ABORTION DEFENSE NETWORK

Know Your State's Abortion Laws

A Guide for Medical Professionals

KENTUCKY

Since *Roe v. Wade* was overturned in June 2022, medical providers across the country have struggled to understand their state's abortion laws, which contain undefined terms and non-medical language.

Fear and confusion throughout the medical community has led some hospitals to adopt policies that are overly strict or burdensome, causing patients to be denied care in emergencies. While the law remains in flux and some questions have no clear answers, this document aims to provide clarification, where possible, of what conduct is still permitted in your state. Know what your state's law does and does not require, so you can advocate for yourself and your patients.

Last updated October 2025

Key Takeaways

Providing contraception, including emergency contraception, is legal.

Providing medical care for ectopic pregnancies and pregnancies with no cardiac activity is legal.

Providing information about how to obtain a legal abortion in another state is legal.

Abortion is prohibited under Kentucky law unless the patient has a “medical emergency,” meaning abortion is necessary to “prevent the death” of the patient or to prevent “the serious, permanent impairment of a life-sustaining organ.”

Kentucky voters rejected a constitutional amendment that would have prohibited constitutional protection for abortion, meaning that litigation can be brought to challenge the constitutionality of Kentucky’s abortion bans. Because the Kentucky Supreme Court ruled that a case must be brought by patients, the ACLU is currently looking for pregnant patients to participate.

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Definition of Abortion & Contraception

ABORTION

Kentucky law defines abortion as "the performance of any act with the intent to terminate the clinically diagnosable pregnancy of a woman known to be pregnant with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child."[1] The definition of abortion excludes treatment of ectopic and molar pregnancies.[2]

Miscarriage care is legal whenever there is no cardiac activity.[3] Additionally, Kentucky law excludes from the definition of abortion "[l]ifesaving miscarriage management, which includes medically necessary interventions when the pregnancy . . . is in the unavoidable and untreatable process of ending due to spontaneous or incomplete miscarriage" as well as "[s]epsis and hemorrhage emergency medical interventions required when a miscarriage or impending miscarriage results in a life-threatening infection or excessive bleeding."[4]

With respect to self-managed abortion, it is legal for providers to give medical care to a pregnant person who has initiated or recently completed a self-managed abortion provided there is no embryonic or fetal cardiac activity or the patient qualifies under the medical emergency exception to Kentucky's bans (see below). A pregnant person cannot be convicted under Kentucky's abortion ban for self-managing their abortion because the state's criminal abortion ban explicitly exempts pregnant people from liability.[5]

CONTRACEPTION

Contraception is not illegal in any state in the country. Kentucky defines contraceptives as "a drug, device, or chemical that prevents conception."[6]

Abortion Bans

Kentucky voters in 2022 rejected a constitutional amendment that would have prohibited constitutional protection for abortion, meaning that litigation can be brought to challenge the constitutionality of Kentucky's abortion bans. The Kentucky Supreme Court has held that patients, rather than health care providers, must bring the case. The ACLU is currently looking for patients to participate in a lawsuit. Any interested pregnant patients can reach the ACLU at 617-297-7012.

Total Ban/Trigger Ban: Kentucky's most restrictive abortion ban is a total ban (also sometimes referred to as a "trigger ban"). The so-called "trigger ban," which bans abortion throughout pregnancy, became operative following the overturning of *Roe v. Wade*.[7] The ban states that "No person may knowingly: 1. Administer to, prescribe for, procure for, or sell to any pregnant woman any medicine, drug, or other substance with the specific intent of causing or abetting the termination of the life of an unborn human being, or 2. Use or employ any instrument or procedure upon a pregnant woman with the specific intent of causing or abetting the termination of the life of an unborn human being."[8] The statute explicitly does not outlaw contraceptive use before pregnancy.[9] Providing an abortion that violates Kentucky's total ban is a class D felony[10] punishable with not less than one and no more than five years in prison.[11] The pregnant person cannot be charged under this statute.[12]

6-Week Ban: Kentucky also has a ban that prohibits abortion after cardiac activity is detectable. Because cardiac activity is detectable starting around 6 weeks LMP, this is sometimes referred to as a 6-week abortion ban. The ban requires a provider to "determine whether there is a detectable fetal heartbeat" and then prohibits the provision of an abortion "with the specific intent of causing or abetting the termination of the" pregnancy where a

"fetal heartbeat has been detected."[13] Violation of the ban is a class D felony,[14] chargeable with not less than one and no more than five years in prison.[15] Abortion patients can themselves bring a civil action for violation of the ban.[16] The pregnant person cannot be charged under this ban.[17]

