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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* *pro hac vice* application forthcoming