ABORTION DEFENSE NETWORK

Know Your State's Abortion Laws

A Guide for Medical Professionals

MISSOURI

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 November 2024

Key Takeaways

Providing contraception, including emergency contraception, is legal.

Providing medical care for 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 Missouri law, but the law provides an affirmative defense where the patient has a “medical emergency,” meaning an “immediate abortion” is necessary to “avert death” or “a serious risk of substantial and irreversible physical impairment of a major bodily function.”

A constitutional amendment protecting abortion was approved by voters in November of 2024, but Missouri’s bans and restrictions remain in effect for now.

Last updated December 2024

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Definition of Abortion & Contraception

ABORTION

Missouri law defines "abortion" as (a) "[t]he act of using or prescribing any instrument, device, medicine, drug, or any other means or substance with the intent to destroy the life of an embryo or fetus in his or her mother's womb"; or (b) "intentional termination of the pregnancy . . . by using or prescribing any instrument, device, medicine, drug, or other means or substance with an intention other than to increase the probability of a live birth or to remove a dead unborn child."[1]

Miscarriage care, which is widely understood to mean care provided when there is no fetal cardiac activity, is not illegal, so long as the intention of the provider is to "remove a dead unborn child."[2] Missouri law does not explicitly exclude ectopic pregnancies from the definition of abortion, but there are a few key reasons why terminating an ectopic pregnancy would likely be justifiable under Missouri law. First, tubal ectopics are not in the "womb," so terminations are arguably not included in the definition of abortion. Additionally, terminating an ectopic pregnancy should, in the vast majority of cases, be permissible in medical emergencies (see below).

There is no explicit crime of self-managed abortion in Missouri, and Missouri law states that a pregnant person "shall not be prosecuted for a conspiracy to violate" the Missouri trigger ban[3] or viability ban (see discussion of cascading gestational age bans below).[4] However, the Jackson County Prosecutor has also stated in litigation that "[a]lthough the criminal provisions state that '[a] woman upon whom an abortion is performed or induced in violation of this subsection shall not be prosecuted for a conspiracy to violate the provisions of this subsection' the language permits prosecution of a woman acting as the princip[al] in termination of her pregnancy."[5, 6]

CONTRACEPTION

Contraception, including emergency contraception, is legal.[7]

Abortion Bans[8]

Trigger Ban: Missouri's total abortion ban is the so-called "trigger ban," which took effect on June 24, 2022. The ban states that "no abortion shall be [knowingly] performed or induced upon a woman."[9]

The criminal penalties for violating the ban are: (1) a person can be charged with a class B felony,[10] which is punishable by between 5-15 years[11] and (2) "[i]f the person has gained money or property through the commission of the offense," they can be court-ordered to pay criminal fines "not exceeding double the amount of the person's gain from the commission of the offense."[12] Additionally, any medical provider who "willfully and knowingly" performs an abortion or violates other restrictions on abortion care in Missouri is subject to having their "license, application for license, or authority to practice [their] profession . . . in the state of Missouri rejected or revoked by the appropriate state licensing board."[13] Finally, medical providers may face "civil liability for medical malpractice for negligent acts or certification" related to abortion care.[14] The trigger ban is currently in effect.

Other Bans and Restrictions: If the trigger ban is ever blocked by court order, abortion care will not immediately become legal and accessible across the board in Missouri. Missouri has a series of cascading gestational age bans, intended to continue to operate even if the most restrictive ban is blocked by a court. For example, if the trigger ban is blocked, another law will still ban abortion at eight weeks LMP, unless it too is enjoined.[15] Similarly, there are existing bans that apply "notwithstanding" any other law at fourteen-weeks,[16] eighteen-weeks,[17] twenty-weeks,[18]

and at "viability." In making a determination of viability under the viability ban, the physician must "perform or cause to be performed such medical examinations and tests as are necessary to make a finding of the gestational age, weight, and lung maturity" of the fetus and "enter such findings and determination of viability" in the pregnant person's medical record.[19]

Additionally, other abortion restrictions are currently in effect, including a 72-hour waiting period and biased counseling requirements,[20] parental involvement laws,[21] and medication abortion restrictions.[22] As discussed more fully below, some of Missouri's restrictions continue to apply to abortions performed in cases of medical emergency. Moreover, if an abortion is performed in Missouri in violation of the total abortion ban, a provider may also be penalized under one of these other restrictions. These restrictions will continue to apply even if the total ban is enjoined.

