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.

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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 legal until “viability” in Missouri, subject to physician-only, in-person, mandatory ultrasound, and parental involvement for young people requirements.

Abortion is prohibited under Missouri law after “viability,” but the law provides exceptions in a medical emergency, or to preserve the life of the pregnant person, or where there is a “risk of substantial and irreversible physical impairment of a major bodily function.”

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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 viability ban.[3] However, the Jackson County Prosecutor has also stated in litigation that "[a]lthough the criminal provisions [in Chapter 188: Regulation of Abortions] 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."[4, 5]

CONTRACEPTION

Contraception, including emergency contraception, is legal.[6]

Abortion Ban[7]

Viability Ban:[8] Missouri law prohibits abortion after viability. The law requires physicians to determine the gestational age of the pregnancy by "mak[ing] such inquiries of the pregnant woman and perform[ing] or caus[ing] to be performed such medical examinations, imaging studies, and tests as a reasonably prudent physician… would consider necessary to perform and consider in making an accurate diagnosis with respect to gestational age."[9] If the physician determines that the gestational age is 20 weeks or more, the physician must then make a determination of viability by "perform[ing] or caus[ing] 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 records and "in the individual abortion report submitted to the department" described below.[10, 11]

Any person who "knowingly performs or induces an abortion" in violation of the viability ban can be charged with a class D felony and, if found guilty or if the person pleads guilty, imprisoned for at least one year and fined $10,000-$50,000.[12] Any physician who pleads guilty or is found guilty "shall be subject to suspension or revocation of" their license to practice medicine by the Missouri state board of registration for the healing arts.[13] Additionally, any "practitioner of medicine, surgery, or nursing, or other health personnel" 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."[14] And any hospital that "knowingly allows" an abortion to be performed in violation of this section "may be subject to suspension or revocation of its license."[15] Finally, medical providers may face "civil liability for medical malpractice for negligent acts or certification" related to abortion care.[16]

Abortion Restrictions

Abortion care provided before viability or after viability under the "life" and "risk to major bodily function" exceptions (described below) is subject to several restrictions that apply in hospital settings.[17]

In-Person, Same-Physician, and Ultrasound Requirements: Only a physician may "perform or induce an abortion."[18] Except in a medical emergency, the same physician who is to provide the abortion must first meet with the patient in person.[19] However, no delay is required between this first meeting and the abortion itself. Before the abortion, either the physician who will perform or induce the abortion or "a qualified professional" must provide the patient with "the opportunity to view . . . an active ultrasound" and to "hear a heartbeat . . . if the heartbeat is audible."[20] A "qualified professional" means any "physician, physician assistant, registered nurse, licensed practical nurse, psychologist, licensed professional counselor, or licensed social worker . . . acting under the supervision of the physician performing or inducing the abortion, and acting within the course and scope of his or her authority provided by law."[21]

Parental Involvement, Young People Under 18: Except in a medical emergency, the physician must "secure[] the informed written consent of the minor and one parent or guardian, and the consenting parent or guardian of the minor has notified any other custodial parent in writing prior to the securing of the informed written consent of the minor and one parent or guardian."[22] Such parental consent and notification is not required where the minor "or next friend" of the minor obtains a judicial bypass.[23] To obtain this court order, the minor or next friend must submit a petition to the juvenile court stating that "the minor has been fully informed of the risks and consequences of the abortion; that the minor is of sound mind and has sufficient intellectual capacity to consent to the abortion; that, if the court does not grant the minor majority rights for the purpose of consent to the abortion, the court should find that the abortion is in the best interest of the minor and give judicial consent to the abortion," and that the court should appoint a guardian ad litem of the child as well as counsel, if the minor does not have an attorney already.[24] The court must then hold a hearing on the petition as soon as possible within five days of the filing of the petition and find either that the minor may self-consent to abortion or that an abortion is "in the best interests of the minor and give judicial consent."[25]

Exceptions to Viability Ban

Missouri does not have any exceptions or defense for cases of rape or incest.

