**IN THE CIRCUIT COURT OF JACKSON COUNTY,**

**MISSOURI, AT KANSAS CITY**

**COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, PLANNED PARENTHOOD GREAT RIVERS-MISSOURI**

Plaintiffs,

v.

**THE STATE OF MISSOURI,**

Serve: Missouri Attorney General's Office, Supreme Court Building, 207 West High Street, Jefferson City, Missouri 65102;

**MICHAEL L. PARSON,** in his official capacity as Governor for the State of Missouri,

Serve: 201 West Capitol Avenue, Jefferson City, Missouri 65101;

**ANDREW BAILEY**, in his official capacity as Attorney General for the State of Missouri,

Serve: 207 West High Street, Jefferson City, Missouri 65102;

**DEPARTMENT OF HEALTH AND SENIOR SERVICES**

Serve: 930 Wildwood Drive, Jefferson City, Missouri 65109

**PAULA F. NICKELSON,** in her official capacity as Director of the Department of

No. _____

Health and Senior Services,

Serve: 930 Wildwood Drive, Jefferson City, Missouri 65109;

**MISSOURI DIVISION OF PROFESSIONAL REGISTRATION, BOARD OF REGISTRATION FOR THE HEALING ARTS**,

Serve: 3605 Missouri Boulevard, Jefferson City, Missouri 65102;

**JADE D. JAMES-HALBERT**, in her official capacity as a member of the Missouri Board of Registration for the Healing Arts,

Serve: 3605 Missouri Boulevard, Jefferson City, Missouri 65102;

**DOROTHY M. MUNCH**, in her official capacity as a member of the Missouri Board of Registration for the Healing Arts,

Serve: 3605 Missouri Boulevard, Jefferson City, Missouri 65102;

**JEFFREY D. CARTER**, in his official capacity as a member of the Missouri Board of Registration for the Healing Arts,

Serve: 3605 Missouri Boulevard, Jefferson City, Missouri 65102;

**IAN L. FAWKS**, in his official capacity as a member of the Missouri Board of Registration for the Healing Arts,

Serve: 3605 Missouri Boulevard, Jefferson City, Missouri 65102;

**NAVEED RAZZAQUE**, in his official capacity as a member of the Missouri Board of Registration for the Healing Arts,

Serve: 3605 Missouri Boulevard, Jefferson City, Missouri 65102;

**MARK K. TAORMINA**, in his official capacity as a member of the Missouri Board of Registration for the Healing Arts,

Serve: 3605 Missouri Boulevard, Jefferson City, Missouri 65102;

**CHRISTOPHER J. WILHELM**, in his official capacity as a member of the Missouri Board of Registration for the Healing Arts,

Serve: 3605 Missouri Boulevard, Jefferson City, Missouri 65102;

**MISSOURI DIVISION OF PROFESSIONAL REGISTRATION, BOARD OF NURSING**,

Serve: 3605 Missouri Boulevard, Jefferson City, Missouri 65102;

**JULIE MILLER**, in her official capacity as a member of the Missouri Board of Registration for Nursing,

Serve: 3605 Missouri Boulevard, Jefferson City, Missouri 65102;

**TREVOR J. WOLFE**, in his official capacity as a member of the Missouri Board of Registration for Nursing,

Serve: 3605 Missouri Boulevard, Jefferson

City, Missouri 65102;
**MARGARET BULTAS**, in her official capacity as a member of the Missouri Board of Registration for Nursing,

Serve: 3605 Missouri Boulevard, Jefferson City, Missouri 65102;

**BONNY KEHM**, in her official capacity as a member of the Missouri Board of Registration for Nursing,

Serve: 3605 Missouri Boulevard, Jefferson City, Missouri 65102;

**COURTNEY OWENS**, in her official capacity as a member of the Missouri Board of Registration for Nursing,

Serve: 3605 Missouri Boulevard, Jefferson City, Missouri 65102;

**DENISE WILLIAMS**, in her official capacity as a member of the Missouri Board of Registration for Nursing,

Serve: 3605 Missouri Boulevard, Jefferson City, Missouri 65102;

**JEAN PETERS BAKER**, in her official capacity as Jackson County Prosecuting Attorney and on behalf of a Defendant Class of all Missouri Prosecuting Attorneys,

Serve: 415 East 12th Street, 11th Floor Kansas City, Missouri 64106;

Defendants.[1]

[1] Because this lawsuit alleges that a statute is unconstitutional, a copy of this filing will be served on the Missouri Attorney General, Mo. Sup. Ct. R. 87.04, and notice will be

## PETITION FOR INJUNCTIVE AND DECLARATORY RELIEF

Plaintiffs Comprehensive Health of Planned Parenthood Great Plains and Planned Parenthood Great Rivers–Missouri hereby allege in this petition for injunctive and declaratory relief:

## INTRODUCTION

1. In 2022, on the same day the U.S. Supreme Court decided *Dobbs v. Jackson Women's Health Organization*, which overturned *Roe v. Wade* and its progeny, Missouri became one of the first states in the country to outlaw abortion altogether, stripping Missourians of the ability to make deeply personal, critical decisions about their health, bodies, lives, and futures.

2. Yet even in 2019, it was already nearly impossible to access abortion in Missouri. Due to a web of impenetrable, onerous, and medically unnecessary restrictions targeted at abortion providers, one of Planned Parenthood's two affiliates operating in Missouri had been forced to stop providing abortions entirely, and the other was reduced to providing abortions in a single health center in St. Louis, on the easternmost edge of the state, and on an extremely limited basis. If a Missourian wanted a medication abortion, they were out of luck, even if they could travel to St. Louis: medication abortion was unavailable because Missouri law required patients to undergo a medically unnecessary, invasive vaginal exam that providers could not

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provided to the speaker of the house of representatives and the president pro tempore of the senate within fourteen days of filing. § 1.185, RSMo. A motion to certify a defendant class is filed concurrently.

administer consistent with high-quality, patient-centered care. If a Missourian chose a procedural abortion, Missouri law required them to travel to St. Louis at least twice–for no medical reason. At their first appointment, patients had to endure a state-mandated biased information session, during which the physician who was going to provide the abortion was first forced to tell the patient in person that they were "terminat[ing] the life of a separate, unique, living human being." Then, the patient had to wait at least seventy-two hours before coming back to the health center for their abortion. This delay was often much longer due to the scarcity of physicians who could provide abortions in Missouri, a direct result of the State's pervasive criminalization.

3. But the voters of Missouri have said "enough." On November 5, 2024, Missourians voted to amend their Constitution to add the Right to Reproductive Freedom Initiative and protect the right to reproductive freedom, including the right to make decisions about abortion without governmental interference. This amendment returns reproductive health care decisions back to where they belong: with individuals and their trusted health care providers, not Missouri politicians.

4. No later than December 5, 2024, when the Right to Reproductive Freedom Initiative automatically takes effect, "[t]he right to reproductive freedom shall not be denied, interfered with, delayed, or otherwise restricted," except in very narrow circumstances, and "[a]ny denial, interference, delay, or restriction of the right to reproductive freedom shall be presumed invalid." Mo. Const. art. I, § 36.3.

5. This presumption plainly applies to the multiple, overlapping abortion bans on Missouri's books and its myriad abortion restrictions aimed precisely at making abortion as difficult to access as possible. The State has no compelling interest in any of these, much less a compelling interest that "has the limited effect of improving or maintaining the health of a person seeking care, is consistent with widely accepted clinical standards of practice and evidence-based medicine, and does not infringe on that person's autonomous decision-making," as the Right to Reproductive Freedom Initiative requires. Mo. Const. art. I, § 36.3. Indeed, evidence-based medicine shows that delaying and preventing abortion is *detrimental* to patient health.

6. Plaintiffs seek a declaration that Missouri's laws and regulations banning and restricting abortion, as set forth herein, are unconstitutional. Plaintiffs also seek preliminary and permanent injunctive relief preventing Defendants from enforcing these laws and regulations so that they may once more provide abortion in the state.

7. Absent relief from this Court, Plaintiffs, their patients, and their providers and staff will suffer irreparable harm: Plaintiffs' patients will be unable to exercise their constitutionally protected right to reproductive freedom and Plaintiffs, their providers and staff will be unable to assist in providing this constitutionally protected care.

## PARTIES

### I. Plaintiffs

8. Comprehensive Health of Planned Parenthood Great Plains ("Comp Health") is a not-for-profit corporation organized under the laws of Kansas and registered to do business in Missouri. Until 2018, Comp Health provided medication abortion up

to ten weeks gestational age, as measured from the first day of a patient's last menstrual period ("LMP"), and procedural abortion up to twenty-two weeks LMP at two health centers in Missouri. In 2018, Comp Health stopped providing abortions in Missouri because of Missouri's medically unnecessary and onerous regulations. Comp Health is prepared to offer both medication and procedural abortion in Missouri to the full extent allowed by law, if relief is granted in this case. Comp Health brings this suit on behalf of itself, its patients, and the physicians, providers, and staff whom it employs to provide services to patients.

9. Planned Parenthood Great Rivers-Missouri ("Great Rivers") is a not-for-profit corporation organized under the laws of Missouri that provides high-quality reproductive health care in Missouri. Great Rivers operates six health centers throughout Missouri, and provides contraception, adoption referral, and miscarriage management, as well as other sexual and reproductive health care to its patients. Until 2019, through a related organization, Reproductive Health Services of Planned Parenthood Great Rivers (then operating as Reproductive Health Services of Planned Parenthood of the St. Louis Region), Great Rivers provided medication abortion up to ten weeks LMP, and procedural abortion up to twenty-two weeks LMP. From Fall 2019 until the *Dobbs* decision, Reproductive Health Services of Planned Parenthood Great Rivers provided only procedural abortion because of Missouri's medically unnecessary and onerous regulations on medication abortion. Great Rivers is prepared to offer both medication and procedural abortion in Missouri to the full extent allowed by law, if relief is granted in this case. Great Rivers brings this suit on behalf of itself,

its patients, and the physicians, providers, and staff whom it employs to provide services to patients.

## II. Defendants

10. The State of Missouri is responsible for enforcement of the State's laws, including the abortion bans and restrictions that are challenged in this case.

11. Michael L. Parson is sued in his official capacity as the Governor of the State of Missouri. The supreme executive power is vested in the Governor. Mo. Const. art. IV, § 1. It is his duty to take care that the laws are faithfully executed in Missouri. Mo. Const. art. IV, § 2. Also under Article IV of the Missouri Constitution, Governor Parson is directly responsible for ensuring that all Missouri agencies, including the Missouri State Board of Registration for the Healing Arts (the "Board of Healing Arts"), the Missouri Board of Nursing (the "Board of Nursing") and the Department of Health and Senior Services ("DHSS"), comply with applicable federal and state laws.

12. Andrew Bailey is sued in his official capacity as the Attorney General of the State of Missouri. He is the State's chief legal enforcement officer and is charged with instituting any proceeding necessary to enforce state statutes. § 27.060, RSMo 2016.[2] He has "concurrent original jurisdiction throughout the state, along with each prosecuting attorney and circuit attorney within their respective jurisdictions, to commence actions for a violation of any provision of [chapter 188], for a violation of

[2] All statutory citations are to Missouri Revised Statutes (2016), as updated, unless otherwise noted.

any state law on the use of public funds for an abortion, or for a violation of any state law which regulates an abortion facility or a person who performs or induces an abortion." § 188.075(3), RSMo.

13. DHSS is a state agency created by § 192.005, RSMo. DHSS is statutorily charged with the licensing of abortion facilities, §§ 197.200–.240, RSMo, and can deny, suspend, or revoke a clinic's license if a facility is determined to have violated any of the challenged provisions. *See* § 197.200, RSMo (granting DHSS the authority to deny, suspend, or revoke a clinic's license for any violation of state law).

14. Paula F. Nickelson is sued in her official capacity as Director of DHSS.

15. The Board of Healing Arts is the licensing entity in the State of Missouri responsible for issuing, reviewing, renewing, and revoking professional licenses for medical providers as well as conducting disciplinary review and making disciplinary decisions for physicians and physician assistants. The Board of Healing Arts has the duty to administer and execute the statutes, rules, and regulations of the Healing Arts Practice Act. Responsibilities of the Board of Healing Arts include: promoting ethical standards, examination, licensure, regulation, investigation of complaints and discipline of individuals practicing in the field. It is also the Board of Healing Arts's duty to investigate all complaints against its licensees in a fair and equitable manner. The Board of Healing Arts is also charged with imposing licensing penalties on a final adjudication of guilt, guilty plea, or plea of nolo contendere in a criminal prosecution under the Challenged Provisions. *See* §§ 334.100(1), (2)(2), RSMo.

16. Jade D. James-Halbert is a member and the President of the Board of Healing Arts. Dorothy M. Munch is a member and the Secretary of the Board of Healing Arts. Jeffrey D. Carter, Ian L. Fawks, Naveed Razzaque, Marc K. Taormina, and Christopher J. Wilhem are members of the Board of Healing Arts (collectively with Jade D. James-Halbert and Dorothy M. Munch, the "Board of Healing Arts Members"). The Board of Healing Arts Members are sued in their official capacities.

17. The Board of Nursing regulates licensed nurses in the state, including by setting the standards for the approval of nursing schools in Missouri and determining the scope of practice of licensed nurses, including licensed nurses who are Advanced Practice Clinicians ("APCs"). The Board of Nursing is responsible for issuing, reviewing, renewing, and revoking professional licenses for licensed nurses as well as conducting disciplinary review and making disciplinary decisions for licensed nurses. The Board of Nursing is responsible for ensuring that licensed nurses, including those that are APCs, comply with the Revised Statutes of Missouri Chapter 335, the Nursing Practice Act. The Board of Nursing is also charged with imposing licensing penalties on a final adjudication of guilt, guilty plea, or plea of nolo contendere in a criminal prosecution under the Challenged Provisions. *See* § 335.066, RSMo.

18. Julie Miller is a member and the President of the Board of Nursing. Trevor J. Wolfe is a member and Vice President of the Board of Nursing. Margaret Bultas is a member and the Secretary of the Board of Nursing. Defendants Bonny Kehm, Courtney Owens, and Denise Williams are members of the Board (collectively with

Julie Miller, Trevor J. Wolfe, and Margaret Bultas, the "Board of Nursing Members"). The Board of Nursing members are sued in their official capacities.

19. Defendant Jean Peters Baker is the Jackson County Prosecuting Attorney. She is sued in her official capacity and as a representative of a Defendant class of county prosecuting attorneys who enforce Missouri's criminal laws, including those challenged herein.[3]

**ALLEGATIONS IN SUPPORT OF CLASS CERTIFICATION**

20. Defendant Baker is a member of the class of prosecuting attorneys in Missouri.

21. Defendant Baker and all prosecuting attorneys throughout the state have the authority to enforce Missouri's criminal laws, including those challenged herein.

22. The criminal laws challenged herein are described below in paragraph 171.

23. Defendant Baker and all prosecuting attorneys also have the authority to bring a cause of action for injunctive relief for violation of certain Missouri abortion restrictions, including those challenged herein.

24. The laws for which Defendant Baker and all prosecuting attorneys have authority to bring a cause of action for injunctive relief include nearly all the laws challenged herein. § 188.075(3), RSMo.

25. There are 114 counties in Missouri and 115 prosecuting attorney offices, including the Prosecuting Attorney for the City of St. Louis (a city not within a

[3] A motion to certify a defendant class is filed concurrently with this Petition.

county), which makes the members of the prospective defendant class so numerous that joinder of all members of the class would be impracticable.

26. The laws challenged herein give the prospective defendant class the same enforcement authority to engage in conduct implicating Plaintiffs' rights such that there is a common nucleus of operative facts and law.

27. Any defenses that could be raised by Defendant Baker would have the same essential characteristics as the defenses of the defendant class at large.

28. Defendant Baker will fairly and adequately protect the interests of the prospective defendant class.

29. Defendant Baker and members of the prospective defendant class have the authority and responsibility to enforce the laws challenged herein within their respective jurisdictions and, in doing so, will be acting under color of law.

**JURISDICTION AND VENUE**

30. The Court has original subject-matter jurisdiction over this action pursuant to sections 478.220, 526.010, and 527.010, RSMo, and Missouri Supreme Court Rule 87.01 and Rule 92.01.[4]

31. Venue is proper in this Court pursuant to § 508.010, RSMo because Plaintiffs would like to provide abortions in Jackson County and thus the claims for relief arise in part in Jackson County. Comp Health would like to provide abortions at multiple health centers, specifically including a health center located in Kansas City, Jackson

[4] All Rule references are to Missouri Supreme Court Rules, as updated, unless otherwise noted.

County. Venue is also proper in this Court because Jackson County Prosecuting Attorney Jean Peters Baker maintains offices in Jackson County, Missouri.

## FACTUAL ALLEGATIONS

### I. The Right to Reproductive Freedom Initiative

32. Thanks to a citizen initiative petition, as of December 5, 2024, the Missouri Constitution protects Missourians' "fundamental right to reproductive freedom, which is the right to make and carry out decisions about all matters relating to reproductive health care, including . . . abortion care." Mo. Const. art. I, § 36.2.

33. That effort began on March 8, 2023, when Dr. Anna Fitz-James, on behalf of Missourians for Constitutional Freedom, filed the Right to Reproductive Freedom Initiative with the Missouri Secretary of State in an attempt to amend the Missouri Constitution and enshrine within it a fundamental right to reproductive freedom.[5]

34. Through the actions of the Attorney General and the Secretary of State, certification of the petition's official ballot title (which should take about a month by statute and is statutorily required for the gathering of signatures) took over eight months and required litigation to ensure that the fundamental right to initiative petition was protected and the Right to Reproductive Freedom Initiative could move forward into the signature-collection phase. *See State ex rel. Fitz-James v. Bailey*, 670

[5] Article III, Section 49 of the Missouri Constitution guarantees to citizens the right to propose constitutional amendments through the initiative process. Mo. Const. art. III, § 49.

S.W.3d 1 (Mo. banc 2023); *Fitz-James v. Ashcroft*, 678 S.W.3d 194 (Mo. App. W.D. 2023); and *Kelly v. Fitzpatrick*, 677 S.W.3d 622 (Mo. App. W.D. 2023).[6]

35. After the official ballot title was finally certified, and with much less time than would normally be available, proponents began the arduous process of collecting signatures for the measure to appear on the November 2024 general election ballot.

36. Ultimately, over 380,000 signatures were collected.

37. The petition pages were timely submitted to the Secretary of State for signature validation in May 2024.

38. Following the Secretary of State's signature sufficiency certification on August 13, 2024, the petition was again attacked—unsuccessfully—by anti-abortion activists and politicians in an eleventh-hour attempt to thwart the democratic process, again requiring litigation to ensure that the initiative could stay on the ballot. *See Coleman v. Ashcroft*, 696 S.W.3d 347 (Mo. banc 2024).

39. The Right to Reproductive Freedom Initiative appeared on the November 5, 2024, general election ballot, and Missouri voters approved the measure, thereby securing a fundamental right to reproductive freedom, including the right to make and carry out decisions about abortion care, for all Missourians.

[6] Chapter 116 of the Revised Statutes of Missouri provides the statutory process for statewide initiatives that is generally divided into four phases: phase one – review of the form of submitted petitions (within fifteen days of submission); phase two – preparation of an official ballot title for use in circulation of initiative petitions and placement of the measure on the ballot (ordinarily within fifty-one days of submission); phase three – circulation of petitions for signature (from certification of official ballot title until six months before the general election); and phase four – submission and certification of signed petitions for sufficiency for placement on the ballot.

40. As passed, the Right to Reproductive Freedom Initiative amends Article I of the Missouri Constitution by adopting a new Section 36, which provides the following:

> 1. This Section shall be known as "The Right to Reproductive Freedom Initiative."
>
> 2. The Government shall not deny or infringe upon a person's fundamental right to reproductive freedom, which is the right to make and carry out decisions about all matters relating to reproductive health care, including but not limited to prenatal care, childbirth, postpartum care, birth control, abortion care, miscarriage care and respectful birthing conditions.
>
> 3. The right to reproductive freedom shall not be denied, interfered with, delayed, or otherwise restricted unless the Government demonstrates that such action is justified by a compelling governmental interest achieved by the least restrictive means. Any denial, interference, delay, or restriction of the right to reproductive freedom shall be presumed invalid. For purposes of this Section, a governmental interest is compelling only if it is for the limited purpose and has the limited effect of improving or maintaining the health of a person seeking care, is consistent with widely accepted clinical standards of practice and evidence-based medicine, and does not infringe on that person's autonomous decision-making.
>
> 4. Notwithstanding subsection 3 of this Section, the general assembly may enact laws that regulate the provision of abortion after Fetal Viability provided that under no circumstance shall the Government deny, interfere with, delay, or otherwise restrict an abortion that in the good faith judgment of a treating health care professional is needed to protect the life or physical or mental health of the pregnant person.
>
> 5. No person shall be penalized, prosecuted, or otherwise subjected to adverse action based on their actual, potential, perceived, or alleged pregnancy outcomes, including but not limited to miscarriage, stillbirth, or abortion. Nor shall any person assisting a person in exercising their right to reproductive freedom with that person's consent be penalized, prosecuted, or otherwise subjected to adverse action for doing so.
>
> 6. The Government shall not discriminate against persons providing or obtaining reproductive health care or assisting another person in doing so.

7. If any provision of this Section or the application thereof to anyone or to any circumstance is held invalid, the remainder of those provisions and the application of such provisions to others or other circumstances shall not be affected thereby.

8. For purposes of this Section, the following terms mean:

(1) "Fetal Viability": the point in pregnancy when, in the good faith judgment of a treating health care professional and based on the particular facts of the case, there is a significant likelihood of the fetus's sustained survival outside the uterus without the application of extraordinary medical measures.
(2) "Government": a. the state of Missouri; or b. any municipality, city, town, village, township, district, authority, public subdivision or public corporation having the power to tax or regulate, or any portion of two or more such entities within the state of Missouri

41. Constitutional amendments automatically take effect thirty days after the election in which they pass. Mo. Const. art. XII, § 2(b). The Right to Reproductive Freedom Initiative passed on November 5, 2024, and will automatically take effect on December 5, 2024.

## II. Abortion Generally

42. Abortion is extremely common: approximately one in four women in the United States will have an abortion by age forty-five.

43. Guided by their individual health, values, and circumstances, Missourians seek abortions for a variety of deeply personal reasons, including medical, familial, and financial concerns. Some patients have abortions because they conclude it is not the right time to become a parent; others are already parents and may be concerned about their ability to provide and care for their existing children. Others seek abortion

because continuing with pregnancy could pose a risk to their health, and yet others seek abortions because of a diagnosis of a fetal medical condition.

44. There are two main methods of abortion: medication abortion and procedural abortion.

45. Medication abortion typically involves a two-drug regimen: mifepristone, which ends the pregnancy, followed at least one day later by misoprostol, which helps to expel the pregnancy while the patient is in the location of their own choosing, usually in the comfort of their own home. Abortion using medication alone is available up to twelve weeks LMP and requires no anesthesia or sedation.

46. Procedural abortion is performed by dilating the uterine cervix and using suction and/or instruments to empty the contents of the uterus. Starting at approximately fourteen weeks LMP, suction alone may no longer be sufficient to perform a procedural abortion, and providers may begin using the dilation and evacuation (D&E) method, which involves the removal of the fetus and other products of conception from the uterus using instruments, such as forceps, in conjunction with suction. This process generally takes approximately two to fifteen minutes, depending on gestational age. Starting at approximately eighteen weeks LMP, patients usually require two consecutive days of care: on the first day, the patient's cervix is dilated, and on the second, the patient receives the abortion procedure. Procedural abortion is not surgery, as it does not involve any incision into the patient's skin.

47. Abortion, by any method, is one of the safest medical procedures in the United States.

48. Complications related to abortion are very rare: fewer than one percent of patients obtaining abortions experience a serious complication.

49. While abortion is extremely safe, risks do increase as gestational age increases. Patients generally try to get an abortion as early in their pregnancies as possible; however, numerous obstacles can and do cause delays. Some patients, especially those with irregular menstrual cycles, may not realize they are pregnant for weeks or even months. A patient may then be further delayed while confirming the pregnancy, researching options, making the decision to have an abortion, contacting a provider, and scheduling an appointment. Patients often are also delayed in obtaining funds necessary for the procedure and related expenses (travel and childcare), as well as by difficulties in making the necessary logistical arrangements (e.g., obtaining time off from work and arranging transportation and childcare). Patients may also experience a delay in seeking an abortion because testing for fetal medical conditions is not available until later in the pregnancy. Still other patients seek abortions later in pregnancy because of the progression of maternal health issues that may not emerge, be diagnosed, or make an abortion medically advisable until later in pregnancy. If the patient is an unemancipated minor and must obtain consent from a parent or a court order from a judge before they can receive an abortion, this can also delay care.

50. Economic and logistical barriers to obtaining abortion are particularly problematic for patients who are low income. From 2020–2022, an average of 11.5% of Missourians were living at or below the federal poverty level.[7]

51. Patients who are delayed in accessing care are forced to remain pregnant against their will. They may also be denied their preferred type of abortion, have their confidentiality compromised, or face greater costs for abortions at later gestational ages.

52. Some patients who are prevented from accessing abortion are forced to carry pregnancies to term against their will, with all of the physical, emotional, and financial costs that entails.

53. Abortion is much safer than continuing a pregnancy to childbirth (studies have estimated that a patient's risk of death associated with childbirth nationwide is twelve to fourteen times higher than that associated with abortion), and every pregnancy-related complication is more common among patients giving birth than among those having abortions.

54. In Missouri, from 2017–2021, the pregnancy-related mortality ratio was 32.2 deaths per 100,000 live births, significantly higher than the national average (in 2019, 20.1 maternal deaths per 100,000, and 23.8 per 100,000 in 2020). For Black women in Missouri, the ratio of pregnancy-related mortality is 2.5 times the ratio of white women. The ratio of pregnancy-related deaths was 2.8 times higher for people

[7] Emily A. Shrider & John Creamer, *Poverty in the United States: 2022* 47 tbl. B-5, U.S. Census Bureau (2023).

covered by MO HealthNet than those with private insurance. For pregnant women with a high school diploma or GED, the rate of pregnancy-related mortality was 3.3 times higher than for women who had obtained education beyond the high school level. Seventy-seven percent of pregnancy-related deaths were determined to be preventable in Missouri. Further, the second leading cause of pregnancy-related deaths, just after cardiovascular disease, was mental health conditions. Suicides represented fourteen percent of pregnancy-related deaths, and most occurred between forty-three days and one year postpartum.[8]

55. Even in an uncomplicated pregnancy, an individual experiences a wide range of physiological challenges. Individuals experience a quicker heart rate, a substantial rise in their blood volume, digestive difficulties, increased production of clotting factors, significant weight gain, changes to their breathing, and a growing uterus. These and other changes increase a pregnant patient's risk of blood clots, nausea, hypertensive disorders, anemia, and other complications. Pregnancy can also exacerbate preexisting health conditions, including diabetes, obesity, autoimmune disorders, and other pulmonary disease. It can lead to the development of new and serious health conditions as well, such as hyperemesis gravidarum, preeclampsia, deep vein thrombosis, and gestational diabetes.

[8] See *generally* Mo. Dep't of Health & Senior Servs., *A Multi-Year Look at Maternal Mortality: 2017–2021 Pregnancy Associated Mortality Review, Pregnancy-Associated Mortality Rev.* 15 (2024); *see also* Donna L. Hoyert, *Maternal Mortality Rates in the United States, 2020*, CDC: Nat'l Ctr. for Health Stats.: Health E-Stats, (2022).

56. Many people seek emergency medical care at least once during a pregnancy, and people with comorbidities (either preexisting or those that develop as a result of their pregnancy) are significantly more likely to seek emergency medical care. People who develop pregnancy-induced medical conditions are also at higher risk of developing the same condition in subsequent pregnancies.

57. Pregnancy can also induce or exacerbate mental health conditions. Some people with histories of mental illness experience a recurrence of their illness during pregnancy. Mental health risks can be higher for patients with unintended pregnancies, who may face physical and emotional changes and risks that they did not choose to take on.

58. Some pregnant patients also face an increased risk of intimate partner violence, with the severity of that violence sometimes escalating during or after pregnancy. Injury from homicide was the fourth leading cause of pregnancy-related deaths in Missouri. Sixty-seven percent of these homicides occurred between forty-three days and one year postpartum, and in every case, the perpetrator was a current or former partner, most with a documented history of intimate partner violence.[9]

59. Separate from pregnancy, labor and childbirth are themselves significant medical events with many risks. Complications during labor occur in over half of all hospital stays, and the vast majority of childbirth delivery stays have a complicating

[9] *See* Mo. Dep't of Health & Senior Servs., *A Multi-Year Look at Maternal Mortality: 2017–2021 Pregnancy Associated Mortality Review, Pregnancy-Associated Mortality Rev.* 15 (2024).

condition. Even a normal pregnancy with no comorbidities or complications can suddenly become life-threatening during labor and delivery. Adverse events include hemorrhage, transfusion, ruptured uterus or liver, stroke, unplanned hysterectomy (the surgical removal of the uterus), and perineal laceration (the tearing of the tissue around the vagina and rectum).

60. The most severe perineal tears involve tearing between the vagina through the anal sphincter and into the rectum and must be surgically repaired. These can result in long-term urinary and fecal incontinence and sexual dysfunction.

61. Vaginal delivery may also lead to injury to the pelvic floor and pelvic organ prolapse (the displacement of internal organs, resulting in some cases in their protrusion from the vagina).

62. Anesthesia or epidurals administered during labor also carry risks.

63. Those who deliver by a cesarean section ("C-section") rather than vaginally also take on risks. A C-section is an open abdominal surgery that requires hospitalization for at least a few days and carries significant risks of hemorrhage, infection, blood clots, and injury to internal organs. It can also have long-term risks, including an increased risk of placenta accreta (when the placenta grows into and possibly through the uterine wall causing a need for complicated surgical interventions, massive blood transfusions, hysterectomy, and risk of maternal death) or placenta previa (when the placenta covers the cervix, resulting in vaginal bleeding and requiring bed rest) in subsequent pregnancies, and bowel or bladder injury in future deliveries.

64. Pregnant people with a prior history of mental health conditions also face a heightened risk of postpartum illness, which may go undiagnosed for months or even years.

65. Pregnancy-related health care and childbirth are also some of the most expensive hospital-based health services, particularly for complicated or at-risk pregnancies.

66. Women who seek but are denied an abortion are, when compared to those who are able to access abortion, more likely to lower their future goals, and less likely to be able to exit abusive relationships. Their existing children are also more likely to suffer measurable reductions in achievement of child developmental milestones and an increased chance of living in poverty.

67. As compared to women who received an abortion, women denied an abortion are less likely to be employed full-time, more likely to be raising children alone, more likely to receive public assistance, and more likely to not have enough money to meet basic living needs.

68. If Missouri's bans and other unnecessary abortion restrictions are allowed to remain in effect, the economic impact of forced pregnancy, childbirth, and parenting will also have dramatic, negative effects on families' financial stability. Some side-effects of pregnancy render patients unable to work, or unable to work the same number of hours as they otherwise would. For example, some patients with hyperemesis gravidarum must adjust their work schedules because they vomit throughout the day. And other patients with preeclampsia must severely limit activity

for a significant amount of time. These conditions may result in job loss, especially for people who work jobs without predictable schedules, paid sick or disability leave, or other forms of job security. Even without these conditions, pregnancy-related discrimination can result in lower earnings both during pregnancy and over time.

69. Given the impact of pregnancy and childbirth on an individual's health and well-being, finances, and personal relationships, whether to become or remain pregnant is one of the most personal and consequential decisions a person will make in their lifetime. Certainly, many people decide that adding a child to their family is well worth these risks and consequences, but without the availability of abortion, Missourians are forced to assume those risks involuntarily.

## III. Missouri's Abortion Restrictions

70. The State of Missouri has spent decades attempting to eliminate or severely reduce abortion access through medically unnecessary bans, restrictions, and regulations—even when *Roe* still guaranteed a federal constitutional right to abortion.

71. This means that Plaintiffs have spent decades challenging these laws, including outright bans on abortion at various gestational ages and abortion restrictions so onerous that they had the same practical effect and forced abortion providers out of the state despite *Roe*. *See, e.g.*, *Reprod. Health Servs. of Planned Parenthood of the St. Louis Region v. Parson*, 408 F.Supp.3d 1049 (W. D. Mo. 2019); *Comprehensive Health of Planned Parenthood Great Plains v. Williams*, 263 F.Supp.3d 729 (W.D. Mo. 2017); *Comprehensive Health of Planned Parenthood Great Plains v. Hawley*, 903 F.3d 750 (8th Cir. 2018); *Comprehensive Health of Planned Parenthood Great*

*Plains v. Hawley*, No. 1716-CV24109 (Mo. Cir. Ct. Jackson Cnty. 2018); *Planned Parenthood of Kansas and Mid-Missouri v. Drummond*, No. 07-4164-CV-C-ODS, 2007 WL 2811407 (W.D. Mo. 2007).

72. After the United States Supreme Court decided *Dobbs*, which overturned *Roe* and "return[ed] the power to weigh those arguments [about how abortion should be regulated] to the people and their elected representatives," *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 259 (2022), Missouri's total abortion ban went into effect, eliminating altogether the minimal abortion access that remained in the state.

73. But now, the people of Missouri have spoken, and have determined that abortion is a fundamental right and that abortion restrictions are subject to a much higher standard than that ever articulated by the United States Supreme Court.

74. There can be no doubt that the following bans, restrictions, and regulations, challenged herein, are presumptively unconstitutional because they deny, interfere with, delay, and otherwise restrict abortion access. Nor can there be any doubt that the bans, restrictions, and regulations are unsupported by any compelling interest. They also discriminate against pregnant Missourians who choose abortion and penalize and discriminate against abortion providers who assist Missourians exercising this fundamental right. Mo. Const. art. I, §§ 36.3, 36.6. Accordingly, Plaintiffs seek declaratory and injunctive relief that will allow them to carry out the will of the voters and restore abortion access in Missouri.

### A. The Total Ban, Gestational Age Bans, and Reasons Ban

75. Missouri statutes contain numerous abortion bans that are unconstitutional under the Right to Reproductive Freedom Initiative, including: (1) a total ban on abortion, § 188.017, RSMo (the "Total Ban"); (2) cascading gestational age bans on abortion, §§ 188.056, 188.057, 188.058, and 188.375, RSMo (the "Gestational Age Bans"); and (3) bans on abortions for certain reasons, §§ 188.038, 188.052, RSMo; 19 C.S.R. § 10-15.010(1) (the "Reasons Ban"). These bans flatly "deny or infringe upon a person's fundamental right to reproductive freedom," which includes "the right to make and carry out decisions about . . . abortion," by taking this decision away altogether. Mo. Const. art. I, § 36.2. Because they are wholly out of step with the Constitution's new guarantees, they must be declared unconstitutional and preliminarily and permanently enjoined.[10]

76. Missouri's Total Ban, § 188.017, RSMo which went into effect on June 24, 2022, the day the United States Supreme Court issued its decision in *Dobbs*, prohibits all abortions in Missouri at any gestational age, without any exceptions. Medical providers who violate the Total Ban are subject to Class B felony charges, §

[10] Missouri also has a law that remains on the books even though it is unenforceable requiring that "[e]very abortion performed at sixteen weeks gestational age or later . . . be performed in a hospital," which would ban Plaintiffs from performing these abortions and would ban most of these abortions altogether. § 188.025, RSMo. That law has been permanently enjoined since 1988. *See Reprod. Health Servs. v. Webster*, 851 F.2d 1071 (8th Cir. 1988), *rev'd in part sub nom. Webster v. Reprod. Health Servs.*, 492 U.S. 490 (1989) (reversing other parts of the Eighth Circuit ruling, but not addressing § 188.025, RSMo because it was not appealed). Separate and apart from the 1988 permanent injunction, this law is also unconstitutional under the Right to Reproductive Freedom Initiative for the same reasons listed herein.

