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State of Minnesota
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STATE OF MINNESOTA	**SECOND JUDICIAL DISTRICT**
COUNTY OF RAMSEY	**CIVIL DIVISION**

Case Type: Civil Other / Miscellaneous
Court File No.: _____
Judge: _____

DR. JANE DOE; MARY MOE; and FIRST UNITARIAN SOCIETY OF MINNEAPOLIS,

Plaintiffs,

v.

STATE OF MINNESOTA; GOVERNOR OF MINNESOTA; ATTORNEY GENERAL OF MINNESOTA; MINNESOTA COMMISSIONER OF HEALTH; MINNESOTA BOARD OF MEDICAL PRACTICE; and MINNESOTA BOARD OF NURSING,

Defendants.

COMPLAINT

Plaintiffs, by and through their undersigned attorneys, bring this complaint against the above-named Defendants, and in support thereof allege the following:

PRELIMINARY STATEMENT

1. The Minnesota Supreme Court has long recognized abortion access as a fundamental right because "few decisions" are "more intimate, personal, and profound than a woman's decision between childbirth and abortion."[1] *Doe v. Gomez*, 542 N.W.2d 17, 27 (Minn. 1995).

[1] Most people with the capacity to become pregnant identify as women. Historically, both jurisprudence and public health data have focused on women when addressing reproductive rights and health. But there is an emerging recognition in society that not all people who may become pregnant identify as women. *See, e.g.*, Thomas Beatie, *Labor of Love: The Story of One Man's Extraordinary Pregnancy* (2008); Robin Marantz Henig, *How Science Is Helping Us Understand Gender*, Nat'l Geographic, Jan. 2017, https://www.nationalgeographic.com/magazine/2017/01/how-science-helps-us-understand-gender-identity/. The Minnesota Constitution protects the right of all individuals to make pregnancy-related decisions, regardless of gender identity.

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2. Minnesota's laws concerning abortion and treatment of sexually-transmitted infections ("STI"s) have become outdated. Many of these laws are out-of-step with contemporary medical practice, are contrary to Minnesota's constitutional respect for individual privacy, and reflect antiquated views about women's role in society. In addition, they fail to honor the diverse religious traditions of Minnesota residents.

3. These outdated laws harm Minnesotans in several ways. First, they deny people seeking sexual and reproductive healthcare the benefits of scientific progress, forcing their healthcare providers to ignore scientific advancements and practice medicine in accordance with obsolete standards.

4. Second, they discriminate against women and religious minorities, denying them equal respect under the law.

5. Third, they impose burdensome and unnecessary restrictions on healthcare providers, increasing the cost and decreasing the availability of sexual and reproductive healthcare in Minnesota. These harms disproportionately impact low-income people, people of color, immigrants, people who lack health insurance, and others who are marginalized, running afoul of Minnesota's "long tradition of affording persons on the periphery of society a greater measure of government protection and support than may be available elsewhere." *Gomez*, 542 N.W.2d at 30.

6. Plaintiffs, who are healthcare providers and people of faith, challenge the validity of these laws under the Minnesota Constitution; Minnesota's Uniform Declaratory Judgments Act, Minn. Stat. §§ 555.01-555.16; and Minnesota Rules of Civil Procedure 57 and 65. Their goal is a system of just laws that upholds the rights and dignity of all Minnesotans and ensures that everyone has access to high-quality sexual and reproductive healthcare.

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PARTIES, JURISDICTION & VENUE

I. PLAINTIFFS

7. Dr. Jane Doe[2] is a Board-certified obstetrician-gynecologist licensed by the Minnesota Board of Medical Practice. Dr. Doe's practice includes full-scope obstetric and gynecology care, including pregnancy care, adolescent healthcare, contraception and family planning services, and well-woman gynecology care. She provides abortions for patients with maternal or fetal indications, and she provides referrals to patients seeking abortions in other circumstances. Dr. Doe brings this lawsuit on behalf of herself and her patients.

8. Mary Moe[3] is a certified nurse midwife licensed by the Minnesota Board of Nursing. She has practiced in Minnesota for more than a dozen years. She specializes in providing sexual and reproductive healthcare to at-risk communities and treats patients seeking abortion care. Currently, she attempts to refer those patients to healthcare providers who meet Minnesota's requirements for providing abortions. Some of her patients are unable to access care from these other providers because of financial barriers, lack of transportation, and fear of domestic violence or community retribution. Ms. Moe seeks to provide abortion care in Minnesota herself to minimize the obstacles that her patients face in accessing that care. Ms. Moe brings this lawsuit on behalf of herself and her patients.

9. First Unitarian Society of Minneapolis ("First Unitarian Society") is a Minnesota nonprofit corporation that operates a religious congregation in Minneapolis, Minnesota. Founded in 1881, the First Unitarian Society is a member congregation of the Unitarian Universalist

[2] Jane Doe is a pseudonym. Dr. Doe wishes to keep her true name confidential to protect herself, her family, and her colleagues from violence, harassment, and retaliation.

[3] Mary Moe is a pseudonym. Ms. Moe wishes to keep her true name confidential to protect herself, her family, and her colleagues from violence, harassment, and retaliation.

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Association. It is deeply committed to promoting social justice, and its vision of social justice includes access to high-quality sexual and reproductive healthcare for all people regardless of income, race, and other socio-economic factors. First Unitarian Society supports its members who seek and provide sexual and reproductive healthcare, including abortion care. It brings this lawsuit on behalf of itself and its members.

II. DEFENDANTS

10. The State of Minnesota is a proper defendant because many of the challenged laws may be enforced through criminal penalties, as detailed below, and criminal prosecutions are brought in the State's name.

11. The Governor of Minnesota ("Governor") is the chief executive officer of the State and "shall take care that the laws be faithfully executed." Minn. Const., art. 5, § 3. The Governor may direct the Attorney General to prosecute "any person charged with an indictable offense," including the criminal laws challenged in this case. Minn. Stat. § 8.01. The Governor's offices are in Ramsey County.

12. The Attorney General of Minnesota ("Attorney General") is an executive officer whose service is constitutionally mandated. Minn. Const., art. 5, §§ 1, 4. At the request of the Governor or a county attorney, the Attorney General may enforce any of the criminal laws challenged in this case. Minn. Stat. § 8.01. In addition, the Attorney General "shall act as the attorney for all state officers and all boards or commissions created by law in all matters pertaining to their official duties." Minn. Stat. § 8.06. The Attorney General's offices are in Ramsey County.

13. The Minnesota Commissioner of Health ("Health Commissioner") has "general authority as the state's official health agency," Minn. Stat. § 144.05, subd. 1, including statutory authority to enforce some of the laws challenged in this action, as detailed below. The Health Commissioner is named as a defendant in accordance with Minn. Stat. § 543.21. The Health

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Commissioner's offices are in Ramsey County.

14. The Minnesota Board of Medical Practice ("Medical Board") has statutory authority to impose professional discipline on licensed medical professionals, including physicians and physician assistants, for violating Minnesota laws concerning healthcare. *See* Minn. Stat. §§ 147.091, subd. 1(f), 147A.13, subd. 1(6). The Medical Board is named as a defendant in accordance with Minn. Stat. § 543.21. The Medical Board's offices are in Hennepin County.

15. The Minnesota Board of Nursing ("Nursing Board") has statutory authority to impose professional discipline on licensed nurses, including nurse practitioners and nurse midwives, for violating Minnesota laws concerning healthcare. *See* Minn. Stat. § 148.261, subd. 1(18). The Nursing Board is named as a defendant in accordance with Minn. Stat. § 543.21. The Nursing Board's offices are in Hennepin County.

III. JURISDICTION AND VENUE

16. This Court has jurisdiction over Plaintiffs' claims pursuant to Minn. Const. art. VI, § 3, and Minn. Stat. § 484.01, subd. 1.[4]

17. Venue is proper in Ramsey County pursuant to Minn. Stat. § 542.09 because some of the named defendants reside here.

[4] Minn. Stat. § 145.4249 provides that "[t]he Minnesota Supreme Court has original jurisdiction over an action challenging the constitutionality" of the mandatory disclosure and delay laws identified below. Even if that provision were constitutionally valid, which is doubtful, it does not create exclusive jurisdiction in the Minnesota Supreme Court. Accordingly, this Court has jurisdiction over this case in any event. *See Minn. Voters All. v. Simon*, 885 N.W.2d 660, 666 (Minn. 2016) (*per curiam*) (declining to exercise original jurisdiction and holding that a statutory grant of original jurisdiction to the Supreme Court "does not deprive the district court of its original jurisdiction").

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FACTS

I. BACKGROUND

A. Abortion

18. Abortion is a common medical intervention.

19. In 2014, the most recent year for which nationwide data are currently available, approximately 926,200 abortions were induced in the United States. Of those, 9,760 took place in Minnesota.[5]

20. The Minnesota Department of Health reports that approximately 10,000 abortions have been provided on an annual basis in Minnesota since 2014.[6]

21. At current rates, approximately one in every four women in the United States will have an abortion by age 45.[7]

22. Most abortion patients are in their 20s (60%) and 30s (25%).[8]

23. Nearly 60% of abortion patients have previously given birth to a child.[9]

24. No racial or ethnic group comprises the majority of abortion patients. Nationwide,

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[5] *See* Guttmacher Inst., *State Facts About Abortion: Minnesota* 1 (2018), https://www.guttmacher.org/sites/default/files/factsheet/sfaa-mn.pdf.

