

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.

Key Takeaways

Abortion access is a fundamental right under Missouri's Constitution.

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

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

Speech about abortion is legal. Providing information and/or resources toward helping someone to obtain a legal abortion in Missouri or another state is legal.

Providing contraception, including emergency contraception, is legal.

State Constitutional Protection for Abortion

Missouri previously had a total abortion ban which went into effect after the 2022 *Dobbs* decision. However, on November 5, 2024, Missourians voted to approve a ballot measure that enshrines abortion access and other reproductive freedoms in Missouri's Constitution.¹ This measure amended 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."² The amendment took effect on December 5, 2024. Following a lawsuit brought under the new constitutional amendment, on June 18, 2026, a Missouri state court declared unconstitutional and permanently enjoined Missouri's total abortion ban, other gestational age bans, and a variety of other abortion-specific restrictions.³ Some abortion restrictions remain (discussed below), but the criminal penalties for the remaining abortion laws have been removed.

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."⁴

Miscarriage care is legal. Whenever there is no fetal cardiac activity, a health care provider can provide miscarriage care, including medications, procedures,

and labor induction, without the need to comply with Missouri's abortion restrictions. If there is fetal cardiac activity, the provider can also treat the miscarriage patient but must comply with all applicable abortion restrictions (explained below).⁵

Missouri law does not explicitly exclude ectopic pregnancies from the definition of abortion. However, as with miscarriage care, treatment for ectopic pregnancies without embryonic or fetal cardiac activity can be completed without compliance with Missouri's abortion restrictions. Treating ectopic pregnancies where there is embryonic or fetal cardiac activity is permitted, but the provider must comply with all applicable abortion restrictions (see below). Because an ectopic pregnancy should, in the vast majority of cases, be considered a medical emergency, any abortion restriction with a medical emergency exception need not be followed (see below).

There is no explicit crime of self-managed abortion in Missouri and the state constitution provides that "No person shall be penalized, prosecuted, or otherwise subjected to adverse action based on their actual, potential, perceived, or alleged pregnancy outcomes, including but not limited to miscarriage, stillbirth, or abortion."⁶ Additionally, Missouri law states that a pregnant person "shall not be prosecuted for a conspiracy to violate" the Missouri post-viability restriction.⁷

CONTRACEPTION

Contraception, including emergency contraception, is legal.⁸

Abortion Restrictions

Abortion care can be provided before viability for any reason. Abortion care can also be provided after viability for certain limited reasons and with additional requirements that must be followed (see further below). The following restrictions apply

regardless of at what point in pregnancy an abortion is provided and regardless of the abortion method.

Physician-only Requirement: Only a physician may “perform or induce an abortion.”⁹

Informed Consent Requirements: Unless there is a medical emergency, generally applicable laws governing informed consent for medical care apply to abortion care, except that the patient must have an in-person visit and receive the informed consent information from a physician.^{10,11}

Determine Gestational Age: Except in the case of a medical emergency, 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.”¹²

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.”¹³ Such parental consent and notification is not required where the minor “or next friend” of the minor obtains a judicial bypass.¹⁴ 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.¹⁵ 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.”¹⁶

Post-Viability Restrictions

Abortion care is prohibited after viability except in certain limited circumstances (described below).¹⁷ The Missouri Constitution defines “fetal viability” as “the point in pregnancy when, in the good faith judgment of a treating health care professional and based on the particular facts of the case, there is a significant likelihood of the fetus’s sustained survival outside the uterus without the application of extraordinary medical measures.”¹⁸

POST-VIABILITY EXCEPTIONS

No Exception for Rape or Incest: Missouri does not have any exceptions or defense for cases of rape or incest.

Exception for Mental Health: A post-viability abortion is permissible to protect the mental health of the pregnant person. The Missouri Constitution provides that “under no circumstance shall the Government deny, interfere with, delay, or otherwise restrict [a post-viability] abortion that in the good faith judgment of a treating health care professional is needed to protect the ... mental health of the pregnant person.”¹⁹

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.”²⁰ 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.”²¹

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.”²²

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.”²³ “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.”²⁴

PROVIDING UNDER THE POST-VIABILITY EXCEPTIONS

The abortion restrictions described above all apply to post-viability abortions provided under the exceptions. In addition, Missouri law contains several additional requirements that must be

followed for any post-viability abortion provided under the exceptions.

