MONTANA FIRST JUDICIAL DISTRICT COURT
LEWIS AND CLARK COUNTY

ALL FAMILIES HEALTHCARE; BLUE MOUNTAIN CLINIC; and HELEN WEEMS, MSN, APRN-FNP, on behalf of themselves, their employees, and their patients, Plaintiffs, v. STATE OF MONTANA; MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES; and CHARLIE BRERETON, in his official capacity as Director of the Department of Public Health and Human Services, Defendants.	Cause No.: DDV-2023-592 **OPINION AND ORDER ON MOTION FOR PRELIMINARY INJUNCTION**

For many years, abortion has been one of the most divisive subjects in American political discourse. This Court's role, however, is not to take sides in that debate. To the contrary, while "abortion raises moral and spiritual questions over which honorable persons can disagree sincerely and profoundly," that disagreement does not relieve the Court of its "duty to apply the Constitution faithfully." *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 772 (1986), *overruled by Planned Parenthood of S.E. Penn. v. Casey*, 505 U.S. 833 (1992). In other words, the Court must faithfully apply Montana law on this contentious subject as it is, not as some—even many—might wish it to be.

As to the law: Whatever one's views may be, the law in Montana is well-established. Women have a state constitutional right of access to pre-viability abortions from a qualified medical provider of their choice. *Armstrong v. State*, 1999 MT 261, ¶ 75, 296 Mont. 361, 989 P.2d 364; *Weems v. State ex rel. Knudsen*, 2023 MT 82, ¶ 36, 412 Mont. 132, 529 P.3d 798; *Planned Parenthood of Mont. v. State*, 2024 MT 178, ¶ 22, 417 Mont. 457, 554 P.3d 153. The holdings of *Armstrong* and its progeny are binding on this Court, and this Court is dutybound to faithfully apply them. *See State v. Whitehorn*, 2002 MT 54, ¶ 14, 309 Mont. 63, 50 P.3d 121. Moreover, voters recently affirmed the core holding of *Armstrong* when they approved the addition of an express right to abortion access to the Montana Constitution. *See* Const. Initiative 128 [CI-128] (approved Nov. 5, 2024).

The present case concerns the application of the right to abortion access recognized in *Armstrong* to House Bill 937, 2023 Mont. Laws 492, which requires the licensure and regulation of abortion clinics. This summer, the

Montana Department of Public Health and Human Services (DPHHS or "the Department") promulgated administrative rules implementing House Bill 937. 18 Mont. Admin. Reg. 2242–2268 (Sept. 10, 2024), codified at Admin. R. Mont. 37.106.3101–37.106.3114. Plaintiffs All Families Healthcare, Blue Mountain Clinic, and Helen Weems (collectively, "Providers"), represented by Alex Rate, Hillary Schneller (argued), Jacqueline Harrington, Nina S. Riegelsberger, Tabitha Crosier, Hartley M.K. West, and Iricel Payano, brought suit and have moved the Court for a preliminary injunction *pendente lite* to enjoin enforcement of HB 937 and the implementing rules. Defendants State of Montana, DPHHS, and Charles Brereton (collectively, "the State"), represented by Michael D. Russell, Thane Johnson (argued), Alwyn Lansing, Michael Noonan, and Emily Jones, oppose the motion. A hearing on the motion was held November 8, 2024. The Court heard testimony from Tara Wooten, received Exhibits A–H, and heard oral argument from counsel.

The Court has considered the written evidentiary record, Wooten's testimony, and the briefing and arguments of counsel. For the reasons that follow, the Court is persuaded that Plaintiffs are likely to show House Bill 937's licensure requirement and implementing rules infringe on Providers' and their patients' right to equal protection of the laws. The Court is further persuaded that without judicial intervention, Providers and their patients will suffer irreparable harm and that the balance of the equities favors injunctive relief. Accordingly, to maintain the status quo pending a determination of the merits, the Court will preliminarily enjoin enforcement of House Bill 937 and the implementing rules promulgated by the Department.

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BACKGROUND[1]

A. Abortion care in Montana

Abortion is a lawful medical procedure in Montana, and it has been for decades. Access to pre-viability abortions was protected under the United States Constitution from 1973 to 2022. *See Roe v. Wade*, 410 U.S. 113 (1973), *overruled in Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215 (2022). In 1999, the Montana Supreme Court first held that the Montana Constitution, which contains privacy protections distinct from and broader than those found in the federal Constitution, protects a woman's right to obtain "a pre-viability abortion[] from a health care provider of her choice." *Armstrong*, ¶ 75. Even after the United States Supreme Court abandoned federal recognition of the right of abortion access in *Dobbs*, the Montana Supreme Court has repeatedly reaffirmed *Armstrong*'s holding. *E.g., Weems v. State ex rel. Knudsen*, 2023 MT 82, ¶ 51, 412 Mont. 132, 529 P.3d 798. Moreover, the court has affirmed numerous injunctions—both temporary and permanent—of legislative attempts to regulate abortion since *Armstrong*. *See Planned Parenthood of Mont. v. State*, 2024 MT 228, ¶ 42, __ Mont. __, __ P.3d __ (Oct. 9,2024) [*PPMT-Medicaid*][2], ¶ 42 (preliminary injunction of various regulations of abortions covered by Medicaid); *Planned Parenthood of Mont. v. State ex rel. Knudsen*, 2024 MT 227, ¶ 41, __ Mont. __, __ P.3d __ (Oct. 9, 2024) [*PPMT-2023 Laws*], ¶ 41 (preliminary injunction of statutes prohibiting dilation & evacuation (D&E) abortions and requiring ultrasounds prior to abortion); *Planned Parenthood of Mont. v. State*, 2024 MT 178, ¶ 56, 417 Mont. 457, 554 P.3d 153

[1] The following constitutes the Court's findings of fact. Mont. R. Civ. P. 52(a)(2).