[6] Minn. Dep't of Health, *Induced Abortions in Minnesota January – December 2017: Report to the Legislature* 35 (2018) ("Health Dep't 2017 Report") (10,177 abortions provided in 2017; 10,017 abortions provided in 2016), https://www.health.state.mn.us/data/mchs/pubs/abrpt/docs/2017abrptr2.pdf; Minn. Dep't of Health, *Induced Abortions in Minnesota January – December 2015: Report to the Legislature* 3 (2016) ("Health Dep't 2015 Report") (9,861 abortions provided in 2015), https://www.health.state.mn.us/data/mchs/pubs/abrpt/docs/2015abrpt.pdf.

[7] Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortions: United States, 2008-2014*, 107 Am. J. Pub. Health 1904, 1908, https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2017.304042.

[8] Jenna Jerman, Rachel K. Jones & Tsuyoshi Onda, *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008* 5 (2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.

[9] *Id.* at 7.

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approximately 39% of abortion patients are White; 28% are Black; 25% are Hispanic; 6% are Asian or Pacific Islander; and 3% identify with other racial or ethnic classifications.[10]

25. Most abortion patients (62%) are religiously affiliated. Fifty-four percent are Christians; 46% are affiliated with other religious traditions.[11]

26. Three-quarters of abortion patients in the United States are low-income, with nearly half living below the federal poverty level.[12] In 2018, the federal poverty level for an individual was an annual income of $12,140; the federal poverty level for a family of four was an annual income of $25,100.

27. Three methods of abortion are commonly used in the United States: medication abortion, aspiration abortion, and D&E abortion.

28. Medication abortion entails the administration of medications that end a pregnancy and cause the uterus to expel its contents. This method may be used from the start of pregnancy through ten weeks gestation as measured from the first day of a patient's last menstrual period ("lmp").

29. Aspiration abortion entails the use of suction to empty the contents of the uterus. This method is typically used from six weeks lmp through fourteen to sixteen weeks lmp.

30. D&E abortion entails the use of suction and medical instruments to empty the contents of the uterus. This method is typically used beginning at fourteen to sixteen weeks lmp.

31. A fourth method of abortion—called induction—is also sometimes used in the United States. It entails the administration of medications to induce labor and delivery of a fetus,

[10] *Id.* at 5.

[11] *Id.* at 7.

[12] *Id.* at 7.

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typically after sixteen weeks lmp.

32. A Committee of the National Academies of Sciences, Engineering, and Medicine ("Committee") recently issued a Consensus Study Report on the Safety and Quality of Abortion Care in the United States after reviewing all available evidence. It concluded that abortion in the United States is safe; serious complications of abortion are rare; and abortion does not increase the risk of long-term physical or mental health disorders.[13]

33. The Committee assessed the quality of abortion care based on six factors: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. It concluded that the quality of abortion care depends to a great extent on geography. In particular, it found that "[i]n many parts of the country, state regulations have created barriers to optimizing each dimension of quality care."[14]

34. In a recent decision striking down a pair of Texas abortion restrictions, the U.S. Supreme Court likewise concluded that abortion is safe and complications from abortion are rare. *See Whole Woman's Health v. Hellerstedt*, __ U.S. __, 136 S. Ct. 2292, 2311, 2315 (2016). Indeed, the Supreme Court found that abortion is safer than many other procedures commonly performed in outpatient settings. *See id.* at 2315. It also recognized that unnecessary regulation may diminish the quality of care that patients receive. *See id.* at 2318.

35. Notably, abortion entails significantly less medical risk than carrying a pregnancy to term and giving birth.[15]

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[13] Nat'l Acads. of Scis., Eng'g, and Med., *The Safety and Quality of Abortion Care in the United States* 1-16 (2018), https://doi.org/10.17226/24950.

[14] *Id.* at 10.

[15] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216-17 (2012).

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36. The United States has a higher rate of maternal mortality than other developed nations, and it has been increasing in recent years.[16]

37. Pregnancy-related deaths disparately impact communities of color. Black women die from pregnancy-related causes at a much higher rate than White women.[17]

38. Although abortion is safe throughout pregnancy, the risk, complexity, duration, and cost of abortion increase with gestational age. Delayed access to abortion care therefore harms patients.

39. Nationwide and in Minnesota, the vast majority of abortions occur early in pregnancy. In 2017, more than 80% of abortions took place during the first ten weeks lmp. Ninety-three percent of abortions took place during the first-trimester of pregnancy.

40. Individuals from every region of Minnesota have had abortions in recent years.[18]

41. The number of abortion providers in the State has decreased over time.

42. Each year, hundreds of Minnesota residents travel out-of-state to access abortion care.

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[16] *See generally* Katy B. Kozhimannil, *Reversing the Rise in Maternal Mortality*, 37 Health Affairs 1901, 1901-04 (2018), https://www.healthaffairs.org/doi/pdf/10.1377/ hlthaff.2018.1013; John Lundy, *Hospitals Seek to Address Troubling Increase in Maternal Mortality Across U.S.*, Duluth News Tribune, Feb. 26, 2019, https://www.duluthnewstribune.com/business/healthcare/4576407-hospitals-seek-address-troubling-incre ase-maternal-mortality-across-us; Alison Young, *Hospitals Know How to Protect Mothers. They Just Aren't Doing It.*, USA Today, July 27, 2018, http://ee.usatoday.com/Olive/ODN/USATSample/shared/ShowArticle.aspx?doc=USA%2F2018%2F07%2F27&entity=Ar00105&sk=B028FA02&mode=text.

[17] Kozhimannil, *supra*, at 1903 ("In the US no group bears this burden more heavily than black mothers, who are more than three times as likely as white women to die giving birth and—if they survive—more than twice as likely as white women to bury their babies before their first birthday.").

[18] *See* Health Dep't 2017 Report, *supra*, at 7, 42; Health Dep't 2015 Report, *supra*, at 9.

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B. Unintended Pregnancy and STIs

43. Unintended pregnancy can have significant, negative consequences for individuals and society. It is linked with adverse maternal and child health outcomes as well as social and economic challenges.[19]

44. In 2011, the most recent year for which nationwide data are currently available, nearly half of all pregnancies in the United States were unintended, including 75% of teen pregnancies.[20]

45. In 2010, 40% of all pregnancies in Minnesota were unintended, amounting to 38,000 unintended pregnancies.[21] Fifty-eight percent of those pregnancies resulted in births, and 28% resulted in abortions.[22]

46. Low-income individuals are disproportionately affected by unintended pregnancy.[23]

47. Among opioid-abusing women, nearly 90% of pregnancies are unintended.[24]

48. Most STIs are treatable. The development of antibiotic cures for syphilis and gonorrhea beginning in the 1940s marked a major advancement in public health. The development of anti-retroviral therapy beginning in the 1990s to treat human immunodeficiency virus ("HIV") and reduce the risk of its transmission marked another such advancement. These advancements

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[19] Guttmacher Inst., *State Facts About Unintended Pregnancy: Minnesota* 1-2 (2016), https://www.guttmacher.org/sites/default/files/factsheet/mn_17.pdf.

[20] *Id.* at 1.

[21] *Id.*

[22] *Id.*

[23] *Id.*

[24] Sarah H. Heil et al., *Unintended Pregnancy in Opioid-Abusing Women*, 40 J. Substance Abuse Treatment 199, 199-202 (2011).

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have greatly reduced mortality from STIs.

49. Nevertheless, STIs remain a major public health concern in Minnesota. Over 32,000 STI cases were reported to the Minnesota Department of Health in 2018.[25] Rates of chlamydia and gonorrhea increased steadily from 2007 to 2018.[26] STI rates are especially high among Minnesota teenagers.[27]

50. A dramatic increase in syphilis among women and newborns led the Minnesota Department of Health to recommend, earlier this year, that all pregnant people be screened for the disease at least twice during pregnancy.[28]

51. Moreover, gonorrhea "has developed resistance to nearly all of the antibiotics used for its treatment."[29] The Centers for Disease Control and Prevention describe antibiotic-resistant gonorrhea as "an urgent public health threat."[30]

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[25] Minn. Dep't of Health, *STD Statistics—2018: Summary*, https://www.health.state.mn.us/diseases/stds/stats/2018/index.html (last updated Apr. 30, 2019).

[26] *See* Minn. Dep't of Health, *Sexually Transmitted Disease (STD) Surveillance Report, 2017* 11, https://www.health.state.mn.us/diseases/stds/stats/2017/stdreport.pdf; *see also* Minn. Dep't of Health, *STD Statistics—2018: Summary*, *supra*.