"Medical Emergency" Affirmative Defense to Abortion Bans

There is an affirmative defense to a violation of Missouri's total abortion ban in "cases of medical emergency." While this may sometimes be referred to as an "exception," it is not a true exception because it forces the defendant to bear the burden of proving in court that they did not violate the law, whereas a true "exception" would prevent a defendant from being charged or sued in the first place. Missouri does not have any defense or exceptions for cases of rape or incest.

Language of Defense: Missouri's abortion ban states that "[i]t shall be an affirmative defense" to an alleged violation of the ban "that the person performed or induced an abortion because of a medical emergency."[23] An affirmative defense is very limited. 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, would defeat liability or conviction. The affirmative defense in Missouri's abortion ban means that a physician charged under the ban would have to prove in court that a medical emergency existed.[24] 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.

Missouri's medical emergency affirmative defense is available where, based on "reasonable medical judgment," a condition "so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert the death of the pregnant woman or for which a delay will create a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman."[25] "Reasonable medical judgment" is "a medical judgment that would be made by a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved."[26] "Major bodily function" is not defined in the total abortion ban, but it is defined in the "viability" ban as "includ[ing], but [] not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions."[27]

Legal Requirements in Emergencies: If a physician has determined that the medical emergency defense is available, they may still be required to comply with some Missouri abortion restrictions that were passed before *Dobbs*. That said, some pre-*Dobbs* abortion restrictions themselves contain a medical emergency affirmative defense available in criminal, civil, and administrative proceedings, using the same definition of emergency as the affirmative defense in the total ban. Providers

seeking to use the affirmative defense to charges under abortion restriction laws "shall have the burden of persuasion that the defense is more probably true than not."[28]

In addition to the affirmative defense, there are true emergency *exceptions* to the laws mandating a 72-hour delay. A physician who seeks to rely on these exceptions must "clearly certify in writing the nature and circumstances of the medical emergency" and signs the certification,[29] and report it to the Department of Health and Senior Services, as described in the Documentation & Reporting section below.[30]

Two provisions which may apply in cases of medical emergency, and which *do not* separately contain either an exception or an affirmative defense for medical emergencies, contain counseling requirements:

Information on "Medical Risks": The same physician that will perform or induce the abortion must inform the patient orally and in person of: "(1) The immediate and long-term medical risks to the woman associated with the proposed abortion method including, but not limited to, infection, hemorrhage, cervical tear or uterine perforation, harm to subsequent pregnancies or the ability to carry a subsequent child to term, and possible adverse psychological effects associated with the abortion; and (2) The immediate and long-term medical risks to the woman, in light of the anesthesia and medication that is to be administered, the unborn child's gestational age, and the woman's medical history and medical conditions."[31]

Other provisions which apply but which practically speaking are likely meaningless in medical emergencies, are as follows:

Prohibited Reasons: The physician may not perform the abortion if they know that the patient is "seeking the abortion solely because of the sex or race" or "solely because of a prenatal diagnosis, test, or screening indicating Down Syndrome or the potential of Down Syndrome."[32] The physician must certify as such in the abortion report completed after the procedure.[33] An individual who is experiencing a medical emergency under Missouri law would presumably not be seeking an abortion "*solely* because of" the sex, race, or diagnosis of an embryo or fetus.

Information About Availability Of Other Services: "If the physician has reason to believe that the woman is being coerced into having an abortion," the physician must inform the patient about the availability of services including rape crisis centers, domestic violence shelters, and orders of protection, and provide them with "private access to a telephone and information about such services."[34] If the abortion is taking place due to a medical emergency, it would seem unlikely that it could be coerced.

EMTALA

A federal law called the Emergency Medical Treatment & Labor Act ("EMTALA") requires emergency abortion care in some cases. EMTALA requires Medicare-participating hospitals with emergency departments (which includes most hospitals), to perform a medical screening to determine whether an emergency medical condition exists of any individual who comes to the emergency department and requests an examination or treatment.[35] Stabilizing medical treatment must be provided to individuals experiencing an emergency medical condition,[36] including people in labor or with emergency pregnancy complications.[37] 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."[38] A person experiencing an emergency medical condition can only be transferred to a different hospital once they are stable or if certain conditions

are met such as the medical benefits of transfer outweigh the increased risks to the person experiencing the medical emergency.[39] 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."[40] 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."[41] The stabilizing treatment required by EMTALA can include abortion care in certain circumstances.