188.017.2, RSMo, which are punishable by five to fifteen years in prison § 558.011.1(2), RSMo, and the loss of their professional licenses, § 188.017(2), RSMo. The only "affirmative defense" to a violation of the Total Ban is that the abortion was performed because of a medical emergency. § 188.017(3), RSMo. "Medical emergency" is not defined and the provider charged has "the burden of persuasion that the defense is more probably true than not." *Id.*

77. Missouri's cascading Gestational Age Bans—which prohibit abortion at eight weeks LMP, fourteen weeks LMP, eighteen weeks LMP, and twenty weeks LMP—also deny patients the right to make and carry out decisions relating to their pregnancy, in flat contradiction of the right now enshrined in the Missouri Constitution.

§§ 188.056, 188.057, 188.058, 188.375, RSMo. Each of these prohibits abortion at a pre-viability stage of pregnancy, as defined by the Reproductive Freedom Initiative. Mo. Const. art. I, § 36.8(1). There are no exceptions. The only affirmative defense to the Gestational Age Bans is a "medical emergency" necessitating an "immediate" abortion to save those patients' lives or prevent substantial and irreversible impairment of a major bodily function. *See* §§ 188.015(7), 188.056(1), 188.057(1), 188.058(1), 188.375(3), RSMo. Each of the Gestational Age Bans is purportedly "severable" such that, in the event a more restrictive ban is found unconstitutional or invalid, the other, less restrictive gestational age ban(s) are intended to remain in effect, hence the "cascading" nature of these bans. §§ 188.056(4), 188.057(4), 188.058(4), 188.375(9), RSMo. Those who violate any of the Gestational Age Bans

face Class B felony charges and the loss of their professional licenses. *See* §§ 188.056(1), 188.057(1), 188.058(1), 188.375(3), RSMo.

78. The Reasons Ban proscribes abortion at any stage of pregnancy, including before viability, if the provider "knows" that the patient's decision to terminate their pregnancy is based on (1) a "prenatal diagnosis, test, or screening" indicating Down syndrome or the potential for it, or (2) the sex or race of the embryo or fetus. §§ 188.038.2, 188.038.3, RSMo. The Reasons Ban requires "a certification that the physician does not have any knowledge that the patient sought the abortion solely because of a prenatal diagnosis, test, or screening indicating Down Syndrome or the potential of Down Syndrome" or "because of the sex or race" of the embryo or fetus. §§ 188.038, 188.052(1), RSMo; 19 C.S.R. § 10-15.010(1). A violation exposes providers to criminal and civil penalties, including professional licensing penalties. *See, e.g.*, §§ 188.038.4, 188.075, RSMo.

79. Although some of Plaintiffs' patients disclose information about their reasons for seeking an abortion during non-directive discussions with their health care providers, Plaintiffs do not require that patients disclose any or all of their reasons for seeking an abortion, consistent with best medical practices. However, Plaintiffs are aware that some of their patients seek abortions based solely or in part on a prenatal diagnosis of Down syndrome. Down syndrome is the common name for a genetic condition, known as Trisomy 21, which results from an extra copy (full or partial) of the twenty-first chromosome. Patients who choose abortion based solely or in part on a prenatal diagnosis of Down syndrome typically come to the clinic or hospital after

having already undergone extensive counseling with genetic counselors and/or maternal-fetal medicine physicians, as well as having engaged in extensive reflection and conversation with the most important people in their lives.

80. Additionally, while Plaintiffs are unaware of any patient who has sought an abortion based solely on the sex or race of the embryo or fetus, patients at times ask the sex of the embryo or fetus when the ultrasound is performed, and the sex or race of the embryo or fetus may occasionally be mentioned during non-directive counseling.

81. These bans—on their face—deny Missourians the right to make and carry out the decision to have an abortion, as well as penalize and discriminate against abortion providers by subjecting them to penalties faced by no other health care providers.

82. Because all of these bans deny the fundamental "right to make and carry out decisions about . . . abortion care" on their face, they are presumed invalid and the burden shifts to the State to show that they are for the purpose of "improving or maintaining the health of [the] person seeking care." Mo. Const. art. I, § 36.3. But there is no patient health benefit that can justify these bans. And, even if there were a purported patient health benefit, it would not be one that is "consistent with widely accepted clinical standards of practice and evidence-based medicine, and does not infringe on that person's autonomous decision-making." *Id.* Indeed, by their very nature, these abortion bans *always* infringe on autonomous decision-making by removing a patient's ability to decide what care is best for them if that care is abortion. That is impermissible under the Right to Reproductive Freedom Initiative.

### B. Targeted Restrictions on Abortion Providers

83. Even if Missouri's abortion bans are declared unconstitutional and enjoined, abortion will be nearly impossible or extremely difficult to provide in the state because of a complicated, overlapping, and medically unnecessary set of restrictions on abortion facilities and providers (collectively, the "TRAP laws").

84. As a result of Missouri's TRAP laws, the fundamental right to reproductive freedom—specifically abortion—has been, and will continue to be, "denied, interfered with, delayed, or otherwise restricted" absent relief. *Id*.

85. These TRAP laws include: (1) a requirement that health centers that provide abortions be licensed as a type of ambulatory surgical center ("ASC"), §§ 197.200–235, 334.100.2(27), RSMo, 19 C.S.R. §§ 30-30.050–.070, 20 C.S.R. § 2150-7.140(2)(V) ("the Abortion Facility Licensing Requirement"); (2) requirements that abortion providers have "clinical privileges at a hospital which offers obstetrical or gynecological care located within thirty miles of the location at which the abortion is performed,"[11] §§ 188.080, 188.027.1(1)(e), 197.215(2), RSMo; 19 C.S.R. § 30-30.060(1)(C)(4) (the "Hospital Relationship Restrictions"); (3) a DHSS-approved complication plan requirement for use of medication abortion, which would severely

[11] In order to obtain an Abortion Facility License under Missouri law, providers must have various forms of hospital admitting privileges and/or a written transfer agreement with a nearby hospital, § 197.215, RSMo; 19 C.S.R. § 30-30.060. However, because of § 188.080, even if a health center is able to obtain a written transfer agreement—which is itself difficult if not impossible for Plaintiffs to obtain—its physicians are still unable to provide abortions unless they have local hospital privileges.

curtail access to medication abortion, § 188.021.2, RSMo; 19 C.S.R. §§ 10-15.050, 30-30.061 (the "Medication Abortion Complication Plan Requirement"); (4) medically unnecessary pathology requirements that are incredibly difficult if not impossible to comply with and that would decimate procedural abortion access in the state, § 188.047, RSMo; 19 C.S.R. § 10-15.030, 19 CSR 30-30.060(5)(B) (the "Pathology Requirement"); (5) reporting requirements that impermissibly single out abortion providers and are weaponized against them and their patients, § 188.052, RSMo; 19 C.S.R. §§ 10-15.010, 10-15.020 (the "Reporting Requirements"); (6) a requirement that patients receive state-mandated, biased information designed to interfere with their decision before obtaining an abortion, §§ 188.027, 188.033, 188.039, RSMo (the "Biased Information Law"); (7) a requirement that patients make two, in-person visits to the health center at least seventy-two hours apart and meet with the same physician who is providing the abortion, which unnecessarily increases delays in accessing care §§ 188.027, 188.039, RSMo (the "Waiting Period, In-Person, and Same Physician Requirements"); (8) a ban on the use of telemedicine for abortion that makes abortion much less accessible than any other comparable health service, § 188.021.1, RSMo (the "Telemedicine Ban"); and (9) a ban on the provision of abortion by Advanced Practice Clinicians ("APCs"), for whom abortion is within their scope of practice and who can safely provide this care in Missouri, as they do in many other states, §§ 188.020, 188.080, 334.245, 334.735.3, RSMo (the "APC Ban").

86. These are enforced through criminal penalties and potential professional license revocation. §§ 197.235, 334.100.2(27), RSMo (Abortion Facility Licensing

criminal and Abortion Facility Licensing physician's license, respectively); 20 C.S.R. § 2150-7.140(2)(V) (Abortion Facility Licensing Physician Assistants' license[12]); §§ 197.220(1), 197.230, RSMo (complication plan license); § 188.065, RSMo (hospital relationship, reporting, biased information, waiting period, in-person, same physician, telemedicine, and APC ban license); § 188.080, RSMo (hospital relationship and APC Ban criminal); § 188.075, RSMo (complication plan, pathology, reporting, biased information, 72-hour, same physician, in-person, telemedicine, and APC ban criminal); § 188.047.2, RSMo (pathology license); § 334.245, RSMo (APC Ban criminal);

§§ 334.100.2(4)(g), 335.066.2(2), RSMo (APC Ban license).

87. These restrictions severely curtailed abortion access in Missouri even before *Dobbs*; they effectively prevented all but one health center in Missouri from providing abortion, and even then, it was provided on an extremely limited basis.

**i. The Abortion Facility Licensing Requirement**

88. Despite abortion not being a form of surgery, Missouri law requires that any facility "in which abortions are performed or induced other than a hospital" be licensed as a special kind of ASC called an Abortion Facility. § 188.015, RSMo (definition of "abortion facility"); § 197.200, RSMo (referencing § 188.015, RSMo); § 197.205.1, RSMo (requiring special Abortion Facility License for abortion facilities). Operating a health center that provides abortions without an Abortion

[12] Physician Assistants cannot currently provide abortions in Missouri because of the APC Ban, which Plaintiffs are also challenging.

Facility License is a Class A misdemeanor. § 197.235, RSMo. And a physician faces professional discipline if they "operate, conduct, manage, or establish an abortion facility, or [if they] perform an abortion in an abortion facility," that does not have an Abortion Facility License. § 334.100.2(27), RSMo; 20 C.S.R. § 2150-7.140(2)(V) (same professional discipline for Physician's Assistants).

89. In order to obtain an Abortion Facility License, abortion providers must jump through a host of medically unnecessary hoops, including physical facility requirements and standards for operation that make it extremely difficult if not impossible to provide abortion in Missouri.

90. For example, Abortion Facilities are required to have procedure rooms with dimensions of at least twelve feet by twelve feet and a minimum ceiling height of nine feet, patient corridors at least six feet wide, door widths at least forty-four inches wide, and similarly specific requirements regarding facilities' HVAC systems and finishes for ceilings, walls, and floors, among others. *See* 19 C.S.R. § 30-30.070.

91. Most of the health centers at which Plaintiffs wish to provide abortions do not meet these physical facility requirements.

92. The Abortion Facility Licensing Requirement's standards for operation are similarly burdensome and unconstitutional. These include but are not limited to: (1) requiring an invasive and uncomfortable pelvic exam for all abortions, including medication abortions, that would require patients to remove their clothing and have their internal organs, including their vagina, internally and externally inspected with instruments and palpated with the provider's hands, *see, e.g.*, 19 C.S.R. § 30-

30.060(2)(D); (2) requiring ultrasounds and requiring that they be performed either by physicians or by someone with "certification by the American Registry for Diagnostic Medical Sonography (ARDMS) with advanced training in obstetric/gynecological imaging, or other certified training deemed acceptable by the department," *see, e.g.*, 19 C.S.R. § 30-30.060(2)(E); and (3) requiring that tissue from procedural abortions be sent to a pathology laboratory, *see, e.g.*, 19 C.S.R. § 30-30.060(5).[13] All of these purported standards make it more difficult to provide and obtain an abortion, and therefore, deny, interfere with, delay, or otherwise restrict the right to reproductive freedom.

93. Indeed, Great Rivers ceased providing medication abortions in the state because its doctors could not comply with the pelvic exam mandate for medication abortions consistent with providing high-quality, patient-centered care.

94. For the same reason, neither Plaintiff would be able to comply with this mandate for medication abortion patients and therefore neither would be able to provide medication abortion in Missouri if it remains in effect.

95. The Abortion Facility Licensing Requirement does not "improv[e] or maintain[] the health of [the patient]." Abortion is extremely safe. The Abortion

[13] This list is not exhaustive. For example, the statute's implementing regulations reiterate medically unnecessary requirements contained elsewhere in the code, including mandatory biased information, waiting period, and same physician requirements, *see, e.g.*, 19 C.S.R. §§ 30-30.060(2)(B)–(C), 30-30.060(1)(A)(8), and an APC Ban, *see, e.g.*, 19 C.S.R. § 30-30.060(2)(A). Because the Abortion Facility Licensing Requirement is unconstitutional and must be enjoined, all of its implementing regulations must be enjoined as well.

Facility Licensing Requirement is particularly inappropriate in the context of medication abortion, which involves patients simply swallowing a pill. Complications from medication abortion are rare, and, if they do occur, are unlikely to occur at the health center, but rather, after the patient has taken the second medication twenty-four to forty-eight hours after leaving the health center at a location of their choosing, usually at home.

96. Indeed, there is no medical basis for these requirements in the context of abortion at all. The Abortion Facility Licensing Requirement's rules for the size of procedure rooms and recovery rooms, and the widths of corridors and doorways are unnecessary for the safe provision of abortion care, including procedural abortion, which involves only a small number of medical personnel and a small amount of equipment, and does not involve the use of general anesthesia. The excess space Missouri mandates does not provide a health benefit to patients. In addition, some of Missouri's requirements, such as those related to scrub facilities, are geared toward maintaining a sterile operating environment such as would be appropriate for a procedure involving an incision into a sterile bodily cavity, which abortion is not, *see supra* ¶ 46.

97. Furthermore, many procedures commonly performed in office-based settings are comparable to or riskier than procedural abortion, including gynecological procedures such as insertion/removal of intrauterine devices, diagnostic dilation and curettage, hysteroscopy, completion of miscarriage, colposcopy with cervical biopsy, and loop electrosurgical excision of the cervix. Other non-gynecological office-based

procedures such as colonoscopy, many forms of plastic surgery, and dermatological cancer surgery are comparable to or riskier than abortion. Indeed, some of these procedures are performed under general anesthesia, which, by itself, is much riskier than abortion. But Missouri law does not require that facilities in which these procedures are performed be licensed as ASCs unless they are operated primarily for the purpose of performing surgical procedures.

98. DHSS has recognized that a health center can safely provide both procedural and medication abortion services without complying with these physical facility requirements. As a result of a prior lawsuit, *Planned Parenthood of Kansas & Mid-Missouri Inc. v. Drummond*, No. 07-4164-CV-C-ODS, 2007 WL 2811407 (W.D. Mo. 2007), DHSS entered into a settlement agreement allowing both Comp Health's Columbia and Kansas City health centers to be licensed by complying with lesser (though still onerous and medically unnecessary) sets of physical facility requirements than those required by the Abortion Facility Licensing Requirement. However, DHSS repeatedly changed its position on what it would require under the settlement agreement, making the Abortion Facility Licensing Requirement a continuing impediment to abortion access in the state.

99. Nor is the Abortion Facility Licensing Requirement "consistent with widely accepted clinical standards of practice and evidence-based medicine." Mo. Const. art. I, § 36.3. Both medication and procedural abortions can be safely performed in office-based settings, such as doctors' offices and specialized clinics, and this is the accepted medical practice nationally.

100. The Abortion Facility Licensing Requirement impermissibly discriminates against abortion providers and imposes licensing standards that will be difficult or impossible to meet for Plaintiffs. All other medical facilities must be licensed as ASCs only if they are "operated primarily for the purpose of performing surgical procedures or . . . childbirths."[14] § 197.200(2), RSMo (emphasis added); *see also* 19 C.S.R. § 30-30.010(1)(b). The Abortion Facility Licensing Requirement therefore singles out, and discriminates against, abortion as the only medical service for which an ASC license is required without regard to the number or frequency of any procedure. More importantly, as discussed *supra* ¶ 46, abortion is not surgery.

101. Because the Abortion Facility Licensing Requirement must be struck down as unconstitutional as applied to abortion facilities, all of its implementing regulations and requirements must be as well. *See* 19 C.S.R. §§ 30-30.050–.070.

**ii. Hospital Relationship Restrictions**

102. Additionally, Missouri law contains several overlapping hospital relationship requirements. Missouri law makes it a crime for a physician to provide an abortion without "clinical privileges at a hospital which offers obstetrical or gynecological care located within thirty miles of the location at which the abortion is performed." § 188.080, RSMo; *see also* § 188.027.1(1)(e), RSMo. Violation of this statute is a Class A misdemeanor. § 188.080, RSMo. It also carries professional licensing

[14] Regulations implementing the licensing requirement define "primarily for the purpose of" to mean that at least 51% of the patients treated or 51% of the revenues received were for a surgical procedure. 19 C.S.R. § 30-30.010(1)(b)(1).

consequences. § 188.065, RSMo. Additional laws require abortion providers to have variations on this hospital privileges requirement (collectively, the "Hospital Relationship Restrictions").[15]

103. The Hospital Relationship Restrictions "den[y], interfere[] with, delay[], [and] restrict[] . . . the right to reproductive freedom" because they are impossible to comply with because, in some areas of Missouri, there are no local hospitals willing to work with Plaintiffs. Mo. Const. art. I, § 36.3.

104. Even if hospitals were willing to work with Plaintiffs, abortion providers are often unable to meet hospitals' requirements for privileges because of the nature of their practices (e.g., some hospitals have a minimum admission requirement in order to obtain privileges; but because abortion complications are so rare, abortion providers cannot meet this requirement). Many hospitals also require physicians to

[15] One of the statutory licensing requirements for ASCs requires that surgical procedures may be performed "only by physicians . . . who at the time are privileged to perform surgical procedures in at least one licensed hospital in the community in which the ambulatory surgical center is located" or there must be a "current working agreement with at least one licensed hospital in the community in which the ambulatory surgical center is located, guaranteeing the transfer and admittance of patients for emergency treatment." § 197.215(2), RSMo. The regulatory scheme for Abortion Facility Licensing similarly requires that "physicians performing abortions at [an abortion facility] have staff privileges at a hospital within fifteen (15) minutes' travel time from the facility or the facility shall show proof there is a working arrangement between the facility and a hospital within fifteen (15) minutes' travel time from the facility granting the admittance of patients for emergency treatment whenever necessary." 19 C.S.R. § 30-30.060(1)(C)(4). However, the existence of this criminal statute makes it practically impossible for abortion facilities to utilize the option of having a transfer agreement with a local hospital because, even if they are able to obtain such an agreement, the facility's physicians still would be unable to provide abortions unless they had local hospital privileges.

name a backup physician who already has privileges at the hospital and agrees to provide coverage, but this requirement is impossible to meet because physicians are not willing to risk harassment or harm to their own practices from associating with a physician who provides abortion. Some hospitals also have local residency or shift requirements which serve to exclude many providers from privileges.

The Hospital Relationship Restrictions do not "improv[e] or maintain[] the health of [the patient]." *Id*. The few complications that do occur often do not present until after a patient has left the health center. And a physician's local hospital privileges or a facility's transfer agreement are not indicative of where a patient might seek emergency health care. Patients experiencing complications at home should seek treatment at their nearest hospital emergency department, and patients being transported by ambulance often go to the hospital that the paramedics determine is best for them or that the patient prefers. Regardless of whether a physician has local hospital privileges or whether a facility has a written transfer agreement with a hospital, appropriate care is ensured because hospitals provide necessary care to patients who need it. Moreover, even if a physician has local admitting privileges at the hospital where a patient presents for care, they are not the ones necessarily handling any complications. Additionally, hospitals must comply with the federal Emergency Medical Treatment & Labor Act, which requires hospitals to treat and stabilize all emergency patients. 42 U.S.C. § 1395dd(b) (commonly referred to as EMTALA).

105. Nor are the Hospital Relationship Restrictions consistent with "widely accepted clinical standards of practice and evidence-based medicine." Mo. Const. art. I, § 36.3. Even though abortion is extremely safe, Plaintiffs are prepared to provide high-quality care in the rare event of complications, as is the standard of care. Plaintiffs provide their patients upon discharge with phone numbers to call if they experience complications or have concerns at any time, day or night, after they have left the health center. In nearly all cases, the patients' concerns or complications can be addressed over the phone by a qualified health care professional, or through a return visit to the clinic. In the rare instances where additional or after-hours care is required, Plaintiffs' staff will refer the patient to a local emergency room, which is what is consistent with the "widely accepted clinical standards of practice and evidence-based medicine." *Id*.

106. The Hospital Relationship Restrictions also "discriminate against persons providing . . . reproductive health care." *Id*., § 36.6. As with the Abortion Facility Licensing Requirement, Missouri does not require facilities that perform non-abortion procedures that are of comparable or higher risk to meet any of the Hospital Relationship Restrictions unless the facility is operated primarily for the purpose of performing surgical procedures or childbirth, typically far more complex procedures than abortion. This includes nearly identical care provided by the same providers for miscarriage management.

### iii. Medication Abortion Complication Plan Requirement

107. Under Missouri law, Plaintiffs cannot provide medication abortion without approval of a complication plan that meets DHSS's requirements. § 188.021.2, RSMo; 19 C.S.R. § 30-30.061. Specifically, providers of medication abortion (and medication abortion only) need to have a written agreement with a board-certified or board-eligible obstetrician-gynecologist ("ob-gyn") or group of ob-gyns who has agreed to be "on-call and available twenty-four hours a day, seven days a week" to "personally treat all complications" from medication abortion. 19 C.S.R. § 30-30.061. Additionally, even though it is not in the regulations, DHSS has previously interpreted its regulations to require the ob-gyn to also have hospital admitting privileges near the facility where the patient obtains the medication abortion. A physician who violates this statute faces criminal liability, and the corresponding facility risks loss of its license. § 188.075.1, RSMo (Class A misdemeanor); § 197.220(1), RSMo (license suspension/revocation if facility's officers violate a criminal abortion statute); *see also* § 197.230 (authorizing DHSS to inspect abortion facilities for compliance with abortion statutes).

108. Plaintiffs would be unable to comply with the medically unnecessary Medication Abortion Complication Plan Requirement for the same reasons they are unable to comply with the Hospital Relationship Restrictions, which would effectively ban medication abortion.

109. In fact, it was these requirements that ultimately forced Comp Health to stop providing abortions in Columbia because it could not identify physicians willing to

enter into the required written agreement. Comp Health would still be unable to comply with these requirements in Columbia, and Great Rivers would be unable to comply outside of St. Louis.

110. By severely curtailing, if not outright eliminating, medication abortion access, the Medication Abortion Complication Plan Requirement "denie[s], interfere[s] with, delay[s], or otherwise restrict[s]" patients' ability to "make and carry out decisions about *all matters* relating to reproductive health." Mo. Const. art. I, §§ 36.2–.3 (emphasis added). Patients choose medication abortion for myriad reasons. For some, it is preferable for medical reasons. For others, medication abortion feels more natural—like a miscarriage. For some victims of intimate partner violence, medication abortion can be a safer option because it allows a patient to disguise their abortion as a miscarriage. Some victims of rape or patients who have experienced sexual abuse or other trauma may choose medication abortion to feel more in control of the experience and to avoid further trauma from having instruments placed in their vagina. Others prefer to end their pregnancies in the comfort of their own home or another place of their choosing.

111. The Medication Abortion Complication Plan Requirement does not "improv[e] or maintain[] the health of [patients]." *Id.*, § 36.3. DHSS has admitted as much, stating in its justification for the regulation that without medication abortion, "every patient obtaining an abortion would have to obtain a [procedural] abortion. A [procedural] abortion would not be in the best medical interest of every patient and could put some patients at unnecessary risk." 19 C.S.R. § 30-30.061; *Emergency*

*Rules*, Mo. Dept. of Health and Senior Servs., https://www.sos.mo.gov/CMSImages/AdRules/main//EmergenciesforInternet//19c30-30.061IE.pdf. Indeed, when this requirement was challenged in federal court, the District Court for the Western District of Missouri "conclude[d] that the regulation has virtually no benefit." *Comprehensive Health of Planned Parenthood Great Plains v. Williams*, 322 F. Supp. 3d 921, 931 (W.D. Mo. 2018). As that court noted, it strongly suspected that "this requirement ha[d] been imposed specifically because DHSS is aware that it is difficult for abortion providers to comply with it, and simply constitutes a backdoor effort to require admitting privileges . . . ." *Id*. at 931 n.11.

112. Nor is the Medication Abortion Complication Plan Requirement "consistent with widely accepted clinical standards of practice and evidence-based medicine." Mo. Const. art. I, § 36.3. As the American College of Obstetricians and Gynecologists, the leading professional organization of physicians who provide reproductive health care, has stated: a requirement that physicians who provide medication abortion have a contract with a backup physician with hospital admitting privileges "does nothing to enhance the quality or safety of abortion care, and in fact creates a grave risk to public health." *See* Br. of Amici Curiae Am. Pub. Health Ass'n & Am. Coll. of Obstetricians & Gynecologists in Supp. of Appellees at 3, *Planned Parenthood of Ark. & E. Okla. v. Jegley*, No. 16-2234 (8th Cir. Nov. 10, 2016); *see also* Ushma D. Upadhyay et al., *Admitting Privileges and Hospital-Based Care After Presenting for Abortion: A Retrospective Case Series*, 54 Health Servs. Rsch. 425 (2019). Indeed, Senator Andrew Koenig, the main sponsor of the Medication

Abortion Complication Plan Requirement, stated publicly that its purpose was to prevent Planned Parenthood from expanding access to abortion to additional health centers in Missouri following the entry of the preliminary injunction in different litigation enjoining the Hospital Relationship Restrictions. Jason Hancock, *Fate of New Abortion Limits Unclear as Missouri Senators Return to Capitol*, Kan. City Star (July 24, 2017, 7:00 AM), http://www.kansascity.com/article163000723.html.

113. The Medication Abortion Complication Plan Requirement also infringes on patients' "autonomous decision-making" by limiting their ability to choose the type of abortion that is best for them, and, in some circumstances, the only abortion option available. Mo. Const. art. I, § 36.3.

114. Moreover, the Medication Abortion Complication Plan Requirement "discriminate[s] against persons providing . . . reproductive health care" by singling out medication abortion and its providers for different and more burdensome requirements compared to other comparable medical services and the providers who offer these. This includes countless medical procedures that are much riskier and for which complications are much more prevalent than medication abortion, as well as miscarriage management, which can use the same exact drug regimen as medication abortion. *Id*. § 36.6.

115. Accordingly, Missouri's Medication Abortion Complication Plan Requirement is unconstitutional and must be enjoined, as must its implementing regulations. *See* § 188.021.3, RSMo ("This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to

review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after October 24, 2017, shall be invalid and void.").

**iv. Pathology Requirements**

116. Under Missouri law, any tissue "removed at the time of abortion shall be submitted within five days to a board-eligible or certified pathologist for gross and histopathological examination." § 188.047, RSMo; *see also* 19 C.S.R. § 10-15.030, 19 CSR 30-30.060(5)(B). The pathologist must then "file a copy of the tissue report with the state department of health and senior services, and . . . [t]he pathologist's report shall be made a part of the patient's permanent record." § 188.047, RSMo. If a discrepancy is found between the report required by Missouri law to be filed by abortion facilities, *see infra* ¶ 124, and a tissue report, and the deficiency is not cured, "the department shall consider such noncompliance a deficiency requiring an unscheduled inspection of the facility to ensure the deficiency is remedied . . . ." § 188.047, RSMo.

117. Upon information and belief, there is not currently any pathologist in the state of Missouri willing to take on the responsibilities mandated by the Pathology Requirements for all required tissue. Sending all required tissue out of state is burdensome and expensive. Many pathologists are unwilling to work with Plaintiffs for fear of being penalized by the state or attracting negative publicity. These requirements accordingly make Plaintiffs' ability to provide abortions—and Missourians' ability to receive them—entirely contingent on business relationships

that could be fragile. If Plaintiffs cannot find a pathologist who is willing to work with them, they will be unable to provide procedural abortions in the state.

118. There is no state interest in the Pathology Requirements that "has the limited effect of improving or maintaining the health of a person seeking care, is consistent with widely accepted clinical standards of practice and evidence-based medicine, and does not infringe on that person's autonomous decision-making." Mo. Const. art. I, § 36.3.

119. Moreover, disposing of tissue from abortion like all other medical waste—including identical tissue resulting from miscarriage care—is consistent with widely accepted standards of practice. Plaintiffs' practices already provide that tissue from an abortion be sent to a pathologist when there is a medical need to do so.

120. The Pathology Requirements also "infringe on [a patient's] autonomous decision-making" because it would remove the option of procedural abortion altogether. *Id*. Some patients prefer or need a procedural abortion. This can be because they prefer to complete the abortion in the health center rather than find additional time away from work or caretaking responsibilities to expel the products of conception at home or elsewhere. For others, such as those with specific medical conditions, procedural abortion is medically indicated.

121. The Pathology Requirements "discriminate against persons providing . . . reproductive health care" by singling out procedural abortion and its providers for different and more burdensome requirements compared to other comparable medical

services and the providers who offer these, including miscarriage management, which can involve the same procedures as procedural abortion. *Id*., § 36.6.

122. All regulations implementing the Pathology Requirements must also be enjoined. The statute provides that "if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after October 24, 2017, shall be invalid and void." § 188.021.3, RSMo.

**v. Reporting Requirements**

123. Under Missouri law, physicians who provide abortion must complete "[a]n individual abortion report for each abortion performed or induced upon a [patient]." § 188.052.1, RSMo. Moreover, physicians are required to complete "[a]n individual complication report for any post-abortion care," § 188.052.2, RSMo, even though not all post-abortion care required to be reported actually reflects a complication, *see* 19 C.S.R. § 10-15.020. This report also requires a "certification that the physician does not have any knowledge that the [patient] sought the abortion solely because of a prenatal diagnosis, test, or screening indicating Down Syndrome or the potential of Down Syndrome . . . and a certification that the physician does not have any knowledge that the [patient] sought the abortion solely because of the sex or race of the unborn child." § 188.052, RSMo; *see also* 19 C.S.R. § 10-15.010. These reports are required to be submitted to DHSS within forty-five days of the "post-abortion care." § 188.052.3, RSMo. Failure to comply with these reporting requirements is a

class A misdemeanor and can result in loss of the physician's license. §§ 188.065, 188.075, RSMo.

124. These requirements "discriminate against persons providing [and] obtaining reproductive health care." Mo. Const. art. I, § 36.6. In the past, DHSS has used individually identified patient information from abortion reports to surveil patients by tracking their periods,[16] and it has also used this information to target abortion facilities for licensing investigations in an effort to stop abortion services. No other health care service data collected by DHSS is used in this manner, and certainly not without being de-identified and aggregated. Moreover, the Reporting Requirements discriminate against abortion providers by subjecting them to criminal penalties for failing to comply with what are essentially administrative duties when there is no other provider of comparable health care services subject, by law, to these types of reporting requirements on pain of criminal penalties.[17]

125. These requirements are therefore impermissible under the Reproductive Freedom Initiative.

[16] Yasmeen Abutaleb & Emily Wax-Thibodeaux, Missouri Reviewed Data About Planned Parenthood's Patients, Including Their Periods, to Identify Failed Abortions, The Washington Post (Oct. 30, 2019), https://www.washingtonpost.com/health/missouri-tracked-planned-parenthood-patients-periods-in-spreadsheet-top-health-official-says/2019/10/30/e96791d0-fb42-11e9-ac8c-8eced29ca6ef_story.html.

[17] Additionally, the requirement that physicians certify that they do not have knowledge of the patient's sole reason for seeking an abortion, if the reason is Down Syndrome or sex constitutes a ban on abortion for some patients, as discussed *supra* ¶¶ 78–82.

### vi. Biased Information Law

126. Missouri law requires that, before they can receive an abortion, patients must receive a host of biased, medically inaccurate, and harmful state-mandated information. §§ 188.027, 188.033, 188.039, RSMo. For example, Missouri's Biased Information Law dictates that patients must receive biased materials and statements, including, but not limited to:

- "Printed materials provided by [DHSS] which describe the probable anatomical and physiological characteristics of the unborn child at two-week gestational increments from conception to full term, including color photographs or images of the developing unborn child at two-week gestational increments. Such descriptions shall include information about brain and heart functions, the presence of external members and internal organs during the applicable stages of development and information on when the unborn child is viable. The printed materials shall prominently display the following statement: 'The life of each human being begins at conception. Abortion will terminate the life of a separate, unique, living human being.'";

- An opportunity to view "an active ultrasound of the unborn child and hear the heartbeat of the unborn child if the heartbeat is audible"; and

- Printed materials provided by DHSS that include "information on the possibility of an abortion causing pain in the unborn child." § 188.027, RSMo.

127. Section 188.033 of the Revised Statutes of Missouri requires "an abortion facility or a family planning agency located in this state, or any of its agents or employees acting within the scope of his or her authority or employment" that "provides to a woman considering an abortion the name, address, telephone number, or website of an abortion provider that is located outside of the state" to "also provide to such woman the printed materials produced by [DHSS]."

128. Violation of the law is a Class A misdemeanor and can result in loss of the physician's license. §§ 188.065, 188.075, RSMo.

129. These requirements harm patients and "interfere[] with, delay[], [and] otherwise restrict[]" a patient's decision to choose an abortion by purposefully presenting them with information that has no basis in science or medicine and that is expressly designed to steer them towards continued pregnancy, to discourage them from choosing abortion, and to shame them. Mo. Const. art. I, § 36.3. It also interferes with their relationship with their health care provider by requiring the physician to give patients information that patients have expressed they do not want.

130. This information does not further patient health. It is also inconsistent with "widely accepted clinical standards of practice and evidence-based medicine" to provide patients with information that is irrelevant to the health care they are seeking and that is intended to stigmatize them and steer them towards a state-preferred health care decision. *Id*. Consistent with their ethical duty and standard medical practice, prior to providing an abortion, Plaintiffs' providers already ensure that their patients are able to give informed and voluntary consent and would continue to do so like all other medical providers do, independent of Missouri's Biased Information Law. Moreover, the Biased Information Law clearly "infringe[s] on [the patient's] autonomous decision-making" by inserting the state between the patient and their provider—indeed, forcing the provider to speak the state's words—in an attempt to dissuade patients from choosing abortion. *Id*.

131. The Biased Information Law also discriminates against patients who choose abortion and their providers. *See id*., § 36.6. No other comparable medical procedure is subject to state-mandated information sessions on top of the informed consent already required by common law. In no other medical setting does the state mandate that patients be steered away from their lawful decisions. Nor does the State force any other health care providers to be its unwilling mouthpieces.

**vii. Waiting Period, In-Person, and Same Physician Requirements**

132. Under Missouri law, all abortion patients must make a medically unnecessary trip to a health center at least seventy-two hours before they can obtain an abortion. In the event that the seventy-two hour waiting period is enjoined, the law provides that the waiting period should become twenty-four hours. §§ 188.027.12, 188.039.7, RSMo. At that in-person visit, the same physician or physicians who will "perform or induce" the abortion must be the ones to describe certain biased, state-mandated information to the patient, §§ 188.027, 188.039, RSMo, as opposed to the other qualified health professionals, such as other physicians, physician assistants, registered nurses, licensed practical nurses, and so forth, who are able to conduct patient education and counseling for every other medical procedure. Violating the law is a class A misdemeanor and could result in loss of the physician's license. §§ 188.065, 188.075, RSMo.

133. This impermissibly singles out and poses extreme burdens on abortion patients and providers—by their very nature, delaying abortion by at the very least three days more than medically necessary—without any patient health benefit, much less one

that is "consistent with widely accepted clinical standards of practice and evidence-based medicine, and does not infringe on th[e patient's] autonomous decision-making." Mo. Const. art. I, § 36.3. Indeed, the sole reason for these requirements is to discourage patients from obtaining an abortion.

134. When abortion was still available in Missouri, Plaintiffs struggled to comply with the waiting period, in-person, and same physician requirements. None of the physicians who provided abortion services were able to be at the health center each day of the week. Most providers had one or more other jobs providing health services at other facilities, including facilities out of state. This would likely remain the case if Plaintiffs are able to resume providing abortions.

135. This meant that it was extremely onerous—and often impossible—for the same physician to conduct both the mandatory biased information session, and then, three days later, the abortion. In reality, this delay was often much longer. For example, if a physician could only provide abortions in Missouri every other week, some patients would have to wait *at least* two weeks between their initial biased information session and their actual abortion procedure, assuming that appointments were available and that the patient was able to arrange their other responsibilities to make that appointment. If, for some reason, the physician was unavailable for the second appointment (e.g., due to illness or other emergencies), the patient would have to restart the clock entirely with a new physician. A weeks-long delay could result in losing access to medication abortion, or from obtaining an abortion altogether if it

pushes patients past the point in pregnancy at which abortions are available. It cannot be disputed that abortion care is time sensitive.

