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

WHOLE WOMAN'S HEALTH, et al.,	)	
	)	
Plaintiffs,	)	
	)	CIVIL ACTION
v.	)	
	)	CASE NO. 1:16-cv-01300-
CHARLES SMITH	)	DAE-AWA
	)	
Defendant.	)	

PLAINTIFFS' PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

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PROPOSED FINDINGS OF FACT

I. The Parties.

1. Plaintiffs are Texas healthcare providers bringing claims on behalf of themselves and their patients against Chapter 697 of the Texas Health & Safety Code ("Chapter 697" or "the Act") and its implementing regulation, 25 Tex. Admin. Code Chapter 138 ("the Implementing Regulation").

2. Plaintiffs have provided a wide array of pregnancy-related medical services—including abortion care, miscarriage management, and treatment of ectopic pregnancy—to Texas women for decades. Their patients come from diverse backgrounds, representing a broad array of religious and cultural traditions. Plaintiffs are committed to providing their patients with respectful and culturally sensitive care that respects patients' dignity and autonomy. They have always accommodated patients who wish to have interment or cremation following an abortion or miscarriage. They object to forcing such practices onto patients who would not choose them voluntarily.

3. Plaintiff Whole Woman's Health operates clinics offering comprehensive gynecology services, including abortion care. Whole Woman's Health operates licensed abortion facilities in McAllen, Fort Worth, and San Antonio. They have been open since 2004, 2009, and 2010, respectively.[1]

4. Plaintiff Whole Woman's Health Alliance is a Texas nonprofit corporation that operates a licensed abortion facility in Austin. It has provided abortion services since 2017.

5. Whole Woman's Health and Whole Woman's Health Alliance operate with a holistic philosophy of care—honoring each patient's head and heart as well as their body—and believe that each woman must be at the center of her own health care decisions. This philosophy

[1] In 2014-16, the McAllen and Fort Worth clinics were forced to suspend services for significant periods while the admitting privileges requirement of Texas House Bill 2 of 2013 was in effect, before it was struck down in *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016). Two additional clinics, Whole Woman's Health of Beaumont and Whole Woman's Health of Austin, closed permanently.

is grounded in the knowledge, gained from years of experience providing care, that women experience reproductive healthcare in both a cultural and social context, and that women's identity, values, hopes, and dreams are deeply connected to that care.

6. Plaintiff Dr. Bhavik Kumar, a board-certified family physician, who is the Texas medical director of Whole Woman's Health and Whole Woman's Health Alliance, provides procedures including surgical abortion and miscarriage management. He received his M.D. from the Texas Tech University School of Medicine, and his M.P.H. from Columbia University, and undertook a fellowship in family planning at the Albert Einstein College of Medicine.

7. Plaintiff Brookside Women's Medical Center PA operates Brookside Women's Medical Center and Austin Women's Health Center, which have both provided reproductive healthcare services to Texas women for 40 years. Austin Women's Health Center is a licensed abortion facility. Brookside Women's Medical Center is a gynecological and primary care practice. The two entities share premises in Austin.

8. Plaintiff Dr. Lendol L. ("Tad") Davis is the Medical Director of Austin Women's Health Center and Brookside Women's Medical Center in Austin. He performs procedures, including miscarriage management and abortion, at those locations and at several Austin-area hospitals. He has practiced medicine in Texas for nearly 50 years. He is a board-certified ob-gyn, a Fellow of the American College of Obstetricians and Gynecologists ("ACOG"), and a certified Diplomat of the American Board of Obstetrics Gynecology. He received his M.D. from the University of Texas Health Science Center School of Medicine in San Antonio, and he undertook his residency in obstetrics and gynecology at Scott and White Memorial Hospital in Temple. He is a member of the Texas Medical Association and the Travis County Medical Association.

9. Plaintiff Alamo City Surgery Center d/b/a Alamo Women's Reproductive Services is a licensed ambulatory surgical center in San Antonio. It provides a range of reproductive health services, including abortion. It operates according to the philosophy that patients know what is best for themselves, for their bodies, and for their lives, and they highly

value respect for patients' dignity. All doctors on staff are certified by the American Board of Obstetrics and Gynecology.

10. Dr. Alan Richard Braid is the owner and medical director of Alamo Women's Reproductive Services. He has a specialty certification from the American Board of Obstetrics and Gynecology, and he has over four decades of active practice in Texas. Dr. Braid received his M.D. from the University of Texas Medical School, and he undertook his residency in obstetrics and gynecology at the University of Texas health Science Center in San Antonio.

11. Charles Smith was Executive Commissioner of the Texas Health and Human Services Commission (the "Commission" or "HHSC") until May 31, 2018. HHSC is currently led by an Acting Executive Commissioner, Cecile Young. HHSC is charged with enforcing the Act and Implementing Regulation.

II. Procedural History.

12. The Texas Department of State Health Services ("DSHS")[2] originally enacted regulations in 1989 governing the disposal of "special waste from health care-related facilities" which included all human tissue that is the product of medical care. *See* 25 Tex. Admin. Code §§ 1.131-1.137 ("Subchapter K"). For twenty-seven years, embryonic and fetal tissue was treated no differently from any other human tissue. *See* 14 Tex. Reg. 1457-62 (Mar. 21, 1989) (creating 25 Tex. Admin. Code §§ 1.131-1.137). Both could be disposed of by standard medical means—typically, incineration followed by disposition of the ash in a sanitary landfill.

13. In 2016, DSHS proposed amendments to those regulations ("the Amendments"), intended to prohibit healthcare facilities from using ordinary medical methods to dispose of "fetal tissue."

[2] DSHS' Commissioner John Hellerstedt, M.D., was the original defendant in this action. As part of an administrative reorganization, in 2017, DSHS' rulemaking and enforcement functions relevant to the Act passed to HHSC, and Executive Commissioner Smith was substituted as Defendant. Dkt No. 117.

14. DSHS issued multiple versions of the proposed Amendments in the latter half of 2016. The initial set of proposed regulations stated that "the public benefit anticipated as a result of adopting and enforcing these rules will be enhanced protection of the health and safety of the public." 41 Tex. Reg. 4773 (July 1, 2016). A re-publication of the proposal three months later likewise stated that "the public benefit anticipated as a result of adopting and enforcing these rules would be enhanced protection of the health and safety of the public by ensuring that the disposition methods specified in the rules continue to be limited to methods that prevent the spread of disease." 41 Tex. Reg. 7660 (Sept. 30, 2016).

15. The adopted version of the Amendments was published in the Texas Register on December 9, 2016. 41 Tex. Reg. 9709-41 (Dec. 9, 2016). Under the heading "Public Benefit," DSHS added a second justification: "Additional public benefit will be realized in bringing up-to-date the department's rules to reflect the Legislature's articulated policy objectives of respect for life and protecting the dignity of the unborn." 41 Tex. Reg. 9732 (Dec. 9, 2016).

16. The Amendments created a new category of "pathological waste" called "fetal tissue," defined as "[a] fetus, body parts, organs or other tissue from a pregnancy," not including "the umbilical cord, placenta, gestational sac, blood or body fluids." 41 Tex. Reg. 9733 (Dec. 9, 2016) (creating 25 Tex. Admin Code § 1.132(28)). The Amendments limited the permissible disposal methods for "fetal tissue," each of which ultimately required final disposition by "interment," which was defined to include burial[3] or cremation. 41 Tex. Reg. 9733-34, 9738-39 (Dec. 9, 2016) (amending 25 Tex. Admin. Code §§ 1.132(33), 1.136(a)(4)).

17. Although the Amendments did not, on their face, prohibit the disposal of ashes from cremation of "fetal tissue" in a sanitary landfill, DSHS took the position that they in fact did so.

[3] The Amendments used the phrase "entombment, burial, or placement in a niche," 41 Tex. Reg. 9733-34 (Dec. 9, 2016) (amending 25 Tex. Admin. Code § 1.132(33)), which the parties referred to in shorthand as "burial" throughout the first part of this case.

18. On December 12, 2016, Plaintiffs filed a lawsuit challenging the Amendments on constitutional grounds. The same day, Plaintiffs filed a motion for a temporary restraining order or preliminary injunction, to block the Amendments from taking effect before December 18, their planned effective date.

