No. 22-1362

In the United States Court of Appeals for the Eighth Circuit

Planned Parenthood Minnesota, North Dakota, South Dakota, and Sarah A. Traxler, M.D.,

Plaintiffs-Appellees,

v.

Kristi Noem, Governor, Joan Adam, Interim Secretary of Health, Department of Health, Philip Meyer, D.O., President, South Dakota Board of Medical and Osteopathic Examiners, in their official capacities,

Defendants-Appellants.

On Appeal from the United States District Court for the District of South Dakota
Civil Action No. 4:22-cv-04009-KES
Judge Karen E. Schreier

OPPOSITION TO MOTION TO STAY PRELIMINARY INJUNCTION PENDING APPEAL

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases ***Page(s)***

Rules ***Page(s)***

PRELIMINARY STATEMENT

For over twenty years, patients in South Dakota, like those nationwide, have had the option of choosing a safe, early abortion using medications alone. Yet in January 2022, the South Dakota Department of Health (the "Department") promulgated Rule 44:67:04:13 (the "Rule") which would end that option by making South Dakota the only state where patients must make three separate trips to meet with a physician at state-mandated time intervals—a requirement the state's only abortion provider cannot comply with. After thorough briefing and argument, the district court preliminarily enjoined the Rule, finding that Plaintiffs-Appellees (hereinafter "Appellees") made a clear showing that they were likely to succeed in proving its unconstitutionality.

Defendants-Appellants (hereinafter "Appellants") have appealed and now ask this Court for extraordinary relief: a stay pending appeal and expedited consideration of their appeal. But Appellants meet none of the required factors for a stay. Nor is there any reason to expedite the appeal, a briefing schedule for which has already been issued. Appeal Briefing Schedule Order 2. The only harm Appellants claim is their inability to enforce an unconstitutional administrative rule that is the first of its kind, furthers no health interest, and harms patients. In contrast, the preliminary injunction maintains the status quo and allows Appellees to continue practicing

medicine according to the universally-recognized standard of care, as they have always done. There is no reason this appeal should not proceed in due course.

Critically, Appellants have not shown that they are likely to succeed on the merits. Appellees clearly established the Rule's unconstitutionality on several bases: that it is not reasonably related to a legitimate government purpose under *June Medical Services L.L.C. v. Russo*, 140 S.Ct. 2103, 2138 (2020) (Roberts, C.J., concurring); that it will unduly burden a large fraction of patients using any numerator or denominator; and that it violates Equal Protection under any standard of review. Appellants have not made a "strong showing" that they are likely to succeed in challenging any of these holdings, much less all of them. *Hilton v. Braunskill*, 481 U.S. 770, 776 (1987).

Nor are Appellants any more likely to succeed on the other factors for a stay pending appeal. They have established neither irreparable harm nor any harm that outweighs that which would befall Appellees' patients. Indeed, Appellants seem to concede that the Rule—promulgated in the name of patient safety—is likely to harm patients, but claim they are entitled to a stay because not *enough* patients will be harmed. *See* Opp'n to Prelim. Inj., ECF No. 19, at 18; Ex. 2 to Stay Mot. 13 (hereinafter "Op."). Appellants' motions should be denied.

FACTUAL AND PROCEDURAL BACKGROUND

Appellee Planned Parenthood Minnesota, North Dakota, South Dakota ("PPMNS") is the only general abortion provider in South Dakota. It operates a clinic in Sioux Falls which provides medication abortions up to 11 weeks, as measured from the first day of the patient's last menstrual period ("LMP"), and procedural abortions up to 13.6 weeks LMP. Medication abortion refers to a regimen of two Food and Drug Administration ("FDA")-approved drugs taken 24–48 hours apart (mifepristone followed by misoprostol) to expel a pregnancy in a manner similar to miscarriage. About 40% of abortions performed at the Sioux Falls clinic are medication abortions. Op. 2.

Patients prefer medication abortion for a variety of reasons, including that it is less invasive, which is particularly important for survivors of rape, and that it offers more flexibility, which is particularly important for those trying to conceal their abortion from abusive partners or family members. Medication abortion is also safer and medically indicated for some patients. *Id*. at 5–6, 11. Current South Dakota law requires all patients seeking an abortion to make two in-person visits to the health center, at least 72 hours apart, excluding holidays and weekends. At the first visit, patients receive state-mandated counseling; at the second, patients who choose medication abortion receive both mifepristone and misoprostol, as well as follow-up information. Patients take the mifepristone in the clinic and 24–48 hours later, they

self-administer the misoprostol at a location of their choice. *Id.* at 3–5. About 24% of medication abortion patients travel more than 150 miles round trip to the clinic, and 11% travel more than 300 miles. Thirty-one percent of medication abortion patients have incomes below 110% of the federal poverty level, which was $14,168 for a family of one in 2021. *Id.* at 3. Nearly two-thirds of all abortion patients are already parents. *Id.* at 2.