The U.S. Department of Health and Human Services ("HHS") reaffirmed these requirements in guidance issued after *Roe v. Wade* was overturned. That guidance emphasizes that stabilizing treatment required by EMTALA could include abortion care if the examining physician or other qualified medical personnel determines that such treatment is required to stabilize a patient experiencing an emergency medical condition, including a condition that is "likely or certain to become emergent without stabilizing treatment."[42] The guidance made clear those conditions might include, but are not limited to: "ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features."[43] The guidance reiterates that if EMTALA requires the provision of abortion care, then EMTALA expressly preempts any state law prohibiting or restricting access to abortion.[44] Indeed, HHS has recently cited hospitals in Kansas, Missouri and Florida for violating EMTALA by failing to provide abortion care to a patient with PPROM.[45]

Notwithstanding EMTALA's clear requirements with respect to emergency abortion, there is ongoing litigation relating to attempts by state officials in Idaho and Texas to restrict hospitals from complying with their federal legal obligations. In 2022, a federal district court in Idaho issued a preliminary injunction ensuring that Idaho's abortion ban could not be enforced to prohibit health-saving emergency abortions required under EMTALA.[46] The U.S. Supreme Court temporarily stayed that injunction, allowing Idaho to enforce its abortion ban even in cases where abortion care is required under EMTALA.[47] But, in June 2024, the Supreme Court lifted that stay and restored the preliminary injunction.[48] In other words, Idaho may not currently enforce its abortion ban to prohibit health-saving abortions required under EMTALA. In July 2024, following that order, HHS issued a statement reiterating that EMTALA requires hospitals to provide emergency abortion care when it is necessary stabilizing treatment.[49] Meanwhile, HHS had asked the U.S. Supreme Court to review a Fifth Circuit decision that affirmed a lower court decision temporarily blocking federal enforcement of HHS' guidance in Texas and as to other plaintiffs in that case. HHS petitioned the Supreme Court to reverse the preliminary injunction.[50] However, in October 2024, the Supreme Court declined to review the Fifth Circuit's decision,[51] meaning the guidance is still blocked in Texas.

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.[52]

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.[53]

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.[54]

Resident Training: The Accreditation Council for Graduate Medical Education (ACGME) requires that accredited programs provide access to training in the provision of abortion.[55] 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.[56]

Documentation & Reporting

Generally, Missouri law does not require documentation of irrelevant or non-medical information in patient charts. Nor does it require reporting patients who receive abortions out of state or self-manage their own abortion to law enforcement.[57] All documentation must be "maintained in the permanent files of the abortion facility or hospital in which the abortion was performed for a period of seven years[58] and are confidential.[59] The only abortion-specific documentation and reporting requirements in Missouri are:

Emergency Documentation: Missouri law requires that when a physician performs an abortion under the "medical emergency" exception, the physician who performed or induced the abortion "clearly certif[ies] in writing the nature and circumstances of the medical emergency" and signs the certification.[60] Additionally, the abortion, and the "physician certification that the abortion was due to a 'medical emergency,'" must be reported to the Department of Health and Senior Services as part of the "abortion report" discussed immediately hereafter.[61]

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: Missouri law requires that when a physician performs an abortion, the physician must complete an "individual abortion report" in which they "certif[y] that the physician does not have any knowledge that the woman sought the abortion solely because of a prenatal diagnosis, test, or screening indicating Down Syndrome or the potential of Down Syndrome, . . . [or] because of [its] sex or race." The "abortion report[] shall be signed by the attending physician who performed or induced the abortion[,] submitted to the department within forty-five days from the date of the abortion," and "made a part of the medical record of the patient of the abortion facility or hospital in which the abortion was performed or induced."[62]

Complication Reporting: For any patient that receives post-abortion care for a complication (which is not defined in the law), the physician providing the care must submit an "individual complication report" including: (1) "[t]he date of the abortion," (2) "[t]he name and address of the abortion facility or hospital where the abortion was performed or induced," and (3) "[t]he nature of the abortion complication diagnosed or treated." The

report "shall be signed by the physician providing the post-abortion care and submitted to the department within forty-five days from the date of the post-abortion care."[63]

