ABORTION DEFENSE NETWORK

# Know Your State's Abortion Laws

## A Guide for Medical Professionals

MONTANA

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 ectopic pregnancies and pregnancies with no cardiac activity is legal.

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

Abortion is legal in Montana up to viability.

Abortion is prohibited under Montana law after viability unless necessary to “preserve the life or health” of the pregnant person.

Montana’s state constitution protects the right to abortion, and Montana courts review the constitutionality of state abortion restrictions under the highest legal standard.

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# MONTANA

## State Constitutional Protection for Abortion

Montana has constitutional protections for abortion established through both cases decided by the Montana Supreme Court and a voter-approved amendment to the Montana Constitution. In 1999, the Montana Supreme Court held that the Montana Constitution's explicit privacy guarantee protects the right to procreative autonomy, which includes the right of each person to make their own decision regarding whether to continue a pregnancy.[1] Based on this ruling, under the Montana Constitution, abortion restrictions are reviewed by courts in the state under the highest level of scrutiny.[2]

In November 2024, Montanans voted to amend the Montana Constitution to include an even more explicit "right to make and carry out decisions about one's own pregnancy, including the right to abortion" and to prohibit the government from denying or burdening the right to abortion prior to fetal viability unless the restriction survives the highest level of judicial scrutiny.[3] The amendment, which takes effect July 1, 2025, also prohibits the government from penalizing anyone who assists someone in exercising their right to make and carry out voluntary decisions about their pregnancy.[4]

The Montana Supreme Court has also held that the state cannot restrict the provision of abortion to physicians only, thus permitting advanced practice clinicians (APCs) (physician assistants, nurse midwives, and nurse practitioners) to provide abortion care consistent with their scope of practice.[5] As part of its decisions, the court determined that restricting APCs from providing abortion interferes with a person's state constitutional right to access abortion care from a qualified health care provider of their choosing.[6]

## Definition of Abortion & Contraception

### ABORTION

Montana law defines abortion as "the use or prescription of any instrument, medicine, drug, or other substance or device to intentionally terminate the pregnancy of a woman known to be pregnant, with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead fetus."[7]

The term "dead fetus," while undefined, is generally understood to mean an embryo or fetus that lacks cardiac activity.[8] Considering this understanding and the definition of abortion together, this means that:

- If there is no fetal cardiac activity, the provider can provide miscarriage care, including medications, D&C, D&E, and labor induction, and does not need to comply with Montana's abortion restrictions. Montana law does not contain specific legal requirements for miscarriage care.
- If there is fetal cardiac activity and the pregnancy is prior to viability (after which point abortion is prohibited in Montana), the provider can provide an abortion, complying with all applicable abortion laws.
- If there is fetal cardiac activity and the pregnancy is at or after viability, abortion may be provided only under the exceptions to the viability ban (explained below).

As a result, providing miscarriage care is not considered providing an abortion under Montana law as long as there is no fetal cardiac activity detected. Additionally, although Montana's definition of abortion does not explicitly exclude the removal of ectopic pregnancies, since 2021,

Montana has enacted three abortion restrictions (none of which is currently in effect) that contain exceptions for the removal of ectopic pregnancies.[9] One requires that providers inform patients seeking an abortion that they can view an ultrasound and listen to "the fetal heart tone," but the law does not apply to "procedure[s] performed with the intent to . . . remove an ectopic pregnancy."[10] Two other laws, one banning dilation and evacuation procedures (D&E) procedures and one imposing various restrictions on medication abortion, define "abortion" to exclude "an act to remove an ectopic pregnancy."[11] All three laws are currently enjoined, meaning they are not in effect while litigation proceeds.[12] But they give some indication that the legislature does not consider the removal of ectopic pregnancies to be an abortion.

Montana continues to provide public funding for abortion care. Although in 2023, the state passed two laws and Montana DPHHS promulgated a new rule that would make it harder for Medicaid patients to access abortions, both laws and the regulation are enjoined and not in effect while litigation proceeds.[13] A previous attempt to limit Medicaid funding for abortion was also unsuccessful.[14]

With respect to self-managed abortion, there is no explicit crime of self-managed abortion in Montana and no civil law explicitly prohibiting a person from self-managing an abortion. Montana's prohibition on abortion post-viability (discussed below) specifically exempts the pregnant person from penalties.[15]

### CONTRACEPTION

Contraception is not illegal in any state, including Montana. Montana law does not contain specific provisions outlining the provision and use of contraceptives.

