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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

fundamental right to pre-viability abortions by decreasing the number and geographic distribution of MAB providers.

142. No PPMT MAB provider is credentialed to "handle" all the complications listed in HB 171. The omnibus MAB restrictions law thus will prevent these providers from offering a safe, effective, and constitutionally protected form of abortion—that they are fully qualified and prepared to provide—unless they are able to contract with another provider or providers who will attest to being able to "handle" the vague litany of complications required by the law. And it will be extremely difficult—if not impossible—to identify a practitioner who can "handle" all those complications.

143. *Second*, the provider qualifications requirement is unconstitutionally vague. HB 171's requirement that an abortion provider be "credentialed and competent" to "handle" "complications management"—with an incredibly expansive definition of "complications" that includes "death"—is vague (*e.g.*, what credentialing makes a provider competent to "handle" death?). It requires providers to guess at whether they are complying with the law while risking severe criminal penalties.

144. *Third*, the provider qualifications requirement violates Montana's equal protection guarantee. On information and belief, no similar credential or contract requirements are imposed on other health care providers, including those who provide other reproductive health care, such as pregnancy or vasectomies, or other care, such as colonoscopies or outpatient plastic surgery. Indeed, providers routinely provide care even when they would not be the provider who would treat the patient in the event of a complication.

145. HB 171's differential treatment of women and providers based on the women's decision to exercise a fundamental right is not narrowly tailored to serve any compelling State interest.

146. The Legislature has offered no compelling reasons to justify these provider qualification provisions. Nor could they, as these requirements are totally unnecessary given the safety of abortion.

147. All PPMT providers who provide abortions, including MABs, are properly credentialed, licensed, and trained. PPMT providers complete Continuing Medication Education courses annually to meet board requirements. Some providers are trained in their schooling or residency on abortions. Moreover, PPMT's providers are trained in the risks of MAB. They are able to recognize symptoms—in person or through telehealth visits—that require additional or acute care, to provide care for those complications where consistent with their training and expertise, and to refer patients for other care, including for emergency care if necessary, without the need for a contract.

148. Because it is difficult to imagine a contract that *could* cover the potential universe of complications, or a practitioner or practitioners willing to enter into such an agreement, HB 171's provider qualification provisions may effectively ban the provision of some constitutionally protected MAB, without any medical justification.

149. In some cases, HB 171's provider qualification requirements will deprive women of the ability to obtain an abortion.

iv. Burdensome MAB Reporting Requirements

150. Section 9 of HB 171 sets up an onerous reporting system that requires providers such as PPMT to provide the Department with a litany of information on their provision of

MAB. It requires MAB providers to submit reports to the Department, signed by the provider "who provided the abortion-inducing drug . . . 15 days after each reporting month."

151. The § 9 MAB reports must include, among other information:

i. the identity of the provider who provided the drug;

ii. the identity of the referring provider, if any;

iii. the pregnant woman's county, state, and country of residence;

iv. the pregnant woman's age and race;

v. the number of previous pregnancies, number of live births, and number of previous abortions of the pregnant woman;

vi. the "probable gestational age of the unborn child as determined by both patient history and ultrasound results used to confirm the gestational age;"

vii. "preexisting medical conditions of the pregnant woman that would complicate the pregnancy, if any;"

viii. whether the woman returned for a follow-up examination, including, "the date and results of the follow-up examination, and what reasonable efforts were made by the qualified medical practitioner to encourage the woman to return for a follow-up examination if the woman did not;" and

ix. information on any "complications," which include psychiatric conditions such as "depression, suicidal ideation, anxiety, and sleeping disorders."

152. Section 9(8) also provides that MAB reports "must be deemed public records and must be available to the public in accordance with the confidentiality and public records reporting laws of this state."

153. HB 171's reporting requirements are unconstitutional for several independent reasons.

154. *First*, the reporting requirements violate the Montana Constitution's rights to privacy, individual dignity, and to seek safety, health, and happiness because they restrict women's fundamental right to pre-viability abortion. These requirements impose unnecessary hurdles interfering with PPMT's ability to provide lawful and constitutionally protected pre-viability abortions, including by making the identity of abortion providers public.

155. Under current law, reports on abortion are "treated with the confidentiality afforded to medical records, subject to such disclosure as is permitted by law." Section 50-20-110(5), MCA.

156. But HB 171 requires MAB reports to be made public—including the abortion provider's name and any referring provider's name.

157. Publicly disclosing the names of abortion providers and referring providers will lead to harassment of providers, discourage providers from offering abortion, and reduce the number of abortion providers available in a state where they already are few and far between.

158. The omnibus MAB restrictions law's reporting requirements also could make public the identities of women who have obtained abortions, putting their safety at risk and chilling the ability to obtain pre-viability abortions.

159. HB 171 requires that PPMT report various patient identifiers—including the patient's county, age, race, and number of previous abortions the patient has had—which are then made available to the public. That information may be sufficient to identify women in certain communities, especially in rural communities in Montana, which is particularly problematic for patients who are subject to intimate partner violence.

160. Because HB 171 makes abortion reports public records, patients may be chilled from seeking MABs altogether.

161. *Second*, HB 171's MAB reporting requirements violate Montana's right to informational privacy, which is guaranteed by Article II, Section 10 of the Montana Constitution.

162. The right to informational privacy guarantees individuals the right to control the disclosure and circulation of personal information. *Montana Shooting Sports Ass'n, Inc. v. State*, 2010 MT 8, ¶ 14, 355 Mont. 49, 55, 224 P.3d 1240, 1244. The right extends to the details of a patient's medical and psychiatric history, because "[m]edical records are quintessentially 'private' and deserve the utmost constitutional protection." *State v. Nelson* (1997), 283 Mont. 231, 242, 941 P.2d 441, 448.

163. HB 171's MAB reporting requirements expose patients' private medical and psychiatric history to the public. The law requires public disclosure of the provider who dispensed the abortion-inducing drug and patients' personal information and medical history. The law further requires public disclosure of patients' psychiatric information, including "depression, suicidal ideation, anxiety, and sleeping disorders."

164. *Third*, HB 171's MAB reporting requirements violate Montana's equal protection guarantee. On information and belief, no similar State-mandated reporting is required of any other reproductive care, including childbirth, which is far more dangerous than abortion.

165. *Fourth*, HB 171's reporting requirements are unconstitutionally vague. HB 171 requires providers to report "whether the woman suffered any complications" and any "preexisting medical conditions of the pregnant woman that would complicate the pregnancy."

166. HB 171 defines "complications" in such a broad and ambiguous way that the law could be read to require providers to report expected effects of MABs, like heavy bleeding, as

well as a host of medical events that may be wholly unconnected to abortion.[16] It is unclear whether providers would be required to report such intended (or unrelated) results as "complications."

167. Rather than adding to the sum of medical and public health knowledge, HB 171's reporting requirement would thus distort public knowledge by creating the false impression that nearly *every* MAB entails complications.

168. "Preexisting medical conditions" is similarly broad and ambiguous, yet undefined. Smoking and mental health issues could complicate a pregnancy, for example, but providers are not given any guidance as to whether they should report such commonplace and widespread factors as a "preexisting medical condition."

169. The Legislature has offered no compelling justification for the MAB reporting requirements. They cannot be justified on the basis of "promoting the health and safety of women by adding to the sum of medical and public health knowledge," as HB 171's legislative findings section contends.

170. The data that HB 171 would require providers to report, such as the identity of the referring provider or the patient's county of residence, is not medically relevant.

171. The data that HB 171 would require providers to report bears no resemblance to standard efforts to collect information regarding adverse effects.

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16 The reporting provisions also require MAB providers to report "the amount billed to cover the treatment for specific complications, including whether the treatment was billed to [M]edicaid, private insurance, private pay, or another method, including charges for any physician, hospital, emergency room, prescription or other drugs, laboratory tests, and other costs for treatment rendered." It is possible that the MAB provider may not know whether the patient has a complication. And because it may take weeks before PPMT receives bills from other providers, such as hospitals or labs, it will be extremely difficult, if not impossible, for providers such as PPMT to report information required by the law within 15 days after the end of the reporting month.

172. "[P]romoting maternal health" is an overly broad and ambiguous reason that cannot outweigh the fundamental right to informational privacy.

c. The Ultrasound Offer (HB 140)

173. HB 140 forces providers to (1) offer patients the opportunity to view an "active ultrasound" and "ultrasound image," and to listen to the "fetal heart tone," irrespective of the provider's medical judgment regarding whether the offers are in the best interest of the patient, and (2) make their patients sign a State-created form indicating whether they chose to view or hear fetal activity. There is no medical purpose for making this suite of offers or recording a woman's answer.

174. The ultrasound offer law violates several provisions of the Montana Constitution: (1) it infringes Plaintiffs' rights to privacy, individual dignity, and to seek safety, health, and happiness; (2) it violates the equal protection guarantee; (3) and it violates the right to free speech.

i. Provisions

175. HB 140 requires "a person performing an abortion" to offer patients the opportunity to view an "active ultrasound" and "ultrasound image," and to "listen to the fetal heart tone." The patient must sign a State-developed certification form attesting that they received these offers and stating whether they chose to accept them.

176. HB 140 excepts only those abortions performed in order to: (a) save the life of the woman; (b) ameliorate a serious risk of causing the woman substantial and irreversible impairment of a bodily function; or (c) remove an ectopic pregnancy.