Fetal Death Reporting: "Each spontaneous fetal death of twenty completed weeks gestation or more" from last menstrual period, *or* which weighs 350 grams or more, "shall be reported within seven days after delivery to the local registrar or as otherwise directed by the state registrar."[64] A "spontaneous fetal death" is defined as "a noninduced death prior to the complete expulsion or extraction from its mother of a fetus, irrespective of the duration of pregnancy."[65]

"When a dead fetus[66] is delivered in an institution, the person in charge of the institution or his or her designated representative shall prepare and file the report."[67] "When a dead fetus is delivered outside an institution, the physician in attendance at or immediately after delivery shall prepare and file the report." If the spontaneous fetal death occurs without any medical attendance at or immediately after delivery, or when inquiry is otherwise required by the medical examiner or coroner, the "medical examiner or coroner shall investigate the cause of spontaneous fetal death and shall prepare and file the report within seven days."[68]

Other Mandatory Reporting: Abortion providers that have "prima facie evidence"[69] that a patient "has been the victim of statutory rape in the first degree or statutory rape in the second degree,[70] or if the patient is under the age of eighteen, that he or she has been the victim of sexual abuse, including rape . . . or incest, shall be required to report such offenses in the same manner as provided for by section 210.115."[71]

All other general mandatory reporting to the Missouri Children's Division, Department of Health and Senior Services, etc., also applies for abortion patients.[72] This includes reporting of child abuse or neglect, which includes physical, sexual, and emotional abuse, human trafficking,[73] and abuse of an adult with a disability.[74]

Electronic Medical Records: Many electronic medical record systems (EMRs) allow healthcare providers to securely share patient records across healthcare institutions.[75] While EMRs have settings that allow patients to choose how and when their records are shared, hospital systems often instead use their EMR's default settings that widely share patient records. Though often done for continuity of care purposes, these settings 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.[76]

The federal government has taken steps to address this concern by issuing a new HIPAA rule, effective June 25, 2024.[77] The rule prohibits the use or disclosure of protected health information (PHI) if sought to conduct a criminal, civil, or administrative investigation into or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating lawful reproductive healthcare, or identifying any person for these purposes.[78] A provider who receives a request for disclosure of PHI potentially related to reproductive care must obtain a signed attestation from the requestor that the request is not for a prohibited purpose.[79] The attestation is required when the request is for: law enforcement purposes, disclosures to coroners and medical examiners, judicial and administrative proceedings, and health oversight activities.[80] If the abortion care – self-managed or otherwise – was provided by someone else, a provider is allowed to assume the care was provided lawfully unless 1) the patient tells them otherwise or 2) the attestation provides evidence of unlawfully provided care.[81]

The new rule only applies to healthcare providers who are subject to HIPAA. Separate from HIPAA,

interoperability rules may apply when a healthcare provider uses EMRs.[82] Because of this, we encourage you to discuss alternative EMR settings and information blocking exceptions with your institution's compliance officers, counsel, and/or technology officers, who may be able to offer customized solutions.[83]

Counseling & Referral

Speech about abortion is legal in Missouri. Medical professionals in Missouri can thus (1) provide accurate options counseling, including about abortion; and (2) refer patients to medical providers in states where abortion is legal. Missouri has some additional requirements for abortion-related counseling:

Documentation of Referral: This requirement applies to all "abortion facilit[ies]" and "family planning agenc[ies]" located in Missouri, as well as any "agents or employees acting within the scope of his or her authority or employment" at those abortion facilities or family planning agencies.[84] An "abortion facility" is defined as a "clinic, physician's office, or any other place or facility in which abortions are performed or induced other than a hospital."[85] A hospital may, however, qualify as a family planning agency.[86]

Whenever an abortion facility or family planning agency "provides to a woman considering an abortion the name, address, telephone number, or website of an abortion provider that is located outside of the state," the facility or agency must also provide "printed materials produced [and provided free of cost] by the department under section 188.027." If counseling and/or referrals take place online, the facility or agency must still offer the printed materials to the patient and, if the patient requests, the printed materials must be sent to the patient "at no cost to her the same day or as soon as possible either electronically or by U.S. mail overnight delivery service or by other overnight or same-day delivery service to an address of [the patient]'s choosing."[87]