19. Following oral argument on December 15, 2016, the Court issued a temporary restraining order against enforcement of the Amendments, effective through January 6, 2017. Dkt. No. 24. The Court held an evidentiary hearing on Plaintiffs' preliminary injunction motion on January 3-4, 2017. At the conclusion of the hearing, the Court extended the temporary restraining order through January 27, 2017. Dkt. No. 40.

20. On January 27, 2017, after considering live and written testimony offered during a two-day hearing, as well as the parties' briefs and arguments, the Court granted Plaintiffs' motion for a preliminary injunction, concluding that Plaintiffs had a substantial likelihood of success on the merits of their substantive due process and vagueness claims, and that the other requirements for issuance of a preliminary injunction were satisfied. *Whole Woman's Health v. Hellerstedt*, 231 F. Supp. 3d 218, 221, 226-23 (W.D. Tex. 2017).

21. Defendant appealed the preliminary injunction, and the Court stayed the proceedings pending appeal.

22. On June 6, 2017, while Defendant's appeal of Plaintiffs' first preliminary injunction was pending, the State enacted Senate Bill 8 ("SB 8"). Chapter 697 of SB 8 ("the Act"), sought to create in statute the same basic requirement that DSHS previously attempted to impose through the Amendments: mandatory interment or cremation of "embryonic or fetal tissue remains" ("EFTR").[4]

[4] As enacted, SB 8 contains numerous restrictions on pregnancy-related medical care, including a ban on the most common method of abortion after approximately fifteen weeks of pregnancy, which a court of this District struck down in November. *Whole Woman's Health v. Paxton*, 280 F. Supp. 3d 938 (W.D. Tex. 2017), *appeal docketed*, No. 17-51060 (5th Cir.). The present challenge concerns only Chapter 697 of SB 8.

23. The Act also required HHSC to issue implementing regulations by December 1, 2017. The Implementing Regulation was first published on January 26, 2018. 43 Tex. Reg. 465-73 (Jan. 26, 2018) (creating 25 Tex. Admin. Code Ch. 138).

24. On December 6, 2017, Defendant moved to voluntarily dismiss its appeal, citing the Act's pending effectiveness and HHSC's ongoing rulemaking. The Fifth Circuit granted the motion the next day. The following week, the Court lifted the stay. Plaintiffs filed an Amended Complaint on December 22, 2017, challenging the Act and any implementing regulations that would be issued, and a second motion for a preliminary injunction on January 3, 2018.

25. On January 29, 2018, the Court granted that motion, concluding that Plaintiffs had a substantial likelihood of success on the merits of their substantive due process claim, and that the other requirements for issuance of a preliminary injunction were satisfied. Dkt. No. 110. Noting the Act articulated no health and safety purpose despite its presence in the Texas Health and Safety Code, the Court found the State's purported interest may simply be a pretext for restricting abortion, and that, "even if the asserted state interest is not a pretext, there is no precedent showing . . . [it] is a valid state interest." *Id*. at 4, 10-11. Moreover, this Court found the Act likely imposes an undue burden because its burdens outweigh its benefits. *Id.* at 13. Those burdens include a prescription of "what is orthodox concerning the beginning of life," *id*.; a "negative effect on women's health by causing grief and shame and possibly discouraging women from obtaining gynecological care, particularly abortions and miscarriage management, from a medical facility," *id*. at 12-13 (internal citation omitted); and logistical challenges for healthcare providers, *id*. at 12.

26. The Court also concluded that the Act was likely unconstitutionally vague, in light of HHSC's ongoing rulemaking and implementation process. *Id.* at 9.

27. The parties agreed to a compressed discovery schedule, *see* Dkt. Nos. 115, 113, and conducted discovery between mid-February and mid-June of this year.

28. In addition to the provisions regulating the disposition of EFTR, the Act also provides for the "establish[ment] and maintain[ance of] a registry of participating funeral homes

and cemeteries willing to provide free common burial or low-cost private burial [and] private nonprofit organizations that register with the department to provide financial assistance for the costs associated with burial or cremation of [EFTR]" ("the Burial or Cremation Assistance Registry" or "Registry"). Tex. Health & Safety Code § 697.005. It also directs HHSC to "develop a grant program that uses private donations to provide financial assistance for the costs associated with disposing of embryonic and fetal tissue remains" ("the Grant Program"). Tex. Health & Safety Code § 697.006. These were established early this year.[5]

29. The Implementing Regulation did not repeal the Amendments. On May 18, 2018, HHSC issued other regulations that effectively did so. 43 Tex. Reg. 3242 (May 18, 2018) (adopting without change proposed regulations, 43 Tex. Reg. 1560-62 (Mar. 16, 2018)).

30. On May 11, 2018, the Texas Commission on Environmental Quality ("TCEQ") proposed amendments to their regulations governing incinerators and crematoriums to bring them into line with the Act. 43 Tex. Reg. 2943-48 (May 11, 2018). Notably, the proposed amendments, if finalized, would allow crematories to cremate EFTR. 30 Tex. Admin. Code §§106.494(a)(5), 106.494(b)(2)(G). As of today, this remains prohibited. *Id.* § 106.494(b)(2)(G).

III. The Act.

31. The Act creates a new, *sui generis* classification under Texas law: EFTR, defined as "an embryo, a fetus, body parts, or organs from a pregnancy," exclusive of "the umbilical cord, placenta, gestational sac, blood, or body fluids." Tex. Health & Safety Code § 697.002(3). It establishes that EFTR is "not pathological waste under state law." Tex. Health & Safety Code § 697.003.[6]

32. The Act permits only two methods of final disposition of EFTR: "interment"—defined as "the disposition of remains by entombment, burial, or placement in a niche"—and "cremation"—defined as "the irreversible process of reducing remains to bone fragments

[5] The Plaintiffs do not challenge the constitutionality of the Registry or Grant Program, and they were not subject to the Court's preliminary injunction.

[6] The Act does not define EFTR as human remains.

through direct flame, extreme heat, and evaporation." Tex. Health & Safety Code §§ 697.002, 697.004(a). Ash resulting from cremation shall be "interred or scattered in any manner as authorized by law for human remains," and "may not be placed in a landfill." Tex. Health & Safety Code § 697.004(b).

33. The Act permits incineration or steam disinfection of EFTR before interment, as an optional first step in the process of *treatment* of waste. Tex. Health & Safety Code § 697.004(a). This is of no practical significance, however, as interment is still the ultimate required method of *disposal* after incineration. *Id*. In any event, incinerators are not permitted to send ash anywhere other than to a sanitary landfill. 30 Tex. Admin. Code § 326.41(c)(1) ("Incinerator ash shall be disposed of in a permitted landfill . . ."). Since the Act forbids this, it forbids incineration in practice.

34. Though excluded from the definition of EFTR, the umbilical cord, placenta, gestational sac, blood, or body fluids "may be disposed of in the same manner" as EFTR. Tex. Health & Safety Code § 697.004(d).

35. The Implementing Regulation largely reproduces the Act verbatim. *See* 43 Tex. Reg. 465-473 (Jan. 26, 2018). It also includes a provision that "any person or entity authorized to store, handle, or transport human remains by the Texas Funeral Service Commission [("TFSC")], or special waste from health care facilities by the TCEQ, is authorized to store, handle, or transport [EFTR]," as is the healthcare facility generating the EFTR. 25 Tex. Admin. Code § 138.6. The Implementing Regulation also adds new definitions; limitations on the containers that may be used to store, transport, and dispose of EFTR; recordkeeping requirements; and exemptions for tissue that is not defined as EFTR or within a "healthcare facility" as defined by the Act. 25 Tex. Admin. Code §§ 138.2, 138.4, 138.5, 138.6, 138.7. The Implementing Regulation also implements the Registry. 25 Tex. Admin. Code § 138.8.

36. Subsequent to the Implementing Regulation, HHSC issued a set of regulations establishing that "[p]athological waste excludes [EFTR]," and therefore Subchapter K "does not apply to [EFTR]." 43 Tex. Reg. 3243 (May 18, 2018), 43 Tex. Reg. 1560-61 (Mar. 16, 2018).

