heflin. "The Changing Face of the United States and the Provision of Social Services." Annual meeting of the Association of Public Policy & Management. November 6-8, 2014. Albuquerque, NM.

Hodges, Leslie Beasley, Colleen Heflin and Andrew London. "TAPped out: An Evaluation of the Department of Defense's Transition Assistance Program." Annual meeting of the Association of Public Policy & Management. November 6-8, 2014. Albuquerque, NM.

Heflin, Colleen and Irma Arteaga. "Participation in the National School Lunch Program and Food Security: An Analysis of Transitions into Kindergarten*."* Annual meeting of the Association of Public Policy & Management. November 6-8, 2014. Albuquerque, NM.

Heflin, Colleen and Irma Arteaga. "The Child and Adult Care Food Program and Food Insecurity*."* Annual meeting of the Population Association of America. May 1-3, 2014. Boston, MA.

Mueser, Peter and Colleen Heflin. "Aid to Jobless Workers in Florida in the Face of the Great Recession: The Interaction of Unemployment Insurance and the Supplemental Nutritional Assistance Program." Annual meeting of the Population Association of America. May 1-3, 2014. Boston, MA.

Kukla-Acavado, Sharon and Colleen Heflin. "Participation in the Unemployment Insurance Program and Childhood Achievement." Annual meeting of the Population Association of America. May 1-3, 2014. Boston, MA.

Heflin, Colleen, Irma Arteaga and Sara Gable. "Families with Hungry Children and the Transition from Preschool to Kindergarten." Research Program on Childhood Hunger, Food and Nutrition Service. March 13, 2014. Washington, D.C.

Heflin, Colleen and Irma Arteaga. "Participation in the National School Lunch Program and Food Security: An Analysis of Transitions into Kindergarten." National RIDGE Small Grants Conference, December 17, 2013. Washington, D.C.

Potochnick, Stephanie, Irma Arteaga and Colleen Heflin. "An Examination of Household Food Insecurity among Low-Income Immigrant Children." Annual meeting of the Association of Policy Analysis & Management. November 7-9th, 2013. Washington. D.C.

Heflin, Colleen and Ashley Price. "Emergency Food Assistance and the Great Recession." Annual Conference of the Association of Policy Analysis & Management. November 7-9th, 2013. Washington. D.C.

Heflin, Colleen and Irma Arteaga. "Participation in the National School Lunch Program and Food Security: An Analysis of Transitions into Kindergarten." Southern Rural Development Center RIDGE Small Grants Conference. August 22, 2013. Denver, CO.

Heflin, Colleen and Peter Mueser. "Aid to Jobless Workers in Florida in the Face of the Great Recession: The Interaction of Unemployment Insurance and the Supplemental Nutritional Assistance Program." Annual meeting of the National Association of Welfare Researchers and Statisticians. August 21, 2013. Chicago, IL.

McKelvey, Bill, Jennifer Schnell, Nikki Raedeke, Sandy Rikoon, Matt Foulkes, Colleen Heflin, Joan Hermsen and Ashley Vancil. "A Food Systems Approach to Addressing Obesity Among Food Pantry Clients in Missouri" (poster presentation). Annual meeting of the Society for Nutrition Education and Behavior. August 11, 2013. Portland, OR. *The abstract was published in the *Supplement to Journal of Nutrition Education and Behavior* 45:4S (July/August), p. S89.

Heflin, Colleen. "Child Poverty" Annual meeting of the American Sociological Association. August 10, 2013. New York, NY.

Heflin, Colleen and Peter Mueser. "Aid to Jobless Workers in Florida in the Face of the Great Recession: The Interaction of Unemployment Insurance and the Supplemental Nutritional

Assistance Program." IZA/OECD/World Bank Conference on Safety Nets and Benefit Dependence: Evidence and Policy Implications. May 21-22, 2013. Paris, France.

Heflin, Colleen, Jacob Cronin and Ashley Price. "Best Practices for Implementing and Evaluating Evidenced-Based Teen Pregnancy Prevention Programs with Diverse Populations." Annual meeting of the Association of Policy Analysis & Management. November 4-6, 2012. Baltimore, MD.

Kukla-Acevedo, Sharon and Colleen Heflin. "Unemployment Insurance Participation and Early Childhood Development." Annual meeting of the Association of Policy Analysis & Management. November 4-6, 2012. Baltimore, MD.

Arteaga, Irma, Colleen Heflin and Sara Gable. "Hungry Children and the Transition from WIC." Annual Conference of the Association of Policy Analysis & Management. November 4-6, 2012, Baltimore, MD.

McKelvey, Bill, Jennifer Schnell, Nikki Raedeke, Sandy Rikoon, Matt Foulkes, Colleen Heflin, and Joan Hermsen. "Food Systems Approach to Addressing Obesity among Food Client Households in Missouri" (poster presentation). 45th Annual Conference of the Society for Nutrition Education and Behavior. July 14-17. Washington, DC.

Arteaga, Irma, Colleen Heflin, and Sara Gable. "Hungry Children and the Transition from WIC". Annual meeting of the Population Association of America. May 4, 2012. San Francisco, CA.

Wilmoth, Janet M., Andrew S. London, and Colleen Heflin. "Economic Well-Being among Older Adult Households: Variation by Veteran and Disability Status." Annual meeting of the Gerontological Society of America. December, 2011. Boston, MA.

Heflin, Colleen, and Peter Mueser. "Aid to Jobless Workers in Florida in the Face of the Great Recession: The Interaction of Unemployment Insurance and the Supplemental Nutritional Assistance Program." Annual meeting of the Association for Public Policy and Management. November 4-5, 2011. Washington, DC.

London, Andrew S., Colleen Heflin and Janet M. Wilmoth. "Work-Related Disability, Veteran Status, and Poverty: Implications for Family Well-Being." Annual meeting of the American Sociological Association. August, 2011. Las Vegas, NV.

Heflin, Colleen, and Ngina Chiteji. "My Brother's Keeper? The Association between Having Siblings in Poor Health and Wealth Accumulation." Western Economic Association Annual Meetings. June 30, 2011. San Diego, CA.

Heflin, Colleen, Andrew London and Janet Wilmoth. "Veteran Status, Disability, Poverty, and Material Hardship." Annual meeting of the Association for Public Policy and Management. November 4-5, 2010. Boston, MA.

Heflin, Colleen, Andrew London and Janet Wilmoth. "Veteran Status, Disability, Poverty and Material Hardship." SIPP Analytics Research Conference. October 14-15, 2009. Washington, DC.

Keiser, Lael and Colleen Heflin. "Impact of TANF on the Material Well-Being of Low Income Families." Reducing Poverty Conference hosted by The Institute for Advanced Policy Solutions. November 19-20, 2009. Atlanta, GA.

Heflin, Colleen and Peter Mueser. "Assessing the Impact of Modernization on Florida's Food Stamp Caseload." Annual meeting of the Association of Public Policy and Management. November 5-7, 2009. Washington, D.C.

Keiser, Lael and Colleen Heflin. "Impact of TANF on the Material Well-Being of Low Income Families." Annual meeting of the Association of Public Policy and Management. November 5-7, 2009. Washington, D.C.

Heflin, Colleen and Peter Mueser. "Assessing the Impact of On-line Application on Florida's Food Stamp Caseload." RIDGE Conference at the US Department of Agriculture, Economic Research Service. October 15-16, 2009. Washington, DC.

Heflin, Colleen, Andrew London and Ellen Scott. "Mitigating Material Hardship: The Strategies Low-income Mothers Employ to Reduce the Consequences of Poverty." Annual meeting of the American Sociological Association. August 8-11, 2009. San Francisco, CA.

Heflin, Colleen and Peter Mueser. "Assessing the Impact of On-line Application on Florida's Food Stamp Caseload." Southern Rural Development Center Mid-Year Grantees Conference. August 5-6, 2009. Atlanta, GA.

Keiser, Lael and Colleen Heflin. "Explaining the Consequences of TANF Policy Choices Across and Within U.S. States" State Politics and Policy Conference (Hosted by the University of North Carolina-Chapel Hill and Duke University). May 22-23, 2009. Chapel Hill, NC.

Heflin, Colleen and Peter Mueser. "Assessing the Impact of On-line Application on Florida s Food Stamp Caseload." University of Kentucky Center for Poverty Research Small Grants Conference. Mat 19, 2009. Lexington, KY.

Heflin, Colleen and Peter Mueser. "Assessing the Impact of On-line Application on Florida s Food Stamp Caseload." Annual meeting of the Population Association of America. April 30, 2009. Detroit, MI.

Heflin, Colleen. "Macroeconomic Performance and Material Hardship across Time, Space and Race." West Coast Poverty Center Speaker Series. March 9, 2009. Seattle, WA.

Heflin, Colleen and Ngina Chiteji. "Do Middle Class Members Take on Debt in Order to Help Their Poor Siblings Weather Shocks?" Annual meeting of the Association of Public Policy and Management, November 6, 2008. Los Angeles, CA.

Heflin, Colleen. "State-Level Variation in Material Hardship Among Households with Children." Annual meeting of the Population Association of America. April 16, 2008. New Orleans, LA.

Heflin, Colleen and Sharon Kukla-Acavedo. "Welfare and Children's Cognitive Test Scores." Annual meeting of the Population Association of America. April 16, 2008. New Orleans, LA.

Heflin, Colleen and Sharon Kukla-Acavedo. "Does the Size of the Welfare Check Matter? New Results on the Effects of Welfare on Children's Cognitive Test Scores." Annual meeting of the Association of Public Policy and Management. November 4, 2006. Madison, WI.

Heflin, Colleen and John Iceland. "Poverty, Material Hardship and Mental Health." Annual meeting of the Association of Public Policy and Management. November 3, 2006. Madison, WI.

Heflin, Colleen and Jim Ziliak. ”Food Insufficiency, Food Stamp Participation and Mental Health.” Institute for Research on Poverty Summer Workshop. June 22, 2006. Madison, WI.

Heflin, Colleen and John Iceland. “Poverty, Material Hardship and Mental Health.” Annual meeting of the Population Association of America. April 1, 2006. Los Angeles, CA.

Heflin, Colleen and Seok-Woo Kwon. “Social Capital and Racial Wage Inequality.” Annual meeting of the Population Association of America. April 1, 2006. Los Angeles, CA.

Heflin, Colleen. “Dynamics of Different Forms of Material Hardship.” February 1, 2006. McGill University,

Heflin, Colleen. “Dynamics of Different Forms of Material Hardship in the Women’s Employment Survey.” Annual meeting of the Association of Public Policy and Management. November 3, 2005. Washington, DC:.

Heflin, Colleen. “Dynamics of Different Forms of Material Hardship in the Women’s Employment Survey.” Food Assistance and Nutrition Research Small Grants Programs Conference, USDA Economic Research Service. October, 2005.

Heflin, Colleen. “Determinants of Different Forms of Material Hardship in the Women’s Employment Survey.” Institute for Research On Poverty’s Small Grant Conference. May 20, 2005. Madison, WI.

Siefert, Kristine, Colleen Heflin and David R. Williams, David R. “Household Food Insufficiency in African American and White Women." Annual meeting of the Society for Social Work and Research. January 18, 2004. New Orleans, LA.

Siefert, Kristine, Colleen Heflin, Mary Corcoran and David R. Williams, David R., "Food Insufficiency and Physical and Mental Health in a Longitudinal Survey of African American and White Women." Annual meeting of the American Public Health Association. November 17, 2003. San Francisco, CA.

Heflin, Colleen. “Who Exits the Food Stamp Program after Welfare Reform?” Annual meeting of the Association of Public Policy and Management. November 7, 2003, Washington, DC.

Swaroop, Sapna, Colleen Heflin and Reynolds Farely. “What About Arabs? White and Black American’s Attitudes Toward Arab Americans in Detroit in 1992?” Annual meeting of the American Sociological Association. August 17, 2003. Atlanta, GA.

Noonan, Mary and Colleen Heflin. “Do Women’s Wages Depreciate While on Welfare?” Annual meeting of the American Sociological Association. August 19, 2003. Atlanta, GA.

Swaroop, Sapna, Colleen Heflin and Reynolds Farely. “What About Arabs? White and Black American’s Attitudes Toward Arab Americans in Detroit in 1992?” (poster presentation) Annual meeting of the Population Association of America. May 2, 2003. Minneapolis, MN.

Siefert, Kristine, Colleen Heflin, and David R. Williams. “Household Food Insufficiency and Depression in African American and White Low-Income Women.” Annual meeting of the American Journal of Public Health Association. November 9, 2002. Philadelphia, PA.

Siefert, Kristine, Colleen Heflin, Mary Corcoran and David R. Williams. "Food Insecurity and Hunger: Implications of Recent Research for Maternal and Child Health Programs." 15th Annual U.S. Department of Health and Human Services Regions V and VII Maternal and Child Health Leadership Conference. April 22, 2002. Chicago, IL.

Siefert, Kristine, Colleen Heflin, Mary Corcoran and David R. Williams. "Food Insufficiency and the Physical and Mental Health of Current and Former Welfare Recipients." Annual meeting of the Association of Public Policy and Management. Washington, DC.

Heflin, Colleen and Mary Corcoran. "Barriers to Work among Housing Assistance Recipients." Annual meeting of the National Association of Welfare Researchers and Statisticians. Baltimore, MD.

Heflin, Colleen, Sheldon Danziger and Nathaniel J. Anderson. "Poverty Dynamics after Welfare Reform." Annual meeting of the Association of Public Policy and Management.

Siefert, Kristine, Colleen Heflin, Mary Corcoran and David R. Williams. "Food Insufficiency and Women's Health: Findings from a Longitudinal Survey of Welfare Recipients." Food Assistance and Nutrition Research Small Grants Programs Conference, USDA Economic Research Service. 2000.

Heflin, Colleen, Sheldon Danziger and Nathaniel J. Anderson. "Income Dynamics after Welfare Reform ". Annual meeting of the *National Association of Welfare Researchers and Statisticians*, Scottsdale, AZ.

Heflin, Colleen and Mary Pattillo-McCoy. "Kin Effects on Black-White Account and Home Ownership." Annual meeting of the American Sociological Association. August, 2000. Washington, D.C.

Danziger, Sheldon, Colleen Heflin and Mary Corcoran. "Does Work Pay for Single Mothers?" Annual meeting of the Population Association of America. 2000. Los Angeles, CA..

Siefert, Kristine, Colleen Heflin, and Mary Corcoran. "Food Insecurity and the Physical and Mental Health of Low Income Single Mothers." Annual meeting of the American Public Health Association Annual Meeting, 1999. Chicago, IL.

Pattillo McCoy, Mary and Colleen M. Heflin. "Poverty in the Family: Exploring the Kin Networks of the Black and White Middle Class." Annual meeting of the American Sociological Association. 1999. Chicago, IL..

Corcoran, Mary E. and Colleen Heflin. "Changes in Women's Wages, 1979-1989 by Race and Ethnicity." Annual meeting of the Population Association of America. 1999. New York, NY.

Goldberg, Heidi, Colleen Heflin and Kristin Seefeldt. "Welfare-to-Work Programs and Barriers to Employment." Annual meeting of the National Association of Welfare Research and Statistics. 1999. Chicago, IL.

Corcoran, Mary and Colleen Heflin. "Race, Ethnic and Skill-Based Inequalities in Women's Employment and Wages." Presented at the Institute for Women's Policy Research Conference. 1998. Washington, D.C..

Hall, Richard L. and Colleen Heflin. "The Importance of Color in Congress: Minority Members and the Representation of Race and Ethnicity in the U.S. House." Midwest Conference of Political Science Association. 1998. Chicago, IL.

Hall, Richard L. and Colleen M. Heflin. "The Importance of Color in Congress: Minority Members and the Representation of Race and Ethnicity in the U.S. House." Presented at the Midwest Conference of Political Science Association. 1994. Chicago, IL.

TEACHING EXPERIENCE

Public Program Evaluation
Poverty and Social Policy
Research Methods II (Applied Regression)

COMMUNITY SERVICE

Member, Data Advisory Team for the Boone Indicators Dashboard Project, a collaboration of the City of Columbia, County of Boone, and Heart of Missouri United Way, 2016–2017.

Member, Indicator Review Committee, Missouri Kids Count, Fall 2015.

PROFESSIONAL SERVICE

Program Committee, Annual Meeting of the Association for Public Policy and Management, 2013 and 2015.

Invited speaker at Minnesota Department of Labor Conference, “Sustaining Employment in the New Millennium,” February 2000.

UNIVERSITY SERVICE

Syracuse University (Fall 2017 to present)

University Service

Promotion and Tenure Committee, 2018 to 2019
Maxwell Faculty Committee, 2018 to 2019
Equipment Task Force Committee, 2018 to present
SU representative to NYFSRDC, 2017 to present
Policy Studies Program Advisory Committee, 2017 to present

Departmental Service

MPA Curriculum Committee, 2017- present (Chair, 2018 to present)
Executive Committee, 2018 to present
Health Care Policy & Management Search Chair, 2019
Economics of Aging Search Committee, 2018
APPAM Policy Camp Committee, 2018

University of Missouri Service (Fall 2007 to Spring 2017)

University Service

Tenure Committee, 2016 to 2017
Lecture Committee, 2012 to 2017
Population, Education and Health Seminar Organizer, 2013 to 2014
Population, Education and Health Center Founder and Co-Director, 2014 to 2017

Departmental Service

Truman School Ph.D. Program Coordinator, 2014 to 2017
Truman School Seminar Series Co-Organizer, 2014 to 2015
Truman School Doctoral Committee Member, Fall 2007 to 2009; 2013 to 2014
Truman School Personnel Committee, 2012 to 2017
Institute for Public Policy Advisory Committee, Spring 2008 to 2010
Truman School Policy Committee, Fall 2008 to 2009; 2013 to 2017
Chair, Policy Faculty Search 2012
Food Policy Faculty Search 2013

University of Kentucky Service (Fall 2002 to Summer 2007)

University Service

University of Kentucky Center for Poverty Research Advisory Board, 2002-2007

Departmental Service

Martin School of Public Policy MPA Admissions Committee, Fall 2002 – Summer 2007
Martin School of Public Policy MPA Curriculum Committee, Fall 2002 – Summer 2007
Martin School Director's Search Committee, Fall 2002 and Fall 2003
Martin School Faculty Search Committee, Spring 2003
Martin School Internal Brownbag Seminar Organizer, 2005-2006
Revising the Capstone Committee, Fall 2005 to Spring 2006

MEMBERSHIP AND AFFILIATIONS

American Sociological Association, Member
Association for Public Policy and Management, Member
Population Association of America, Member

EXHIBIT 30

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE; *et al.*,	)	
	)	CIVIL ACTION
Plaintiffs,	)	
	)	CASE NO. 1:20-cv-323-LY
v.	)	
	)	
GREG ABBOTT, in his official capacity as Governor; *et al.*,	)	
	)	
Defendants.	)	

DECLARATION OF MARSHA JONES IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

MARSHA JONES hereby declares under penalty of perjury that the following statements are true and correct:

1. I am the Executive Director of The Afiya Center, a Dallas-based nonprofit organization that addresses the unique needs of Black women and other women of color through education, advocacy, leadership and building economic power.

2. I have provided services at The Afiya Center for 12 years to meet the unique and arising needs of Black women and other women of color in Texas. Our work originally addressed the disproportionate rates of HIV among Black women in Texas. The work has expanded to include advocating for access to the full range of reproductive healthcare for Black women and other women of color in Texas.

3. In my current role as Executive Director of The Afiya Center, I oversee all of our programs, including the SYS (Supporting Your Sistahs) Fund, founded specifically to meet the unique needs of Black women requiring practical and financial support to access abortion care. The Afiya Center's programs are run by 13 staff members and four volunteers.

4. I regularly speak with staff and volunteers about our clients' needs concerning abortion access. I have regularly spoken with clients about these needs because I have personally provided practical support at times (e.g., I have accompanied a client to a procedure). In addition, I coordinate with other organizations providing financial assistance and practical support, such as help with lodging and transportation, to Texas residents seeking abortion care to better assist our clients. The conversations I have with The Afiya Center's staff, volunteers, clients and colleagues at other organizations include discussion about a client's employment, education, location, finances, reasons for seeking an abortion, children, relationships, access to transportation, support system, and lodging needs to determine the client's needs and how to meet them.

5. I provide the following testimony based on personal knowledge acquired through my service at The Afiya Center and review of the organization's business records.

SYS Fund

6. The SYS Fund was conceptualized in 2017 after Black women in our community asked us to create and maintain this support system. We began offering financial assistance and practical support that year and officially launched the SYS Fund in 2019.

7. The SYS Fund is available 24 hours a day, 7 days a week. Callers can contact us via email or phone. A staff member or volunteer returns the caller's message, usually within 24 hours. At that point, we assess the client's needs. For example, we ask the caller how far along they are in their pregnancy; whether they need help creating a plan for childcare and/or transportation to their appointments; and the cost of their abortion.

8. The SYS Fund provides direct financial assistance and practical support to clients seeking abortion care. These services include coordinating childcare for clients during their appointments; driving clients to and from their appointments; arranging for rideshares to transport

clients to and from their appointments; providing snacks for clients' children while the clients are obtaining care; placing orders for meal delivery; emotional support; and financial support after their abortion. We also provide every client with a "Power Pack," which includes condoms and instructions on their use, info on PrEP, a drug used to help prevent HIV, information on emergency contraception, and menstrual pads.

9. We stay in touch with each client for 13 months after they obtain the abortion. We check in with clients the day before, the day of, and the day after their abortion to assess their emotional and practical support needs. We check in with clients once a week for the first month after their abortion, then once a month for three months, and then every three months after that, again to assess their emotional and practical support needs. Clients also proactively reach out to us if they have specific needs. We have provided clients with direct financial assistance for rent or utility payments during this 13-month period.

10. The Afiya Center coordinates with local abortion funds in Texas and the National Abortion Federation, groups that provide direct financial support to people who cannot afford abortion care, to identify additional sources of funding for our clients. Oftentimes, the financial assistance that the client receives from these sources will not cover the full cost of their care and ancillary expenses. We are committed to ensuring that our clients receive the care they need so we endeavor to make up the cost differential. Every client receives a minimum of $250, but if they need more than $250 to cover the total cost of care and have exhausted every other available resource, The Afiya Center will always cover the difference. We have never turned a client away who needed our support to obtain abortion care.

11. In January and February of this year, our call volume remained unchanged.

However, the week of March 23, 2020, we received more calls from people in need of our services.

Impact of Executive Order on Abortion Access

12. Even prior to the COVID-19 outbreak, it was difficult, and sometimes impossible, for our clients to access an abortion in Texas. For example, Texas forces most abortion patients to make at least two trips to obtain abortion care, which makes accessing abortion care more expensive and logistically complex. As a result, some callers must unnecessarily delay their appointments to raise additional funds or solve logistical problems. Some callers delay care while they raise money for the abortion and ancillary costs, like gas. Others delay care because they cannot take off two days in one pay period or two consecutive days from work. Others delay care because they do not have paid time off from work and cannot afford to lose pay for two days in one pay period. Some delay care because they cannot secure childcare. Some callers lack access to a reliable car and must delay care to find a ride. For some callers, renting a car is not an option because it requires a credit card, which they do not have. Delay not only increases our callers' stress and anxiety, but it also increases the cost of their care because the cost of an abortion increases with gestational age.

13. The public health crisis precipitated by COVID-19 has exacerbated the difficulties Texans, particularly low-income people and people of color, have affording abortion care. Many of our recent callers are struggling with layoffs and furloughs, dealing with the possibility of eviction or loss of childcare, experiencing other unforeseen medical costs, and contending with increased utility bills caused by sheltering at home.

14. I understand that on March 22, 2020, Governor Abbott issued an Executive Order that required health care providers to postpone "non-essential" surgeries and procedures

throughout Texas until April 21, 2020. I further understand that certain State officials have threatened to enforce the Executive Order as a ban on abortion care. Because of this, Texas abortion providers have suspended nearly all services and cancelled hundreds of scheduled appointments.