Referrals for Young People Under 18: Medical professionals in Missouri can also provide this same counseling and referral to young people under 18. Under Missouri law, a physician may not "cause, aid, or assist a minor to obtain an abortion" without complying with parental consent or judicial bypass requirements.[88] But according to the Supreme Court of Missouri, providing people under 18 with information and counseling related to abortion does not constitute prohibited "aid" or "assistance."[89]

Counseling for Miscarriages: In the case of "spontaneous fetal demise" that occurs at a health facility before twenty weeks of gestation, the facility must provide the patient with counseling or refer them to "another provider of appropriate counseling services."[90]

Medication Abortion

All of the requirements discussed in this fact sheet apply to both procedural and medication abortion. Missouri also has additional rules that apply specifically to "any drug or chemical is used for the purpose of inducing an abortion" including RU-486 (mifepristone). Practically speaking, now that abortion is largely prohibited in Missouri, these rules only apply to abortions performed in "medical emergencies." That means that when these drugs are used for medical care that does not fall within the legal definition of abortion, the rules do not apply. Thus, when these drugs are used to treat patients for miscarriage care where no cardiac activity is present, or for cervical dilation, the rules for "abortion-inducing drugs" do not apply.

The following rules apply to the use of "abortion-inducing drugs" for patients needing abortions in medical emergencies. A physician must provide the medication(s) and be physically present in the room

when it is taken. The physician, "or a person acting on such physician's behalf" must then "make all reasonable efforts to ensure that the patient returns" for a follow-up visit, though a follow up visit is not necessary where the termination of their pregnancy is confirmed and the patient is "assessed by a licensed physician" in the initial appointment.[91]

A physician prescribing mifepristone (or any other drug used for the purpose of inducing an abortion whose FDA label includes any clinical study in which more than 1% of patients required surgical intervention)[92] must have a complication plan approved by the Missouri Department of Health and Senior Services which includes "any information deemed necessary by the department to ensure the safety of any patient suffering complications as a result of the administration of the drug or chemical in question." However, no complication plan is required "where the patient is administered the drug in a medical emergency at a hospital *and* is then treated as an inpatient at a hospital under medical monitoring by the hospital until the abortion is completed."[93]

Disposition of Fetal Tissue Remains

Fetal Tissue After an Abortion: Fetal tissue removed during an abortion can be used "to determine the cause or causes of any anomaly, illness, death, or genetic condition of the fetus, the paternity of the fetus, or for law enforcement purposes."[94] All tissue not used for those purposes must be submitted to a board-eligible or certified pathologist who will perform an examination and produce a tissue report. If, in their examination, the pathologist "fails to identify evidence of a completed abortion," the pathologist must notify the facility within twenty-four hours.[95] The tissue report will be filed with (a) the state department of health and senior services, and (b) the facility where the abortion was performed or induced, where the report shall become "part of the patient's permanent record."[96]

Fetal Tissue After "Spontaneous Fetal Demise": Every licensed health care facility must have written standards for disposition of fetal tissue in the case of "*spontaneous* fetal demise . . . after a gestation period of less than twenty completed weeks."[97] Acceptable standards must be in accordance with state law and administrative rules and may include "cremation, interment by burial, incineration in an approved medical waste incinerator, or other means authorized by the director of the department of health and senior services. . . . If the remains are disposed of by incineration, the remains shall be incinerated separately from other medical waste."[98]

In the case of spontaneous fetal demise—but not abortion—the pregnant person "has the right to determine the final disposition of the remains of the fetus, regardless of the duration of the pregnancy," and "may choose any means of final disposition authorized by law or by the director of the department of health and senior services."[99] Within twenty-four hours of a "miscarriage [that] occurs spontaneously or accidentally" at a health care facility, the facility must provide a written copy of the facility's standards and disclose to the formerly pregnant person, orally and in writing, the patient's right to determine the final disposition of the fetus.[100]

Embryonic Tissue: Missouri does not have any laws explicitly regulating the disposition of embryonic tissue remains.

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), If/When/How: Lawyering for Reproductive Justice, National Women's Law Center (NWLC), and Resources for Abortion Delivery (RAD).