177. A person who performs or attempts to perform an abortion without complying with HB 140 is subject to a civil penalty of $1,000.

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

ii. HB 140 is Unconstitutional and Will Cause Irreparable Harm

179. HB 140 is unconstitutional for several independent reasons.

180. *First*, HB 140 violates the Montana Constitution's rights to privacy, individual dignity, and to seek safety, health, and happiness.

181. "[M]edical decisions affecting one's bodily integrity and health must often and necessarily be made in partnership with a health care provider[,]" and a "serious[] ... infringement of personal autonomy and privacy [] accompanies the government usurping, through laws or regulations which dictate how and by whom a specific medical procedure is to be performed, the patient's own informed health care decisions made in partnership with his or her chosen health care provider." *Armstrong*, ¶ 58.

182. A core tenet of patient-centered care is that the provider, using her best professional judgment, tailors her counseling to each individual patient's circumstances, needs, and expressed preferences and values.

183. PPMT does not offer every woman the opportunity to view an "active ultrasound" and "ultrasound image," and to listen to a "fetal heart tone;" providers exercise their medical discretion as to what offers are in the best interest of the patient.

184. HB 140 takes that discretion away from providers, and requires them to ask every single patient if they want to view an "active ultrasound" and "ultrasound image," and listen to the "fetal heart tone," even where the provider believes, in her medical judgment, that doing so will be stigmatizing to the patient and not in her best interest. HB 140 also requires that providers obtain the patient's signature on a State-developed certification form that "indicates whether the woman viewed the active ultrasound or ultrasound image or listened to the fetal

heart tone." There is no medical purpose for these mandates. Given that HB 140 uses stigmatizing language like "unborn child," it is likely that any State-developed certification form will as well—further stigmatizing patients with no medical reason and discouraging them from seeking abortion care. In doing so, HB 140 intrudes on the provider-patient relationship and risks harm to patients.

185. HB 140 requires that abortion providers use a "certification form" developed by the Department, but it imposes no timeframe in which the Department must create the form. If the Department does not create the form by the law's effective date, it is not clear how providers, including PPMT, will be able to provide abortions. Providers should not be subjected to such ambiguity. And should providers, including PPMT, effectively be banned from providing *any* abortions in Montana, that ban, even if temporary, would unconstitutionally restrict access to abortion in violation of the right to privacy.

186. For the same reasons, HB 140 violates the Montana Constitution's right to individual dignity and inalienable right to seek safety, health, and happiness. Pregnant women seeking abortions have a fundamental right to procreative autonomy and the best medical advice of their health care providers. *See supra* ¶¶ 4, 70, 181. HB 140, by inserting the State between women and their health care providers, interferes with this fundamental right.

187. *Second*, HB 140 violates the Montana Constitution's free speech clause. By requiring providers to give the State's suite of offers, the law both compels providers to make certain statements and regulates providers' speech on the basis of its content.

188. *Third*, the ultrasound offer law violates Montana's right to equal protection. The law deprives women who seek abortions and abortion providers the full benefits of the medical "partnership" protected by the right to privacy, whereas other pregnant patients and their

providers retain access to that protected relationship. And no similar State-mandated requirement exists for other pregnancy care, so the law cannot be justified by reference to maternal health.

189. The State lacks any compelling interest in these mandates—indeed, the Legislature, in enacting HB 140, offered none in the text of the law.

190. There is no conceivable medical reason to force providers to ask patients whether they want to see an "active ultrasound" and "ultrasound image," and to hear audio of the fetus, and then to document the patient's decision.

191. These offers stigmatize a woman's exercise of a fundamental right and do nothing to protect a woman's health.

d. The Coverage Ban (HB 229)

192. HB 229 forces individuals on insurance plans funded by the Affordable Care Act ("ACA") to pay out of pocket for nearly all abortions.

193. HB 229 violates several provisions of the Montana Constitution: (1) it infringes the rights to privacy, individual dignity, and to seek safety, health, and happiness; and (2) it violates the equal protection guarantee.

i. Provisions

194. Under the ACA, states are required to establish health insurance exchanges. These exchanges are virtual marketplaces where consumers and small business owners and employees can shop for and purchase private health insurance coverage and, where applicable, be connected to public health insurance programs.

195. Exchanges may be established either by the state itself or by the Secretary of Health and Human Services as a federally-facilitated exchange ("FFE").

196. Montana uses an FFE, where its exchange is federally established, run, and funded.

197. HB 229 prohibits a qualified health plan offered on a health insurance exchange established in Montana pursuant to the ACA from providing abortion coverage.

198. The law only allows for plans to provide coverage for an abortion procedure performed when: (1) "the life of the mother is endangered by a physical disorder, physical illness, or physical injury," including a life-threatening condition caused by or arising from the pregnancy itself; and (2) the pregnancy is a result of rape or incest. *See* HB 229 § 1.

199. On information and belief, there are three health plans offered on the Montana health insurance exchange, one of which covers abortion outside of HB 229's exceptions but no longer would be permitted to do so if HB 229 goes into effect.

ii. HB 229 Is Unconstitutional and Will Cause Immediate, Irreparable Harm

200. HB 229 is unconstitutional for several independent reasons.

201. *First*, HB 229 violates the Montana Constitution's rights to privacy, individual dignity, and to seek safety, health, and happiness.

202. The coverage ban burdens Montanans' fundamental right to a pre-viability abortion by forcing individuals on exchange insurance plans to pay out of pocket for abortion procedures, with only very narrow exceptions.

203. Out-of-pocket costs for such care can range from several hundred to thousands of dollars.[17]

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[17] *See, e.g.*, Alina Salganicoff et al., *Coverage for Abortion Services in Medicaid, Marketplace Plans and Private Plans*, Kaiser Family Foundation (June 24, 2019), https://www.kff.org/womens-health-policy/issue-brief/coverage-for-abortion-services-in-medicaid-marketplace-plans-and-private-plans/.

204. For the same reasons, HB 229 violates Montana's right to individual dignity and to seek safety, health, and happiness. Pre-viability abortions are constitutionally protected medical procedures to which pregnant women have a fundamental right, and HB 229 seeks to prevent women from obtaining comprehensive health insurance that covers (constitutional) abortion care.

205. *Second*, HB 229 violates Montana's equal protection guarantee. Montana allows other individuals to buy comprehensive policies on the exchange covering all of their health care needs but prohibits women who seek to exercise their fundamental right to an abortion from doing so, without any compelling justification for such discrimination.

206. There is no justification for the coverage ban. Montana courts have already said that regulations limiting insurance coverage for abortions "do[] nothing to further the state's interest in maternal health," and that any State interest "in preserving potential life" prior to "the last three months of pregnancy" is outweighed by a "mother's interest in necessary medical care." *See Jeannette v. Ellery*, No. BDV-94-811, 1995 WL 17959705 (Mont. Dist. Ct. May 19, 1995).

207. Because there is no compelling State interest in abridging fundamental rights, HB 229 violates the Montana Constitution.

208. The Legislature also cannot justify the infringement by claiming that it is intended to forbid government funding of abortion, or by citing to supposed anti-abortion public sentiment. No State funding is at issue.

209. In addition, any argument by the Legislature (as asserted in HB 229's preamble) that "the provision of federal funding for health insurance plans that provide abortion coverage is nothing short of taxpayer-funded and government-endorsed abortion" cannot constitute a

legitimate State interest because the Hyde Amendment already precludes the use of federal funds for abortion except in instances of rape, incest, or if the pregnancy endangers a woman's life. *See, e.g.*, Appropriations Act of Oct. 21, 1993, Pub. L. 103-112, 107 Stat. 1113.

210. Furthermore, the ACA requires health exchange plans that offer abortion coverage to segregate funds paying for abortion procedures from all other federal funds used to subsidize covered premium costs. 42 U.S.C. § 18023(b)(2). The Montana Legislature's insistence in the HB 229's preamble that this coverage is "an unprecedented change in federal abortion funding policy that fails to take into account the Hyde Amendment" is simply untrue. The State cannot have a legitimate interest in stopping "taxpayer-funded and government-endorsed abortion" because Congress has already legislated to prohibit federal funds from covering abortions in the ACA marketplace.

211. Moreover, the State's "need to represent the anti-abortion views of a portion of its population," as stated in the law's preamble, cannot constitute a compelling State interest or else the State could "justify almost any action imaginable on the basis that some of its citizens felt it was appropriate." *Ellery*, 1995 WL 17959705.

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

e. The cumulative impact of laws on Plaintiffs and their patients

213. HB 136, HB 171, HB 140, and HB 229 individually violate Plaintiffs' and their patients' constitutional rights by restricting access to constitutionally protected pre-viability abortion care, and by stigmatizing and discriminating against pregnant women who are seeking to exercise this fundamental right and providers seeking to perform abortions.

214. Taken together, they attack Montanans' fundamental rights from all angles. The laws target Montanans' access to MAB (an abortion option available earlier in pregnancy) as well as procedural abortion (an abortion option available to women both earlier and later in pregnancy).

215. Not only do the laws create additional unnecessary hurdles to pregnant women's access to constitutionally protected abortion, they also replace providers' medical judgment with State-mandated requirements that are unsupported by science.