Exceptions for "Life" and "Risk to Major Bodily Function": Missouri law contains exceptions to the ban on abortion after viability to preserve the life of a pregnant person "whose life 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 "when continuation of the pregnancy will create a serious risk of substantial and irreversible physical impairment of a major bodily function."[26] A "major bodily function" is defined 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]

The abortion restrictions described above all apply to abortions provided after viability under these exceptions.

When a physician provides an abortion after viability under the "life" and "risk to major bodily function" exceptions, they must "obtain the agreement of a second physician with knowledge of accepted obstetrical and neonatal practices and standards who shall concur that the abortion is necessary to preserve the life of the pregnant woman, or that continuation of the pregnancy would cause a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman."[28] They must also "first certify in writing the medical threat posed to the life of the pregnant woman, or the medical reasons that continuation of the pregnancy would cause a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman."[29] The second physician may not "have any legal or financial affiliation or relationship with the physician performing or inducing the abortion, except that such prohibition shall not apply to physicians whose legal or financial affiliation or relationship is a result of being employed by or having staff privileges at the same hospital . . . ."[30]

After providing an abortion after viability under one of these exceptions, both the providing physician and the second physician must "report the reasons and determinations for the abortion . . . to the health care facility in which the abortion is performed and to the state board of registration for the healing arts."[31] Both the providing physician and the second physician must also "enter such findings and determinations in the medical record" of the person receiving the abortion and "in the individual abortion report submitted to the department" described below.[32]

Exception for "Medical Emergency": Missouri law contains an exception to the ban on abortion after viability "in the case of a medical emergency." A "medical emergency" is defined as "a condition which, based on reasonable medical judgment, 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."[33]

Missouri's medical emergency exception applies 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."[34] "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."[35]

A physician who provides abortion in a medical emergency must "clearly certify in writing the nature and circumstances of the medical emergency" and sign the certification,[36] and report it to the Department of Health and Senior Services, as described in the Documentation & Reporting section below.[37]

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 for any individual who comes to the emergency department and requests an examination or treatment.[38] Stabilizing medical treatment must be provided to individuals experiencing an emergency medical condition,[39] including people in labor or with emergency pregnancy complications.[40] 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."[41] 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 outweighing the increased risks to the person experiencing the emergency medical condition.[42] 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."[43] 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."[44] 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."[45] 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."[46] 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.[47] Indeed, since *Dobbs*, HHS has cited hospitals in Kansas, Missouri, and Florida for violating EMTALA by failing to provide abortion care to a patient with PPROM or other life-threatening pregnancy condition.[48]

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.

In 2022, in *United States v. Idaho*, the federal government sued Idaho and obtained a preliminary injunction ensuring that Idaho's abortion ban could not be enforced to prohibit health-saving emergency abortions required under EMTALA.[49] After temporarily staying that injunction,[50] the U.S. Supreme Court lifted the stay and restored the preliminary injunction in June 2024.[51]

Following the change of presidential administrations, the United States dismissed its case, effectively eliminating the injunction entered in that case. [52] By that time, however, a hospital system had filed a separate lawsuit and obtained a temporary restraining order, and subsequently a preliminary injunction, effectively maintaining the status quo, meaning that Idaho still cannot enforce its abortion ban in circumstances where EMTALA would require abortion care. [53]

Meanwhile in Texas, the U.S. Supreme Court refused to review a Fifth Circuit decision that affirmed a lower court decision blocking federal enforcement

of HHS' 2022 EMTALA guidance in Texas and as to other plaintiffs in that case. As a result, the Fifth Circuit's decision affirming the permanent injunction against the 2022 EMTALA guidance is final. This means HHS may not enforce the 2022 guidance in Texas or against any member of the American Association of Pro-Life OBGYNs (AAPLOG) or Christian Medical & Dental Associations (CMDA).[54, 55]

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.[56]

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.[57]

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.[58]

Resident Training: The Accreditation Council for Graduate Medical Education (ACGME) requires that accredited programs provide access to training in the provision of abortion.[59] 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.[60]

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.[61] 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[62] and are confidential.[63] 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.[64] 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.[65]

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."[66]

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."[67]

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."[68] 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."[69]

"When a dead fetus[70] is delivered in an institution, the person in charge of the institution or his or her designated representative shall prepare and file the report."[71] "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."[72]