[27] J. Farris, J. Austin & C. Brown, Univ. of Minn. Healthy Youth Dev. Prevention Research Ctr., *2018 Minnesota Adolescent Sexual Health Report* 5 (2018), https://www.pediatrics.umn.edu/sites/pediatrics.umn.edu/files/2018_ashr_report_final_0.pdf.

[28] Minn. Dep't of Health, *Revised Syphilis Screening Recommendations for Pregnant Women* (Feb. 15, 2019), https://www.health.state.mn.us/diseases/syphilis/hcp/syphpreg2019.pdf.

[29] Ctrs. for Disease Control & Prevention, *Antibiotic-Resistant Gonorrhea Basic Information*, https://www.cdc.gov/std/gonorrhea/arg/basic.htm (last visited May 27, 2019).

[30] *Id.*

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C. Minnesota Demographics

52. Approximately 5.6 million people live in Minnesota,[31] including over one million women of reproductive age.[32]

53. Eighty percent of Minnesota residents are White; 20% are people of color.[33]

54. Approximately 8% of Minnesota residents are immigrants.[34] The largest immigrant communities in Minnesota are from Mexico, Somalia, India, Southeast Asia, China, and Ethiopia.[35]

55. In 2017, Minnesota's median household income was $65,699.[36]

56. The State's overall poverty rate that year was 10.5%.[37] Poverty rates were higher among people of color. Thirty-two percent of Black people were living in poverty; 31% of American Indians were living in poverty; and 21% of Hispanics were living in poverty.[38]

57. Nearly 300,000 Minnesota residents lacked health insurance in 2017.[39]

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[31] Minn. State Demographic Ctr., *Our Estimates* (Aug. 2018), https://mn.gov/admin/demography/data-by-topic/population-data/our-estimates/.

[32] Ctrs. for Disease Control & Prevention, Nat'l Ctr. for Chronic Disease Prevention & Health Promotion, Div. of Reproductive Health, *Women's Health Statistics: Minnesota* 1, https://www.cdc.gov/reproductivehealth/data_stats/pdfs/minnesota.pdf (last visited May 27, 2019).

[33] Minn. State Demographic Ctr., *Age, Race & Ethnicity*, https://mn.gov/admin/demography/data-by-topic/age-race-ethnicity/ (last visited May 27, 2019).

[34] Minn. State Demographic Ctr., *Immigration & Language*, https://mn.gov/admin/demography/data-by-topic/immigration-language/ (last visited May 27, 2019).

[35] *Id.*

[36] Minn. State Demographic Ctr., *Income & Poverty*, https://mn.gov/admin/demography/data-by-topic/income-poverty/ (last visited May 27, 2019).

[37] *Id.*

[38] *Id.*

[39] Minn. State Demographic Ctr., *Health & Disability*, https://mn.gov/admin/demography/data-by-topic/health-disability/ (last visited May 27, 2019).

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II. CHALLENGED LAWS

A. Targeted Regulation of Abortion Provider ("TRAP") Laws

58. Targeted regulation of abortion provider ("TRAP") laws single out abortion providers for regulatory requirements that are different and more burdensome than those governing other healthcare providers.

59. The requirements imposed by these laws are not based on differences between abortion and other medical procedures that are reasonably related to patient health.

60. TRAP laws reduce the availability and affordability of abortion care—and often diminish the quality of care that patients receive—without providing significant medical benefits.

61. Many of Minnesota's TRAP laws embody outdated medical standards.

62. All people seeking abortion care in Minnesota are harmed by TRAP laws. The harm is felt most acutely by low-income people, people of color, immigrants, people who lack health insurance, and others who are marginalized.

i. Physician-Only Law

63. Plaintiffs challenge the "physician-only law" codified at Minn. Stat. § 145.412, subd. 1(1).

64. The physician-only law provides that an abortion may only be performed "by a physician licensed to practice medicine [under Minnesota law], or a physician in training under the supervision of a licensed physician." Minn. Stat. § 145.412, subd. 1(1).

65. It prohibits qualified, advance-practice clinicians ("APCs"), such as physician assistants, nurse practitioners, and nurse midwives, from providing abortions.

66. Failure to comply with the physician-only law is a felony. Minn. Stat. § 145.412, subd. 4. In addition, it subjects licensed clinicians to professional discipline by the Medical Board, *see* Minn. Stat. § 147.091, subd. 1(f), and the Nursing Board, *see* Minn. Stat. § 148.261, subd.

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1(18), (26).

67. The physician-only law was enacted in 1974 and has become out-of-date. While older abortion methods may have warranted a physician-only requirement, contemporary abortion methods do not.

68. Extensive medical evidence shows that APCs can provide medication and aspiration abortion as safely and effectively as physicians.

69. Numerous medical societies and professional organizations endorse APCs providing abortion care. These include the American College of Obstetricians and Gynecologists; the American Public Health Association; the American College of Nurse Midwives; the American Association of Physician Assistants; the World Health Organization; and the National Abortion Federation.

70. Medical evidence led the Montana Supreme Court to strike down a Montana physician-only requirement in 1999. *See Armstrong v. State*, 989 P.2d 364, 382 (Mont. 1999) ("There is simply no evidence in the record of this case that laws requiring pre-viability abortions be performed only by a physician to the exclusion of a trained, experienced and medically competent physician assistant . . ., working under the supervision of a licensed physician, are necessary to protect the life, health or safety of women in this State. Indeed, there is overwhelming evidence to the contrary . . . .").

71. In the absence of the physician-only law, Minnesota's generally-applicable laws concerning APCs' scope-of-practice would govern APCs' ability to provide abortion care. *See, e.g.*, Minn. Stat. §§ 147A.09 (defining the scope-of-practice for physician assistants); 148.171, subd. 10 (defining the scope-of-practice for nurse midwives); 148.171, subd. 11 (defining the scope of practice for nurse practitioners).

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72. Minnesota law currently permits APCs to provide medical care that entails greater risk than medication or aspiration abortion.

73. But for the physician-only law, some APCs would be willing and able to provide abortion care in Minnesota.

74. The physician-only law limits the pool of qualified clinicians who may lawfully provide abortions in Minnesota and thereby decreases the availability and affordability of abortion care in the State.

75. The physician-only law infringes on the fundamental right to abortion access.

76. The physician-only law is not necessary to serve Minnesota's interest in patient health or any compelling state interest.

ii. Hospitalization Requirements

77. Plaintiffs challenge the "hospitalization requirements" codified at Minn. Stat. § 145.412, subds. 1(2), 3(1), as applied to pre-viability abortion.

78. Minn. Stat. § 145.412, subd. 1(2), provides that an abortion must be performed "in a hospital or abortion facility if the abortion is performed after the first trimester."

79. Minnesota law defines "abortion facility" as "those places properly recognized and licensed by the state commissioner of health under lawful rules promulgated by the commissioner for the performance of abortions." Minn. Stat. § 145.411, subd. 4. But the rules promulgated by the Health Commissioner concerning abortion facility licensure were declared unconstitutional,[40] and the Health Commissioner does not administer any program through which abortion clinics

[40] Licensing regulations adopted by the Health Commissioner in 1974 were declared unconstitutional, in relevant part, by a three-judge panel of the U.S. District Court for the District of Minnesota. *See Hodgson v. Lawson*, No. 4-74-155, slip op. at 7 (D. Minn. Mar. 4, 1977) (on remand from the Eighth Circuit) (annexed hereto as Exhibit A).

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may become licensed. Accordingly, there is no way for a healthcare provider to meet the definition of "abortion facility" under Minnesota law.

80. The only way to satisfy Minn. Stat. § 145.412, subd. 1(2), is to provide all abortions in a hospital after the first-trimester. It therefore imposes a hospitalization requirement on all pre-viability abortions performed during the second-trimester of pregnancy.

81. The Minnesota Department of Health places the start of the second-trimester at sixteen weeks lmp.[41]

82. Pursuant to Minn. Stat. § 145.412, subd. 3(1), an abortion must be performed "in a hospital" after twenty weeks lmp.

83. Failure to comply with the hospitalization requirements is a felony. Minn. Stat. § 145.412, subd. 4. In addition, failure to comply with the requirements subjects licensed clinicians to professional discipline by the Medical Board, *see* Minn. Stat. § 147.091, subd. (1)(f), and the Nursing Board, *see* Minn. Stat. § 148.261, subd. 1(18), (26).

84. Minnesota's hospitalization requirements are a relic from an earlier era. In 1973, it was medically appropriate for second-trimester abortions to be performed in a hospital. *See City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 435 (1983), *overruled in part on other grounds by Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992).

85. "Since then, however, the safety of second-trimester abortions has increased dramatically." *Id.* at 435-36.

86. This increase in safety is generally attributed to the development of the D&E method of abortion. D&E is the most common method of second-trimester abortion, and

[41] *See* Minn. Dep't of Health, *If You Are Pregnant: Information on Fetal Development, Abortion and Alternatives* 9 (2009), https://www.health.state.mn.us/docs/people/wrtk/handbook_eng.pdf.

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"experience indicates that D&E may be performed safely on an outpatient basis in appropriate nonhospital facilities." *Id.* at 436.