Other Bans and Restrictions: Several other abortion bans are also currently in effect, including a ban on telehealth abortions,[18] a reason ban (prohibiting "sex-, race-, color-, national origin-, or disability-based abortion"),[19] a 15-week ban,[20] a ban on dilation and evacuation ("D&E") abortions,[21] and a ban on post-viability abortions.[22] Kentucky law retains additional abortion restrictions and requirements, including informed consent requirements,[23] parental consent for young people under 18,[24] physician-only requirements,[25] a prohibition on abortions in publicly owned health care facilities,[26] and requirements that "born-alive infants" be provided certain medical care.[27]

"Medical Emergency" Exception to Abortion Bans

In March of 2025, Kentucky lawmakers amended the definition of "abortion" to exclude any medical procedure that "separat[es] a pregnant woman from her unborn child," "when performed by a physician," that is "necessary based on reasonable medical judgment to prevent the death or substantial risk of death of the pregnant woman due to a physical condition, or to prevent serious, permanent impairment of a life-sustaining organ of a pregnant woman. However, the physician shall make reasonable medical efforts under the circumstances to preserve both the life of the mother and the life of the unborn child in a manner consistent with reasonable medical practice."[28] Kentucky law defines "reasonable medical judgment" to mean "the range of conclusions or recommendations that licensed medical practitioners with similarly sufficient training and experience may communicate to a patient based upon current available medical evidence."[29]

However, Kentucky has not amended or repealed the definitions of medical emergency that exist in other parts of state law. Both the trigger ban and the 6-week ban, as well as the 15-week ban and post-viability ban, have either exceptions[30] or affirmatives defenses[31] for preventing death or serious injury to the pregnant person. The total ban has an *exception* which states it is not a violation of the ban for a licensed physician to provide a medical procedure "necessary in [their] reasonable medical judgment to prevent the death or substantial risk of death due to a physical condition, or to prevent the serious, permanent impairment of a life-sustaining organ of a pregnant woman."[32]

Similarly, the 6-week ban also contains an exception, laying out that the ban "shall not apply to a physician who performs a medical procedure that, in the physician's reasonable medical judgment, is designed or intended to prevent the death of the pregnant woman or to prevent a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman."[33] The ban also only applies to intrauterine pregnancies.[34]

The 15-week ban contains an *affirmative defense*[35] for if "the physician determined, in the physician's reasonable medical judgment, based on the facts known to the physician at that time, that either of the following applied: (a) The probable gestational age of the unborn child was less than fifteen (15) weeks; or (b) The abortion was necessary to prevent the death of the pregnant woman or to avoid a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman."[36] The statute explicitly states that mental health repercussions do not qualify as "substantial and irreversible impairment of a major bodily function" under the ban.[37] Except "when a medical emergency exists that prevents compliance" with one of the

statute's requirements, the law contains additional requirements for providing abortion under the affirmative defenses, such as getting the opinion of a second medical provider[38] and having a second provider in the room during the procedure.[39]

The post-viability ban provides that no abortion may be provided after the fetus "may reasonably be expected to have reached viability, except when necessary to preserve the life or health of the woman."[40] When an abortion is performed under the exception, "the person performing the abortion shall take all reasonable steps in keeping with reasonable medical practices to preserve the life and health of the child."[41]

EMTALA

A federal law called the Emergency Medical Treatment & Labor Act ("EMTALA") requires the provision of abortion care when necessary to stabilize an emergency medical condition. Specifically, EMTALA requires hospitals with emergency departments that participate in Medicare (i.e., most hospitals) to perform a medical screening exam for any individual who comes to the emergency department and requests evaluation or treatment, in order to determine whether the individual has an emergency medical condition.[42] EMTALA defines "emergency medical condition" to include "acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part."[43] Additionally, "with respect to a pregnant woman who is having contractions," an "emergency medical condition" is further defined to include when "there is inadequate time to effect a safe transfer to another hospital before delivery" or when "transfer may pose a threat to the health or safety of the woman or the unborn child."[44]

EMTALA requires stabilizing medical treatment be provided to any individual experiencing an emergency medical condition,[45] including people in labor or with emergency pregnancy complications,[46] unless the individual refuses to consent to such treatment.[47] Under the EMTALA statute, "to stabilize" means to provide medical treatment "as may be necessary" to ensure, "within reasonable medical probability, that no material deterioration of the condition is likely."[48] A person experiencing an emergency medical condition can be transferred to a different hospital only once they are stable or if certain other conditions are met, such as the medical benefits of transfer outweighing the increased risks to the person experiencing the emergency medical condition.[49] Even where a hospital is permitted to transfer such a person without first stabilizing them, the hospital still must provide "the medical treatment within its capacity which minimizes the risks to the individual's health."[50]