Other Mandatory Reporting: Abortion providers that have "prima facie evidence"[73] that a patient "has been the victim of statutory rape in the first degree or statutory rape in the second degree,[74] 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."[75]

All other general mandatory reporting to the Missouri Children's Division, Department of Health and Senior Services, etc., also applies for abortion patients.[76] This includes reporting of child abuse or neglect, which includes physical, sexual, and emotional abuse, human trafficking,[77] and abuse of an adult with a disability.[78]

Electronic Medical Records: Many electronic medical record systems (EMRs) allow healthcare providers to securely share patient records across healthcare institutions.[79] 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.[80]

The federal government has taken steps to address this concern by issuing a HIPAA rule that became effective on June 25, 2024.[81] The rule prohibits the

use or disclosure of protected health information (PHI) if sought to conduct an investigation into or impose liability on any person solely for seeking, obtaining, providing, or facilitating lawful reproductive healthcare, or identifying any person for these purposes.[82] A provider who receives a request to disclose PHI potentially related to reproductive care must obtain an attestation from the requestor that the request is not for a prohibited purpose.[83] 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.[84] If the abortion care – self-managed or otherwise – was provided by someone else, the rule allows a provider to assume it was provided lawfully unless 1) the patient tells them otherwise or 2) the attestation provides evidence of unlawfully provided care.[85] The rule only applies to healthcare providers who are subject to HIPAA.[86] Though several states are challenging this rule in litigation, it currently remains in place as these cases move forward.[87]

Separate from HIPAA, interoperability rules that penalize certain information blocking may apply when a healthcare provider uses EMRs.[88] Because of this, we encourage you to discuss alternative EMR settings and information blocking exceptions that may be available with your institution's compliance officers, counsel, and/or technology officers.[89]

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[90]:

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.[91] 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."[92]

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."[93]

Medication Abortion

All of the requirements discussed in this fact sheet apply to both procedural and medication abortion. Thus, the prescribing physician must first meet with the patient in person[94] and determine gestational age, and either that physician or a "qualified professional" must provide the patient with the opportunity to view an ultrasound and hear a heartbeat, if audible (see above). However, medication abortion may be provided via telemedicine in Missouri, meaning that the prescribing physician does not need to be physically present in the room when prescribing mifepristone or when the patient takes the medication.[95]

Missouri law requires prescribing physicians to first obtain approval from the department of health and senior services of a complication plan which "include[s] any information deemed necessary by the department to ensure the safety of any patient suffering complications as a result of the administration" of mifepristone.[96] However, the current department regulations detailing what this complication plan should include have been blocked by a court.[97]

Missouri's medication abortion rules do not apply when these drugs are used for medical care that does not fall within the legal definition of abortion. 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.

Disposition of Fetal Tissue Remains

Fetal Tissue After an Abortion[98]: 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."[99]

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."[100] 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."[101]

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."[102] 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.[103]

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).

ACLU

CENTER for REPRODUCTIVE RIGHTS

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THE LAWYERING PROJECT

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Justice for Her. Justice for All.

