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, et al. Defendants,	No. _____

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

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INTRODUCTION

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

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

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

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

FACTUAL AND STATUTORY BACKGROUND

A. The Right to Reproductive Freedom Initiative

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

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

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

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

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

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

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

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

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

B. Abortion is safe and common

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

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

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

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

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

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

C. Missouri bans and restricts abortion in every way possible

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. Plaintiffs are ready to provide abortion in Missouri again

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

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

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

ARGUMENT

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

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

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

I. Plaintiffs are likely to succeed on the merits.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

II. The remaining preliminary injunction factors heavily favor Plaintiffs.

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

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

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

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

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

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

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

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

[constitutional rights] outweighs whatever damage the preliminary injunction may cause Defendants' inability to enforce what appears to be an unconstitutional statute." (citation omitted)); *Kirkeby v. Furness*, 52 F.3d 772, 775 (8th Cir. 1995) (public interest favored injunction against unconstitutional ordinance); *Saint v. Neb. Sch. Activities Ass'n*, 684 F. Supp. 626, 628 (D. Neb. 1988) (no harm to defendant in losing the ability to enforce unconstitutional regulations).

III. Bond

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

CONCLUSION

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

Respectfully submitted,

/s/ Gillian R. Wilcox
GILLIAN R. WILCOX, #61278
JASON ORR, #56607
ACLU of Missouri Foundation
406 West 34th Street, Ste. 420
Kansas City, MO 64111
Phone: (816) 470-9938
gwilcox@aclu-mo.org
jorr@aclu-mo.org

KRISTIN M. MULVEY, #76060
JONATHAN D. SCHMID, #74360
TORI M. SCHAFER, #74359
ACLU of Missouri Foundation
906 Olive Street, Suite 1130
St. Louis, Missouri 63101
Phone: (314) 652-3114
kmulvey@aclu-mo.org
jschmid@aclu-mo.org
tschafer@aclu-mo.org

ELLA SPOTTSWOOD*
CAMILA VEGA*
Planned Parenthood Federation of America
123 William Street, 9th Floor
New York, NY 10038
Phone: (212) 541-7800
ella.spottswood@ppfa.org
camila.vega@ppfa.org

CHELSEA TEJADA*
ACLU Foundation
125 Broad Street, Floor 18
New York, NY 10004
Phone: (212) 549-2633
ctejada@aclu.org

Attorneys for All Plaintiffs

ERIN THOMPSON*
Comprehensive Health of Planned Parenthood Great Plains
4401 West 109th Street, Suite 200
Overland Park, KS 66211
Phone: (913) 345-4617

Attorney for Comprehensive Health of Planned Parenthood Great Plains

RICHARD MUNIZ, #74282
Planned Parenthood Great Rivers–Missouri
4251 Forest Park Avenue,
St. Louis, MO 63108
Phone: (314) 828-1804

Attorney for Planned Parenthood Great Rivers–Missouri

* *pro hac vice* application forthcoming