136. This is in addition to the burdens placed on patients, who had to travel to a health center not once, but twice—at least three full days apart. As discussed *supra* ¶¶ 49–50, patients already face a host of logistical difficulties accessing abortion, including their own inflexible work schedules, caretaking responsibilities, and travel costs. These difficulties are even more acute for patients with low incomes, for whom it may take time to save up money for the procedure and associated expenses (which are made more expensive due to the waiting period and same physician requirements). All of these obstacles delay care and are exacerbated by the medically unnecessary requirement of two in-person visits to a clinic at least three days apart, which requires extra costs for travel and arranging for even more time off of work and caregiving responsibilities. All of these costs make it more difficult to obtain an abortion, which in turn further delays access to care.

137. The waiting period, in-person, and same physician requirements also pose particular harms to especially vulnerable populations, such as victims of domestic violence and those whose pregnancy is the result of rape or other forms of abuse; those who face medical risks from pregnancy, and those whose pregnancies involve a severe fetal anomaly.

138. By requiring that the same physician who will offer the abortion also provide biased, state-mandated information to the patient, *and* that this be done in-person and at least seventy-two hours before providing the abortion, the waiting period and same

physician requirements "interfere[] with, delay[], [and] restrict[]" patients' right to "make and carry out decisions about all matters relating to . . . abortion care." Mo. Const. art. I, §§ 36.2–.3. In some cases, they can even deny patients the ability to choose abortion altogether. A twenty-four hour waiting period would have the same effect.

139. These requirements do not "improve[] or maintain[] the health of [the patient]." *Id.* § 36.3. They cause delays which are harmful to patients and push them further into pregnancy. Nor are they consistent with "widely accepted clinical standards of practice and evidence-based medicine." *Id.* Patients do not need to have two appointments with the same physician, three days apart to receive *any other health care*, including miscarriage management, which is substantially similar to abortion, or even prenatal care and childbirth. *See id.* § 36.6. Evidence-based medicine recommends removing barriers to abortion access; not erecting them. Furthermore, these requirements "infringe on [patients'] autonomous decision-making" by placing medically unnecessary hurdles in their way, whose only purpose is to detract them from getting the care they have chosen for themselves. *Id.*

140. And the requirements "discriminate against persons providing or obtaining reproductive health care" by singling out abortion patients and their providers for different and more burdensome treatment than all other patients or health care providers. *Id.* For patients, this includes all the harms discussed above. For providers, this treatment includes, but is not limited to, severely limiting a provider's ability to

manage their medical practice and placing medically unnecessary restraints on the timely and efficient delivery of health care under threat of criminal penalties.

**viii. Telemedicine Ban**

141. Missouri law requires that

> [w]hen RU-486 (mifepristone) or any drug or chemical is used for the purpose of inducing an abortion, the initial dose of the drug or chemical shall be administered in the same room and in the physical presence of the physician who prescribed, dispensed, or otherwise provided the drug or chemical to the patient.

§ 188.021.1, RSMo. This effectively bars the use of telemedicine for medication abortion, and substantially increases the distances patients have to travel to obtain medication abortion (the "Telemedicine Ban"). Violation is a class A misdemeanor and can result in loss of the physician's license. §§ 188.075, 188.065, RSMo.

142. Telemedicine refers to traditional clinical diagnosis and monitoring that a health care provider delivers live to patients via audio and/or video. Missouri authorizes the use of telehealth for "[a]ny licensed health care provider . . . if such services are within the scope of practice for which the health care provider is licensed and are provided with the same standard of care as services provided in person," § 191.1145.2, RSMo—unless that service is abortion.

143. If the Telemedicine Ban were enjoined, Plaintiffs could provide Telemedicine medication abortion directly to patients. This means that patients would not have to travel to obtain medication abortion. This would greatly reduce barriers to care from travel and having to rearrange work schedules and caregiving responsibilities, and would therefore decrease delays in accessing abortion.

144. By restricting access to care in this way, the Telemedicine Ban impermissibly "denie[s], interfere[s] with, delay[s], or otherwise restrict[s]" the right to reproductive freedom." Mo. Const. art. I, § 36.3. It makes it more difficult for patients to access care, results in delays due to difficulty obtaining resources or time off to travel to obtain care, and, for patients who are unable to reach a health center at all, will deny care altogether.

145. There is no patient health-related reason that supports a Telemedicine Ban. Although rare, the most common adverse events from medication abortion are incomplete abortion, which involves retained tissue in the uterus, and continuing pregnancy, in which the medications are not effective at ending the pregnancy. These adverse events can almost always be handled in an outpatient setting on a non-emergency basis. And when these rare adverse events or complications from medication abortion arise, it would not matter whether the patient obtained a medication abortion in person or through telemedicine because such events would occur only after the patient has left the clinic. The lack of health benefit to the Telemedicine Ban is underscored by the fact that telemedicine is permitted for miscarriage management, which can involve the same exact drug regimen.[18]

146. Neither is a telemedicine ban "consistent with widely accepted clinical standards of practice and evidence-based medicine." *Id.* Telemedicine medication

[18] The statute also requires that "[t]he physician inducing the abortion, or a person acting on such physician's behalf, shall make all reasonable efforts to ensure that the patient returns." § 188.021.1, RSMo. Returning for a follow-up visit for medication abortion is also medically unnecessary and is not standard practice.

abortion has been studied extensively, and has been found to be a safe and effective way of providing this care. Indeed, telemedicine for medication abortion is as safe and effective as fully in-person treatment. The rate of clinically significant complications for medication abortion is exceedingly low whether it is provided in-person or by telemedicine, and the reported low risks of medication abortion are similar in magnitude to the adverse effects of common prescriptions and over-the-counter medications. The Telemedicine Ban also "infringe[s] on [a patient's] autonomous decision-making," including by making abortion less accessible and by putting abortion wholly out of reach for those who cannot visit a clinic in person, including victims of domestic violence who may be tracked by their abusers. *Id.*

147. The Telemedicine Ban also impermissibly discriminates against patients who choose abortion. *See id*. § 36.6. Missourian health care providers are allowed to use telemedicine to access other health care services that are comparable in risk, including miscarriage management, which is substantially similar to medication abortion.

**ix. Advanced Practice Clinician Ban**

148. Missouri law states that "[n]o person shall perform or induce an abortion except a physician." § 188.020, RSMo; *see also* §§ 188.080, 334.245, 334.735.3, RSMo. This effectively bars advanced practice clinicians ("APCs") from providing safe abortion care consistent with their scope of practice, which APCs are highly qualified to provide, as they do in many other states. Even though abortion is extraordinarily safe, Missouri law singles out abortion and makes it a crime for APCs

to provide this care. §§ 334.245, 188.080, RSMo. A violation can also result in loss of licensure. §§ 188.065, 334.100.2(4)(g), 335.066.2(2), RSMo.

149. APCs are licensed health care providers with advanced education and training. They include advanced practice registered nurses ("APRNs") and physician assistants ("PAs"). APRNs are defined in Missouri law as "a person who is licensed . . . to engage in the practice of advanced practice nursing as a certified clinical nurse specialist, certified nurse midwife, certified nurse practitioner, or certified registered nurse anesthetist," § 335.016(2), RSMo, and are regulated by the Board of Nursing. PAs, as defined by Missouri law, § 334.735, RSMo, are regulated by the Board of Healing Arts.

150. APCs, with an appropriate collaborative agreement with a physician, §§ 334.037, 334.104, RSMo, may perform a range of medical procedures that are comparable to or more complicated than abortion, including delivering babies, inserting and removing intrauterine contraceptive devices ("IUDs"), performing endometrial biopsies (the removal of tissue from uterine lining), colposcopy, vasectomy, LEEP, endometrial ablation, and prescribing medication, including certain controlled substances. Notably, APCs are also able to treat miscarriage, including by prescribing mifepristone and misoprostol—the exact same drug regimen used for medication abortion.

151. APCs in twenty-one states and the District of Columbia can and do provide abortion care.

152. The APC Ban "denie[s], interfere[s] with, delay[s], or otherwise restrict[s]" patients' rights to obtain an abortion by severely restricting the number of providers available to provide abortions, and, therefore, abortion access. Mo. Const. art. I, § 36.3.

153. Together, Plaintiffs employ only eight physicians who can provide abortions. However, they employ seventeen APCs. APCs provide the majority of care to Plaintiffs' patients. However, under Missouri law they would be unable to provide abortions.

154. If they were able to provide medication abortions, this would significantly expand access to care. For example, Plaintiffs would be able to offer medication abortion at nearly all of Plaintiffs' health centers. This care would be even more expansive if Missouri's Telemedicine Ban were also enjoined. This would greatly reduce delays and make abortion less burdensome to access for patients. It would also increase access to later procedural abortions, because physicians would have more capacity to perform these.

155. The APC Ban necessarily causes delays and interferes with abortion access by requiring appointments to be contingent on physician schedules rather than available every day the health centers are open.

156. It also interferes with patients' ability to "carry out decisions about *all matters* relating to reproductive health care" by limiting the providers from whom they may choose to access abortion care. Mo. Const. art. I, § 36.2 (emphasis added).

157. The APC Ban does not "improv[e] or maintain[] the health of a person seeking care." *Id.* § 36.3. As with every other health care service, existing scope of practice laws in Missouri are more than sufficient to ensure that APCs, like physicians, provide care only for which they are educationally and clinically prepared and for which competency has been maintained.

158. These restrictions are also contrary to "widely accepted clinical standards of practice and evidence-based medicine." *Id.* Peer-reviewed medical literature uniformly demonstrates that APCs can safely and effectively provide abortion care, and medical authorities ranging from the American College of Obstetricians and Gynecologists, to the American Public Health Association, to the World Health Organization, and the National Academies of Sciences, Engineering, and Medicine have all concluded that laws prohibiting APCs from providing this care are medically unfounded. Moreover, the U.S. Food and Drug Administration ("FDA"), which regulates pharmaceuticals, allows APCs to provide medication abortion: In 2016 the FDA updated the label for medication abortion to clarify that this treatment can be provided by or under the supervision of APCs as well as physicians, based on studies that the FDA recognized "found no differences in efficacy, serious adverse events, ongoing pregnancy or incomplete abortion between the groups."[19]

[19] Ctr. for Drug Evaluation & Res., *Application Number 020687Origls020: Mifeprex Medical Review(s)*, FDA at 79 (Mar. 29, 2016).

159. The APC Ban also "infringe[s] on [a patient's] autonomous decision-making" by artificially restricting when and from whom patients may receive abortions. *Id.*

160. Furthermore, the APC Ban "discriminate[s] against persons providing or obtaining reproductive health care" because it is the only law that restricts a medical professional's scope of practice with regards to a particular health care service. *Id.* § 36.6.

161. The APC Ban serves only to harm patients seeking abortion, delaying and impeding them from accessing care—and in some cases, preventing them from accessing care altogether.

### C. Discriminatory Interference with Medical Assistance Law

162. Missouri law provides that

> [a] person commits the offense of interference with medical assistance if he or she, while serving in his or her capacity as an employee of an abortion facility: (1) Knowingly orders or requests medical personnel to deviate from any applicable standard of care or ordinary practice while providing medical assistance to a patient for reasons unrelated to the patient's health or welfare; or (2) Knowingly attempts to prevent medical personnel from providing medical assistance to a patient in accordance with all applicable standards of care or ordinary practice for reasons unrelated to the patient's health or welfare.

§ 574.200, RSMo. The law applies to physicians and surgeons, nurses, emergency medical services personnel, and anyone operating under their supervision. § 574.200.3, RSMo. Violating this law is a class A misdemeanor. § 574.200.2, RSMo.

163. The statute was enacted when Great Rivers asked Emergency Medical Services to refrain from using sirens for non-emergency hospital transfers to avoid drawing attention from protestors, which in the past had led to false claims about patient medical care.

164. The law discriminates against "persons providing . . . reproductive health care" because it is a crime targeting solely abortion facilities and their providers and staff. Mo. Const. art. I, § 36.6. It is not a crime for health care providers employed by any other facility providing comparable or more dangerous care, including facilities providing miscarriage management and birthing centers.

**D. Post-Viability Restriction**

165. Missouri's Post-Viability Restriction prohibits all abortions after viability "[e]xcept in the case of a medical emergency" or

> unless the abortion is necessary to preserve the life of the pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, or when continuation of the pregnancy will create a serious risk of substantial and irreversible physical impairment of a major bodily function.

§ 188.030, RSMo. Even then, unless there is a medical emergency, the abortion provider must

> obtain the agreement of a second physician with knowledge of accepted obstetrical and neonatal practices and standards who shall concur that the abortion is necessary to preserve the life of the pregnant woman, or that continuation of the pregnancy would cause a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant [person].

166. § 188.030.2(4)(c), RSMo. Both providers must document the reasons for the abortion. § 188.030.2(4)(b)–(c), RSMo. Additionally, there must be a second physician present at the abortion "who shall take control of and provide immediate medical care for a child born as a result of the abortion." § 188.030.2(4)(e), RSMo. "Viability" is defined as "that stage of fetal development when the life of the unborn child may be continued indefinitely outside the womb by natural or artificial life-supportive systems." § 188.015(12), RSMo. Violation of the Post-Viability Restriction is a Class D felony and can carry a term of imprisonment, as well as civil and professional licensing consequences. §§ 188.030.3–.4, RSMo. Abortion facilities that allow abortions in violation of this section can be subject to license suspension or revocation. § 188.030.6, RSMo.

167. These requirements for post-viability abortion are inconsistent with and more stringent than what Missouri's constitutional amendment allows, which are

> [L]aws that regulate the provision of abortion after Fetal Viability provided that under no circumstance shall the Government deny, interfere with, delay, or otherwise restrict an abortion that in the good faith judgment of a treating health care professional is needed to protect the life or physical or mental health of the pregnant person.

Mo. Const. art. I, § 36.4.

168. The Right to Reproductive Freedom Initiative defines fetal viability as "the point in pregnancy when, in the good faith judgment of a treating health care professional and based on the particular facts of the case, there is a significant likelihood of the fetus's sustained survival outside the uterus without the application of extraordinary medical measures." *Id.* § 36.8(1). A pregnancy typically lasts forty

weeks LMP. Viability—which is a case-by-case determination—does not occur until after twenty-four weeks LMP at the earliest.

169. The Post-Viability Restriction does not allow for abortions to protect the pregnant patient's mental health, and its definition of "viability" is broader than what is now constitutionally permissible. Its requirement that providers unnecessarily consult with a second physician before providing care, and that they locate another physician to attend the abortion, are also incompatible with the Right to Reproductive Freedom Initiative's plain language.

**E. Criminal Penalties for Abortion Providers**

170. All of the previously mentioned restrictions impose not only onerous civil, professional licensing penalties on abortion providers, but *criminal* penalties as well: Violating almost any part of chapter 188 is a class A misdemeanor (unless otherwise specified), § 188.075, RSMo; violating the Medical Interference law and operating an abortion clinic without a license are class A misdemeanors, §§ 197.235, 574.200.2, RSMo; violating the Total Ban, Gestational Age Bans, or the APC Ban is a class B felony, §§ 188.017.2, 188.056.1, 188.057.1, 188.058.1, 188.080, 188.375.3, 334.245, RSMo; and violating the Post-Viability Restriction (for example, by providing an abortion in reliance on the protections for patient health enshrined in the constitutional amendment) is a class D felony, § 188.030, RSMo.

171. These penalties also—by their very nature— "*penalize*[]" those "assisting [patients] in exercising their right to reproductive freedom," and subject them to "prosecut[ion]" precisely for helping patients obtain an abortion. Mo. Const. art. I,

§ 36.5 (emphasis added). Accordingly, any laws with these penalties should be struck in their entirety. If, however, the underlying law is found to be severable or survive constitutional scrutiny, the criminal penalties themselves must be removed.

172. In the alternative, criminal penalties "interfere[] with" and "restrict[]" the right to reproductive freedom by chilling abortion providers. *Id.* § 36.3. Indeed, these criminal penalties chill practice and are one of the reasons there are so few physicians willing to provide abortion in Missouri.

173. Enforcing criminal penalties does not advance patient health, as evidenced by the fact that no other medical service is regulated in this way. Quite the opposite: criminal abortion penalties make it more likely that patients seeking lawful abortions, pregnancy care, miscarriage care, or emergency care are unable to receive it because of the threat of criminal penalties for providers.

174. "[W]idely accepted clinical standards of practice and evidence-based medicine" support expanding abortion access—not criminalizing it. *Id.*

175. Criminal penalties also "discriminate against persons providing . . . reproductive health care" because there are no other health care professionals in Missouri who could go to prison for simply doing their jobs and providing patients care to which they are constitutionally entitled. *Id.* § 36.6.

176. Therefore, even if any of the restrictions described herein are found to comport with the Reproductive Freedom Initiative, the criminal penalties attached to them must be enjoined.

## IV. Irreparable Harm of Denying, Interfering With, Delaying, and Restricting Abortion

177. If relief is granted in this case, Plaintiffs will be able to resume providing abortions in Missouri, which would actualize the right guaranteed under the Right to Reproductive Freedom Initiative. These laws, individually and taken together, have long decimated abortion access in Missouri. Indeed, they completely halted Comp Health from providing abortions by 2018, and severely curtailed the care Great Rivers was able to offer by 2019. According to DHSS data, in 2020, the first full year when abortion access was severely constrained, there were 167 abortions provided in this state, down from 3,903 in 2017. The medical need for abortion is evident from this statistic alone.

178. If left in place, the above-described restrictions will continue to be catastrophic for Missourians. They will either prevent care altogether or severely delay or interfere with care. These are not acceptable outcomes under the Right to Reproductive Freedom Initiative.

179. Without relief from this Court, Plaintiffs, their providers, and their patients will be irreparably harmed because they will be deprived of their constitutional rights. Plaintiffs and their providers and staff will suffer additional harms, including the threat of criminal, civil, and licensing penalties, reputational harm, and harm to their livelihoods.

180. Plaintiffs expressly state that they are not asserting or attempting to assert any claim under the United States Constitution or any federal statute.

## CLAIMS FOR RELIEF

### Count I

(Right to Reproductive Freedom Initiative – Total Ban, Gestational Age Bans, and Reasons Ban)

181. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1 through 181.

182. "The Government shall not deny or infringe upon a person's fundamental right to reproductive freedom, which is the right to make and carry out decisions about all matters relating to reproductive health care, including but not limited to . . . abortion care." Mo. Const. art. I, § 36.2.

183. Missouri's Total Ban, § 188.017, RSMo, Gestational Age Bans, §§ 188.056, 188.057, 188.058, 188.375, RSMo, and Reasons Ban, §§ 188.038, 188.052, RSMo, 19 C.S.R. § 10-15.010(1), deny Missourians the ability to make autonomous decisions about whether to continue a pregnancy and bear a child, depriving them of the agency, bodily autonomy, and control over their own reproductive futures as guaranteed by the fundamental constitutional right to reproductive freedom. Even if the bans did not outright deny Missourians the right to make and carry out decisions about reproductive health care, the bans also impermissibly infringe upon this right by interfering with, delaying, and restricting patients' access to abortion.

184. Therefore, the bans "shall be presumed invalid." Mo. Const. art. I, § 36.3.

185. State action restricting the fundamental right to reproductive freedom is not permitted "unless the Government demonstrates that such action is justified by a compelling governmental interest achieved by the least restrictive means." *Id.*

186. A "governmental interest is compelling only if it is for the limited purpose and has the limited effect of improving or maintaining the health of a person seeking care, is consistent with widely accepted clinical standards of practice and evidence-based medicine, and does not infringe on that person's autonomous decision-making." *Id.* If the asserted governmental interest does not meet any one of these three requirements, it is not compelling.

187. The State has no compelling governmental interest in these bans because the abortion bans undoubtedly "infringe on th[e] [pregnant] person's autonomous decision-making" by making abortion wholly unavailable at some or all gestational ages to some or all Missourians. *Id.* Even if these bans did not directly infringe on Missourians' autonomous decision-making, any governmental interest in the bans would not be "for the limited purpose" nor have "the limited effect of improving or maintaining the health of a person seeking care" or be "consistent with widely accepted clinical standards of practice and evidence-based medicine." *Id.* And even if the State had a compelling interest, the bans are not the "least restrictive means" of furthering that interest. *Id.*

188. The abortion bans cannot meet the stringent test set forth in the Right to Reproductive Freedom Initiative and must be declared unconstitutional and enjoined.

189. These bans also discriminate against persons obtaining reproductive health care by barring access to abortion, and they discriminate against persons providing reproductive health care by impermissibly penalizing abortion providers, including Plaintiffs, for providing that care. *Id.* § 36.6.

190. If these bans remain in effect, Plaintiffs, their patients, and their staff will suffer significant constitutional, medical, emotional, financial, and other harm for which there exists no other adequate remedy at law.

191. Plaintiffs are entitled to a declaratory judgment pursuant to § 527.010, RSMo that the Total Ban, the Gestational Age Bans, and the Reasons Ban violate their constitutional rights, and an injunction preventing these from being enforced.

**Count II**

(Right to Reproductive Freedom Initiative – Targeted Restrictions on Abortion Providers, Abortion Facility Licensing Requirement)

192. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1 through 192.

193. "The Government shall not deny or infringe upon a person's fundamental right to reproductive freedom, which is the right to make and carry out decisions about all matters relating to reproductive health care, including but not limited to . . . abortion care." Mo. Const. art. I, § 36.2.

194. Missouri's Abortion Facility Licensing Requirement, §§ 197.200–197.235, 334.100.2(27), RSMo, and all of its implementing regulations, 19 C.S.R. §§ 30-30.050–.070, 20 C.S.R. § 2150-7.140(2)(V), "den[y], interfere[ with], delay, [and]

restrict[] . . . the right to reproductive freedom." Mo. Const. art. I, § 36.3. Indeed, these are the very regulations that caused Great Rivers to stop providing medication abortion altogether, nearly three years before the federal right to abortion was abolished. Today, it would be similarly impossible or extremely difficult for Plaintiffs to comply with these restrictions, which would reduce abortion access and make abortion more difficult to access for patients.

195. By denying, interfering with, and delaying patients' access to abortion, these restrictions infringe on Missourians' fundamental right to reproductive freedom.

196. Therefore, the Abortion Facility Licensing Requirement "shall be presumed invalid." *Id.*

197. State action restricting the fundamental right to reproductive freedom is not permitted "unless the Government demonstrates that such action is justified by a compelling governmental interest achieved by the least restrictive means." *Id.*

198. A "governmental interest is compelling only if it is for the limited purpose and has the limited effect of improving or maintaining the health of a person seeking care, is consistent with widely accepted clinical standards of practice and evidence-based medicine, and does not infringe on that person's autonomous decision-making." *Id.* If the asserted governmental interest does not meet any one of these three requirements, it is not compelling.

199. The State has no compelling governmental interest in the Abortion Facility Licensing Requirement because it is not for "the limited purpose and has the limited effect of improving or maintaining the health of a person seeking care" or "consistent

with widely accepted clinical standards of practice and evidence-based medicine." *Id.* And even if the State had a compelling interest, this requirement is not the "least restrictive means" of furthering that interest. *Id.*

200. Additionally, this requirement discriminates against providers assisting their patients in obtaining abortions because the demands it imposes on abortion are more onerous than those on any other medical procedure. *Id.* § 36.6.

201. This requirement cannot meet the stringent test set forth in the Right to Reproductive Freedom Initiative and must be declared unconstitutional and enjoined.

202. If the Abortion Facility Licensing Requirement remains in effect, Plaintiffs, their patients, and their staff will suffer significant constitutional, medical, emotional, financial, and other harm for which there exists no other adequate remedy at law.

203. Plaintiffs are entitled to a declaratory judgment pursuant to § 527.010, RSMo that the Abortion Facility Licensing Requirement violates their constitutional rights, and an injunction preventing this requirement from being enforced.

**Count III**

(Right to Reproductive Freedom Initiative – Targeted Restrictions on Abortion Providers, Hospital Relationship Restrictions)

204. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1 through 204.

205. "The Government shall not deny or infringe upon a person's fundamental right to reproductive freedom, which is the right to make and carry out decisions about all

matters relating to reproductive health care, including but not limited to . . . abortion care." Mo. Const. art. I, § 36.2.

206. Missouri's Hospital Relationship Restrictions, §§ 188.080, 188.027.1(1)(e), 197.215.(2), RSMo, 19 C.S.R. § 30-30.060(1)(C)(4), "den[y], interfere[ with], delay, [and] restrict[] . . . the right to reproductive freedom." Mo. Const. art. I, § 36.3. Comp Health would be unable to comply with these requirements, and Great Rivers would be unable to comply at all of its health centers outside of St. Louis.

207. Therefore, the Hospital Relationship Restrictions "shall be presumed invalid." *Id.*

208. State action restricting the fundamental right to reproductive freedom is not permitted "unless the Government demonstrates that such action is justified by a compelling governmental interest achieved by the least restrictive means." *Id.*

209. A "governmental interest is compelling only if it is for the limited purpose and has the limited effect of improving or maintaining the health of a person seeking care, is consistent with widely accepted clinical standards of practice and evidence-based medicine, and does not infringe on that person's autonomous decision-making." *Id.* If the asserted governmental interest does not meet any one of these three requirements, it is not compelling.

210. The State has no compelling governmental interest in these restrictions because they are not for "the limited purpose and [have] the limited effect of improving or maintaining the health of a person seeking care" or "consistent with widely accepted clinical standards of practice and evidence-based medicine." *Id.* And even if the State

had a compelling interest, these restrictions are not the "least restrictive means" of furthering that interest. *Id.*

211. Additionally, these restrictions discriminate against providers assisting their patients in obtaining abortions because the requirements they impose on abortion are more onerous than those on any other medical procedure—including the identical use of the identical medications used in medication abortion for treatment of other conditions, such as miscarriage. *Id.* § 36.6.

212. These restrictions cannot meet the stringent test set forth in the Right to Reproductive Freedom Initiative and must be declared unconstitutional and enjoined.

213. If the Hospital Relationship Restrictions remain in effect, Plaintiffs, their patients, and their staff will suffer significant constitutional, medical, emotional, financial, and other harm for which there exists no other adequate remedy at law.

214. Plaintiffs are entitled to a declaratory judgment pursuant to § 527.010, RSMo that the Hospital Relationship Restrictions violate their constitutional rights, and an injunction preventing these from being enforced.

**Count IV**

(Right to Reproductive Freedom Initiative – Targeted Restrictions on Abortion Providers, Medication Abortion Complication Plan Requirement)

215. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1 through 215.

216. "The Government shall not deny or infringe upon a person's fundamental right to reproductive freedom, which is the right to make and carry out decisions about all

matters relating to reproductive health care, including but not limited to . . . abortion care." Mo. Const. art. I, § 36.2.

217. Missouri's Medication Abortion Complication Plan Requirement, § 188.021.2, RSMo; 19 C.S.R. § 30-30.061, "den[ies], interfere[s with], delays, [and] restrict[s] . . . the right to reproductive freedom." Mo. Const. art. I, § 36.3. It essentially reimposes a backdoor hospital relationship requirement for medication abortion on Plaintiffs, and was passed after the hospital relationship requirements were enjoined under the then-applicable federal undue burden standard. It was these requirements that ultimately forced Comp Health to stop providing abortions in Columbia. Comp Health would still be unable to comply with these requirements at its Columbia health center, and Great Rivers would be unable to comply at all of its health centers outside of St. Louis.

218. Therefore, the Medication Abortion Complication Plan Requirement "shall be presumed invalid." *Id.*

219. State action restricting the fundamental right to reproductive freedom is not permitted "unless the Government demonstrates that such action is justified by a compelling governmental interest achieved by the least restrictive means." *Id.*

220. A "governmental interest is compelling only if it is for the limited purpose and has the limited effect of improving or maintaining the health of a person seeking care, is consistent with widely accepted clinical standards of practice and evidence-based medicine, and does not infringe on that person's autonomous decision-making." *Id.*

If the asserted governmental interest does not meet any one of these three requirements, it is not compelling.

221. The State has no compelling governmental interest in this requirement because it is not for "the limited purpose and has the limited effect of improving or maintaining the health of a person seeking care" or "consistent with widely accepted clinical standards of practice and evidence-based medicine." *Id.* Moreover, the Medication Abortion Complication Plan Requirement "infringe[s] [patients'] autonomous decision-making" because it would severely curtail or outright eliminate access to medication abortion. *Id.* And even if the State had a compelling interest, this requirement is not the "least restrictive means" of furthering that interest. *Id.*

222. Additionally, the Medication Abortion Complication Plan Requirement discriminates against providers assisting their patients in obtaining abortions because the requirements they impose on abortion are more onerous than those on any other medical procedure—including the identical use of the identical medications used in medication abortion for treatment of other conditions, such as miscarriage. *Id.* § 36.6.

223. This requirement cannot meet the stringent test set forth in the Right to Reproductive Freedom Initiative and must be declared unconstitutional and enjoined.

224. If the Medication Abortion Complication Plan Requirement remains in effect, Plaintiffs, their patients, and their staff will suffer significant constitutional, medical, emotional, financial, and other harm for which there exists no other adequate remedy at law.

225. Plaintiffs are entitled to a declaratory judgment pursuant to § 527.010, RSMo that the Medication Abortion Complication Plan Requirement violates their constitutional rights, and an injunction preventing this requirement from being enforced.

**Count V**

(Right to Reproductive Freedom Initiative – Targeted Restrictions on Abortion Providers, Pathology Requirements)

226. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1 through 226.

227. "The Government shall not deny or infringe upon a person's fundamental right to reproductive freedom, which is the right to make and carry out decisions about all matters relating to reproductive health care, including but not limited to . . . abortion care." Mo. Const. art. I, § 36.2.

228. Missouri's Pathology Requirements, § 188.047, RSMo, 19 C.S.R. § 10-15.030, 19 CSR 30-30.060(5)(B), "den[y], interfere[with], delay[], [and] restrict[] . . . the right to reproductive freedom." Mo. Const. art. I, § 36.3. At this time, Plaintiffs are unable to comply with the Pathology Requirements. This would eliminate procedural abortion in the state altogether.

229. Therefore, the Pathology Requirements "shall be presumed invalid." *Id.*

230. State action restricting the fundamental right to reproductive freedom is not permitted "unless the Government demonstrates that such action is justified by a compelling governmental interest achieved by the least restrictive means." *Id.*

231. A "governmental interest is compelling only if it is for the limited purpose and has the limited effect of improving or maintaining the health of a person seeking care, is consistent with widely accepted clinical standards of practice and evidence-based medicine, and does not infringe on that person's autonomous decision-making." *Id.* If the asserted governmental interest does not meet any one of these three requirements, it is not compelling.

232. The State has no compelling governmental interest in the Pathology Requirements because they are not for "the limited purpose and [have] the limited effect of improving or maintaining the health of a person seeking care" or "consistent with widely accepted clinical standards of practice and evidence-based medicine." *Id.* Moreover, the Pathology Requirements "infringe [patients'] autonomous decision-making" because they would severely curtail or outright eliminate access to procedural abortion. *Id.* And even if the State had a compelling interest, these restrictions are not the "least restrictive means" of furthering that interest. *Id.*

233. Additionally, the Pathology Requirements discriminate against providers assisting their patients in obtaining abortions because the requirements they impose on abortion are more onerous than those on any other medical procedure, including miscarriage. *Id.* § 36.6.

234. These requirements cannot meet the stringent test set forth in the Right to Reproductive Freedom Initiative and must be declared unconstitutional and enjoined.

235. If the Pathology Requirements remain in effect, Plaintiffs, their patients, and their staff will suffer significant constitutional, medical, emotional, financial, and other harm for which there exists no other adequate remedy at law.

236. Plaintiffs are entitled to a declaratory judgment pursuant to § 527.010, RSMo that the Pathology Requirements violate their constitutional rights, and an injunction preventing these from being enforced.

**Count VI**

(Right to Reproductive Freedom Initiative – Targeted Restrictions on Abortion Providers, Reporting Requirements)

237. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1 through 237.

238. "The Government shall not discriminate against persons providing or obtaining reproductive health care or assisting another person in doing so." Mo. Const. art. I, § 36.6.

239. Missouri's Reporting Requirements, § 188.052, RSMo; 19 C.S.R. §§ 10-15.010, 10-15.020, discriminate against patients and providers assisting their patients in obtaining abortions. On information and belief, other procedures and medications of similar or greater risk levels, including miscarriage care, do not require similar reporting. Moreover, the requirements impose criminal penalties on abortion providers for failing to complete administrative tasks—penalties that no other provider of comparable medical services is subject to.

240. These requirements cannot meet the stringent test set forth in the Right to Reproductive Freedom Initiative and must be declared unconstitutional and enjoined.

241. If the Reporting Requirements remain in effect, Plaintiffs, their patients, and their staff will suffer significant constitutional, medical, emotional, financial, and other harm for which there exists no other adequate remedy at law.

242. Plaintiffs are entitled to a declaratory judgment pursuant to § 527.010, RSMo that the Reporting Requirements violates their constitutional rights, and an injunction preventing these from being enforced.

**Count VII**

(Right to Reproductive Freedom Initiative – Targeted Restrictions on Abortion Providers, Biased Information Law)

243. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1 through 243.

244. "The Government shall not deny or infringe upon a person's fundamental right to reproductive freedom, which is the right to make and carry out decisions about all matters relating to reproductive health care, including but not limited to . . . abortion care." Mo. Const. art. I, § 36.2.

245. Missouri's Biased Information Law, §§ 188.027, 188.033, 188.039, RSMo, "den[ies], interfere[s with], delay[s], [and] restrict[s] . . . the right to reproductive freedom." Mo. Const. art. I, § 36.3.

246. Therefore, the Biased Information Law "shall be presumed invalid." *Id.*

247. State action restricting the fundamental right to reproductive freedom is not permitted "unless the Government demonstrates that such action is justified by a compelling governmental interest achieved by the least restrictive means." *Id.*

248. A "governmental interest is compelling only if it is for the limited purpose and has the limited effect of improving or maintaining the health of a person seeking care, is consistent with widely accepted clinical standards of practice and evidence-based medicine, and does not infringe on that person's autonomous decision-making." *Id.* If the asserted governmental interest does not meet any one of these three requirements, it is not compelling.

249. The State has no compelling governmental interest in the Biased Information Law because it is not for "the limited purpose and has limited effect of improving or maintaining the health of a person seeking care." *Id.* Even if the State could put forth such an interest, this law is not "consistent with widely accepted clinical standards of practice and evidence-based medicine." *Id.* Moreover, the Biased Information Law "infringe[s] [patients'] autonomous decision-making" because it is intended to deter patients from choosing abortion care. *Id.* And even if the State had a compelling interest, this restriction is not the "least restrictive means" of furthering that interest. *Id.*

250. The Biased Information Law cannot meet the stringent test set forth in the Right to Reproductive Freedom Initiative and must be declared unconstitutional and enjoined.

251. Additionally, the Biased Information Law discriminates against providers assisting their patients in obtaining abortions because the requirements they impose on abortion are more onerous than those on any other medical service. *Id.* § 36.6.

252. If the Biased Information Law remains in effect, Plaintiffs, their patients, and their staff will suffer significant constitutional, medical, emotional, financial, and other harm for which there exists no other adequate remedy at law.

253. Plaintiffs are entitled to a declaratory judgment pursuant to § 527.010, RSMo that the Biased Information Law violates their constitutional rights, and an injunction preventing it from being enforced.

**Count VIII**

(Right to Reproductive Freedom Initiative – Targeted Restrictions on Abortion Providers, Waiting Period, In-Person, and Same Physician Requirements)

254. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1 through 254.

255. "The Government shall not deny or infringe upon a person's fundamental right to reproductive freedom, which is the right to make and carry out decisions about all matters relating to reproductive health care, including but not limited to . . . abortion care." Mo. Const. art. I, § 36.2.

256. Missouri's Waiting Period, In-Person, and Same Physician Requirements, §§ 188.027, 188.039, RSMo, "den[y], interfere[with], delay[], [and] restrict[] . . . the right to reproductive freedom." Mo. Const. art. I, § 36.3. They de facto delay patients' ability to obtain an abortion, and they make that care more difficult–indeed, in some cases, nearly impossible–to obtain.

257. Therefore, the Waiting Period, In-Person, and Same Physician Requirements "shall be presumed invalid." *Id*.

258. State action restricting the fundamental right to reproductive freedom is not permitted "unless the Government demonstrates that such action is justified by a compelling governmental interest achieved by the least restrictive means." *Id*.

259. A "governmental interest is compelling only if it is for the limited purpose and has the limited effect of improving or maintaining the health of a person seeking care, is consistent with widely accepted clinical standards of practice and evidence-based medicine, and does not infringe on that person's autonomous decision-making." *Id*. If the asserted governmental interest does not meet any one of these three requirements, it is not compelling.

260. The State has no compelling governmental interest in these restrictions because they are not for "the limited purpose and [have] the limited effect of improving or maintaining the health of a person seeking care." *Id*. Even if the State could put forth such an interest, these requirements are not "consistent with widely accepted clinical standards of practice and evidence-based medicine." *Id.* Moreover, these requirements "infringe[s] [patients'] autonomous decision-making" because they are intended to deter patients from choosing abortion care. *Id.* And even if the State had a compelling interest, these restrictions are not the "least restrictive means" of furthering that interest. *Id*.

261. Additionally, the Waiting Period, In-Person, and Same Physician Requirements discriminate against providers assisting their patients in obtaining abortions because the requirements they impose on abortion are more onerous than those on any other medical service. *Id*. § 36.6.

262. These requirements cannot meet the stringent test set forth in the Right to Reproductive Freedom Initiative and must be declared unconstitutional and enjoined.

263. If these requirements remain in effect, Plaintiffs, their patients, and their staff will suffer significant constitutional, medical, emotional, financial, and other harm for which there exists no other adequate remedy at law.

264. Plaintiffs are entitled to a declaratory judgment pursuant to § 527.010, RSMo that the Waiting Period, In-Person, and Same Physician Requirements violate their constitutional rights, and an injunction preventing these from being enforced.

**Count IX**

(Right to Reproductive Freedom Initiative – Targeted Restrictions on Abortion Providers, Telemedicine Ban)

265. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1 through 265.

266. "The Government shall not deny or infringe upon a person's fundamental right to reproductive freedom, which is the right to make and carry out decisions about all matters relating to reproductive health care, including but not limited to . . . abortion care." Mo. Const. art. I, § 36.2.

267. Missouri's Telemedicine Ban, § 188.021, RSMo, "den[ies], interfere[s with], delay[s], [and] restrict[s] . . . the right to reproductive freedom," Mo. Const. art. I, § 36.3, by making it more difficult to obtain a medication abortion than other comparable health care and increasing the distance patients must travel to obtain this care.

268. Therefore, the Telemedicine Ban "shall be presumed invalid." *Id.*

269. State action restricting the fundamental right to reproductive freedom is not permitted "unless the Government demonstrates that such action is justified by a compelling governmental interest achieved by the least restrictive means." *Id.*

270. A "governmental interest is compelling only if it is for the limited purpose and has the limited effect of improving or maintaining the health of a person seeking care, is consistent with widely accepted clinical standards of practice and evidence-based medicine, and does not infringe on that person's autonomous decision-making." *Id.* If the asserted governmental interest does not meet any one of these three requirements, it is not compelling.

271. The State has no compelling governmental interest in the Telemedicine Ban because it is not for "the limited purpose and has the limited effect of improving or maintaining the health of a person seeking care" or "consistent with widely accepted clinical standards of practice and evidence-based medicine." *Id.* Moreover, the Telemedicine Ban "infringe[s] [patients'] autonomous decision-making" because it is yet another barrier intended to dissuade patients from choosing abortion. *Id.* And even if the State had a compelling interest, this ban is not the "least restrictive means" of furthering that interest. *Id.*

272. Additionally, the Telemedicine Ban discriminates against providers assisting their patients in obtaining abortions because the requirements it imposes on abortion are more onerous than those on any other medical service. *Id.* § 36.6.

273. The Telemedicine Ban cannot meet the stringent test set forth in the Right to Reproductive Freedom Initiative and must be declared unconstitutional.

274. If the Telemedicine Ban remains in effect, Plaintiffs, their patients, and their staff will suffer significant constitutional, medical, emotional, financial, and other harm for which there exists no other adequate remedy at law.

275. Plaintiffs are entitled to a declaratory judgment pursuant to § 527.010, RSMo that the Telemedicine Ban violates their constitutional rights, and an injunction preventing it from being enforced.

**Count X**

(Right to Reproductive Freedom Initiative – Targeted Restrictions on Abortion Providers, Advanced Practice Clinician Ban)

276. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1 through 276.

277. "The Government shall not deny or infringe upon a person's fundamental right to reproductive freedom, which is the right to make and carry out decisions about all matters relating to reproductive health care, including but not limited to . . . abortion care." Mo. Const. art. I, § 36.2.

278. Missouri's Advanced Practice Clinician Ban, §§ 188.020, 188.080, 334.245, 334.735.3, RSMo, "den[ies], interfere[s with], delay[s], [and] restrict[s] . . . the right to reproductive freedom," Mo. Const. art. I, § 36.3, by restricting the pool of available abortion providers and barring APCs from providing safe abortion care consistent with their scope of practice, which APCs are highly qualified to provide, and as they do in many other states. It also interferes with patients' ability to "carry out decisions about *all matters* relating to reproductive health care" by limiting the providers from whom they may choose to access abortion care. *Id.* § 36.2 (emphasis added).

279. Therefore, the APC Ban "shall be presumed invalid." *Id.* § 36.3.

280. State action restricting the fundamental right to reproductive freedom is not permitted "unless the Government demonstrates that such action is justified by a compelling governmental interest achieved by the least restrictive means." *Id.*

281. A "governmental interest is compelling only if it is for the limited purpose and has the limited effect of improving or maintaining the health of a person seeking care, is consistent with widely accepted clinical standards of practice and evidence-based medicine, and does not infringe on that person's autonomous decision-making." *Id.* If the asserted governmental interest does not meet any one of these three requirements, it is not compelling.

282. The State has no compelling governmental interest in the APC Ban because it is not for "the limited purpose and has the limited effect of improving or maintaining the health of a person seeking care" and "consistent with widely accepted clinical standards of practice and evidence-based medicine." *Id.* Moreover, the APC Ban "infringe[s] [patients'] autonomous decision-making" by restricting when and from whom patients may receive abortions. *Id.* And even if the State had a compelling interest, this restriction is not the "least restrictive means" of furthering that interest. *Id.*

283. Additionally, the APC Ban "discriminate[s] against persons providing or obtaining reproductive health care" by restricting the care APCs can provide only with respect to abortion, but not to substantively identical or more complicated care. *Id.* § 36.6.

284. The APC Ban cannot meet the stringent test set forth in the Right to Reproductive Freedom Initiative and must be declared unconstitutional and enjoined.

285. If the APC Ban remains in effect, Plaintiffs, their patients, and their staff will suffer significant constitutional, medical, emotional, financial, and other harm for which there exists no other adequate remedy at law.

286. Plaintiffs are entitled to a declaratory judgment pursuant to § 527.010, RSMo that the APC Ban violates their constitutional rights, and an injunction preventing it from being enforced.

**Count XI**

(Right to Reproductive Freedom Initiative – Discriminatory Interference with Medical Assistance Law)

287. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1 through 287.

288. The Government "shall not discriminate against persons providing or obtaining reproductive health care or assisting another person in doing so." Mo. Const. art. I, § 36.6.

289. Missouri's Discriminatory Interference with Medical Assistance Law, § 574.200, RSMo, discriminates against providers assisting their patients in obtaining abortions because the requirements they impose on abortion are more onerous than those on any other medical procedure, and target only abortion providers for criminal penalties. Mo. Const. art. I, § 36.6.

290. The Discriminatory Interference with Medical Assistance Law cannot meet the stringent test set forth in the Right to Reproductive Freedom Initiative and must be declared unconstitutional and enjoined.

291. If the Discriminatory Interference with Medical Assistance Law remains in effect, Plaintiffs, their patients, and their staff will suffer significant constitutional, medical, emotional, financial, and other harm for which there exists no other adequate remedy at law.

292. Plaintiffs are entitled to a declaratory judgment pursuant to § 527.010, RSMo that the Discriminatory Interference with Medical Assistance Law violates their constitutional rights, and an injunction preventing it from being enforced.

**Count XII**

(Right to Reproductive Freedom Initiative – Post-Viability Restriction)

293. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1 through 293.

294. The Right to Reproductive Freedom Initiative states:

> [T]he general assembly may enact laws that regulate the provision of abortion after Fetal Viability provided that under no circumstance shall the Government deny, interfere with, delay, or otherwise restrict an abortion that in the good faith judgment of a treating health care professional is needed to protect the life or physical or mental health of the pregnant person.

Mo. Const. art. I, § 36.4.

295. Fetal viability is defined as "the point in pregnancy when, in the good faith judgment of a treating health care professional and based on the particular facts of the

case, there is a significant likelihood of the fetus's sustained survival outside the uterus without the application of extraordinary medical measures." *Id.* § 36.8(1).

296. While the Right to Reproductive Freedom Initiative allows some bans of post-viability abortion, Missouri's Post-Viability Restriction, § 188.030, RSMo, contains provisions that are inconsistent with the Right to Reproductive Freedom Initiative's protections for patient health. These include the Restriction's failure to authorize an exception if the abortion is needed to protect the mental health of the pregnant person; its requirement that the treating physician "obtain the agreement of a second physician with knowledge of accepted obstetrical and neonatal practices and standards who shall concur that the abortion is necessary" rather than deferring to the good faith judgment of a treating health care professional as the Right to Reproductive Freedom Initiative requires; and its requirement that a second doctor attend every post-viability abortion. § 188.030.2(4)(c), RSMo. All of these inconsistencies make it more difficult to obtain care, increase the time it takes to provide care, and impermissibly jeopardize patient life and health.

297. The Post-Viability Restriction also contains a definition of viability that differs from that found in the Right to Reproductive Freedom Initiative, and to the degree it applies to abortions not considered viable under the Right to Reproductive Freedom Initiative, such an application would violate Missouri's new constitutional protection. The State has no compelling governmental interest in any such overly broad application of the Post-Viability Restriction because it is not for "the limited purpose and has the limited effect of improving or maintaining the health of a person seeking

care" and "consistent with widely accepted clinical standards of practice and evidence-based medicine." Mo. Const. art. I, § 36.3. Moreover, this application "infringe[s] [patients'] autonomous decision-making" by restricting when and from whom patients may receive abortions. *Id.* And even if the State had a compelling interest, this application is not the "least restrictive means" of furthering that interest. *Id.*

298. Unconstitutional provisions of the Post-Viability Restriction should be severed, and the remainder of the Post-Viability Restriction should be construed so as to comport with the Right to Reproductive Freedom Initiative to avoid being unconstitutional.

299. Without this relief, Plaintiffs, their patients, and their staff will suffer significant constitutional, medical, emotional, financial, and other harm for which there exists no other adequate remedy at law.

300. Plaintiffs are entitled to a declaratory judgment pursuant to § 527.010, RSMo that the Post-Viability Restriction cannot be read to be more restrictive than permitted under the Right to Reproductive Freedom Initiative and any parts that are more restrictive should be severed, and an injunction preventing the Restriction from being enforced in an unconstitutional way.

**Count XIII**

(Right to Reproductive Freedom Initiative – Criminal Penalties for Abortion Providers)

301. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1 through 301.

302. "The Government shall not deny or infringe upon a person's fundamental right to reproductive freedom, which is the right to make and carry out decisions about all matters relating to reproductive health care, including but not limited to . . . abortion care." Mo. Const. art. I, § 36.2.

303. Missouri's Criminal Penalties for Abortion Providers, §§ 188.017.2, 188.030.3, 188.056.1, 188.057.1, 188.058.1, 188.075, 188.080, 188.375.3, 197.235, 334.245, 574.200.2, RSMo, by their very nature, "*penalize*[]" those "assisting [patients] in exercising their right to reproductive freedom," and subject them to "prosecut[ion]" precisely for helping patients obtain an abortion. Mo. Const. art. I, § 36.5 (emphasis added). Accordingly, any laws with these penalties should be struck in their entirety. If, however, the underlying law is found to be severable or survive constitutional scrutiny, the criminal penalties themselves must be removed.

304. In the alternative, these penalties "den[y], interfere[with], delay[], [and] restrict[] . . . the right to reproductive freedom" by chilling abortion providers from providing care that is now not only lawful, but constitutionally protected. *Id.* § 36.3.

305. Therefore, the Criminal Penalties for Abortion Providers "shall be presumed invalid." *Id.*

306. State action restricting the fundamental right to reproductive freedom is not permitted "unless the Government demonstrates that such action is justified by a compelling governmental interest achieved by the least restrictive means." *Id.*

307. A "governmental interest is compelling only if it is for the limited purpose and has the limited effect of improving or maintaining the health of a person seeking care,

is consistent with widely accepted clinical standards of practice and evidence-based medicine, and does not infringe on that person's autonomous decision-making." *Id.* If the asserted governmental interest does not meet any one of these three requirements, it is not compelling.

308. The State has no compelling governmental interest in the Criminal Penalties for Abortion Providers because they are not "for the limited purpose" and do not have "the limited effect of improving or maintaining the health of a person seeking care." *Id.* Even if the State could put forth such an interest, these criminal penalties are not "consistent with widely accepted clinical standards of practice and evidence-based medicine," and they "infringe on [the patient's] autonomous decision-making." *Id.* And even if the State had a compelling interest, these criminal penalties are not the "least restrictive means" of furthering that interest. *Id.*

309. Additionally, the Criminal Penalties for Abortion Providers "discriminate against persons providing or obtaining reproductive health care" because abortion providers are the only health care professionals subject to criminal penalties merely for doing their jobs. *Id.* § 36.6. For example, a health care provider helping a patient with miscarriage management by using the same drugs and procedures used in abortion is not subject to criminal penalties for doing so.

310. The Criminal Penalties for Abortion Providers cannot meet the stringent test set forth in the Right to Reproductive Freedom Initiative and must be declared unconstitutional.

311. If the Criminal Penalties for Abortion Providers remain in effect, Plaintiffs, their patients, and their staff will suffer significant constitutional, medical, emotional, financial, and other harm for which there exists no other adequate remedy at law.

312. Plaintiffs are entitled to a declaratory judgment pursuant to § 527.010, RSMo that the Criminal Penalties for Abortion Providers violate their constitutional rights, as well as an injunction preventing any law with these penalties from being enforced, or, in the alternative, from the criminal penalties being enforced.

## REQUESTS FOR RELIEF

WHEREFORE, Plaintiffs ask this Court:

A. To issue a temporary restraining order and/or preliminary injunction effective on or before December 5, 2024, and later a permanent injunction, restraining Defendants, their employees, agents, and successors in office from enforcing the provisions challenged herein;

B. To enter a judgment declaring that these laws violate the Missouri Constitution, Article I, Section 36, by denying and/or infringing on Plaintiffs', their patients', and their providers' Right to Reproductive Freedom, and/or "discriminat[ing] against persons providing or obtaining reproductive health care," and/or "penaliz[ing] . . . or otherwise subject[ing] to adverse action" those who "assist[] a person in exercising their right to reproductive freedom;" and

C. To grant such other and further relief as the Court deems just and proper.

Respectfully submitted,

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**IN THE CIRCUIT COURT OF JACKSON COUNTY,**

**MISSOURI, AT KANSAS CITY**

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| COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, PLANNED PARENTHOOD GREAT RIVERS-MISSOURI<br><br>Plaintiffs,<br><br>v.<br><br>THE STATE OF MISSOURI, et al.<br><br>Defendants, | No. _____ |

**PLAINTIFFS' SUGGESTIONS IN SUPPORT OF THEIR MOTION FOR PRELIMINARY INJUNCTION OR, IN THE ALTERNATIVE, TEMPORARY RESTRAINING ORDER**

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## INTRODUCTION

On November 5, 2024, by decisive majority, the people of Missouri approved an amendment to their constitution with a very clear dictate: the right to reproductive freedom is fundamental, and, except under extremely limited circumstances, cannot be in any way curtailed by the government. As the Right to Reproductive Freedom Initiative states: "The Government shall not deny or infringe upon a person's fundamental right to reproductive freedom . . . including but not limited to . . . abortion care . . . . Any denial, interference, delay, or restriction of the right to reproductive freedom shall be presumed invalid." Mo. Const. art. I, §§ 36.2–.3 (attached as Exhibit A). But this dictate will remain meaningless unless abortion access is restored in Missouri, which cannot happen until relief is granted in this case. Plaintiffs respectfully request this relief by December 5, 2024, the day the Right to Reproductive Freedom Initiative will take effect, so as to avoid imminent constitutional injury to their patients, their providers, and their staff.

The Missouri State Legislative and Executive branches have spent decades targeting abortion through various restrictive and medically unnecessary laws and regulations, ultimately driving most abortion providers out of the state in 2019, three years before the U.S. Supreme Court abolished the federal constitutional right to abortion in *Dobbs v. Jackson Women's Health Organization*, 597 U.S. 215 (2022). After *Dobbs*, Missouri was the first state to enact a total ban on abortion. But *Dobbs* also recognized that states retain

the power to protect this important right. Missourians have now spoken, and they reject these restrictions on necessary medical care for thousands of Missourians.

Plaintiffs are prepared to provide abortion in Missouri as soon as the Right to Reproductive Freedom Initiative, Article I, Section 36 of the Missouri Constitution, takes effect on December 5, and ask this Court to enjoin Missouri's unconstitutional abortion restrictions so that they may do so. All of the laws challenged in this PI motion must be enjoined in order for the Plaintiffs to begin carrying out the Right to Reproductive Freedom Initiative's promise and restoring abortion access in the state. Plaintiffs respectfully request that this Court enter an expedited briefing and hearing schedule to ensure sufficient time for the Court to issue a preliminary injunction just as the Right to Reproductive Freedom Initiative goes into effect on December 5 or, in the alternative, that the Court issue a temporary restraining order that goes into effect that day.

## FACTUAL AND STATUTORY BACKGROUND

### A. The Right to Reproductive Freedom Initiative

On November 5, 2024, Missouri voters approved the Right to Reproductive Freedom Initiative. This amendment will automatically take effect thirty days after the vote, on December 5, 2024. Mo. Const. art. XII, § 2(b).

With the passage of the Right to Reproductive Freedom Initiative, "the right to make and carry out decisions about all matters relating to reproductive health care, including … abortion," became a fundamental right under the Missouri Constitution. Mo. Const. art. I, § 36.2. Therefore, "[t]he right to reproductive freedom shall not be denied, interfered with,

delayed, or otherwise restricted unless the Government demonstrates that such action is justified by a compelling governmental interest achieved by the least restrictive means." *Id.* § 36.3. A "governmental interest is compelling only if it is for the limited purpose and has the limited effect of improving or maintaining the health of a person seeking care, is consistent with widely accepted clinical standards of practice and evidence-based medicine, and does not infringe on that person's autonomous decision-making." *Id.* The amendment separately provides: "The Government shall not discriminate against persons providing or obtaining reproductive health care or assisting another person in doing so." *Id.* § 36.6. "Nor shall any person assisting a person in exercising their right to reproductive freedom with that person's consent be penalized, prosecuted, or otherwise subjected to adverse action for doing so." *Id.* § 36.5.

Proponents of the measure, working as Missourians for Constitutional Freedom, successfully submitted this amendment despite multiple efforts by state actors to thwart the initiative before it reached the voters. *See Coleman v. Ashcroft*, 696 S.W.3d 347 (Mo. banc 2024) (denying an attempt by Secretary of State and anti-abortion activists to strike the Right to Reproductive Freedom Initiative from the ballot after the Secretary of State had already certified it); *State ex rel. Fitz-James v. Bailey*, 670 S.W.3d 1 (Mo. banc 2023) (mandamus compelling Attorney General to approve the legal content and form of the fiscal note summary); *Fitz-James v. Ashcroft*, 678 S.W.3d 194 (Mo. App. W.D. 2023) (correcting the insufficient and unfair summary statement drafted by the Secretary of State); *Kelly v. Fitzpatrick*, 677 S.W.3d 622 (Mo. App. W.D. 2023) (denying petition from

anti-abortion politicians and activists to rewrite the fiscal note summary); *Fitz-James v. Ashcroft*, No. 24AC-CC06970 (Mo. Cir. Ct. Cole Cnty. Sept. 5, 2024) (rewriting "fair ballot language" to comport with the summary statement approved by the Court of Appeals).[1]

Despite these delays, which limited the amount of time proponents had to collect signatures, Missourians for Constitutional Freedom submitted the petition with more than 380,000 signatures of Missourians wishing to see the measure placed on the November 2024 ballot. And Missouri voters have now enshrined this new protection in their constitution.

In *Brown v. Carnahan*, the Missouri Supreme Court states: "The people, from whom all constitutional authority is derived, have reserved the 'power to propose and enact or reject laws and amendments to the Constitution.'" 370 S.W.3d 637, 645 (Mo. banc 2012) (quoting *Missourians to Protect the Initiative Process v. Blunt*, 799 S.W.2d 824, 827 (Mo. banc 1990)). And "[n]othing in our constitution so closely models participatory democracy in its pure form. Through the initiative process, those who have no access to or influence with elected representatives may take their cause directly to the people." *Id.*

[1] As a part of the Secretary's review of the petition, the Secretary also determined the Right to Reproductive Freedom Initiative complies with the Missouri Constitution, including Article III, Section 50, and with chapter 116 of the Revised Statutes of Missouri, including section 116.050.2(2). *See* § 116.120.1, RSMo 2016.

The people of Missouri have spoken resoundingly to protect their unfettered right to reproductive health care, including abortion. This Court must now make that right a reality.

**B. Abortion is safe and common**

Abortion is a safe and common medical procedure. Approximately one in four women, for a wide variety of reasons, have an abortion by the age of forty-five. Aff. of Dr. Selina Sandoval in Supp. of Mot. for Prelim. Inj. or. in the Alternative, Temporary Restraining Order ("Sandoval Aff.") ¶ 8 (attached as Exhibit B). Pregnant patients may, for example, decide they do not want to have children, or instead plan to have children (or additional children) when they are older, financially able to provide necessities for them, and/or in a supportive relationship with a partner so that their children will have two parents. Many are parents already, who have decided that they cannot parent another child at this time. Other patients may desire to have a child but learn of a medical diagnosis affecting their health or the health of their pregnancy. *Id.* ¶ 9. Abortion is also safer than carrying a pregnancy to term, as to both morbidity and mortality. *Id.* ¶¶ 17–20. While legal abortion is very safe, the medical risks do increase as pregnancy progresses. *Id.* ¶ 16. Delay in accessing abortion thus increases the risks a patient faces.

There are two methods of abortion: medication abortion and procedural abortion. *Id.* ¶ 10. For pregnancies up to twelve weeks, dated from the first day of a patient's last menstrual period ("LMP"), a patient may have an abortion using medications alone. *Id.*

¶ 6. No anesthesia or sedation is involved. In a medication abortion, the patient takes first one medication and then a second one 24–48 hours later, and then passes the products of conception, usually in their home, in a process similar to an early miscarriage. *Id.* ¶¶ 11–12.

Procedural abortion, which is also available early in pregnancy, involves dilating the cervix and using suction and/or instruments to empty the contents of the uterus. *Id.* ¶ 13. Starting at approximately fifteen weeks LMP, suction alone may no longer be sufficient to perform a procedural abortion, and providers may begin using the dilation and evacuation (D&E) method, which involves the removal of the fetus and other products of conception from the uterus using instruments, such as forceps, in conjunction with suction. *Id.* This process generally takes approximately 2–15 minutes. *Id.* Starting at approximately eighteen weeks LMP, patients usually require two consecutive days of care: on the first day, the patient's cervix is dilated, and on the second, the patient receives the abortion procedure. *Id.* Procedural abortion is not surgery because it does not involve an incision into the patient's skin. *Id.*

Abortion is time-sensitive, essential health care. Delaying or denying access to abortion is extremely harmful for patients and their families. *Id.* ¶ 22. Even an uncomplicated pregnancy carries risks and physical burdens which increase as the pregnancy progresses, so every day a person is forced to remain pregnant against their will

causes physical and sometimes psychological harm—more so if the pregnancy worsens underlying health conditions. *Id.* And although abortion is extremely safe, the risk of serious complications associated with abortion also increases as a patient's pregnancy advances. *Id.* Legal barriers to abortion care exacerbate pre-existing logistical and financial difficulties, which are especially challenging for low-income patients often juggling work and childcare responsibilities. Delays in access to abortion can cause patients to miss the window in which to have their preferred type of abortion and sometimes deny patients access to abortion altogether. *Id.*

### C. Missouri bans and restricts abortion in every way possible

The Missouri Legislature has been clear in pursuing its long-held goal to severely restrict—and ultimately eliminate—access to abortion in Missouri. *See, e.g.*, § 188.010, RSMo 2016[2] ("It is the intention of the general assembly of the state of Missouri to . . . regulate abortion to the full extent permitted by the Constitution . . . ."). Missouri has passed nearly every abortion ban and restriction invented by the anti-abortion movement, culminating in the 2019 passage of a total abortion ban which took effect within forty-five minutes of the U.S. Supreme Court overturning *Roe v. Wade* in *Dobbs*, 597 U.S. 215. § 188.017, RSMo ("Total Ban"). In addition to that Total Ban, Missouri has passed multiple, overlapping abortion bans starting at eight weeks LMP, § 188.056, RSMo

[2] All statutory citations are to Missouri Revised Statutes (2016), as updated, unless otherwise noted.

("Eight-Week Ban"), fourteen weeks LMP, § 188.057, RSMo ("Fourteen-Week Ban"), eighteen weeks LMP, § 188.058, RSMo ("Eighteen-Week Ban"), and twenty weeks LMP, § 188.375, RSMo ("Twenty-Week Ban") (collectively, the "Gestational Age Bans"),[3] as well as a ban on abortion where the provider "knows" a patient is seeking an abortion "solely because of a prenatal diagnosis, test, or screening indicating Down syndrome" or the potential for it, or on the basis of the sex or race of the embryo or fetus, §§ 188.038, 188.052, RSMo; 19 C.S.R. § 10-15.010(1) ("Reasons Ban"). The Total Ban and Gestational Age Bans have no exceptions, but each contains a single, narrow affirmative defense for medical emergencies.[4]

Separate from the bans outright prohibiting access to abortion, Missouri spent over two decades enacting successive waves of medically unnecessary abortion restrictions that single out, stigmatize, and interfere with abortion, distinct from any other medical care. These laws discriminate against and treat abortion differently even from miscarriage management, which involves exactly the same drugs and procedures as abortion care. For example, several Targeted Restrictions on Abortion Provider ("TRAP") laws, including:

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[3] Each of the Gestational Age Bans takes effect prior to viability. Each of the Gestational Age Bans is also purportedly "severable" such that, in the event any of them is found unconstitutional or invalid, the other Gestational Age Bans are intended to remain in effect. *See* §§ 188.056.4, 188.057.4, 188.058.4, 188.375.9, RSMo.

[4] A "medical emergency" is narrowly defined as a condition that necessitates an "immediate" abortion "to avert the death of the pregnant woman" or a "serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman." § 188.015.8, RSMo; *see also* §§ 188.017.2-3, 188.056.1-2, 188.057.1-2, 188.058.1-2, 188.375.3-4, RSMo.

- Laws singling out abortion for prohibitive and unnecessary hospital-like requirements that succeeded in causing most health centers to stop providing abortion in 2019, well before *Dobbs* allowed the Total Ban to go into effect. §§ 197.200–.235, 334.100.2(27), RSMo; 20 C.S.R. § 2150-7.140(2)(V), 19 C.S.R. §§ 30-30.050–.070 (the "Abortion Facility Licensing Requirement"). These restrictions include a requirement that any health center that provides an abortion—even a single medication abortion—must be annually licensed as an "ambulatory *surgical* center," with large, hospital-like corridors, doorways, and rooms.
- Several overlapping requirements that abortion providers have admitting privileges (or similar) at a local hospital—privileges which are a poor fit for abortion providers as well as unnecessary for the safe provision of abortion, and are correspondingly hard to get. §§ 188.080, 188.027.1(1)(e), 197.215.2, RSMo; 19 C.S.R. § 30-30.060(1)(C)(4) (the "Hospital Relationship Restrictions").
- A special "complication plan" that requires any provider of medication abortion to have a detailed contract with an ob-gyn who will be "on-call and available" around the clock to "personally treat all complications" arising from medication abortion. § 188.021.2, RSMo; 19 C.S.R. § 30-30.061;[5] (the

[5] A very similar complication plan regulation, 19 C.S.R. § 10-15.050, applies to medication abortion provided by physicians in hospitals.

"Medication Abortion Complication Plan Requirement"). No other medication–particularly not one with a safety profile on par with ibuprofen–requires such an onerous and unnecessary arrangement.

- A requirement that *all* tissue removed from an abortion be promptly sent to a pathologist for examination and report, regardless of medical need. § 188.047, RSMo; 19 C.S.R. § 10-15.030, 30-30.060(5)(B) (the "Pathology Requirement").
- Abortion providers must give every patient a lengthy list of state-mandated, biased information and materials, including graphic illustrations of fetal development and information about carrying a pregnancy to term, designed to interfere with the patient's autonomous decision to have an abortion. §§ 188.027, 188.039, 188.033, RSMo (the "Biased Information Law").
- Restrictions that force patients to travel to a health center for *two in-person* appointments, at least seventy-two hours apart, with the *same doctor* who will provide the abortion, create frequently impossible logistical hurdles for both patient and provider. §§ 188.027, 188.039, RSMo (the "Waiting Period, In-Person, Same Physician Restrictions"). The purpose of the first in-person appointment, which delays already extremely time-sensitive health care, is simply to present the patient with the state-scripted mandatory "disclosures" described above.

- A ban on telemedicine abortion, which requires a patient to take the first of the two medication abortion drugs "in the same room and in the physical presence" of the prescribing physician. § 188.021.1, RSMo (the "Telemedicine Ban"). All other health care may be provided via telemedicine in Missouri, within the scope of the provider's practice.
- Restrictions that ban qualified, licensed health care professionals other than a physician from providing abortions, including medication abortion, §§ 334.245, 334.735.3, 188.020, 188.080, RSMo, even though it is well within the scope of practice for advanced practice clinicians ("APCs"), such as physician's assistants or advanced practice registered nurses, to do so—as they routinely and safely do for similar and even more complex care (the "APC Ban").

Missouri enforces almost all of the above laws using criminal penalties, as well as licensing and other civil penalties against providers. Violations of the Total Ban, Gestational Age Bans, and the APC Ban are each punishable as a Class B felony. §§ 188.017.2 (Total Ban), 188.056.1 (Eight-Week Ban), 188.057.1 (Fourteen-Week Ban), 188.058.1 (Eighteen-Week Ban), 188.375.3 (Twenty-Week Ban), 334.245 (APC Ban), 188.080, RSMo (APC Ban); *see also* § 558.011.1(2), RSMo (Class B felony punishable by five to fifteen years in prison). All of the other laws described above are punishable as a class A misdemeanor. *See* §§ 188.075 (class A misdemeanor for any violation of chapter 188 unless otherwise specified), 197.235 (class A misdemeanor for failure to meet

Abortion Facility Licensing Requirement), 188.080, RSMo (class A misdemeanor for physician providing abortion without clinical privileges at nearby hospital); *see also* § 558.011.1(6), RSMo (class A misdemeanor punishable by up to one year in prison).

These laws, collectively and individually, have denied, interfered with, delayed, and restricted Missourians' access to abortion for many years and must be enjoined under the new protections of the Right to Reproductive Freedom Initiative.

**D. Plaintiffs are ready to provide abortion in Missouri again**

Plaintiffs are not-for-profit organizations that once provided abortions in Missouri and plan to do so again as soon as legally possible—which, given the drastic restrictions above, will require an injunction of all laws in this preliminary injunction motion in order for Plaintiffs to begin carrying out the Right to Reproductive Freedom Initiative's promise and restoring abortion access in the state.

Comprehensive Health of Planned Parenthood Great Plains ("Comp Health") is organized under the laws of Kansas and registered to do business in Missouri. Comp Health stopped providing abortions in Missouri in 2018 because Missouri's many overlapping, overly restrictive Targeted Restrictions on Abortion Providers proved too difficult to comply with. Aff. of Emily Wales in Supp. of Mot. for Prelim. Inj. or. in the Alternative, Temporary Restraining Order ("Wales Aff.") ¶¶ 5–16 (attached as Exhibit C). Comp Health plans to provide medication and procedural abortions at health centers run by Planned Parenthood Great Plains in Kansas City and Columbia on December 5, or as soon as the unconstitutional restrictions are enjoined. *Id.* ¶¶ 4, 17.

Planned Parenthood Great Rivers-Missouri ("Great Rivers") is based in Missouri and currently operates six health centers in the state. Aff. of Richard Muniz in Supp. of Mot. for Prelim. Inj. or. in the Alternative, Temporary Restraining Order ("Muniz Aff.") ¶ 3 (attached as Exhibit D). Through an affiliated organization, Great Rivers (then operating as Planned Parenthood of the St. Louis Region and Southwest Missouri) stopped providing abortion in Missouri on June 24, 2022, when the Total Ban went into effect. *Id.* ¶ 1. Great Rivers plans to begin providing medication and procedural abortion again on December 5, or as soon as the unconstitutional restrictions are enjoined, starting with its main health center in St. Louis and then moving to its other health centers in St. Louis and Southwest. *Id.* ¶¶ 4, 8.

**ARGUMENT**

Missouri Supreme Court Rule ("Rule") 92.02 and section 526.030 allow for the issuance of injunctive relief where "immediate and irreparable injury, loss, or damage will result in the absence of relief." Rule 92.02(a); § 526.030, RSMo ("The remedy by writ of injunction or prohibition shall exist in all cases . . . to prevent the doing of any legal wrong whatever, whenever in the opinion of the court an adequate remedy cannot be afforded by an action for damages."). A court need not, and should not, wait until some identifiable injury occurs before granting immediate temporary relief. *See, e.g.*, *Osage Glass, Inc. v. Donovan*, 693 S.W.2d 71, 75 (Mo. banc 1985).

In deciding a motion for a temporary restraining order or a preliminary injunction, the trial court weighs "[1] the movant's probability of success on the merits, [2] the threat

of irreparable harm to the movant absent the injunction, [3] the balance between this harm and the injury that the injunction's issuance would inflict on other interested parties, and [4] the public interest." *State ex rel. Dir. of Revenue v. Gabbert*, 925 S.W.2d 838, 839 (Mo. banc 1996) (citations omitted). Although "[n]o single factor in itself is dispositive," *United Indus. Corp. v. Clorox Co.*, 140 F.3d 1175, 1179 (8th Cir. 1998), some showing of probability of success is required, *Gabbert*, 925 S.W.2d at 839; *CitiMortgage, Inc. v. Just Mortg.*, Inc., No. 4:09 CV 1909 DDN, 2013 WL 6538680, at *3 (E.D. Mo. Dec. 13, 2013). In addition, the movant must supply some evidence supporting each of these considerations; however, the inquiry is "flexible" and should not be accomplished with "mathematical precision." *Gabbert*, 925 S.W.2d at 840 (quoting *Dataphase Sys., Inc. v. C L Sys., Inc.*, 640 F.2d 109, 113 (8th Cir. 1981)). As explained below, all of these factors weigh heavily in Plaintiffs' favor.

## I. Plaintiffs are likely to succeed on the merits.

Missouri's abortion bans and restrictions are flatly incompatible with the new, highly protective right to reproductive freedom that Missourians overwhelmingly voted to approve on November 5, 2024. Plaintiffs are highly likely to succeed under the new heightened standards of subsections 3, 5, and 6 of the Right to Reproductive Freedom Initiative.

As the Right to Reproductive Freedom Initiative states, in a subsection 3 challenge to a law or regulation that infringes on the "right to make and carry out decisions about . . . reproductive health care, including . . . abortion care," the infringing law "shall be

presumed invalid" and the burden is on the government to "demonstrate[] that such action is justified" under a heightened strict scrutiny standard.[6] Mo. Const. art. I, §§ 36.2–.3; *see also* Reply Br. of Appellant 6, *Fitz-James v. Ashcroft*, 678 S.W.3d 194 (Mo. App. W.D. 2023) (No. WD 86595) (arguing that "*[e]very* regulation is. . . presumed invalid. And that presumption is rebuttable only if . . . state or local officials satisfy a standard even stricter than strict scrutiny"); *id.* at 8 (arguing the invalid "presumption can be rebutted only by satisfying a new tier of scrutiny much more stringent even than strict scrutiny"); *id.* at 10 (stating regulations that delay abortions are subject to "ultrastrict scrutiny"). The state has the burden to prove that a challenged abortion restriction is constitutional.[7]

To do so, subsection 3 requires the Government to demonstrate both that the challenged restriction is "justified by a compelling governmental interest" and that such

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[6] *Cf. Pearson v. Koster*, 367 S.W.3d 36, 45 (Mo. banc 2012) ("The purpose behind stating that statutes are 'presumed' constitutional is . . . to allocate the burden of proof to the plaintiff for its claim that a statute is unconstitutional.").

[7] The presumption of unconstitutionality can be found in other areas of constitutional law. *See, e.g., Fox v. State*, 640 S.W.3d 744, 750 (Mo. banc 2022) ("Laws that regulate speech based on its communicative content 'are *presumptively unconstitutional* and may be justified only if the government proves that they are narrowly tailored to serve compelling state interests.'" (emphasis added)); *Preterm-Cleveland v. Yost* ("*Preterm-Cleveland II*"), No. A2203203, 2024 WL 4577118, at *12 (Ohio C.P. Oct. 24, 2024) ("Interestingly, the structure of the [Ohio Reproductive Rights] Amendment places the right to abortion in Ohio on par with the right to possess a firearm under the U.S. Supreme Court's decision in *New York State Rifle & Pistol Assoc, Inc. v. Bruen*, 597 U.S. 1 (2022) . . . [which] places the burden on [the] State . . . to prove that gun regulations are [constitutional.]"); *cf. Hodes & Nauser, MDs, P.A. v. Stanek*, 551 P.3d 62, 74 (Kan. 2024) (finding, under Kansas constitution, any infringement "*regardless of degree* and *even if the infringement is slight*" is sufficient to trigger the government's burden under traditional strict scrutiny).

interest is being "achieved by the least restrictive means." Mo. Const. art. I, § 36.3. subsection 3 also limits the governmental interest that may be compelling:

> [A] governmental interest is compelling only if it [1] is for the limited purpose and has the limited effect of improving or maintaining the health of a person seeking care, [2] is consistent with widely accepted clinical standards of practice and evidence-based medicine, and [3] does not infringe on that person's autonomous decision-making.

*Id.* The asserted governmental interest must meet *all three* of these requirements to be found compelling. But because of requirement [1], the *only* government interest that ever can be found compelling must be an interest in improving or maintaining a pregnant person's health.

As a result of these requirements, the fundamental right to reproductive freedom is more protected under the Missouri Constitution than it ever was under the federal Constitution. *See Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 877 (1992) ("A finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.").[8]

Additionally, subsection 6 of the Right to Reproductive Freedom Initiative explicitly prohibits discrimination based on abortion: "The Government shall not

[8] Statutes and regulations that were previously ruled unconstitutional under the old federal undue standard would still be unconstitutional under Missouri's new heightened strict scrutiny standard. However, the same is not true for statutes and regulations previously deemed constitutional under that old standard. Due to the new, heightened standard of the Right to Reproductive Freedom Initiative, statutes and regulations that were previously deemed constitutional may now be unconstitutional under the Missouri Constitution.

discriminate against persons providing or obtaining reproductive health care or assisting another person in doing so." Mo. Const. art. I, § 36.6. Laws that single out abortion care as distinct from other health care —including miscarriage care involving identical drugs and procedures—without medical basis fail the plain terms of subsection 6.

Finally, subsection 5 of the Right to Reproductive Freedom Initiative provides that no person "assisting a person in [consensually] exercising their right to reproductive freedom" shall "be penalized, prosecuted, or otherwise subjected to adverse action for doing so." *Id.* § 36.5. At a minimum, enforcing abortion restrictions through criminal penalties when other healthcare is not regulated in this way violates the Right to Reproductive Freedom Initiative's prohibition on "penalizing" or "prosecuting" abortion providers.

Plaintiffs are highly likely to succeed on the claims brought under the Right to Reproductive Freedom Initiative because the challenged laws all violate subsections 3, 5, and/or 6. All of the laws challenged herein, for which Plaintiffs seek immediate injunctive relief, single out abortion for discriminatory treatment compared with other health care, in violation of subsection 6. Mo. Const. art. I, § 36.6. All of the laws also deny, interfere with, delay, or otherwise restrict Missourians' right to reproductive freedom under subsection 3. *Id*. § 36.3. Moreover, the government will be unable to overcome the presumption of invalidity accompanying subsection 3 by showing that these infringements on the fundamental right to reproductive freedom have "the limited purpose and . . . the limited effect of improving or maintaining the health of a person seeking care, [are] consistent with

widely accepted clinical standards of practice and evidence-based medicine, and do[] not infringe on that person's autonomous decision-making." *Id*. Nor can the government demonstrate that the challenged laws achieve a subsection 3 compelling governmental interest through the least restrictive means. *Id*. Finally, because all of the laws challenged herein are enforced through criminal penalties, these laws also violate subsection 5. *Id*. § 36.5.

**a. The Total Ban and multiple, overlapping Gestational Age and Reasons Bans violate Missourians' fundamental right to reproductive freedom.**

Missouri's web of multiple, overlapping abortion bans are blatantly, per se unconstitutional prohibitions on abortion under the Right to Reproductive Freedom Initiative. Missouri's (1) Total Ban; (2) four separate Gestational Age Bans prohibiting abortions at and after 8, 14, 18, and 20 weeks LMP; and (3) Reasons Ban each prohibit pre-viability abortions, and therefore deny and restrict the right to reproductive freedom in violation of Article I, Section 36, subsection 3. Indeed, these bans strike directly at the heart of reproductive freedom: "the right to make and carry out decisions about all matters relating to reproductive health care, including . . . abortion." *Id*. § 36.2; *see* § 188.017, RSMo (Total Ban); §§ 188.056, 188.057, 188.058, 188.375, RSMo (Gestational Age Bans); §§ 188.038, 188.052, RSMo; 19 C.S.R. § 10-15.010(1) (Reasons Ban).

There can be no doubt that the government cannot overcome the presumption of the Bans' invalidity under subsection 3. Under the Right to Reproductive Freedom Initiative, there simply can be no compelling interest in an outright ban on constitutionally protected

health care like abortion. Any governmental interest in the bans is simply not for "the limited purpose and . . . limited effect of improving or maintaining the health of a person seeking care" or "consistent with widely accepted clinical standards of practice and evidence-based medicine." *Id*. § 36.3. Indeed, because abortion is safer than carrying to term and giving birth, these bans by definition cannot advance an interest in the pregnant person's health. Sandoval Aff. ¶¶ 17–20. And by making abortion wholly unavailable at different points in pregnancy or for certain reasons, Missouri's abortion bans irrefutably "infringe on th[e] [pregnant] person's autonomous decision-making." Mo. Const. art. I, § 36.3; *see also Preterm-Cleveland II*, 2024 WL 4577118, at *8 (noting that parties had agreed that a felony ban on abortion after "detection of embryonic cardiac activity" was unconstitutional under Ohio's new state constitutional reproductive rights protections). For instance, a significant number of Missourians would be denied the choice to have an abortion under any of the Gestational Age Bans. Muniz Aff. ¶ 11. The State cannot have a compelling interest in any law that infringes on Missourians' "autonomous decision-making" around abortion—which by definition, these bans do, by removing the option of abortion altogether for the patients to whom they apply. Mo. Const. art. I, § 36.3. Nor could a complete prohibition on abortion ever be the "least restrictive means" to achieve a governmental interest in the pregnant person's health—the only state interest cognizable under subsection 3. *Id.*

Plaintiffs are extremely likely to succeed on their claim that Missouri's abortion bans, including the Total Ban, Gestational Age Bans, and Reasons Ban, violate the

Missouri Constitution's right to reproductive freedom. The Total Ban, Gestational Age Bans, and Reasons Ban violate subsection 3 of the Right to Reproductive Freedom Initiative and should be enjoined.[9]

**b. The Targeted Restrictions on Abortion Providers violate Missourians' fundamental right to reproductive freedom.**

Missouri further denies, interferes with, delays, and restricts abortion by requiring health centers that provide abortion to adhere to onerous, medically unnecessary, hospital-like requirements, including that they be licensed as ambulatory surgical centers when abortion—especially medication abortion—is not surgery (Abortion Facility Licensing Requirement); requiring abortion providers—who rarely, if ever, admit patients to a hospital—to have hard-to-get admitting privileges at a local hospital (Hospital Relationship Restrictions); requiring a complex and hard-to-fulfill "complication plan" for medication abortion, which is safer than ibuprofen (Medication Abortion Complication Plan Requirement); requiring all tissue removed from every abortion to be sent for an expensive and generally pointless pathology examination (Pathology Requirement); requiring every patient who wants an abortion be provided with a long list of stigmatizing, false or misleading, anti-abortion material (the "Biased Information Law"); requiring an additional unnecessary in-person appointment that must be held a mandatory waiting period of seventy-two hours prior to the abortion with the same physician that will provide the

[9] Because the Total Ban, Gestational Age Bans, and Reasons Ban target and prohibit abortion care but not comparable miscarriage and pregnancy care, they additionally violate the Right to Reproductive Freedom Initiative's prohibition on government discrimination "against persons providing or obtaining reproductive health care." Mo. Const. art. I, § 36.6.

abortion, creating impossible and unnecessary barriers to abortion scheduling (the "Waiting Period, In-Person, Same Physician Requirements"); a ban on prescribing abortion over telemedicine, when all other health care may be conducted via telehealth within a provider's scope of practice (the "Telemedicine Ban"); and a ban on anyone other than a physician providing abortions, when trained and qualified Advanced Practice Clinicians can safely and effectively provide some abortions within their scope of practice (the "APC Ban"). These TRAP laws—singling out, targeting, and restricting abortion care—violate Missourians' fundamental right to reproductive freedom.

**1. The requirement that abortion facilities be licensed as ambulatory surgical centers violates Missourians' fundamental right to reproductive freedom.**

Missouri law requires that any facility "in which abortions are performed or induced other than a hospital" be licensed as a specific type of Ambulatory Surgical Center called an "Abortion Facility." §§ 197.200 –.235, 334.100.2(27), RSMo; 20 C.S.R. § 2150-7.140(2)(V), 19 C.S.R. §§ 30-30.050–.070 (collectively, Abortion Facility Licensing Requirement).[10] Other medical facilities must be licensed as ambulatory surgical centers only if they are "operated *primarily* for the purpose of performing surgical procedures or . . . childbirths." § 197.200(2), RSMo (emphasis added); *see also* 19 C.S.R. § 30-30.010(1)(b).[11]

[10] DHSS may attempt to revoke or not renew an abortion facility's license on the basis of a violation of any of Chapter 188. §§ 197.220, .230, RSMo; 19 C.S.R. § 30-30.050.
[11] None of Plaintiffs' health centers are operated "primarily for the purpose of surgeries" and would not rise to that level, even if procedural abortion was considered surgery and

To be licensed as an Ambulatory Surgical Center, among other things, abortion facilities must have procedure rooms of at least twelve feet by twelve feet and a minimum ceiling height of nine feet, patient corridors at least six feet wide, door widths at least forty-four inches wide, patient counseling rooms at least ten feet by ten feet, and similarly specific requirements regarding facilities' HVAC systems and finishes for ceilings, walls, and floors, among other items. *See* 19 C.S.R. § 30-30.070(3). These physical facility requirements apply to any facility offering any kind of abortion.[12]

The Abortion Facility Licensing Requirement also requires certain standards of operation that are just bad for patients. For example, the Requirement forces all abortion providers to give every abortion patient an invasive and unnecessary pelvic exam, even for medication abortion. To submit to a pelvic exam, a patient must take off their clothes and allow the provider to examine their genitalia and put both a speculum and the provider's hands inside their vagina. Sandoval Aff. ¶ 30. Yet many patients choose medication abortion because they do not want instruments inserted into their vagina. *Id.* This is so far

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Plaintiffs were providing procedural abortions at pre-*Dobbs* levels. Wales Aff. ¶ 23; Muniz Aff. ¶ 20.

[12] On its face, the regulation "does not apply to abortion facilities that do not perform surgical abortions or *surgical intervention for abortion complications*." 19 C.S.R. § 30-30.070(1) (emphasis added). But facilities that provide medication abortion must have a complication plan, which must include a plan for the abortion doctor or on-call ob-gyn to "[p]ersonally treat all complications, *including those requiring surgical intervention*." *Id.* § 30-30.061(2)(G), (K) (emphasis added). So the Abortion Facility Licensing Requirements for physical facilities apply to facilities providing both medication and procedural abortion, unless the medication abortion complication plan provides that complications needing "surgical intervention"—which are rare—may be treated at a different facility.

outside of the standard of high-quality, patient-centered care, and so harmful to the patient-provider relationship, that Plaintiffs' providers will not provide medication abortion at all if they have to conduct a pelvic exam in order to do so. *Id.*; Wales Aff. ¶ 25; Muniz Aff. ¶ 23.

The Abortion Facility Licensing Requirement violates subsection 6 of the Right to Reproductive Freedom Initiative because it singles out abortion care for discriminatory treatment. Mo. Const. art. I, § 36.6. Medical services are typically regulated by generally applicable professional licensing laws and regulations, and providers have professional obligations to comply with the standard of care. Licensed health care professionals are regulated by their applicable licensing boards, and if there is a concern about a professional's care, licensing boards have authority to investigate, and discipline, the professional. Abortion care and miscarriage care, which involve the same medications and procedures, are both subject to generally applicable standards of medical services and health care professions. But the Abortion Facility Licensing Requirement is not a generally applicable rule. Instead, it singles out abortion as the only medical service for which the licensing requirement is triggered regardless of how many abortions are done, and indeed, *even if the facility provides only medication abortion*—despite the fact that, as explained below, the Abortion Facility Licensing Requirement is medically inappropriate to the nature of all abortion services. This includes procedural abortion, which as noted above is not surgery. Sandoval Aff. ¶ 13. Any facility offering substantially similar miscarriage care is not required to comply with Ambulatory Surgical Center requirements—only abortion

care. And while birthing facilities are subject to a separate licensing law, childbirth—like surgery—is an inherently riskier and more complex procedure than abortion. Sandoval Aff. ¶¶ 17–20.

Moreover, many surgeries may still be provided at a health center or medical office without an Ambulatory Surgical Center license, that does not conform to the physical facility requirements, as long as the facility does not exist "primarily for the purpose of" surgery. § 197.200(2), RSMo. And many minor surgeries and other medical procedures more complex than abortion happen in office-based settings, such as uterine polypectomy (removing polyps from the uterus), vasectomy, colposcopy and LEEP (examination and procedures of the cervix, including curettage of tissue samples), and miscarriage care. Sandoval Aff. ¶ 28. Surgeries happening outside of licensed surgical facilities, like all medical procedures, are still regulated by all the generally applicable rules of professional licensing and professional ethics. In contrast, under threat of criminal penalties, no health center may provide a single abortion—not even dispensing the pills for a medication abortion—without meeting the Abortion Facility Licensing Requirement. Because the Abortion Facility Licensing Requirement discriminates against abortion, it must be enjoined under subsection 6. Mo. Const. art. I, § 36.6.

The Abortion Facility Licensing Requirement also violates subsection 3. Plaintiffs are ready to start providing abortion at multiple facilities, but cannot do so because of this restriction—even if all the other laws Plaintiffs challenge are enjoined. And even if some facilities were able to obtain licensure, the Abortion Facility Licensing Requirement would

deprive patients of the ability to obtain an abortion at the most convenient location, or a medical abortion at any of Plaintiffs' health centers. Wales Aff. ¶ 24; Muniz Aff. ¶ 22. The Abortion Facility Licensing Requirement therefore interferes with and restricts abortion care in Missouri and is "presumed invalid." *Id*. § 36.3. Unless and until the government demonstrates a compelling interest to justify the Abortion Facility Licensing Requirement, and that the restriction is the least restrictive means of achieving that governmental interest, this law must also be enjoined under subsection 3. *Id*. § 36.3.

But Defendants will not be able to meet their burden to rebut the presumption established under subsection 3 of the Right to Reproductive Freedom Initiative because (among other things) the Abortion Facility Licensing Requirement does not improve patient health. The Abortion Facility Licensing Requirement does not "help[] to cure" any "significant health-related problem," nor does it "provide any more protection" for patient health than the generally applicable health professional licensing laws. *Stanek*, 551 P.3d at 80 (permanently enjoining abortion-specific facilities regulations under strict scrutiny standard for lack of compelling government interest); *accord Whole Woman's Health v. Hellerstedt*, 579 U.S. 582, 619 (2016) (finding, under much less stringent federal undue burden standard, that nearly identical Texas Ambulatory Surgical Center requirement has "such a tangential relationship to patient safety in the context of abortion as to be nearly arbitrary"). There can be no possible patient health justification, for instance, in requiring that patients only be handed pills in rooms of a certain size. And the pelvic exam requirement is so inconsistent with the standard of patient-centered care, particularly for

medication abortion, that Plaintiffs' providers refuse to offer medication abortion at all rather than subject their patients to such an intimately invasive and unnecessary procedure. Sandoval Aff. ¶ 30; Wales Aff. ¶ 25; Muniz Aff. ¶ 23. The Abortion Facility Licensing Requirement is therefore also inconsistent with "widely accepted clinical standards of practice and evidence-based medicine." Mo. Const. art. I, § 36.3. And because the Abortion Facility Licensing Requirement will greatly limit the number of health centers that are able to offer any abortion—possibly to a single facility in St. Louis—and may effectively ban medication abortion altogether, it will also "infringe on [patients'] autonomous decision-making" by limiting access across the state. *Id.*; *see* Sandoval Aff. ¶ 29; Wales Aff. ¶ 24; Muniz Aff. ¶ 22.

Plaintiffs are likely to succeed on their claims that the Abortion Facility Licensing Requirement violates subsections 6 and 3 of the Right to Reproductive Freedom Initiative.

**2. The Hospital Relationship Restrictions violate Missourians' fundamental right to reproductive freedom.**

Missouri further denies, interferes with, delays, and restricts abortion through the Hospital Relationship Restrictions, which require physicians providing abortion to have admitting privileges at a hospital near (within thirty miles or fifteen-minutes travel time) to the health center where they provide any abortion. §§ 188.080, 188.027.1(1)(e), 197.215.1(2), RSMo; 19 C.S.R. § 30-30.060(1)(C)(4) (collectively, Hospital Relationship Restrictions).[13] A written transfer agreement with a nearby hospital is an option for

[13] And not just any hospital, but a hospital that offers obstetric or gynecological care. § 188.027.1(1)(e), RSMo.

complying with some, but not all, of these privileges requirements.

Because the Hospital Relationship Restrictions single out abortion from other health care, including miscarriage care, Plaintiffs are likely to succeed in showing that they violate the nondiscrimination provision of subsection 6. Mo. Const. art. I, § 36.6. Miscarriages are frequently treated in ob-gyn and primary care provider offices, using the same medications and procedures as abortion care, with no requirement that the treating provider have any kind of privileges or agreement with any hospital—let alone a hospital within fifteen minutes of the office. Sandoval Aff. ¶ 28. Imposing these requirements on providers of abortion, but not miscarriage care, singles out abortion for discriminatory treatment. The Hospital Relationship Restrictions should be enjoined under subsection 6.

The Hospital Relationship Restrictions are also presumptively invalid under subsection 3 because they deny, restrict, and interfere with Missourians' right to reproductive freedom. Plaintiffs are ready to offer abortions at all of their health centers, but are unable to do so at most of them because they cannot meet the Hospital Relationship Restrictions—even if all the other laws Plaintiffs challenge are enjoined. Wales Aff. ¶¶ 26–29; Muniz Aff. ¶¶ 26, 29. The nature of abortion practice makes it difficult for providers to keep hospital admitting privileges. Wales Aff. ¶ 28. While admitting privileges requirements vary by hospital, they often require providers to admit a certain number of patients per year to the hospital. Because abortion is so safe, providers often do not have enough patients admitted to any hospital to meet that requirement. *Id.* Many Catholic-affiliated hospitals categorically will not give privileges to abortion providers. *Id.* ¶ 27.

Some hospitals require local residency, or an agreement to take emergency department call shifts, which out-of-town providers cannot meet. Wales Aff. ¶ 28. And the Hospital Relationship Restrictions contain strict geographical limits, such that a provider would need to maintain privileges at multiple hospitals to work at multiple health centers. Wales Aff. ¶ 28; Muniz Aff. ¶¶ 25–26. There can be no question that the Hospital Relationship Restrictions will restrict the number of abortion providers and abortion clinics in Missouri, particularly rural Missouri. Wales Aff. ¶ 28; Muniz Aff. ¶ 29; Sandoval Aff. ¶ 32. The Hospital Relationship Restrictions interfere with and restrict abortion care in Missouri and are "presumed invalid" under subsection 3 of the Right to Reproductive Freedom Initiative. Mo. Const. art. I, § 36.3. Unless and until the government demonstrates that it has a compelling interest justifying the law, and that the restriction is the least restrictive means of achieving that governmental interest, this law must be enjoined.

Indeed, the government will be unable to make any such showing under subsection 3. Mo. Const. art. I, § 36.3. Hospital admitting privileges and transfer agreements have, time and again, not been shown to advance patient health. *Stanek*, 551 P.3d at 81 (finding no evidence that requirement of admitting privileges at hospital within thirty miles of abortion facility furthered state's alleged interest in maternal health); *see also Planned Parenthood Sw. Ohio Region v. Hodges*, 138 F. Supp. 3d 948, 959–60 (S.D. Ohio 2015) (finding, in federal undue burden case challenging an Ohio restriction that required abortion providers to have either a hospital transfer agreement or a variance from the state, that failure to meet this requirement did not pose risks to patient health and safety); *accord*

*Comprehensive Health of Planned Parenthood Great Plains v. Williams*, No. 2:16-CV-04313-BCW, 2019 WL 8359569, at *6 (W.D. Mo. Feb. 22, 2019) (calling the State's assertions of health benefits of Hospital Relationship Restrictions "dubious" even while denying preliminary injunction under the more-permissive federal undue burden standard).

Although it is not Plaintiffs' burden to show under subsection 3, Plaintiffs' existing practices more than meet the widely accepted standard of care. Their medication abortion patients are extremely unlikely to have any problem at all, and most concerns can be addressed via phone and/or on a return visit during business hours. Sandoval Aff. ¶ 37; Muniz Aff. ¶ 28. Patients are provided with a phone number staffed 24/7 to call if they experience concerns or complications. Sandoval Aff. ¶ 37; Muniz Aff. ¶ 28. The extremely rare patient who needs more immediate treatment will be directed to the patient's nearest emergency department—which, because of the timing of medication abortion complications, may not be at the hospital where the provider has privileges. Sandoval Aff. ¶ 37; Muniz Aff. ¶ 28. In the extremely rare case of a medical emergency, all hospitals are required to treat all patients under EMTALA, the Emergency Medical Treatment and Active Labor Act. 42 U.S.C. § 1395dd; Sandoval Aff. ¶ 37.

Leading professional organizations for abortion providers—such as the American College of Obstetricians and Gynecologists, the National Abortion Federation, and Planned Parenthood Federation of America—do not recommend that abortion providers have admitting privileges or transfer agreements at a nearby hospital. Sandoval Aff. ¶ 38. Plaintiffs' practices for follow-up care comply with the standards of care recommended by

these organizations. *Id.* ¶¶ 37–38; Muniz Aff. ¶ 28. Admitting privileges and transfer agreements simply do not impact the hospital-based care provided to recent abortion patients. Ushma D. Upadhyay et al., *Admitting Privileges and Hospital-Based Care After Presenting for Abortion: A Retrospective Case Series*, 54 Health Servs. Rsch. 425 (2019). And to the extent the Hospital Relationship Restrictions prevent Missouri providers, like Plaintiffs, from providing abortion to Missourians, they function as a ban that impermissibly infringes on abortion patients' autonomous decision-making. Mo. Const. art. I, § 36.3.

Plaintiffs are likely to succeed in showing that the Hospital Relationship Restrictions violate subsections 3 and 6 of the Right to Reproductive Freedom Initiative and should be enjoined. Mo. Const. art. I, § 36.3, 6.

**3. The Medication Abortion Complication Plan Requirement violates Missourians' fundamental right to reproductive freedom.**

Missouri requires that providers have a complex and unnecessary "complication plan" in place before providing medication abortion. § 188.021.2, RSMo. DHSS's implementing regulation singles out medication abortion providers and requires them to have a written contract with a board-certified or board-eligible ob-gyn (or ob-gyn group) who has agreed to be "on-call and available twenty-four hours a day, seven days a week" to "personally treat all complications" from medication abortion "except in any case where doing so would not be in accordance with the standard of care, or in any case where it

would be in the patient's best interest for a different physician to treat her." 19 C.S.R. § 30-30.061 (collectively, Medication Abortion Complication Plan Requirement).

By treating medication abortion care as categorically different from miscarriage care, the law discriminates against providers and patients who need or choose abortion care in violation of the nondiscrimination provision of subsection 6. Mo. Const. art. I, § 36.6. No other uses of mifepristone or misoprostol, including for miscarriage care, are subject to anything like the Medication Abortion Complication Plan Requirement. Further, the Medication Abortion Complication Plan Requirement imposes standards not imposed on *any* other oral medication, and indeed, not imposed on invasive surgeries or other procedures with far greater complication rates than medication abortion. Because the Medication Abortion Complication Plan Requirement discriminates against abortion, it violates subsection 6 and should be enjoined.

The Medication Abortion Complication Plan Requirement is also presumptively invalid under subsection 3 because it denies, interferes with, delays and otherwise restricts abortion care. Mo. Const. art. I, § 36.3. It is extremely difficult to find physicians willing to take on these responsibilities in Missouri (particularly ob-gyns, who are scarce in Missouri,[14] and historically have often feared a threat to their ob-gyn practice if they take

[14] *See* Anna Spoerre, *After Missouri Banned Abortion, the State Saw 25% Drop in OB-GYN Residency Applicants*, Mo. Indep. (June 4, 2024, 9:00 AM), https://missouriindependent.com/2024/06/04/missouri-ob-gyn-residents-maternal-health-abortion/ ("More than 41% of counties in Missouri are designated maternity care deserts, meaning there are no maternity care providers or birthing facilities" which is higher than the national average.).

on a public role in connection with abortion). Sandoval Aff. ¶¶ 33–34; Wales Aff. ¶ 26. These requirements are accompanied by a host of regulations that are nearly impossible to satisfy by design—and which DHSS has enforced inconsistently so as to limit abortion access.

The result is that this scheme contributed to the decimation of abortion access in Missouri pre-*Dobbs*. Indeed, due to the Medication Abortion Complication Plan Requirement, Comp Health was blocked from providing medication abortion at its Columbia health center (even though it could, for a time, provide procedural abortions), Sandoval Aff. ¶¶ 33–34, and Great Rivers was forced to cancel plans to provide medication abortion at its Springfield health center. Muniz Aff. ¶ 27. As a result, medication abortion was available only in Kansas City and St. Louis. Unless and until the government demonstrates that there is a compelling interest to justify these laws, and that the restrictions are the least restrictive means of achieving the government's interest, they must be enjoined under subsection 3.

Defendants will not be able to meet their burden under subsection 3 to rebut the presumption of invalidity. There can be no compelling governmental interest to justify this abortion restriction, including because the law does not have "the limited effect of improving or maintaining the health of a person seeking care," nor is it "consistent with widely accepted clinical standards of practice and evidence-based medicine." Mo. Const. art. I, § 36.3. Indeed, after hearing two days of live testimony along with affidavits and deposition evidence, a federal court held that the Medication Abortion Complication Plan

Requirement "has virtually no benefit" for patients. *Comprehensive Health of Planned Parenthood Great Plains v. Williams*, 322 F. Supp. 3d 921, 931 (W.D. Mo. 2018).[15] Nor could the government demonstrate that the Medication Abortion Complication Plan Requirement has the "limited purpose and . . . limited effect of improving or maintaining the health of a person seeking care," Mo. Const. art. I, § 36.3, because the stated purpose of the law was to limit abortion; indeed, a federal court remarked that the requirement is a backdoor privileges requirement enacted in defiance of federal court rulings holding that admitting privileges law violated the then-federal undue burden standard. *Williams,* 322 F. Supp. 3d at 931 n.11.

The Medication Abortion Complication Plan Requirement cannot be justified by a compelling government interest for all the same reasons that the Hospital Relationship Restrictions cannot—a backup ob-gyn with hospital admitting privileges does not advance patient health any more than the abortion provider having admitting privileges. *See supra* Part I.b.2. Plaintiffs' existing practices more than meet the standard of care. *Id.* And at any rate, the quality of the patient's care will not be impacted by having a pre-identified ob-

[15] The court ultimately denied plaintiffs' motion for preliminary injunction in that case, finding that the Plan imposed no "substantial obstacle" to abortion under the federal undue burden standard because, even though some health centers would stop providing medication abortion—as some of Plaintiffs' health centers did—patients still had the option of either traveling farther or having a procedural abortion instead. 322 F. Supp. 3d at 933–34. But any regulation that removes the most common form of abortion from everywhere other than Kansas City and St. Louis, without any benefit to patient health, cannot be constitutional under the Right to Reproductive Freedom Initiative.

gyn who the patient has never met, but who has promised to "personally treat" her "twenty-four hours a day, seven days a week." 19 C.S.R. § 30-30.061.

This medically unnecessary, discriminatory requirement restricts abortion care and, in doing so, threatens (rather than improves) individual patient health. The Medication Abortion Complication Plan Requirement is not "consistent with widely accepted clinical standards of practice" for all the same reasons that the Hospital Relationship Restrictions do not meet this requirement. Mo. Const. art. I, § 36.3; Sandoval Aff. ¶ 38. To the extent the Medication Abortion Complication Plan Requirement prevents Plaintiffs and other providers from providing abortion to Missourians, it functions as an effective ban that impermissibly infringes on abortion patients' autonomous decision-making. Mo. Const. art. I, § 36.3.

Plaintiffs are likely to succeed on their claim that the Medication Abortion Complication Plan Requirement violates the Missouri Constitution's right to reproductive freedom subsections 6 and 3, and the law should be enjoined.

#### 4. The Pathology Requirement violates Missourians' fundamental right to reproductive freedom.

Missouri requires that "[a]ll tissue . . . removed at the time of abortion shall be submitted within five days to a board-eligible or certified pathologist for gross and histopathological examination." § 188.047, RSMo. The pathologist then needs to file a "tissue report" with DHSS and provide a copy to the health center that provided the

abortion. *Id.*; *see also* 19 C.S.R. § 10-15.030, 19 C.S.R. § 30-30.060(5)(B) (collectively, Pathology Requirement).

Once again, the Pathology Requirement treats abortion very differently from miscarriages and other health care and therefore violates the anti-discrimination provisions of subsection 6. Mo. Const. art. I, § 36.6. If a provider removes tissue after a miscarriage, which is an extremely common and necessary post-miscarriage treatment, the provider exercises their professional judgment to decide whether to send the tissue to a pathologist. Sandoval Aff. ¶ 40. In fact, *no* other procedures—including significant surgeries—have a mandatory pathology requirement. *Id.* In all health care other than abortion, Missouri trusts providers to determine which tissue requires pathological analysis and which does not, subject to the general professional licensure and ethical rules of each provider. Sandoval Aff. ¶ 40. It is only abortion providers who are subject to anything like the Pathology Requirement—under threat of criminal penalty. The Requirement also stigmatizes abortion patients and providers by requiring pathological surveillance and reporting of every abortion. It therefore violates the nondiscrimination provision in subsection 6. Mo. Const. art. I, § 36.6.

The Pathology Requirement also denies, restricts, and interferes with abortion care and is therefore presumptively unconstitutional under subsection 3. Because of the stigma attached to abortion care, Plaintiffs are unaware of any pathologists in Missouri who are willing to contract with them to provide such an examination and report. Wales Aff. ¶ 30; Muniz Aff. ¶ 31. Without a pathologist available to fulfill the Pathology Requirement, this

law will prohibit Plaintiffs from providing any procedural abortions at all. Sandoval Aff. ¶ 42; Wales Aff. ¶ 30; Muniz Aff. ¶ 31. And even if a pathologist could be found who was willing to take on this role, the medically irrelevant obligation would jeopardize Plaintiffs' ability to provide abortions by forcing them to depend on a tenuous relationship. Wales Aff. ¶ 30. Unless and until the government can demonstrate that a compelling government interest justifies the Pathology Requirement, and that the restriction is the least restrictive means of achieving the government's interest, it is presumptively unconstitutional and should be enjoined.

Defendants will not be able to meet their burden under subsection 3 to rebut the presumption of invalidity. Defendants will be unable to show the Pathology Requirement has the limited purpose and effect of "improving or maintaining the health" of the pregnant person, that it is "consistent with widely accepted clinical standards of practice and evidence-based medicine," or that it "does not infringe on [the patient's] autonomous decision-making." Mo. Const. art. I, § 36.3. To the contrary, this Requirement does not have the limited purpose and effect of improving patient health. And it is contrary to widely accepted clinical standards, which allow each provider to decide, in their best professional judgment, whether to involve a pathologist in their patient's care. Sandoval Aff. ¶ 40; Wales Aff. ¶ 30. Moreover, given that the Pathology Requirement would effectively ban procedural abortion, it will greatly infringe on patients' autonomous decision-making about whether to seek a procedural abortion—which may be the only available option for many patients to exercise their right to reproductive freedom.

Plaintiffs are likely to succeed on their claims that the Pathology Requirement violates subsections 3 and 6 of the Right to Reproductive Freedom Initiative and must be enjoined.

**5. The Biased Information Law violates Missourians' fundamental right to reproductive freedom.**

Missouri law requires abortion facilities to present their patients—who have already chosen to have an abortion—with a laundry list of biased materials and statements designed to stigmatize the patient's decision. §§ 188.027, 188.039, 188.033, RSMo (collectively, Biased Information Law). These materials include "[t]he anatomical and physiological characteristics of the [fetus] at the time the abortion is to be performed or induced[.]" § 188.027.1(1)(g), RSMo. They also include "printed materials provided by the department, which describe the probable anatomical and physiological characteristics of the [fetus] at two-week gestational increments from conception to full term," including "information about brain and heart functions," "information on when the [fetus] is viable" and "including color photographs or images of the developing [fetus] at two-week gestational increments. . . . The printed materials shall prominently display the following statement: 'The life of each human being begins at conception. Abortion will terminate the life of a separate, unique, living human being.'" § 188.027.1(2), RSMo. The abortion provider must also provide the patient with materials describing completely inaccurate "risks" of abortion "including, but not limited to . . . harm to subsequent pregnancies or the

ability to carry a subsequent child to term, and possible adverse psychological effects associated with the abortion[.]" § 188.027.1(1)(b), RSMo.

The materials provided "shall include information on the possibility of an abortion causing pain in the [fetus]," and "shall include" information which the medical consensus agrees is not proof of pain in a fetus, such as that eight to fourteen week gestational age fetuses "show reflex responses to touch" and that a surgeon may "provide[] anesthesia to [fetuses] as young as sixteen weeks gestational age in order to alleviate the [fetus]'s pain[.]" § 188.027.1(5), RSMo.[16]

The patient must also be given the opportunity to view "an active ultrasound" of the fetus and to "hear the heartbeat of the [fetus] if the heartbeat is audible." § 188.027.1(4), RSMo.

The provider must *also* offer a DHSS-provided list of organizations offering "alternatives to abortion" and a list of organizations providing pregnancy assistance. § 188.027.1(6), RSMo. The materials must also include the statement:

> There are public and private agencies willing and able to help you carry your child to term, and to assist you and your child after your child is born, whether you choose to keep your child or place him or

[16] The required disclosures on fetal pain are deeply misleading if not outright false: the medical consensus agrees that a fetus cannot feel pain at those gestational ages, if ever. Am. Coll. Obstetricians & Gynecologists, *Facts Are Important: Gestational Development and Capacity for Pain*, https://www.acog.org/advocacy/facts-are-important/gestational-development-capacity-for-pain (last visited Nov. 4, 2024); Royal Coll. Obstetricians & Gynaecologists, *RCOG Fetal Awareness Evidence Review, December 2022* at 9, https://www.rcog.org.uk/media/gdtnncdk/rcog-fetal-awareness-evidence-review-dec-2022.pdf (June 19, 2022); Soc'y Maternal-Fetal Med. et al., *Society for Maternal-Fetal Medicine Consult Series #59: The Use of Analgesia and Anesthesia for Maternal-Fetal Procedures*, 225 Am. J. Obstetrics & Gynecology B2, B7 (2021).

> her for adoption. The state of Missouri encourages you to contact those agencies before making a final decision about abortion.

*Id.* Finally, the patient must receive information about the biological father's child support obligations. § 188.027.1(7), RSMo.

No other health care is subject to comparably lengthy, biased, stigmatizing, and medically irrelevant mandatory counseling. This is a blatant violation of the Right to Reproductive Freedom Initiative's prohibition on government discrimination "against persons providing or obtaining reproductive health care." Mo. Const. art. I, § 36.6. Without the Biased Information Law, the provision of abortion care would function just as all other health care does: consistent with the medical provider's ethical duties, the providers share with each patient all the relevant information the individual needs to make their decision about whether to proceed with consenting to and obtaining the health care. Sandoval Aff. ¶ 45. Instead, "[t]he State is metaphorically putting its finger on the scale" with the Biased Information Law in an attempt to convince abortion patients to not have the abortion the patients requested. *Northland Fam. Plan. Ctr. v. Nessel*, No. 24-000011-MM, slip op. at 42 (Mich. Ct. Cl. June 25, 2024).[17] In doing so, the government is actively discriminating against abortion patients and providers. The Biased Information Law discriminates against patients who choose abortion by subjecting them to these mandatory, anti-abortion, pro-birth materials when no other patients—including patients with a wanted pregnancy at a prenatal appointment—are subjected to anything similar. And it discriminates against

[17] Available at https://www.courts.michigan.gov/49ec2c/siteassets/case-documents/opinions-orders/coc-opinions-(manually-curated)/2024/24-000011-mm.pdf.

abortion providers, when health care providers in all other contexts are trusted to provide all necessary informed consent requirements and subject only to generally applicable ethical and professional regulations. Sandoval Aff. ¶¶ 44–45. Plaintiffs are likely to succeed on their claim that the Biased Information Law violates the nondiscrimination provisions of the Right to Reproductive Freedom Initiative, Mo. Const. art. I, § 36.6, and must be enjoined.

The Biased Information Law is also presumptively unconstitutional under subsection 3 of the Right to Reproductive Freedom Initiative. *Id*. § 36.3. This law directly "interfere[s] with" abortion care by mandating abortion patients receive certain information about their pregnancy and the requested health care, including when it is irrelevant, redundant or misleading to the individual patient. *Id.* Indeed, the information in the Biased Information Law is designed to interfere with, delay, and restrict the right to abortion care. It "guides a patient away from the choice of having an abortion by juxtaposing content that is clearly more relevant and suitable to those seeking to complete a pregnancy." *Northland Fam. Plan. Ctr.*, slip op. at 41 (finding similar mandatory consent requirements to "infringe upon a patient's right to make and effectuate decisions about abortion care"). In addition, the fact that some of the information is required to come from materials provided by DHSS "squarely inserts the [State] in between the patient and provider relationship." *Id*. at 42. The law is thus presumptively unconstitutional and must also be enjoined under subsection 3.

And Defendants cannot rebut the presumption of unconstitutionality here. Defendants have no compelling governmental interest in the Biased Information Law because no compelling interest can "infringe on [a patient's] autonomous decision-making." Mo. Const. art. I, § 36.3. Plaintiffs already offer all relevant information to obtain informed consent, as required by medical ethics and the common law. Wales Aff. ¶ 32; Muniz Aff. ¶ 34. But beyond this standard practice, a patient's "forced deliberation, through the mandatory informed-consent process, burdens and infringes upon a patient's right to make and effectuate decisions about abortion care." *Northland Fam. Plan. Ctr.*, slip op. at 42; *see also Preterm-Cleveland v. Yost* ("*Preterm-Cleveland I*"), No. 24 CV 2634, 2024 WL 3947516, at *12 (Ohio C.P. Aug. 23, 2024) (enjoining similar state-mandated information requirement); *Preterm-Cleveland II*, 2024 WL 4577118, at *20 (enjoining mandatory patient acknowledgement of state-mandated information). Providing this explicitly anti-abortion material is a blatant attempt to interfere with the patient's decision-making process.

Defendants also cannot show that the Biased Information Law improves patient health or is based on clinical best practices. Mo. Const. art. I, § 36.3. To the contrary, most of the information is unrelated to abortion care; instead, the biased information stigmatizes and shames patients and providers and damages the patient-provider relationship. Wales Aff. ¶ 31–32. And, as noted, Plaintiffs already provide informed consent based on best clinical practices. For this additional reason, Plaintiffs are likely to succeed on their claim

that the Biased Information Law violates the Missouri Constitution's right to reproductive freedom, Mo. Const. art. I, § 36, and should be enjoined.

### 6. The Waiting Period, In-Person, and Same Physician Requirements violate Missourians' fundamental right to reproductive freedom.

Before a patient in Missouri can obtain an abortion, Missouri law requires that the patient go to the health center at least seventy-two hours *before* the abortion to meet *with the abortion provider* in order to receive certain information, including the biased information mentioned above, and give informed consent for the abortion care *in person*. §§ 188.027, 188.039, RSMo (collectively, Waiting Period, In-Person, and Same Physician Requirements). These requirements, by their very nature, delay abortion—at least seventy-two hours more than medically necessary, but sometimes by a week or more depending on patient and physician schedules. Wales Aff. ¶ 35; Muniz Aff. ¶ 36. The court can enjoin sections 188.027 and 188.039 for multiple reasons, including on the basis that any or all of the delay, in-person, and same-doctor requirements—as well as the Biased Information Law—violate the Right to Reproductive Freedom Initiative.

Under subsection 3 of the Right to Reproductive Freedom Initiative, "[a]ny … delay … of the right to reproductive freedom shall be presumed invalid." Mo. Const. art. I, § 36.3. Requiring a patient to wait a minimum of seventy-two hours before they can receive abortion care they have already consented to is a "delay." The seventy-two-hour delay is thus presumptively unconstitutional. In the event that the seventy-two-hour waiting period is enjoined, the law provides that the waiting period should become twenty-four hours.

§§ 188.027.12, 188.039.7, RSMo. Twenty-four hours is also a delay. That provision, too, is presumptively unconstitutional and it must be enjoined unless and until the government carries its heavy burden to show that it has a compelling interest.

Looking at the waiting period alone, the State cannot meet its burden to justify either a seventy-two-hour or a twenty-four-hour waiting period under subsection 3. Forcing a patient who has already decided to have, and provided informed consent for, an abortion to wait days—if not weeks—before being permitted to access this time-sensitive health care, "infringe[s] on th[e] [pregnant] person's autonomous decision-making" and must be found unconstitutional. Mo. Const. art. I, § 36.3. Even a twenty-four-hour wait "forces needless delay on patients after they are able to consent . . . thus . . . infringing upon a patient's access to abortion care" and therefore unconstitutionally infringing on their autonomous decision-making. *Northland Fam. Plan. Ctr.*, slip op. at 37. A mandatory delay denies patients their choice of when to have an abortion. It also denies some patients their choice of how to have an abortion, or even whether to have one at all, if during the mandatory delay the patient's pregnancy advances too far for their desired method of abortion, or their desired health center location. Wales Aff. ¶ 37.

Further, even if a mandatory waiting period did not interfere with Missourians' autonomous decision-making, it neither "has the limited effect of improving or maintaining the health of a person seeking care" nor "is consistent with widely accepted clinical standards of practice and evidence-based medicine." Mo. Const. art. I, § 36.3. Instead, a "mandatory delay exacerbates the burdens that patients experience seeking abortion care,

including by increasing costs, prolonging wait times, increasing the risk that a patient will have to disclose their decision to others, and potentially preventing a patient from having the type of abortion that they prefer." *Northland Fam. Plan. Ctr.*, slip op. at 36–37; *see also Preterm-Cleveland I*, 2024 WL 3947516, at *11 (same). Although abortion is extremely safe, risks and complications of abortion increase with gestational age. Sandoval Aff. ¶ 16. It is not possible that forcing every patient to delay their abortion can improve or maintain patient health. Plaintiffs are likely to succeed on their claim that mandatory waiting periods violate the Missouri Constitution's right to reproductive freedom, Mo. Const. art. I, § 36.3, and sections 188.027 and 188.039 must be enjoined.

The in-person requirement also restricts and delays abortion care and is presumptively invalid under subsection 3. Because the law requires the pre-abortion counseling appointment happen in person, it necessitates at least two in-person trips to the health center. Getting to an additional in-person appointment is more difficult for a patient than receiving information over phone or video call, as patients do for other forms of medical care. The in-person requirement "places extra economic burdens on patients who must arrange time off work, childcare, and transportation for each visit, in addition to paying for the medical care." *Preterm-Cleveland I*, 2024 WL 3947516, at *12; Wales Aff. ¶ 37. In-person appointments also require greater resources for providers, who have to be in the clinic themselves, and have to dedicate appointment space and staff time checking patients in and out. In-person appointments therefore take longer to schedule. The in-

person requirement therefore delays and restricts abortion care and is presumptively unconstitutional under subsection 3.

Defendants cannot meet their burden to rebut this presumption with a compelling government interest under subsection 3. The in-person counseling requirement certainly does not improve or maintain patient health. It is especially antiquated now that so much information—including health care information and counseling appointments—is easily exchanged remotely. For this reason, too, Plaintiffs are likely to succeed on their claim that sections 188.027 and 188.039 violate subsection 3 and must be enjoined.

Additionally, the requirement that the doctor providing the abortion be the same one to meet with the patient in person at least seventy-two hours in advance to orally convey specific information denies, interferes with, delays, and restricts all abortion and should be presumed invalid. Abortion providers' time is limited and heavily scheduled. Muniz Aff. ¶ 38. Many providers work at multiple health centers and may not come back to the same location for a week or more; thus making the seventy-two-hour waiting period into a de facto waiting period of potentially weeks to see the same provider, if multiple appointments can even be found. Sandoval Aff. ¶ 48. If the first provider becomes unavailable at the time of the second appointment for any reason, the patient will need to make at least three total trips to the clinic and possibly sit through a second mandatory counseling appointment with a second provider—all while the patient's pregnancy advances. This may result in patients being forced into later abortions, which carry more risks than earlier abortion, or forced into a procedural abortion when medication abortion was preferred or medically indicated,

or a patient may be denied an abortion altogether. Because the same-doctor requirement denies, interferes with, restricts and delays abortion care, it is presumptively invalid under subsection 3. Mo. Const. art. I, § 36.3.

Defendants cannot rebut the presumption of invalidity to justify the requirement that the same doctor providing the abortion also be the one to orally convey the informed consent requirements during a counseling appointment. There is simply no individual health justification, as required under subsection 3, that the informed consent conversation needs to come from the same person: "information and counseling regarding an abortion can be provided to a pregnant woman by another skilled health professional [and] achieve the same result[.]" *Doe v. State*, No. 62-CV-19-3868, 2022 WL 2662998, at *55 (Minn. Dist. Ct. July 11, 2022). Such a requirement "limits the amount of time physicians have to provide other services, which increases the cost of abortion care," as well as other reproductive care, and "impacts patients." *Id.* Due to provider schedules, it also increases the length of the waiting period, sometimes exponentially. Sandoval Aff. ¶ 48. And because other trained medical personnel can be equally qualified to provide patient counseling, *id.* ¶ 49, Defendants cannot show that the same-physician requirement is the least restrictive means to advance any compelling interest. *Doe*, 2022 WL 2662998, at *55. For this reason, too, Plaintiffs are likely to succeed on their claim that sections 188.027 and 188.039 violate the Missouri Constitution's right to reproductive freedom, Mo. Const. art. I, § 36.3, and must be enjoined.

The waiting period, in-person, and same-physician requirements are uniquely imposed on abortion providers and patients. No other health care in Missouri is subjected to anything similar. Sandoval Aff. ¶¶ 49, 52. All these requirements therefore also violate the Right to Reproductive Freedom Initiative's non-discrimination provision and should be enjoined for that reason, too. Mo. Const. art. I, § 36.6.

### 7. The Telemedicine Ban on medication abortion violates Missourians' fundamental right to reproductive freedom.

Section 188.021 requires that the first of the two drugs required for medication abortion be taken "in the same room and in the physical presence" of the prescribing provider. § 188.021.1, RSMo (Telemedicine Ban). This requirement, which is not medically necessary, is increasingly outdated and restrictive—particularly so for patients in Missouri's large rural areas and those who may not be able to manage time off of work, afford travel expenses, or manage childcare responsibilities to drive several hours to the nearest health center to be handed an oral medication.

The Telemedicine Ban discriminates against abortion patients and providers because it singles out abortion for different treatment compared to any other type of health care which can safely be provided through telemedicine. Missouri generally allows non-abortion health care providers to provide telemedicine services that fall within their scope of practice. § 191.1145, RSMo. In other words, Missouri allows patients experiencing a miscarriage, but not patients who want an abortion, to access the exact same medication used in a medication abortion via telemedicine. Sandoval Aff. ¶ 54. The in-person

requirement for medication abortion alone violates the non-discrimination provision in the Right to Reproductive Freedom Initiative. Mo. Const. art. I, § 36.6.

The Telemedicine Ban is a restriction on abortion and is therefore presumptively unconstitutional under subsection 3 of the Reproductive Freedom Initiative. Mo. Const. art. I, § 36.3. The Telemedicine Ban "denie[s], interfere[s] with, [and] delay[s]" patients in accessing constitutionally protected abortion care, *id.*, including by requiring patients to overcome logistical challenges such as time off work, transportation, financial constraints, potentially hours of travel time, and childcare needs that simply don't exist for telemedicine appointments. Wales Aff. ¶ 37. Mandatory in-person appointments also jeopardize patients' ability to keep their confidential health information private from potentially disapproving employers, colleagues, family, and abusive or controlling partners. *Id.* The Telemedicine Ban is presumptively unconstitutional under subsection 3 and unless and until the government demonstrates that there is a compelling interest that justifies the ban, and that the restriction is the least restrictive means of achieving the government's interest, it must be enjoined.

Defendants will not be able to meet their burden under subsection 3 to rebut the presumption of invalidity. There can be no compelling governmental interest to justify this abortion restriction, including because the law does not have "the limited effect of improving or maintaining the health of a person seeking care," nor is it "consistent with widely accepted clinical standards of practice and evidence-based medicine" and it "infringe[s] on [a patient's] autonomous decision-making." Mo. Const. art. I, § 36.6. There

is no medical reason for the Telemedicine Ban. Providing medication abortion by telemedicine "is effective, safe, and comparable to . . . in-person medication abortion care." Br. of Am. Coll. of Obstetricians and Gynecologists, Am. Med. Ass'n, & Other Med. Soc'ys as Amici Curiae in Supp. of Pet'rs at 23, *Food & Drug Admin. v. All. for Hippocratic Med.*, 602 U.S. 367 (2024) (No. 23–235 & 23–236), 2024 WL 399937 (quotation omitted); *see Planned Parenthood of the Heartland, Inc. v. Iowa Bd. of Med.*, 865 N.W.2d 252, 268 (Iowa 2015) (finding little or no health benefit to an in-person medication abortion requirement); *Stanek*, 551 P.3d at 80 (same). Indeed, the FDA stopped recommending in-person visits to prescribe mifepristone during the COVID-19 pandemic—and finalized dropping the in-person requirement in a formal rule change in 2021.[18] *All. for Hippocratic Med.*, 602 U.S. at 376. The Telemedicine Ban also infringes on patients' autonomous decision-making because it restricts patients from deciding when and where to begin their abortions. Because the Telemedicine Ban restricts abortion care with no compelling governmental interest, it violates subsection 3. Plaintiffs are likely to succeed on their claim that the Telemedicine Ban violates the Missouri Constitution's right to reproductive freedom under subsections 3 and 6, and the law should be enjoined.

[18] And even under the prior FDA rule, patients were not required to take mifepristone in the presence of the prescribing physician—they could take it at a time and place of their choosing. Sandoval Aff. ¶ 57.

### 8. The Advanced Practice Clinician Ban violates Missourians' fundamental right to reproductive freedom.

Missouri also bans Advanced Practice Clinicians ("APCs"), such as physician's assistants ("PAs") and Advanced Practice Registered Nurses ("APRNs"), from providing abortions, even though these licensed clinicians are perfectly qualified to provide many forms of abortion care, including medication abortions, and safely and routinely provide more complex care. §§ 334.245, 334.735.3, 188.020, 188.080, RSMo (APC Ban).

The APC Ban delays, restricts and interferes with abortion care, so it is presumptively invalid under subsection 3. Together, Plaintiffs employ only eight physicians who can provide abortions, but they employ seventeen APCs who are qualified to provide abortion care. Sandoval Aff. ¶ 60; Wales Aff. ¶ 42; Muniz Aff. ¶ 43. If not for the APC Ban, Plaintiffs could more efficiently and quickly allocate provider time to treat all patients seeking reproductive health care, including abortion care. Sandoval Aff. ¶ 63; Wales Aff. ¶ 44; Muniz Aff. ¶ 44. Because the APC Ban delays, restricts, and interferes with abortion care, it is presumptively invalid under subsection 3 of the Right to Reproductive Freedom Initiative. Unless and until the government demonstrates that it has a compelling interest that justifies the APC Ban, and that the restriction is the least restrictive means of achieving the government's interest, this law must be enjoined.

Indeed, Defendants will be unable to make any such showing under subsection 3. Mo. Const. art. I, § 36.3. While it is not Plaintiffs' burden to show the lack of governmental compelling interest, there is no individual patient health benefit to the APC ban. All major

medical health organizations agree that APCs can provide early abortion care just as safely as physicians. Sandoval Aff. ¶¶ 61–62. This is emphasized by the fact that, under Missouri law, APCs are able to treat miscarriages and incomplete abortions, including by using the very same drugs used in a medication abortion or by providing aspiration just as would be used for an early procedural abortion. *Id.* ¶ 60; Wales Aff. ¶ 43; Muniz Aff. ¶ 44. If there were any individual health benefit to the APC Ban, surely APCs would not be able to provide this identical care. The APC Ban does not further any individual health benefit. *See, e.g.*, *Weems v. State ex rel. Knudsen*, 412 Mont. 132, 153 (2023) (finding no "medically acknowledged, bona fide health risk" addressed by law prohibiting APRNs from providing abortions and finding law invalid under state constitutional right to privacy); *Doe*, 2022 WL 2662998, at *27 (same for physician-only law); *Planned Parenthood Great Nw., Haw., Alaska, Ind., Ky. v. Alaska*, No. 3AN-19-11710CI, slip op. at 24 (Alaska Super. Ct. Sept. 4, 2024) (same) (attached as Exhibit E); *Planned Parenthood S.W. Ohio Region v. Ohio Dept. of Health*, No. A 2101148, 2024 WL 4183292, at *7 (Ohio C.P. Sept. 10, 2024) (same); *Northland Fam. Plan. Ctr.*, slip op. at 46 (finding physician-only law "excludes qualified clinicians from providing abortion care without any medical justification" and likely to be invalid under state constitutional right to reproductive freedom). Not only does the APC Ban have no relation to improving the health of a pregnant patient or the other two factors required to show a compelling interest, but even if it did, Defendants could not possibly also show that it is the least restrictive means of achieving that interest. *See Doe*, 2022 WL 2662998, at *27 (finding physician-only law

"not narrowly tailored" to alleged interest in patient health). Plaintiffs are likely to succeed on their claim that the APC Ban violates the Missouri Constitution's right to reproductive freedom, and the law should be enjoined.

Further, by treating abortion care as categorically different from miscarriage care or any other pregnancy care, the APC Ban discriminates against abortion providers and patients. *See Planned Parenthood Great Nw., Haw., Alaska, Ind., Ky.*, slip op. at 24 (finding Alaska's APC ban violates the state constitutional equal protection guarantee on this basis). Thus, the APC Ban also violates the Right to Reproductive Freedom Initiative's prohibition on government discrimination "against persons providing or obtaining reproductive health care." Mo. Const. art. I, § 36.6.

**c. Missouri's criminalization of abortion care violates Missourians' fundamental right to reproductive freedom.**

The State's criminalization of abortion care is unconstitutional under subsections 3, 5, and 6 of the Right to Reproductive Freedom Initiative.

In Missouri, as elsewhere, health care services are typically regulated through the licensing of health care providers, and in some cases certain entities, as well as civil medical malpractice cases. *See generally* ch. 197, RSMo (health care facility licensing), ch. 334, RSMo (physician licensing). Only in the context of constitutionally protected abortion care does the State also threaten Missouri health care providers with imprisonment for providing requested, carefully chosen, and consented-to medical care.

Missouri imposes criminal penalties on health care providers for all of the abortion bans and restrictions challenged herein. A violation of the Total Ban, § 188.017.2, RSMo; Eight-Week Ban, § 188.056.1, RSMo; Fourteen-Week Ban, § 188.057.1, RSMo; Eighteen-Week Ban, § 188.058.1, RSMo; Twenty-Week Ban, § 188.375.3, RSMo; or the APC Ban, §§ 334.245.2, 188.080, RSMo, is a Class B felony punishable by five to fifteen years in prison, § 558.011.1(2), RSMo. A violation of the Abortion Facility Licensing Requirement, § 197.235.1, RSMo, and all other abortion restrictions challenged in this Motion, is a Class A misdemeanor, §§ 188.075.1, 188.080, RSMo, punishable by up to one year in prison. § 558.011.1(6), RSMo.

Missouri's abortion laws must be fully decriminalized under the Right to Reproductive Freedom Initiative for three separate reasons. First, subsection 5 provides that no "person assisting a person in [consensually] exercising their right to reproductive freedom" shall "be penalized, prosecuted, or otherwise subjected to adverse action for doing so." Mo. Const. art I, § 36.5. Abortion providers, by providing requested abortion care, directly assist Missourians exercising their right to abortion. Subsection 5's protection against "penaliz[ation]" and "prosecut[ion]" ensures that providers cannot face some of society's most serious sanctions for doing so. At minimum, this subsection prohibits the criminal penalties that Missouri attaches to the above bans and restrictions on providing abortion. Any Missouri abortion ban or restriction that imposes criminal penalties must be stricken entirely and, even if the underlying law is found to be severable or survive constitutional scrutiny, the criminal penalties themselves must be removed.

Second, attaching felony and misdemeanor penalties to abortion "denie[s], interfere[s] with, delay[s], [and] otherwise restrict[s]" the right to reproductive freedom under subsection 3. Mo. Const. art I, § 36.3. The criminal penalties—including a minimum of five years imprisonment for violation of any of the cascading Gestational Age Bans—restrict access to abortion by chilling abortion providers from practice, and therefore preventing Missourians from carrying out their constitutionally protected reproductive health care decisions. *See, e.g.*, *Okla. Call for Reprod. Just. v. Drummond*, 543 P.3d 110, 116 (Okla. 2023) ("The chilling effect of these new laws," which imposed criminal sanctions, punitive damages, and professional disciplinary action for violation of pre-abortion ultrasound and abortion provider admitting privileges requirements, "is such that no physician would likely risk providing constitutionally protected care for fear of violating these statutes."); *Doe*, 2022 WL 2662998, at *39 ("It is not difficult to appreciate that the threat of felony prosecution would have a chilling effect on current or potential abortion providers, which indirectly affects access to abortion care."); *see also* Sandoval Aff. ¶ 65; Wales Aff. ¶ 46; Muniz Aff. ¶ 45. Indeed, the threat of criminalization for clinicians who provide abortion curtails access not just to abortion care itself but also to other forms of constitutionally protected reproductive health care, including care for pregnant Missourians experiencing miscarriage (or other health-threatening situations).[19] Criminal

[19] *See, e.g.*, Usha Ranji et al., *Dobbs-Era Abortion Bans and Restrictions: Early Insights About Implications for Pregnancy Loss*, KFF (May 2, 2024), https://www.kff.org/womens-health-policy/issue-brief/dobbs-era-abortion-bans-and-restrictions-early-insights-about-implications-for-pregnancy-loss/.

penalties for abortion providers are therefore presumptively invalid under subsection 3. Mo. Const. art I, § 36.3.

Even if this Court were to find that the government might have a compelling interest in one of the substantive laws or regulations Plaintiffs challenge in this lawsuit, there is no corresponding compelling interest in enforcing those laws with criminal penalties as they do not "improv[e] or maintain[] the health of a person seeking care," as required under subsection 3. Mo. Const. art I, § 36.3. In fact, although it is not Plaintiffs' burden to show, the truth is quite the opposite: there have been numerous reports across the country of doctors tragically unwilling to treat patients seeking lawful abortion or even other pregnancy care, for fear of risking criminal prosecution if, for example, a prosecutor disagrees with the medical professional's judgment that there is a medical emergency. § 188.017.3, RSMo ("It shall be an affirmative defense for any person alleged to have violated the [Total Ban] that the person performed or induced an abortion because of a medical emergency. The defendant shall have the burden of persuasion that the defense is more probably true than not."); § 188.056.2, RSMo (same for Eight-Week Ban); § 188.057.2, RSMo (same for Fourteen-Week Ban); § 188.058.2, RSMo (same for Eighteen-Week Ban); § 188.375.4, RSMo (same for Twenty-Week Ban).[20] Defendants

[20] *See, e.g.*, Kavitha Surana, *Abortion Bans Have Delayed Emergency Medical Care. In Georgia, Experts Say This Death Was Preventable*, ProPublica (Sept. 16, 2024, 5:00 AM), https://www.propublica.org/article/georgia-abortion-ban-amber-thurman-death; Cassandra Jaramillo & Kavitha Surana, *A Woman Died After Being Told It Would Be a "Crime" to Intervene in Her Miscarriage at a Texas Hospital*, ProPublica (Oct. 30, 2024, 5:00 AM), https://www.propublica.org/article/josseli-barnica-death-miscarriage-texas-abortion-ban; Lizzie Presser & Kavitha Surana, *A Pregnant Teenager Died After Trying to*

cannot show that criminal penalties for abortion providers have "the limited purpose and . . . limited effect of improving or maintaining the health of a person seeking care" and they are certainly not "consistent with widely accepted clinical standards of practice[.]" Mo. Const. art. I, § 36.3. Because these penalties restrict and stigmatize care, they also "infringe" on a patient's "autonomous decision-making." *Id.* And criminal penalties cannot be the "least restrictive means" to achieving any asserted governmental interest, where government regulations on providing other types of health care are rarely, if ever, enforced through criminal penalties. *Id.*

Third, and finally, targeting only abortion care for criminal punishment "discriminate[s] against persons providing or obtaining reproductive health care or assisting another person in doing so," in direct violation of subsection 6. *Id*. § 36.6. To Plaintiffs' knowledge, Missouri does not threaten criminal penalties to health care providers for any other form of medical care.[21] Indeed, Missouri does not impose the abortion laws' criminal penalties on provision of the exact same procedures by the exact same health care providers in the context of miscarriage management. The singling out of abortion care for criminal penalties stigmatizes and discriminates against abortion patients and providers. Sandoval Aff. ¶ 64. Criminal penalties for enforcing abortion laws and regulations are therefore also invalid under subsection 6. Mo. Const. art. I, § 36.6.

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*Get Care in Three Visits to Texas Emergency Rooms*, ProPublica (Nov. 1, 2024, 6:00 A.M.), https://www.propublica.org/article/nevaeh-crain-death-texas-abortion-ban-emtala.

[21] Even if there were some other form of medical care on which Missouri attempted to impose criminal penalties, the fact that reproductive health care is now constitutionally protected makes the use of criminal penalties here distinguishable and inappropriate.

For all these reasons, Plaintiffs are likely to succeed on their claim that the challenged laws and their criminal enforcement provisions violate the Right to Reproductive Freedom Initiative and should be enjoined.

## II. The remaining preliminary injunction factors heavily favor Plaintiffs.

The violation of Plaintiffs' and their patients' constitutional rights caused by the challenged statutes constitutes irreparable injury. *See Elrod v. Burns*, 427 U.S. 347, 373 (1976); *Deerfield Med. Ctr. v. City of Deerfield Beach*, 661 F.2d 328, 338 (5th Cir. Unit B. Nov. 1981) (threatening the fundamental right to privacy mandates a finding of irreparable injury); *Planned Parenthood of Minn., Inc. v. Citizens for Cmty. Action*, 558 F.2d 861, 867 (8th Cir. 1977) (holding that plaintiff's showing of interference "with the exercise of its constitutional rights and the rights of its patients supports a finding of irreparable injury"). Irreparable harm applies with special force in the context of a fundamental right to abortion care, because it is a decision that "simply cannot be postponed, or it will be made by default with far-reaching consequences." *Bellotti v. Baird*, 443 U.S. 622, 643 (1979); *see also Smith v. W. Elec. Co.*, 643 S.W.2d 10, 13 (Mo. App. E.D. 1982) (finding exposure to conditions deleterious to one's health is an irreparable harm "particularly . . . where the harm has not yet resulted in full-blown disease or injury"); *Karnoski v. Trump*, No. C17-1297-MJP, 2017 WL 6311305, at *9 (W.D. Wash. Dec. 11, 2017) ("[M]onetary damages proposed by Defendants will not . . . cure the medical harms caused by the denial of timely health care.").

Irreparable harm can also be established if monetary remedies cannot provide adequate compensation for improper conduct. *Peabody Holding Co., Inc. v. Costain Grp. PLC*, 813 F. Supp. 1402, 1421 (E.D. Mo. 1993). The term "no adequate remedy at law" generally means that damages will not adequately compensate the plaintiff for the injury or threatened injury, or that the plaintiff would be faced with a multiplicity of suits at law. *Kugler v. Ryan*, 682 S.W.2d 47, 50 (Mo. App. E.D. 1984).

Violations of the new constitutional right to reproductive freedom unquestionably constitutes an irreparable injury for which there is no adequate remedy at law. *See Mo. State Med. Ass'n v. State*, No. 07AC-CC00567, 2007 WL 6346841 (Mo. Cir. Ct. Cole Cnty. July 3, 2007) (granting temporary restraining order against law that restricted practice of midwifery and would impose irreparable injury on physicians and their pregnant patients); *Harris v. Bd. of Supervisors, L.A. Cnty.*, 366 F.3d 754, 766 (9th Cir. 2004) (plaintiffs established likelihood of irreparable harm where evidence showed they would experience pain, complications, and other adverse effects due to delayed medical treatment); *Planned Parenthood of Kan. & Mid-Mo. v. Lyskowski*, No. 2:15-CV-04273-NKL, 2015 WL 9463198, at *4 (W.D. Mo. Dec. 28, 2015) (any period during which plaintiff could not perform abortions because of the loss of its license constitutes irreparable injury); *Planned Parenthood of Kan. & Mid-Mo. v. Drummond*, No. 07-4164-CV-C-ODS, 2007 WL 2463208, at *3 (W.D. Mo. Aug. 27, 2007) (plaintiff's showing that Missouri's ASC Restriction will force two health centers to cease providing abortion and therefore "will interfere with the exercise of its constitutional rights and the rights of its patients constitutes

irreparable harm" (internal quotation omitted)); *see also Deerfield Med. Ctr.*, 661 F.2d at 338 (5th Cir. 1981) (an infringement on the constitutional right to have an abortion "mandates" a finding of irreparable injury because "once an infringement has occurred it cannot be undone by monetary relief").

Missourians have lacked accessible, in-state abortion care since even before the *Dobbs* decision. Traveling out-of-state for abortion care can be expensive and time-consuming in many ways, including costs of travel, lodging, childcare, taking time off work, and risk of exposing a private and personal decision to abusive or controlling parents, partners, or managers. Those unable to leave the state for an abortion have been subjected to forced pregnancies and all of the associated risks to physical, mental, emotional, and socioeconomic health that forced pregnancies entail. The economic impact of forced pregnancy, childbirth, and parenting have dramatic negative effects on families' financial stability.[22] Some side-effects of pregnancy render patients unable to work, or unable to work the same number of hours as they otherwise would. For example, some patients with hyperemesis gravidarum must adjust their work schedules because they vomit throughout

[22] Nat'l P'ship for Women & Fams., *By the Numbers: Women Continue to Face Pregnancy Discrimination in the Workplace* 1 (2016), https://nationalpartnership.org/wp-content/uploads/2023/02/by-the-numbers-women-continue-to-face-pregnancy-discrimination-in-the-workplace.pdf; *see generally* Kelly Jones & Anna Bernstein, *The Economic Effects of Abortion Access: A Review of the Evidence*, Inst. for Women's Pol'y Rsch. 1 (2019), https://iwpr.org/wp-content/uploads/2020/07/B377_Abortion-Access-Fact-Sheet_final.pdf (finding that access to abortion results in women "invest[ing] more heavily in their own human capital, leading to increased schooling and improved labor market outcomes" and that "this is true even for women who never have an unintended pregnancy").

the day. And other patients with preeclampsia must severely limit activity for a significant amount of time. These conditions may result in job loss, especially for people who work jobs without predictable schedules, paid sick or disability leave, or other forms of job security. Even without these conditions, pregnancy-related discrimination can result in lower earnings both during pregnancy and over time. While many people decide that adding a child to their family is well worth these risks and consequences, without the availability of abortion, Missourians are forced to assume these risks involuntarily.

Moreover, the balance of harms tips heavily in favor of Plaintiffs, and the public interest weighs in favor of a preliminary injunction or, in the alternative, temporary restraining order. The balance-of-harms and public-interest factors "merge when the Government is the opposing party." *Nken v. Holder*, 556 U.S. 418, 435 (2009). Plaintiffs and their patients are suffering serious harm, whereas Defendants only stand to lose the ability temporarily to enforce laws that are likely to be held unconstitutional and which further no valid compelling state interest. Neither the State nor the public has any interest in the enforcement of an unconstitutional law. *See Hill v. Mo. Conservation Comm'n*, No. 15OS-CC00005-01, 2016 WL 8814770, at *18 (Mo. Cir. Ct. Gasconade Cnty. Nov. 17, 2016) ("[T]here can be no public interest in enforcement of an unauthorized government action."); *Mo. State Med. Ass'n*, 2007 WL 6346841 ("[B]alancing of the harms favors immediate injunctive relief, because a restraining order will not harm the State of Missouri and will actually further its interests in ensuring the health and safety of its citizens."); *see also ACLU v. Johnson*, 194 F.3d 1149, 1163 (10th Cir. 1999) ("[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." (citation omitted)); *Kirkeby v. Furness*, 52 F.3d 772, 775 (8th Cir. 1995) (public interest favored injunction against unconstitutional ordinance); *Saint v. Neb. Sch. Activities Ass'n*, 684 F. Supp. 626, 628 (D. Neb. 1988) (no harm to defendant in losing the ability to enforce unconstitutional regulations).

### III. Bond

Plaintiffs respectfully submit that, if required, bond be set at no more than the nominal amount of $100. *See Planned Parenthood of Kan. & Mid-Mo. v. Nixon*, No. 0516-CV25949, 2005 WL 3116528 (Mo. Cir. Ct. Jackson Cnty. Nov. 8, 2005) (maintaining $100 bond for TRO and subsequent preliminary injunction in case challenging law creating civil cause of action related to minors' abortions).

## CONCLUSION

The Court should grant Plaintiffs' Motion for a Preliminary Injunction or, in the Alternative, Temporary Restraining Order, effective December 5, to enjoin Defendants and successors in office from enforcing any provision of the challenged laws during the pendency of this litigation and allow Missourians to begin to access the rights and relief they voted to enshrine in their constitution.

Respectfully submitted,

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# EXHIBIT B

**IN THE CIRCUIT COURT OF JACKSON COUNTY,**

**MISSOURI, AT KANSAS CITY**

| | |
|---|---|
| COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, PLANNED PARENTHOOD GREAT RIVERS-MISSOURI<br><br>Plaintiffs,<br><br>v.<br><br>THE STATE OF MISSOURI, et al.<br><br>Defendants, | No. _____ |

**AFFIDAVIT OF DR. SELINA SANDOVAL IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION OR, IN THE ALTERNATIVE, TEMPORARY RESTRAINING ORDER**

I, Selina Sandoval, M.D., M.P.H., declare and state the following:

1. I am the Associate Medical Director of Comprehensive Health of Planned Parenthood Great Plains ("Comp Health"), where I provide abortion services and other reproductive health care. I have worked for Comp Health since September 1, 2022, and I live in Missouri.

2. The facts I state here and the opinions I offer are based on my education, years of medical practice, my expertise as a doctor and specifically as an abortion provider, my personal knowledge, and my familiarity with relevant medical literature and statistical data recognized as reliable in the medical profession.

3. I understand that on December 5, 2024, Missouri's Right to Reproductive Freedom Initiative goes into effect, and that the Missouri Constitution will protect a right to make decisions about one's reproductive health care, including abortion.

4. I submit this affidavit in support of Plaintiffs' Motion for Preliminary Injunction or, in the Alternative, Temporary Restraining Order seeking to prevent the State from enforcing various abortion bans, restrictions, and regulations that are now unconstitutional under Missouri's new Right to Reproductive Freedom Initiative. I have reviewed the laws being challenged in this case and am generally familiar with their contents. Missouri law currently contains a host of harmful restrictions that do not further patients' health, are contrary to best medical practices, and infringe patients' autonomy. I understand that these laws impose numerous criminal and civil penalties on physicians, like myself, and on other health care providers. If these laws are not enjoined, they will prevent me and other providers in Missouri from offering patients the health care to which they are now constitutionally entitled.

**My Background**

5. I am a board-certified obstetrician-gynecologist ("ob-gyn") and Complex Family Planning physician with 8 years of experience in reproductive health. I am licensed to practice medicine in the states of Missouri and Kansas. I earned a Bachelor of Science in Biology from the University of Arizona and graduated from the University of Illinois College of Medicine in 2016. I completed my residency in Obstetrics and Gynecology at the University of Kansas. I completed a fellowship in

Complex Family Planning at the University of California, San Diego. I am board certified in both Obstetrics and Gynecology and Complex Family Planning. I also have a Masters in Public Health from the University of California, San Diego. I am currently the Family Planning Resident Rotation Director at the University of Kansas Medical Center and Overland Park Regional Medical Center, and I am a Reproductive Health Programs Trainer for the American College of Obstetricians and Gynecologists ("ACOG"). I attach a copy of my curriculum vitae as Exhibit 1.

6. I currently provide abortions for Comp Health at its health centers in Kansas. I provide medication abortion up to 12 weeks gestational age as measured from the first day of a pregnant patient's last menstrual period ("LMP"), and procedural abortion through 21 weeks 6 days LMP.[1] I provide these abortions in an outpatient setting.

7. In my current role as Associate Medical Director for Comp Health, I oversee the medical services provided by Comp Health, including abortion. My responsibilities include providing medical expertise to develop and adjust protocols; overseeing our resident, student and fellow trainees; overseeing and training the clinicians providing care throughout our health centers, and supervising our health center pharmacist.

[1] A full-term pregnancy is about 40 weeks LMP.

**Abortion Is Common and Safe**

8. Abortion is extremely common. Approximately one in four women in this country will have an abortion by age 45.[2]

9. People choose abortion for a variety of deeply held and personal reasons. For some, it is not the right time to become a parent. Others are already parents and decide that they cannot parent another child at this time. For others, continuing with a pregnancy could pose a risk to their health; and others seek an abortion because they have received a diagnosis of a fetal medical condition. At Comp Health, we strive to make our care as accessible, affordable, respectful, and high quality as possible for all patients.

10. There are two main methods of abortion: medication abortion and procedural abortion.

11. Medication abortion typically involves a two-drug regimen of pills. The first drug, mifepristone—or Mifeprex, which is its brand name—is provided to end the pregnancy. The second drug, misoprostol, or Cytotec, causes the uterus to contract and expel the products of conception, in a process that mimics miscarriage.

12. After receiving the medications from their provider, patients take the medications and complete the abortion in the location of their choosing, often from the comfort of their home. This is in keeping with widely accepted clinical standards of practice and evidence-based medicine. However, in some states, like Missouri,

[2] Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014*, 107 Am. J. Pub. Health 1904, 1907 (2017).

medically unnecessary laws require patients to take the mifepristone at the health center in the presence of the medical provider. There is no medical reason that either mifepristone or misoprostol has to be taken either at the health center or in the presence of a medical provider.

13. A procedural abortion involves dilating the uterine cervix and using suction and/or instruments to remove the products of conception. Although sometimes procedural abortion is called "surgical abortion," procedural abortion is not surgery in the traditional sense because it does not involve cutting into the patient's skin. Starting at approximately 14 weeks LMP, it is common to use the dilation and evacuation (D&E) method, which involves using forceps and other instruments, in conjunction with suction, to remove the products of conception. Starting at approximately 18 weeks LMP, abortion is typically a two-day procedure, with the patient's cervix being dilated on the first day, and the abortion occurring on the second. It typically takes me between 2–15 minutes to do a procedural abortion.

14. Some patients strongly prefer medication abortion.[3] This could be because it feels more natural to them, *i.e.* it mimics a miscarriage. This is also important for victims of domestic violence or others who may want to keep the fact that they obtained an abortion private. For some, medication abortion is medically indicated. And others, like victims of rape, prefer not to have instruments inserted into their vagina.

[3] *See* Daniel Grossman et al., *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine*, 118 Obstetrics & Gynecology 296, 300 (2011) (finding 71% of study participants said they strongly preferred medication abortion).

15. Similarly, some patients prefer or need a procedural abortion. This can be because they prefer to complete the abortion in the health center rather than find additional time away from work or caretaking responsibilities to expel the products of conception at home or elsewhere. For others, such as those with specific medical conditions, procedural abortion is medically indicated.

16. Abortion by either method is extraordinarily safe.[4] Fewer than 1% of abortion patients have a serious complication.[5] The risk of a patient experiencing a complication that requires hospitalization is even lower, approximately 0.23%.[6] Although rare, the risk of complications increases as gestational age increases. All major medical organizations agree that patients should be able to access care as soon as they need it, and that abortion restrictions and other barriers to care are harmful to patients.

17. The alternative to abortion is remaining pregnant and carrying a pregnancy to term. Pregnancy carries much greater health risks than abortion. Some studies estimate that the risk of death associated with childbirth nationwide is between 12–14 times more than that associated with abortion.[7]

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[4] Nat'l Acads.of Scis., Eng. & Med., *The Safety and Quality of Abortion Care in the United States*, at 77–78, 161–62 (2018), https://nap.edu/catalog/24950/the-safety-and-quality-of-abortion-care-in-the-united-states [hereinafter "Nat'l Acads."].

[5] Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175 (2015).

[6] *Id.* at 175.

[7] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216–17, 217 fig.1 (2012); Nat'l Acads., note 4 at 27, 75 tbl. 2–4, 77–78.

18. In Missouri, from 2017–2021, the pregnancy-related mortality ratio was 32.2 deaths per 100,000 live births,[8] significantly higher than the national average (in 2019, 20.1 maternal deaths per 100,000, and 23.8 per 100,000 in 2020)[9]. For Black women in Missouri, the ratio of pregnancy-related mortality is 2.5 times the ratio of white women.[10] The ratio of pregnancy-related deaths was 2.8 times higher for people covered by MO HealthNet than those with private insurance.[11] For pregnant women with a high school diploma or GED, the rate of pregnancy-related mortality was 3.3 times higher than for women who had obtained education beyond the high school level.[12] Seventy-seven percent of pregnancy-related deaths were determined to be preventable in Missouri.[13] Further, the second leading cause of pregnancy-related deaths, just after cardiovascular disease, was mental health conditions.[14] Suicides represented 14% of pregnancy-related deaths, and most occurred between 43 days and one year postpartum.[15]

19. Pregnancy increases a patients' risk of blood clots, nausea, hypertensive disorders, and anemia (among other conditions), and can also exacerbate preexisting

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[8] Mo. Dep't of Health & Senior Servs., *A Multi-Year Look at Maternal Mortality: 2017–2021 Pregnancy Associated Mortality Review, Pregnancy-Associated Mortality Rev.* 15 (2024).
[9] Donna L. Hoyert, *Maternal Mortality Rates in the United States, 2020*, CDC: Nat'l Ctr. for Health Stats.: Health E-Stats, (2022), https://stacks.cdc.gov/view/cdc/113967/cdc_113967_DS1.pdf.
[10] Mo. Dep't of Health & Senior Servs., note 8, at 15.
[11] *Id.* at 29.
[12] *Id.*
[13] *Id.* at 15.
[14] *Id.*
[15] *Id.* at 48.

health conditions like diabetes, obesity, autoimmune disorders, pulmonary disease, and mental health conditions. Pregnant patients can also develop new and debilitating health conditions like hyperemesis gravidarum, preeclampsia spectrum, deep vein thrombosis, and gestational diabetes.

20. Labor and childbirth are also significant medical events. Serious complications during labor and delivery include hemorrhage, transfusion, ruptured uterus or liver, stroke, unplanned hysterectomy (the surgical removal of the uterus), and perineal laceration (the tearing of the tissue around the vagina and rectum), some of which can result in long-term urinary and fecal incontinence and sexual dysfunction. Both vaginal and cesarean section ("C-section") delivery carry a host of risks that can lead to permanent health issues, serious injuries, complications in later pregnancies, and can become life-threatening. Every pregnancy-related complication is more common among patients giving birth than among those having abortions.

21. Although Missouri's post-*Dobbs* total abortion ban is currently in effect, Missourians still need and obtain abortions. In my practice in Kansas, I have seen and treated many Missourians who have had to travel to obtain care; some have traveled countless miles. Patients generally seek abortion as soon as they are able, but many, including many of the Missourians I have seen, face an array of logistical obstacles that can delay access to abortion, including working multiple jobs, having caregiving responsibilities, not having access to transportation, not having the funds for the service, and so forth. Traveling out of state can be a huge additional barrier to care, and for some, it may be insurmountable.

22. Delaying or denying access to abortion is extremely harmful to patients and their families. Being forced to remain pregnant against a person's will can cause physical and psychological harm. Even uncomplicated pregnancies carry risks and physical burdens which increase as the pregnancy advances. While abortion is extremely safe, the risk of serious complications associated with abortion increase as a pregnancy advances. Delays in abortion access can cause patients to miss the window in which to have their preferred type of abortion, or the type that's offered by their local health center, and sometimes denies them access to abortion altogether.

**Missouri's Abortion Restrictions Deny, Interfere with, Delay, and Restrict Abortion Access**

23. I understand that Plaintiffs'Motion for Preliminary Injunction or, in the Alternative, Temporary Restraining Order seeks to prevent the State from enforcing: (1) the Total, Gestational Age, and Reasons Bans; (2) the Abortion Facility Licensing Requirement; (3) the Hospital Relationship Restrictions; (4) the Medication Abortion Complication Plan Requirement; (5) the Pathology Requirements; (6) the Biased Information Law; (7) the 72-hour Waiting Period, In-Person, and Same Physician Requirements; (8) the Advanced Practice Clinician Ban; (9) the Telemedicine Ban; and (10) the Criminal Penalties for Abortion Providers, which target abortion providers like myself.[16]

24. All of these laws have negative consequences for patients. Moreover, they do not further patient health, go against clinical standards of practice and evidence-based

[16] I am referring to these the same way that I understand them to be used in the pleadings.

medicine, and hurt patients' autonomous decision making. The National Academies of Sciences, Engineering, and Medicine—a body of esteemed experts that was established by Congress to provide independent, objective expert analysis and advice to the nation to inform public policy and is "focused on finding reliable, scientific information"—has concluded that restrictions like the ones in Missouri "may limit the number of available providers, misinform women of the risks of the procedures they are considering, overrule women's and clinician's medical decision making, or require medically unnecessary services and delays in care," thus increasing the risks of abortion without any medical benefit.[17]

*Total, Gestational Age, and Reasons Bans*

25. I understand that Missouri currently has a total abortion ban in place. In addition, I understand that Missouri has cascading abortion bans at 8 weeks LMP, 14 weeks LMP, 18 weeks LMP, and 20 weeks LMP. All of these bans prohibit abortion prior to any definition of fetal viability. I understand that Missouri law also bans abortions at any gestational age if the provider knows that the patients' decision to obtain an abortion is based on a potential Down syndrome diagnosis or the fetus's sex or race.

[17] Nat'l Acads., note 4 at 11 tbl. S-1.

26. The total, gestational age, and reasons bans[18] all flatly deny patients the ability to access abortion because they categorically prevent certain patients from accessing abortion.

*Abortion Facility Licensing Requirement*

27. I understand that Missouri law also requires abortion providers to obtain an ambulatory surgical center license for their facilities. I understand that, in order to do so, the health centers must meet stringent physical facility requirements and must follow certain standards of operation that, in my opinion, are harmful to patients, among other requirements.

28. As discussed above in paragraph 13, abortion is not what is traditionally considered surgery, so it is confusing to me as a clinician who provides abortion services why Missouri would require an ambulatory *surgical* license. This is a

[18] Consistent with best medical practices, Comp Health does not require patients to tell us their reasons for seeking an abortion. Nonetheless, it is not possible or reasonable for physicians to actively avoid knowing why patients are seeking an abortion. This could come up in patient counseling, or it may be revealed from medical records, or the patient may have been referred to us by another doctor who diagnoses certain fetal anomalies, including Down syndrome. It is counter to the doctor-patient relationship for physicians to warn patients not to disclose certain information during these conversations. If the Reasons Ban remains in effect (even if the court strikes down the other laws challenged in this case), I—and the other abortion providers in Missouri—will face unjustifiable risk in providing abortion care to patients if we know that a patient has, for example, had a prenatal screening indicating Down Syndrome; or if the embryo or fetus's race or sex comes up in patient counseling; or if the patient asks the sex of the fetus during an ultrasound. In order to be certain that we are not violating the Reasons Ban, I and other providers in Missouri may need to violate best medical practices by probing a patient's reasons for seeking abortion care, even when the patient does not volunteer that information, so as to avoid personal legal liability. It is inconsistent with the ethical obligations of a physician to intrude on my patients' privacy in this way and would interfere with the doctor-patient relationship.

particularly bad fit in the case of medication abortion, which involves patients only taking pills. Medical procedures of similar or greater risk and complexity are routinely performed in an office setting, including: uterine polypectomy (removing polyps from the uterus); vasectomy; colposcopy and LEEP (examination and procedures of the cervix), including scraping or curettage of tissue samples for biopsy; and miscarriage care, including the same medications and procedures used in abortion care.

29. This requirement singles out abortion care and harms patients by limiting the facilities at which abortion can be obtained. For example, our Gladstone and Independence health centers, where we would like to begin offering medication abortion, we would be unable to because those health centers do not meet the physical facility requirements.

30. The standards of operation are harmful to patients. For example, the Abortion Facility Licensing Requirement mandates that physicians conduct a medically unnecessary pelvic exam on *all* abortion patients, even medication abortion patients. A pelvic exam requires patients to remove their clothing and have their genitalia inspected both externally and internally, including using a speculum and the provider's hands. Again, some of these patients choose medication abortion precisely because they do not want instruments inserted into their vagina. I cannot and will not subject my patients to medically unnecessary exams, especially ones so intimate in nature. I would consider this inconsistent with high-quality, patient-centered care and harmful to the physician-patient relationship based on trust.

*Hospital Relationship Restrictions*

31. I understand that under Missouri law, in order to provide medication or procedural abortions, I, and other providers, would be required to have clinical privileges at a hospital that offers obstetrical or gynecological care within thirty miles of the health centers plus a written transfer agreement, or have clinical privileges at a hospital that offers obstetrical or gynecological care within fifteen minutes travel time of the health centers.

32. This would be impossible for me and the other providers to do at all of our health centers, especially at our Columbia Health Center, where we would be extremely unlikely to find physicians with local hospital admitting privileges willing and able to provide abortion.

*Medication Abortion Complication Plan*

33. I understand that Missouri's Medication Abortion Complication Plan would separately require me, and other providers, to have a written contract with a board-certified or board-eligible ob-gyn (or ob-gyn group) who has agreed to be "on-call and available twenty-four hours a day, seven days a week" to "personally treat all complications" from medication abortion "except in any case where doing so would not be in accordance with the standard of care or the patient's best interest for a different physician to treat her."[19] I also understand that the ob-gyn or ob-gyn group has to be local and have hospital privileges. I understand that the Columbia Health Center was not previously able to comply with this requirement because of the lack of

[19] 19 C.S.R. § 10-15.050.

physicians willing and able to work with us, and that this is in part what forced it to stop providing medication abortions.

34. It would be impossible for our providers to comply with this requirement for all of our health centers, especially in Columbia.

35. This requirement makes little sense, especially in the context of medication abortion. The safety of medication abortion is comparable to that of taking ibuprofen.[20]

36. Medication abortion is also an increasingly common choice, especially as telemedicine has become more accessible in many states. In 2023 (the most recent data available nationwide), medication abortions accounted for 63% of all non-hospital abortions; this is up from 53% in 2020.[21]

37. The Medication Abortion Complication Plan Requirement does not further patient health. In the event of complications, Comp Health is prepared to offer high-quality care, consistent with the standard of care. When medication abortion patients leave the clinic, they are provided a phone number to call if they experience concerns or complications. That phone number is answered every day, day and night, 24/7. In nearly all cases, patients' concerns can be addressed over the phone or with a

[20] The National Academies has concluded that, "[t]he risks of medication abortion are similar in magnitude to the risks of taking commonly prescribed and over-the-counter medications such as antibiotics and NSAIDs [nonsteroidal anti-inflammatory drugs]," such as ibuprofen. Nat'l Acads., note 4 at 79.

[21] Rachel Jones & Amy Friedrich-Karnik, *Medication Abortion Accounted for 63% of All US Abortions in 2023 — An Increase from 53% in 2020* Guttmacher (Mar. 19, 2024), https://www.guttmacher.org/2024/03/medication-abortion-accounted-63-all-us-abortions-2023-increase-53-2020.

follow-up visit, but if a patient needs additional or after-hours care, Comp Health refers them to an emergency room close to them. Moreover, patients being transported by ambulance are not required to go to the hospital where my providers, or our contracted ob-gyns, would have privileges (if they could even get these privileges). And in the exceedingly rare case of a medical emergency, *all* hospitals are required to treat *all* patients under EMTALA.

38. The practice guidelines of the leading professional organization of ob-gyns–like the American Congress of Obstetricians and Gynecologists ("ACOG"), Planned Parenthood Federation of America, and the leading professional organization of abortion providers, the National Abortion Federation ("NAF")–recognize that clinics that perform abortions should have protocols in place for transferring patients who require emergency treatment, but do not suggest or require that abortion-providing physicians have contracts with ob-gyns to be on call 24/7 and "personally treat" all complications. They also do not require agreements with local ob-gyns who have admitting privileges at a nearby hospital. ACOG states that clinicians who perform abortions "in their offices, clinics, or freestanding ambulatory care facilities should have a plan to ensure prompt emergency services if a complication occurs and should establish a mechanism for transferring patients who require emergency treatment."[22] NAF states that "Protocols for the management of

[22] ACOG, *Guidelines for Women's Health Care: A Resource Manual* 720 (4th ed. 2014); *see also* ACOG, *Statement on State Legislation Requiring Admitting Privileges for Physicians Providing Abortion Services* (Apr. 25, 2013).

medical emergencies must be in place" but "[h]ospital admitting privileges are not needed to provide safe abortion care."[23]

*Pathology Requirements*

39. I understand that Missouri law requires all tissue removed from an abortion procedure to be sent to a pathologist.

40. In miscarriage care, and every other procedure that involves removing bodily tissue, it is standard practice for the health care provider to first analyze the removed tissue and then decide (at their discretion) whether there is a medical reason to send the removed tissue for additional analysis from a pathologist.

41. In states where Comp Health provides abortion, we currently dispose of abortion tissue just as we dispose of all other tissue, including identical tissue from miscarriage management, which is consistent with the widely accepted standard of care. We would do the same in Missouri. There are times when it is appropriate to send tissue to a pathologist–such as when the patient has a suspected molar pregnancy, which, if left undiagnosed, can lead to cancer and/or result in a hysterectomy. Comp Health has procedures in place for sending this tissue to a pathologist.

42. However, there is no reason for sending *all* tissue from procedural abortion to a pathologist. This is an unnecessary burden, both financially and physically, and, if we cannot comply, we will be prevented from providing procedural abortions.

[23] National Abortion Federation, 2024 *Clinical Policy Guidelines for Abortion Care* 1 (2024).

*The Biased Information Law*

43. The biased information that patients are required to receive in order to start the 72-hour clock before they can receive their abortion is also uniquely harmful both to patients and to their abortion providers. I understand that the law requires us to give patients medically inaccurate information that is meant to shame them and stigmatize abortion, such as that their abortion will "terminate the life of a separate, unique, living human being," and that their abortion may cause the fetus pain.[24]

44. These are statements that neither I nor the providers I supervise know to be true. It goes against our medical training to say these things, and against our ethical obligations to our patients. It is contrary to best clinical practice. And I believe that being forced to give my patients this false and biased information will damage their trust in me as a provider.

45. I know of no other health care in which Missouri mandates such a lengthy and biased amount of information in an attempt to influence a patient's medical decision. For all other health care, providers have informed consent counseling conversations with their clients subject to their own professional and ethical obligations and tailored to their client's specific needs. This includes providers treating patients having a miscarriage or other pregnancy care, including prenatal appointments.

*The 72-Hour Waiting Period, In-Person, and Same Physician Requirements*

46. I understand that under Missouri law, patients are required to make two, in-person trips to the health center at least 72 hours apart. At the first appointment, I

[24] § 188.027, RSMo 2016.

understand that they are required to receive certain state-mandated information from the same physician who is to provide the abortion.

47. The number of abortion providers available to provide abortion in Missouri is limited, in part because abortion is heavily stigmatized and abortion providers are subjected to frequent harassment and threats.

48. We currently have 5 physicians on staff who are licensed in Missouri and prepared to provide abortions at Comp Health's Missouri health centers. All would likely also provide abortions in other states. It would be impossible for our physicians to consistently be staffed at the same health center on shifts 72 hours apart. In reality, physicians who provide abortions tend to be scheduled much more irregularly at each health center, due to their other scheduling commitments. Comp Health has also historically relied on physicians who come from out of state to fill out its abortion appointment schedules. These physicians may only come through Missouri once every month or less.

49. There is no medical or ethical reason for the same provider to conduct the informational appointment and to provide the abortion. In other types of health care, and consistent with the standard of care, informed consent is frequently obtained by a different professional than the one actually providing the chosen procedure. For example, in a hospital setting, a resident physician may obtain consent for a surgery provided by an attending physician, which is then confirmed by the surgeon before surgery. I am unaware of any other medical care that is required by Missouri law to

have the same provider get informed consent and give the procedure. ACOG acknowledges that "same physician" requirements like Missouri's reduce access to abortion and are medically unnecessary. Accordingly, ACOG "opposes such requirements because they improperly regulate medical care and do not improve patient safety or quality of care."[25]

50. Seventy-two hours is, in and of itself, a delay and can be exceptionally harmful for patients who are near the cut-off for their preferred method of abortion, such as medication abortion, or who are close to 18 weeks LMP, when the procedure is more likely to take two days. However, because of our current staffing, this delay is almost guaranteed to be much longer than 72 hours before a patient can come back to see the same doctor, and could be even further exacerbated if a physician is unable to come to the clinic due to unforeseen circumstances, like illness.

51. These delays will harm patients. They will push them further into pregnancy, exposing them for longer to the physical risks associated with pregnancy, as well as to the emotional toll of remaining pregnant longer than desired. They will also increase the risks associated with abortion, which, though rare, are more likely as pregnancy progresses.

52. I know of no other medical procedure in Missouri where a patient is mandated by law to see a physician (much less the same physician) twice, three days or more apart, in order to receive care.

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[25] ACOG Comm. on Health Care for Underserved Women, *Opinion Number 815: Increasing Access to Abortion*, 136 Obstetrics & Gynecology e107, e109 (2020).

*Telemedicine Ban*

53. It is also my understanding that Missouri law bars the use of telemedicine for medication abortion by requiring the first drug taken in a medication abortion to be taken in the provider's physical presence. This means that, for those who have difficulty coming to the health center, abortion will be difficult to access or may be out of reach altogether. It also means that some patients will be delayed more than necessary due to logistical challenges of physically going to an appointment.

54. I also understand that this same ban does not apply when mifepristone is used for miscarriage management or any other health care. In other words, it is permissible for me to prescribe mifepristone via telemedicine for miscarriage, but it is against the law—and subjects me to criminal and licensing penalties—to prescribe the same exact medication for abortion. In none of these other settings does the ban on telemedicine apply.

55. Telemedicine has been shown to be a safe and effective way of providing medication abortion. It can be done either site-to-site, with the provider meeting with the patient via face-to-face secure, interactive videoconference rather than in person; or direct-to-patient, which involves a videoconference with a provider, who then mails the eligible patient the medication abortion medications.

56. Telemedicine abortion improves access to medication abortion in underserved areas (including rural areas), and increases access to abortion for patients with low incomes or who otherwise find it difficult to travel. Patients report greater satisfaction

rates with the telemedicine abortion service (particularly with their wait time).[26] Telemedicine also allows patients to obtain abortions earlier in pregnancy, when the risks of complications are lower and procedures are less costly, and in the privacy of their own home, where they do not have to confront anti-abortion protestors.

57. Providing medication abortion via telemedicine is safe and effective. This is evident from the fact that the FDA stopped recommending in-person visits to prescribe mifepristone during the COVID pandemic, and then finalized this rule change in 2021. Even under the previous rule, the FDA did not require a patient to take the mifepristone in the provider's presence. Research also confirms that telemedicine abortion is safe, effective, and well-liked by both patients and providers.[27] Consistent with this research, ACOG updated its guidance on medication abortion in 2020 to recognize that medication abortion provided through telemedicine is not only as safe, effective, and as well-liked as in-person care, it may also help reduce delays to care.[28]

*The APC Ban*

58. It is my understanding that Missouri law also does not allow Advanced Practice Clinicians ("APCs") to provide abortion, even though it is within their scope

[26] Grossman et al., note 3 at 300.

[27] *See, e.g.*, Margit Endler et al., *Telemedicine for Medical Abortion: A Systematic Review*, 126 BJOG: Int'l J. Obstetrics & Gynaecology 1094, 1097 tbl.1, 1100 (2019); Grossman et al., note 3; *see also* Daniel Grossman, *Telemedicine for Medical Abortion – Time to Move Towards Broad Implementation*, 126 BJOG: Int'l J. Obstetrics & Gynecology 1103 (2019).

[28] ACOG Comm. on Prac. Bulls.–Gynecology & Soc'y of Fam. Plan., *Practice Bulletin Number 225: Medication Abortion Up to 70 Days of Gestation*, 136 Obstetrics & Gynecology e31 (2020).

of practice to do so. It is my understanding this is the only medical procedure that is within APCs' scope of practice that is otherwise prohibited by law. Laws like this APC Ban, which limit APCs' scope of practice categorically by prohibiting APCs from providing abortion, restrict patients' access to safe and effective abortion care.

59. APCs are a category of highly trained health care professionals. They include Advanced Practice Registered Nurses ("APRNs") and Physician's Assistants ("PAs").

60. We currently have seven APCs on staff in Missouri. APCs are in our health centers every day that the centers are open and provide the majority of the care we offer, including care that is comparable to, or more complicated than, abortions. For example, APCs can insert and remove intrauterine contraceptive devices ("IUDs"); they can perform endometrial biopsies, which involves removing tissue from the uterine lining; they can perform colposcopies, vasectomies, and they can provide follow-up care for medication abortions. APCs also provide miscarriage management.

61. With the relevant training and experience, APCs are qualified to provide safe and effective medication and early procedural (aspiration) abortion. There is no medical reason APCs should not be able to provide abortions, consistent with their scope of practice, as they already do in 21 states and the District of Columbia. The FDA stated in 2016 that medication abortion can safely be provided by APCs or under APC supervision, because studies "found no differences in efficacy, serious adverse events, ongoing pregnancy or incomplete abortion between the groups."[29]

[29] Ctr. for Drug Evaluation & Rsch., *Application Number 020687Orig1s020: Mifeprex Medical Review(s)*, FDA at 79 (Mar. 29, 2016).

62. The National Academies, the American Public Health Association ("APHA") and the World Health Organization ("WHO") agree that APCs "can provide medication and aspiration abortions safely and effectively."[30] Per ACOG, studies "show no difference in outcomes in first-trimester medical and aspiration abortion by provider type and indicate that trained APCs can provide abortion services safely."[31] ACOG therefore opposes bans on APCs providing abortion, like Missouri's law here.[32]

63. If APCs were able to provide abortions in Missouri, this would allow us to significantly expand care by offering abortion every day that the clinics are open and allowing physicians like myself to focus on more complex care. This would be especially true if the telemedicine ban were also lifted. Allowing APCs in Missouri to provide medication abortion via telemedicine—the same way APCs currently provide miscarriage management via telemedicine—will vastly increase access to abortion in Missouri's rural areas.

*Criminal Penalties for Providing Abortion*

64. Finally, I understand that the laws and regulations described above are enforced through criminal penalties. Abortion providers are already disproportionally

[30] Nat'l Acads., note 4 at 14; *see Policy No. 20112: Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants*, APHA (Nov. 1, 2011), https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/28/16/00/provision-of-abortion-care-by-advanced-practice-nurses-and-physician-assistants; WHO, *Safe Abortion: Technical and Policy Guidance for Health Systems* (2d ed. 2012).

[31] ACOG Comm. on Health Care for Underserved Women, *Opinion Number 612: Abortion Training and Education*, at 1, 3 (Nov. 2014, reaff'd 2019).

[32] *Id.*

stigmatized and subject to constant threats just for doing their jobs. Threatening them with criminal penalties at every turn only perpetuates this.

65. All ob-gyns, especially abortion providers, are far less likely to practice in states with criminal penalties. We have already seen a decrease in residency applications in states with hostile laws. This can have disastrous consequences for all pregnant patients, including those seeking abortion, because it decreases access to obstetrical care throughout the state, especially in our rural regions.

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66. I work at Comp Health because I believe in its mission and in helping patients do what's best for their bodies and their lives. Missouri's abortion restrictions single out abortion patients and providers for worse treatment than patients and providers of other comparable health care services, like miscarriage, and they will prevent me from offering patients the care they deserve—and are constitutionally entitled to—without any health benefit.

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

10/31/24
Selina Sandoval M.D., M.P.H.

Subscribed and sworn to before me this 31 day of October, 2024.

(NOTARIAL SEAL)

Callie Holmgren
Notary Public State of Kansas
My Appt Expires 6/28/28

Printed Name: Callie Holmgren

# EXHIBIT C

**IN THE CIRCUIT COURT OF JACKSON COUNTY,**

**MISSOURI, AT KANSAS CITY**

| | |
|---|---|
| COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, PLANNED PARENTHOOD GREAT RIVERS-MISSOURI<br><br>Plaintiffs,<br><br>v.<br><br>THE STATE OF MISSOURI, et al.<br><br>Defendants, | No. _____ |

**AFFIDAVIT OF EMILY WALES IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION OR, IN THE ALTERNATIVE, TEMPORARY RESTRAINING ORDER**

I, Emily Wales, declare and state the following:

1. I am President and CEO of Comprehensive Health of Planned Parenthood Great Plains, Inc. ("Comp Health"), a not-for-profit corporation headquartered in Kansas and registered to do business in Missouri. Comp Health and its predecessor organizations provided abortions intermittently in Missouri from 1987 until 2018, when Missouri's continually expanding list of medically unnecessary abortion restrictions finally became so onerous that compliance was impossible. I am responsible for the management of Comp Health and therefore am familiar with our operations, including the services we provide and the communities we serve. I work closely with our providers and clinical teams and

have partnered directly with our health care operations leaders about our decisions to provide the best patient care possible in Missouri.

2. I submit this affidavit in support of Plaintiffs' Motion for Preliminary Injunction or, in the Alternative, Temporary Restraining Order seeking to prevent the state from enforcing various abortion restrictions that are unconstitutional under Missouri's new Right to Reproductive Freedom Initiative, which enshrines the right to reproductive freedom in Missouri's Constitution. These restrictions prevent us from being able to provide patients the care to which they are constitutionally entitled—and some make it impossible for us to begin providing abortions at all. The Initiative was approved by a substantial majority of voters on November 5, 2024, and I understand it becomes automatically effective on December 5, 2024.

3. Planned Parenthood Great Plains ("PPGP"), the network under which Comp Health provides care, currently has health centers in Columbia, Gladstone, Independence, and Kansas City, Missouri. At these health centers, PPGP offers a range of sexual and reproductive health care, including birth control, pregnancy testing and prenatal referrals, testing and treatment for sexually transmitted infections (STIs), PrEP, PEP, clinical breast exams, breast and cervical cancer screenings, colposcopy and biopsy, condyloma treatment, gender affirming care, and vasectomies. PPGP does not offer abortions, but Comp Health does, including currently in Kansas. When abortion was still available in Missouri, Comp Health would contract with PPGP to use its health centers to provide abortion.

4. If a preliminary injunction or TRO is granted in this case, Comp Health is prepared to quickly begin offering both medication and procedural abortion again in Missouri at PPGP's health centers.

**Comp Health's Provision of Abortion in Missouri**

5. Historically, Comp Health offered abortion at PPGP's Health Centers in Columbia and Kansas City; the Kansas City center is known as the "Patty Brous" or "Brous" health center in honor of a former staff member. Over the years, the types of abortions offered at both health centers varied—due in large part to Missouri's decades-long attempts to eliminate abortion access in the State, and during some periods, one or both health centers were unable to provide abortions. By 2018, both health centers were only providing abortion on a very limited basis before ultimately being forced to stop altogether that year.

6. When Comp Health offered abortions in Missouri, a physician had to have hospital admitting privileges to provide abortions in Missouri health centers. Over the years, this law was difficult or impossible to comply with and caused us to suspend abortion services periodically when we were not able to meet this requirement.

7. Since 2007, to provide abortion under Missouri law, both health centers had to be licensed as ambulatory surgical centers ("ASCs"). An ASC license for abortion facilities is always medically unnecessary because abortion is not surgery. It is a particularly bad fit in the case of medication abortion, which only involves a regimen of pills. Missouri made it impossible for our centers to fulfill the criteria for obtaining these licenses, including by imposing onerous physical requirements, a requirement to have local hospital admitting privileges or a written transfer agreement, and other requirements for standards of

operation that were wholly out of step with best medical practices. Moreover, even if we would have been able to obtain a written transfer agreement for both facilities—which in and of itself would have been incredibly difficult—we would have still had to comply with Missouri's additional, overlapping law requiring abortion providers to have local hospital privileges.

8. PPGP's predecessor, Planned Parenthood of Kansas and Mid-Missouri ("PPKM"), challenged these requirements in 2007, and ultimately entered into a settlement agreement with the State, which agreed to modify the facility requirements for the Columbia Health Center (which, at the time, provided procedural abortions up to 13 weeks after the first day of a patient's last menstrual period ("LMP")) and waive the facility requirements entirely for the Brous Health Center (which only provided medication abortions).

