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IN THE DISTRICT COURT OF THE FOURTH JUDICIAL DISTRICT OF THE STATE OF IDAHO, IN AND FOR THE COUNTY OF ADA

JENNIFER ADKINS; **JILLAINE ST.MICHEL**; **KAYLA SMITH**; **REBECCA VINCEN-BROWN**; **EMILY CORRIGAN, M.D.,** on behalf of herself and her patients; **JULIE LYONS, M.D.,** on behalf of herself and her patients; and **IDAHO ACADEMY OF FAMILY PHYSICIANS**, on behalf of itself, its members, and its members' patients,

Plaintiffs,

v.

STATE OF IDAHO; **BRAD LITTLE**, in his official capacity as Governor of the State of Idaho; **RAÚL LABRADOR**, in his official capacity as Attorney General of the State of Idaho; and **IDAHO STATE BOARD OF MEDICINE**,

Defendants.

CV01-23-14744

Case No. _____

COMPLAINT FOR DECLARATORY JUDGMENT AND INJUNCTIVE RELIEF

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COME NOW Plaintiffs Jennifer Adkins, Jillaine St.Michel, Kayla Smith, Rebecca Vincen-Brown, Emily Corrigan, M.D., Julie Lyons, M.D., and the Idaho Academy of Family Physicians and state as follows in support of their complaint for injunctive and declaratory relief:

INTRODUCTION

1. In the fifteen months since the Supreme Court overturned *Roe v. Wade*, Idaho's reproductive healthcare infrastructure has spiraled into crisis. A devastating combination of the most restrictive abortion laws in the country, predominantly rural geography, and an exodus of reproductive health care providers has left pregnant Idahoans with limited options for the basic healthcare they need to protect themselves and their families.

2. Idaho's abortion bans have sown confusion, fear, and chaos among the medical community, resulting in grave harms to pregnant patients whose health and safety hang in the balance across the state. While Idaho's abortion bans purport to contain "medical exceptions," these so-called exceptions simply do not function as such in practice. Instead, Idaho's interlocking abortion bans hinder and delay necessary obstetric care and make it nearly impossible for medical professionals to continue providing obstetric care in the state.

3. This is not hypothetical. Since *Roe* was overturned, obstetrician-gynecologists ("OB-GYNs") and maternal fetal medicine specialists ("MFMs") are resigning and leaving Idaho in droves. Of the nine MFMs practicing in Idaho before the abortion bans went into effect, four have already left the state and another intends to retire at the end of 2023. Two rural Idaho hospitals have closed their labor-and-delivery centers, with one directly attributing the closure to physicians' resignations over Idaho's restrictive abortion bans. Leaders of Idaho's major hospital systems and family practices alike are having difficulty hiring and retaining physicians. Prominent physicians are warning that Idaho's abortion bans are creating an extensive healthcare desert where both

maternal and infant mortality rates will spike. This collapse of Idaho's healthcare system will have spiraling effects not just for pregnant people, but the overall well-being of Idahoans more broadly.

4. Simultaneously, the Idaho Legislature has opted to cover up the measurable impact of its bans by allowing Idaho's Maternal Mortality Review Committee ("MMRC")—originally established by the legislature to identify, review, analyze, and share findings of maternal deaths in Idaho and to provide recommendations for prevention—to sunset in 2023. Idaho is now the only state in the country that does not systematically review data on maternal deaths.

5. Idaho's healthcare crisis is borne out by the real experiences of patients and their doctors. Plaintiffs Jennifer Adkins, Jillaine St.Michel, Kayla Smith, and Rebecca Vincen-Brown, as well as numerous other pregnant Idahoans, have been denied necessary and potentially life-saving obstetric care because, as Plaintiffs Dr. Emily Corrigan, Dr. Julie Lyons, and members of the Idaho Academy of Family Physicians attest, medical professionals throughout the state reasonably fear liability under Idaho's abortion bans.

6. Mrs. Adkins, already mom to a two-year old son, was 12 weeks pregnant when she learned that her baby had only a one percent chance of survival and that continuing her pregnancy could endanger her health or kill her. All she could think about was staying alive for her son, who was waiting for her at home. She was forced to seek abortion care in another state, which was only possible after receiving financial assistance from two abortion funds.

7. At Ms. St.Michel's routine 20-week ultrasound appointment, she learned that her baby's organ systems showed severe developmental conditions. She too was forced to travel out of state to receive what she determined to be the most compassionate care for her baby and the safest choice for her health.

8. During her first pregnancy, Mrs. Smith developed preeclampsia, a potentially life-threatening condition she worried would recur during her second pregnancy. Then at 19 weeks, she learned that her baby had a severe congenital heart condition that made survival after birth very unlikely. Mrs. Smith and her husband did not want their baby to experience any pain, and worried about Mrs. Smith's life because of her elevated risk of developing preeclampsia again. But her doctors said they could not provide her with the abortion care she needed, so Mrs. Smith was forced to travel out of state to protect her health and her family.

9. Ms. Vincen-Brown, her husband, and their two-year-old daughter were excited about growing their family when, at 16 weeks, she was told that her baby likely had a serious genetic condition and was unlikely to survive to birth. Moreover, carrying the pregnancy risked endangering her health. After being denied abortion care in Idaho, Ms. Vincen-Brown, her husband, and their daughter drove seven hours to a clinic in Oregon where she began the first step of a two-day procedural abortion. Ms. Vincen-Brown ultimately passed the pregnancy in the hotel bathroom as her daughter slept on the other side of the door.

10. All of the above-described women in this case wanted children, and all suffered unimaginable tragedy and health risks due to Idaho's abortion bans. Their experiences show that contrary to their stated purpose of furthering life, the bans endanger pregnant Idahoans, risking loss of fertility, injury, and even death.

11. Local newspapers and social media abound with other stories of abortion bans harming pregnant patients and their families, in Idaho and around the country. In every person's story, the same themes emerge: First, abortion is necessary health care. Second, Idaho's abortion bans are preventing pregnant Idahoans from receiving the medical care they need in times of crisis.

And third, pervasive fear and uncertainty throughout the medical community regarding the scope of the exceptions to abortion bans have put patients' lives and physicians' liberty at grave risk.

12. Plaintiffs file this Complaint for Declaratory Judgment and Injunctive Relief because uncertainty surrounding the exceptions to Idaho's abortion bans, codified at I.C. § 18-622(2) (the medical exception to the Total Abortion Ban) and I.C. § 18-8801(5) (the medical exception to the Six-Week Abortion Ban) (collectively, the "Medical Exceptions"), has caused and threatens to cause harm to Plaintiffs.

13. Idaho's "Trigger Ban" or "Total Abortion Ban", I.C. § 18-622, was enacted in 2020 and went into effect after *Roe v. Wade* was overturned in 2022. Until July 1, 2023, it prohibited abortion at all stages of pregnancy *without exceptions* and imposed felony criminal penalties of two to five years in state prison. While the Total Abortion Ban was amended to create an explicit exception for abortions necessary to prevent a pregnant woman's death beginning on July 1, 2023, it is unclear if the exception protects Idahoans like the patient plaintiffs here, for whom pregnancy poses serious threats to their health and safety, and that of their families.

14. A separate ban on abortion after six weeks is also in effect in Idaho, which imposes civil and felony criminal penalties for physicians and grants family members of the "preborn child" the ability to sue an abortion provider for thousands of dollars. Adding to the confusion, the medical exception to the Six-Week Abortion Ban conflicts with that of the Total Abortion Ban.

15. Facing the threats of losing their medical licenses, thousands of dollars in fines, and up to five years in prison, it is no wonder that doctors and hospitals in Idaho are turning patients away—even women in medical emergencies like Mrs. Adkins, Ms. St.Michel, Mrs. Smith, and Ms. Vincen-Brown.

16. Plaintiffs respectfully ask this Court for a declaratory judgment clarifying the scope of Idaho's Medical Exceptions, and granting any and all declaratory or injunctive relief necessary to protect the health and lives of pregnant people in Idaho.

JURISDICTION AND VENUE

17. This Court has original jurisdiction over this action under I.C. § 1-705.

18. Venue is proper in this Court under I.C. § 5-402 because the State of Idaho, the State Governor, and the State Attorney General are named as defendants in this action, and Ada County encompasses the capital city of Boise.

19. In addition, the State Capitol and center of State government is in Ada County, and the unconstitutional statutes, I.C. §§ 18-622, -8801, -8804, -8805 and -8807, that Plaintiffs complain about in this action were passed and enacted in Ada County.

20. This Petition challenges the Defendants' violation of:

i. the Idaho Constitution's protection of the inalienable rights to enjoy and defend life, pursue happiness, and secure safety, IDAHO CONST. Art. I, §§ 1, 13;

ii. the Idaho Constitution's guarantee of equal protection under the law, IDAHO CONST. Art. I, §§ 1, 2; and

iii. the Idaho Constitution's protection of the inalienable rights to "acquiring, possessing and protecting property," IDAHO CONST. Art. I, § 1, and guarantees that "[n]o person shall . . . be deprived of life, liberty, or property without due process of law," IDAHO CONST. Art. I, §13.

PARTIES

I. PLAINTIFFS

A. Jennifer Adkins

21. Mrs. Adkins is 31 years old and lives in Caldwell, Idaho.

22. Mrs. Adkins and her husband welcomed their first baby—a happy and healthy baby boy—in 2021. Mrs. Adkins' first pregnancy proceeded without incident under the care of both a midwife and an OB-GYN.

23. Mrs. Adkins learned she was pregnant again in February 2023, the day after Valentine's Day. Mrs. Adkins' due date was Halloween, so she and her husband began referring to their baby as "Baby Spooky."[1] They were very excited and expected that Mrs. Adkins would have the same experience as she did with her first pregnancy.

24. However, at Mrs. Adkins' routine 12-week ultrasound scan on April 21, 2023, she learned this pregnancy would be markedly different from her first.

25. Mrs. Adkins had previously worked as a veterinary technician and had some experience reading ultrasounds. She knew just from looking at the ultrasound screen that there was an unexpected amount of fluid in and around her baby's head. Her provider then performed a nuchal translucency screening via ultrasound, which measures the thickness of the tissue and amount of fluid around the baby's head to assess the risk of certain fetal conditions.

26. Immediately after her ultrasound, Mrs. Adkins was brought into an office to meet with a genetic counselor. An MFM also joined via Zoom. Together, the doctors told Mrs. Adkins that her ultrasound showed a high likelihood that her baby had Monosomy X, or Turner syndrome,

[1] This petition describes pregnancy using medical terminology, unless describing a particular patient's pregnancy, in which case, consistent with principles of medical ethics, it adopts the terminology preferred by the individual patient.

a rare chromosomal condition that affects female fetuses when one of the X chromosomes is deleted at conception. She was told that Turner syndrome occurs in 1% of all pregnancies, and accounts for 15% of all miscarriages.

27. The doctors explained that the ultrasound showed multiple signs of Turner syndrome. First, it showed increased nuchal translucency. The higher the nuchal translucency, the higher the chances of aneuploidy, or an atypical number of chromosomes. For example, a nuchal translucency of 5.5-6.4mm indicates a 50% chance of aneuploidy, and more than 8.5mm indicates a 75% chance of aneuploidy. Mrs. Adkins' baby had a nuchal translucency of 11.7mm. Although Down syndrome is a common condition associated with an increased nuchal translucency, the doctors explained that because Mrs. Adkins' ultrasound showed the baby's nasal bone was present, the doctors were able to rule out Down syndrome and conclude it was more likely that her baby had Turner syndrome. Second, the ultrasound showed evidence of edema, or severe swelling, which included hydrops fetalis, a condition where excess fluid develops in the baby's body, and a cystic hygroma, or fluid-filled sac that can occur in the head and neck area of a developing fetus. Mrs. Adkins was told these conditions have a high mortality rate, particularly when diagnosed within the first or second trimester.

28. All told, the doctors explained to Mrs. Adkins that her pregnancy was likely not viable. In fact, they expressed surprise that Mrs. Adkins had made it as far as 12 weeks into her pregnancy because Turner syndrome almost always results in early miscarriage. Mrs. Adkins' doctors said that even if she did not miscarry, there was a high likelihood that she would develop mirror syndrome—a life-threatening condition in which the pregnant person develops edema, as well as preeclampsia—if she continued to carry the pregnancy.

29. Mrs. Adkins understood that continuing the pregnancy would endanger her health and potentially her life. Mrs. Adkins needed to stay alive for her two-year-old son. She talked the diagnosis over with her husband, who agreed that abortion was necessary to protect her life and their family.

30. Mrs. Adkins told her doctors that she understood what the diagnosis meant for her. She knew about Idaho's abortion laws and was unsure about how to talk with her doctors about terminating her pregnancy. She asked whether, if the laws in Idaho were different, they would be offering her termination as an option. Her doctors confirmed that before *Roe* was overturned, they would have referred her to an abortion clinic in Boise. However, due to Idaho's abortion bans, they said they were afraid to refer her to any abortion provider, even one outside the state.

31. This meant Mrs. Adkins and her husband had to figure out their options on their own. Instead of grieving the diagnosis with her family, Mrs. Adkins spent the rest of the day calling abortion clinics in neighboring states. The closest out-of-state clinic to her provided abortion care up to only 10 weeks, so it was not an option. She eventually secured an appointment for around a week later in Portland, Oregon. But paying out of pocket for flights, a hotel, and the procedure would mean Mrs. Adkins and her husband could not pay their mortgage that month. Mrs. Adkins remembered seeing an Instagram post about an abortion fund that could provide financial assistance for out-of-state care, so she reached out to them.

32. In the meantime, Mrs. Adkins chose to have additional fetal testing to help confirm the Turner syndrome diagnosis. Mrs. Adkins was told that cell-free DNA (cfDNA) testing, also known as non-invasive prenatal testing (NIPT), could screen for the likelihood of several chromosomal conditions. She returned to the clinic several days later for the test. During this appointment, she also had another ultrasound to check if her baby still had a heartbeat. For the first

time, Mrs. Adkins hoped she would not see the familiar flicker of her baby's heartbeat on the screen, so she could get the care she needed in her home state. But her baby still had a heartbeat. At the end of her appointment, Mrs. Adkins' doctors sent her home with a miscarriage kit, so that if she started bleeding, she could collect a tissue sample to confirm her baby's diagnosis.

33. The days crawled by. While Mrs. Adkins waited to travel to her appointment in Oregon, she silently prayed that she would miscarry instead—something she never thought she would hope for.

34. Mrs. Adkins and her husband left their son with his grandparents and, using financial assistance from two abortion funds, traveled to Portland, Oregon on April 27, 2023. Mrs. Adkins felt incredibly lucky that her husband was able to travel with her, as many others facing similar situations are forced to travel alone.

35. The next day, Mrs. Adkins arrived at the clinic in Portland. Finally, Mrs. Adkins was able to receive the medical care she needed. The clinic staff showed her compassion, and her abortion procedure proceeded without incident. After the procedure, the clinic staff in Oregon provided Mrs. Adkins with a tissue sample, so that she could request diagnostic testing using the miscarriage kit that her Idaho doctors had given her.

36. In the weeks that followed, Mrs. Adkins and her husband received the results of the cfDNA test, which showed a 78% chance of Turner syndrome, and the diagnostic test from her miscarriage kit, which confirmed the Turner syndrome diagnosis.

37. Ultimately, Mrs. Adkins and her husband know that traveling to Oregon to get the abortion care that Mrs. Adkins needed was the right decision for their family. Mrs. Adkins felt loved and cared for at the abortion clinic in Oregon. But her journey there left her feeling like a refugee—forced to flee her home state for basic medical care. Mrs. Adkins was angry that Idaho's

laws added needless grief, delay, and risk to an already awful experience. She felt compelled to tell her story publicly.

38. Mrs. Adkins hopes to be pregnant again in the future. But she is anxious about becoming pregnant again in Idaho because of its abortion laws. She is also anxious that her hospital has lost its genetic counselor and will soon lose its last remaining MFM—leaving her with few to no in-state options for genetic counseling and high-risk pregnancy care should she need it again.

39. Mrs. Adkins' claims are capable of repetition but evading review. Mrs. Adkins sues on her own behalf.

B. Jillaine St.Michel

40. Ms. St.Michel is 37 years old and lives with her husband in Meridian, Idaho.

41. Ms. St.Michel and her husband have been married for eight years and have a two-and-a-half-year-old daughter. After giving birth to her daughter, Ms. St.Michel and her husband hoped to have a second child.

42. Around July 2022, Ms. St.Michel got a positive result on a home pregnancy test. She texted her husband that she had "very exciting" news for him. He immediately understood what she meant.

43. For the first few weeks, Ms. St.Michel's pregnancy went smoothly. She had less nausea, fatigue, and aches than she had experienced when carrying her daughter. At around eight weeks, she and her husband began attending routine obstetric appointments together.

44. On November 28, 2022, Ms. St.Michel attended her 20-week anatomy scan with an MFM. She went alone, intending to go straight to work afterward. At first, the sonographer was chatty and friendly, but soon fell silent. Ms. St.Michel is a chiropractor who is knowledgeable about human anatomy and while she was watching the ultrasound screen, she thought that

something did not quite seem right with her baby's arms. The sonographer completed the scan and told Ms. St.Michel that the MFM would review her ultrasound results and be in shortly to speak with her.

45. Ms. St.Michel waited for over 20 minutes, wondering why the MFM needed so much time to go over her ultrasound results.

46. The MFM finally entered the room, along with a genetic counselor. The MFM suggested that Ms. St.Michel call her husband to come in before they discussed the ultrasound results.

47. After her husband arrived, the MFM informed Ms. St.Michel and her husband that their baby had severe and rare genetic and developmental conditions impacting multiple organ systems. These included:

- Caudal regression sequence, a rare congenital condition located in the lower spinal segments and the neural tube, which can lead to incomplete closure of the skeletal bones around the spine;
- Contractures on the upper and lower extremities, which presented as undeveloped arm and leg bones;
- Bilateral echogenic intracardiac foci, or small bright spots seen on a developing fetus' heart during an ultrasound, which in Ms. St.Michel's baby's case, were correlated with serious cardiac conditions including an enlarged left atrium, a dilated inferior vena cava (a condition in which there is improper venous return of blood to the heart), ventricular septal defect (a hole between the left and right pumping chambers of the heart), and developmental issues in the curvature of the

aorta (which could indicate the fetus is unable to receive proper blood flow from the heart and therefore, low oxygen delivery to the tissues);

- A small thoracic (chest) circumference, which could indicate underdeveloped lungs, heart, and/or skeletal dysplasia, a developmental condition;
- Possible hydroureter, a condition when the ureter gets bigger than usual due to blockage that keeps it from emptying; and
- Cystic hygroma, described above, which is often associated with chromosomal conditions and can lead to miscarriage or stillbirth.

48. Ms. St.Michel's MFM explained that the severity, number, and combination of conditions affecting multiple organ systems rendered the pregnancy unlikely to reach full term and survive past birth.

