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MONTANA THIRTEENTH JUDICIAL DISTRICT COURT,
YELLOWSTONE COUNTY

PLANNED PARENTHOOD OF MONTANA and JOEY BANKS, M.D., on behalf of themselves and their patients, Plaintiffs, vs. STATE OF MONTANA, by and through AUSTIN KNUDSEN, in his official capacity as Attorney General, Defendant.	Cause No.: DV 21-00999 Judge: Jessica T. Fehr **VERIFIED COMPLAINT**

Planned Parenthood of Montana ("PPMT") and Dr. Joey Banks, M.D. (collectively, "Plaintiffs") bring this Verified Complaint against the State of Montana, and in support thereof state the following:

PRELIMINARY STATEMENT

1. Plaintiffs bring this action on behalf of themselves and their patients. They seek declaratory and permanent injunctive relief from four unconstitutional laws enacted by the Montana Legislature and signed by the Governor. Plaintiffs also seek preliminary injunctive relief from three of those laws in order to preserve the status quo and prevent immediate and irreparable harm.

2. These laws, individually and collectively, ban abortion at a pre-viable gestational age, restrict access to medication abortion (including prohibiting its provision by telehealth), target abortion patients and providers with burdens not imposed on other patients or providers, compel providers to present medically inaccurate information to their patients, stigmatize the decision to obtain an abortion, and bar insurance plans from covering abortion care. Moreover, these laws threaten Montana health care providers with severe criminal and civil penalties, and civil lawsuits, for providing women with access to constitutionally guaranteed health care.[1] And they do so based on unconstitutionally vague prohibitions and requirements.

3. These laws are nothing more than poorly disguised attempts to chip away at Montanans' access to safe and constitutional abortion. They will reduce the number and geographic distribution of locations in Montana where women can access safe and effective abortion care. Their combined effect is particularly cruel and prohibitive—pushing women

[1] Plaintiffs use "women" as shorthand for people who are or may become pregnant, but people of other gender identities, including transgender men and gender-diverse individuals, may also become pregnant, seek abortion services, and be harmed by the laws.

seeking abortion later into pregnancy and also cutting off access to abortion at an earlier gestational age.

4. These laws clearly violate the Montana Constitution and contravene binding precedent from the Montana Supreme Court. "Article II, Section 10 of the Montana Constitution broadly guarantees each individual the right to make medical judgments affecting her or his bodily integrity and health in partnership with a chosen health care provider free from government interference." *Armstrong v. State*, 1999 MT 261, ¶ 14, 296 Mont. 361, 989 P.2d 364. Section 10 thus "protects a woman's right of procreative autonomy," including "the right to seek and to obtain a specific lawful medical procedure, a pre-viability abortion, from a health care provider of her choice." *Id.*

5. House Bill 136 ("HB 136" or the "20-week ban") criminalizes the provision of abortion beginning 20 weeks after the first day of a woman's last menstrual period ("LMP"), subject only to very limited and vague exceptions. *See* HB 136, 2021 Leg. Reg. Sess. (Mont. 2021) (to be codified in Mont. Code Ann. tit. 50, ch. 20) (attached hereto as Exhibit 1). It does so notwithstanding the fact that such safe and effective procedures are performed pre-viability and therefore are protected by the Montana Constitution.

6. House Bill 171 ("HB 171" or the "omnibus MAB restrictions law") restricts access to abortion provided early in pregnancy by imposing a litany of restrictions on the provision of medication abortion ("MAB"), a common procedure that is both safe and effective. *See* HB 171, 2021 Leg. Reg. Sess. (Mont. 2021) (to be codified in Mont. Code Ann. tit. 50, ch. 20) (attached hereto as Exhibit 2). The law includes requirements that patients make at least two trips for in-person appointments with the same health care provider for care that can be—and

currently is—provided by telemedicine, a 24-hour mandated delay between those visits, and other medically unnecessary requirements.

7. House Bill 140 ("HB 140" or the "ultrasound offer law") mandates that abortion providers ask patients whether they want to view "an active ultrasound" and "ultrasound image," and to "listen to the fetal heart tone"—and requires patients to sign a State-created form indicating their answers to those questions. It imposes this mandate—which has no medical purpose—to stigmatize a woman's decision to have an abortion and even when the provider believes, in her medical judgment, that those offers would be harmful to the patient. *See* HB 140, 2021 Leg. Reg. Sess. (Mont. 2021) (to be codified in Mont. Code Ann. tit. 50, ch. 20) (attached hereto as Exhibit 3).

8. House Bill 229 ("HB 229" or the "coverage ban") prohibits subsidized health insurance plans on the Affordable Care Act ("ACA") exchange in Montana from providing coverage for abortion, even though no State funds are involved. *See* HB 229, 2021 Leg. Reg. Sess. (Mont. 2021) (to be codified in Mont. Code Ann. tit. 33, ch. 22) (attached hereto as Exhibit 4).

9. Each of these laws will take effect on October 1, 2021, if not enjoined by this Court.

10. These laws violate fundamental rights of Plaintiffs and their patients under the Montana Constitution, including a woman's "right to seek and to obtain ... a pre-viability abortion[] from a health care provider of her choice." *Armstrong*, ¶ 14.

11. The 20-week ban infringes the Montana Constitution's right to privacy, right to individual dignity, and right to seek safety, health, and happiness by banning constitutionally protected pre-viability abortions; it violates the Montana Constitution's equal protection

guarantee by unlawfully singling out women seeking abortions and abortion providers, and unlawfully targeting women seeking abortions beginning at 20 weeks; and it violates the Montana Constitution's due process clause because it does not give fair notice of the conduct it prohibits.

12. The omnibus MAB restrictions law infringes the Montana Constitution's right to privacy, right to individual dignity, and right to seek safety, health, and happiness by restricting access to a constitutional and safe medical procedure; it violates the Montana Constitution's equal protection guarantee by unlawfully singling out women seeking abortions and abortion providers; it violates the right to free speech guaranteed by the Montana Constitution because it compels particular speech by the provider, even when that information is false and the provider objects to the content of that speech; and it violates the Montana Constitution's due process clause because it does not give fair notice of the conduct it prohibits.

13. The ultrasound offer law infringes the Montana Constitution's right to privacy, right to individual dignity, and right to seek safety, health, and happiness by restricting access to a constitutional and safe medical procedure; it violates the Montana Constitution's equal protection guarantee by unlawfully singling out women seeking abortions and abortion providers; and it violates the Montana Constitution's guarantees of free speech, because the State lacks a compelling interest in forcing providers to ask patients stigmatizing questions irrespective of the provider's medical judgment regarding whether those questions are in the patient's best interest, and to sign a State-developed form that records the patients' answers.

14. The coverage ban infringes the Montana Constitution's right to privacy, the right to individual dignity, and the right to seek safety, health, and happiness by restricting access to a

constitutional and safe medical procedure; and it violates Montana's equal protection guarantee by singling out women seeking abortions.