Providing Under the Exceptions for Mental Health, Life, and Risk to Bodily Function: Except in the case of a medical emergency, 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.²⁵

Except in the case of a medical emergency, when a physician provides an abortion after viability under one of the exceptions, 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.”²⁶ There is no longer a need to involve a second physician in the provision of these post-viability abortions.²⁷

After providing an abortion after viability under one of these non-emergency exceptions, the providing 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.”²⁸ The providing physician must also “enter such findings and determinations in the medical record” of the person receiving the abortion.²⁹

Providing Under the Medical Emergency Exception: A physician who provides a post-viability abortion in a medical emergency must “clearly certify in writing the nature and circumstances of the medical emergency,” sign the certification, and retain it in the patient’s medical

record for seven years.³⁰

“Born-Alive” Requirements: If a child is born alive after an abortion or attempted abortion, any healthcare provider must “exercise the same degree of professional skill, care, and diligence to preserve the life, health, and comfort of the child as a reasonably diligent and conscientious healthcare provider would render to any other child born alive at the same gestational age.”³¹

Penalties

The Missouri Constitution provides that “any person assisting a person in exercising their right to reproductive freedom with that person’s consent” shall not be “penalized, prosecuted, or otherwise subjected to adverse action for doing so.”³² In June 2026, a court ruled that most of Missouri’s criminal penalties for violating the state’s abortion restrictions are unconstitutional.³³ However, the born-alive law, updated in July 2026, makes it first degree murder to “knowingly perform[] or attempt[] to perform an overt act that kills a child born alive” after an abortion or attempted abortion.³⁴

Violation of Missouri’s abortion laws could carry civil penalties and/or licensure consequences for healthcare professionals or facilities. Any “practitioner of medicine, surgery, or nursing, or other health personnel” who “willfully and knowingly” violates the restrictions on abortion care in Missouri could have 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.”³⁵ Additionally, any hospital that “knowingly allows” an abortion to be performed in violation of the Post-Viability Restrictions “may be subject to suspension or revocation of its license.”³⁶ Finally, medical providers may face “civil liability for medical malpractice for negligent acts or certification” related to abortion care.³⁷

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.³⁸ 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.”³⁹ 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.”⁴⁰

EMTALA requires stabilizing medical treatment be provided to any individual experiencing an emergency medical condition,⁴¹ including people in labor or with emergency pregnancy complications,⁴² unless the individual refuses to consent to such treatment.⁴³ 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.”⁴⁴ 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.⁴⁵ 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.”⁴⁶

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.⁴⁷

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.”⁴⁸ 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.”⁴⁹ 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.”⁵⁰ 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.⁵¹

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.⁵² 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].”⁵³ 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.⁵⁴ That case made it all the way to the U.S. Supreme Court, where the appeal was ultimately dismissed as prematurely granted in June 2024.⁵⁵ Following the change of presidential administrations, the United States dismissed that case entirely.⁵⁶

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.⁵⁷ As a result, the Fifth Circuit’s decision is final.^{58 59}

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.⁶⁰

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.⁶¹

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.⁶²

Resident Training: The Accreditation Council for Graduate Medical Education (ACGME) requires that accredited programs provide access to training in the provision of abortion.⁶³ 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.⁶⁴

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.⁶⁵ 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 years⁶⁶ and are confidential.⁶⁷ The only abortion-specific documentation and reporting requirements in Missouri are:

Emergency Documentation: Missouri law requires that when a physician performs an abortion in a “medical emergency”—and therefore does not obtain informed consent prior to the abortion—the physician who performed or induced the abortion must “clearly certify in writing the nature and circumstances of the medical emergency,” sign the certification, and retain it in the patient’s medical record for seven years.⁶⁸

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.

