IN THE SUPREME COURT OF THE STATE OF MONTANA
No. DA 25-0040

ALL FAMILIES HEALTHCARE; BLUE MOUNTAIN CLINIC; and HELEN WEEMS, MSN, APRN-FNP, on behalf of themselves, their employees, and their patients,

Plaintiffs and Appellees,

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 and Appellants.

On appeal from the Montana First Judicial district court, Lewis and Clark County
Cause No. DDV 23–592, the Honorable Christopher Abbott, Presiding

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APPELLEES' RESPONSE BRIEF

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STATEMENT OF THE ISSUES

1. Whether the district court manifestly abused its discretion in granting a preliminary injunction after independently assessing the four preliminary injunction factors and concluding that the Plaintiff Providers established a "likelihood of success" on of each of them.
2. Whether the district court manifestly abused its discretion in entering a preliminary injunction against HB 937 and all its implementing rules, based on and tailored to the court's conclusion that their "entire edifice" likely violated patients' fundamental equal protection rights and imposed irreparable harms.

STATEMENT OF THE CASE

For decades, Montana has regulated patients' access to health care through two separate and generally applicable schemes relevant here: one for clinics and providers' offices (through professional licensing boards) and another for "health care facilities" (which are licensed by the Department of Public Health and Human Services (DPHHS)). Under current law, a "health care facility" licensed by DPHHS includes a variety of facility types—but explicitly "***does not include*** offices of private physicians" and other licensed health professionals. § 50-5-101(20)(b), MCA (emphasis added). People access a variety of health services—including vasectomies, gynecological procedures, and miscarriage and abortion care by the

same medications and procedures—from Montana providers subject to State regulation, but whose facilities DPHHS does not license.

Plaintiffs All Families Healthcare; Blue Mountain Clinic; and Helen Weems, APRN-FNP (collectively, "the Plaintiff Providers" or "the Providers") are health care providers that offer comprehensive reproductive health care, including abortion, in Montana. Patients' access to care—including abortion—from the Providers has consistently been subject to regulation but not mandatory facility licensure, just as access to a variety of other health services from other providers in the state has been.

HB 937, which Governor Gianforte signed on May 16, 2023, changes that—exclusively for abortion. HB 937 imposes a $1,000-per-day penalty for operating an "abortion clinic" without a license from DPHHS or failing to comply with any of its implementing rules. §§ 50-5-111, 50-5-112(1), MCA. "Abortion clinic" means a facility where any abortion procedure is performed or that provides an "abortion-inducing drug" to five or more patients per year for the purpose of abortion. § 50-20-901, MCA. The law directs DPHHS to promulgate rules about the licensure process and requirements across 15 categories for abortion clinic licensure. § 50-20-903, MCA.

HB 937's licensure requirement was set to take effect October 1, 2023. DPHHS had yet to even propose rules by September 1, 2023, making compliance by that date impossible and threatening to force the Providers to cease offering abortion

care or shut down altogether. TRO and Order to Show Cause, Dkt. No. 48, Sept. 27, 2023.

Accordingly, Providers filed suit and moved for a temporary restraining order and/or a preliminary injunction, which the district court granted. *Id.* The parties stipulated to extend the court's order until 60 days from the effective date of DPHHS's final rules. Order Extending TRO and Vacating Prelim. Inj. Hr'g, Dkt. No. 54, Oct. 18, 2023.

Nearly a year later, DPHHS published proposed rules. 14 Mont. Admin. Reg. 1767-83 (July 26, 2024) (App. G). DPHHS made no substantive changes in response to comments and adopted final rules on September 20, 2024, with an immediate effective date. 18 Mont. Admin. Reg. 2242-68 (Sep. 20, 2024) (App. G).

On October 1, 2024, All Families and Blue Mountain submitted to DPHHS applications for licensure, subject to requests for waivers from certain requirements. Weems Aff. ¶ 58 (App. C); Banks Aff. ¶ 79 (App. C). On October 7, the Providers moved for another TRO and/or preliminary injunction. Mem. ISO Pls.' Mot. for TRO and Prelim. Inj. (App. C). The Providers argued HB 937 and its final rules (collectively, "the Challenged Scheme" or "the Scheme") violated their patients' fundamental rights to privacy and equal protection, violated their own rights to equal protection, and was void for vagueness. *Id.*

In support, the Providers submitted uncontested evidence from Ms. Weems, Dr. Joey Banks (a family medicine physician who provides abortion at Blue Mountain), and Dr. Jennifer Mayo (an ob-gyn who provides gynecological care, including miscarriage care, at an outpatient clinic in Montana). Among other things, that evidence established that:

- Abortion and miscarriage care are identical, yet the Scheme does not apply to clinics that offer miscarriage care, nor to patients seeking that care. Order 17:5-14 (App. A).

- Abortion is safely provided in clinics and providers' offices, and is identical to miscarriage care and comparable in risk, technique, and duration to other gynecological care safely and routinely provided in office settings, including in Montana. *Id.* 7:18-19, 9:4-10.

- There is no health or other valid reason to regulate abortion differently than comparable or identical care, such as miscarriage care. Weems Aff. ¶ 21 (App. C); Banks Aff. ¶¶ 30-34 (App. C); Mayo Aff. ¶ 16 (App. C). Facility licensure and regulation is especially irrational for the provision of medication abortion, where patients take medications at home, not at a clinic. Weems Aff. ¶ 20 (App. C); Banks Aff. ¶¶ 61, 66 (App. C).

- Enforcement would end or significantly curtail access to abortion. Order 25:13-23 (App. A).

The State submitted no affidavit testimony or other evidence in support of the Scheme.

The district court held a hearing on November 8, 2024. As of that date, the Providers had not received a response to their licensure application or requests for waivers from DPHHS.

Plaintiff Providers and the State presented argument. Tara Wooten, the DPHHS Licensure Bureau Chief, testified for the State that:

- Prior to HB 937, Montana licensed providers provided abortion care, miscarriage care, and other gynecological care practice in office-based settings subject to regulation, including by the Department of Labor and Industry, but without DPHHS *facility* licensure. App. F, 16:1-18:11, 20:20-21:4.

- Prior to HB 937, DPHHS knew of no safety incident with Montana facilities providing abortion. App. F, 16:12-14.

- DPHHS based its HB 937 and its implementing rules on its rules for outpatient surgical centers, where surgeries like "knee replacements or . . . shoulder surgeries" are performed . App. F, 17:16-18, 30:2-15.

- DPHHS received licensure applications and waiver requests from the Plaintiff Providers, but did not take any action in light of the preliminary injunction hearing. App. F, 22:18-23:13.

On October 29, 2024, this Court decided *Stensvad v. Newman Ayers Ranch, Inc.*, which held that an applicant for a preliminary injunction must make a "sufficient showing" as to each of the four preliminary injunction factors, based on the "serious questions" or "sliding scale" framework. 2024 MT 246, ¶¶ 25-29, 418 Mont. 378, 557 P.3d 1240.

On November 15, 2024, the district court granted the Providers' motion for a preliminary injunction, concluding the Providers had established a likelihood of each of the four preliminary injunction factors. Order Granting Pls.' Mot. for Prelim. Inj. ("Order") 28:7-13 (App. A).

On January 14, 2025, the State noticed this appeal.

On March 25, 2025—more than four months after the preliminary injunction was entered—an amendment to the preliminary injunction statute took effect, stating courts "may not use a sliding scale test, the serious questions test, flexible interplay, or another federal circuit modification to the criteria." H.B. 409, 69th Leg., Reg. Sess. (Mont. 2025), codified at § 27-19-201(4)(b), MCA (the "2025 Amendment").