87. Medical evidence led the U.S. Supreme Court to strike down a pair of similar hospitalization requirements more than 35 years ago. *See id.* at 438 ("By preventing the performance of D&E abortions in an appropriate nonhospital setting, Akron has imposed a heavy, and unnecessary, burden on women's access to a relatively inexpensive, otherwise accessible, and safe abortion procedure."); *Planned Parenthood Assoc. of Kan. City, Mo., Inc. v. Ashcroft*, 462 U.S. 476, 481-82 (1983).

88. Further medical advancements have made D&E abortion even safer today than in 1983.

89. Current medical evidence demonstrates that D&E may be safely performed in outpatient settings throughout the second-trimester of pregnancy.

90. Minnesota law permits medical care that entails greater risk than D&E abortion to be provided in outpatient settings.

91. The hospitalization requirements infringe on the fundamental right to abortion access.

92. The hospitalization requirements are not necessary to serve Minnesota's interest in patient health or any compelling state interest.

93. Recognizing that the hospitalization requirements are unconstitutional, some Minnesota abortion providers perform second-trimester abortions in outpatient settings. These providers do not hide this practice from State officials. To the contrary, they report the gestational age of each abortion they perform to the Health Commissioner as required by Minn. Stat. § 145.4131, subd. 1(b)(3), and Minn. R. 4615.3600, subp. 2(A)(11), and the Health Commissioner

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incorporates this information into an annual public report, as required by Minn. Stat. § 145.4134.

94. On information and belief, Defendants have never taken enforcement action against an abortion provider for violating the hospitalization requirements.

95. Nevertheless, the fact that they remain on the books and can be enforced through felony criminal penalties has a chilling effect of the provision of second-trimester abortions. Qualified healthcare providers would be more likely to provide second-trimester abortions in outpatient settings if the Court were to declare the hospitalization requirements unconstitutional and/or unenforceable.

iii. Reporting Requirements

96. Plaintiffs challenge the "reporting requirements" codified at Minn. Stat. §§ 145.413, 145.4131, subd. 1(b)(1)-(12), 145.4132, 145.4134, 145.4246, subd. 3, and Minn. R. 4615.3600.

97. Minn. Stat. § 145.4131, subd. 1(b)(1)-(12), requires a "physician or facility performing an abortion" to report detailed information about the abortion patient, procedure, and provider to the Health Commissioner. The required information includes the patient's "specific reason for the abortion"; the number of prior abortions and miscarriages the patient had; and the patient's method of payment for the abortion. Minn. Stat. § 145.4131, subd. 1(b)(1)-(12).

98. Facilities providing abortion care must also report each patient's race; city, county, and state of residency; census tract if the patient resides in Minneapolis or St. Paul; age; marital status; and number of children, among other information. Minn. R. 4615.3600, subp. 2(A).

99. In addition, Minn. Stat. § 145.4132 requires that "[a] physician licensed and practicing in the state who knowingly encounters an illness or injury that, in the physician's medical judgment, is related to an induced abortion or the facility where the illness or injury is encountered shall complete and submit an abortion complication reporting form to the

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commissioner."

100. Further, Minn. Stat. § 145.4246 requires physicians who provide abortion care to report additional information about patients to whom mandatory disclosures are made pursuant to Minn. Stat. § 145.4242.

101. Altogether, the "data collection instruments" created by the Health Commissioner to gather this information comprise nine pages.[42]

102. Moreover, Minn. Stat. § 145.413, subd. 2 (the "mortality reporting requirement") provides that: "If any woman who has had an abortion dies from any cause within 30 days of the abortion or from any cause potentially related to the abortion within 90 days of the abortion, that fact shall be reported to the state commissioner of health." A physician who performs an abortion and fails to "transmit the required information to the state commissioner of health within 30 days after the abortion is guilty of a misdemeanor." Minn. Stat. § 145.413, subd. 3.

103. This requirement is duplicative of Minn. R. 4615.0800, which provides in relevant part that: "Any death associated with pregnancy, including abortion . . ., whether or not it is the actual cause of death, shall be reported by mail within three days after death to the Minnesota Department of Health . . . by the attending physician and by the hospital where the death occurred." The regulation is not associated with any criminal penalties.

104. The mortality reporting requirement singles out physicians who provide abortions for harsher penalties than other physicians in connection with failure to report patient deaths.

105. Abortion has a much lower mortality rate than carrying a pregnancy to term.

106. Laws that subject abortion providers to disparate criminal liability discourage qualified healthcare providers from providing abortion care.

[42] Health Dep't 2017 Report, *supra,* at 62-71.

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107. Violation of the reporting requirements gives rise to administrative penalties imposed by the Health Commissioner, *see* Minn. Stat. §§ 145.4135(a), 145.4246, subd. 5; professional discipline by the Medical Board, *see* Minn. Stat. § 147.091, subd. 1(f); and in some cases, criminal liability, *see* Minn. Stat. § 145.412, subds. 2, 4 (making it a felony to violate "lawful rules promulgated by the state commissioner of health" in connection with the performance of an abortion), 145.4135(c) (subjecting physicians to criminal liability for knowingly or recklessly submitting a false report); and civil liability, *see* Minn. Stat. § 145.4247, subd. 1.

108. The Health Commissioner must, on an annual basis, issue a public report summarizing the information collected as a result of the reporting requirements. *See* Minn. Stat. § 145.4134.

109. The Health Commissioner estimates that the most recent report "cost approximately $4,000 to prepare, including staff time, printing and mailing expenses."[43]

110. The reporting requirements intrude on the privacy of abortion patients and impose heavy administrative burdens on abortion providers.

111. The data collected as a result of the reporting requirements are not necessary to facilitate public health research concerning abortion care.

112. Public health researchers regularly collect data concerning the provision of abortion care using reliable, non-coercive research methods.

113. The reporting requirements subject abortion patients and providers to burdens that are not imposed on other patients and healthcare providers.

114. The reporting requirements infringe on the fundamental right to abortion access.

115. The reporting requirements are not necessary to serve Minnesota's interest in public

[43] Health Dep't 2017 Report, *supra,* at inside cover.

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health or any compelling state interest.

iv. Felony Penalties for Regulatory Infractions

116. Plaintiffs challenge the imposition of "felony penalties for regulatory infractions" codified at Minn. Stat. § 145.412, subds. 1(3), 4.

117. The statute provides that "[i]t shall be unlawful to willfully perform an abortion unless the abortion is performed" "in a manner consistent with the lawful rules promulgated by the state commissioner of health." Minn. § 145.412, subd. 1(3). "A person who performs an abortion in violation of this section is guilty of a felony." Minn. Stat. § 145.412, subd. 4.

118. The statute's *mens rea* requirement applies to performance of the abortion, not violation of the rules. It therefore appears that even inadvertent regulatory infractions may subject an abortion provider to felony criminal liability.

119. Minn. R. 4615.3500 requires a "pregnancy termination facility" to "keep a signed consent form of each patient undergoing a pregnancy termination procedure." Under Minn. Stat. § 145.412, subds. 1(3), 4, loss of a patient's form may subject the facility and its employees to felony criminal liability.

120. Minn. R. 4615.3600 requires an "ambulatory facility" specializing in abortion care to report 13 categories of information about each patient to the Health Commissioner. Under Minn. Stat. § 145.412, subds. 1(3), 4, omission of a single detail such as a patient's race or marital status may subject the facility and its employees to felony criminal liability.

121. If the felony penalties imposed by Minn. Stat. § 145.412, subds. 1(3), 4, were eliminated, abortion providers would still be subject to administrative penalties and professional discipline for violating lawful regulations.

122. Other healthcare providers are not subject to felony penalties for minor regulatory infractions.

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123. Laws that subject abortion providers to disparate criminal liability discourage qualified healthcare providers from providing abortion care.

124. The felony penalties for regulatory infractions infringe on the fundamental right to abortion access.

125. The felony penalties for regulatory infractions are not necessary to serve Minnesota's interest in patient health or any compelling state interest.

B. Mandatory Disclosure and Delay Laws

126. Minnesota's mandatory disclosure and delay laws turn the traditional informed consent process for medical treatment on its head. Although legal and ethical principles generally require healthcare providers to give their patients accurate, unbiased information about the risks of and alternatives to a medical treatment, the mandatory disclosure and delay laws require abortion providers to give their patients misleading and ideologically charged information in an effort to discourage them from obtaining abortion care.

127. These laws also require patients to delay their abortions for at least twenty-four hours after consenting to the procedure no matter how certain they are of their decision or how long it took them to reach an abortion provider in the first place.

128. The mandatory disclosure and delay laws are motivated by a paternalism that embodies an outdated view of women's decision-making ability and role in society, and they employ false pretenses to deter people from ending unwanted pregnancies.

129. The Minnesota Supreme Court has long recognized, however, "that the right of privacy under our constitution protects not simply the right to an abortion, but rather it protects the woman's *decision* to abort; any legislation infringing on the decision-making process, then, violates this fundamental right." *Gomez*, 542 N.W. 2d at 31.