Where abortion, including the premature delivery of a non-viable fetus, is the medical treatment necessary to, within a reasonable probability, ensure no material deterioration of an individual's condition, EMTALA requires a covered hospital provide such care or, if the aforementioned criteria are met, an appropriate transfer. The U.S. Department of Health and Human Services ("HHS") has reaffirmed these requirements numerous times.[51]

Most recently, on June 13, 2025, HHS Secretary Robert F. Kennedy distributed a letter to health care providers reiterating that, notwithstanding the recent rescission of earlier guidance on the subject, "EMTALA continues to ensure pregnant women facing medical emergencies have access to stabilizing care."[52] The letter specifically states that EMTALA "applies equally to expectant mothers facing obstetric emergencies, including ectopic

pregnancies, miscarriages, premature ruptures of membranes, trophoblastic tumors, and other similar conditions."[53] And, during a June 24, 2025, subcommittee hearing in the U.S. House of Representatives, Secretary Kennedy was asked explicitly about whether he agreed that in some circumstances abortion is the necessary stabilizing care that EMTALA requires hospitals to provide, to which he responded, "Yes, and that is what President Trump believes." [54] Further, as recently as May 2025, HHS announced that it had cited at least one hospital in Texas for violating EMTALA by failing to properly screen a patient with an ectopic pregnancy, an emergency medical condition that threatened the patient's life and future fertility.[55]

Notwithstanding EMTALA's clear requirements with respect to emergency abortion, state officials in Idaho and Texas have attempted to restrict hospitals from complying with their federal legal obligations, resulting in litigation, but with only varying degrees of success.

In January 2025, Idaho's largest hospital system, St. Luke's Health System, filed a lawsuit seeking to prevent the state of Idaho from enforcing its abortion ban, which creates criminal penalties for the provision of certain emergency abortions required under EMTALA.[56] St. Luke's was successful in obtaining a preliminary injunction that prevents the state of Idaho from enforcing its abortion ban "against St. Luke's or any of its medical providers as applied to medical care required by [EMTALA]."[57] Litigation in that case is ongoing. St. Luke's case is related to one brought in 2022 by the Biden Administration, *United States v. Idaho*, in which the federal government sued Idaho challenging its abortion ban to the extent that it conflicted with EMTALA.[58] That case made it all the way to the U.S. Supreme Court, where the appeal was ultimately dismissed as prematurely granted in June 2024.[59] Following the change of presidential administrations, the United States dismissed that case entirely. [60]

And, in October 2024, the U.S. Supreme Court refused to review a Fifth Circuit decision that affirmed a lower court decision blocking federal enforcement of EMTALA in certain circumstances in Texas and as to other organizational plaintiffs in that case.[61] As a result, the Fifth Circuit's decision is final.[62] [63]

Other Federal Laws & Professional Guidelines

In addition to EMTALA, hospitals and/or medical providers are required to abide by the following:

Conditions of Participation in Medicare and Medicaid (COP): The federal COP regulations require hospitals that participate in Medicare and Medicaid to inform patients of their rights in advance of furnishing or discontinuing care which include: the right to be informed of their health status, be involved in care planning and treatment, and participate in the development of their plan of care.[64]

Protection Against Discrimination in Employment: The federal law known as the Church Amendments prohibits hospitals that receive certain federal funds from discriminating against health care providers who participate or are willing to participate in abortion care or sterilization procedures.[65]

Medical Malpractice: While this document does not detail state-specific medical malpractice law, medical providers should be aware that they risk liability under state medical malpractice law for failing to provide pregnant patients with the standard of care.[66]

Resident Training: The Accreditation Council for Graduate Medical Education (ACGME) requires that accredited programs provide access to training in the provision of abortion.[67] The federal law known as the Coats-Snowe Amendment both

protects medical professionals in learning to provide abortion, and limits the government's ability to penalize programs or institutions that fail to comply with ACGME requirements.[68]

Documentation & Reporting

Generally, state law does not require documentation of irrelevant or non-medical information in patient charts. Nor does it explicitly require reporting to law enforcement patients who receive abortions out of state or self-manage their own abortion.[69] The only abortion-specific documentation and reporting requirements are:

Documentation: Abortions performed under the medical exceptions above must be documented as follows:

Terminations of pregnancy that occur under the amended definition of abortion that excludes procedures intended to preserve the life or avert serious, permanent impairment to a life-sustaining organ (as well as lifesaving or emergency miscarriage care before embryonic or fetal demise) require the physician to "document in the pregnant woman's medical record the pregnant woman's informed consent to the treatment or procedure following a discussion, acknowledged in writing by the woman, of the risks, benefits, and alternatives to the treatment or procedure, sufficient in scope for a reasonable person to make an informed decision."[70] The physician who is to provide the treatment or perform the procedure or the referring physician must describe the basis for his or her reasonable medical judgment that the action is necessary on a government-prescribed form.[71] The foregoing requirements do not apply "when, in the reasonable medical judgment of the attending physician based on the particular facts of the case before him or her, there exists a medical emergency."[72] In a medical emergency, the physician must describe the basis of his or her reasonable medical judgment that the emergency exists on a government-prescribed form.[73] Nevertheless, even in a medical emergency "which limits the time available for documentation or the scope of the informed consent discussion, the physician shall endeavor to complete the [informed consent and documentation] requirements . . . to the extent possible without undue risk to the woman's life or health and shall promptly complete any required documentation when the emergency no longer exists."[74]

The 6-week ban requires that physicians providing abortions under an exception must provide in writing that the abortion falls under the exception and "[s]pecify the pregnant woman's medical condition that the medical procedure is asserted to address and the medical rationale for the physician's conclusion that the medical procedure is necessary to prevent the death of the pregnant woman or to prevent a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman."[75]

The 15-week ban requires both the abortion provider and the second physician to certify in writing that an abortion performed over 15 weeks falls under one of the two affirmative defenses (i.e., that it is "necessary to prevent the death of the pregnant woman or to avoid a serious risk of the substantial and irreversible impairment of a major bodily function" or that "in the physician's reasonable medical judgment the unborn child's probable gestational age is less than fifteen (15) weeks").[76] The physician must also certify "the available method or techniques considered and the reasons for choosing the method or technique employed."[77]

Some hospitals may impose additional documentation requirements for abortions performed as medical emergencies, including attestations by multiple physicians and/or approvals by an ethical review board. While intended to

insulate the hospital from liability, these are not legal requirements.

Abortion Reporting: Kentucky law provides that "[e]ach abortion . . . regardless of the length of gestation, shall be reported to the Vital Statistics Branch by the person in charge of the institution within three (3) days after the end of the month in which the abortion occurred."[78] The report must include the patient's demographic information and medical history, as well as information about the abortion procedure.[79]

Complication Reporting: Complications or adverse effects from abortion[80] "that the attending physician, hospital staff, or facility staff has reason to believe is a primary or secondary result of an abortion" must be reported within thirty days of discharge or death of the patient.[81]

Fetal Death Reporting: Kentucky health care providers and institutions must report any fetal death that occurs after 20 weeks' gestational age or where the fetus weighs 350 grams or more.[82] The fetal death should be reported on a combination birth-death certificate.[83] Kentucky law defines "fetal death" as "death prior to the complete expulsion or extraction from [the pregnant person] of a product of human conception, irrespective of the duration of pregnancy,"[84] and explicitly excludes abortion.

Other Mandatory Reporting: All other general mandatory reporting to the Department of Family and Protective Services, local law enforcement, etc., also applies for abortion patients.[85] This includes reporting of sexual abuse of young people under 18, child abuse, and vulnerable adult abuse.[86]

Electronic Medical Records: Many electronic medical record systems (EMRs) allow healthcare providers to securely share patient records across healthcare institutions. Hospital and other healthcare systems often use their EMR's default settings that widely share patient records.[87] Though these settings are often helpful for continuity of care, they may put abortion providers and patients (or patients obtaining other sensitive care) at risk, and many patients do not know their records are shared in this way.[88, 89]

EMRs have settings that can limit sharing of certain records and/or allow patients to choose how and when their records are shared, but because these are not the default settings, healthcare systems often must take steps to implement them.[90] For example, one EMR, Epic, has a filter that each Epic healthcare system can choose to turn on that exclusively blocks abortion care information from patients' externally-shared medical records, while allowing each patient's other medical records to be transmitted in full, in line with their authorization. We encourage you to discuss with your institution's general counsel and/or compliance or technology officers counsel alternative settings such as this that can protect abortion patient information while also complying with any other legal requirements.[91]

Counseling & Referral

Speech about abortion is legal in Kentucky. Medical professionals in Kentucky can thus (1) provide accurate options counseling, including about abortion; and (2) refer patients to medical providers in states where abortion is legal. However, "[p]ublic agency funds shall not be directly or indirectly used, granted, paid, or distributed to any entity, organization, or individual that performs, induces, refers for, or counsels in favor of abortions" except to comply with requirements of certain federal programs like Medicaid.[92]