216. The cumulative burden of the four laws is particularly great in Montana, where access to abortion is already limited.

217. The risks associated with limiting or delaying access to abortion are substantial. If pregnant women are unable to access abortion when needed or desired, they will face greater risk and cost; they will experience the side effects of pregnancy itself, such as nausea, for a longer period; they may have more difficulty hiding their pregnancy, which could expose some patients to increased risk of disclosure to an abusive or unsupportive partner, family member, or employer; and they may become ineligible for certain types of abortion or abortion altogether.

CLAIMS FOR RELIEF

First Claim
Violation of the Right to Privacy
Of Article II, Section 10 of the Montana Constitution

218. Plaintiffs hereby reaffirm and reallege each and every allegation made in ¶¶ 1-217 as if set forth fully herein.

219. Article II, Section 10 of the Montana Constitution provides that "[t]he right of individual privacy is essential to the well-being of a free society and shall not be infringed without the showing of a compelling state interest." This right includes the fundamental "right to seek and to obtain a specific lawful medical procedure, a pre-viability abortion, from a health

care provider of her choice." *Armstrong v. State*, 1999 MT 261, ¶ 14, 296 Mont. 361, 989 P.2d 364.

220. Article II, Section 10 of the Montana Constitution also includes a right to informational privacy, which guarantees individuals the right to control the disclosure and circulation of personal information, including medical records and psychiatric history. *State v. Nelson* (1997), 283 Mont. 231, 242, 941 P.2d 441, 448.

221. Any violations of these rights are subject to strict scrutiny by the Court.

222. HB 136, HB 171, HB 140, and HB 229 violate the right to privacy of women seeking pre-viability abortions in Montana without being narrowly tailored to effectuate a compelling State interest, in violation of Article II, Section 10 of the Montana Constitution.

223. HB 171 violates the right of informational privacy of Plaintiffs and their patients without being narrowly tailored to effectuate a compelling State interest, in violation of Article II, Section 10 of the Montana Constitution.

Second Claim
Violation of the Right to Equal Protection of the Laws Of Article II, Section 4 of the Montana Constitution

224. Plaintiffs hereby reaffirm and reallege each and every allegation made in ¶¶ 1-217 as if set forth fully herein.

225. Article II, Section 4 of the Montana Constitution provides that "[n]o person shall be denied the equal protection of the laws."

226. HB 136, HB 171, HB 140, and HB 229 violate the right to equal protection of the laws of Plaintiffs and their patients because they discriminate against women seeking to exercise their fundamental right to seek pre-viability abortions and abortion providers without being narrowly tailored to effectuate a compelling State interest, in violation of the equal protection guarantee in Article II, Section 4 of the Montana Constitution. *See Snetsinger v. Montana Univ.*

Sys., 2004 MT 390, ¶ 17, 325 Mont. 148, 104 P.3d 445 (explaining that strict scrutiny applies if the distinctions drawn by a law affect fundamental rights).

227. HB 136, HB 171, HB 140, and HB 229 violate the right to equal protection of the laws of Plaintiffs and their patients because they discriminate against women. They have a disproportionate impact on women and are based on impermissible stereotypes about women's decision making, in violation of the equal protection guarantee in Article II, Section 4 of the Montana Constitution.

228. HB 136 also violates the right to equal protection of the laws of Plaintiffs and their patients because it targets abortion beginning at 20 weeks LMP, but not abortion before 20 weeks LMP, in violation of the equal protection guarantee in Article II, Section 4 of the Montana Constitution.

Third Claim
Violation of the Inalienable Right to Seek Safety, Health, and Happiness Of Article II, Section 3 of the Montana Constitution

229. Plaintiffs hereby reaffirm and reallege each and every allegation made in ¶¶ 1-217 as if set forth fully herein.

230. Article II, Section 3 of the Montana Constitution provides that all Montanans have the "[i]nalienable rights" to "seek[] their safety, health and happiness in all lawful ways."

231. HB 136, HB 171, HB 140, and HB 229 violate the right of Plaintiffs and their patients to seek "safety, health and happiness in all lawful ways" because the laws infringe on Montanans' right to a constitutionally protected procedure, a pre-viability abortion, and on the provider-patient relationship, in violation of Article II, Section 3 of the Montana Constitution.

Fourth Claim
Violation of the Right to Individual Dignity
Of Article II, Section 4 of the Montana Constitution

232. Plaintiffs hereby reaffirm and reallege each and every allegation made in ¶¶ 1-217 as if set forth fully herein.

233. Article II, Section 4 of the Montana Constitution provides that all Montanans have the right to individual dignity.

234. HB 136, HB 171, HB 140, and HB 229 violate the right to individual dignity of Plaintiffs and their patients in violation of Article II, Section 4 of the Montana Constitution.

Fifth Claim
Violation of the Right to Free Speech
Of Article II, Section 7 of the Montana Constitution

235. Plaintiffs hereby reaffirm and re-allege each and every allegation made in ¶¶ 1-217 as if set forth fully herein.

236. Article II, Section 7 of the Montana Constitution provides that "[n]o law shall be passed impairing the freedom of speech[.]"

237. HB 171, by requiring providers to present false information about MAB, including about supposed complications and so-called "reversals," violates Plaintiffs' right to freedom of speech, as guaranteed by Article II, Section 7 of the Montana Constitution.

238. HB 140, by requiring providers to offer patients the opportunity to view an "active ultrasound" and "ultrasound image," and to listen to "the fetal heart tone," and to sign a State-developed form that records the patients' answers, violates Plaintiffs' right to freedom of speech, as guaranteed by Article II, Section 7 of the Montana Constitution.

Sixth Claim
Violation of the Right to Due Process of Law
Of Article II, Section 17 of the Montana Constitution

239. Plaintiffs hereby reaffirm and reallege each and every allegation made in ¶¶ 1-217 as if set forth fully herein.

240. Article II, Section 17 of the Montana Constitution provides that "[n]o person shall be deprived of life, liberty, or property without due process of law."

241. "A statute is unconstitutionally vague and void on its face if 'it fails to give a person of ordinary intelligence fair notice that his contemplated conduct is forbidden.'" *State v. Hamilton*, 2018 MT 253, ¶ 20, 393 Mont. 102, 428 P.3d 849 (quoting *State v. Brogan* (1995), 272 Mont. 156, 168, 900 P.2d 284, 291). "It is a basic principle of due process that an enactment is void for vagueness if its prohibitions are not clearly defined." *State v. Dugan*, 2013 MT 38, ¶ 66, 369 Mont. 39, 303 P.3d 755 (quoting *City of Whitefish v. O'Shaughnessy* (1985), 216 Mont. 433, 440, 704 P.2d 1021, 1025).

242. The exceptions to HB 136 are void on their face as they fail to give a person of ordinary intelligence fair notice that she falls within an exception to conduct that HB 136 criminalizes.

243. Several aspects of HB 171—including its definitions, follow-up appointment requirements, provider qualifications requirements, and reporting requirements—are void on their face as they fail to give a person of ordinary intelligence fair notice of conduct that HB 171 criminalizes.

PRAYER FOR RELIEF

THEREFORE, Plaintiffs respectfully request that this Court:

1. Issue a declaratory judgment that HB 136, HB 171, HB 140, and HB 229 violate the rights of Plaintiffs and their patients, as protected by the Montana Constitution, and therefore are void and of no effect;

2. Issue a permanent injunction prohibiting Defendant, its agents, employees, appointees, or successors from enforcing, threatening to enforce, or otherwise applying the challenged provisions of HB 136, HB 171, HB 140, and HB 229;

3. Issue a preliminary injunction prohibiting Defendant, its agents, employees, appointees, or successors from enforcing, threatening to enforce, or otherwise applying the challenged provisions of HB 136, HB 171, HB 140, and HB 229 pending final judgment.

4. Grant Plaintiffs' attorneys' fees and costs pursuant to the Declaratory Judgment Act and the Private Attorney General Doctrine; and/or

5. Grant such further relief as may be just and proper.

Respectfully submitted this 16th day of August, 2021.

GRAYBILL LAW FIRM, PC

Raphael J.C. Graybill
300 4th Street North
PO Box 3586
Great Falls, MT 59403

VERIFICATION

I, Joey Banks, being first duly sworn, upon oath depose and say:

1. I am a Plaintiff in the action set forth above.

2. I verify the foregoing Verified Complaint for and on behalf of Plaintiffs.

3. I have personal knowledge that the facts and information set out in the foregoing Verified Complaint are true; that the facts therein have been assembled by counsel and Plaintiffs; and that the allegations therein are true and correct to the best of my knowledge.

4. I declare under penalty of perjury that the foregoing is true and correct.

Joey Banks

Subscribed and sworn to before me this 13 day of August, 2021.

Sundi Jo Hamilton

(NOTARIAL SEAL)

Printed Name: Joey Banks

Sundi Jo Hamilton

SUNDI JO HAMILTON
NOTARY PUBLIC for the
State of Montana
Residing at Missoula, MT
My Commission Expires
November 08, 2024.

EXHIBIT 1

AN ACT ADOPTING THE MONTANA PAIN-CAPABLE UNBORN CHILD PROTECTION ACT; PROHIBITING THE ABORTION OF AN UNBORN CHILD CAPABLE OF FEELING PAIN; PROVIDING EXCEPTIONS; PROVIDING DEFINITIONS; AND AMENDING SECTION 50-20-109, MCA.