15. As a result, one of The Afiya Center's clients was unable to obtain an abortion in Texas. Because no appointments were available in Texas, this client drove with a support person to Albuquerque, New Mexico, to obtain an abortion. The need to travel out-of-state ultimately delayed the client's abortion by approximately two weeks. The drive from Dallas to Albuquerque took approximately ten hours, as did the return trip. As a result of the delay in obtaining care, the cost of the abortion increased by approximately $1,500. We provided financial support for the abortion. We also booked a hotel room in Albuquerque for this client and the support person and paid for the hotel as well as the gasoline needed for the trip. Flying was not an option for this client due to air travel restrictions.

16. Many of our clients are classified as essential workers or work in the food service industry, which increases their risk of contracting COVID-19. Forcing them to engage in long-distance travel to obtain abortion care further increases their risk of contracting and spreading COVID-19.

Dated: April 16, 2020

/s/ Marsha Jones
Marsha Jones

EXHIBIT 31

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE; *et al.*,	)	
	)	CIVIL ACTION
Plaintiffs,	)	
	)	CASE NO. 1:20-cv-323-LY
v.	)	
	)	
GREG ABBOTT, in his official capacity as Governor; *et al.*,	)	
	)	
Defendants.	)	

DECLARATION OF JOAN LAMUNYON SANFORD IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

JOAN LAMUNYON SANFORD hereby declares under penalty of perjury that the following statements are true and correct:

1. I am the Executive Director of the New Mexico Religious Coalition for Reproductive Choice ("NM RCRC"), a New Mexico-based nonprofit organization that provides practical support to people seeking abortion care in New Mexico and facing practical and logistical difficulties accessing care. Our work is grounded in religious principles of love and acceptance of all people. We believe that all people should have access to full-spectrum reproductive and sexual health information and services, including abortion.

2. NM RCRC was founded in 1978 by volunteers from several Christian and Jewish denominations. I first joined NM RCRC as a volunteer over twenty years ago. In 1999, we changed from all volunteers to a staffed organization. That year, I also became the Executive Director, a position I have since held. Today, NM RCRC has four staff members, including a practical support program coordinator. In my current role as Executive Director, I supervise our practical support

program, which utilizes an extensive volunteer network to provide information, rides, accommodation, meals, and emotional support to people seeking abortion care in New Mexico.

3. People unable to access abortion in other states because of restrictions sometimes travel to New Mexico to seek abortion care. NM RCRC's clients come from all over the United States, including Texas.

4. Most of our clients have limited financial means. Many had never left their communities until they were forced to travel out of state for abortion care.

5. Most of our clients are people of color and people of faith.

6. NM RCRC assists both adolescents and adults.

7. I provide the following testimony based on personal knowledge acquired through my service at NM RCRC and review of the organization's business records.

NM RCRC's Practical Support Program

8. Clients primarily contact NM RCRC through our online intake system, which allows them to complete an application explaining their needs. Until 2017, I would personally respond to these applications. In 2017, our program coordinator took on the responsibility for calling them, usually within twenty-four hours of receiving their application1, except that if a client contacts us over the weekend, in most circumstances we are unable to call them back until the following Monday. During these follow-up calls, we assess the client's needs. For example, we determine whether the client has an abortion appointment and needs a ride, accommodation, or company during the appointment. After assessing the client's needs, we do our best to help secure practical support for the client through our network of volunteers. While we are unable to provide financial assistance to help pay for the cost of the abortion, we refer callers in need to other organizations for funds.

9. Texas residents seek abortion care in New Mexico for a variety of reasons. Some travel to New Mexico because the combination of Texas' restrictive laws and the scarcity of abortion providers—especially in West Texas—make it extremely difficult for them to access abortion in Texas, particularly if they are more than eighteen weeks pregnant, as measured from the first day of their last menstrual period ("lmp"). I understand that abortion patients who exceed this gestational age must obtain an abortion at an ambulatory surgical center in Texas, but I am not aware of any outside of Texas's four major metropolitan areas.

Impact of the Executive Order on Texas Residents Seeking Abortion Care

10. The COVID-19 pandemic has exacerbated the difficulties our clients experience, including our Texas clients. The current pandemic has heightened the stress associated with arranging transportation, navigating an unknown place, finding childcare, and missing work or school. For example, clients fear losing their jobs if they take time off, which is always stressful, but even more so given today's high unemployment rates. Clients who have lost wages and jobs because businesses have closed face difficulty gathering the funds necessary to pay for abortion care.

11. The COVID-19 pandemic has significantly complicated air travel to New Mexico. Flights are sometimes delayed or cancelled (sometimes because they are undersold), which results in clients being at the airport for longer and sometimes requires them to make multiple trips to the airport. Last week four Texas clients made the trip to New Mexico only to miss their appointments due to delayed or cancelled flights. To obtain care, three of those clients will return this week and the fourth next week. Texas clients are also confused about New Mexico's rules concerning out-of-state travelers, in part because Texas does not have similar rules, which adds to their distress. The New Mexico Department of Public Health has requested that anyone traveling into New

Mexico from outside the state voluntarily isolate for fourteen days or the duration of their stay, whichever is shorter, and monitor for COVID-19 symptoms. Governor Lujan Grisham issued an executive order requiring air travelers (who are permitted to leave their hotels to obtain medical care) and their companions to self-isolate. During the pandemic, we have seen Texas clients arrive both by air and driving, including distances up to 860 miles, one way.

12. The COVID-19 pandemic has also interfered with NM RCRC's ability to serve Texas clients. For example, we can no longer provide accommodation at a volunteer's home, for most clients a more comfortable and private alternative to a hotel, which is where we are currently hosting clients who need lodging. As a result, the care packages that we provided when clients occasionally stayed at a hotel, have become routine. These care packages contain a cloth mask sewed by a volunteer, as well as meals and snacks. Clients have always had difficulty affording takeout or delivery after paying for their abortion care, but now, even if a client has the resources, COVID-19 has made it harder to order takeout or delivery. Because some volunteers are social distancing, we also have significantly fewer volunteers available to provide rides. Due to COVID-19-related social distancing policies, we are unable to escort clients into and out of the clinic to provide emotional support. This can be particularly hard on clients because there are regularly protestors outside of the clinic who shout at them. Governor Lujan Grisham's executive order requiring air travelers and their companions to self-isolate also makes it more difficult for our clients' companions to fully support them. The companions cannot, for example, leave the hotel. As a result, our clients feel even more isolated accessing abortion care in an unfamiliar place.

13. Overcoming the many barriers to abortion care often requires a client to work with multiple organizations providing different types of financial and practical support, which together

enable the client to access care. This is often confusing for clients. Securing these various resources can also sometimes force them to delay appointments.

14. I understand that Texas has threatened to enforce an Executive Order by Governor Abbott as a ban on abortion care (the "EO"), which has made abortion care virtually unavailable in Texas.

15. In 2019, NM RCRC assisted over seventy-five Texas residents seeking abortion care in New Mexico. The vast majority of those clients were over eighteen weeks lmp, including many over twenty-two weeks lmp.

16. This year, we have already assisted over forty Texas residents seeking abortion care in New Mexico. Since the EO went into effect, we have assisted nearly twenty Texas residents, which is far more than we would normally expect to serve in that time period. Since then, we have also seen more Texas residents in their first trimesters than we are accustomed to. For example, over the last two weeks, we assisted five Texas residents who were less than eleven weeks lmp.

17. Since March 23, most of our Texas clients were between fifteen and twenty-two weeks lmp.

18. Governor Abbott's EO has forced NM RCRC's Texas clients to travel to New Mexico for abortion care they would have otherwise obtained in Texas. It has done so at a time when travel is increasingly fraught, and even dangerous. And it has made their abortion experience stressful, scary, and overwhelming.

Dated: April 16, 2020

/S/ Joan Lamunyon Sanford
JOAN LAMUNYON SANFORD

EXHIBIT 32

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE; *et al.*,	)	
Plaintiffs,	)	CASE NO. 1:20-cv-323-LY
v.	)	
GREG ABBOTT, in his official capacity as Governor; *et al.*,	)	
Defendants.	)	

DECLARATION OF ALMA LOE, M.D., IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

Alma Loe hereby declares under penalty of perjury that the following statements are true and correct:

1. I am a board-certified emergency medicine physician in Texas. I graduated from the David Geffen School of Medicine at UCLA in 2004, and I completed my residency in emergency medicine at Alameda County Medical Center Highland Hospital in 2009. I am a fellow of the American College of Emergency Medicine. Including residency, I have been practicing emergency medicine for 15 years.

2. I provide the following testimony based on my personal knowledge as well as my training and experience as an emergency medicine physician. The statements in this declaration are attributable solely to me. I do not speak on behalf of any institution or organization with which I am affiliated.

3. Since I finished residency and fellowship in July 2010, I have worked in the emergency department at a hospital system in Texas.

4. I am a member of the executive committee for the emergency department where I work. Additionally, I am involved in planning, operations, and policy updates for my emergency department's response to COVID-19. Based on my experience in that role, and in my role as a practicing emergency physician, I am very familiar with the impact of COVID-19 on emergency care at my hospital.

5. Our emergency department has been preparing for the COVID-19 outbreak since late February 2020. To prevent COVID-19 transmission within the hospital, we instituted visitation limitations, employee screening, new triage procedures, education requirements, and mandatory personal protective equipment (PPE) requirements.

6. I understand the term "PPE" to refer to gloves, masks, gowns, and eye protection. In the context of aerosol-generating procedures, PPE includes N95 masks or powered air-purifying respirators. Aerosol-generating procedures in the emergency department are most commonly nebulization of medications, use of non-invasive ventilators, and endotracheal intubations. PPE guidelines have been evolving during this pandemic but we have, at a minimum, followed current CDC guidelines. Our hospital currently reports a sufficient supply of PPE, particularly after we instituted guidelines for permissible mask and eye protection re-use and implementation of a process to clean N95 masks for re-use.

7. My hospital had our first patient with confirmed COVID-19 in early March. Since then, our emergency department has treated dozens of COVID-19 patients. Because we began preparation for the pandemic early and because community spread came to our geographic area relatively late, our hospital capacity has fortunately been sufficient to handle the volume of COVID-19 patients.

8. In terms of capacity, my biggest concern is the number of intensive care beds, ventilators, and critical supplies such as oxygen and medications used for intubation and sedation in critically ill patients. While our hospital has plans in place to accommodate a surge of COVID-19 patients in most respects, the number of ICU beds, nurses, and ventilators is a limiting factor in the number of patients we could care for at a given time. For context, the majority of patients we have treated for COVID-19-like symptoms are discharged home from the emergency department. General estimates from communities with COVID-19 surges are that approximately 12% of patients diagnosed with COVID-19 are admitted to the hospital, and that 5% of patients diagnosed with COVID-19 require ICU-level care.[1]

9. A major factor in our ability to absorb the COVID-19 patient volume is the fact that the number of emergency department visits is significantly down, likely due to the fact that people are staying home from work and school and are generally avoiding in-person medical visits. Ordinarily, multiple times per day we treat traumatic injuries from work, play, and traffic accidents. We also usually see a number of pediatric patients for fever from illness they are exposed to at daycare or school, but that number seems to have decreased in general due to social-distancing programs and school closures. The number of all these types of emergency department visits has decreased substantially. We are still performing surgeries for emergent medical problems like appendicitis, but in general the emergency department is seeing far fewer overall cases than we ordinarily would.

10. I learned about the standard of care for abortion in medical school, but I do not provide abortions.

[1] Ctrs. for Disease Control & Prevention COVID-19 Response Team, Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19)—United States, February 12–March 16, 2020, 69 Morbidity and Mortality Weekly Report 343 (2020).

11. In my experience, emergency complications from abortion are exceedingly rare. In my 15 years of emergency medicine practice, I have seen fewer than five patients admitted to the hospital with an abortion complication.

12. I occasionally encounter patients referred by abortion providers for suspected ectopic pregnancy. (The ectopic pregnancy is not caused by the abortion, but rather can be detected as part of routine screening before an abortion.) In those instances, I have been impressed by the medical judgment and careful communication reflected in the documentation sent to me by those providers.

13. More generally when I have treated patients who intend to obtain an abortion or have had an abortion in the past, I find that these patients readily disclose those facts to me because they recognize the importance of giving a complete medical history. Even were a patient reticent, I am confident that I would be able to obtain this information quickly. My work as an emergency physician requires that I effectively interview patients in a nonjudgmental manner and obtain sensitive information from them as necessary to evaluate their condition, such as information about sexual activity and drug use. I have been trained to do this, and I do it every shift; in my opinion, this is a core competency for the practice of emergency medicine.

14. I frequently treat patients experiencing complications from pregnancy. The most common complications we see are vomiting, abdominal pain, and vaginal bleeding in the first trimester, for example from spontaneous miscarriage or ectopic pregnancy. In my emergency medicine practice, I encounter patients experiencing pregnancy complications like these about five to ten times per month. I have treated several patients for pregnancy complications since the COVID-19 outbreak began. Like all patients that present to the emergency department with a

complaint unrelated to COVID-19, treating those patients would typically require gloves and a face mask.

15. I understand that Governor Abbott has issued an executive order prohibiting "all surgeries and procedures that are not immediately medically necessary" during the COVID-19 crisis, with an exception for surgeries and procedures that "would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 disaster." I also understand that Texas state officials have interpreted the Executive Order to prohibit most abortion.

16. Based on my experience as an emergency medicine physician and member of my department's COVID-19 response planning team, I do not think the prohibition on abortion will help our ability to respond to the COVID-19 pandemic. As stated, in my fifteen years of emergency medicine practice I have rarely encountered a patient requiring treatment for complications from abortion, whereas complications related to pregnancy are a common reason for patients to present to the emergency department for care. Moreover, as I explained, our main capacity constraints are the number of ICU beds and ventilators. While it is theoretically possible that a complication from abortion could require an ICU bed, I have never seen such a complication during my 15 year career; in contrast, complications from pregnancy do occasionally require an ICU bed, for example, when patients present with HELLP syndrome, eclampsia, pulmonary embolism, or sepsis.

17. In sum, because we neither provide abortion nor regularly treat patients with complications from abortion, prohibiting abortion has no connection to our ability to respond to the COVID-19 pandemic.

18. I want to file this declaration with my name under seal because I fear that I would face personal and professional retaliation if my name were publicly associated with this case. Additionally, I am aware that many physicians who support abortion rights, or who are perceived as doing so, can face substantial harassments by anti-abortion activists, including threats of violence.[2] Out of an abundance of caution for myself and my family, I prefer to keep my name private.

Dated: April 17, 2020

/s/ *Alma Loe*
Alma Loe, M.D.

[2] *See, e.g.*, *Antiabortion Protesters Target Clinic's Landlord Outside Child's Md. School*, Wash. Post, Sept. 12, 2011, https://www.washingtonpost.com/national/health-science/anti-abortion-protesters-target-clinics-landlord-outside-childs-md-school/2011/09/12/gIQAn8z2NK_story.html; Carter Sherman, *Anti-Abortion Harassment Forced a Planned Parenthood Clinic to Shut Down. It Didn't Perform Abortions.* Vice News, July 11, 2018, https://www.vice.com/en_us/article/594pgd/anti-abortion-harassment-forced-this-planned-parenthood-to-shut-down-it-doesnt-perform-abortions; Niraj Choksi, *Chicago Man Charged in Death Threat Against Abortion Clinic*, N.Y. Times, Aug. 19, 2019, https://www.nytimes.com/2019/08/19/us/ifunny-threat-abortion.html; Kate Smith, *Violence Against Abortion Clinics Hit a Record High Last Year. Doctors Say It's Getting Worse.*, CBS News, Sept. 17, 2019, https://www.cbsnews.com/news/ violence-against-abortion-clinics-like-planned-parenthood-hit-a-record-high-last-year-doctors-say-its-getting-worse/.

EXHIBIT 33

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE; *et al.*,	)	
	)	CIVIL ACTION
Plaintiffs,	)	
	)	CASE NO. 1:20-cv-323-LY
v.	)	
	)	
GREG ABBOTT, in his official capacity as Governor; *et al.*,	)	
	)	
Defendants.	)	

DECLARATION OF ALEX MOE IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

ALEX MOE hereby declares under penalty of perjury that the following statements are true and correct:

1. I am the Helpline Manager of the West Fund, a nonprofit organization based in El Paso, Texas, that provides direct financial assistance to Texas residents who want to end a pregnancy but cannot afford the cost of abortion care.

2. I first began providing services at West Fund as a helpline volunteer in 2015. In 2018, I joined the staff as the Helpline Manager. In my current role, among other things, I oversee our helpline and recruit, train, and supervise volunteer case managers who provide information about abortion services and financial assistance to callers through the helpline. Currently, I supervise six volunteers. I regularly speak with staff and volunteers about our clients' needs concerning abortion access. I also regularly speak directly with clients about these needs. In addition, I speak with other organizations providing financial assistance and practical support (e.g., help with lodging and transportation) to Texas residents seeking abortion care. The conversations I have with West Fund staff, volunteers, and clients, and colleagues at other organizations include

discussion about a person's employment, education, location, finances, reasons for seeking an abortion, children, relationships, access to transportation, support system, and lodging needs.

3. I have assisted hundreds of Texas residents seeking abortion care.

4. I provide the following testimony based on personal knowledge acquired through my service at the West Fund and review of the organization's business records.

5. Alex Moe is a pseudonym. I would like to keep my real name out of the public record because I fear harassment and retaliation by abortion opponents. There is a great deal of hostility toward abortion in El Paso, where I live.

West Fund's Helpline

6. The helpline is open for intake twenty-four hours a day, seven days a week. Callers contact us and leave a message explaining their needs. A staff member or volunteer calls them back, usually within twenty-four hours. During these follow-up calls, we assess the caller's needs. For example, we ask the caller how far along they are in their pregnancy; whether they have an appointment scheduled, and if so, where; and the cost of their abortion. We also inquire about whether the caller needs other practical support, for example, a ride back from the appointment. If so, we do our best to help the caller secure practical support from another organization.

7. Our callers must often travel long distances to obtain care. For example, Texas requires abortions to be performed in an ambulatory surgical center or hospital beginning at eighteen weeks from the first day of a patient's last menstrual period (lmp). It is my understanding that the closest ambulatory surgical center to El Paso providing abortion care is in San Antonio. As a result, if an El Paso caller is at or past eighteen weeks lmp and seeking abortion care, they must make the eight- to nine-hour car ride, which is considerably longer by bus, to San Antonio to obtain care in Texas.

8. In 2019, West Fund provided over $38,093 to assist 122 Texas residents seeking help paying for an abortion. Between January and March of this year, we provided over $12,715 to assist 28 Texas residents with their abortion care. We generally provide our callers funds to cover the full cost of a first-trimester abortion, which in my experience is approximately $450-800, though this does not cover other related expenses such as transportation, lodging, and childcare. After the first trimester, an abortion is significantly more expensive; our pledge amount is a minimum of $500, and sometimes higher, depending on the caller's circumstances and the resources we have available then. Unfortunately, because the cost of obtaining an abortion after the first trimester exceeds a thousand dollars (and it is not uncommon for these abortions to cost several thousand dollars), we are not able to cover the full cost of the abortion. For example, in my experience, the cost of an abortion for our callers at nineteen to twenty weeks lmp is approximately $2400, and the cost increases with gestational age.

9. West Fund receives calls from all over Texas. Unfortunately, we cannot help every caller who needs financial assistance because of our limited financial resources. West Texas is expansive. At the same time, it has few abortion providers and organizations assisting people seeking abortion care. West Fund therefore prioritizes assisting people who reside in West Texas.

10. We assist both adolescents and adults. Most of our callers are uninsured. Some callers have insurance, but almost none have insurance coverage for abortion except in extremely narrow circumstances. As result, our callers must pay for their abortion and related expenses out-of-pocket. Most callers are parents, and some have more than one child.

11. Towards the end of last year, West Fund increased its monthly helpline budget to $6,000 to enable us to cover the full cost of our clients' first trimester abortions. We did so after recognizing that when we were covering only a portion of the cost of care, clients were forced to

delay care, sometimes into their second trimesters, as they attempted to gather the money needed to pay for their abortions, sometimes from multiple organizations. Not only did this make the cost of care more expensive, but it also increased their stress.

12. Although our finances are limited, we almost always find a way to help every caller from West Texas. Last month, however, caller need far exceeded our resources. We were unable to provide financial assistance to some West Texas callers (and even more callers from other parts of the state). We referred these callers to other organizations for assistance. In all my time at West Fund, this is the first time we have been unable to provide at least some financial assistance to a West Texas-based caller.

Impact of the Executive Order on Texas Residents Seeking Abortion Care

13. I understand that the State has threatened to enforce an Executive Order by Governor Abbott as a ban on abortion care (the "EO"), which has made abortion care virtually unavailable in Texas.

14. Even prior to the COVID-19 outbreak, it was difficult, and sometimes impossible, to access an abortion in Texas. For example, Texas forces most abortion patients to make at least two trips to obtain abortion care, which increases the logistical and financial burdens associated with accessing care. As a result, some callers must unnecessarily delay their appointments. Some callers delay care while they gather money for the abortion and related transportation, lodging, or childcare. Others delay care because of difficulty taking even one day off from work. Some delay care because they cannot secure childcare or find someone to accompany them to the clinic. Some callers lack access to a reliable car and must delay care to find a ride. Delay not only increases our callers' stress and anxiety, but also the cost of their care since the cost of an abortion increases

with gestational age. It is not uncommon for our callers to miss an appointment because of these barriers, which results in even further delayed care.

15. The COVID-19 outbreak has profoundly impacted everyday life in Texas, including the lives of our callers. As a result of COVID-19, many of our callers are struggling with loss of work, income, employer-sponsored health insurance, and childcare. They are finding it difficult to pay their rents, mortgages, and bills. Callers who can work remotely from home are also juggling homeschooling their kids because schools are closed. Callers who still have jobs outside of their homes worry about becoming infected with COVID-19 and then exposing the children and family members with whom they live.

16. The EO banning most abortion care is exacerbating the difficulties, stress, and fear our callers are experiencing from the COVID-19 crisis. On top of everything else, they are forced to be pregnant when they do not want to be. If they are able, they must contend with traveling out of state to obtain care.

17. Since April 1, West Fund has helped ten callers who contacted us because they were unable to obtain abortions in Texas as a result of the EO. In addition, we referred one Houston-based caller who plans to obtain care out of state to another organization that provides financial assistance to people located in that region of Texas. We have received messages from additional callers requesting assistance accessing abortion care and are in the process of following-up with them.

18. Six callers had appointments in Texas that were cancelled because of the EO. The EO has forced all ten callers to delay obtaining abortion care, and they either have or will travel to New Mexico to obtain care. When we spoke with them, several callers between sixteen and twenty-two weeks lmp. Some will travel from as far away as Dallas. By April 1, the New Mexico clinic

had no appointments available until the second week of April, and the callers are scheduled for appointments between April 8 and April 24. In our experience, the New Mexico clinic is generally able to see our callers within a week of being contacted. Because of COVID-19, the clinic has reduced the number of patients they see and the spacing of appointments. As a result, fewer appointments are available, and people must wait longer to obtain care at the clinic.

19. One caller I spoke with on or about April 2 was experiencing intimate partner violence. Unable to access abortion in Texas because of the EO, she planned to obtain care in New Mexico last week, but her ride fell through and she was unable to make the appointment. She is now a few days past twenty-two weeks lmp, and therefore ineligible for an abortion in Texas. If she is unable to obtain care in another state, she will be forced to carry her pregnancy to term. Her abuser does not know that she is pregnant, and she is afraid for him to find out.

20. Our callers have been extremely distressed that they could not obtain abortion care in Texas. The burdens associated with making plans to obtain care out of state were exacerbating their distress. For example, a mother called on behalf of her daughter. Mother and daughter had been recently been laid off. Now, as result of the EO, they would be forced to make an unexpected trip during the COVID-19 outbreak to New Mexico for the daughter's abortion care, which was adding to the stress and anxiety they were both already experiencing. Another caller with a wanted pregnancy received a diagnosis of a fetal anomaly. During her pregnancy, the caller had been to the doctor multiple times and even once to the emergency room for care. Now, she must travel to New Mexico to obtain abortion care she sought to access in Texas but cannot because of the EO.