STATEMENT OF THE FACTS

The district court found that the Providers "produced extensive evidence by affidavit that is largely unrebutted by the State." Order 6 n.5 (App. A).

I. The Plaintiff Providers

Plaintiff Providers are health care providers that offer sexual and reproductive health services, including abortion care, in Montana. *Id.* 5:21-6:6, 6:14-20 (App. A).

Blue Mountain Clinic, in Missoula, opened in 1977 as the first and only abortion clinic in the state. *Id.* 5:21-22. It provides care across a patient's lifespan, including family medicine and gynecological care. *Id.* 6:1-2; Banks Aff. ¶¶ 35, 39 (App. C). Blue Mountain has provided abortion care in the same physical facility for 30 years. Banks Aff. ¶ 4 (App. C).

All Families, in Whitefish, is the only clinic providing abortion care in Northwest Montana. Weems Aff. ¶ 2 (App. C). It also provides gender-affirming care, gynecological exams, contraception, and miscarriage management. Order

6:17-20 (App. A). Helen Weems, a nurse practitioner licensed by the Montana Board of Nursing, owns All Families and is its sole clinician. *Id*. 6:15-16.

Plaintiff Providers offer both medication abortion (in-person and via telehealth) and procedural abortion. *Id.* 6:7-12, 6:21-7:5, 7:18-19.

II. Abortion and Other Care Provided in Office-Based Settings.

As this Court affirmed just two years ago: "[t]he overwhelming evidence" establishes that "abortion care is one of the safest procedures in this country and the world;" "[c]omplication rates from abortion are similar to or lower than other outpatient procedures;" and "[w]hen complications do occur, they are usually minor and easily treatable—normally at home or in an outpatient setting." *Weems v. State*, 2023 MT 82, ¶ 48, 412 Mont. 132, 529 P.3d 798 ("*Weems II*"); *see also Planned Parenthood of Mont. v. State*, 2024 MT 178, ¶ 30, 417 Mont. 457, 554 P.3d 153 ("*PPMT Parental Consent*") ("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* [*II*]."); Order 7 n.7 (finding Providers' affidavits consistent with *Weems II* record). Abortion is far safer than its only alternative—carrying a pregnancy to term and childbirth. Order 7:12-14 (App. A).

It is undisputed the same medications are prescribed for medication abortion as to manage spontaneous miscarriages. *Id.* 8:2-4. *see also Weems II*, ¶ 47.

It is also undisputed that procedural abortion is the same procedure that providers perform to manage a patient's spontaneous miscarriage. Order 8:12-13 (App. A); *see also Weems II*, ¶ 47. Despite sometimes being referred to as "surgical," these procedures are not: they involve no incision, are routinely performed in office-based settings while the patient remains awake with only local anesthetic or moderate sedation, and involve minimal recovery. Banks Aff. ¶ 20 (App. C); Mayo Aff. ¶ 14 (App. C); *see also Weems II*, ¶ 48.

Additionally, abortion, whether by medication or procedure, is safely and effectively provided in office settings, like Providers' clinics. Order 7:18-19, 9:4-6 (App. A). Like procedural abortion, other office procedures involve in-office administration of local anesthesia or moderate sedation. *Id*. 9:11-12. Medication abortion is also safely provided via telehealth without an office visit. *Id.* 7:18-19.

Consistent with this evidence, leading medical authorities have concluded that there is no health or safety reason to regulate abortion differently than identical or comparable care, such as by mandating that abortion be performed in settings that mirror surgical centers. Weems Aff. ¶ 21 (App. C); Banks Aff. ¶¶ 30-34 (App. C); Mayo Aff. ¶¶ 8, 12, 16 (App. C).

III. Regulation of Health Care, Including Abortion, in Montana

Montana licenses and regulates health care providers through a generally applicable scheme, and licenses and regulates, some, but not all, facilities where that care is delivered.

A. Licensure and Regulation of Health Care Providers

Montana health care providers, including the Plaintiff Providers, are subject to generally applicable state, federal, and professional oversight and regulation. Like other clinicians in Montana, state professional boards license and regulate the Plaintiff Providers pursuant to Title 37 of the Montana Code. Order 16:14-19 (App. A); §§ 37-3-101, *et seq.*, 37-8-101, *et seq.*, 37-20-101, *et seq.*, 37-27-101, *et seq.*, MCA. For instance, the State Board of Nursing licenses advanced practice registered nurses ("APRNs"), including nurse practitioners like Ms. Weems, permitting them to practice independently and provide care consistent with their education, training, and experience. § 37-8-101, MCA; Admin. R. Mont. 24.159.1405. The Board of Nursing also grants prescriptive authority, permitting APRNs to prescribe medications. Admin. R. Mont. 24.159.1461. The State Board of Medical Examiners licenses physicians and physician assistants and regulates medical assistants. §§ 37-3-101, -102(12), -104, 37-20-403, MCA. These professional licensing boards and the Montana Department of Labor and Industry are charged with investigating

complaints about and disciplining licensees. §§ 37-1-101, 37-3-323, 37-8-202(1)(f), MCA.

The Providers also are subject to state regulation and inspection by the Montana Board of Pharmacy because they dispense medications. Weems Aff. ¶ 15 (App. C); Banks Aff. ¶ 36 (App. C); § 37-7-201, MCA; Admin. R. M. 24.174.1802, 24.174.1803, 24.174.830. They are further subject to oversight and regulation by DPHHS through federal Clinical Laboratory Improvement Amendments (CLIA), which DPHHS implements and conducts inspections for, and through Montana abortion-reporting requirements, which DPHHS enforces. Weems Aff. ¶ 15 (App. C); Banks Aff. ¶ 36 (App. C).

B. Licensure and Regulation of Health Care Facilities

Montana has a *separate* set of licensure requirements for some health care *facilities*. *See* §§ 50-5-103(1), 50-5-204(3), MCA. "Health care facilities" licensed by DPHHS include hospitals, outpatient surgical centers, and long-term care facilities, among others. § 50-5-101(20)(a), MCA. "Health care facility" "***does not*** include offices of private physicians, dentists, or other physical or mental health care workers regulated under Title 37 [of the Montana Code]." § 50-5-101(20)(b), MCA (emphasis added). The Providers' offices thus are not required to be licensed as "health care facilities."

Some providers may *choose* to have their offices or clinics licensed as health care facilities, for example, so that they can charge a facility fee to insurance. *See* 7 Mont. Admin. Reg. 578-79 (Apr. 14, 2011) (Response #1); 22 Mont. Admin. Reg. 2696 (Nov. 26, 2010); App. F, 23:24-25:16 (Wooten Test.). But as Ms. Wooten testified, providers licensed under Title 37 may practice ***without*** additionally licensing the *facilities* in which they practice. App. F, 20:20-21:4, 23:24-25:16.

DPHHS has said the same in prior rulemakings. For instance, when implementing a physician medical director rule for licensed outpatient centers for primary care, DPHHS assured nurse practitioners that they could continue to run their own clinics *without* a physician medical director because facility licensure was available but ***not*** required. 7 Mont. Admin. Reg. 578-79 (Apr. 14, 2011) (Response #1).

Similarly, freestanding clinics that operate as birth centers—where pregnant people labor and give birth—may obtain facility licensure so that they can bill insurance a facility fee, but they are ***not*** required to be licensed facilities. *See* 22 Mont. Admin. Reg. 2696 (Nov. 26, 2010). They may still "operate under the independent scope of practice of [] health care professional[s]." *Id.* This is so even though childbirth carries significantly higher risk of mortality and morbidity than abortion. Order 7:12-14 (App. A); Banks Aff. ¶ 25 (App. C).