WHEREAS, pain receptors are present throughout an unborn child's entire body no later than 16 weeks after fertilization, and nerves link these receptors to the brain's thalamus and subcortical plate by no later than 20 weeks gestational age; and

WHEREAS, by 8 weeks after fertilization, an unborn child reacts to stimuli that would be recognized as painful if applied to an adult human, for example, by recoiling; and

WHEREAS, in the unborn child, application of painful stimuli is associated with significant increases in stress hormones known as the stress response; and

WHEREAS, subjection to painful stimuli is associated with long-term harmful neurodevelopmental effects, such as altered pain sensitivity and, possibly, emotional, behavioral, and learning disabilities later in life; and

WHEREAS, for the purposes of surgery on unborn children, fetal anesthesia is routinely administered and is associated with a decrease in stress hormones compared to their level when painful stimuli are applied without anesthesia; and

WHEREAS, there is substantial medical evidence that an unborn child is capable of experiencing pain by 20 weeks gestational age; and

WHEREAS, the state asserts a compelling state interest in protecting the lives of unborn children from the stage at which substantial medical evidence indicates that they are capable of feeling pain; and

WHEREAS, 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.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Short title. [Sections 1 through 6] may be cited as the "Montana Pain-Capable Unborn Child Protection Act".

Section 2. Definitions. As used in [sections 1 through 6], the following definitions apply:

(1) "Fertilization" means the fusion of a human spermatozoon with a human ovum.

(2) "Gestational age" means the age of an unborn child, calculated from the first day of the woman's last menstrual period.

(3) "Knowing" or "knowingly" has the meaning provided in 45-2-101.

(4) (a) "Medical emergency" means 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.

(b) The term 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.

(5) "Medical practitioner" means a person authorized under 50-20-109 to perform an abortion.

(6) "Probable gestational age of an unborn child" means what, in reasonable medical judgment, will with reasonable probability be the gestational age of the unborn child at the time the abortion is planned to be performed or attempted.

(7) "Purposeful" or "purposely" has the meaning provided in 45-2-101.

(8) "Reasonable medical judgment" means a medical judgment that would be made by a reasonably prudent medical practitioner who is knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved.

(9) "Serious health risk to the unborn child's mother" means that, in reasonable medical judgment, the

mother has 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. No 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.

(10) "Unborn child" or "fetus" means an individual organism of the species homo sapiens from fertilization until live birth.

Section 3. Protection of unborn child capable of feeling pain from abortion. (1) (a) A person may not perform or attempt to perform an abortion of an unborn child capable of feeling pain unless it is necessary to prevent a serious health risk to the unborn child's mother.

(b) For the purposes of this subsection (1), an unborn child is capable of feeling pain when it has been determined by the medical practitioner performing or attempting the abortion or by another medical practitioner on whose determination the medical practitioner relies that the probable gestational age of the unborn child is 20 or more weeks.

(2) Except in the case of a medical emergency, an abortion may not be performed or attempted unless the medical practitioner has first made a determination of the probable gestational age of the unborn child or relied on a determination made by another medical practitioner. In making this determination, the medical practitioner shall make inquiries of the woman and perform or cause to be performed medical examinations and tests that a reasonably prudent practitioner who is knowledgeable about the case and the medical conditions involved would consider necessary to perform in making an accurate diagnosis with respect to gestational age.

(3) When an abortion of an unborn child capable of feeling pain is necessary to prevent a serious health risk to the unborn child's mother, the medical practitioner shall terminate the pregnancy in the manner that, in reasonable medical judgment, provides the best opportunity for the unborn child 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, not including psychological or emotional conditions, of the woman than would other available methods. No greater risk may be determined to exist if it 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.

Section 4. Criminal penalties. A person who purposely or knowingly performs or attempts to perform an abortion in violation of [section 3] is guilty of a felony punishable in accordance with 50-20-112.

Section 5. Civil remedies. (1) A woman on whom an abortion has been performed or attempted in violation of [section 3] or the father of the unborn child who was the subject of the abortion may maintain an action against the person who performed or attempted the abortion in a purposeful or knowing violation of [section 3] for actual and punitive damages.

(2) (a) A cause of action for injunctive relief against a person who has purposely or knowingly violated [section 3] may be maintained by:

(i) the woman on whom an abortion was performed or attempted or, if the woman is a minor, the woman's parent or guardian;

(ii) a person who is the spouse of the woman on whom an abortion has been performed or attempted;

(iii) a prosecuting attorney with appropriate jurisdiction; or

(iv) the attorney general.

(b) The injunction must prevent the person from performing or attempting additional abortions in violation of [section 3] in this state.

(3) If judgment is rendered in favor of the plaintiff in an action described in this section, the court shall order the defendant to pay reasonable attorney fees to the plaintiff.

(4) If judgment is rendered in favor of the defendant and the court finds that the plaintiff's lawsuit was frivolous and brought in bad faith, the court shall order the plaintiff to pay reasonable attorney fees to the defendant.

(5) Damages or attorney fees may not be assessed against the woman on whom an abortion was performed or attempted except in accordance with subsection (4).

Section 6. Protection of privacy in court proceedings. In a civil or criminal proceeding brought under [section 4] or [section 5], the court shall determine whether the anonymity of the woman on whom an abortion has been performed or attempted must be preserved from public disclosure if the woman does not consent to the disclosure. The court, on motion or sua sponte, shall make a determination and, on determining that the woman's anonymity should be preserved, shall issue orders to the parties, witnesses, and counsel and shall direct the sealing of the record and exclusion of individuals from courtrooms or hearing rooms to the extent necessary to safeguard the woman's identity from public disclosure. The order must be accompanied by specific written findings explaining 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. In the absence of written consent of the woman on whom an abortion has been performed or attempted, anyone, other than a public official, who brings an action under [section 5(1) or (2)] shall do so under a pseudonym. This section may not be construed to conceal from the defendant or from attorneys for the defendant the identity of the plaintiff or of witnesses.

Section 7. Section 50-20-109, MCA, is amended to read:

"**50-20-109. Control of practice of abortion.** (1) Except as provided in 50-20-401, an abortion may not be performed within the state of Montana:

(a) except by a licensed physician or physician assistant;

(b) ~~after viability of the fetus, except as provided in subsection (2)~~ on an unborn child capable of feeling pain, except as provided in [section 3].

~~(2) An abortion under subsection (1)(b) may be performed only to preserve the life or health of the mother and only if:~~

~~(a) the judgment of the physician who is to perform the abortion is first certified in writing by the physician, setting forth in detail the facts relied upon in making the judgment; and~~

~~(b) two other licensed physicians have first examined the patient and concurred in writing with the judgment. The certification and concurrence in this subsection (2)(b) are not required if a licensed physician certifies that the abortion is necessary to preserve the life of the mother.~~

~~(3) The timing and procedure used in performing an abortion under subsection (1)(b) must be such that the viability of the fetus is not intentionally or negligently endangered, as the term "negligently" is defined in 45-2-101. The fetus may be intentionally endangered or destroyed only if necessary to preserve the life or health of the mother.~~

~~(4) For purposes of this section, "health" means the prevention of a risk of substantial and irreversible impairment of a major bodily function.~~

~~(5)~~(2) The supervision agreement of a physician assistant may provide for performing abortions.

~~(6)~~(3) Violation of ~~subsections (1) through (3)~~ subsection (1) is a felony."

Section 8. Codification instruction. [Sections 1 through 6] are intended to be codified as a new part in Title 50, chapter 20, and the provisions of Title 50, chapter 20, apply to [sections 1 through 6].

- END -

I hereby certify that the within bill,

HB 136, originated in the House.

_____

Chief Clerk of the House

_____

Speaker of the House

Signed this _____day

of_____, 2021.

_____

President of the Senate

Signed this _____day

of_____, 2021.

HOUSE BILL NO. 136

INTRODUCED BY L. SHELDON-GALLOWAY, F. ANDERSON, D. BARTEL, B. BEARD, S. BERGLEE, M. BINKLEY, L. BREWSTER, E. BUTTREY, J. CARLSON, G. CUSTER, J. DOOLING, N. DURAM, P. FIELDER, R. FITZGERALD, F. FLEMING, G. FRAZER, J. FULLER, S. GALLOWAY, W. GALT, J. GILLETTE, S. GIST, S. GUNDERSON, E. HILL, C. HINKLE, J. HINKLE, K. HOLMLUND, M. HOPKINS, J. KASSMIER, S. KERNS, C. KNUDSEN, R. KNUDSEN, D. LENZ, B. LER, D. LOGE, M. MALONE, R. MARSHALL, W. MCKAMEY, B. MITCHELL, T. MOORE, M. NOLAND, J. PATELIS, B. PHALEN, J. READ, A. REGIER, M. REGIER, V. RICCI, J. SCHILLINGER, K. SEEKINS-CROWE, D. SKEES, J. TREBAS, B. TSCHIDA, B. USHER, S. VINTON, K. WHITMAN, K. REGIER, S. GREEF, L. REKSTEN, M. BLASDEL , K. BOGNER B. BROWN, C. GLIMM, G. HERTZ, S. HINEBAUCH, D. HOWARD, B. KEENAN, T. MANZELLA, T. MCGILLVRAY, D. SALOMON, C. SMITH

AN ACT ADOPTING THE MONTANA PAIN-CAPABLE UNBORN CHILD PROTECTION ACT; PROHIBITING THE ABORTION OF AN UNBORN CHILD CAPABLE OF FEELING PAIN; PROVIDING EXCEPTIONS; PROVIDING DEFINITIONS; AND AMENDING SECTION 50-20-109, MCA.