Research shows that barriers to care delay, and in some cases prevent, people from accessing care, and that delay increases medical risks. *Id.* at 15–17. That is why, since mifepristone was approved in 2000, the standard of care has been for patients to obtain the two medications at the same time and self-administer the misoprostol. *Id.* at 11. Indeed, misoprostol is widely prescribed for other uses, including miscarriage, and the FDA has never placed any restrictions on its use.[1] While there is no evidence that taking misoprostol without first taking mifepristone is dangerous, the same is not true of taking mifepristone without misoprostol, which can lead to heightened risks of hemorrhage. *Id.* at 12.

Yet, on January 7, 2022, the Department promulgated a rule that would require medication abortion patients to make a third in-person visit to a health clinic

[1] The FDA has explicitly recognized that "[t]here is no medical rationale against permitting the woman to be given the misoprostol on the day of the initial clinic/office visit and self-administer it at a convenient time in the next 24–48 hours at home," and that, in fact, self-administration has several benefits. Op. 9–10.

24–72 hours after the second visit, solely to receive misoprostol.[2] This Rule was promulgated at the direction of Governor Noem allegedly in response to a change in the FDA's regulation of *mifepristone*.[3] *Id.* at 12–15. In an Executive Order, Governor Noem directed the Department to "begin emergency rulemaking to be implemented pursuant to the current FDA REMS." *Id.* at 12. As she recently stated, her goal was "just not making telemedicine, chemical abortions more available over the internet or over the phone with strangers," *Noem speaks on Haugaard's anti-abortion bill, critical race theory and marijuana,* Dakota News Now (Feb. 17, 2022), https://www.dakotanewsnow.com/2022/02/17/noem-speaks-haugaards-anti-abortion-bill-critical-race-theory-marijuana/. In issuing the Rule, the Secretary of the Department stated that the Rule was necessary "[t]o protect the health and safety of women that is at-risk due to the expected FDA lifting of additional safety protocols regarding the use of mifepristone and misoprostol." Op. 14.

However, the FDA has *never* imposed any restrictions on misoprostol and South Dakota's mandatory in-person visits already prevent the use of telemedicine for abortion, as Appellees informed Appellants at numerous hearings. The Rule,

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[2] The Rule also contains other provisions not at issue in this litigation. Ex. 1 to Stay Mot.

[3] Despite the safety and efficacy of medication abortion, the FDA has subjected mifepristone to a federal Risk Evaluation and Mitigation Strategy which, until recently, required "in-person dispensing" of mifepristone. Op. 9. In December 2021, the FDA indicated it would lift this requirement, which never applied to misoprostol.

therefore, has nothing to do with the FDA's changes to mifepristone regulation, nor with the Executive Order. Moreover, as Appellees and the South Dakota State Medical Association (which opposed the Rule) testified, it could put patients at increased risk of complications. Op. 32.

Appellees sued. The district court issued a Temporary Restraining Order, and, on February 8, after holding an evidentiary hearing and considering evidence from experts on both sides, it granted Appellees' motion for preliminary injunction in a thorough, 40-page opinion. It found that Appellees were likely to succeed on both their substantive due process and equal-protection claims. As to substantive due process, the court held that the Rule failed the "threshold requirement" that it be reasonably related to a legitimate purpose, *June Med.*, 140 S.Ct. at 2138 (Roberts, C.J., concurring), because "the FDA, which has never required in-person administration of misoprostol, has not recently made any change regarding misoprostol" and because "[n]othing in the Executive Order indicates a change in FDA regulations regarding misoprostol." Op. 26–28. Although it properly found that the Rule "should be enjoined on this basis alone," the court conducted an extensive analysis of the Rule's effects, concluding that it posed a substantial obstacle for a large fraction of patients. Op. 28, 31–33. The court also found that Appellees were likely to succeed on their equal-protection claim. *Id.* at 37–40. Turning to the

remaining factors—irreparable harm, balance of equities, and the public interest—the court found that these also favored a preliminary injunction. Op. 35–37.