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i. Mandatory Disclosure Requirements

130. Plaintiffs challenge the "mandatory disclosure requirements" codified at Minn. Stat. § 145.4242.

131. The statute requires abortion providers to make three different sets of disclosures to their patients.

132. First, "the physician who is to perform the abortion or . . . a referring physician" must tell the patient: "(i) the particular medical risks associated with the particular abortion procedure to be employed including, when medically accurate, the risks of infection, hemorrhage, breast cancer, danger to subsequent pregnancies, and infertility"; "(ii) the probable gestational age of the unborn child at the time the abortion is to be performed"; "(iii) the medical risks associated with carrying her child to term"; and "(iv) for abortions after 20 weeks gestational, whether or not an anesthetic or analgesic would eliminate or alleviate organic pain to the unborn child caused by the particular method of abortion to be employed and the particular medical benefits and risks associated with the particular anesthetic or analgesic." Minn. Stat. § 145.4242(a)(1).

133. Second, "the physician who is to perform the abortion, . . . a referring physician, or . . . an agent of either physician" must inform the patient: "(i) that medical assistance benefits may be available for prenatal care, childbirth, and neonatal care"; "(ii) that the father is liable to assist in the support of her child, even in instances when the father has offered to pay for the abortion"; and "(iii) that she has the right to review . . . printed materials [published by the Health Commissioner], that these materials are available on a state-sponsored website, and what the website is." Minn. Stat. § 145.4242(a)(2). In addition, the "physician or the physician's agent" must "orally inform the female that the materials have been provided by the state of Minnesota and that they describe the unborn child, list agencies that offer alternatives to abortion, and contain

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information on fetal pain." Minn. Stat. § 145.4242(a)(2)(iii).

134. Third, an unspecified person must inform a patient whose fetus has been "diagnosed with fetal anomaly incompatible with life . . . of available perinatal hospice services and offer[] this care as an alternative to abortion." Minn. Stat. § 145.4242(c).

135. The patient must certify in writing that the required disclosures have been made as a condition of obtaining an abortion. *See* Minn. Stat. § 145.4242(a)(3).

136. The statute equates failure to provide the mandated disclosures with failure to obtain informed consent from an abortion patient. *See* Minn. Stat. § 145.4242(a).

137. The mandatory disclosure requirement is partially excused "in the case of a medical emergency or if the fetus has an anomaly incompatible with life, and the female has declined perinatal hospice care." Minn. Stat. § 145.4242(a). In the case of a medical emergency, "the physician shall inform the female, prior to the abortion if possible, of the medical indications supporting the physician's judgment that an abortion is necessary to avert her death or that a 24-hour delay will create serious risk of substantial and irreversible impairment of a major bodily function." Minn. Stat. § 145.4245. In the case of a "fetal anomaly incompatible with life," partial compliance with the mandatory disclosure requirements is required. *See* Minn. Stat. § 145.4242(c).

138. Failure to comply with the mandatory disclosure requirements gives rise to civil liability. Minn. Stat. § 145.4247, subd. 1. It also subjects licensed clinicians to professional discipline by the Medical Board, *see* Minn. Stat. §§ 147.091, subd. 1(f), 147A.13, subd. 1(6), and Nursing Board, Minn. Stat. § 148.261, subd. 1(18).

139. Some of the information that the mandatory disclosure requirements compel abortion providers to tell their patients is irrelevant, misleading, and/or ideologically charged.

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140. Some of the information in the printed materials published by the Health Commissioner is irrelevant, misleading, and/or ideologically charged.

141. The printed materials published by the Health Commissioner exaggerate the risks of abortion and understate the risks of carrying a pregnancy to term. For example, the printed materials devote three paragraphs to the potential for "negative feelings" after an abortion, but they fail to identify "baby blues" or post-partum depression as medical risks of childbirth, even though the latter conditions are common.[44]

142. No credible scientific evidence supports the claim that having an abortion increases a person's risk of breast cancer. Leading medical associations, including the American Cancer Society, have debunked this false claim.[45]

143. No credible scientific evidence supports the claim that a previability fetus can feel pain. Leading medical associations, including the American College of Obstetricians & Gynecologists, have debunked this false claim.[46]

144. Absent the mandatory disclosure requirements, abortion providers would have an affirmative obligation to obtain informed consent from their patients prior to providing abortion care pursuant to generally-applicable Minnesota law. *See Cornfeldt v. Tongen*, 262 N.W.2d 684, 699 (Minn. 1977).

145. In connection with the informed consent process, Minnesota clinicians are generally required to disclose: the "nature and character" of a proposed treatment; any "risk that

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[44] *See* Mayo Clinic, *Postpartum depression*, https://www.mayoclinic.org/diseases-conditions/postpartum-depression/symptoms-causes/syc-20376617 (last updated Sept. 1, 2018).

[45] *See* Am. Cancer Soc'y, *Abortion and Breast Cancer Risk*, https://www.cancer.org/cancer/cancer-causes/medical-treatments/abortion-and-breast-cancer-risk.html (last updated June 19, 2014).

[46] *See* Am. Coll. of Obstetricians & Gynecologists, *Facts Are Important: Fetal Pain* (July 2013), https://www.acog.org/-/media/Departments/Government-Relations-and-Outreach/FactAreImportFetalPain.pdf.

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would have been disclosed under accepted medical practice"; and any "significant risk of treatment or of an alternative treatment." *Id.* at 699, 702. In determining whether a risk is "significant," a clinician must take into account both what "a skilled practitioner of good standing in the community would reveal," and whether "a patient attaches a particular significance to risks not generally considered serious enough to require discussion." *K.A.C. v. Benson*, 527 N.W. 2d 553, 561 (Minn. 1995).

146. The U.S. Supreme Court has struck down laws similar to the mandatory disclosure requirements under strict scrutiny. In *City of Akron*, for example, the Court struck down a municipal ordinance specifying "a litany of information that the physician must recite to each woman regardless of whether in his judgment the information is relevant to her personal decision." 462 U.S. at 445, *overruled in part by Casey*, 505 U.S. at 881-82. Similarly, in *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 763 (1986), *overruled in part by Casey*, 505 U.S. at 881-82, the Court struck down a Pennsylvania statute that "is, or comes close to being, state medicine imposed upon the woman, not the professional medical guidance she seeks."

147. The mandatory disclosure requirements treat abortion patients and providers differently than other patients and healthcare providers.

148. The mandatory disclosure requirements compel healthcare providers to say things to their patients that are incompatible with accepted medical standards and bioethical principles.

149. The mandatory disclosure requirements infringe on the fundamental right to abortion access.

150. The mandatory disclosure requirements are not necessary to serve any compelling state interest.

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ii. Physician Disclosure Requirement

151. Plaintiffs challenge the "physician disclosure requirement" codified at Minn. Stat. § 145.4242(a)(1).

152. The physician disclosure requirement provides that certain mandatory disclosures may only be provided by a licensed physician—either "the physician who is to perform the abortion" or "a referring physician." Minn. Stat. § 145.4242(a)(1). It prohibits those physicians from delegating the disclosures to other qualified personnel.

153. Failure to comply with the physician disclosure requirement gives rise to civil liability. Minn. Stat. § 145.4247, subd. 1. It also subjects physicians to professional discipline by the Medical Board. *See* Minn. Stat. § 147.091, subd. 1(f).

154. The physician disclosure requirement requires physicians to personally provide information that others could competently provide under the physician's supervision.

155. The physician disclosure requirement delays some patient's access to abortion care and drives up the cost of abortion care.

156. Both the U.S. Supreme Court and the Tennessee Supreme Court have struck down laws similar to the physician disclosure requirement.

157. The U.S. Supreme Court held that: "We are not convinced . . . that there is [a] vital . . . state need for insisting that the physician performing the abortion, or for that matter any physician, personally counsel the patient in the absence of a request. The State's interest is in ensuring that the woman's consent is informed and unpressured; the critical factor is whether she obtains the necessary information and counseling from a qualified person, not the identity of the person from whom she obtains it." *City of Akron*, 462 U.S. at 448, *overruled in part by Casey*, 505 U.S. at 884-85.

158. The Tennessee Supreme Court held that: "Because it is not necessary that the

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physician personally impart the required information to the woman in order for informed consent to occur, the physician-only counseling requirement is not narrowly tailored to further a compelling state interest and will not be upheld." *Planned Parenthood of Middle Tenn. v. Sundquist*, 38 S.W.3d 1, 22 (Tenn. 2000).

159. The physician disclosure requirement treats abortion patients and providers differently than other patients and healthcare providers.

160. The physician disclosure requirement infringes on the fundamental right to abortion access.

161. The physician disclosure requirement is not necessary to serve any compelling state interest.

iii. Mandatory Delay Requirement

162. Plaintiffs challenge the "mandatory delay requirement" codified at Minn. Stat. § 145.4242(a)(1)-(2).

163. Pursuant to the mandatory delay requirement, an abortion provider must delay the provision of abortion care to a patient for at least twenty-four hours after the mandatory disclosures are made to the patient. *See* Minn. Stat. § 145.4242(a)(1)-(2).