21. The COVID-19 outbreak has also made travel more difficult. For example, airlines have cut back on flights, which sometimes results in callers having their flights delayed or cancelled.

22. The EO banning most or all abortion care in Texas has made the current public health crisis an even more traumatic experience for our callers.

Dated: April 16, 2020

/S/ Alex Moe
Alex Moe

EXHIBIT 34

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE, *et al.*, Plaintiffs, v. GREG ABBOTT, in his official capacity as Governor of Texas, *et al.*, Defendants.	No. 1:20-cv-00323-LY

SECOND DECLARATION OF TRAM NGUYEN IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, Tram Nguyen, declare as follows:

1. I am the Senior Director of Quality Assurance & Abortion Access at Planned Parenthood Gulf Coast ("PPGC"), as well as the Ambulatory Surgical Center Administrator at Plaintiff Planned Parenthood Center for Choice ("PPCfC").

2. I submitted a declaration previously in support of Plaintiffs' motion for a preliminary injunction, which was filed as Exhibit 15 to Plaintiffs' Notice of Supplemental Filing, ECF Docket No. 49-5. I submit this declaration in further support of Plaintiffs' motion.

3. I assert the facts here based on my role in overseeing operations related to abortion care at PPCfC's health centers. If called and sworn as a witness, I could and would testify competently thereto.

4. Due to the state's enforcement of GA-09 as a total previability abortion ban, as of the end of the day on April 11, 2020, our health centers at PPCfC have been forced to turn away three hundred and thirty-eight (338) patients seeking abortion care. This remains an

underestimation, as this number accounts only for patients who have had either an ultrasound or abortion appointment cancelled because of the enforcement of GA-09, or patients who have had an ultrasound appointment and who have not been able to schedule an abortion appointment due to the enforcement of GA-09. This number cannot account for all the patients who called to make an appointment during the ban, but were turned away, nor the patients who have not called for an appointment at all because they were aware that Texas was not permitting people to obtain abortion care.

5. I know for certain that at least ten (10) of these patients will be beyond the 22-week LMP statutory gestational age limit in Texas by the time the Executive Order expires on April 22, 2020, assuming it is not extended. This figure is also an underestimate, however, because so many of the 338 patients who have been turned away have not obtained ultrasounds to date their pregnancies.

6. The intermittent services we have been forced to provide across this period have left patients in extraordinarily difficult situations, including that twice in less than two weeks a temporary restraining order allowing abortion services to proceed was stayed while patients were present at the health center preparing for abortion services. Both times, we were forced to turn those patients away without providing the care they had come for.[1] Other patients had multiple abortion appointments scheduled and then cancelled. At least sixteen (16) patients had two scheduled appointments that were canceled because of the Executive Order. And at least one patient had her abortion appointment scheduled and then cancelled *three* times. It is incredibly distressing for patients to have this time-sensitive care cancelled and then rescheduled multiple

[1] It is worth noting that any patient in a health center for an abortion appointment has necessarily already come to the clinic at least 24-hours earlier for the state-mandated ultrasound appointment. Thus, patients who had their abortion appointments cancelled while they were at the clinic and then have to return, will have had to make *three* trips to a health center to obtain their abortion.

times, and especially so when we cannot give them any guarantee of when we will be able to provide them care.

7. PPCfC operates an ASC in Houston and an abortion facility in Stafford, Texas. Prior to the COVID-19 pandemic, the two health centers together performed approximately 130 abortions per week.

8. Prior to the COVID-19 pandemic, a patient seeking an abortion would wait, on average, one to three days for their state-mandated ultrasound appointment, and then another one to two days for their abortion appointment.

9. It is my understanding that a Planned Parenthood affiliate with health centers in New Mexico, Colorado, and Southern Nevada has provided abortion care to approximately one hundred and thirty-five (135) patients from Texas since March 23, 2020. In my previous declaration, I had noted that this same affiliate had seen 35 patients from Texas in February, but I now understand that number to be an overestimate, as it included patients seeking non-abortion services, as well as appointments that were not kept. It is my understanding now that for the entire month of February, that affiliate had only provided abortions to sixteen Texas patients—meaning that that out-of-state affiliate has seen over a 700% increase in Texas patients seeking abortion care since March 23 than it had in the entire month of February.

10. Generally, the longer abortion care is delayed, the more time the patient has to spend at a health center. Generally speaking, a patient spends approximately two hours obtaining a medication abortion; approximately three to four hours obtaining an aspiration abortion; generally approximately six to seven hours obtaining an abortion after 15 weeks gestation; and for two-day procedures generally conducted later in the second trimester, a patient generally spends approximately two hours in the health center on each visit, meaning approximately four hours in

the health center (and often an overnight stay in a hotel, if the patient does not live near the health center).

11. Due to the pandemic, even before this litigation, we had determined that patients eligible for both procedural and medication abortion would be provided a medication abortion, unless there is a strong reason why procedural abortion is the more appropriate method for that specific patient. If we regain our ability to provide both medication and procedural abortion, that is how we intend to proceed while the need to conserve PPE continues.

12. I understand that one of the issues in this case concerns whether the state of Texas is treating abortion-related care differently from other, similar types of activities. I believe that the exact same type of activity—providing an ultrasound—is being treated differently when it is conducted at one of our health centers in relation to a patient's abortion care than when an ultrasound is conducted elsewhere and in other contexts.

13. My understanding is that the state of Texas is arguing that medication abortions should not proceed until GA-09 expires because medication abortions require an ultrasound and transvaginal ultrasounds utilize PPE (i.e., a pair of non-sterile gloves).

14. Other non-abortion providing entities are currently providing ultrasounds which have no medical or diagnostic value. So far as I am aware, these other entities have not been closed down or forced to stop providing ultrasounds by the state of Texas.

15. Today, I searched the websites of so-called "crisis pregnancy centers" (CPC) in Texas. These are organizations, usually religiously-affiliated, that seek to dissuade women from terminating their pregnancies, often by providing pregnant women with ultrasounds. These ultrasounds are usually advertised as a way to "confirm pregnancy," because they do not provide

any medical or diagnostic purpose.[2] Often these CPCs do not inform women that they do not provide abortions (frequently opening centers near abortion-providing health centers and advertising "options counseling"), and many women who visit them mistake them for health centers that provide abortion.[3]

16. I found the following CPCs explicitly advertised on their websites that they are continuing to conduct ultrasounds during the COVID-19 pandemic:

a. Pregnancy Care Center of San Antonio states on its website at www.sapregnancy.com: "[W]e are limiting our services to Pregnancy Testing, STI Testing & Ultrasounds for Pregnancy Confirmation." The website further states "our licensed healthcare providers may be wearing additional gloves, gowns, or masks during your visit" and that "tissues, masks, and hand sanitizers are available throughout the Center."

b. Guiding Star El Paso states on its website, guidingstarelpaso.org, that "[w]e continue to provide FREE essential medical services to eligible clients, including ultrasounds to verify pregnancy, pregnancy tests, and information." (emphasis in original)

c. Hope Pregnancy Center states on its website, www.hopecanton.com, that "[l]imited sonograms will be scheduled for Axia Center, Tyler" and that "pregnancy tests will be scheduled 1 per hour."

[2] "Why Crisis Pregnancy Centers are Legal but Unethical," Amy G. Bryant, MD, MSCR and Jonas J. Swartz, MD, MPH AMA Journal of Ethics, March 2018 Policy Forum, https://journalofethics.ama-assn.org/article/why-crisis-pregnancy-centers-are-legal-unethical/2018-03; "Crisis Pregnancy Centers, Money for Nothing," Austin Chronicle, July 20, 2018; https://www.austinchronicle.com/news/2018-07-20/crisis-pregnancy-centers-money-for-nothing/.
[3] *Id.*

d. Hill Country Pregnancy Care Center states on its website, https://www.lifesprecious.org/book-online, that it is currently providing "Pregnancy tests, STD screenings and treatment, & Sonograms (LIMITED APPOINTMENTS)." (emphasis in original).

17. A true and correct copy of each of the aforementioned website pages, which I saved as screenshots from each website on April 13, 2020, is attached hereto as Exhibit A.

18. It is my understanding that Drs. Heidi Abraham and Timothy Harstad, who provided declarations in support of State Defendants' Response to Plaintiffs' Motion for a Temporary Restraining Order, have indicated that their hospitals or health systems are suffering from a shortage of PPE. Dr. Abraham, the EMS Medical Director for Austin/Travis County Emergency Medical Services, stated that "hospitals and other emergency medical personnel in Austin/Travis County are currently experiencing shortages" of PPE, including N95 masks. Abraham Decl. ¶ 6. However, the president of the Austin EMS Association stated that "Our department has done a good job in stockpiling N95s. So, we have N95 [masks] for quite a few months."[4] Dr. Harstad, the perinatal medical director at St. David's Medical Center in Austin, likewise opined that N95 masks are in short supply. Harstad Decl. ¶ 4. However, the chief medical officer of St. David's HealthCare recently stated that St. David's HealthCare facilities currently have adequate supplies of PPE and even issued a new protocol for staff that expands mask use beyond patient areas with suspected or positive COVID-19 cases.[5] Hospitals in Drs. Abraham and Harstad's region appear to have sufficient capacity to deal with current patient volume. Austin-

[4] Pattrik Perez, *On the Front Lines: A Conversation with the Austin EMS Association About Working Through the COVID-19 Pandemic*, KVUE (Mar. 30, 2020), https://www.kvue.com/article/news/health/coronavirus/coronavirus-austin-ems-working-through-the-covid19-pandemic/269-4b5a5dba-5f06-4f19-a1a4-0b5e5df66ebe.

[5] Tony Cantu, *Coronavirus: St. David's HealthCare Expands Mask Use in Austin*, Patch (Apr. 1, 2020), https://patch.com/texas/downtownaustin/coronavirus-st-davids-healthcare-expands-mask-use-austin.

Travis County officials have said that hospitals are currently operating at about fifty percent capacity,[6] and St. David's HealthCare has closed some locations due to the significant decrease in patient volume.[7]

19. I declare under penalty of perjury that the foregoing is true and correct.

Tram Nguyen

Executed April 16, 2020

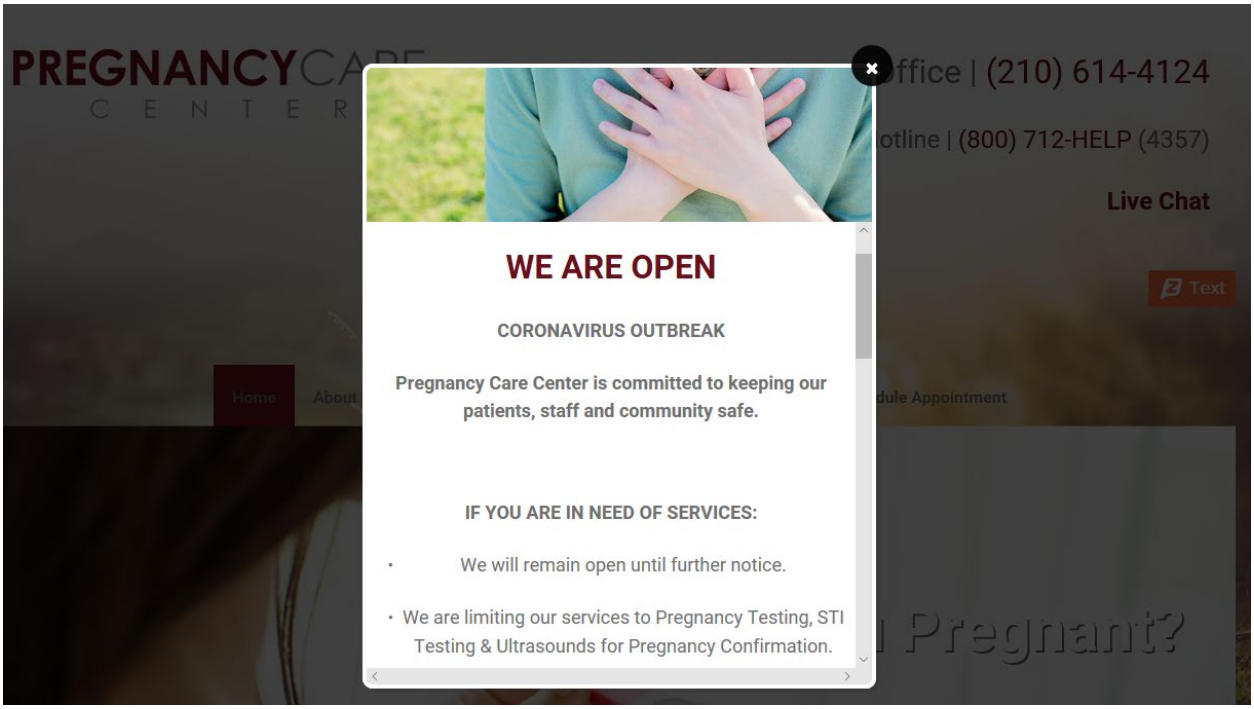
[6] Press Release, City of Austin, Surge Plan Developed to Treat COVID-19 Patients if Hospitals are Overwhelmed (Apr. 8, 2020), https://www.austintexas.gov/news/surge-plan-developed-treat-covid-19-patients-if-hospitals-are-overwhelmed.

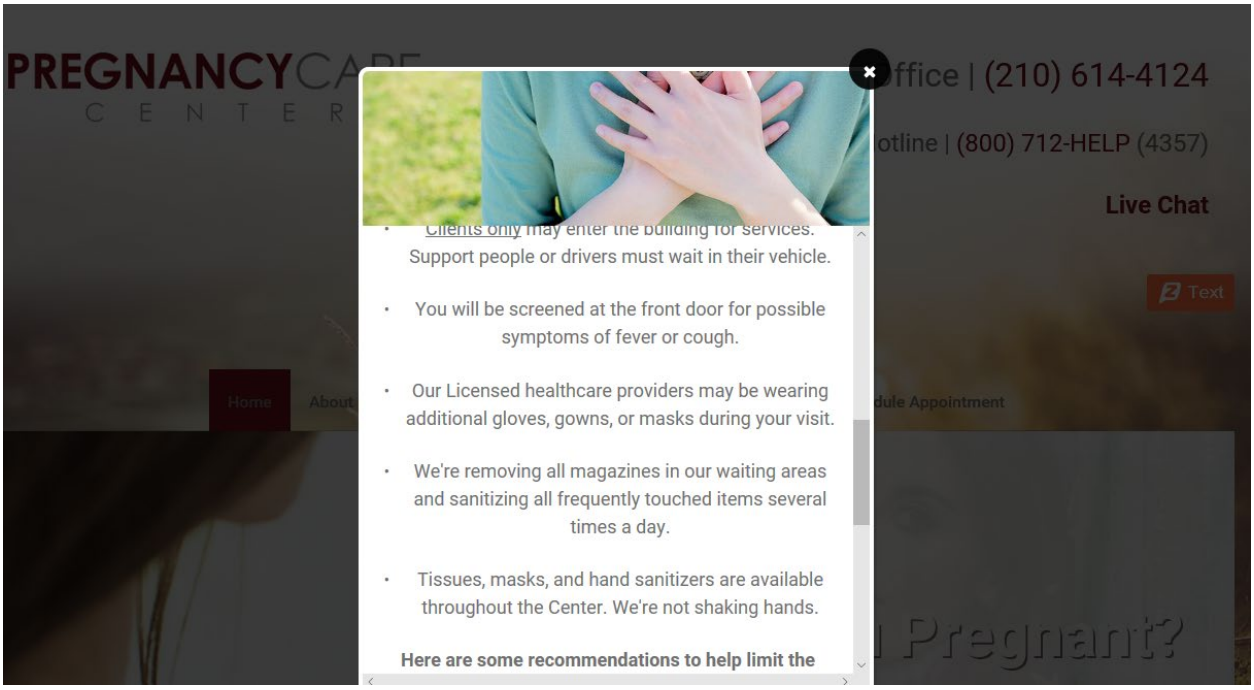
[7] Luz Moreno-Lozano, *St. David's Temporarily Closes 3 Austin-Area Locations in Response to Coronavirus*, Statesman (Apr. 2, 2020), https://www.statesman.com/news/20200402/st-davidrsquos-temporarily-closes-3-austin-area-locations-in-response-to-coronavirus.

EXHIBIT A

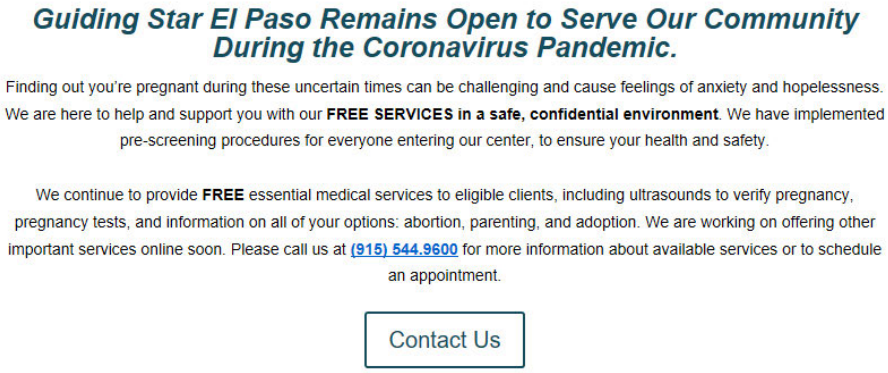
Crisis Pregnancy Centers During COVID-19

Pregnancy Care Center of San Antonio - https://www.sapregnancy.com/





Guiding Star El Paso - https://guidingstarelpaso.org/



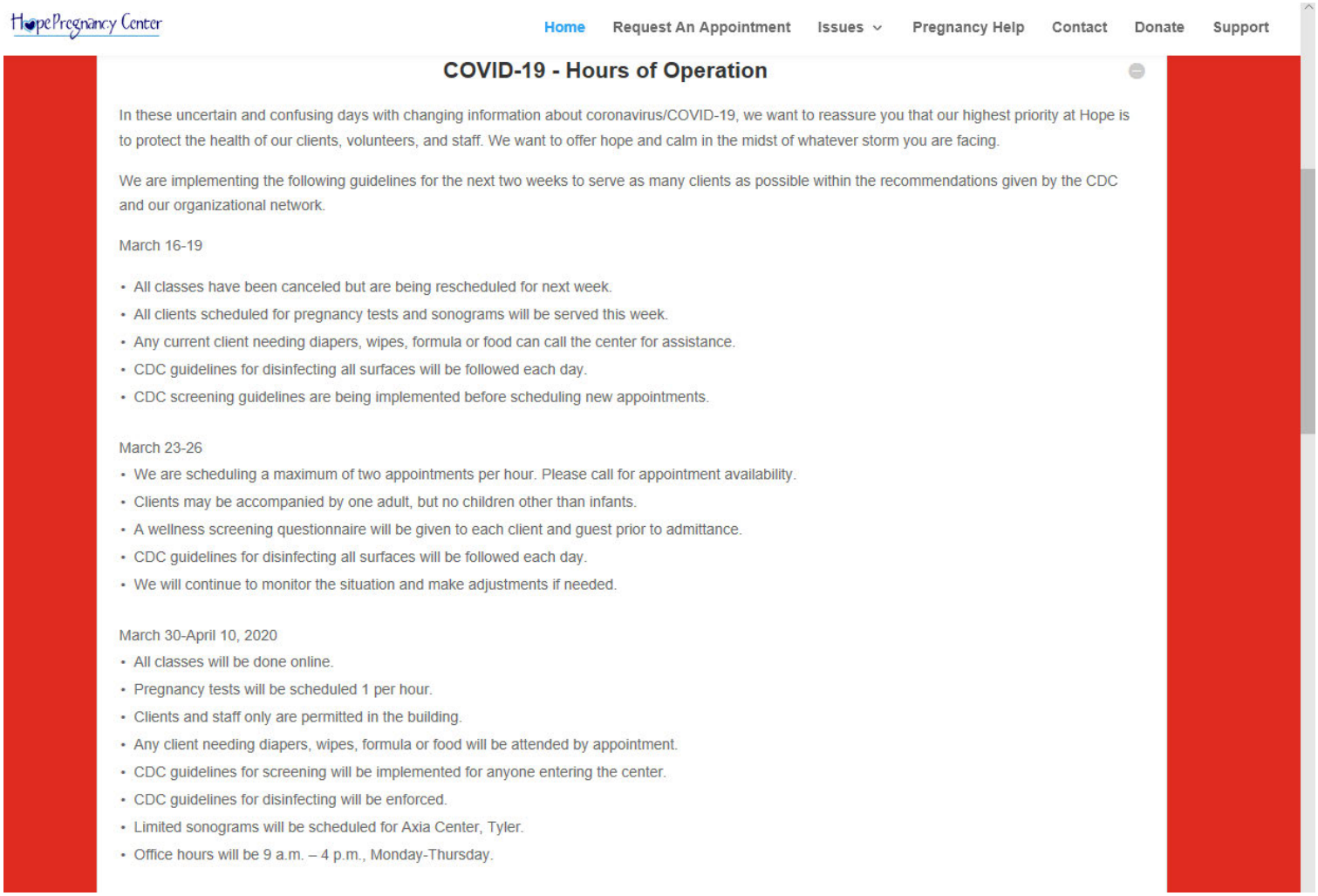
Guiding Star El Paso Remains Open to Serve Our Community During the Coronavirus Pandemic.

Finding out you're pregnant during these uncertain times can be challenging and cause feelings of anxiety and hopelessness. We are here to help and support you with our **FREE SERVICES in a safe, confidential environment**. We have implemented pre-screening procedures for everyone entering our center, to ensure your health and safety.

We continue to provide **FREE** essential medical services to eligible clients, including ultrasounds to verify pregnancy, pregnancy tests, and information on all of your options: abortion, parenting, and adoption. We are working on offering other important services online soon. Please call us at (915) 544.9600 for more information about available services or to schedule an appointment.

Contact Us

Hope Pregnancy Center – www.hopecanton.com



Hope Pregnancy Center

Home | Request An Appointment | Issues | Pregnancy Help | Contact | Donate | Support

COVID-19 - Hours of Operation

In these uncertain and confusing days with changing information about coronavirus/COVID-19, we want to reassure you that our highest priority at Hope is to protect the health of our clients, volunteers, and staff. We want to offer hope and calm in the midst of whatever storm you are facing.

We are implementing the following guidelines for the next two weeks to serve as many clients as possible within the recommendations given by the CDC and our organizational network.

March 16-19

- All classes have been canceled but are being rescheduled for next week.
- All clients scheduled for pregnancy tests and sonograms will be served this week.
- Any current client needing diapers, wipes, formula or food can call the center for assistance.
- CDC guidelines for disinfecting all surfaces will be followed each day.
- CDC screening guidelines are being implemented before scheduling new appointments.

March 23-26

- We are scheduling a maximum of two appointments per hour. Please call for appointment availability.
- Clients may be accompanied by one adult, but no children other than infants.
- A wellness screening questionnaire will be given to each client and guest prior to admittance.
- CDC guidelines for disinfecting all surfaces will be followed each day.
- We will continue to monitor the situation and make adjustments if needed.

March 30-April 10, 2020

- All classes will be done online.
- Pregnancy tests will be scheduled 1 per hour.
- Clients and staff only are permitted in the building.
- Any client needing diapers, wipes, formula or food will be attended by appointment.
- CDC guidelines for screening will be implemented for anyone entering the center.
- CDC guidelines for disinfecting will be enforced.
- Limited sonograms will be scheduled for Axia Center, Tyler.
- Office hours will be 9 a.m. – 4 p.m., Monday-Thursday.

