ABORTION DEFENSE NETWORK

Know Your State's Abortion Laws

A Guide for Medical Professionals

MICHIGAN

Since *Roe v. Wade* was overturned in June 2022, medical providers across the country have struggled to understand their state's abortion laws, which contain undefined terms and non-medical language.

Fear and confusion throughout the medical community has led some hospitals to adopt policies that are overly strict or burdensome, causing patients to be denied care in emergencies. While the law remains in flux and some questions have no clear answers, this document aims to provide clarification, where possible, of what conduct is still permitted in your state. Know what your state's law does and does not require, so you can advocate for yourself and your patients.

Last updated October 2025

Key Takeaways

Abortion is legal in Michigan throughout pregnancy.

Providing contraception, including emergency contraception, is legal.

Medication abortion is legal, including medication abortion provided through telehealth.

Speech about abortion is legal, including providing information about how to obtain a legal abortion in another state.

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Definition of Abortion & Contraception

ABORTION

Michigan law defines abortion as the "intentional use of an instrument, drug, or other substance or device to terminate a woman's pregnancy for a purpose other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a fetus that has died as a result of natural causes, accidental trauma, or a criminal assault on the pregnant woman."[1] This means that treatment for a miscarriage where there is no cardiac activity (including medications, D&C, D&E, and labor induction) are *not* abortions under Michigan law and thus are not impacted by abortion regulations. This definition of abortion excludes contraception and drugs or devices intended as contraception.[2]

CONTRACEPTION

Michigan law does not define contraception. Contraception is not illegal in any state in the country.

Abortion Bans

Michigan does not ban abortion at any stage of pregnancy.[3] As of December 24, 2022, the Michigan Constitution protects an individual's right to reproductive freedom, which includes "the right to make and effectuate decisions about all matters relating to pregnancy, including … abortion care."[4] Although the state may regulate abortion after fetal viability, it may never prohibit an abortion that a health care provider has determined is medically indicated "to protect the life or physical or mental health of the pregnant individual."[5]

Michigan does not criminalize self-managed abortion,[6] and the state Constitution protects individuals who provide abortion support from prosecution.[7] Accordingly, it is legal for providers in Michigan to give medical care before, during, or after a self-managed abortion.

Exceptions to Abortion Bans

Prevent Death or Medical Emergency: Michigan's state Constitution explicitly allows any abortion that a provider has determined is medically indicated "to protect the life or physical or mental health of the pregnant individual."[8] Because Michigan does not have an abortion ban, providers do not need to consider whether this provision applies when treating adult or emancipated minor patients.

Medical Exceptions to Parental Consent: Michigan's requirement of parental consent for unemancipated minors before having an abortion, described below, contains a medical emergency exception. Parental consent is waived when a minor has a "condition which, on the basis of a physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate an immediate abortion of that woman's pregnancy to avert her death, or for which a delay in performing an abortion will create serious risk of substantial and irreversible impairment of a major bodily function."[9]

Although the state Constitution permits any abortion that a provider has determined is medically indicated "to protect the life or physical or mental health of the pregnant individual,"[10] this protection has not been legally tested in the case of minors.

Rape or Incest: As Michigan does not ban abortion at any stage of pregnancy, there is no exception to apply.

OTHER ABORTION RESTRICTIONS

Parental Consent: Providers treating an unemancipated patient under age 18 must obtain written consent from a parent or legal guardian before providing abortion care. Alternatively, the patient may file a petition for waiver of parental consent in probate court,[11] more commonly known as judicial bypass. As explained above, the parental consent requirement does not apply in a medical emergency.[12]

Mandatory Delay & Biased Counseling: Providers must orally screen patients for "coercion to abort" using a state-provided tool before providing an abortion.[13] This requirement is waived in medical emergencies, but providers must document the basis for the emergency.[14]

In February 2024, Northland Family Planning Center sued the state over several abortion regulations that they argue conflict with Michigan's Constitution. On June 25, 2024, a Michigan court enjoined three of Michigan's abortion laws: the 24-hour mandatory waiting period, the requirement that providers give patients state-mandated information as part of the informed consent process, and the ban on advanced practice clinicians (APCs) providing abortion care.[15] This case is still proceeding.