Medication Abortion

Kentucky has an "Abortion-Inducing Drug Certification Program" which establishes certification requirements for manufacturers and distributors of abortion-inducing drugs, pharmacies that dispense abortion-including drugs, and licensed

abortion facilities.[93] The certification program requires recognition that "abortion-inducing drugs may only be provided to patients by qualified physicians who are registered as nonsurgical abortion providers and that abortion-inducing drugs shall not intentionally, knowingly, or recklessly be provided directly to a patient outside of the parameters of Kentucky's Abortion-Inducing Drug Certification Program."[94] The Attorney General has the right to demand from the Governor of another state "the surrender of any person found in the other state who is charged in Kentucky with the crime of violating [Kentucky's Abortion-Inducing Drug Certification laws]."[95]

A qualified physician providing an abortion-inducing drug must examine the patient in person to verify that a pregnancy exists, "[i]nform the patient that the remains of the unborn child may be visible in the process of completing the abortion;" and document the pregnancy in the patient's medical chart.[96] The physician "shall schedule a follow-up visit for the patient for approximately seven (7) to fourteen (14) days after administration of the abortion-inducing drug to confirm that the pregnancy is completely terminated and to assess any degree of bleeding."[97] Abortion-inducing drugs may not be provided in schools, and the law is not intended "to make lawful an abortion that is otherwise unlawful."[98]

Disposition of Fetal Tissue Remains

Kentucky law requires that twenty-four hours before an abortion or twenty-four hours after a miscarriage, "the healthcare facility or abortion clinic shall disclose to the parent or parents of the fetus, both orally and in writing, the parents' right to determine if they will take responsibility for the final disposition of the fetal remains or relinquish the responsibility for final disposition to the healthcare facility or abortion clinic."[99] The facility must document the results of the decision and the status of the fetal remains.[100]

Need legal advice?

This document should not be construed as legal advice. If you need individualized legal advice, please contact the Abortion Defense Network, where you will be matched with a pro bono attorney.

The Abortion Defense Network is managed by the Lawyering Project in partnership with the American Civil Liberties Union, Center for Reproductive Rights (CRR), National Women's Law Center (NWLC), and Resources for Abortion Delivery (RAD).

ACLU

CENTER for REPRODUCTIVE RIGHTS

NATIONAL WOMEN'S LAW CENTER
Justice for Her. Justice for All.

THE LAWYERING PROJECT

RAD RESOURCES FOR ABORTION DELIVERY

References

[1] KY. REV. STAT. ANN. § 311.720(1).
[2] KY. REV. STAT. ANN. § 311.723(1)(e)-(g). Additionally, the Six-Week Ban explicitly applies only to intrauterine pregnancies, *see* KY. REV. STAT. ANN. § 311.7703. Furthermore, Kentucky Attorney General Daniel Cameron stated in an advisory opinion that "[a]s a general matter, removal of an ectopic pregnancy is not an abortion." *See* Daniel Cameron, *Second Attorney General Advisory Opinion: The Effect and Scope of the Human Life Protection Act* (Oct. 26, 2022), https://www.ag.ky.gov/Advisories/22.10.26%20Second%20Advisory%20on%20Human%20Life%20Protection%20Act.pdf.
[3] KY. REV. STAT. ANN. § 311.723(1)(d).
[4] KY. REV. STAT. ANN. § 311.723(1)(b), (c).
[5] KY. REV. STAT. ANN. § 311.772(5).
[6] KY. REV. STAT. ANN. § 311.7701. This definition expressly applies to the 6-week ban (KRS 311.7701 to .7711). The total ban does not define the term "contraceptives."
[7] *See EMW Women's Surgical Ctr., P.S.C. v. Cameron,* No. 2022-CA-0906-I (Ky. Ct. App., Aug. 1, 2022); *see also* Daniel Cameron, *Attorney General Advisory: The Effect and Scope of the Human Life Protection Act in Light of Dobbs v. Jackson Women's Health Organization* (June 24, 2022), https://www.ag.ky.gov/Press%20Release%20Attachments/Human%20Life%20Protection%20Act%20Advisory.pdf.
[8] KY. REV. STAT. ANN. § 311.772(3). The term "unborn human being" is defined as "an individual living member of the species homo sapiens throughout the entire embryonic and fetal stages of the unborn child from fertilization to full gestation and childbirth. KY. REV. STAT. ANN. § 311.772(1)(c).
[9] KY. REV. STAT. ANN. § 311.772(6).
[10] KY. REV. STAT. ANN. § 311.772(3)(b).
[11] KY. REV. STAT. ANN. § 532.060(2)(d).
[12] KY. REV. STAT. ANN. § 311.772(5).
[13] KY. REV. STAT. ANN. §311.7706(1); KY. REV. STAT. ANN. § 311.7704 (explaining determination of fetal heartbeat).
[14] KY. REV. STAT. ANN. § 311.990(22).
[15] KY. REV. STAT. ANN. §532.060(2)(d).
[16] KY. REV. STAT. ANN. § 311.7709.
[17] KY. REV. STAT. ANN. § 311.7706(4).
[18] KY. REV. STAT. ANN. § 311.728.
[19] KY. REV. STAT. ANN. § 311.731.
[20] KY. REV. STAT. ANN. § 311.782(1).
[21] KY. REV. STAT. ANN. § 311.787.
[22] KY. REV. STAT. ANN. § 311.780.
[23] KY. REV. STAT. ANN. § 311.724.
[24] KY. REV. STAT. ANN. § 311.732.
[25] KY. REV. STAT. ANN. § 311.750.
[26] KY. REV. STAT. ANN. § 311.800.
[27] KY. REV. STAT. ANN. § 311.823. This statute concerns infants "born alive" after an attempted abortion. Explicitly *excluded* from the definition of abortion in cases of a "born-alive infant" are cases in which the abortion was done with intent to: "(a) Save the life or preserve the health of the unborn child; (b) Remove a dead unborn child caused by spontaneous abortion; or (c) Remove an ectopic pregnancy." KY. REV. STAT. ANN. § 311.821 (1980).
[28] KY. REV. STAT. ANN. § 311.723(1)(h).
[29] KY. REV. STAT. ANN. § 311.720(16).
[30] An "exception" means that conduct is not prohibited by the statute.
[31] An "affirmative defense" is a defense that a defendant to a lawsuit can introduce into evidence and, if proven, defeats liability or conviction. So while it can help a defendant be acquitted, it does not stop an individual from being sued or arrested in the first place.
[32] KY. REV. STAT. ANN. § 311.772(4).
[33] KY. REV. STAT. ANN. § 311.7706(2)(a).