Hill Country Pregnancy Center - https://www.lifesprecious.org/book-online

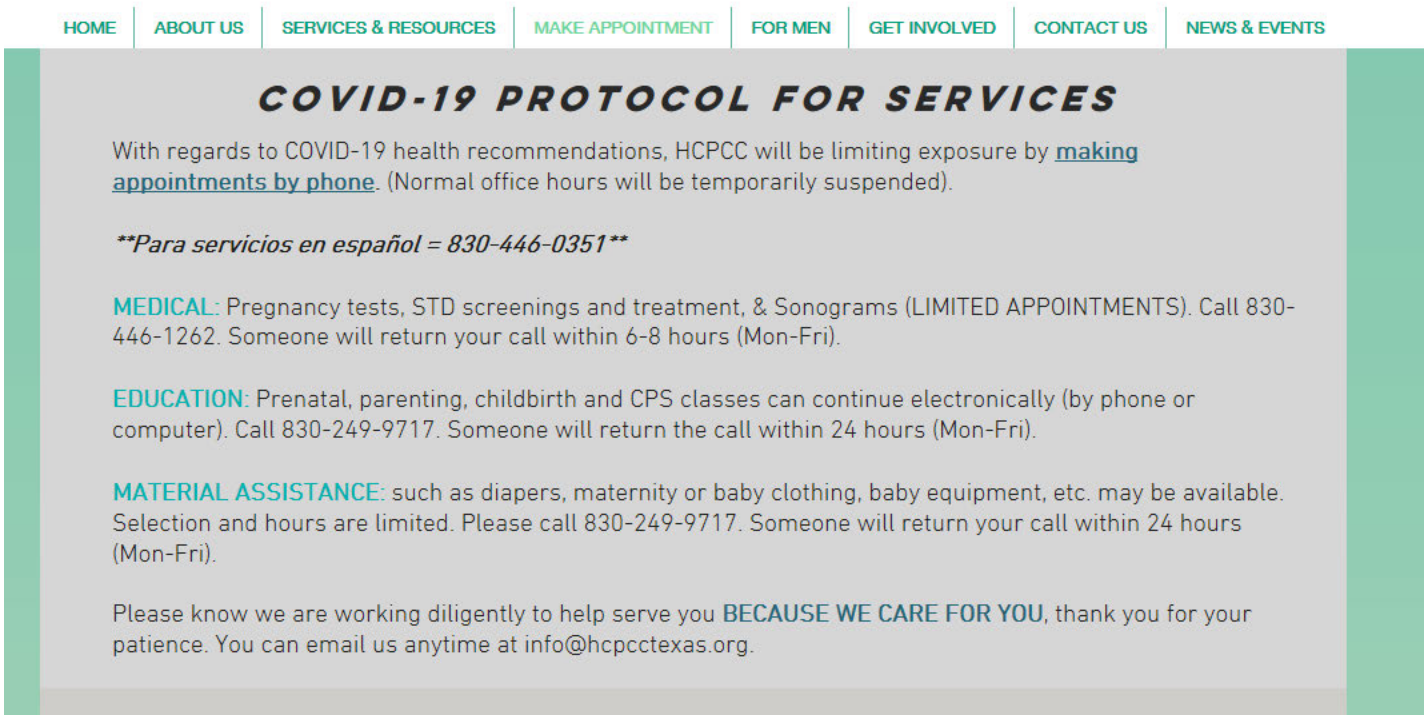


EXHIBIT 35

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE; *et al.*,	)	
Plaintiffs,	)	CASE NO. 1:20-cv-323-LY
v.	)	
GREG ABBOTT, in his official capacity as Governor; *et al.*,	)	
Defendants.	)	

DECLARATION OF MARY ROE, M.D., IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

MARY ROE, M.D., hereby declares under penalty of perjury that the following statements are true and correct:

1. I am a board-certified emergency medicine physician. I have practiced medicine since 2012 and finished my residency in emergency medicine in 2015. I am currently serving as an emergency medical physician in emergency rooms at two different facilities in El Paso, Texas.

2. I provide the following testimony based on my personal knowledge as well as my training and experience as an emergency medicine physician. The statements in this declaration are attributable solely to me. I do not speak on behalf of any institution or organization with which I am affiliated.

3. As an emergency medicine physician, I understand well the impact COVID-19 is having on hospitals, health care systems, and health care workers.

4. I am further familiar with Governor Greg Abbott's executive order ("EO") prohibiting "all surgeries and procedures that are not immediately medically necessary" during the COVID-19 crisis, with an exception for surgeries and procedures that "would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 disaster."

5. At both of the emergency rooms I work at, there is a shortage of personal protective equipment ("PPE"). As a result, all personal protective equipment is being rationed, meaning that we must re-use equipment, including face masks.

6. I have treated approximately 30 patients with COVID-19 already and have intubated one (a procedure with a high risk of exposure, requiring the most PPE). I am dedicated to my patients and to showing up when they need me. I am also, however, mindful that I am risking my life by showing up to work every day.

7. Nevertheless, banning abortions—whether medication abortions or procedural abortions—will not relieve this burden on emergency room physicians like myself. It does nothing more than prevent pregnant patients from obtaining the full range of time-sensitive medical care that they need.

8. It is my understanding that Texas state officials are interpreting the EO to ban abortions, arguing that doing so will help conserve PPE and/or prevent hospitalizations.

9. I understand that medication abortions do not require any PPE, and that procedural abortions generally require some PPE, including face masks and gloves, from a small number of providers.

10. Pregnant patients are far more likely to present to the emergency room than people who have obtained abortions.

11. Prior to COVID-19, I saw at least a few pregnant patients every day who were presenting to the emergency room for something other than a delivery.

12. Even now, with the COVID-19 pandemic, I still see a few pregnant patients present to the delivery room every day for issues other than delivery, the majority of which have pregnancies less than 22 weeks gestational age.

13. In my eight years of practice, to my knowledge, I have never seen a patient present to the emergency room for an abortion complication.

14. Now, with the pandemic, when a pregnant patient presents to the emergency room, substantial PPE is used to see them in order to reduce the risk of the pregnant patient contracting COVID-19 at a hospital. Thus, even if the patient is not suspected of having COVID-19, health care workers still must wear an N95 mask, a surgical mask, eye protection, and gloves. Patients who present to waiting rooms also generally need to wait for 1-2 hours to be seen, increasing the risk of COVID-19 transmission.

15. I fear that if pregnant people in Texas are not allowed to obtain abortions legally at health centers, some will turn to unsafe means to induce their own abortions, which could require hospitalization.

16. I want to file my name and CV under seal because I am aware that many physicians who advocate for abortion rights or who are perceived as doing so can face substantial harassments by anti-abortion activists, including threats of violence.[1] I hope to avoid this harassment by keeping my name and identity confidential.

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[1] *See, e.g.*, *Antiabortion Protesters Target Clinic's Landlord Outside Child's Md. School*, Wash. Post, Sept. 12, 2011, https://www.washingtonpost.com/national/health-science/anti-abortion-protesters-target-clinics-landlord-outside-childs-md-school/2011/09/12/gIQAn8z2NK_story.html; Carter Sherman, *Anti-Abortion Harassment Forced a Planned Parenthood Clinic to Shut Down. It Didn't Perform Abortions.* Vice News, July 11, 2018, https://www.vice.com/en_us/article/594pgd/anti-abortion-harassment-forced-this-

Dated: April 17, 2020

/s/ Mary Roe
MARY ROE, M.D.

planned-parenthood-to-shut-down-it-doesnt-perform-abortions; Niraj Choksi, *Chicago Man Charged in Death Threat Against Abortion Clinic*, N.Y. Times, Aug. 19, 2019, https://www.nytimes.com/2019/08/19/us/ifunny-threat-abortion.html; Kate Smith, *Violence Against Abortion Clinics Hit a Record High Last Year. Doctors Say It's Getting Worse.*, CBS News, Sept. 17, 2019, https://www.cbsnews.com/news/violence-against-abortion-clinics-like-planned-parenthood-hit-a-record-high-last-year-doctors-say-its-getting-worse/.

EXHIBIT 36

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE; *et al.*,	)	
Plaintiffs,	)	CASE NO. 1:20-cv-323-LY
v.	)	
GREG ABBOTT, in his official capacity as Governor; *et al.*,	)	
Defendants.	)	

DECLARATION OF ODILE SCHALIT IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

ODILE SCHALIT hereby declares under penalty of perjury that the following statements are true and correct:

1. I am the Executive Director of The Brigid Alliance, Inc. ("Brigid"), a New York City-based nonprofit organization that arranges and funds safe, confidential, and personalized logistical support for individuals across the U.S. seeking abortion care. Brigid's services include, but are not limited to: arranging and paying for lodging and transportation, such as bus, plane, or train tickets; covering expenses, such as gas, tolls, childcare, and meals; coordinating local transportation; referring clients to local volunteer organizations for clinic escort services and other support; and providing compassionate support throughout each client's journey.

2. In my role as Executive Director, I oversee Brigid's strategic operations and program support, supervise our direct services team of two full-time intake coordinators, provide direct support to clients when needed, and maintain relationships with fellow practical support organizations, abortion funds, and abortion providers. In addition, I direct Brigid's work to ensure

that it is rooted in and responsive to the needs of our clients, who rely on us and organizations like ours to overcome obstacles to care.

3. I provide the following testimony based on personal knowledge acquired through my service at Brigid and review of the organization's business records.

Overview of Brigid

4. Brigid is a referral-based organization. Our clients are primarily referred to us by abortion providers and individuals at other organizations that help people access abortion care. After a client is referred to us, we contact the client to assess their needs concerning abortion. After identifying the client's barriers to care, we work closely with the client to develop and implement a plan to overcoming those barriers. Sometimes new obstacles arise after we develop a plan; we do our best to help the client surmount those as well. We stay in close contact with the client throughout their journey to provide logistical and emotional support.

5. Brigid specializes in providing support associated with accessing abortion care later in pregnancy. Generally, by the time a client reaches out to us, they have been unable to obtain assistance at earlier stages of gestation.

6. Since 2018, Brigid has provided financial and travel assistance to approximately 850 people across the U.S. who must travel to access abortion care. To date, Brigid has helped clients from 47 states, including Texas, travel an average of 1,200 miles. Brigid supports approximately 55 clients per month, and provides, on average, financial assistance of $850 per client to help them access care.

7. Brigid's clients, including our Texas-based clients, are lower income.

8. Since August 2018, Brigid has provided travel assistance to 52 Texas residents seeking abortion care.

9. We serve clients located throughout Texas. Most of our Texas clients live in West, South, and North Texas.

Impact of the Executive Order on Texas Residents Seeking Abortion Care

11. The current public health crisis has exacerbated the difficulties facing our clients, including our Texas-based clients. Among other things, clients have lost income, jobs, and childcare, which has made it harder for them to afford the cost of abortion care.

12. I understand that on March 22, 2020, Governor Abbott issued an Executive Order that required healthcare providers to postpone "non-essential" surgeries and procedures throughout Texas, and that on March 23, 2020, the Texas Attorney General threatened to enforce the Executive Order as a ban on abortion care. I further understand that Texas abortion providers subsequently suspended nearly all services and canceled hundreds of appointments.

13. On average, Brigid helps two to three Texas residents access abortion care per month. In January and February 2020, Brigid helped nine Texas residents access care. Since the Executive Order went into effect, Brigid provided nine Texas residents—far more than we would expect to serve in a little over three weeks—with logistical and financial support to enable them to travel out of state for care.

14. Until recently, most of our Texas-based clients were more than 22 weeks pregnant, as measured from the person's last menstrual period ("lmp"). Since the Executive Order went into effect, we have seen an increase in requests for assistance from Texas-based clients who are less than 22 weeks lmp.

15. The Executive Order is forcing people who are able, to leave the state to access abortion care. With Brigid's assistance, six Texas residents will travel to New Mexico to access abortion as a result of the Executive Order. Most of these clients will fly. Flights during the

COVID-19 outbreak are increasingly delayed or canceled, which means that clients must stay at the airport longer or make multiple trips to the airport to access care. Most of these clients also live with other people. They risk contracting COVID-19 during their journeys and going home to expose the people with whom they live.

16. As a result of the Executive Order, other Texas residents have traveled to Kansas and Illinois to access care.

Dated: April 16, 2020

/S/ *Odile Schalit*
ODILE SCHALIT

EXHIBIT 37

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE, *et al.*, Plaintiffs, v. GREG ABBOTT, in his official capacity as Governor of Texas, *et al.*, Defendants.	No. 1:20-cv-00323-LY

SECOND DECLARATION OF ANN SCHUTT-AINE, M.D., IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, Ann Schutt-Aine, M.D., declare as follows:

1. I am a board-certified obstetrician and gynecologist ("OB/GYN") licensed to practice in the state of Texas, and I have been practicing in Houston, Texas, since 2008. I have served as the Chief Medical Officer of Planned Parenthood Center for Choice ("PPCFC") since 2017.

2. I submitted a previous declaration in this case in support of Plaintiffs' motion for a temporary restraining order and preliminary injunction along with my curriculum vitae.

3. In addition to my duties with PPCFC, I provide general OB/GYN care in a hospital setting on a weekly basis, including during the ongoing COVID-19 pandemic. In that capacity, I am routinely involved in labor and delivery, gynecological surgeries, and obstetrical and gynecological consultations for pregnant patients who have visited the emergency department.

4. The facts and opinions included here are based on my education, training, practical experience, information, and personal knowledge I have obtained as an OB/GYN and an abortion

provider; my attendance at professional conferences; review of relevant medical literature; and conversations with other medical professionals. If called and sworn as a witness, I could and would testify competently thereto.

Hospital Care for Pregnant Patients

5. Pregnancy is approximately 40 weeks in duration measured from the first day of the patient's last menstrual period ("LMP"). Pregnancy causes physiological changes in many organ systems. For example, there is a dramatic increase in the volume and rate of blood pumped with each beat of the patient's heart, particularly between 10 weeks and 22 weeks. Throughout pregnancy, the patient's cardiac output (and renal function) increases 30% to 50%. The depth of each breath also increases, with pulmonary function increasing about 20% to meet the oxygen needs of the patient and fetus. In addition, the enlarging uterus puts pressure on the surrounding organs and urinary tract, and hormones produced by the placenta slow the gastrointestinal tract.

6. As a result of the changes pregnancy causes, pregnant individuals are more prone to experiencing symptoms and complications that require evaluation by a medical provider. Common symptoms include shortness of breath, nausea and vomiting, frequent urination and feelings of dizziness. Complications seen more often in pregnancy that require evaluation include dehydration, urinary tract infections ("UTIs"), and anemia (among other complications). Pregnant individuals also are at greater risk of certain infections. Many of these complications are mild and resolve without the need for medical intervention; however, some require evaluation and occasionally urgent or emergent care to preserve the patient's health or life.

7. Other complications may arise during pregnancy, such as hypertensive disorders (e.g., preeclampsia, eclampsia, gestational hypertension), deep venous thrombosis, and gestational diabetes. Many of these pregnancy-induced conditions occur with increasing frequency as the

pregnancy progresses. Patients with a history of a pregnancy-induced condition are at higher risk of developing the same condition in a subsequent pregnancy.

8. In addition to these new conditions, pregnancy can aggravate preexisting health conditions such as high blood pressure (hypertension), diabetes, kidney disease, autoimmune disorders, and asthma. Patients with comorbidities, such as asthma, obesity, or diabetes, are significantly more likely to seek emergency care. Approximately 12% of Texas adults have had asthma in their lifetime.[1] About 12% of Texans have diabetes.[2] Approximately one-quarter of pregnant Texans are obese.[3]

9. These pregnancy-induced complications (and others) generally require frequent monitoring and occasionally intervention. As a result, pregnant patients frequently require hospital care or monitoring—or present to the emergency department for care. According to one study, 20% of pregnant patients seek care in the emergency department at least once during pregnancy.[4]

10. Patients with unplanned pregnancies or without an obstetrician are more likely to present to the emergency department for urgent and non-urgent care during pregnancy.[5] Approximately 54% of pregnancies in Texas are unintended, and one-third of Texas women do

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[1] Ctrs. for Disease Control & Prevention, *Asthma in Texas*, https://www.cdc.gov/asthma/stateprofiles/Asthma_in_TX.pdf (last visited Apr. 14, 2020).

[2] Tex. Diabetes Council, State Plan for Diabetes and Obesity Treatment 3 (Nov. 2019), https://www.dshs.state.tx.us/legislative/2019-Reports/2019-State-Plan-for-Diabetes-and-Obesity-Treatment-and-Education.pdf.

[3] Nicholas P. Deputy et al., Ctrs. for Disease Control & Prevention, *Prevalence and Trends in Prepregnancy Normal Weight — 48 States, New York City, and District of Columbia, 2011–2015*, 66 Morbidity and Mortality Weekly Report 1405 tbl. 2 (2018), https://www.cdc.gov/mmwr/volumes/66/wr/pdfs/mm665152a3-H.PDF.

[4] Shayna D. Cunningham et al., *Association Between Maternal Comorbidities and Emergency Department Use Among a National Sample of Commercially Insured Pregnant Women*, 26 Acad. Emergency Med. 940, 942 (2017).

[5] *E.g.*, Kimberly A. Kilfoyle et al., *Non-Urgent and Urgent Emergency Department Use During Pregnancy: An Observational Study*, 216 Am. J. Obstetrics & Gynecology 181.e1 (2017).

not have a dedicated health care provider.[6] (Latinas, younger women, and women with low incomes are less likely to have a dedicated provider.[7])

11. Pregnant patients who are early in pregnancy most commonly seek hospital care for abnormal bleeding, cramping, pain, not feeling fetal movement, and vaginal discharge. Patients who present to the hospital with these symptoms will nearly always require a transvaginal ultrasound and lab work for evaluation of hormone levels. The purpose of this care is not solely to ensure continued pregnancy. It is necessary to rule out, for example, an ectopic pregnancy that could be life-threatening to the pregnant patient, to determine if there is pelvic pathology that would require surgery, or to determine whether a patient will require follow-up care for miscarriage management.

12. If the patient does have an ectopic pregnancy, treatment is by an injection of the medication methotrexate or surgery (salpingostomy and salpingectomy), depending on the severity of the patient's condition.

13. UTIs are another common reason that pregnant patients—particularly those without health insurance and/or an established medical provider—present to an emergency department. Although UTI is a common infection in reproductive-age women that is usually mild, left untreated in pregnant people, UTIs can lead to severe kidney infections and systemic infections (sepsis), which are life-threatening and require hospitalization.

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[6] Kathryn Kost, Guttmacher Inst., Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002, at 8 (Jan. 2015), https://www.guttmacher.org/sites/default/files/report_pdf/stateup10.pdf; Am.'s Health Rankings, United Health Found., *Dedicated Health Care Provider - Texas*, https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/dedicated_HC_provider_women/state/TX (last visited Apr. 16, 2020).

[7] Am.'s Health Rankings, *supra* note 6.

14. If a patient who is in the first trimester of pregnancy presents to the emergency department, an emergency department nurse and physician will perform the initial evaluation of the patient. Generally the OB/GYN on call will provide consultative services to the emergency department physician either by phone or in person, and sometimes will take over care—such as when the patient needs surgery—or transfer the patient to the obstetrics and gynecology department (*i.e.*, labor and delivery) for further evaluation and treatment. The emergency department evaluation will require non-sterile gloves, and if a pelvic examination is required, the provider will also use a gown and surgical mask if there is concern regarding respiratory infection. Gloves will also be used for any diagnostic testing, such as ultrasound or blood tests.

15. For persons under investigation ("PUI") for COVID-19, full PPE is used: surgical mask, face shield, and isolation gown.[8] In addition, we use N-95 respirators for any aerosol-generating procedures, such as when the patient is placed under general anesthesia, or during second-stage labor or a cesarean delivery ("C-section").

16. Pregnant patients in the second trimester are routed to labor and delivery for evaluation and treatment if they present to an emergency department. These patients will ultimately be seen by several staff: an emergency department triage nurse, a labor and delivery

[8] Ctrs. for Disease Control & Prevention, *Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19* (Mar. 30, 2020), https://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf; Occupational Safety and Health Admin., U.S. Dep't of Labor, Guidance on Preparing Workplaces for COVID-19, at 25, https://www.osha.gov/Publications/OSHA3990.pdf. Isolation gowns are not the same as surgical gowns. Isolation gowns provide greater protection by covering larger critical zones. U.S. Food & Drug Admin., *Medical Gowns* (Mar. 11, 2020), https://www.fda.gov/medical-devices/personal-protective-equipment-infection-control/medical-gowns; Ctrs. for Disease Control & Prevention, *Using Personal Protective Equipment (PPE)*, https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html (last rev. Apr. 3, 2020).

intake nurse and OB/GYN physician or midwife, and if admitted for treatment, by that care team. All of these individuals would be fitted with the appropriate PPE.

17. Pregnant individuals may also experience miscarriage (defined as pregnancy loss before 20 weeks) and preterm premature rupture of membranes ("PPROM"). Approximately one in five pregnancies end in miscarriage. Although most miscarriages occur in the first trimester, approximately 20% of miscarriages occur in the second trimester.[9] The rate of miscarriage sharply increases with advancing maternal age: 40% at age 40 years and 80% at age 45 years.[10]

18. In the first trimester, miscarriage is sometimes managed expectantly (*i.e.*, waiting and seeing if the products of conception will pass on their own). However, in at least 20% of cases, medical intervention is needed to evacuate the uterus. If the patient is under 11 weeks, the miscarriage can either be treated with medications, similar to those used for medication abortion, or treated with an aspiration procedure to empty the contents of the uterus (sometimes called a dilation and curettage or "D&C"). After 11 weeks, because of the risk of hemorrhage, a D&C is recommended. Similarly, miscarriages in the second trimester will need to be managed with a procedure—either a D&C or a dilation and evacuation ("D&E")—or by induction of labor.[11] (I described the difference between an aspiration abortion and D&E in my earlier declaration in this case. *See* Schutt-Aine Decl. ¶ 16.)

19. A pregnant patient is more likely to experience a miscarriage requiring an in-clinic or hospital procedure to complete it than she is to have a complication from abortion that would require a similar hospital-based procedure.

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[9] ACOG, Practice Bulletin No. 200, Early Pregnancy Loss (Nov. 2018), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/11/early-pregnancy-loss.

[10] *Id.*

[11] *Id.*

20. In the second trimester, a miscarriage can be managed with medication to induce labor and delivery; this is called an induction. Induction procedures must be performed at a hospital or hospital-like facility because the length of the procedure can vary from several hours up to several days. Following an induction, up to one-third of patients will have a retained placenta and must undergo a D&C to have it removed.[12] In some cases, the induction may fail, and a D&E must be performed urgently if infection or heavy bleeding occurs.

21. PPROM—when the amniotic sac ruptures before term—is also quite common in pregnancy. PPROM always requires medical attention. In the second trimester, the patient is admitted for a D&E or induction of labor.

22. While both D&Cs and D&Es can safely and appropriately be done on an outpatient basis using less staff and PPE, most D&Cs and D&Es are done in the hospital operating room at our hospital, though some D&Cs for miscarriage management are performed in the outpatient clinic. If the procedure is done in the hospital operating room, we have at least six hospital staff members: the attending OB/GYN physician, OB/GYN resident, surgical technician, two anesthesia personnel, and circulating nurse. All the staff wear a surgical hat, mask, and shoe covers when entering the operating room. The surgical technician and physicians additionally wear a surgical gown and sterile gloves after they have "scrubbed" for the procedure.

23. As with an outpatient procedural abortion, D&Cs to treat miscarriages that are done in the emergency department or in the outpatient clinic, a physician uses eye protection, gloves, and possibly a gown.

[12] Amy M. Autry et al., *A Comparison of Medical Induction and Dilation and Evacuation for Second Trimester Abortion*, 187 Am. J. Obstetrics & Gynecology 393, 394 (2002).

Consequences of Delaying Abortion Care

24. Accessing abortion as early in pregnancy as possible is the single most important factor for ensuring the safety of abortion.

25. Although legal abortion is very safe, the risks of mortality and morbidity increase as the pregnancy advances.[13] Overall, the mortality risk from abortion is very low: 0.7 per 100,000 abortions. To put that in perspective, there are 16.9 pregnancy-related deaths per 100,000 live births in the United States.[14]

26. While extremely low throughout pregnancy, the risk of death associated with abortion increases with gestational age—increasing 38% each week.[15] The risk of death is lowest earlier in pregnancy: 0.3 per 100,000 abortions at eight weeks or less, 0.5 at 9–13 weeks, 2.5 at 14–17 weeks, and 6.7 at 18 weeks and greater.[16] Because the risk increases with gestational age, delaying an abortion by a week in the second trimester significantly increases the mortality risk than a week-long delay in the first trimester.