49. Ms. St.Michel and her husband were shocked and devastated. The MFM told Ms. St.Michel she could carry the pregnancy to term and undergo further fetal imaging to evaluate the level of spinal cord involvement and associated conditions more precisely; confer with pediatric urology, cardiology, and orthopedic specialists; and receive subsequent palliative care for her baby. Or she could terminate the pregnancy.

50. As heartbroken as Ms. St.Michel and her husband were, they believed abortion was the most compassionate option for their baby and family. The MFM stated, however, that because of Idaho's abortion bans, they could not provide her abortion care. Ms. St.Michel was instead given a sheet of paper containing information about abortion clinics in nearby states.

51. Ms. St.Michel's husband picked up their daughter from daycare, and Ms. St.Michel spent the rest of the day holding their daughter close while her husband began calling out-of-state abortion clinics.

52. Some of the clinics on the list did not provide abortion care beyond 20 weeks and those that did had weeks-long waiting lists—which felt like an eternity to Ms. St.Michel. She could not bear going into work, day after day, knowing she needed to terminate her pregnancy because her baby would not survive. Thankfully, a clinic in Seattle, Washington was able to squeeze them in due to an appointment cancellation.

53. Within days, Ms. St.Michel and her husband had to find the money to pay for airplane tickets, a rental car, three nights of lodging, and incidentals on top of the high cost of the procedure itself. Ms. St.Michel's medical insurance plan covered abortion care, but her procedure was considered out-of-network because she needed to go out of state to receive it. Idaho's abortion bans meant she had to pay the otherwise insured cost of her medical care out of pocket.

54. On December 3, 2022, Ms. St.Michel underwent a dilation and evacuation (D&E) abortion.

55. Ms. St.Michel is currently pregnant again and is due to give birth in January 2024.

56. Ms. St.Michel's claims are capable of repetition but evading review. Ms. St.Michel sues on her own behalf.

C. Kayla Smith

57. Mrs. Smith is 31 years old and formerly lived in Nampa, Idaho.

58. Originally from Washington, Mrs. Smith moved to Idaho in 2010 to attend college. She met her husband shortly after she graduated, and they have been married for four years.

59. Mrs. Smith and her husband have a three-year-old daughter. Her first pregnancy was not without complications. Mrs. Smith developed preeclampsia, a serious condition involving increased blood pressure or hypertension, as well as high levels of protein in the urine. If left untreated, preeclampsia can lead to serious, even fatal, complications for both the pregnant person

and the developing fetus. During Mrs. Smith's first pregnancy, she had to be induced early at 33 weeks because her hypertension had resulted in intrauterine growth restrictions for her baby. At this stage in pregnancy, Mrs. Smith's doctors expected her daughter to weigh between 4.5 to five pounds, but Mrs. Smith's daughter barely weighed four pounds when she was born.

60. Mrs. Smith and her husband knew they wanted to have a second child and began trying to get pregnant after their daughter turned two. On Mother's Day 2022, she and her husband were overjoyed to learn they were expecting.

61. Mrs. Smith and her husband began attending prenatal appointments together. On advice of her obstetrician, Mrs. Smith began taking a low dose of aspirin to deter preeclampsia because, having developed preeclampsia during her first pregnancy, she was told she had an elevated risk of developing preeclampsia again.

62. A few weeks into her pregnancy, Mrs. Smith heard the news that the United States Supreme Court overturned *Roe v. Wade*. Her first thought was she hoped nothing would go wrong with her high-risk pregnancy.

63. Mrs. Smith's pregnancy progressed, and she and her husband learned they were having a boy. They were thrilled and named him Brooks. They began to refer to him as Baby Brooks in conversations with their daughter.

64. At 19 weeks, Mrs. Smith and her husband attended her ultrasound anatomy scan. Mrs. Smith's husband noticed the sonographer was quiet and kept returning over and over to views of the baby's heart.

65. After their scan, Mrs. Smith's obstetrician told them the ultrasound suggested their baby had both a serious heart condition and increased nuchal transparency. But the obstetrician could not say more without consulting specialists who could speak to Mrs. Smith and her husband

about the severity of the condition and conduct further testing. Mrs. Smith recalls feeling like she had been struck by lightning.

66. They saw an MFM the next morning—the same MFM Mrs. Smith had seen for her first pregnancy when she developed preeclampsia. The MFM performed another ultrasound and told them the baby had fetal critical aortic stenosis and hypoplastic left heart syndrome, a congenital heart condition where a fetus' left ventricle does not develop as it should, and as a result cannot pump adequate blood into the aorta. The ultrasound showed significant muscle death on the left side of the fetal heart. The MFM said she could not detect the aorta, as if it was not even there. The MFM told Mrs. Smith that, in all her years of practice, she had never seen a fetal heart condition this severe before and had never seen them combined this way.

67. Mrs. Smith's MFM had tears in her eyes as she explained their options: Mrs. Smith could continue to carry her pregnancy, and her doctors would refer her to pediatric cardiologists to consider potential medical interventions and arrange for palliative care. Or Mrs. Smith could have an abortion. But her MFM said that because of Idaho's abortion laws, the staff would not be able to do anything to help Mrs. Smith, or even refer her to an abortion clinic out of state.

68. Mrs. Smith's primary question was whether Baby Brooks could survive past birth. Her MFM referred her to a pediatric cardiologist, who reviewed Mrs. Smith's ultrasound and explained the potential medical interventions. There were some surgical procedures that could potentially help Mrs. Smith's baby, but they did not guarantee survival. Mrs. Smith and her husband would likely have to travel out of state to deliver Baby Brooks in a medical institution where he could be taken to surgery right away. And even if the surgeries were successful, there was no way to know for sure how his overall health could be impacted, or whether Baby Brooks could handle multiple surgeries so early in his life.

69. The pediatric cardiologist conferred with his colleagues, along with experts at prominent pediatric hospitals in Boston, Denver, and San Francisco to see if any of them could offer viable surgical procedures. Because of the severity of the baby's heart condition, not one pediatric cardiologist could confidently offer a viable surgical option. Mrs. Smith's doctors answered her primary question: no, Baby Brooks was unlikely to survive past birth.

70. Mrs. Smith and her husband did not want their baby to suffer. Even with palliative care, Mrs. Smith could not stand the thought of Baby Brooks gasping for air until his heart eventually gave out. She and her husband decided abortion was the care that she needed.

71. Mrs. Smith was also concerned for her own health if she continued her pregnancy. Because she had developed preeclampsia during her first pregnancy, she was told she had a 40% chance of developing preeclampsia again. She worried she might die and leave her daughter without a mother. Mrs. Smith and her husband knew that an abortion would not only spare Baby Brooks pain, but it would also protect Mrs. Smith and her ability to stay alive and healthy to raise their daughter.

72. Mrs. Smith and her husband decided to travel with their daughter to Washington state. Mrs. Smith grew up there, and had family who could watch their daughter while Mrs. Smith had her procedure.

73. On September 6, 2022, Mrs. Smith had an induction abortion at 21 weeks and delivered Baby Brooks stillborn after 12 hours of labor.

74. Mrs. Smith and her husband took out a personal loan of $16,000 to pay for Mrs. Smith's abortion—on top of the expenses related to travel. A local abortion fund and their family and friends helped pay some of the costs.

75. Ultimately, Mrs. Smith felt like she went through hell, and is still healing from the experience. Yet she and her husband still feel lucky they were able to leave the state and get the medical care they needed.

76. Mrs. Smith is pregnant again and is due to give birth later this fall. She recently found out that she and her husband are having another baby girl. Due to her concerns about the prospect of raising two daughters in Idaho, and what that means for their bodily autonomy and access to reproductive and maternal health care services when they are older, Mrs. Smith and her family recently moved to Washington. However, because Mrs. Smith and her family moved to a rural part of the state in the middle of her high-risk pregnancy, Mrs. Smith continues to receive medical care from her MFM in Boise. Additionally, Mrs. Smith and her family plan to return to Idaho frequently to visit family and friends.

77. Mrs. Smith's claims are capable of repetition but evading review. Mrs. Smith sues on her own behalf.

D. Rebecca Vincen-Brown

78. Ms. Vincen-Brown is 31 years old and lives in Ada County, Idaho.

79. Ms. Vincen-Brown and her husband have a two-year-old daughter and were eager to grow their family. In November 2022, they were overjoyed to learn that Ms. Vincen-Brown was pregnant.

80. At Ms. Vincen-Brown's initial prenatal appointments, everything looked good. Ms. Vincen-Brown and her husband opted to perform first trimester NIPT genetic testing as a standard precaution.

81. Then on February 7, 2023, when Ms. Vincen-Brown was 12 weeks pregnant, she learned from her OB-GYN that the results of her first NIPT testing were inconclusive due to a low

fraction of fetal DNA in Ms. Vincen-Brown's blood sample. Her OB-GYN explained the result indicated Ms. Vincen-Brown's baby could have one of three chromosomal conditions: triploidy, trisomy 13, or trisomy 18. Her OB-GYN recommended further testing.

82. Several days later, Ms. Vincen-Brown had a nuchal translucency ultrasound and consulted with an MFM and a genetic counselor. She was told that the ultrasound results were normal, so they recommended she redo the NIPT screening test.

83. On February 20, 2023, Ms. Vincen-Brown received a phone call from her genetic counselor who explained the results of the NIPT screening test were once again inconclusive. Like with the first test result, the second test result indicated a high risk for the same three chromosomal conditions, but the results were based on a low fetal DNA fraction.

84. At this point, Ms. Vincen-Brown had two options for further diagnostic tests: amniocentesis or an early anatomy ultrasound scan. Because Ms. Vincen-Brown was concerned with the risks associated with amniocentesis, she opted to schedule an early anatomy scan when she would be 16 weeks pregnant.

85. As she waited for her next ultrasound, Ms. Vincen-Brown worried for her baby but also for her own health. She had been lightly bleeding since the 12th week of her pregnancy, and as she waited, the bleeding continued.

86. On March 6, 2023, at 16 weeks, Ms. Vincen-Brown went in for her anatomy scan. At this appointment, she saw her whole care team—her OB-GYN, an MFM, and a genetic counselor. The ultrasound revealed there were a number of developmental issues with Ms. Vincen-Brown's baby: the baby was smaller than expected; there were developmental issues with the baby's right hand, jaw, and stomach; the baby's two kidneys seemed to have fused together, forming what is referred to as a horseshoe kidney; there were significant problems with the baby's

heart, which showed a smaller-than-expected axis, indicating that the baby may later develop atrioventricular canal defect, a condition where the heart's chambers and muscle wall do not fuse properly; and the baby's network of blood vessels in the brain had not properly attached to the ventricular wall running along the middle of the brain. According to Ms. Vincen-Brown's MFM, the results of the anatomy scan combined with the NIPT results suggested that her baby very likely had triploidy, a rare chromosomal condition that occurs when a fetus has 69, instead of 46, chromosomes, and which typically causes infant death soon after birth.

87. Ms. Vincen-Brown and her husband asked what options were available to them. Ms. Vincen-Brown's doctors explained that she could continue the pregnancy, but that it was likely she would miscarry. If she decided to continue her pregnancy, she risked developing preeclampsia or severe hemorrhaging, which would put her own health at risk. If the baby survived to birth, there might be some potential surgical interventions but the outlook was grim. The other option was to leave the state to terminate the pregnancy, as abortion was not available in Idaho for patients in her situation.

88. Ms. Vincen-Brown discussed the risks with her husband, and they opted to have an abortion. They worried about their baby's suffering as well as Ms. Vincen-Brown's health. Ms. Vincen-Brown wanted to be healthy and present for her two-year-old daughter. She and her husband also wanted to have more children in the future.

89. Ms. Vincen-Brown and her husband began researching their options out of state. They were able to make an appointment in Portland, Oregon for several days later, but because they could not obtain childcare, Ms. Vincen-Brown and her husband had to bring their daughter with them for the seven-hour drive to Portland.

90. The next morning, Ms. Vincen-Brown went to the abortion clinic to begin the dilation stage of her procedural abortion. She was sent back to her hotel and told to return the next day to complete her procedure.

91. That night, Ms. Vincen-Brown could not sleep for hours because she began to experience labor contractions. Her husband stayed awake with her and spoke on the phone with the on-call doctor for the abortion clinic to ask for advice. At 4 a.m., Ms. Vincen-Brown ultimately passed her pregnancy in the hotel bathroom. To help the bleeding stop, Ms. Vincen-Brown's husband performed several rounds of fundal massage on Ms. Vincen-Brown's stomach. They both had to be careful not to make any noise while their daughter slept.

92. Later that morning, Ms. Vincen-Brown returned to the abortion clinic so the doctors could examine her, make sure they removed any excess tissue, and ensure she was not at risk for infection. That same day, Ms. Vincen-Brown and her family drove the long way home.

93. Ms. Vincen-Brown and her husband grieved their loss in the following months, but they felt strongly that they made the right decision for their family. Following genetic testing of her pregnancy tissue, Ms. Vincen-Brown and her husband later received a triploidy diagnosis.

94. Ms. Vincen-Brown is currently pregnant again and is due to give birth to a baby girl next year. She continues to fear for her safety and that of her family as her pregnancy continues. She is also especially fearful for her two daughters' futures and access to reproductive and maternal health care when they are older.

95. Ms. Vincen-Brown's claims are capable of repetition but evading review. Ms. Vincen-Brown sues on her own behalf.

E. Emily Corrigan, M.D.

96. Plaintiff Emily Corrigan, M.D., is a board-certified Obstetrician-Gynecologist and Vice Chair of the Department of Obstetrics and Gynecology at a large tertiary care hospital which provides specialized health care services in Boise, Idaho. Dr. Corrigan has been a practicing OB-GYN for over 16 years. She is licensed to practice medicine in Idaho and has been practicing in the state since 2019. She is also the Idaho Section Chair of the American College of Obstetricians and Gynecologists.

97. Dr. Corrigan is a member of the Obstetric Hospitalist Group at her hospital, which is a team of OB-GYNs within the Labor and Delivery unit ("L&D") who manage patient care for pregnant patients in the hospital 24/7. She and her colleagues work 12- or 24-hour shifts to care for all patients arriving to L&D with pregnancy complications. In addition, they accept transports of patients from outlying hospitals that do not have the resources to care for them. Dr. Corrigan's facility is a regional trauma center and often cares for trauma patients who are pregnant. Dr. Corrigan and her colleagues often consult with specialists when determining appropriate medical care for their patients.

98. Dr. Corrigan has cared for thousands of pregnant people and delivered thousands of babies in her career. In the course of her work as an OB-GYN, and particularly as a doctor who works in a hospital, she has encountered numerous patients with a wide variety of obstetric and other pregnancy-related health complications. She specializes in and frequently cares for pregnant people with conditions including, but not limited to: second trimester miscarriage (the medical term is spontaneous abortion or "SAB"); preterm prelabor rupture of membranes ("PPROM"), a condition where a pregnant person's amniotic sac breaks prematurely; placental abruption; hemorrhaging caused by complications in pregnancy; preeclampsia; hyperemesis gravidarum;

lethal fetal conditions; traumatic injuries during pregnancy; and patients for whom maternal comorbidities create acute risks for continued pregnancy.

99. Before *Roe* was overturned and Idaho's abortion bans went into effect, Dr. Corrigan routinely treated patients with such pregnancy complications and, consistent with the standard of care, always provided them with necessary medical care to preserve their health—including abortion care. For example, Dr. Corrigan has provided abortion care in the hospital setting to patients with severe preeclampsia, placental abruption, and PPROM. Before *Roe* was overturned and Idaho's abortion bans went into effect, Dr. Corrigan and her colleagues routinely offered abortion care to such patients at the time their conditions were diagnosed, without waiting for signs of severe life-threatening symptoms like hemorrhage, infection, or seizures.

100. Over the past year, Dr. Corrigan's practice and that of her hospital colleagues has been drastically altered. Lack of clarity surrounding the exceptions to Idaho's abortion bans, coupled with the threats of criminal repercussions, licensure penalties, and civil liability, have impeded her and other physicians' ability to provide prompt, medically necessary, life-saving care. The result is that her patients' access to urgent abortion care is being delayed or even denied entirely at other institutions.

101. The impacts also ripple out to the other obstetric patients cared for by Dr. Corrigan and her team. The additional time Dr. Corrigan and her colleagues must spend conferring with hospital administration, legal counsel, and all other hospital staff involved in a particular patient's care about whether they are allowed to provide abortion care under Idaho's laws means time spent away from directly caring for their other patients.

102. Dr. Corrigan has personally struggled to understand what care she can still legally provide and what information regarding out-of-state care she can give to her patients. Dr. Corrigan

and her colleagues often treat patients with likely fatal fetal diagnoses. She is unsure when, if ever, such patients can receive an abortion under Idaho law. She also fears repercussions from the state if she provides information about the availability of out-of-state abortion care to such patients.

103. Dr. Corrigan fears that so long as Idaho's abortion bans remain in effect in their current form, her department will never be able to meet the demands of incoming patients and will continue to lose physicians.

104. Ultimately, Idaho's abortion bans and the lack of clarity regarding their Medical Exceptions have made it nearly impossible for Dr. Corrigan and her colleagues to do their jobs.

105. Dr. Corrigan sues on her own behalf and on behalf of her patients.

F. The Idaho Academy of Family Physicians

106. The Idaho Academy of Family Physicians ("IAFP") is a professional membership organization with 656 members, consisting of physicians, residents, and medical students. IAFP's physician and resident members practice medicine throughout Idaho. About 28% of its members practice medicine in rural areas.

107. Approximately one-third of IAFP's members provide obstetric care as part of their family medicine physician services. Although there are no obstetric residency programs in Idaho, all accredited family medicine programs in the state include training in obstetrics. Upon graduation, family physicians may opt to include obstetrics in their practice. Some family physicians, including IAFP member Dr. Nichole Aker, D.O., even complete an additional year of obstetrics fellowship training to better serve their patient population. Indeed, in rural areas of the

state, a significant portion of family medicine physicians provide obstetric care as part of their practice.[2]

108. The IAFP is committed to quality health care, education, and advocacy on behalf of Idaho's family physicians and their patients. To that end, the IAFP's mission is to advocate for family physicians and their patients through initiatives that improve the health of all Idahoans. To achieve this, the IAFP provides timely political and professional information to its members on issues affecting Idaho family physicians, advocates on behalf of Idaho family physicians with payers and policymakers, and engages in legislative advocacy on issues of concern to Idaho family physicians.

109. As part of its ongoing advocacy work, following the Idaho state legislature's passage of the Six-Week Abortion Ban in 2022, the IAFP joined its national counterpart, the American Academy of Family Physicians, in opposing laws and policies that "interrupt or interfere in the confidential relationship between a patient and their physician" because "patients must be able to rely on their physicians to assist them in making critical decisions about their personal health." The IAFP also expressed its support for policies and practices that protect patients and clinicians who provide medically necessary care, prevent private citizens from interfering in their members' patients' healthcare decisions, provide continued access to evidence-based comprehensive care and information, protect the integrity of the physician-patient relationship, and prevent government overreach and interference into this relationship. [3]

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[2] Ed Baker et al., *Rural Idaho family physicians' scope of practice*, 26 J. Rural Health 85 (2010), https://pubmed.ncbi.nlm.nih.gov/20105273/.