37. Additionally, TCEQ has proposed rules to "adhere to the directives of the legislature and maintain consistency with the regulations of DSHS and HHSC." 43 Tex. Reg. 2943 (May 11, 2018). These proposed rules would permit licensed crematories to dispose of EFTR. *Id*. This is in contrast to current law. 30 Tex. Admin. Code 106.494(b)(2)(G) ("Crematories shall be used for the sole purpose of cremation of human remains and appropriate containers."). The proposed rules would also adopt the Act's definition of EFTR, as well as HHSC's new definition of pathological waste, which excludes EFTR. 43 Tex. Reg. 2947 (May 11, 2018); 43 Tex. Reg. 1560 (Mar. 16, 2018). As of today, these rules have not been finalized.

38. In contrast to the Act's requirements, no Texas law requires healthcare providers to dispose of human remains by any particular method,[7] and the statute requiring HHSC to regulate the disposition of human remains states that its only purpose is to "regulate the disposal, transportation, interment, and disinterment of dead bodies to the extent reasonable and necessary to protect public health and safety," not to further respect for life. Tex. Health & Safety Code § 694.001.

Plaintiffs' current practices concerning disposition of EFTR

39. Absent a patient request for special treatment, Plaintiffs dispose of EFTR using standard medical methods. All pregnancy tissue, including EFTR, within Plaintiffs' facilities is treated as biohazardous waste and handled with universal precautions for infection control. Following a procedure, the tissue is placed in plastic bags and stored in a freezer. At intervals of one to three weeks, depending on the facility, the frozen EFTR is put into a biohazardous waste disposal container and transferred to a medical waste services vendor for incineration.

40. Like most healthcare practices, Plaintiffs must contract with medical waste disposal vendors to collect, transport, treat, and dispose of medical waste, including all forms of

[7] Texas does regulate how funeral directors, cemeteries, and crematories handle human remains, *see generally* Tex. Health & Safety Code Chs. 711, 716; Tex. Occ. Code Ch. 651—but these rules are not applicable to the general public, and no Texas laws require anyone to dispose of bodies through licensed professionals or facilities.

tissue and non-tissue waste such as sharps,[8] drapes, table paper, and other soiled examination room products. Under the terms of their contracts, waste disposal vendors collect Plaintiffs' EFTR, incinerate it, and dispose of it in a sanitary landfill, consistent with standard medical disposal of other human tissue.

41. Occasionally, Plaintiffs' patients request that their EFTR be released to a funeral home rather than disposed of in the standard way. Consistent with their commitment to providing patient-centered and culturally-sensitive care, Plaintiffs respect these requests. It is their practice to assist a patient in locating a suitable and willing funeral home or cemetery, and then releasing the EFTR to the custody of that facility, with the patient's permission, generally on the same day as the patient's medical procedure.

42. The Act would require Texas healthcare facilities to cease disposing of EFTR as they dispose of all other human tissue that is the product of medical care—by incineration, followed by disposition of the ashes in a sanitary landfill. Rather, they will have to dispose of EFTR either by interment or cremation.

43. Healthcare facilities, including Plaintiffs, will need to identify a vendor who is willing and able to provide this service for EFTR, while continuing to dispose of their other medical waste by standard means. Unless and until TCEQ's final regulations are adopted, EFTR must be interred; if the proposed regulations are finalized, cremation will also become an option.[9]

The Registry and the Grant Program

44. Pursuant to the Act, HHSC has established a Registry for funeral homes and cemeteries willing to provide free common burial or low cost private burial, and private non-

[8] Sharps are potentially contaminated disposable sharp objects such as blades and needles.

[9] The technical difference between incineration and cremation is minor. The Act defines "cremation" as "the irreversible process of reducing remains to bone fragments through direct flame, extreme heat, and evaporation," typically followed by a grinding process to reduce bone fragments in size. Tex. Health & Safety Code § 697.002. The Act defines "incineration" very similarly as "the process of burning remains in an incinerator." *Id*.

profit organizations to provide financial assistance for cremation and burial. The Burial or Cremation Assistance Registry Application Form is available on HHSC's website.

45. The one-page application requires an entity to provide its name, mailing address, and website (if any), as well as the name, title, and contact information for a contact person. The applicant must state whether it is a funeral home, cemetery, or private non-profit, and whether it is willing to provide "[f]ree/low-cost transportation, burial, or cremation services; [f]inancial assistance; [and/or o]ther."

46. HHSC provides no definition for "low-cost," nor of "other." There are no standards for what kind, quantity, or price of services an entity must offer to be included on the Registry.

47. HHSC has not undertaken any efforts to verify the accuracy of any of the information provided in Registry applications, nor applicants' willingness or capacity to provide services. Nor has HHSC contacted registrants to confirm that their applications were approved. HHSC maintains that it "cannot answer any questions regarding registrants of their capacity or provide assistance and is not responsible for any promises or offers made by registrants."

48. Some of the registrants have provided incorrect contact information.

49. The Act and Implementing Regulation do not permit HHSC to provide a copy of the Registry to women or families seeking low-cost burial or cremation services following a miscarriage or abortion. Rather, it is available to physicians and health care facilities. To date, fewer than ten have sought it.

50. Pursuant to the Act, HHSC has established a Grant Program "that uses private donations to provide financial assistance for the costs associated with disposing of [EFTR]." Tex. Health & Safety Code § 697.006. The Grant Program has received no donations, and has awarded no grants.

IV. Burdens on Liberty.

51. Plaintiffs' patients come from a variety of backgrounds, representing a broad array of religious and cultural traditions. They are racially and ethnically diverse. They speak

many languages. They belong to a variety of religious traditions, and some are not religious. Some patients integrate their religious beliefs into their care by praying or bringing religious ministers to the clinic with them.

52. Plaintiffs are committed to providing their patients with respectful and culturally sensitive care that respects patients' dignity and autonomy.

53. Plaintiffs respect their patients by listening to them, answering their questions in a non-judgmental and non-directive manner, using the patients' own vocabularies in those answers, and allowing patients a wide latitude to make choices that tailor their care in a way that makes them comfortable—for example, choosing among a variety of medically-valid treatment options, or being accompanied by a support person.

54. Plaintiffs obtain their patients' informed consent before providing an abortion. Informed consent is the process by which a patient is told about her medical options, including the risks and benefits of each. As part of the informed consent process, the patient is given the opportunity to discuss and ask questions about issues important to her with her physician and to ultimately choose the option that is right for her. Out of respect for their patients' autonomy, Plaintiffs refrain from directing patients' course of care based on Plaintiffs' own preferences. Instead, Plaintiffs provide the care that the patient selects, and refrain from imposing medically-unnecessary requirements on patients, except to the extent required by Texas law.

55. Each of Plaintiffs' abortion patients participates in non-directive counseling: Plaintiffs provide them with information about their options without expressing a preference among any of the medically-valid options available to the patient. Patients generally meet with a trained patient advocate and a physician. Both the advocate and the physician are able to answer patient questions that go beyond the scope of informed consent, including questions about the disposition of EFTR.

56. Respect for patient autonomy is important in Plaintiffs' practice for several reasons. It is a fundamental ethical principle in medicine. It promotes trust in the patient-provider relationship, and thereby improves communication. It is necessary for ensuring that patients are

receiving the care they seek. It allows patients to make choices consistent with their personal, moral values. It increases the quality of care and promotes better health outcomes.

57. Respect for patient autonomy counsels that people should be supported in making un-coerced, authentic, and voluntary choices after having been provided all material information regarding the decision at issue that is appropriate for the individual patient to achieve the best health outcomes for that patient.

58. Plaintiffs' deference to their patients' wishes regarding EFTR disposition is an important component of Plaintiffs' respect for patients' autonomy and individuality.

59. When patients want interment or cremation of EFTR following an abortion or miscarriage, assisting them in obtaining those services promotes their well-being. It is an expression of respect that is responsive to a patient's autonomy and emotional needs.

60. Similarly, by disposing of EFTR as medical waste for patients who do not seek a burial or cremation, Plaintiffs respect patients' desire not to have their pregnancy tissue treated in an extraordinary or commemorative fashion. It serves exactly the same purpose of respecting patients' autonomy and supporting their wellbeing.