## Abortion Bans & Restrictions

### Gestational Bans and Exceptions

Montana has two bans that restrict abortion after a certain gestational age: (1) a viability ban that is in effect[16] and (2) a 20-week ban that has been enjoined and is not currently in effect while it is being litigated.[17]

**Viability ban:** Montana law bans abortion after fetal viability.[18] Viability is defined as "the ability of a fetus to live outside the mother's womb, albeit with artificial aid."[19] Violating the viability ban is a felony, punishable by up to five years in prison and a fine of up to $1,000.[20] The law provides that no penalty can be imposed on the pregnant person.[21]

Montana's viability ban does allow abortions "to preserve the life or health of the mother."[22] These life or health exceptions have requirements attached. Before a provider performs an abortion to preserve the life or health of the pregnant person, they must certify in writing that the abortion is performed for those reasons by "setting forth in detail the facts relied upon in making [their] judgment."[23] If a provider performs a post-viability abortion to preserve the patient's health, two licensed physicians, not including the physician providing the abortion, must examine the patient and concur in writing that the abortion is necessary to preserve the patient's health.[24]

**20-week ban (not currently in effect):** Montana also has a 20-week ban, but it is currently not in effect. In 2021, Montana passed a law banning abortion after 20 weeks gestation, defined as the time elapsed since the first day of the person's last menstrual period (more commonly referred to as "LMP").[25] The law provides an exception that allows an abortion after 20 weeks LMP if "necessary to prevent a serious health risk to the unborn child's mother."[26] The law places a condition on this

exception, however, stating that if an abortion is necessary to prevent a serious health risk to the pregnant person, the provider must "terminate the pregnancy in the manner that, in reasonable medical judgment, provides the best opportunity for the unborn child to survive" unless, in the provider's "reasonable medical judgment, termination of the pregnancy in that manner would pose a greater risk either of the death of the pregnant woman or of the substantial and irreversible physical impairment of a major bodily function" than other available methods.[27] Under the ban, there is no "greater risk" if it is based on a "claim or diagnosis" that the pregnant person will engage in conduct they intend to result in either their death or the substantial and irreversible physical impairment of a major bodily function.[28]

A Montana trial court held that the 20-week ban is unconstitutional and permanently enjoined it.[29] The state has appealed the decision to the Montana Supreme Court, [30] which has not yet issued a ruling.

## Other Bans and Exceptions

Montana has two other abortion bans that are not based on gestational age: (1) a ban on intact D&E (also called D&X, or dilation and extraction) procedures, which is in effect[31] and (2) a ban on D&E procedures that has been enjoined and is not currently in effect.[32]

**Intact D&E/D&X ban:** Montana law prohibits intact D&E/D&X procedures.[33] Montana law refers to intact D&E as "partial-birth abortion."[34] The law provides an exception that allows intact D&E procedures to be performed "to save the life of a woman because the woman's life is endangered by a physical disorder, illness, or injury, including a life-endangering condition caused by or arising from the pregnancy itself, if no other medical procedure would save the life of the woman."[35] The penalties for violating the ban are: (1) criminal: a felony, punishable by a fine of up to $50,000 and between 5 to 10 years in prison, and (2) professional: violating the ban is punishable by permanent revocation of a physician's license.[36] The law exempts the pregnant person from liability.[37]

**D&E ban (not currently in effect):** In 2023, Montana passed a ban on D&E procedures (referred to in the law as "dismemberment abortion"), but this ban has been temporarily enjoined and is not currently in effect.[38] The law has an exception under which a D&E procedure can be performed pre-viability in a "medical emergency."[39] The law defines "medical emergency" as "a condition that, on the basis of a physician's good faith clinical judgment," makes a D&E procedure "necessary to preserve the life of a pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition arising from the pregnancy itself, or when the continuation of the pregnancy will create a serious risk of substantial and irreversible impairment of a major bodily function."[40] The law specifies that "medical emergency" does not include "mental or psychological conditions."[41] Violating the ban is a felony and can be considered unprofessional conduct, leading to the suspension of a provider's license for at least one year.[42]

## Other Abortion Restrictions

Montana has other abortion restrictions that are not in effect because of court orders blocking their enforcement either permanently or temporarily, while they are being litigated.[43] In 2021, Montana passed a law that requires a provider to inform patients seeking an abortion that they can view two types of ultrasounds and listen to "the fetal heart tone."[44] A Montana trial court found this law unconstitutional and enjoined it, but an appeal is pending before the Montana Supreme Court.[45]

In 2023, Montana passed a law that requires a patient to obtain and an abortion provider to review an

ultrasound to determine fetal viability before an abortion, thereby mandating an in-person visit and preventing providers from offering medication abortion through telemedicine.[46] This requirement is being challenged, and it is preliminarily enjoined while the litigation proceeds.[47]

Other restrictions that are specific to medication abortion are explained below.

### Parental Involvement

Montana has a parental notification law that is in effect and a parental consent law that has been enjoined.