[2] There are so many decisions in the last four years captioned *Planned Parenthood of Montana v. State* that it can be difficult to coherently cite them. Rather than use a numbering system, the Court will attempt to describe them by the statutes challenged.

[*PPMT-Consent*] (permanent injunction of parental consent statute); *Weems*, ¶ 51 (permanent injunction of statute prohibiting advanced practice registered nurses from performing abortions); *Planned Parenthood of Mont. v. State*, 2022 MT 157, ¶¶ 3, 61, 409 Mont. 378, 515 P.3d 301 [*PPMT-2021 Laws*] (preliminary injunction of statutes imposing a twenty-week ban on abortion, limiting telehealth services for medication abortions, and requiring an ultrasound)[3].

Most recently, the voters approved a constitutional amendment, CI-128 (to be codified at Mont. Const. art. II, § 36), guaranteeing the "right to make and carry out decisions about one's own pregnancy, including the right to abortion" and providing that this right "shall not be denied or burdened unless justified by a compelling government interest achieved by the least restrictive means." A "compelling" government interest is one that "clearly and convincingly addresses a medically acknowledged, bona fide health risk to a pregnant patient and does not infringe on the patient's autonomous decision making."[4]

There are several healthcare providers operating in Montana who perform abortions, including Planned Parenthood (who operates multiple clinics but is not a party to this case), Plaintiff All Families Healthcare (operated by Plaintiff Helen Weems) and Plaintiff Blue Mountain Clinic.

Blue Mountain Clinic, located in Missoula, first opened in 1977 and is Montana's oldest abortion provider. (Joey Banks Aff. ¶ 4, Dkt. 58 at

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[3] An appeal of a permanent injunction of these statutes is currently pending. *See Planned Parenthood of Mont. v. State*, No. DA 24-147

[4] CI-128 is slated to become part of the Constitution on July 1, 2025. *See* Mont. Const. art. XIV, § 9(3). While CI-128 is not yet part of the Constitution, it almost certainly will be in short order, and it therefore informs the Court's assessment of the Providers' showing of a likelihood of success on the merits.

89–112.[5]) The clinic's services are not limited to abortion, but also include primary family care. (*Id.* ¶ 39.) Blue Mountain serves 3,000 patients per year, with about one quarter living more than 50 miles away. (*Id.* ¶¶ 37–38.) Blue Mountain also provides patients with various in-office procedures, including miscarriage management, loop electrosurgical excisions (LEEPs), colposcopies, and Nexplanon and intrauterine device (IUD) insertions and removals. (*Id.* ¶ 39.)

In 2023, Blue Mountain provided 350 abortions. (*Id.* ¶ 40.) For patients whose gestation is up to 11 weeks LMP (since last menstrual period), the standard of care is medication abortion, typically a mifepristone-misoprostol or misoprostol-only regimen. (*Id.* ¶¶ 15–16.) "Procedural" abortions[6]—consisting of vacuum aspiration and D&E abortions—are performed up to 21 weeks and 6 days LMP. (*Id.* ¶ 41.) Most abortions provided in Montana (90% in 2022) were performed at 13 weeks LMP or earlier. (*Id.* ¶ 13.)

All Families Healthcare, located in Whitefish, opened in 2018. (Helen Weems Aff. ¶ 2, Dkt. 58 at 60–80.) Weems, the owner and sole clinician, is an advanced practice registered nurse who is board certified in family practice. (*Id.* ¶ 3.) All Families Healthcare provides "comprehensive sexual and reproductive health care services," including abortion services, contraceptive options (including insertion of IUDs and Nexplanon implants), and miscarriage care. (*Id.* ¶ 5.) They served 800 patients in 2022. (*Id.*)

In 2023, All Families Healthcare provided approximately 380 abortions. (*Id.* ¶ 9, Dkt. 58 at 62.) Most abortions performed are medication

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[5] In evaluating an application for a preliminary injunction, the Court may generally consider affidavits in lieu of live testimony. Mont. Code Ann. § 27-19-303(2); *see also Flynt Distrib. Co. v. Harvey*, 734 F.2d 1389, 1394 (9th Cir. 1984) (evidentiary standards are relaxed for preliminary injunctions). Providers have produced extensive evidence by affidavit that is largely unrebutted by the State. Thus, for the purposes of the preliminary injunction application, the Court has mostly adopted Providers' evidence.

[6] "Procedural" abortions are sometimes referred to as "surgical" abortions, although Providers dispute whether such procedures can be thought of as "surgery."

abortions, which can be done through an in-person or telehealth visit. (*Id.* ¶ 10.) Approximately half of medication abortions are provided via telehealth, which facilitates treatment for patients who live in rural areas far away from any of Montana's abortion clinics. (*Id.* ¶ 12.) All Families Healthcare also performs vacuum aspiration abortions. (*Id.* ¶ 13.) No evidence was presented to the Court that either All Families Healthcare or Blue Mountain Clinic (which has been operating for decades) have any notable history of providing unsafe care to their patients.

B. Evidence regarding safety of abortion care

The Montana Supreme Court has repeatedly found that "abortion is exceedingly safe" and "one of the safest forms of medical care in this country and the world." *PPMT-Consent*, ¶ 37 (quoting *Weems*, ¶¶ 1, 46)[7]. Childbirth has a risk of death thirteen times higher than that associated with abortion. (Banks Aff. ¶ 23, Dkt. 58 at 94.) Major complications of abortion are less than a fraction of one percent, and complications of all types occur in only two percent of abortions. (*Id.* ¶ 24.) Abortion has a similar or lower risk than vasectomy, an outpatient procedure commonly performed in a doctor's office. (*Id.* ¶ 24.)