[34] KY. REV. STAT. ANN. § 311.7703.
[35] In contrast to an exception, which should prevent a person from being sued or criminally charged in the first place, an affirmative defense is a defense that a defendant, who has either already been charged with a crime or sued civilly, can introduce into evidence that, if proven, defeats liability or conviction. It is important to note that an affirmative defense does not mean that a physician will not be sued or arrested in the first place. Rather, this affirmative defense may help a physician defendant be acquitted of charges under the abortion ban.
[36] KY. REV. STAT. ANN. § 311.782(2).
[37] KY. REV. STAT. ANN. § 311.782(2).
[38] KY. REV. STAT. ANN. § 311.782(3)(b)(2).
[39] KY. REV. STAT. ANN. § 311.782(3)(b)(6).
[40] KY. REV. STAT. ANN. § 311.780.
[41] KY. REV. STAT. ANN. § 311.780.
[42] EMTALA, 42 U.S.C. § 1395dd(a).
[43] EMTALA, 42 U.S.C. § 1395dd(e)(1)(A).
[44] EMTALA, 42 U.S.C. § 1395dd(e)(1)(B).
[45] EMTALA, 42 U.S.C. § 1395dd(b)(1)(A).
[46] EMTALA, 42 U.S.C. § 1395dd(e)(1).
[47] EMTALA, 42 U.S.C. § 1395dd(b)(2).
[48] EMTALA, 42 U.S.C. § 1395dd(e)(3)(A).
[49] EMTALA, 42 U.S.C. § 1395dd(c)(2) (requiring hospital to use "qualified personnel and transportation equipment" when making a permitted transfer under EMTALA, among other requirements).
[50] EMTALA, 42 U.S.C. § 1395dd(c)(1)(B)–(c)(2)(A).
[51] For example, in 2022, the Biden Administration issued guidance reiterating past administrative statements that the treatment required by EMTALA includes abortion care when such care is necessary to stabilize a pregnant person's emergency medical condition. Ctrs. for Medicare & Medicaid Servs., *Reinforcement of EMTALA Obligations Specific to Patients who are Pregnant or are Experiencing Pregnancy Loss* (updated July 2022) ("2022 EMTALA Guidance"). While this guidance has since been rescinded, the requirements of EMTALA as outlined in it and other prior HHS statements have not changed. Indeed, in the Trump Administration's June 3, 2025 statement rescinding the 2022 guidance, the Administration stated that "CMS will continue to enforce EMTALA . . . including for identified emergency medical conditions that place the health of a pregnant woman or unborn child in serious jeopardy." Ctrs. for Medicare & Medicaid Servs., *CMS Statement on Emergency Medical Treatment and Labor Act (EMTALA)* (June 3, 2025); *see also* Letter from Robert F. Kennedy Jr., Sec'y, U.S. Dep't of Health & Hum. Servs., to Healthcare Providers (June 13, 2025) ("Kennedy Letter"), available at https://essentialhospitals.org/wp-content/uploads/2025/06/6.13.25-EMTALA-letter-final.pdf.pdf.
[52] Kennedy Letter.
[53] Kennedy Letter.
[54] *Hearing on the Fiscal Year 2026 Dep't of Health and Hum. Servs. Budget Before the H. Comm. on Energy & Com., Subcomm. on Health,* 119th Cong. (2025) (statement of Robert F. Kennedy Jr., Sec'y of Health & Hum. Serv.).
[55] Center for Reproductive Rights, *Complaints Against Texas Hospitals for Denying Emergency Care for Ectopic Pregnancies*, (updated May 8, 2025).
[56] *St. Luke's Health System, LTD. v. Labrador*, No. 1:25-cv-00015, ECF No. 1 (D. Idaho Jan 14, 2025).
[57] *St. Luke's Health System, LTD v. Labrador*, No. 1:25-cv-00015, ECF No. 49 at 59 (D. Idaho Mar. 20, 2025).
[58] *United States v. Idaho*, 623 F. Supp. 3d 1096, 1117 (D. Idaho 2022).
[59] *Moyle v. United States*, 144 S. Ct. 2015 (June 27, 2024) (per curiam).
[60] *Idaho v. United States*, No. 1:22-cv-00329, ECF No. 182 (D. Idaho Mar. 5, 2025).
[61] *Becerra v. Texas*, No. 23-1076 (U.S. Oct. 7, 2024) (denying certiorari).
[62] *Texas v. Becerra*, 89 F.4th 529, 546 (5th Cir. 2024) (affirming permanent injunction barring HHS from enforcing the 2022 EMTALA Guidance's "interpretation that Texas abortion laws are preempted by EMTALA" and "it's interpretation of EMTALA—both as to when an abortion is required and EMTALA's effect on state laws governing abortion—within the State of Texas or against [plaintiff organizations'] members."); *see also* Ctrs. for Medicare & Medicaid Servs., *Emergency Medical Treatment & Labor Act (EMTALA)*, https://www.cms.gov/medicare/regulations-