15. This Verified Complaint and the claims it makes should come as no surprise to the Legislature. Its own attorneys warned that HB 136 and HB 171 likely violated women's right to privacy under the Montana Constitution. *See* HB 136 Legal Review Note ("Because HB136 prohibits abortion entirely after a fetus has reached a gestational age of 20 or more weeks, the bill raises potential conformity issues with the requirements of the . . . Montana Constitution.") (attached hereto as Exhibit 5); HB 171 Legal Review Note ("Given Montana's broad right to privacy . . . , HB 171, as drafted, may raise a constitutional conformity issue regarding the infringement of a woman's right to privacy, specifically a woman's right to seek and obtain a pre-viability abortion.") (attached hereto as Exhibit 6).

PARTIES

A. Plaintiffs

16. Plaintiff PPMT is a not-for-profit corporation organized under the laws of Montana. It is headquartered in Billings and operates five health centers: two in Billings (Planned Parenthood Heights and Planned Parenthood West), one in Missoula, one in Great Falls, and one in Helena.

17. PPMT provides clinical, educational, and counseling services. It is the largest provider of reproductive health care in Montana, serving more than 11,000 people annually. The services that PPMT provides include: pregnancy diagnosis and counseling; contraceptive counseling; provision of all methods of contraception; HIV/AIDS testing and counseling; testing, diagnosis, and treatment of sexually transmitted infections; screenings for cervical and breast cancer; gender affirming care; miscarriage management; and abortion.

18. PPMT sues on its own behalf; on behalf of its current and future physicians, medical staff, servants, officers, and agents who participate in activities that could subject them to liability under HB 136, HB 171, and/or HB 140, or that will be affected by HB 229; and on behalf of its patients seeking abortions.

19. Plaintiff Joey Banks, M.D., is a physician licensed to practice medicine in Montana, with over 20 years' experience providing primary care and reproductive health care, and over 15 years' experience providing and supervising abortions. Dr. Banks sues on her own behalf, and on behalf of her patients seeking abortions. At PPMT, Dr. Banks provides MABs through 11 weeks LMP (both in person and through telemedicine) and procedural abortions through 21.6 weeks LMP.

20. But for the abortion restrictions challenged here, Dr. Banks and PPMT would continue to provide MABs through 11 weeks LMP (both in person and through telemedicine) and procedural abortions through 21.6 weeks LMP.

B. Defendant

21. The State of Montana is a governmental entity subject to suit for injuries to persons. Mont. Const. art. II, § 18. The State of Montana, through its Legislature, adopted HB 136, HB 171, HB 140, and HB 229.

22. Austin Knudsen is the Attorney General of Montana. He is the chief law enforcement officer of the State of Montana. Pursuant to Montana law, he exercises supervisory powers over county attorneys. Section 2-15-501, MCA. He will be responsible for the enforcement of HB 136, HB 171, HB 140, and HB 229 unless restrained by this Court. Knudsen is sued in his official capacity.

JURISDICTION AND VENUE

23. Jurisdiction is conferred on this Court by article VII, section 4 of the Montana Constitution and § 3-5-302, MCA.

24. Plaintiffs' claims for declaratory and injunctive relief are authorized by §§ 27-8-101 et seq., MCA, as well as the general equitable powers of this Court.

25. Venue is appropriate pursuant to §§ 25-2-126 & 25-2-117, MCA, because the State of Montana is a Defendant and PPMT is a resident of Yellowstone County and operates two health centers in Billings, Yellowstone County, which provide abortions, including one that provides procedural abortions.

STANDING

26. Plaintiffs have standing to bring the claims asserted in this Verified Complaint because the challenged laws infringe on their and their patients' fundamental rights under the Montana Constitution.

27. "[W]hen 'governmental regulation directed at health care providers impacts the constitutional rights of women patients,' the providers have standing to challenge the alleged infringement of such rights." *Weems v. State by and through Fox*, 2019 MT 98, ¶ 12, 395 Mont. 350, 440 P.3d 4 (quoting *Armstrong v. State*, 1999 MT 261, ¶¶ 8-13, 296 Mont. 361, 989 P.2d 364).

28. Plaintiffs also have standing to bring their own due process, equal protection, and free speech claims because the challenged provisions directly infringe on Plaintiffs' rights under the Montana Constitution. *See Weems*, ¶ 14 (holding that abortion provider plaintiffs who "are impacted by the statute" have standing to challenge it). But for the challenged provisions,

Plaintiffs would provide abortion services and make decisions regarding those services according to their own medical judgments, rather than the State's decrees.

FACTUAL ALLEGATIONS

A. Abortion Care

29. Abortion, through medication or procedure, is safe and common. Nationwide, one in five pregnancies ends in abortion.[2] About one in four American women will have an abortion by the time she reaches age 45.[3]

30. MAB allows a pregnant woman to terminate an early pregnancy by taking two medications, mifepristone and misoprostol, which together induce the equivalent of an early miscarriage.

31. With procedural abortion, a medical provider uses a suction device, sometimes along with other instruments, to empty the uterus. Despite sometimes being referred to as "surgical abortion," procedural abortion is not what is commonly understood to be "surgery" as it involves no incisions, usually does not require general anesthesia, and is almost always performed in an outpatient setting.

32. Complications from both medication and procedural abortion are extremely rare. When complications do occur, they can usually be managed in an outpatient setting, either at the time of the abortion or in a follow-up visit.

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2 Rachel K. Jones et al., *Abortion Incidence and Service Availability in the United States, 2017*, at 1, Guttmacher Inst. (Sept. 2019), https://www.guttmacher.org/sites/default/files/report_pdf/abortion-incidence-service-availability-us-2017.pdf.

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

33. Both procedural and medication abortion are effective in terminating a pregnancy. Procedural abortions are successful 99% of the time and, according to the Food and Drug Administration ("FDA"), the success rate for MABs is 97.4%.[4]

34. For some patients, one method is medically indicated over the other. For example, MAB may be medically indicated for certain pregnant women (*e.g.*, women with certain uterine anomalies), and strongly preferred by others (*e.g.*, sexual assault survivors for whom the insertion of instruments into the vagina may cause emotional and psychological trauma, or minors who have never had a pelvic exam). And for some pregnant women in abusive relationships, access to MAB—the results of which look identical to a miscarriage—is essential to protect themselves from violence and retaliation for their decision to have an abortion.

35. Women decide to end a pregnancy for a variety of reasons, including familial, medical, financial, and personal ones. Some women decide that it is not the right time to have a child or to add to their families; some end a pregnancy because of a severe fetal anomaly; some choose not to carry a pregnancy to term because they have become pregnant as a result of rape; some choose not to have biological children; and for some, continuing with a pregnancy could pose a significant risk to their health.