EMTALA

A federal law called the Emergency Medical Treatment & Labor Act ("EMTALA") requires the provision of abortion care when necessary to stabilize an emergency medical condition. Specifically, EMTALA requires hospitals with emergency departments that participate in Medicare (i.e., most hospitals) to perform a medical screening exam for any individual who comes to the emergency department and requests evaluation or treatment, in order to determine whether the individual has an emergency medical condition.[16] EMTALA defines "emergency medical condition" to include "acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part."[17] Additionally, "with respect to a pregnant woman who is having contractions," an "emergency medical condition" is further defined to include when "there is inadequate time to effect a safe transfer to another hospital before delivery" or when "transfer may pose a threat to the health or safety of the woman or the unborn child."[18]

EMTALA requires stabilizing medical treatment be provided to any individual experiencing an emergency medical condition,[19] including people in labor or with emergency pregnancy complications,[20] unless the individual refuses to consent to such treatment.[21] Under the EMTALA statute, "to stabilize" means to provide medical treatment "as may be necessary" to ensure, "within reasonable medical probability, that no material deterioration of the condition is likely."[22] A person experiencing an emergency medical condition can be transferred to a different hospital only once they are stable or if certain other conditions are met, such as the medical benefits of transfer outweighing the increased risks to the person experiencing the emergency medical condition.[23] Even where a hospital is permitted to transfer such a person without first stabilizing them, the hospital still must provide "the medical treatment within its capacity which minimizes the risks to the individual's health."[24]

Where abortion, including the premature delivery of a non-viable fetus, is the medical treatment necessary to, within a reasonable probability, ensure no material deterioration of an individual's condition, EMTALA requires a covered hospital provide such care or, if the aforementioned criteria are met, an

appropriate transfer. The U.S. Department of Health and Human Services ("HHS") has reaffirmed these requirements numerous times.[25]

Most recently, on June 13, 2025, HHS Secretary Robert F. Kennedy distributed a letter to health care providers reiterating that, notwithstanding the recent rescission of earlier guidance on the subject, "EMTALA continues to ensure pregnant women facing medical emergencies have access to stabilizing care."[26] The letter specifically states that EMTALA "applies equally to expectant mothers facing obstetric emergencies, including ectopic pregnancies, miscarriages, premature ruptures of membranes, trophoblastic tumors, and other similar conditions."[27] And, during a June 24, 2025, subcommittee hearing in the U.S. House of Representatives, Secretary Kennedy was asked explicitly about whether he agreed that in some circumstances abortion is the necessary stabilizing care that EMTALA requires hospitals to provide, to which he responded, "Yes, and that is what President Trump believes." [28] Further, as recently as May 2025, HHS announced that it had cited at least one hospital in Texas for violating EMTALA by failing to properly screen a patient with an ectopic pregnancy, an emergency medical condition that threatened the patient's life and future fertility.[29]

Notwithstanding EMTALA's clear requirements with respect to emergency abortion, state officials in Idaho and Texas have attempted to restrict hospitals from complying with their federal legal obligations, resulting in litigation, but with only varying degrees of success.

In January 2025, Idaho's largest hospital system, St. Luke's Health System, filed a lawsuit seeking to prevent the state of Idaho from enforcing its abortion ban, which creates criminal penalties for the provision of certain emergency abortions required under EMTALA.[30] St. Luke's was successful in obtaining a preliminary injunction that prevents the state of Idaho from enforcing its abortion ban "against St. Luke's or any of its medical providers as applied to medical care required by [EMTALA]."[31] Litigation in that case is ongoing. St. Luke's case is related to one brought in 2022 by the Biden Administration, *United States v. Idaho*, in which the federal government sued Idaho challenging its abortion ban to the extent that it conflicted with EMTALA.[32] That case made it all the way to the U.S. Supreme Court, where the appeal was ultimately dismissed as prematurely granted in June 2024.[33] Following the change of presidential administrations, the United States dismissed that case entirely. [34]

And, in October 2024, the U.S. Supreme Court refused to review a Fifth Circuit decision that affirmed a lower court decision blocking federal enforcement of EMTALA in certain circumstances in Texas and as to other organizational plaintiffs in that case.[35] As a result, the Fifth Circuit's decision is final.[36,37]

Other Federal Laws & Professional Guidelines

In addition to EMTALA, hospitals and/or medical providers are required to abide by the following:

Conditions of Participation in Medicare and Medicaid (COP): The federal COP regulations require hospitals that participate in Medicare and Medicaid to inform patients of their rights in advance of furnishing or discontinuing care which include: the right to be informed of their health status, be involved in care planning and treatment, and participate in the development of their plan of care.[38]

Protection Against Discrimination in Employment: The federal law known as the Church Amendments prohibits hospitals that receive certain federal funds from discriminating against health care providers who participate or are willing to participate

in abortion care or sterilization procedures.[39]

Medical Malpractice: While this document does not detail state-specific medical malpractice law, medical providers should be aware that they risk liability under state medical malpractice law for failing to provide pregnant patients with the standard of care.[40]

Resident Training: The Accreditation Council for Graduate Medical Education (ACGME) requires that accredited programs provide access to training in the provision of abortion.[41] The federal law known as the Coats-Snowe Amendment both protects medical professionals in learning to provide abortion, and limits the government's ability to penalize programs or institutions that fail to comply with ACGME requirements.[42]

Documentation & Reporting

Generally, state law does not require documentation of irrelevant or non-medical information in patient charts. Nor does it explicitly require reporting to law enforcement patients who receive abortions out of state or self-manage their own abortion.[43] Some hospitals may impose additional documentation requirements for abortions performed as medical emergencies. While intended to insulate the hospital from liability, these are not legal requirements.

Abortion Reporting: Michigan does not require providers to report abortions that they perform.

Complication Reporting: Michigan does not require providers to report abortion complications.

Fetal Death Reporting: Michigan requires reporting of fetal deaths, including stillbirths, for fetuses at or after 20 weeks gestation as well as fetuses that weigh at least 400 grams.[44]

If a fetal death occurs inside an institution, the individual in charge of the institution or an authorized representative must file the report.[45] If a fetal death occurs outside an institution, the physician in attendance must file the report.[46] If a fetal death occurs without medical personnel, the birthing person, attendant, or other person with knowledge of the fetal death must notify the medical examiner, who will investigate the cause of death and prepare and file the fetal death report.[47] The medical examiner must also investigate the cause and prepare and file a fetal death report if inquiry into the fetal death is required.[48]

Fetal deaths must be reported to the state registrar within 5 days of the death or becoming aware of the death.[49]

Other Mandatory Reporting: If an individual under age 18 discloses that they were coerced to have an abortion by someone who is responsible for the minor's health or welfare, health care providers must make a report to the Child Protective Services division of the Michigan Department of Health and Human Services.[50] Only the fact of coercion to abort must be reported. Health care providers can help ensure young people under 18 understand a provider's role as a mandatory reporter by explaining relevant reporting requirements prior to giving care where possible.

All other general mandatory reporting to the Department of Health and Human Services, local law enforcement, etc., also applies for abortion patients.[51] In Michigan, this includes reporting of sexual abuse of young people, child abuse, vulnerable adult abuse, and injuries inflicted by violent means.[52] Under Michigan law, a pregnancy is not considered grounds for reasonable suspicion of abuse or neglect unless it occurs in a minor younger than 12.[53]

Electronic Medical Records: Many electronic medical record systems (EMRs) allow healthcare providers to securely share patient records across healthcare institutions. Hospital and other healthcare

systems often use their EMR's default settings that widely share patient records.[54] Though these settings are often helpful for continuity of care, they may put abortion providers and patients (or patients obtaining other sensitive care) at risk, and many patients do not know their records are shared in this way.[55, 56]

EMRs have settings that can limit sharing of certain records and/or allow patients to choose how and when their records are shared, but because these are not the default settings, healthcare systems often must take steps to implement them.[57] For example, one EMR, Epic, has a filter that each Epic healthcare system can choose to turn on that exclusively blocks abortion care information from patients' externally-shared medical records, while allowing each patient's other medical records to be transmitted in full, in line with their authorization. We encourage you to discuss with your institution's general counsel and/or compliance or technology officers counsel alternative settings such as this that can protect abortion patient information while also complying with any other legal requirements.[58]

Counseling & Referral

Speech about abortion is legal in Michigan. Medical professionals in Michigan can thus (1) provide accurate options counseling, including about abortion, and (2) refer patients to abortion providers in states where abortion is legal.