EXHIBIT 2

AN ACT ADOPTING THE MONTANA ABORTION-INDUCING DRUG RISK PROTOCOL ACT; PROVIDING REQUIREMENTS FOR PROVIDING ABORTION-INDUCING DRUGS TO PREGNANT WOMEN; PROHIBITING PROVIDING ABORTION-INDUCING DRUGS IN SCHOOLS AND ON SCHOOL GROUNDS; REQUIRING INFORMED CONSENT; PROVIDING FOR THE REPORTING OF CHEMICAL ABORTIONS AND ADVERSE EVENTS AND COMPLICATIONS; PROVIDING DEFINITIONS; AND PROVIDING PENALTIES, CIVIL REMEDIES, AND PROFESSIONAL SANCTIONS.

WHEREAS, in September 2000, the U.S. Food and Drug Administration (FDA) approved the distribution and use of mifepristone (brand name Mifeprex), originally referred to as "RU-486", an abortion-inducing drug, under the authority of 21 C.F.R. 314.520, also referred to as "Subpart H", which is the only FDA approval process that allows for postmarketing restrictions. Specifically, the Code of Federal Regulations provides for accelerated approval of certain drugs that are shown to be effective but "can be safely used only if distribution or use is restricted". The approved FDA protocol for Mifeprex/mifepristone was modified in March 2016; however, the FDA still requires that the distribution and use of Mifeprex/mifepristone be under the supervision of a qualified health care provider who has the ability to assess the duration of pregnancy, diagnose ectopic pregnancies, and provide surgical intervention or who has made plans to provide surgical intervention through another qualified physician; and

WHEREAS, court testimony by Planned Parenthood and other abortion providers has demonstrated that providers routinely and intentionally failed to follow the September 2000 FDA-approved protocol for Mifeprex/mifepristone. See, e.g., Planned Parenthood Cincinnati Region v. Taft, 459 F. Supp. 2d 626 (S.D. Oh. 2006); and

WHEREAS, the use of Mifeprex/mifepristone presents significant medical risks, including but not limited to uterine hemorrhage, viral infections, abdominal pain, cramping, vomiting, headache, fatigue, and pelvic inflammatory disease. Medical evidence demonstrates that women who use abortion-inducing drugs risk four

times more complications than those who undergo surgical abortions. At least 3% to 8% of medical abortions fail to evacuate the pregnancy tissue and require surgical completion. One percent will fail to kill the fetus. If surgical completion is required after a failed medical abortion, the risk of premature delivery in a subsequent pregnancy is more than three times higher. Failure rates increase as gestational age increases. The gestational age range of 63 to 70 days has been inadequately studied. The 2016 FDA gestational age extension was based on only one study worldwide of little more than 300 women; and

WHEREAS, a woman's ability to provide informed consent depends on the extent to which the woman receives information sufficient to make an informed choice. The decision to abort "is an important, and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences". Planned Parenthood v. Danforth, 428 U.S. 52, 67 (1976); and

WHEREAS, in recent years, physicians have developed a method to potentially reverse the effects of Mifeprex/mifepristone. This abortion pill reversal or "rescue" process has been discussed in a peer-reviewed study and is based on decades of the safe use of progesterone to stabilize and continue pregnancies. Progesterone has been used safely in pregnancies for decades and is used in in vitro fertilization, infertility treatments, and high-risk pregnancies, including those experiencing preterm labor. Using progesterone to reverse the effects of Mifeprex/mifepristone is a targeted response that is safe for the woman; and

WHEREAS, abortion "record keeping and reporting provisions that are reasonably directed to the preservation of maternal health and that properly respect a patient's confidentiality and privacy are permissible". Planned Parenthood v. Danforth, 428 U.S. 80 at 52, 79-81 (1976).

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Short title. [Sections 1 through 14] may be cited as the "Montana Abortion-Inducing Drug Risk Protocol Act".

Section 2. Legislative findings and purpose. The purpose of [sections 1 through 14] is to further the important and compelling state interests of:

(1) protecting the health and welfare of a woman considering a chemical abortion;

(2) ensuring that a medical practitioner examines a woman prior to dispensing an abortion-inducing drug in order to confirm the gestational age of the unborn child, the intrauterine location of the unborn child, and that the unborn child is alive because 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;

(3) ensuring that a medical practitioner does not prescribe or dispense an abortion-inducing drug after 70 days have elapsed since the first day of a woman's last menstrual period;

(4) reducing 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;

(5) ensuring that a woman considering a chemical abortion receives comprehensive information on abortion-inducing drugs, including the potential to reverse the effects of the drugs if the woman changes the woman's mind, and that a woman submitting to an abortion does so only after giving voluntary and fully informed consent to the procedure; and

(6) promoting the health and safety of women by adding to the sum of medical and public health knowledge through the compilation of relevant data on chemical abortions performed in the state as well as data on all medical complications and maternal deaths resulting from these abortions.

Section 3. Definitions. As used in [sections 1 through 14], the following definitions apply:

(1) "Abortion" means the act of using or prescribing an instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman, with knowledge that termination by those means will with reasonable likelihood cause the death of the unborn child. The term does not include an act to terminate a pregnancy with the intent to:

(a) save the life or preserve the health of the unborn child;

(b) remove a dead unborn child caused by spontaneous abortion;

(c) remove an ectopic pregnancy; or

(d) treat a maternal disease or illness for which the prescribed drug is indicated.

(2) "Abortion-inducing drug" or "chemical abortion" means a medicine, drug, or any other substance provided with the intent of terminating the clinically diagnosable pregnancy of a woman with knowledge that the

termination will with reasonable likelihood cause the death of the unborn child. This includes the off-label use of drugs known to have abortion-inducing properties, which are prescribed specifically with the intent of causing an abortion, such as mifepristone, misoprostol, and methotrexate. The term does not include drugs that may be known to cause an abortion that are prescribed for other medical indications.

(3) "Adverse event" means an untoward medical occurrence associated with the use of a drug in humans, whether or not considered drug related. The term does not include an adverse event or suspected adverse reaction that, had it occurred in a more severe form, might have caused death.

(4) "Associated medical practitioner" means a person authorized under 50-20-109 to perform an abortion who has entered into an associated medical practitioner agreement.

(5) "Complication" means 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.

(6) "Last menstrual period" or "gestational age" means the time that has elapsed since the first day of the woman's last menstrual period.

(7) "Medical practitioner" means a person authorized under 50-20-109 to perform an abortion in this state.

(8) "Pregnant" or "pregnancy" means the female reproductive condition of having an unborn child in the uterus.

(9) "Provide" mean any act of giving, selling, dispensing, administering, transferring possession to, or otherwise providing or prescribing an abortion-inducing drug.

(10) "Qualified medical practitioner" means a medical practitioner who has the ability to:

(a) identify and document a viable intrauterine pregnancy;

(b) assess the gestational age of pregnancy and inform the woman of gestational age-specific risks;

(c) diagnose ectopic pregnancy;

(d) determine blood type and administer RhoGAM if a woman is Rh negative;

(e) assess for signs of domestic abuse, reproductive control, human trafficking, and other signals of coerced abortion;

(f) provide surgical intervention or who has entered into a contract with another qualified medical practitioner to provide surgical intervention; and

(g) supervise and bear legal responsibility for any agent, employee, or contractor who is participating in any part of a procedure, including but not limited to preprocedure evaluation and care.

(11) "Unborn child" means an individual organism of the species homo sapiens, beginning at fertilization, until the point of being born alive as defined in 1 U.S.C. 8(b).

Section 4. In-person requirement. An abortion-inducing drug may be provided only by a qualified medical practitioner following the procedures set forth in [sections 1 through 14]. A manufacturer, supplier, medical practitioner, qualified medical practitioner, or any other person may not provide an abortion-inducing drug via courier, delivery, or mail service.

Section 5. Distribution of abortion-inducing drugs. (1) Because the failure and complication rates from a chemical abortion increase with advancing gestational age and because the physical symptoms of chemical abortion can be identical to the symptoms of ectopic pregnancy and abortion-inducing drugs do not treat ectopic pregnancies and are contraindicated in ectopic pregnancies, the qualified medical practitioner providing an abortion-inducing drug shall examine the woman in person and, prior to providing an abortion-inducing drug, shall:

(a) independently verify that a pregnancy exists;

(b) determine the woman's blood type, and if the woman is Rh negative, be able to and offer to administer RhoGAM at the time of the abortion;

(c) inform the woman that the woman may see the remains of the unborn child in the process of

completing the abortion; and

(d) 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, as diagnosed by the most accurate standard of medical care.

(2) A qualified medical practitioner providing an abortion-inducing drug must be credentialed and competent to handle complications management, including 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. Each woman to whom a qualified medical practitioner provides an abortion-inducing drug must be given the name and phone number of the associated medical practitioner.