A. The Act Imposes the State's View Regarding the Status of an Embryo or Fetus on Individuals' Diverse Beliefs.

The Act establishes the State's view regarding the status of an embryo or fetus

61. Interment or cremation, the only two methods of disposition permitted by the Act, are associated with human remains. The Act thus likens the disposition of EFTR to the disposition of human remains.

62. The Act recognizes this fact on its face, as the Registry of service providers it establishes is limited to cemeteries and funeral homes—institutions created for the disposition of human remains. Medical waste services vendors are not permitted to join the Registry, even though they also may legally provide the services required by the Act.

63. Further, the Act prohibits disposition of ashes from treated EFTR in the one location where ashes from incinerated medical waste are required to be disposed of—a sanitary landfill.

64. By requiring healthcare providers to ensure that EFTR is disposed of in ways normally associated with human remains, the Act inferentially establishes that embryos and fetuses have a status demanding the same respect as people, even from the earliest stages of pregnancy. This is a belief that not all people share.

Individuals hold a diversity of beliefs regarding the nature of an embryo or fetus

65. Individuals' beliefs regarding the nature of embryos and fetuses are integral to their identities, their religious beliefs, and their most important life plans, such as whether and under what circumstances to have children.

66. People disagree about when in a developing pregnancy an embryo or fetus attains the special status that the Act imposes. Some identify different developmental benchmarks, such as fertilization, viability, or birth. Others point to spiritual ones, such as conception or ensoulment. Others may point to quickening.

67. These views are often informed by religion.

68. Historically, the Jewish tradition, the Catholic Church, and Islamic theologies have all held that life emerges only gradually over the course of the pregnancy.

69. For Jews, the developing form remained "like water" until birth, though it acquired more and more human features, with form at "40 days," a period that has biblical significance.

70. For the Catholic Church before 1869, there was no one accepted official position. Rather, Catholic theologians debated the extent to which an individual human life was held to begin at the biblical 40 days, or at quickening (the point in pregnancy when a woman could feel movement), or at the several alternative ideas of the moment of "ensoulment." In 1869, Pope Pius IX determined that "life begins at conception."

71. Contemporary Christian interpretations reflect a wide range of understandings. Different denominations, and individuals within those denominations, assign different values and meanings to developing human life and hold different positions. They thus hold different views on matters such as contraception, abortion, and assisted reproductive technologies.

72. Muslim theologians hold similarly diverse views. The majority view is that ensoulment occurs at 120 days after fertilization; the minority view is that physiological developmental from an embryo to a fetus is the most important determinant of increased moral complexity and meaning. Some believe that all human tissue is of equal status.

73. Individuals' beliefs are also informed by scientific understandings of embryonic and fetal development.

74. As a matter of biology, an "embryo" is the earliest stage of human development, typically defined as the time from fertilization of an egg cell up to the time when the organ systems have emerged in the most rudimentary form. An embryo becomes a "fetus" at the point when the rudimentary form exists, and when the most important organ systems are outlined though not fully formed or functioning. This transition occurs near the end of the first trimester of pregnancy.

75. As a fetus develops from its earliest stages, it acquires a sequence of gradually emerging functions until it is able to survive birth.

76. Some ascribe special status once the heart beats, others point to the quite late development of the nervous system, still others see the formation of a developed brain or the ability to survive birth as critical points. Sometimes individuals change their views in light of new scientific evidence, and sometimes assign greater priority to other values.

77. Many peoples' beliefs about an embryo or fetus are not fixed in the abstract, but dependent on circumstances. People may view a pregnancy differently depending on whether it is viable or non-viable, wanted or unwanted, intended or unintended, consensual or the product of rape. Some peoples' beliefs are informed by the knowledge that others may hold views different from their own.

Individuals have a diversity of preferences, based on their beliefs, regarding how EFTR should be treated

78. Individuals have different preferences about disposition of EFTR based on their personal beliefs and values.

79. Although most of Plaintiffs' patients do not ask about tissue disposition, a certain percentage does. Those patients are generally satisfied with the explanation that the EFTR is disposed of as medical waste. Occasionally, patients may ask other questions about the tissue, such as whether they can see it after the procedure.

80. The majority of miscarriages and abortions occur during the embryonic stage, where there is very little EFTR to dispose of, and it may be so small so as to be invisible.

81. It is very rare for patients to request disposal of EFTR in a manner associated with human remains, even when asking about tissue or how it will be disposed of.

82. Some individuals state an explicit preference for disposal as medical waste, because they are concerned that any other method would amount to others ascribing a status to their tissue that they believe it does not have.

83. Some of Plaintiffs' patients, as discussed *supra* ¶ 41, seek disposition of EFTR by interment or cremation.

84. Miscarriage is a very common pregnancy outcome. Many people who experience a miscarriage opt to dispose of their pregnancy tissue by flushing into a sanitary sewer. They do not view this as a disrespectful act.

85. Similarly, most patients who choose medication abortion opt to dispose of their tissue in the same way.

86. The choice of interment or cremation, as opposed to medical management of EFTR, is relatively rare. For funeral homes, interment or cremation after miscarriage is a rare part of their practice—especially during the early period of pregnancy to which the Act applies.

87. There is also a diversity of beliefs regarding how human remains should be disposed of. Just as with individuals' beliefs regarding embryos and fetuses, views regarding the proper disposition of human remains are informed by religion, science, morality, and culture. In

some religious traditions, cremated ashes should not be scattered. Some are opposed to cremation altogether, while others are opposed to burial.

88. People who desire disposition of EFTR in a manner associated with human remains may seek a method consistent with their beliefs regarding the disposition of human remains. Thus, even among individuals who seek to dispose of their EFTR in a manner akin to human remains, there are differences of belief regarding the proper method.

Forcing people to dispose of EFTR in a manner associated with human remains against their will is harmful and inconsistent with their dignity

89. Forcing patients to dispose of their EFTR in a manner inconsistent with the diversity of belief regarding what is appropriate violates their autonomy.

90. It is inconsistent with basic principles of medical ethics, notably the principle of respect for autonomy. It limits patients' ability to make authentic choices consistent with their health care values and preferences. It prevents patients from exercising their abilities to apply their personal values and preferences to an aspect of medical treatment that, for many, has an important moral component. It uniquely defines people impacted by the Act—those who seek surgical abortion or miscarriage treatment—as unqualified to exercise values-based judgment over a morally-significant aspect of their medical treatment.

91. It is also inconsistent with the medical ethical principles of justice, beneficence, and non-maleficence, by imposing unique burdens and harms on individuals whose beliefs are inconsistent with the Act's requirements.

92. It is also inconsistent with dignity. Dignity is a state of being worthy of honor or respect. Depriving individuals of their ability to develop and act on beliefs regarding controverted moral questions is not respectful, nor does it honor the individual whose moral authority is taken away. In contrast, there is no universal agreement about what methods of disposition of EFTR are consistent with dignity, due to the wide variety of relevant moral beliefs. *Supra* ¶¶ 79-89. It is not respectful of individuals' dignity for the State to impose its views over and above individuals' ability to develop and act on moral beliefs about this question themselves.

93. Depriving patients of the ability to exercise their moral judgment additionally causes grief, stress, shame, and stigma.

94. Stigma is an attribute that marks individuals as different or "other" than their fellow community members and, consequently, as less valuable people. It is a judgment imposed by moral authorities in society.

95. By distinguishing individuals who have obtained surgical abortion or miscarriage care as uniquely unsuited to exercise moral judgment regarding their embryo or fetus, mandating the cremation or interment of EFTR enhances the stigma associated with abortion and miscarriage. It also imposes the judgment that not regarding one's embryo or fetus as akin to a human being is wrong and immoral, thus causing individuals who choose abortion to be judged as wrongdoers.

96. For example, in 2015, Valerie Peterson was deprived of prompt medical attention to terminate her pregnancy after the diagnosis of a lethal anomaly, by a series of Texas laws that would have required her to wait a week or more to have an abortion and drawn the procedure out over three or four days. She went to Florida to terminate her pregnancy instead. Already grieving the loss of the opportunity to have another child, the Texas laws caused her further grief, stress, and anguish, and a sense of being judged.