Under the parental notification law, a provider must give notice either in writing or by phone to a parent or legal guardian at least 48 hours before providing an abortion to a person who is under the age of 16 and not an emancipated minor.[48] Either the abortion provider or a referring provider can give parental notice.[49] If a referring provider does so, the abortion provider must receive a written statement certifying that the referring provider has indeed given parental notice.[50] If after "reasonable effort," it is not possible to give parental notice either in writing by phone, the provider must give notice through certified mail sent to a parent's "usual place of residence." Unless an exception applies, providing an abortion without parental notice subjects providers to misdemeanor criminal liability and civil liability, in the form of a civil action for violating professional obligations and potentially for punitive damages.[51]

Parental notice is not required in three circumstances. The first is when a provider certifies in the patient's chart that (1) a medical emergency" exists and (2) "there is insufficient time to provide notice."[52] The law defines "medical emergency" as "a condition that, on the basis of the [provider's] good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of the woman's pregnancy to avert the woman's death or a condition for which a delay in treatment will create serious risk of substantial and irreversible impairment of a major bodily function."[53] The second circumstance in which parental notice is not required is when a parent or legal guardian waives the notice requirement in writing.[54] And the third is when the young person is granted judicial bypass.[55]

Montana's parental consent law, by contrast, is not currently in effect. In 2024, the Montana Supreme Court found unconstitutional a law preventing minors (defined as those under 18 years of age who are not emancipated) from obtaining an abortion unless they obtain notarized written consent from one of their parents or are granted judicial bypass.[56] In January 2025, the state petitioned the U.S. Supreme Court to review this ruling.[57]

## 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.[58] 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."[59] 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."[60]

EMTALA requires stabilizing medical treatment be provided to any individual experiencing an emergency medical condition,[61] including people in labor or with emergency pregnancy complications,[62] unless the individual refuses to consent to such treatment.[63] 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."[64] 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.[65] 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."[66]

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.[67]

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."[68] 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."[69] 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."[70] 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.[71]

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.[72] 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]."[73] 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.[74] 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.[75]

Following the change of presidential administrations, the United States dismissed that case entirely. [76]

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.[77] As a result, the Fifth Circuit's decision is final.[78,79]

## 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.[80]

**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.[81]

**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.[82]

**Resident Training:** The Accreditation Council for Graduate Medical Education (ACGME) requires that accredited programs provide access to training in the provision of abortion.[83] 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.[84]

## Documentation & Reporting

Generally, state law does not require documentation of irrelevant or non-medical information in patient charts. Nor does it explicitly require reporting to law enforcement patients who receive abortions out of state or self-manage their own abortion.[85]

The only abortion-specific reporting and documentation requirements in Montana are listed below.

**Documentation:** Montana law requires all facilities[86] where an abortion is performed to keep on file a statement that contains certain information about each abortion.[87] A Montana DPHHS rule lists all information that the statement must contain.[88] Montana law also requires facilities where abortions are performed to keep on file a pathology report for each abortion.[89]

In addition to documenting the information above, a provider who prescribes medication for a medication abortion must keep on file, on a form created by Montana DPHHS, a statement that reports "any adverse side effects" the patient experienced.[90] The provider must date and certify this statement.[91]

Montana does not specify how long the documents must be maintained.

**Abortion Reporting:** For each abortion, facilities also must file a report with Montana DPHHS.[92] The report must be filed within 30 days after the abortion is performed.[93]

For medication abortions, if the provider documented any adverse side effects experienced by the patient, the provider must file a report with such information within 30 days of prescribing the abortion medications.[94]

Violation of the documentation and reporting requirements is a misdemeanor, punishable by up to 6 months in jail and a $500 fine.[95] In addition, it is considered unprofessional conduct for a healthcare provider to fail to keep on file the dated and certified statement describing any adverse side effects from medication abortion, and to fail to file a report with Montana DPHHS within 30 days after an abortion is performed.[96] These statutory violations are subject to various professional sanctions, including suspension of a provider's license for one year.[97]

**Post-Viability Reporting:** As explained in the "Abortion Bans & Restrictions" section of this document, providers who perform a post-viability abortion to preserve the life or health of the pregnant person must follow specific documentation requirements. For both the life and health exceptions, the provider must certify in writing that the abortion is being performed to preserve the life or health of the pregnant person, by "setting forth in detail the facts relied upon in making" that judgment.[98] For abortions under the health exception, two licensed physicians, not including the physician providing the abortion, must first examine the patient and concur in writing that the abortion is needed to preserve the patient's health.[99]

**D&E Reporting (not currently in effect):** In addition to the reporting and documentation requirements described above, Montana has specific reporting requirements for D&E procedures. However, these requirements are not currently in effect because the law banning D&E procedures except in medical emergencies is enjoined while litigation challenging it proceeds.[100]