36. Women seeking an abortion generally do so as soon as they are able. But logistical challenges can delay abortion access. Patients must arrange and pay for transportation, childcare, and/or lodging, and arrange to take time off from work. For low-wage workers, who often have no paid time off or sick leave, these burdens are particularly acute.

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[4] MIFEPREX (Mifepristone) Tablets Label, FDA (Mar. 2016), https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf.

37. Abortion patients who experience intimate partner violence face even more difficulty accessing abortion.[5]

38. Delay of abortion care inflicts physical, psychological, and/or financial harms on abortion patients. Although abortion is extremely safe throughout pregnancy and significantly safer than continuing pregnancy through childbirth, delaying abortion care unnecessarily increases medical risk. A patient whose care is delayed—*i.e.*, who must remain pregnant longer—will suffer both increased risks associated with remaining pregnant and comparatively increased risks associated with the abortion procedure.

39. As a result of unnecessary delay, some patients are prevented from obtaining MABs because they are pushed past the gestational age limit. Others are prevented from obtaining an abortion altogether.

40. Timely abortion care is important to public health. The American College of Obstetricians and Gynecologists has explained that abortion "is an essential component of comprehensive health care" and "a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks [to patients] or potentially make it completely inaccessible."[6]

41. The cost of the abortion procedure also increases as the pregnancy advances. If women are forced to wait to have abortions, they incur increased costs.

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[5] Ann M. Moore et al., *Male Reproductive Control of Women Who Have Experienced Intimate Partner Violence in the United States*, Guttmacher Inst., at 8-9 (2010), https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/socscimed201002009.pdf.

[6] Press Release, ACOG et al., Joint Statement on Abortion Access During the COVID-19 Outbreak (Mar. 18, 2020), https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak.

42. If women are not able to access abortion, some may resort to unsafe means to end their pregnancies. Others may have to travel to other states with later gestational age limits, incurring greater expense and risk. And some women may be forced to carry their pregnancies to term, depriving them of their ability to decide whether and when to have a child.

43. For Montanans seeking abortion, these challenges are particularly acute given Montana's lack of providers. Approximately 90% of the counties in Montana do not have an abortion provider, and about 50% of Montanans live in those counties.

44. In addition, the size of Montana and its long winters make travel particularly difficult. It is common for patients to travel six to eight hours round trip to visit PPMT's health centers. And those challenges have been exacerbated due to the health risks caused by and public safety restrictions imposed during the COVID-19 pandemic.

45. Abortion is legal in Montana until viability. Section 50-20-109(1)(b), MCA.

46. In a normally progressing pregnancy, viability typically will not occur before approximately 24 weeks LMP.

47. Some fetuses are never viable, such as those with fetal anomalies, including anencephaly, severe brain anomalies, and severe cardiac anomalies.

B. PPMT's Provision of Abortion Care

48. PPMT provides procedural abortion, in-person MAB, and two forms of telehealth MAB: site-to-site and direct-to-patient. PPMT has provided telehealth MABs for over four years.[7] PPMT's provision of site-to-site and direct-to-patient MABs expands access to abortion care for Montanans.

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[7] See Julia E. Kohn, et al., *Introduction of Telemedicine for Medication Abortion: Changes in Service Delivery Patterns in Two U.S. States*, 103 Contraception 151, 152 (Mar. 2021).

49. There are few abortion providers in Montana, and PPMT is not able to staff abortion providers at each PPMT health center every day. Site-to-site MABs allow PPMT to bridge potential gaps in care by offering MABs at PPMT health centers where a provider is not physically present. For site-to-site MABs, a patient at a PPMT health center—accompanied by a clinical team member at that health center—connects through a telehealth visit with an abortion provider at another PPMT health center. Site-to-site MAB also decreases the amount of travel and expense required for patients, who can travel to the nearest PPMT health center, rather than to a health center where an abortion provider is physically present—which may be hours away.

50. PPMT also offers direct-to-patient MABs, which make abortion care more accessible particularly for women who do not live near any providing health center. For direct-to-patient MABs, a patient consults with a PPMT provider via telehealth from wherever in Montana the patient is located and then receives abortion medication by mail from PPMT to a Montana address—eliminating the need to travel to a PPMT health center in person and providing a safe and effective way to overcome barriers to abortion access in Montana. During the telehealth visit, providers review patients' medical history; explain the options that are available; if the patients are eligible for direct-to-patient MAB, instruct them on when to take the mifepristone and misoprostol; and counsel them on potential side effects or complications. The patients are then mailed the medications, which they take in accordance with the providers' instructions. Patients sign consent forms electronically, and are not required to have an ultrasound or blood work unless medically necessary.

51. The safety of mailing drugs (including for medication abortion[8]) is well-documented, and telemedicine is instrumental in making abortion care more accessible while lowering its costs.

52. PPMT provides abortions at each of its five health centers. The Helena and Billings Heights health centers offer procedural abortion, in-person MAB, and site-to-site MAB. The Billings West health center offers in-person and site-to-site MAB. The Great Falls health center provides site-to-site MAB. The Missoula health center provides direct-to-patient MAB.

53. PPMT provides MAB through 77 days (11 weeks) LMP.

54. Approximately 75% of abortions performed by PPMT are MABs.

55. In FY 2021, PPMT provided 935 MABs and 255 procedural abortions.[9] Of the 935 MABs provided, 715 (or about 76%) were provided using telehealth. Specifically, 140 MABs were provided direct-to-patient, and 575 MABs were provided site-to-site.

56. Of the 140 direct-to-patient MABs provided by PPMT in FY 2021, 56% were provided to women who would have been forced to drive at least one to two hours each way, assuming no stopping, traffic, or inclement weather, to reach the nearest MAB provider, and 18% were provided to women who would have been forced to drive at least two to five hours each way, assuming no stopping, traffic, or inclement weather.

57. PPMT provides procedural abortion up to 21.6 weeks LMP.

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8 *See generally* Erica Chong, et al., *Expansion of a Direct-to-Patient Telemedicine Abortion Service in the United States and Experience During the COVID-19 Pandemic*, 104 Contraception 43 (Mar. 2021).

9 FY 2021 for PPMT was July 1, 2020 through June 30, 2021.

C. The Challenged Laws

a. The 20-Week Ban (HB 136)

58. The 20-week ban prohibits abortion beginning at 20 weeks LMP—prior to fetal viability—absent very narrow (and vague) exceptions. It imposes criminal and civil penalties on health care providers who do not comply with its specifications.

59. The 20-week ban violates several provisions of the Montana Constitution. It (1) restricts pre-viability abortion in violation of the rights to privacy, individual dignity, and to seek safety, health, and happiness; (2) unlawfully singles out women seeking abortions and abortion providers, and unlawfully targets abortion beginning at 20 weeks LMP but not before, in violation of the equal protection guarantee; and (3) is unconstitutionally vague because it does not give fair notice of the conduct it prohibits.