Accordingly, today, patients access care from licensed providers who practice in office settings without DPHHS licensure. For decades, this is how the State regulated health services including abortion. Order 16:14-21 (App. A); Weems Aff. ¶ 16 (App. C); Banks Aff. ¶ 36 (App. C); Mayo Aff. ¶ 3 (App. C).

IV. The Challenged Scheme: HB 937 and its Rules

HB 937 and its implementing rules make it unlawful to operate an abortion clinic without a DPHHS license and create an entirely new and unique regulatory regime exclusively for clinics that offer abortion care. §§ 50-20-901 - 50-20-904, 50-5-111, 50-5-112, MCA; Admin. R. Mont. 37.106.3101–37.106.3114. HB 937 directed DPHHS to adopt rules addressing virtually every aspect of clinic operations and patient access to abortion. § 50-20-903(2), MCA.

HB 937 ***does not*** alter existing law, which provides that "health care facility" "***does not*** include offices of private physicians, dentists, or other physical or mental health care workers regulated under Title 37." § 50-5-101(20)(b), MCA (emphasis added). Accordingly, the Scheme subjects the clinics (and patients seeking care at those clinics) to mandates that do not apply to *identical* miscarriage care or to health services with similar or greater risk of complications. And, Montana law continues to permit clinics to be unlicensed—unless those clinics, like the Plaintiff Providers, offer abortion care.

Neither the legislative debate nor the DPHHS rulemaking identify any safety issues with abortion in Montana, let alone any issues would warrant imposing a new and abortion-specific licensure scheme. *See* App. F, 16:12-14 (Wooten Test.).

None of the Scheme's requirements bear *any* specific relationship to abortion. Further, the Plaintiff Providers do not meet several of the requirements, and imposition of the Scheme would deny or substantially curtail Plaintiffs' patients' access to abortion for no health and safety reason—simply because it is abortion care. Order 25:13-23 (App. A). For example:

Application fee and annual licensure: An abortion clinic must pay a $450 license fee with its initial application and each annual renewal application. Admin. R. Mont. 37.106.3102(4). That is substantially higher than the licensure fees for any other health care facility, which may be licensed for up to three years. *See* § 50-5-202, MCA ($20 for facilities with 20 beds or fewer, and $1 per bed for facilities with 21 or more beds); Admin. R. Mont. 37.106.310(3) (two- and three-year license); App. F, 20:8-19 (Wooten Test.).

Physical plant requirements: All "patient rooms" in an abortion clinic must be 100 square feet, with 4 feet available on one side of the exam table and 3 feet on all other sides, and corridors must be at least 6 feet wide. Admin. R. Mont. 37.106.3103(2), (4). DPHHS does not define "patient room," but stated in responses

to the final rules that "patient rooms" are rooms "in which a patient is assessed or treated." 18 Mont. Admin. Reg. 2260 (Sept. 20, 2024) (Response #65) (App. G).

Accordingly, patients receiving medication for abortion must be counseled and provided medications in rooms of a specific size, but not patients who are provided any other medication—including patients given the ***exact same*** medications for miscarriage management. Patients obtaining procedural abortion must be treated in a room with these precise dimensions—but not patients obtaining the ***same*** procedure to complete a miscarriage or other in-office procedures of comparable risk and protocol. And the hallway-width requirement is arbitrary; it is not necessary, for example, to allow passage by emergency services or wheelchairs, which All Families and Blue Mountain's hallways already do. Weems Aff. ¶ 25 (App. C); Banks Aff. ¶ 50 (App. C).

Plaintiffs meet neither the patient-room dimensions nor the hallway-width dimensions. Weems Aff. ¶¶ 24-25 (App. C); Banks Aff. ¶ 48 (App. C).

Physician medical director: Every abortion clinic must have a physician medical director. Admin. R. Mont. 37.106.3105(1). Advance practice clinicians, including Ms. Weems, are thus prohibited from providing abortion care unless they secure physician oversight.

Physical exam requirements: Abortion clinics must document and thus have every patient undergo a physical exam, testing for Rh factor, and pregnancy test or

"pathological exam of tissue . . . to verify pregnancy," regardless of medical necessity, the patient's individual circumstances, or clinicians' judgment.[1] Admin. R. Mont. 37.106.3107(1). Mandating that patients travel to a clinician to undergo unnecessary tests and exams would end access to abortion via telehealth. Weems Aff. ¶¶ 33, 40 (App. C); Banks Aff. ¶¶ 54, 58, 62 (App. C).

Written transfer agreement with a hospital: Abortion clinics must have a written transfer agreement with a hospital. Admin. R. Mont. 37.106.3109(3). Providers already have emergency protocols in the rare event a patient receiving any type of health care service needs to be transferred to the hospital. Weems Aff. ¶ 41 (App. C); Banks Aff. ¶ 64 (App. C). A transfer agreement mandate is especially irrational for medication abortion patients, who pass their pregnancy at home, which may be hours from the clinic. Weems Aff. ¶ 42 (App. C); Banks Aff. ¶ 66 (App. C). It is also irrational for patients obtaining procedural abortion, who, like all patients, are advised to go to the hospital in the rare event they experience a complication after returning home. Weems Aff. ¶ 44 (App. C); Banks Aff. ¶ 66 (App. C).

Restriction on administration of anesthesia: At an abortion clinic, anesthesia may be administered only by physicians and certified registered nurse anesthetists.

[1] Rh testing involves a blood draw and lab test to identify whether a person has Rh factor, a protein on the surface of red blood cells that can affect the development of antibodies in some pregnant people. Weems Aff. ¶ 35 (App. C). Major medical organizations agree that Rh testing is not necessary in early pregnancy. Weems Aff. ¶ 36 (App. C).

Admin. R. Mont. 37.106.3110(2). There is no definition of "anesthesia." *See* 18 Mont. Admin. Reg. 2260 (Sept. 20, 2024) (Response #65) (App. G) (declining to define term).

The Scheme thus denies patients seeking abortion care basic pain management available to other patients. Weems Aff. ¶ 48 (App. C); Banks Aff. ¶ 71 (App. C). It bars All Families' patients from receiving local anesthesia administered by Ms. Weems and bars the minimal and moderate sedation Blue Mountain offers, which a registered nurse administers as prescribed by a physician. Weems Aff. ¶¶ 46-47 (App. C); Banks Aff. ¶ 71 (App. C). But Ms. Weems and registered nurses at Blue Mountain can continue to offer local anesthesia and minimal and moderate sedation for a range of other procedures. Weems Aff. ¶¶ 47-48 (App. C); Banks Aff. ¶ 29, 71 (App. C).

***Waivers*:** The rules reference waivers, but DPHHS provided no concrete guidance on what information needed to seek a waiver, the criteria DPHHS would use to determine whether to grant one, or which specific requirements, other than the physical plant requirement, may or may not be waived. *See* Admin. R. Mont. 37.106.3101(5), 37.106.3103(7); 18 Mont. Admin. Reg. 2260 (Sept. 20, 2024) (Response #66) (App. G); *see also* App. F, 22:3-14; 27:5-8 (Wooten Test.) (requirements associated "exclusively" with procedural abortion may be waived for

medication abortion only clinics, but not defining requirements associated "exclusively" with procedural abortion).