Practically, if in effect, these reporting requirements would apply only to D&E procedures that are performed in medical emergencies because, under the ban, that is the only situation in which D&E procedures can be performed.[101]

**Fetal Death Reporting:** Abortions are not reportable as fetal deaths or stillbirths in Montana.[102]

Montana law defines "fetal death" as "death of the fetus prior to the complete expulsion or extraction from its mother as a product of conception, notwithstanding the duration of pregnancy."[103] The death is "indicated by the fact that after 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."[104]

Montana requires a fetal death certificate to be filed with the local registrar of the county where the death occurred if the fetus weighed 350 grams or more, *or* when the weight is unknown, if the fetus reached 20 weeks LMP or greater.[105] Rules created by Montana DPHHS specify the timing for the different steps in the process of completing and filing the fetal death certificate. Within three working days after being notified of the death or receiving authorization for the removal, transportation, and final disposition of the fetus, whichever occurs first, the "person in charge of the final disposition" of the fetus must present the fetal death certificate to the physician, advanced practice registered nurse, or coroner for cause-of-death certification.[106] Within 48 hours of receipt, the physician, advanced practice registered nurse, or coroner must then complete and return the death certificate to the person in charge of the final disposition of the fetus.[107] Ultimately, using a current Montana certificate of death form or Montana's Electronic Death Registration System, this person must file the completed fetal death certificate within 10 calendar days after either (1) the date of the fetal death, or (2) the date the fetal death was first

discovered.[108]

If delivery of a dead fetus occurs outside a licensed medical facility, any person who assists in the delivery must report the fetal death to the coroner of the county in which the death occurred "by the earliest means available."[109]

Under Montana law, a stillbirth certificate, in addition to a fetal death certificate, must be filed with the local registrar of the county where the stillbirth occurred if one of parents requests a stillbirth certificate to be filed.[110] "Stillbirth" is defined as "a fetal death occurring after a minimum of 20 weeks of gestation" and specifically excludes abortion.[111] The stillbirth certificate must be filed within 10 calendar days of either the date of delivery or the date of the request.[112] It may be filed by: the physician, physician's designee, or direct-entry midwife licensed to practice in Montana who was in attendance at the stillbirth; any other person in attendance at the stillbirth; either parent; or if the parents are unable to do so, the person in charge of the facility where the stillbirth occurred or the local registrar.[113]

**Other Mandatory Reporting:** All other general mandatory reporting to Montana DPHHS, local law enforcement, etc., also applies to abortion patients.[114] This includes physical, sexual, or emotional abuse or neglect of children and vulnerable adults.[115]

**Electronic Medical Records:** Many electronic medical record systems (EMRs) allow healthcare providers to securely share patient records across healthcare institutions.[116] 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.[117]

The federal government has taken steps to address this concern by issuing a HIPAA rule that became effective on June 25, 2024.[118] 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.[119] 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.[120] 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.[121] 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.[122] The rule only applies to healthcare providers who are subject to HIPAA.[123] Though several states are challenging this rule in litigation, it currently remains in place as these cases move forward.[124]

Separate from HIPAA, interoperability rules that penalize certain information blocking may apply when a healthcare provider uses EMRs.[125] 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.[126]

## Counseling & Referral

Speech about abortion is legal in Montana and every other state. Medical professionals in Montana can thus (1) provide accurate options counseling, including about abortion; and (2) refer patients to

medical providers in states where abortion is legal.

## Medication Abortion

In addition to the law described in the "Documentation & Reporting" section above that requires providers to document and report adverse side effects experienced by patients having a medication abortion, Montana has other laws that apply specifically to medication abortion. But none of those are currently in effect.

Montana law defines "abortion-inducing drug" (referred to alternatively in the law as "chemical abortion") as "a medicine, drug, or any other substance provided with the intent of terminating the clinically diagnosable pregnancy of a woman with knowledge that the termination will with reasonable likelihood cause the death of the unborn child."[127] This definition includes "the off-label use of drugs known to have abortion-inducing properties, which are prescribed specifically with the intent of causing an abortion, such as mifepristone, misoprostol, and methotrexate."[128] It does not include medications "that may be known to cause an abortion that are prescribed for other medical indications."[129] The statute governing "abortion-inducing drugs" explicitly excludes from the definition of abortion the termination of a pregnancy with the intent to remove an ectopic pregnancy or to "remove a dead unborn child."[130] The definition of "abortion" indicates that when these drugs are used to treat patients with ectopic pregnancies, for miscarriage care when no cardiac activity is present, or for cervical dilation, the rules do not apply. Those are all circumstances in which the drugs are used for medical care other than the legal definition of abortion.