60. By banning pre-viability abortions beginning at 20 weeks, HB 136 directly contravenes the Montana Supreme Court's binding decision in *Armstrong*.

i. Provisions

61. The 20-week ban prohibits abortions beginning at 20 weeks LMP, which is before viability. Specifically, it prohibits performing or attempting to perform "an abortion of an unborn child capable of feeling pain unless it is necessary to prevent a serious health risk to the ... mother." *See* HB 136 § 3. The law asserts, without citing any medical evidence, that fetuses are capable of feeling pain beginning at 20 weeks LMP. *Id.*

62. The 20-week ban includes only limited and ambiguous exceptions. Abortion beginning at 20 weeks LMP is permitted if the procedure is necessary to prevent a "serious health risk" to the pregnant woman, which is defined as "a condition that so complicates the mother's medical condition that it necessitates the abortion of the mother's pregnancy to avert

the mother's death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions." HB 136 §§ 2, 3. Further, "[n]o greater risk may be determined to exist if it is based on a claim or diagnosis that the mother will engage in conduct that the mother intends to result in the mother's death or in substantial and irreversible impairment of a major bodily function." *Id.* § 2. Abortion beginning at 20 weeks LMP is also permitted "in the case of a medical emergency," which is defined as "a condition that, in reasonable medical judgment, so complicates the medical condition of a pregnant woman that it necessitates the immediate abortion of the woman's pregnancy without first determining gestational age in order to avert the woman's death or for which the delay necessary to determine gestational age will create serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions." *Id.* §§ 2, 3. A "medical emergency" "does not include a condition that is based on a claim or diagnosis that the woman will engage in conduct that the woman intends to result in the woman's death or in substantial and irreversible physical impairment of a major bodily function." *Id.* § 2.

63. If, notwithstanding the ambiguity inherent in these definitions, a provider determines that the "serious health risk" exception applies, the 20-week ban requires the provider to "terminate the pregnancy in the manner that, in reasonable medical judgment, provides the best opportunity" for the fetus to survive "unless, in reasonable medical judgment, termination of the pregnancy in that manner would pose a greater risk either of the death of the pregnant woman or of the substantial and irreversible physical impairment of a major bodily function" than other methods. HB 136 § 3. The law provides no clarification or explanation regarding what method(s) of terminating a pregnancy provide the best opportunity for a *pre-viability* fetus to

survive, but rather leaves providers to interpret this incoherent requirement under the threat of criminal penalties.

64. The 20-week ban subjects providers to severe criminal penalties. Anyone who knowingly or purposefully performs or attempts to perform an abortion in violation of HB 136 is guilty of a felony punishable in accordance with § 50-20-112, MCA. Pursuant to §§ 50-20-112(1) and 45-5-102, MCA, a person that "purposely or knowingly causes the death of a fetus of another with knowledge that the woman is pregnant" constitutes deliberate homicide, which is punishable by death or life imprisonment. Under § 50-20-112(2), a person convicted of a felony other than deliberate (or mitigated or negligent homicide) is subject to up to five years in prison.

65. In addition, a civil action for actual and punitive damages may be brought against the provider by "a woman on whom an abortion has been performed or attempted in violation of [the law]" or the father. HB 136 § 5. Injunctive relief is also available to "the woman on whom an abortion was performed or attempted," her spouse, a prosecuting attorney with appropriate jurisdiction, or the attorney general. *Id.*

66. In any civil or criminal proceeding arising out of 20-week abortions and brought under the law, HB 136 § 6 presumptively makes public the identity of the woman who had the abortion unless the court can justify "why the anonymity of the woman should be preserved from public disclosure, why the order is essential to that end, how the order is narrowly tailored to serve that interest, and why no reasonable, less restrictive alternative exists."

ii. HB 136 Is Unconstitutional and Will Cause Immediate, Irreparable Harm

67. The 20-week ban is unconstitutional for several independent reasons.

68. *First*, it violates women's right to privacy under Article II, Section 10 of the Montana Constitution. The right to privacy protects women's fundamental right to a pre-

viability abortion. *Armstrong v. State*, 1999 MT 261, ¶ 44, 296 Mont. 361, 989 P.2d 364. By banning abortion beginning at 20 weeks LMP, HB 136 plainly infringes on this fundamental right, denying women the right to a constitutional medical procedure and prohibiting Plaintiffs from offering abortion care safeguarded by the Montana Constitution.

69. Even if the 20-week ban could withstand constitutional scrutiny (which it cannot), the exceptions to the ban are so narrow that the law would still violate the right to privacy under the Montana Constitution. *See supra* ¶ 62. The definition of "serious health risk" to the pregnant woman, for example, does not allow abortions when necessary to avert death of the mother by suicide; treat serious but not immediately life-threatening health conditions, such as pre-existing medical conditions that become exacerbated during pregnancy (*e.g.*, pregnancy-related exacerbation of breathing complications related to COVID-19 or gestational diabetes); or address a severe fetal anomaly diagnosis. The same is true of the "medical emergency" exception. Beginning at 20 weeks LMP, a patient with a health-threatening medical condition may be prohibited from obtaining an abortion or have to delay the procedure until her condition worsens to the point where immediate action is necessary, and the abortion therefore meets the medical emergency exception's exacting requirements.

70. *Second*, and for the same reasons, the 20-week ban violates the right to individual dignity guaranteed by Article II, Section 4 of the Montana Constitution, and the "inalienable right[]" to seek "safety, health and happiness in all lawful ways" guaranteed by Article II, Section 3 of the Montana Constitution, which protects the right "to make personal judgments affecting one's own health and bodily integrity without government interference" and "does not permit the government's infringement of personal and procreative autonomy in the name of political ideology." *Armstrong*, ¶¶ 72-73.

71. *Third*, HB 136 violates the equal protection of the laws guaranteed by Article II, Section 4 of Montana's Constitution. HB 136 unlawfully targets women seeking to exercise the fundamental right to have a pre-viability abortion and abortion providers. It also targets abortion beginning at 20 weeks LMP, but not abortion before 20 weeks LMP, in violation of the equal protection guarantee.

72. *Fourth*, HB 136 is unconstitutionally vague because the exceptions to the 20-week ban do not give a provider fair notice of when she or he would be subject to criminal liability for violating the law. *See, e.g., State v. Stanko*, 1998 MT 321, ¶ 22, 292 Mont. 192, 974 P.2d 1132 ("A statute is void on its face if it fails to give a person of ordinary intelligence fair notice that his contemplated conduct is forbidden.") (quoting *State v. Woods* (1986), 221 Mont. 17, 22, 716 P.2d 624, 627). The 20-week ban's exceptions are problematic for several reasons:

a. What constitutes a "serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions" is undefined, inherently ambiguous, and subject to disagreement among reasonable health care providers.

b. Whether a condition "*so* complicates" a woman's medical condition that it "*necessitates*" an abortion turns on two discretionary judgments, both of which are bound to differ as between reasonable medical providers, much less the "ordinary people" relevant to the constitutional standard.[10]

c. Even if the "serious health risk" exception applies, the manner in which an abortion must be performed to fall within the exception is itself unconstitutionally vague. The

[10] The exceptions also bar providers from considering the risk of psychological or emotional conditions—including self-imposed harm—notwithstanding the exceptions' goal of averting the woman's death.

law requires a provider to terminate the pregnancy in the manner that, "in reasonable medical judgment, provides the best opportunity" for the fetus to survive unless doing so would "pose a greater risk either of the death" or "substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions," of the pregnant woman. There is no method of ending a pregnancy at or around 20 weeks LMP that will provide a meaningful opportunity of survival, so it is unclear how providers can ensure the "best opportunity" for survival.