Medication Abortion

Michigan law allows medication abortions, and providers can prescribe abortion pills via telehealth.[59] The state does not have any legal restrictions specific to medication abortion, but the parental consent requirement still applies to unemancipated minors, and the coercion counseling restriction still applies in all cases.

Disposition of Fetal Tissue Remains

In 2023, the Michigan legislature passed, and the governor signed, the Reproductive Health Act, which repealed a number of abortion restrictions, including the state's abortion-specific fetal tissue disposal law.[60] While Michigan still has a law that governs the disposition of fetal remains following a stillbirth or miscarriage, that law has never been interpreted to apply to abortion care.[61] It is therefore unclear what legal requirements apply to the disposition of fetal tissue after an abortion.

Abortion providers in Michigan are engaged in discussions with the Department of Health and Human Services to obtain clarity on this question. If you have questions about on this issue, you should contact your facility's general counsel or the ADN.

Need legal advice?

This document should not be construed as legal advice. If you need individualized legal advice, please contact the Abortion Defense Network, where you will be matched with a pro bono attorney.

The Abortion Defense Network is managed by the Lawyering Project in partnership with the American Civil Liberties Union, Center for Reproductive Rights (CRR), National Women's Law Center (NWLC), and Resources for Abortion Delivery (RAD).

ACLU

CENTER *for* REPRODUCTIVE RIGHTS

THE LAWYERING PROJECT

NATIONAL WOMEN'S LAW CENTER
Justice for Her. Justice for All.

RAD RESOURCES FOR ABORTION DELIVERY

References

[1] MCL § 333.17015 (definition in the Health Code for general abortion regulations); *see also* MCL § 722.902 (substantially similar definition used in Children Code under the Parental Consent Law); MCL § 333.2803(1) (similar definition used in the Health Code for vital statistics purposes, but specifically excluding extrauterine pregnancies).
[2] MCL § 333.17015.
[3] Guttmacher Institute, Interactive Map: US Abortion Policies and Access After Roe (last updated Feb. 5, 2025).
[4] MI Const. art. I, § 28.
[5] *Id.* Although there are no current restrictions, that the state does have the power to regulate abortion after fetal viability. When interpreting the state Constitution, "'[f]etal viability' means: the point in pregnancy when, in the professional judgment of an attending health care professional and based on the particular facts of the case, there is a significant likelihood of the fetus's sustained survival outside the uterus without the application of extraordinary medical measures." *Id.*
[6] *In re Vickers*, 123 N.W.2d 253, 254 (Mich. 1963) ("At common law she as not guilty of a crime even though she performed the aborting act upon herself or assisted or assented thereto. The majority view is that not only may [a pregnant person] not be held for abortion upon herself but neither as an accomplice.") (internal citations omitted).
[7] MI Const. art. I, § 28(3).
[8] MI Const. art. I, § 28.
[9] MCL §§ 722.905, 722.902.
[10] MI Const. art. I, § 28.
[11] MCL § 722.903. A judge will determine if the minor is sufficiently mature and informed enough to seek care without an adult, and if the waiver of consent is in the minor's best interest. MCL § 722.904.
[12] MCL § 722.905. "'Medical emergency' means that condition which, on the basis of a physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate an immediate abortion of that woman's pregnancy to avert her death, or for which a delay in performing an abortion will create serious risk of substantial and irreversible impairment of a major bodily function." MCL § 722.902.
[13] MCL § 333.17015a.
[14] MCL § 333.17015(6)(a) ("Subject to subsection (10), before obtaining the patient's signature on the acknowledgment and consent form, a physician [shall] … confirm with the patient that the coercion to abort screening required under section 17015a was performed"); MCL § 333.17015(10) ("If the attending physician, utilizing the physician's experience, judgment, and professional competence, determines that a medical emergency exists and necessitates performance of an

abortion before the requirements of subsection[] … (6) can be met, the physician is exempt from the requirements of subsection[] … (6), may perform the abortion, and shall maintain a written record identifying with specificity the medical factors upon which the determination of the medical emergency is based.").

[15] *Northland Family Planning Center v. Nessel*, Case No. 24-000011-MM (Mich. Ct. Cl. June 25, 2024).