9. Under the terms of the settlement, the State agreed to accept physician privileges at the Menorah or Research Medical Centers in the Kansas City area in satisfaction of state requirements for the Brous center's licensure. No modification relating to physician privileges was noted in the agreement related to the Columbia health center.

10. Comp Health was forced to challenge these requirements again in 2015. At that time, our Columbia Health Center physician had admitting privileges at University Hospital, part of the University of Missouri Health Care system (known as "MU Health"); those privileges allowed her to comply with the state's medically unnecessary restriction and provide medication abortions in Columbia. However, after multiple hearings by the Missouri Senate's "Sanctity of Life" Committee that focused on the hospital's relationship with Planned Parenthood, MU Health revoked these privileges, which were required to

keep our license. MU Health's decision was unrelated to the quality of care our physician provided. As a result, the Missouri Department of Health and Senior Services ("DHSS") threatened to prematurely revoke the Columbia Health Center's ASC license. Comp Health challenged this decision and was successful.

11. In 2016, the U.S. Supreme Court decided *Whole Woman's Health v. Hellerstedt*, 579 U.S. 582, invalidating almost identical ASC and local hospital privileges restrictions in Texas under the then-applicable federal undue burden standard after detailed analysis of their lack of medical benefit and the impediment to care they can present. As a result, Comp Health and others once more challenged these Missouri restrictions. After obtaining hard-fought preliminary injunctions in federal district court, we were able to resume providing abortions. However, that preliminary injunction was later vacated, and a subsequent injunction was denied.

12. While we were providing abortions in Columbia and Kansas City, the Missouri legislature passed yet another law that imposed novel restrictions closely related to those the court enjoined. This law required us to have in place a medication abortion complication plan, and the DHSS regulations implementing the law required that plan to include a contract with a local ob-gyn physician who had hospital admitting privileges near the facility and could be on call 24/7 to treat any emergencies—even though emergencies related to medication abortion are extremely rare, can be treated in-clinic, and usually occur, when they occur at all, once the patient has left the clinic and returned home, which might not be near the clinic.

13. DHSS knew based on previous litigation that it would be impossible for the Columbia Health Center to meet this requirement, and also knew how low the complication rates are for abortion.

14. Comp Health and others challenged the medication complication plan requirement in court under the federal undue burden standard, but that law and its implementing regulations were ultimately allowed to go into effect. This meant that we had to stop providing medication abortions in Columbia in 2017 because, despite contacting all of the ob-gyns and ob-gyn practices in Columbia, we could not find a local ob-gyn with hospital admitting privileges who was willing to contract with us. Ultimately, because of the medication abortion complication plan requirement, the Columbia center was able to offer only one day of medication abortion services after fighting to be relicensed; subsequently, the Columbia center provided only procedural abortion.

15. Meanwhile, the Brous Health Center was forced to stop providing medication abortions in 2018 after staffing changes meant Comp Health no longer could comply with the complication plan mandates and admitting privileges requirement that, by then, had gone back into effect. Although Comp Health's medical director maintained privileges in compliance with the 2010 settlement agreement, Comp Health had begun working with providers who traveled from out of state to provide abortion services and could not get local admitting privileges. Additionally, other Comp Health physicians were unable to arrange their schedules to perform the biased counseling regime, in person, 72 hours before providing care *and* be available 24/7 for emergencies. The complex web of restrictions put

impossible requirements on Comp Health's limited number of providing physicians, ending medication abortion services in Kansas City.

16. All told, as a direct result of Missouri's abortion restrictions, Comp Health was forced to stop providing abortion in the state four years before the U.S. Supreme Court eliminated the federal right to abortion in *Dobbs v. Jackson Women's Health Organization*, 597 U.S. 215 (2022). As a result, abortions were wholly unavailable in the central and western parts of the state.

**Effect of Challenged Laws on Comp Health's Plan to Resume Abortion Services**

17. Now that Missouri's Right to Reproductive Freedom Initiative has passed and will become effective December 5, 2024, Comp Health is prepared to once more start providing abortions in Missouri. We are prepared to resume offering abortions at the Columbia Health Center and the Brous Health Center, and would like to start providing medication abortion at PPGP's other Missouri health centers in Gladstone and Independence. However, each of the restrictions below impairs our ability to offer abortions, the locations and frequency with which we can offer them, the types of abortions we can provide, the quality of care we are able to offer patients, and/or the obstacles patients have to overcome to get abortions, and thus inhibit patient choice. Without a preliminary injunction prohibiting the State from enforcing these provisions, our patients, providers, and staff will have their constitutional rights abridged.

*Abortion Bans*

18. Comp Health cannot offer the full range of constitutionally protected care we are prepared to provide to Missourians while the State's multiple, overlapping abortion bans remain in place.

19. Missouri's Total Ban,[1] which went into effect the day the U.S. Supreme Court decided *Dobbs*, prevents us from providing any abortions and targets abortion providers with criminal and professional sanctions. If Missouri's total abortion ban remains in place, Comp Health will be unable to provide constitutionally protected care to Missourians.

20. Missouri's Gestational Age Bans and Reasons Ban similarly prevent us from providing abortions. Each of Missouri's gestational age bans would make it impossible for us to provide abortions for Missourians who are at or beyond 8, 14, 18, or 20 weeks pregnant.[2] Similarly the Reasons Ban would intrude on the provider-patient relationship by conditioning patients' access to abortion on their reason for ending the pregnancy—which will cause some patients to feel judged, risk chilling patients in discussing their full medical situation with their treating clinician, and force us to deny care to patients with a constitutional right to that care. If Missouri's Gestational Age Bans and Reasons Ban remain in place, Comp Health will be unable to provide constitutionally protected care to Missourians.

[1] Throughout this affidavit, I am referring to the restrictions the same way that I understand them to be used in the pleadings.
[2] These gestational ages are all pre-viability.

21. These bans entirely deny Missourians their right to reproductive freedom by removing the option of abortion altogether for most patients, contradict widely accepted clinical standards, and do nothing to further individual patient health.

*Targeted Restrictions on Abortion Providers*

22. Even if Missouri's outright bans are enjoined, Comp Health will remain unable to provide care in the State so long as the Targeted Restrictions on Abortion Providers, that years ago drove it out of the State, remain in place. These include the Abortion Facility Licensing Requirement; the Hospital Relationship Restrictions; the Medication Abortion Complication Plan Requirement; the Pathology Requirements; the Biased Information Law; the 72-Hour, In-Person, and Same-Physician Requirements; the Telemedicine Ban; and the APC Ban.

a. Abortion Facility Licensing Requirement

23. I understand that Missouri law still requires health centers that provide abortions be licensed as ambulatory surgical centers. None of our health centers primarily provide surgeries. Abortion is not surgery, not even procedural abortions. Even if it were considered surgery, it is an outpatient procedure similar to other procedures regularly done in doctor's offices. Additionally, it would be only one of the many services we offer and not the primary service.

24. The Columbia, Gladstone, and Independence Health Centers do not meet the physical plant requirements imposed by the Abortion Facility Licensing Requirement. Neither does the Brous Health Center, which was previously the subject of the settlement

agreement with the state. If applied, the physical plant requirements would prevent Comp Health from providing any abortions at those health centers.

25. I understand that the Abortion Facility Licensing Requirement also imposes certain standards of operation that our providers strongly believe contradict good patient care, including a medically unnecessary and invasive pelvic exam for medication abortion patients. This requirement would force all Comp Health health centers to stop providing medication abortions and prevent Missourians from receiving care that meets widely accepted clinical standards.

b. Hospital Relationship Restrictions and
Medication Abortion Complication Plan Requirement

26. The Columbia, Gladstone, and Independence Health Centers would also be unable to secure the relationships with local hospitals and/or providers required by the Hospital Relationship Restrictions and Medication Abortion Complication Plan Requirement—which I understand are both still in Missouri's books. As history shows, many physicians and hospitals do not want to associate with abortion providers because they fear being targeted and threatened. Their fears are not unfounded—just in 2019, our Columbia Health Center was damaged by arson that did significant damage, requiring professional remediation, construction, and a period of closure to patients. Columbia has been unsuccessful in securing the required relationships for substantial periods in the past, and nothing has changed that would make this any easier or that would mean these requirements are now understood to improve patient care. The Brous Health Center may

be able to comply with some of the requirements, but it is not a given, and doing so is not in accordance with standard practice.

27. Many hospitals elsewhere in Missouri will not give privileges to abortion providers because of political or ideological opposition to abortion. Catholic hospitals typically will not work with abortion providers at all for this reason. Other hospitals refuse privileges to abortion providers for additional reasons that also are not related to professional standards.

28. Separately, because of the nature of abortion practice, it can be hard for an abortion provider to get and maintain privileges at any hospital, let alone a hospital local to every community in which they provide. For example, many hospitals require providers to treat a minimum number of cases in that hospital to maintain privileges. Because abortion is extremely safe, it is rare for abortion patients to be admitted to the hospital, and abortion providers are typically unable to meet this requirement. Other requirements may include local residency or an agreement to take emergency department call shifts, which out-of-town providers cannot meet. I do not believe there are local abortion providers who qualify for privileges and are ready to work with Comp Health in all or most towns in which Comp Health would like to provide.

29. Requiring local hospital admitting privileges and other hospital and back-up doctor relationships puts abortion clinics and their patients in a precarious position where their ability to provide abortion is reliant upon fragile personal and business relationships in a politically hostile environment, in the service of a medically unnecessary requirement.

c. Pathology Requirements

30. With regards to the Pathology Requirements, I know of no other comparable medical procedure for which state law mandates that *all* tissue be sent to a pathologist. This is not the standard practice for abortion care. It also means our ability to provide procedural abortions hinges on business relationships that are never guaranteed. I currently know of no pathologist in Missouri willing to take all of our procedural abortion tissue. Even if there were, it would significantly increase the cost of abortions in the state without medical justification.

d. Biased Information Law

31. It is my understanding that before patients receive an abortion, current Missouri law requires they must receive certain biased, state-mandated information. This information causes patients harm, does not improve patient health, and is not standard practice. Per these requirements, we were forced to provide patients with unwanted anatomical descriptions of the fetus, tell patients medically inaccurate information (e.g. that "the life of each human begins at conception," and that an abortion could cause the fetus pain), offer an opportunity to view the ultrasound and hear an amplification of fetal cardiac activity, and provide inaccurate state-developed materials, among other things. The only purpose of this information is to try to convince patients not to get an abortion, even if they have already decided that this is the best choice for them. This harms patients by making them feel judged or second-guessed about their decision, which also harms the patient-provider relationship. For some patients—such as those who were the victims of rape, or who were getting an abortion because of fetal anomalies—these requirements are particularly cruel.

32. Being forced to share medically inaccurate information also harms my providers and staff. Our staff come to work because they believe in our mission: providing comprehensive reproductive health services. Forcing them to provide information that they know is harmful to patients severely undercuts this mission.

33. If the biased information law is enjoined, Comp Health is prepared to offer abortions using its usual patient-informed consent counseling, as is consistent with best medical practices and medical ethics.

e. 72-Hour Waiting Period, In-Person, and Same Physician Requirements

34. It is my understanding that before a patient can obtain an abortion in Missouri, Missouri law requires them to attend an additional in-person appointment with the same physician who is to provide the abortion at least 72 hours before the abortion occurs. In my experience, this requirement severely delayed patients' ability to access care and made it extremely difficult for our physicians to provide care—all without any patient health benefit.

35. At minimum, this requirement on its face delays patients' ability to obtain an abortion by at least three days. But in practice, delays can be even more severe. Because our physicians and patients have other professional and personal responsibilities, their schedules are incredibly complex. When we provided abortion in Missouri, it was largely impossible to staff the same physician at the same health center 72 hours after they did the biased counseling. This meant that most patients had to wait at least a week between receiving the in-person biased counseling and obtaining their abortion. For patients who are near the cut-off for medication abortion, this delay could mean that they were no longer

eligible for the type of abortion that was best for them. If either the patient or the provider was not able to make it back to the clinic the following week, this would result in even further delays, and sometimes three independent trips to the clinic if they had to restart the process with a different physician.

36. I understand that if the 72-hour waiting period is enjoined, the law imposes a 24-hour waiting period with the same requirements. This would also make patient and physician scheduling challenging, and would still require patients to make an unnecessary second visit to the health center. Twenty-four hours is also a delay and causes the same burdens on patients and abortion providers described above.

37. Comp Health's patients have historically faced an uphill battle to get care in Missouri, even without all the State's abortion restrictions. When we still provided abortion in Missouri, many of our patients were low-income. Many were already parents or had other caregiving responsibilities; many worked multiple jobs with erratic schedules. Some were in abusive relationships, which made getting to the health center without their abuser finding out very difficult—and sometimes, impossible. It was not unusual for patients to be unable to return to the health center for several weeks to obtain their abortion after the waiting period had passed because of these challenges. Some were unable to return at all.

38. If these requirements were enjoined, Comp Health would provide abortions to patients who are certain of their decision without requiring an unnecessary additional appointment, as is consistent with best medical practices and medical ethics and the way that other medical care is provided.

f. Telemedicine Ban

39. It is my understanding that Missouri law currently prohibits the use of telemedicine for medication abortion, even though it permits the use of telemedicine for other types of health services, including miscarriage care, which involves substantially similar care. It does this by requiring that the first of the two medications typically used in a medication abortion regimen be taken in the physical presence of the provider. This requirement does not apply when the same medication is being used to treat miscarriage.

40. If this requirement did not exist, Comp Health would begin offering medication abortion through telemedicine. This would make it easier for patients at early gestational ages to get care by reducing the distances they need to travel, reducing travel-related expenses, and increasing appointment flexibility.

g. The Advanced Practice Clinician Ban

41. It is my understanding that, under Missouri law, Advanced Practice Clinicians ("APCs")—a category of health care providers that includes Advanced Practice Registered Nurses ("APRNs") and Physicians Assistants ("PAs")—cannot provide abortions even though it is otherwise within their scope of practice to do so. If APCs were able to provide abortions, we would be able to significantly expand our services.

42. While there are currently five physicians on staff at Comp Health who would be able to provide abortions, we have seven APCs who currently work in Missouri and another three who are licensed in Missouri. Even though there is not always a physician at the clinics every day, there are APCs who staff our health centers every day that they are open.

If the APC Ban is enjoined, all of our APCs could begin training to provide abortions, consistent with their scope of practice.

43. All major experts agree that APCs are able to safely provide abortions, as they do in 21 states and the District of Columbia. In fact, even in Missouri, APCs are already able to provide miscarriage care, which is substantially similar and can involve the use of the very same medications and procedures.

44. If APCs were legally permitted to provide abortions within their scope of practice, this would greatly expand our ability to provide abortions in Missouri, especially medication abortions. For example, if the APC Ban were enjoined, we would be able to provide medication abortion at all four of our health centers. Patients who already see an APC for other types of health care, such as primary care, would also be able to get an abortion from a provider with whom they already have a pre-existing relationship.

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45. None of these restrictions apply to facilities providing substantially similar care, such as miscarriage care. They do not further individual patient health, but rather target abortion providers and patients with the goal—and effect—of limiting or ending abortion in the State.

*Criminal Penalties*

46. Finally, the criminal penalties attached to most of the restrictions defined above severely harm our providers and staff, and make it difficult to recruit health care professionals to work at our health centers, for fear that an inadvertent failure to follow a legal requirement with no basis in medicine will result in criminal charges. These penalties

are harsher than those attached to any other area of health care for no reason other than to punish those who are helping patients exercise their constitutionally protected rights. Without criminal penalties, abortion will still be regulated through the same mechanisms as other types of health care.

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47. Comp Health is committed to providing patients the best health care possible. Not only do Missourians deserve this care, they have voted that they should be entitled to it. Comp Health looks forward to making this a reality for Missourians, and to resuming services in the state if the laws described above are preliminarily enjoined.

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

Emily Wales, President & CEO
Comprehensive Health of
Planned Parenthood Great Plains, Inc.

Subscribed and sworn to before me this 5 day of November, 2024.

(NOTARIAL SEAL)

CARA HILE
NOTARY PUBLIC - NOTARY SEAL
STATE OF MISSOURI
MY COMMISSION EXPIRES JUNE 5, 2027
JACKSON COUNTY
COMMISSION #23449182

Printed Name: Cara Hile

# EXHIBIT D

**IN THE CIRCUIT COURT OF JACKSON COUNTY,**

**MISSOURI, AT KANSAS CITY**

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|---|---|
| COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, PLANNED PARENTHOOD GREAT RIVERS-MISSOURI<br><br>Plaintiffs,<br><br>v.<br><br>THE STATE OF MISSOURI, et al.<br><br>Defendants, | No. _____ |

**AFFIDAVIT OF RICHARD MUNIZ IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION OR, IN THE ALTERNATIVE, TEMPORARY RESTRAINING ORDER**

I, Richard Muniz, declare and state the following:

1. I am interim President and CEO of Planned Parenthood Great Rivers-Missouri ("Great Rivers"), a Missouri not-for-profit corporation. Great Rivers (through a related organization, Reproductive Health Services of Planned Parenthood of the St. Louis Region[1] ("RHS")) provided abortions in Missouri until the *Dobbs* decision, though these services were, by that time, extremely limited due to Missouri's many, overlapping, highly restrictive abortion laws and regulations. I am responsible for the management of Great Rivers and therefore am familiar with its operations, including the services we provide

[1] Reproductive Health Services of Planned Parenthood of the St. Louis Region later changed its legal name to Reproductive Health Services of Planned Parenthood of Great Rivers.

and the communities we serve, and I work closely with our clinical teams, including providers.

2. I submit this affidavit in support of Plaintiffs' Motion for Preliminary Injunction or, in the Alternative, Temporary Restraining Order seeking to prevent the state from enforcing various abortion restrictions that are unconstitutional under Missouri's new Right to Reproductive Freedom Initiative, which enshrines the right to reproductive freedom in Missouri's Constitution. These restrictions prevent us from being able to provide patients the care to which they are constitutionally entitled—and some make it impossible for us to begin providing abortions at all. The Initiative was approved by a substantial majority of voters on November 5, 2024, and I understand it becomes automatically effective on December 5, 2024.

3. Great Rivers operates six health centers throughout Missouri. These health centers are in St. Louis (including the larger St. Louis region), Rolla, Springfield, and Joplin.[2] We offer a range of sexual and reproductive health care to patients, including contraception, nondirective pregnancy options counseling, miscarriage management, pregnancy testing, testing and treatment for sexually transmitted infections (STIs), pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), breast and cervical cancer screenings, colposcopy and LEEP (examination and procedures of the cervix), gender-affirming care, and vasectomies. Until 2019, we offered medication abortion up to 10 weeks gestational age, as measured from the first day of a patient's last menstrual period

[2] The Joplin health center will cease operations on December 31, 2024.

("LMP"). We stopped offering medication abortion by the fall of 2019 because Missouri law started requiring us to perform an invasive, medically unnecessary vaginal exam that was inconsistent with high-quality, patient-centered care. We also provided procedural abortion up to 22 weeks LMP until Missouri's total abortion ban took effect following the *Dobbs* decision.

4. If a temporary restraining order or preliminary injunction is granted in this case, Great Rivers will promptly provide both medication and procedural abortion again in Missouri to the full extent allowed by law.

**Great Rivers's Provision of Abortion in Missouri**

5. Before Missouri's total abortion ban took effect, Great Rivers offered procedural abortion at its health center in St. Louis. But even before then, its abortion services were extremely limited due to Missouri's complex, medically unnecessary restrictions on this type of health care.

6. At our Central West End location in St. Louis, the care we were able to offer was extremely limited. From fall 2019 until June 2022, when the total ban went into effect, we provided only procedural abortions because the Department of Health and Social Services ("DHSS") began interpreting the seventy-two-hour Waiting Period[3] and Biased Information Law and the Abortion Facility Licensing Requirement to mandate providers to conduct a medically inappropriate, invasive pelvic exam before every abortion,

[3] Throughout this affidavit, I am referring to the restrictions the same way that I understand them to be used in the pleadings.

including medication abortion, which our providers felt was not consistent with high-quality, patient-centered care and their medical ethics.

7. All told, Great Rivers was forced to stop providing medication abortion in the state three years before the U.S. Supreme Court eliminated the federal right to abortion in *Dobbs v. Jackson Women's Health Organization*, 597 U.S. 215 (2022). As a result, medication abortions were wholly unavailable in the state, since, by that time, we were the only abortion facility left in Missouri.

**Effect of Challenged Laws on Great Rivers's Plan to Resume Abortion Services**

8. Great Rivers is prepared to start offering abortion once the Right to Reproductive Freedom Initiative becomes effective on December 5, but it cannot do so unless Missouri's abortion bans and restrictions are enjoined. We are prepared to resume medication and procedural abortions to the full extent allowed by law in St. Louis immediately, and we would also like to provide medication abortion at several of our other health centers, as well as procedural abortion at our Springfield health center. Each of the restrictions below negatively impacts—or downright prohibits—our ability to provide patients the care to which they are now constitutionally entitled, and/or negatively impacts patients accessing that care.

9. Therefore, without a preliminary injunction or temporary restraining order prohibiting the State from enforcing these provisions, our patients, providers, and staff will have their constitutional rights denied.

### *Abortion Bans*

10. Missouri law imposes a total ban on abortion which took effect immediately after *Dobbs*. The Total Ban—by its very name—prevents us from providing any abortions, which is completely irreconcilable with the Right to Reproductive Freedom Initiative.

11. Missouri law also includes a series of overlapping Gestational Age Bans that abolish almost all abortion as early as eight weeks LMP. Missouri law then incrementally increases the gestational age at which the Bans apply, from 8 weeks, to 14 weeks, to 18 weeks, to 20 weeks in the event that any of the earlier gestational age bans are declared unconstitutional or invalid. There are no exceptions for pregnancies resulting from rape or incest. Looking at the Missouri DHSS abortion statistics from 2016 through 2019, Missouri recorded between 1,471 and 4,562 abortions each year: More than half of all abortions each year were provided at or after nine weeks gestational age, 10–20% were provided after 14 weeks gestational age, and 1–4% at or after 20 weeks gestational age.[4] Assuming similar numbers, these are all patients who would be denied constitutionally protected care if the Gestational Age Bans remain in place.

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[4] Bureau of Vital Stat., Mo. Dep't of Health & Senior Servs., *Table 12B. Recorded Abortions by Race, Age, and Type of Procedure by Weeks of Gestation: Missouri, 2016* (2017), https://health.mo.gov/data/vitalstatistics/mvs16/Table12b.pdf; Bureau of Vital Stat., Mo. Dep't of Health & Senior Servs., *Table 12B. Recorded Abortions by Race, Age, and Type of Procedure by Weeks of Gestation: Missouri, 2017* (2018), https://health.mo.gov/data/vitalstatistics/mvs17/Table12b.pdf; Bureau of Vital Stat., Mo. Dep't of Health & Senior Servs., *Table 12B. Recorded Abortions by Race, Age, and Type of Procedure by Weeks of Gestation: Missouri, 2018* (2019), https://health.mo.gov/data/vitalstatistics/mvs18/Table12b.pdf; Bureau of Vital Stat., Mo. Dep't of Health & Senior Servs., *Table 12B. Recorded Abortions by Race, Age, and Type of Procedure by Weeks of Gestation: Missouri, 2019* (2020), https://health.mo.gov/data/vitalstatistics/mvs19/Table12ab.pdf.

12. Missouri law prohibits any person from performing or inducing an abortion if they know that the pregnant person is seeking the abortion (i) solely because of a prenatal diagnosis, test, or screening indicating Down syndrome or the potential of Down syndrome in the embryo or fetus, or (ii) solely because of the sex or race of the embryo or fetus. This prohibition applies at any gestational age, including before fetal viability.

13. Each of the bans described in this paragraph carries severe criminal penalties and put providers at risk of losing their licenses.

14. Great Rivers cannot offer patients the care they are constitutionally entitled to if the Total Ban, the Gestational Age Bans, and the Reasons Ban remain in place.

***Targeted Restrictions on Abortion Providers***

15. Even if Missouri's outright bans are enjoined, Great Rivers will be severely limited in its ability to provide abortions in the state—and its patients will be impeded in accessing that care—if the Targeted Restrictions on Abortion Providers are still enforceable. These include the Abortion Facility Licensing Requirement; the Hospital Relationship Restrictions; the Medication Abortion Complication Plan Requirement; the Pathology Requirements; the Biased Information Law; the Waiting Period, In-Person, and Same-Physician Requirements; the Telemedicine Ban; and the APC Ban. In some cases, these restrictions will bar Great Rivers from providing abortions in the state altogether.

**a. Abortion Facility Licensing Requirement**

16. Missouri's Abortion Facility Licensing Requirement and its implementing regulations require any health center providing abortion to be licensed as a special abortion facility ambulatory surgical center, and impose certain requirements for such licensure,

including that abortion facilities have rooms and hallways of a certain size ("physical facility requirements") and that every abortion patient be subjected to a pelvic exam.

17. In 2007, the Legislature amended the Ambulatory Surgical Center Licensing Law to require "any establishment operated for the purpose of performing or inducing any second or third-trimester abortions or five or more first-trimester abortions per month" be licensed as ambulatory surgical centers ("ASCs") (the "Abortion Facility Licensing Requirement"). *See* H.B. 1055, 94th Gen. Assemb., Reg. Sess. (Mo. 2007) (amending § 197.200, RSMo 2016).[5] Before this amendment, Ambulatory Surgical Center Licensing Law only required an ASC license for "any public or private establishment operated primarily for the purpose of performing surgical procedures or primarily for the purpose of performing childbirths." *Id.*

18. Then in 2017, then-Governor Greitens called the Legislature back for a special session on abortion, a result of which was Senate Bill 5.[6] That bill amended several statutes regulating abortion, including sections 197.200 and 197.205. Under S.B. 5, any facility that offers a single abortion, including medication abortion, is required to obtain an abortion facility license. S.B. 5 (amending §§ 197.200, 197.205, RSMo).

19. The only purpose of the Abortion Facility Licensing Requirement was to limit the provision of abortion services—and in that sense, it succeeded. Indeed, Senator Andrew Koenig, the main sponsor of S.B. 5, stated publicly that its purpose was to prevent

[5] All statutory citations are to Missouri Revised Statutes (2016), as updated, unless otherwise noted.
[6] S.B. 5, 99th Gen. Assemb., 2d Spec. Sess (Mo. 2017) ("S.B. 5").

Planned Parenthood from expanding access to abortion to additional health centers in Missouri.[7] Our St. Louis Health Center was the only one of our health centers able to meet the stringent and medically irrelevant physical facility requirements for this type of license.

20. None of Great Rivers's health centers is operated primarily for the purpose of surgery. And none of Great Rivers's health centers is or has ever been operated primarily for the purpose of procedural abortion, which is just one of many reproductive health services we have offered.

21. The Abortion Facility Licensing Requirement is also difficult or impossible for Great Rivers to meet at its current facilities. Without the Abortion Facility Licensing Requirement, Great Rivers would offer medication abortion at several of its health centers and both medication and procedural abortion in one of its St. Louis health centers as well as potentially its Springfield health center. If the Abortion Facility Licensing Requirement remains in place, Great Rivers may be able to get a license to provide abortion at one location in St. Louis, but will be unable to meet the Abortion Facility Licensing Requirements at its remaining health centers outside the St. Louis region.

22. We have only been able to comply with the physical facility requirements at our health center in the Central West End, St. Louis. Accordingly, these requirements are one of the multiple medically irrelevant requirements that have kept us from being able to

[7] Jason Hancock, *Fate of New Abortion Limits Unclear as Missouri Senators Return to Capitol*, Kan. City Star (July 24, 2017, 7:00 AM), http://www.kansascity.com/article163000723.html.

provide abortions at any of our other locations in Missouri. This severely restricted the number of abortion appointments we could offer in Missouri. We could still only meet the physical requirements in St. Louis.

23. Moreover, the Abortion Facility Licensing Requirements' pelvic exam mandate would prevent us from providing medication abortions, even at that one facility. Our providers continue to believe that it is inappropriate and inconsistent with a high standard of care to subject a patient to a medically unnecessary pelvic exam.

24. If the Abortion Facility Licensing Requirements remain in effect, we will be unable to offer any abortion outside of the City of St. Louis, and if we are able to offer abortion in St. Louis, we will be unable to offer anything but procedural abortion.

**b. Hospital Relationship Restrictions and Medication Abortion Complication Plan Requirement**

25. Missouri statutes require abortion providers to have clinical privileges at a hospital that offers obstetrical or gynecological care located within 30 miles of the health center. The Abortion Facility Licensing Requirement's implementing regulations separately require that abortion providers have staff privileges at a hospital within 15 minutes' travel time from the health center or that the health center have a written transfer agreement with a hospital within 15 minutes' travel time (the "Hospital Relationship Restrictions").

26. Our staff physicians hold clinical privileges at Barnes Jewish Hospital in St. Louis, which is a highly respected teaching hospital. But Barnes Jewish Hospital is too far away from any health centers outside of the City of St. Louis to meet the geographic

limitations of the Hospital Relationship Restrictions. This includes our health centers in Manchester and St. Peters, Missouri.

27. Missouri's Medication Abortion Complication Plan Requirement imposes similar requirements and also includes a requirement to contract with an ob-gyn who is on-call and available 24/7 to treat complications. We would be unable to comply with this requirement outside of St. Louis. Indeed, when we tried to comply in Springfield, we could not identify any local ob-gyn (or ob-gyn group) willing to contract with us.

28. Great Rivers has policies in place to ensure that any complications from medication abortion are handled in accordance with widely accepted clinical standards of practice. All Great Rivers abortion patients receive detailed instructions on what to expect during the medication abortion, including what level of bleeding or other symptoms constitute cause for concern, as well as a 24-hour, seven days per week emergency care line to call with any questions or concerns. This number is staffed by a registered nurse, and an on-call ob-gyn physician is always available for consultation. Oftentimes, the nurse will resolve any concern over the phone; other times, the nurse will direct the patient to return to the health center for evaluation. If a complication requires emergency care, patients are directed to their closest emergency room. If an emergency room physician decides that it is necessary to involve an ob-gyn in a patient's care, the physician will contact the ob-gyn on call at that hospital who can admit the patient if necessary. Health center staff subsequently call the patient to confirm whether the patient went to the emergency room, what care (if any) was given, and whether any further follow-up is appropriate. Our follow-up procedure for complications after medication abortions is

consistent with our follow-up procedure for other, similar kinds of health care, like miscarriage care.

29. If the completely unnecessary Hospital Relationship Restrictions and Medication Abortion Complication Plan Requirement remain in place, they will almost certainly limit our provision of abortions to one health center in St. Louis. Between 2019 and 2022, the combination of the Abortion Facility Licensing Requirement, the Hospital Relationship Restrictions, and the Medication Abortion Complication Plan Requirement, together stopped every health center in Missouri from providing abortion except for our St. Louis health center, which, due to the pelvic exam requirement, only provided procedural abortions.

**c. Pathology Requirements**

30. Missouri law requires that all tissue removed at the time of an abortion be submitted within five days to a pathologist, who then needs to examine the tissue and file a tissue report.

31. I am not aware of any pathologist in Missouri, or anywhere close to Missouri, who is willing and able to fulfill this requirement. Even if there were, it would increase the costs of the procedure for no medical benefit.

32. I am also not aware of any other health care, including surgical procedures and miscarriage care, subjected to a similar requirement.

**d. Biased Information Law**

33. Missouri's Biased Information Law requires abortion providers to present a great deal of mandatory information to their abortion patients in Missouri. Much of this information is false, biased, and/or irrelevant to getting an abortion.

34. Great Rivers will provide all of its patients—abortion patients and non-abortion patients—with all relevant information needed to obtain the patient's informed consent, consistent with providers' ethical and professional obligations and the standard of care. The Biased Information Law only serves to make patient decisions less, and not more, informed. Instead, the Biased Information Law will be stigmatizing and confusing for patients and is therefore contrary to the standard of care.

**e. Waiting Period, In-Person, and Same Physician Requirements**

35. Missouri law requires that an abortion patient (1) attend an in-person, mandatory session to receive the State's biased information, (2) with the same doctor who is to provide the abortion, (3) at least 72 hours before the abortion occurs (or, if the 72 hour waiting period is enjoined, 24 hours).

36. The Waiting Period, In-Person, and Same Physician Requirements dramatically restrict the availability of abortion appointments and delays this time-sensitive procedure, often even longer than 72 hours, by adding additional complex staffing and scheduling considerations to every appointment, as well as increasing travel and other logistical burdens for our patients. There is no medical reason for this requirement, and there is no other health care I am aware of subject to anything similar in Missouri law.

37. There are a small number of providers who are willing and able to provide abortion in Missouri. These providers tend to divide their clinical time among different practices and procedures. Some providers have had to travel to Missouri, or from Missouri to other nearby states, to provide abortions.

38. Scheduling these providers, all of whom have many other demands and obligations on their time, to provide consistent coverage for abortion care is already a challenge without also requiring that the *same* provider see the *same* patient *in person* at least three days before the patient's abortion.

39. If these requirements were enjoined, when a patient has made the decision to have an abortion, Great Rivers would allow them to proceed without an additional, medically unnecessary appointment, obtaining informed consent on the day of their care, as we do for all other medical services.

**f. Telemedicine Ban**

40. Missouri law requires that the first of two drugs required for medication abortion be taken in the physical presence of the prescribing physician, thereby making it impossible to use telemedicine for medication abortion, as is safely and commonly done in many other states. Missouri allows other kinds of health care to be provided via telehealth if the health care falls within a provider's scope of practice and is medically appropriate to provide in this manner. I am unaware of any other health care service categorically excluded by law from being provided via telehealth in Missouri.

41. If this requirement did not exist, Great Rivers would begin offering medication abortion through telemedicine. This would make it easier for patients at early

gestational ages to get care by reducing the distances they need to travel and travel-related expenses, as well as increase appointment flexibility.

**g. The Advanced Practice Clinician Ban**

42. Missouri law prohibits anyone who is not a physician from providing abortion. I understand that this includes advanced practice clinicians ("APCs"), such as physician assistants ("PAs") and advanced practice registered nurses ("APRNs"). Reducing the number of abortion providers through a categorical ban on APCs restricts the location, timing, and number of available abortion appointments and, correspondingly, increases financial and logistical barriers to access. These barriers further delay access to this time-sensitive care.

43. If APCs were able to provide abortions, we would be able to significantly expand our services. In Missouri, Great Rivers has three physicians on staff, but it has 10 APCs on staff. Without the APC Ban, Great Rivers could offer abortion every day that the health centers are open.

44. APCs already provide the majority of health care at our health centers, including care and procedures that are very similar to abortion, like miscarriage care. Many of our patients have a pre-existing relationship with an APC. If APCs were able to provide abortions, more of our patients could get an abortion from a provider with whom they already have a relationship. This would help provide continuity of care for our patients.

### *Criminal Penalties*

45. Finally, I understand that violations of most of the laws discussed above—and most of Missouri's restrictions on abortion, generally—are punishable through criminal penalties. These penalties restrict access to abortion by making it harder to recruit and retain abortion providers, by causing providers to limit even legal abortion care out of fear that a prosecutorial expert might disagree with their decisions, and by stigmatizing abortion even further than it already is.

46. I know of no other law or regulation related to a specific health care service that is enforced through criminal penalties in Missouri.

47. Criminal penalties deny, restrict, and interfere with abortion care by making providers scared to provide abortions, or scared to provide abortions to the full extent of the law.

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48. All of these laws and regulations prevent us from providing constitutionally protected care to our patients. Once these laws are enjoined, Great Rivers is prepared to immediately begin providing Missourians the health care they need—and have voted to safeguard.

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

Richard Muniz, Interim President & CEO

Subscribed and sworn to before me this 6th day of November, 2024.

(NOTARIAL SEAL)

KRISTINA WINKELMAN
Notary Public - Notary Seal
Franklin County - State of Missouri
Commission Number 14119325
My Commission Expires Dec 5, 2026

Printed Name: Kristina Winkelman