(3) The qualified medical practitioner providing an abortion-inducing drug, or an agent of the qualified medical practitioner, shall schedule a follow-up visit for the woman at approximately 7 to 14 days after administration of the abortion-inducing drug to confirm that the pregnancy is completely terminated and to assess the degree of bleeding. The qualified medical practitioner shall make all reasonable efforts to ensure that the woman returns for the scheduled appointment. A brief description of the efforts made to comply with this subsection, including the date, time, and identification by name of the person making the efforts, must be included in the woman's medical record.

Section 6. Prohibition on providing abortion-inducing drugs at elementary, secondary, and postsecondary schools. An abortion-inducing drug may not be provided in an elementary, secondary, or postsecondary school facility or on school grounds.

Section 7. Informed consent requirements for abortion-inducing drugs. (1) An abortion-inducing drug may not be provided without the informed consent of the pregnant woman to whom the abortion-inducing drug is being provided.

(2) Informed consent to a chemical abortion must be obtained at least 24 hours before the abortion-inducing drug is provided to the pregnant woman, except when, in reasonable medical judgment, compliance with this subsection would pose a greater risk of:

(a) the death of the pregnant woman; or

(b) the substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions, of the pregnant woman.

(3) A form created by the department must be used by a qualified medical practitioner to obtain the consent required prior to providing an abortion-inducing drug.

(4) A consent form is not valid and consent is not sufficient unless:

(a) the woman initials each entry, list, description, or declaration required to be included in the consent form as provided in subsection (5);

(b) the woman signs the consent statement described in subsection (5)(j); and

(c) the qualified medical practitioner signs the qualified medical practitioner declaration described in subsection (5)(k).

(5) The consent form must include, but is not limited to the following:

(a) the probable gestational age of the unborn child as determined by both patient history and ultrasound results used to confirm gestational age;

(b) a detailed description of the steps to complete the chemical abortion;

(c) 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;

(d) 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, which can lead to complications and miscarriage in future pregnancies;

(e) a description of the risks of complications from a chemical abortion, including incomplete abortion, which increase with advancing gestational age;

(f) information about the possibility of reversing the effects of the chemical abortion if the pregnant woman changes the woman's mind and that time is of the essence;

(g) information that the pregnant woman could see the remains of the unborn child in the process of completing the abortion;

(h) information 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 initial studies suggest that there is no increased risk of maternal mortality after reversing the effects of an abortion-inducing drug;

(i) notice that information on and assistance with reversing the effects of abortion-inducing drugs are available in the state-prepared materials; and

(j) an acknowledgment of risks and consent statement, which must be signed by the woman. The statement must include but is not limited to the following declarations, which must be individually initialed by the woman, that:

(i) the woman understands that the abortion-inducing drug regimen or procedure is intended to end the woman's pregnancy and will result in the death of the unborn child;

(ii) the woman is not being forced to have an abortion, the woman has the choice not to have the abortion, and the woman may withdraw the woman's consent to the abortion-inducing drug regimen even after beginning the abortion-inducing drug regimen;

(iii) the woman understands that the chemical abortion regimen or procedure to be used has specific risks and may result in specific complications;

(iv) 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;

(v) the woman was specifically 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";

(vi) the woman has been provided access to state-prepared, printed materials on informed consent for abortion;

(vii) if applicable, the woman has been given the name and phone number of the associated medical practitioner who has agreed to provide medical care and treatment in the event of complications associated with the abortion-inducing drug regimen or procedure;

(viii) the qualified medical practitioner will schedule an in-person follow-up visit for the woman approximately 7 to 14 days after providing the abortion-inducing drug or drugs to confirm that the pregnancy is

completely terminated and to assess the degree of bleeding and other complications;

(ix) the woman has received or been given sufficient information to give the woman's informed consent to the abortion-inducing drug regimen or procedure; and

(x) the woman has a private right of action to sue the qualified medical practitioner under the laws of the state if the woman feels coerced or misled prior to obtaining an abortion and how to access state resources regarding the woman's legal right to obtain relief; and

(k) a qualified medical practitioner declaration that must be signed by the qualified medical practitioner, stating that the qualified medical practitioner has explained the abortion-inducing drug or drugs to be used, has provided all of the information required in this subsection (5), and has answered all of the woman's questions.

Section 8. Information required in state-prepared materials. (1) The department shall publish state-prepared, printed materials on informed consent for abortion and shall include the following statement:

"Information on the potential ability of qualified medical practitioners 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."

(2) The department shall annually review and update, if necessary, the statement requirement under subsection (1).

(3) As part of the informed consent counseling services required in [section 7], the qualified medical practitioner shall inform the pregnant woman about abortion pill reversal and provide the woman with the state-prepared materials described in subsection (1).

Section 9. Reporting on chemical abortions. (1) For the purpose of promoting maternal health and adding to the sum of medical and public health knowledge through the compilation of relevant data, a report of each chemical abortion performed must be made to the department on forms prescribed by the department. The reports must be completed by the facility in which the abortion-inducing drug was provided, signed by the qualified medical practitioner who provided the abortion-inducing drug, and transmitted to the department within

15 days after each reporting month.

(2) A report must include, at a minimum, the following information:

(a) identification of the qualified medical practitioner who provided the abortion-inducing drug;

(b) whether the chemical abortion was completed at the facility in which the abortion-inducing drug was provided or at an alternative location;

(c) the referring medical practitioner, agency, or service, if any;

(d) the pregnant woman's county, state, and country of residence;

(e) the pregnant woman's age and race;

(f) the number of previous pregnancies, number of live births, and number of previous abortions of the pregnant woman;

(g) the probable gestational age of the unborn child as determined by both patient history and ultrasound results used to confirm the gestational age. The report must include the date of the ultrasound and gestational age determined on that date.

(h) the abortion-inducing drug or drugs used, the date each was provided to the pregnant woman, and the reason for the abortion, if known;

(i) preexisting medical conditions of the pregnant woman that would complicate the pregnancy, if any;

(j) whether the woman returned for a follow-up examination to determine completion of the abortion procedure and to assess bleeding, the date and results of the follow-up examination, and what reasonable efforts were made by the qualified medical practitioner to encourage the woman to return for a follow-up examination if the woman did not;

(k) whether the woman suffered any complications and, if so, what specific complications arose and what follow-up treatment was needed; and

(l) the amount billed to cover the treatment for specific complications, including whether the treatment was billed to medicaid, private insurance, private pay, or another method, including charges for any physician, hospital, emergency room, prescription or other drugs, laboratory tests, and other costs for treatment rendered.

(3) Reports required under this section may not contain:

(a) the name of the pregnant woman;

(b) common identifiers, such as a social security number or driver's license number; or

(c) other information or identifiers that would make it possible to identify, in any manner or under any circumstances, a pregnant woman who has obtained or seeks to obtain a chemical abortion.

(4) A qualified medical practitioner who provides an abortion-inducing drug to a pregnant woman who knows that the woman experiences, during or after the use of the abortion-inducing drug, an adverse event shall provide a written report of the adverse event within 3 days of the event to the United States food and drug administration via the medwatch reporting system, to the department, and to the state board of medical examiners.

(5) (a) A medical practitioner, qualified medical practitioner, associated medical practitioner, or other health care provider who treats a woman, either contemporaneously to or at any time after a chemical abortion, for an adverse event or complication related to a chemical abortion shall make a report of the adverse event to the department on forms prescribed by the department. The reports must be completed by the facility in which the adverse event or complication treatment was provided, signed by the medical practitioner, qualified medical practitioner, associated medical practitioner, or other health care provider who treated the adverse event or complication, and transmitted to the department within 15 days after each reporting month.

(b) The report must include, at a minimum:

(i) the information required under subsections (2)(a) through (2)(j) and (2)(l); and

(ii) information about the specific complications that arose, whether an emergency transfer was required, and whether any follow-up treatment was needed, including whether additional drugs or medications were provided in order to complete the abortion.

(6) The department shall prepare a comprehensive annual statistical report for the legislature based on the data gathered from reports under this section. The aggregated data must also be made available to the public by the department in a downloadable format.

(7) The department shall summarize aggregate data from the reports required under [sections 1 through 14] and submit the data to the U.S. centers for disease control and prevention for the purpose of inclusion in the annual vital statistics report.

(8) Reports filed pursuant to this section must be deemed public records and must be available to the public in accordance with the confidentiality and public records reporting laws of this state. Original copies of all reports filed under this section must be available to the state board of medical examiners, state board of

pharmacy, state law enforcement officials, and child protective services for use in the performance of their official duties.

(9) Absent a valid court order or judicial subpoena, the department or any other state department, agency, office, or employee may not compare data concerning chemical abortions or abortion complications maintained in an electronic or other information system file with data in any other electronic or other information system, the comparison of which could result in identifying, in any manner or under any circumstances, a woman obtaining or seeking to obtain a chemical abortion.

(10) Statistical information that may reveal the identity of a woman obtaining or seeking to obtain a chemical abortion may not be maintained by the department or any other state department, agency, office, employee, or contractor.

(11) The department shall communicate the reporting requirements of this section to all medical professional organizations, medical practitioners, and facilities operating in the state.

Section 10. Production of reporting forms. The department shall create and distribute the forms required by [sections 1 through 14] within 60 days after [the effective date of this act].