[3] *Idaho Academy of Family Physicians Statement on Protecting the Physician-Patient Relationship*, Idaho Academy of Family Physicians (Feb. 2022), https://idahofamilyphysicians.org/wp-content/uploads/2022/02/IAFP-Statement-on-Physician-Patient-Relationship_2.14.202293.pdf; *see also IAFP Statement in Response to the Supreme Court Decis*

110. Also in 2022, the IAFP formed a Reproductive Health Committee consisting of IAFP members tasked with reviewing evidence-based practices, educating IAFP members on reproductive health topics, and advocating for reproductive health access in Idaho. To date, the Committee has worked to mitigate the impact of Idaho's abortion bans by educating IAFP members about the laws, conducting outreach and education regarding EMTALA compliance, and advocating for the continuation, and now reinstatement of, Idaho's MMRC.

111. Since Idaho's abortion bans have been in effect, IAFP members have experienced and observed the myriad harms perpetuated by the laws. Because the bans lack clarity regarding how and when the Medical Exceptions apply, and because there are serious threats of criminal prosecution, civil liability, and licensing penalties for violating the bans, many IAFP members have been forced to alter the way they provide medical care to avoid legal consequences. This has resulted in harm to their patients and to the state's broader health care system. Even after the amendments to the Total Abortion Ban went into effect on July 1, 2023, IAFP members continue to experience harms.

112. First, IAFP members are unable to provide prompt abortion care when a pregnant patient's health is at risk due to pregnancy complications, including when a patient receives a diagnosis of a lethal fetal condition or experiences an obstetric emergency.

113. For example, Dr. Aker provides full-spectrum family medicine, including obstetric care, in Mountain Home, Idaho. As part of her practice, Dr. Aker regularly encounters patients

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ion on Roe v. Wade, Idaho Academy of Family Physicians (June 2022), https://idahofamilyphysicians.org/wp-content/uploads/2022/06/06-16-Roe-V-wade- ("The IAFP supports the evidence-based practice of medicine and opposes policies that criminalize the patient-physician relationship and inhibit the delivery of safe and timely comprehensive care.").

experiencing pregnancy complications, some of whom require immediate abortion care that Dr. Aker cannot provide due to the abortion bans.

114. Second, physicians do not understand what medical care they are allowed to provide to pregnant patients under the bans, and so are forced to delay or, in some cases, deny necessary medical care to these patients. Since the abortion bans have gone into effect, IAFP members have observed and experienced the impact of widespread physician confusion and fear around all manner of reproductive health care, not just abortion care.

115. For example, IAFP member and chair of IAFP's Reproductive Health Committee, Dr. Loren Colson, D.O., provides full-spectrum obstetric and gynecological care to his patients, including contraception, prenatal care, and vaginal deliveries. Because of the lack of clarity in Idaho's laws and physicians' inability to understand how to apply them in their medical practices, Dr. Colson has had to provide contraceptive and miscarriage management care to patients who were initially denied those services by other physicians out of confusion regarding the Medical Exceptions and fear of the abortion bans' penalties.

116. Even after the amendments to the Total Abortion Ban went into effect, this confusion and fear has persisted. Physicians' inability to navigate the abortion bans' Medical Exceptions has resulted in additional testing, which delays patient care and subjects patients to additional, potentially invasive, and medically unnecessary tests—all because physicians worry that their medical judgment and discretion can be questioned by law enforcement and other state entities tasked with enforcing Idaho's abortion bans. Furthermore, physicians now must over-document their medical reasoning, patient symptoms, and other relevant information to justify the provision of evidence-based medical care.

117. Third, many IAFP members are afraid to have open and frank conversations with their patients about the full spectrum of reproductive and maternal health care options available to them, including when a patient is experiencing a pregnancy complication. These IAFP members are concerned about their liability under Idaho's abortion bans if they counsel, provide referrals, or even speak with their patients about abortion as part of the full spectrum of care.

118. In addition to its commitment to advocating on behalf of its physician members and their patients, the IAFP is also committed to contributing to Idaho's broader healthcare system by promoting Family Medicine as the foundation of high-quality health care in the state. To achieve this, the IAFP supports: (1) continuing medical education and life-long learning with its physician members throughout Idaho, (2) graduate medical education in Idaho including the advancement of medical student interest, and (3) recruitment of family physicians to work in Idaho.

119. Since Idaho's abortion bans have been in effect, the quality of care that Idaho patients receive during pregnancy has declined. IAFP members have been forced to reckon with how Idaho's criminalization of medical care and mistrust for physicians' judgment, training, education, and expertise have begun to impact the state's healthcare workforce. Because Idaho's abortion bans impose serious penalties and lack clarity regarding how and when exceptions apply, some IAFP members have considered leaving the state to practice medicine elsewhere.

120. All of the above-described impacts on Idaho's already strained medical system are likely to worsen if the abortion bans, in their current form, remain in effect. A collapse of the system seems inevitable and will result in grave danger to all Idahoans needing any form of health care—not only those who may need abortion care in the future.

121. Because of IAFP members' experiences since the bans have taken effect, the IAFP believes that Idaho's abortion bans must be clarified and must include an exception in cases where

the pregnant patient's health is in danger. As written, the bans directly "impact . . . the practice of medicine for all medical professionals, including Family Physicians . . . putting patients' health at risk."[4]

122. The IAFP sues on behalf of itself, its members, and its members' patients.

G. Julie Lyons, M.D.

123. Plaintiff Julie Lyons, M.D., is a board-certified full-spectrum family physician and Chief of Staff of St. Luke's Wood River Medical Center in Hailey, Idaho, where she has worked since 2009. She is a member of the Idaho Academy of Family Physicians.

124. Dr. Lyons is licensed to practice medicine in Idaho and has been practicing in the state for over 17 years. In her practice, Dr. Lyons works with a team of four family physicians and two OB-GYNs to provide prenatal and obstetric care to patients in Blaine County and surrounding areas. Dr. Lyons cares for about 30 to 40 pregnant patients annually and dedicates roughly 50% of her practice to obstetrics and women's health care more broadly.

125. Dr. Lyons is also the Clinical Preceptor and former Site Director for medical students at the University of Washington School of Medicine's Washington, Wyoming, Alaska, Montana, and Idaho program, which brings students to Hailey every year to gain hands-on clinical experience with practicing physicians.

126. Since Idaho's abortion bans went into effect, Dr. Lyons' practice has experienced difficulties navigating the uncertainty and lack of clarity in the Medical Exceptions and ensuring compliance with the laws. As a result, their patients have been denied or delayed in accessing necessary medical care.

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[4] *Idaho's Abortion Laws Need Clarification*, Idaho Academy of Family Physicians (Winter 2023), https://idahofamilyphysicians.org/wp-content/uploads/2023/01/Idaho-Current-Abortion-Laws-1.pdf.

127. Even after the state legislature amended the Total Abortion Ban, Dr. Lyons' practice group has been forced to deny essential abortion care because the most recent clarifications in the law's Medical Exceptions do not capture the full scope of pregnancy complications that Dr. Lyons and her colleagues encounter.

128. Dr. Lyons and her colleagues have also had to navigate delays in accessing MFM specialist care for their patients since the abortion bans went into effect. They used to be able to rely on six MFMs in Boise—but now there are only four in St. Luke's entire hospital system. The resulting delays in accessing specialist care pose a danger to Dr. Lyons' patients' health. Delays in accessing specialist care means patients must wait to receive more information about a potential fetal condition or pregnancy complication, which in turn delays their ability to make an informed decision about whether to terminate their pregnancy. This pushes a patient further into pregnancy, potentially placing them outside the gestational limits of care offered by abortion clinics in nearby states. If pushed too far, patients would have to travel further to access the care they need or be completely prevented from accessing necessary abortion care.

129. Dr. Lyons' patients tend to have higher rates of prenatal complications and are more likely to develop high-risk pregnancies due to systemic barriers to health care access in rural areas. As long as the bans remain in effect, Dr. Lyons and her colleagues are thus likely to continue to see patients experiencing complications and may be forced to deny or delay necessary medical care to them in the future.

130. Further, Dr. Lyons' practice has had to navigate the lack of clarity in the abortion bans' Medical Exceptions and the resulting need to over-document the justifications for providing necessary medical care to pregnant patients to ward against arrest, criminal prosecution, or civil lawsuits for money damages. Compared to the period before *Roe* was overturned, Dr. Lyons and

her colleagues now spend more time documenting patient notes and running additional tests, screens, and labs than medically necessary. These additional hoops take time away from direct patient care, drive up overall costs for her patients who already struggle to make ends meet, and increase Dr. Lyons' chances of developing burnout.

131. Dr. Lyons sues on her own behalf and on behalf of her patients.

II. DEFENDANTS

132. Defendant the State of Idaho maintains the following statutes that prohibit abortion: the Total Abortion Ban, I.C. §§ 18-622; and the Six-Week Abortion Ban, I.C. §§ 18-8801, -8804, -8805; -8807. Defendant the State of Idaho is required to abide by the Idaho Constitution. *State v. Village of Garden City*, 74 Idaho 513, 524, 265 P.2d 328, 333 (1953).

133. Defendant Attorney General Raúl Labrador has the duty, "[w]hen required by the public service, to repair to any county in the state and assist the prosecuting attorney thereof in the discharge of duties." I.C. § 67-1401(7).

134. Defendant Governor of the State of Idaho, Brad Little, is responsible for ensuring that Idaho's "laws are faithfully executed," IDAHO CONST. Art. IV, § 5, which includes the Total Abortion Ban and the Six-Week Abortion Ban.

135. Defendant Idaho State Board of Medicine is charged with disciplining individuals licensed to practice medicine in Idaho who perform (or aid and abet the performance of) an unlawful abortion in violation of the Total Abortion Ban and/or the Six-Week Abortion Ban by suspending or revoking their medical licenses. I.C. §§ 18-8805(3), 54-1814(6).

FACTUAL ALLEGATIONS

I. Background

A. Abortion is Health Care

136. The American Medical Association ("AMA"),[5] the American College of Obstetricians and Gynecologists ("ACOG"),[6] the American College of Emergency Physicians ("ACEP"),[7] the Society for Maternal-Fetal Medicine ("SMFM"),[8] and the American Academy of

[5] The AMA clarifies, "physicians must have latitude to act in accord with their best professional judgment" and be "expressly permitt[ed] . . . to perform abortions in keeping with good medical practice." *AMA announces new adopted policies related to reproductive health care*, Am. Med. Ass'n (Nov. 16, 2022), https://www.ama-assn.org/press-center/press-releases/ama-announces-new-adopted-policies-related-reproductive-health-care. The AMA also provides, "Like all health care decisions, a decision to terminate a pregnancy should be made privately within the relationship of trust between patient and physician in keeping with the patient's unique values and needs and the physician's best professional judgment." Amendment to Opinion 4.2.7, Abortion H-140.823, CEJA Opinion, 4.2.7, Am. Med. Ass'n (2022), https://policysearch.ama-assn.org/policyfinder/detail/%224.2.7%20Abortion%22?uri=%2FAMADoc%2FHOD.xml-H-140.823.xml.

[6] ACOG, the nation's leading organization of physicians who provide health services to people seeking obstetric or gynecologic care, has the following prevailing policy on abortion: "All people should have access to the full spectrum of comprehensive, evidence-based health care. Abortion is an essential component of comprehensive, evidence-based health care." *Abortion Policy (Statement of Policy)*, ACOG (May 2022), https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/abortion-policy.

[7] ACEP highlighted the following in its letter to the U.S. Department of Veterans Affairs: "Because pregnancy termination is part of the medically indicated treatment to stabilize patients in certain emergency scenarios, physicians—to comply both with EMTALA and the principles of medical ethics—must, and do, consider abortion a necessary treatment option." *Re: Reproductive Health Services*, ACEP (Oct. 11, 2022), https://www.acep.org/siteassets/new-pdfs/advocacy/acep-response-to-va-reproductive-health-ifr-10.11.22.pdf.

[8] SMFM stated the following in its special statement on abortion care: "The medical literature is unequivocal, and no dispute exists within the medical community: abortion care is an essential component of comprehensive reproductive health care, and access to such care reduces pregnancy-related morbidity and mortality. Thus, abortion care is life-saving and life-sustaining." Cara C. Heuser, MD, MS, et al., *Society for Maternal-Fetal Medicine Special Statement: A critical examination of abortion terminology as it relates to access and quality of care*, SMFM, at B2 (Mar. 2023), https://www.ajog.org/article/S0002-9378(22)02580-7/pdf.

Family Physicians ("AAFP")[9] all recognize abortion as necessary health care. These major mainstream medical organizations believe that governmental interference into patient-physician relationships is contrary to the appropriate exercise of professional judgment that is necessary for medical professionals to care for their patients.

137. Idaho's bans are a classic example of this kind of governmental interference that results in grave harms to patients.

138. The medical definition of abortion is well understood as an intervention intended to terminate a pregnancy so that it does not result in a live birth.[10]

139. Although the medical treatment is generally the same, medical professionals may distinguish a "spontaneous abortion" or "miscarriage"—where the embryo or fetus has no discernable cardiac activity—from an "induced abortion"—where the embryo or fetus has cardiac activity.

140. In the United States, most abortions are accomplished by use of medications (medication abortion) or by an outpatient procedure (procedural abortion).

141. Medication abortions are typically indicated up to 11.0 weeks from the last menstrual period ("LMP"), and the standard method involves ingesting two medications to

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[9] AAFP's policy on Reproductive and Maternity Health Services is to "support[] access to comprehensive pregnancy and reproductive health services, including but not limited to abortion, pregnancy termination, contraception, and surgical and non-surgical management of ectopic pregnancy, and oppose[] nonevidence-based restrictions on medical care and the provision of such services. The AAFP believes pregnancy and reproductive health services are essential to general health care and should be covered under all insurance plans." *AAFP Policy on Reproductive and Maternity Health Services*, AAFP (Sept. 2022), https://www.aafp.org/about/policies/all/reproductive-maternity-health-services.html.

[10] *See, e.g.*, "Induced Abortion," reVITALize: Gynecology Data Definitions, ACOG, https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-gynecology-data-definitions.

terminate the pregnancy. The pregnancy is then expelled by vaginal bleeding, akin to a spontaneous abortion (commonly known as a miscarriage).

142. Procedural abortions are feasible throughout pregnancy and involve a two-step process where the medical provider first partially dilates the patient's cervix and then evacuates the uterus using suction aspiration, instruments, or some combination of the two. The evacuation phase of a procedural abortion is done the same day or a day or two after the dilation phase begins, and typically takes up to 10 minutes if done in the first trimester of pregnancy and less than 30 minutes if done during the second trimester.[11]

143. The other medically proven abortion method is induction abortion, where a physician uses medication to induce labor and delivery of a non-viable fetus. Induction of labor accounts for only about 2% of second-trimester abortions nationally. Induction abortions are usually performed in a hospital or similar facility that has the capacity to closely monitor a patient and provide adequate pain management (*e.g.*, intravenous pain medication or an epidural). Induction abortions can last anywhere from five hours to three days; are extremely expensive; and entail more pain, discomfort, medical risks, and recovery time for the patient—similar to giving birth—than procedural abortion.[12]

144. Mainstream medical professionals use the term "abortion care" to mean the treatment of a range of life and health circumstances of pregnant patients that require termination of a pregnancy. They understand that pregnant patients across the board, in consultation with their medical providers, should be able to choose the method of abortion to fit their circumstances.

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[11] *See The Safety and Quality of Abortion Care in the United States*, Nat'l Acads. of Sci., Eng'g, & Med. (Mar. 2018) Ch; 2 at 59–65, https://nap.nationalacademies.org/read/24950/chapter/4#54.

[12] *Id*. at 5–8, 66–68.

B. Pregnancies Pose Emergent Medical Risks to Pregnant People's Lives and Health

145. Medically unnecessary delays in access to abortion care always harm pregnant people. All pregnancy care, including abortion, is time sensitive. Yet pregnancy can lead to any number of emergent situations where especially prompt termination of pregnancy is necessary to preserve the life, health, and/or future fertility of the pregnant person. The American Board of Emergency Medicine ("ABEM") defines "emergent" conditions as cases where the "[p]atient presents with symptoms of an illness or injury that may progress in severity or result in complications with a high probability for morbidity if treatment is not begun quickly."[13]

146. ACOG highlights, "it is impossible to create an inclusive list of conditions that qualify" as emergent or emergencies and that it is "dangerous to attempt to create a finite list of conditions to guide the practice of clinicians attempting to navigate their state's abortion restrictions."[14] Indeed, "[t]he practice of medicine is complex and requires individualization—it cannot be distilled down to a one-page document or list that is generalizable for every situation; No single patient's condition progresses at the same pace; A patient may experience a combination of medical conditions or symptoms that, together, become life-threatening; Pregnancy often exacerbates conditions or symptoms that are stable in nonpregnant individuals; There is no uniform set of signs or symptoms that constitute an 'emergency'; Patients may be lucid and appear to be in stable condition but demonstrate deteriorating health."[15]

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[13] Michael S. Beeson et al., *The 2019 Model of the Clinical Practice of Emergency Medicine*, 59 J. of Emergency Med. 96, 97 (July 2020), https://www.jem-journal.com/article/S0736-4679(20)30154-2/fulltext.

[14] *Understanding and Navigating Medical Emergency Exceptions in Abortion Bans and Restrictions*, ACOG (Aug. 15, 2022), https://www.acog.org/news/news-articles/2022/08/understanding-medical-emergency-exceptions-in-abortion-bans-restrictions.

[15] *Id.*

147. Medical organizations, however, have described broad categories of types of conditions in pregnancy that are emergent.

148. For example, ABEM's Model of Clinical Practice of Emergency Medicine, the definitive source and guide to the content found on emergency physicians' board examinations, provides literature on "Complications of Pregnancy," "Complications of Labor," and "Complications of Delivery." Emergent conditions include: (1) conditions that can lead to dangerous bleeding or hemorrhage, including placental issues; (2) severe forms of hypertension; (3) conditions that can lead to dangerous infection, including PPROM; and (4) extreme hyperemesis gravidarum (dangerous nausea and vomiting leading to hospitalization).[16]

149. Hemorrhaging during pregnancy is particularly dangerous for patients, as it can lead to organ damage, organ failure, and even death. A variety of pre-existing chronic health conditions and health conditions that begin during pregnancy can become emergent due to the risk of hemorrhage. These conditions include but are not limited to placenta previa (where the placenta covers the cervix); placental abruption (where the placenta prematurely detaches from the uterine lining); placenta accreta (where the placenta grows into the uterine wall); uterine fibroids (which inhibit the uterus from contracting effectively and stopping bleeding from the placental implantation site); and other forms of first or second trimester bleeding.[17]

150. Severe forms of hypertension in pregnancy can also lead to life-threatening conditions. For example, preeclampsia is a pregnancy complication which, when severe, can cause seizures, injury to the pregnant person's liver and kidneys, stroke, and death. HELLP (Hemolysis, Elevated Liver Enzymes and Low Platelets) syndrome is a particularly dangerous form of

[16] *See* Beeson et al., *supra* at 110 n.13.