27. Similarly, while very low, the risk of complications from abortion increases with gestational age. Complications occur in 1.26% of first-trimester procedural abortions and 1.47% of second-trimester abortions. Major complications—defined as complications requiring hospital admission, surgery, or blood transfusion—occur in 0.16% of first-trimester procedural abortion

[13] Nat'l Acads. of Scis. Eng'g & Med., The Safety & Quality of Abortion Care in the United States 60–62, 63–65 (2018).

[14] Ctrs. for Disease Control & Prevention, *Pregnancy Mortality Surveillance System*, https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm (last reviewed Feb. 4, 2020).

[15] Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion–Related Mortality in the United States*, 103 Obstetrics & Gynecology 729, 731 (2004).

[16] Suzanne Zane et al., *Abortion-Related Mortality in the United States: 1998–2010*, 126 Obstetrics & Gynecology 258, 262 fig.2 (2015).

cases and in 0.41% of procedural abortions in the second trimester or later.[17] Thus, the risk of major complication is approximately 2.5 times greater in the second trimester than in the first.

28. As the number of weeks increases, the invasiveness of the procedure and the need for additional sedation also increase, and each carries greater risks to the patient. Indeed, in one study, the incidence of anesthesia-related complications was twice as much in the second trimester than in the first trimester.[18]

29. As I described in my previous declaration, early in pregnancy, procedural abortions are performed using a technique called aspiration, in which the clinician uses gentle suction from a narrow, flexible tube to empty the contents of the patient's uterus, which takes less than 10 minutes to perform. (*See* Schutt-Aine Decl. ¶ 16.) Many patients do not require any anesthesia, aside from a local anesthetic (called a paracervical block). Others choose oral or intravenous medications to manage any procedural pain.

30. Starting around twelve to thirteen weeks LMP, an abortion patient will require same-day cervical preparation to ensure that the procedure can be safely performed. Patients are administered medication, such as misoprostol, which slowly softens the cervix, allowing the suction cannula to safely pass without causing injury to the cervix or uterus. Abortion patients requiring same-day cervical preparation generally spend several hours in the health center to allow the medication to work before the abortion procedure.

31. Beginning around fifteen weeks LMP, clinicians generally must use instruments like forceps, in addition to a suction cannula, to complete a procedural abortion because suction alone is not sufficient to empty the contents of the uterus, in a technique called dilation and

[17] Ushma Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 181 (2015).

[18] *Id.*

evacuation ("D&E"). A D&E procedure typically takes less than 30 minutes, though usually less than 20 minutes.

32. Later in the second trimester, typically around eighteen weeks LMP depending on the physician's discretion, a patient requires greater cervical dilation before a D&E procedure. Accordingly, a patient at this gestational age may need to come to the health center on two consecutive days: the first for placement of osmotic dilators that will dilate the cervix overnight, and the second for the actual evacuation component of the procedure. Physicians determine when a particular patient requires a two-day procedure based on a case-by-case assessment of the circumstances, including gestational age, whether the patient has had previous vaginal births, age of the patient, and whether the patient has a history of C-section.

33. Because D&Es require greater dilation and instrumentation, patients receive intravenous sedation to ease the patient's discomfort.

34. Because D&E procedures take longer to perform and require more staff, delaying a patient to the point where she requires a more complex procedure results in longer physical contact between the patient and the health care team. As I pointed out in my initial declaration (¶ 23), Texas also requires a medically unnecessary extra visit, which necessarily requires additional contact between the patient and staff. *See* Tex. Health & Safety Code § 171.012.

35. Delay may also compromise the patient's privacy. The longer a pregnancy progresses, the more difficult it is for a patient to conceal her pregnancy from others.

36. Delaying an abortion to the point where the patient will have to carry to term will result in even more PPE use and interactions with the health care system. These patients will need routine prenatal care, as well as care during labor and delivery. Texas ranks eighth nationally in

the share of deliveries performed by C-section, which requires more hospital staff and thus comparatively more PPE use than vaginal delivery.

37. If a patient attempts a self-managed abortion using unsafe methods, this may result in the patient seeking hospital care, including care in the emergency department, to control bleeding or empty the uterus with an aspiration or D&E procedure.

Medication Abortion

38. As I discussed in my first declaration (¶ 13), medication abortion involves providing the patient with two medications. A physician provides the first medication, mifepristone, to the patient and observes as she swallows the pill. We then provide the patient with a bottle of the second medication, misoprostol, and explain how she should self-administer the medication at home 24–48 hours later. This process requires no PPE and takes just a few minutes.

39. As I stated in my initial declaration, medication abortion is not a procedure. I understand that Defendants claim an ultrasound examination done prior to a medication abortion is a procedure.

40. Putting aside a Texas law that requires an abortion provider to conduct an ultrasound before any abortion (Tex. Health & Safety Code § 171.012), routine ultrasounds are not needed before a medication abortion, except where there is concern of the patient's eligibility for medication abortion, such as risk factors for ectopic pregnancy.[19] A transabdominal ultrasound is usually adequate for the purpose of ensuring the patient is a candidate for medication abortion. Use of PPE is not required for transabdominal ultrasound examinations. For some patients, a

[19] *See* U.S. Food & Drug Admin., *Mifeprex* 2 (rev. Mar. 2016), https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf ("Assess the pregnancy by ultrasonographic scan if the duration of pregnancy is uncertain or if ectopic pregnancy is suspected.").

transvaginal ultrasound examination may be needed, and physicians or ultrasound technicians typically wear only non-sterile gloves that are discarded after each scan.

41. According to the Texas Medical Board, "[a] 'procedure' does not include physical examinations, non-invasive diagnostic tests, the performing of lab tests, or obtaining specimens to perform laboratory tests."[20]

42. An ultrasound examination before a medication abortion is not a procedure. An ultrasound examination is an examination, not a procedure; its primary use is diagnostic. Sometimes it is used to guide procedures, such as ultrasound-guided biopsies or other minimally invasive surgeries. In the medication abortion context, ultrasound's function is diagnostic.

43. A transvaginal ultrasound exam does not deplete PPE or the hospital bed capacity needed to cope with COVID-19 disaster when performed in accordance with the commonly accepted standard of clinical practice. That is because only one non-sterile glove is needed to conduct the exam. It is my understanding that there is not a shortage of non-sterile gloves.

44. Complications associated with medication abortion are rare: only 0.31% of medication abortions result in complications requiring hospitalization, surgery, or blood transfusion.[21]

45. The need for follow-up aspiration to complete a medication abortion is also uncommon. The regimen on the FDA-approved label for mifepristone, which PPCFC follows, has an aspiration follow-up rate of 2.6%.[22] (This rate does not, however, indicate whether the

[20] Tex. Med. Bd., *Updated Texas Medical Board (TMB) Frequently Asked Questions (FAQs) Regarding Non-Urgent, Elective Surgeries and Procedures During Texas Disaster Declaration for COVID-19 Pandemic* (Mar. 29, 2020), http://www.tmb.state.tx.us/idl/59C97062-84FA-BB86-91BF-F9221E4DEF17.

[21] Upadhyay et al., *supra* note 17, at 181.

[22] U.S. Food & Drug Admin., *Mifeprex* 13 tbl.3 (rev. Mar. 2016), https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf).

aspirations where medically necessary to complete the abortion. As the FDA notes on the label, this rate includes surgical intervention at the patient's request.) The large majority of these are not emergent or urgent and can safely be treated in the outpatient setting.

46. As research shows, medication abortion can be safely and effectively provided through telemedicine.[23] But for Texas laws that require a medically unnecessary ultrasound examination before an abortion, PPCFC could reduce physical encounters for medication abortion by providing some aspects of care through telemedicine or on a single day.

47. Medications with a far greater chance of causing complications that lead to hospital-based care than medication abortion continue to be routinely provided during the COVID-19 crisis. These include common medications like acetaminophen (Tylenol),[24] aspirin, ACE inhibitors (to treat high blood pressure),[25] and biologic drugs to treat moderate plaque psoriasis.[26]

Guidance to Medical Professionals on the Application of the Executive Order

48. As physicians, we always exercise our professional judgment when caring for patients, relying on our medical training, experience, and professional guidance, as well as patient-specific considerations, to inform our recommendations to patients. Physicians can reasonably differ on their recommendations to patients with the same condition (or even the same patient),

[23] Daniel Grossman & Kate Grindlay, *Safety of Medical Abortion Provided Through Telemedicine Compared With In Person*, 130 Obstetrics & Gynecology 778 (2017); Daniel Grossman et al., *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine*, 118 Obstetrics & Gynecology 296 (2011).

[24] Jacqueline M. Major et al. *Trends in Rates of Acetaminophen-related Adverse Events in the United States*, 25 *Pharmacoepidemiology & Drug Safety* 590 (2016).

[25] *See* Shira Bezalel et al., *Angiotensin-converting Enzyme Inhibitor-induced Angioedema*, 128 Am. J. Med. 120–25 (2015) (up to 0.70% of ACE initiators developed angioedema, a rare but potentially serious complication).

[26] *E.g.*, Robert E. Kalb et al., *Risk of Serious Infection with Biologic and Systemic Treatment of Psoriasis: Results from the Psoriasis Longitudinal Assessment and Registry (PSOLAR)*, 151 JAMA Dermatology 961 (2015).

exercising their own judgment and considering their patient's specific circumstance. Our judgment is not questioned so long as the patient is not injured by a physician's negligence. The exception to this rule is abortion, which has always been scrutinized and second-guessed.

49. Indeed, although the Executive Order specifically requires the *physician* to determine which surgeries and procedures can be safely postponed, I understand Defendants have singled out abortion and determined that nearly all abortions are categorically prohibited under the Executive Order.

50. Non-abortion providing physicians maintain discretion to determine whether a procedure or surgery can be safely delayed. Indeed, the first "tip" the Texas Medical Board advises physicians complying with the Executive Order to consider is: "GA 09 and the TMB rules allow providers to use their judgment in determining whether a surgery or procedure will prevent serious adverse medical consequences or death."[27] I attach as Exhibit A a copy of the Board's Frequently Asked Questions ("FAQs"), which includes those tips. The Board's FAQs emphasize that "**the physician must determine** if these types of procedures are delayed or canceled, will a patient be at risk for serious adverse medical consequences or death."[28] The Board also recommends to physicians that "[r]eferencing legitimate literature and guidelines, such as the CDC, CMS, or specialty guidelines will be very helpful" in determining which procedures and surgeries are allowed.[29]

[27] Tex. Med. Bd., *supra* note 20.

[28] *Id.* (emphasis in original).

[29] If the Board is called on to review the "justification for the necessity and urgency of [a particular] surgery or procedure," it will use the "the process used in normal investigations before the COVID-19 disaster began," meaning the determination to provide a surgery or procedure "will be determined by at least two physicians in the same or similar specialty of the physician under investigation" after "reviewing the medical records and utilizing applicable guidelines and literature, as appropriate." *Id.* The FAQs also provide that "medical or specialty guidelines and

51. Additionally, the Board advises: "If you normally could not or would not wait a few weeks to provide the surgery or procedure being considered for a specific patient based on the patient's unique circumstances, then that might help you decide what to do." Because of the risks outlined above, abortion is not a procedure PPCFC would normally wait a few weeks to provide.

52. Furthermore, the Board defines "urgent" or "elective urgent" procedures that should not be postponed as "a surgery or procedure is scheduled where there is a risk of patient deterioration or disease progression that is likely to occur if the procedure or surgery is not undertaken immediately and/or the surgery or procedure is significantly delayed. The resulting decline in the patient's health could make them more vulnerable to COVID-19 and other issues." As I discuss above, the risks of procedural abortion significantly increase as the pregnancy advances, which is why the American College of Obstetricians and Gynecologists, the American Board of Obstetrics and Gynecology, the American College of Surgeons, and many other major medical organizations have cautioned that abortion is a time-sensitive procedure that should not be delayed.[30]

53. The Texas Medical Association, moreover, reiterated that "****TMB recognizes that the physician's judgment is important for this element**" of determining whether "the surgery or procedure, in the physician's judgment, [is] 'immediately medically necessary.'"[31] I attach as Exhibit B a copy of that guidance.

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literature . . . will help determine . . . if the surgery or procedure was medically necessary as defined in GA 09 and TMB rules." *Id.*

[30] ACOG et al., Joint Statement on Abortion Access During the COVID-19 Outbreak (Mar. 18, 2020), https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak; ACS, COVID-19 Guidelines for Triage of Gynecology Patients (Mar. 24, 2020), https://www.facs.org/covid-19/clinical-guidance/elective-case/gynecology.

[31] Tex. Med. Ass'n, *TMB Releases Emergency Rules: Non-Urgent Surgeries and Procedures* (Mar. 29, 2020),

54. The Texas Medical Association has compiled a list of professional guidance on delaying non-essential procedures.[32] Medical professional organizations are in agreement that the decision whether to delay a procedure—and for how long—must be based on sound clinical judgment.[33] Indeed, the Texas Medical Association has called on the Governor to clarify that physicians be permitted to rely on the guidance of nationally recognized medical or specialty entities in determining whether a procedure can appropriately be postponed.[34] I attach as Exhibit C a copy of that letter.

55. I declare under penalty of perjury that the foregoing is true and correct.

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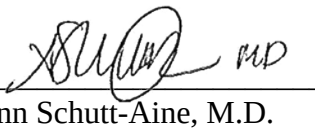
https://www.texmed.org/uploadedFiles/Current/2016_Public_Health/Infectious_Diseases/Emergency%20rule%20guidance%20-%203.25%20Update.pdf (emphasis in original).

[32] Tex. Med. Ass'n, *Coronavirus Disease 2019 (COVID-19) Resources: Concerning Non-Urgent and Elective Surgeries and Procedures During the COVID-19 Pandemic* (Apr. 8, 2020), https://www.texmed.org/uploadedFiles/Current/2016_Public_Health/Infectious_Diseases/308959%20COVID%20resource%20list.pdf.

[33] *See, e.g.*, Am. Coll. of Surgeons, *COVID-19: Elective Case Triage Guidelines for Surgical Care* (Mar. 24, 2020), https://www.facs.org/covid-19/clinical-guidance/elective-case; Am. Coll. of Cardiology & Soc'y for Cardiovascular Angiography and Interventions, *Triage Considerations for Patients Referred for Structural Heart Disease Intervention During the Coronavirus Disease 2019 (COVID-19) Pandemic: An ACC /SCAI Consensus Statement* (Apr. 2, 2020), http://interventions.onlinejacc.org/content/early/2020/04/05/j.jcin.2020.04.001; Am. Dental Ass'n, *ADA Interim Guidance for Management of Emergency and Urgent Dental Care* (Apr. 1, 2020), https://www.ada.org/~/media/CPS/Files/COVID/ADA_Int_Guidance_Mgmt_Emerg-Urg_Dental_COVID19.pdf; Am. Heart Ass'n, Ass'n of Am. Med. Colls., Children's Hosp. Ass'n & Fed'n of Am. Hosps., *AHA Letter to Surgeon General Re: Elective Surgeries and COVID-19* (Mar. 15, 2020), https://www.aha.org/lettercomment/2020-03-15-aha-letter-surgeon-general-re-elective-surgeries-and-covid-19; COVID-19 Pandemic Breast Cancer Consortium: Am. Soc'y of Breast Surgeons, Nat'l Accreditation Program for Breast Ctrs., Nat'l Comprehensive Care Network, Comm'n on Cancer & Am. Coll. of Radiology, *Recommendations for Prioritization, Treatment and Triage of Breast Cancer Patients During the COVID-19 Pandemic* (Apr. 13, 2020), https://www.facs.org/-/media/files/quality-programs/napbc/asbrs_napbc_coc_nccn_acr_bc_covid_consortium_recommendations.ashx.

[34] Letter from David C. Fleeger, President of Tex. Med. Ass'n, to Dawn Buckingham, Donna Campbell, Lois Kolkhorst & Charles Schwertner, Tex. State Senators (Apr. 13, 2020), https://www.texmed.org/uploadedFiles/Current/2016_Public_Health/Infectious_Diseases/Four%20Senators%20response%20-%204-13-20.pdf.



Ann Schutt-Aine, M.D.

Executed April 17, 2020

EXHIBIT A

Updated
Texas Medical Board (TMB) Frequently Asked Questions (FAQs) Regarding Non-Urgent, Elective Surgeries and Procedures During Texas Disaster Declaration for COVID-19 Pandemic

March 29, 2020

***Disclaimer – The COVID-19 Disaster is a fluid and rapidly evolving situation. Please check these FAQs often as, events may warrant frequent updates.**

Should I reschedule non-urgent elective in-patient, out-patient, and office-based surgeries and procedures?

Yes, if the non-urgent elective surgery or procedure violates Executive Order GA 09, or emergency rule 22 Texas Administrative Code (TAC) §187.57(c). Additionally, Texas Attorney General Ken Paxton issued a statement on Executive Order GA 09.

What does Executive Order GA 09 prohibit?

Governor Greg Abbott issued Executive Order GA 09 on March 22, 2020. This executive order (EO) states:

> "beginning now and continuing until 11:59 p.m. on April 21, 2020, all licensed health care professionals and all licensed health care facilities shall postpone all surgeries and procedures that are not immediately medically necessary to correct a serious medical condition of, or to preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician[. However, this] prohibition shall not apply to any procedure that, if performed in accordance with the commonly accepted standard of clinical practice, would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID- 19 disaster."

What is the effect of emergency rule 22 Texas Administrative Code (TAC) §187.57(c)?

The Texas Medical Board (TMB) Executive Committee, during an emergency meeting on March 23, 2020, adopted an emergency rule amendment to 22 TAC §187.57(c). This emergency amendment adds language stating that the performance of a non-urgent elective procedure is considered a continuing threat to the public welfare during the battle against COVID-19, and will be prosecuted by the Board pursuant to this standard.

What was Attorney General Paxton's statement on Executive Order GA 09?

Texas Attorney General Ken Paxton, on March 23, 2020, issued a statement that Executive Order GA 09's prohibitions:

> "applies throughout the State and to all surgeries and procedures that are not immediately medically necessary, including routine dermatological, ophthalmological, and dental procedures, as well as most scheduled healthcare procedures that are not immediately medically necessary such as orthopedic surgeries or any type of abortion that is not medically necessary to preserve the life or health of the mother."

Executive Order GA 09 and 22 TAC §187.57(c) provide that this "prohibition shall not apply to a *procedure* that, if performed in accordance with the commonly accepted standard of clinical practice, would not deplete the hospital capacity or the personal protective equipment [PPE] needed to cope with the COVID- 19 disaster." What does this mean?

If the procedure is performed in accordance with the commonly accepted standards of clinical practice, and would not potentially deplete the hospital capacity or the PPE needed to cope with the COVID-19 disaster, then the procedure may proceed. However, if the procedure is performed in accordance with the commonly accepted

standard of clinical practice, but could deplete the hospital capacity or the PPE needed to cope with the COVID-19 disaster, then the procedure may not proceed.

Can I still schedule and perform office-based visits for my patients?

Probably, as the prohibition does not apply to office-based visits without surgeries or procedures. However, the office-based visits should be conducted in accordance with standard protocols, including safety measures that prevent the spread of COVID-19.

What is not included in the term "procedure"?

A "procedure" does not include physical examinations, non-invasive diagnostic tests, the performing of lab tests, or obtaining specimens to perform laboratory tests.

What else changed regarding elective surgeries or procedures?

During the emergency meeting of the TMB Executive Committee on March 23, 2020, emergency rule 22 TAC §178.4 was amended to include,

> "Pursuant to Executive Order GA 09, and not withstanding any other statute, rule or provision concerning timing or when a report must be made to the Board, any peer review committee, licensee, and other group, entity, or person named in §§160.003, 204.208, 205.304, and 206.159 of the Act shall be immediately required to report any physician scheduling to perform, preparing to perform, performing, or who has performed a non-urgent elective surgery or procedure, as defined in §187.57(c) of this subtitle, while Executive Order GA 09 is in effect, immediately to the board. This duty to report is mandatory whether any type of proceeding, inquiry, investigation, or action of any kind is being considered, has been initiated, or is on-going at a hospital, ambulatory surgical center, or any other facility or medical setting. All reporting under this emergency rule is subject to confidentiality under

§§160.004-160.008 of the Act; immunity for civil liability under §160.010 of the Act; and the prohibitions against discipline and discrimination under §160.012 of the Act."

If I report a violation, will it be confidential?

Yes. While the law does not allow for the TMB to accept *anonymous* complaints, a complainant's identity will remain confidential. This means that the TMB will know the complainant's identity, but no one else will.

Can I be sued, fired, or otherwise retaliated against for filing a complaint?

All reporting, including reporting under this emergency rule, is subject to confidentiality under §§160.004-160.008 and 164.007(c) of the Act; immunity for civil liability under §160.010 of the Act; and the prohibitions against discipline and discrimination under §160.012 of the Act.

How long will this prohibition on non-urgent elective surgeries last?

Until Executive Order GA 09 expires on April 21, 2020 or, if it is extended by the governor, when that extension expires.

What does the Centers for Disease Control and Prevention (CDC) guidance on non-urgent elective procedures say about all of this?

Current CDC guidelines include rescheduling elective surgeries at inpatient facilities and rescheduling non-urgent outpatient visits, as necessary. TMB agrees with the intent and interpretation of these guidelines -- for licensees to **postpone all non-urgent elective surgeries and procedures in inpatient and outpatient settings** to help limit the spread of COVID-19.

Why does the TMB use the phrase "non-urgent elective surgery or procedure"?

Facilities have different levels of need for "elective" surgeries. These levels are often distinguished by the terms "urgent" or "emergent" by facilities. Some facilities or providers may use the term "acuity." Regardless, the **physician must determine** if these types of procedures are delayed or canceled, will a patient be at risk for serious adverse medical consequences or death.

Elective, non-urgent cases are defined as cases where there is no anticipated short-term nor long-term negative impact as a result of delaying a procedure or surgery. Examples are screening for a nonlife-threatening chronic condition or most cosmetic procedures.

"Urgent or Elective Urgent" means a surgery or procedure is scheduled where there is a risk of patient deterioration or disease progression that is likely to occur if the procedure or surgery is not undertaken immediately and/or the surgery or procedure is significantly delayed. The resulting decline in the patient's health could make them more vulnerable to COVID-19 and other issues.

"Emergent" means a life-threatening condition in which the surgery or procedure must be undertaken and/or cannot be safely delayed for any significant period of time.

What is a non-urgent elective procedure or surgery?

Non-urgent elective cases are being defined as instances where there is no anticipated short-term nor long-term negative impact on the patient because of delaying a procedure or surgery. Examples include screening for a nonlife-threatening chronic condition and most cosmetic procedures.

What should I do if I determine an elective surgery is necessary and will not violate Executive Order GA 09 or TMB rules?

Documentation is key. It is very important that the medical record clearly reflects why the elective surgery or procedure was urgent and necessary to prevent serious

adverse medical consequences or death. This documentation could include information on the patient's medical history, prescriptions, lab results, imaging, or other relevant factors used to make the determination of the urgent necessity of the elective surgery or procedure.

If a complaint is received, how will the TMB determine if the surgery or procedure met the requirements of Executive Order GA 09 or TMB rules?

The TMB can only act on a valid complaint. Complaints cannot be filed anonymously, but the complainant's identity will remain confidential with TMB. If a complaint is received, then TMB will begin by reviewing the complaint. If there is enough information in the complaint to proceed with an investigation, including requesting medical records for review.

Depending on the level of urgency to address the alleged violation, TMB may conduct a temporary suspension or restriction hearing with or without notice. If a temporary suspension or restriction hearing is conducted *without* notice, then a follow up temporary suspension or restriction hearing *with* notice must be offered at the earliest possible date after 10 days' notice of the hearing. If the level of urgency does not warrant a temporary suspension or restriction hearing, then TMB will follow the normal investigative process, which would include obtaining expert physician review.