Section 11. Criminal penalties. (1) A person who purposely or knowingly or negligently violates any provision of [sections 1 through 14] is guilty of a felony and upon conviction shall be fined an amount not to exceed $50,000, be imprisoned in a state prison for a term not to exceed 20 years, or both. As used in this section, "purposely", "knowingly", and "negligently" have the meanings provided in 45-2-101.

(2) A criminal penalty may not be assessed against the pregnant woman on whom the chemical abortion is attempted or performed.

Section 12. Civil remedies and professional sanctions. (1) In addition to all other remedies available under the laws of this state, failure to comply with the requirements of [sections 1 through 14]:

(a) provides a basis for a civil malpractice action for actual and punitive damages;

(b) provides a basis for professional disciplinary action under Title 37 for the suspension or revocation of the license of a health care provider; and

(c) provides a basis for recovery for the woman's survivors for the wrongful death of the woman under 27-1-513.

(2) Civil liability may not be imposed against the pregnant woman on whom the chemical abortion is attempted or performed.

(3) When requested, the court shall allow a woman to proceed using solely the woman's initials or a pseudonym and may close any proceedings in the case and enter other protective orders to preserve the privacy of the woman on whom the chemical abortion was attempted or performed.

(4) If judgment is rendered in favor of the plaintiff, the court shall also render judgment for reasonable attorney fees in favor of the plaintiff against the defendant.

(5) If judgment is rendered in favor of the defendant and the court finds that the plaintiff's suit was frivolous and brought in bad faith, the court may render judgment for reasonable attorney fees in favor of the defendant against the plaintiff.

Section 13. Construction. [Sections 1 through 14] may not be construed to:

(1) create or recognize a right to abortion;

(2) make lawful an abortion that is otherwise unlawful; or

(3) repeal, replace, or otherwise invalidate existing federal laws, regulations, or policies.

Section 14. Right of intervention. The legislature, by joint resolution, may appoint one or more of its members, who sponsored or cosponsored [sections 1 through 14] in the member's official capacity, to intervene as a matter of right in any case in which the constitutionality of [sections 1 through 14] is challenged.

Section 15. Codification instruction. [Sections 1 through 14] are intended to be codified as a new part in Title 50, chapter 20, and the provisions of Title 50, chapter 20, apply to [sections 1 through 14].

Section 16. Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

- END -

I hereby certify that the within bill,

HB 171, originated in the House.

_____

Chief Clerk of the House

_____

Speaker of the House

Signed this _____day

of_____, 2021.

_____

President of the Senate

Signed this _____day

of_____, 2021.

HOUSE BILL NO. 171

INTRODUCED BY S. GREEF, B. BROWN, C. FRIEDEL, S. HINEBAUCH, D. HOWARD, D. KARY, T. MANZELLA, K. REGIER, D. SALOMON, C. SMITH

AN ACT ADOPTING THE MONTANA ABORTION-INDUCING DRUG RISK PROTOCOL ACT; PROVIDING REQUIREMENTS FOR PROVIDING ABORTION-INDUCING DRUGS TO PREGNANT WOMEN; PROHIBITING PROVIDING ABORTION-INDUCING DRUGS IN SCHOOLS AND ON SCHOOL GROUNDS; REQUIRING INFORMED CONSENT; PROVIDING FOR THE REPORTING OF CHEMICAL ABORTIONS AND ADVERSE EVENTS AND COMPLICATIONS; PROVIDING DEFINITIONS; AND PROVIDING PENALTIES, CIVIL REMEDIES, AND PROFESSIONAL SANCTIONS.

EXHIBIT 3

AN ACT REQUIRING THAT A PREGNANT WOMAN MUST BE AFFORDED THE OPPORTUNITY TO VIEW AN ACTIVE ULTRASOUND AND ULTRASOUND IMAGES AND LISTEN TO THE FETAL HEART TONE OF THE UNBORN CHILD BEFORE UNDERGOING AN ABORTION; PROVIDING EXCEPTIONS; PROVIDING A PENALTY; AND AMENDING SECTION 50-20-105, MCA.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Provision of information -- exceptions -- penalty. (1) (a) Except as provided in subsection (2), a person performing an abortion on a pregnant woman or that person's agent shall inform the woman of the opportunity to:

(i) view an active ultrasound of the unborn child;

(ii) view an ultrasound image of the unborn child; and

(iii) listen to the fetal heart tone of the unborn child, if audible.

(b) The quality of the active ultrasound, ultrasound image, and auscultation of the fetal heart tone must be consistent with standard medical practices in the community in which the abortion is being performed.

(2) Subsection (1) does not apply to a procedure performed with the intent to:

(a) save the life of the woman;

(b) ameliorate a serious risk of causing the woman substantial and irreversible impairment of a bodily function; or

(c) remove an ectopic pregnancy.

(3) The person performing the abortion or that person's agent shall obtain the woman's signature on a certification form developed by the department that:

(a) contains an acknowledgment that the woman was informed of the opportunities provided for in

subsection (1); and

(b) indicates whether the woman viewed the active ultrasound or ultrasound image or listened to the fetal heart tone.

(4) (a) Before an abortion is performed or attempted, the person who is performing or attempting the abortion must receive a copy of the signed certification form provided for in subsection (3).

(b) A copy of the certification form must be retained in the woman's medical record.

(5) A person who performs or attempts to perform an abortion in violation of this section is subject to a civil penalty of $1,000.

Section 2. Section 50-20-105, MCA, is amended to read:

"**50-20-105. Duties of department.** (1) The department shall make regulations to provide for the humane disposition of dead infants or fetuses.

(2) The department shall make regulations for a comprehensive system of reporting of maternal deaths and complications within the state resulting directly or indirectly from abortion, subject to the provisions of 50-20-110(5).

(3) The department shall report to the attorney general any apparent violation of this chapter.

(4) The department shall develop a certification form for use in accordance with [section 1]."

Section 3. Codification instruction. [Section 1] is intended to be codified as an integral part of Title 50, chapter 20, part 1, and the provisions of Title 50, chapter 20, part 1, apply to [section 1].

- END -

I hereby certify that the within bill,

HB 140, originated in the House.

_____

Chief Clerk of the House

_____

Speaker of the House

Signed this _____day

of_____, 2021.

_____

President of the Senate

Signed this _____day

of_____, 2021.

HOUSE BILL NO. 140

INTRODUCED BY A. REGIER, K. REGIER, F. ANDERSON, M. BINKLEY, P. FIELDER, J. FULLER, S. GALLOWAY, E. HILL, D. LENZ, B. LER, B. MITCHELL, M. NOLAND, M. REGIER, L. SHELDON-GALLOWAY, J. GILLETTE, S. VINTON, D. SKEES, J. HINKLE, L. REKSTEN, B. TSCHIDA

AN ACT REQUIRING THAT A PREGNANT WOMAN MUST BE AFFORDED THE OPPORTUNITY TO VIEW AN ACTIVE ULTRASOUND AND ULTRASOUND IMAGES AND LISTEN TO THE FETAL HEART TONE OF THE UNBORN CHILD BEFORE UNDERGOING AN ABORTION; PROVIDING EXCEPTIONS; PROVIDING A PENALTY; AND AMENDING SECTION 50-20-105, MCA.

EXHIBIT 4

AN ACT PROHIBITING QUALIFIED HEALTH INSURANCE PLANS OFFERED THROUGH A HEALTH INSURANCE EXCHANGE IN MONTANA FROM COVERING ABORTION SERVICES.

WHEREAS, under Public Law 111-148, the Patient Protection and Affordable Care Act, federal tax dollars are routed to exchange-participating health insurance plans through affordability credits provided to individuals with incomes of up to 400% of the federal poverty level to assist the individuals with purchasing health insurance coverage, including health insurance plans that provide coverage for abortions; and

WHEREAS, federal funding of insurance plans that provide coverage for abortions is an unprecedented change in federal abortion funding policy that fails to take into account the Hyde Amendment that prohibits federal funds from subsidizing health insurance plans that provide coverage of abortions; and

WHEREAS, the provision of federal funding for health insurance plans that provide abortion coverage is nothing short of taxpayer-funded and government-endorsed abortion; and

WHEREAS, Public Law 111-148 allows a state to opt out of permitting health insurance plans that cover abortions from participating in the health insurance exchanges within that state and thus prohibit taxpayer money from subsidizing plans that cover abortions within that state; and

WHEREAS, the U.S. Supreme Court has, in past decisions, concluded that the decision not to fund abortion services places no governmental obstacle in the path of a woman who chooses to terminate her pregnancy and that a state may engage in unequal subsidization of abortion and other medical services to encourage alternative activity considered to be in the public interest; and

WHEREAS, a January 2010 Quinnipiac University poll showed that 7 in 10 Americans were opposed to provisions in federal health care reform that use federal funds to pay for abortions and abortion coverage.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Prohibition on coverage of abortion services in qualified health plans. (1) A qualified health plan, as defined by 42 U.S.C. 18021, may not be offered or otherwise made available through a health insurance exchange established in the state pursuant to Public Law 111-148, the Patient Protection and Affordable Care Act, if the plan provides coverage for abortion as defined in 50-20-104.

(2) The prohibition in this section does not apply to a plan that provides coverage for an abortion performed when:

(a) the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself; or

(b) the pregnancy is the result of an act of rape or incest.