* * *

The State asserted, and Ms. Wooten testified, that many aspects of the Scheme are based on Montana rules for outpatient surgical centers. Ex. H (App. G); App. F, 9:6-13, 17:6-18 (Wooten Test.). The medical consensus agrees such standards are inappropriate to mandate for abortion. Weems Aff. ¶ 21 (App. C); Banks Aff. ¶¶ 30-34 (App. C); Mayo Aff. ¶ 16 (App. C); *see also Whole Woman's Health v. Hellerstedt*, 579 U.S. 582, 624 (2016) (holding unconstitutional application of surgical-center requirements to abortion), *abrogated by Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215 (2022).

The State also asserted that the Scheme merely brings abortion in line with other health regulation. Defs.' Resp. in Opp'n to Pls.' Mot. for TRO and Prelim. Inj. 10 (App. D). In support, the State listed only four rules with citations indicating that those rules apply to some other DPHHS licensed facilities. *Id.* But as the State continues to ignore, *not a single one of those rules* is mandatory for any clinics or providers' offices—unless, per the Scheme, they provide abortion.

Moreover, no part of the Scheme would apply to the Providers if they ceased providing abortion but continued to offer all the other care they provide, including *identical* miscarriage care. Order 12:6-11, 17:5-14 (App. A). Nor does Montana

mandate facility licensure or aspects of the Scheme for clinics where patients access health care that carries similar or *greater* risk of complications than abortion, including for continued pregnancy and childbirth. *Id.* 11:24-12:11. Yet, the State does not call that care—or any other health care (except abortion) patients access in unlicensed offices or clinics—"unregulated." *Contra* Defs.' Resp. in Opp'n to Pls.' Mot. for TRO and Prelim. Inj. 12, 15 (App. D).

STANDARD OF REVIEW

This Court reviews the grant of a preliminary injunction for a manifest abuse of discretion. *Planned Parenthood of Mont. v. State*, 2022 MT 157, ¶ 5, 409 Mont. 378, 515 P.3d 301 ("*PPMT 2021 Laws PI*"). A court abuses its discretion when it acts "arbitrarily, without employment of conscientious judgment, or exceeds the bounds of reason resulting in substantial injustice." *Id.* A manifest abuse of discretion is one that is "obvious, evident, or unmistakable." *Id.*

"The grant or denial of injunctive relief is a matter within the broad discretion of the district court based on applicable findings of fact and conclusions of law." *Davis v. Westphal*, 2017 MT 276, ¶ 10, 389 Mont. 251, 405 P.3d 73. The district court's factual findings are reviewed for clear error. *See State v. Reynolds*, 2017 MT 25, ¶ 13, 386 Mont. 267, 389 P.3d 243. A court's "findings of fact are clearly erroneous if they are not supported by substantial credible evidence, if the court misapprehended the effect of the evidence, or if a review of the record leaves this

Court with the definite and firm conviction that a mistake has been made." *Id.* To the extent the district court's ruling is based on legal conclusions, this Court "review[s] the district court's conclusions of law to determine whether the interpretation of the law is correct." *Weems v. State*, 2019 MT 98, ¶ 7, 395 Mont. 350, 440 P.3d 4 ("*Weems I*").

"Statutes are presumed constitutional, and the party challenging a statute has the burden of proving it unconstitutional or showing that the statute infringes on a fundamental right." *Mont. Democratic Party v. Jacobsen*, 2024 MT 66, ¶ 11, 416 Mont. 44, 545 P.3d 1074. Once "the challenger shows an infringement on a fundamental right, a presumption of constitutionality is no longer available." *Id.* Then, the law is subject to "a higher level of scrutiny and the burden necessarily shifts to the State to demonstrate that the statute is constitutional." *Id*. (citing *Weems II*, ¶ 34).

SUMMARY OF THE ARGUMENT

The Scheme is the latest of the State's many efforts to violate Montanans' fundamental rights to privacy and equal protection by singling out abortion for unique, additional, and medically unnecessary restrictions, despite ***no*** threat to patient health and safety.

Binding Montana precedent squarely controls this case. This newest set of restrictions follows the same playbook as the numerous other abortion laws Montana

courts have enjoined in recent years, and indeed conflicts with several preliminary or permanent injunctions. And it mirrors targeted restrictions on abortion provider ("TRAP") laws several states passed a decade ago that courts likewise held unconstitutional. *E.g.*, *Hodes & Nauser v. Stanek*, 318 Kan. 995, 551 P.3d 62 (2024) (holding 2011 Kansas abortion facility licensing statutes and regulations violated state constitutional right to abortion); *Whole Woman's Health*, 579 U.S. at 624; *Doe v. State*, No. 62-CV-19-3868, 2022 WL 2662998, at *30-34 (Minn. Dist. Ct. July 11, 2022) (holding law requiring abortion after first trimester be provided in hospital or "abortion facility" violated fundamental rights to privacy and equal protection).

The district court correctly held that the Plaintiff Providers established a likelihood of success on each of the four preliminary injunction factors. It held the Scheme likely discriminates based on how a person exercises their fundamental rights to privacy and procreative autonomy: interfering with patients seeking abortion care but not those seeking identical miscarriage care, or other pregnancy-related care, including for continued pregnancy and childbirth. Order 20:7-16 (App. A). Accordingly, strict scrutiny applied, and the Scheme likely failed that exacting test. *Id.* 21:10-22:6. Based on its conclusion that the "entire edifice" of the Scheme was likely unconstitutional, the court tailored its remedy to that constitutional violation by entering a preliminary injunction against the Scheme as a whole. *Id.* 25:1-4.

The State does not defend the Scheme under strict scrutiny. Nor could it: the Scheme is not narrowly tailored to avert any "medically-acknowledged *bona fide* health risk." *Weems II*, ¶¶ 44-45. Indeed, the Scheme fails to satisfy even rational basis review, as there is no rational reason to treat abortion and miscarriage care differently. *See id.* ¶ 47.

Instead, the State misrepresents how Montana currently regulates health care and rehashes arguments this Court has rejected time and again, to try to distinguish this case from *Armstrong v. State*, 1999 MT 261, 296 Mont. 361, 989 P.2d 364, and the ***seven*** abortion cases that have since reaffirmed and applied that precedent.[2]

This case is also an exceptionally poor vehicle to apply a 2025 amendment to the preliminary injunction statute, which took effect four months after the preliminary injunction entered in this case. But even if that amendment applied here, it would not change the outcome as the district court held the Plaintiff Providers

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[2] *PPMT 2021 Laws PI*, ¶¶ 1, 3 (affirming preliminary injunction of 20-week abortion ban, omnibus medication abortion restrictions that included a telehealth ban, and mandatory ultrasound); *Planned Parenthood of Mont. v. State*, 2025 MT 120, ¶ 128, 2025 WL 1618896 ("*PPMT 2021 Laws SJ*") (holding those laws unconstitutional); *Planned Parenthood of Mont. v. State*, 2024 MT 227, ¶¶ 5-6, 42, 418 Mont. 226, 557 P.3d 471 ("*PPMT Telehealth and D&E Ban*") (affirming preliminary injunction of telehealth abortion ban and ban on common method of second-trimester abortion); *Planned Parenthood of Mont. v. State*, 2024 MT 228, ¶¶ 1-3, 418 Mont. 253, 557 P.3d 440 ("*PPMT Medicaid*") (affirming preliminary injunction of DPHHS rules and statutes that restrict Medicaid coverage of abortion); *PPMT Parental Consent*, ¶ 1 (holding unconstitutional parental consent law for abortion); *Weems I*, ¶ 1 (affirming preliminary injunction of law restricting provision of abortion to only physicians and physician assistants); *Weems II*, ¶ 51 (holding that law unconstitutional).

established a "likelihood of success" on *each* of the four preliminary injunction factors as the amended statute now requires.