If a temporary suspension or restriction hearing is conducted, then a panel of three board members (one of which must be a physician) will decide if any type of restriction or suspension is warranted, or if no action should be taken. The justification for both the necessity and urgency of the surgery or procedure at issue will be determined by the three-member panel. This would include reviewing the medical records and utilizing applicable guidelines and literature, as appropriate. This process was already the process in temporary suspension or restriction hearings before the COVID-19 disaster began.

If a temporary suspension or restriction hearing is not necessary, the normal investigative process will be followed. The justification for the necessity and urgency of the surgery or procedure at issue will be determined by at least two

physicians in the same or similar specialty of the physician under investigation. This would include reviewing the medical records and utilizing applicable guidelines and literature, as appropriate. This process was already the process used in normal investigations before the COVID-19 disaster began.

So again, when reviewing the medical records, TMB will determine, based on the medical record documentation, if the surgery or procedure was medically necessary, as defined in GA 09 and TMB rules. Further, TMB will determine whether or not the standard of care (SOC) was met by, in part, consulting applicable guidelines such as the Centers for Disease Control and Prevention (CDC), Centers of Medical and Medicaid Services (CMS), or other medical or specialty guidelines and literature. These guidelines and the medical records will help determine if the SOC was met and if the surgery or procedure was medically necessary as defined in GA 09 and TMB rules.

What are the benefits to postponing a non-urgent surgery?

Postponement creates several key benefits, including:

1. It preserves resources such as, Personal Protective Equipment (PPE), ventilator availability, and creates a general reduction in the overall use of critical medical resources;

2. It keeps a bed available for treatment of a COVID-19 patient, especially intensive care unit (ICU) beds;

3. It preserves significant healthcare practitioner time and availability which can be devoted to COVID-19 patients; and

4. It limits patients and health care workers' potential exposure to COVID-19.

What happens if I violate the Executive Order or Board rules?

Both the Executive Order GA 09 and Attorney General Paxton's statement provide that "Failure to comply with an executive order issued by the governor related to the COVID-19 disaster can result in penalties of up to $1,000 or 180 days of jail time."

Either of these penalties would come from law enforcement. TMB has no power to issue criminal fines or jail time.

Further, under the TMB's emergency rule 22 TAC § 187.57, performance of a non-urgent elective surgery or procedure is deemed by the Board to be a continuing threat to the public welfare. A complaint of this nature may result in a temporary suspension or restriction hearing with or without notice depending on the circumstances. Any Board action to restrict or suspend a licensee's license, even if temporary, will trigger a mandatory report to the National Practitioner Data Bank (NPDB).

While the definition of a "continuing threat to the public welfare" is expanded under the emergency rule, the Board will follow all existing disciplinary processes and procedures to ensure due process for licensees.

Finally, the Board has mandated by rule that any peer review committee, licensee, and other group, entity, or person named in §§160.003, 204.208, 205.304, and 206.159 of the Act **shall** be required to immediately report violations of Executive Order GA 09 or 22 TAC §187.57(c) to the TMB.

What can help me make decisions on whether I should perform a surgery or procedure?

The Texas Medical Board has developed the following questions to help.

1. **Does this prohibition apply to me or my practice location?**

   The prohibition applies to ALL licensed healthcare providers and their delegates. It also applies to all licensed healthcare facilities. If you are a licensed healthcare professional or delegate, or performing the medical act in a licensed healthcare facility, proceed to #2.

2. **Is the medical act a surgery or procedure?**
   - Yes, proceed to #3.

- No, I am performing other medical acts, such as a history, physical exam, non-invasive diagnostics, or ordering/performing lab tests.

If your answer is no, you may proceed with the medical act.

3. **If the medical act is a surgery or procedure, then you must ask the following questions:**
    - Is this immediately medically necessary to correct a serious medical condition or to preserve the life of a patient?
    - Would this patient, without immediate performance of the surgery or procedure, be at risk for serious adverse medical consequences or death?

If you answer yes to <u>either</u> of the above questions, you can proceed with the medical act. You should document the medical necessity and serious risk in the patient's medical record.

In determining how to answer the above questions, please review the above discussion of urgent vs. nonurgent and elective surgery or procedure. Also note that performance of the following medical acts would generally *not* be considered immediately medically necessary/pose a serious risk:

- Routine dermatological procedures;
- Routine ophthalmological procedures;
- Routine dental procedures;
- Non-urgent orthopedic surgeries;
- Cosmetic and plastic surgeries;
- Nonsurgical cosmetic procedures; and
- Abortion not medically necessary to preserve the life or health of the mother.

4. **Could the surgery or procedure deplete hospital capacity or the supply of personal protective equipment needed to cope with the COVID-19 disaster?**

If your answer is no, you may proceed with the act.

If your answer is yes, you may not proceed with the medical act.

I have read everything and I am still confused. In plain English, what I am supposed to do?

Unfortunately, TMB cannot tell you exactly what to do. TMB understands these are very difficult emotional, societal, cultural, and financial times for everyone around the world. While TMB has a duty to enforce the law, TMB also wants to help patients and licensees navigate providing care as much as possible. TMB cannot provide an exhaustive list of approved or prohibited surgeries and procedures during this time. Nor can TMB answer specific questions about whether or not to provide certain care.

However, TMB can provide these **10 Tips**:

1. GA 09 and the TMB rules allow providers to use their judgment in determining whether a surgery or procedure will prevent serious adverse medical consequences or death;
2. If you normally could or would wait a few weeks to provide the surgery or procedure being considered for a specific patient based on the patient's unique circumstances, then that might help you decide what to do;
3. If you normally could not or would not wait a few weeks to provide the surgery or procedure being considered for a specific patient based on the patient's unique circumstances, then that might help you decide what to do;
4. If you do proceed with a surgery or procedure during this time, then be sure to clearly document why you made that decision;
5. Referencing legitimate literature and guidelines, such as the CDC, CMS, or specialty guidelines will be very helpful;
6. TMB cannot put anyone in jail;
7. The decision to hold a temporary suspension or restriction hearing will meet the same standard as before the COVID-19 disaster;
8. TMB understands the importance of having as many safe licensees available as possible during this time;
9. The TMB Board Members include 12 physicians that also must navigate these times, the Executive Order, and the rules while providing safe patient care; and
10. TMB is and will continue to be understanding that these are unprecedented times.

EXHIBIT B

COVID-19
CORONAVIRUS DISEASE

VISION: To improve the health of all Texans.

MISSION: TMA supports Texas physicians by providing distinctive solutions to the challenges they encounter in the care of patients.

TEXAS MEDICAL ASSOCIATION
Physicians Caring for Texans

TMB Releases Emergency Rules: Non-Urgent Surgeries and Procedures

TMA Office of the General Counsel

UPDATED MARCH 29, 2020

***Disclaimer:** The information relating to COVID-19 is continually evolving, and the information provided here is subject to change at any time. Please contact the TMA Knowledge Center (contact information provided at the end) or view the appropriate agency's website for the most up-to-date information.*

On March 24, the Texas Medical Board (TMB) released emergency rules on the provision of non-urgent, elective surgeries and procedures in all licensed inpatient and outpatient facility and medical settings following Governor Abbott's Executive Order GA-09. TMB also released FAQs to provide guidance on its rules and the governor's order. TMB updated its FAQs on March 29, 2020. The most recent version of the FAQs is discussed herein.

Importantly, please note that TMB's new updated FAQs provide a different interpretation of the governor's order and its own rules than the older version of FAQs. The prior FAQ interpreted the governor's order, as well as the board's own emergency rule 22 T.A.C. 187.57, relating to permitted procedures that do not deplete hospital capacity or personal protective equipment (PPE), more narrowly than the language in the order and rule themselves. The older, narrower version appeared to be based on a news release from the Office of the Attorney General. Now, the updated FAQs appear to align with the express language of the governor's order and the board's rules.

More on the board's rules and recently updated FAQs are discussed below.

I. BACKGROUND

The executive order, issued March 22, directed all licensed health care providers to postpone all surgeries and procedures that "are not immediately necessary to correct a serious medical condition of, or to preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician." Failure to comply may result in the attorney general assessing penalties of up to $1,000 or up to 180 days of jail time. The order is effective until April 21, 2020, and may be extended by the governor.

The purpose of the order is to preserve the availability of health care personnel, PPE, and additional hospital space to care for patients affected by the coronavirus (COVID-19). Accordingly, the governor caveated his directive, stating that "this prohibition shall not apply to any procedure that, if performed in accordance with the commonly accepted standard of clinical practice, would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 disaster."

Attorney General Ken Paxton stated further that the order "applies throughout the State and to all surgeries and procedures that are not immediately medically necessary, including routine dermatological, ophthalmological, and dental procedures, as well as most scheduled healthcare procedures that are not immediately medically necessary such as orthopedic surgeries or any type of abortion that is not medically necessary to preserve the life or health of the mother."

II. TMB EMERGENCY RULES

TMB issued emergency rules (linked above) incorporating the language from the governor's order prohibiting non-urgent, elective surgeries or procedures and providing the enforcement measures it will take to support the governor's order in licensed inpatient and outpatient facility and medical settings. The two major enforcement changes are:

1. An **immediate, mandatory reporting** requirement for "any peer review committee, licensee, and other group, entity, or person" named in sections 160.003, 204.208, 205.304, and 206.159 of the Occupations Code. These named individuals and entities must immediately report any physician "scheduling to perform, preparing to perform, performing, or who has performed a non-urgent elective surgery or procedure" to the board. The mandatory duty to report applies regardless of any other statute, rule, or provision concerning reporting timing to the board and regardless of whether "any type of proceeding, inquiry, investigation, or action of any kind is being considered, has been initiated, or is ongoing at a hospital, ambulatory surgical center, or any other facility or medical setting." *See* 22 T.A.C. § 178.4(d).

2. Performance of a "non-urgent elective surgery or procedure" is now considered a "continuing threat to the public welfare," and the board's disciplinary panel may hold a temporary suspension hearing with or without notice for an alleged violation. The panel may also temporarily restrict or suspend a physician's license if the panel determines a physician's action violated this section. *See* 22 T.A.C. § 187.57. Note further that if a restriction or suspension occurs, even if temporary, the board will report it to the National Practitioner Data Bank. Keep in mind though, the board can only act on a valid complaint. And the action the board takes depends on the "level of urgency to address the alleged violation." *See* TMB FAQ No. 16. For more information on the enforcement process, please look to the board's FAQs or TMB's rules. Also to be clear, TMB does not have the authority to assess the penalties described in the governor's order or to order jail time. TMB retains its regular enforcement authority.

III. TMB FAQS

TMB also published FAQs,[1] updated most recently on March 29, to assist physicians in determining what is considered an elective, non-urgent procedure or surgery and when such procedure or surgery can be performed in inpatient and outpatient facility and medical settings while the executive order is effective. The board's FAQs provide a four-step analysis to assist physicians in making these decisions. However, before moving to the analysis, it is important to note four items:

First, the board describes non-urgent, elective surgeries or procedures as the following:

> Non-urgent elective cases are being defined as instances where **there is no anticipated short-term nor long-term negative impact** on the patient because of delaying a procedure or surgery. Examples include screening for a *non-life-threatening*, chronic condition and most cosmetic procedures. (Emphasis added).

1 Please continue to check the board's website for the most up-to-date information as information is constantly changing to address the impact of the coronavirus.

Second, the board exempts certain medical acts from the term "procedures" for the purpose of enforcing the order – the board expressly states in its FAQs that a "procedure" does ***not*** include physical examinations, noninvasive diagnostic tests, the performing of lab tests, or obtaining specimens to perform laboratory tests.

Third, the governor's order provides two categories of surgeries or procedures that may be performed: (1) a surgery or procedure that is immediately necessary to correct a serious medical condition of, or to preserve the life of, a patient who would be at risk for serious adverse medical consequences or death if the procedure or surgery did not immediately occur, as determined by the physician; or (2) a procedure, performed in accordance with the applicable standard of care, that will not deplete hospital capacity or PPE needed to fight COVID-19. TMB's rules and FAQs reflect the same. *See* 22 T.A.C. § 187.57(c); TMB FAQs Nos. 2, 5.

Fourth, TMB expressly recognizes that a physician's judgment in this matter is important. Indeed, it states that both the governor's order and its emergency rules allow physicians "to use their own judgment in determining whether a surgery or procedure will prevent serious adverse medical consequences or death."

A. TMB's Four-Step Analysis

The board provides a four-step analysis to assist physicians in determining if a surgery or procedure is permissible under the order and the board's rules. *See* TMB FAQ No. 19.

1. First, does the prohibition apply to the physician or the physician's practice?
    a. The order applies to all licensed health care providers and their delegates, as well as all licensed health care facilities, including hospitals, medical spas, and ambulatory surgical centers. This also includes a physician's office if a surgery or procedure is being performed in violation of the order and the board's rules.
    b. If a physician answers yes to this question, then the physician should proceed to question two.
2. Second, is the medical act a surgery or "procedure"?
    a. The board expressly states in its FAQs that a "procedure" does ***not*** include the following: physical examinations, noninvasive diagnostic tests, the performing of lab tests, or obtaining specimens to perform laboratory tests. Thus, these medical acts are outside the scope of the governor's order. If a physician is performing one of these carved-out acts, the analysis ends, and the physician may perform the medical act.
    b. Otherwise, if the answer is yes, the physician should proceed to question three.
3. Third, is the surgery or procedure, in the physician's judgment, "immediately medically necessary"?
    a. Is this immediately medically necessary to correct a serious medical condition or to preserve the life of a patient? If yes, the physician moves to the second part below.
    b. Part Two: Would this patient, without immediate performance of the surgery or procedure, be at risk for serious adverse medical consequences or death?
    c. ****TMB recognizes that the physician's judgment is important for this element.** TMB FAQs Nos. 13, 20. Indeed, its FAQ No. 20 expressly states that the governor's order and the board's rules allow physicians to "use their judgment in determining whether a surgery or procedure will prevent serious adverse consequences or death."

If the physician answers "yes" to these two questions, then the physician may proceed with the surgery or procedure.

If the physician answers "no," and the medical act is a *surgery*, the surgery is prohibited according to the board's FAQs.

If the physician answers "no," and the medical act is *a procedure*, then the physician should proceed to question four.

4. Fourth, if it is a *procedure*, does it deplete PPE or hospital bed capacity needed to cope with COVID-19 disaster when performed in accordance with the commonly accepted standard of clinical practice?

    a. If the answer is no, then the physician may perform the procedure.

    b. If the answer is yes, then the physician may not perform the procedure under the board's FAQs.

In making these determinations using the board's analysis, TMB also suggests reviewing FAQ 13, which describes what facilities generally consider "elective, non-urgent," "urgent or elective urgent," and "emergent." For convenience, those descriptions are provided here:

1. "**Elective, non-urgent**" cases are defined as cases where there is no anticipated short-term or long-term negative impact as a result of delaying a procedure or surgery. Examples are screening for a nonlife-threatening chronic condition or most cosmetic procedures.

2. "**Urgent or elective urgent**" means a surgery or procedure is scheduled where there is a risk of patient deterioration or disease progression that is likely to occur if the procedure or surgery is not undertaken immediately and/or the surgery or procedure is significantly delayed. The resulting decline in the patient's health could make them more vulnerable to COVID-19 and other issues.

3. "**Emergent**" means a life-threatening condition in which the surgery or procedure must be undertaken and/or cannot be safely delayed for any significant period of time.

B. Documentation

The board stresses that in these fact-specific cases, documentation is "key." Specifically, the board's FAQs state:

> It is very important that the medical record clearly reflects why the elective surgery or procedure was necessary to prevent serious adverse medical consequences or death. This documentation could include information on the patient's medical history, prescriptions, lab results, imaging, or other relevant factors used to help make the determination of the necessity of the surgery or procedure.

TMB will determine if a surgery or procedure was medically necessary (or if not, does not deplete PPE or hospital bed capacity) by, among other things, reviewing the patient's medical records. Documentation should include information describing the factors that, in the physician's judgment, made the procedure or surgery immediately necessary to prevent serious adverse medical consequences or death. Boilerplate language or rubber-stamping a patient's file is likely insufficient.

It is also particularly important for a physician being delegated tasks to document the information communicated if the delegate agrees the surgery or procedure is immediately medically necessary (or if the delegate does not believe it is and is not going to perform the delegated task). And of course, if a physician feels a prohibited procedure or surgery is being planned, is being performed, or was

performed, the physician should comply with the board's mandatory reporting requirement. Reporting under the emergency rule is immune from civil liability under Section 160.010 of the Texas Medical Practice Act, and the prohibitions on discipline and discrimination under Section 160.012 of the act also protect reporters.

Also it may be helpful, given the uncertainty at this time, to document a physician's decision to delay a procedure or surgery. For example, a physician might include the factors for his or her decision and cite to the executive order and board's emergency rules, as well as any specific board FAQ the physician may be relying on for the delay. Proper documentation may provide the physician support in the event a patient suffers an unanticipated negative consequence due to the delay mandated by the governor's order and the board's emergency rules.

The board may continue to update its FAQs or release other guidance as it obtains new information. It is good risk management practice to retain a copy of each FAQ or other guidance. Each FAQ and other guidance is generally dated. This is important, because a physician may have made a decision on a date an earlier FAQ was in place that may or may not be permissible under a new FAQ. **Maintaining a copy of each update, as well as a copy of the executive order and the news release by the Office of the Attorney General (linked above) is a good risk management practice during this confusing and ever-changing time.**

C. Medical Acts That Are Generally Prohibited or Permitted

The board's FAQs identify the following surgeries or procedures that are generally prohibited while the order is in effect:

1. Screening for a nonlife-threatening chronic condition,
2. Most cosmetic procedures,
3. Routine dermatological procedures,
4. Routine ophthalmological procedures,
5. Routine dental procedures,
6. Non-urgent orthopedic surgeries,
7. Most cosmetic and plastic surgeries,
8. Nonsurgical cosmetic procedures, and
9. An abortion not medically necessary to preserve the life or health of the mother.

The board expressly identifies the following medical acts as permissible and outside the governor's order:

1. Office-based visits that do not require surgery or procedures (so long as conducted in accordance with standard protocols, including safety measures that prevent the spread of COVID-19);
2. Nonprocedures (as carved out by the board's definition of "procedures") that involve:
    a. Physical examinations,

b. Noninvasive diagnostic tests,

c. The performing of lab tests, or

d. Obtaining specimens to perform laboratory tests; and

3. Surgeries or procedures immediately medically necessary to correct a serious medical condition of, or to preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician.

D. TMB's 10 Tips

TMB also provided 10 tips to help physicians navigate the board's new emergency rules:

1. The governor's order and TMB's rules allow physicians to use their judgment in determining whether a surgery or procedure will prevent serious adverse medical consequences or death.
2. If a physician could or would normally wait a few weeks to provide the surgery or procedure being considered for a specific patient based on the patient's unique circumstances, then that might help the physician decide what to do.
3. If a physician normally could not or would not wait a few weeks to provide the surgery or procedure being considered for a specific patient based on the patient's unique circumstances, then that might help the physician decide what to do.
4. If a physician proceeds with a surgery or procedure during this time, then he or she should clearly document why the decision was made (also revisit TMA's recommendation on documentation for delaying surgeries or procedures in Section III.B above).
5. Referencing legitimate literature and guidelines, such as the Centers for Disease Control and Prevention (CDC), Centers for Medicare & Medicaid Services (CMS), or specialty guidelines will be very helpful.
6. TMB cannot put anyone in jail.
7. The decision to hold a temporary suspension or restriction hearing will meet the same standard as before the COVID-19 disaster.
8. TMB understands the importance of having as many safe licensees available as possible during this time.
9. TMB board members include 12 physicians who also must navigate these times, the Executive Order, and the rules while providing safe patient care.
10. TMB is and will continue to be understanding that these are unprecedented times.

IV. ADDITIONAL INFORMATION

Please remember that the board's FAQs are intended to provide guidance – the FAQs are not law; however, they reflect the board's view on its enforcement authority and how it intends to apply its rules. Note also that the board's FAQs do not govern how the attorney general will enforce the governor's order. Other than the statement released from the attorney general cited and linked to above, there is no additional information from the Office of the Attorney General at this time on enforcement.

As part of its tips, TMB stated it would be helpful for a physician to refer to "legitimate literature and guidelines, such as CDC, CMS, or specialty guidelines." *See* TMB FAQ No. 20. Accordingly, TMA prepared a document with a compilation of links to resources providing guidance on non-urgent, elective surgeries or procedures, including links to guidance from national medical specialty societies. These resources may be helpful to review. **However, these resources do not bind TMB or the attorney general's interpretation and enforcement of the governor's order. TMA strongly recommends that a physician seek the advice of his or her retained attorney to help navigate the governor's order and the board's rules.**

TMA will continue to update you on developments from TMB regarding its rules and guidance. For a specific fact analysis under the new emergency rules and order, please contact your retained attorney for legal advice. For general questions on the rule and order, please contact the TMA Knowledge Center by email at knowledge@texmed.org or by phone at (800) 880-7955.

EXHIBIT C

TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

April 13, 2020

The Honorable Dawn Buckingham, MD
The Honorable Donna Campbell, MD
The Honorable Lois Kolkhorst
The Honorable Charles Schwertner, MD
Texas Senate
P.O. Box 12068
Austin, TX 78711-2068

Dear Senators Buckingham, Campbell, Kolkhorst, and Schwertner:

Thank you all very much for your letter to Gov. Greg Abbott of April 10. Both of the issues you addressed are extremely important to Texas physicians as we work to care for our patients in this highly unusual time.

As I mentioned in my April 9 letter to you, many community physicians are experiencing extreme difficulty obtaining the personal protective equipment (PPE) they need to safely examine and treat potential COVID-19 patients. We very much appreciate your recommending to Governor Abbott that "a distribution be made through the Regional Advisory Councils or county medical societies of 10% of the allocation of PPE to community-based physicians."

The results of a two-day survey of 1,811 Texas physicians that closed at midnight Friday underscore the dire nature of this situation. Without adequate PPE, our community physicians cannot keep potential COVID-19 patients from overrunning our state's emergency departments and hospitals.

In that survey, 78% said their practice is currently or anticipates having a lack of PPE. Of that group, two-thirds said they are actively rationing and extending the typical use of N95 masks to make their supplies last as long as possible; 75% said they had one week's supply or less of N95 respirators, and 17% said they had only two week's supply. We received similar results regarding available supply of face shields and gowns.

Even more frightening, more than 40% of all physicians answering the survey said they have felt pressure to perform clinical duties without adequate PPE. This is absolutely unacceptable.

On behalf of the 53,000-plus physician and medical student members of the Texas Medical Association, I strongly urge you to reiterate your request to Governor Abbott, emphasizing the critical predicament community physicians are in. TMA, county medical societies, state specialty medical societies, and individual physicians all are doing the same.

The question of how and when to resume non-urgent surgeries and procedures is obviously a pressing issue for many Texas physicians as well. As I wrote in my April 10 letter, we would support a staged reduction in the restrictions that have been placed on Texas citizens and our fellow physicians as part of the governor's work to control the spread of the virus. We believe it is premature at this point to be making decisions on unwinding those restrictions when the surge of COVID-19 illnesses still lies ahead of us. It is not, however, too early to begin planning how best to move forward.

As you know, we recommend the governor appoint a Recovery Task Force, including medicine, public health, business, government, faith, and academic leaders, to help the state make objective decisions on these complex issues. Following the science, the Task Force should establish benchmarks that would determine when regions of the state can relax restrictions safely.

As a practical, short-term step, we are submitting a letter to Governor Abbott today with a specific recommendation for when his current executive order on elective surgeries and procedures expires April 21. When he extends that order, we are asking the governor to expressly permit physicians to reference relevant information such as guidelines or literature on performing or postponing procedures during a pandemic or disaster from the Centers for Disease Control and Prevention, Centers for Medicare and Medicaid Services, or other nationally recognized medical or specialty entities. The Texas Medical Board has already provided similar guidance for physicians in its COVID-19 FAQs on elective, non-urgent surgeries and procedures.