In 2023, Montana passed a law that imposed various restrictions on abortions that involve an "abortion-inducing drug," including: a ban on the use of telemedicine to distribute abortion medication, instead necessitating a series of in-person visits;[131] the provision of written and oral information about, among other things, the alleged possibility of being able to reverse the effects of abortion medication and the potential risks of medication abortion as assessed by the state;[132] a 24-hour delay between obtaining informed consent and providing abortion medication; [133] a broad set of impossible-to-satisfy qualification requirements for providers who prescribe or dispense abortion medication;[134] and a new layer of reporting requirements for each medication abortion.[135] Violation of this statute is a felony and provides a basis for civil actions for damages, professional disciplinary action, and suspension or revocation of a provider's license.[136]

A Montana trial court found these requirements unconstitutional and permanently enjoined them.[137] The case is on appeal before the Montana Supreme Court.[138]

## Disposition of Fetal Tissue Remains

In general, fetal tissue can be treated and disposed of in the same way as other medical waste in Montana.[139] However, if a patient is past 20 weeks LMP, medical care facilities can dispose of fetal tissue remains only if authorized by one or both of the parents, or if the medical care facility tries to obtain such authorization but cannot get an answer.[140] If the parent(s) inform the facility they do not want the facility to dispose of fetal tissue remains, the parent(s) are then responsible for doing so.[141]

## 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] *Armstrong v. State*, 1999 MT 261, ¶ 14, 296 Mont. 361, 989 P.2d 364.
[2] *Id.* ¶ 34.
[3] Ballot Language for Constitutional Initiative No. 128 (CI-128) (to be codified at Mont. Const. art. II, § 36(1)), Mont. Sec'y of State. The amendment prohibits the state from denying or burdening the fundamental right to make and carry out decisions about one's own pregnancy unless its action is "justified by a compelling government interest achieved by the least restrictive means." *Id.* Under the amendment, a government interest is "compelling" only if it satisfies a two-part test: (1) it "clearly and convincingly addresses a medically acknowledged, bona fide health risk to a pregnant patient," and (2) it "does not infringe on the patient's autonomous decision making." *Id.*
[4] *Id.*; Mont. Const. art. XIV, § 9(3).
[5] *Weems v. State of Mont.*, 2023 MT 82, ¶ 51, 412 Mont. 132, 529 P.3d 798 ("*Weems II*"); *Armstrong* ¶¶ 66, 75. *Weems II* also impacts other state laws that presume physician involvement in abortion care. Where state law about abortion uses the word "physician," the law applies equally to advance practice clinicians providing abortion care.
[6] *Weems II* ¶ 51; *Armstrong* ¶¶ 66, 75.
[7] Mont. Code Ann. § 50-20-104(1).
[8] *See* Mont. Code Ann. § 50-15-101(6).
[9] Mont. Code Ann. § 50-20-113(2)(c) (law requiring pregnant person be offered an opportunity to view ultrasound and listen to fetal heart tones before abortion), permanently enjoined by *Planned Parenthood of Mont. v. State of Mont.*, No. DV-21-999, 2024 WL 3886822, at *12-13 (13th Jud. Dist. Feb. 29, 2024) ("*PPMT 2021 Laws*"), *appeal docketed*, No. DA 24-0147 (Mont. March 8, 2024); § 50-20-1002(1)(b)(i) (law banning D&E procedures), temporarily enjoined by *Planned Parenthood of Mont. v. State of Mont.*, 2024 MT 227, ¶¶ 28, 41, 418 Mont. 226, 557 P.3d 471 ("*PPMT D&E*"); § 50-20-703(1)(c) (law imposing various restrictions on medication abortion), permanently enjoined by *PPMT 2021 Laws*, 2024 WL 3886822, at *7, *appeal docketed*, No. DA 24-0147 (Mont. March 8, 2024).
[10] Mont. Code Ann. § 50-20-113(2)(c), permanently enjoined by *PPMT 2021 Laws*, 2024 WL 3886822, at *12-13.
[11] Mont. Code Ann. § 50-20-1002(1)(b)(i), temporarily enjoined by *PPMT D&E*, ¶¶ 28, 41; Mont. Code Ann. § 50-20-

703(1)(c), permanently enjoined by *PPMT 2021 Laws*, 2024 WL 3886822, at *7.
[12] *PPMT 2021 Laws*, 2024 WL 3886822, at *7, 12-13; *PPMT D&E*, ¶¶ 28, 41.
[13] *Planned Parenthood of Mont. v. State of Mont.*, 2024 MT 228, ¶¶ 5-6, 42, 418 Mont. 253, 557 P.3d 440 ("*PPMT Medicaid*") (affirming preliminary injunction of (1) statute and rule that restrict Medicaid patients' access to abortion by limiting patients' providers to physicians only, requiring patients seeking abortion to obtain prior authorization from the state, and creating an abortion-specific definition of "medically necessary service" that limits Medicaid coverage, and (2) separate statute that prohibits Medicaid from covering any medically necessary abortions except in cases of rape or incest or if the abortion is necessary to save the pregnant person's life); *Planned Parenthood of Mont. v. State of Mont.*, Cause No.: ADV-2023-299 (March 11, 2025) (order granting summary judgment in favor of plaintiffs).
[14] *Jeannette R. v. Ellery*, No. BDV-94-811, 1995 WL 17959705 (1st Jud. Dist. May 22, 1995) (holding that similar previous rule violated right to privacy and that the Montana Constitution requires the state to cover all medically necessary abortions for Medicaid patients); Admin. R. Mont. 37.82.102 (for the purpose of Medicaid, defining "medically necessary service" as "a service or item" that is "reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in a patient which: (i) endanger life; (ii) cause suffering or pain; (iii) result in illness or infirmity; (iv) threaten to cause or aggravate a handicap; or (v) cause physical deformity or malfunction").
[15] Mont. Code Ann. § 50-20-112(4)(a).
[16] Mont. Code Ann. §§ 50-20-104, 50-20-109.
[17] Mont. Code Ann. § 50-20-603, permanently enjoined by *PPMT 2021 Laws*, 2024 WL 3886822, at *4.
[18] Mont. Code Ann. § 50-20-109(1)(b) (2019), amended by H.B. 136, 67th Leg., Reg. Sess. (Mont. 2021), codified at Mont. Code Ann. § 50-20-109(1), permanently enjoined by *PPMT 2021 Laws*, 2024 WL 3886822, at *4; also amended by H.B. 575, 68th Leg., Reg. Sess. (Mont. 2023), codified at Mont. Code Ann. § 50-20-109(1), temporarily enjoined by *PPMT D&E* ¶¶ 25, 42.
[19] Mont. Code Ann. § 50-20-104(6).
[20] Mont. Code Ann. §§ 50-20-109(2), 50-20-112(2).
[21] Mont. Code Ann. § 50-20-112(4)(a).
[22] Mont. Code Ann. § 50-20-109(1)(b), (2) (2019).
[23] Mont. Code Ann. § 50-20-109(2)(a) (2019).
[24] Mont. Code Ann. § 50-20-109(2)(b) (2019).
[25] Mont. Code Ann. § 50-20-603(1), (2).
[26] Mont. Code Ann. § 50-20-603(1).
[27] Mont. Code Ann. § 50-20-603(3).
[28] *Id.*
[29] *PPMT 2021 Laws*, 2024 WL 3886822, at *4.
[30] *Id.*, *appeal docketed*, No. DA 24-0147 (Mont. May 8, 2024).
[31] Mont. Code Ann. § 50-20-401(1), 3(c).
[32] Mont. Code Ann. § 50-20-1003(1), temporarily enjoined by *PPMT D&E*, ¶¶ 28, 41.
[33] Mont. Code Ann. § 50-20-401(1).
[34] *Id.*
[35] Mont. Code Ann. § 50-20-401(2)(a).
[36] Mont. Code Ann. § 50-20-401(4).
[37] Mont. Code Ann. § 50-20-401(2)(b).
[38] H.B. 721, 68th Leg., Reg. Sess. (Mont. 2023), codified at Mont. Code Ann. §§ 50-20-1001–1007, temporarily enjoined by *PPMT D&E*, ¶¶ 28, 41.
[39] Mont. Code Ann. § 50-20-1003(1).
[40] Mont. Code Ann. § 50-20-1002(9)(a).
[41] Mont. Code Ann. § 50-20-1002(9)(b).
[42] Mont. Code Ann. §§ 50-1003(2), 50-20-1005(1).

[43] In addition to the laws described above that are being challenged in ongoing litigation, Montana has other abortion laws that remain on the books but that have been found unconstitutional and struck down and therefore are not operative. *See* Mont. Code Ann. §§ 50-20-104(5) (definition of "informed consent" for purpose of state-created counseling materials), permanently enjoined by *Planned Parenthood of Missoula v. State*, BDV-95-722 (1st Jud. Dist. Dec. 29, 1999); 50-20-106(1)–(6) (requiring providers to give patients state-created counseling materials at least 24 hours before an abortion), permanently enjoined by *Missoula*; 50-20-112(4)(b) (creating exemption from liability if state has not created materials), permanently enjoined by *Missoula*; 50-20-303–306, 307(3) (requiring Montana DPHHS to create materials and reporting form) permanently enjoined by *Missoula*.

[44] H.B. 140, 67th Leg., Reg. Sess. (Mont. 2021), codified at Mont. Code Ann. § 50-20-113(1), permanently enjoined by *PPMT 2021 Laws*, 2024 WL 3886822, at *15, *appeal docketed*, No. DA 24-0147 (Mont. May 8, 2024). The law also requires the provider to have the patient sign a form certifying they were told they could view ultrasounds and listen to the fetal heart tone. The law does not apply to abortions "performed with the intent to: (a) save the life of the woman; (b) ameliorate a serious risk of causing the woman substantial and irreversible impairment of a bodily function; or (c) remove an ectopic pregnancy."

[45] *PPMT 2021 Laws*, 2024 WL 3886822, at *15, *appeal docketed*, No. DA 24-0147 (Mont. May 8, 2024).

[46] Mont. Code Ann. § 50-20-104(6)(b)(i), temporarily enjoined by *PPMT D&E*, ¶ 25.

[47] *Planned Parenthood of Mont. v. State of Mont.*, No. ADV-2023-231 (1st Jud. Dist. Jul. 11, 2023), *aff'd* *PPMT D&E*, ¶ 25.

[48] Mont. Code Ann. § 50-20-224 (2011).

[49] *Id.*

[50] *Id.*

[51] *Id.*; Mont. Code Ann. § 50-20-225 (2011). If parental notice is given by certified mail, a return receipt must be requested, and delivery must be restricted to the parent or legal guardian.

[52] Mont. Code Ann. § 50-20-223(4) (2011).

[53] Mont. Code Ann. § 50-20-228(1) (2011).

[54] Mont. Code Ann. §50-20-228(2) (2011).

[55] Mont. Code Ann. §50-20-228(3) (2011).

[56] *Planned Parenthood of Mont. v. State of Mont.*, 2024 MT 178, ¶ 56, 417 Mont. 457, 554 P.3d 153 ("*PPMT Parental Consent*") (holding unconstitutional Mont. Code Ann. §§ 50-20-501–50-20-511).

[57] *Id.*, *petition for cert. filed* (U.S. Jan. 10, 2025) (No. 24A438).

[58] EMTALA, 42 U.S.C. § 1395dd(a).

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

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

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

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

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

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

[65] 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).

[66] EMTALA, 42 U.S.C. § 1395dd(c)(1)(B)–(c)(2)(A).

[67] 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.

[68] Kennedy Letter.

[69] Kennedy Letter.

[70] *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.).

[71] Center for Reproductive Rights, *Complaints Against Texas Hospitals for Denying Emergency Care for Ectopic Pregnancies*, (updated May 8, 2025).

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

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

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

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

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

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

[78] *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).

[79] 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.

[80] 42 C.F.R. §§ 482.13(a)(1), (b)(1), (b)(2).

[81] 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/.

[82] *See, e.g.,* Mont. Code Ann. § 27-6-101 *et seq.*

[83] Accreditation Council for Graduate Med. Educ., *ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology*, ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC. (2023).

[84] 42 U.S.C. § 238n.

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

[86] A "facility" includes a hospital, health care facility, physician's office, or "other place in which an abortion is performed." Mont. Code Ann. § 50-20-104(4).

[87] Mont. Code Ann. § 50-20-110(1); Admin. R. Mont. 37.21.110(1).

[88] Admin. R. Mont. 37.21.110(1).

[89] Mont. Code Ann. § 50-20-110(2); Admin. R. Mont. 37.21.111(5).

[90] Mont. Code Ann. § 50-20-110(5)(4).

[91] *Id.*

[92] Mont. Code Ann. § 50-20-110(5)(a).

[93] Mont. Code Ann. § 50-20-110(5); Mont. Code Ann. § 50-20-110(6); Admin. R. Mont. 37.21.110(2).

[94] Mont. Code Ann. § 50-20-110(5)(b).

[95] Mont. Code Ann. §§ 46-18-212, 50-20-110(7)(a).