guidance/legislation/emergency-medical-treatment-labor-act (last modified Dec. 6, 2024).

[63] A separate challenge to the guidance was filed by the Catholic Medical Association in Tennessee, Compl., *Catholic Med. Ass'n v. Dep't of Health & Hum. Servs.*, No 3:25-cv-00048, ECF No. 1 (M.D. Tenn. Jan. 10, 2025), but the plaintiff voluntarily dismissed that action on June 3, 2025.

[64] 42 C.F.R. §§ 482.13(a)(1), (b)(1), (b)(2).

[65] Know Your Rights: Existing Laws May Protect Health Care Professional Who Provide or Support Abortion from Discrimination in Employment, NAT'L WOMEN'S LAW CTR. (Feb. 9, 2023), https://nwlc.org/resource/know-your-rights-existing-laws-may-protect-health-care-professionals-who-provide-or-support-abortion-from-discrimination-in-employment/.

[66] KY. REV. STAT. ANN. § 304.40-260.

[67] Accreditation Council for Graduate Med. Educ., *ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology* (Sept. 3, 2025).

[68] 42 U.S.C. § 238n.

[69] There is no reason to report a self-managed abortion to the police. Fact sheets from If/When/How with additional detail, including some state-specific fact sheets, are available here. If/When/How adds state-specific fact sheets to their website as they are finalized.

[70] KY. REV. STAT. ANN. § 311.723(2)(a)(2).

[71] KY. REV. STAT. ANN. § 311.723(2)(b).

[72] KY. REV. STAT. ANN. § 311.723(2)(c)(1).

[73] *Id.*

[74] KY. REV. STAT. ANN. § 311.723(2)(c)(2).

[75] KY. REV. STAT. ANN. § 311.7706(2)(b).

[76] KY. REV. STAT. ANN. § 311.782(3)(3)(a).

[77] The statute does not specify whether this refers to the abortion provider or the second physician. *See* KY. REV. STAT. ANN. § 311.782(3)(b)(4) .

[78] KY. REV. STAT. ANN. § 213.101.

[79] KY. REV. STAT. ANN. § 213.101.