References

[1] Mo. Rev. Stat. § 188.015(1).
[2] Mo. Rev. Stat. §§ 188.015(1), 194.005.
[3] Mo. Rev. Stat. § 188.017.2.
[4] Mo. Rev. Stat. § 188.030.
[5] Br. for Resp./Cross-Claimant Jean Peters Baker's Suggestions in Opp. to State Resps' Mot. To Dismiss and Mot. To Strike, *Blackmon v. Missouri*, No. 2322-CC00120 at 10 n.3. (St. Louis City Circuit Court Div. 18 Aug. 14, 2023).
[6] Any patient facing prosecution or investigation because of a pregnancy outcome, including an accusation that they engaged in self-managed abortion in violation of the law, can contact If/When/How's Repro Legal Helpline at www.reprolegalhelpline.org to speak to a lawyer.
[7] Mike Parson (@GovParsonMO), Twitter (June 29, 2022, 6:35 PM), https://twitter.com/GovParsonMO/status/1542275558507220993?s=20&t=0ItTlj96JiGlukxyPsXTQQ (Governor Mike Parson stating, "To address any misinformation: Missouri law has not changed the legality of contraceptives. Contraceptives are not abortions and are not affected by the Right to Life of the Unborn Child Act[, Mo. Rev. Stat. § 188.017].").
[8] On November 5, 2024, Missourians voted to approve a ballot measure that enshrines abortion access and other reproductive freedoms in Missouri's constitution. Ballot Meas. 2024-086 (2024). This measure amends the state constitution to protect Missourians' "fundamental right to reproductive freedom, which is the right to make and carry out decisions about all matters relating to reproductive health care, including . . . abortion care." Mo. Const. art. I, § 36.2. The amendment took effect on December 5, 2024. However, it does not automatically change state abortion law. Rather, bans and restrictions must be challenged in court under this amendment. Planned Parenthood affiliates in Missouri have sued to block multiple of Missouri's bans and restrictions, alleging that they are unconstitutional under the new amendment, seeking immediate court action. *Comprehensive Health of Planned Parenthood Great Plains v. State of Missouri*, Case No. 2416-CV31931 (Jackson Cnty. Cir. Ct.). The court held a hearing on December 4, 2024, on whether to preliminarily block these laws, but it has not yet ruled as of this factsheet's publication date.
[9] Mo. Rev. Stat. § 188.017.
[10] Mo. Rev. Stat. § 188.017.2.
[11] Mo. Rev. Stat. § 558.011.1(2).
[12] Mo. Rev. Stat. § 558.002.1(7).
[13] Mo. Rev. Stat. §§ 188.038.4, 188.065, 188.017.2.
[14] Mo. Rev. Stat. § 188.085.
[15] Mo. Rev. Stat. § 188.056 (eight-week ban).