[96] Mont. Code Ann. § 50-20-110(7)(b).
[97] Mont. Code Ann. §§ 37-1-308, 37-1-312(1)(b)-(j), 50-20-110(7)(b).
[98] Mont. Code Ann. § 50-20-109(2)(a) (2019).
[99] Mont. Code Ann. § 50-20-109(2)(b) (2019).
[100] *PPMT D&E*, ¶¶ 28, 41.
[101] Mont. Code Ann. § 50-20-1004, temporarily enjoined by *PPMT D&E*, ¶¶ 28, 41.
[102] Montana Dep't of Health and Human Servs., 2022 Montana Vital Statistics 15 (May 2024); Mont. Code Ann. § 50-15-101(17)(a).
[103] Mont. Code Ann. § 50-15-101(6).
[104] *Id.* The law distinguishes between "[h]eartbeats and "transient cardiac contractions" and between "[r]espirations" and "fleeting respiratory efforts or gasps." *Id.*
[105] Mont. Code Ann. § 50-15-403(1).
[106] Admin. R. Mont. 37.8.801(3).
[107] Admin. R. Mont. 37.8.801(4).
[108] Admin. R. Mont. 37.8.801(8).
[109] Mont. Code Ann. § 46-4-114.
[110] Mont. Code Ann. § 50-15-208(1); Admin. R. Mont. 37.8.307(1).
[111] Mont. Code Ann. § 50-15-101(17)(a).
[112] Admin. R. Mont. 37.8.307(1).
[113] Mont. Code Ann 50-15-208(2).
[114] Fact sheets from If/When/How with additional detail, including some state-specific fact sheets, are available here. If/When/How adds state-specific fact sheets to their website as they are finalized.
[115] Mont. Code Ann. §§ 41-3-102, 41-3-201(1)-(2), 52-3-803, 52-3-811(1), (3).
[116] 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).
[117] 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.
[118] 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.
[119] 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).
[120] 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.
[121] 42 U.S.C. §§ 164.509(a), 512(d)-(g)(1).
[122] 42 U.S.C. § 164.502(a)(5)(iii).
[123] 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).
[124] 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).

[125] 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.

[126] 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.

[127] Mont. Code Ann. § 50-20-703(2), permanently enjoined by *PPMT 2021 Laws*, 2024 WL 3886822, at *7, *appeal docketed*, No. DA 24-0147 (Mont. May 8, 2024).

[128] *Id.*

[129] *Id.*

[130] Mont. Code Ann. § 50-20-703(1).

[131] Mont. Code Ann. §§ 50-20-704, 50-20-705(1), (3), 50-20-707(2). The law prohibits manufacturers, suppliers, and medical practitioners from providing abortion medication "via courier, delivery, or mail service." Mont. Code Ann. § 50-20-704. It requires providers to deliver written and oral biased counseling information at least 24 hours before providing abortion medication, except in limited circumstances, thereby necessitating multiple patient visits. Mont. Code Ann. § 50-20-707(2). It further requires providers to conduct an in-person examination before providing abortion medication to: verify that the patient is pregnant; determine the patient's blood type and, if the patient is Rh negative, be able to offer RhoGAM; inform the patient that they "may see the remains of the unborn child in the process of completing the abortion"; and document in the patient's medical chart the gestational age and intrauterine location of the pregnancy and whether the patient received RhoGAM. Mont. Code Ann. § 50-20-705(1). In addition, the law requires providers to schedule, and to set forth in the patient's medical record the "reasonable efforts made to ensure" that the patient returns for, a follow-up appointment approximately 7 to 14 days after the medication is administered to confirm pregnancy termination and assess any continued blood loss. Mont. Code Ann. § 50-20-705(3).

[132] Mont. Code Ann. § 50-20-707(2).

[133] Mont. Code Ann. § 50-20-707(2). Providers do not need to wait at least 24 hours between the provision of biased-counseling materials and providing abortion medication "when, in reasonable medical judgment," doing so "would pose a greater risk of…the death of the pregnant woman" or "the substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions, of the pregnant woman." *Id.*

[134] Mont. Code Ann. §§ 50-20-703(5), 50-20-705(2). The law requires abortion providers to be credentialed to handle any "adverse physical or psychological condition arising from the performance of an abortion" and lists 29 such conditions, including, among others, renal failure, pelvic inflammatory disease, metabolic disorder, shock, preterm delivery in subsequent pregnancies, coma, and death. Mont. Code Ann. § 50-20-703(5).

[135] Mont. Code Ann. § 50-20-709. Under the law, within 15 days of each reporting month, facilities must submit and the provider who offered the abortion medication must sign a report for each medication abortion. The report must include: demographic and medical information about the patient, the "probable gestational age of the unborn child as determined by both patient history and ultrasound results used to confirm the gestational age," the date of the ultrasound, the abortion medications and date they were administered, whether the abortion was "completed" at the facility or elsewhere, whether the patient returned for their follow-up appointment, how the provider tried to ensure the patient returned, and whether the patient experienced complications. *Id.* The law also requires providers to report any "adverse event" the patient experienced during or after the use of the abortion medication to the U.S. Food and Drug Administration through the MedWatch Reporting System and to Montana DPHHS. *Id.*

[136] Mont. Code Ann. §§ 50-20-711, 50-20-712.

[137] *PPMT 2021 Laws*, 2024 WL 3886822, at *7, *appeal docketed*, No. DA 24-0147 (Mont. May 8, 2024).

[138] *Id.*

[139] Mont. Code Ann. § 50-20-105(1); Admin. R. Mont. 37.21.115(1).

[140] Admin. R. Mont. 37.21.115(2)-(3).

[141] Admin. R. Mont. 37.21.115(2).