[17] *Practice Bulletin 183: Postpartum Hemorrhage*, ACOG (Oct. 2017), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2017/10/postpartum-hemorrhage.

preeclampsia. For some patients, other forms of hypertension (sometimes in conjunction with other conditions like obesity and diabetes) can increase in severity and cause the same complications seen with severe preeclampsia.[18]

151. Infection of the reproductive organs, which can lead to chorioamnionitis (infection of the placenta or amniotic fluid) or sepsis (where the body's response to infection damages its own tissue and organs), can cause a pregnant person's medical condition to become emergent. For example, premature dilation of the cervix dramatically increases a pregnant person's risk of infection and can be caused by conditions like an incompetent cervix (weak cervical tissue) and/or PPROM before labor. In the United States, PPROM has a relatively high incidence, occurring in approximately 2-3% of pregnancies, and is an emergent condition by itself due to the high risk of infection associated with it.[19] Because any delay in care carries a high risk of severe infection, patients with PPROM are generally offered prompt abortion care at the time of diagnosis.

152. Many other conditions pose special risks to pregnant patients because the treatment for those conditions is unsafe for the developing fetus while they are pregnant. Examples of such conditions include certain cancers requiring radiation, chemotherapy, transplants or other major surgery; and certain cardiac, autoimmune, respiratory, or endocrine diseases or conditions. Pregnant patients generally are not eligible for transplant surgery and thus may lose their only opportunity to receive life-saving care. Intentional acts of violence or accidents, *e.g.*, motor vehicle

[18] *See Practice Bulletin 222: Gestational Hypertension and Preeclampsia*, ACOG (June 2020), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/06/gestational-hypertension-and-preeclampsia; *Practice Bulletin 203: Chronic Hypertension in Pregnancy*, ACOG (Jan. 2019), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2019/01/chronic-hypertension-in-pregnancy.

[19] *See Practice Bulletin 217: Prelabor Rupture of Membranes*, ACOG (Mar. 2020), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/03/prelabor-rupture-of-membranes; Beeson et al., *supra* at 110 n.13 .

crashes, firearm violence, intimate partner violence, etc., and substance use disorder can also lead to emergent conditions. Because each patient's circumstances are unique, it is within the purview of the patient's medical provider to determine whether the patient's comorbidities and/or other circumstances make abortion part of the patient's recommended course of treatment.[20]

153. Additionally, mental health cannot be treated as distinct from a pregnant person's physical health.[21] Certain psychiatric conditions like bipolar disorder, major depressive disorder, anxiety disorders, and psychotic disorders can all be emergent, depending on the circumstances.

154. For example, in a recent challenge to Georgia's six-week abortion ban, the Chair of the Department of Psychiatry at the University of North Carolina's School of Medicine testified about a patient who came to her with debilitating postpartum psychosis, a condition related to bipolar disorder that is often characterized by delusional thinking, typically focused on the infant. This patient was still being treated for bipolar disorder when she learned she was pregnant. The patient was faced with the choice of stopping her medication during pregnancy and experiencing a worsening of her bipolar disorder or continuing her medication and exposing the fetus to serious teratogenic risks. As the physician explained, the patient was "terrified at the thought of experiencing postpartum psychosis again and potentially hurting her child or herself. This patient

[20] *See, e.g.*, *High-Risk Pregnancy*, Cleveland Clinic, (last updated Dec. 14, 2021), https://my.clevelandclinic.org/health/diseases/22190-high-risk-pregnancy (describing how certain preexisting conditions exacerbate the risks of the pregnancy); *Practice Bulletin 189: Nausea and Vomiting of Pregnancy*, ACOG (Jan. 2018), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/01/nausea-and-vomiting-of-pregnancy; Nicole T. Christian & Virginia F. Borges, *What* Dobbs *Means for Patients with Breast Cancer*, 387 New Eng. J. Med. 765 (Sept. 1, 2022).

[21] *About Mental Health*, CDC (Apr. 25, 2023), https://www.cdc.gov/mentalhealth/learn/index.htm; Kavitha Kolappa et al., *No physical health without mental health: lessons unlearned?*, 91 Bull. World Health Org. 3 (Jan. 1, 2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3537253/#R1.

told me repeatedly that she felt such overwhelming distress at the thought of continuing the pregnancy that she would rather die than go on."[22]

155. While U.S. studies show postpartum depression affects about 1 in 8 women, depression during pregnancy may be even more prevalent.[23] In fact, mental health conditions, including deaths by suicide and substance use disorder, became a leading underlying cause of pregnancy related deaths in 2017 to 2019, ahead of heart conditions, infections, and bleeding, according to the Centers for Disease Control and Prevention.[24]

156. Certain fetal conditions or diagnoses can also increase a pregnant person's health risks such that, when combined with the person's other comorbidities, their medical provider may determine that an abortion is necessary or recommended to prevent serious jeopardy to their health.

157. Neural tube conditions (including anencephaly); trisomies like trisomy 13 and 18 (the presence of an extra chromosome); triploidy; certain gastric and cardiac conditions in the fetus; acrania (the absence of a cranial vault and cerebral hemispheres) and Potter syndrome (where the fetus does not properly develop kidneys), are examples of conditions where the fetus either will not survive delivery or likely will not survive more than a few hours or days after birth.

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[22] Aff. of Samantha Meltzer-Brody, M.D. ¶¶ 40–41, *SisterSong Women of Color Reprod. Just. Collective v. Georgia*, No. 2022CV367796, 2022 WL 3335938 (Ga. Super. Ct. July 23, 2022).

[23] Brenda L. Bauman, MSPH et al., *Vital Signs: Postpartum Depressive Symptoms and Provider Discussions About Perinatal Depression — United States, 2018*, Morbidity & Mortality Weekly Report, CDC (May 15, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6919a2.htm?s_cid=mm6919a2_w; Lindsey Tanner, *Mental crises excluded from some state abortion exemptions*, AP News (Nov. 17, 2022), https://apnews.com/article/abortion-science-health-government-and-politics-arizona-fc2114ecfce72eeca65e21fb970ca62f.

[24] *Four in 5 pregnancy-related deaths in the U.S. are preventable,* CDC (Sept. 19, 2022), https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html; Tanner, *supra* note 23.

Abortion is generally indicated for these patients because it is typically medically safer than carrying the pregnancy to term and delivering an infant with no meaningful chance of survival.

158. Additionally, some fetal conditions pose acute risks to the pregnant person. For example, mirror syndrome is another emergent pregnancy complication where both the pregnant person and fetus experience severe fluid retention that can lead to death.

159. In cases of multiple pregnancies, a fetal condition in one or more of the fetuses, combined with the pregnant person's comorbidities, can lead to an emergent condition where selective abortion (sometimes called selective "fetal reduction" or "fetal termination") of one (or more) fetus is necessary to give the pregnant person and the remaining fetus(es) the best chance of survival.[25]

160. The discussion above highlights some of the emergent medical conditions necessitating prompt abortion care, but the list is by no means exhaustive, nor could it be. Mainstream medical associations emphasize that physician discretion to diagnose and treat emergent conditions is paramount to patient health. A list of emergent medical conditions necessitating prompt abortion care can never be exhaustive.

161. When a physician determines that such treatment includes abortion, the physician must be able to provide that treatment without fear that exercising their professional judgment will put them in prison, subject them to fines, and/or cause them to lose their medical license.

[25] *Practice Bulletin 231: Multifetal Gestations Twin Triplet and Higher-Order Multifetal Pregnancies*, ACOG (June 2021), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2021/06/multifetal-gestations-twin-triplet-and-higher-order-multifetal-pregnancies.

C. Idaho's Unfolding Maternal Health Crisis

162. As the Plaintiffs' experiences show, Idahoans are battling a maternal health crisis that, while already developing before the overturning of *Roe*, has skyrocketed over the last year. Health outcomes among pregnant people in the state are worsening, making the need for access to comprehensive reproductive healthcare, including abortion, more critical than ever.

163. According to Idaho's Idaho Maternal Mortality Review Committee (MMRC)[26], the state's Pregnancy-Related Mortality Ratio (PRMR)—a key indicator of the overall health and status of pregnant people in a given population—surged by over 200%, from 13.6 pregnancy-related deaths[27] per 100,000 live births in 2019 to a striking 41.8 deaths per 100,000 live births in 2020.[28] In 2021 (the most recent year for which data is available), Idaho's PRMR remained alarming at 40.1 deaths per 100,000 live births.[29]

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[26] *Maternal Mortality Review Committee*, Idaho Dep't of Health & Welfare, https://healthandwelfare.idaho.gov/about-dhw/boards-councils-committees/maternal-mortality-review-committee (last visited Sept. 4, 2023).

[27] The Idaho MMRC defines pregnancy-related death as "deaths reviewed and determined by Idaho's MMRC and defined as the death of a woman while pregnant or within 1 year of the end of a pregnancy – regardless of the outcome, duration, or site of the pregnancy – from any cause related to or aggravated by the pregnancy or its management, including deaths due to injury, accidental, or incidental causes." *2021 Maternal Deaths in Idaho Annual Report*, Idaho Dep't of Health & Welfare at 18 n.(v.) (June 2023) ("2021 MMRC Report"), https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=26443&dbid=0&repo=PUBLIC-DOCUMENTS.

[28] *2019 Maternal Deaths in Idaho Annual Report*, Idaho Dep't of Health & Welfare at 4 (Dec. 2021) ("2019 MMRC Report"), https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=20799&dbid=0&repo=PUBLIC-DOCUMENTS; *2020 Maternal Deaths in Idaho Annual Report*, Idaho Dep't of Health & Welfare at 5 (Dec. 2022) ("2020 MMRC Report"), https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=24216&dbid=0&repo=PUBLIC-DOCUMENTS.

[29] 2021 MMRC Report at 6.

164. Of the maternal deaths[30] reviewed by the MMRC from 2018 to 2021, an astounding 98% (all but one) were preventable.[31]

165. The MMRC also reported that mental health conditions were the most common underlying cause of pregnancy-related deaths between 2018 and 2021.[32] This includes deaths related to suicide and substance use disorders[33] (which can be extremely challenging to treat during pregnancy[34]).

166. Other common underlying causes of pregnancy-related death included infection, neurologic/neurovascular conditions, pulmonary conditions, cardiovascular conditions, and hypertensive conditions which are considered emergent or may become emergent during pregnancy.[35]

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[30] "Maternal death" or pregnancy-associated death is the death of a woman from any cause during pregnancy or within one year following the end of the pregnancy. (May be related or unrelated to pregnancy). *Id*. at 5.

[31] *2018 Maternal Deaths in Idaho Annual Report*, Idaho Dep't of Health & Welfare at 19 (Jan. 2021) ("2018 MMRC Report") https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=16014&dbid=0&repo=PUBLIC-DOCUMENTS; 2019 MMRC Report at 16; 2020 MMRC Report at 19–20; 2021 MMRC Report at 22–23.

[32] 2021 MMRC Report at 49.

[33] 2018 MMRC Report at 17; 2019 MMRC Report at 15; 2020 MMRC Report at 5; 2021 MMRC Report at 6.

[34] For example, pregnant patients using certain medications to treat mental health conditions risk fetal medication exposure that may result in serious conditions that can impact the development of fetal organ systems. *Pregnancy and Mental Health*, Stanford Medicine (last visited Aug 11, 2023), https://med.stanford.edu/womensneuroscience/wellness_clinic/Pregnancy.html#risks_of_fetal_medicationexposure; *see also* Linda H. Chaudron, *Complex Challenges in Treating Depression During Pregnancy*, 170 Am. J. Psychiatry 12 (Dec. 2013); Richard A. Epstein et al., *Treatment of bipolar disorders during pregnancy: maternal and fetal safety and challenges*, Drug, Healthcare & Patient Safety 7 (Dec. 2014). In addition, patients with substance use disorders may avoid seeking treatment due to a fear of criminalization. Nora Volkow, *Pregnant People With Substance Use Disorders Need Treatment, Not Criminalization,* Nat'l Institute on Drug Abuse (Feb. 15, 2023), https://nida.nih.gov/about-nida/noras-blog/2023/02/pregnant-people-substance-use-disorders-need-treatment-not-criminalization.

[35] 2021 MMRC Report at 49.

167. Severe Maternal Morbidity (SMM)—defined as "unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health"[36]—is also a crucial indicator of maternal health in a population. Although Idaho's MMRC acknowledges that SMM is "100 times more common than a pregnancy-related death," it has not reported any findings on SMM rates in the state.[37] Idaho is also one of only two states in the nation that did not provide any data for an independent study of U.S. SMM rates.[38]

168. Accessing quality healthcare throughout one's pregnancy poses a significant challenge for many Idahoans. A 2022 report from the Association of American Medical Colleges found that Idaho ranked the lowest for the overall number of active physicians out of any U.S. state, with just 196.1 physicians per 100,000 population.[39] Another 2022 University of Washington (UW) report found that there were a mere 9.7 obstetrician-gynecologists (OB-GYNs) and 4.9 psychiatrists per 100,000 people in Idaho.[40]

169. This is not a new problem. As far back as 2013, the state's own Labor Department statistics showed Idaho had the lowest overall patient to primary care provider ratio, lowest psychiatrist to patient ratio, and 47th lowest OB-GYN to patient ratio out of 50 states (and D.C.).[41]

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[36] *Id*. at 9.

[37] *See id.*

[38] Ashley H. Hirai et al., *Trends in Severe Maternal Morbidity in the US Across the Transition to ICD-10-CM/PCS From 2012-2019*, 5(7) JAMA Open Network (July 28, 2022), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2794738. ("Alabama and Idaho were the only states that did not contribute any data during the study period").

[39] *2021 State Physician Workforce Data Report*, Ass'n of Am. Med. Coll. 4, 6-7 (Jan. 2022), https://www.aamc.org/data-reports/workforce/report/state-physician-workforce-data-report.

[40] Arati Dahal & Susan M. Skillman, *Idaho's Physician Workforce in 2021*, Univ. of Wash., Ctr. for Health Workforce Stud. 3 (July 2022), https://familymedicine.uw.edu/chws/wp-content/uploads/sites/5/2022/08/Idaho_Physicians_FR_July_2022.pdf.

[41] Cheryl Foster, *Idaho Primary Care Physicians*, Idaho Dep't of Lab. 6, 64-68 (2013),

And as discussed *infra* at Section III.B, the number of MFMs in Idaho has plummeted since *Roe* was overturned.

170. Provider shortages disproportionately affect pregnant people living in rural areas, which constitute around 80% of Idaho's counties.[42] For example, the UW report found that while there were 11.1 OB-GYNs per 100,000 people in Idaho's urban areas, there were only 6.6 per 100,000 people in rural areas.[43] Additionally, every one of the 47.7% of Idaho counties that are "maternity care deserts," where obstetric care services are absent or severely limited, are rural.[44]

171. Poverty is also a major barrier to healthcare access in Idaho—one that disproportionately impacts women, people of color, and other marginalized groups. According to the Census Bureau, an estimated 12.1% of Idaho's women live in poverty compared to 9.9% of men.[45] And an estimated 27.6% of Black Idahoans, 22.9% of American Indian and Alaskan Native Idahoans, and 12.1% of Asian Idahoans live in poverty compared to 10.2% of white Idahoans.[46] Furthermore, around 10.6% of Idahoan women of reproductive age and a shocking 21.4% of

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https://www.labor.idaho.gov/wp-content/uploads/publications/physicians_whitepaper.pdf (Overall, Idaho had just 88.9 primary care physicians per 100,000 population. The state also had a mere 9.4 OB-GYNs, 8.9 pediatricians, and 6.3 psychiatrists per 100,000 population.)

[42] *Rural Health and Underserved Areas*, Idaho Dep't of Health & Welfare, https://healthandwelfare.idaho.gov/providers/rural-health-and-underserved-areas/rural-health-and-underserved-areas (last visited Sept. 3, 2023).

[43] Dahal & Skillman, *supra* at 4 n.40.

[44] Christina Brigance, MPH, et al., *Nowhere to Go: Maternity Care Deserts Across the U.S.*, March of Dimes 6 (2022), https://www.marchofdimes.org/research/maternity-care-deserts-report.aspx (identifying Benewah, Shoshone, Clearwater, Lewis, Adams, Valley, Custer, Boise, Payette, Butte, Clark, Fremont, Teton, Camas, Gooding, Lincoln, Minidoka, Power, Oneida, Franklin, and Owyhee Counties as maternity care deserts based on 2020 data); *Rural Health and Underserved Areas*, *supra* note 42.

[45] *American Community Survey S1701: Poverty Status in the Past 12 Months*, U.S. Census Bureau, https://data.census.gov/table?q=idaho+poverty+&tid=ACSST1Y2021.S1701 (last visited Sept. 4, 2023).

[46] *Id*.

Idahoan women ages 18 to 64 living in poverty are uninsured, making it one of the lower ranking states for insurance rates among poor women.[47] Idaho also remains one of the few remaining states in the country that have refused to expand postpartum Medicaid coverage from a mere 60 days to 12 months.[48]

172. The MMRC reports end with several recommendations to improve the state's poor maternal health outcomes. These include expanding Idaho's Medicaid coverage for pregnant women to 12 months postpartum, regardless of pregnancy outcome; allocating state funds to establish a Statewide Perinatal Quality Collaborative; increasing funding and support for social services; investing in resources and programs that assist people with the transition from pregnancy to the postpartum period; increasing access to primary care providers to help prevent delays in Idahoans accessing care and treatment; providing access to a licensed psychiatrist for patients diagnosed with mental health conditions; and removing the sunset date on Title 39, Chapter 96, so that the MMRC can continue."[49]

173. To date, the State of Idaho has not fully implemented or has simply ignored several of these crucial MMRC recommendations.

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[47] *Health Insurance/Income* (*Uninsured women: Idaho, 2011- 2021)*, March of Dimes (Dec. 2020), https://www.marchofdimes.org/peristats/data?reg=99&top=11&stop=158&lev=1&slev=4&obj=1&sreg=16; *An Ecosystem of Minority Health and Health Disparity Resources ("Idaho Insurance – Table: Percent Uninsured, 138% Poverty")*, Nat'l Inst. of Minority Health& Health Disparities, https://hdpulse.nimhd.nih.gov/data-portal/healthcare/table?healthcaretopic=040&healthcaretopic_options=healthcare_3&demo=00043&demo_options=insurance_12&race=00&race_options=raceall_1&sex=2&sex_options=sex_3&age=174&age_options=age_4&statefips=16&statefips_options=area_states (last visited Sept. 11, 2023).

[48] Matt Volz, *More states OK postpartum Medicaid coverage beyond two months*, Idaho Cap. Sun (June 3, 2023), https://idahocapitalsun.com/2023/06/03/more-states-ok-postpartum-medicaid-coverage-beyond-two-months/.

[49] 2020 MMRC Reports at 25–26; 2021 MMRC Report at 29.

174. Instead, Idaho's legislature has chosen to abolish the MMRC, refusing to renew the Committee's mandate to document and investigate maternal deaths in the state.