164. Failure to comply with the mandatory delay requirement gives rise to civil liability. Minn. Stat. § 145.4247, subd. 1. It also subjects licensed clinicians to professional discipline by the Medical Board, *see* Minn. Stat. §§ 147.091, subd. 1(f), 147A.13, subd. 1(6), and Nursing Board, Minn. Stat. § 148.261, subd. 1(18).

165. In Minnesota, many abortion providers are not available to provide abortion care every day of the week.

166. For some abortion patients, it is difficult to arrange a confidential telephone call with an abortion provider to discuss medical issues in addition to arranging an appointment for

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abortion care. The difficulty is especially acute for employees who get paid by the hour and/or do not control their work schedules; teenagers who are in school; individuals who want to keep an abusive partner or relative from finding out about their pregnancy; and those who are not proficient in English.

167. For the foregoing reasons, the mandatory delay requirement sometimes causes delays in abortion access that are longer than twenty-four hours.

168. Patients who seek other medical care of equal or greater risk, including other reproductive healthcare, are not subject to a mandatory delay.

169. Studies show that most people who decide to have an abortion have a high degree of decisional certainty, and that mandatory delay laws do not increase the decisional certainty of people who have abortions.

170. Studies show that few people who have abortions come to regret their decision later. No credible evidence supports the claim that mandatory delay laws result in fewer people having abortions that they later come to regret.

171. The mandatory delay law embodies outdated views about women's decision-making capacity.

172. Women are just as capable as men of making decisions about their healthcare, and they are entitled to the same degree of autonomy that men have when making healthcare decisions.

173. The mandatory delay law sends a message that women cannot be trusted to make decisions about their pregnancies and must be protected from their impulsiveness.

174. The Iowa Supreme Court recently struck down an Iowa mandatory delay statute. *See Planned Parenthood of the Heartland v. Reynolds ex rel. State*, 915 N.W.2d 206, 212 (Iowa 2018). The court found that: "[T]he evidence conclusively demonstrates that the Act will not result

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in a measurable number of women choosing to continue a pregnancy they would have terminated without a mandatory 72-hour waiting period. Moreover, the burdens imposed on women by the waiting period are substantial, especially for women without financial means." *Id.* at 242. The court also concluded that the Iowa law discriminated against women based on outdated stereotypes. *See id.* at 244-45 ("For much of our state's, and nation's, history, biological differences have been used to justify women's subordinate position in society. . . . Yet, as time has progressed, so too have our understandings of freedom and equality.").

175. The U.S. Supreme Court and Tennessee Supreme Court have also struck down mandatory delay laws directed toward abortion patients.

176. The U.S. Supreme Court held that: "We find that Akron has failed to demonstrate that any legitimate state interest is furthered by an arbitrary and inflexible waiting period. . . . In accordance with the ethical standards of the profession, a physician will advise the patient to defer the abortion when he thinks this will be beneficial to her. But if a woman, after appropriate counseling, is prepared to give her written informed consent and proceed with the abortion, a State may not demand that she delay the effectuation of that decision." *City of Akron*, 462 U.S. at 450-51 (footnotes omitted), *overruled in part by Casey*, 505 U.S. at 885-86.

177. The Tennessee Supreme Court held that: "Studies . . . suggest that a large majority of women who have endured waiting periods prior to obtaining an abortion have suffered increased stress, nausea and physical discomfort, but very few have reported any benefit from having to wait." *Planned Parenthood of Middle Tenn.*, 38 S.W.3d at 23-24.

178. Minnesota's mandatory delay requirement treats abortion patients and providers differently than other patients and healthcare providers.

179. The mandatory delay requirement infringes on the fundamental right to abortion

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access.

180. The mandatory delay requirement is not necessary to serve any compelling state interest.

iv. Felony Penalties for Failure to Obtain Informed Consent

181. Plaintiffs challenge the imposition of "felony penalties for failure to obtain informed consent" codified at Minn. Stat. § 145.412, subds. 1(4), 4.

182. The statute provides that "[i]t shall be unlawful to willfully perform an abortion unless the abortion is performed" "with the consent of the woman submitting to the abortion after a full explanation of the procedure and effect of the abortion." Minn. § 145.412, subd. 1(4). "A person who performs an abortion in violation of this section is guilty of a felony." Minn. Stat. § 145.412, subd. 4.

183. As discussed above, Minnesota law independently requires all healthcare providers—including abortion providers—to obtain the informed consent of a patient prior to providing a medical intervention. *See Cornfeldt*, 262 N.W.2d at 699. A healthcare provider who fails to obtain informed consent from a patient prior to providing a medical intervention is subject to civil liability for battery and/or medical negligence. *See id.* Plaintiffs do not challenge this requirement.

184. Minn. Stat. § 145.412, subd. 1(4), does not impose any substantive requirements on abortion providers beyond those imposed by generally-applicable Minnesota law. Instead, it targets abortion providers for unique and onerous criminal penalties.

185. Other healthcare providers are not subject to criminal liability for failing to obtain informed consent from a patient.

186. Laws that subject abortion providers to disparate criminal liability discourage qualified healthcare providers from providing abortion care.

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187. The felony penalties for failure to obtain informed consent infringe on the fundamental right to abortion access.

188. The felony penalties for failure to obtain informed consent are not necessary to serve any compelling state interest.

C. Fetal Tissue Disposition Requirement

189. Plaintiffs challenge the "fetal tissue disposition requirement" codified at Minn. Stat. §§ 145.1621-145.1622; Minn. R. 4675.2205.

190. The statute requires that "[r]emains of a human fetus resulting from an abortion or miscarriage, induced or occurring accidentally or spontaneously at a hospital, clinic, or medical facility" be disposed of "by cremation, interment by burial, or in a manner directed by the commissioner of health." Minn. Stat. § 145.1621, subds. 3-4.

191. On information and belief, the Health Commissioner has not "directed" the disposition of fetal tissue in a manner not specified in the statute.

192. Failure to comply with the fetal tissue disposition requirement gives rise to civil and criminal liability. Minn. Stat. § 145.1621, subd. 5. It also subjects licensed clinicians to professional discipline by the Medical Board, *see* Minn. Stat. §§ 147.091, subd. 1(f), 147A.13, subd. 1(6), and Nursing Board, Minn. Stat. § 148.261, subd. 1(18).

193. In medicine, the standard method for disposition of human tissue is incineration followed by deposition in a sanitary landfill.

194. Cremation and burial are methods used for disposition of human remains after a person has died.

195. By requiring fetal tissue to be disposed of by methods used for the remains of a person who has died—to the exclusion of standard medical methods—the fetal tissue disposition requirement equates fetal tissue with the remains of a person who has died.

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196. Minnesota residents have differing beliefs about the status of a fetus based on diverse religious and cultural traditions.

197. Some Minnesota residents believe that a fetus is a person, while others do not.

198. Many people's beliefs about the point at which a developing human organism becomes a person, or otherwise acquires special status, are complex and nuanced.

199. The fetal tissue disposition requirement privileges the religious beliefs of some Minnesota residents over others.

200. Absent the fetal tissue disposition requirement, fetal tissue would be governed by the Infectious Waste Control Act, Minn. Stat. §§ 116.75-116.835, and implementing regulations, Minn. R. 7035.9100-7035.9150. This statute would not prevent a patient from electing to cremate or bury fetal tissue if the patient preferred one of those disposition methods.

201. The fetal tissue disposition requirement causes some individuals who have abortions or miscarriages to experience shame or stigma by sending a message that they are responsible for the death of a person.

202. Some individuals who experience pregnancy loss are comforted by the belief that they lost potential life rather than a fully realized person.

203. The fetal tissue disposition requirement imposes logistical burdens on healthcare providers who must segregate fetal tissue from other medical tissue and arrange for special disposition. This drives up the cost of healthcare.

204. The fetal tissue disposition requirement treats people who must dispose of fetal tissue differently from people who must dispose of other medical tissue.

205. From a public health standpoint, there is no reason to treat fetal tissue differently than other forms of human tissue for disposition purposes. It poses no greater risk of infection or

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environmental contamination.

206. The fetal tissue disposition requirement infringes on the fundamental right to abortion access.

207. The fetal tissue disposition requirement burdens the exercise of religious beliefs by miscarriage and abortion patients.

208. The fetal tissue disposition requirement serves no secular purpose.

209. The fetal tissue disposition requirement is not necessary to serve Minnesota's interest in public health or any compelling state interest.

210. Minnesota's fetal tissue disposition requirement was previously challenged in federal court. *See Planned Parenthood of Minn. v. State*, 910 F.2d 479, 481 (8th Cir. 1990).[47] In that case, the State took the position that incineration is a permissible method of disposition under the fetal tissue disposal requirement because it is a form of cremation. *See id.* at 483 n.4. The Eighth Circuit rejected that position, *id.*, but its construction of the statute is not binding on Minnesota courts.

211. The State's prior interpretation of the fetal tissue disposition requirement to permit incineration is plausible and would mitigate the requirement's constitutional infirmities.