ARGUMENT

I. The District Court Did Not Manifestly Abuse Its Discretion in Its Application of the Preliminary Injunction Standard.

The district court entered its preliminary injunction on November 15, 2024, just weeks after this Court's *Stensvad* decision held that an applicant must make at least a "sufficient showing" of each of the four preliminary injunction factors, based on the "serious questions" and "sliding scale" approach. *Stensvad*, ¶¶ 25-29. But, nowhere in the district court's assessment of the merits did it mention "serious questions" or "sliding scale." *See* Order 14:9-25:4 (App. A). Instead, the court went beyond what *Stensvad* required, holding Plaintiffs established a "likelihood" on each of the preliminary injunction factors, just as the State argues it should have. *Id.* 25:1-3, 26:23-24, 28:7-13.

On March 25, 2025, the 2025 Amendment to the preliminary injunction statute took effect. The amended statute continues to require a court to assess the four preliminary injunction factors independently but adds that a court "may not use a sliding scale test, the serious questions test, flexible interplay, or another federal circuit modification to the criteria." H.B. 409, 69th Leg., Reg. Sess. (Mont. 2025), codified at § 27-19-201(4)(b), MCA.

For the first time on appeal, the State argues the district court abused its discretion by not adhering to the amended preliminary injunction statute, which took effect four months after the court entered its order in this case. That amendment has no application here. Even if it did, it would not change the outcome, because the district court did not rely on the "serious questions" or "sliding scale" test.

A. The District Court Held Plaintiffs Established the Likelihood of Each of the Preliminary Injunction Factors.

The district court did not manifestly abuse its discretion in entering the preliminary injunction, because it held the Providers established a "likelihood" on each of the four preliminary injunction factors.

In its order, the district court described the "serious questions" and "sliding scale" test adopted in *Stensvad* just weeks before. Order 13:3-18 (App. A). It is perfectly appropriate, and indeed, essential, for a district court to articulate and comply with this Court's binding precedent. But the district court went *beyond* the floor set by *Stensvad* to find not a "sufficient showing" of "serious questions," but that the Plaintiff Providers established a "likelihood" of each preliminary injunction factor, based on the extensive evidence they presented.

First, the district court held the Providers were "*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." *Id.* 28:7-9 (emphasis added); *see also e.g.*, *id.* 25:2-3 (finding Providers demonstrated that "they will *likely succeed* on the merits

of their equal protection claim") (emphasis added). The court went step-by-step through the likelihood-of-success analysis, finding that the Providers were "likely" to succeed in showing that the Scheme discriminated against similarly situated patients, *id.* 3:17-19; and next, that they were "likely" to succeed in showing that the classification must be reviewed under strict scrutiny, *id.* 20:14-16. Then, "the burden shifts to the State to justify the statute by showing the challenged classification is necessary to promote a compelling state interest." *Id.* 21:10-12 (citing *PPMT Parental Consent*, ¶ 32). The State "did not argue whether HB 937 or its implementing regulations survive strict scrutiny," but the court engaged in that inquiry anyway. *Id*. 21:17-18. It concluded that although there may be a compelling interest in protecting the health and safety of pregnant people, the Scheme was "not narrowly tailored" to advance that interest. *Id*. 21:17-22:6.

Throughout its analysis, the district court relied on multiple decisions by this Court—from *Armstrong* in 1999 through this Court's three abortion cases in 2024. "Indeed," the district court concluded, "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." *Id.* 28:13-16. Just last week, this Court issued yet another decision affirming a trial court ruling holding a series of abortion restrictions violated

individuals' fundamental rights to privacy and/or equal protection. *PPMT 2021 Laws SJ*, ¶ 128.

Nonetheless, the State complains that, in a footnote, the district court noted that the CI-128 "inform[ed] the Court's assessment of the Providers' showing of a likelihood of success." *Id.* 5 n.4. But the State does not argue the court manifestly abused its discretion for referencing CI-128, nor could it. The court was clear that CI-128 was "not yet part of the Constitution" and would not be until July 1, 2025. *Id*. Despite the reference to CI-128, the court's likelihood-of-success analysis was thoroughly grounded in the Montana Constitution and this Court's binding precedent.

Second, the district court held the Providers demonstrated "irreparable harm is *likely* to result absent an injunction." *Id*. 26:23-24 (emphasis added). Indeed, the court went further, stating, "without judicial intervention, Providers and their patients *will* suffer irreparable harm." *Id.* 3:20-21 (emphasis added). The court emphasized, "Providers must show 'irreparable injury is *likely*, not merely speculative, in the absence of an injunction.'" *Id*. 13:9-10 (emphasis added) (quoting *Montanans Against Irresponsible Densification, LLC v. State*, 2024 MT 200, ¶ 15, 418 Mont. 78, 555 P.3d 759 ("*MAID*"), the case the State says the 2025 Amendment codified, Appellants' Br. 14 n.5 & 15).

Third and fourth, the district court assessed "the final two factors"—"the balance of equities and public interest." *Id.* 27:2-3. It explained that these two factors are "very similar": the balance of the equities addresses the impact on the parties, while the public interest focuses on the impact on non-parties. *Id.* 27:2-4. Accordingly, when an injunction is sought against the government, these elements are considered together. *Id.* 27:6-8. *E.g.*, *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 26-33 (2008); App. F, 72:20-21 (counsel for the State noting at the preliminary injunction hearing that the balance of the equities and the public interest "obviously . . . meld together"). As to the balance of equities, as this Court has explained, and the district court echoed, any harm to the State from an injunction is "heavily mitigated when there is a strong showing that the statute infringes on a fundamental right," as "'the government suffers no harm from an injunction that merely ends unconstitutional practices.'" Order 27:20-25 (quoting *PPMT Telehealth and D&E Ban*, ¶ 36) (cleaned up). Along the same lines, "it is always in the public interest" to prevent the violation of constitutional rights. *PPMT Telehealth and D&E Ban*, ¶ 37. Accordingly, the court concluded, the Providers independently satisfied both factors: "Providers have further demonstrated . . . that the balance of equities and public interest favor an injunction." Order 28:12-13 (App. A).

B. The 2025 Amendment to the Preliminary Injunction Statute Has No Application Here.

For the first time on appeal, the State argues that the 2025 Amendment, which took effect more than four months *after* the court entered the preliminary injunction here, abrogates that order. But to put the 2025 Amendment at issue in this case, the State should have dismissed its appeal and moved for reconsideration of the district court's order, to give that court the first opportunity to consider this wholly new argument.

In any event, although, as set out above, application of the 2025 Amendment would not change the outcome of this appeal, it does not apply here. First, this Court's review of a preliminary injunction "is confined to whether the district court manifestly abused its discretion . . . under the *governing* preliminary injunction standards." *Mercer v. Mont. Dep't of Pub. Health & Hum. Servs*., 2025 MT 9, ¶ 12, 420 Mont. 201, 562 P.3d 502 (emphasis added). The 2025 Amendment could not have been governing law at the time the district court entered the preliminary injunction more than four months before the Amendment took effect.

Second, no Montana law is retroactive "unless expressly so declared." § 1-2-109, MCA. And for good reason. The State's ask would call into question every preliminary injunction issued prior to March 25, 2025. When the preliminary injunction statute was amended in 2023, to set out the preliminary injunction factors as conjunctive rather than disjunctive, it contained no statement about retroactivity.

S.B. 191, 68th Leg., Reg. Sess. (Mont. 2023). And courts did not revisit every preliminary injunction issued prior to that change taking effect.