We are also asking the governor to remove the criminal sanctions provision from his order. The regulatory authority of the TMB to revoke a physician's license for violating the order is already an adequate deterrence measure. Removing the provision would relieve the fear of criminal prosecution from the minds of physicians who are trying to make the best decision they can for their patients. We will send you a copy of that letter as soon as it is finalized.

Once again, I thank you for your ongoing support of Texas physicians and our patients in this difficult situation. TMA leaders and staff look forward to working closely with you in the weeks and months – and years – it will take our state to recover from this natural disaster.

As Governor Abbott wrote in a commentary published Easter morning in The Dallas Morning News, "We are saving lives. That is the bottom line. By continuing to work together while remaining apart, we will save even more lives — and turn more quickly to restarting our resilient economy to help lift every Texas family."

Sincerely,

David C. Fleeger, MD
President

EXHIBIT 38

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE, *et al.*, Plaintiffs, v. GREG ABBOTT, in his official capacity as Governor of Texas, *et al.*, Defendants.	No. 1:20-cv-00323-LY

SECOND DECLARATION OF JOSHUA SHARFSTEIN, M.D. IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, Joshua Sharfstein, M.D., declare as follows:

1. I am Professor of the Practice in Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health.

2. I am offering this declaration on my own behalf and not on behalf of Johns Hopkins University.

3. Prior to my current position, I served as Secretary of the Maryland Department of Health and Mental Hygiene (including during the Ebola pandemic in 2014), the Acting Commissioner and then the Principal Deputy Commissioner of the U.S. Food and Drug Administration (including during the H1N1 Flu pandemic of 2009), and Commissioner of Health for the City of Baltimore. I have been elected as a member of the National Institute of Medicine

and the National Academy of Public Administration. My complete curriculum vitae is attached as Exhibit A.

4. My areas of teaching and research include public health crisis and response, healthcare payment, and the opioid epidemic. I teach a class entitled "Crisis and Response in Public Health Policy and Practice" and am the author of the Public Health Crisis Survival Guide: Leadership and Management in Trying Times, from Oxford University Press.

5. I am closely following the COVID-19 pandemic. I have written articles about the pandemic in the *Journal of the American Medical Association*, USA Today, and the New York Times.

6. I understand that as part of its efforts to conserve personal protective equipment and hospital resources, Texas has issued an executive order barring "all surgeries and procedures that are not immediately medically necessary to correct a serious medical condition, or to preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician," with an exception for surgeries or procedures that "would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 disaster."

7. I further understand that Texas state officials have interpreted this executive order to prohibit most or all abortion services in the state, and that if a patient is not able to obtain an abortion in Texas while this prohibition remains in effect, they will be forced to either remain pregnant for the duration of the order or travel to another state to attempt to obtain an abortion.

8. Delaying non-essential procedures is a responsible act by public health officials and the healthcare system as a mitigation measure during a public health crisis. However, multiple

medical professional organizations,[1] led by the American College of Obstetricians and Gynecologists ("ACOG"), have stated that

> Abortion is an essential component of comprehensive health care. It is also a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks or potentially make it completely inaccessible. The consequences of being unable to obtain an abortion profoundly impact a person's life, health, and well-being.[2]

If Texas is leaving to physicians the determination of whether a procedure can be delayed without risk of serious adverse medical consequences, it does not make sense from a public health perspective to categorically exclude abortion services from this area of clinical judgment.

9. I am concerned that stopping abortion care will unnecessarily complicate the response to the coronavirus pandemic and, indeed, may worsen the public health crisis for three reasons.

10. First, if patients travel to attempt to obtain an abortion in another state, they will expose themselves and others they come in contact with to an increased risk of COVID-19 infection. According to a recent analysis conducted by the Guttmacher Institute, "[t]he average (median) one-way driving distance to an abortion clinic for a woman of reproductive age in Texas would increase from 12 miles to 243 miles (or 1,925% longer) if legal abortion care in the state

[1] These include: the American Association of Gynecologic Laparoscopists, the American Gynecological & Obstetrical Society, the American Society for Reproductive Medicine, the Society for Academic Specialists in General Obstetrics and Gynecology, the Society of Family Planning, and the Society for Maternal-Fetal Medicine.

[2] ACOG et al., *Joint Statement on Abortion Access During the COVID-19 Outbreak*, (Mar. 18, 2020), https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak

were shut down." Additionally, if clinics in the state are closed, the distance from the county farthest from a clinic to that clinic would be 678 miles.[3]

11. Second, I have reviewed the declaration of Dr. Schutt-Aine (Decl. of Anne Schutt-Aine, M.D., in Supp. of Pls.' Mot. for TRO & Prelim. Inj., attached as Ex. 7 to Pls.' Mot. for TRO & Prelim. Inj., ECF No. 7-7) and understand from that declaration that if patients are delayed for weeks or more in obtaining an abortion, some will be required to have a two-day procedure instead of a one-day procedure, or a procedural abortion instead of a medication abortion, and that either of these changes results in the use of more personal protective equipment.

12. Third, I understand there is concern and uncertainty about whether coronavirus infection could be more severe in pregnant women. The Centers for Disease Control and Prevention (CDC) states the agency "do[es] not currently know if pregnant people have a greater chance of getting sick from COVID-19 than the general public nor whether they are more likely to have serious illness as a result"; however the CDC "do[es] know that pregnant people have changes in their bodies that may increase their risk of some infections" and "pregnant people have had a higher risk of severe illness when infected with viruses from the same family as COVID-19 and other viral respiratory infections, such as influenza."[4] The Texas Department of State Health Services directs viewers to that CDC guidance as the entirety of its COVID-19 website section on

[3] Jonathan Bearak et al., Guttmacher Inst., *COVID-19 Abortion Bans Would Greatly Increase Driving Distances for Those Seeking Care* (Apr. 8, 2020), https://www.guttmacher.org/article/2020/04/covid-19-abortion-bans-would-greatly-increase-driving-distances-those-seeking-care

[4] Ctrs. for Disease Control & Prevention, Coronavirus Disease 2019 (COVID-19), *Pregnancy and Breastfeeding* (Apr. 15, 2020), https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/pregnancy-breastfeeding.html.

pregnant patients.[5]. Delaying a woman from being able to access abortion services may increase the risk for a severe infection that places her and the healthcare system at greater risk.

13. I understand that state officials are taking the position that prohibiting most or all abortion services in the state for some period of time is acceptable because services may be resumed in the relatively near future. Given the trajectory of the pandemic, it is highly unlikely that the United States or Texas will be in a substantially better position quickly. The White House has made recommendations for social distancing to be in place until at least April 30, and significant restrictions are likely to be in place further.[6] With respect to personal protective equipment, shortfalls may be anticipated to continue for several months.[7]

14. Texas has other public health measures available that are calculated to be more effective than prohibiting abortion, such as imposing more stringent social distancing measures,

[5] Tex. Dep't of State Health Servs., COVID-19, *Information for Communities & Other Specific Groups* (Apr. 16, 2020), https://www.dshs.texas.gov/coronavirus/other.aspx#pregchild.

[6] Quint Forgey, *Social Distancing Guidelines Will Likely Be in Place Beyond April, Surgeon General Says*, Politico, Apr. 1, 2020, https://www.politico.com/news/2020/04/01/jerome-adams-coronavirus-social-distancing-guidelines-158998.

[7] *See, e.g.*, Tyler Clifford, *Hospital Supplier Owens & Minor Is Expanding Capacity to Meet Personal Protective Equipment Demands*, CNBC, Mar. 27, 2020, https://www.cnbc.com/2020/03/27/hospital-supplier-owens-minor-expanding-capacity-to-meet-ppe-demands.html (CEO of U.S.-based hospital supplier saying that factory production is already "running 24/7" and will still need "probably 5 to 6 months" to be able to expand PPE production to meet demand); Farhad Manjoo, *How the World's Richest Country Ran Out of a 75-Cent Face Mask*, N.Y. Times, Mar. 25, 2020, https://www.nytimes.com/2020/03/25/opinion/coronavirus-face-mask.html (COO of Canadian-based PPE manufacturer saying that production is already "at full capacity" and that "extending further will take anywhere between three to four months").

which many other states have done and which are showing results in reducing the number of coronavirus infections.

15. As another alternative to the current approach, Texas could take steps to assure that all healthcare providers, including providers of abortion services, have specific plans to reduce spread of coronavirus infection.

16. These alternative steps would accomplish the goals of the state in the coronavirus pandemic, unlike the policy at issue in this case.

17. I declare under penalty of perjury that the foregoing is true and correct.

Joshua Sharfstein, M.D.

Executed on: April 16, 2020

EXHIBIT A

December 2019

CURRICULUM VITAE

Joshua M. Sharfstein, M.D.

PERSONAL DATA

EDUCATION AND TRAINING

2001	Fellowship in General Academic Pediatrics Boston University School of Medicine Boston, MA
1999	Boston Combined Residency Program in Pediatrics Boston Children's Hospital and Boston Medical Center Boston, MA
1996	M.D. Harvard Medical School Boston, MA
1991	A.B., Social Studies, *summa cum laude* Harvard College Cambridge, MA

Medical Licensure

2001-	Maryland
2001-	District of Columbia (inactive)
1997-2001	Massachusetts

Board Certification

2016	Passed Maintenance of Certification exam
2006	Recertification in Pediatrics by American Board of Pediatrics
1999	Certification in Pediatrics by American Board of Pediatrics

PROFESSIONAL EXPERIENCE

1/15 - Faculty, Johns Hopkins Bloomberg School of Public Health

Professor of the Practice in the Department of Health Policy and Management. Associate Dean for Public Health Practice and Training (1/15-3/18). Inaugural Director, Bloomberg American Health Initiative (11/15-). Vice Dean for Public Health Practice and Community Engagement (3/18-)

1/11 - 12/14 Secretary, Maryland Department of Health and Mental Hygiene

Appointed by Governor Martin O'Malley and confirmed by Maryland State Senate. Co-chair of Maryland Health Care Quality & Cost Council and chair of Maryland Health Benefit Exchange.

3/09 - 1/11 Acting Commissioner (until 6/09) and then Principal Deputy Commissioner, U.S. Food and Drug Administration

Appointed by President Barack Obama to second-highest ranking position in the agency.

12/05 - 3/09 Commissioner of Health, Baltimore City

Appointed by Mayor Martin O'Malley and re-appointed by Mayor Sheila Dixon, with confirmation by City Council, to lead the oldest, continuously operating health department in the United States. Chair of Baltimore Substance Abuse Systems, Inc., Baltimore Healthcare Access, Inc., Baltimore City Healthy Start, Inc., and Baltimore Animal Rescue and Care Shelter, Inc.

7/01 - 12/05 Minority Professional Staff and Health Policy Advisor, Government Reform Committee, U.S. House of Representatives.

For Congressman Henry A. Waxman.

PROFESSIONAL ACTIVITIES

Society Membership and Leadership

- Elected Fellow, Institute of Medicine, 2014-Present
- Elected Fellow, National Academy of Public Administration, 2013-Present
- Fellow, American Academy of Pediatrics, 2001-Present

Advisory Panels

- Member, Committee of Science, Technology, and Law of the National Academies of Science, Engineering, and Medicine.
- Co-Chair, Population Health Roundtable, National Academies of Science, Engineering and Medicine, 1/18-
- Chair, Advisory board for Network for Public Health Law, 6/2017- 2/2019.
- Member, Board on Population Health and Public Health Practice, Institute of Medicine, 2007-2009 and 2013-2019.
- Member, Health Information Technology Policy Advisory Committee, U.S. Department of Health and Human Services, 2012-2014.
- Member, Advisory Board, Leadership for Healthy Communities, 2007-2009

EDITORIAL ACTIVITIES

Peer Review Activities (recent)

- Journal of the American Medical Association
- New England Journal of Medicine
- JAMA Internal Medicine
- JAMA Pediatrics
- Pediatrics

Editorial Board Membership

- Journal of the American Medical Association, 2011- .
    - Co-editor of Special Issue on Health Policy, November 13, 2013.
- Public Health Reports, Contributing Editor for Local Acts, 2007-2009

Other Editorial Activity

- Guest Editor, JAMA Internal Medicine, October 2014 issue on medical devices

HONORS AND AWARDS

2018 Advising, Mentoring, Teaching Recognition Award, Johns Hopkins Bloomberg School of Public Health

2014	Heart Healthy, Stroke Free Award, National Forum for Heart Disease & Stroke Prevention
2013	Circle of Commendation Award, Consumer Product Safety Commission NARAL Pro-Choice Maryland Leadership Award
2008	Public Official of the Year, Governing Magazine
1999	Alpha Omega Alpha, Boston University School of Medicine
1996	Rose Seegal Award for Research, Community Service Award, Robert H. Ebert Prize in Primary Care, Harvard Medical School
1994	Jay S. Drotman Memorial Award, American Public Health Association
1991	Phi Beta Kappa, Thomas Temple Hoopes Prize, Frederick Sheldon Traveling Fellowship, Harvard College

Named Lectureships

February 6, 2019	Ernest M. Haddad Lecture. Massachusetts General Hospital Internal Medicine Grand Rounds. *Mission Impossible? Asking Health Care to Advance the Health of the Population*
October 25, 2019	C. Everett Koop Distinguished Lecture, C. Everett Koop Institute, Dartmouth College. *The Politics of Public Health: The Case of the Opioid Epidemic.*
May 24, 2018	Leon Kassel Lecture, Sinai Hospital. *The U.S. Opioid Epidemic: Past, Present, and Future.*
November 15, 2016	John C. Robinson Lecture, Massachusetts General Hospital for Children. *Will Changes in Healthcare Mean Better Health for Children?*
April 18, 2014	Charles C. Leighton MD Memorial Lecture, Leonard Davis Institute at the University of Pennsylvania. *Maryland's Unique Hospital Payment Policy.*
October 15, 2013	Seidman Lecture, Harvard Medical School. *Lashed to the Mast: Navigating through Health CarePolicy, Politics, and Reform in 2014 and Beyond.*
June 26, 2013	Hunt Lectureship, Maryland State Medical Society. *History of the FDA.*
October 4, 2012	Hirsch Lecture in Health Law and Policy, George Washington School of Public Health. *Aligning Health Care with Health.*

April 26, 2012	Albert J. Himelfarb Lecture, Sinai Hospital Department of Medicine, *Health Care 2015 -- and How Do We Get There?*
April 27, 2011	Paul A. Harper Lecture, Johns Hopkins Bloomberg School of Public Health, *Advocacy for Children*
October 5, 2010	Francis S. Balassone Lecture, University of Maryland School of Pharmacy. *Regulation at FDA*
April 24, 2010	Theodore E. Woodward Annual Lecture, University of Maryland School of Medicine, *FDA, Clinical Medicine, and Public Health*
August 21, 2008	Moira J. Whitehead Memorial Lecture, Children's Hospital of Pittsburgh. *From Bedside to Policy: Pediatrics and Public Health*

PUBLICATIONS

Journal Articles: **Peer Reviewed Studies and Reviews**

1. Heyward J, Olson L, Sharfstein JM, Stuart EA, Lurie P, Alexander GC. Evaluation of the Extended-Release/Long-Acting Opioid Prescribing Risk Evaluation and Mitigation Strategy Program by the US Food and Drug Administration: A Review. JAMA Intern Med. 2019 Dec 30. [Epub ahead of print]

2. Pérez AV, Trujillo AJ, Mejia AE, Contreras JD, Sharfstein JM. Evaluating the centralized purchasing policy for the treatment of hepatitis C: The Colombian CASE. Pharmacol Res Perspect. 2019 Dec 10;7(6):e00552.

3. Wallace M, Sharfstein J, Lessler J. Performance and Priorities: A Cross-sectional Study of Local Health Department Approaches to Essential Public Health Services. Public Health Rep. 2020 Jan;135(1):97-106.

4. Rollman JE, Heyward J, Olson L, Lurie P, Sharfstein J, Alexander GC. Assessment of the FDA Risk Evaluation and Mitigation Strategy for Transmucosal Immediate-Release Fentanyl Products. *Journal of the American Medical Association*. 2019 Feb 19;321(7):676-685.

5. Wallace M, Sharfstein JM, Kaminsky J, Lessler J. Comparison of US County-Level Public Health Performance Rankings With County Cluster and National Rankings: Assessment Based on Prevalence Rates of Smoking and Obesity and Motor Vehicle Crash Death Rates. *JAMA Network Open.* 2019 Jan 4;2(1):e186816.

6. Xu T, Klein EY, Zhou M, Lowenthal J, Sharfstein JM, Peterson SM. Emergency Department Utilization Among the Uninsured During Insurance Expansion in Maryland. *Ann Emerg Med.* 2018 Aug;72(2):156-165.

7. Horon IL, Singal P, Fowler DR, Sharfstein JM. Standard Death Certificates Versus Enhanced Surveillance to Identify Heroin Overdose-Related Deaths. *Am J Public Health.* 2018 Jun;108(6):777-781.

8. Alexander GC, Ballreich J, Socal MP, Karmarkar T, Trujillo A, Greene J, Sharfstein J, Anderson G. Reducing branded prescription drug prices: A review of policy options. *Pharmacotherapy*. 2017 Aug 14. [Epub ahead of print]

9. Tschudy MM, Sharfstein J, Matsui E, Barnes CS, Chacker S, Codina R, Cohn JR, Sandel M, Wedner HJ. Something new in the air: Paying for community-based environmental approaches to asthma prevention and control. *J Allergy Clin Immunol.* 2017 Feb 10. pii: S0091-6749(17)30223-3.

10. Rebbert-Franklin K, Haas E, Singal P, Cherico-Hsii S, Baier M, Collins K, Webner K, Sharfstein J. Development of Maryland Local Overdose Fatality Review Teams: A Localized, Interdisciplinary Approach to Combat the Growing Problem of Drug Overdose Deaths. *Health Promot Pract*. 2016 Jul;17(4):596-600.

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12. Cherico-Hsii S, Bankoski A, Singal P, Horon I, Beane E, Casey M, Rebbert-Franklin K, Sharfstein J. Sharing Overdose Data Across State Agencies to Inform Public Health Strategies: A Case Study. *Public Health Rep*. 2016 Mar-Apr;131(2):258-63..

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14. Schwartz RP, Gryczynski J, O'Grady KE, Sharfstein JM, Warren G, Olsen Y, Mitchell SG, Jaffe JH. Opioid agonist treatments and heroin overdose deaths in Baltimore, Maryland, 1995-2009. *American Journal of Public Health* 2013;103:917-22.

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Books or Monographs

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2. Sharfstein J. *The Public Health Crisis Survival Guide: Leadership and Management in Trying Times*. Oxford: Oxford University Press, 2018.

3. Sharfstein JM, Chrysler D, Bernstein J, Armijos L, Tolosa-Leiv, L, Taylor H, and Rutkow, . (2017, December). Using Electronic Health Data for Community Health:Example Cases and Legal Analysis. Retrieved from http://www.debeaumont.org/EHDforCommunityHealth.

4. Sharfstein J, Gerovich S, Moriarty E, Chin D. An emerging approach to payment reform: All-payer global budgets for large safety-net hospital systems. Commonwealth Fund. August 2017.

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3. Sunderji A, Mena KN, Winickoff J, Melinek J, Sharfstein J. Influenza Vaccination and Migration at the US Southern Border. Am J Public Health. 2020 Apr;110(4):466-467. doi: 10.2105/AJPH.2019.305547.

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5. Felix C, Sharfstein JM, Olsen Y. Help Is on the Way: Medicare Coverage of Opioid Treatment Programs. J Am Geriatr Soc. 2019 Dec 11. doi: 10.1111/jgs.16281. [Epub ahead of print]

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8. Sharfstein JM, Olsen Y. Lessons Learned From the Opioid Epidemic. *Journal of the American Medical Association*. 2019 Aug 5. doi: 10.1001/jama.2019.9794. [Epub ahead of print]

9. Kawasaki S, Sharfstein JM. The cost of the opioid epidemic, in context. *American Journal of Managed Care.* 2019 Jul;25(13 Suppl):S241-S242. PubMed PMID: 31361433.

10. Sharfstein JM, Slocum J. Private Equity and Dermatology-First, Do No Harm. *JAMA Dermatology*. 2019 Jul 24.

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17. Rajagopal S, Barnhill A, Sharfstein JM. The evidence-and acceptability-of taxes on unhealthy foods. *Isr J Health Policy Res*. 2018 Nov 20;7(1):68.

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22. Sharfstein JM. How Do You Solve a Problem Like Juul? *Milbank Q.* 2018 Sep;96(3):417-420.

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25. Sharfstein JM. A Health Policy Sonnet. *Milbank Quarterly*. 2018 Mar;96(1):9-12.

26. Green TC, Rich JD, Sharfstein J. Commentary on 'Revisiting the 'paradigm shift' in opioid use: Developments and implications 10 years later'. *Drug Alcohol Rev.* 2018 Apr;37 Suppl 1:S206-S207.

27. Sharfstein JM. A New Year's Wish on Opioids. JAMA. 2018 Feb 13;319(6):537-538.

28. Sharfstein JM, Stuart EA, Antos J. Maryland's All-Payer Health Reform-A Promising Work in Progress. JAMA Intern Med. 2018 Feb 1;178(2):269-270.

29. Sharfstein JM. Common Ground on Responsibility for Health. *Milbank Quarterly*. 2017 Dec;95(4):718-721.

30. Hatef E, Sharfstein JM, Labrique AB. Innovation and Entrepreneurship: Harnessing the Public Health Skill Set in a New Era of Health Reforms and Investment. *J Public Health Manag Pract*. 2017 Oct 24.

31. Sharfstein JM, Gerovich S, Chin D. Global Budgets for Safety-Net Hospitals. *Journal of the American Medical Association.* 2017 Nov 14;318(18):1759-1760.

32. Sharfstein JM. Science and the Trump Administration. *Journal of the American Medical Association*. 2017 Oct 10;318(14):1312-1313

33. Sharfstein JM. Public Health Bundles. *Milbank Quarterly*. 2017 Sep;95(3):474-477.

34. Poku MK, Blum AB, Sharfstein JM. US Hospital Awards and Community Health Improvement. Am J Public Health. 2017 Jul;107(7):1076-1077.

35. Redberg RF, Jacoby AF, Sharfstein JM. Power Morcellators, Postmarketing Surveillance, and the US Food and Drug Administration. *Journal of the American Medical Association*. 2017 Jul 25;318(4):325-326.

36. Sharfstein JM, Silver DL. Relationship Between the American Academy of Pediatrics and Infant Formula Companies. *JAMA Pediatr.* 2017 Jul 1;171(7):613-614.

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Selected Blog Posts

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10. Sharfstein J. JAMA Forum: Medical boards and the public's health. 10 April 2014. http://newsatjama.jama.com/2014/04/10/jama-forum-hiding-in-plain-sight-medical-boards-and-the-publics-health/

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SELECTED PRACTICE ACTIVITIES

Johns Hopkins Bloomberg School of Public Health

- Supported strategic plans on opioids in Staten Island (2018), West Virginia (2018), and Louisiana (2018).
- Supported launch of Johns Hopkins Baltimore Violence Reduction Collaborative. 2016.
- Developed proposal and advised Baltimore City Health Department for BFRIEND falls prevention initiative. Proposal funded by Robert Wood Johnson Foundation. 2015-2017.
- Advised Baltimore City Public Schools, Baltimore City Health Department, and DC Public Schools on absenteeism project. 2016-2018.
- Advised Rhode Island Health Commissioner on response to opioid epidemic. 2015-Present.
- Led review of teen pregnancy and healthy birth strategy for Baltimore's Promise. 2015.