Post-Viability Documentation: As discussed above, Missouri law also has documentation requirements for providing post-viability abortions under the exceptions. Physicians who provide post-viability abortions under the exceptions must enter the reasons and determinations for the post-viability abortion in the patient’s medical record for seven years.⁶⁹

Some hospitals may impose additional documentation requirements for abortions performed after viability, 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: There is no longer any Missouri law in effect requiring abortion providers to report all abortions to the state.⁷⁰ However, post-viability abortions provided under the non-emergency exceptions 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.”⁷¹

Complication Reporting: There is no longer any Missouri law in effect requiring abortion providers to report post-abortion care or complications.⁷²

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.”⁷³ 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.”⁷⁴

“When a dead fetus⁷⁵ is delivered in an institution, the person in charge of the institution or his or her designated representative shall prepare and file the report.”⁷⁶ “When a dead fetus is delivered outside an institution, the physician in attendance at or immediately after delivery shall prepare and file the report.”⁷⁷ 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.”⁷⁸

Other Mandatory Reporting: Abortion providers that have “prima facie evidence”⁷⁹ that a patient “has been the victim of statutory rape in the first degree or statutory rape in the second degree,⁸⁰ 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.”⁸¹

All other general mandatory reporting to the Missouri Children’s Division, Department of Health and Senior Services, etc., also applies for abortion patients.⁸² This includes reporting of child abuse or neglect, which includes physical, sexual, and emotional abuse, human trafficking,⁸³ and abuse of an adult with a disability.⁸⁴

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.⁸⁵ 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.^{86, 87}

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.⁸⁸ 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.⁸⁹

Counseling & Referral

Abortion Counseling & Referral: Speech about abortion is legal in Missouri. Medical professionals in Missouri can thus (1) provide patients with accurate options counseling, including about

abortion; and (2) refer patients to medical providers in Missouri and other states where abortion is legal.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 after Miscarriage: In the case of a miscarriage that “occurs spontaneously or accidentally at a ... health care facility,” the facility must provide the patient with “counseling concerning the death of the fetus” or refer them to “another provider of appropriate counseling services.”⁹³

Medication Abortion

All of the abortion laws discussed in this fact sheet apply to both procedural and medication abortion. While Missouri, like some other states, has passed additional laws that apply specifically to medication abortion, none are currently in effect in the state.⁹⁴

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.”⁹⁵ Sending fetal tissue removed during an abortion for pathological examination is optional and not required.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.

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 \(RAD\)](#).



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References

¹ [Ballot Meas. 2024-086](#) (2024).

² [Mo. Const. art. I, § 36.2](#).

³ *Comprehensive Health of Planned Parenthood Great Plains v. Missouri*, Case No. 2416-CV31931 (Mo. Cir. Ct., June 18, 2026), <https://www.courts.mo.gov/fv/c/2416-CV31931JUDGMENT.PDF?courtCode=16&di=31517003> (“June 18 Order”).

⁴ [Mo. Rev. Stat. § 188.015.1](#).

⁵ [Mo. Rev. Stat. §§ 188.015.1, 194.005](#).

⁶ [Mo. Const. art. I, § 36.5](#).

⁷ [Mo. Rev. Stat. § 188.030](#).

⁸ See, e.g., Savannah Hawley-Bates, *Saint Luke’s resumes offering Plan B after raising concerns over Missouri’s abortion ban*, KCUR (August 26, 2025 at 11:56 AM CDT), <https://www.kcur.org/news/2022-06-29/one-of-kansas-citys-major-hospitals-stops-offering-plan-b-because-of-missouris-abortion-ban> (“[Governor Mike] Parson then followed up with a statement on Twitter: ‘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].’”).

⁹ [Mo. Rev. Stat. § 188.020](#).

¹⁰ [June 18 Order](#) (enjoining Missouri’s abortion-specific pre-abortion requirements, [Mo. Rev. Stat. §§ 188.027 & 188.033](#), except the need for an in-person visit and to receive informed consent information from a physician).

¹¹ In the event of a medical emergency, the physician who provides the abortion must instead “clearly certify in writing the nature and circumstances of the medical emergency,” sign the certification, and retain it in the patient’s medical record for seven years. [Mo. Rev. Stat. § 188.027.7](#). “Medical emergency” is defined by statute 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.” [Mo. Rev. Stat. § 188.015.8](#).

¹² [Mo. Rev. Stat. § 188.030.2\(1\)](#).

¹³ [Mo. Rev. Stat. § 188.028.1\(1\)](#).

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ [Mo. Rev. Stat. § 188.028.1\(2\)](#).

¹⁷ See [Mo. Const. art. I § 36.4](#); [Mo. Rev. Stat. § 188.030](#); [June 18 Order](#).

