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MONTANA FIRST JUDICIAL DISTRICT COURT, LEWIS AND CLARK COUNTY

PLANNED PARENTHOOD OF MONTANA; et al., Plaintiffs, v. STATE OF MONTANA; et al., Defendants.	Cause No.: ADV 2023–231 Honorable Mike Menahan **DEFENDANTS' RESPONSE IN OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

INTRODUCTION

Immediately following the Governor's signing of House Bill ("HB") 575 on May 3, 2023, Plaintiffs filed their Verified Amended Complaint in this matter along with their current "Motion for Temporary Restraining Order & Preliminary Injunction on HB 575 (Direct to Patient

Medication Ban)" and Brief in Support. Plaintiffs, in relevant part, seek a preliminary injunction barring the implementation and enforcement of HB 575 in its entirety, pending the Court's final decision on the merits. Plaintiffs base their Motion largely on their erroneous conclusion that HB 575 "bans direct-to-patient telehealth medication abortions" and is therefore unconstitutional. (*See generally* Doc. 24.) In doing so, Plaintiffs mischaracterize and exaggerate the substance and effect of HB 575, and they mistakenly rely on the Thirteenth Judicial District Court's inapplicable injunction of a separate law under an entirely different standard. (*Id.*) As set forth further below, Plaintiffs fail to demonstrate an entitlement to a preliminary injunction because: (1) they cannot establish a likelihood of success on the merits; (2) they do not show a likelihood of irreparable harm absent preliminary relief; (3) the balance of equities do not favor Plaintiffs; and (4) a preliminary injunction is not in the public interest. The Court should deny Plaintiffs' Motion accordingly.

STATEMENT OF FACTS

I. HB 575.

As relevant to Plaintiffs' Motion, HB 575 amends Section 50-20-104(6), MCA's definition of "viability" as that term is used in the Montana Abortion Control Act to specify that a qualified provider must review an ultrasound in determining the gestational age, and therefore viability, of a fetus. (*See* Doc. 22 at Ex. 3.) HB 575 does not require the ultrasound to be performed by the provider making the viability determination or by any other specific provider, nor does it dictate the specific time or location where the ultrasound must be performed. (*Id.*) It merely requires the provider making the viability determination to review an ultrasound during that process. HB 575 also does not prohibit any particular type of pre-viability abortion according to its plain language

and explicit terms. (*Id.*) In fact, HB 575 also amends Section 50-20-109(1), MCA to allow for *post-viability* abortions when necessary to preserve the life of the mother. (*Id.* at 2–3.)[1]

II. Ultrasounds and Determining Fetal Viability.

Obtaining an ultrasound is the standard of care for determining the viability of a fetus. (Aff. George Mulcaire-Jones, M.D., at ¶ 16 (May 12, 2023), attached as **Exhibit A**.) This is in part because ultrasounds ensure the accuracy of viability determinations and bolster the ability of providers to obtain patients' informed consent. (*Id.*). Moreover, obtaining and reviewing an ultrasound in determining fetal viability substantially mitigates the legal and medical risks associated with a provider's potentially inaccurate gestational age determinations. (*Id.* at ¶ 17). Because ultrasounds are generally available via hospitals, including critical care access hospitals, throughout Montana, including Indian Health Service facilities and other clinics serving rural areas of the state, requiring a provider to review an ultrasound in determining fetal viability before performing an abortion does not impose any significant additional burdens on patients seeking pre-viability abortions in Montana. (*Id.* at ¶¶ 18-19).

III. HB 171 (2021) and the Thirteenth Judicial District Court's Preliminary Injunction.

Given Plaintiffs' characterization of HB 575 as a "virtually identical ban" as the currently enjoined House Bill 171 (2021) ("HB 171"), a more detailed review of HB 171 and the Thirteenth Judicial District Court's preliminary injunction of the same is warranted for the Court's edification. (*See* Doc. 24 at 1, and *generally*).

HB 171 created an entirely new section of Montana's statutory code entitled the "Montana Abortion-Inducing Drug Risk Protocol Act." (*See* HB 171 (2021), attached as **Exhibit B**, at 1). HB 171 contains a variety of detailed provisions including but not limited to: enumerated

[1] The Court's May 4, 2023 Temporary Restraining Order enjoined this provision as well.

definitions (Section 3); an explicit in-person examination requirement and ban on the mailing of abortion-inducing drugs (Section 4); requirements for the distribution of abortion-inducing drugs (Section 5); a prohibition on distributing the same at certain schools (Section 6); extensive informed consent requirements for abortion-inducing drugs (Section 7); compulsory provision of state-prepared informational materials (Section 8); and chemical abortion reporting requirements (Section 9). (*See Id.* at 3–12).

On October 7, 2021, the Thirteenth Judicial District Court issued its Order preliminarily enjoining the enforcement of HB 171 ("HB 171 PI Order"). (*See* the HB 171 PI Order, attached as **Exhibit C**, at 35). That court enjoined HB 171 based on its application of the prior preliminary injunction standard,[2] its review of HB 171's various provisions, its overall analysis of the parties' respective arguments and expert testimony, and its conclusions that the plaintiffs had established "a prima facie case that HB 171 is unconstitutional[]" and a likelihood of irreparable harm. (*Id.* at 14–16, 23–30, 32). The defendants subsequently appealed the HB 171 PI Order, and the Montana Supreme Court affirmed based on its analysis of the same under the prior preliminary injunction standard in *Planned Parenthood of Montana v. State*, 2022 MT 157, 409 Mont. 378, 515 P.3d 301 ("*Planned Parenthood I*"). The *Planned Parenthood I* Court did not reach the merits of the plaintiffs' challenge to HB 171. *Id.*

LEGAL STANDARDS

In 2023, the Montana State Legislature amended Section 27-19-201, MCA, the statute governing the circumstances in which courts may grant injunctive relief. *See* § 27-19-201, MCA (2023). This is an entirely new legal standard for issuing preliminary injunctions. *Id.* Under this new standard, a preliminary injunction may be granted only when the applicant establishes that:

[2] That preliminary injunction standard no longer applies as explained below.

a) the applicant is likely to succeed on the merits; b) the applicant is likely to suffer irreparable harm in the absence of preliminary relief; c) the balance of equities tips in the applicant's favor; ***and*** d) the order is in the public interest. *Id.* at § 1. The Legislature also expressly stated its intention that "the language in subsection (1) mirror the federal preliminary injunction standard, and that interpretation and application of subsection (1) closely follow United States supreme court case law." *Id.*; *see also Winter v. Natl. Res. Def. Council, Inc.*, 555 U.S. 7 (2008) (applying identical test contained in the current version of Section 27-19-201, MCA) (citing *Munaf v. Geren*, 553 U.S. 674, 689–690 (2008); *Amoco Production Co. v. Gambell*, 480 U.S. 531, 542 (1987); *Weinberger v. Romero-Barcelo*, 456 U.S. 305, 311–312 (1982)).

This new standard significantly alters an applicant's burden in seeking a preliminary injunction by replacing the former five-part *disjunctive* test with the current four-part *conjunctive* test. *Compare* § 27-19-201, MCA (2021) with § 27-19-201, MCA (2023). In other words, an applicant must now satisfy ***all*** elements set forth in Section 27-19-201(1) before a preliminary injunction may issue. *See Benisek v. Lamone*, 138 S. Ct. 1942, 1943–44 (it is not enough for a movant to show a likelihood of success on the merits; a movant must also establish the other three elements to obtain an injunction) (citing *Winter*, 555 U.S. at 20). Indeed, "a preliminary injunction is 'an extraordinary remedy never awarded as of right.'" *Id.* at 1943 (quoting *Winter*, 555 U. S. at 24).

Moreover, statutes passed by the Legislature are presumed to be constitutional under Montana law; to the extent Plaintiffs present a facial challenge, they must demonstrate unconstitutionality in all possible applications of the challenged statute beyond a reasonable doubt. *See Powder River Cnty. v. State*, 2002 MT 259, ¶ 73, 312 Mont. 198, 60 P.3d 357; *Satterlee v. Lumberman's Mut. Cas. Co.*, 2009 MT 368, ¶ 10, 353 Mont. 265, 222 P.3d 566; *Mont. Cannabis*

Indus. Ass'n., 2016 MT 44, ¶ 14, 382 Mont. 256, 368 P.3d 1131; *Advocates for Sch. Trust Lands v. State*, 2022 MT 46, ¶ 29, 408 Mont. 39, 505 P.3d 825.

ARGUMENT

Plaintiffs' current Motion should be denied because they cannot meet any, no less *all*, of the four elements necessary to obtain a preliminary injunction. Plaintiffs cannot show a likelihood of success on the merits, a likelihood of suffering irreparable harm, that the balance of the equities tips in their favor, or that a temporary restraining order is in the public interest. Because the test is conjunctive, any one of these deficiencies is sufficient to defeat Plaintiffs' Motion.

I. PLAINTIFFS ARE NOT LIKELY TO SUCCEED ON THE MERITS.

In their Brief, Plaintiffs only assert they are likely to succeed on the merits based on their claims that HB 575 is an unconstitutional ban on direct-to-patient MABs and that HB 575's purported "Physician or Physician Assistant" requirement is unconstitutional. (Doc. 24 at 6–9; Doc. 22 at ¶¶ 74–83.) Therefore, Plaintiffs must show a likelihood of success on the merits as to the alleged unconstitutionality of HB 575. Satisfaction of a likelihood of success on the merits is "the irreducible minimum requirement to granting any equitable and extraordinary relief." *City & Cnty. of San Francisco v. U.S.*, 944 F.3d 773, 789 (citing *Trump v. Hawaii*, 138 S. Ct. 2392, 2423 (2018)). The analysis ends if the moving party fails to show a likelihood of success on the merits of its claims. *Id.* at 790 (citing *Trump v. Hawaii*, 138 S. Ct. at 2423).

A. PLAINTIFFS LACK STANDING BECAUSE THEY HAVE NO FUNDAMENTAL OR CONSTITUTIONAL RIGHT TO PERFORM ABORTIONS FREE FROM SPECIFIC VIABILITY DETERMINATION REQUIREMENTS.

"Standing is one of several justiciability doctrines which limit Montana courts, like federal courts, to deciding only 'cases and controversies.'" *Heffernan v. Missoula City Council*, 2011 MT 91, ¶ 29, 360 Mont. 207, 255 P.3d 80 (citing *Plan Helena, Inc. v. Helena Reg'l. Airport Auth. Bd.*,

2010 MT 26, ¶¶ 6–8, 355 Mont. 142, 226 P.3d 567); *see also* U.S. Const. art. III, § 2; Mont. Const. art. VII, § 4. This language embodies the same limitations as are imposed on federal courts. *Plan Helena, Inc.*, ¶ 6 (citing *Olson v. Dept. of Revenue*, 223 Mont. 464, 469–70, 726 P.2d 1162, 1166 (1986); *Seubert v. Seubert*, 2000 MT 241, ¶ 17, 301 Mont. 382, 13 P.3d 265. Federal precedents are, therefore, persuasive authority for interpreting the justiciability requirements of Article VII, § 4(1) of the Montana Constitution. *Id.* (citing *Armstrong v. State*, 1999 MT 261, ¶¶ 6–13, 296 Mont. 361, 989 P.2d 364).

Standing is a threshold, jurisdictional requirement in every case. *Heffernan*, ¶ 29 (citing *Bryan v. Yellowstone Cnty. Elem. Sch. Dist. No. 2*, 2002 MT 264, ¶ 19, 312 Mont. 257, 60 P.3d 381). "The parties cannot waive objections to standing . . .[.]" *Id.* (citing J*ones v. Mont. Univ. Sys.,* 2007 MT 82, ¶ 48, 337 Mont. 1, 155 P.3d 1247). "The question of standing is whether the litigant is entitled to have the court decide the merits of the dispute." *Id.* at ¶ 30 (citing *Helena Parents Comm'n. v. Lewis and Clark Cnty. Comm'rs*, 277 Mont. 367, 371, 922 P.2d 1140, 1142 (1996)). Standing is determined as of the time the action is brought. *Id.* (citing *Becker v. Fed. Election Comm'n*, 230 F.3d 381, 386 n. 3 (1st Cir. 2000); *Nova Health Sys. v. Gandy*, 416 F.3d 1149, 1154–55 (10th Cir. 2005)).

There are two strands to standing: the case-or-controversy requirement imposed by the Constitution, and judicially self-imposed prudential limitations. *Id.* at ¶ 31 (citing *Olson*, 223 Mont. at 469–70, 726 P.2d at 1166 (1986); *Elk Grove Unified Sch. Dist. v. Newdow*, 542 U.S. 1, 11–12 (2004). For reasons explained below, it is important to distinguish between these two strands. "'The irreducible constitutional minimum of standing' has three elements: injury in fact (a concrete harm that is actual or imminent, not conjectural or hypothetical), causation (a fairly traceable connection between the injury and the conduct complained of), and redressability (a

likelihood that the requested relief will redress the alleged injury)". *Id.* at ¶ 32 (citing *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560–61 (1992); *Steel Co. v. Citizens for a Better Env.*, 523 U.S. 83, 103 (1998)). "Beyond these minimum constitutional requirements, the Supreme Court has adopted several prudential limits: the plaintiff generally must assert her own legal rights and interests; the courts will not adjudicate generalized grievances more appropriately addressed in the representative branches; and the plaintiff's complaint must fall within the zone of interests protected by the law invoked." *Id.* (citing *Elk Grove Unified Sch. Dist.*, 542 U.S. at 12). These rules are "closely related to Art. III concerns but essentially matters of judicial self-governance." *Id.* (citing *Warth v. Seldin*, 422 U.S. 490, 499–500 (1975)).

"Similarly, in Montana, to meet the constitutional case-or-controversy requirement, the plaintiff must clearly allege a past, present, or threatened injury to a property or civil right." *Id.* at ¶ 33 (citing *Olson*, 223 Mont. at 470, 726 P.2d at 1166; *Bd. of Trustees v. Cut Bank Pioneer Press*, 2007 MT 115, ¶ 15, 337 Mont. 229, 160 P.3d 482). Thus, standing often turns on the source of the plaintiff's claim, since the actual or threatened injury required by the Constitution might exist solely by virtue of statutes creating legal rights. *Id.* at ¶ 35 (citing *Warth*, 422 U.S. at 500). While discretionary limits on the exercise of judicial power "cannot be defined by hard and fast rules," a litigant may only assert his or her own constitutional rights or immunities. *Id.* at ¶ 33 (citing *Missoula City-County Air Pollution Control Bd. v. Bd. of Envtl. Rev.*, 282 Mont. 255, 260, 937 P.2d 463, 466 (1997); *Jones*, ¶ 48; *In re B.F.*, 2004 MT 61, ¶ 16, 320 Mont. 261, 87 P.3d 427). "But in all events, the standing requirements imposed by the Constitution must always be met." *Id.* at ¶ 34 (citing *In re Vainio*, 284 Mont. 229, 235, 943 P.2d 1282, 1286 (1997) ("The mere fact that a person is entitled to bring an action under a given statute is insufficient to establish standing; the party must allege some past, present or threatened injury which would be alleviated by

successfully maintaining the action."); *Gollust v. Mendell*, 501 U.S. 115, 126 (1991)). "The alleged injury must be 'concrete' rather than 'abstract.'" *Mitchell v. Glacier Cnty.*, 2017 MT 258, ¶ 10, 389 Mont. 122, 126, 406 P.3d 427, 431 (citation omitted). "Allegations of possible future injury are not sufficient." *Meland v. Weber*, 2 F.4th 838, 844 (9th Cir. 2021) (citation omitted); *see also Advs. for School Trust Lands v. State*, 2022 MT 46, ¶ 26, 408 Mont. 39, 505 P.3d 825.

The Montana Supreme Court has carved out a special exception to this well-settled standing jurisprudence. When the State directly interdicts the normal functioning of the physician-patient relationship by criminalizing certain procedures, abortion providers "have standing to assert on behalf of their women patients the individual privacy rights under Montana's Constitution of such women to obtain a pre-viability abortion from a health care provider of their choosing." *Armstrong*, ¶¶ 12–13; *see also Weems v. State*, 2019 MT 98, ¶ 12, 395 Mont. 250, 440 P.3d 4 ("when 'governmental regulation directed at health care providers impacts the constitutional rights of women patients,' the providers have standing to challenge the alleged infringement of such rights.") (quoting *Armstrong*, ¶¶ 8–13).

In reliance on *Armstrong* and *Weems*, Plaintiffs bring their claims on behalf of themselves, PPMT's "current and future physicians, physician assistants, advanced practice registered nurses, medical staff, servants, officers, and agents…[,] and on behalf of [their] patients seeking abortions." (Doc. 22 at ¶¶ 16–17.) But the U.S. Supreme Court has "disavowed the theories of third-party standing that previously allowed doctors to raise patients' claims in abortion cases." *Alliance for Hippocratic Med. v. FDA*, 2023 U.S. App. LEXIS 8898, n.4 (5th Cir. 2023) (citing *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228, 2275 and n.61 (2022) (comparing *Warth v. Seldin*, 422 U.S. 490, 499 (1975) and *Elk Grove Unified Sch. Dist. v. Newdow* 542 U.S. 1, 15 (2004) with *June Medical*, 140 S. Ct. 2103 (Alito, J. dissenting), *id.* at (Gorsuch, J. dissenting)

(collecting cases), and *Whole Woman's Health*, 579 U.S. at 632, n.1 (Thomas, J. dissenting)). In light of this shifting legal landscape, the Court should apply the federal test for third-party standing (also recognized by the Montana Supreme Court), which Plaintiffs cannot meet here.

As a general rule, a plaintiff "must assert his own legal rights and interests and cannot rest his claim to relief on the legal rights or interests of third parties." *Warth*, 422 U.S. at 499 (1975); *Baxter Homeowners Ass'n v. Angel*, 2013 MT 83, ¶ 15, 369 Mont. 398, 298 P.3d 1145. The U.S. Supreme Court has recognized a "limited" exception to this rule, but in order to qualify, a litigant must demonstrate (1) closeness to the third party and (2) a hindrance to the third party's ability to bring suit. *Kowalski v. Tesmer*, 543 U.S. 125, 129–30 (2004); *see also Powers v. Ohio*, 499 U.S. 400, 410–11 (1991); *Baxter*, ¶ 15 (citing *Powers*, 499 U.S. at 410–11). Third-party standing is not appropriate where there is a potential conflict of interest between the plaintiff and the third party. *Elk Grove Unified Sch. Dist.*, 542 U.S. at 9, 15, and n.7 (2004). Additionally, parties lack a sufficiently "close relationship" with as-yet unknown clients. *Kowalski*, 543 U.S. at 130–31 (attorneys did not have a close relationship with unknown clients); *see also Baxter*, ¶ 15. Even where enforcement of the challenged restriction *against the litigant* would indirectly violate third parties' rights, the plaintiffs must still establish "a close relationship" with the third party, which does not exist with hypothetical clients. *See id.* (emphasis in the original); *Baxter*, ¶ 15.

Plaintiffs have failed to demonstrate sufficient third-party standing in this case. They have neither pled nor argued that they have a "close relationship" to the women for whom they perform direct-to-patient MABs or advanced practice nurse practitioners ("APRNs"), or a hindrance to these individuals' ability to bring suit. (*See generally* Docs. 22 and 24.) "A woman who obtains an abortion typically does not develop a close relationship with the doctor who performs the procedure. On the contrary, their relationship is generally brief and very limited." *June Med. Servs.*

L.L.C. v. Russo, 140 S. Ct. 2103, 2168 (2020) (Alito, J., dissenting) *abrogated by Dobbs*, 142 S. Ct. at 2275 and n.61. Moreover, "abortionists have a 'financial interest in avoiding burdensome regulations,' while women seeking abortions 'have an interest in the preservation of regulations that protect their health.'" *Id.* Finally, Plaintiffs have no constitutional or fundamental rights to perform abortions or to do so in any manner they desire. They cannot establish a concrete injury in fact sufficient to confer standing. Because they cannot clear this threshold jurisdictional issue, they are not likely to succeed on the merits of their claims, and a preliminary injunction should not issue for this reason alone.

B. HB 575 IS CONSTITUTIONAL.

To obtain a preliminary injunction, Plaintiffs must also establish a likelihood of success on the merits of their claim that HB 575 is unconstitutional. Plaintiffs endeavor to do so by unilaterally declaring HB 575 to be an outright ban on direct-to-patient telehealth medication abortions ("MABs") and therefore invalid under *Armstrong*. Plaintiffs base their conclusion on their strained attempt to equate HB 575 with HB 171 and then bootstrap the HB 171 PI Order onto HB 575. However, a mere cursory review of HB 575's plain language, HB 171's various provisions, and the reasoning underlying the HB 171 PI Order exposes Plaintiffs' argument to be dubious at best.

To be sure, HB 575 is anything but 'virtually identical' to HB 171 as Plaintiffs argue. A side-by-side comparison of those bills demonstrates this obvious reality—HB 575 amends the definition of "viability" as described above, whereas HB 171 enacts an entirely new statutory scheme regulating chemical abortions in extensive detail.[3] HB 575's effect on direct-to-patient MABs is limited to requiring an ultrasound in determining fetal viability before the MABs can proceed. Nothing in HB 575 prevents patients who seek MABs from obtaining an ultrasound

[3] *See* Statement of Facts, above.

wherever available in Montana (or elsewhere), having the same emailed to an abortion provider, or receiving MABs through the mail. This stands in stark contrast to HB 171, which explicitly bans abortion providers from providing MABs to patients by mail. (*See* Ex. 2, at 5). Indeed, aside from HB 575's discrete ultrasound requirement, it bears absolutely no substantive resemblance to HB 171. This only scratches the surface of the respective bills' many differences, but it should be obvious that Plaintiffs' argument falls flat in this regard.

It further strains the bounds of credulity for Plaintiffs to claim that the HB 171 PI Order has any bearing on the Court's analysis in this case. That decision not only addresses a completely different statute, but it is also predicated on the application of a preliminary injunction standard that no longer exists in Montana law. (*See* Ex. C at 14) ("Under the Montana Code Annotated (MCA), a preliminary injunction may be granted on five enumerated grounds. § 27-19-201(1-5). Only two are relevant for the purposes of this matter."); *Contra* § 27-19-201(1) (2023)).[4] Plaintiffs also grossly overstate that court's focus on HB 171's ultrasound requirements in its analysis of that bill's provisions and its reasoning underlying its preliminary injunction. (*See* Ex. C at 23–30). The ultimate reality is that the preliminary injunction of HB 171 was predicated on numerous provisions and a legal standard that simply do not apply to HB 575. The HB 171 PI Order therefore provides no precedential value or meaningful guidance for the Court's consideration of the current Motion, and Plaintiffs fail to demonstrate otherwise.

HB 575 also comes nowhere near running afoul of the Montana Supreme Court's decision in *Armstrong*, which explicitly limits a woman's right to obtain an abortion to pre-viability abortions. *See id.* at ¶ 49 ("Implicit in this right of procreative autonomy is a woman's moral right and moral responsibility to decide, *up to the point of fetal viability*, what her pregnancy demands

[4] *See* Legal Standards, above.

of her in the context of her individual values, her beliefs as to the sanctity of life, and her personal situation.") (emphasis added). HB 575's requirements addressing the determination of viability not only comport with *Armstrong*, but they also ensure compliance with that precedent by establishing an effective mechanism to verify gestational age and viability.

Moreover, HB 575's ultrasound requirement falls well within the State of Montana's inherent power to regulate for the health and safety of its citizens. *Wiser v. Mont. Dep't. of Comm*., 2006 MT 20, ¶ 19, 331 Mont. 28, 129 P.3d 133. The Montana Supreme Court has made clear that the right to health care is limited to the right to obtain a "lawful medical procedure" from a "competent" and "licensed" provider. *Id.* at ¶ 15–16 (quoting *Armstrong*, ¶ 62). The notion that a procedure must be lawful necessarily implies some authority of the State to regulate procedures such as chemical abortions. Indeed, "an individual does not have a fundamental affirmative right of access to a particular drug[, and a] patient's 'selection of a particular treatment, or at least a medication, is within the area of governmental interest in protecting public health,' and regulation of that medication does not implicate a fundamental constitutional right." *Mont. Cannabis Indus. Assn.*, ¶ 24 (citation omitted). *See also Weems v. State*, ¶ 19 ("not every restriction on medical care impermissibly infringes [the right to privacy]"). Thus, HB 575's discrete ultrasound requirement neither implicates nor violates any fundamental right under Montana's constitution.

For all of the reasons set forth above, Plaintiffs fail to establish a likelihood of success on the merits of their claims, particularly considering the presumption as a matter of law that HB 575 is constitutional. The Court should deny the requested preliminary injunction accordingly.

II. PLAINTIFFS WILL NOT SUFFER IRREPARABLE HARM IN THE ABSENCE OF A PRELIMINARY INJUNCTION.

Plaintiffs likewise fail to satisfy the requisite showing that they are likely to suffer irreparable harm if HB 575 is in effect during the pendency of this litigation. Plaintiffs must show

more than a possibility of future harm; they are required "to demonstrate that irreparable injury is *likely* in the absence of an injunction." *Winter*, 555 U.S. at 22 (emphasis in the original) (citing *Los Angeles v. Lyons*, 461 U.S. 95, 103 (1983); *Granny Goose Foods, Inc. v. Teamsters*, 415 U.S. 423, 441 (1974); *O'Shea v. Littleton*, 414 U.S. 488, 502 (1974); 11A Charles Alan Wright, Arthur R. Miller, & Mary Kay Kane, *Federal Practice and Procedure* § 2948.1, 139 (2d ed. 1995) ("Wright & Miller") (applicant must demonstrate that in the absence of a preliminary injunction, "the applicant is likely to suffer irreparable harm before a decision on the merits can be rendered"); Wright & Miller at 154–155 ("A preliminary injunction will not be issued simply to prevent the possibility of some remote future injury"). Issuing a preliminary injunction based only on a possibility of irreparable harm is inconsistent with the U.S. Supreme Court's characterization of injunctive relief as an extraordinary remedy that may only be awarded upon a clear showing that the plaintiff is entitled to such relief. *Winter* 555 U.S. at 22 (citing *Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997) (per curiam). "Speculative injury does not constitute irreparable injury sufficient to warrant granting a preliminary injunction. A plaintiff must do more than merely allege imminent harm sufficient to establish standing; a plaintiff must demonstrate immediate threatened injury as a prerequisite to preliminary injunctive relief." *Boardman v. Pac. Seafood Grp.*, 822 F.3d 1011, 1022 (9th Cir. 2016) (citing *Caribbean Marine Servs. Co., Inc. v. Baldrige*, 844 F.2d 668, 674 (9th Cir. 1988).

Here, Plaintiffs neither plead nor present any convincing argument that HB 575's viability determination provisions will imminently result in such irreparable harm that would justify the drastic remedy of a preliminary injunction prior to full adjudication of Plaintiffs' claims on the merits. Plaintiffs argue direct-to-patient telehealth MABs are "a critical form of abortion care for Montanans[]" because they mitigate the burdens associated with travel to a PPMT center, but they

ignore the fact that HB 575 in no way requires patients seeking MABs to travel to a PPMT center or any other specific provider. They can simply obtain an ultrasound from the nearest available source and transmit the results to their chosen provider who can then have MABs mailed directly to the patient. This is similar to (and more flexible than) the available option of "site-to-site telehealth, in which a patient at a health center meets by video with a provider located at another health center." (Doc. 24 at 2–3.) Plaintiffs make no effort to explain how such options do not allow for a patient to obtain an ultrasound and subsequent MABs while simultaneously addressing their purported concerns about travel burdens.[5]

Further, Plaintiffs admit that, in the possible event of complications from MABs, patients "can speak to a PPMT provider…in person at a health center, regardless of the fact that their initial visit was conducted through telehealth." (Doc. 22 at ¶ 41.) In other words, Plaintiffs undercut their own argument regarding the burdens of travel in admitting that patients do in fact presently have access to in-person visits with providers, and therefore ultrasounds, if necessary. Plaintiffs also make no allegation or showing that any MABs will imminently occur but for HB 575 such that would justify a preliminary injunction.

Plaintiffs therefore fail to show immediate and irreparable harm resulting from the implementation of HB 575's viability determination requirements. The court should deny Plaintiffs' Motion for this reason as well.

III. THE BALANCE OF EQUITIES AND THE PUBLIC INTEREST FAVOR DEFENDANTS.

A preliminary injunction movant must show that "the balance of equities tips in his favor." *Shell Offshore, Inc. v. Greenpeace, Inc.*, 709 F.3d 1281, 1291 (9th Cir. 2013) (citing *Winter*, 555

[5] Plaintiffs also ignore the reality that Montanans regularly cope with and adapt to the various inherent challenges of rural life, including traveling long distances not just for medical care, but also for all manner of goods and services. This is hardly a new development.

U.S. at 20). In assessing whether plaintiffs have met this burden, courts have a "duty . . . to balance the interests of all parties and weigh the damage to each." *See Stormans, Inc. v. Selecky*, 586 F.3d 1109, 1139 (9th Cir. 2009). Courts should also consider whether a preliminary injunction would be in the public interest if "the impact of an injunction reaches beyond the parties, carrying with it a potential for public consequences." *Boardman*, 822 F.3d at 1023 (quoting *Stormans, Inc.*, 586 F.3d at 1138–39 (9th Cir. 2009)). "When the reach of an injunction is narrow, limited only to the parties, and has no impact on non-parties, the public interest will be 'at most a neutral factor in the analysis rather than one that favor[s] [granting or] denying the preliminary injunction.'" *Stormans, Inc. v. Selecky,* 586 F.3d 1109, 1139 (9th Cir. 2009) (quoting *Bernhardt v. L.A. County*, 339 F.3d 920, 931 (9th Cir. 2003)). "If, however, the impact of an injunction reaches beyond the parties, carrying with it a potential for public consequences, the public interest will be relevant to whether the district court grants the preliminary injunction." *Id.* (citation omitted). When an injunction is sought that will adversely affect a public interest, a court may in the public interest withhold relief until a final determination on the merits, even if the postponement is burdensome to the plaintiff. *Id.* (citing *Weinberger*, 456 U.S. at 312–13 (1982)). In fact, courts "should pay particular regard for the public consequences in employing the extraordinary remedy of injunction." *Id.* (quoting *Weinberger*, 456 U.S. at 312).

Here, the balance of the equities and the public interest strongly favor Defendants. Defendants have numerous interests that outweigh Plaintiffs' claimed interests with respect to HB 575's viability determination requirements. *See* Statement of Facts, above; § 50-20-102(1), MCA ("The legislature finds that a compelling state interest exists in the protection of viable life"). Defendants also have the constitutional duty to ensure that the laws passed by the Legislature are faithfully executed. Mont. Const. Art. VI, § 4. That interest with HB 575 in mind is to ensure that

abortions are generally limited to pre-viability abortions in accordance with the will of the people of Montana and in compliance with *Armstrong*. Defendants further have an interest in protecting the health, safety, and well-being of women and unborn children by imposing requirements surrounding viability determinations, thereby helping to ensure that the services are high quality and performed by the appropriate level of health care professional in accordance with the applicable standard of care and meaningful informed consent.

In contrast, Plaintiffs' claimed interests amount to ensuring a marginally increased level of convenience for unidentified future patients by preserving the ability to provide direct-to-patient MABs without an ultrasound. Plaintiffs make no sufficient showing of any real hardship imposed by HB 575 and only make speculative arguments as opposed to the State's compelling interest in protecting the heath and safety of women and the lives of unborn viable children. Plaintiffs have no legitimate interest in preventing adequate and reliable viability determinations, especially on the basis of avoiding minor inconvenience. Plaintiffs' Motion fails for these reasons as well.

IV. ANY PRELIMINARY INJUNCTION MUST BE APPROPRIATELY LIMITED.

Lastly, if the Court were to conclude that a preliminary injunction should issue, the injunctive relief "should be no more burdensome to the [Defendants] than necessary to provide complete relief to the [P]laintiffs." *Califano v. Yamasaki*, 442 U.S. 682, 702 (1979). This means, for example, that to the extent the Court may be inclined to preliminarily enjoin HB 575's purported limitation on the practice of abortion to the exclusion of APRNs in light of its issuance of a permanent injunction in *Weems v. State*, Cause No. ADV-2018-73 (Feb. 25, 2022), such injunction should be limited to that issue and should not bar the enforcement of HB 575's viability determination requirements or other provisions.

CONCLUSION

For all of the reasons explained herein, Plaintiffs fail to satisfy their heavy burden in seeking a preliminary injunction of HB 575. Plaintiffs are not likely to succeed on the merits, especially considering the presumed constitutionality of the challenged law, they are not likely to suffer irreparable harm in the absence of injunctive relief, and the balance of equities and the public interest weigh against the issuance of a preliminary injunction. Defendants therefore respectfully request that the Court enter an order denying Plaintiffs' Motion.

DATED this 12th day of May, 2023.

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EXHIBIT A

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MONTANA FIRST JUDICIAL DISTRICT COURT, LEWIS AND CLARK COUNTY

PLANNED PARENTHOOD OF MONTANA; et al., Plaintiffs, v. STATE OF MONTANA; et al., Defendants.	Cause No.: ADV 2023–231 Honorable Mike Menahan **AFFIDAVIT OF GEORGE MULCAIRE-JONES, M.D.**

STATE OF MONTANA)
:ss
County of Missoula)

George Mulcaire-Jones states under oath:

1. I am over the age of eighteen and competent to testify, and I make this affidavit based on my personal knowledge.

2. I am a board-certified family medicine physician who practiced obstetrics, pediatrics and primary care in Butte, Montana at St. James Hospital from October 1991 till July 20, 2021.

3. In addition to my family medicine residency, I completed an obstetrical fellowship, and my practice over the past 29 years has included management of both low and high-risk pregnancies.

4. In addition to my practice in Butte, I provided periodic weekend obstetrical and family medicine coverage for Barrett Hospital in Dillon, Montana.

5. On average, I have delivered between 60 and 100 babies a year. My practice includes Cesarean sections, care of miscarriages/fetal demise, external cephalic version, repair of 3rd and 4th degree lacerations and assisted vaginal deliveries with vacuum extraction.

6. I am skilled and experienced in the management of obstetrical emergencies including shoulder dystocia, obstructed labor, fetal distress, and postpartum hemorrhage.

7. I have considerable experience in developing safe birth training programs for midwives, nurses, and physicians in low resource settings in Africa.

8. I have been the physician lead in implementing a perinatal behavioral health and support program (A Healthy 1st Thousand Days of Life) for pregnant women with substance use and mental health conditions at SCL Health St. James. The 1000 Day model has also been adapted for use at other Montana hospital sites.

9. As a part of my practice, I worked with the Montana Chemical Dependency Center to provide obstetrical care for patients undergoing in-patient treatment at the center and also

admitted and cared for pregnant patients needing withdrawal. These patients were from various parts of Montana including rural communities and Native communities on or near Montana's Native reservations.

10. As part of my family medicine and obstetrical practice, I have provided holistic care for women and families. As part of that holistic care, I have a deep awareness of the social determinants of health and the impact of adverse childhood experiences, mental illness, unemployment, domestic violence, substance use, and dysfunctional intimate partner relationships have on the health and well-being of women.

11. Since July 2021, I have served as a clinical consultant for the Montana Perinatal Quality Care Collaborative ("MPQC") which is providing quality improvement bundles to Montana hospitals to improve obstetrical care and reduce maternal mortality and morbidity.

12. Since July 2021, I have served as a clinical consultant for Montana Obstetrical Maternal Support ("M.O.M.S.") which provides simulation training for obstetrical care primarily directed to rural health care facilities.

13. Since July 2021, I have been the project director for the Southwest Montana Community Substance Use/Opioid Use Coalition, a RCORP (Rural Community Opioid Response Program) grantee, focusing on improving treatment and care of pregnant and postpartum women and parents with substance use and/or mental illness.

14. Over the past two years, I have reviewed ultrasounds for the Options Clinic in Helena and the New Hope Pregnancy Support Center in Dillon. These ultrasounds are done at no cost to establish fetal viability and gestational age and to ensure there is no evidence of an ectopic pregnancy.

15. From my nearly 30 years' experience of practicing obstetrics in Montana and in my work in ongoing quality improvement that engages both urban and rural health facilities, I am well aware of the capacities and challenges that exist in order to provide skilled and evidence-based obstetrical and perinatal care. It is clear to me and should be clear to anyone practicing obstetrical and/or gynecological/reproductive health care in Montana that ultrasound is a critical modality and not to provide ultrasound for pregnancy dating and management (including pregnancy termination) is sub-standard and negligent care.

Importance of Ultrasounds and HB 575

16. I have read the provisions of House Bill ("HB") 575 requiring the review of an ultrasound by a provider making the requisite viability determination prior to performing an abortion, and it is my opinion that said requirement comports with the applicable standard of care, ensures the accuracy of viability determinations, and bolsters the ability of a provider to obtain a patient's informed consent.

17. It is also my opinion that HB 575's viability determination requirements help to mitigate providers' concerns about potential legal liability by significantly reducing the risks associated with inaccurate gestational age determinations. For example, without an ultrasound, a provider risks relying on a patient's potentially inaccurate subjective reports regarding the date of her last menstrual cycle or other relevant factors, which could result in a prohibited post-viability abortion and/or additional medical complications secondary to the abortion procedure. Reviewing an ultrasound in making viability determinations significantly reduces, if not eliminates, such risks.

18. In my experience, ultrasounds are generally available via hospitals, including critical care access hospitals, throughout Montana, including Indian Health Service facilities and

other clinics serving rural areas of the state. Ultrasounds are also provided by many Ob/Gyn practices and some primary care/family medicine practices.

19. Based on my review of HB 575 and my knowledge regarding the general availability of ultrasounds in Montana, it is my opinion that requiring providers to review ultrasounds in making viability determinations does not impose any significant additional burdens on patients seeking pre-viability abortions, particularly considering the general availability of ultrasounds in Montana and the benefits of ultrasounds as identified above.

DATED this 12th day of May, 2023.

George Mulcaire-Jones M.D.

GEORGE MULCAIRE-JONES, M.D.

Subscribed and sworn to before me, a Notary Public, this 12th day of May, 2023 by George Mulcaire-Jones, M.D.

(S E A L)

JOHN RIGDON
NOTARY PUBLIC for the
State of Montana
Residing at Missoula, Montana
My Commission Expires
November 12, 2025

Notary Public for the State of Montana

EXHIBIT B

AN ACT ADOPTING THE MONTANA ABORTION-INDUCING DRUG RISK PROTOCOL ACT; PROVIDING REQUIREMENTS FOR PROVIDING ABORTION-INDUCING DRUGS TO PREGNANT WOMEN; PROHIBITING PROVIDING ABORTION-INDUCING DRUGS IN SCHOOLS AND ON SCHOOL GROUNDS; REQUIRING INFORMED CONSENT; PROVIDING FOR THE REPORTING OF CHEMICAL ABORTIONS AND ADVERSE EVENTS AND COMPLICATIONS; PROVIDING DEFINITIONS; AND PROVIDING PENALTIES, CIVIL REMEDIES, AND PROFESSIONAL SANCTIONS.

WHEREAS, in September 2000, the U.S. Food and Drug Administration (FDA) approved the distribution and use of mifepristone (brand name Mifeprex), originally referred to as “RU-486”, an abortion-inducing drug, under the authority of 21 C.F.R. 314.520, also referred to as “Subpart H”, which is the only FDA approval process that allows for postmarketing restrictions. Specifically, the Code of Federal Regulations provides for accelerated approval of certain drugs that are shown to be effective but “can be safely used only if distribution or use is restricted”. The approved FDA protocol for Mifeprex/mifepristone was modified in March 2016; however, the FDA still requires that the distribution and use of Mifeprex/mifepristone be under the supervision of a qualified health care provider who has the ability to assess the duration of pregnancy, diagnose ectopic pregnancies, and provide surgical intervention or who has made plans to provide surgical intervention through another qualified physician; and

WHEREAS, court testimony by Planned Parenthood and other abortion providers has demonstrated that providers routinely and intentionally failed to follow the September 2000 FDA-approved protocol for Mifeprex/mifepristone. See, e.g., Planned Parenthood Cincinnati Region v. Taft, 459 F. Supp. 2d 626 (S.D. Oh. 2006); and

WHEREAS, the use of Mifeprex/mifepristone presents significant medical risks, including but not limited to uterine hemorrhage, viral infections, abdominal pain, cramping, vomiting, headache, fatigue, and pelvic inflammatory disease. Medical evidence demonstrates that women who use abortion-inducing drugs risk four

times more complications than those who undergo surgical abortions. At least 3% to 8% of medical abortions fail to evacuate the pregnancy tissue and require surgical completion. One percent will fail to kill the fetus. If surgical completion is required after a failed medical abortion, the risk of premature delivery in a subsequent pregnancy is more than three times higher. Failure rates increase as gestational age increases. The gestational age range of 63 to 70 days has been inadequately studied. The 2016 FDA gestational age extension was based on only one study worldwide of little more than 300 women; and

WHEREAS, a woman's ability to provide informed consent depends on the extent to which the woman receives information sufficient to make an informed choice. The decision to abort "is an important, and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences". Planned Parenthood v. Danforth, 428 U.S. 52, 67 (1976); and

WHEREAS, in recent years, physicians have developed a method to potentially reverse the effects of Mifeprex/mifepristone. This abortion pill reversal or "rescue" process has been discussed in a peer-reviewed study and is based on decades of the safe use of progesterone to stabilize and continue pregnancies. Progesterone has been used safely in pregnancies for decades and is used in in vitro fertilization, infertility treatments, and high-risk pregnancies, including those experiencing preterm labor. Using progesterone to reverse the effects of Mifeprex/mifepristone is a targeted response that is safe for the woman; and

WHEREAS, abortion "record keeping and reporting provisions that are reasonably directed to the preservation of maternal health and that properly respect a patient's confidentiality and privacy are permissible". Planned Parenthood v. Danforth, 428 U.S. 80 at 52, 79-81 (1976).

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Short title. [Sections 1 through 14] may be cited as the "Montana Abortion-Inducing Drug Risk Protocol Act".

Section 2. Legislative findings and purpose. The purpose of [sections 1 through 14] is to further the important and compelling state interests of:

(1) protecting the health and welfare of a woman considering a chemical abortion;

(2) ensuring that a medical practitioner examines a woman prior to dispensing an abortion-inducing drug in order to confirm the gestational age of the unborn child, the intrauterine location of the unborn child, and that the unborn child is alive because the routine administration of an abortion-inducing drug following spontaneous miscarriage is unnecessary and exposes the woman to unnecessary risks associated with the abortion-inducing drug;

(3) ensuring that a medical practitioner does not prescribe or dispense an abortion-inducing drug after 70 days have elapsed since the first day of a woman's last menstrual period;

(4) reducing the risk that a woman may elect an abortion only to discover later, with devastating psychological consequences, that the woman's decision was not fully informed;

(5) ensuring that a woman considering a chemical abortion receives comprehensive information on abortion-inducing drugs, including the potential to reverse the effects of the drugs if the woman changes the woman's mind, and that a woman submitting to an abortion does so only after giving voluntary and fully informed consent to the procedure; and

(6) promoting the health and safety of women by adding to the sum of medical and public health knowledge through the compilation of relevant data on chemical abortions performed in the state as well as data on all medical complications and maternal deaths resulting from these abortions.

Section 3. Definitions. As used in [sections 1 through 14], the following definitions apply:

(1) "Abortion" means the act of using or prescribing an 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 termination by those means will with reasonable likelihood cause the death of the unborn child. The term does not include an act to terminate a pregnancy with the intent to:

(a) save the life or preserve the health of the unborn child;

(b) remove a dead unborn child caused by spontaneous abortion;

(c) remove an ectopic pregnancy; or

(d) treat a maternal disease or illness for which the prescribed drug is indicated.

(2) "Abortion-inducing drug" or "chemical abortion" means 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. This 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. The term does not include drugs that may be known to cause an abortion that are prescribed for other medical indications.

(3) "Adverse event" means an untoward medical occurrence associated with the use of a drug in humans, whether or not considered drug related. The term does not include an adverse event or suspected adverse reaction that, had it occurred in a more severe form, might have caused death.

(4) "Associated medical practitioner" means a person authorized under 50-20-109 to perform an abortion who has entered into an associated medical practitioner agreement.

(5) "Complication" means an adverse physical or psychological condition arising from the performance of an abortion, including but not limited to uterine perforation, cervical perforation, infection, heavy or uncontrolled bleeding, hemorrhage, blood clots resulting in pulmonary embolism or deep vein thrombosis, failure to actually terminate the pregnancy, incomplete abortion, pelvic inflammatory disease, endometritis, missed ectopic pregnancy, cardiac arrest, respiratory arrest, renal failure, metabolic disorder, shock, embolism, coma, placenta previa in subsequent pregnancies, preterm delivery in subsequent pregnancies, free fluid in the abdomen, hemolytic reaction due to the administration of ABO-incompatible blood or blood products, adverse reactions to anesthesia and other drugs, subsequent development of breast cancer, death, psychological complications such as depression, suicidal ideation, anxiety, and sleeping disorders, and any other adverse event.

(6) "Last menstrual period" or "gestational age" means the time that has elapsed since the first day of the woman's last menstrual period.

(7) "Medical practitioner" means a person authorized under 50-20-109 to perform an abortion in this state.

(8) "Pregnant" or "pregnancy" means the female reproductive condition of having an unborn child in the uterus.

(9) "Provide" mean any act of giving, selling, dispensing, administering, transferring possession to, or otherwise providing or prescribing an abortion-inducing drug.

(10) "Qualified medical practitioner" means a medical practitioner who has the ability to:

(a) identify and document a viable intrauterine pregnancy;

(b) assess the gestational age of pregnancy and inform the woman of gestational age-specific risks;

(c) diagnose ectopic pregnancy;

(d) determine blood type and administer RhoGAM if a woman is Rh negative;

(e) assess for signs of domestic abuse, reproductive control, human trafficking, and other signals of coerced abortion;

(f) provide surgical intervention or who has entered into a contract with another qualified medical practitioner to provide surgical intervention; and

(g) supervise and bear legal responsibility for any agent, employee, or contractor who is participating in any part of a procedure, including but not limited to preprocedure evaluation and care.

(11) "Unborn child" means an individual organism of the species homo sapiens, beginning at fertilization, until the point of being born alive as defined in 1 U.S.C. 8(b).

Section 4. In-person requirement. An abortion-inducing drug may be provided only by a qualified medical practitioner following the procedures set forth in [sections 1 through 14]. A manufacturer, supplier, medical practitioner, qualified medical practitioner, or any other person may not provide an abortion-inducing drug via courier, delivery, or mail service.

Section 5. Distribution of abortion-inducing drugs. (1) Because the failure and complication rates from a chemical abortion increase with advancing gestational age and because the physical symptoms of chemical abortion can be identical to the symptoms of ectopic pregnancy and abortion-inducing drugs do not treat ectopic pregnancies and are contraindicated in ectopic pregnancies, the qualified medical practitioner providing an abortion-inducing drug shall examine the woman in person and, prior to providing an abortion-inducing drug, shall:

(a) independently verify that a pregnancy exists;

(b) determine the woman’s blood type, and if the woman is Rh negative, be able to and offer to administer RhoGAM at the time of the abortion;

(c) inform the woman that the woman may see the remains of the unborn child in the process of

completing the abortion; and

(d) document in the woman's medical chart the gestational age and intrauterine location of the pregnancy and whether the woman received treatment for Rh negativity, as diagnosed by the most accurate standard of medical care.

(2) A qualified medical practitioner providing an abortion-inducing drug must be credentialed and competent to handle complications management, including emergency transfer, or must have a signed contract with an associated medical practitioner who is credentialed to handle complications and must be able to produce the signed contract on demand by the woman or by the department. Each woman to whom a qualified medical practitioner provides an abortion-inducing drug must be given the name and phone number of the associated medical practitioner.

(3) The qualified medical practitioner providing an abortion-inducing drug, or an agent of the qualified medical practitioner, shall schedule a follow-up visit for the woman at approximately 7 to 14 days after administration of the abortion-inducing drug to confirm that the pregnancy is completely terminated and to assess the degree of bleeding. The qualified medical practitioner shall make all reasonable efforts to ensure that the woman returns for the scheduled appointment. A brief description of the efforts made to comply with this subsection, including the date, time, and identification by name of the person making the efforts, must be included in the woman's medical record.

Section 6. Prohibition on providing abortion-inducing drugs at elementary, secondary, and postsecondary schools. An abortion-inducing drug may not be provided in an elementary, secondary, or postsecondary school facility or on school grounds.

Section 7. Informed consent requirements for abortion-inducing drugs. (1) An abortion-inducing drug may not be provided without the informed consent of the pregnant woman to whom the abortion-inducing drug is being provided.

(2) Informed consent to a chemical abortion must be obtained at least 24 hours before the abortion-inducing drug is provided to the pregnant woman, except when, in reasonable medical judgment, compliance with this subsection would pose a greater risk of:

(a) the death of the pregnant woman; or

(b) the substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions, of the pregnant woman.

(3) A form created by the department must be used by a qualified medical practitioner to obtain the consent required prior to providing an abortion-inducing drug.

(4) A consent form is not valid and consent is not sufficient unless:

(a) the woman initials each entry, list, description, or declaration required to be included in the consent form as provided in subsection (5);

(b) the woman signs the consent statement described in subsection (5)(j); and

(c) the qualified medical practitioner signs the qualified medical practitioner declaration described in subsection (5)(k).

(5) The consent form must include, but is not limited to the following:

(a) the probable gestational age of the unborn child as determined by both patient history and ultrasound results used to confirm gestational age;

(b) a detailed description of the steps to complete the chemical abortion;

(c) a detailed list of the risks related to the specific abortion-inducing drug or drugs to be used, including but not limited to hemorrhage, failure to remove all tissue of the unborn child, which may require an additional procedure, sepsis, sterility, and possible continuation of pregnancy;

(d) information about Rh incompatibility, including that if the pregnant woman has an Rh negative blood type, the woman should receive an injection of Rh immunoglobulin at the time of the abortion to prevent Rh incompatibility in future pregnancies, which can lead to complications and miscarriage in future pregnancies;

(e) a description of the risks of complications from a chemical abortion, including incomplete abortion, which increase with advancing gestational age;

(f) information about the possibility of reversing the effects of the chemical abortion if the pregnant woman changes the woman's mind and that time is of the essence;

(g) information that the pregnant woman could see the remains of the unborn child in the process of completing the abortion;

(h) information that initial studies suggest that children born after reversing the effects of an abortion-

inducing drug have no greater risk of birth defects than the general population and that initial studies suggest that there is no increased risk of maternal mortality after reversing the effects of an abortion-inducing drug;

(i) notice that information on and assistance with reversing the effects of abortion-inducing drugs are available in the state-prepared materials; and

(j) an acknowledgment of risks and consent statement, which must be signed by the woman. The statement must include but is not limited to the following declarations, which must be individually initialed by the woman, that:

(i) the woman understands that the abortion-inducing drug regimen or procedure is intended to end the woman's pregnancy and will result in the death of the unborn child;

(ii) the woman is not being forced to have an abortion, the woman has the choice not to have the abortion, and the woman may withdraw the woman's consent to the abortion-inducing drug regimen even after beginning the abortion-inducing drug regimen;

(iii) the woman understands that the chemical abortion regimen or procedure to be used has specific risks and may result in specific complications;

(iv) the woman has been given the opportunity to ask questions about the woman's pregnancy, the development of the unborn child, alternatives to abortion, the abortion-inducing drug or drugs to be used, and the risks and complications inherent to the abortion-inducing drug or drugs to be used;

(v) the woman was specifically told that “information on the potential ability of qualified medical professionals to reverse the effects of an abortion obtained through the use of abortion-inducing drugs is available at www.abortionpillreversal.com, or you can contact (877) 558-0333 for assistance in locating a medical professional who can aid in the reversal of an abortion”;

(vi) the woman has been provided access to state-prepared, printed materials on informed consent for abortion;

(vii) if applicable, the woman has been given the name and phone number of the associated medical practitioner who has agreed to provide medical care and treatment in the event of complications associated with the abortion-inducing drug regimen or procedure;

(viii) the qualified medical practitioner will schedule an in-person follow-up visit for the woman approximately 7 to 14 days after providing the abortion-inducing drug or drugs to confirm that the pregnancy is

completely terminated and to assess the degree of bleeding and other complications;

(ix) the woman has received or been given sufficient information to give the woman's informed consent to the abortion-inducing drug regimen or procedure; and

(x) the woman has a private right of action to sue the qualified medical practitioner under the laws of the state if the woman feels coerced or misled prior to obtaining an abortion and how to access state resources regarding the woman's legal right to obtain relief; and

(k) a qualified medical practitioner declaration that must be signed by the qualified medical practitioner, stating that the qualified medical practitioner has explained the abortion-inducing drug or drugs to be used, has provided all of the information required in this subsection (5), and has answered all of the woman’s questions.

Section 8. Information required in state-prepared materials. (1) The department shall publish state-prepared, printed materials on informed consent for abortion and shall include the following statement:

“Information on the potential ability of qualified medical practitioners to reverse the effects of an abortion obtained through the use of abortion-inducing drugs is available at www.abortionpillreversal.com, or you can contact (877) 558-0333 for assistance in locating a medical professional who can aid in the reversal of an abortion.”

(2) The department shall annually review and update, if necessary, the statement requirement under subsection (1).

(3) As part of the informed consent counseling services required in [section 7], the qualified medical practitioner shall inform the pregnant woman about abortion pill reversal and provide the woman with the state-prepared materials described in subsection (1).

Section 9. Reporting on chemical abortions. (1) For the purpose of promoting maternal health and adding to the sum of medical and public health knowledge through the compilation of relevant data, a report of each chemical abortion performed must be made to the department on forms prescribed by the department. The reports must be completed by the facility in which the abortion-inducing drug was provided, signed by the qualified medical practitioner who provided the abortion-inducing drug, and transmitted to the department within

15 days after each reporting month.

(2) A report must include, at a minimum, the following information:

(a) identification of the qualified medical practitioner who provided the abortion-inducing drug;

(b) whether the chemical abortion was completed at the facility in which the abortion-inducing drug was provided or at an alternative location;

(c) the referring medical practitioner, agency, or service, if any;

(d) the pregnant woman's county, state, and country of residence;

(e) the pregnant woman's age and race;

(f) the number of previous pregnancies, number of live births, and number of previous abortions of the pregnant woman;

(g) the probable gestational age of the unborn child as determined by both patient history and ultrasound results used to confirm the gestational age. The report must include the date of the ultrasound and gestational age determined on that date.

(h) the abortion-inducing drug or drugs used, the date each was provided to the pregnant woman, and the reason for the abortion, if known;

(i) preexisting medical conditions of the pregnant woman that would complicate the pregnancy, if any;

(j) whether the woman returned for a follow-up examination to determine completion of the abortion procedure and to assess bleeding, the date and results of the follow-up examination, and what reasonable efforts were made by the qualified medical practitioner to encourage the woman to return for a follow-up examination if the woman did not;

(k) whether the woman suffered any complications and, if so, what specific complications arose and what follow-up treatment was needed; and

(l) the amount billed to cover the treatment for specific complications, including whether the treatment was billed to medicaid, private insurance, private pay, or another method, including charges for any physician, hospital, emergency room, prescription or other drugs, laboratory tests, and other costs for treatment rendered.

(3) Reports required under this section may not contain:

(a) the name of the pregnant woman;

(b) common identifiers, such as a social security number or driver's license number; or

(c) other information or identifiers that would make it possible to identify, in any manner or under any circumstances, a pregnant woman who has obtained or seeks to obtain a chemical abortion.

(4) A qualified medical practitioner who provides an abortion-inducing drug to a pregnant woman who knows that the woman experiences, during or after the use of the abortion-inducing drug, an adverse event shall provide a written report of the adverse event within 3 days of the event to the United States food and drug administration via the medwatch reporting system, to the department, and to the state board of medical examiners.

(5) (a) A medical practitioner, qualified medical practitioner, associated medical practitioner, or other health care provider who treats a woman, either contemporaneously to or at any time after a chemical abortion, for an adverse event or complication related to a chemical abortion shall make a report of the adverse event to the department on forms prescribed by the department. The reports must be completed by the facility in which the adverse event or complication treatment was provided, signed by the medical practitioner, qualified medical practitioner, associated medical practitioner, or other health care provider who treated the adverse event or complication, and transmitted to the department within 15 days after each reporting month.

(b) The report must include, at a minimum:

(i) the information required under subsections (2)(a) through (2)(j) and (2)(l); and

(ii) information about the specific complications that arose, whether an emergency transfer was required, and whether any follow-up treatment was needed, including whether additional drugs or medications were provided in order to complete the abortion.

(6) The department shall prepare a comprehensive annual statistical report for the legislature based on the data gathered from reports under this section. The aggregated data must also be made available to the public by the department in a downloadable format.

(7) The department shall summarize aggregate data from the reports required under [sections 1 through 14] and submit the data to the U.S. centers for disease control and prevention for the purpose of inclusion in the annual vital statistics report.

(8) Reports filed pursuant to this section must be deemed public records and must be available to the public in accordance with the confidentiality and public records reporting laws of this state. Original copies of all reports filed under this section must be available to the state board of medical examiners, state board of

pharmacy, state law enforcement officials, and child protective services for use in the performance of their official duties.

(9) Absent a valid court order or judicial subpoena, the department or any other state department, agency, office, or employee may not compare data concerning chemical abortions or abortion complications maintained in an electronic or other information system file with data in any other electronic or other information system, the comparison of which could result in identifying, in any manner or under any circumstances, a woman obtaining or seeking to obtain a chemical abortion.

(10) Statistical information that may reveal the identity of a woman obtaining or seeking to obtain a chemical abortion may not be maintained by the department or any other state department, agency, office, employee, or contractor.

(11) The department shall communicate the reporting requirements of this section to all medical professional organizations, medical practitioners, and facilities operating in the state.

Section 10. Production of reporting forms. The department shall create and distribute the forms required by [sections 1 through 14] within 60 days after [the effective date of this act].

Section 11. Criminal penalties. (1) A person who purposely or knowingly or negligently violates any provision of [sections 1 through 14] is guilty of a felony and upon conviction shall be fined an amount not to exceed $50,000, be imprisoned in a state prison for a term not to exceed 20 years, or both. As used in this section, “purposely", "knowingly", and "negligently" have the meanings provided in 45-2-101.

(2) A criminal penalty may not be assessed against the pregnant woman on whom the chemical abortion is attempted or performed.

Section 12. Civil remedies and professional sanctions. (1) In addition to all other remedies available under the laws of this state, failure to comply with the requirements of [sections 1 through 14]:

(a) provides a basis for a civil malpractice action for actual and punitive damages;

(b) provides a basis for professional disciplinary action under Title 37 for the suspension or revocation of the license of a health care provider; and

(c) provides a basis for recovery for the woman's survivors for the wrongful death of the woman under 27-1-513.

(2) Civil liability may not be imposed against the pregnant woman on whom the chemical abortion is attempted or performed.

(3) When requested, the court shall allow a woman to proceed using solely the woman's initials or a pseudonym and may close any proceedings in the case and enter other protective orders to preserve the privacy of the woman on whom the chemical abortion was attempted or performed.

(4) If judgment is rendered in favor of the plaintiff, the court shall also render judgment for reasonable attorney fees in favor of the plaintiff against the defendant.

(5) If judgment is rendered in favor of the defendant and the court finds that the plaintiff's suit was frivolous and brought in bad faith, the court may render judgment for reasonable attorney fees in favor of the defendant against the plaintiff.

Section 13. Construction. [Sections 1 through 14] may not be construed to:

(1) create or recognize a right to abortion;

(2) make lawful an abortion that is otherwise unlawful; or

(3) repeal, replace, or otherwise invalidate existing federal laws, regulations, or policies.

Section 14. Right of intervention. The legislature, by joint resolution, may appoint one or more of its members, who sponsored or cosponsored [sections 1 through 14] in the member's official capacity, to intervene as a matter of right in any case in which the constitutionality of [sections 1 through 14] is challenged.

Section 15. Codification instruction. [Sections 1 through 14] are intended to be codified as a new part in Title 50, chapter 20, and the provisions of Title 50, chapter 20, apply to [sections 1 through 14].

Section 16. Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

- END -

I hereby certify that the within bill,

HB 171, originated in the House.

_____

Chief Clerk of the House

_____

Speaker of the House

Signed this _____day

of_____, 2021.

_____

President of the Senate

Signed this _____day

of_____, 2021.

HOUSE BILL NO. 171

INTRODUCED BY S. GREEF, B. BROWN, C. FRIEDEL, S. HINEBAUCH, D. HOWARD, D. KARY, T. MANZELLA, K. REGIER, D. SALOMON, C. SMITH

AN ACT ADOPTING THE MONTANA ABORTION-INDUCING DRUG RISK PROTOCOL ACT; PROVIDING REQUIREMENTS FOR PROVIDING ABORTION-INDUCING DRUGS TO PREGNANT WOMEN; PROHIBITING PROVIDING ABORTION-INDUCING DRUGS IN SCHOOLS AND ON SCHOOL GROUNDS; REQUIRING INFORMED CONSENT; PROVIDING FOR THE REPORTING OF CHEMICAL ABORTIONS AND ADVERSE EVENTS AND COMPLICATIONS; PROVIDING DEFINITIONS; AND PROVIDING PENALTIES, CIVIL REMEDIES, AND PROFESSIONAL SANCTIONS.

EXHIBIT C

MONTANA THIRTEENTH JUDICIAL DISTRICT COURT,

YELLOWSTONE COUNTY

PLANNED PARENTHOOD OF MONTANA and JOEY BANKS, M.D., on behalf of themselves and their patients, Plaintiffs, vs. STATE OF MONTANA, by and through AUSTIN KNUDSEN, in his official capacity as Attorney General, Defendant.	Cause No.: DV 21-00999 Judge Michael G. Moses **ORDER GRANTING PRELIMINARY INJUNCTION**

Plaintiffs moved for a Preliminary Injunction on August 16, 2021. The State of Montana (the State) responded in opposition to the motion for a Preliminary Injunction on September 7, 2021. A Show Cause hearing regarding the Preliminary Injunction was held in front of Judge Todd on September 23, 2021. The issues

concerning the Preliminary Injunction were deemed fully briefed and submitted subject to the State's rights to file rebuttal affidavits. (*See* Show Cause Hr'g Tr. 76:11-82:23, Sept. 23, 2021). The rebuttal affidavits were timely filed. This matter was assigned to this Court, after Judge Todd recused himself, on September 30, 2021. This Court granted Plaintiffs' Temporary Restraining Order on September 30, 2021, temporarily enjoining House Bills 136 (HB 136), 171 (HB 171), and 140 (HB 140) from going into effect on October 1, 2021. The Court has reviewed the transcript from the Show Cause Hearing, the affidavit testimony submitted by the parties, the submitted motions, supporting briefs, and declarations.

The sole issue before the Court is whether to grant Plaintiff's Motion for a Preliminary Injunction prohibiting the State from enforcing HB 136, HB 171, and HB 140 during the pendency of this litigation.

Statement of Facts

On April 26, 2021, Governor Greg Gianforte signed HB 136, HB 171, and HB 140 into law. The effective date of these laws was to be October 1, 2021. The Temporary Restraining Order granted by this Court delayed these laws from becoming effectual for ten days or until this Court issued a decision on the Plaintiff's Motion for a Preliminary Injunction.

Plaintiff Planned Parenthood of Montana, Inc. (PPMT) is a non-profit Montana corporation that operates five health centers in the state of Montana. (Aff. Martha Stahl

¶ 4, Aug. 16, 2021). PPMT is the largest provider of reproductive health care in Montana. (Aff. Stahl ¶ 5). PPMT provides, in addition to other health services, abortions at each of its five facilities either through medication abortion (referred to in HB 171 as a 'chemical abortion') or procedural abortion. (Aff. Joey Banks ¶ 7, Aug. 16, 2021; Aff. Stahl ¶¶ 5-7). PPMT presently provides procedural abortions up to 21.6 weeks from the first day of the woman's last menstrual period (LMP). (Aff. Banks ¶ 8; Aff. Stahl ¶¶ 7-9). Medication (or 'chemical') abortions are provided at PPMT up to eleven weeks from the first day of the woman's last menstrual period. (Aff. Banks ¶ 8; Aff. Stahl ¶¶ 7-9).

PPMT provided 935 medical abortions and 255 procedural abortions between July 1, 2020 and June 30, 2021. (Aff. Stahl ¶ 10). Based on information provided by abortion providers (including All Families Healthcare, Billings Clinic, Blue Mountain Women's Clinic, PPMT, and others) pursuant to MCA § 50-20-110, between January 1, 2016 and August 18, 2021, "there were 8,402 induced abortions." (Decl. in Opp'n Todd Koch ¶ 4, Sept. 7, 2021). 5,754 of those abortions occurred when the gestational age of the fetus was 8 weeks or fewer.[1] (Decl. in Opp'n Koch ¶ 4). 1,966 abortions occurred when the gestational age of the fetus was between 9 to 13 weeks. (Decl. in Opp'n Koch ¶ 4). 276 abortions occurred when the gestational age was 14 to 15 weeks. (Decl. in

[1] The gestational age of the fetus was not reported for 13 of the abortions that occurred during this time. (Decl. in Opp'n Koch ¶ 4).

Opp'n Koch ¶ 4). 177 abortions occurred at 16 to 17 weeks. (Decl. in Opp'n Koch ¶ 4). 166 abortions occurred at 18 to 20 weeks. (Decl. in Opp'n Koch ¶ 4). 50 abortions occurred at 21 weeks or greater. (Decl. in Opp'n Koch ¶ 4).

Plaintiff Dr. Joey Banks is a contract physician and Laboratory Director at PPMT. (Aff. Banks ¶ 1). Dr. Banks currently performs procedural and medication abortions at PPMT. (Aff. Banks ¶ 6). Dr. Banks performs procedural abortions up to 21.6 weeks from the first day of the woman's last menstrual period (LMP). (Aff. Banks ¶ 8).

PPMT currently provides medication (or 'chemical') abortions "through in-person appointments and via telehealth visits." (Aff. Banks ¶ 9). Telehealth visits at PPMT are provided in two ways. (Aff. Banks ¶ 9). One way is direct-to-patient, in which a "patient in Montana consults with a PPMT provider via teleconference from wherever she is located and then receives abortion medication by mail from PPMT to a Montana address." (Aff. Banks ¶ 9). In fiscal year 2021, PPMT provided 140 direct-to-patient medical abortions. (Aff. Stahl ¶ 21). Of those, 56% "were provided to women who would have been forced to drive at least one to two hours each way to reach the nearest [medical abortion] provider." (Aff. Stahl ¶ 21). 18% would have had to drive at least two to five hours each way. (Aff. Stahl ¶ 21). The second way PPMT provides telehealth visits is site-to-site, "where a patient who is physically located at one PPMT

health center meets via teleconference with an abortion provider who is physically located at another PPMT health center." (Aff. Banks ¶ 9).

During these telehealth visits, PPMT providers review the patient's medical history, discuss the patient's available options, and if the patient is determined to be eligible for a medical abortion, the PPMT provider gives the patient directions to follow on how to take the abortion-inducing medication (which consists of mifepristone and misoprostol) and counsels the patient on potential side effects or complications. (Aff. Banks ¶ 9). The patient is then mailed the medication. (Aff. Banks ¶ 9). During this process, the patient electronically signs consent forms and is not required to have an ultrasound or blood work, unless it is determined to be medically necessary. (Aff. Banks ¶ 9).

A. HB 136

HB 136 provides that "[a] person may not perform an abortion of an unborn child capable of feeling pain unless it is necessary to prevent a serious health risk to the unborn child's mother." 2021 Mt. HB 136 § 3(1)(a). "Serious health risk to the unborn child's mother" is defined in the statute as "a condition that so complicates the mother's condition that it necessitates the abortion of the mother's pregnancy to avert the mother's death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions." § 2(9). This condition is to be determined by "reasonable medical

judgment" which is defined in the statute as "a medical judgment that would be made by a reasonably prudent medical practitioner who is knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved." § 2(8-9). Further, according to the statute, an "unborn child is capable of feeling pain when it has been determined by the medical practitioner performing or attempting the abortion or by another medical practitioner on whose determination the medical practitioner relies that the probable gestational age of the unborn child is 20 or more weeks." § 3(1)(b).

The only exception to the above gestational age of 20 or more weeks rule is when there is a "medical emergency." §3(2). The statute defines "medical emergency" as "a condition that...so complicates the medical condition of a pregnant woman that it necessitates the immediate abortion of the woman's pregnancy without first determining the gestational age in order to avert the woman's death or for which delay necessary to determine gestational age will create serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions." § 2(4)(a). This exception has a condition placed on it in the statute, specifically, "[w]hen an abortion of an unborn child capable of feeling pain is necessary to prevent a serious health risk to the ... mother, the medical practitioner shall terminate the pregnancy in the manner that... provides the best opportunity for the unborn child to survive unless... 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, not including psychological or emotional conditions, of the woman than would other available methods." § 3(3).

Additionally, HB 136 provides for criminal penalties when someone "purposely or knowingly performs or attempts to perform an abortion in violation of [section 3]." § 4. Civil remedies, providing for actual and punitive damages, are similarly provided. *See* § 5(1-5).

B. HB 171

HB 171 requires, inter alia, that an "abortion-inducing drug" be provided only by a "qualified medical practitioner." A "qualified medical practitioner" is defined in HB 171 as a:

> [M]edical practitioner who has the ability to:
> (a) identify and document a viable intrauterine pregnancy;
> (b) assess the gestational age of pregnancy and inform the woman of gestational age-specific risks;
> (c) diagnose ectopic pregnancy;
> (d) determine blood type and administer RhoGAM if a woman is Rh negative;
> (e) assess for signs of domestic abuse, reproductive control, human trafficking, and other signals of coerced abortion;
> (f) provide surgical intervention or who has entered into a contract with another qualified medical practitioner to provide surgical intervention; and
> (g) supervise and bear legal responsibility for any agent, employee, or contractor who is participating in any part of a procedure, including but not limited to preprocedure evaluation and care.

2021 Mt. Hb § 171(10)(a-g). Under this law, the qualified medical practitioner (or any other person) "may not provide an abortion-inducing drug via courier, delivery, or mail service." § (4).

Moreover, under HB 171, prior to providing an abortion-inducing drug, the qualified medical practitioner must verify the existence of a pregnancy, determine the woman's blood type for potential administration of RhoGAM during the abortion, "inform the woman that the woman may see the remains of the unborn child in the process of completing the abortion," and "document in the woman's medical chart the gestational age and intrauterine location of the pregnancy and whether the woman received treatment for Rh negativity, as diagnosed by the most accurate standard of medical care." § 5(1)(a-d).

An additional requirement imposed by HB 171 is the qualified medical practitioner (or their agent) must "schedule a follow-up visit for the woman at approximately 7 to 14 days after the administration of the abortion-inducing drug to confirm that the pregnancy is completely terminated and to assess the degree of bleeding." § 5(3). Also, "[t]he qualified medical practitioner shall make all reasonable efforts to ensure that the woman returns for the scheduled appointment." § 5(3). Further, "[a] brief description of the efforts made to comply with this subsection, including the date, time, and identification by name of the person making the efforts, must be included in the woman's medical record." *Id.*

Furthermore, HB 171 requires the qualified medical practitioner to be "credentialed and competent to handle complications management, including emergency transfer, or must have signed a contract with an associated medical practitioner who is credentialed to handle complications and must be able to produce the signed contract on demand by the woman or by the department." § 5(2).

HB 171 also has additions to informed consent. Specifically, it requires that informed consent be obtained "at least 24 hours before the abortion-inducing drug is provided to the pregnant woman." § 7(2). A qualified medical practitioner must use a form drafted by the State to obtain consent. § 7(3). The consent form is only valid if "the woman initials each entry, list, description, or declaration required to be included in the consent form," "the woman signs the consent statement," and "the qualified medical practitioner signs the qualified medical practitioner declaration." § 7(4)(a-c). The consent form must contain:

> (a) the probable gestational age of the unborn child as determined by both patient history and ultrasound results used to confirm gestational age;
> (b) a detailed description of the steps to complete the chemical abortion;
> (c) a detailed list of the risks related to the specific abortion-inducing drug or drugs to be used, including but not limited to hemorrhage, failure to remove all tissue of the unborn child, which may require an additional procedure, sepsis, sterility, and possible continuation of pregnancy;
> (d) information about Rh incompatibility, including that if the pregnant woman has an Rh negative blood type, the woman should receive an injection of Rh immunoglobulin at the time of the abortion to prevent Rh incompatibility in future pregnancies, which can lead to complications and miscarriage in future pregnancies;
> (e) a description of the risks of complications from a chemical abortion, including incomplete abortion, which increase with advancing gestational age;

(f) information about the possibility of reversing the effects of the chemical abortion if the pregnant woman changes the woman's mind and that time is of the essence;

(g) information that the pregnant woman could see the remains of the unborn child in the process of completing the abortion;

(h) information that initial studies suggest that children born after reversing the effects of an abortion-inducing drug have no greater risk of birth defects than the general population and that initial studies suggest that there is no increased risk of maternal mortality after reversing the effects of an abortion-inducing drug;

(i) notice that information on and assistance with reversing the effects of abortion-inducing drugs are available in the state-prepared materials; and

(j) an acknowledgment of risks and consent statement, which must be signed by the woman. The statement must include but is not limited to the following declarations, which must be individually initialed by the woman, that:

(i) the woman understands that the abortion-inducing drug regimen or procedure is intended to end the woman's pregnancy and will result in the death of the unborn child;

(ii) the woman is not being forced to have an abortion, the woman has the choice not to have the abortion, and the woman may withdraw the woman's consent to the abortion-inducing drug regimen even after beginning the abortion-inducing drug regimen;

(iii) the woman understands that the chemical abortion regimen or procedure to be used has specific risks and may result in specific complications;

(iv) the woman has been given the opportunity to ask questions about the woman's pregnancy, the development of the unborn child, alternatives to abortion, the abortion-inducing drug or drugs to be used, and the risks and complications inherent to the abortion-inducing drug or drugs to be used;

(v) the woman was specifically told that "information on the potential ability of qualified medical professionals to reverse the effects of an abortion obtained through the use of abortion-inducing drugs is available at www.abortionpillreversal.com, or you can contact (877) 558-0333 for assistance in locating a medical professional who can aid in the reversal of an abortion";

(vi) the woman has been provided access to state-prepared, printed materials on informed consent for abortion;

(vii) if applicable, the woman has been given the name and phone number of the associated medical practitioner who has agreed to provide

medical care and treatment in the event of complications associated with the abortion-inducing drug regimen or procedure;

(viii) the qualified medical practitioner will schedule an in-person follow-up visit for the woman approximately 7 to 14 days after providing the abortion-inducing drug or drugs to confirm that the pregnancy is completely terminated and to assess the degree of bleeding and other complications;

(ix) the woman has received or been given sufficient information to give the woman's informed consent to the abortion-inducing drug regimen or procedure; and

(x) the woman has a private right of action to sue the qualified medical practitioner under the laws of the state if the woman feels coerced or misled prior to obtaining an abortion and how to access state resources regarding the woman's legal right to obtain relief; and

(k) a qualified medical practitioner declaration that must be signed by the qualified medical practitioner, stating that the qualified medical practitioner has explained the abortion-inducing drug or drugs to be used, has provided all of the information required in this subsection (5), and has answered all of the woman's questions.

§ 7 (5)(a-k).

HB 171 also requires the department to publish "state-prepared, printed materials on informed consent for abortion" that include the statement that "[i]nformation on the potential ability of qualified medical practitioners to reverse the effects of an abortion obtained through the use of abortion-inducing drugs is available at www.abortionpillreversal.com, or you can contact (877) 558-0333 for assistance in locating a medical professional who can aid in the reversal of an abortion." § 8(1). The qualified medical practitioner must "inform the pregnant woman about abortion pill reversal and provide the woman with the state-prepared materials..." § 8(3).

Also under HB 171, significant reporting requirements "must be completed by the facility in which the abortion-inducing drug was provided, signed by the qualified medical practitioner who provided the abortion-inducing drug, and transmitted to the department within 15 days after each reporting month." § 9(1). The report must include a minimum of 12 items of information. § 9(2)(a-l). These 12 items are:

> (a) identification of the qualified medical practitioner who provided the abortion-inducing drug;
> (b) whether the chemical abortion was completed at the facility in which the abortion-inducing drug was provided or at an alternative location;
> (c) the referring medical practitioner, agency, or service, if any;
> (d) the pregnant woman's county, state, and country of residence;
> (e) the pregnant woman's age and race;
> (f) the number of previous pregnancies, number of live births, and number of previous abortions of the pregnant woman;
> (g) the probable gestational age of the unborn child as determined by both patient history and ultrasound results used to confirm the gestational age. The report must include the date of the ultrasound and gestational age determined on that date.
> (h) the abortion-inducing drug or drugs used, the date each was provided to the pregnant woman, and the reason for the abortion, if known;
> (i) preexisting medical conditions of the pregnant woman that would complicate the pregnancy, if any;
> (j) whether the woman returned for a follow-up examination to determine completion of the abortion procedure and to assess bleeding, the date and results of the follow-up examination, and what reasonable efforts were made by the qualified medical practitioner to encourage the woman to return for a follow-up examination if the woman did not;
> (k) whether the woman suffered any complications and, if so, what specific complications arose and what follow-up treatment was needed; and
> (l) the amount billed to cover the treatment for specific complications, including whether the treatment was billed to medicaid, private insurance, private pay, or another method, including charges for any physician, hospital, emergency room, prescription or other drugs, laboratory tests, and other costs for treatment rendered.

§ 9(2)(a-l).

Further, HB 171 adds criminal penalties for "[a] person who purposely or knowingly or negligently violates any provision of [HB 171] is guilty of a felony and upon conviction shall be fined an amount not to exceed $50,000, be imprisoned in a state prison for a term not to exceed 20 years, or both." § 11(1). HB 171 provides for civil remedies and professional sanctions as well. *See* § 12(1-5).

C. HB 140

HB 140 requires, among other things, abortion providers to inform a pregnant woman of the opportunity to "view an active ultrasound of the unborn child," "view an ultrasound image of the unborn child," and "listen to the fetal heart tone of the unborn child, if audible." 2021 Mt. HB 140 § 1(1)(a)(i-iii). This law additionally requires abortion providers to "obtain the woman's signature on a certification form developed by the department." § 1(3). The certification form must contain "an acknowledgement that the woman was informed of the opportunities" to view an ultrasound and listen to the fetal heart tone of the fetus. § 1(3)(a). The form must also "indicate whether the woman viewed the active ultrasound or ultrasound image or listened to the fetal heart tone." § 1(3)(b). The abortion provider must, prior to performing or attempting to perform an abortion, "receive a copy of the signed certification form." § 1(4)(a). Finally, "a copy of this form must be retained in the woman's medical record." § 1(4)(b). Exceptions to this requirement include if a

procedure is 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." § 1(2)(a-c).

Legal Standard

Under the Montana Code Annotated (MCA), a preliminary injunction may be granted on five enumerated grounds. § 27-19-201(1-5). Only two are relevant for the purposes of this matter. Specifically, an injunction may be granted:

> (1) when it appears that the applicant is entitled to the relief demanded and the relief or any part of the relief consists in restraining the commission or continuance of the act complained of, either for a limited period or perpetually; (2) when it appears that the commission or continuance of some act during the litigation would produce a great or irreparable injury to the applicant;

§ 27-19-201(1-2), MCA. Only one of the five enumerated grounds needs to be met for an injunction to issue because the subsections are disjunctive. *Four Rivers Seed Co. v. Circle K Farms*, 2000 MT 360, ¶ 13, 303 Mont. 342, ¶ 13, 16 P.3d 342, ¶ 13; *Weems v. State*, 2019 MT 98, ¶ 17, 395 Mont. 350, ¶ 17, 440 P.3d 4, ¶ 17. Importantly, "[t]he purpose of a preliminary injunction is to prevent 'further injury or irreparable harm by preserving the status quo of the subject in controversy pending an adjudication on the merits.'" *City of Billings v. Cty. Water Dist.* (1997), 281 Mont. 219, 226, 935 P.2d 246, 250 (quoting *Knudson v. McDunn* (1995), 271 Mont. 61, 894 P.2d 295, 298). The Supreme Court has defined the "status quo" as "'... the last actual, peaceable, noncontested condition which preceded the pending controversy...'" *Porter v. K & S P'ship* (1981),

192 Mont. 175, 181, 627 P.2d 836, 839 (quoting *State v. Sutton* (1946), 2 Wash.2d 523, 98 P.2d 680, 684); *see also Davis v. Westphal*, 2017 MT 276, ¶ 24, 389 Mont. 251, ¶ 24, 405 P.3d 73, ¶ 24 (quoting *Porter v. K & S P'ship* (1981), 192 Mont. 175, 181, 627 P.2d 836, 839).

To make a sufficient showing for a preliminary injunction to issue, applicants need "only establish a prima facie case, not entitlement to final judgment." *Weems*, ¶ 18. "'Prima facie' means literally 'at first sight' or 'on first appearance but subject to further evidence or information.'" *Id.* (quoting *Prima facie, Black's Law Dictionary* (10th ed. 2014)). Additionally, "all requests for preliminary injunctive relief require some demonstration of threatened harm or injury, whether under the 'great or irreparable injury' standard of subsection (2), or the lesser degree of harm implied within the other subsections of § 27-19-201, MCA."[2] *BAM Ventures, Ltd. Liab. Co. v. Schifferman*, 2019 MT 67, ¶ 16, 395 Mont. 160, ¶ 16, 437 P.3d 142, ¶ 16; *see also Weems* ¶ 17. The "loss of a constitutional right constitutes irreparable harm for the purpose of determining

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[2] The State argues that, under § 27-19-201(1), an applicant must show additional elements including a "'likelihood of success on the merits'" (Def's Br. in Opp'n at 3; quoting *M.H. v. Montana High Sch. Ass'n*, 280 Mont. 123, 135, 929 P.2d 239 (1997)). However, the Supreme Court only adopted the use of those elements in narrow circumstances, specifically, the Supreme Court adopted those elements as a test "to determine whether a preliminary injunction should issue **when a party's monetary judgment may be made ineffectual by the actions of the adverse party thereby irreparably injuring the applicant**." *Van Loan v. Van Loan* (1995), 271 Mont. 176, 895 P.2d 614, 617 (emphasis added). Thus, that four-part test as delineated in *Van Loan* (and the individual elements in it) is inapplicable to the case at hand, given monetary judgments are not at issue. *See Van Loan v. Van Loan* (1995), 271 Mont. 176, 895 P.2d 614, 619 ("Our holding, and the above four-part test, apply only in cases where a party seeking money damages alleges that the defendant is hiding or dissipating his/her assets in such a manner that a money judgment will be ineffectual and/or the plaintiff will be irreparably injured.").

whether a preliminary injunction should be issued." *Mont. Cannabis Indus. Ass'n v. State*, 2012 MT 201, ¶ 15, 366 Mont. 224, 229, 296 P.3d 1161, 1165.

Analysis

A. Standing

The State argues Plaintiffs lack standing because their claims are asserted, according to the State, "only on behalf of hypothetical, unidentified women." (Def's Br. in Opp'n at 5). The State seems to concede (at this stage) that "[b]ecause HBs 136 and 171 impose criminal penalties for noncompliance, *Armstrong* appears applicable to Plaintiffs' challenges to those laws." (Def's Br. in Opp'n at 5). However, the State preserved their arguments regarding standing as to HB 136 and HB 171 for appeal. (Def's Br. in Opp'n at 6). Plaintiffs similarly preserved their arguments as to standing for HB 136 and HB 171 for appeal. (Pls.' Reply Br. at 2).

The State did, however, raise the issue of standing as to HB 140. The State argues Plaintiffs "must establish normal third-party standing to sustain their challenge to HB 140." (Def's Br. in Opp'n at 6). The State further argues that noncompliance with HB 140 would result in no criminal penalties, and thus *Armstrong* is not applicable. (Def's Br. in Opp'n at 6). Plaintiffs argue the standing holding in *Armstrong* is not limited to criminal statutes. (Pls.' Reply Br. at 2).

In *Armstrong*, the Supreme Court held that "Plaintiff health care providers have standing to assert on behalf of their women patients the individual privacy rights

under Montana's Constitution of such women to obtain a pre-viability abortion from a health care provider of their choosing." *Armstrong v. State*, 1999 MT 261, ¶ 13, 296 Mont. 361, ¶ 13, 989 P.2d 364, ¶ 13. In *Weems*, the Supreme Court further described that when "'governmental regulation directed at health care providers impacts the constitutional rights of women patients,' the providers had standing to challenge the alleged infringement of such rights." *Weems*, ¶ 12 (quoting *Armstrong*, ¶¶ 8-13). Abortion providers in *Weems* were found to have standing when they were "plainly impacted by the statute." *Weems*, ¶ 14.

Here, HB 140 imposes new requirements on Plaintiffs in their providing of abortions. HB 140, as described above, would require abortion providers to inform a pregnant woman of the opportunity to view an active ultrasound and an ultrasound image of the fetus. 2021 Mt. HB 140 § 1 (a)(i-ii). Additionally, abortion providers would have to inform a pregnant woman of the opportunity to listen to the fetal heart tone of the fetus, if audible. § 1(a)(iii). Abortion providers would also have to "obtain the woman's signature on a certification form developed by the department" and abortion providers would have to retain that form "in the woman's medical record." § 3; § 4(b).

The failure by the abortion provider to comply with any of the requirements in HB 140 could result in "a civil penalty of $1,000." § 1(5). These potential new requirements to the providing of abortions would change Plaintiffs current practices when

providing abortion services. (Verified Compl. ¶ 28). Thus, Plaintiffs have standing to challenge HB 140 given they are plainly impacted by it.

To the extent this Court needs to address standing regarding HB 136 and HB 171, this Court finds that *Armstrong* is directly applicable. HB 136 and HB 171, as discussed above, both effect the right to obtain pre-viability abortions from health care providers. Abortion is legal in Montana until viability. § 50-20-109(1)(b), MCA. When *Armstrong* was decided, viability was determined to be reached at about 26 weeks gestation. *See Armstrong*, ¶ 44. According to Plaintiffs' expert, "it is commonly accepted in the field of OB/GYN that a normally developing fetus will not obtain viability—i.e., will not have a reasonable chance of survival outside the womb with or without artificial assistance—until approximately 24 weeks LMP." (Aff. Colleen McNicholas ¶ 34, September 7, 2021). Plaintiffs' and the State's experts disagree on when viability is reached (but they all agree that viability is not reached by 20 weeks LMP or at any earlier gestational age). HB 136 prohibits abortions after only 20 weeks gestation, which is pre-viability. *See* 2021 Mt. HB 136 § 3(1)(a-b). HB 171 adds voluminous restrictions and regulations to the providing of medication abortions, which, given that medication abortions are only provided up to eleven weeks from the first day of the woman's last menstrual period, are also pre-viability. *See* 2021 Mt. HB 171 §§ 1 *et seq.*; (*see also* Aff. Banks ¶ 8).

Thus, under *Armstrong*, health care providers, like Plaintiffs, "have standing to assert on behalf of their women patients the individual privacy rights under Montana's Constitution." *Armstrong*, ¶ 13. HB 171 and HB 136 both concern Plaintiffs patients' individual privacy rights, so Plaintiffs have established standing.

B. Have Plaintiffs established a prima facie case that they are entitled to the relief requested such that a preliminary injunction should be granted pursuant to § 27-19-201(1)?

Under the first statutory criteria in which a District Court may grant a preliminary injunction, which is "when it appears that the applicant is entitled to the relief demanded and the relief...consists in restraining the commission or continuance of the act complained of, either for a limited period or perpetually," this Court considers whether Plaintiffs have established a prima facie case that HB 136, HB 171, and HB 140 are unconstitutional. *See* § 27-19-201(1). This Court "should restrict itself to determining whether the applicant has made a sufficient case to warrant preserving a right in status quo until a trial on the merits can be had." *Weems*, ¶ 18 (quoting *Knudson v. McDunn*, 271 Mont. 61, 65, 894 P.2d 295, 298 (1995)).

This Court addresses each law separately as to whether Plaintiffs have made a prima facie case that the law is unconstitutional and whether that warrants preserving the status quo until a trial on the merits can be had.

1. <u>HB 136</u>

Plaintiffs contend the criminalization of pre-viability abortions in HB 136 is unconstitutional for four separate reasons. First, because it "infringes on the right to

privacy" and does not survive strict scrutiny. (Pls.' Br. at 5). Second, because it is unconstitutionally vague. (Pls.' Br. at 5). Third, it "violates Montanan's right to seek safety, health, and happiness by restricting access to a lawful medical procedure." (Pls.' Br. at 5). Fourth, it violates the equal protection clause of Montana's Constitution. (Pls.' Br. at 5).

As to the infringement of the right of privacy, Plaintiffs contend that HB 136 bans pre-viability abortions which was held to be unconstitutional in *Armstrong*. Plaintiffs and the State provided testimony in the form of affidavits and declarations from experts. As previously described above, Plaintiffs' expert testified the field of OB/GYB commonly accepts that viability is not reached until about 24 weeks LMP. (Aff. McNicholas ¶ 34). Dr. McNicholas also opines that "no fetus is viable at 20 weeks LMP or at any earlier gestational age" and "[e]ven under the best of circumstances, the likelihood of sustained survival outside the womb for a periviable birth before 23 weeks is very low (5-6%), which do not reflect a reasonable likelihood of sustained survival outside the womb." (Aff. McNicholas ¶ 35; Rebuttal Aff. Colleen McNicholas ¶ 35, September 17, 2021). The State's experts disagree as to the viability timeline arguing viability is reached at 21 weeks LMP (Decl. in Opp'n Ingrid Skop ¶ 35, September 7, 2021) and 22-23 weeks LMP (Decl. in Opp'n Robin Pierucci ¶¶ 9-17, September 7, 2021). Even so, HB 136 bans abortions beginning at 20 weeks LMP, and thus pre-viability.

The State argues HB 136 "is a law aimed at protecting women's health and fetal life, both of which the State may vigorously purs[u]e." (Def's Br. in Opp'n at 9). Further, the State argues this law should not be subject to strict scrutiny review because that is the wrong standard for health and safety regulations. (Def's Br. in Opp'n at 11). Thus, the State did not argue why this law would hold up under a strict scrutiny analysis.[3]

In *Armstrong*, the Supreme Court described that the right to privacy, which is "explicit in the Declaration of Rights of Montana's Constitution" is a "fundamental right" and "legislation infringing the exercise of the right of privacy must be reviewed under a strict scrutiny analysis." *Armstrong*, ¶ 34. The Court described the right of privacy's "separate textual protection in our Constitution reflects Montanans' historical abhorrence and distrust of excessive governmental interference in their personal lives." *Armstrong*, ¶ 34 (quoting *Gryczan v. State* (1997), 283 Mont. 433, 455,

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[3] At the Show Cause hearing, the State argued "*Armstrong* doesn't categorically hold that any regulation of abortion automatically triggers strict scrutiny for several reasons." (Show Cause Hr'g Tr. 32:3-7). The State described regulations affecting the fundamental right to keep and bear arms are not subject to strict scrutiny. (Show Cause Hr'g Tr. 32:8-17). No authority was cited. The State also argued that if *Armstrong* is read to require strict scrutiny review of regulations concerning the right of privacy than any regulation that protects the health and safety of women obtaining abortions would not survive. (Show Cause Hr'g Tr. 32:8-17). The State also argues that *Wiser* stands for the proposition that there "is presumptive legislative power to regulate for the health and safety of citizens without navigating strict scrutiny." (Show Cause Hr'g Tr. 33:5-11). Further the State argues "An analysis of these laws shows that they do not inhibit a woman's right to a previability abortion under *Armstrong* at all. They do add some steps to various processes to advance women's care and other important State interests. And they should be reviewed under rational basis." (Show Cause Hr'g Tr. 34:19-24). This Court disagrees with the State's interpretation of *Wiser*. The Court specifically describes strict scrutiny is not utilized when the right affected is not a **fundamental** right. *Wiser v. State*, 2006 MT 20, ¶ 19, 331 Mont. 28, ¶ 19, 129 P.3d 133, ¶ 19. At issue here is a fundamental right which is directly implicated by the laws at issue.

942 P.2d 112, 125). Under a strict scrutiny analysis, lawmaking infringing the exercise of the right of privacy "must be justified by a compelling state interest and must be narrowly tailored to effectuate only that compelling interest." *Armstrong*, ¶ 34.

This Court finds that Plaintiffs have established a prima facie case that HB 136 is unconstitutional. *Armstrong* specifically holds that "Article II, Section 10, protects a woman's right of procreative autonomy--here, the right to seek and to obtain a specific lawful medical procedure, a pre-viability abortion, from a health care provider of her choice." *Armstrong*, ¶ 75. While there is disagreement among the State's and Plaintiffs' experts as to when viability is, there was no disagreement that viability was reached by 20 weeks LMP and viability is generally accepted in the field of OB/GBYN to be reached at 24 weeks LMP. Thus, HB 136—which would ban abortions beginning at 20 weeks (and therefore, pre-viability)—is likely unconstitutional.

Plaintiffs also establish a prima facie case that HB 136 violates the Montana Constitution's guarantee of equal protection and the right of due process. The State does not appear to engage with Plaintiffs' equal protection argument. Plaintiffs assert that statutes that affect or draw distinctions based on the exercise of fundamental rights are subject to strict scrutiny. *See Snetsinger v. Mont. Univ. Sys.*, 2004 MT 390, ¶ 17, 325 Mont. 148, 154, 104 P.3d 445, 449–50. Because the right to obtain an abortion before viability (including beginning at 20 weeks LMP) is a fundamental right, strict scrutiny applies.

As to Plaintiffs' due process claims, the State cites inapposite federal law and fails to show that HB 136's exceptions provide the notice constitutionally required of a statute with such severe criminal penalties.

HB 171

Plaintiffs contend they have made a prima facie showing HB 171 is unconstitutional because it imposes significant barriers to medication abortion, which violates the right to privacy. (Pls.' Reply Br. at 11). Specifically, Plaintiffs argue HB 171 effectively bars experienced medication abortion providers, bans telehealth medication abortion, imposes a 24-hour mandatory delay on all medication abortions, compels provider speech, and imposes a reporting regime that makes public information that could be used to identify the women who seek abortions and that identifies the providers who offer (or even refer for) that care.

The State argues "Plaintiffs mischaracterize HB 171's requirements in an effort to make it seem more burdensome, claiming it requires an in-person examination and ultrasound 24 hours prior to the first abortion drug. But HB 171 does not clearly require either of those, and would be permissible even if it did." (Def's Br. in Opp'n at 7).

Plaintiffs argue strict scrutiny should be applied when analyzing this law, since the right of privacy is infringed, and therefore the telehealth abortion ban and other

restrictions in HB 171 must be justified by a compelling state interest. *See Weems*, ¶¶ 19, 23; *Armstrong*, ¶¶ 2, 62.

Here, HB 171 requires "the qualified medical practitioner providing an abortion-inducing drug shall examine the woman **in person**." 2021 Mt. HB 171 § 5 (1) (emphasis added). HB 171 further requires:

> [T]he qualified medical practitioner...prior to providing an abortion-inducing drug, shall:
>
> (a) independently verify that a pregnancy exists;
>
> (b) determine the woman's blood type, and if the woman is Rh negative, be able to and offer to administer RhoGAM at the time of the abortion;
>
> (c) inform the woman that the woman may see the remains of the unborn child in the process of completing the abortion; and
>
> (d) document in the woman's medical chart the gestational age and intrauterine location of the pregnancy and whether the woman received treatment for Rh negativity, as diagnosed by the most accurate standard of medical care

2021 Mt. HB 171 § 5 (1)(a-d).

Also, HB 171 imposes higher restrictions than § 50-20-109, MCA,[4] on who can perform a medication abortion. Specifically, under HB 171 only a "qualified medical practitioner" can provide abortion-inducing drugs, verify the existence of the pregnancy, and determine the woman's blood type. HB 171 defines a "qualified medical practitioner" as:

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[4] As to who can perform abortions in Montana, the MCA states "an abortion may not be performed within the state of Montana: (a) except by a licensed physician or physician assistant;". Mont. Code Ann. § 50-20-109(1)(a).

> "Qualified medical practitioner" means a medical practitioner [as defined in § 50-20-109, MCA] who has the ability to:
>
> (a) identify and document a viable intrauterine pregnancy;
>
> (b) assess the gestational age of pregnancy and inform the woman of gestational age-specific risks;
>
> (c) diagnose ectopic pregnancy;
>
> (d) determine blood type and administer RhoGAM if a woman is Rh negative;
>
> (e) assess for signs of domestic abuse, reproductive control, human trafficking, and other signals of coerced abortion;
>
> (f) provide surgical intervention or who has entered into a contract with another qualified medical practitioner to provide surgical intervention; and
>
> (g) supervise and bear legal responsibility for any agent, employee, or contractor who is participating in any part of a procedure, including but not limited to preprocedure evaluation and care

2021 Mt. HB 171 § 3 (10)(a-g). HB 171 further requires that a qualified medical practitioner providing an abortion-inducing drug to be "credentialed and competent to handle complications management, including emergency transfer, or must have a signed contract with an associated medical practitioner who is credentialed to handle complications and must be able to produce the signed contract on demand by the woman or by the department." 2021 Mt. HB 171 § 5 (2).

The State's argument for implementing more stringent requirements for medical practitioners providing medication abortions than § 50-20-109, MCA is that these additional qualifications "reasonably require[] chemical abortion providers to 'be credentialed and competent to handle complications management, including emergency transfer, or must have a signed contract with an associated medical practitioner who is.'" (Def's Br. in Opp'n at 18).

Plaintiffs contend that while PPMT providers are trained in the risks associated with medication abortions and can recognize symptoms (in person or via telehealth) that no PPMT provider (and likely no provider anywhere) has the capability to handle all the listed complications in HB 171. Thus, HB 171 "effectively bars providers who are experienced and well-equipped to provide MAB from providing any abortions at all, without any medical justification." (Pls.' Br. at 12). Dr. McNicholas opines that "[t]here is no single person who could be 'credentialed' in handling all of the 'complications' HB 171 identifies" and even if there were the requirement is "medically unnecessary" because "the very rare complications from medication abortion occur long after the patient has left the health center and "if the patient required care that the provider could not provide, the patient would be advised to go to a health care provider near them..." (Aff. McNicholas ¶¶ 68-69.)

As to the telehealth ban in HB 171, a medication abortion is a pre-viability abortion. (Aff. Banks ¶ 8). The State's experts do not dispute that medication abortions are pre-viability. Thus, the ban on using telehealth for medication abortion plainly infringes the right to privacy and must be justified by a compelling state interest. *See Weems*, ¶¶ 19, 23; *Armstrong*, ¶¶ 2, 62.

The State's arguments as to why the in-person requirement is important include that "it allows providers to verify that there is...a pregnancy. It allows providers to

determine a woman's blood type for possible RhoGam treatment." (Show Cause Hr'g Tr. 41:13-23). Additionally, the State argues, the in-person requirement aids in the gestational age determination which is "important because, the later a pregnancy goes, the higher risk that abortion drugs either don't work or they cause more or severe complications." (Show Cause Hr'g Tr. 41:24-42:13).

Plaintiff's expert testified "'the risks of medication abortion are similar in magnitude to the risks of taking commonly prescribed and over-the-counter medications such as antibiotics and NSAIDs' such as ibuprofen." (Rebuttal Aff. McNicholas at ¶ 6). Dr. McNicholas also testified that "multiple studies have demonstrated that medication abortion by...telehealth is just as safe and effective as in person." (Rebuttal Aff. McNicholas ¶ 27). Dr. McNicholas further rebuts the State's reasons for HB 171's requirements, describing ultrasounds are not necessary to screen for ectopic pregnancies and that providers can look to risk factors like symptoms and patient history to detect an ectopic pregnancy. (Rebuttal Aff. McNicholas ¶ 27). Additionally, she opines the "Rh requirement is also medically unnecessary. Research has shown that the risk of Rh sensitization after an early abortion is negligible." (Rebuttal Aff. McNicholas ¶ 27).

Further Plaintiffs described how telehealth enables their providers to provide healthcare for Montanans in remote areas without causing them to have to drive significant distances. Plaintiffs also argue that telemedicine provides patients with the

opportunity to receive care earlier in their pregnancy, which is when the medications are most likely to be effective and least likely to cause complications. (Rebuttal Aff. McNicholas ¶ 30).

As to the mandatory 24-hour delay required by HB 171 ("Informed consent to a chemical abortion must be obtained at least 24 hours before the abortion-inducing drug is provided to the pregnant woman"), Plaintiffs point out that a Montana district court has already held that imposing a 24-hour mandatory delay violates the right to privacy. *See Planned Parenthood of Missoula v. State*, No. BDV 95-722, 1999 Mont. Dist. LEXIS 1117, at *22 (Mont. Dist. Ct. Mar. 12, 1999) (striking down a 24-hour mandatory delay where the initial consultation could be performed by phone). That court reasoned that, "the State, through its 24-hour waiting period, is telling a woman that she cannot exercise a fundamental constitutional right for a 24-hour period." *Id.* at *9.

The State is correct in its argument that another district court's decision is not binding on this Court, however this Court disagrees with the State's argument that this regulation would not be subject to strict scrutiny. (*See* Show Cause Hr'g Tr. 48:8-19). The State argues the above cited district court case is not persuasive because "it applies strict scrutiny" which "after *Wiser*, the Montana Supreme Court made clear that the State may use its police powers to regulate the doctor-patient relationship without triggering strict scrutiny." (Show Cause Hr'g Tr. 48:8-19) This Court, as previously described, disagrees with the State's use of *Wiser*. In *Wiser*, the Supreme

Court describes, "this Court has recognized that the State's exercise of its police powers often implicates individual rights... when the rights affected are not fundamental, we do not utilize strict scrutiny review..." *Wiser v. State*, 2006 MT 20, ¶ 19, 331 Mont. 28, ¶ 19, 129 P.3d 133, ¶ 19. At issue here is a fundamental right, therefore, strict scrutiny would apply.

HB 171 also requires that providers inform patients about "...information on the potential ability of qualified medical professionals to reverse the effects of an abortion obtained through the use of abortion-inducing drugs is available at www.abortionpillreversal.com ..." HB 171 § 7(j)(v).

Plaintiffs' expert describes "medication abortion 'reversal' is an experimental treatment, the safety and efficacy of which has never been demonstrated." (Rebuttal Aff. McNicholas ¶ 38). The State's own expert describes the experimental nature of this "abortion reversal treatment." (Decl. in Opp'n Skop ¶ 63 ("animal studies show that natural progesterone can reverse the effects of mifepristone by outcompeting for the progesterone receptors"); ¶ 68 ("A retrospective study of over 750 women who sought Abortion Pill Reversal has been performed.").

Plaintiffs argue the mandate in HB 171 that providers discuss the above-mentioned abortion-pill reversal, the possible need for Rh immunoglobulin, and breast cancer risk violate their right to free speech. In defending the speech required of health care providers, the State does not engage with the Montana Constitution's

prohibition on compelled speech and content-based regulations. *See Denke v. Shoemaker*, 2008 MT 418, ¶ 47, 347 Mont. 322, 337–38, 198 P.3d 284, 296 ("It is axiomatic that the government may not regulate speech based on its substantive content or the message it conveys." (quoting *Rosenberger v. Rector and Visitors of the Univ. of Va.*, 515 U.S. 819, 828 (1995))). The State further concedes that HB 171 imposes new, public reporting requirements on Plaintiffs, but does not adequately rebut Plaintiffs showing that this data indicates that certain demographic categories of women obtaining abortions contain very few members, which makes obvious the risk of identification through the additional data the law requires. And the State does not contend with Plaintiffs' argument that HB 171 is unconstitutionally vague. The fact that the State's interpretation of what is required of providers under the law differs so significantly from Plaintiffs' understanding itself bolsters Plaintiffs' prima facie case that HB 171 fails the requirement that "ordinary people can understand what conduct is prohibited," *State v. Samples*, 2008 MT 416, ¶ 16, 347 Mont. 292, 295, 198 P.3d 803, 806.

This Court finds that Plaintiffs have established a prima facie case that HB 171 is unconstitutional.

HB 140

Plaintiffs contend that HB 140 violates providers' free speech rights, their patient's right to privacy, the right to equal protection and individual dignity. The State argues HB 140 does not violate a constitutional abortion right. (Def's Br. in Opp'n

at 13). The State argues "the ultrasound offer empowers woman to more fully understand the nature of the procedure, which will terminate the life of a human person: her own child." (Def's Br. in Opp'n at 13). Plaintiffs argue HB 140 "mandate[s] that providers offer images and sounds to patients that have no medical purpose and would only serve to convey the State's disapproval of abortion." (Pls.' Reply Br. at 17). Further, Plaintiffs contend the right to privacy is specifically violated due to the "stigmatizing effect on patients that results from the combination of receiving the State's set of 'offers,' along with being required to sign a State-created form indicating whether they chose to view or listen to fetal activity." (Pls.' Reply Br. at 17).

In *Armstrong*, the Supreme Court states:

> while it may not be absolute, no final boundaries can be drawn around the personal autonomy component of the right of individual privacy. It is, at one and the same time, as narrow as is necessary to protect against a specific unlawful infringement of individual dignity and personal autonomy by the government--as in *Gryczan*--and as broad as are the State's ever innovative attempts to dictate in matters of conscience, to define individual values, and to condemn those found to be socially repugnant or politically unpopular.
>
> *Armstrong*, ¶ 38.

Plaintiffs have made out a prima facie case that HB 140 violates the right to privacy, insofar as HB 140 serves to stigmatize or discourage women from obtaining an abortion in Montana—a constitutionally protected right. Plaintiffs also make out a prima facie case that HB 140 violates the right to equal protection and individual dignity. The State's response to these constitutional arguments was that HB 140

provides "truthful, non-misleading information relevant to a patient's decision to have an abortion. No free speech rights are implicated." (Show Cause Hr'g Tr. 54:20-25). The state argues that same reason is why the right of privacy the other individual rights are not violated. (Show Cause Hr'g Tr. 55:4-6)

In sum, this Court finds that Plaintiffs have established a prima facie case that HB 136, HB 171, and HB 140 are unconstitutional. Based on the prima facie showing of the unconstitutionality of these laws, the Court further finds that Plaintiffs have also established harm to Plaintiffs and their patients is likely to occur, given that the "loss of a constitutional right constitutes irreparable harm..." *Mont. Cannabis Indus. Ass'n*, ¶ 15, 366 Mont. at 229, 296 P.3d at 1165. Thus, pursuant to § 27-19-201(1) Plaintiffs are entitled to the granting of their Motion for a Preliminary Injunction which would enjoin the implementation and enforcement of HB 136, HB 171, and HB 140 during the pendency of this litigation.

C. *Have plaintiff's shown, pursuant to § 27-19-201(2), MCA, that the commission or continuance of these laws during the litigation would produce a great or irreparable harm to plaintiffs and their patients?*

Montana law is clear that the loss of a constitutional right "constitutes irreparable harm for the purpose of determining whether a preliminary injunction should be issued." *Id.*

Plaintiffs have established that they and their patients will suffer concrete and irreparable harm absent preliminary relief. Specifically, if the challenged laws take

effect, women in Montana will not be able to obtain surgical abortions between 20 weeks LMP and viability; they will not be able to obtain medication abortions via telehealth or without a 24-hour mandatory delay; and they will not be able to obtain either surgical or medication abortions without being subjected to severe restrictions.

Additionally, the challenged laws criminalize—or, in the case of HB 140 penalize—activities that are currently lawful in Montana. There is no dispute that Plaintiffs engage in these activities while caring for their patients. It is plain from the record and the pleadings that if the challenged laws take effect, Plaintiffs must substantially alter their practice (and encounter the attendant medical, emotional, and social harm to themselves and their patients) or be subjected to serious legal repercussions. In other words, "it appears that the commission or continuance of some act during the litigation would produce a great or irreparable injury to the applicant." § 27-19-201(2), MCA.

Plaintiffs have also established that the restrictions and regulations of the challenged laws inflict constitutional injuries on Plaintiffs and their patients. HB 136 bans pre-viability abortions at 20 weeks, in direct contravention of *Armstrong*. HB 171 bans medication abortions provided via telehealth and imposes mandatory delays on women seeking an abortion, significantly reducing their access to that care. HB 140 compels government-approved speech that interferes with the doctor-patient relationship. Plaintiffs have established a prima facie case that each of the challenged

laws are incompatible with the Montana Constitution and give rise to constitutional injuries. These injuries support the issuance of a preliminary injunction to preserve the status quo during the litigation. Notwithstanding the State's arguments to the contrary, such injuries are sufficient without any additional showing of likely success on the merits. *Driscoll*, ¶¶ 13, 17; *Weems*, ¶ 26.[5]

Plaintiffs have established that they and their patients will face "great or irreparable harm" absent a preliminary injunction.

Conclusion

Plaintiffs have established that they meet at least two of the five statutory criteria in which a preliminary injunction may be granted under § 27-19-201(1-5), MCA. The purpose of a preliminary injunction is to prevent "'further injury or irreparable harm by preserving the status quo of the subject in controversy pending an adjudication on the merits.'" *City of Billings v. Cty. Water Dist.* (1997), 281 Mont. 219, 226, 935 P.2d 246, 250 (quoting *Knudson v. McDunn* (1995), 271 Mont. 61, 894 P.2d 295, 298). If HB 136, 171, and 140 become effective during the pendency of this litigation, Plaintiffs and their patients will be irreparably harmed through the loss of their constitutional rights, thus the preservation of the status quo is necessary to prevent that harm.

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[5] The State also argues that a preliminary injunction will not preserve the status quo. Its logic is difficult to follow. A preliminary injunction that prevents these laws from significantly altering Montana's regulation of abortion will preserve the status quo, not disturb it.

The Court has considered all the papers and briefs on file. Being fully informed, the Court orders the following:

IT IS HEREBY ORDERED that Plaintiffs' Motion for Preliminary Injunction is **GRANTED** and Defendant is enjoined from enforcing any aspect of HB 136, HB 171, and HB 140 during the pendency of this action according to the prayer of the Plaintiffs' Motion and Complaint.

DATED this 7th day of October, 2021.

Michael G. Moses
DISTRICT JUDGE

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CERTIFICATE OF SERVICE
This is to certify that the foregoing was duly served by email upon the parties or their attorneys of record at their last known email addresses this 7 day of October, 2021.
BY Jane Bushman
Judicial Assistant to Hon. Michael G. Moses

CERTIFICATE OF SERVICE

I, Michael D. Russell, hereby certify that I have served true and accurate copies of the foregoing Answer/Brief - Brief in Opposition to the following on 05-12-2023:

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