Medication abortion is considered safe and effective, and it can be safely provided either in-clinic or via telehealth. (Banks Aff. ¶ 17.). Medication abortions typically consist either of an administration of mifepristone and misoprostol, or less commonly, misoprostol only. (*Id.* ¶ 16.) Patients seeking medication abortion are screened for their eligibility for medication and are dispensed pills. (*Id.* ¶ 17.) In the two-drug regimen, the patient takes mifepristone

[7] Although these statements were predicated on the factual record developed in *Weems*, the Supreme Court has afforded these findings precedential effect in deciding other abortion cases. *See PPMT-Consent*, ¶ 30 ("To the extent any of the State's compelling interests are premised upon a contention that abortion care presents a medical health risk, we may easily dispose of such a contention by relying on *Weems*."). Additionally, Providers' affidavits in this matter appear consistent with the record described in *Weems*.

first, followed by misoprostol up to 72 hours later, and the patient undergoes a loss of the pregnancy similar to that in a spontaneous miscarriage. (*Id.* ¶ 16.) The medications used for abortion are the same as those prescribed for managing spontaneous abortion. (*Id.* ¶ 15.) No anesthesia is needed. (*Id.* ¶ 18.)

Medication abortion has been demonstrated to be safe in multiple studies. (Banks Aff. ¶ 19.) The complications are similar to or less than the risks from taking various medications like antibiotics, aspirin, acetaminophen, and Viagra. (*Id*.) More to the point, the risks of complication from mifepristone and misoprostol are no greater when used to induce an abortion than when used to manage a spontaneous miscarriage. (*Id.* ¶ 28; Jennifer Mayo Aff., ¶¶ 8, 13, Dkt. 58 at 126–131.)

The procedures Providers use for non-medication abortions are also the same procedures commonly used in miscarriage care. (Banks Aff. ¶ 27; Mayo Aff. ¶ 9.) The procedures are variously described as vacuum aspiration abortion, dilation and evacuation (D&E), or dilation and curretage (D&C). They involve "dilating (opening) the uterine cervix and then evacuating the uterus using suction aspiration, instruments, or some combination." (Banks Aff. ¶ 20.) Dilation is done either the same day or the day before, and the procedure itself typically takes between ten and twenty minutes. (*Id.*) A local anesthetic is administered to numb the cervix, and patients are also sometimes offered a mild to moderate sedative to assist them in relaxation. (*Id.* ¶ 21; Mayo Aff., ¶ 12.) Administration of general anesthesia is generally unnecessary. (Mayo Aff. ¶ 12.)

"Procedural" abortions of the types performed by Providers pose risks similar risks to miscarriage management and are similar in invasiveness and risk to common gynecological procedures traditionally performed in a clinician's

office. (Banks Aff. ¶¶ 9–10, 29; Mayo Aff. ¶¶ 9–11.) Procedural abortions are performed with administration of local anesthesia and sometimes use of a moderate sedative; they do not typically require use of general anesthesia. (Banks Aff., ¶ 29; Mayo Aff. ¶ 12.) Providers produced evidence from various organizations and studies indicating that the abortion procedures Providers use may be safely performed in a clinician's office. (Banks Aff. ¶¶ 30, 32–34; Mayo Aff. ¶¶ 12, 14.) These abortion procedures are comparable to other gynecological procedures commonly performed in-office in terms of "risk, invasiveness, duration, and instrumentation," including hysteroscopy, loop electrosurgical excision procedures, and insertion and removal of IUD and Nexplanon implants. (Mayo Aff. ¶ 11.) These procedures also commonly involve administration of a local anesthetic and sedating or anti-anxiety medication. (*Id.*)

All of the foregoing has gone essentially unrebutted by the State at the preliminary injunction stage. The State's only witness, Tara Wooten, is an experienced administrator within DPHHS, but she is not herself a medical professional or competent to opine on the safety of abortion or other obstetric or gynecological care. The State did not produce any live or affidavit testimony from medical experts with a contrary view to that submitted by Providers. Additionally, the Court reviewed the Department's statement of reasonable necessity and its response to comments in its final Notice of Adoption. Although the Department asserted at several junctures that there "are real risks associated with both surgical abortion and medical/medication abortion," e.g., 18 Mont. Admin. Reg. at 2250, 2252 (Sept. 20, 2024), the Department's responses neither cited any experts or studies nor performed any comparison to procedures of

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comparable risk that are currently performed in clinician offices that are not regulated as healthcare facilities.

C. House Bill 937

In 2023, the legislature enacted House Bill 937 (HB 937), which provides for the licensure and regulation of abortion clinics. Abortion clinics are classified as health care facilities under statute and required to obtain a license from the Department. The statute directs the Department to adopt rules covering an array of subjects, ranging from architecture and layout to standards for patient care. The statute establishes a $450 licensing fee. Mont. Code Ann. § 50-20-903(2)(d)(ii). It also requires annual inspections and authorizes the Department to conduct additional investigations "as needed" in response to any complaints involving an abortion clinic. *Id.* § 50-2-904. An "abortion clinic" is defined as any facility (other than a hospital, critical access hospital, or outpatient surgery center) that "performs surgical abortion procedures" or "provides an abortion-inducing drug" to at least five patients a year. *Id.* § 50-20-901(1).

Even without the adoption of any other rules, the legislature's classification of abortion clinics as health care facilities imposes a certain baseline of regulation. Health care facilities are subject to annual inspection, and they may be subject to additional unannounced inspections whenever the Department considers it necessary. Mont. Code Ann. §§ 50-5-116, 50-5-204(6). The Department has promulgated minimum standards that are generally applicable to all health care facilities. Admin. R. Mont. 36.106.301–.331. The term "health care facility" includes a wide array of facilities, ranging from outpatient clinics, eating disorder clinics, home health providers, dialysis clinics, and chemical dependency facilities to rehabilitation facilities and hospitals, but it

excludes private physician and other health care workers' offices. Mont. Code Ann. § 50-5-101(20)(a). Importantly, however, the definition of healthcare facilities expressly excludes "offices of private physicians, dentists, or other physical or mental health care workers regulated under Title 37, including licensed addiction counselors." *Id.* § 50-5-101(20)(b).