Appellants filed a motion for stay pending appeal in the district court,[4] and appealed. This Court has set a briefing schedule with Appellants' brief due in approximately six weeks. But Appellants claim they also need emergency relief: a stay pending appeal, expedited briefing on the stay motion (which Appellees already opposed), and that their appeal be expedited. Appellants' requests should be denied.[5]

ARGUMENT

"A stay is an intrusion into the ordinary process[] of . . . judicial review, and . . . is not a matter of right." *Nken v. Holder*, 556 U.S. 418, 427 (2009) (cleaned up). It can only issue if four factors weigh in its favor: (1) a strong showing the applicant is likely to succeed on the merits; (2) irreparable injury absent a stay; (3) whether issuance of the stay will substantially injure other interested parties; and (4) the public interest. *Id.* at 425–26, 434. The most important factor is likelihood of success. *Brady v. Nat'l Football League*, 640 F.3d 785, 789 (8th Cir. 2011) (per curiam). "The party requesting a stay bears the burden of showing that the

[4] That motion—for which Appellants did not request expedited consideration—remains pending in the district court. Appellants have not shown that waiting for its decision is impracticable, Fed. R. App. P. 8(2)(A)(i), nor can they say that the district court failed to afford the relief requested, *id.* 8(2)(A)(ii).

[5] If the Court issues a stay, Appellees agree the appeal should be expedited as their and their patients' constitutional rights would be abridged every day the Rule is in effect.

circumstances justify [its entry]." *Nken*, 556 U.S. at 433–34. Appellants cannot meet that burden.

I. Appellants Have Not Made a Strong Showing of Success on the Merits

Appellants cannot make the required "strong showing" that they are likely to succeed on the merits. Instead, they rehash arguments that the district court properly rejected: maintaining that they are likely to succeed on appeal because the Rule is rationally related to a legitimate state interest, because it would not unduly burden a large fraction of patients, and because it complies with equal protection. The first argument misconstrues decades of abortion law; the second ignores the district court's well-supported factual findings; and the third waves away clear evidence of animus. All three should be rejected.

A. The Rule Is Not Reasonably Related to a Legitimate Purpose

The parties agree that this Court has adopted Chief Justice Roberts' *June Medical* concurrence under which an abortion regulation is unconstitutional if it fails a "threshold requirement" that it be "reasonably related" to a "legitimate purpose." *June Med.*, 140 S.Ct. at 2138; *see Hopkins v. Jegley*, 968 F.3d 912, 915 (8th Cir. 2020). The district court properly applied this test: it looked at "the purposes [of the Rule] as stated by the executive branch" and found that rather than further the state's interest, the Rule's "third appointment and time delay for misoprostol increase the risks to patients' health." Op. 28.

Appellants fault this conclusion, claiming that "[t]he district court's role is only to ask whether it is *possible to imagine* that the Rule might do something to advance the state's interests in patient safety." Stay Mot. 10. But the Supreme Court has never applied this extraordinarily deferential test to an abortion regulation. Indeed, Appellants' argument was squarely considered and rejected in *Whole Woman's Health v. Hellerstedt*, 136 S.Ct. 2292, 2309 (2016) ("[It] is wrong to equate the judicial review applicable to the regulation of a constitutionally protected personal liberty with the less strict review applicable where, for example, economic legislation is at issue." (citing *Williamson v. Lee Optical of Okla., Inc.*, 348 U.S. 483, 491 (1955))). In his *June Medical* concurrence, Chief Justice Roberts did not overrule any longstanding abortion jurisprudence, including *Hellerstedt*. 140 S.Ct. at 2138–39 ("We should respect the statement in *Whole Woman's Health* that it was applying the undue burden standard of *Casey*.").

Appellants confuse the order of events when they claim that the district court erred by considering *Hellerstedt*, *Gonzales v. Carhart*, 550 U.S. 124 (2007), and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 883 (1992) because "none of those cases were purporting to interpret or apply the 'threshold requirement' from Chief Justice Roberts's *June Medical* concurrence." Stay Mot. 6. As Chief Justice Roberts made clear, *he* was the one relying on these cases, particularly *Casey*, as setting out the relevant test; and, rather than "repudiate"

Hellerstedt, as Appellants suggest, *id.* at 7, the Chief Justice interpreted that case's analysis of benefits as *going to* the threshold requirement. *See June Med.*, 140 S.Ct. at 2138 (Roberts, C.J., concurring) (rejecting a balancing test of benefits and burdens and interpreting benefits as going to the "threshold requirement"). At no point did he suggest that *Hellerstedt* was wrong to reject rational basis review nor did he criticize the *June Medical* district court for making factual findings on the law's benefits.

The conclusion that some form of heightened scrutiny applies is inescapable.[6] As even the cases cited by Appellants confirm, the sort of rational basis review for which they advocate is not appropriate when fundamental rights are at stake. *See Friedman v. Rogers*, 440 U.S. 1, 17 (1979) (applying rational basis "[u]nless a classification trammels fundamental personal rights"); *Honeywell, Inc. v. Minn. Life & Health Ins. Guar. Ass'n*, 110 F.3d 547, 554–55 (8th Cir. 1997) (applying rational basis for "economic legislation"); *Parrish v. Mallinger*, 133 F.3d 612, 614–15 (8th Cir. 1998) (applying rational basis in part because no constitutional rights implicated); *Casbah, Inc. v. Thone*, 651 F.2d 551, 557 (8th Cir. 1981) (applying rational basis "[w]here no suspect classifications are involved and no fundamental

[6] Appellants make much of the fact that the district court did not name the standard it was using. Stay Mot. 8–9. Whether it is called reasonable relation, rational basis with bite, heightened or intermediate scrutiny, or something else entirely is irrelevant to its substance: the district court properly asked whether the Rule "further[s]" a legitimate state interest. Op. 23–28.

rights" were at issue). There can be no doubt that laws restricting abortion access implicate fundamental rights. *See, e.g.*, *Casey*, 505 U.S. at 834, 851 (the "decision whether to bear or beget a child" is one of those "fundamental[]" choices that is "central to the liberty protected by the Fourteenth Amendment" (quoting *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972))).

Therefore, courts must look at the available record evidence when determining whether an abortion restriction is "reasonably related to"—or "furthers"—the state's asserted purpose. *June Medical*, 140 S.Ct. at 2138 (Roberts, C.J., concurring) (quoting *Casey,* 505 U.S. at 878); *see also*, *e.g.*, *Gonzales*, 550 U.S. at 158 (2007) ("The Act's ban on abortions that involve partial delivery of a living fetus furthers the Government's objectives."); *Casey*, 505 U.S. at 900–901 (upholding recordkeeping and reporting requirements only after concluding they were "reasonably directed to the preservation of maternal health" (quoting *Planned Parenthood of Cent. Mo. v. Danforth,* 428 U.S. 52, 80 (1976))).[7] Nothing in the case law offers support for the bold assertion that courts no longer "retain[] an independent constitutional duty to review factual findings where constitutional

[7] Although Appellants are correct that the Sixth Circuit has found that rational basis review applies, *see EMW Women's Surgical Center, P.S.C. v. Friedlander*, 978 F.3d 418, 433 (6th Cir. 2020), that decision was wrongly decided. But even that court did not "imagine" its own rationale for the challenged restriction, but looked to the district court's factual findings. *See id.* at 439 ("The district court found that it is sometimes necessary to transfer a patient from an abortion facility to an emergency room because of an abortion-related complication.").

rights are at stake." *Gonzales*, 550 U.S. at 165. *Gonzales*'s guidance is not limited to mere "'findings' that appear in the Rule or any other enactment," Stay Mot. 8, but describes the court's general obligations when considering constitutional questions. *Gonzales*, 550 U.S. at 165 ("In cases brought to enforce constitutional rights, the judicial power of the United States necessarily extends to the independent determination of all questions, both of fact and law, necessary to the performance of that supreme function." (quoting *Crowell v. Benson*, 285 U.S. 22, 60 (1932))).

Properly applying this standard, as the district court did, there is no doubt that the Rule does not "further[] [a] valid state interest."[8] 505 U.S. at 877. As Appellants do not contest, requiring patients to return for a third visit for misoprostol is not reasonably related to the Executive Order.[9] Rather than further patient health, "the third appointment and time delay for misoprostol increase the risks to patients' health." Op. 28.

But even if this Court decides that rational basis applies, Appellees meet even this standard. Appellants provide three post-hoc rationales for the Rule: (1) it

[8] Although Appellants suggest that this language refers to the substantial obstacle "prong" of the undue burden analysis, Stay Mot. 6, a plain reading shows otherwise, as the phrase "while furthering . . . a valid state interest" appears as its own clause describing the term "statute." *Casey*, 505 U.S. at 877.

[9] The district court properly did not reach any post-hoc rationales for the Rule and this Court need not either. *See United States v. Virginia*, 518 U.S. 515, 533 (1996) (plurality opinion) (finding that "[t]he justification must be genuine, not hypothesized or invented *post hoc* in response to litigation," in an intermediate scrutiny analysis).

"ensure[s]" that a physician determines whether the patient has already aborted before administering the misoprostol; (2) it allows a physician to determine whether the patient is experiencing complications from taking mifepristone; and (3) it allows a physician to assess the patient's needs for pain control before the misoprostol is administered. Harrison Decl., ¶¶ 31–34, ECF No. 19-2; Stay Op. 9–10. But the Rule does not contemplate that physicians examine patients when they return for a third visit, much less determine whether they have already aborted (which would require an ultrasound or testing),[10] are experiencing complications, or need additional pain control. The Rule only mandates that a physician hand patients misoprostol. Even if courts need only "ask whether it is *possible to imagine* that the Rule might do something to advance the state's interest in patient safety," Stay Mot. 10, it is *impossible* to do so here. Rational basis review is not "toothless." *Kansas City Taxi Cab Drivers Ass'n, L.L.C. v. City of Kansas City*, 742 F.3d 807, 810–11 (8th Cir. 2013). Appellees are, therefore, likely to succeed on their claim that the Rule "fails to meet th[e] threshold requirement" and "should be enjoined on this basis alone." Op. 28.

[10] Appellants seem to think it notable that a minority of patients abort from just the first medication, but what is notable is that not even their expert considers a third visit to pick up misoprostol required for patient safety. Harrison Decl., ¶¶ 10–14, ECF No. 19-2.

B. The Rule Poses a Substantial Obstacle for a Large Fraction of Patients

Appellants have also failed to make a strong showing that the district court erred in holding that "Planned Parenthood has made a clear showing that the third appointment and mandatory delay impose substantial obstacles on a large fraction of relevant cases regardless of whether the relevant cases consist of all abortions in South Dakota or the smaller subset of medication abortions only."[11] Op. 34. As they did below, Appellants' arguments rest on the incorrect assumption that a substantial obstacle must be a complete one. Stay Mot. 12. Although this Court has held that the number of patients who forego an abortion may be *relevant*, *Planned Parenthood of Ark. & E. Okla v. Jegley*, 864 F.3d 953, 959 (8th Cir. 2017), it is not *determinative*. In fact, in *June Medical*, Chief Justice Roberts accepted the finding that "longer waiting times, and increased crowding," as well as increased travel times, all amounted to a substantial obstacle without finding that they prevented access altogether. 140 S.Ct. at 2140 (Roberts, C.J., concurring). The question is not whether this Court "would reach the same findings [as the district court] from the same record," but whether the district court committed "clear error." *June Med.*, 140 S.Ct. at 2141 (Roberts, C.J., concurring). It did not do so here.

[11] Appellants claim "the district court used the wrong denominator." Stay Mot. 11–12. But the district court found that the Rule was an undue burden using either the denominator Appellants criticize (patients seeking medication abortion) or that which they favor (all patients seeking abortion).

The district court found that 100% of medication abortion patients, or 40% of all abortion patients, would be impacted by the Rule because Appellees would not be able to comply, thereby eliminating medication abortion access. In support of their position that patients do not have a right to their "preferred method" of abortion, Appellants cite to *Gonzales* and *Whole Woman's Health v. Paxton*, 10 F.4th 430, 453 (5th Cir. 2021). Stay Mot. 12. But both of these involved bans on a procedural method of abortion based on the state's claimed interest in fetal life that left patients the option of another method that, from a patients' perspective, was very similar. Indeed, the *Gonzales* court specifically supported its conclusion that the ban did not impose an undue burden with the fact that comparable alternatives (including the *banned* method itself in some circumstances) were available. 550 U.S. at 164.[12] However, a medication abortion and a procedural abortion are not comparable. As the district court properly found, "procedural abortion[] is more invasive—a fact that imposes an obstacle for patients who prefer the flexible timing and lesser degree of bodily invasion of a medication abortion." Op. 31. Neither *Gonzales* nor *Paxton* permit what Appellants suggest South Dakota can do: force 40% of patients to have

[12] Even in *Gonzales*, the Court left open the possibility that certain patients could petition for as-applied relief, 550 U.S. at 124, which the district court also granted here, Op. 34–35 n.3, and which Appellants do not challenge in their motion.

a procedure in which instruments are inserted into their vaginas when they would prefer (and for some, it would be safer) to use medications alone.[13]

Even if this Court does not accept for purposes of this motion that the wholesale elimination of a safe, effective early method of first trimester abortion poses a substantial obstacle, Appellees also presented evidence that shifting to only providing procedural abortions would profoundly impact patients. Because procedural abortions take longer to complete, Appellees would need to reduce appointments by 30%, "congest[ing] Planned Parenthood's already busy schedule of procedural abortions, and thus [negatively affecting] . . . the availability of procedural abortions." Op. 36. Appellants' complaints about the district court's conclusion that this would burden a large fraction of patients are misplaced. Stay Mot. 16–17. As the district court explained, Planned Parenthood is the only provider in the state, it provides only first-trimester abortions, it is "already scheduling abortions four weeks out," and "[a]bortions are safer and lower risk when performed earlier in gestation." Op. 34. It was findings like these—not a "number or fraction" of patients, Stay Mot. 16—that led the Supreme Court to invalidate the regulations at issue in *June Medical* and *Hellerstedt*. *See June Med.*, 140 S.Ct. at 2140 (Roberts, C.J., concurring) (considering "longer waiting times for appointments," "increased

[13] Appellants also cite *Benten v. Kessler*, 505 U.S. 1084, 1084 (1992), but that case, which deals with the importation of mifepristone prior to FDA approval, has no bearing here.

crowding," "difficulty affording or arranging for transportation and childcare on the days of their clinic visits," and "[i]ncreased travel distance" (citations omitted)); *Hellerstedt*, 136 S.Ct. at 2318 (examining "long distances," "crammed-to-capacity superfacilities," and "waiting rooms so full, patients had to sit on the floor or wait outside"). As this Court has made clear, the large fraction calculation does not require the "mathematical precision" for which Appellants advocate. *Jegley*, 864 F.3d at 960.

And, if this Court believes that Appellees could continue to provide medication abortions under the Rule—a position Appellants do not take—Appellees have shown that 24% of medication abortion patients will need to travel over 450 miles total to obtain an abortion, and that the 39% of medication abortion patients who are at 110% of the Federal Poverty Level will face significant hurdles in accessing care. Op. 3, 32–33. Moreover, "[t]he requirement of a third appointment necessarily puts all medication abortion patients at greater risk of hemorrhage or other complications," and "[t]hose unnecessary risks are burdens in themselves." Op. 32. Appellants claim that the district court's analysis is "untenable" because "[a] court cannot facially enjoin the enforcement of an abortion regulation based on a harm that will befall only a small fraction of abortion patients." Stay Mot. 14. But it is Appellants' argument that is untenable because that is precisely what the Supreme Court did in *Casey* when it struck down a spousal notification law that "likely"

affected a "significant number of women" out of the *1%* of patients obtaining abortions for whom the law was relevant. 505 U.S. at 894; *see also June Med.*, 140 S.Ct. at 2137 (Roberts, C.J., concurring). Equally untenable is Appellants' stunning position that it is of no import that "some patients will miss or delay their follow-up appointment for misoprostol after ingesting mifeprex, putting them at risk of hemorrhage or other complications that can arise from failing to take misoprostol at the proper time," Stay Mot. 13 (emphasis omitted), just as long as not too many patients are harmed.

Finally, while Appellants accuse the district court of "rank speculation," *id.* at 16, they are the ones guilty of this offense, making numerous baseless assertions, including that "[m]any patients can easily make the extra trip"; that "[o]ther patients will switch to surgical abortion to avoid the extra travel"[14]; and that "abortion funds can defray the costs for indigent patients," among others. *Id.* at 14–16. There is *zero* evidence in the record from which to deduce these astounding conclusions.[15]

Quite the opposite, Appellees provided evidence from two experts to support the district court's well-reasoned conclusion that that the Rule will likely pose a

[14] As is clear from the district court opinion, the increased travel percentages reflect only medication abortion patients, contrary to Appellants' assertion. Op. 3.

[15] Appellants' claim that the district court's reliance on patients' poverty is "meaningless," Stay Mot. 15, also shows complete disregard for the lived experiences of low-income patients, most of whom who are parents, may have inflexible jobs, and are trying to navigate a labyrinth of restrictions. *See* Op. 33.

substantial obstacle to a "large fraction" of relevant patients using any numerator and any denominator. *See, e.g.*, *Planned Parenthood, Sioux Falls Clinic v. Miller*, 63 F.3d 1452, 1462 n.10 (8th Cir. 1995) (facially enjoining an abortion restriction in part because at least 18% of minors would have no bypass option).

C. The Rule Fails Equal Protection Review

Appellants have also not made a strong showing that the district court's Equal Protection holding was erroneous. Based on this Court's observation in *Planned Parenthood of Mid-Missouri & Eastern Kansas, Inc. v. Dempsey*, 167 F.3d 458, 464 (8th Cir. 1999), that "[s]ince *Casey*, we have applied the undue burden test in cases involving legislation that affects the right to abortion," the district court found that "the Rule's disparate treatment of misoprostol and abortion patients taking misoprostol violates the equal protection clause" because "the third appointment and mandatory delay required by the Rule are unnecessary regulations and constitute an undue burden on a patient's right to choose an abortion." Op. 38–39. Appellants' argument that "[m]edical necessity is irrelevant when applying the undue-burden standard," Stay Mot. 17, is belied by decades of precedent. *See* Section I.A, *supra*.

Separately, the district court properly concluded that the Rule does not pass rational basis review because it is completely divorced from the state's purported health justifications. *See* Op. 39. As the district court explained, "under the Rule, patients are allowed to self-administer misoprostol when taken for purposes other

than medication abortion," including to manage a miscarriage, despite that "the record clearly shows that misoprostol is safer when taken in the context of medication abortion than when taken for other medical purposes." *Id.*; *see also id.* at 11 ("Use of misoprostol to address incomplete abortion, management of postpartum hemorrhage, and miscarriage management involves a higher risk of bleeding than for use in a medication abortion."). In fact, miscarriage was initially covered by the Rule, but was removed following comments submitted by the South Dakota State Medical Association and others about the harms the Rule would cause. As a result, the Rule only applies to misoprostol used for abortion. Appellants claim this underinclusivity cannot be a basis on which to strike down the law, but as the Supreme Court found in *Romer v. Evans*, "[this] amendment seems inexplicable by anything but animus toward the class it affects." 517 U.S. 620, 632 (1996); *see also Ranschburg v. Toan,* 709 F.2d 1207, 1211 (8th Cir. 1983) ("An intent to discriminate is not a legitimate state interest."). For this reason as well, Appellants have failed to make the "strong showing" of success on the merits required for a stay pending appeal.

II. The Remaining Factors Weigh Against Issuing a Stay

The remaining three factors also weigh against a stay pending appeal. Any "irreparable harm" caused by not being able to enforce the Rule does not occur if "that [law] is unconstitutional." *Abbott v. Perez*, 138 S.Ct. 2305, 2324 (2018). On

the contrary, if the Rule goes into effect, Appellees and their patients will be deprived of their constitutional rights. Op. 35. "[T]hreatened injury to [constitutional rights] outweighs whatever damage the preliminary injunction may cause Defendants' inability to enforce what appears to be an unconstitutional statute." *Am. Civil Liberties Union v. Johnson*, 194 F.3d 1149, 1163 (10th Cir. 1999) (citation omitted). A stay would also harm the public interest. As the district court properly held, "[t]here is a public interest in protecting the right to choose an abortion. And the public has a clear interest in ensuring the supremacy of the United States Constitution. While the public also has an interest in the enforcement of state administrative rules, that interest is secondary to [these other interests]." Op. 37.

CONCLUSION

A stay is unwarranted in this case, as is expedited consideration of the appeal. Appellees respectfully request that Appellants' motions be denied.

Dated: February 28, 2022

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on February 28, 2022, I electronically filed the foregoing document with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit by using the CM/ECF system. I certify that counsel for the Defendants-Appellants are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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CERTIFICATE OF COMPLIANCE

This brief complies with: (1) the type-volume limitation of Federal Rule of Appellate Procedure 21(d) because it contains 5184 words, excluding the parts exempted by Rule 32(f); and (2) the typeface and type style requirements of Rule 32(a)(5) and Rule 32(a)(6) because it has been prepared in a proportionally spaced typeface (14-point Times New Roman) using Microsoft Word (the program used for the word count). This brief has been scanned for viruses and is virus-free.

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