175. On July 1, 2023, Idaho became the only state without a legal requirement or specialized committee to review maternal deaths related to pregnancy. This decision coincided with Idaho legislators' decision to not expand postpartum Medicaid coverage.[50]

176. The legislature's decision to sunset the MMRC is sure to further obscure the drivers of maternal mortality and morbidity in the state, particularly following the overturning of *Roe v. Wade*. It will conceal the harms Idaho's abortion bans are having on pregnant people, women, people of color, people with disabilities, people living in poverty, and members of other marginalized groups. This will make it harder, if not impossible, to first document and then address the state's rapidly worsening maternal health outcomes.[51]

II. Idaho's Abortion Laws

A. Historical Criminalization of Abortion in Idaho

177. Since its territorial days, Idaho has a long and uninterrupted history of allowing physicians to provide abortion care in cases of medical need. Indeed, over the course of 160 years, when Idaho has criminalized or regulated abortion care, it has always done so with an exception to "save" or "preserve" the life of the pregnant person. *See Planned Parenthood Great Nw. v. State*, 171 Idaho 374, 522 P.3d 1132, 1149–52 (2023).

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[50] Natalie Schachar, *As US maternal mortality rates surge, Idaho abandons panel investigating pregnancy-related deaths*, Idaho Cap. Sun (June 30, 2023), https://idahocapitalsun.com/2023/06/30/as-us-maternal-mortality-rates-surge-idaho-abandons-panel-investigating-pregnancy-related-deaths/.

[51] *See* Randi Kaye & Stephen Samaniego, *Idaho's murky abortion law is driving doctors out of the state*, CNN (May 13, 2023), https://www.cnn.com/2023/05/13/us/idaho-abortion-doctors-drain/index.html.

178. The inaugural session of the legislative assembly for the Territory of Idaho, which first convened in 1863, enacted Idaho's first abortion ban. The law criminalized the procedure except when a physician, "in the discharge of his professional duties," "deem[ed] it necessary . . . in order to save the woman's life." Act of Feb. 4, 1864, ch. IV, § 42, 1863–64 Idaho Terr. Sess. Laws 443.

179. The next year, the assembly re-enacted the very same law, adopting the same exception for cases where the physician deemed abortion to be necessary to save the life of the pregnant person. Act of Dec. 23, 1864, ch. III, § 42, 1864 Idaho Terr. Sess. Laws 305. Idaho adopted the same language repeatedly in the decade that followed, with minimal changes. *See* Act of Jan. 14, 1875, ch. IV, § 42, 1874–75 Idaho Terr. Sess. Laws 328.

180. In 1887, the assembly changed the prohibition by swapping out "save" in favor of "preserve" for the life exception, Act of June 1, 1887, ch. III §§ 6794, 6795, 1887 Idaho Terr. Sess. Laws 734–35, thus continuing to allow abortions when "necessary to preserve [the] life" of the pregnant person. *Id.*

181. After Idaho achieved statehood in 1890, a period of revisions and amendments of Idaho's laws followed, H.R. J. Idaho, 1st Sess. 1–221 (Dec. 8, 1890, to Mar. 14, 1891); Sen. J. Idaho, 1st Sess. 1–222 (Dec. 8, 1890, to Mar. 14, 1891), but the criminal abortion laws *and their exceptions* continued—and they remained the same for another 18 years.

182. In the decades that followed, as Idaho periodically compiled and recodified its laws, the criminal abortion laws *and their exceptions* remained substantially the same. *See* Idaho Rev. Code (R.C.) §§ 6794, 6795 (1909); Idaho Comp. Stat. (C.S.) §§ 8281, 8282 (1919); I.C. §§ 17-1810, 17-1811 (1932); I.C. §§ 18-601, 18-602 (1947).

183. It was not until after the United States Supreme Court's decision in *Roe v. Wade*, 410 U.S. 113 (1973), that the Idaho Legislature repealed its criminal abortion laws and enacted abortion regulations—including a trigger provision that would enact, "in the event that the states are again permitted to safeguard the lives of unborn infants before the twenty-fifth week of pregnancy," and a ban on abortion except when, based on the professional judgment of the physician, an abortion is "in the best medical interest" of the pregnant person. S.B. 1184, 1973 Idaho Sess. Laws ch. 197 §§ 1, 7, 14.

184. In 1973, the Idaho Legislature enacted a law allowing physicians to provide abortions during the first and second trimesters of pregnancy after considering factors that "in his medical judgment he deems pertinent, including, but not limited to physical, emotional, psychological and/or familial factors, that the child would be born with some physical or mental defect, that the pregnancy resulted from rape, incest or other felonious intercourse, . . . the patient's age and any other consideration relevant to her well-being or directly or otherwise bearing on her health and, in addition to medically diagnosable matters." S.B. 1184, 1973 Idaho Sess. Laws ch. 197 § 7.[52]

185. Further, the same law allowed abortions in the third trimester if "in the judgment of the attending physician, corroborated by a like opinion of a consulting physician concurring therewith, either is necessary for the preservation of the life of such woman or, if not performed, such pregnancy would terminate in birth or delivery of a fetus unable to survive." *Id*.

186. In the years that followed, the Idaho Legislature enacted additional bans—but always included exceptions for the life and health of the pregnant person. For example, in 1998,

[52] This language was struck only recently, in 2022. *See* H.B. 521, 2022 Idaho Sess. Laws ch. 177 (amending I.C. § 18-608(1)).

the Idaho Legislature enacted a ban on a specific method of abortion care more common in later stages of pregnancy but ensured that it "shall not apply to . . . abortions necessary to save the life of the mother when her life is endangered by a physical disorder, illness, or injury." H.B. 576, 1998 Idaho Sess. Laws ch. 34 (establishing I.C. § 18-613). Later in 2011, the Idaho Legislature enacted a ban on abortion beginning at 20 weeks LMP "unless, in reasonable medical judgment," the pregnant person "has a condition that so complicates her medical condition as to necessitate the abortion of her pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions." S.B. 1115, 2011 Idaho Sess. Laws ch. 152 (establishing I.C. § 18-8505).

B. The Total Abortion Ban

187. It was against this backdrop that the Idaho legislature in 2020 deviated from over a century of precedent to enact a total abortion ban with *no exceptions at all*. S.B. 1385, 2020 Idaho Sess. Laws ch. 284 (codified at I.C. § 18-622(2) (2020)) (the "Trigger Ban" or "Total Abortion Ban").

188. The Total Abortion Ban made it a felony to "perform[ ] or attempt[ ] to perform an abortion" at any stage of pregnancy. *Id.* It relied on a pre-existing definition of abortion as "the use of any means to intentionally terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child." S.B. 1385, 2020 Idaho Sess. Laws ch. 284 (codified at I.C. § 18-622(2) (2020). "[P]regnancy" is then defined as "the reproductive condition of having a developing fetus in the body and commences with fertilization." I.C. § 18-604(11). While there is no express definition, it is generally understood that in the context of Idaho's definition of abortion, "death" means that there is no cardiac activity present in the embryo or fetus.

189. Violation of the Total Abortion Ban is punishable by at least two but not more than five years in state prison for each offense, suspension of professional licensure for a minimum of six months for the first offense, and permanent revocation of professional licensure for any subsequent offense. I.C. § 18-622(1).

190. When it was first enacted in 2020, there were no exceptions to the Total Abortion Ban, including no exceptions for cases of rape, incest, fatal fetal conditions, or to preserve the life and/or health of the pregnant person. *See* S.B. 1385, 2020 Idaho Sess. Laws ch. 284 (codified at I.C. § 18-622(2) (2020)).

191. Instead, the original Total Abortion Ban created an affirmative defense, applicable only when "the physician determined, in his good faith medical judgment and based on the facts known to the physician at the time, that the abortion was necessary to prevent the death of the pregnant woman" and thus "performed or attempted to perform the abortion in the manner that, in his good faith medical judgment and based on the facts known to the physician at the time, provided the best opportunity for the unborn child to survive, unless, in his good faith medical judgment, termination of the pregnancy in that manner would have posed a greater risk of the death of the pregnant woman." S.B. 1385, 2020 Idaho Sess. Laws ch. 284 (codified at I.C. § 18-622(3)(a)(i)–(iii) (2020)).

192. An affirmative defense also applied in cases where the pregnancy was the result of rape or incest, but only if the pregnant person "has reported the act of rape or incest to a law enforcement agency and provided a copy of such report to the physician who is to perform the abortion," or, if the pregnant person is a minor, only if the minor or the minor's parent or guardian "has reported the act of rape or incest to a law enforcement agency or child protective services and a copy of such report has been provided to the physician who is to perform the abortion." S.B.

1385, 2020 Idaho Sess. Laws ch. 284 (codified at I.C. § 18-622(3)(a)(i)–(iii), (3)(b)(i)–(iv) (2020)).

193. The only qualifier of the affirmative defense is that: "No abortion shall be deemed necessary to prevent the death of the pregnant woman because the physician believes that the woman may or will take action to harm herself." S.B. 1385, 2020 Idaho Sess. Laws ch. 284 (codified at I.C. § 18-622(3)(a)(ii) (2020)).

194. The bill's sponsor, Idaho Senator Todd Lakey, was clear in stating that, in writing this bill, the health of pregnant people was secondary to that of their "unborn children."[53]

195. The Total Abortion Ban did not take effect immediately. Instead, the law was set to "become effective thirty (30) days following . . . [t]he issuance of the judgment in any decision of the United States [S]upreme [C]ourt that restores to the states their authority to prohibit abortion," S.B. 1385, 2020 Idaho Sess. Laws ch. 284, sec. 1 (codified at I.C. § 18-622(1)(a) (2020)).

196. Following the issuance of judgment in *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022), which overturned *Roe v. Wade*, the Total Abortion Ban went into effect two months later, on August 25, 2022.

197. While several state's trigger bans went into effect in the summer of 2022, only two of the states whose laws took effect—Idaho and Tennessee—contained no explicit exceptions.

198. In response to the impending effective date of Idaho's Total Abortion Ban, the United States filed a lawsuit alleging that Idaho's extreme abortion ban conflicted with certain requirements of the federal Emergency Medical Treatment and Labor Act (EMTALA) by

[53] Keith Ridler, *Idaho governor OKs bill outlawing abortion if Roe reversed*, AP (Mar. 27, 2020), https://apnews.com/article/03127ebfbf23ddf00e2e5458eb3144ce.

prohibiting abortions that, under federal law, must be provided in certain hospital emergency rooms in certain emergency situations. On August 24, 2022, a federal court enjoined Idaho from enforcing its abortion bans to the extent they conflict with EMTALA-mandated care. *United States v. Idaho*, 623 F. Supp. 3d 1096 (D. Idaho 2022), *reconsideration denied*, No. 1:22-CV-00329-BLW, 2023 WL 3284977 (D. Idaho May 4, 2023); 42 U.S.C.A. § 1395dd.

199. While this limited injunction remains in place for now, Idaho's Total Abortion Ban is still enforceable in all other instances, including for medical situations and at medical centers that are not subject to EMTALA.

C. Amendments to the Total Abortion Ban

200. When Idaho's Total Abortion Ban took effect, reproductive healthcare was immediately thrown into chaos as physicians struggled to provide appropriate care to their obstetric patients.

201. By contrast, many anti-abortion organizations celebrated, calling Idaho's abortion ban "the strongest in the nation."[54] Some anti-abortion politicians even advocated for *stricter* abortion laws: Idaho Lieutenant Governor Janice McGeachin called on Governor Brad Little to call a special session of the Legislature to eliminate the affirmative defense altogether;[55] and the

[54] Carolyn Komatsoulis, *Many 'pro-life' activists want exceptions for life of the mother, counter to Idaho GOP platform*, KTVB7 (July 31, 2022). https://www.ktvb.com/article/news/local/idaho-press/pro-life-activists-want-exceptions-for-life-of-the-mother-countering-idaho-gop-platform/277-c6e589cf-1362-46b1-b252-b8375b368629.

[55] Betsy Z. Russell, *McGeachin calls for special session to remove all exceptions from abortion 'trigger law,'* Idaho Press (May 22, 2022), https://www.idahopress.com/elections/mcgeachin-calls-for-special-session-to-remove-all-exceptions-from-abortion-trigger-law/article_cc0b8c1f-aae9-5bf2-b61a-fdab661b8d90.html.

Idaho Republican Party voted to eliminate all defenses and exceptions in favor of an absolute ban on abortion.[56]

202. In advance of the 2023 legislative session, John Werdel, M.D., medical director of women's services at St. Luke's Medical Center in Boise, expressed that, under the Total Abortion Ban, providers felt "terrified" and were "constantly second-guessing their decisions," and urged the state legislature to amend the Total Abortion Ban to "allow for appropriate and medically necessary exceptions in the cases of terminations."[57]

203. As the 2023 legislative session began, potential amendments to the Total Abortion Ban were introduced with the purported aim of clarifying the law and easing physicians' fears.

204. On March 20, 2023, State Representative Megan Blanksma, lead House sponsor of the Total Abortion Ban in 2020, introduced H.B. 342—a bill drafted in consultation with the Idaho Medical Association.[58] Among other changes, the bill sought to convert the ban's affirmative defenses into standard exceptions and amend the Total Abortion Ban's definition of abortion to exclude the treatment of an ectopic or molar pregnancy, treatment of a person who is no longer pregnant, and removal of a "dead unborn child."[59] It also attempted to introduce an exception

[56] Komatsoulis, *supra* note 54.

[57] John Werdel, Commentary, *Change is needed in Idaho's abortion laws before it is too late*, Idaho Cap. Sun (Mar. 7, 2023), https://idahocapitalsun.com/2023/03/07/change-is-needed-in-idahos-abortion-laws-before-it-is-too-late/.

[58] House Bill 342, 67th Idaho Leg. Reg. Sess. (2023), https://legislature.idaho.gov/sessioninfo/2023/legislation/h0342/ (last visited Sept. 4, 2023); Kelcie Moseley-Morris, *Idaho legislators pass contentious bill that adds clarification language to abortion ban*, Idaho Cap. Sun (Mar. 29, 2023), https://idahocapitalsun.com/2023/03/29/idaho-legislators-pass-contentious-bill-that-adds-clarification-language-to-abortion-ban/.

[59] House Bill 342, *supra* note 58, at sec. 1.

allowing physicians "to treat a physical condition of the woman that if left untreated would be life-threatening."[60]

205. In response, the Idaho Republican Party put out a "Call to Action" urging the public to call and tell members of the House State Affairs Committee that the Total Abortion Ban "is working" as is.[61] After receiving intense criticism from Dorothy Moon, Chairwoman of the Idaho Republican Party, the Committee tabled the bill just before it was expected to receive a hearing.[62]

206. On March 28, 2023, Representative Blanksma introduced a new bill—H.B. 374—which sought to make the same changes as H.B. 342. But the language creating an exception for "life-threatening" conditions was removed. H.B. 374, 2023 Idaho Sess. Laws 906, 906-909.

207. Debate on H.B. 374 was rushed and stifled at every juncture, and several important concerns about the bill's deficiencies went unaddressed.

208. For example, legislators highlighted that the bill would not help patients with "health-threatening, future-fertility-threatening, lifelong-disability threatening conditions" or adequately address physicians' concerns about the original Total Abortion Ban.[63]

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[60] *Id.* at sec. 2.

[61] *CALL TO ACTION*, Idaho GOP (Mar. 21, 2023), https://idgop.org/2023/03/21/idgop-statement-indictment-of-president-trump-2/.

[62] Moseley-Morris, *supra* note 58; House Bill 342, *supra* note 58.

[63] House Chambers, 67th Leg., Reg. Sess. (Idaho Mar. 29, 2023) (Rep. Necochea), https://insession.idaho.gov/IIS/2023/House/Chambers/HouseChambers03-29-2023.mp4, (02:15:22-02:15:37); Laura Guido, *Abortion exception bill passes Idaho Senate, heads to governor*, Idaho Press (Mar. 30, 2023), https://www.idahopress.com/news/local/abortion-exception-bill-passes-idaho-senate-heads-to-governor/article_c14235d6-cf4f-11ed-91c3-730822913b54.html.

209. Plaintiff Dr. Corrigan warned legislators that the medical exception to the Total Abortion Ban was insufficient and that patients could still be harmed if doctors feel they must wait for imminent death before being able to perform an abortion.[64]

210. The IAFP, too, urged legislators to eliminate the affirmative defenses in favor of clear exceptions that would apply not only when abortion care is necessary to prevent a pregnant person's death, but also when the pregnant person's health is at risk, including when the patient has received a diagnosis of a lethal fetal condition. In its advocacy, the IAFP emphasized the importance of allowing physicians to exercise their medical judgment and discretion when caring for their patients and explained that harms to patients and the broader healthcare system will result from government overreaches into medical decision-making and provision of care.[65]

211. Dr. Lauren Miller, M.D., then an MFM at St. Luke's, told the press that the amended law still lacks clarity and leaves doctors querying: "How close to death [do] you need to be before you can intervene?"[66]

212. Representative Blanksma admitted she did not know or understand what, exactly, would fall under the bill's exceptions. In responding to a question about whether any of the exceptions would cover the condition anencephaly, or whether a patient would have to continue her pregnancy to full term even if it had been determined that the brain of the fetus did not develop,

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[64] House State Affairs Committee, 67th Leg., Reg. Sess. (Idaho Mar. 29, 2023, https://insession.idaho.gov/IIS/2023/House/Committee/State%20Affairs/230329_hsta_0100PM-Meeting.mp4, (00:33:50–00:39:01).

[65] *Idaho's Laws Need Clarification*, IAFP (Jan. 2023), https://idahofamilyphysicians.org/wp-content/uploads/2023/01/Idaho-Current-Abortion-Laws-1.pdf.

[66] Andrew Baertlein, *Idaho doctor's concerns are not fixed by abortion clarity bill*, KTVB7 (Mar. 28, 2023), https://www.ktvb.com/article/news/local/capitol-watch/local-idaho-doctors-concerns-not-fixed-by-abortion-clarity-bill/277-e42e4a7a-c175-45c1-833a-e076c63a91e1.

she stated, "I think that the physician would have to determine if that is a developing fetus or not. I'm not a medical professional—never claimed to be one."[67]

213. Senator Todd Lakey, the lead Senate sponsor of the original Total Abortion Ban and H.B. 374, also admitted that H.B. 374 was unlikely to resolve physicians' concerns: "There is a procedural difference, Senators, between a standard exception and an affirmative defense. But, from my perspective . . . as a former prosecutor, there's not a real practical difference between the two."[68]

214. Instead of working to further clarify what would or would not fall under the exceptions, one Idaho Senator suggested that Idaho's physicians consult with the lawyers that they assumed worked at their medical practices to interpret the law and resolve issues.[69]

215. Ultimately, after approximately three and a half hours of committee and floor debate spanning only two days, both houses of the Idaho Legislature passed H.B. 374, amending the original Total Abortion Ban. H.B. 374, 2023 Idaho Sess. Laws ch. 298 (codified at I.C. §§ 18-604, 18-622).