D. Department Rulemaking

For a long time, the Department did not publicly propose any rules to implement HB 937. Tara Wooten, the Department's Licensure Bureau Chief, was involved in the rulemaking process. She testified that the Department began rulemaking in July 2023. The Department looked at regulations for various other types of healthcare facilities licensed by the Department as well as licensure regimes for abortion clinics in some other states, including California, Massachusetts, and Mississippi. According to the Department's statement of reasonable necessity, most of the regulations are "based on the licensure and regulatory requirements for outpatient centers for surgical services, while some are derived from the regulatory requirements and minimum standards imposed on all health care facilities." 14 Mont. Admin. Reg. 1767, 1775 (July 26, 2024). On July 16, 2024, the Department published its proposed rules and set a comment period running through August 23, 2024. *Id.* at 1782. A public hearing was held Aug. 16. *Id.* at 1767. On September 10, 2024, the Department published the final rules with a few changes. 2024 Mont. Admin. Reg. 2242. The rules were to have immediate effect, subject to the stipulated temporary restraining order in place in this case. *Id.* at 2267.

Importantly, Wooten agreed that many doctors and other healthcare providers are not required to have any facility licensure. Wooten noted

that private medical practices—including clinics with multiple doctors, nurse practitioners, or advanced practice registered nurses who provide primary care—are not required to be licensed by the Department when they are not affiliated with a larger institution like a hospital (although some choose to seek licensure). Wooten noted that examples of licensed outpatient centers for primary care often include orthopedic and physical therapy practices. There is no requirement that doctors providing gynecological or obstetric services be licensed, even if they are performing in-office procedures. Wooten provided as examples of outpatient surgical centers facilities that perform orthopedic surgeries like knee and hip replacements, etc. OB/GYNs and other doctors who perform in-office procedures are not required to license their offices as outpatient surgical centers.

STANDARDS

The purpose of a preliminary injunction is "to preserve the relative positions of the parties until a trial on the merits can be held." *Stensvad v. Newman Ayers Ranch, Inc.*, 2024 MT 246, ¶ 28, __ Mont. __, __ P.3d __ (Oct. 29, 2024) (quoting *Starbucks Corp. v. McKinney*, __ U.S. __, 144 S. Ct. 1570, 1576 (June 13, 2024)). To obtain a preliminary injunction, a party must establish each of the following elements: (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." Mont. Code Ann. § 27-19-201(1). This is a conjunctive test, meaning the applicant must sufficiently establish an entitlement to relief for each element. *Id.*; *Montanans Against Irresponsible Densification, LLC v. State [MAID]*, 2024 MT 200, ¶ 12, 418 Mont. 78,

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555 P.3d 759. The burden of establishing the need for a preliminary injunction is on the applicant. Mont. Code Ann. § 27-19-201(3).

In establishing what constitutes a sufficient showing as to each of these elements, the Montana Supreme Court has recently adopted the "sliding scale" approach articulated in *Alliance for the Wild Rockies v. Cottrell*, 632 F.3d 1127 (9th Cir. 2011). *Stensvad*, ¶¶ 23–29. Under this approach, an applicant must always demonstrate a likelihood they will suffer irreparable harm if a preliminary injunction is not issued. *MAID*, ¶ 15 ("Plaintiffs must demonstrate that irreparable injury is likely, not merely speculative, in the absence of an injunction."). A preliminary injunction must also be shown to be in the public interest. *See Stensvad*, ¶ 23 (quoting *All. for the Wild Rockies*, 632 F.3d at 1135). The applicant, however, need not strictly show an absolute likelihood of success on the merits, provided they make a sufficiently strong showing that the equities favor an injunction. Thus, the Court may issue a preliminary injunction where the applicant shows that "serious questions going to the merits were raised" and "the balance of hardships tips sharply in the plaintiff's favor." *Stensvad*, ¶ 23 (quoting *All. for the Wild Rockies*, 632 F.3d at 1134–1135).

Finally, special considerations are at play in cases seeking a preliminary injunction blocking enforcement of a statute. "[I]t is the Legislature's prerogative to legislate under their general police power." *Weems v. State ex rel. Knudsen*, 2023 MT 82, ¶ 34, 412 Mont. 132, 529 P.3d 798. The principle of separation of powers demands deference to the legislature's exercise of its legislative powers. *Weems*, ¶ 34. Thus, this Court presumes that statutes duly enacted by the legislature are constitutional, and the party challenging the statute

has the burden to show otherwise. *PPMT-Medicaid*, ¶ 21. The presumption of unconstitutionality is a "high burden to overcome." *Weems*, ¶ 34. Nevertheless, at the preliminary injunction stage, the applicant does not have to show the statute unconstitutional "beyond a reasonable doubt," even if that is the ultimate burden on the merits. *See MAID*, ¶ 13.

DISCUSSION[8]

Each of the four elements of a preliminary injunction application are addressed in turn.

A. Likelihood of Success on the Merits

Article II, Section 4 of the Montana Constitution provides:

> **Individual dignity.** The dignity of the human being is inviolable. No person shall be denied the equal protection of the laws. Neither the state nor any person, firm, corporation, or institution shall discriminate against any person in the exercise of his civil or political rights on account of race, color, sex, culture, social origin or condition, or political or religious ideas.

This provision of the Montana Constitution confers on Montanans a right to equal protection that is superior to that guaranteed by the United States Constitution. *Gazelka v. St. Peter's Hosp.*, 2018 MT 152, ¶ 8, 392 Mont. 1, 420 P.3d 528. It embodies a fundamental principle of fairness: that "the law must treat similarly situated individuals in a similar manner." *Snetsinger v. Mont. Univ. Sys.*, 2004 MT 390, ¶ 14, 325 Mont. 148, 104 P.3d 445. Article II, Section 4 ensures that Montana citizens are not subject to arbitrary or discriminatory state action. *Mont. Cannabis Indus. Ass'n v. State [MCIA II]*, 2016 MT 44, ¶ 15, 382 Mont. 256, 368 P.3d 1131.

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[8] The following constitutes the Court's conclusions of law. Mont. R. Civ. P. 52(a)(2).

There is a well-established methodology for evaluating an equal protection claim under the Montana Constitution. First, the Court identifies the classes involved and determines whether the classes are similarly situated. *Gazelka*, ¶ 15. The classes involved are similarly situated "if they are equivalent in all relevant respects other than the factor. . . constituting the alleged discrimination." *PPMT-Consent*, ¶ 27.

Second, the Court determines the appropriate level of scrutiny to apply. *Gazelka*, ¶ 15. Classifications that interfere with the exercise of a fundamental right or discriminate against a suspect class are subject to strict scrutiny. *Wadsworth v. State*, 275 Mont. 1165, 1174, 911 P.2d 1165, 1174. Strict scrutiny is triggered when the government confers or denies a benefit or otherwise discriminates in its treatment of a person because of their exercise of a fundamental constitutional right. *See Trinity Lutheran Church of Columbia, Inc. v. Comer*, 582 U.S. 449, 461 (2017); *Espinoza v. Mont. Dep't of Revenue*, 591 U.S. 464, 484 (2020) (applying strict scrutiny where "otherwise eligible recipients [were] disqualified from a public benefit solely because of their religious character" (internal quotation marks omitted)); *PPMT-Medicaid*, ¶ 24 ("Strict scrutiny is appropriate 'where the government, by selectively denying a benefit to those who exercise a constitutional right, effectively deters the exercise of that right.'" (quoting *State v. Planned Parenthood of Alaska*, 28 P.3d 904, 909 (Alaska 2001)). By contrast, classifications affecting a right that is conferred by the Constitution but not fundamental is subject to middle-tier scrutiny; and classifications implicating neither fundamental rights nor other constitutional rights are subject to rational-basis review. *Mont. Cannabis Indus. Ass'n v. State [MCIA I]*, 2012 MT 201, ¶ 16, 366 Mont. 224, 286 P.3d 1161.

Finally, the Court applies the appropriate level of scrutiny. Although Providers bear the basic burden of demonstrating the regulations' unconstitutionality, once Providers demonstrate that strict scrutiny applies, the burden shifts to the State to demonstrate the regulation is "justified by a compelling state interest and is narrowly tailored to effectuate only that compelling interest." *PPMT-Medicaid*, ¶ 21 (quoting *Weems*, ¶ 34). By contrast, if rational basis review applies, the classification must merely "be rationally related to a legitimate governmental interest." *Snetsinger*, ¶ 19. With rational basis review, there is a "strong presumption of validity" and "those attacking the rationality of the legislative classification have the burden 'to negative every conceivable basis which might support it.'" *FCC v. Beach Commc'ns, Inc.*, 508 U.S. 307, 315 (1993). Thus, in rational basis review, the burden remains with the challengers.

Before and since passage of HB 937, abortion providers have been subject to regulation by their relevant licensing boards (organized under the Department of Labor and Industry) under Title 37, Mont. Code Ann. As relevant here, this includes physicians and advanced practice registered nurses. *See* Mont. Code Ann. §§ 37-3-301–357 (physicians), 37-8-409 (advanced practice registered nurses). The facilities at which they provide abortion services, however, have neither been regulated nor subject to any licensure requirements by DPHHS.

HB 937 changes that. It requires "abortion clinics" to be licensed by DPHHS and classifies abortion clinics as "healthcare facilities" that are subject to certain baseline regulations and a licensure requirement. Mont. Code Ann. §§ 50-20-902(1), -101(20)(a). Before HB 937's passage, the offices of

abortion providers generally fell within the statutory exclusion for the "offices of private physicians, dentists, or other physical or mental health care workers regulated under Title 37, including licensed addiction counselors." *Id.* § 50-20-101(20)(b).

After HB 937 takes effect, any private healthcare providers who provide "abortion-inducing drugs" to at least five patients per year or perform any "surgical abortion procedures" in their offices must be licensed by DPHHS and subject both to DPHHS's minimum standards for healthcare facilities and DPHHS's minimum standards specific to abortion clinics. This indisputably includes both All Families Healthcare and Blue Mountain Clinic. By contrast, private healthcare professionals who perform the *exact same* procedures and prescribe the *exact same* medications, but who do so for the purpose of managing spontaneous miscarriage instead of inducing abortion, are not subject to regulation or licensure by the Department at all.

HB 937 therefore creates a classification dividing two groups of providers: those healthcare providers who, acting within the scope of their practice and Title 37 licensure, prescribe mifepristone or misoprostol, or who perform dilation & evacuation or vacuum aspiration procedures for the purpose of managing spontaneous miscarriages; and Providers, who, also acting within the scope of their practice and Title 37 licensure, prescribe the same drugs and perform the same procedures, but with the purpose of inducing an abortion.[9]

Providers will likely show these two groups are similarly situated because they appear to be identical in all respects except for the challenged classification. In *PPMT-Consent*, the Supreme Court reached a nearly identical

[9] The Supreme Court has previously found that, consistent with the record described above, the treatments employed for miscarriage care are identical to the procedures involved in abortion. *Weems*, ¶ 12.

conclusion, finding that the two classes there—"pregnant minors who want to obtain an abortion" and "pregnant minors who do not want an abortion"—were similarly situated because the only factor separating the classes was the decision "to choose a particular type of medical care—an abortion." *PPMT-Consent*, ¶ 28. If the pregnant minor wanted to carry to term, the parental consent law did not apply; if the pregnant minor wanted an abortion, the parental consent law did apply. *PPMT-Consent*, ¶ 28. And in *PPMT-Medicaid*, the court found two similarly situated classes there as well: indigent pregnant Medicaid-eligible women who are either (1) seeking care to terminate their pregnancy; or (2) seeking care to carry the pregnancy to term. *PPMT-Medicaid*, ¶ 31. So it is here: the only factor separating Providers (who must be licensed) from other healthcare providers prescribing the same medications and performing the same procedures (who generally need not be licensed) is the intent of the treatment: to induce abortion.[10]

Additionally, the Supreme Court has previously rejected the contention that there is a material distinction between providers who offer miscarriage care and providers who perform abortions. In *Weems*, the court rejected the State's contentions that APRNs lacked the qualifications of physicians and physician assistants to safely manage complications arising from abortion care. Weems, ¶¶ 45–49. In so holding, the court observed—consistent with the record now before this Court—that "the protocols, procedures, and the attendant complications of abortion care are identical to miscarriage care."

