

IN THE SUPREME COURT OF THE STATE OF MONTANA
No. DA 25-0602

PLANNED PARENTHOOD OF MONTANA, *et al.*,

Plaintiffs and Appellees/Cross-Appellants,
v.

STATE OF MONTANA, *et al.*,

Defendants and Appellants/Cross-Appellees.

On appeal from the Montana First Judicial District Court, Lewis and Clark County
Cause No. ADV 23-299, the Honorable Mike Menahan, Presiding

**BRIEF OF *AMICUS CURIAE* NATIONAL HEALTH LAW PROGRAM IN
SUPPORT OF APPELLEES**

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STATEMENT OF INTEREST OF AMICUS CURIAE

Founded in 1969, *amicus curiae*, the National Health Law Program (NHLP), is a public interest organization dedicated to advancing access to quality health care, including the full range of reproductive health care services, and protecting the legal rights of low-income and other underserved individuals. To achieve its mission, *amicus curiae* advocates, educates, and litigates at the state and federal levels.

House Bill 862 (2023), House Bill 544 (2023), and the challenged Department of Public Health and Human Services rule, 8 Mont. Admin. Reg. 414 (Apr. 28, 2023), (collectively, “the Challenged Restrictions”) severely limit coverage of abortion services for Montana residents who are enrolled in the Medicaid program. HB 544 and the DPHHS rule limit coverage by: (1) narrowly defining when an abortion is medically necessary; (2) permitting coverage only for abortions performed by a physician; and (3) imposing prior authorization requirements that, in effect, eliminate coverage of medication abortions provided via telehealth. HB 862 bans coverage of abortion services except when the pregnancy is the result of rape or incest or when an abortion is necessary to save the life of the pregnant person.

The Challenged Restrictions dramatically curtail access to necessary health care services among Montana Medicaid enrollees, thereby increasing risks to their

health. *See* App.A16. NHeLP submits this brief to bring information to the Court about who is eligible for Medicaid in Montana due to pregnancy, who will be disproportionately affected by the elimination of coverage for abortion services provided to Medicaid enrollees via telehealth, and the fiscal effects of the Challenged Restrictions.

SUMMARY OF THE ARGUMENT

In Montana, only pregnant individuals with very low incomes qualify for Medicaid coverage. American Indian and Alaska Native (AI/AN) Montanans are disproportionately likely to rely on Medicaid for their health care coverage. Similarly, AI/AN individuals and women are disproportionately likely to rely on telehealth to receive care. Telehealth is also particularly critical for low-income individuals living in rural areas of Montana, where there is limited access to quality, in-person health care services, including abortion services. The Challenged Restrictions cause disproportionate harm to these Montanans. Further, all available evidence indicates that the Challenged Restrictions will increase State spending.

ARGUMENT

I. Montanans Who Are Eligible for Medicaid

Title XIX of the Social Security Act establishes the federal-state partnership program known as the Medicaid program. *See* 42 U.S.C. §§ 1396-1396w-8 (“the Medicaid Act”). Congress enacted the Medicaid Act to enable states to provide

“medical assistance” to families and individuals “whose income and resources are insufficient to meet the costs of necessary medical services.” *Id.* § 1396-1.

The Medicaid Act describes the population groups that are eligible to receive medical assistance. *Id.* § 1396a(a)(10)(A), (C). States must provide coverage to certain population groups, *see id.* § 1396a(a)(10)(A)(i), and have the option to provide coverage to other population groups, *see id.* § 1396a(a)(10)(A)(ii), 1396a(a)(10)(C). To receive coverage, individuals who fall within a covered group must meet the financial eligibility criteria applicable to that group, reside in the state in which they apply, and have U.S. citizenship or qualified immigration status. *Id.* §§ 1396a(a)(10)(A), 1396a(b)(2), (3), 1396b(v); 8 U.S.C. §§ 1611, 1612, 1641; *see* An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14, Pub. L. No. 119-21, § 71109, 139 Stat. 172, 297 (2025) (further restricting immigrant eligibility as of October 1, 2026).

One mandatory population group is pregnant women. 42 U.S.C. § 1396a(a)(10)(A)(i)(III), (IV). The minimum income eligibility cap for this group varies by state, but ranges from 133% to 185% of the federal poverty level (FPL). *Id.* § 1396a(a)(10)(A)(i)(IV), 1396a(l)(1)(A), 1396a(l)(2)(A). States have the option to cover pregnant women with higher household incomes. *Id.* § 1396a(a)(10)(A)(ii)(IX). To be eligible for Medicaid coverage in Montana, pregnant people must have a household income below 157% of the FPL. Mont.