216. The amended Total Abortion Ban contains only three substantive changes to the 2020 Total Abortion Ban.

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[67] House State Affairs Committee, 67th Leg., Reg. Sess. (Idaho Mar. 29, 2023) (Rep. Gannon & Rep. Blanksma), https://insession.idaho.gov/IIS/2023/House/Committee/State%20Affairs/230329_hsta_0100PM-Meeting.mp4, (0:02:50-0:04:42).

[68] Senate State Affairs Committee, 67th Leg., Reg. Sess. (Idaho Mar. 30, 2023), https://insession.idaho.gov/IIS/2023/Senate/Committee/State%20Affairs/230330_ssta_0800AM-Meeting.mp4, (00:12:15–00:12:30).

[69] Senate Chambers, 67th Leg., Reg. Sess. (Idaho Mar. 30, 2023) (Sen. Foreman), https://insession.idaho.gov/IIS/2023/Senate/Chambers/SenateChambers03-30-2023.mp4, (03:10:14–03:11:03); Guido, *supra* note 63.

217. First, the amended Total Abortion Ban altered the definition of abortion found in I.C. § 18-604 to permit abortion for (1) "[t]he removal of a dead unborn child," (2) "[t]he removal of an ectopic or molar pregnancy," and (3) "[t]he treatment of a woman who is no longer pregnant." H.B. 374, 2023 Idaho Sess. Laws ch. 298, sec. 1 (codified at I.C. § 18-604(1)(b)–(d)).

218. Second, the amended Total Abortion Ban converts the affirmative defenses described in ¶¶ 191 – 193, above, into exceptions. H.B. 374, 2023 Idaho Sess. Laws ch. 298, sec. 2 (codified at I.C. § 18-622(2)(a)–(b)).

219. Third, the amended Total Abortion Ban narrows the time and gestational limits for the rape and incest exceptions. H.B. 374, 2023 Idaho Sess. Laws ch. 298, sec. 2 (codified at I.C. § 18-622(3)).

220. The amended Total Abortion Ban became effective on July 1, 2023. H.B. 374, 2023 Idaho Sess. Laws ch. 298, sec. 3.

221. In the end, the amendments to the Total Abortion Ban only brought Idaho's exceptions in line with several other states, like Texas, whose abortion ban exceptions still provide no guidance to physicians for which patients qualify for the exceptions. As has been well documented in the press and the courts, Texas is in its own healthcare crisis due to the lack of clarity in its exception. *See Zurawski v. Texas*, Cause No. D-1-GN-23-000968 (Travis Cnty. Dist. Ct.), appeal docketed, No. 23-0629 (Tex.).

D. The Six-Week Abortion Ban

222. Idaho's Total Abortion Ban was not the only abortion ban that took effect in Idaho after *Roe v. Wade* was overturned.

223. In 2021, the Idaho Legislature enacted the Six-Week Abortion Ban, prohibiting abortion beginning "when a fetal heartbeat has been detected," which typically occurs around six

weeks LMP, a period when a pregnant person may not even know that they are pregnant. H.B. 366, 2021 Idaho Sess. Laws ch. 289 (currently codified as I.C. § 18-8804). A "'[f]etal heartbeat' means embryonic or fetal cardiac activity or the steady and repetitive rhythmic contraction of the fetal heart within the gestational sac." I.C. § 18-8801.

224. Like the Total Abortion Ban, the Six-Week Abortion Ban did not take effect immediately. Instead, the legislature scheduled it to take effect "thirty (30) days following the issuance of the judgment in any United States appellate court case in which the appellate court upholds a restriction or ban on abortion for a preborn child because a detectable heartbeat is present on the grounds that such restriction or ban does not violate the United States constitution." I.C. § 18-8805(1).

225. The Six-Week Abortion Ban, as it was originally enacted, exempts cases of medical emergency, defined as "a condition that, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function." H.B. 366, 2021 Idaho Sess. Laws ch. 289, sec. 1 (codified as I.C. § 18-8701(5) (2021)). It also contains exceptions for certain circumstances involving rape and incest. I.C. § 18-8804(1)(a)–(b).

226. Violation of the Six-Week Abortion Ban is punishable by at least two and no more than five years of imprisonment for each offense, suspension of professional licensure for a minimum of six months for the first offense, and permanent revocation of professional licensure for any subsequent offense. I.C. § 18-8805.

227. The Six-Week Abortion Ban also provided a civil cause of action for "[a]ny woman on whom an abortion is performed" in violation of the Ban, allowing them to recover "all damages

available to [them] under Idaho law." H.B. 366, 2021 Idaho Sess. Laws ch. 298, sec. 1, § 18-8707 (currently codified as I.C. § 18-8807).

228. The Total Abortion Ban supersedes the Six-Week Abortion Ban if both laws are simultaneously in effect and enforceable. I.C. § 18-8805(4).

229. The Six-Week Abortion Ban's *criminal* penalty became enforceable on August 19, 2022. *Planned Parenthood,* 522 P.3d at 1158. This penalty was enforceable until the Total Abortion Ban superseded it on August 25, 2022. *Id.*

E. Amendments to the Six-Week Abortion Ban

230. The following year, in 2022, the Idaho Legislature amended and recodified the Six-Week Abortion Ban, making the following relevant substantive changes:

a. First, the scope of the medical exception to the Six-Week Abortion Ban was amended to "a condition that, *in reasonable medical judgment*, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function." S.B. 1309, 2022 Idaho Sess. Laws, ch. 152, sec. 1 (codified at I.C. § 18-8801(5)) (emphasis added). Previously, the determination of "medical emergency" could be based on "a physician's good faith clinical judgment." *Compare* H.B. 366, 2021 Idaho Sess. Laws ch. 298, sec. 1, § 18-8701(5).

b. Second, the Six-Week Abortion Ban's civil penalty provisions were altered to more closely emulate Sections 171.201 through 171.212 of Texas' Health and Safety Code (Texas' Senate Bill 8 or "S.B. 8"). S.B. 1309, 2022 Idaho Sess. Laws ch. 152, sec. 6 (codified as I.C. § 18-8807). Like Texas' S.B. 8, the amended Six-Week

Abortion Ban expanded the civil cause of action to allow the father, grandparent, sibling, aunt, or uncle of the fetus to sue over a violation of the Six-Week Abortion Ban. *Id*. § 18-8807(1). And the amendments clarified that recoverable damages now include statutory damages of at least $20,000 and related costs and attorneys' fees. *Id*. § 18-8807(1)(b)–(c).

231. The legislature also clarified that the Total Abortion Ban only supersedes the Six-Week Abortion Ban's *criminal* penalties. I.C. § 18-8805(4). This allows the Total Abortion Ban and the civil liability provision of the Six-Week Abortion Ban to be enforced simultaneously.

232. The civil liability provisions of the Six-Week Abortion Ban went into effect on April 22, 2022. *Planned Parenthood,* 522 P.3d at 1153.

F. Confusion Regarding the Medical Exceptions

233. Understandable confusion regarding the scope of the Medical Exceptions to the abortion bans, combined with fear for the legal consequences if physicians are wrong, are leading physicians to deny care to patients. This includes patients presenting with pregnancy complications—even when such care likely would fall within an exception. As Plaintiffs' experiences show, because of the Medical Exceptions' lack of clarity and the bans' serious penalties, physicians are generally over-complying with the laws to the detriment of their patients' lives and health.

234. Idaho has failed to provide clarification or guidance on the meaning of the Medical Exceptions, despite repeated requests from the medical community. *See supra* ¶¶ 203, 209 – 212.

235. The Medical Exceptions to Idaho's abortion bans can and should be read to ensure that doctors have wide discretion to determine the appropriate course of treatment, including abortion care, for their patients who present with emergent medical conditions—without being

second guessed by the Attorney General, the Idaho Board of Medicine, a local prosecutor, or a lay jury. Such discretion is best assured through a "good faith" standard for care, rather than a "reasonable medical judgment" standard.

236. The Medical Exceptions currently contain conflicting language as to physician discretion and intent. This leaves physicians uncertain whether the treatment decisions they make in good faith, based on their medical judgment, will be respected or will be later disputed.

237. For example, a physician prosecuted under the medical exception to the Total Abortion Ban must demonstrate that they determined in their "good faith medical judgment and based on the facts known to the physician at the time, that the abortion was necessary to prevent the death of the pregnant woman . . . ." I.C. § 18-622(2)(a)(i). This is a "subjective standard, focusing on the particular physician's judgment." *Planned Parenthood,* 522 P.3d at 1203.

238. But the medical exception to the Six-Week Abortion Ban requires physicians to prove that their decision to provide abortion care during a medical emergency was based on "reasonable medical judgment." I.C. § 18-8801(5). Unlike the subjective "good faith medical judgment" standard under the medical exception to the Total Abortion Ban, the "reasonable medical judgment" standard under the Six-Week Abortion Ban is an objective standard when exercising medical judgment. It is "a standard for *minimum competency* that physicians are routinely expected to satisfy." *Planned Parenthood,* 522 P.3d at 1208 (citing *United States v. Vuitch*, 402 U.S. 62, 72 (1971)) (emphasis in original).

239. Idaho law also provides little to no guidance on how to interpret the medical exception to the Total Abortion Ban.

240. For example, a physician is permitted to provide abortion care under the Total Abortion Ban if it is necessary to "prevent the death" of the pregnant person. I.C. § 18-622(2)(a)(i).

Yet the Idaho Code offers no further information as to how physicians are to determine when an abortion is permissible under this standard. Must the pregnant patient be hours away from death? Minutes? Or is it sufficient for there to be a risk that the patient may die if an abortion is not provided urgently?

III. The Bans are Endangering the Lives and Health of Pregnant Idahoans

A. Plaintiffs' Stories Underscore Harmful Impacts of Idaho's Abortion Bans

241. Mrs. Adkins, Ms. St.Michel, Mrs. Smith, and Ms. Vincen-Brown's experiences are not isolated incidents. Other pregnant Idahoans, including patients treated by Dr. Corrigan, Dr. Lyons, Dr. Colson, Dr. Aker, and their colleagues, have been denied healthcare necessary to treat pregnancy complications because of Idaho's intertwined Total Abortion Ban and Six-Week Abortion Ban.

242. PPROM patients have been particularly at risk due to the confusion and fear doctors are grappling with about the legality of care under the abortion bans' exceptions. Dr. Corrigan is aware that, in many situations, physicians in Idaho are sending patients with PPROM home from the hospital because they are not exhibiting acute signs of infection, such as a high fever or an elevated white blood cell count. Others are transferring such patients out of state via medical transport, which ultimately delays care and increases the risk of sepsis and death.

243. For example, Dr. Corrigan cared for a patient in July 2022 with PPROM who had driven hundreds of miles from a rural part of the state to Boise for care. When the patient presented to Dr. Corrigan's hospital, she was 21 weeks pregnant, and reported that she had been diagnosed with PPROM at a routine ultrasound appointment two weeks prior. Her primary obstetrician had advised her that abortion was not an option because Idaho's Total Abortion Ban was in effect (though it was not). The patient had also visited another hospital in Southwest Idaho that morning, where a physician said they could only provide her with oral antibiotics and not the abortion she

had requested. By the time she arrived at Dr. Corrigan's unit, the patient had been experiencing uterine cramping and chills (signs of infections) for three days.

244. Dr. Corrigan provided the patient with medications to begin an induction abortion and the patient delivered within a few hours. Shortly after the delivery, the patient started hemorrhaging because the placenta would not detach from her uterus. She required a dilation and curettage (D&C) procedure to remove the placenta, a blood transfusion, and a three-day stay in the hospital. Dr. Corrigan observed that this patient's delays in care were due to physicians' confusion and fear of Idaho's Total Abortion Ban, even though it was not yet in effect. Without Dr. Corrigan's quick action, this patient would have likely experienced sepsis and a significant risk of death.

245. After the Total Abortion Ban took effect, Dr. Corrigan and her colleagues continued to receive patients with previable PPROM who were previously denied care at other institutions. These denials of care were occurring despite a federal court enjoining enforcement of the Total Abortion Ban where it conflicted with EMTALA.

246. In the fall of 2022, one of Dr. Corrigan's colleagues cared for a patient at 18 weeks with PPROM. When the patient first experienced bleeding and leakage of amniotic fluid, she was visiting a rural part of Idaho and went to a small local hospital. There, an OB-GYN told her that abortion care was not legal in Idaho and encouraged her to leave the state for care. The patient drove six hours back to her home hospital in Southwest Idaho and was told the same thing by another physician. By the time she reached Dr. Corrigan's hospital, the patient was bleeding and experiencing abdominal pain and chills and was diagnosed with chorioamnionitis (infection of the placenta or amniotic fluid). After consultation with an MFM specialist, as well as the hospital's ethics representative, Dr. Corrigan's colleague offered the patient abortion care.

247. The following month, one of Dr. Corrigan's MFM colleagues alerted her to a patient whose routine ultrasound scan in the late first trimester revealed no amniotic fluid around the fetus but continued cardiac activity. The MFM diagnosed the patient with PPROM and instructed her to go to L&D for further evaluation and management. Upon evaluation, the patient exhibited abdominal tenderness and purulent amniotic fluid in her vagina, both signs of infection. It was clear to Dr. Corrigan that the best course of action was to immediately move toward terminating the pregnancy while administering intravenous antibiotics. But several nurses involved in the patient's care expressed fear and confusion about what was allowable under Idaho law. The prolonged approval process involved six different OB-GYNs trying to navigate the best course of action for the patient's health amid Idaho's overlapping abortion bans and inconsistent Medical Exceptions. The confusion delayed the patient's treatment for three hours, increasing the risk of sepsis with every passing minute.

248. Earlier this year, Dr. Corrigan's team treated another PPROM patient, this time at 15 weeks, who had already been denied abortion care at a different Idaho hospital. Even though the patient, her family, and multiple physicians agreed that abortion was the safest option, the patient was not offered that care on the first day of her hospitalization because of fear amongst her physician team that it was not legal to offer this to her in Idaho without a diagnosis of a complication *in addition* to PPROM. On the patient's second day of hospitalization, Dr. Corrigan's colleague found the patient had developed signs of infection, including a tender abdomen and bloody fluid, and so abortion care was finally offered.

249. Unfortunately, these are not rare cases. Dr. Corrigan is aware of many other patients who have had to seek care from several medical facilities in Idaho before a correct diagnosis was made and treatment offered to preserve these patients' lives and health. Before Idaho's abortion

bans were in effect, these situations would not have occurred. A patient who clearly had PPROM after the initial ultrasound and evaluation would have been offered abortion care straight away. Now, patients are told they must undergo multiple ultrasounds, and only after that will a patient be offered a complete physical exam, including a pelvic exam, to confirm the diagnosis. Ultimately, this results in delays in the detection of signs of complications, such as abdominal tenderness, bloody or purulent amniotic fluid, prolapsed membranes or umbilical cord, or dilated cervix. If these signs of complications are not discovered right away, the patient is at risk of severe morbidity or death.

250. Dr. Aker, an IAFP member, also treats patients experiencing PPROM and other pregnancy complications as part of her medical practice. Within the past year, she treated a patient previously diagnosed with cervical insufficiency. A pelvic exam revealed the patient had a dilated cervix and membranes protruding through the cervix that had not yet ruptured. Before *Roe* was overturned, Dr. Aker and her colleagues would have immediately offered the patient abortion care as a necessary medical treatment to avoid the patient developing PPROM and being placed at risk of infection and death. But this situation occurred after Idaho's abortion bans went into effect. Because there remained fetal cardiac activity, the physicians were unable to provide prompt care according to their training, education, and expertise. Instead, after consultation with specialists and hospital administration, the patient was sent home and instructed to return to the hospital as soon as possible if her condition worsened. And, indeed, 30 minutes after the patient was discharged, she returned to the hospital because her membranes had ruptured. But even then, her physicians had to confirm there was no longer fetal cardiac activity before they could provide an abortion.

251. This patient's experience is not rare. Dr. Aker works in a rural part of Idaho where patients are more likely to have low incomes and, as a result, face challenges when accessing all

manner of health care services. In Dr. Aker's experience, where there are systemic barriers to healthcare access, pregnant patients are more likely to develop pregnancy complications, which may result in poorer maternal and infant health outcomes. It is thus very likely that Dr. Aker and her colleagues will repeatedly be forced to delay or deny immediate care to a patient experiencing a pregnancy complication due to the Medical Exceptions' ambiguity when a pregnant person's health is at risk.

252. Patients facing a myriad of other pregnancy complications have likewise been turned away or delayed in receiving critical care because of physician fear, confusion, and uncertainty regarding the abortion bans. For example, in the spring of 2023, IAFP member Dr. Colson cared for a patient who became pregnant despite having an intrauterine device ("IUD") in place. The patient decided to continue the pregnancy and asked her community physician to remove her IUD. However, because IUD removal may result in miscarriage, the community physician was concerned that performing the care requested by the patient could be considered an abortion under the bans, and so declined to remove the patient's IUD. By the time the patient reached Dr. Colson, she had already been denied care twice.

253. Dr. Colson believes that, before Idaho's abortion bans went into effect, a physician would not have hesitated to remove the patient's IUD because leaving an IUD in a patient's uterus during pregnancy presents risks not only to the developing fetus but also to the patient. While Dr. Colson ultimately provided the patient the care that she requested and needed to continue the pregnancy safely, he was wracked with fear and worry that he could be prosecuted, thrown in jail, and have his licensed revoked simply for providing evidence-based medical care.

254. Dr. Colson also recently cared for a patient who was initially diagnosed with a probable miscarriage in a local emergency room after undergoing a transvaginal ultrasound. The

patient was told that her pregnancy was likely not viable, but because a miscarriage could not be diagnosed with certainty, the patient was sent home to continue miscarrying instead of being provided immediate miscarriage management care (such as a D&C) in the ER. But because the patient continued to bleed, she sought medical care and another ultrasound was performed, which confirmed a miscarriage.

255. This patient was then referred to Dr. Colson who, out of fear of potentially violating the abortion bans, performed a third transvaginal ultrasound to confirm the miscarriage since he would be the physician performing the uterine aspiration. Before Idaho's abortion bans went into effect, Dr. Colson would have offered miscarriage management care based on the imaging performed by his colleagues. But because of the serious penalties imposed by the abortion bans, Dr. Colson felt it was necessary for the patient to undergo a third transvaginal ultrasound to be sure that there was no fetal cardiac activity prior to providing the patient with necessary care. In addition, Dr. Colson felt compelled to meticulously over-document the care he provided to protect himself should his medical judgment and discretion be called into question through criminal arrest or prosecution, or a civil lawsuit. This has occurred on more than one occasion where Dr. Colson has repeated an ultrasound even though one had already been performed by a colleague so that he could document his findings of a certain miscarriage before performing a procedure that could potentially be construed as an abortion.