[16] Mo. Rev. Stat. § 188.057 (fourteen-week ban).
[17] Mo. Rev. Stat. § 188.058 (eighteen-week ban).
[18] Mo. Rev. Stat. § 188.375 (twenty-week ban).
[19] Mo. Rev. Stat. § 188.030 (ban at "viability").
[20] Mo. Rev. Stat. §§ 188.027.1, .027.5 (seventy-two hour waiting period, mandatory biased counseling); Mo. Rev. Stat. § 188.039.2 (requirement that the same physician who performs the abortion provide counseling).
[21] Mo. Rev. Stat. § 188.028 (parental consent or judicial bypass for young people under 18).
[22] Mo. Rev. Stat. § 188.021 (mifepristone complication plan).
[23] Mo. Rev. Stat. § 188.017.3.
[24] One county prosecutor in the state has argued in court that it is unconstitutional to relieve the government of the burden of proving a lack of medical emergency, but this argument has not been ruled on. Br. for Resp./Cross-Claimant, *Blackmon*, No. 2322-CC00120, *supra* n. 4.
[25] Mo. Rev. Stat. § 188.015(7).
[26] Mo. Rev. Stat. § 188.015(9).
[27] Mo. Rev. Stat. § 188.030.
[28] Mo. Rev. Stat. § 188.075.2.
[29] Mo. Rev. Stat. § 188.027.7.
[30] Mo. Rev. Stat. § 188.052; 19 CSR § 10-15.010.
[31] Mo. Rev. Stat. § 188.027.5.
[32] Mo. Rev. Stat. § 188.038.2-.3.
[33] Mo. Rev. Stat. § 188.052.1.
[34] Mo. Rev. Stat. § 188.027.4.
[35] EMTALA, 42 U.S.C. § 1395dd(a).
[36] EMTALA, 42 U.S.C. § 1395dd(b)(1)(A).
[37] EMTALA, 42 U.S.C. § 1395dd(e)(1).
[38] EMTALA, 42 U.S.C. § 1395dd(e)(3)(A).
[39] 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).
[40] EMTALA, 42 U.S.C. § 1395dd(c)(1)(B)–(c)(2)(A).
[41] EMTALA, 42 U.S.C. § 1395dd(e)(1).
[42] Ctrs. for Medicare & Medicaid Servs., Reinforcement of EMTALA Obligations Specific to Patients who are Pregnant or are Experiencing Pregnancy Loss (updated July 2022).
[43] *Id.*
[44] *Id.*; *see also* EMTALA, 42 U.S.C. § 1395dd(f) ("The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.").
[45] Ctrs. for Medicare & Medicaid Servs., *Freeman Health System—Freeman West, Statement of Deficiencies and Plan of Correction* (April 10, 2023); Ctrs. for Medicare & Medicaid Servs., *University of Kansas Hospital, Statement of Deficiencies and Plan of Correction* (April 10, 2023); Press Release, U.S. Dep't of Health and Human Servs., *HHS Secretary Xavier Becerra Statement on EMTALA Enforcement* (May 1, 2023).
[46] *United States v. Idaho*, 623 F. Supp. 3d 1096, 1117 (D. Idaho 2022).
[47] *Idaho v. United States*, 144 S. Ct. 541 (Mem) (2022).
[48] *Moyle v. United States*, 144 S. Ct. 2015 (June 27, 2024) (per curiam).
[49] Press Release, U.S. Dep't of Health and Human Servs., *Biden-Harris Administration Reaffirms Commitment to EMTALA Enforcement* (July 2, 2024).
[50] *Texas v. Becerra*, No. 23-10246, 2024 WL 20069 (5th Cir. Jan. 2, 2024), *petition for cert. filed* (U.S. Apr. 1, 2024) (No. 23-1076).
[51] *Becerra v. Texas*, No. 23-1076, 2024 WL 4426546 (U.S. Oct. 7, 2024) (denying cert).
[52] 42 C.F.R. §§ 482.13(a)(1), (b)(1), (b)(2).

[53] 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/.
[54] Mo. Rev. Stat. § 516.105; Mo. Rev. Stat. § 538.225 (requiring plaintiff to submit a "written opinion of a legally qualified health care provider which states that the defendant health care provider failed to use such care as a reasonably prudent and careful health care provider would have under similar circumstances").
[55] Accreditation Council for Graduate Med. Educ., *ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology*, ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC. (Sept. 17, 2022), https://www.acgme.org/globalassets/pfassets/programrequirements/220_obstetricsandgynecology_9-17-2022_tcc.pdf.
[56] 42 U.S.C. § 238n.
[57] *See* Mo. Rev. Stat. § 188.033 (allows abortion facilities and family planning agencies to provide out of state resources to patient.). Fact sheets from If/When/How with additional detail, including some state-specific fact sheets, are available here: https://drive.google.com/drive/folders/165750vkNOx92DTqGHoCF76MzLFDT84PY. If/When/How adds state-specific fact sheets to this folder as they are finalized.
[58] Mo. Rev. Stat. § 188.060.
[59] Mo. Rev. Stat. § 188.070.
[60] Mo. Rev. Stat. § 188.027.7.
[61] Mo. Rev. Stat. § 188.052; 19 CSR § 10-15.010.
[62] Mo. Rev. Stat. § 188.052.
[63] Mo. Rev. Stat. § 188.052.
[64] Mo. Rev. Stat. § 193.165.
[65] Mo. Rev. Stat. § 193.015 ("[T]he death is indicated by the fact that after such expulsion or extraction the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.").
[66] Mo. Rev. Stat. § 194.005 (defining death to mean "[w]hen respiration and circulation are not artificially maintained, there is an irreversible cessation of spontaneous respiration and circulation," or "[w]hen respiration and circulation are artificially maintained, and there is a total and irreversible cessation of all brain function, including the brain stem and that such determination is made by a licensed physician.").
[67] Mo. Rev. Stat. § 193.165.
[68] Mo. Rev. Stat. § 193.165 ("When a spontaneous fetal death occurs in a moving conveyance and the fetus is first removed from the conveyance in [Missouri], or when a dead fetus is found in [Missouri] and the place of the spontaneous fetal death is unknown, the spontaneous fetal death shall be reported in [Missouri]. The place where the fetus was first removed from the conveyance or the dead fetus was found shall be considered the place of the spontaneous fetal death.").
[69] Prima facie evidence is evidence that, on its face, would raise a presumption of fact or conclusion., https://www.law.cornell.edu/wex/prima_facie.
[70] Mo. Rev. Stat. §§ 566.032, 566.034.
[71] Mo. Rev. Stat. § 188.023.
[72] Mo. Rev. Stat. § 210.115.
[73] Mo. Rev. Stat. § § 210.115, 210.110.
[74] Mo. Rev. Stat. § 192.2405.
[75] For example, one EMR, Epic, uses a tool called Care Everywhere to securely share information between healthcare institutions (e.g., from one hospital system to another) and allows robust sharing within a single institution (e.g., a Texas hospital treating a patient may be able to see the patient's records from an Illinois hospital that within the same system).
[76] 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.
[77] Although effective on June 25, 2024, compliance with this rule is not required until December 23, 2024, except for the applicable requirements for revising Notice of Policy Practices (as required by 45 CFR 164.520), which must be complied