Like the 2023 change, the 2025 Amendment includes nothing to suggest it has retroactive effect. By contrast, when Montana lawmakers have made changes to laws governing injunctions retroactive, they have done so explicitly. For example, an amendment to § 27-19-103, MCA, regarding "when an injunction may not be granted," expressly states that the changes apply "retroactively, within the meaning of 1-2-109, to all occurrences on or after January 1, 2021." S.B. 135, 68th Leg., Reg. Sess. (Mont. 2023), codified at § 27-19-103, MCA.

The State's attempt to escape this general rule that statutes operate prospectively by urging an exception when the "change in a law . . . is merely procedural rather than substantive" fails. Appellants' Br. 13. As noted above, the Montana legislature understands the requirements of § 1-2-109, MCA, to apply to changes to statutes governing injunctions. And the legislature did not make the 2025 Amendment retroactive.

None of the authorities the State cites supports its argument that the 2025 Amendment applies here. The amended statute at issue in *State v. Daniels* was in effect *before* the alleged criminal offense took place and thus *before* the conviction from which the defendant appealed. 2011 MT 278, ¶¶ 5, 10 n.1, 362 Mont. 426, 265 P.3d 623. The issue in *Daniels* was about the extent to which the amended statute

abrogated prior caselaw—there was no question that the amended version of statute applied to the trial court's rulings that the defendant later challenged on appeal. *See id.* ¶¶ 15, 41. *Dempsey v. Allstate Insurance Company* and *Utah v. Su* also do not apply: they involved the general rule that judicial decisions have retroactive effect absent certain exceptions. 2004 MT 391, ¶ 29, 325 Mont. 207, 104 P.3d 483; 109 F.4th 313, 319 (5th Cir. 2024). By contrast, statutes presumptively operate only prospectively. *See Landgraf v. USI Film Prods.*, 511 U.S. 244, 265 (1994). *City of Helena v. Community of Rimini* similarly arose in a different context. 2017 MT 145, 388 Mont. 1, 397 P.3d 1. There, the Court held that a water court properly applied an amended statute by relying on precedent governing the legal status of municipal water rights in Montana. *Id.* ¶¶ 18-19, 38.

For all these reasons, the 2025 Amendment has no application here. Even if it did, the district court entered its order consistent with the amended statute, finding the Providers established a "likelihood" on each of the four preliminary injunction factors.

II. The District Court Correctly Held that the Providers Are Likely to Succeed on Their Claim that the Scheme Violates Their Patients' Fundamental Rights.

The State did not defend the Scheme at the district court under strict scrutiny and does not do so here. Instead, the State attempts to escape the straightforward

conclusion that the Scheme discriminates based on how patients exercise their fundamental rights and thus strict scrutiny applies.[3]

First, the State makes the same argument this Court has rejected time and again: the laws here do not implicate patients' fundamental rights because they are about providers, only involve the State's power to enact health and safety regulations, and to find otherwise would mean abortion is unregulated. Each time, the State tweaks the argument slightly, to add to the category of laws that may implicate patients' fundamental rights the latest abortion restriction this Court has held unconstitutional. *Compare Weems II*, ¶ 42 (State argued law banning certain licensed providers from providing abortion did not implicate privacy right but "merely regulates" who can provide that care), *with* Appellants' Br. 20-21, 23 ("right to privacy covers laws . . . prohibiting a category of licensed providers"). But the underlying argument remains the same, and, as *Weems II* put it, "that ship has already sailed." *Weems II*, ¶ 42. The Scheme here interferes with patients' fundamental rights in precisely the same way as the law in *Weems II*, *Armstrong*, and the multiple other cases challenging abortion laws: it targets abortion for unique and additional regulation, subjecting patients who decide to end their pregnancy differently than

[3] Some of the State's objections to the district court's conclusion that the Scheme, as a whole, triggers strict scrutiny relate to its complaint that the court did not evaluate the Scheme as if it were a series of isolated provisions. That is addressed in the next section.

patients exercising their right to privacy by making a different choice about their pregnancy; and interfering with patient decision-making, with the patient-provider relationship, and access to care.

Second, the State accuses the district court of holding that every abortion regulation "automatically" implicates patients' fundamental rights and must be evaluated under strict scrutiny. Appellants' Br. 20. The district court did no such thing. It did what this Court has always done when assessing the constitutionality of abortion laws: consider whether the laws implicate patients' fundamental rights.

Every abortion restriction to come before this Court has been a restriction on *providers* that interferes with *patients'* rights. That is the purported point of the restrictions: to regulate providers to protect patient health and safety. Accordingly, there is *often* a relationship between restrictions on abortion providers and patients' fundamental right to make decisions about and access that care. *See, e.g.*, *PPMT 2021 Laws SJ*, ¶ 104 (credentialing requirements infringe on privacy right because they dictate who can provide medication abortion); *Weems II*, ¶ 47 (challenged law was about "State's ability to restrict the pool of health care providers and, *concomitantly*, a woman's choice of who provides her health care" (emphasis added)); *Armstrong*, ¶ 58 (that "medical decisions affecting one's bodily integrity and health must often and necessarily be made in partnership with a health care

provider . . . . points up the seriousness of the infringement" imposed by laws dictating "how and by whom" abortion is performed).

Certainly, not every restriction necessarily "impermissibly infringe[s]" on patients' fundamental rights. *Weems II*, ¶ 38. And so, in each case, this Court assessed whether the restriction targeted at providers—every one of which applied exclusively to abortion—implicated patients' fundamental rights.

The laws in *Armstrong* and *Weems* criminalized the provision of abortion by anyone other than certain health care providers. *Weems II*, ¶ 1 (physician and physician-assistant only law); *Armstrong*, ¶ 75 (physician-only law). Those laws "removed qualified [providers] from the pool of health care providers from which women may choose to obtain lawful medical procedures," thus implicating a patient's fundamental right of privacy. *Weems II*, ¶ 43 (considering constitutionality of law prohibiting APRNs from providing abortion but not "a broad range of health care within their scope of practice that is identical to, or significantly more complex, than early abortion care," including miscarriage care, for which "the protocols, procedures, and attendant complications" are "identical" to abortion); *Armstrong*, ¶ 64 (legislature chose to prohibit physician assistant from performing abortions "yet made no attempt to prohibit her from performing other more risky medical procedures").

The 2021 laws would have exposed providers to civil and criminal penalties for providing abortion after 20 weeks, providing medication abortion except subject to numerous restrictions (including a telehealth ban, multiple in-person visits, mandatory delay, and credentialing and reporting requirements), and providing abortion care unless the provider first offered each patient an opportunity to view their ultrasound. *PPMT 2021 Laws SJ*, ¶¶ 3-5. They implicated patients' fundamental rights because "they ban certain pre-viability abortions, they restrict access to medication abortions, and they stigmatize and deter patients from seeking out abortion." *PPMT 2021 Laws PI*, ¶ 56; *accord PPMT 2021 Laws SJ*, ¶¶ 56, 81, 89, 104, 111, 121.

The 2023 laws would have criminalized providers offering a common method of second trimester abortion and mandated an ultrasound before an abortion, prohibiting telehealth abortion. *PPMT Telehealth and D&E Ban*, ¶¶ 5-6. These laws implicated individuals' right to privacy by restricting access to or banning abortion. *Id.* ¶¶ 22, 24, 28-30.