97. Dr. Peterson does not agree that her fetus is a person, or should be treated like one, or be afforded precedence over her own moral choices. Requiring her EFTR be treated in a manner associated with human remains would cause her the same type of grief, stress, and anguish that being forced out-of-state to avoid a delayed and drawn out abortion did. It would make her feel forced to accept the judgment of a State who views her pregnancy differently from her, even though the State cannot know her or her circumstances. It would also cause her worry over what was being done to her EFTR without her approval or knowledge. In sum, it would make her feel unequal and less human.

98. Similarly, Blake Norton was told she had no choice but to inter her EFTR after seeking treatment for a miscarriage at an Austin hospital in 2015, even though she requested

standard medical disposition. After her procedure, she felt violated, traumatized and deprived of her autonomy. Faced with the Hobson's choice of foregoing needed medical care—which would have included removing her IV and walking out of the hospital with no plan for how to address her health needs or move forward with her grieving process—she was coerced into a burial she felt was perverse. That experience not only violated her beliefs and hindered her grieving, it also violated her trust in the patient-provider relationship significantly enough that, when she became pregnant again, she sought a new ob/gyn to replace the one who had not told her in advance about the policy, and who worked at a hospital that did not mandate burial of EFTR.

99. For the same reasons, Karen Swenson, an Austin ob/gyn, has stopped scheduling miscarriage management procedures at a hospital that requires burial of EFTR. One of her patients—a Muslim woman—became greatly distressed after being told about the requirement and delayed her procedure to seek spiritual guidance from her imam. Several other patients in Dr. Swenson's practice expressed opposition to the requirement. To protect their patients, Dr. Swenson and her practice partners now perform procedures requiring disposition of EFTR elsewhere.

Requiring patients to have their EFTR disposed of in a manner not respectful of their beliefs or healthcare choices violates their dignity.

100. To date, twelve cemeteries, three funeral homes, and one non-profit organization have joined the Registry. Each of the twelve cemeteries is sectarian and morally opposed to abortion. Some of these cemeteries intend to provide commemoration or conduct ceremonies regarding EFTR, and some advocated for the Act's passage in order to have the opportunity to do so.

101. It does not promote the dignity of an abortion patient for her or her healthcare provider to coordinate with a service provider morally opposed to her choice of an abortion for the disposal of her EFTR. To the contrary, doing so would cause some patients great concern,

grief, and worry, and subject them to the unwelcome moral disapproval and judgment of people who do not know them.[10]

102. Likewise, if a patient does not share a cemetery's religious affiliation, or does not approve of having her EFTR commemorated or solemnized by that cemetery, then it undermines her dignity for the cemetery to do so against her will.

103. Cemeteries and funeral homes keep records of the names of the patients whose EFTR they cremate or inter. Disposing of tissue through cemeteries and funeral homes therefore implies that patient names will be given to third parties. Disclosing the name of a patient to strangers without her consent—especially strangers who may judge or condemn her choice of medical care, or provide her name to others who might—does not promote dignity. To the contrary, such a violation of patient privacy understandably concerns and worries patients.

104. Further, the Act does not prevent cemeteries and funeral homes from marking the graves or otherwise disclosing patient names to third parties. In fact, it establishes no privacy safeguards at all.[11]

Various practices consistent with the Act are inconsistent with widely-held notions of dignity

105. Dignity is a universal value, but what constitutes dignity in a particular circumstance can be subjective.

106. For instance, although the Act prohibits disposal of ashes in the place they are typically sent—a sanitary landfill—ashes may be scattered on virtually any other privately-owned location with the owner's consent, including a scrapyard or parking lot. The Defendant has also argued that healthcare facilities could store co-mingled tissue from thousands of

[10] The Texas Legislature explicitly rejected a proposed amendment to the Act that would have created an exception for persons for whom "compliance would violate a sincerely held religious belief of the person."

[11] The Implementing Regulation states that it does not authorize the disclosure of information confidential under "state or federal privacy or confidentiality laws." 25 Tex. Admin. Code, §138.4(a). This is but a restatement of the truism that an administrative regulation cannot override a state or federal statute.

abortions or miscarriages in a freezer together for up to a year, and then cremate it and deposit the ashes jointly in a mass grave, a practice that would strike many people as undignified.

107. Reputable funeral homes are unwilling to dispose of EFTR absent patient consent, as this would violate their professional norms and expose their reputations to harm within the community.

B. The Act Burdens Reproductive Healthcare Providers, to their Patients' Detriment.

The Act is a burden on providers of reproductive healthcare

108. The Act imposes compliance challenges on the providers of reproductive healthcare. Attempting to meet these challenges detracts from their ability to provide healthcare to their patients.

109. Healthcare facilities do not transport, treat, or dispose of medical waste themselves; they do so through a vendor. A vendor is thus necessary for a healthcare facility to be able to operate.

110. To comply with the Act, healthcare facilities must therefore find and maintain a relationship with one or multiple vendors willing and able to transport, treat, and dispose of EFTR through interment or cremation. In addition, they will need to maintain a relationship with a vendor that can dispose of all the other forms of regulated waste generated by a medical facility—such as sharps, human tissue other than EFTR, and other contaminated, disposable items. Funeral home licenses awarded by the Texas Funeral Service Commission do not grant permission to dispose of these items. Finding and maintaining a relationship with a vendor takes staff time and resources away from patient care.

111. Finding and maintaining a waste disposal vendor is a particular challenge for abortion providers. Anti-abortion activists have long identified medical waste disposal as a "weak link" in abortion clinic operations and sought to close clinics down by depriving them of the ability to transport, treat, and dispose of medical waste. The activities of anti-abortion activists aimed at vendors can cause them to refuse to do business with Plaintiffs. Whole

Woman's Health has had three waste disposal vendors refuse to do business with them for this reason in recent years. Brookside Women's Medical Center has had two, including one who started work and then ceased almost immediately after one of its drivers was followed and harassed. After that, it took Brookside nearly two months to find a replacement, and the clinic came within a few weeks of suspending operations. Plaintiffs are not aware of any vendor within the state of Texas, other than their current one, who is willing to transport, treat, and dispose of their medical waste, including EFTR.

112. It is economically precarious for clinics to be tied to a limited pool of vendors of a legally-required service. The pool required by the Act will remain especially limited as long as crematoriums cannot legally cremate EFTR.

113. Moreover, even if clinics are able to find a willing and able vendor, being tied to a limited pool makes clinics' futures seems uncertain, and consequently they find it harder to obtain loans, hire and retain employees, and engage in other activities that any healthcare provider must do to remain operational.

114. If no vendors of this service are available, clinics would close.

115. The Act's establishment of the Registry does not fix this problem.

116. Registered organizations are not required to be reliable partners for healthcare facilities. They are under no obligation to enter into a contract with healthcare facilities. HHSC has established no criteria for inclusion on the registry, other than checking a box labeled "free/low-cost transportation, burial, or cremation services," "financial assistance," or "other." HHSC has not even defined those key terms, such as what "services" qualify, if those services include transportation and treatment in addition to disposal, what "low-cost" means, and what "other" refers to. HHSC likewise does not undertake any verification or oversight to ensure registered organizations are actually willing and able to provide services that comply with the law, nor what quantity of services. HHSC does not even verify that registered organizations have provided accurate information by which they may be contacted.

117. As a result, some registrants only offer services to individuals in their immediate community, or impose other criteria that prevent them from serving all of a healthcare providers' patients, let alone the tens or hundreds of thousands that would require services statewide every year. Many of the registered organizations also do not provide all the services necessary to dispose of EFTR—for example, they can only accept for burial ash that has been cremated elsewhere, or they do not offer transportation.[12]

118. Even so, the Registry has struggled to attract providers. At last year's preliminary injunction hearing, Jennifer Allmon, the Executive Director of the Texas Conference of Catholic Bishops, testified that each of the State's Roman Catholic dioceses would identify a cemetery willing to offer disposal of cremated EFTR for free, but a year and a half later, numerous dioceses still have not done so. And although cemeteries that are ideologically opposed to abortion are not good partners for abortion providers or their patients, no non-sectarian cemeteries have registered.

119. The Grant Program has also not stimulated the availability of services. No money has been donated to the Grant Program, and as a consequence it has not made a single grant.

The Act's burdens are imposed unequally on similar reproductive healthcare choices.