Maryland Department of Health and Mental Hygiene

- Led the negotiation with the Centers for Medicare & Medicaid Services to establish a new model for hospital payment in Maryland, essentially ending fee-for-service payment across all payers for Maryland residents.
- Established clear public health goals for Maryland through the State Health Improvement Process, which involves 18 local planning coalitions and a website with accessible, local data.
- Oversaw a strategic shift to community-based long-term care, including the merger of several waiver programs, the introduction of consumer choice, and a significant expansion of access to home care.
- Led the consolidation of the Alcohol and Drug Abuse Administration with the Mental Hygiene Administration into the new Behavioral Health Administration, and developed and implemented a more rational financing approach to behavioral and somatic care.
- Led several regulatory initiatives, including a ban on the sale of baby bumper pads and a revised consent form for indoor tanning devices for teenagers.
- Oversaw the building of a new public health laboratory, the reform of the Developmental Disabilities Administration, improvements in state psychiatric facilities, and transformation of the Maryland Board of Physicians.
- Oversaw reports on youth use of candy-flavored tobacco and health care worker-related transmission of the Hepatitis B virus.

Food and Drug Administration

- Led the development of FDA-Track, a performance management system across the agency. The U.S. Department of Health and Human Services recognized FDA-Track with an award for innovation in 2011.
- Led the agency's transparency initiative, which made substantially more information available about the regulatory process.
- Coordinated federal efforts between CDC, FDA, and the Trade and Tax Bureau on caffeinated, alcoholic beverages, leading to a ban on these unsafe products.
- Represented FDA on key public issues including the use of antibiotics in animals, the safety of bisphenol-A, the safety of infant positioners, the labeling of bottled water, the safety of dietary supplements, the *Salmonella* outbreak from contaminated eggs, and drug safety.
- Oversaw reports on integrity in FDA decisionmaking and transparency at the agency.

Baltimore City Health Department

- Developed initiatives that won four model practice awards from the National Association of County and City Health Officers, including:
    - Facilitating the transition to Medicare Part D using an emergency management approach;
    - The Reach and Read Public Health Challenge to promote literacy in pediatric primary care;
    - The Baltimore Buprenorphine Initiative, which expanded access to effective drug treatment and was associated with a substantial reduction in heroin overdoses; and
    - The Fluoride Varnish initiative, which trained and reimbursed pediatric practices for applying fluoride varnish to reduce dental caries.
- Led successful regulatory initiatives to improve reporting for influenza vaccination and ban the sale of lead-tainted children's jewelry.
- Introduced Health Leads programs on the Hopkins, UMBC, and Loyola campuses, which have involved more than 1,000 students volunteering to connect patients to resources at multiple health care sites in the city.
- Oversaw significant progress towards making the city animal shelter a "no-kill" shelter.
- Drafted the city plan on infant mortality that would be implemented and contribute to substantial improvements over time.
- Advocated for and implemented the ban on indoor smoking in bars and restaurants and the ban on transfats in foods.

- Led a successful, national petition calling for the removal of cough-and-cold medications for young children from the market.
- Oversaw reports on heart disease and salt and arsenic contamination at Swann Park.

Congressional Testimony

April 3, 2014	Testimony before the House Oversight and Government Reform Committee, Subcommittee on Economic Growth, Job Creation, and Regulatory Affairs, Subcommittee on Energy Policy, Health Care, and Entitlements, on the Maryland Health Benefit Exchange
December 13, 2012	Testimony before the House Energy and Commerce Committee, Subcommittee on Health, on Implementation of the Affordable Care Act in Maryland
March 17, 2011	Testimony before the Senate Committee on Health, Education, Labor, and Pensions, on the Implementation of the Affordable Care Act in Maryland
September 30, 2010	Testimony before the House Committee on Oversight and Government Reform, Johnson and Johnson's Recall of Children's Tylenol and Other Children's Medicines
September 22, 2010	Testimony before the House Energy and Commerce Committee, Subcommittee on Oversight and Investigations, on the Outbreak of Salmonella in Eggs
July 14, 2010	Testimony before the House Energy and Commerce Committee, Subcommittee on Health, on Antibiotic Resistance and the Use of Antibiotics in Animal Agriculture
May 27, 2010	Testimony before the House Committee on Oversight and Government Reform, Johnson and Johnson's Recall of Children's Tylenol and Other Children's Medicines
May 26, 2010	Testimony before the Senate Special Committee on Aging, Oversight of Dietary Supplements
March 10, 2010	Testimony before the House Energy and Commerce Committee, Subcommittee on Health, on Drug Safety: An Update from FDA.
July 13, 2009	Testimony before the House Committee on Rules on the Preservation of Antibiotics for Medical Treatment Act of 2009
July 8, 2009	Testimony before the House Committee on Oversight and Government Reform, Subcommittee on Oversight and Investigations, on Regulation

	of Bottled Water.
May 21, 2009	Testimony before the House Committee on Appropriations, Subcommittee on Agriculture, Rural Development, Food and Drug Administration, and Related Agencies, on President's FY 2010 Budget Request
May 7, 2009	Testimony before the before the Senate Committee on Appropriations, Subcommittee on Agriculture, Rural Development, Food and Drug Administration, and Related Agencies, on H1N1 Flu Virus
April 30, 2009	Testimony before the House Energy and Commerce Committee, Subcommittee on Health, on H1N1 Flu Virus.

Testimony Before the Maryland General Assembly

I have testified more than 75 times before the Maryland General Assembly on budget and policy matters. Successful legislative initiatives have included:

2007 session	SB 349 Expedited Partner Therapy Pilot Program for Baltimore City
2011 session	HB 166 Maryland Health Benefit Exchange Act
2012 Session	HB 86 Health Improvement and Disparities Reduction Act HB 443 Maryland Health Benefit Exchange Act HB 658 Emergency Plans for Human Services Facilities and Dialysis Centers
2013 Session	HB 228 Maryland Health Progress Act HB 986 Sterile Compounding HB 1009 Regulation of Cosmetic Surgery Centers SB 1057 Regulation of Health Care Staffing Agencies
2014 Session	HB 1510 Establishment of Behavioral Health Administration

TEACHING

1/1/2015-	Professor of the Practice, Department of Health Policy and Management
7/1/2006 - 6/30/2009	Adjunct Assistant Professor, Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health
9/15/2006 - 6/30/2018	Adjunct Professor, Volunteer, Department of Pediatrics, University of Maryland School of Medicine

Advisees

MPH Capstone

1. Marc Rabner. *School Absenteeism and Public Health. 2016*
2. Laura Mandel. *Provider Network Adequacy in Maryland Managed Care Organizations. 2016.*
3. Megan Collins. *Vision for Baltimore - a 3 year program to provide school-based eye care. 2017.*
4. Maria Armijos. *A policy recommendation for antibiotic use in upper respiratory tract infections in Ecuador. 2017.*
5. Madeline Jackson. *Section 1498 and Public Health Access to Specialty Drugs. 2017.*
6. Charlotte Kaye. *Integrating Public Health Programming into Child Welfare Policy in Baltimore City. 2017.*
7. Jenny X. Wen. *Overcoming systemic barriers to opioid use disorder treatment: evidence and recommendations for the National Academy of Medicine, 2018.*
8. Ali Bokhari. *Drug pricing in public health emergencies, 2018.*

Oral Exams

1. Roza Vazin. Health Policy and Management, PhD. 2016.
2. Amber Cox. International Health, PhD. 2016.
3. Megan Wallace. Epidemiology, DrPH. 2016.

Classroom Instruction: Principal Instructor

1. Crisis and Response in Public Health Policy and Practice. 300.650.01. 3nd term. 29 students. 2018-2019.
2. The Opioid Crisis: Problem Solving Seminar. PH 308.615. 1st term. 71 students. 2018-2019.
3. Crisis Response in Public Health Practice: International Perspectives. 302.843.98. Barcelona Institute. 20 students. 2018.
4. Public Health Policy. 300.610. Summer term. 260 students. 2018.
5. The Practice of Public Health Through Vaccine Case Studies: Problem Solving Seminar. 223.630. 4th Term. 33 students. 2017-2018.
6. Crisis and Response in Public Health Policy and Practice. 300.650.01. 2nd term. 38 students. 2017-2018.
7. Crisis Response in Public Health Practice: International Perspectives. 302.843.98. Barcelona Institute. 15 students. 2017.
8. Crisis Response in Public Health Practice: Workshop. Barcelona Institute. Approximately 10 students. 2017.
9. The Opioid Crisis: Problem Solving Seminar. 308.615.81. 62 students. 2017.
10. Crisis and Response in Public Health Policy and Practice. 300.650.01. 2nd term. 33 students. 2016-2017.

11. Crisis Response in Public Health Practice: International Perspectives. 302.843.98. Barcelona Institute. 25 students. 2016.
12. Crisis and Response in Public Health Policy and Practice. 300.650.01. 1st term. 40 students. 2015-2016.

The Crisis and Response in Public Health Policy and Practice (domestic and international) and Opioid Crisis Problem Solving Seminar have received outstanding range evaluations.

RESEARCH GRANT PARTICIPATION

Technical support for data sharing	De Beaumont Foundation	April 2019-March 2020	90.000

Co-Investigator. We are working with principal investigators at the University of Michigan to provide technical support for localities seeking to

Global Budgeting Policy Academy	Robert Wood Johnson Foundation (via Princeton University)	March 1, 2018 - August 1, 2018	30,000

Principal Investigator. We hosted a policy academy and produced a Q and A document for states on global hospital budgeting in rural areas.

Using Healthcare Data in Public Health Practice	De Beaumont Foundation	September 1, 2016 to September 1, 2017	$100,000

Principal Investigator. The purpose of this grant was to develop use cases and legal pathways for public health departments to use healthcare data. This project was a collaboration with the National Public Health Law Network, and the paper was published in December 2017.

Transparency at the U.S. Food and Drug Administration	Laura and John Arnold Foundation	August 8, 2016 to March 31, 2018	$175,583

Principal Investigator. The purpose of this grant was to develop recommendations to improve transparency at the U.S. FDA. I coordinated an academic team including experts from Johns

Hopkins, Harvard, and Yale, and we published a supplement to the Journal of Law, Medicine, and Ethics.

Assessing the Applicability of Global Hospital Budgeting to Large Safety Net Systems	Commonwealth Fund	June 1, 2016 to June 30, 2017	$49,489

Principal Investigator. The purpose of this grant was to develop a report for the Commonwealth Fund on global hospital budgeting for safety net health systems. This report was published in the summer of 2017.

Reforming States Group letter to the New Administration	Milbank Memorial Fund	April 1, 2016 - December 31, 2016	$10,000

Principal Investigator. The purpose of this grant was to help draft a bipartisan letter on opportunities in health policy for the new administration. This letter was sent in the fall of 2016, and the lead members of the Reforming States Group published an article summarizing the letter in the *New England Journal of Medicine*.

Pharmaceutical Pricing	Laura and John Arnold Foundation	2016 - 2019 2019-	*

Investigator. Professor Gerard Anderson is the Principal Investigator on this project. My main role is to develop public health approaches to pharmaceutical pricing. These efforts culminated in a publication in the *Journal of the American Medical Association* and support for Louisiana's subscription model for hepatitis C elimination.

Healthcare Pricing	Laura and John Arnold Foundation	2019-	*

Investigator. Professor Gerard Anderson is the Principal Investigator on this project. My main role is to assist with work on global-budget type arrangements for hospitals and others in the healthcare system.

SCHOOL SERVICE

Committee	**Role**

Committee of the Whole	Member, 2015-
Graduate Medical Education Committee	Chair, 2015-
Practice Integration Committee	Chair, 2015-2019

EXHIBIT 39

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE; *et al.*,	)	
Plaintiffs,	)	CASE NO. 1:20-cv-323-LY
v.	)	
GREG ABBOTT, in his official capacity as Governor; *et al.*,	)	
Defendants.	)	

DECLARATION OF KARI WHITE, PH.D., IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

KARI WHITE, PH.D., hereby declares under penalty of perjury that the following statements are true and correct:

My Professional Background and Qualifications

1. I am an Associate Professor of Social Work and Sociology at the University of Texas at Austin ("UT Austin").

2. I am also the Principal Investigator of the Texas Policy Evaluation Project ("TxPEP"), a collaborative group of university-based investigators who evaluate the impact of legislation in Texas related to women's reproductive health. Based at UT Austin's Population Research Center, the project began in 2011. Its mission is to conduct methodologically principled research and communicate the results to a broad audience through peer-reviewed scientific publications, research briefs, and other materials.

3. I earned a Master of Public Health degree from Tulane University School of Public Health in New Orleans, Louisiana, and a Ph.D. in sociology with a specialization in demography from UT Austin.

4. My research focuses on family planning services provided at publicly funded clinics, access to abortion, and vasectomy. I also study postpartum contraceptive use. I lecture on reproductive health policy, family planning, and immigrant health.

5. Prior to joining the faculty of UT Austin, I served as an Associate Professor at the University of Alabama at Birmingham.

6. I am a member of the American Public Health Association, the Population Association of America, and the Society of Family Planning.

7. I have authored more than sixty peer-reviewed articles, and I serve as a reviewer for several respected journals, including the American Journal of Public Health, the American Journal of Obstetrics and Gynecology, Contraception, and Perspectives on Sexual and Reproductive Health.

8. The following testimony is based on my personal knowledge, professional experience, original research, and knowledge of the relevant professional literature.

Executive Order GA-09

9. On March 22, 2020, Governor Greg Abbott of Texas issued Executive Order GA-09 ("Executive Order") stating that all surgeries and procedures that are not medically necessary to correct a serious medical condition or to preserve the life of a patient should be postponed because of the coronavirus pandemic.[1] I understand that the Executive Order is to remain in effect until 11:59 p.m. on April 21, 2020, but it may be extended by the Governor.

[1] Abbott, G. Executive order GA 09: Relating to hospital capacity during the COVID-19 disaster. March 22, 2020. https://gov.texas.gov/uploads/files/press/EO-GA_09_COVID-19_hospital_capacity_IMAGE_03-22-2020.pdf.

10. In a follow-up press release,[2] Attorney General Ken Paxton declared that, as a result of the Executive Order, abortion providers must postpone "any type of abortion that is not medically necessary to preserve the life or health of the mother." Texas abortion providers subsequently suspended nearly all services, canceling hundreds of scheduled appointments.

Outpatient Facilities That Provide Abortions in Texas

11. As part of my work with TxPEP, I study the location and characteristics of outpatient facilities that provide abortions in Texas.

12. There are currently 24 outpatient facilities in Texas that, but for Executive Order GA-09, would be providing abortion care. Sixteen of these are licensed abortion facilities ("clinics") and 8 are licensed ambulatory surgical centers ("ASCs").

13. With respect to the clinics, 3 are located in Austin; 1 is located in Dallas; 1 is located in Fort Worth; 2 are located in El Paso; 6 are located in the Houston metropolitan area; 1 is located in McAllen; 1 is located in San Antonio; and 1 is located in Waco.

14. With respect to the ASCs, 1 is located in Austin; 2 are located in Dallas; 1 is located in Fort Worth; 2 are located in Houston; and 2 are located in San Antonio.

15. By law, Texas abortion clinics may only provide abortions up to 18 weeks of pregnancy as measured from the first day of a patient's last menstrual period ("LMP").[3] Absent exceptional circumstances, Texas law prohibits abortion beginning at 22 weeks LMP.[4]

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[2] Paxton, K. Health care professionals and facilities, including abortion providers, must immediately stop all medically unnecessary surgeries and procedures to preserve resources to fight COVID-19 pandemic. Press release. March 23, 2020. https://www.texasattorneygeneral.gov/news/releases/health-care-professionals-and-facilities-including-abortion-providersmust-immediately-stop-all.

[3] Tex. Health & Safety Code § 171.004.

[4] Tex. Health & Safety Code § 171.044.

16. The ASC in Fort Worth provides abortions only up to 13 weeks LMP. One of the ASCs in Houston provides abortions only up to 20 weeks LMP. One of the ASCs in San Antonio provides abortions only up to 16 weeks LMP.

17. Thus, there are only 6 ASCs in Texas that provide abortions after 18 weeks LMP, and only 5 of them provide abortions after 20 weeks LMP. All of the ASCs that provide abortions after 18 weeks LMP are located in one of the following cities: Austin, Dallas, Houston, and San Antonio.

Impact of Executive Order GA-09 on Abortion Access

18. To evaluate the impact the Executive Order would have if it is not enjoined or rescinded, TxPEP evaluated survey data that we had collected between June and December 2018. The survey involved 603 patients seeking abortion at 12 Texas facilities. Patients completed a self-administered tablet-based survey and were asked to report their gestational age at their ultrasound visit. Among the 567 with valid data, we estimated gestational age and eligibility for medication abortion (≤10 weeks from last menstrual period) and need for second-trimester surgical abortion (12-21 weeks from last menstrual period) if they were required to wait 1 to 6 additional weeks to return for their procedure. We estimated the distance from the population-weighted centroid of each Texas county to the nearest facility in Texas and neighboring states (Arkansas, Louisiana, Oklahoma, and New Mexico) using the georoute command in Stata 15. We published the results in a research brief.[5]

[5] White, K, Sierra, G, Vizcarra, E, Dixon, L, Baum, S, Hopkins, K, Potter, JE, and Grossman, D. The potential impacts of Texas' executive order on patients' access to abortion care. Texas Policy Evaluation Project. Research Brief. 2020. https://liberalarts.utexas.edu/txpep/research-briefs/executive-order-abortion.php.

19. We found that the Executive Order will prevent many women from accessing medication abortion in Texas.

20. If Texas' abortion facilities have to suspend all services while the Executive Order remains in effect, many patients seeking abortion care in early pregnancy will no longer be eligible for medication abortion because they will be pushed past the gestational age limit for the method (10 weeks LMP). Based on our patient survey, most clients seeking care (88%) were eligible for medication abortion at the time of their initial consultation and ultrasound visit. If patients have to wait 4 weeks until the executive order expires, fewer than half (48%) would still be able to utilize this method.

21. Our prior research found that abortion facilities are not able to immediately accommodate an increased demand for services, leading to long wait times for patients seeking appointments and patients receiving care at later gestations.[6] Because of these scheduling challenges, we expect some patients may not be able to return for their abortion visit immediately after the order expires. If patients who were seeking abortion when the Executive Order was issued were delayed for 6 weeks, only 6% would still be eligible for medication abortion.

22. A growing percentage of people obtaining abortion care in Texas use medication abortion.[7] Many patients prefer this method over a surgical procedure because they feel that it is more natural and the process can occur in the privacy and comfort of their home.

[6] K. White, S. Baum, K. Hopkins, J.E. Potter, and D. Grossman. 2019. Change in second-trimester abortion after implementation of a restrictive state law. *Obstetrics & Gynecology* 133(4): 771-779; Texas Policy Evaluation Project. "Abortion wait times in Texas: The shrinking capacity of facilities and the potential impact of closing non-ASC facilities" October 2015. http://sites.utexas.edu/txpep/files/2016/01/Abortion_Wait_Time_Brief.pdf

[7] Baum, SE, White, K, Hopkins, K, Potter JE, Grossman D. Rebound of medication abortion in Texas following updated mifepristone label. *Contraception*. 2019;99(5):278-280.

23. We also found that the Executive Order will cause many women seeking an abortion during the first-trimester of pregnancy to be delayed into the second trimester.

24. If patients are forced to delay their abortion while the Executive Order remains in effect, many will not be able to obtain care until the second trimester (after 12 weeks LMP). In our patient survey, approximately 9% of patients were in the second trimester at the time of their initial consultation and ultrasound visit. However, after a 4-week delay between their ultrasound and abortion visits, more than one-third (35%) of patients would need second-trimester abortion care.

25. Second-trimester abortions are safe, but the risk of complications increases with gestational age. In addition, these procedures are more expensive, and fewer facilities offer the service. Indeed, after the Executive Order expires, it is unlikely that the existing clinics and ASCs in Texas will have the capacity to provide care for all the second-trimester patients who will need it. This capacity constraint may lead patients to wait even longer for services and push some past the state's gestational age limit for abortion (22 weeks LMP).

26. These effects would fall disproportionately on Black and lower income patients, who are more likely to seek later abortion care.[8]

27. The above projections apply to patients who would have already attended an initial consultation visit and then had their abortion visit canceled when the Executive Order was issued. Patients who call Texas facilities to schedule their initial appointment while the Executive Order is in effect would also experience delays obtaining care. Wait times for visits at Texas facilities may increase when services are re-established and staff work to see patients whose visits were canceled.

[8] K. White, S. Baum, K. Hopkins, J.E. Potter, and D. Grossman. 2019. "Change in second-trimester abortion after implementation of a restrictive state law." *Obstetrics & Gynecology* 133(4): 771-779.

28. Patients also may face delays as they identify and try to arrange travel to out-of-state facilities.

29. If Texas clinics and ASCs are forced to suspend abortion services while the Executive Order remains in effect, patients seeking abortion care in other states will have to travel long distances. Most Texas counties (94%) are 100 miles or more from the nearest out-of-state abortion provider, and approximately three-quarters (72%) are more than 200 miles away.

30. It is often difficult for patients seeking abortion to make the necessary arrangements to travel to a clinic, especially one that is far away. Finding child care, taking time off work and covering the cost of gas increase patients' out-of-pocket expenses and are logistically challenging to arrange.

31. Out-of-state travel may be more difficult for patients during the current pandemic because they face economic uncertainty from lost wages and need to care for children who are at home. In addition, long-distance travel is being discouraged by public health authorities because it creates increased risk of COVID-19 transmission.

32. Those who are able to travel may have difficulties scheduling an appointment elsewhere because facilities in neighboring states are unable to meet the increased demand for care.

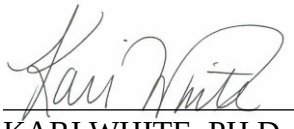
33. It is likely that many people considering abortion will be unable to afford these travel costs and will end up continuing an unwanted pregnancy. Our previous research on the impact of clinic closures found that increased distance from a facility following clinic closures was associated with a large decrease in the number of abortions.[9]

[9] Grossman, D, White, K, Hopkins, K, Potter, JE. Change in distance to nearest facility and abortion in Texas, 2012 to 2014. *JAMA*. 2017;317(4):437-439.

34. People who are undocumented will be unlikely to travel at all because they will be unable to pass through interior border checkpoints.

35. In conclusion, if Texas abortion facilities are forced to suspend services while the executive order is in effect, many patients who remain in Texas will have to delay care until later in pregnancy, and those who can obtain care out of state will be forced to travel considerably longer distances for services. This would create unnecessary economic hardships and increase the health risks for those who undergo second-trimester procedures or end up continuing an unwanted pregnancy.

Dated: April 15, 2020



KARI WHITE, PH.D.

EXHIBIT 40

Induced Terminations of Pregnancy by Facility and Post-Fertilization Age - 2017* **

FACILITY	TOTAL	< 9 WEEKS	9-10 WEEKS	11-12 WEEKS	13-14 WEEKS	15-16 WEEKS	17-20 WEEKS	21-24 WEEKS	>= 25 WEEKS	NOT STATED
ABORTION FACILITY	**25,823**	22,101	1,840	1,015	656	175	0	0	0	36
PHYSICIAN'S OFFICE	**41**	40	1	0	0	0	0	0	0	0
HOSPITAL	**89**	6	2	4	15	23	29	9	1	0
AMBULATORY SURGERY CENTER	**27,324**	21,912	2,016	1,193	833	595	772	3	0	0
OUT OF STATE	**566**	408	56	43	27	3	2	3	0	24
TOTAL	**53,843**	**44,467**	**3,915**	**2,255**	**1,531**	**796**	**803**	**15**	**1**	**60**

Notes:

* Based on the 83rd Texas Legislature requirement, starting with 2014 Induced Terminations of Pregnancy (ITOP) data, fetus age is reported in weeks post-fertilization versus the previously reported weeks of gestation. Post-Fertilization Age (PFA) is generally two weeks less than gestational age. For out-of-state records, post-fertilization age is estimated based on gestational age.

** Includes reported abortions that were either performed in Texas on out of state residents (1,174) or were performed on Texas residents elsewhere (566).

Data Sources: Reports of induced termination of pregnancy sent to Texas Health and Human Services per the Texas Abortion Facility Reporting and Licensing Act, Health and Safety Code, Chapter 245 and through public health surveillance agreements with other states.

Prepared by: Data Dissemination, Center for Analytics and Decision Support, Texas HHSC, February 2019
Filename: 2017 ITOP by Post-Fertilization Age and Type of Facility_Final.xlsx

End of worksheet