¹⁸ [Mo. Const. art. I, § 36.8\(1\)](#). A Missouri statute defines viability differently than the state Constitution. See [Mo. Rev. Stat.](#)

[§ 188.015.12](#). If you have questions about providing post-viability care, consult an attorney or your hospital’s general counsel.

¹⁹ [Mo. Const. art. I § 36.4](#). Although the statute outlining the exceptions for post-viability abortion does not contain this mental health exception, *see* [Mo. Rev. Stat. § 188.030.2\(4\)\(a\)](#), the Constitution added this exception for post-viability abortion care. *See* [June 18 Order](#) (finding that the constitutional amendment “expand[s] the statutory exceptions.”).

²⁰ [Mo. Rev. Stat. § 188.030.1](#).

²¹ *Id.*

²² [Mo. Rev. Stat. § 188.015.8](#).

²³ [Mo. Rev. Stat. § 188.015.7](#).

²⁴ [Mo. Rev. Stat. § 188.015.9](#).

²⁵ [Mo. Rev. Stat. § 188.030.2\(2\)](#).

²⁶ [Mo. Rev. Stat. § 188.030.2\(4\)\(b\)](#).

²⁷ The provision of the statute that required the involvement of a second physician, [Mo. Rev. Stat. § 188.030.2\(4\)\(c\)](#), has been ruled unconstitutional and enjoined. *See* [June 18 Order](#).

²⁸ [Mo. Rev. Stat. § 188.030.2\(4\)\(b\)](#).

²⁹ [Mo. Rev. Stat. § 188.030.2\(4\)\(b\)](#). Although the statute also mentions entering such findings and determinations “in the individual abortion report submitted to the department,” as discussed in the Documentation & Reporting section, those abortion reports are no longer required. *See* [June 18 Order](#) (finding unconstitutional and enjoining [Mo. Rev. Stat. § 188.052](#)).

³⁰ [Mo. Rev. Stat. § 188.027.7](#).

³¹ [Mo. Rev. Stat. § 188.035.3](#) (updated July 2026 by [S.B. 999](#)).

³² [Mo. Const. art. I § 36.5](#).

³³ [June 18 Order](#) (finding unconstitutional and enjoining Mo. Rev. Stat. §§ [188.017.2](#), [188.030.3](#), [188.056.1](#), [188.057.1](#), [188.058.1](#), [188.075](#), [188.080](#), [188.375.3](#), [197.235](#), [334.245](#), [574.200.2](#)). If you have questions about Missouri criminal law, consult an attorney or your hospital’s general counsel.

³⁴ [Mo. Rev. Stat. § 188.035.4](#) (updated July 2026 by [S.B. 999](#)).

³⁵ [Mo. Rev. Stat. § 188.065](#).

³⁶ [Mo. Rev. Stat. § 188.030.5](#).

³⁷ [Mo. Rev. Stat. § 188.085](#).

³⁸ [EMTALA, 42 U.S.C. § 1395dd\(a\)](#).

³⁹ [EMTALA, 42 U.S.C. § 1395dd\(e\)\(1\)\(A\)](#).

⁴⁰ [EMTALA, 42 U.S.C. § 1395dd\(e\)\(1\)\(B\)](#).

⁴¹ [EMTALA, 42 U.S.C. § 1395dd\(b\)\(1\)\(A\)](#).

⁴² [EMTALA, 42 U.S.C. § 1395dd\(e\)\(1\)](#).

⁴³ [EMTALA, 42 U.S.C. § 1395dd\(b\)\(2\)](#).

⁴⁴ [EMTALA, 42 U.S.C. § 1395dd\(e\)\(3\)\(A\)](#).

⁴⁵ [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).

⁴⁶ [EMTALA, 42 U.S.C. § 1395dd\(c\)\(1\)\(B\)—\(c\)\(2\)\(A\)](#).

⁴⁷ 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>.

⁴⁸ [Kennedy Letter](#).

⁴⁹ [Kennedy Letter](#).

⁵⁰ *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.).

⁵¹ Center for Reproductive Rights, [Complaints Against Texas Hospitals for Denying Emergency Care for Ectopic Pregnancies](#), (updated May 7, 2026).