Dep't of Pub. Health & Hum. Servs., *Presentation to the 2025 Health and Human Services Joint Appropriation Subcommittee: Medicaid in Montana* 9 (2025), <https://dphhs.mt.gov/assets/2025Legislature/MedicaidReport2025.pdf> (“*Medicaid in Montana*”). Compared to other states, Montana has one of the lowest income eligibility limits for pregnant people. *See* KFF, *Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the Federal Poverty Level* (Jan. 1, 2025), <https://bit.ly/3S6zd6n> (adding a 5% income disregard, as provided for in the Medicaid Act, and showing Montana has the ninth lowest eligibility cut-off). Currently, 157% of the FPL equates to an annual income of \$33,974 for a household of two and \$51,810 for a household of four. *See* Annual Update of the HHS Poverty Guidelines, 91 Fed. Reg. 1797, 1798 (Jan. 15, 2026).

Certainly, before they become pregnant, some individuals are already enrolled in Medicaid through a different coverage group. Some of the most common eligibility categories for adults of child-bearing age include parents and caretaker relatives, *see* 42 U.S.C. § 1396a(a)(10)(A)(i)(I), the Medicaid adult expansion group, *see id.* § 1396a(a)(10)(A)(i)(VIII), and individuals who receive Supplemental Security Income (SSI) benefits due to disability, *see id.* § 1396a(a)(10)(A)(i)(II). The income eligibility cap for each of those categories is lower than 157% of the FPL. *See Medicaid in Montana* at 9-10. As a result,

pregnant individuals who qualify for Medicaid coverage in Montana generally have very low incomes.¹

Due to a variety of historical, political, and economic factors, the poverty rate among AI/AN individuals in Montana (30.2%) is more than three-and-a-half times higher than the poverty rate among White individuals in the State (8.2%). KFF, *Poverty Rate by Race/Ethnicity* (2024), <https://bit.ly/3H7GBrS>. Similarly, the poverty rate is two times higher among Hispanic Montanans (17.6%). *Id.*

As a result, AI/AN and Hispanic individuals disproportionately rely on Medicaid for their health care coverage.² AI/AN and Hispanic individuals account for only 6.4% and 4.9%, respectively, of the total population of Montana, U.S. Census Bur., *QuickFacts, Montana* (July 1, 2024), <https://census.gov/quickfacts/MT> (“Census Bur., *QuickFacts*”), but 14.4% and

¹ Individuals with higher incomes and substantial medical expenses may be able to qualify for Medicaid as “medically needy” when they spend their excess income on health care services. *See* 42 U.S.C. § 1396a(a)(10)(C); *Medicaid in Montana* at 11-12 (noting the medically needy income level is \$525/month for a family size of one or two people).

² There are additional potential reasons for this. For example, when compared to White individuals, AI/AN individuals are significantly less likely to have access to private health insurance coverage, *see* Latoya Hill & Samantha Artiga, KFF, *Health Coverage Among American Indian and Alaska Native and Native Hawaiian and Other Pacific Islander People* (2023), <https://bit.ly/3U1ZYKR>, and as discussed below, significantly more likely to have a disability.

9.4%, respectively, of nonelderly Medicaid enrollees in the State.³ KFF, *Distribution of People Ages 0-64 with Medicaid by Race/Ethnicity* (2024), <https://bit.ly/3NSDMi9> (“KFF, *Distribution by Race/Ethnicity*”). Conversely, White (non-Hispanic) individuals account for roughly 89% of the State population, but only 67% of nonelderly Medicaid enrollees. Census Bur., *QuickFacts*; KFF, *Distribution by Race/Ethnicity*. The disparity is even starker among pregnant individuals, with AI/AN individuals making up over 20% of all pregnant Medicaid enrollees in Montana. Mont. Dep’t Pub. Health & Hum. Servs., *Montana Medicaid Enrollment, Medicaid and CHIP Enrollment October 2025* (Jan. 5, 2026), <https://dphhs.mt.gov/interactivedashboards/medicaidenrollmentdashboard>.

Similarly, individuals with a disability disproportionately rely on Medicaid for their health coverage. In Montana, approximately 18% of the general population has a disability, while nearly 37% of Medicaid enrollees have a disability. State Health Access Data Assistance Ctr., *Collection of Self-Reported Disability Data in Medicaid Applications: A Fifty-State Review of the Current Landscape* 14 (2024), <https://bit.ly/3ZkZT6c>. Most Medicaid enrollees who have a disability qualified for the program on a basis other than disability. *Id.* at 2; *see also* MaryBeth Musumeci & Kendal Orgera, KFF, *People with Disabilities Are at*

³ Individuals who identify as two or more races also disproportionately rely on Medicaid for their health care coverage. *See* Census Bur., *QuickFacts* (3.1% of the population); KFF, *Distribution by Race/Ethnicity* (8.9% of Medicaid enrollees).

Risk of Losing Medicaid Coverage Without the ACA Expansion (2020),

<https://bit.ly/4bff3Pi> (finding that more than six in ten nonelderly adult Medicaid enrollees with a disability do not receive SSI). Notably, nationwide data show that AI/AN adults are significantly more likely than any other racial or ethnic group to have a disability. See Ctrs. for Disease Control & Prevention, *Infographic: Adults with Disabilities: Ethnicity and Race* (Apr. 7, 2025),

<https://www.cdc.gov/disability-and-health/articles-documents/infographic-adults-with-disabilities-ethnicity-and-race.html>.

II. Montanans Who Need to Access Services Via Telehealth

Some groups of individuals are more likely to rely on telehealth to access health care. According to a nationwide survey conducted in 2021, women are more likely than men to use telehealth. Jacqueline W. Lucas & Maria A. Villarroel, Ctrs. for Disease Control & Prevention, Nat'l Ctr. for Health Stat., *Data Brief No. 445, Telemedicine Use Among Adults: United States, 2021* at 1 (2022),

<https://www.cdc.gov/nchs/data/databriefs/db445.pdf> (finding approximately 42% of women and 32% of men used telemedicine in the past 12 months). AI/AN

individuals are also more likely than any other racial or ethnic group to use telehealth.⁴ *Id.* at 2.

⁴ Research suggests that the rate of telehealth use among individuals of different racial or ethnic backgrounds is not consistent across the income spectrum. See, e.g., Cynthia Williams & Di Shang, *Telehealth Usage Among Low-Income Racial*

A number of studies conducted prior to the COVID-19 pandemic showed that individuals living in rural areas are more likely to use telehealth than those living in urban areas. *See, e.g.,* Jean A Talbot et al., *Patterns of Telehealth Use Among Rural Medicaid Beneficiaries*, 35 *J. Rural Health* 298 (2019), <https://bit.ly/4jSeYWv> (finding that in 2011, rural Medicaid beneficiaries were more likely than their urban counterparts to use telehealth services); Lincoln R. Sheets et al., *Similarities and Differences Between Rural and Urban Telemedicine Utilization*, 18 *Persps. Health Info. Mgmt.* 1e (2020), <https://bit.ly/3Nz3tHh> (examining telemedicine visits with University of Missouri Health Care from 2008 to 2017 and finding rural patients were nearly four times more likely than urban patients to use telemedicine services).

Indeed, it is abundantly clear that telehealth is critical for improving access to quality health care in rural areas. Many individuals in rural areas have limited access to care, particularly specialty care, making telehealth an effective tool for reducing the rural health gap. *See generally* Shreya Kolluri et al., *Telehealth in*

and Ethnic Minority Populations During the COVID-19 Pandemic: Retrospective Observational Study, 25 *J. Med. Internet Rsch.* e43604 (2023), <https://bit.ly/3LsmIBR> (finding, in contrast to studies including individuals with a range of incomes, that among individuals with incomes below 200% of FPL, Hispanic patients had higher odds of using telehealth services than non-Hispanic White and Black patients).

Response to the Rural Health Disparity, 10 Health Psych. Rsch. 1 (2022),

<https://bit.ly/4b6JjOG>.

Recent research demonstrates the importance of telehealth for individuals in rural areas who need abortion care. For example, one study involving patients receiving abortion services via telehealth from a clinic in Washington found that individuals living further from the clinic were more likely to opt for a telehealth appointment. See Anna E. Fiasco et al., *Telehealth vs. In-Clinic Medication Abortion Services*, 6 JAMA Network Open e2331900 (2023), <https://bit.ly/468CMj1>. Another study found that telehealth was more likely to make timely access to abortion possible for patients living in rural areas (vs. urban areas) and for patients who avoided more than 100 miles of round-trip driving (vs. fewer miles of round-trip driving) by receiving services via telehealth. See Leah R. Koenig et al., *The Role of Telehealth in Promoting Equitable Abortion Access in the United States: Spatial Analysis*, 9 JMIR Pub. Health & Surveillance e45671 (2023), <https://bit.ly/4qtoMIQ> (concluding that telehealth “has the potential to address geographic inequities in access to care for those living in abortion deserts or rural areas” within states where abortion is legal). See also Fekede Asefa Kumsa et al., *Medicaid Abortion Via Digital Health in the United States: A Systematic Scoping Review*, 6 NPJ Digit. Med. 128 (2023), <https://bit.ly/49OLyDM> (conducting a review of the literature and determining that telehealth increases

access to abortion care, especially for patients living in remote places); Kirsten M.J. Thompson et al., *Association of Travel Distance to Nearest Abortion Facility with Rates of Abortion*, 4 JAMA Network Open e2115530 (2021), <https://bit.ly/4pQlbn2> (finding greater travel distances to abortion services are associated with lower abortion rates and suggesting the use of telemedicine to decrease unmet need).

Given the size of Montana, its many rural areas, and the scarcity of abortion providers in the State, coverage of abortion services provided via telehealth is particularly critical. For example, without the option of receiving care via telehealth, Medicaid-eligible individuals who live on the Fort Peck Indian Reservation and need abortion care would have no choice but to drive roughly eight hours, each way, to Whitefish, which has the nearest abortion clinic accepting Medicaid patients. *See* Appellants' Opening Br. at 43; Supp.App.B08-09, ¶¶ 17, 19 (noting the locations of the abortion providers in the State that continue to serve Medicaid enrollees); [googlemaps.com](https://www.google.com/maps) (directions from Fort Peck Indian Reservation to All Families Healthcare in Whitefish) (last accessed Jan. 14, 2026).

To travel such distances for care, individuals need to have transportation, lodging, childcare, and time off work. *See generally* Ushma D. Upadhyay & Daniel Grossman, *Telemedicine for Medication Abortion*, 100 *Contraception* 351 (2019), <https://bit.ly/49A7PGT>. These financial and logistical challenges can be

insurmountable for individuals with low incomes. Compared to individuals with higher incomes, individuals with low incomes are more likely to face transportation barriers, Mary K. Wolfe et al., *Transportation Barriers to Health Care in the United States: Findings from the National Health Interview Survey, 1997-2017*, 110 Am. J. Pub. Health 815, 819 (2020), <https://bit.ly/4a6Byr0>, and less likely to have paid leave from work. U.S. Bur. of Labor Stat., *Economic News Release, Table 6. Selected paid leave benefits: Access* (Mar. 2025), <https://www.bls.gov/news.release/ebs2.t06.htm>. Traveling a long distance to receive in-person care can pose additional challenges for individuals with disabilities. For example, some individuals with a disability need the assistance of a caregiver to leave home and/or have a health condition that requires them to avoid busy public spaces.

In sum, eliminating coverage of medication abortions provided via telehealth will disproportionately harm AI/AN individuals and individuals living in rural areas (particularly those with very low incomes and/or a disability).

III. The Effect of the Challenged Restrictions on State Medicaid Spending

While Montana suggests that the Challenged Restrictions will save money, *see* Appellants' Opening Br. at 41-42, the facts show otherwise. *See* Supp.App.F14 (Pls.' Statement of Undisputed Material Facts in Supp. of Pls.' Mot. for Summ. J. ("SUMF")) ¶¶ 59-61). As the Alaska Supreme Court has observed, if restrictions on

abortion coverage “divert a significant number of Medicaid-eligible women toward childbirth and its additional expenses,” then the restrictions “undermine, rather than further, the State’s interest in reducing costs.” *State v. Planned Parenthood of the Great Nw.*, 436 P.3d 984, 1005 (Alaska 2019). Indeed, repeated research shows that these kinds of abortion restrictions force many Medicaid-eligible individuals to carry a pregnancy to term against their will.

According to a 2009 review of that research, “a reasonable estimate is that lack of funding influences about a quarter of Medicaid-eligible women to continue unwanted pregnancies.” See Stanley K. Henshaw et al., Guttmacher Inst., *Restrictions on Medicaid Funding for Abortions: A Literature Review* 27 (2009), <https://bit.ly/49t4UQ9>. A more recent study of pregnant women in Louisiana reached a similar estimate, finding that “about 29% . . . of Medicaid-eligible pregnant women who would have an abortion if Medicaid covered abortion instead give birth.” Sarah C.M. Roberts et al., *Estimating the Proportion of Medicaid-eligible Pregnant Women in Louisiana Who Do Not Get Abortions When Medicaid Does Not Cover Abortion*, 19 BMC Women’s Health 1, 4 (2019), <https://bit.ly/3LFiruT>. The authors concluded that every year, approximately 3,000

women in Louisiana give birth instead of having an abortion due to the lack of abortion coverage for Medicaid-eligible individuals.⁵ *Id.*

Preventing Medicaid-eligible individuals from accessing abortion care can have serious consequences for their health and financial well-being.⁶ In addition, it comes with significant costs to the State. According to DPHHS, the average cost to Montana to cover an abortion for a Medicaid beneficiary is \$534.50.

Supp.App.F14 (SUMF ¶ 60). In comparison, the State spends far more when Medicaid enrollees have no choice but to carry a pregnancy to term. Montana must cover prenatal care, labor and delivery, postpartum care, and at least one year of

⁵ Conversely, recent research underscores that state coverage of abortion services for Medicaid enrollees “is associated with increased utilization of abortion care.” Heide M. Jackson & Michael S. Rendall, *Lifetime Abortion Incidence When Abortion Care is Covered By Medicaid: Maryland Versus Five Comparison States*, 59 Health Servs. Rsch. e14358 (2024), <https://bit.ly/4pTdsoj>; Susan K.R. Heil et al., *The Impact of State Medicaid Coverage of Abortion on People Accessing Care in Three States*, 56 Persps. Sexual & Reprod. Health 255 (2024), <https://bit.ly/3Znc82a>.

⁶ See, e.g., Sarah Miller, et al., *The Economic Consequences of Being Denied An Abortion*, National Bureau of Economic Research Working Paper 26662 (2020), <https://bit.ly/4adrZ8L>; Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 Am. J. Pub. Health 407 (2018), <https://bit.ly/4pUPmJV>; Dovile Vilda et al., *State Abortion Policies and Maternal Death in the United States, 2015-2018*, 111 Am. J. Pub. Health 1696 (2021), <https://bit.ly/45rKsNb>; Caitlin Gerdts et al., *Side Effects, Physical Health Consequences, and Mortality Associated with Abortion and Birth after an Unwanted Pregnancy*, 26 Women’s Health Issues 55 (2016), <https://bit.ly/4pVL3y1>; Sarah C.M. Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12 BMC Med. 144 (2014), <https://bit.ly/4qthGnI>.

Medicaid coverage for the infant. 42 U.S.C. § 1396a(e)(1); 42 C.F.R. § 435.117. DPHHS has indicated that the estimated cost to the State to cover a live birth for a Medicaid beneficiary is \$13,625. Supp.App.F14 (SUMF ¶ 60). That does not include the cost of providing ongoing Medicaid coverage or additional public benefits to the child. *See, e.g.,* Travis Speice, *Estimating the Economic Impact of Restricting Reproductive Healthcare Access in Ohio*, 56 Persps. Sexual & Reprod. Health 303 (2024), <https://bit.ly/49zD5FN> (estimating the total public costs associated with an abortion ban in Ohio, including medical care and public assistance provided to children born to women who could not access abortion care). Given the public expenses associated with childbirth, researchers have estimated that covering abortion services for Medicaid-eligible individuals would result in significant public savings overall. Stanley K. Henshaw et al., Guttmacher Inst., *Restrictions on Medicaid Funding for Abortions: A Literature Review* 26 (2009), <https://bit.ly/49t4UQ9>.

CONCLUSION

Amicus curiae respectfully requests that this Court affirm the summary judgment order below.

Dated: January 30, 2026

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Rule 11 of the Montana Rules of Appellate Procedure, I certify that this amicus curiae brief is printed with a proportionately spaced, 14-point Times New Roman font, is double spaced, and the word count calculated by Microsoft Word is 3,076 words, excluding the cover page, tables, and certificates.

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