256. In addition, many public reports from providers at St. Luke's Health System, the largest hospital system in Idaho, corroborate the accounts of the Plaintiffs and their members. For example, Dr. Miller has publicly explained that it is unclear whether providers in Idaho can treat pregnant patients with a kidney or heart disease, which can be exacerbated by pregnancy and can

lead to death within a few years.[70] She told reporters that she was forced to send her pregnant patient with a serious kidney disease out of state to receive an abortion due solely to Idaho's abortion bans.[71] Her patient was forced to endure the burdens and medical risks of travel even though Dr. Miller's medical center was fully resourced with kidney specialists and an intensive care unit to adequately care for her.[72] Her patient had to leave her family and fly several hours away to receive that critical abortion care while putting her health and safety in danger during travel.[73]

257. Dr. Werdel has publicly expressed similar concerns. St. Luke's sees an average of 30 pregnancy related complications per week that may require termination of pregnancy to protect the pregnant person's health. Dr. Werdel has stated that physicians addressing these complications fear facing felony charges for providing care and many do not want to take the risk to treat these patients.[74]

258. Idaho's abortion bans have also caused unbearable pain for patients, like Plaintiffs Mrs. Adkins, Ms. St.Michel, Mrs. Smith, and Ms. Vincen-Brown, who were unable to receive care despite receiving lethal fetal diagnoses that posed harms to their health and safety.

259. For example, Dr. Lyons had a patient who was told by an MFM that her pregnancy was likely not viable. In addition to a likely chromosomal condition, the fetus had significant development issues with its brain and heart. The MFM told the patient that if she decided to carry

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[70] Moseley-Morris, *supra* note 58.

[71] Sarah Varney, *After Idaho's Strict Abortion Ban, OB-GYNs Stage a Quick Exodus*, KFF Health News (May 2, 2023), https://kffhealthnews.org/news/article/after-idahos-strict-abortion-ban-ob-gyns-stage-a-quick-exodus/.

[72] *Id.*

[73] *Id.*

[74] *See* Werdel, *supra* note 57.

to term, the MFM could help provide her with expectant management care and, if the baby survived after birth, arrange for palliative care. But if the patient chose to have an abortion, there was no assistance available in Idaho because of the abortion bans. Afterwards, Dr. Lyons' patient called her in tears. Knowing full well that this was a wanted pregnancy for her patient, Dr. Lyons gently explained that continuing the pregnancy put the patient at risk for developing severe preeclampsia, PPROM, and sepsis. If that happened, the patient would need to drive 2.5 hours away to the nearest medical center in Boise, because the critical access hospital in Dr. Lyons' area is not equipped to handle deliveries before 35 weeks. In that scenario, her other option would have been to get life-flighted at an estimated expense of $20,000. The patient elected to have an abortion out-of-state to avoid danger to her health as well as needless suffering for herself and her baby.

260. In addition to the danger patients face when forced to travel for abortion care to treat emergent conditions, the costs of being forced to travel out of state are prohibitive for many. These injustices uniquely impact low-income families because they do not have the resources to pay for the logistical hurdles that are associated with travelling out of state to obtain an abortion.

261. For example, Dr. Corrigan routinely cares for non-English speaking patients who are part of the Idaho Refugee Resettlement Program. About 1,000 refugees are placed in Idaho every year, most of whom are women and children. Language access is already a hurdle that these patients must navigate, given they speak minimal English, and their primary languages (such as Swahili, Pashto, or Dari) are not commonly spoken by staff in medical facilities. Now, Dr. Corrigan additionally finds it difficult to inform them about the confusing limitations the state has placed on their healthcare options in Idaho and that they must arrange travel to another state to receive abortion care. Her refugee patients are seeking asylum in Idaho to escape from unspeakable atrocities in their home countries only to navigate a terrain of uncertainty here and face the

possibility of being denied necessary medical care. These patients also have very limited financial resources to travel out of state for care.

262. Similarly, the community served by Dr. Lyons' hospital spans hundreds of miles, and includes a large and growing immigrant, refugee, and indigenous population. Many have low incomes and lack reliable access to transportation, childcare, or cannot easily take time off from work. This impedes access to all manner of health care services, including prenatal and obstetric care. Additionally, many of Dr. Lyons' immigrant patients are undocumented and do not a have driver's license, so they cannot drive long distances. For some patients with complex or high-risk pregnancies, the drive to Boise to see an MFM specialist is challenging enough; out-of-state travel to get an abortion because their pregnancy poses a risk to their health is insurmountable.

B. Idaho's Abortion Bans Are Causing a Collapse of the State's Healthcare System

263. Idaho's abortion bans are fueling a mass exodus of OB-GYNs and MFMs because they are preventing physicians from providing their patients with necessary medical care and complying with their professional and ethical obligations when treating pregnant people.[75] This is contributing to, and exacerbating, the maternal health crisis in Idaho that has been ongoing for years, *see supra* at Section I.C.

264. Approximately 41% of Idaho's physicians who work in maternal health care recently surveyed by the Idaho Coalition for Safe Reproductive Health Care stated that they were considering leaving Idaho, and another approximately 23% answered "maybe" to whether they're

[75] Kaye & Samaniego, *supra* note 51.

considering leaving.[76] Considering both combined groups, approximately 97% cited Idaho's abortion bans as the reason for considering leaving.[77]

265. Over the past year, the total number of MFMs in the entire state of Idaho has dwindled from nine to five. Four MFMs left Idaho to practice in states without extreme abortion restrictions.[78]

266. Odette C. Bolano, the President and CEO of St. Alphonsus Health System, the second largest health system in Idaho, announced in a news interview in May 2023 that two of the system's MFMs departed within a month, and its sole remaining MFM is planning to retire early, by November 2023.[79] She warned about the ripple effects of this exodus, as obstetricians and family medicine providers rely on MFMs for consults on high risk and complex pregnancies.[80]

267. Following the early retirement of St. Alphonsus's sole remaining MFM in November, Idaho will have only four MFMs—a 55% reduction since *Roe* was overturned.

268. Dr. Maria Palmquist, M.D., one of the departing MFMs who previously worked at St. Alphonsus Regional Medical Center in Boise, explained that Idaho's bans were causing

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[76] McKay Cunningham, Commentary, *Survey shows Idaho's maternal health doctors are leaving the state, or soon will*, Idaho Cap. Sun (Apr. 7, 2023), https://idahocapitalsun.com/2023/04/07/survey-shows-idahos-maternal-health-doctors-are-leaving-the-state-or-soon-will/?utm_source=substack&utm_medium=email.

[77] *Id.*

[78] Kay & Samaniego, *supra* note 51.

[79] *A St. Alphonsus CEO said Idaho is losing doctors due to restrictive medical legislation*, KTVB7 (4:15) (May 1, 2023), https://www.ktvb.com/video/news/local/208/a-st-alphonsus-ceo-said-idaho-is-losing-doctors-due-to-restrictive-medical-legislation/277-b503d6ff-640d-4497-bb94-831c704c7469.

[80] *Id.*

providers anxiety around treating patients experiencing pregnancy complications.[81] Dr. Palmquist is now working in Nevada, a state without an extreme abortion ban.

269. Similarly, Dr. Miller cited Idaho's Total Abortion Ban as a factor in her decision to resign from St. Luke's and leave the state. Dr. Miller explained that Idaho's abortion bans caused her to fear being prosecuted for a felony "simply for saving someone's life" and that the Total Abortion Ban "goes against what we're taught as physicians to protect the health of our patients." She has moved her practice to Colorado, where abortion remains legal and she can practice medicine without fear of criminal repercussions.[82]

270. Dr. Kylie Cooper, M.D., another MFM who previously practiced at St. Luke's and acted as the Vice Chair of the Idaho section for the American College of Obstetricians and Gynecologists, recently moved her practice to Minnesota where abortion care is legal. Dr. Cooper stated, "[t]o watch somebody get sicker in front of your eyes and not be able to help them is hard to comprehend . . . . That is not the way I was trained to practice medicine."[83]

271. In February 2023, Dr. Cooper poignantly wrote in an op-ed, "I need to be able to protect my patients' lives, their health and future fertility without fear of becoming a felon. This fear is why I'm leaving Idaho. Idaho's maternal and infant health is worsening, mothers are dying at an increasing rate. A lack of physicians and access to care are major contributors. These bans make it difficult to attract physicians to the state. The loss of health care providers due to the criminalization of medicine will only further these health disparities. These factors made my

[81] Kelcie Moseley-Morris, *Her fetus had 1% chance of survival. Idaho's ban forced her to travel for an abortion*, Idaho Cap. Sun (May 10, 2023), https://idahocapitalsun.com/2023/05/10/her-fetus-had-1-chance-of-survival-idahos-ban-forced-her-to-travel-for-an-abortion/.

[82] Kaye & Samaniego, *supra* note 51.

[83] *Id*.

decision to leave an immensely difficult one, but I cannot continue to practice in a place where I do not feel safe."[84]

272. Idaho patients were already experiencing difficulties obtaining consultations and ultrasound appointments for complex and time-sensitive pregnancy complications before the abortion bans went into effect. The departure of so many MFMs from Idaho is exacerbating the maternal health crisis unfolding in the state. Based on Dr. Corrigan's personal knowledge of her medical community, once the MFM at her hospital retires in November, the other tertiary care hospital in Boise will not have the capacity to absorb the 100 MFM ultrasound and consultation appointments per week usually provided at Dr. Corrigan's hospital.

273. The mass exodus of MFMs has been tremendously disruptive for physicians trying to serve patients with complex and time-sensitive pregnancy complications. MFMs are routinely consulted on the appropriate care for a patient with a medically complex pregnancy. Yet since the abortion bans went into effect, Dr. Corrigan has often been forced to complete many of her shifts without an MFM available for consultation. This lack of specialist support greatly increases Dr. Corrigan's fears that without an MFM resource, she and her colleagues may not be able to provide proper care to patients with complex pregnancy complications. Many of the part-time physicians that occasionally fill in for Dr. Corrigan's group when there are schedule gaps are now reluctant to take shifts due to the lack of MFMs for support. In addition, the obstetrics genetic counselor at Dr. Corrigan's medical system has recently left the state, which has increased the workload for the physicians in the department.

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[84] Kylie Cooper, Commentary, *I came to provide care for complicated pregnancies; I'm leaving because of Idaho's abortion bans*, Idaho Cap. Sun (Feb 10, 2023), https://idahocapitalsun.com/2023/02/10/i-came-to-provide-care-for-complicated-pregnancies-im-leaving-because-of-idahos-abortion-bans/.

274. Given the shortage of MFMs in Idaho, Dr. Corrigan and her colleagues have explored arranging remote consultative services with Idaho-licensed MFMs in other states. Dr. Corrigan is aware that some of these MFMs have expressed that they will not practice medicine in a state with such strict abortion bans due to fear of criminal prosecution and civil liability.

275. Idaho's abortion bans have also endangered pregnant Idahoans by impacting the recruitment and retention of other OB-GYNs into Idaho.

276. Ten general OB-GYNs in northern rural Idaho have reportedly left the state since Idaho's abortion bans went into effect.[85]

277. For example, Dr. Amelia Huntsberger, M.D., an OB-GYN who practiced for more than a decade alongside her husband, who is an emergency physician, at Bonner General Health in Sandpoint, Idaho, has also moved her practice out of Idaho because of the abortion bans and the state legislature's decision to shut down its MMRC.[86] She explained she did not know whether the Medical Exceptions to Idaho's abortion bans allow her to treat patients in dangerous scenarios. She explained: "For instance, there's something called an inevitable abortion, meaning the cervix is open, the pregnancy is going to pass, but has not yet. You could have a woman bleeding heavily, and yet there still might be a heartbeat. When is it okay for me to act? Can I just say this, without treatment, is really, really risking her life and I should act now? Or do I wait until she bleeds out?

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[85] Abigal Abrams, '*It's demoralizing': Idaho abortion ban takes toll on medical providers*, The Guardian (July 16, 2023), https://www.theguardian.com/us-news/2023/jul/16/idaho-abortion-ban-ob-gyn-doctors.

[86] Kelcie Moseley-Morris, *Citing staffing issues and political climate, North Idaho hospital will no longer deliver babies*, Idaho Cap. Sun (Mar. 17, 2023), https://idahocapitalsun.com/2023/03/17/citing-staffing-issues-and-political-climate-north-idaho-hospital-will-no-longer-deliver-babies; *see also* Kathleen McLaughlin, *No OB-GYNs left in town: what came after Idaho's assault on abortion*, The Guardian (Aug. 22, 2023),https://www.theguardian.com/us-news/2023/aug/22/abortion-idaho-women-rights-healthcare.

Do I wait until we do CPR? When is it that I can intervene? How close to death does she need to be before I take care of her in the way that I trained years to know how to do?"[87]

278. Following Dr. Huntsberger's departure, the only labor and delivery ward in Sandpoint—a city of more than 9,000 people—was forced to shut down.[88] Bonner General Health officials cited the Total Abortion Ban as a driving force in the decision to close the ward as "[h]ighly respected, talented physicians are leaving" and "[r]ecruiting replacements will be extraordinarily difficult."[89] In a statement, the hospital warned, "the Idaho Legislature continues to introduce and pass bills that criminalize physicians for medical care nationally recognized as the standard of care."[90]

279. Bonner General Health delivered 265 babies in 2022.[91] Due to this closure, at least 16 OB-GYN nurses lost their jobs[92] and patients are now forced to travel an additional hour or 46 miles across northern Idaho to receive care.[93]

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[87] *Idaho's strict abortion laws create uncertainty for OB-GYNs in the state*, PBS NewsHour (May 1, 2023), https://www.pbs.org/video/afterroe-1682976218/.

[88] Moseley-Morris, *supra* note 86.

[89] *PRESS RELEASE 3/17/2023: Discontinuation of Labor & Delivery Services at Bonner General Hospital*, Bonner Gen. Health (Mar. 17, 2023), https://bonnergeneral.org/wp-content/uploads/2023/03/Bonner-General-Health-Press-Release-Closure-of-LD-3.17.2023.pdf.

[90] *Id*.

[91] Olafimihan Oshin, *Idaho city's only hospital blames anti-abortion laws as it ends obstetrical services*, The Hill (Mar. 20, 2023), https://thehill.com/policy/healthcare/3909594-idaho-citys-only-hospital-blames-anti-abortion-laws-as-it-ends-obstetrical-services/.

[92] Alanna Vagianos, *'Immense And Needless Suffering': Idaho's Abortion Ban Is Creating A Crisis Of Care*, HuffPost (updated Mary 2, 2023), https://www.huffpost.com/entry/idaho-abortion-ban-crisis_n_6446c837e4b011a819c2f792.

[93] Moseley-Morris, *supra* note 86.

280. In rural Emmett, Idaho, Valor Health also stopped labor and delivery services as of June 1, 2023, in part due to staffing shortages and difficulties in recruitment and retention of staff.[94]

281. Dr. Corrigan's hospital has similarly been impacted by OB-GYN staffing shortages. It usually employs six physicians in the Obstetric Hospitalist Group. Due to retirements over the past two years, there are currently only four physicians remaining. Though the open positions have been advertised extensively, to Dr. Corrigan's knowledge, her hospital has not received any out-of-state applicants in almost one year. The hospital is also having difficulty finding locums (travel) physicians who are willing to provide obstetric care in Idaho due to the abortion bans. These physician shortages are making it increasingly difficult to fill the schedule of Obstetric Hospitalists that must be available at Dr. Corrigan's hospital 24/7. Maintaining this physician availability is critical for patient safety at a tertiary care trauma hospital.

282. Dr. Werdel of St. Luke's reports similar struggles to recruit and retain physicians specializing in pregnancy-related care because of the threat of prosecution under Idaho's bans.[95] St. Luke's is the largest employer in Idaho and would normally receive multiple applications for one OB-GYN opening. It now receives only one or two applications for positions that have been open for over a year.[96]

283. Further contributing to the abortion bans' chilling effect on obstetric care in Idaho, in March 2023, Dr. Corrigan and her colleagues learned that Defendant Attorney General Raúl

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[94] *PRESS RELEASE 3/29/2023: Discontinuation of Labor & Delivery Services at Valor Health Hospital*, Valor Health (Mar. 29, 2023), https://www.valorhealth.org/discontinuation-of-labor-delivery-services/.

[95] Ryan Suppe, *As doctors flee state, Idaho bill expands exemptions for abortion. Health isn't one of them*, Idaho Statesman (Mar. 30, 2023), https://www.idahostatesman.com/news/politics-government/state-politics/article273748485.html.

[96] Vagianos, *supra* note 92.

Labrador had issued a letter to the Idaho legislature stating that it is a violation of Idaho's abortion bans to refer patients for abortion care in states where it is legal. Although Defendant Labrador was recently enjoined from carrying out this threat, *Planned Parenthood Greater Northwest. v. Labrador*, No. 1:23-CV-00142-BLW, 2023 WL 4864962 (D. Idaho July 31, 2023), the damage was already done as several more physicians had already decided to leave the state.

284. Just three months later, in June 2023, a group of Idaho legislators sent letters to all of the hospitals in Idaho demanding that they report the number of abortions each institution has provided pursuant to the Medical Exceptions to Idaho's abortion bans. The letters cite no statutory authority for legislators to demand such data from healthcare institutions.[97] The demand letters have further heightened the atmosphere of extreme fear and distress among physicians who treat patients with pregnancy complications.

285. This exodus of OB-GYNs from Idaho will have ripple effects on all aspects of reproductive healthcare because OB-GYNs treat conditions unrelated to pregnancy, including menstrual conditions, endometriosis, and pelvic pain.[98]

286. The abortion bans are also impacting recruitment of medical residents to work in Idaho. With its population of nearly two million people, Idaho is one of only six states that does not have an OB-GYN residency program. This means that every OB-GYN that works in Idaho has to be recruited from another state. But there is fierce competition for OB-GYNs in the region: of the six states that border Idaho, only four have an OB-GYN residency program. These four programs produce only 26 new Obstetrics and Gynecology-trained physicians per year to supply

[97] Rachel Sun & Laura Guido, *UPDATED: Idaho Freedom Caucus asked hospitals for abortion records*, Nw. Pub. Broad. (Aug. 3, 2023), https://www.nwpb.org/2023/08/03/idaho-freedom-caucus-asked-hospitals-for-abortion-records/.

[98] Varney, *supra* note 71.

a population of over 22 million people across Idaho, Utah, Montana, Wyoming, Oregon, Washington, and Nevada. Idaho is the only one of these states with an extreme total abortion ban in effect with no health exception.

287. As noted above, *supra* ¶ 107, physicians who wish to provide obstetric care in Idaho are often trained and become certified in Family Medicine. IAFP members who are involved in the recruitment and training of medical students in Family Medicine residency programs and post-residency fellowships in the state have reported that "Idaho will suffer" because its healthcare workforce is "losing out" on applicants.[99] A large family medicine residency program in Idaho expects that, based on interviews with about 400 students, a fifth will likely choose not to train in Idaho due to concerns around the state's abortion bans.[100] Because over half of physicians nationwide stay and practice medicine within 100 miles of where they train as residents, Idaho will not have the physician workforce it needs in years to come.[101]

288. And the abortion bans are not just endangering pregnant people; they are fueling the collapse of Idaho's broader medical system by driving physicians from across the spectrum of healthcare to flee Idaho as it has become impossible to treat pregnant people without running afoul of Idaho's scheme of abortion bans. This vacuum in obstetric care creates a domino effect that adversely impacts the availability of care for the broader patient population.

