ABORTION DEFENSE NETWORK

Know Your State's Abortion Laws

A Guide for Medical Professionals

NEBRASKA

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

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

Last updated June 2026

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Key Takeaways

Providing contraception, including emergency contraception, is legal.

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

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

Abortion is prohibited in Nebraska after 12 weeks LMP unless:

(1) The abortion is necessary to avert the person's death or "a serious risk of substantial and irreversible physical impairment of a major bodily function or

(2) The pregnancy resulted from sexual assault or incest.

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First Trimester Constitutional Ban

Nebraska's constitution bans abortion after the first trimester except in the case of a "medical emergency," sexual assault, or incest.[1] None of the terms used in this ban, including "trimester," "medical emergency," "sexual assault" or "incest" are defined, but the ban is generally understood to align with Nebraska's statutory abortion ban that prohibits abortion at or over 12.0 weeks from the pregnant person's last menstrual period ("the 12-week ban"), discussed below. This amendment means that unless the Nebraska Constitution changes, no law can be enacted that is less restrictive than the constitutional ban.

Definition of Abortion & Contraception

ABORTION

Nebraska law defines the word "abortion" in various ways in different statutes, but generally, the definition applies to the use or prescription of any instrument, medicine, drug, or other substance or device to terminate a pregnancy.[2]

Each definition excludes certain acts from the definition of abortion. The 12-week ban specifically excludes: (i) removal of an ectopic pregnancy; (ii) removal of remains of an embryo or fetus "who has already died;" (iii) an act done with the intention to save the life or preserve the health of the embryo or fetus; (iv) the accidental or unintentional termination of the embryo or fetus; or (v) the termination of an embryo "who is not being carried inside a woman's body" during in vitro fertilization or another assisted reproductive technology.[3]

Although the statutory language defining abortion varies, including what is excluded from each definition, all the definitions exclude "removal" of a fetus that is "dead." Though "dead" is not defined for these purposes in Nebraska law, within the abortion context, Nebraska defines a child "born alive" as exhibiting "any evidence of life," such as breathing, a heartbeat, umbilical cord pulsation, and/or "definite movement of voluntary muscles," all of which suggest that "dead" means that there is no cardiopulmonary activity present in the embryo or fetus.[4] This means that treatment for miscarriage where there is no cardiac activity (including medications, D&C, D&E, and labor induction) is not an abortion under Nebraska law and thus not prohibited.

The removal of an ectopic pregnancy is only explicitly excluded from the definitions of abortion in the 12-week ban and the parental/guardian involvement law.[5] The definitions of abortion in the laws applicable to biased counseling requirements, the physician-only law, certain reporting requirements, and the viability and 20-week postfertilization bans (all discussed below) do not explicitly exclude ectopic pregnancies.[6]

Nebraska does have a law explicitly criminalizing of self-managed abortion, and no civil law explicitly prohibits a person from self-managing an abortion.[7] The 12-week ban, along with several other abortion bans and restrictions, specifically exclude the pregnant person from liability.[8]

CONTRACEPTION

Contraception is not illegal in any state in the country, including Nebraska.

Abortion Bans

12-week Ban: Physicians in Nebraska must determine the fetus's gestational age prior to the abortion.[9] If the gestational age is 12 weeks from the patients last menstrual period ("LMP") or more, the abortion is prohibited unless: (1) there is a medical emergency or (2) the pregnancy resulted from sexual assault or incest.[10] These exceptions are explained more in the next section of this guide. The penalty for violating the 12-week ban is permanent revocation of the physician's medical license, with the ability to seek reinstatement after two years.[11]

Other Bans: Nebraska has two other bans based on gestational age in effect:

- A ban on abortion at or over 20 weeks "postfertilization." Postfertilization is defined as the gestational age as calculated from fertilization. The ban does not apply if the abortion is necessary to: (1) avert the pregnant person's death or "a serious risk of substantial and irreversible physical impairment of a major bodily function" or (2) preserve the fetus's life.[12]
- A ban on abortion after viability. Viability is defined as the stage of development when the fetus "is potentially able to live more than merely momentarily outside the womb . . . by natural or artificial means." The ban does not apply if the abortion is "necessary to preserve the life or health" of the pregnant person.[13]

Note that these bans still apply even with the 12-week ban in effect. This means that to provide an abortion after 20 weeks postfertilization, exceptions to both the 12-week and 20-week postfertilization bans must be met. To provide an abortion after viability, exceptions to the 12-week, 20-week postfertilization, and viability bans must be met.

Nebraska also bans dilation and evacuation ("D&E") procedures. The ban does not apply in a medical emergency, defined as "a condition which, in reasonable medical judgment. . . necessitate[s] the immediate abortion . . . to avert [the pregnant person's] death or for which a delay will create a serious risk of substantial and irreversible physical impairment of a major bodily function.[14]

Exceptions to 12-week Ban

As mentioned, the 12-week ban has exceptions for (1) a medical emergency and (2) sexual assault or incest. It does not have an exception based on fetal diagnosis, nor do any of Nebraska's other bans. As mentioned, if an abortion is provided at or after 20 weeks postfertilization and/or viability, the exceptions for those bans must also be met.

Medical Emergency: The 12-week ban allows abortions after 12 weeks LMP if there is a "medical emergency." It defines "medical emergency" as "any condition which, in reasonable medical judgment, so complicates the medical condition of the pregnant woman as to necessitate the termination of her pregnancy to avert her death or for which a delay in terminating her pregnancy will create a serious risk of substantial and irreversible physical impairment of a major bodily function."[15] The only situation that is explicitly excluded from this exception is if the emergency is "based on a claim or diagnosis that the woman will engage in conduct which would result in her death or in substantial and irreversible physical impairment of a major bodily function."[16]

The ban defines "reasonable medical judgement" as "a medical judgment that could be made by a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved."[17]

In October 2024, the Nebraska Department of Health and Human Services ("DHHS") published a non-binding advisory opinion about the 12-week ban. In it, DHHS stated that the medical emergency exception "does not require a medical emergency to be immediate. Physicians understand that it is difficult to predict with certainty whether a situation will cause a patient to become seriously ill or die, but physician do know what situations could lead to serious outcomes. Physicians should exercise their best clinical judgement, and the law allows intervention consistent with prevailing standards of care. The law is deferential to a physician's judgment in these circumstances."[18]

If a medical emergency exists, the physician does not need to determine the fetus's gestational age and may provide the abortion after 12 weeks LMP.

Sexual Assault or Incest: The 12-week ban allows abortions after 12 weeks LMP in the case of sexual assault or incest. The 12-week ban defines sexual assault to include sexual penetration that occurs: (1) without consent, (2) by an actor who knew or should have known that the other person was mentally or physically incapable of resisting or appraising the nature of their conduct, or (3) when the actor is 19 or older and the other person is 15 or younger.[19] The 12-week ban defines incest as sexual penetration or intermarrying between a parent and child, grandparent and grandchild, whole or half siblings, aunts/uncles and nieces/nephews, or sexual penetration with a stepchild who is under 19 years old.[20]

Other Abortion Restrictions

While not the focus of this document, Nebraska has many other laws that restrict abortion, including: mandatory biased counseling,[21] a 24-hour waiting period,[22] if an ultrasound is provided, a one-hour waiting period between the ultrasound and the abortion and certain requirements for the ultrasound,[23] a physician-only law,[24] a requirement that the physician be in-person with the patient for the abortion,[25] and a requirement that the physician determine the postfertilization age of the fetus prior to the abortion (this is a separate requirement from the gestational age determination required in the 12-week ban).[26] Unemancipated young people under 18 and adults who have guardians must obtain parental, guardian, or judicial consent to obtain an abortion.[27] The state also prohibits the use of public funds and health plans offered through the Nebraska health insurance exchange to cover abortion procedures.[28] Nebraska also requires facilities that provide 10 or more abortions per week to be licensed as a health clinic if they are not otherwise licensed as a hospital or ambulatory surgical center.[29]

Many of Nebraska's abortion restrictions do not apply in a medical emergency. Specifically: mandatory biased counseling,[30] the 24-hour waiting period,[31] the one-hour waiting period after an ultrasound and ultrasound requirements (if provided),[32] determination of postfertilization age,[33] and the parental, guardian, or judicial consent requirement.[34]

In general, these medical emergency exceptions apply when an abortion is necessary to avert the pregnant person's death or a serious health impairment. However, there is some variation in how "medical emergency" is defined across Nebraska's abortion restrictions. For example, the medical emergency definition applicable to the biased counseling, waiting period, and ultrasound requirements applies when a delay would create a risk of a "substantial impairment of a major bodily function," whereas other restrictions (and the abortion bans) require that there be a risk of a "substantial *and irreversible physical impairment* of a major bodily function."[35] Additionally, the definitions applicable to all medical emergency exceptions except for the 12-week ban's exception

require the patient's condition necessitates an "immediate" abortion.[36]

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.[37] 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."[38] 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."[39]

EMTALA requires stabilizing medical treatment be provided to any individual experiencing an emergency medical condition,[40] including people in labor or with emergency pregnancy complications,[41] unless the individual refuses to consent to such treatment.[42] 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."[43] 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.[44] 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."[45]

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.[46]

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."[47] 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."[48] 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."[49] 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.[50]

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.[51] 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]."[52] 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.[53] 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.[54] Following the change of presidential administrations, the United States dismissed that case entirely. [55]

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.[56] As a result, the Fifth Circuit's decision is final.[57,58]

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 participating in Medicare and Medicaid to inform patients of their rights before 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.[59]

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.[60]

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.

Resident Training: The Accreditation Council for Graduate Medical Education (ACGME) requires that accredited programs provide access to training in the provision of abortion.[61] 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.[62]

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.[63]

The reporting and documentation requirements specific to abortion care in Nebraska are:

Documentation: As mentioned, the 12-week ban requires that the physician determine the gestational age of the fetus prior to the abortion. The physician must document the method used to determine the gestational age and the date, time, and results.[64] Additionally, the 12-week ban requires that if the abortion is based on a medical emergency, the physician, in writing, certify that the emergency existed and explain the emergency.[65] If the physician provides an abortion based on sexual assault or incest, they must, in writing, certify that this is the basis for the abortion and that they complied with the reporting requirements that apply when providing medical care for physical injury related to sexual assault (note that a report is not required in all circumstances).[66] These certifications must be kept in the patient's medical record.[67]

Nebraska law also requires that patients certify in writing that they received all required biased counseling information and, if an ultrasound was performed, that all requirements for the ultrasound were met. A copy of the certification must be kept in the patient's medical record.[68]

If a physician provides an abortion to an unemancipated young person under 18 or an adult with a legal guardian without obtaining the required consent due to a medical emergency, they must certify that the medical emergency exists and that there is insufficient time to obtain the required consent.[69] If, when parental or guardian consent is required, a physician instead seeks to obtain consent from a grandparent as allowed under an exception to the parental/guardian consent requirement, the physician must obtain a signed, written statement from the patient that they are a victim of abuse or neglect by a parent or guardian, certify in the patient's medical record that they received the statement, and inform the patient of the physician's duty to make a mandatory report to state officials.[70]

Hospitals or other medical facilities may impose additional documentation requirements for abortions performed under a medical emergency or other exception, including attestations by multiple physicians and/or approvals by an ethical review board. While intended to insulate facilities from liability, these are not legal requirements.

Abortion Reporting: All abortions in Nebraska must be reported to DHHS on a form provided by DHHS.[71] The report must include the patient's demographic information and medical history and information about the abortion.[72] Nebraska also requires reporting "of every attempt at continuing a woman's pregnancy after taking mifepristone," and requires nearly identical information to be reported.[73] The reports must be signed by the attending medical professional and sent to DHHS within 15 days after each reporting month.[74]

Physicians who perform or attempt to perform an abortion must also report to DHHS information related to the probable postfertilization age of the fetus, including: the probable postfertilization age; the method and basis for determining the postfertilization age; if a determination was not made due to a medical emergency, the basis for the emergency.[75] If the gestational age was 12 weeks LMP or more, the physician must also report (1) the basis for determining that the abortion was necessary to avert the pregnant person's death or a serious risk of substantial and irreversible physical impairment of a major bodily function, or to "preserve the life of" the fetus and (2) whether the abortion method "provided the best opportunity for the unborn child to survive" and, if not, the basis of the determination that that method would pose a greater risk of death or substantial and irreversible physical impairment

of a major bodily function of the pregnant person than other available methods.[76]

Nebraska law also requires that abortion providers submit a monthly report regarding parental and guardian consent requirements, including: the number of consents obtained, the number and types of exceptions made, the pregnant person's age, and the number of prior pregnancies and abortions of the pregnant person.[77]

Fetal Death Reporting: Nebraska requires a fetal death certificate to be filed for all stillbirths, defined to mean fetuses that are 20 weeks gestation or more.[78] Though the vital statistics law does not explicitly define "stillbirth" to exclude abortion, other statutes and information on the vital statistics website indicate this is the case.[79]

The physician, physician assistant, or nurse practitioner in attendance must complete the "medical certificate of death" portion of the fetal death certificate within 24 hours of the fetal death.[80] A certificate must be filed with DHHS or the local vital statistics office within 5 business days after the fetal death.[81] The person responsible for filing the fetal death certificate must notify the parent(s) that they may request a "certificate of birth resulting in stillbirth" from DHHS and must provide any information necessary for the request.[82]

Fetal death certificates are not required for miscarriages that are less than 20 weeks gestation (referred to as "nonviable births" in Nebraska law).[83] However, the healthcare practitioners who attended or diagnosed the miscarriage or their designee must inform the patient that they may request a commemorative certificate from DHHS and provide the patient with either a letter or DHHS form verifying the miscarriage.[84]

Other Mandatory Reporting: All general mandatory reporting to DHHS, local law enforcement, etc., applies to abortion patients.[85] This includes child and vulnerable adult physical, sexual, or emotional abuse or neglect.[86] Health clinics (which includes abortion facilities) must develop policies for reporting child and vulnerable adult abuse and provide staff orientation on the topic.[87] Hospitals must provide staff orientation on abuse and neglect and must report the abuse or neglect the abuse and neglect hotlines "via telephone immediately" and the local law enforcement "as required by state and federal laws."[88] Hospitals must investigate incidents of abuse and neglect and submit a written report of the investigation to DHHS within 5 working days of the occurrence.[89]

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.[90] 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.[91, 92]

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.[93] 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.[94]

Counseling & Referral

Speech about abortion is legal in Nebraska and every other state. Medical professionals in Nebraska can thus (1) provide accurate options counseling, including about abortion; and (2) refer patients to medical providers in states where abortion is legal; and (3) refer patients to medical providers in Nebraska for care that is lawful in Nebraska. However, certain public funds may not be used for abortion counseling or referral.[95]

Medication Abortion

All of the requirements discussed in this document apply to both procedural and medication abortion. Nebraska additionally has a law that impacts the use of telemedicine for medication abortion. The law states that no abortion (including the use or prescription of any drug or medicine) may be performed or attempted unless the physician "is physically present in the same room with the patient when the physician performs. . . or attempts to perform" the abortion.[96]

Disposition of Fetal Tissue

In general, fetal tissue can be treated and disposed of in the same way as other medical waste in Nebraska. Nebraska has a law applicable only to licensed hospitals related to disposing of fetal tissue from miscarriages at any gestational age.[97] Hospitals must: (1) have a written policy on fetal tissue disposition for miscarriages, (2) provide the parent(s) with a copy of the policy, and (3) notify the parent(s) that they have the right to direct the tissue disposition and, if the parent does not do so after 14 days, the hospital will do so instead.[98]

Nebraska law criminalizes the "sale, transfer, distribution, or giving away of any live or viable aborted child for any form of experimentation" or the aiding or abetting of these acts or "other unlawful disposition."[99] Nebraska allows donation of fetal tissue following a stillbirth or miscarriage for research.[100]

Need legal advice?

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

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

ACLU

CENTER for REPRODUCTIVE RIGHTS

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

RAD RESOURCES FOR ABORTION DELIVERY

References

[1] Neb. Const. art. 1, § 31.
[2] Neb. Rev. Stat. Ann. §§ 28-326 (applicable to biased counseling requirements, the physician-only requirement, in-person requirement, certain reporting requirements, and the viability ban, this law defines abortion as "the use or prescription of any instrument, medicine, drug, or other substance or device intentionally to terminate the pregnancy of a woman known to be pregnant"), 28-3,103 (applicable to the 20-week postfertilization ban, this law defines abortion as "the use or prescription of any instrument, medicine, drug, or other substance or device to terminate the pregnancy of a woman known to be pregnant"), 71-6901 (applicable to parental involvement requirements, this law defines abortion as "the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child"), 71-6914 (applicable to the 12-week ban, this law defines abortion as "the prescription or use of any instrument, device, medicine, drug, or substance to or upon a woman known to be pregnant with the specific intent of terminating the life of" the embryo or fetus.).
[3] *Id.* § 71-6914. *See also id.* §§ 28-326 (applicable to biased counseling requirements, the physician-only requirement, in-person requirement, certain reporting requirements, and the viability ban, this law excludes from its definition of abortion acts intended 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 unborn child, and which causes the premature termination of the pregnancy"), 28-3,103 (applicable to the 20-week postfertilization ban, this law excludes from its definition abortion acts intended 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 unborn child who died as the result of natural causes in utero, accidental trauma, or a criminal assault on the pregnant woman or her unborn child, and which causes the premature termination of the pregnancy, 71-6901 (applicable to parental involvement requirements, this law excludes from its definition of abortion acts intended to: "(a) save the life or preserve the health of an unborn child; (b) remove a dead unborn child caused by a spontaneous abortion; or (c) remove an ectopic pregnancy").
[4] *Id.* § 28-331.
[5] *Id.* §§ 71-6901, 71-6914.
[6] *Id.* §§ 28-326, 28-3,103.
[7] Nebraska has a law on the books allowing the pregnant person or their survivors to bring a civil cause of action against anyone except a physician or pharmacist who "aids or abets the commission of a self-induced abortion." *Id.* § 28-327.11. However, this law is permanently enjoined, meaning it cannot be enforced. *Planned Parenthood of the Heartland v. Heineman*, No. 4:10-cv-3122 (D. Neb. Aug. 24, 2010).
[8] Neb. Rev. Stat. Ann. § 71-6917. *See also id.* §§ 28-335, 28-347, 28-3,108 (all exempting the pregnant person from liability).
[9] *Id.* § 71-6915.
[10] *Id.*
[11] *Id.* §§ 38-178, 38-179, 38-192, 38-193, 38-196, 38-1,100, 38-2021.
[12] *Id.* §§ 28-3,102 – 28-3,111. The exceptions do not apply if they are based on a claim or diagnosis that the pregnant person will engage in conduct that would result in these exceptions being met. *Id.* § 28-3,106. The penalties for intentionally or recklessly violating this ban are: (1) criminal: a Class IV felony, punishable by up to two years imprisonment and twelve month post-release supervision and/or up to a $10,000 fine; (2) civil: the patient or the father of the fetus may bring a civil action and seek damages; and (3) professional: violating the ban is considered unprofessional conduct. This law explicitly states that no criminal penalties or civil damages may be assessed against the pregnant person. *Id.* §§ 28-105; 28-3,108, 28-3,109; 38-2021.
[13] *Id.* §§ 28-326, 28-329–28-332. The penalties for violating this ban are criminal: intentional and knowing violation of the viability ban is a Class IV felony, punishable by up to two years imprisonment and twelve month post-release supervision and/or up to a $10,000 fine. *Id.* §§ 28-105, 28-332.
[14] *Id.* §§ 28-347–28-347.06. The medical emergency exception does not apply if it is based on a claim or diagnosis that the pregnant person will engage in conduct that would result in creating a medical emergency. *Id.* § 28-3,103.
[15] *Id.* § 71-6914.
[16] *Id.*
[17] *Id.*
[18] Nebraska Department of Health and Human Services, Health Alert Network Advisory: Preborn Child Protection Act Clarification 2 (2024).
[19] Neb. Rev. Stat. Ann. §§ 28-319, 28-319.01, 71-6915.
[20] *Id.* §§ 28-702, 28-703, 71-6915.

[21] *Id.* §§ 28-327–28-327.12. *See also Planned Parenthood of the Heartland v. Heineman*, No. 4:10-cv-3122 (D. Neb. Aug. 24, 2010) (permanently enjoining certain biased counseling requirements).
[22] Neb. Rev. Stat. Ann. § 28-327.
[23] *Id.*
[24] *Id.* § 28-335.
[25] *Id.*
[26] *Id.* §§ 28-3,105. In making the postfertilization age determination, the physician must perform or cause to be performed exams and tests that a "reasonably prudent physician, knowledgeable about the case and the medical conditions involved, would consider necessary to perform" to make the determination. *Id.*
[27] *Id.* §§ 71-6901 – 6911.
[28] *See, e.g.*, *id.* §§ 44-1615.01, 44-8403, 71-7606. *See also* Neb. Exec. Order No. 25-16 (Nov. 6, 2025) (restricting state Medicaid funding from going to abortion providers in Nebraska regardless of whether the funding is used for services other than abortion care).
[29] Neb. Rev. Stat. Ann. § 71-416, 175 Neb. Admin. Code Ch. 7, 001 *et seq*.
[30] Neb. Rev. Stat. Ann. § 28-327. If a physician does not comply with the biased counseling and waiting period requirements due to a medical emergency, they must inform the patient, prior to the abortion, if possible, of the medical indications supporting the determination that a medical emergency exists. *Id.* § 28-327.02. If a physician does not comply with the waiting period requirements due to a medical emergency, they must inform the patient, prior to the abortion, if possible, of the medical indications supporting the determination that a medical emergency exists. *Id.* § 28-327.02.
[31] *Id.* § 28-327. If a physician does not comply with the ultrasound requirements due to a medical emergency, they must inform the patient, prior to the abortion, if possible, of the medical indications supporting the determination that a medical emergency exists. *Id.* § 28-327.02.
[32] *Id.* § 28-327.
[33] *Id.* § 28-3,105.
[34] *Id.* § 71-6902. The physician must certify in the pregnant person's medical record that a medical emergency exists and there is insufficient time to obtain the required consent. *Id.* § 71-6906. Other exceptions apply to obtaining parental, guardian, or judicial consent as well. *See Id.* §§ 71-6902.01, 71-6902.02.
[35] *See Id.* §§ 28-326 (using the term "emergency situation"), 28-347, 28-3,103, 71-6901, 71-6914. In addition to the variation in the "medical emergency" definitions noted in the main text, there are a few other differences. First, while the 12-week, 20-week postfertilization, and D&E bans use a "reasonable medical judgment" standard to determine if the medical emergency exception applies, the exceptions for the biased counseling, waiting period, and parental/guardian consent requirements allow physicians to apply their "good faith clinical judgment" as to whether an emergency exists. Second, all of the medical emergency definitions *except* the 12-week ban require that the patient's condition necessitates an *immediate* abortion. Lastly, the definitions of "medical emergency" in the 12-week, D&E, and 20-week postfertilization bans explicitly state that they do not apply if based on the person potentially engaging in conduct that would create the conditions to meet the exception, while the definitions applicable to the biased counseling, waiting period, and parent/guardian consent requirements do not specify this.
[36] *See id.* §§ 28-326, 28-347, 28-3,103, 71-6901, 71-6914
[37] EMTALA, 42 U.S.C. § 1395dd(a).
[38] *Id.* § 1395dd(e)(1)(A).
[39] *Id.* § 1395dd(e)(1)(B).
[40] *Id.* § 1395dd(b)(1)(A).
[41] *Id.* § 1395dd(e)(1).
[42] *Id.* § 1395dd(b)(2).
[43] *Id.* § 1395dd(e)(3)(A).
[44] *Id.* § 1395dd(c)(2) (requiring hospital to use "qualified personnel and transportation equipment" when making a permitted transfer under EMTALA, among other requirements).
[45] *Id.* § 1395dd(c)(1)(B)–-(c)(2)(A).

[46] 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.

[47] Kennedy Letter.

[48] Kennedy Letter.

[49] 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.).

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

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

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

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

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

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

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

[57] *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).

[58] 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.

[59] 42 C.F.R. §§ 482.13(a)(1), (b)(1), (b)(2).

[60] Nat'l Women's Law Ctr., *Know Your Rights: Existing Laws May Protect Health Care Professional Who Provide or Support Abortion from Discrimination in Employment* (Feb. 9, 2023).

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

[62] 42 U.S.C. § 238n.

[63] 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.

[64] Neb. Rev. Stat. Ann. § 71-6915.