⁵² *St. Luke's Health System, LTD. v. Labrador*, No. 1:25-cv-00015, ECF No. 1 (D. Idaho Jan 14, 2025).

⁵³ *St. Luke's Health System, LTD v. Labrador*, No. 1:25-cv-00015, ECF No. 49 at 59 (D. Idaho Mar. 20, 2025).

⁵⁴ [United States v. Idaho](#), 623 F. Supp. 3d 1096, 1117 (D. Idaho 2022).

⁵⁵ *Moyle v. United States*, 144 S. Ct. 2015 (June 27, 2024) (per curiam).

⁵⁶ [Idaho v. United States](#), No. 1:22-cv-00329, ECF No. 182 (D. Idaho Mar. 5, 2025).

⁵⁷ *Becerra v. Texas*, No. 23-1076 (U.S. Oct. 7, 2024) (denying certiorari).

⁵⁸ *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).

⁵⁹ 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.

⁶⁰ 42 C.F.R. §§ 482.13(a)(1), (b)(1), (b)(2).

⁶¹ 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/>.

⁶² [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").

⁶³ Accreditation Council for Graduate Med. Educ., [ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology](#) (Sept. 3, 2025).

⁶⁴ 42 U.S.C. § 238n.

⁶⁵ 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.

⁶⁶ [Mo. Rev. Stat. § 188.060](#).

⁶⁷ [Mo. Rev. Stat. § 188.070](#).

⁶⁸ [Mo. Rev. Stat. § 188.027.7](#).

⁶⁹ [Mo. Rev. Stat. § 188.030.2\(4\)\(b\)](#); [Mo. Rev. Stat. § 188.027.7](#). *See also* [Mo. Rev. Stat. § 188.060](#).

⁷⁰ [Mo. Rev. Stat. § 188.052](#), which previously required an individual abortion report for each abortion provided, has been ruled unconstitutional and enjoined. *See* [June 18 Order](#).

⁷¹ [Mo. Rev. Stat. § 188.030.2\(4\)\(b\)](#).

⁷² [Mo. Rev. Stat. § 188.052](#), which previously required an individual complication report for any post-abortion care provided, has been ruled unconstitutional and enjoined. *See* [June 18 Order](#).

⁷³ [Mo. Rev. Stat. § 193.165](#).

⁷⁴ [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.").

⁷⁵ [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.”).

⁷⁶ [Mo. Rev. Stat. § 193.165.](#)

⁷⁷ *Id.*

⁷⁸ *Id.* (“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.”).

⁷⁹ 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.

⁸⁰ [Mo. Rev. Stat. §§ 566.032, 566.034.](#)

⁸¹ [Mo. Rev. Stat. § 188.023.](#)

⁸² [Mo. Rev. Stat. § 210.115.](#)

⁸³ [Mo. Rev. Stat. §§ 210.115, 210.110.](#)

⁸⁴ [Mo. Rev. Stat. § 192.2405.](#)

⁸⁵ 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).

⁸⁶ 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.

⁸⁷ 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 went 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.

⁸⁸ 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.

⁸⁹ 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.

⁹⁰ [Mo. Rev. Stat. § 188.033](#), which previously required providing state-mandated, biased information when providing a patient with information about obtaining an out-of-state abortion, has been ruled unconstitutional and enjoined. [June 18 Order](#).

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 See [June 18 Order](#) (finding unconstitutional and enjoining the in-person ingestion requirement, [Mo. Rev. Stat. § 188.021.1](#); the medication abortion complication plan requirements, [Mo. Rev. Stat. § 188.021.2](#) & [19 CSR 30-30.061-.062](#); and the medication abortion tail insurance requirement, [Mo. Rev. Stat. § 188.044](#)).

⁹⁵ [Mo. Rev. Stat. § 188.047.5](#).

⁹⁶ Missouri Revised Statute [Section 188.047](#), [19 CSR 10-15.030](#), and [19 CSR 30-30.060\(5\)\(B\)](#)—which previously required pathology for fetal tissue after an abortion—have been ruled unconstitutional and enjoined. See [June 18 Order](#).

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

⁹⁸ [Mo. Rev. Stat. § 194.381](#).

⁹⁹ [Mo. Rev. Stat. § 194.378](#).

¹⁰⁰ [Mo. Rev. Stat. § 194.387.1](#).