Section 2. Construction. (1) The provisions of [section 1] may not be construed as creating or recognizing a right to abortion.

(2) It is not the intent of [section 1] to make lawful an abortion that is currently unlawful.

Section 3. Codification instruction. [Sections 1 and 2] are intended to be codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [sections 1 and 2].

- END -

I hereby certify that the within bill,

HB 229, originated in the House.

_____

Chief Clerk of the House

_____

Speaker of the House

Signed this _____day

of_____, 2021.

_____

President of the Senate

Signed this _____day

of_____, 2021.

HOUSE BILL NO. 229

INTRODUCED BY J. GILLETTE

AN ACT PROHIBITING QUALIFIED HEALTH INSURANCE PLANS OFFERED THROUGH A HEALTH INSURANCE EXCHANGE IN MONTANA FROM COVERING ABORTION SERVICES.

EXHIBIT 5

LEGAL REVIEW NOTE

Bill No.: HB136

LC#: LC804 To Legal Review Copy, as of November 25, 2020

Short Title: Adopt Pain-Capable Unborn Child Protection Act

Attorney Reviewer: Todd Everts/Alexis Sandru

Date: December 31, 2020

CONFORMITY WITH STATE AND FEDERAL CONSTITUTIONS

As required pursuant to section 5-11-112(1)(c), MCA, it is the Legislative Services Division's statutory responsibility to conduct "legal review of draft bills". The comments noted below regarding conformity with state and federal constitutions are provided to assist the Legislature in making its own determination as to the constitutionality of the bill. The comments are based on an analysis of jurisdictionally relevant state and federal constitutional law as applied to the bill. The comments are not written for the purpose of influencing whether the bill should become law but are written to provide information relevant to the Legislature's consideration of this bill. The comments are not a formal legal opinion and are not a substitute for the judgment of the judiciary, which has the authority to determine the constitutionality of a law in the context of a specific case.

This review is intended to inform the bill draft requestor of potential constitutional conformity issues that may be raised by the bill as drafted. This review IS NOT dispositive of the issue of constitutional conformity and the general rule as repeatedly stated by the Montana Supreme Court is that an enactment of the Legislature is presumed to be constitutional unless it is proven beyond a reasonable doubt that the enactment is unconstitutional. See Alexander v. Bozeman Motors, Inc., 356 Mont. 439, 234 P.3d 880 (2010); Eklund v. Wheatland County, 351 Mont. 370, 212 P.3d 297 (2009); St. v. Pyette, 337 Mont. 265, 159 P.3d 232 (2007); and Elliott v. Dept. of Revenue, 334 Mont. 195, 146 P.3d 741 (2006).

Legal Reviewer Comments:

As drafted, HB136 adopts the Montana Pain-Capable Unborn Child Protection Act, which prohibits the abortion of an unborn child capable of feeling pain. The Act defines an unborn child capable of feeling pain as an unborn child whose probable gestational age is 20 or more weeks.

The Due Process Clause of the Fourteenth Amendment to the United States Constitution and Article II, section 10, of the Montana Constitution protect a woman's decision to terminate her

pregnancy. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846 (1992); *Armstrong v. St.*, 1999 MT 261, 296 Mont. 361, 989 P.2d 364. The United States Supreme Court has interpreted this right to mean that a woman has a right to choose to have an abortion before viability without undue interference from the state, *Casey*, 505 U.S. at 846, and has acknowledged that viability may exist at 23 to 24 weeks since a woman's last menstrual period. *Id.* at 860. The federal Ninth Circuit Court of Appeals held that Idaho's Pain-Capable Unborn Child Protection Act, which banned the abortion of fetuses 20 or more weeks post-fertilization, was unconstitutional on its face because the act categorically banned pre-viability abortions and placed an arbitrary time limit on when woman can obtain abortions. *McCormack v. Herzog*, 788 F.3d 1017, 1032 (9th Cir. 2015).

Under Montana's unique constitutional guarantee to the right of privacy, which provides broader protection of the right of privacy than is afforded under the United State Constitution, the Montana Supreme Court has interpreted the right to mean that a woman has a right to choose to have an abortion before viability unless the state can demonstrate a compelling interest for infringing the right. *Armstrong*, 1999 MT 261, ¶ 75, 296 Mont. 361, 390, 989 P.2d 364, 384.

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 United States Constitution and Montana Constitution.

Requester Comments:

MCA 41-1-103 states that unborn children are deemed an existing person for interests in its birth. HB136 would protect unborn children from the pain of abortion. As medical science advances more is known about gestation and fetal development. In Planned Parenthood v. Casey, 505 U.S. 833, 869 (1992) the U.S. Supreme Court established that "the liberty of the woman to terminate her pregnancy is not unlimited. At a later point in fetal development the State's interest in life has sufficient force so that the right of the woman to terminate the pregnancy can be restricted." HB136 is reasonable policy for the state of Montana and does pass constitutional scrutiny.

EXHIBIT 6

LEGAL REVIEW NOTE

Bill No.: HB 171

LC#: LC820, To Legal Review Copy, as of January 12, 2021

Short Title: Adopt the Montana Abortion-Inducing Drug Risk Protocol Act

Attorney Reviewers: Todd Everts, Alexis Sandru

Date: January 15, 2021

CONFORMITY WITH STATE AND FEDERAL CONSTITUTIONS

As required pursuant to section 5-11-112(1)(c), MCA, it is the Legislative Services Division's statutory responsibility to conduct "legal review of draft bills". The comments noted below regarding conformity with state and federal constitutions are provided to assist the Legislature in making its own determination as to the constitutionality of the bill. The comments are based on an analysis of jurisdictionally relevant state and federal constitutional law as applied to the bill. The comments are not written for the purpose of influencing whether the bill should become law but are written to provide information relevant to the Legislature's consideration of this bill. The comments are not a formal legal opinion and are not a substitute for the judgment of the judiciary, which has the authority to determine the constitutionality of a law in the context of a specific case.

This review is intended to inform the bill draft requestor of potential constitutional conformity issues that may be raised by the bill as drafted. This review IS NOT dispositive of the issue of constitutional conformity and the general rule as repeatedly stated by the Montana Supreme Court is that an enactment of the Legislature is presumed to be constitutional unless it is proven beyond a reasonable doubt that the enactment is unconstitutional. See Alexander v. Bozeman Motors, Inc., 356 Mont. 439, 234 P.3d 880 (2010); Eklund v. Wheatland County, 351 Mont. 370, 212 P.3d 297 (2009); St. v. Pyette, 337 Mont. 265, 159 P.3d 232 (2007); and Elliott v. Dept. of Revenue, 334 Mont. 195, 146 P.3d 741 (2006).

Legal Reviewer Comments:

HB 171, as drafted, provides that an abortion-inducing drug may only be provided to a pregnant woman by a qualified medical practitioner who examines the woman in person prior to providing the drug and prohibits the provision of an abortion-inducing drug by courier, delivery, or mail service. HB 171 also requires that informed consent to a chemical abortion must be obtained at least 24 hours before the abortion-inducing drug is provided to the pregnant woman, with exceptions.

Although not jurisdictionally relevant, laws similar to HB 171 are in effect in other states and have withstood constitutional challenges in other states. *See, e.g., MKB Mgmt. Corp. v. Burdick*, 2014 ND 197, 855 N.W.2d 31.

However, HB 171 may raise potential constitutional conformity issues concerning Montana's unique constitutional guarantee of the right to privacy, Article II, section 10, which provides:

> The right of individual privacy is essential to the well-being of a free society and shall not be infringed without the showing of a compelling state interest.

Montana's constitutional right to privacy is one of the most stringent protections of the right to privacy in the United States and provides broader protection of the right of privacy than is afforded under the United States Constitution. *See Armstrong v. St.*, 1999 MT 261, ¶ 34, 296 Mont. 361, 989 P.2d 364. This is apparent in the constitutional analysis of abortion legislation. While the United States Constitution protects "a woman's right to choose to have an abortion before fetal viability and to obtain it without undue interference or undue burden from the state," Montana's Constitution demands more, requiring that the government demonstrate a compelling state interest for infringing upon a woman's right of procreative autonomy. *Armstrong*, ¶ 40 (internal quotations omitted).

In *Armstrong v. St.*, the Montana Supreme Court struck down the "physician only" provisions of the Montana Abortion Control Act, Title 50, chapter 20, MCA, which prohibited physician assistants from performing abortions on pregnant women, noting that the legislation was an "attempt to make it as difficult, as inconvenient and as costly as possible for women to exercise their right to obtain, from the health care provider of their choice, a specific medical procedure" and holding that a woman's right to seek and obtain a pre-viability abortion from a health care provider of her choice was constitutionally protected. *Armstrong*, ¶ 65, ¶ 75.

Following the *Armstrong* decision, the First Judicial District Court, Lewis and Clark County, entered judgment declaring that the "Woman's Right-to Know Act", Title 50, ch. 20, part 3, MCA, and related provisions pertaining to informed consent were unconstitutional under Article II, section 10, of the Montana Constitution and permanently enjoined the enforcement of those provisions. *Planned Parenthood of Missoula v. St.*, Montana First Judicial District Court, Lewis and Clark County (December 29, 1999). The decision was not appealed to the Montana Supreme Court.

Given Montana's broad right to privacy and the foregoing precedent, 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.

Requestor Comments: