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IN THE SUPREME COURT OF THE STATE OF MONTANA

PLANNED PARENTHOOD OF MONTANA, et al.,
Plaintiffs-Appellees,

v.

STATE OF MONTANA, et al.,
Defendants-Appellants.

On Appeal from the Montana First Judicial District Court, Lewis & Clark County, No. ADV-23-299, Honorable Judge Mike Menahan

BRIEF OF *AMICI CURIAE* AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, SOCIETY FOR MATERNAL-FETAL MEDICINE, AND SOCIETY OF FAMILY PLANNING IN SUPPORT OF PLAINTIFFS

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TABLE OF CONTENTS

Page

INTERESTS OF *AMICI CURIAE* 1

INTRODUCTION 3

ARGUMENT 4

I. Medicaid Is Integral To Providing Health Care In Montana, Including Abortion Care 4

II. There Is No Medical Justification For H.B. 544, H.B. 862, Or The DPH Rule 10

- A. The Statutes' And The DPH Rule's Restrictions On Abortion Endanger Patients' Health 11
- B. The Prior Authorization Requirement Serves No Medical Purpose And Will Delay Access To Care 14
- C. There Is No Medical Justification For Preventing Non-Physicians From Providing Abortion Services 17

III. H.B. 544, H.B. 862, And The DPH Rule Will Disproportionately Impact Rural And Low-Income Patients 19

IV. H.B. 544, H.B. 862, And The DPH Rule Will Undermine Physicians' Ability to Perform Their Jobs 20

- A. Statutes That Restrict Access To Abortion Undermine The Patient-Physician Relationship 21
- B. Statutes That Restrict Access To Abortion Violate The Principles Of Beneficence And Non-Maleficence 23
- C. Statutes That Restrict Access To Abortion Violate The Ethical Principle Of Respect For Patient Autonomy 24

CONCLUSION 25

TABLE OF AUTHORITIES

Page(s)

Cases

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INTERESTS OF *AMICI CURIAE*

The American College of Obstetricians and Gynecologists (ACOG) is the nation's leading group of physicians providing evidence-based obstetric and gynecologic care. As a private, voluntary nonprofit organization of more than 60,000 members, ACOG advocates for equitable, exceptional, and respectful care for all people in need of obstetric and gynecologic care; maintains the highest standards of clinical practice and continuing education of its members; promotes patient education; and increases awareness among its members and the public of the changing issues facing patients and their families and communities. ACOG's Montana Section has over 130 members who, together with their patients, are directly affected by laws restricting access to abortion care and other reproductive health care. ACOG has appeared as *amicus curiae* in courts throughout the country. Its briefs and medical practice guidelines have been cited by numerous authorities, including the U.S. Supreme Court, which recognize ACOG as a leading provider of authoritative scientific data regarding childbirth and abortion.

The Society for Maternal-Fetal Medicine (SMFM) is the medical professional society for maternal-fetal medicine subspecialists, who are

obstetricians with additional training in high-risk pregnancies. SMFM was founded in 1977, and it represents more than 6,500 members caring for high-risk pregnant people. SMFM provides education, promotes research, and engages in advocacy to advance optimal and equitable perinatal outcomes for all people who desire and experience pregnancy. SMFM and its members are dedicated to ensuring that all medically appropriate treatment options are available for individuals experiencing high-risk pregnancies. SMFM's *amicus* briefs also have been cited by many courts.

The Society of Family Planning (SFP) is a leading source for abortion and contraception science. It represents more than 1,800 clinicians and scholars who believe in just and equitable abortion and contraception informed by science. SFP works to build a diverse, equitable, inclusive, and multidisciplinary community of scholars and partners engaged in the science and medicine of abortion and contraception. It seeks to support the production and resourcing of research primed for impact, ensure clinical care is evidence-informed and person-centered through guidance, medical education, and other activities, and develop leaders in abortion and contraception to transform the health care system.

INTRODUCTION

Abortion is an essential part of comprehensive health care, and it is safe. For years, Montana Medicaid has covered abortions that are medically necessary. But House Bills 544 and 862 and the Department of Public Health and Human Services' amendment to Admin. R. Mont. 37.82.102 and 37.86.104 (the DPH Rule) impose new restrictions on abortions provided to Medicaid patients without medical justification and in ways that are dangerous for Montana residents.

H.B. 862 prohibits Montana Medicaid from covering abortions except in cases of rape, incest, or threat of death to the pregnant person. H.B. 544 and the DPH Rule narrow the scope of abortions covered by Montana Medicaid, by creating a new, more restrictive definition of when care is "medically necessary" that applies only to abortion. H.B. 544 and the DPH Rule also require Montana Medicaid patients to obtain prior authorization before obtaining an abortion except in emergencies. And H.B. 544 and the DPH Rule prohibit non-physicians from providing abortion services.

Amici curiae are leading medical societies representing physicians and other clinicians who serve patients in Montana and nationwide.

Their policies represent the education, training, and experience of the vast majority of clinicians in this country. *Amici* all agree that H.B. 544, H.B. 862, and the DPH Rule are not based on any medical or scientific rationale and that, if the statutes and the DPH Rule go into effect, they will adversely affect the health of Montana residents, including some of the most vulnerable Montanans. *Amici* urge the Court to affirm the district court's temporary injunction.

ARGUMENT

I. Medicaid Is Integral To Providing Health Care In Montana, Including Abortion Care

Medicaid providers, many of whom are *amici's* members, play a critical role in the United States health care system. They offer much needed health care to individuals with lower incomes, most of whom are otherwise unable to afford such services.

Medicaid is the largest public health insurance program in the United States, and it continues to grow.[1] In 2015, Medicaid covered 48%

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[1] *See* Peggah Khorrami & Benjamin D. Sommers, *Changes in U.S. Medicaid Enrollment During the COVID-19 Pandemic*, JAMA Network Open (May 5, 2021), https://bit.ly/3Hzzh8R. The program covers Americans from low-income families to qualified children, adolescents, pregnant women, and individuals receiving Supplemental Security Income. *See*

of reproductive-age women with incomes below the federal poverty line, a disproportionate number of whom were women of color.[2] Medicaid accounts for 75% of all public family planning expenditures, and the federal government matches 90% of state family planning expenditures through the program, a higher rate than for other services.[3]

Medicaid is crucial to ensuring that Montanans have access to health care. More than 30% of Montanans have incomes below 200% of the Federal Poverty Level (FPL), and nearly 30% of adult Montanans do not have a primary care provider.[4] Medicaid covers one in six Montanans, including 21% of all Montanan women ages 15 to 49, with over 300,000 Montanans enrolled in the program.[5] Thus, for Montanans with

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Ctrs. for Medicare & Medicaid Servs., *List of Medicaid Eligibility Groups, Mandatory Categorically Needy* (Dec. 2019), https://bit.ly/3SDshy7.

[2] Adam Sonfield, *Why Protecting Medicaid Means Protecting Sexual and Reproductive Health*, 20 Guttmacher Pol'y Rev. 39 (Mar. 9, 2017).

[3] Kaiser Family Found., *Medicaid's Role for Women* 4 (Mar. 28, 2019), https://bit.ly/47UZmtq; *see* Ivette Gomez et al., Kaiser Family Found., *Medicaid Coverage for Women* (Feb. 17, 2022), https://bit.ly/3OBZQhy.

[4] Kaiser Family Found., *State Health Care Snapshots: Montana*, https://bit.ly/4bdtjbd (last accessed Feb. 5, 2024).

[5] Kaiser Family Found., *Medicaid in Montana* (June 2023), https://bit.ly/4bhfsAx.

limited resources, Medicaid provides a lifeline to essential health services.

Medicaid is particularly critical for providing Montanans with access to abortion care. For nearly three decades, Montana Medicaid has covered abortions that are "medically necessary"[6] – meaning abortions that are "reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in a patient which (i) endanger life; (ii) cause suffering or pain; (iii) result in illness or infirmity; (iv) threaten to cause or aggravate a handicap; or (v) cause physical deformity or malfunction."[7]

The overwhelming weight of medical evidence conclusively demonstrates that abortion is a very safe medical procedure.[8] Complication rates from abortion are extremely low, averaging around 2%, and most

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[6] *See Jeannette R. v. Ellery*, No. BDV-94-811, 1995 Mont. Dist. Lexis 795 (1st Jud. Dist. Court, May 22, 1995).

[7] Mont. Admin. R. 37.82.102(18)(a).

[8] *See, e.g.*, Nat'l Acad. of Scis., Eng'g, Med., *The Safety and Quality of Abortion Care in the United States* 10 (2018) (*Safety and Quality of Abortion Care*) ("The clinical evidence clearly shows that legal abortions in the United States – whether by medication, aspiration, D&E, or induction – are safe and effective. Serious complications are rare.").

complications are minor and easily treatable.[9] Major complications from abortion are exceptionally rare, occurring in just 0.23 to 0.50% of instances across gestational ages and types of abortion methods.[10] The risk of patient death from an abortion is even rarer: Nationally, fewer than one in 100,000 patients die from an abortion-related complication.[11] Abortion is so safe that there is a greater risk of complications or mortality for procedures like wisdom-tooth removal, cancer-screening colonoscopy, and plastic surgery.[12]

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[9] *See, e.g.*, Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 181 (2015) (Upadhyay) (finding 2.1% abortion-related complication rate); *Safety and Quality of Abortion Care*, *supra* note 8, at 55, 60.

[10] Kari White et al., *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 Contraception 422, 434 (2015).

[11] Katherine Kortsmit et al., U.S. Dep't of Health & Human Servs., Ctrs. for Disease Control and Prevention, *Abortion Surveillance – United States, 2019*, 70 Morbidity & Mortality Weekly Rep. No. 9, 29 tbl.15 (Nov. 26, 2021) (Kortsmit) (finding mortality rate from 0.00041% to 0.00078% for approximately five-year periods from 1978 to 2014); Suzanne Zane et al., *Abortion-Related Mortality in the United States, 1998-2010*, 126 Obstetrics & Gynecology 258, 261 (2015) (noting an approximate 0.0007% mortality rate for abortion).

[12] Advancing New Standards in Reproductive Health, *Safety of Abortion in the United States*, Issue Brief No. 6, at 1-2 (2014) (2.1% of abortions result in complications – with 1.88% resulting in minor complications and 0.23% resulting in major complications – compared to 7% of wisdom-tooth extractions, 8-9% of tonsillectomies, and 29% of childbirths); Am. Soc'y

Continuing a pregnancy to term also carries a much higher risk than having an abortion. For many patients, continuing a pregnancy to term can exacerbate underlying health conditions or lead to newly arising health issues. For example, sickle-cell disease can worsen during pregnancy, leading to severe anemia and vaso-occlusive crisis, a condition resulting in significant pain.[13] Pregnant patients with inherited thrombophilia, which can be undetected until a triggering event such as pregnancy, have a high risk of developing life-threatening blood clots.[14] Pregnancy can exacerbate asthma, making it a life-threatening

for Gastrointestinal Endoscopy, *Complications of Colonoscopy*, 74 Gastrointestinal Endoscopy 745, 745 (2011) (33% of colonoscopies result in minor complications); Frederick M. Grazer & Rudolph H. de Jong, *Fatal Outcomes from Liposuction: Census Survey of Cosmetic Surgeons*, 105 Plastic & Reconstructive Surgery 436, 441 (2000) (mortality rate from liposuction in late 1990s was 20 per 100,000); Kortsmit, *supra* note 11, at 29 tbl.15 (mortality rate from legal induced abortion was between 0.52 and 0.63 per 100,000 in late 1990s, dropping to 0.41 in 2013-2018).

[13] ACOG, Practice Bulletin No. 78, *Hemoglobinopathies in Pregnancy*, 109 Obstetrics & Gynecology 229-230 (Jan. 2007, reaff'd 2022); Ashley Appiagyei Cole et al., *Sickle Cell Crises in Pregnancy: Fetal and Neonatal Implications*, 24 Neoreviews 7 (July 2023), https://bit.ly/3UuAplP.

[14] ACOG, Practice Bulletin No. 197, *Inherited Thrombophilias in Pregnancy*, 132 Obstetrics & Gynecology e18 (July 2018, reaff'd 2022) (ACOG, *Inherited Thrombophilias*).

condition.[15] Approximately 6 to 7% of pregnancies are complicated by gestational diabetes mellitus, which frequently leads to maternal and fetal complications, including developing diabetes later in life.[16] And preeclampsia, a relatively common complication, is a disorder associated with new-onset hypertension that occurs most often after 20 weeks of gestation and can result in fluctuating blood pressure, heart disease, liver issues, seizures, and death.[17] These are just a few of the complications that can occur during pregnancy; there are myriad other situations where patients may need access to abortion care.

Labor and delivery likewise carry significant risks. These include hemorrhage, placenta accreta spectrum (a potentially life-threatening complication that occurs when the placenta is unable to detach at childbirth), hysterectomy, cervical laceration, and debilitating postpartum

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[15] ACOG, Practice Bulletin No. 90, *Asthma in Pregnancy* 2 (Feb. 2008, reaff'd 2020).

[16] ACOG, Practice Bulletin No. 190, *Gestational Diabetes Mellitus* 131 Obstetrics & Gynecology e49 (Feb. 2018, reaff'd 2019) (ACOG, *Gestational Diabetes*).

[17] ACOG, Practice Bulletin No. 222, *Gestational Hypertension and Preeclampsia*, 135 Obstetrics & Gynecology e237 (June 2020) (ACOG, *Gestational Hypertension*).

pain.[18] Approximately one in three people who give birth in the United States do so by cesarean delivery, a major surgical procedure that carries increased risk of complications.[19] Again, these are only a few examples of potential complications that occur in pregnant patients.

Thus, for many Montanans, Medicaid coverage is essential for receiving critical care, including abortion care.

II. There Is No Medical Justification For H.B. 544, H.B. 862, Or The DPH Rule

The restrictions and requirements imposed by H.B. 544, H.B. 862, and the DPH Rule serve no medical purpose and will prevent Medicaid patients in Montana from accessing the care they need.

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[18] ACOG, Practice Bulletin No. 183, *Postpartum Hemorrhage*, 130 Obstetrics & Gynecology e68 (Oct. 2017, reaff'd 2019); ACOG, Obstetric Care Consensus No. 7, *Placenta Accreta Spectrum*, 132 Obstetrics & Gynecology e259-60 (July 2012, reaff'd 2021) (ACOG, *Placenta Accreta Spectrum*); ACOG, Practice Bulletin No. 198, *Prevention and Management of Obstetric Lacerations at Vaginal Delivery*, 132 Obstetrics & Gynecology e87 (Sept. 2018, reaff'd 2022); ACOG, Clinical Consensus No. 1, *Pharmacologic Stepwise Multimodal Approach for Postpartum Pain Management*, 138 Obstetrics & Gynecology 507 (Sept. 2021).

[19] Ctrs. for Disease Control and Prevention, *National Vital Statistics Reports Vol. 70, No. 2, Births: Final Data for 2019* (2021); ACOG, Clinical Practice Guideline No. 8, *First and Second Stage Labor Management* (Jan. 2024).

A. The Statutes' And The DPH Rule's Restrictions On Abortion Endanger Patients' Health

The statutes and the DPH Rule would significantly narrow Montana Medicaid's coverage of abortion care. H.B. 862 would prohibit Montana Medicaid from covering abortions except in cases of rape, incest, or where the pregnant person is "in danger of death unless an abortion is performed."[20] H.B. 544 and the DPH Rule would create a new definition of "medically necessary" that would apply only to abortion.[21] Under that new definition, an abortion would be covered only if the pregnant person suffers from a physical or psychological condition that "*would* be significantly aggravated by the pregnancy."[22] This is significantly more restrictive than the current standard, which covers an abortion when it is "reasonably calculated" to prevent, cure, or alleviate a health condition.[23]

The statutes' and the DPH Rule's restrictions on abortion coverage would endanger patients' health by preventing medical professionals from providing needed medical care, as that concept has been defined and practiced in Montana for decades. Eliminating the ability to treat

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[20] H.B. 862 § 1.

[21] H.B. 544 § 1(1)(c) & (3).

[22] *Id.* at § 1(3)(a) (emphasis added); *see* App.C02.

[23] Mont. Admin. R. 37.82.102(18)(a).

medical conditions as they occur and requiring an unconscionable wait-and-see approach will prove deadly for some patients. Delays in emergency care can be traumatic and devastating to pregnant patients, contribute to maternal morbidity, may permanently impair fertility, and can make it impossible to provide the optimal treatment for preventing a harmful, or even fatal, outcome. By requiring physicians to delay treatment until a patient's life or physical or psychological condition are in immediate and indisputable danger, the statutes and the DPH Rule will put patients at risk of death and of serious, life-altering complications, and subject them (and their loved ones) to serious and needless additional emotional trauma as a result.

Pregnancy can exacerbate existing health issues that do not necessarily lead to death or "significantly aggravate" a physical or psychological condition. Some examples include Alport Syndrome (a form of kidney inflammation), valvular heart disease (abnormal leakage or partial closure of a heart valve), lupus (a connective tissue disease that may suddenly worsen during pregnancy and lead to blood clots and other serious complications), and pulmonary hypertension (increased pressure within

the lung's circulation system that can escalate during pregnancy).[24] Further, sometimes patients seek abortion care because of significant medical issues that they experienced during prior pregnancies. If abortion care is unavailable, those prior conditions could progress or reoccur, endangering the health of the pregnant patient and directly affecting fetal development and survival. Additional examples include preeclampsia, placental abruption (separation of the placenta from the uterine wall), placenta accreta, peripartum cardiomyopathy (enlargement of the heart in or after pregnancy), and thrombophilia.[25]

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[24] *See* Koji Matsuo et al., *Alport Syndrome and Pregnancy*, 109 Obstetrics & Gynecology 531, 531 (Feb. 2007); Karen K. Stout & Catherine M. Otto, *Pregnancy in Women with Valvular Heart Disease*, 93 Heart Rev. 552, 552 (May 2007); Josefina Cortés-Hernández et al., *Clinical Predictors of Fetal and Maternal Outcome in Systemic Lupus Erythematosus: A Prospective Study of 103 Pregnancies*, 41 Rheumatology 643, 646-647 (2002); David G. Kiely et al., *Pregnancy and Pulmonary Hypertension: A Practical Approach to Management*, 6 Obstetric Med. 144, 153 (2013); Michael F. Greene & Jeffrey L. Ecker, *Abortion, Health and the Law*, 350 New Eng. J. Med. 184, 184 (2004).

[25] ACOG, *Gestational Hypertension*, *supra* note 17; ACOG, Obstetric Care Consensus No. 10, *Management of Stillbirth*, 135 Obstetrics & Gynecology e116, e120-121 (March 2009, reaff'd 2021); ACOG, *Placenta Accreta Spectrum*, *supra* note 18, at e260; ACOG, Practice Bulletin No. 212, *Pregnancy and Heart Disease*, 133 Obstetrics & Gynecology e320, e332 (May 2019, reaff'd 2021); ACOG, *Inherited Thrombophilias*, *supra* note 14, at e21-23.

Clinicians should not be put in the position of either letting a patient deteriorate until death or "significant aggravation" of a health condition is indisputable or imminent, or risk being uncompensated for providing needed care consistent with their training, expertise, and experience. Montana residents should not be forced to bear the cost of waiting for needed care until it may be too late to save the pregnant patient's life or protect the patient's health.

B. The Prior Authorization Requirement Serves No Medical Purpose And Will Delay Access To Care

Even where H.B. 544 and the DPH Rule permit an abortion, the statute and DPH Rule impose burdensome and unnecessary documentation requirements that serve only to delay the provision of care. Specifically, H.B. 544 and the DPH Rule require a physician to obtain prior authorization before performing an abortion, except in an undefined "emergency situation."[26] To obtain prior authorization (or to be reimbursed for an abortion performed in an emergency without prior authorization), the physician needs to undertake a burdensome administrative process, which includes conducting an in-person physical examination of the

[26] H.B. 544, § 1(4).

patient, which may not be medically necessary, and interviewing the patient about an array of private and potentially intrusive topics, not all of which will be relevant in every case.[27] These time-consuming and medically unnecessary requirements will make care inaccessible to many Montana residents.

The prior authorization requirement effectively precludes the possibility of providing medication abortions through telehealth consultations. Medication abortion, which accounts for more than half of all abortions in the United States, is a common method of abortion during the first trimester of pregnancy and is increasingly preferred.[28] The evidence shows that clinicians can safely provide medication abortions through telehealth consultations without needing to see the patients in person.[29] The prior authorization requirement in H.B. 544 and the DPH Rule

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[27] *See id.* § 1(5).

[28] Rachel K. Jones et al., Guttmacher Inst., *Medication Abortion Now Accounts for More than Half of All US Abortions* (Mar. 2, 2022); Nathalie Kapp et al., *Efficacy of Medical Abortion Prior to 6 Gestational Weeks: A Systematic Review*, 97 Contraception 90, 90 (2018); Tara C. Jatlouti et al., Ctrs. for Disease Control and Prevention, Morbidity and Mortality Weekly Report, *Abortion Surveillance – United States, 2013*, at 8 (2016).

[29] Nathaniel DeNicola et al., *Telehealth Interventions to Improve Obstetric and Gynecologic Health Outcomes*, 135 Obstetrics & Gynecology 371, 371-72 (2020).

forecloses this approach, because it requires a physician to conduct an in-person physical examination before providing abortion care.

Further, the prior authorization requirement will lead to delays in obtaining care, which could entail significant health risks. Neither H.B. 544 nor the DPH Rule guarantee that prior authorization will be granted, nor specify a time within which the State will complete its review. So despite having determined that an abortion is medically necessary even under the more restrictive definition in the statute and the DPH Rule, a physician still would have to wait for the State to agree before providing abortion care. Although the risk of complications from abortions overall remains exceedingly low – especially compared to the health risks of carrying a pregnancy to term – increasing gestational age increases the chance of complications as well as the costs of obtaining an abortion.[30]

For some patients, the prior authorization requirement may altogether foreclose the option of obtaining abortion care. Medication abortion often is not offered in the United States after ten weeks of gestation and, as a result, those who are delayed in obtaining an abortion may be

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[30] *See, e.g.*, Upadhyay, *supra* note 9, at 181.

deprived of this option,[31] including those for whom it may have been the more medically appropriate procedure.[32] Further, more than 90% of Montana counties do not have a single abortion provider.[33] In those counties, removing access to medication abortion may mean residents have no access to abortion care at all.

C. There Is No Medical Justification For Preventing Non-Physicians From Providing Abortion Services

H.B. 544 and the DPH Rule further restrict the provision of abortion care by requiring that abortions be performed by physicians to be covered by Medicaid, despite the fact that non-physicians, such as advanced practice clinicians (APCs), physician assistants, and nurse practitioners, are appropriate providers of this safe, basic reproductive health care.[34]

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[31] *See* ACOG, Practice Bulletin No. 225, *Medication Abortion Up to 70 Days of Gestation*, 136 Obstetrics & Gynecology e31, e34, e39 (Oct. 2020).

[32] For example, medication abortion is frequently the most appropriate method for pregnant people who have uterine fibroids. *See* Mitchell D. Creinin, *Medically Induced Abortion in a Woman with a Large Myomatous Uterus*, 175 Am. J. Obstetrics & Gynecology 1379, 1379 (1996).

[33] Guttmacher Inst., *Data Center*, https://bit.ly/3OEhIrU (last accessed Feb. 8, 2024).

[34] *See* H.B. 544 § 1(1).

The evidence shows that qualified non-physicians can provide the same level of abortion care as physicians. Studies have found no difference in outcomes in first-trimester medication and aspiration abortion by provider type, and that first-trimester abortions are just as safe when performed by trained non-physicians as when performed by physicians.[35] There is no evidence to support a categorical ban on non-physicians providing abortion services.

Further, that ban will serve only to further reduce access to care. Already, over two-thirds of states have reported challenges in ensuring there are enough Medicaid providers to serve patients.[36] As a result, individuals covered by Medicaid often are limited in their choice of provider, and many rely on publicly funded health care centers. In the family-planning realm, of about 8.6 million women who received publicly funded contraceptive services in 2015, 72% (or 6.2 million) received care

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[35] ACOG Committee Opinion No. 612, *Abortion Training and Education* 3 (Nov. 2014, reaff'd 2022); Tracy A. Weitz et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistance Under a California Legal Waiver*, 103 Am. J. Pub. Health 454, 454, 458-59 (2013).

[36] *See* U.S. Gov't Accountability Office, GAO-13-55, *Medicaid: States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance* 19 (Nov. 2012), https://bit.ly/3SBkctD.

at family-planning clinics, while only 28% (or 2.4 million) received care from private clinicians, such as private doctors' offices.[37] In Montana, a majority of counties face primary care shortages.[38]

Removing access to a pool of clinicians that can provide safe and effective care will only exacerbate the difficulties Montanans face in accessing care.[39] Eliminating access to certain health care practitioners is "inappropriate, ill-advised, and dangerous for patient health."[40]

III. H.B. 544, H.B. 862, And The DPH Rule Will Disproportionately Impact Rural And Low-Income Patients

H.B. 544, H.B. 862, and the DPH Rule will disproportionately affect patients of color, those living in rural areas and those with limited economic resources, patients that have historically had the least access to care and the greatest rates of maternal morbidity and mortality. *Amici* are opposed to abortion policies that increase the inequities that already plague the health care system in this country. By definition, patients

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[37] Jennifer J. Frost et al., Guttmacher Inst., *Publicly Funded Contraceptive Services at U.S. Clinics, 2015* (Apr. 2017), https://bit.ly/3UjrXFG.

[38] Beth Saboe, *A Majority of Montana Counties Face Primary Care Shortages*, High Country News (Jan. 11, 2018), https://bit.ly/47SPDUM.

[39] ACOG Committee Opinion No. 826, *Protecting and Expanding Medicaid To Improve Women's Health*, 137 Obstetrics & Gynecology e166 (June 2021).

[40] *Id.*

served by Montana Medicaid have low incomes. Many live in rural areas with limited access to clinics and hospitals, and people of color are disproportionately represented in the Medicaid program.[41]

Limiting the scope of abortions available under Medicaid effectively forces more prospective patients to continue pregnancies, which increases their risk of complications and death. For adults, the risk of death associated with childbirth is about 14 times higher than that associated with abortion,[42] with Black and Indigenous pregnant people facing higher risks.[43] The statutes and DPH Rule would thus exacerbate inequities in health care and disproportionately harm the most vulnerable Montanans.

IV. H.B. 544, H.B. 862, And The DPH Rule Will Undermine Physicians' Ability to Perform Their Jobs

Abortion restrictions like those imposed by H.B. 544, H.B. 862, and the DPH Rule violate long-established and widely accepted principles of

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41 Mont. Hosp. Ass'n, *Access to Care*, https://bit.ly/46pbH8u (accessed Feb. 5, 2024).

42 Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012).

43 Elizabeth Howell, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61 Clinical Obstetrics & Gynecology 387, 387-88 (2018).

medical ethics by substituting legislators' opinions for a physician's individualized patient-centered counseling and creating a manufactured conflict of interest between patients and medical professionals. The restrictions attempt to force medical professionals to violate the age-old principles of beneficence and non-maleficence and require medical professionals to ignore the ethical principle of respect for patient autonomy.

A. Statutes That Restrict Access To Abortion Undermine The Patient-Physician Relationship

The patient-physician relationship is critical for the provision of safe and quality medical care.[44] At the core of this relationship is the ability to counsel frankly and confidentially about important issues and concerns based on patients' best medical interests with the best available scientific evidence.[45] ACOG's Code of Professional Ethics states that "the welfare of the patient must form the basis of all medical judgments," and that obstetrician-gynecologists should "exercise all reasonable means to ensure that the most appropriate care is provided to the patient."[46] The

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[44] ACOG, Statement of Policy, *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (May 2013, reaff'd and amended Aug. 2021).

[45] Am. Med. Ass'n, Code of Medical Ethics Opinion 1.1.1, *Patient-Physician Relationships* (Aug. 2022) (AMA Opinion 1.1.1).

[46] ACOG, *Code of Professional Ethics* 2 (Dec. 2018) (ACOG Code).

American Medical Association (AMA) Code of Medical Ethics places on physicians the "ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others."[47]

Abortions are safe, routine, and, for many patients, the best medical choice available for their specific health circumstances. There is no rational or legitimate basis for interfering with a physician's ability to provide an abortion when the physician and patient conclude that it is the medically appropriate course. Laws or regulations that would restrict abortion – such as the H.B. 544, H.B. 862, and the DPH Rule – are inconsistent with the reality of contemporary medical practice and have no grounding in science or medicine. H.B. 544 and the DPH Rule will further undermine the patient-physician relationship by requiring physicians to collect extensive, unnecessary personal information from patients and submit this information to the State for permission to provide abortion services, undermining the trust essential to the patient-physician relationship.

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[47] AMA Opinion 1.1.1, *supra* note 45.

B. Statutes That Restrict Access To Abortion Violate The Principles Of Beneficence And Non-Maleficence

Beneficence, the obligation to promote the wellbeing of others, and non-maleficence, the obligation to do no harm, have been the cornerstones of the medical profession since the Hippocratic traditions.[48] Both principles arise from the foundation of medical ethics that requires the welfare of the patient to form the basis of medical decision-making.

Obstetricians, gynecologists, and other clinicians providing abortion care respect these ethical duties by engaging in patient-centered counseling, providing patients with information about risks, benefits, and pregnancy options, and ultimately empowering patients to make decisions informed by both medical science and their individual lived experiences.[49]

H.B. 544, H.B. 862, and the DPH Rule will effectively prevent physicians from providing appropriate treatment unless it meets an overly narrow view of medical necessity and the physician clears unnecessary

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[48] Am. Med. Ass'n, *Principles of Medical Ethics* (rev. June 2001); ACOG, Committee Opinion No. 390, *Ethical Decision Making in Obstetrics and Gynecology*, 110 Obstetrics & Gynecology 1479, 1481-82 (Dec. 2007, reaff'd 2019).

[49] ACOG Code, *supra* note 46, at 1-2.

and burdensome procedural hurdles. They place physicians at the ethical impasse of choosing between providing the best available medical care to their patients and risking nonpayment, or complying with medically unnecessary rules that interfere with access to essential reproductive health care. This dilemma challenges the very core of the Hippocratic Oath: "Do no harm."

C. Statutes That Restrict Access To Abortion Violate The Ethical Principle Of Respect For Patient Autonomy

Finally, a core principle of medical practice is patient autonomy – the respect for patients' ultimate control over their bodies and right to a meaningful choice when making medical decisions.[50] Patient autonomy is rooted in self-determination, which, in turn, is safeguarded by the ethical concept of informed consent and its rigorous application to a patient's medical decisions.[51] H.B. 544, H.B. 862, and the DPH Rule will deny Montanans who rely on Medicaid the right to fully make their own choices about health care if they decide they need to seek an abortion.

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[50] *Id.* at 1 ("[R]espect for the right of individual patients to make their own choices about their health care (*autonomy*) is fundamental.").

[51] ACOG, Committee Opinion No. 819, *Informed Consent and Shared Decision Making in Obstetrics and Gynecology*, 137 Obstetrics & Gynecology e35 (Feb. 2021); Am. Med. Ass'n, Code of Medical Ethics Opinion 2.1.1, *Informed Consent* (2017).

CONCLUSION

This Court should affirm the district court's temporary injunction.

Dated: February 14, 2024

Respectfully submitted,

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