with by February 16, 2026.

[78] 42 U.S.C. § 164.502(a)(5)(iii). *See also HIPAA Privacy Rule Final Rule to Support Reproductive Health Care Privacy: Fact Sheet*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.hhs.gov/hipaa/for-professionals/special-topics/reproductive-health/final-rule-fact-sheet/index.html (content last reviewed April 22, 2024).

[79] 42 U.S.C. § 164.509. The U.S. Department of Health & Human Services (HHS) recently released a model attestation, available here: https://www.hhs.gov/sites/default/files/model-attestation.pdf.

[80] 42 U.S.C. §§ 164.509(a), 512(d)-(g)(1).

[81] 42 U.S.C. § 164.502(a)(5)(iii).

[82] 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). 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. HHS intends to expand disincentives to other groups of health care providers in future rulemaking.

[83] In the past year, states and the federal government have taken steps to address these vulnerabilities, specifically for abortion and gender-affirming care. Maryland and California have passed bills that restrict disclosure of abortion-related records and require EMRs to develop tools to limit or prohibit such disclosure. As these laws are implemented, the landscape for how electronic abortion records are handled may change.

[84] Mo. Rev. Stat. § 188.033.

[85] Mo. Rev. Stat. § 188.015(2).

[86] *See* Title X, Missouri Family Health Council, Inc., https://mfhc.org/programs-services/ (last visited Dec. 13, 2023).

[87] Mo. Rev. Stat. § 188.033.

[88] Mo. Rev. Stat § 188.028, 188.250

[89] *Planned Parenthood of Kansas v. Nixon*, 220 S.W.3d 732 (Mo. 2007).

[90] Mo. Rev. Stat. § 194.387.2.

[91] Mo. Rev. Stat. § 188.021.1.

[92] "When the Food and Drug Administration label of any drug or chemical used for the purpose of inducing an abortion includes any clinical study in which more than one percent of those administered the drug or chemical required surgical intervention after its administration, no physician may prescribe or administer such drug or chemical to any patient without first obtaining approval from the department of health and senior services of a complication plan from the physician for administration of the drug or chemical to any patient." Mo. Ann. Stat. § 188.021.2. The FDA label for mifepristone indicates that surgical intervention was required in more than 1% of cases where mifepristone was administered for abortion. Mifeprex, Food & Drug Administration Label at 13 (last updated Jan. 2023), https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/020687Orig1s025Lbl.pdf.

[93] Mo. Rev. Stat. § 188.021.2.

[94] Mo. Rev. Stat. § 188.047.5.

[95] Mo. Rev. Stat. § 188.047.1.

[96] Mo. Rev. Stat. § 188.047.1; *see also* 19 CSR § 10-15.030 (detailing the types of exams required to be conducted).

[97] Mo. Rev. Stat. § 194.384 (emphasis added); Mo. Rev. Stat. 194.375 (defining disposition of fetal remains).

[98] Mo. Rev. Stat. § 194.381.

[99] Mo. Rev. Stat. § 194.378.

[100] Mo. Rev. Stat. § 194.387.1.