73. As a result, the 20-week ban will subject health care providers to the threat of severe criminal and civil penalties for providing abortions that they believe are excepted from the law's prohibitions.

74. The violations of Plaintiffs' and their patients' constitutional rights will cause irreparable harm. *See Mont. Cannabis Indus. Ass'n v. State*, 2012 MT 201, ¶ 15, 366 Mont. 224, 286 P.3d 1161 ("[T]he loss of a constitutional right constitutes irreparable harm for the purpose of determining whether a preliminary injunction should be issued.").

iii. The 20-week ban is not supported by any compelling State interest

75. No compelling interest supports the 20-week ban.

76. The Legislature attempted to justify the 20-week ban based on the desire to avoid "fetal pain."

77. There is consensus in the medical and scientific community that, based on the most up-to-date evidence and research, it is not possible for a fetus to feel pain before at least 24 weeks LMP.[11]

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[11] *See* Susan J. Lee et al., *Fetal Pain: A Systematic Multidisciplinary Review of the Evidence*, 294 JAMA 947, 947 (2005) ("Fetal awareness of noxious stimuli requires functional thalamocortical connections. Thalamocortical fibers begin appearing between 23 to 30 weeks' gestational age, while electroencephalography suggests the capacity for functional pain

78. The Legislature's assertion that "an abortion occurring later in pregnancy may increase the risk to the woman of the occurrence of infection, sepsis, heavy bleeding, or a ruptured or perforated uterus" also cannot support the 20-week ban.

79. Abortion, including during the second trimester, is safe. Indeed, abortion is substantially safer than continuing a pregnancy through to childbirth.

80. Increased risks cannot be the basis for an outright ban of a medical procedure without a weighing of costs and benefits to public health. Under the Legislature's oversimplified logic, heart surgeries, for example, should be banned entirely as well.

81. The State's asserted interest in protecting patients against risks related to abortions performed later in pregnancy is further undermined by the State's enactment of this ban in conjunction with other abortion restrictions that will cause substantial *delay* and *increase* the proportion of women obtaining abortions after the first trimester. *See, e.g., infra* ¶ 100 (regarding the effects of HB 171's mandatory delay). The State cannot prevent women from obtaining early abortion care and then deny them the right to obtain an abortion later in pregnancy out of a purported concern for women's health.

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perception [...] probably does not exist before 29 or 30 weeks."); *see also Facts Are Important: Fetal Pain*, Am. Coll. of Obstetricians & Gynecologists, https://www.acog.org/advocacy/facts-are-important/fetal-pain (last visited August 11, 2021) ("A human fetus does not have the capacity to experience pain until after viability."); *see also* Royal College of Obstetricians & Gynecologists, Fetal Awareness: Review of Research and Recommendations for Practice (Mar. 2010), https://www.rcog.org.uk/globalassets/documents/guidelines/rcogfetalawarenesswpr0610.pdf (concluding that fetal pain is not possible before 24 weeks gestation, based on a review of available medical and scientific literature by a panel of experts from fields such as neuroscience, neonatology, obstetrics, and psychology).

82. Given that there is no medical or scientific support for targeting abortion beginning at 20 weeks LMP, and that the 20-week ban will not safeguard women's health, there is no State interest—let alone a compelling one—to support these restrictions.

b. The Omnibus MAB Restrictions Law (HB 171)

83. HB 171 limits women's ability to access abortion care early in their pregnancy by imposing a litany of unnecessary and burdensome restrictions on MAB. It compels providers to give patients medically inaccurate information and exposes providers to risk of felony conviction and up to 20 years' imprisonment for even negligent violations of the law. And it subjects providers to harsh civil penalties, including civil malpractice actions and suspension or revocation of their license.

84. The omnibus MAB restrictions law, if not enjoined, will eliminate or restrict access to MAB for many Montanans—indeed, HB 171 would have banned approximately 76% of MABs performed by PPMT in FY 2021. *See supra* ¶ 55.

85. The omnibus MAB restrictions law will decrease the availability of MAB by requiring patients to undergo a 24-hour mandatory delay before receiving care and make multiple in-person trips; mandating that the same provider examine the patient in person and later provide the abortion medication; banning the provision of MAB by telehealth and by mail; and imposing unnecessary reporting requirements designed to scare women from accessing abortion care.

86. The omnibus MAB restrictions law will further decrease the availability of abortions by limiting the number of available MAB providers and forcing them to make the unconscionable choice between continuing to provide abortions or telling their patients false information. HB 171 imposes onerous provider qualification requirements and compels

providers who remain "qualified" under the law to choose between providing medically inaccurate information—most notably about so-called "abortion reversals" and a supposed risk of "subsequent development of breast cancer"—to patients as required by the law or complying with their ethical obligations. Some providers may choose not to provide inaccurate information and thus not to provide MABs. And to further discourage providers from offering MAB, HB 171 threatens providers with severe criminal penalties.

87. The omnibus MAB restrictions law will expose women seeking MABs to misinformation and cause them to endure additional travel, stress, expense, and medical risk. These significant restrictions on access to lawful and constitutionally protected abortions indisputably infringe on patients' right to privacy and cause irreparable harm.

88. The omnibus MAB restrictions law violates the Montana Constitution's guarantees of privacy; individual dignity; safety, health, and happiness; equal protection; and free speech. Because the law subjects providers to criminal and civil penalties based on ambiguous prohibitions, it is also unconstitutionally vague.

89. The violations of Plaintiffs' and their patients' constitutional rights will cause irreparable harm.

i. Mandatory Delay, Multiple-Trip, and Biased Counseling Requirements

90. Under the guise of an "informed consent requirement," the omnibus MAB restrictions law unconstitutionally imposes a 24-hour mandatory delay and a multiple-trip requirement (one in-person appointment for an ultrasound, blood work, and to sign forms, a second to obtain the abortion medication, and a third for a patient who returns for a follow up that providers are required to schedule); effectively bans very early MABs; and mandates the provision of inaccurate information regarding complications and so-called MAB "reversals."

91. Section 7 of HB 171 states that MABs may not be provided "without the informed consent of the pregnant woman to whom the abortion-inducing drug is being provided" and that such consent "must be obtained at least 24 hours before" the MAB medication is provided. The only exception is when, "in reasonable medical judgment," advanced informed consent would risk the death of the pregnant woman or the "substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions, of the pregnant woman."