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[10] The State offers several regulations that it contends are tailored to abortion, including requirements around mandatory reporting and detecting sexual victimization and sex trafficking. Nothing in the record, however, suggests that these concerns do not also sometimes arise with women seeking other forms of pregnancy care, and there is no reason offered why abortion providers should have special regulation around reporting of sexual abuse and trafficking, while other providers of gynecological and obstetric healthcare should not be subject to similar regulation.

Weems, ¶ 47. The court further observed that the risk of complications arising from abortion are the same as those that exist with miscarriage care. *Weems*, ¶ 47. The court rejected the analogy to the risks attendant to "surgery," noting that "abortion care is one of the safest procedures in the world," and that "[c]complication rates from abortion are similar to or lower than other outpatient procedures." *Weems*, ¶ 48. And the court noted that there was no basis for separating out abortion care from similar or more complex procedures performed by APRNs, including biopsies and the insertion and removal of IUDs, intubations, neuraxial anesthesia, central line insertions, and the prescription of drugs with more addictive properties and safety risks than mifepristone and misoprostol. *Weems*, ¶¶ 48–49. The same logic employed in *Weems* compels the conclusion here that the two classes created by HB 937 are likely substantially similar.

Moreover, Providers will likely show that this classification must be reviewed under strict scrutiny. This prediction, too, is driven by recent binding Montana Supreme Court precedent. In *PPMT-Consent*, because "the classification discriminate[d] against minors who choose to have an abortion because only they have their right to privacy infringed," the classification discriminated based on the exercise of a fundamental right and triggered strict scrutiny. *PPMT-Consent*, ¶ 29. Similarly, in *PPMT-Medicaid*, the court applied strict scrutiny to regulations on abortion care covered by Medicaid on both privacy and equal protection grounds, noting that "otherwise eligible recipients would be disqualified or otherwise restricted from certain public healthcare benefits based on their exercise of their fundamental right to privacy." *PPMT-Medicaid*, ¶ 23. The court continued, "Strict scrutiny is appropriate 'where the

government, by selectively denying a benefit to those who exercise a constitutional right, effectively deters the exercise of that right.'" *PPMT-Medicaid*, ¶ 24 (quoting *State v. Planned Parenthood of Alaska*, 28 P.3d 904, 909 (Alaska 2001)). So it is here: HB 937 applies only to providers who perform D&E and vacuum aspiration or prescribe mifepristone or misoprostol if their patients are not seeking care for the purpose of inducing abortion.

From the patients' perspective, they have access to the full panoply of providers qualified to perform these procedures if they are seeking care to manage a spontaneous miscarriage; by contrast, the pool of available providers is now constricted to those facilities licensed as abortion clinics if the patients seek the exact same treatments, but for the purpose of inducing an abortion instead. *See Weems*, ¶ 50 (in Montana, "limiting the pool of qualified abortion providers would significantly interfere with a patient's right of privacy because of significant cost and travel required to access a provider"). Because HB 937 appears to discriminate on the basis of how a patient exercises a fundamental right, it is likely subject to strict scrutiny.

The State points out, correctly enough, that the right to privacy in medical decision-making does not imply that the State may never restrict or regulate medical care, including abortion care. *See Wiser v. State*, 2006 MT 20, ¶ 15, 331 Mont. 28, 129 P.3d 133. Likewise, the State's police power indeed extends to regulation of healthcare providers and facilities, including abortion providers, for the common health, safety, and welfare. *See Weems*, ¶¶ 40–41. Nevertheless, "once the state 'has entered an area that is covered by the zone of privacy,' such as the constitutional right to a pre-viability abortion, "the state must be neutral." *PPMT-Medicaid*, ¶ 22 (quoting *Jeannette R. v. Ellery*,

Cause No. BDC-1994-811, 1995 WL 17959705, at *25 (1st Jud. Dist. Ct. May 22, 1995)). As with any regulation within the State's police power, if the State chooses to regulate two similarly situated groups differently and does so on the basis of how a fundamental right is exercised, the State must be prepared to justify the choice in a way that can withstand the rigors of strict scrutiny. Had the State chosen to require all private healthcare providers who offer similar procedures and prescribe similar medication to license their offices as healthcare facilities, this would pose a more challenging case from an equal protection standpoint. But the State did not do that.

Because strict scrutiny likely applies, the burden shifts to the State to justify the statute by showing the challenged classification is necessary to promote a compelling state interest. *PPMT-Consent*, ¶ 32. Additionally, "the means chosen to accomplish the State's asserted purpose must be specifically and narrowly framed to accomplish that purpose." *PPMT-Consent*, ¶ 32. Strict scrutiny is a demanding standard that is seldom satisfied. *State ex rel. Bartmess v. Bd. of Trustees*, 223 Mont. 269, 275, 726 P.2d 801, 804 (1986).

The State's response did not argue whether HB 937 or its implementing regulations survive strict scrutiny, instead contesting whether strict scrutiny should apply at all. (*See* Resp. Br. at 9, Dkt. 62.) Nevertheless, the Court recognizes that there may well be a compelling state interest in protecting the safety and health of women seeking pregnancy-related or gynecological medical care. Even so, the regulations seeking to advance that interest must be narrowly tailored, meaning they may not be "underinclusive or overinclusive in scope." *PPMT-Consent*, ¶ 32 (quoting *IMDb.com, Inc. v. Becerra*, 962 F.3d 1111, 1125 (9th Cir. 2020)). Here, if the purpose is to ensure women are treated in safe,

sanitary facilities that are equipped to manage any complications that may arise, that purpose applies equally to the offices of private doctors and other healthcare professionals where they provide the same procedures for miscarriage management, but whose offices are not subject to any of these new regulations. Because the requirements of House Bill 937 and its implementing regulations are underinclusive in scope, they are not narrowly tailored.