[80] A "complication" or "abortion complication" is defined as "only the following physical or psychological conditions which, in the reasonable medical judgment of a licensed healthcare professional, arise as a primary or secondary result of an induced abortion: uterine perforation, cervical laceration, infection, vaginal bleeding that qualifies as a Grade 2 or higher adverse event according to the Common Terminology Criteria for Adverse Events, pulmonary embolism, deep vein thrombosis, failure to actually terminate the pregnancy, incomplete abortion (retained tissue), pelvic inflammatory disease, missed ectopic pregnancy, cardiac arrest, respiratory arrest, renal failure, shock, amniotic fluid embolism, coma, death, free fluid in the abdomen, allergic reactions to anesthesia and abortion-inducing drugs, psychological complications as diagnosed that are listed in the current Diagnostic and Statistical Manual of Mental Disorders, and any other 'adverse event' as defined by the Food and Drug Administration criteria provided in the MedWatch Reporting System." KY. REV. STAT. ANN. § 311.7731.

[81] KY. REV. STAT. ANN. § 311.7741.

[82] KY. REV. STAT. ANN. § 213.096.

[83] *Id.*

[84] KY. REV. STAT. ANN. § 213.011.

[85] Fact sheets from If/When/How with additional detail, including some state-specific fact sheets, are available here. If/When/How adds state-specific fact sheets to their website as they are finalized.

[86] KY. REV. STAT. ANN. § 620.030; KY. REV. STAT. ANN. § 209.030.

[87] For example, an EMR may employ a tool that securely shares information among healthcare institutions that use the same EMR (e.g., from one hospital system to another) and allows robust sharing among affiliated healthcare institutions (e.g., a Texas hospital treating a patient may be able to see the patient's records from an Illinois hospital within the same health system).

[88] For example, if a patient travels from a ban state to an access state for abortion care or obtains an abortion in the ban

state under an exception, then later obtains any type of healthcare at a different provider that uses the same EMR, the patient's records may be automatically shared with the second provider. If the second provider believes that the care violated the state's abortion ban, they may report it to authorities.

[89] Some states have taken steps to address vulnerabilities in information sharing, specifically for abortion and gender-affirming care. For example, Maryland and California, among other states, have enacted laws that restrict disclosure of abortion-related records and require EMRs to develop tools to limit or prohibit such disclosure. *See, e.g.,* H.B. 812, 445th Leg., Reg. Sess. (Md. 2023), A.B. 352, 2023 Leg., Reg. Sess. (Cal. 2023).

While the federal government under the Biden administration created additional HIPAA protections related to the disclosure of reproductive health care records by issuing a HIPAA Reproductive Health Rule, in 2025, a federal district court vacated the rule nationwide and the requirements of the rule are no longer in effect (except for the notice of privacy practices provisions related to substance use disorder treatment records, which go into effect on February 16, 2026). HIPAA Privacy Rule to Support Reproductive Health Care Privacy, 89 Fed. Reg. 32976 (2024) (modifying 45 C.F.R. §§ 160, 164), *Purl v. U.S. Dep't of Health & Hum. Servs.*, No. 2:24-cv-228-Z (N.D. Tex. Jun 18, 2025) (vacating the majority of the rule). All HIPAA protections that were in place prior to this rule remain in place.

[90] Many of these setting options are quite broad, blocking not only a subsequent provider's access to more "sensitive" information, but also to less sensitive information that is critical to continuity of care. For this reason, many patients may not want to limit access to their records.

[91] E.g., healthcare institutions must comply with interoperability rules that penalize certain information blocking (though exceptions are available). *See* 21st Century Cures Act: Interoperability, Information Blocking and the ONC Health IT Certification Program, 85 Fed. Reg. 25642 (May 1, 2020) (amending 45 C.F.R. §§ 170, 171), 21st Century Cures Act: Establishment of Disincentives for Health Care Providers That Have Committed Information Blocking, 89 Fed. Reg. 54662 (July 1, 2024) (amending 42 C.F.R. §§ 171 414, 425, 495). *See also* Health Data, Technology, and Interoperability: Protecting Care Access, 89 Fed. Reg. 102512 (Dec. 17, 2024) (adding 45 C.F.R. § 171.206 to except information blocking practices intended to reduce potential exposure to legal action based on lawful reproductive health care provision, subject to certain conditions). Not all healthcare providers are currently subject to the disincentives included in the 2024 rule. However, the Centers for Medicare & Medicaid Services (CMS) may apply disincentives to certain hospitals and merit-based incentive payment system (MIPS) eligible clinicians.

[92] KY. REV. STAT. ANN. § 311.715.

[93] KY. REV. STAT. ANN. § 216B.202.

[94] KY. REV. STAT. ANN. § 216B.202.

[95] KY. REV. STAT. ANN. § 311.7743.

[96] KY. REV. STAT. ANN. § 311.7734(2).

[97] KY. REV. STAT. ANN. § 311.7743(3).

[98] KY. REV. STAT. ANN. § 311.7737.

[99] KY. REV. STAT. ANN. § 213.098(2)(a).

[100] KY. REV. STAT. ANN. § 213.098(2)(d).