92. To obtain "informed consent," providers must use a State-created form and ensure patients obtain an ultrasound and blood work, at least 24 hours prior to the MAB. The form must include, among other requirements:

a. "the probable gestational age of the unborn child as determined by both patient history and ultrasound results used to confirm gestational age," HB 171 § 7(5)(a);

b. "a detailed list of the risks related to the specific abortion-inducing drug or drugs to be used, including but not limited to hemorrhage, failure to remove all tissue of the unborn child, which may require an additional procedure, sepsis, sterility, and possible continuation of pregnancy," *id.* § 7(5)(c);

c. "information about Rh incompatibility, including that if the pregnant woman has an Rh negative blood type, the woman should receive an injection of Rh immunoglobulin at the time of the abortion to prevent Rh incompatibility in future pregnancies," *id.* § 7(5)(d);

d. "a description of the risks of complications from a chemical abortion," *id.* § 7(5)(e), which are defined elsewhere to include everything from cardiac arrest, renal failure,

coma, subsequent development of breast cancer, death, and "any other adverse event," *id.* § 3(5); and

e. information about so-called "MAB reversals," including that "initial studies suggest that children born after reversing the effects of an abortion-inducing drug have no greater risk of birth defects than the general population and . . . that there is no increased risk of maternal mortality after reversing the effects of an abortion-inducing drug" and that "information on and assistance with reversing the effects of abortion-inducing drugs are available in [] state-prepared materials," *id.* § 7(5)(e), (i).[12]

93. The woman is also required to sign and initial an "acknowledgment of risks and consent statement," which must indicate that, among other requirements, "the woman has been given the opportunity to ask questions about the woman's pregnancy, the development of the unborn child, alternatives to abortion, the abortion-inducing drug or drugs to be used, and the risks and complications inherent to the abortion-inducing drug or drugs to be used" and that the woman was specifically (and falsely) told that "information on the potential ability of qualified medical professionals to reverse the effects of an abortion obtained through the use of abortion-inducing drugs is available at www.abortionpillreversal.com, or you can contact (877) 558-0333 for assistance in locating a medical professional who can aid in the reversal of an abortion." *See* HB 171 § 7(5).

94. The provider is also required to sign a declaration certifying she has complied with the law's requirements to provide this biased counseling. HB 171 § 7(5)(k).

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[12] Section 5 of HB 171, which requires the in-person provision of MAB, also mandates, among other requirements, that the MAB provider "independently verify that a pregnancy exists;" determine the woman's blood type and, if the woman is Rh negative, offer to administer Rhogam; and "document in the woman's medical chart the gestational age and intrauterine location of the pregnancy and whether the woman received treatment for Rh negativity[.]"

95. By requiring patients to undergo an ultrasound, receive blood work, and sign a consent form 24 hours prior to providing the MAB, HB 171 imposes a 24-hour mandatory delay on all MAB.

96. HB 171 also creates a multiple-trip requirement, including two trips before the MAB—first for the ultrasound, blood work, and forms, and then, at least 24 hours later, to pick up the medications (which can no longer be provided by mail, *see infra* ¶ 121).

97. HB 171 also requires a provider to "make all reasonable efforts" to ensure that the patient returns for a follow-up appointment seven to 14 days after the MAB, *see* HB 171 §§ 5(3) and 7(5)((j)(viii)—which would require the patient to make a *third* in-person trip.

98. PPMT currently offers several follow-up options for patients who receive MABs, which do not require visiting the health center. Patients may receive an ultrasound at a location of their choosing one to two weeks after the MAB; take an at-home urine pregnancy test four weeks after the MAB; or have their blood drawn the day they take the first pill and again one week later, also at a location of their choosing.

99. The mandatory delay, multiple-trip, and biased counseling provisions violate the Montana Constitution for several independent reasons.

100. *First*, the mandatory delay, multiple-trip, and biased counseling provisions violate the Montana Constitution's rights to privacy, individual dignity, and to seek safety, health, and happiness by infringing on women's fundamental right to pre-viability abortions.

a. Courts in Montana have already concluded that imposing a 24-hour mandatory delay violates the constitutional guarantee to a pre-viability abortion recognized in *Armstrong*. *See Planned Parenthood of Missoula v. State*, No. BDV 95-722, 1999 Mont. Dist. LEXIS 1117 , at *9 (1st Jud. Dist., Mar. 12, 1999) ("[T]elling a woman

that she cannot exercise a fundamental constitutional right for a 24-hour period … is a restriction on a woman's right nonetheless, and the infringement is not supported by a compelling reason.").

b. HB 171 is even more problematic than the 24-hour mandatory delay law previously struck down because, on top of the 24-hour delay, it requires patients to make multiple in-person visits to obtain MAB (unlike the prior delay law which allowed women to initially consult with a provider via telephone, *see Planned Parenthood of Missoula v. State*, No. BDV 95-722, 1995 Mont. Dist. LEXIS 800 (1st Jud. Dist., Nov. 28, 1995)).

c. Requiring two trips at least 24 hours apart before the MAB increases the costs and burdens associated with obtaining an MAB, and interferes with a woman's constitutional right to make health care decisions in consultation with her health care provider. As explained *supra* ¶¶ 49-50 & *infra* ¶ 122, Plaintiffs offer direct-to-patient MABs without requiring any in-person visits for eligible patients and site-to-site MABs that require only one visit to the nearest health center—neither of which they would be permitted to provide under HB 171. Under HB 171, more than 100 out of the 140 women who received direct-to-patient MABs from PPMT in FY 2021 would have had to drive anywhere from four to 20 hours round trip, assuming no stopping, traffic, or inclement weather, to obtain an MAB—which can be safely and effectively completed from the comfort of a woman's own home. *See supra* ¶ 56.

d. For those who cannot afford either the delay or the additional travel, the multiple-trip requirement outright prevents women from obtaining abortion. For many, the additional time and expense required to make multiple visits will be prohibitive.

Given the scarcity of abortion providers and the volume of patients, there is no guarantee a provider will be able to see the patient the next day in order to provide the medication. This is especially likely to be the case given that HB 171 requires that the same provider examine the patient in person and later dispense the MAB in person, which would preclude providers from meeting with patients using telehealth visits. *See infra* ¶¶ 121-122 (same-provider requirement). The resulting delay, which could span weeks, may force patients to undergo a procedural abortion when MAB would have sufficed and/or was preferred.

e. Patients affected by intimate partner violence are particularly likely to be delayed or prevented from obtaining abortion care by HB 171's requirements.

f. A core tenet of patient-centered care is that the provider, using her best professional judgment, tailors her provision of care to each individual patient's circumstances, needs, and expressed preferences and values. By mandating in-person visits 24 hours in advance of the MAB—which PPMT does not currently require—HB 171 replaces that provider judgment with an unnecessary State mandate.

g. Additionally, these provisions arguably require a second unnecessary medical procedure: the provision of Rh immunoglobulin ("Rhogam") to women seeking MABs. It is best practice and PPMT's current approach not to recommend Rhogam for women who are less than eight weeks LMP, and PPMT allows patients to sign a waiver declining the blood work if they are at or over eight weeks LMP. HB 171 arguably would require the provision of Rhogam to all women, which is costly, difficult for patients in rural areas (where Rhogam is less available), and intended to discourage women from obtaining abortions on the basis of false medical advice.

h. The law mandates that the provider, during the required in-person exam, *see infra* ¶ 121, "document in the woman's medical chart the ... intrauterine location of the pregnancy." This requirement is impossible to comply with and nonsensical in early pregnancies, as very early pregnancies are not visible on an ultrasound. More importantly, this provision effectively bans very early MABs, in direct contravention of the fundamental right to a pre-viability abortion guaranteed by the Montana Constitution.

101. *Second*, the mandatory delay, multiple-trip, and biased counseling provisions violate Montana's equal protection guarantee. These provisions unlawfully discriminate against women seeking abortions and abortion providers by limiting access to a lawful and constitutionally protected pre-viability abortion without a compelling justification. On information and belief, the State does not apply any similar mandatory delay, multiple-trip, or biased counseling requirements to other health care, including other reproductive or primary health care. For example, providers are not required to wait 24 hours before providing other, riskier procedures, such as vasectomies, circumcision, colonoscopies, or elective plastic surgery.

102. Additionally, upon information and belief, there is no comparable legal requirement that patients who receive other reproductive care, such as for miscarriages, schedule a follow-up appointment, or that their provider make "all reasonable efforts" to ensure the patient returns.

103. *Third*, the biased counseling requirements compel abortion providers to provide medically inaccurate information to their patients, which violates providers' right to free speech and their right to equal protection under the Montana Constitution.

104. The information on "revers[ing] the effects of an abortion obtained through the use of abortion-inducing drugs" is not supported by medical evidence, and thus directs the provider to make specific representations that are false. The law requires providers to endorse a particular source of medical information, regardless of whether the providers believe that information is accurate or appropriate for their patients. Not only that, it forces providers to steer patients to an experimental treatment that they may regard as risky. These requirements thus force providers to choose between their ethical obligation to provide accurate medical information and safe advice to their patients, and a felony charge under HB 171.

105. The biased counseling requirements also force abortion providers to falsely tell their patients about certain "complications" from MAB, such as developing breast cancer, that are not in fact risks of MAB.

106. Moreover, HB 171 requires providers to use a form created by the State to obtain "informed consent." Requiring this form, which PPMT has yet to see, means that providers have no control over what information is provided to their patients.

107. Accordingly, HB 171 violates the right to free speech guaranteed by the Montana Constitution because it compels speech from providers, even when that information is false and the provider objects to the content of that speech.

108. By requiring providers to give patients false and medically unsupported information, among other things, the omnibus MAB restrictions law also interferes with the provider-patient relationship.

109. Upon information and belief, the State does not compel non-abortion providers to give medically inaccurate information to their patients or steer them toward unproven treatments. For example, upon information and belief, non-abortion providers are not required to inform

their patients that they can "reverse" other medical procedures, such as vasectomies or tubal ligation.

110. *Fourth*, the requirement that providers make "all reasonable efforts" to schedule a follow-up appointment violates Montana's due process guarantee because it is unconstitutionally vague. The law does not give providers sufficient clarity to know what steps they must take in order to exhaust "all reasonable efforts" and avoid the criminal penalties imposed for violating HB 171—which include felony prosecution and a prison term of up to 20 years, including for a negligent violation.

111. Section 10 gives the Department of Health (the "Department") 60 days after HB 171's effective date to create and distribute the forms required by the law, including the "informed consent" forms. This would appear to prevent providers from providing any MAB in Montana until the Department creates the form. Subjecting providers to such ambiguity violates due process. And should abortion providers, including PPMT, effectively be banned from providing MAB for up to two months, that ban, even if temporary, would unconstitutionally restrict access to abortion in violation of the right to privacy.

112. The unconstitutional infringements on abortion access imposed by HB 171 cannot be saved by the Legislature's purported justifications. The mandatory delay, multiple-trip, and biased counseling provisions serve only to further burden access to MABs by adding additional and unnecessary steps. The biased counseling provisions also attempt to scare women out of having an MAB, and are counter to true informed consent, in that they require providers to give patients false and medically unsupported information.

113. HB 171 will not "reduc[e] the risk that a woman may elect an abortion only to discover later, with devastating psychological consequences, that the woman's decision was not fully informed," as the legislative findings section asserts.

114. PPMT already provides patients with the information they need to make an informed decision about MAB and requires patients to sign an informed consent form before undergoing an MAB. In particular, PPMT counsels patients on the options available to them, provides medical information about those options, and includes questions designed to screen patients for uncertainty or coercion.

115. Delay periods do not increase decisional certainty. Multiple studies have shown that living in a state with a mandatory delay or two-trip requirement does not increase the certainty of women seeking abortions.[13] Certainty around the decision to continue or end a pregnancy depends more on whether the pregnancy was intended than on time frame. And decisional certainty following an abortion is high.

116. There is no evidence that supposed MAB "reversals" increase the chance of a pregnancy continuing; to the contrary, there are potential risks associated with interrupting the MAB regimen.[14]

117. Requiring providers to tell patients medically unsupported information about MAB "reversals" undermines true informed consent and harms the provider-patient relationship as well as patient safety. Indeed, counseling about "reversals" could actually create a risk that

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13 *See, e.g.*, Iris Jovel et. al., *Abortion Waiting Periods and Decision Certainty Among People Searching Online for Abortion Care*, 137 Obstetrics & Gynecology 597 (2021).

14 *See, e.g.*, *Abortion Pill "Reversal": Where's the Evidence?*, ANSIRH, UCSF Medical Center, Bixby Center for Global Reproductive Health, (July 2020), https://www.ansirh.org/sites/default/files/publications/files/so-called_medication_abortion_reversal_7-14-2020_1.pdf.

patients proceed with an abortion before they have made a firm decision because they are under the (mistaken) belief that they can change their minds when, in fact, taking the mifepristone alone will often end the pregnancy.

118. The legislative findings section of HB 171 falsely contends that the "administration of an abortion-inducing drug following spontaneous miscarriage ... exposes the woman to unnecessary risks." Mifepristone and misoprostol are in fact evidence-based *treatments* for miscarriage.

119. PPMT's provision of direct-to-patient MABs has demonstrated that they can be successfully provided without in-person ultrasounds and other tests. It also has demonstrated that patients can be effectively screened for ectopic pregnancy via telemedicine, making unnecessary any need to determine the "intrauterine location" of the fetus through ultrasound.