The Medicaid restrictions would have prohibited reimbursement for abortion provided by physicians unless they abided by the restrictions and barred advance practice clinicians from receiving reimbursement for abortion altogether. *PPMT Medicaid*, ¶¶ 5-6. Those restrictions were "not simple funding decisions, they implicate[d] the constitutional rights of Medicaid-eligible Montanans" because

through them, the State was "selectively denying a benefit to those who exercise a constitutional right, effectively deter[ring] the exercise of that right." *Id.* ¶ 24 (citation and internal quotation marks omitted); *see also id*. ¶ 21 (restrictions "interfere with the abortion provider-patient relationship by singling out abortion care for disparate treatment").

The parental consent statute would have barred clinicians from providing abortion care to people under age 18 unless the young person had a parent's consent or obtained a judicial bypass. *PPMT Parental Consent*, ¶¶ 7, 13. It "infringe[d] upon a minor's fundamental right to privacy because it condition[ed] a minor's obtaining an abortion on parental consent or obtaining a judicial waiver, something a minor choosing to carry her pregnancy to term would not have to do." *Id*. ¶ 24.

The district court did the same analysis and came to the same conclusion about the Scheme here. It began by explaining that the Montana Constitution guarantees each individual the right to make decisions about and access abortion from a provider of their choosing and an equal protection right not to be discriminated against because of one's exercise of a fundamental constitutional right. Order 2:12-13, 14:10-24 (App. A); *see* Mont. Const. art. II, §§ 4, 10. This equal protection right is stronger than its federal counterpart. Order 14:16-17 (App. A). The court then catalogued how the Scheme targeted providers of abortion, subjecting them to a regime that does not apply to providers "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." *Id.* 17:5-14. The court then considered the impact "[f]rom the patients' perspective," concluding that

> [patients] 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.

Id. 20:7-11 (citing *Weems*, ¶ 50 and quoting, "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'"). That "[u]nequal treatment is itself an injury from a constitutional infringement," which, the court held, was likely based on "how a patient exercises a fundamental right" and so is "likely subject to strict scrutiny." *Id*. 20:14-16, 26:1-3.

As the district court noted, its conclusion that the two groups of patients are similarly situated except for the "challenged classification" (the decision to access abortion) is "nearly identical" to the conclusion this Court reached in prior cases. *Id.* 17:23-18:1. In *PPMT Parental Consent*, the two classes—"'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 the type of medical care—an abortion.'" *Id.* 18:1-4 (quoting *PPMT Parental Consent*, ¶ 28). In *PPMT Medicaid*, this Court "found two similarly

situated classes . . . : 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." *Id*. ¶ 18:7-10 (citing *PPMT Medicaid*, ¶ 31).

Because that discrimination likely created by the Scheme implicated patients' fundamental rights, the court concluded strict scrutiny applied. *Id.* 20:14-16. That conclusion was also "driven by recent binding Montana Supreme Court precedent." *Id*. 19:15-16. In *PPMT Parental Consent*, "because 'the classification discriminate[d] against minors who choose to have an abortion because only they have their right to privacy infringed,'" it "discriminated based on the exercise of a fundamental right and triggered strict scrutiny." *Id.* 19:16-20 (quoting *PPMT Parental Consent*, ¶ 29). And strict scrutiny applied in *PPMT Medicaid* because "otherwise eligible [Medicaid] recipients would be disqualified or otherwise restricted from certain public healthcare benefits based on their exercise of their fundamental right to privacy." *Id.* 19:20-25 (quoting *PPMT Medicaid*, ¶ 23).

To be sure, the district court discussed how the Scheme treats providers. So do the cases above. And, as in those cases, the district court grounded its conclusion that the Scheme triggers strict scrutiny in its finding that the discrimination at issue implicates a fundamental right—here, "discriminat[ion] on the basis of how a patient exercises [their] fundamental right" to make decisions about and access abortion care. *Id*. 20:15-16.

The Scheme would not even survive under the rational basis review the State claims applies. Rational basis requires courts make "[a] careful inquiry . . . into . . . 'the rationality of the connection between legislative means and purpose [and] the existence of alternative means for effectuating the purpose.'" *In re C.H.* (1984), 210 Mont. 184, 198, 683 P.2d 931, 938 (citation omitted). But there is simply no rational basis for regulating the *same* medications and *same* procedures for abortion and miscarriage differently. *See Weems II*, ¶ 47.

III. The District Court Properly Tailored Its Preliminary Injunction to the Constitutional Violation and Irreparable Harms it Found.

The district court correctly assessed the Scheme as a whole. And its remedy—enjoining the Scheme as a whole—was necessary to prevent the constitutional violation it found likely to occur and the irreparable harms the Scheme would likely impose. That is consistent with this Court's decisions considering multi-part laws, including in the abortion context, as well as the approach of sister courts considering similar abortion-facility licensing schemes. Even the approach the State urges—analyzing each provision in isolation—would not save the Scheme because, as the district court concluded, constitutional defects (and associated irreparable harms) pervade the Scheme.

First, the district court held that the "equal protection claim, if successful, undermines the *entire edifice* of HB 937 and its implementing rules." Order 25:3-4 (App. A) (emphasis added). Additionally, because the State provided no "plausible

justification" for treating the two classes of patients seeking abortion and miscarriage management differently, "a regulation-by-regulation review will not likely save either the licensure requirement in isolation or the various rules implementing it." *Id.* 22:22-25. That is, the requirement that the Providers become licensed and abide by the implementing rules—the very foundation of the Scheme—was likely unconstitutional because it discriminated based on how a patient exercises their fundamental right to access abortion care. Additionally, as a practical matter, the Scheme is comprehensive and interrelated: patients cannot obtain abortion care from providers who meet only *some* parts of it. Because the equal protection violation pervaded the Scheme, the court rejected the State's argument that it was necessary to review each component in isolation.

Second, because "the loss of a constitutional right constitutes irreparable harm," the court's conclusions about irreparable harm follow from its likelihood-of-success conclusion. *See, e.g.*, *PPMT 2021 Laws PI*, ¶ 60; *Mont. Cannabis Indus. Ass'n v. State*, 2012 MT 201, ¶ 15, 366 Mont. 224, 286 P.3d 1161. Based on its conclusion that "the equal protection flaws reside in the very core of the statute," the court determined that the Scheme in its entirety was likely to cause irreparable injury. Order 22:16-17 (App. A). The "[u]nequal treatment" imposed by the core of the Scheme "is itself injury from a constitutional infringement." *Id.* 26:1-2; *see also id*.

25:24-26:1 ("Harm from constitutional infringement [is] adequate to justify a preliminary injunction." (quoting *MAID*, ¶ 16)).

For this same reason, the court correctly held that enjoining the Scheme "in its entirety" was "necessary to remediate adequately [the] constitutional violation." *Id.* 22:10-11. The State offers no authority to support its argument that the district court was required to assess irreparable harm piecemeal after it had already determined that the likely equal protection violation stems from the basic operation of the Scheme and after it had expressly considered and rejected the State's argument that a standalone assessment of each provision was required.

Third, the district court concluded that even if it considered the regulations individually, as the State urged—and argues again here—it would *still* find that the Providers had shown a likely constitutional deprivation because "multiple proposed rules are in clear tension with prior court holdings, binding precedent, or injunctions currently in force." *Id.* 23:2-3. "Numerous regulations" were "predicated on analogizing the services offered by abortion providers to the services offered by outpatient surgical centers," but this Court rejected a similar analogy as justification for prohibiting APRNs from providing abortion. *Id.* 23:4-20 (citing *Weems II*, ¶ 46). The requirement that abortion clinics have a physician medical director and the restriction on the type of providers who can administer anesthesia was "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." *Id.* 24:15-18. And the requirement that patients undergo physical exams and testing was contrary to this Court's affirmance of a preliminary injunction of a law mandating abortion patients undergo an ultrasound and effectively banning abortion via telehealth. *Id.* 24:20-25 (citing *PPMT Telehealth and D&E Ban*, ¶ 25).