[65] *Id.* § 71-6916.

[66] *Id.*§§ 28-902, 71-6916.

[67] *Id.* § 71-6916.

[68] *Id.* § 28-327.

[69] *Id.* § 71-6906.

[70] *Id.* § 71-6902.01.

[71] *Id.* § 28-343, 174 Neb. Admin. Code Ch. 8, 002.

[72] Neb. Rev. Stat. Ann. § 28-343, 174 Neb. Admin. Code Ch. 8, 002. Failure to comply with the reporting requirements is a Class II misdemeanor, punishable by up to six months imprisonment, a one thousand dollars fine, or both. Neb. Rev. Stat. Ann. §§ 28-106, 28-344.

[73] Neb. Rev. Stat. Ann. § 28-327.01, 174 Neb. Admin. Code Ch. 8, 003.
[74] Neb. Rev. Stat. Ann. §§ 28-327.01, 28-343.
[75] *Id.* § 28-3,107. Physicians who fail to submit the report on time are subject to a fine; failure to comply with the reporting requirement constitutes unprofessional conduct; and falsification of a report is a Class V misdemeanor, punishable by a fine of up to one hundred dollars. *Id.* §§ 28-106, 28-3,107.
[76] *Id.* § 28-3,107.
[77] *Id.* § 71-6909. Violation of this requirement is a Class III misdemeanor, punishable by up to three months imprisonment, a five hundred dollars fine, or both. *Id.* §§ 28-106, 71-6907.
[78] *Id.* 174 Neb. Admin. Code Ch. 8, 004.
[79] Neb. Rev. Stat. Ann. § 71-601.01. The vital statistics definitions define fetal deaths of less than 20 weeks gestation to exclude abortion. They use the term "nonviable birth," and specifically define the term to mean "unintentional, spontaneous fetal demise." *Id.* Nebraska's Child and Maternal Death Review Act defines stillbirth as "a spontaneous fetal death which resulted in a fetal death certificate pursuant to [the Vital Records statute]." *Id.* § 71-3405. The DHHS website contains guidelines for hospitals reporting fetal deaths and states that a fetal death "is not an induced termination of pregnancy." Department of Health and Human Services, Nebraska Hospital Guidelines for Reporting Live Births, Infant Deaths, Fetal Deaths and Induced Terminations of Pregnancy.
[80] Neb. Rev. Stat. Ann. §§ 71-605, 71-606.
[81] *Id.* §§ 71-605, 71-606, 71-608.01.
[82] *Id.* § 71-606.
[83] *Id.* §§ 71-601.01, 71-606.
[84] *Id.* § 71-607, Department of Health and Human Services, Nonviable Births (select link to "Nonviable Birth Worksheet").
[85] Fact sheets from If/When/How with additional detail, including some state-specific fact sheets, are available here. If/When/How adds state-specific fact sheets to their website as they are finalized.
[86] *See, e.g.,* Neb. Rev. Stat. Ann. §§ 28-348–387 (adult abuse and neglect), 28-710–727 (child abuse and neglect), 28-902. Licensed health care facilities must also report to DHHS within 24 hours if the death of a patient occurred due to suicide, a violent act, drowning, or the use of restraint or seclusion, and when a patient who needs supervision leaves a facility without staff knowledge. 175 Neb. Admin. Code Ch. 1, 005.
[87] 175 Neb. Admin. Code Ch. 7, 006.
[88] 175 Neb. Admin. Code Ch. 9, 006.
[89] *Id.*
[90] 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).
[91] 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.
[92] 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.
[93] 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.

[94] 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.
[95] *See* Neb. Rev. Stat. Ann. §§ 68-1722, 71-606.
[96] *Id.* § 28-335. Knowing or reckless violation of this law is a Class IV felony. *Id.*
[97] *Id.* § 71-20,121.
[98] *Id.*
[99] *Id.* § 28-342. This restriction does not "prohibit or regulate diagnostic or remedial procedures the purpose of which is to preserve the life or health of the aborted child or mother." *Id. See also id.* § 28-346 (prohibiting the "use of any premature infant aborted alive for any type of. . . experimentation except as necessary to protect or preserve the life or health of such premature infant born alive.").
[100] *Id.* § 71-4825.