The State contends that the Court must review the statute and the regulations individually. (Resp. Br. at 7.) This argument has much initial appeal to the Court. As a general matter, this Court is loath to enjoin a statute or regulatory regime in its entirety unless it is necessary to remediate adequately a constitutional violation, for "[a] ruling of unconstitutionality frustrates the intent of the elected representatives of the people." *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 329 (2006) (quoting *Regan v. Time, Inc.*, 468 U.S. 641, 652 (1984)). Courts should strive to limit their "invasion of the legislative domain" whenever possible. *Id.* at 330. (quoting *United States v. Treasury Employees*, 513 U.S. 454, 479 n.26 (1995)). Here, however, the equal protection flaws reside in the very core of the statute: both the licensure requirement imposed by House Bill 937 and the rules that HB 937 enables apply to healthcare providers who prescribe mifepristone and misoprostol or perform vacuum aspiration or D&E procedures on pregnant women for the purpose of inducing an abortion, but not to providers who offer the same for managing a spontaneous miscarriage. The State has not at this stage provided a plausible justification for regulating those two classes differently. Accordingly, a regulation-by-regulation review will not likely save either the licensure requirement in isolation or the various rules implementing it.

In addition, the Court notes that even if it considered the regulations individually, multiple proposed rules are in clear tension with prior court holdings, binding precedent, or injunctions currently in force.

Numerous regulations are predicated on analogizing the services offered by abortion providers to the services offered by outpatient surgical centers. In *Weems*, the court rejected a similar analogy offered in defense of treating APRNs differently than physicians and PAs:

> The State's reasoning rests on a faulty foundation: it puts aspiration abortions in the category of "surgery" because "instruments" are used to remove "human tissue"; because an aspiration abortion is "surgery" it has all the attendant risks of surgery—hemorrhaging, infection, post-operative care, and monitoring; because abortion is "surgery" it should not be treated any differently than other elective surgery, which occurs in a clinic or hospital; because it is surgery it is not safe unless done where emergency backup is in place and where clinicians who can perform "surgery" are present. This reasoning would exclude APRNs from performing abortion care because, as the State posits, post-abortion care might be beyond what APRNs are capable of handling or authorized to do. Finally, at oral argument, the State represented that APRNs also should not perform medication abortions because complications from a medication abortion could lead to surgery. Therefore, according to the State, APRNs would not be authorized to dispense mifepristone or misoprostol.

Weems, ¶ 46. Moreover, in *Whole Woman's Health v. Hellerstedt*, 579 U.S. 582 (2016), *overruled on other grounds by Dobbs*, 597 U.S. 215, the United States Supreme Court evaluated a similar attempt by the State of Texas to require all "abortion facilities" to meet the minimum standards for ambulatory surgical centers. Applying the "undue burden" standard—a lesser standard that is not used under the Montana Constitution, *see Armstrong*, ¶ 41—the Court invalidated the

regulations, reasoning they bore little relation to patient safety. *Whole Woman's Health*, 579 U.S. at 618. The Court additionally noted that while Texas frequently grandfathered facilities to which the ambulatory surgery center design standards applied, it did not grandfather in abortion facilities. *Id.* Moreover, the Kansas Supreme Court, applying its own state constitutional right to abortion access, recently rejected a similar attempt to regulate abortion services on the same regulatory tier as ambulatory surgery centers. *See Hodes & Nauser, MDs, P.A. v. Stanek*, 551 P.3d 62 (2024). Given that the procedures at issue here are commonly performed in a doctor's private office now and can continue to be preformed there if not for the purpose of inducing abortion, the analogy to outpatient surgical centers will face the same uphill battle in Montana that it has elsewhere.

Additionally, several rules appear to contravene injunctions in effect or binding Montana Supreme Court precedent. By requiring a physical medical director, Admin. R. Mont. 37.106.3105 is difficult (if not impossible) to reconcile with the express holdings of *Weems* and *Armstrong* that the State cannot require physician involvement to the exclusion of all otherwise qualified providers. The same appears true of Admin. R. Mont. 37.106.3110, which limits who may administer anesthesia, while not clarifying whether "anesthesia" means only general anesthesia or also applies to local anesthesia and sedatives. Admin. R. Mont. 37.106.3107—which requires patient files to include "tests for Rh Negative factor", a pregnancy test or pathological exam of tissue—is in tension with the preliminary injunction in *PPMT-2023 Laws*, which enjoined a statute that burdened the ability to seek abortion services by telehealth by requiring certain in-person testing or imaging. *PPMT-2023 Laws*, ¶ 25.

In short, regardless of the merits of Providers' right-to-privacy and vagueness, Providers have demonstrated they will likely succeed on the merits of their equal protection claim. Moreover, Providers' equal protection claim, if successful, undermines the entire edifice of HB 937 and its implementing rules.

B. Irreparable Harm

Next, Providers must demonstrate that if a preliminary injunction is not granted, they or their patients[11] are "likely to suffer irreparable harm before a decision on the merits can be rendered." *Montanans against Irresponsible Densification, LLC v. State* [*MAID*], 2024 MT 200, ¶ 15, 418 Mont. 78, 555 P.3d 759. This is the "single most important prerequisite for the issuance of a preliminary injunction." *MAID*, ¶ 15. Providers must show "irreparable injury is likely, not merely speculative, in the absence of an injunction." *MAID*, ¶ 15.