D. Two-Parent Notification Requirement

212. Plaintiffs challenge the "two-parent notification requirement" codified at Minn. Stat. § 144.343, subds. 2-6.

213. Under Minnesota law, a minor is someone under the age of 18. Minn. Stat. §

[47] The Eighth Circuit upheld the statute based in part on a concession by the plaintiffs that "the state has a legitimate interest in protecting public sensibilities." *Planned Parenthood of Minn.*, 910 F.2d at 488. Plaintiffs here make no such concession. To the contrary, Plaintiffs maintain that the fetal tissue disposition requirement does not serve any valid state interest, much less any compelling state interest.

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645.451, subd. 2.

214. Minnesota law generally authorizes minors to consent to medical treatment related to pregnancy, STIs, and substance abuse without parental involvement. *See* Minn. Stat. 144.343, subd. 1.

215. A pregnant minor may not consent to an abortion, however, unless the abortion provider first notifies both of the minors' parents and observes a forty-eight-hour waiting period. *See* Minn. Stat. § 144.343, subds. 2-3. Alternatively, a pregnant minor may obtain a court order authorizing the abortion to proceed without parental notification. *See* Minn. Stat. § 144.343, subd. 6.

216. The following individuals are exempt from the two-parent notification requirement: "any minor who is living separate and apart from parents or legal guardian . . . and who is managing personal financial affairs," Minn. Stat. § 144.341; "[any] minor who has been married or has borne a child," Minn. Stat. § 144.342; and any minor who is "[]emancipated," Minn. Stat. § 144.343, subd. 2.

217. In addition, the two-parent notification requirement is excused when "the abortion is necessary to prevent the woman's death and there is insufficient time to provide the required notice"; both parents provide written consent; or "[t]he pregnant minor woman declares that she is a victim of sexual abuse, neglect, or physical abuse" and "[n]otice of that declaration" is given to "the proper authorities." Minn. Stat. § 144.343, subd. 4.

218. An abortion provider who fails to comply with the two-parent notification requirement is subject to civil and criminal liability. *See* Minn. Stat. § 144.343, subd. 5. Licensed clinicians are also subject to professional discipline by the Medical Board, *see* Minn. Stat. §§ 147.091, subd. 1(f), 147A.13, subd. 1(6), and Nursing Board, Minn. Stat. § 148.261, subd. 1(18).

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219. Two-hundred-forty-eight minors had abortions in Minnesota in 2017.[48] Ninety-five percent of them were between fifteen and seventeen years old.

220. Most teenagers voluntarily involve their parents in decisions about pregnancy and abortion.

221. Those who do not generally have prudent reasons, such as credible fear of violence or abandonment.

222. Not all teenagers live in two-parent households. Some teenagers do not have a meaningful relationship with their non-custodial parent.

223. Some teenagers have better relationships with other trusted adults—such as grandparents, aunts and uncles, siblings and mentors—than they do with their parents.

224. The two-parent notification requirement delays some pregnant teenagers' access to abortion.

225. The two-parent notification requirement prevents some pregnant teenagers from obtaining an abortion.

226. The two-parent notification requirement significantly increases the anxiety and stress experienced by some teenagers with unintended pregnancies.

227. A pregnant teenager who is unable to obtain an abortion must give birth to a child. Once a minor "has borne a child," the minor "may give effective consent" to all "personal medical, mental, dental and other health services" without parental involvement. Minn. Stat. § 144.342.

228. Seeking a court order authorizing an abortion is a daunting prospect for a pregnant teenager who lacks parental support. Navigating the legal system is intimidating, costly, and time-consuming. Having to prepare for a court appearance and then appear in court increases the time

[48] Health Dep't 2017 Report, *supra,* at 5.

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that pregnant teenagers must be away from home or school in connection with an abortion, making it harder for them to keep their pregnancies confidential.

229. Several state supreme courts have held statutes requiring parental notification or consent for abortion to be unconstitutional, including those in Alaska, California, Florida, Massachusetts, and New Jersey. *See Planned Parenthood of the Great Nw. v. State*, 375 P.3d 1122 (Alaska 2016); *Am. Acad. of Pediatrics v. Lungren*, 940 P.2d 797 (Cal. 1997); *N. Fla. Women's Health & Counseling Servs., Inc. v. State*, 866 So.2d 612 (Fla. 2003); *Planned Parenthood League of Mass., Inc. v. Attorney General*, 677 N.E.2d 101 (Mass. 1997); *Planned Parenthood of Cent. N.J. v. Farmer*, 762 A.2d 620 (N.J. 2000).

230. The Alaska Supreme Court explained: "We must conclude that the State's asserted interests do not justify a distinction between pregnant minors seeking to terminate and those seeking to carry to term." *Planned Parenthood of the Great Nw.*, 375 P.3d at 1143.

231. The California Supreme Court explained: "The testimony . . . revealed that the overwhelming majority of minors who become pregnant have the requisite maturity and capacity to give informed consent to an abortion, and that the interests of those relatively few pregnant minors who do not have the capacity to provide informed consent remain fully protected . . . because a physician may not perform any medical procedure, including an abortion, unless he or she determines that the patient is capable of giving (and has given) informed consent." *Am. Acad. of Pediatrics*, 940 P.2d at 828.

232. The Florida Supreme Court explained that: "[F]ew decisions are more private and properly protected from government intrusion than a woman's decision whether to continue her pregnancy, and yet the Act's notification requirement prohibits a pregnant minor from keeping this matter private." *N. Fla. Women's Health & Counseling Servs.*, 866 So.2d at 632 (footnote omitted).

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233. The Massachusetts Supreme Court explained that: "The requirement that, with certain exceptions, a pregnant unmarried minor must obtain the consent of both parents to her having an abortion, or else must seek judicial approval, lacks sufficient justification to overcome the burden that the two-parent consent requirement places on the minor's constitutional right to choose." *Planned Parenthood League of Mass.*, 677 N.E.2d at 107.

234. The New Jersey Supreme Court explained that: "The reality is that the Act applies to many young women who are justified in not notifying a parent about their abortion decisions." *Planned Parenthood of Cent. N.J.*, 762 A.2d at 637.

235. Minnesota's two-parent notification requirement treats pregnant minors seeking abortion care differently from pregnant minors seeking other reproductive healthcare.

236. The two-parent notification requirement infringes on the fundamental right to abortion access.

237. The two-parent notification requirement is not necessary to serve any compelling state interest.

E. Ban on Advertising STI Treatments

238. Plaintiffs challenge the "ban on advertising STI treatments" codified at Minn. Stat. § 617.28.

239. The statute provides in relevant part: "Any person who shall advertise . . . the treatment or curing of venereal diseases, . . . or who shall advertise in any manner any medicine, drug compound, appliance or any means whatever whereby it is claimed that sexual diseases of men and women may be cured or relieved, or miscarriage or abortion produced, shall be guilty of a gross misdemeanor . . . ." Minn. Stat. § 617.28, subd. 1.

240. The statute was held unconstitutional as applied to abortion-related advertisements more than 35 years ago. *See Meadowbrook Women's Clinic, P.A. v. State*, 557 F. Supp. 1172, 1178

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(D. Minn. 1983) ("[T]he Court finds that Minn. Stat. § 617.28 as it applies to the advertisement and publication of information concerning the inducement of miscarriages or abortions violates the first and fourteenth amendments of the U.S. Constitution.").

241. Some of the Plaintiffs provide healthcare services for people with STIs. They seek the ability to advertise those services without risk of criminal prosecution.

242. Independent of the ban on advertising STI treatments, Minnesota law prohibits practicing medicine without a license, including "advertis[ing], hold[ing] out to the public, or represent[ing] in any manner that the person is authorized to practice medicine in this state." Minn. Stat. § 147.081, subd. 3(1).

243. Independent of the ban on advertising STI treatments, Minnesota law prohibits false advertising by licensed clinicians. *See* Minn. Stat. §§ 147.091, subd. 1(e) (physicians), 147A.13, subd. 1(5) (physician assistants), 148.261, subd. 1(23) (nurses).

244. The ban on advertising STI treatments treats healthcare providers who provide STI treatments differently from healthcare providers who provide other kinds of medical care.

245. The ban on advertising STI treatments is not necessary to serve any compelling state interest.

CLAIMS

Count I
(Right to Privacy)

246. The allegations of paragraphs 1 through 245 are incorporated as though fully set forth herein.

247. The following laws violate the right to privacy guaranteed by Minnesota Constitution art. I, §§ 2, 7, 10:

a. Physician-only law codified at Minn. Stat. § 145.412, subd. 1(1);

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b. Hospitalization requirements codified at Minn. Stat. § 145.412, subds. 1(2), 3(1);

c. Reporting requirements codified at Minn. Stat. §§ 145.413, 145.4131, subd. 1(b)(1)-(12), 145.4132, 145.4134, 145.4246, subd. 3; Minn. R. 4615.3600;

d. Felony penalties for regulatory infractions codified at Minn. Stat. § 145.412, subds. 1(3), 4;

e. Mandatory disclosure requirements codified at Minn. Stat. § 145.4242;

f. Physician disclosure requirement codified at Minn. Stat. § 145.4242(a)(1);

g. Mandatory delay requirement codified at Minn. Stat. § 145.4242(a)(1)-(2);

h. Felony penalties for failure to obtain informed consent codified at Minn. Stat. § 145.412, subds. 1(4), 4;

i. Fetal tissue disposition requirement codified at Minn. Stat. §§ 145.1621-145.1622; Minn. R. 4675.2205; and

j. Two-parent notification requirement codified at Minn. Stat. § 144.343, subds. 2-6.