120. Thus, performing ultrasounds or other tests prior to MABs is not necessary to protect women's health if patients are eligible for service without that care.

ii. Ban on Telehealth MAB

121. Section 5 of HB 171 mandates that the "qualified medical practitioner providing an abortion-inducing drug shall examine the woman in person," and Section 4 prohibits the provision of "abortion-inducing drug[s] via courier, delivery or mail service." HB 171 thus imposes a same-provider requirement—the practitioner who provides the abortion medication must also bc the one to conduct an in-person examination of the patient—and bans telehealth MAB entirely.

122. The same-provider requirement bans PPMT's provision of telehealth MAB. With site-to-site MAB, a woman typically visits the PPMT health center closest to her home. There, she receives in-person services, including any tests deemed necessary by her provider, and an

abortion provider located at another PPMT health center meets with the patient via telehealth and prescribes the MAB. With direct-to-patient MAB, PPMT abortion providers meet with eligible patients via telehealth, and PPMT mails the eligible patients the medication for MAB. No in-person examination occurs unless medically necessary.

123. PPMT's use of telehealth to provide site-to-site MAB and direct-to-patient MAB significantly expands abortion access and, for some Montanans, makes the difference between being able to access abortion care or not. Notably, because it bans telehealth MAB entirely, HB 171 would have banned approximately 76% of all MABs provided by PPMT in FY 2021. *See supra* ¶ 55.

124. The ban on telehealth MAB restricts access to MAB without any justification and violates the Montana Constitution for several independent reasons.

125. *First*, the requirement violates the Montana Constitution's right to privacy by interfering with women's fundamental right to pre-viability abortion. For the same reasons, it also violates the Montana Constitution's rights to individual dignity and to seek safety, health, and happiness.

126. Women in Montana already face significant hurdles to accessing in-person abortion care. Approximately 90% of the counties in Montana do not have an abortion provider, and about 50% of Montanans live in those counties. *See supra* ¶ 43.

127. Given Montana's size, it is common for patients to travel six to eight hours round trip to visit PPMT's health centers. *See supra* ¶ 44.

128. To visit an abortion provider, patients often must arrange and pay for transportation, childcare, and/or lodging, and arrange to take time off work. For low-wage workers, who often have no paid time off or sick leave, these burdens are particularly acute.

129. PPMT is able to significantly expand access to abortion care by allowing patients to either travel to the PPMT health center closest to them for a telehealth MAB appointment (in the case of site-to-site MAB) or consult an MAB provider without incurring any travel-related costs or burdens (in the case of direct-to-patient MAB). Because there already are so few abortion providers in the state, telehealth MAB helps to fill gaps in care that would otherwise exist.

130. If patients are required to travel to the PPMT health center where a provider is physically located, the time and expense required will be significantly more onerous.

131. The burdens imposed by the telehealth MAB ban are exacerbated by HB 171's imposition of a 24-hour mandatory delay. As discussed above, § 7 requires patients to make multiple in-person visits and wait at least 24 hours before accessing MAB. *See supra* ¶¶ 90-98. The combination of the same-provider requirement and 24-hour mandatory delay means that a patient is required to see a provider 24 hours in advance of an MAB, and then must see that *same* provider again, notwithstanding that the provider may not be available the next day or may be working at a different PPMT health center, which could be many hours and miles further away.

132. *Second*, the same-provider requirement violates the Montana Constitution's equal protection guarantee. Upon information and belief, Montana does not impose a same-provider requirement on non-abortion patients. Montana has championed the use of telehealth in other contexts. Indeed, around the same time the Governor signed into law the omnibus MAB restrictions law, he also signed a bill that expands access to telehealth services that were originally extended because of the COVID-19 pandemic. *See* HB 43, 2021 Leg. Reg. Sess. (Mont. 2021) (to be codified in various provisions of the Mont. Code Ann.). The Governor, in signing the bill, recognized that "[t]elehealth services are transforming how care is delivered in

Montana, particularly in our frontier and rural communities."[15] And Montana allows patients to receive many other medications by mail, including everything from birth control pills to blood pressure medication to medication for diabetes and erectile dysfunction.

133. There is no justification for banning telehealth MAB. Banning this form of MAB does not "protect[] the health and welfare of a woman considering an abortion," as HB 171's legislative findings section claims.

134. PPMT's experience and peer-reviewed medical literature demonstrate that MAB can be safely and effectively administered using telehealth.

135. MAB is safe, noninvasive, does not require anesthesia, and can be done at home. The ban on the provision of telehealth MAB serves only to make abortion more difficult to obtain by requiring unnecessary in-person health center visits.

136. The in-person requirement also cannot be justified on the grounds that "the routine administration of an abortion-inducing drug following spontaneous miscarriage is unnecessary and exposes the woman to unnecessary risks associated with the abortion-inducing drug," as HB 171's legislative findings section claims.

137. There is no evidence that providing MAB after a spontaneous miscarriage "exposes the woman to unnecessary risks;" to the contrary, mifepristone and misoprostol are evidence-based *treatments* for miscarriage.

iii. Provider Qualification Requirements

138. Section 5(2) of HB 171 requires that a "qualified medical practitioner" providing MAB be "credentialed and competent to handle complications management, including

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15 Press Release, Governor's Office, Governor Gianforte Signs Bill Expanding Telehealth (Apr. 19, 2021), https://news.mt.gov/governor-gianforte-signs-bill-expanding-telehealth.

emergency transfer, or must have a signed contract with an associated medical practitioner who is credentialed to handle complications and must be able to produce the signed contract on demand by the woman or by the department." The law in turn defines "qualified medical practitioner" as one who has the ability to, among other things, "provide surgical intervention or who has entered into a contract with another qualified medical practitioner to provide surgical intervention."

139. Complication is defined to mean "an adverse physical or psychological condition arising from the performance of an abortion, including but not limited to uterine perforation, cervical perforation, infection, heavy or uncontrolled bleeding, hemorrhage, blood clots resulting in pulmonary embolism or deep vein thrombosis, failure to actually terminate the pregnancy, incomplete abortion, pelvic inflammatory disease, endometritis, missed ectopic pregnancy, cardiac arrest, respiratory arrest, renal failure, metabolic disorder, shock, embolism, coma, placenta previa in subsequent pregnancies, preterm delivery in subsequent pregnancies, free fluid in the abdomen, hemolytic reaction due to the administration of ABO-incompatible blood or blood products, adverse reactions to anesthesia and other drugs, subsequent development of breast cancer, death, psychological complications such as depression, suicidal ideation, anxiety, and sleeping disorders, and any other adverse event."

140. These provisions bar providers who are experienced and well-equipped to provide MAB from providing such abortion care, without any medical justification. They are unconstitutional for several independent reasons.

141. *First*, HB 171's provider requirements violate the Montana Constitution's rights to privacy, individual dignity, and to seek safety, health, and happiness. They restrict women's