120. The Act does not apply to all tissue from embryos and fetuses in healthcare settings. Its burdens are imposed only on providers of certain forms of healthcare, and thus only patients who make certain healthcare choices.

121. The Act only applies to embryonic or fetal tissue "from a pregnancy." It thus does not apply to pre-implantation embryos—embryos fertilized outside of a person's body as part of in vitro fertilization ("IVF"), and which have not been implanted into a person's uterus,

[12] This is true by definition of registered funeral homes and non-profit organizations, who do not provide a place for the final disposition of tissue or ashes. These must be sent to a cemetery or some other authorized location.

commencing a pregnancy. Pre-implantation embryos that die in vitro or are surplus and are disposed of are not subject to the Act.

122. Likewise, the Act does not apply to EFTR from a healthcare facility that is subsequently sent to a pathology lab for testing.[13]

123. Thus, individuals' IVF procedures, as well as surgical abortion and miscarriage management procedures which are followed by being sent for pathological testing, are exempt from the burdens imposed by the Act. But other procedures to terminate a pregnancy, or treat ectopic pregnancy or miscarriage, are subject to the Act.

124. There are no characteristics relevant to "respect for unborn life" that would distinguish between an embryo before and after implantation, nor between EFTR that is to be sent for pathological testing, and EFTR that is not.

C. The Act Does Not Promote Health or Patient Choice.

125. The Act does not improve the safety of any procedure nor improve protections for the public health.

126. The Act does not promote patient choice. Patients who wished to inter or cremate their EFTR could do so under prior law. Plaintiffs facilitated this for their patients.

127. The Act does not require healthcare providers to discuss disposition options with their patients, and the State has encouraged Plaintiffs not to inform their patients about the Act's requirements.

PROPOSED CONCLUSIONS OF LAW

128. The Act violates the Due Process and Equal Protection clauses of the Fourteenth Amendment to the United States Constitution and must be permanently enjoined, along with the Implementing Regulation.

[13] Such testing might be done to determine the cause of a miscarriage or the successful outcome of a procedure.

I. The Act is an Unconstitutional Deprivation of Liberty.

A. The Due Process Clause Protects the Right to Make Personal Choices Central to Dignity and Autonomy.

129. Due Process protects "all fundamental rights comprised within the term liberty." *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 847 (1992) (quoting *Whitney v. California*, 274 U.S. 357, 373 (1927) (Brandeis, J., concurring)). This extends to "personal choices central to individual dignity and autonomy, including intimate choices that define personal identity and beliefs." *Obergefell v. Hodges*, 135 S. Ct. 2584, 2597 (2015).

130. Among these choices are the definitions of one's own moral beliefs, including "[t]he right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." *Casey*, 505 U.S. at 851. *See also Masterpiece Cakeshop v. Colo. Civ. R. Comm'n*, 138 S. Ct. 1719, 1731 (2018) (reversing State determination that individual beliefs may be proscribed as "offensive"). Others include "choices concerning contraception, family relationships, procreation, . . . childrearing," *Obergefell*, 135 S. Ct. at 2599, and "medical treatment," *Casey*, 505 U.S. at 857. *See also id*. at 896 (It is "the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." (quoting *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972)); *Carey v. Population Servs., Int'l*, 431 U.S. 678, 687 (1977) ("[T]he Constitution protects individual decisions in matters of childbearing from unjustified intrusion by the State."). Such choices "are central to the liberty protected by the Fourteenth Amendment." *Casey*, 505 U.S. at 851.

131. The Supreme Court's precedents have long recognized that a State may not force its views about controversial matters onto unwilling individuals. *See, e.g.*, *Masterpiece Cakeshop*, 138 S. Ct. at 1731 (a State may not "send[] a signal of official disapproval of [an individual's] religious beliefs" nor justify differential treatment "based on the government's own assessment of [their] offensiveness."); *Lawrence v. Texas*, 539 U.S. 558, 577 (2003) ("[T]he fact that the governing majority in a State has traditionally viewed a particular practice as immoral is not a sufficient reason for upholding a law prohibiting the practice . . . ." (internal quotation

marks omitted)); *Casey*, 505 U.S. at 851 ("At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State."); *West Virginia State Bd. Of Educ. v. Barnette*, 319 U.S. 624, 642 (1943) ("If there is any fixed star in our constitutional constellation, it is that no official, high or petty, can prescribe what shall be orthodox in politics, nationalism, religion, or other matters of opinion or force citizens to confess by word or act their faith therein."). The Court has further explained that its own "obligation is to define the liberty of all, not to mandate our own moral code." *Lawrence*, 539 U.S. at 571 (quoting *Casey*, 505 U.S. at 850).

B. The Act Imposes an Undue Burden on Women's Liberty.

132. The Act violates the Constitution's prohibition against State interferences in these matters. It infringes on personal choices central to dignity and autonomy, including the freedom of belief and the freedom to form a family. It imposes on individuals' diverse range of beliefs, informed by religion, conscience, science, and individual circumstance, the State's narrow view that an embryo or fetus should be treated in a manner associated with people. It requires individuals who become or wish to become pregnant to face the risk that the State will force their embryo or fetus to be treated this way, regardless of whether this violates their beliefs. They must therefore account for this risk in making their plans about conceiving a child and seeking pregnancy-related medical care.

133. In contrast to the provisions upheld in *Casey*, intended to "inform, . . . not hinder" a woman's choice, the Act here is compulsory and invasive. It deprives women and their families of the autonomy to make a decision for themselves regarding the status of EFTR, and then to act on that determination.

134. There is no dispute that, when allowed to exercise their autonomy, many women do not view their fetus or embryo as like a person, and do not choose interment or cremation after a miscarriage or an abortion. *Supra* ¶¶ 79-89. Nevertheless, the Act imposes the State's

view that the tissue of an embryo or fetus should be disposed of by interment or cremation, in a manner associated with human remains.

135. The Act mandates adherence to a particular belief, which is not universal, defining the dignity of an embryo or fetus as requiring interment or cremation in the manner of human remains. *Supra* ¶¶ 62-78. By imposing the State's viewpoint, the Act intrudes into the "realm of personal liberty" protected by the Constitution, *Casey*, 505 U.S. at 847. Moreover, the State's establishment of the Registry has, in practice, provided disposition options solely through sectarian entities opposed to abortion. *Supra* ¶ 101. Coercing women to ultimately rely for their healthcare on cooperation from groups who disagree with or may condemn their choices magnifies the violation. *See Planned Parenthood Minn., N.D., S.D. v. Daugaard*, 799 F. Supp. 2d 1048, 1060 (D.S.D. 2011) (forcing a woman to work with an anti-abortion counselor to have an abortion "humiliates and degrades her as a human being").

136. The individual liberty protected by the Due Process Clause specifically encompasses "the right of the woman to choose to have an abortion before viability and to obtain it without undue interference from the State." *Casey*, 505 U.S. at 846. This right protects more than mere access to abortion. It protects a woman's autonomy to make decisions about her body based on "her own conception of her spiritual imperatives and her place in society." *Id.* at 852. The Supreme Court's reproductive healthcare jurisprudence makes clear that, while a State may seek to persuade a woman to adopt its views about personhood or abortion, it may not override her autonomy with regard to these matters. *See id.* at 851-53, 877.

137. Restrictions on the practice of abortion are unconstitutional where they impose an "undue burden" on abortion access. *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309 (2106) (hereafter, *Whole Woman's Health I*) (quoting *Casey*, 505 U.S. at 878). The Constitution's limits on government power to interfere with women seeking treatment for miscarriage and ectopic pregnancy are at least as stringent as those regarding abortion. *See generally Casey*, 505 U.S. at 851.

138. The undue burden standard "requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer." *Whole Woman's Health I*, 136 S. Ct. at 2309 (citing *Casey*, 505 U.S. at 887-98). A court must "consider[] the evidence in the record," and "then weigh[] the asserted benefits against the burdens." *Id.* at 2310. Where a law fails to confer "benefits sufficient to justify the burdens," those burdens are "undue"—that is to say, unconstitutional. *Id.* at 2300.