If the Court's temporary restraining order expires, House Bill 937 and the implementing rules will take immediate effect. Thus, Providers will be required to seek and obtain a license to offer services. If they successfully obtain those licenses, they will be required to abide by the implementing rules except for any requirements the Department chooses to waive. This is not a speculative outcome; it will happen by operation of law. Meanwhile, healthcare providers who perform the same procedures and prescribe the same medications will continue to be unregulated by DPHHS. In other words, the disparate treatment under the law that is the *sine qua non* of an equal protection violation will be felt by both Providers and their patients, who will be treated differently from pregnant women who seek the same treatments for miscarriage management. "Harm from constitutional infringement [is] adequate to justify a preliminary

[11] Under *Armstrong*, Providers have standing to assert claims on behalf of their patients. *Armstrong*, ¶ 13; *PPMT-2023 Laws*, ¶ 19.

injunction." *MAID*, ¶ 16. Unequal treatment is itself injury from a constitutional infringement. *See Heckler v. Matthews*, 465 U.S. 728, 739–740 (1984) (unequal treatment is an injury-in-fact for standing purposes).

Additionally, it is not merely speculative that the expiration of the TRO is likely to inhibit access to abortion. First, the Department has represented that it has not processed applications because it was awaiting the outcome of litigation. If the Department "acts" on the applications with anything other than an unqualified approval, the immediate effect of HB 937 would be that Providers must cease operating until they reach an accord with the Department on waiver and compliance with minimum requirements. Second, the Supreme Court has already found that various of the proposed regulations—such as those requiring physician involvement or medical testing—are likely to cause irreparable harm in the context of other preliminary injunction cases. *PPMT-2023 Laws*, ¶¶ 25–26 (burden imposed by legally mandated medical testing or imaging); *Weems*, ¶ 50 (burden imposed by exclusion of APRNs from performing abortions). Third, Providers have averred that they cannot now meet the physical plant requirements for their clinics, and the standard for obtaining a waiver—a showing that compliance would be "extremely difficult or impossible" and that the Department must find "the level of safety to patients and staff is not diminished"—is stringent. The *potential* the Department might grant some waivers (which it is not obliged to extend) does not render Providers' concerns merely speculative.

In short, Providers have demonstrated that irreparable harm is likely to result absent an injunction.

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C. Balance of the Equities and the Public Interest

The final two factors are the balance of the equities and public interest. The "public interest" inquiry is very similar to balance of the equities, but "primarily addresses impact on non-parties rather than the parties." *League of Wilderness Defenders/Blue Mountains Biodiversity Project v. Connaughton*, 752 F.3d 755, 766 (9th Cir. 2014). Where the injunction is sought against the government, the public interest and balance of the equities elements merge. *PPMT-2023 Laws*, ¶ 34.

The Court applies this factor while keeping in mind that the purpose of a preliminary injunction is to maintain the status quo. *PPMT-2023 Laws*, ¶ 16. In this case, the status quo is what has been the case for decades: while abortion providers are subject to applicable federal regulation and regulation by their licensing board, they are not generally considered healthcare facilities subject to a licensure requirement or any DPHHS regulation. HB 937 represents a departure from that status quo.

Second, the Court generally agrees with the sentiment that whenever "a State is enjoined by a court from effectuating statutes enacted by representatives of its people, it suffers a form of irreparable injury." *Maryland v. King*, 567 U.S. 1301 (2012) (order on stay application) (Roberts, C.J., in chambers). This interest, however, is heavily mitigated when there is a strong showing that the statute infringes on a fundamental right, because "the government suffers no harm from an injunction that merely ends unconstitutional practices." *PPMT-2023 Laws*, ¶ 36 (quoting *Doe v. Kelly*, 878 F.3d 710, 718 (9th Cir. 2017)). In this case, the harm occasioned by inflicting constitutional injury on Providers and their patients, who face likely disparate treatment, regulatory

burdens not shared by other, similar, patients and providers, and the strong potential of imminent closure (at a minimum until regulatory compliance is achieved or agreement is reached on waivers) outweigh the government's interest in effectuating a change to the status quo in the form of HB 937.

The balance of equities tips in favor of Providers.

CONCLUSION

Providers have demonstrated that they are likely to succeed in showing that House Bill 937 violates their and their patients' right to equal protection of the laws under Mont. Const. art. II, § 4 by treating abortion providers differently than healthcare professionals who prescribe the same medication and perform the same procedures for purposes other than abortion. Providers have further demonstrated irreparable injury and that the balance of equities and public interest favor an injunction. Indeed, much or most of the foregoing analysis is compelled by binding precedent of the Montana Supreme Court in its cases from the last several years applying *Armstrong* in the context of permanent and preliminary injunctions. Thus, the Court agrees that the strength of Providers' showing is sufficiently strong that the Court should preserve the pre-HB 937 status quo pending a final determination of the merits.

As always, the Court offers an important caveat: a preliminary injunction is just that—*preliminary*. It is based on quickly drafted and considered briefing and a limited evidentiary record. Although the Court concludes Providers are likely to succeed based on what it has seen so far, the Court defers any definitive determinations about the constitutionality of HB 937 and the implementing regulations until the merits can be fully heard.

Accordingly,

IT IS ORDERED:

1. Providers' Application for a Preliminary Injunction (Dkt. 57), filed October 7, 2024, is **GRANTED**.

2. Until further order of the Court, the State of Montana, the Montana Department of Public Health and Human Services, DPHHS Director Charles Brereton, and their respective officers, employees, agents, successors, and assigns, are **ENJOINED** from enforcing any provisions of House Bill 937, 2023 Mont. Laws 492, and Admin. R. Mont. 37.106.3101–37.106.3114.

3. A written undertaking is waived in the interests of justice.

DATED this 15th day of November 2024.

/s/ Christopher D. Abbott
CHRISTOPHER D. ABBOTT
District Court Judge

cc: Alex Rate, via email
Hillary Schneller, via email
Jacqueline Harrington, via email
Nina S. Riegelsberger, via email
Tabitha Crosier, via email
Hartley M.K. West, via email
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Electronically Signed By:
Hon. Judge Christopher D. Abbott
Fri, Nov 15 2024 04:25:36 PM