Count II
(Equal Protection)

248. The allegations of paragraphs 1 through 245 are incorporated as though fully set forth herein.

249. The following laws violate the guarantee of equal protection of the laws embodied in Minnesota Constitution art. I, § 2:

a. Physician-only law codified at Minn. Stat. § 145.412, subd. 1(1);

b. Hospitalization requirements codified at Minn. Stat. § 145.412, subds. 1(2), 3(1);

c. Reporting requirements codified at Minn. Stat. §§ 145.413, 145.4131, subd. 1(b)(1)-(12), 145.4132, 145.4134, 145.4246, subd. 3; Minn. R. 4615.3600;

d. Felony penalties for regulatory infractions codified at Minn. Stat. § 145.412, subds.

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1(3), 4;

e. Mandatory disclosure requirements codified at Minn. Stat. § 145.4242;

f. Physician disclosure requirement codified at Minn. Stat. § 145.4242(a)(1);

g. Mandatory delay requirement codified at Minn. Stat. § 145.4242(a)(1)-(2);

h. Felony penalties for failure to obtain informed consent codified at Minn. Stat. § 145.412, subds. 1(4), 4;

i. Fetal tissue disposition requirement codified at Minn. Stat. §§ 145.1621-145.1622; Minn. R. 4675.2205;

j. Two-parent notification requirement codified at Minn. Stat. § 144.343, subds. 2-6; and

k. Ban on advertising STI treatments codified at Minn. Stat. § 617.28.

Count III
(Special Legislation)

250. The allegations of paragraphs 1 through 245 are incorporated as though fully set forth herein.

251. The following laws violate the prohibition on special legislation set forth in Minnesota Constitution art. XII, § 1:

a. Physician-only law codified at Minn. Stat. § 145.412, subd. 1(1);

b. Hospitalization requirements codified at Minn. Stat. § 145.412, subds. 1(2), 3(1);

c. Reporting requirements codified at Minn. Stat. §§ 145.413, 145.4131, subd. 1(b)(1)-(12), 145.4132, 145.4134, 145.4246, subd. 3; Minn. R. 4615.3600;

d. Felony penalties for regulatory infractions codified at Minn. Stat. § 145.412, subds. 1(3), 4;

e. Mandatory disclosure requirements codified at Minn. Stat. § 145.4242;

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f. Physician disclosure requirement codified at Minn. Stat. § 145.4242(a)(1);

g. Mandatory delay requirement codified at Minn. Stat. § 145.4242(a)(1)-(2);

h. Felony penalties for failure to obtain informed consent codified at Minn. Stat. § 145.412, subds. 1(4), 4;

i. Fetal tissue disposition requirement codified at Minn. Stat. §§ 145.1621-145.1622; Minn. R. 4675.2205;

j. Two-parent notification requirement codified at Minn. Stat. § 144.343, subds. 2-6; and

k. Ban on advertising STI treatments codified at Minn. Stat. § 617.28.

Count IV
(Free Speech)

252. The allegations of paragraphs 1 through 245 are incorporated as though fully set forth herein.

253. The following laws violate the right to free speech guaranteed by Minnesota Constitution art. I, § 3:

a. Mandatory disclosure requirements codified at Minn. Stat. § 145.4242; and

b. Ban on advertising STI treatments codified at Minn. Stat. § 617.28.

Count V
(Vagueness)

254. The allegations of paragraphs 1 through 245 are incorporated as though fully set forth herein.

255. The hospitalization requirements codified at Minn. Stat. § 145.412, subds. 1(2), 3(1), violate the prohibition on vague laws embodied in Minnesota Constitution art. I, § 7.

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Count VI
(Religious Freedom and Neutrality)

256. The allegations of paragraphs 1 through 245 are incorporated as though fully set forth herein.

257. The fetal tissue disposition requirement codified at Minn. Stat. §§ 145.1621-145.1622; Minn. R. 4675.2205, violates the right to religious freedom and prohibition on religious preference set forth in Minnesota Constitution art. I, § 16.

Count VII
(Declaratory Judgment)

258. The allegations of paragraphs 1 through 245 are incorporated as though fully set forth herein.

259. All of the challenged laws are unconstitutional or otherwise unenforceable.

260. Alternatively, the fetal tissue disposition requirement codified at Minn. Stat. §§ 145.1621-145.1622; Minn. R. 4675.2205, is subject to a limiting construction that preserves its constitutionality.

PLEA FOR RELIEF

WHEREFORE, Plaintiffs respectfully ask the Court to:

A. Declare that:

   a. The physician-only law codified at Minn. Stat. § 145.412, subd. 1(1), is unconstitutional; and/or

   b. The hospitalization requirements codified at Minn. Stat. § 145.412, subds. 1(2), 3(1), are

      i. unenforceable due to duesuetude; and/or

      ii. unconstitutional; and/or

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c. The reporting requirements codified at Minn. Stat. §§ 145.413, 145.4131, subd. 1(b)(1)-(12), 145.4132, 145.4134, 145.4246, subd. 3; Minn. R. 4615.3600, are unconstitutional; and/or

d. The felony penalties for regulatory infractions codified at Minn. Stat. § 145.412, subds. 1(3), 4, are unconstitutional; and/or

e. The mandatory disclosure requirements codified at Minn. Stat. § 145.4242 are unconstitutional; and/or

f. The physician disclosure requirement codified at Minn. Stat. § 145.4242(a)(1) is unconstitutional; and/or

g. The mandatory delay requirement codified at Minn. Stat. § 145.4242(a)(1)-(2) is unconstitutional; and/or

h. The felony penalties for failure to obtain informed consent codified at Minn. Stat. § 145.412, subds. 1(4), 4, are unconstitutional; and/or

i. The fetal tissue disposition requirement codified at Minn. Stat. §§ 145.1621-145.1622; Minn. R. 4675.2205

   i. permits incineration followed by disposition of ashes in any lawful place; or

   ii. is unconstitutional; and/or

j. The two-parent notification requirement codified at Minn. Stat. § 144.343, subds. 2-6, is unconstitutional; and/or

k. The ban on advertising STI treatments codified at Minn. Stat. § 617.28 is unconstitutional; and/or

B. Permanently enjoin Defendants and their employees, agents, and successors in office

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from enforcing the following laws:

a. Physician-only law codified at Minn. Stat. § 145.412, subd. 1(1); and/or

b. Hospitalization requirements codified at Minn. Stat. § 145.412, subds. 1(2), 3(1); and/or

c. Reporting requirements codified at Minn. Stat. §§ 145.413, 145.4131, subd. 1(b)(1)-(12), 145.4132, 145.4134, 145.4246, subd. 3; Minn. R. 4615.3600; and/or

d. Felony penalties for regulatory infractions codified at Minn. Stat. § 145.412, subds. 1(3), 4; and/or

e. Mandatory disclosure requirements codified at Minn. Stat. § 145.4242; and/or

f. Physician disclosure requirement codified at Minn. Stat. § 145.4242(a)(1); and/or

g. Mandatory delay requirement codified at Minn. Stat. § 145.4242(a)(1)-(2); and/or

h. Felony penalties for failure to obtain informed consent codified at Minn. Stat. § 145.412, subds. 1(4), 4; and/or

i. Fetal tissue disposition requirement codified at Minn. Stat. §§ 145.1621-145.1622; Minn. R. 4675.2205; and/or

j. Two-parent notification requirement codified at Minn. Stat. § 144.343, subds. 2-6; and/or

k. Ban on advertising STI treatments codified at Minn. Stat. § 617.28; and/or

C. Grant such other and further relief as the Court may deem just, proper, and equitable.

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Dated: May 29, 2019

Respectfully submitted,

/s/ Christy L. Hall

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ACKNOWLEDGMENT

Pursuant to Minn. Stat. § 549.211, subd. 1, the undersigned attorneys hereby acknowledge that the Court may impose an appropriate sanction on any attorney, law firm, or party responsible for violating Minn. Stat. § 549.211, subd. 2, which provides that:

> By presenting to the court, whether by signing, filing, submitting, or later advocating, a pleading, written motion, or other paper, an attorney or unrepresented party is certifying that to the best of the person's knowledge, information, and belief, formed after an inquiry reasonable under the circumstances:
>
> (1) it is not being presented for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation;
>
> (2) the claims, defenses, and other legal contentions are warranted by existing law or by a nonfrivolous argument for the extension, modification, or reversal of existing law or the establishment of new law;
>
> (3) the allegations and other factual contentions have evidentiary support or, if specifically so identified, are likely to have evidentiary support after a reasonable opportunity for further investigation or discovery; and
>
> (4) the denials of factual contentions are warranted on the evidence or, if specifically so identified, are reasonably based on a lack of information or belief.

Dated: May 29, 2019

/s/ Christy L. Hall
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