RAD RESOURCES FOR ABORTION DELIVERY

References

[1] Mo. Rev. Stat. § 188.015(1).
[2] Mo. Rev. Stat. §§ 188.015(1), 194.005.
[3] Mo. Rev. Stat. § 188.030.
[4] 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).
[5] 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.
[6] 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].").
[7] 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. On December 20, 2024, the court preliminarily enjoined Missouri's total abortion ban, all gestational bans up to and including the 20-week ban, and reasons ban. Order at 9-12, *Comprehensive Health of Planned Parenthood Great Plains v. State of Missouri*, Case No. 2416-CV31931 (Jackson Cnty. Cir. Ct. Dec. 20, 2024) (hereinafter, "*PPGP v. Missouri*"). This means that the bans are blocked until the court decides whether they should be permanently struck down. The viability ban remains in effect.
[8] Mo. Rev. Stat. § 188.030.
[9] Mo. Rev. Stat. § 188.030.2(1).
[10] Mo. Rev. Stat. § 188.030.2(2).
[11] The total ban (Mo. Rev. Stat § 188.017), other gestational bans (Mo. Rev. Stat. §§ 188.056, 188.057, 188.058, 188.375), reasons ban (Mo. Rev. Stat § 188.038) have been preliminary enjoined. *See* Order at 10-11, *PPGP v. Missouri*.
[12] Mo. Rev. Stat. § 188.030.3.
[13] Mo. Rev. Stat. § 188.030.4.
[14] Mo. Rev. Stat. § 188.065.
[15] Mo. Rev. Stat. § 188.030.5.
[16] Mo. Rev. Stat. § 188.085.
[17] A court has blocked several of Missouri's restrictions: the mandatory delay of 72-hours or 24 hours; the biased counseling requirements; and the requirement to provide information about the availability of other services to a patient "coerced" into seeking an abortion. Order at 16-18, *PPGP v. Missouri* (preliminarily enjoining Mo. Rev. Stat. §§ 188.027 and 188.039 as to biased counseling and mandatory delay requirements).
[18] Mo. Rev. Stat. § 188.020.
[19] Mo. Rev. Stat § 188.027.1(2)-(3).
[20] Mo. Rev. Stat § 188.027.1(4).
[21] Mo. Rev. Stat § 188.027.9.
[22] Mo. Rev. Stat. § 188.028.1(1).
[23] *Id.*
[24] *Id.*
[25] Mo. Rev. Stat. § 188.028.1(2).
[26] Mo. Rev. Stat. § 188.030.1.
[27] Mo. Rev. Stat. § 188.030.1.
[28] Mo. Rev. Stat. § 188.030.2(4)(c).
[29] Mo. Rev. Stat. § 188.030.2(4)(b).
[30] Mo. Rev. Stat. § 188.030.2(4)(c).
[31] Mo. Rev. Stat. § 188.030.2(4)(b)-(c).

[32] Mo. Rev. Stat. § 188.030.2(4)(b)-(c).
[33] Mo. Rev. Stat. § 188.015(8).
[34] Mo. Rev. Stat. § 188.015(7).
[35] Mo. Rev. Stat. § 188.015(9).
[36] Mo. Rev. Stat. § 188.027.7.
[37] Mo. Rev. Stat. § 188.052; 19 CSR § 10-15.010.
[38] EMTALA, 42 U.S.C. § 1395dd(a).
[39] EMTALA, 42 U.S.C. § 1395dd(b)(1)(A).
[40] EMTALA, 42 U.S.C. § 1395dd(e)(1).
[41] EMTALA, 42 U.S.C. § 1395dd(e)(3)(A).
[42] 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).
[43] EMTALA, 42 U.S.C. § 1395dd(c)(1)(B)–(c)(2)(A).
[44] EMTALA, 42 U.S.C. § 1395dd(e)(1).
[45] Ctrs. for Medicare & Medicaid Servs., *Reinforcement of EMTALA Obligations Specific to Patients who are Pregnant or are Experiencing Pregnancy Loss* (updated July 2022).
[46] *Id.*
[47] *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.").
[48] 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); Caroline Kitchener & Dan Diamond, *She filed a complaint after being denied an abortion. The government shut her down*, Washington Post (Jan. 19, 2024), https://www.washingtonpost.com/politics/2024/01/19/oklahoma-abortion-emtala/ ("Biden officials also confirmed one additional case that the administration had determined violated EMTALA involving a woman who presented at two hospitals in Florida with a life-threatening pregnancy condition in December 2022."); Press Release, U.S. Dep't of Health and Human Servs., *HHS Secretary Xavier Becerra Statement on EMTALA Enforcement* (May 1, 2023).
[49] *United States v. Idaho*, 623 F. Supp. 3d 1096, 1117 (D. Idaho 2022).
[50] *Idaho v. United States*, 144 S. Ct. 541 (Mem) (2024).
[51] *Moyle v. United States*, 144 S. Ct. 2015 (June 27, 2024) (per curiam).
[52] Idaho v. United States, No. 1:22-cv-00329, ECF No. 182 (D. Idaho Mar. 5, 2025).
[53] *St. Luke's Health System, LTD v. Labrador*, No. 1:25-cv-00015, ECF No. 33 (D. Idaho Mar. 4, 2025).
[54] 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).
[55] 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 federal government has not yet responded.
[56] 42 C.F.R. §§ 482.13(a)(1), (b)(1), (b)(2).
[57] 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/.
[58] 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").
[59] 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.
[60] 42 U.S.C. § 238n.

[61] *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.
[62] Mo. Rev. Stat. § 188.060.
[63] Mo. Rev. Stat. § 188.070.
[64] Mo. Rev. Stat. § 188.027.7.
[65] Mo. Rev. Stat. § 188.052; 19 CSR § 10-15.010.
[66] Mo. Rev. Stat. § 188.052.
[67] Mo. Rev. Stat. § 188.052.
[68] Mo. Rev. Stat. § 193.165.
[69] 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.").
[70] 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.").
[71] Mo. Rev. Stat. § 193.165.
[72] 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.").
[73] 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.
[74] Mo. Rev. Stat. §§ 566.032, 566.034.
[75] Mo. Rev. Stat. § 188.023.
[76] Mo. Rev. Stat. § 210.115.
[77] Mo. Rev. Stat. § § 210.115, 210.110.
[78] Mo. Rev. Stat. § 192.2405.
[79] 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).
[80] 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.
[81] Although effective on June 25, 2024, compliance with this rule was required on 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.
[82] 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).
[83] 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.
[84] 42 U.S.C. §§ 164.509(a), 512(d)-(g)(1).
[85] 42 U.S.C. § 164.502(a)(5)(iii).
[86] American Medical Association, *HIPAA Privacy Rule to Support Reproductive Health Care Privacy AMA Drafted Summary of*

Regulatory Changes in Final Rule (April 26, 2024), https://www.ama-assn.org/system/files/summary-regulatory-changes-final-rule-reproductive-health-information.pdf (last visited June 27, 2024).

[87] Tennessee et al. v. U.S. Dept. of Health & Human Servs., et al, Case No. 3:25-cv-00025 (E.D. Tenn. Jan. 17, 2025); Texas v. U.S. Dept. of Health & Human Servs., et al, Case. No. 5:24-cv-00204-H (N.D. Tex. Sept. 4, 2024); Purl v. U.S. Dept. of Health & Human Servs., et al., Case No. 2:24-cv-00228-Z (N.D. Tex. Dec. 22, 2024) (enjoining the 2024 HIPAA Rule as to Dr. Purl only).

[88] 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.

[89] In addition to the federal government, some states have taken steps to address vulnerabilities in this information sharing, specifically for abortion and gender-affirming care. For example, in 2023, Maryland and California passed bills that restrict disclosure of abortion-related records and require EMRs to develop tools to limit or prohibit such disclosure.

[90] A requirement to provide biased documentation when making an out-of-state referral is preliminary enjoined. *See* Order at 17, *PPGP v. Missouri.*

[91] Mo. Rev. Stat § 188.028, 188.250

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

[93] Mo. Rev. Stat. § 194.387.2.

[94] Mo. Rev. Stat § 188.027.1(2)-(3).

[95] Order at 19, *PPGP v. Missouri* (preliminarily enjoining § 188.021.1's requirement that "physician [] be physically present in the room while a patient is taking the medication versus a physician prescribing the medication after an in-person appointment and the patient subsequently taking the medication at home or [] in the abortion facility in the presence of a nurse or other medical professional.").

[96] Mo. Rev. Stat. § 188.021.2-3.

[97] Order at 14, *PPGP v. Missouri* ("The Court finds the language of § 188.021.2 does not necessarily deny, interfere with, delay or otherwise restrict reproductive freedom, but it is the language in the regulations that have this specific requirement that do deny, interfere with, delay or otherwise restrict reproductive freedom without the necessary showing that such restriction has the limited purpose and effect of improving or maintaining the health of the person seeking care.").

[98] Missouri's tissue pathology report requirements have been preliminarily enjoined. *See* Order at 16, *PPGP v. Missouri* (preliminarily enjoining Mo. Rev. Stat. § 188.047.1 and implementing regulations at 19 CSR § 10-15.030).

[99] Mo. Rev. Stat. § 188.047.5.

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

[101] Mo. Rev. Stat. § 194.381.

[102] Mo. Rev. Stat. § 194.378.

[103] Mo. Rev. Stat. § 194.387.1.