139. Applying the undue burden standard requires searching judicial scrutiny. *Id*. at 2310 ("[T]he Court . . . has placed considerable weight upon evidence and argument presented in judicial proceedings."). In evaluating a restriction's benefits and burdens, courts must rely on record evidence, and not simply a State's assertions about any purported benefits or burdens. *Id.* at 2309-10 (explaining that, where "regulation of a constitutionally protected personal liberty . . . is at issue," the "less strict review" applicable to economic legislation is not appropriate). The record must show a law actually "further[s]" the government's asserted interest, *id.* at 2310, and the State may not advance justifications for a law that are pretextual, *see Casey*, 505 U.S. at 877, or absent from the legislative record, *see United States v. Virginia*, 518 U.S. 515, 533 (1996) ("The justification must be genuine, not hypothesized or invented *post hoc* in response to litigation.").

140. Further, "the means chosen by the State to further the interest in potential life must be calculated to inform the woman's free choice, not hinder it." *Casey*, 505 U.S. at 877.

141. To survive scrutiny under the undue burden standard, a law that burdens abortion access must advance a legitimate state interest in a permissible way. *E.g.*, *Whole Woman's Health I*, 136 S. Ct. at 2311 ("We have found nothing in Texas' record evidence that shows that, compared to prior law, . . . the new law advanced Texas' legitimate interest in protecting women's health."); *id.* at 2311-12 ("[W]hen directly asked at oral argument whether Texas knew of a single instance in which the new requirement would have helped even one woman obtain better treatment, Texas admitted that there was no evidence in the record of such a case."); *id.* at 2315 ("There is considerable evidence in the record supporting the District Court's findings

indicating that the statutory provision requiring all abortion facilities to meet all surgical-center standards does not benefit patients and is not necessary."); *see also id.* at 2314 ("The record contains nothing to suggest that H.B. 2 would be more effective than pre-existing Texas law . . .").

The Act does not permissibly further an interest in respect for unborn life.

142. The Act's stated purpose is "to express the state's profound respect for the life of the unborn by providing for a dignified disposition of embryonic and fetal tissue remains." Texas Health & Safety Code § 697.001.

143. *Casey* holds that States may further an interest in "potential life" when regulating abortion, provided that they further this interest by means "calculated to inform the woman's free choice, not hinder it." 505 U.S. at 876-78.

144. There is nothing informative about the Act. Indeed, it permits healthcare providers to keep women in the dark about the requirements it imposes.

145. Rather, the Act is coercive. It imposes a legal definition of "dignity" that is far from universal, preventing people from forming and acting on their own beliefs about the status of their embryo or fetus. It imposes the State's own view of what dignity requires on the diversity of individual beliefs held and circumstances faced by Texas women. For women subject to the law, it permits only one course of action—consistent with the State's view that EFTR is akin to human remains—no matter if a woman's personal moral or religious beliefs do not lead her to view her embryo or fetus as the State does.

146. Thus, it does not advance the State's interest in potential life in a permissible way.

147. Other courts have concluded that this does not further any legitimate state interest. For example, the Southern District of Indiana recently struck down an Indiana law requiring burial or cremation of embryonic or fetal tissue, akin to the Act, holding it failed to further a legitimate state interest. *Planned Parenthood of Indiana & Kentucky, Inc. v. Comm'r, Indiana State Dep't of Health*, 265 F. Supp. 3d 859, 871 (S.D. Ind. 2017) ("Whether or not an individual views fetal tissue as essentially the same as human remains is each person's own personal and

moral decision. . . . The Court cannot resolve this moral question. But as a *legal* question, there is currently no basis which would allow this Court to recognize fetal tissue as a human being, and therefore analogous to human remains . . . . Although the Supreme Court has recognized a legitimate governmental interest in promoting the life of a fetus during a pregnancy, such an interest is always tethered to the notion that the fetus represents a potential life and the State can legitimately promote respect for that potentiality. The Supreme Court has extended these principles no further than that, and the State has not provided a basis so that this Court can do otherwise.") (citations omitted) (appeal on review en banc pending No. 17-3163, 2018 WL 2771362 (7th Cir. June 8, 2018)).[14]

148. Likewise, the Eastern District of Louisiana struck down a comparable requirement, which had provided that "the remains of the unborn child [be] disposed of in a manner consistent with the disposal of other human remains as provided by [Louisiana law]." *Margaret S. v. Edwards*, 488 F. Supp. 181, 221-22 (E.D. La. 1980) ("[T]his Court holds that [the challenged statute] is an unconstitutional exercise of the State's police power because it requires that fetal remains be treated with the same dignity as the remains of a person and, thereby, unduly burdens the right of a woman to obtain an abortion.").

149. Similarly, the Eastern District of Arkansas has preliminarily enjoined a statute requiring abortion providers to dispose of embryonic and fetal tissue following the protocols established by Arkansas law for disposing of human remains. *Hopkins v. Jegley*, 267 F. Supp. 3d 1024, 1105 (E.D. Ark. 2017) (finding "any interest the State has in potential life [cannot] support the Tissue Disposal Mandate because it applies to tissue disposal after an abortion or

[14] *Gonzales v. Carhart*, 550 U.S. 124 (2007), is consistent with this holding. *Gonzales* upheld a ban on a method of aborting "a living fetus," *id.* at 164 (quoting 18 U.S.C. § 1531(b)(1)(A)), recognizing a legitimate state interest in "regulating the medical profession in order to promote respect for life, including life of the unborn," *id.* at 158. The federal statute under review permitted the banned procedure in cases where fetal demise had occurred prior to its commencement. *See id.* at 164. As a result, the Court did not consider whether the Government's interest could justify regulation of conduct that occurred subsequent to fetal demise.

miscarriage, when there is no 'potential life.'"), *appeal filed* No. 17-2879 (8th Cir. Aug. 28, 2017).[15]

150. Because the Act fails to further any interest in potential life in a permissible way, but rather infringes the right to make personal choices central to dignity and autonomy, *supra* ¶¶ 90-93, the weight from this interest in the *Whole Woman's Health* balancing must be zero.

The Act does not fit the State's asserted interest in respect for unborn life.

151. The poor fit between the Act and the range of circumstances in which the State's purported interest in respect for unborn life would also perforce arise highlights the Act's failure to further the State's purported interest. *Cf. Veasey v. Abbott*, 830 F.3d 216, 262 (5th Cir. 2016) (en banc) (even where a State's interest is legitimate, "there cannot be a total disconnect between the State's announced interests and the statute enacted"). The Act does not apply to disposal of embryonic or fetal tissue in a variety of healthcare contexts, notably including IVF clinics, and to any tissue sent for pathological testing—even though there is no logical way to distinguish the State's interest in these circumstances. *Supra* ¶ 125.

152. The Act also does not apply to human remains, further belying the State's assertion of an interest in respect for life through the Act. As discussed *supra* ¶ 38, Texas law does not impose liability on healthcare providers regarding the handling of human remains. Moreover, the State has repeatedly declined to waive its sovereign immunity and assume liability for its own undignified disposition of human remains. *E.g. Robinson v. Univ. of Texas Med. Branch at Galveston*, 171 S.W.3d 365, 370 (Tex. Ct. App. 2005) (commingling of cremation ashes against wishes of deceased and next of kin); *Noah v. Univ. of Texas Med. Branch at Galveston*, 176 S.W.3d 350 (Tex. Ct. App. 2004) (losing fourteen bodies); *Univ. of Texas Med. Branch at Galveston v. Harrison*, No. 14-02-01276-CV, 2003 WL 21803314, at *3 (Tex. Ct.

[15] In contrast, the Eighth Circuit upheld a law requiring disposition of fetal tissue by burial, cremation, "or in a manner directed by the commissioner of health," based on a concession by the plaintiffs that "the state has a legitimate interest in protecting public sensibilities." *Planned Parenthood of Minn. v. Minn.*, 910 F.2d 479, 483, 488 (8th Cir. 1990). Plaintiffs make no such concession here, and Defendant does not defend the Act on this basis.

App. Aug. 7, 2003) (selling body parts for profit). Yet there is no logical way to distinguish the respect owed to human remains as less than that owed to EFTR.

153. The Act simply creates a unique scheme of liability, imposed only on providers of certain forms of pregnancy-related healthcare, and not in analogous situations where the state should have an equal interest. This is inconsistent with the State's assertion that the Act fits the State's interest in respect for unborn life.