Finally, the district court's assessment of the constitutionality of the Scheme, the irreparable harm it imposes, and the scope of its preliminary injunction is consistent with this Court's precedent and authority from other courts. This Court has invalidated a law in its entirety when, like the Scheme here, it "suffers from constitutional defect in its core provisions," *White v. State* (1988), 233 Mont. 81, 93, 759 P.2d 971, 978, and when the whole statute is "infected with" a constitutional deficiency, *Mont. Immigrant Justice All. v. Bullock*, 2016 MT 104, ¶ 46, 383 Mont. 318, 371 P.3d 430. Similarly, it has stricken an entire statute when, like here, multiple provisions "contribute to constitutional violations of equal protection." *Finke v. State ex rel. McGrath*, 2003 MT 48, ¶ 28, 314 Mont. 314, 65 P.3d 576 (granting relief from entire statute when multiple provisions created disparate treatment and were "clearly interrelated"); *see also PPMT 2021 Laws SJ*, ¶¶ 88-89, 96, 101-104, 106 (permanently enjoining omnibus medication abortion restriction upon concluding it violated right to privacy, without going through each of the mandated disclosures or

complications listed in the credentialing requirements); *PPMT Medicaid*, ¶ 38 (affirming preliminary injunction of multi-part Medicaid coverage restrictions that likely violated equal protection rights). And it has done the same when invalidating some provisions while preserving others would require the court to "revise [the law] to edit out major portions in an effort to salvage some small part that might pass constitutional muster," a task within the legislature's province. *Reichert v. State ex rel. McCulloch*, 2012 MT 111, ¶ 87, 365 Mont. 92, 278 P.3d 455.

Likewise, courts that have evaluated similar licensing schemes that regulate abortion facilities like ambulatory surgical centers have invalidated the entire schemes after finding their core provisions unconstitutional. *See Hodes & Nauser*, 318 Kan. at 1033, 551 P.3d at 87 (holding Kansas abortion facility licensing scheme unconstitutional as a whole, finding it imposed comprehensive and interdependent statutory and regulatory scheme); *Whole Woman's Health*, 579 U.S. at 626 (holding unconstitutional statute and rules requiring abortion facilities to meet ambulatory surgical center standards; rejecting state's argument that Court was required to "proceed in piecemeal fashion" when "[t]he statute was meant to require abortion facilities to meet the integrated surgical-center standards—not some subset thereof").

IV. The State's Other Objections to the District Court's Order Are Meritless.

A straightforward reading of the district court's order reveals no basis for the State's other objections.

First, the court did not find that the only provisions likely to cause irreparable harm were the provisions "requiring physician involvement or medical testing." *Compare* Appellants' Br. 30, *with* Order 26:10-13 (App. A). The court pointed to those as examples of requirements that this Court has already found are likely to cause irreparable harm in other cases. Order 26:10-15 (App. A) (citing *PPMT Telehealth and D&E Ban*, ¶¶ 25-26 (patients' right to privacy implicated by mandated ultrasound); *Weems II*, ¶ 50 (patients' right to privacy implicated by ban on APRNs providing abortion care)).

Second, the district court did not primarily base its irreparable harm finding on the fact that the Providers had not yet received licenses from DPHHS.[4] *Compare* Appellants' Br. 30, *with* Order 25:13-26:24 (App. A). The court determined the Providers and their patients would suffer irreparable harm absent relief because the licensing requirement, along with the rules, treated abortion differently than miscarriage management with no constitutionally sufficient justification. *See* Order

[4] Plaintiff Providers applied for licenses before moving for a preliminary injunction. However, Ms. Wooten testified that DPHHS had not responded to the applications because of the litigation. App. F, 23:7-13.

25:13-26:3 (App. A). Moreover, the court concluded, absent relief, the Scheme would "likely inhibit access to abortion." *Id.* 26:4-5. Unless DPHHS gave "unqualified approval" to the Providers' applications, the "immediate effect of HB 937 would be that Providers must cease operating." *Id*. 26:7-10.

Third, the court considered the possibility of waivers from the physical plant requirement. *Contra* Appellants' Br. 30. It stated that "[t]he *potential* the Department might grant some waivers (which it is not obliged to extend) does not render Providers' concerns merely speculative." Order 26:20-22 (App. A). Indeed, as the court noted, the standard for obtaining a waiver from the physical plant requirement—the only requirement the rules clearly state can be waived—is "stringent:" clinics must show compliance would be "extremely difficult or impossible" and that "the level of safety to patients and staff is not diminished." *Id.* 26:17-20 (quoting Admin. R. Mont. 37.106.3103(7)). Moreover, DPHHS is not required to grant waivers; has indicated that certain requirements cannot be waived; and, even for the requirements that could be waived, has provided no guidance on how it would evaluate waiver requests. The State cannot rely on potential, discretionary waivers, either from the physical plant requirements or more broadly, to rebut the irreparable harm that the Providers will suffer if the Scheme were to take effect.

Fourth, as to the balance of the equities and the public interest, the district court correctly held that they weigh in favor of granting relief. *Contra* Appellants' Br. 31. The court agreed 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.'" Order 27:16-18 (App. A) (quoting *Maryland v. King*, 567 U.S. 1301, 1303 (2012) (Roberts, C.J., in chambers)). But it found this interest was "heavily mitigated" because 'the government suffers no harm from an injunction that merely ends unconstitutional practices.'" *Id.* 27:20-23 (quoting *PPMT Telehealth and D&E Ban*, ¶ 36). It then determined that the balance of the equities and public interest both favor an injunction because "the harm occasioned by inflicting constitutional injury on Providers and their patients, who face likely disparate treatment, . . . and the strong potential of imminent closure…outweigh the government's interest in effectuating a change to the status quo in the form of HB 937." *Id.* 27:24-28:4. That determination is not a manifest abuse of discretion.

Moreover, when a plaintiff establishes a likelihood of success, the State cannot simply rely on a generalized presumption that laws should not be enjoined. The government has no legitimate interest in enforcing unconstitutional laws, and "it is always in the public interest to prevent the violation of a party's constitutional rights." *PPMT Medicaid*, ¶ 40; *Baird v. Bonta*, 81 F.4th 1036, 1042 (9th Cir. 2023).

Finally, the State takes issue with the fact that the court's order does not require the Providers to try to become licensed, comply with certain rules, or submit to inspections under HB 937. Appellants' Br. 30. But "[t]he purpose of a preliminary injunction is always to prevent irreparable injury so as to preserve the court's ability to render a meaningful decision on the merits." *Doe #1 v. Trump*, 957 F.3d 1050, 1068 (9th Cir. 2020). It would make little sense to find that the Scheme is likely unconstitutional, and that forced compliance is likely to cause irreparable harm—and then nevertheless order the Providers and their patients to acquiesce to a likely unconstitutional law.

CONCLUSION

This Court should affirm the district court's order entering a preliminary injunction of HB 937 and its rules.

Respectfully submitted June 16, 2025, by:

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CERTIFICATE OF COMPLIANCE

Pursuant to Rule 11 of the Montana Rules of Appellate Procedure, I certify that this principal brief is printed with a proportionately spaced Times New Roman text typeface of 14 points; is double-spaced except for footnotes and for quoted and indented material; and the word count calculated by Microsoft Word Office 365 is 9,984 words, excluding the tables, certificate of service, and certificate of compliance.

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