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[99] Rachel Cohen, *'Idaho will suffer for this': Doctors worry about attracting medical residents due to abortion bans*, Boise State Pub. Radio (Mar. 17, 2023), https://www.boisestatepublicradio.org/news/2023-03-17/idaho-will-suffer-for-this-doctors-worry-about-attracting-medical-residents-due-to-abortion-bans.

[100] *Id.*

[101] *Id.*

289. Jim Souza, M.D., the chief physician executive at St. Luke's in Boise, announced in May 2023 that Idaho is "'at the beginning of the collapse of an entire system of care.'"[102]

290. St. Alphonsus is having trouble recruiting physicians across practice areas, including orthopedic surgery and cardiology. According to St. Alphonsus CEO Ms. Bolano, several interviewees have cited the political climate in Idaho as a reason they hesitate to pursue a job listing at St. Alphonsus.[103]

291. Through her position at her hospital and as Chair of Idaho ACOG, Dr. Corrigan has observed that many physicians and healthcare professionals in specialties other than reproductive health are reluctant to practice medicine in a state that criminalizes physicians for providing evidence-based medical care. They also want to have the full spectrum of reproductive health care available for themselves and their families in the state where they live. And several of the OB-GYNs who have left Idaho due to the abortion bans have spouses who are also physicians in other specialties, further exacerbating the overall physician shortage in the state.

292. And as Idaho physician numbers continue to dwindle because of early retirements and departures caused by the bans, there has been a significant decline in the number of physicians intent on replacing them. In fact, Idaho's abortion bans are discouraging physicians from all medical specialties from practicing in Idaho. The Journal of General Internal Medicine recently published a study with a survey of more than 2,000 current and future physicians on social media where 82% of respondents preferred to work or train in states with preserved abortion access.[104]

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[102] Kaye & Samaniego, *supra* note 51.

[103] *A St. Alphonsus CEO said Idaho is losing doctors due to restrictive medical legislation*, *supra* note 79.

[104] Moseley-Morris, *supra* note 81.

More than 76% of the respondents said they would not apply to states with laws that impose consequences for providing abortion care.[105]

293. IAFP member and Plaintiff Dr. Lyons has served as a Preceptor for medical students who were initially intent on practicing in Idaho after completing medical school but have since changed their minds because of Idaho's abortion laws.

294. Kathryn Tiger and Allie Ward, first-year medical students in Moscow, Idaho, are both planning to become surgeons and are not intending to practice in Idaho for this reason. Ms. Tiger states she "'wouldn't feel safe here as a provider'" or "'as a patient,'" and Ms. Ward highlights Idaho's abortion bans are restricting physicians from providing comprehensive care.[106]

295. Some IAFP members who saw their family medicine practice grow exponentially in recent years are now seeing little to no interest in open physician positions. Recruitment challenges have resulted in heavier and more stressful workloads for those who choose to remain in the state, thereby increasing their likelihood of developing burnout and impacting their ability to provide quality care to all of their patients.

296. For physicians who work in rural areas like IAFP members Dr. Lyons and Dr. Aker, Idaho's abortion bans pose an even greater risk to their recruitment and retention efforts. Already, hospitals and medical groups in rural areas face challenges attracting applicants. With Idaho's abortion bans, family physicians are far less likely to want to practice in the state.

297. Idaho already has the lowest provider to population ratio in the nation,[107] and this disparity will only worsen since the legal landscape is making it more difficult to recruit and retain

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[105] *Id.*

[106] Varney, *supra* note 71.

[107] *Physicians*, CDC (Last Reviewed June 26, 2023), https://www.cdc.gov/nchs/hus/topics/physicians.htm.

physicians.[108] As hospitals are increasingly unable to recruit physicians to replace those leaving the state, all Idahoans' health and safety is being put in jeopardy by the legislature's zeal to ban abortion. The result is nothing short of a healthcare crisis throughout the state of Idaho.

IV. The Idaho Constitution Protects Pregnant People with Pregnancy Complications and Their Physicians from State Deprivation of Their Rights

298. The Supreme Court may have stripped pregnant people of their federal constitutional right to abortion, *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228, 213 L. Ed. 2d 545 (2022), but that does not mean that Plaintiffs are without constitutional rights.

299. The Idaho Constitution guarantees its citizens certain inalienable rights, including "enjoying and defending life and liberty" and "pursuing happiness and securing safety." IDAHO CONST. Art. I, § 1. These are explicit, fundamental, and *inalienable* rights, and should be subject to the highest level of judicial scrutiny. Idaho law cannot demand that a pregnant person sacrifice their life, their fertility, or their health in service of "unborn life," particularly where a pregnancy will not or is unlikely to result in the birth of a living child with sustained life.

300. The Idaho Constitution also prohibits the state from denying pregnant people with certain kinds of medical complications—for example, pregnant people whose health risks are emergent but not imminently "life-threatening"— appropriate and/or life-saving medical care.

301. Specifically, the Idaho Constitution requires that "'all persons in like circumstances should receive the same benefits and burdens of the law.'" *Alpine Vill. Co. v. City of McCall*, 154 Idaho 930, 937, 303 P.3d 617, 624 (2013) (quoting *Bon Appetit Gourmet Foods, Inc. v. State, Dep't of Emp.*, 117 Idaho 1002, 1003, 793 P.2d 675, 676 (1989)); *see also* IDAHO CONST. Art. I, §§ 1, 2.

[108] Vagianos, *supra* note 92.

302. To the extent Idaho's abortion laws ban the provision of abortion to pregnant people to treat medical conditions that pose a risk to their lives or a significant risk to their health, those laws treat pregnant people differently than others with emergent medical conditions and thus violate their fundamental rights to equality.

303. Indeed, Idaho's abortion bans fail any level of constitutional review when applied to such pregnant people. "If [an abortion ban] were to prohibit an abortion even where the mother's life is in jeopardy, I have little doubt that such a statute would lack a rational relation to a valid state objective . . . ." *Roe v. Wade*, 410 U.S. 113, 173 (1973) (Rehnquist, J., dissenting). Because Idaho's abortion bans force pregnant people with pregnancy complications to surrender their lives, health, and/or fertility, they have no rational relationship to protecting life, health, or any other legitimate state interest.

V. Idaho-Licensed Physicians Have Liberty and Property Rights to Provide Care to Pregnant People with Pregnancy Complications

304. The Idaho Constitution grants Idaho citizens the inalienable rights of "acquiring, possessing and protecting property," IDAHO CONST. Art. I, § 1, and guarantees that "[n]o person shall . . . be deprived of life, liberty, or property without due process of law," IDAHO CONST. Art. I, §13. The threatened enforcement of the abortion bans against physicians who in good faith provide abortions for pregnant people suffering pregnancy complications that pose risks to their life or health infringes these constitutional guarantees.

305. Sections 1 and 13 guarantee Idaho-licensed physicians the right to practice their profession by providing abortion care to their pregnant patients to treat emergent medical conditions that the physician determines poses a risk to the patient's life or health.

306. To fulfill this guarantee, physicians must be able to exercise their good faith judgment in the care of their patients with emergent conditions without threat that the state will take their license and/or liberty if a prosecutor or jury second guesses their medical judgment.

307. Idaho law authorizes Defendant Idaho State Board of Medicine (IBOM) to institute disciplinary and licensing proceedings to suspend or revoke the medical license of any physician who performs an abortion that the Board determines did not meet the Medical Exceptions in the Total Abortion Ban or the Six-Week Abortion Ban. I.C. §§18-622(2)(a)–(b), 18-8801(5), and 54-1814(6).

308. Disciplinary actions are reported to the National Practitioner Data Bank[109] and can have collateral consequences on a physician's ability to practice in other U.S. States. Defendant IBOM, for example, requires physicians to make timely reports of any disciplinary actions taken by other jurisdictions against the physician, and can take disciplinary action against physicians based on conduct occurring in other states. I.C. §§ 54-1814, -1818. Upon information and belief, disciplinary sanctions may also result in loss of employment.

309. Physicians must make a substantial investment to obtain a medical license in Idaho. According to the IBOM, to be eligible for a physician's license in Idaho, individuals must: graduate from an accredited medical school, having gained admission through a highly competitive application process which often necessitates incurring significant amounts of debt; complete at least one continuous year of graduate medical training or a fellowship; pass rigorous state examinations; and, *inter alia*, have no relevant disciplinary or criminal history. I.C. § 54-1810. If

[109] *See* 42 U.S.C. § 11132 (requiring state medical boards to report all revocations or suspensions of physician licenses); *see also* Nat'l Prac. Data Bank, Guidebook, at Ch. E: Reports, Table E-1 (Oct. 2018), https://www.npdb.hrsa.gov/guidebook/EOverview.jsp (explaining state medical boards and hospitals have mandatory reporting obligations).

physicians meet these requirements and incur the substantial associated costs, they are eligible to apply for full licensure in Idaho. I.C. § 54-1810. Once granted, a physician may practice medicine within Idaho and has a vested property interest in their license.

310. Revoking or suspending a physician's license based on a flawed interpretation of the Medical Exceptions is improper interference with the physician's vested property interest in their license.

311. Further, sending a physician to prison for up to five years for providing timely and appropriate medical care to a pregnant person with an emergent medical condition is improper interference with the physician's liberty.

312. Physicians have constitutional rights under Sections 1 and 13 of Article I of the Idaho Constitution including rights to liberty, property, and substantive due process of law. Even for laws that only touch on economic rights, Section 13 requires a rational relationship to the purpose of the law.

313. As applied to pregnant people with emergent medical conditions and the physicians treating them, the Total Abortion Ban and the Six-Week Abortion Ban fail to comply with the Idaho Constitution. They do not serve a proper legislative purpose because far from furthering life, they harm the lives of pregnant people and their families and put them in danger.

314. Idaho law also demands that there be a real and substantial connection between a legislative purpose and the language of the law as it functions in practice. For pregnant people with emergent medical conditions, there is none.

CLAIMS FOR RELIEF

Claim I: Declaratory Judgment

315. The allegations of paragraphs 1 through 314 are incorporated as though fully set forth herein.

316. Plaintiffs petition the Court pursuant to the Idaho Declaratory Judgments Act, I.C. § 10-1201 *et seq*. ("IDJA").

317. The IDJA is remedial; "its purpose is to settle and to afford relief from uncertainty and insecurity with respect to rights, status and other legal relations, and is to be liberally construed and administered." I.C. § 10-1212.

318. Under Section 10-1201 of the Idaho Code, a court of proper jurisdiction "shall have power to declare rights, status, and other legal relations, whether or not further relief is or could be claimed. No action or proceeding shall be open to objection on the ground that a declaratory judgment or decree is prayed for. The declaration may be either affirmative or negative in form and effect, and such declarations shall have the force and effect of a final judgment or decree."

319. Plaintiffs thus seek a declaratory judgment that the Medical Exceptions codified at I.C. § 18-622(2) and § 18-8801(5), permit physicians to provide a pregnant person with abortion care when the physician determines, in their good faith judgment and in consultation with the pregnant person, that the pregnant person has an emergent medical condition that poses a risk of death or a risk to their health (including their fertility).

320. Plaintiffs also seek a declaratory judgment that, at a minimum, Idaho's abortion bans do not preclude a physician from providing abortion care where, in the physician's good faith judgment and in consultation with the pregnant person, a pregnant person has: a medical condition or complication of pregnancy that poses a risk of infection, bleeding, or otherwise makes continuing a pregnancy unsafe for the pregnant person; a medical condition that is exacerbated by

pregnancy, cannot be effectively treated during pregnancy, or requires recurrent invasive intervention; and/or a fetal condition where the fetus is unlikely to survive the pregnancy and sustain life after birth.

321. Plaintiffs have sued the State of Idaho and the relevant state officers and agencies, and Plaintiffs seek to have this Court determine the validity of Idaho's Total Abortion Ban and Six-Week Abortion Ban as applied to patients with emergent medical conditions and the physicians who treat such patients. Therefore, the State of Idaho and its officers and agencies are necessary parties to this suit and governmental immunity does not apply.

Claim II: Ultra Vires

322. The allegations of paragraphs 1 through 321 are incorporated as though fully set forth herein.

323. Government officials may not act without legal authority.

324. Any official's enforcement of Idaho's abortion bans against any physician who provides an abortion to a pregnant person after determining that, in the physician's good faith medical judgment, the pregnant person has an emergent medical condition for which abortion would prevent or alleviate a risk of death or risk to their health (including their fertility) would be inconsistent with the Medical Exceptions to Idaho's abortion bans and therefore would be ultra vires.

325. Plaintiffs have sued the Defendant state officers in their official capacities, and they seek prospective relief other than the recovery of monetary damages.

Claim III: Inalienable Rights of Pregnant People

326. The allegations of paragraphs 1 through 325 are incorporated as though fully set forth herein.

327. The Idaho Constitution explicitly guarantees all people the inalienable rights of enjoying and defending life, pursuing happiness, and securing safety. IDAHO CONST. Art. I, § 1.

328. The due process language in Article I, § 13 of the Idaho Constitution protects and ensures the use and enjoyment of the rights declared by Article I, § 1.

329. To the extent the Total Abortion Ban and the Six-Week Abortion Ban, separately or in concert, bar the provision of abortion to pregnant people to treat emergent medical conditions that pose a risk to pregnant people's lives or health (including their fertility), the bans violate pregnant people's fundamental rights to enjoying and defending life, pursuing happiness, and securing safety under Article I, § 1 of the Idaho Constitution.

330. Thus applied, Idaho's abortion bans do not serve a compelling or important state interest and are not sufficiently tailored to serve any compelling interest.

331. Thus applied, Idaho's abortion bans also lack any rational relationship to protecting life, health, or any other legitimate state interest.

332. Plaintiffs seek a declaratory judgment that the explicit rights to enjoying and defending life, pursuing happiness, and securing safety in Article I, § 1 of the Idaho Constitution require that a pregnant person be permitted to receive abortion care in Idaho when the pregnant person has an emergent medical condition that poses a risk of death or risk to their health (including their fertility), and an abortion would prevent or alleviate such risk.

333. Any state official's enforcement of Idaho's abortion bans as applied to a pregnant person with an emergent medical condition for whom an abortion would prevent or alleviate a risk of death or risk to their health (including their fertility) would be inconsistent with Article I, §§ 1 and 13 of the Idaho Constitution and therefore would be ultra vires.

Claim IV: Equal Rights of Pregnant People

334. The allegations of paragraphs 1 through 333 are incorporated as though fully set forth herein.

335. Under the Idaho Constitution "'all persons in like circumstances should receive the same benefits and burdens of the law.'" *Alpine Vill. Co. v. City of McCall*, 154 Idaho 930, 937, 303 P.3d 617, 624 (2013) (quoting *Bon Appetit Gourmet Foods, Inc. v. State, Dep't of Employment*, 117 Idaho 1002, 1003, 793 P.2d 675, 676 (1989)); *see also* IDAHO CONST. Art. I, §§ 1, 2.

336. Idaho does not prevent non-pregnant people or people unable to get pregnant from accessing critical medical treatment nor force them to unnecessarily suffer severe illnesses and injuries and undergo mental anguish.

337. To the extent Idaho's abortion bans bar or delay the provision of abortion to a pregnant person with an emergent medical condition that poses a risk of death or risk to their health (including their fertility), while allowing non-pregnant people and people unable to get pregnant to access medical treatment for emergent medical conditions, Idaho's abortion bans violate pregnant people's right to equal treatment under the law.

338. Thus applied, Idaho's abortion bans do not serve a compelling or important state interest and are not sufficiently tailored to serve any compelling interest.

339. Thus applied, Idaho's abortion bans also lack any rational relationship to protecting life, health, or any other legitimate state interest.

340. Plaintiffs seek a declaratory judgment that Article I, §§ 1 and 2 of the Idaho Constitution guarantee a pregnant person the ability to receive an abortion where the pregnant

person has an emergent medical condition that poses a risk of death or risk to their health (including their fertility), and an abortion would prevent or alleviate such risk.

341. Any official's enforcement of Idaho's abortion bans as applied to a pregnant person with an emergent medical condition for whom an abortion would prevent or alleviate a risk of death or risk to their health (including their fertility) would be inconsistent with Article I, §§ 1 and 2 of the Idaho Constitution and therefore would be ultra vires.

Claim V: Due Process Rights of Physicians

342. The allegations of paragraphs 1 through 341 are incorporated as though fully set forth herein.

343. Under the Idaho Constitution, Idaho citizens are guaranteed the inalienable rights of "acquiring, possessing and protecting property," IDAHO CONST. Art. I, § 1, and "[n]o person shall . . . be deprived of life, liberty, or property without due process of law," IDAHO CONST. Art. I, §13.

344. Article I, §§ 1 and 13 of the Idaho Constitution guarantee Idaho-licensed physicians the right to practice their profession by providing abortion to their pregnant patients to treat emergent medical conditions that the physician determines pose a risk to the pregnant person's life or health (including their fertility).

345. To the extent Idaho's abortions bans bar or delay physicians from providing abortion to treat emergent medical conditions that pose a risk to a pregnant person's life or health (including their fertility), Idaho's abortion bans violate Idaho-licensed physicians' rights under Article I, §§ 1 and 13.

346. Thus applied, Idaho's abortion bans do not serve a proper legislative purpose, there is no real and substantial connection between a legislative purpose and the language of the abortion

bans as those bans function in practice for patients with emergent medical conditions, and Idaho's abortion bans work an excessive burden on Idaho-licensed physicians treating such patients relative to their purpose.

347. Thus applied, Idaho's abortion bans also lack any rational basis.

348. Plaintiffs seek a declaratory judgment that Article I, §§ 1 and 13 of the Idaho Constitution guarantee Idaho-licensed physicians the right to provide an abortion to a pregnant person to treat an emergent medical condition that the physician determines poses a risk to the pregnant person's life or health (including their fertility).

349. Any state official's enforcement of Idaho's abortion bans as applied to an Idaho-licensed physician who provides an abortion to a pregnant person to treat an emergent medical condition that the physician determines poses a risk to the pregnant person's life or health (including their fertility) would be inconsistent with Article I, §§ 1 and 13 of the Idaho Constitution and therefore would be ultra vires.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray for relief against Defendants as follows:

I. For a judgment and decree of this Court declaring:

   a. The scope of the Medical Exceptions consistent with the Idaho Constitution;

   b. Defendant state officials have no right or power to enforce Idaho's abortion bans contrary to the Court's declaration regarding their constitutional scope; and

   c. Idaho's abortion bans, as applied to pregnant people with emergent medical conditions and Idaho-licensed physicians treating such patients, violate the Idaho Constitution.

II. That Defendants be permanently enjoined from:

a. Enforcing Idaho's abortion bans contrary to the Court's declaration regarding their constitutional scope; and

b. Enforcing Idaho's abortion bans to prevent pregnant people with emergent medical conditions from receiving abortion care and Idaho-licensed physicians from providing abortion care to such patients.

III. For the recovery of all reasonable costs and attorneys' fees pursuant to Idaho law;

IV. For such other and further relief as the Court deems just and equitable.

Dated on this 11th day of September, 2023.

Respectfully submitted,

/s/ Scott McKay

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