The Burdens Imposed by the Act Exceed the Benefits It Provides.

154. As detailed above, the Act imposes significant burdens on women's liberty. *See supra* ¶¶ 79-120.

155. An individual has the right to decide for herself whether an embryo or fetal tissue is to be treated in a manner associated with people. *See Casey*, 505 U.S. at 851 (the "defin[ition of] the attributes of personhood [may not be] formed under compulsion of the State."); *see also Carey*, 431 U.S. at 687 ("[T]he Constitution protects individual decisions in matters of childbearing from unjustified intrusion by the State."); *cf. Barnette*, 319 U.S. at 642.

156. The Act replaces this right "[a]t the heart of liberty" with a viewpoint "formed under compulsion of the State." *Casey*, 505 U.S. at 851.

157. The Act imposes the State's belief regarding the status of embryos and fetuses on individuals' diverse range of moral beliefs—beliefs shaped by religion and conscience, and integral to individual identity and to the making of the most important and intimate life choices. *Supra* ¶¶ 62-65. It deprives individuals of their freedom to decide for themselves whether their embryo or fetus should be treated in a manner associated with people. *Supra* ¶¶ 65, 96. The Act compel people who hold different views from the State about a belief that the Constitution leaves to individual determination to acquiesce to the State's view. The Act will force healthcare providers to act as though their patients have no autonomy or moral judgment—as if they cannot determine right from wrong in accordance with their own personal, cultural, and religious beliefs and act accordingly. *See supra* ¶¶ 90-96.

158. Further, the Act will impose grief, stress, shame, and stigma on people who seek pregnancy-related healthcare, but do not share the State's belief. *Supra* ¶¶ 94-99. It may discourage some from seeking pregnancy-related medical care they would otherwise have chosen, because they wish to avoid the Act's harms. *See supra* ¶¶ 98-99. It jeopardizes people's privacy disclosures to third parties. *Supra* ¶¶ 104-105.

159. The Act also threatens women's healthcare access and raises barriers to care. It threatens the viability of abortion clinics in Texas by tying them to a limited and unreliable pool of vendors of a required service. *Supra* ¶¶ 112-119. It redirects healthcare providers' resources from patient care to medically-irrelevant matters. *Supra* ¶ 111.

160. These burdens on freedom of belief, on the freedom to form a family, and on women's health and wellbeing are not justified by sufficiently weighty benefits. Indeed, the Act does not further any legitimate state interest in a permissible way. *Supra* ¶¶ 143-147.

161. As the Act imposes burdens, but no legitimate benefits, it is an unconstitutional infringement of women's liberty. *See Whole Woman's Health I*, 136 S. Ct. at 2309.

II. The Act Unconstitutionally Classifies Among Similarly-Situated Forms of Pregnancy-Related Healthcare.

162. The Equal Protection Clause of the Fourteenth Amendment commands that no State shall "deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. Amend. XIV. States may not establish legislative classifications discriminating against individuals exercising a fundamental constitutional right, or members of a protected class, absent exceedingly weighty justification. *See generally City of Cleburne, Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 440 (1985) ("[W]hen a statute classifies by race, alienage, or national origin . . . [it is] subjected to strict scrutiny and will be sustained only if they are suitably tailored to serve a compelling state interest. Similar oversight by the courts is due when state laws impinge on personal rights protected by the Constitution."). Under heightened scrutiny, a classification must "fit the compelling goal so closely that there is little or no possibility that the motive for the classification was illegitimate . . ." *Grutter v. Bollinger*, 539 U.S. 306, 333 (2003) (citation and

internal punctuation omitted); *see also Eisenstadt*, 405 U.S. at 454 ("there is no more effective practical guaranty against arbitrary and unreasonable government than to require that the principles of law which officials would impose upon a minority must be imposed generally. Conversely, nothing opens the door to arbitrary action so effectively as to allow those officials to pick and choose only a few to whom they will apply legislation and thus to escape the political retribution that might be visited upon them if larger numbers were affected.").

163. Even where a classification does not target a suspect class or a protected constitutional right, at minimum it must be based on a unique characteristic of the targeted group that is related to the State's interest in the law. *City of Cleburne*, 473 U.S. at 448 ("[The] difference [between "the mentally retarded" and others who live in institutional settings] is largely irrelevant unless the [group] home and those who would occupy it would threaten legitimate interests of the city in a way that other permitted uses such as boarding houses and hospitals would not."). Thus, even under the most deferential level of scrutiny, the Equal Protection clause requires that "all persons similarly situated should be treated alike." *Id*. at 439.

164. As discussed *supra* ¶¶ 121-24, the Act classifies among reproductive healthcare choices requiring the disposition of EFTR, imposing obligations as to some, but not others. Notably, the Act exempts from its requirements all preimplantation embryos, such as unused embryos disposed of after IVF, and EFTR sent for pathological testing.

165. The Act thus classifies among similarly-situated healthcare choices, all of which require disposition of EFTR. On one hand, EFTR from procedures for abortion, miscarriage management, or ectopic pregnancy treatment, where no off-site pathological testing is done, must be interred or cremated. On the other, IVF, and abortion, miscarriage management, or ectopic pregnancy treatment procedures when followed by sending EFTR for pathological testing, do not have interment or cremation imposed upon them.

166. By virtue of this, the Act also imposes no obligations on IVF clinics nor any healthcare facilities that send all their EFTR for pathological testing.

167. Heightened scrutiny applies to this classification, because the Act impinges on the fundamental constitutional right to make "personal choices central to individual dignity and autonomy, including intimate choices that define personal identity and beliefs." *Obergefell*, 135 S. Ct. at 2597; *see also Masterpiece Cakeshop*, 138 S. Ct. at 1731 ("no official, high or petty, can prescribe what shall be orthodox in politics, nationalism, religion, or other matters of opinion, [and] it is not . . . the role of the State or its officials to prescribe what shall be offensive.") (citations omitted). *See also supra* ¶¶ 130-33.

168. As discussed *supra* ¶ 131, one such choice is to the choice to define one's own moral beliefs. *Casey*, 505 U.S. at 856; *Masterpiece Cakeshop*, 138 S. Ct. at 1731; *Lawrence*, 539 U.S. at 823. Thus, classifications impinging on the freedom of belief should receive heightened scrutiny. Another such choice is the decision of "whether to bear or beget a child." *Eisenstadt*, 405 U.S. at 453. *Accord, e.g., Lawrence*, 539 U.S. at 565. *See also supra* ¶ 131.

169. The Act's classification among similarly-situated reproductive healthcare options clearly impinges on both the choice of whether and how to form a family, and the choice to define personal identity and beliefs. As to the first, it burdens only a subset of individuals who are or wish to become pregnant: those who obtain a medical procedure that falls within the ambit of the Act. And as to the second, the Act imposes the State's belief that EFTR must be treated in a manner associated with human remains, on individuals' freedom to decide the status of their embryos and fetuses.

170. The Act fails heightened scrutiny because it is under-inclusive. For the purpose of "demonstrating profound respect [through] providing for a dignified disposition," there is no relevant difference between pre- and post-implantation embryos, nor between EFTR sent for pathological testing and other EFTR. Both are, by definition, the remains of an embryo or fetus.

171. Indeed, because there is no "real difference" between the affected and unaffected classes, the Act fails even the minimal relationship required to sustain it under any level of scrutiny. *See Cleburne*, 473 U.S. at 450. *See also June Med. Servs. LLC v. Gee*, 280 F. Supp. 3d 849, 868 (M.D. La. 2017) (declining to dismiss an Equal Protection claim against a Louisiana

law requiring burial or cremation after abortion, but not miscarriage, as this distinction shows "that [abortion] patients are singled out from women who are similarly situated."). *Cf. Planned Parenthood of Indiana & Kentucky, Inc.*, 265 F. Supp. 3d at 872 ("The Court sees no rational relationship between the State's purported goal—treating fetal tissue like human remains—and the law as written, given that it permits [disposal practices such as] the mass cremation of fetal tissue [not allowed for human remains]").

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on this 29th day of July, 2018, I electronically filed a copy of the foregoing document with the Clerk of the Court using the CM/ECF system, which will send notification to all counsel of record.

/s/ David Brown
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