[16] EMTALA, 42 U.S.C. § 1395dd(a).

[17] EMTALA, 42 U.S.C. § 1395dd(e)(1)(A).

[18] EMTALA, 42 U.S.C. § 1395dd(e)(1)(B).

[19] EMTALA, 42 U.S.C. § 1395dd(b)(1)(A).

[20] EMTALA, 42 U.S.C. § 1395dd(e)(1).

[21] EMTALA, 42 U.S.C. § 1395dd(b)(2).

[22] EMTALA, 42 U.S.C. § 1395dd(e)(3)(A).

[23] EMTALA, 42 U.S.C. § 1395dd(c)(2) (requiring hospital to use "qualified personnel and transportation equipment" when making a permitted transfer under EMTALA, among other requirements).

[24] EMTALA, 42 U.S.C. § 1395dd(c)(1)(B)–(c)(2)(A).

[25] For example, in 2022, the Biden Administration issued guidance reiterating past administrative statements that the treatment required by EMTALA includes abortion care when such care is necessary to stabilize a pregnant person's emergency medical condition. Ctrs. for Medicare & Medicaid Servs., *Reinforcement of EMTALA Obligations Specific to Patients who are Pregnant or are Experiencing Pregnancy Loss* (updated July 2022) ("2022 EMTALA Guidance"). While this guidance has since been rescinded, the requirements of EMTALA as outlined in it and other prior HHS statements have not changed. Indeed, in the Trump Administration's June 3, 2025 statement rescinding the 2022 guidance, the Administration stated that "CMS will continue to enforce EMTALA . . . including for identified emergency medical conditions that place the health of a pregnant woman or unborn child in serious jeopardy." Ctrs. for Medicare & Medicaid Servs., *CMS Statement on Emergency Medical Treatment and Labor Act (EMTALA)* (June 3, 2025); *see also* Letter from Robert F. Kennedy Jr., Sec'y, U.S. Dep't of Health & Hum. Servs., to Healthcare Providers (June 13, 2025) ("Kennedy Letter"), available at https://essentialhospitals.org/wp-content/uploads/2025/06/6.13.25-EMTALA-letter-final.pdf.pdf.

[26] Kennedy Letter.

[27] Kennedy Letter.

[28] *Hearing on the Fiscal Year 2026 Dep't of Health and Hum. Servs. Budget Before the H. Comm. on Energy & Com., Subcomm. on Health,* 119th Cong. (2025) (statement of Robert F. Kennedy Jr., Sec'y of Health & Hum. Serv.).

[29] Center for Reproductive Rights, *Complaints Against Texas Hospitals for Denying Emergency Care for Ectopic Pregnancies*, (updated May 8, 2025).

[30] *St. Luke's Health System, LTD. v. Labrador*, No. 1:25-cv-00015, ECF No. 1 (D. Idaho Jan 14, 2025).

[31] *St. Luke's Health System, LTD v. Labrador*, No. 1:25-cv-00015, ECF No. 49 at 59 (D. Idaho Mar. 20, 2025).

[32] *United States v. Idaho*, 623 F. Supp. 3d 1096, 1117 (D. Idaho 2022).

[33] *Moyle v. United States*, 144 S. Ct. 2015 (June 27, 2024) (per curiam).

[34] *Idaho v. United States*, No. 1:22-cv-00329, ECF No. 182 (D. Idaho Mar. 5, 2025).

[35] *Becerra v. Texas*, No. 23-1076 (U.S. Oct. 7, 2024) (denying certiorari).

[36] *Texas v. Becerra*, 89 F.4th 529, 546 (5th Cir. 2024) (affirming permanent injunction barring HHS from enforcing the 2022 EMTALA Guidance's "interpretation that Texas abortion laws are preempted by EMTALA" and "it's interpretation of EMTALA—both as to when an abortion is required and EMTALA's effect on state laws governing abortion—within the State of Texas or against [plaintiff organizations'] members."); *see also* Ctrs. for Medicare & Medicaid Servs., *Emergency Medical Treatment & Labor Act (EMTALA)*, https://www.cms.gov/medicare/regulations-guidance/legislation/emergency-medical-treatment-labor-act (last modified Dec. 6, 2024).

[37] A separate challenge to the guidance was filed by the Catholic Medical Association in Tennessee, Compl., *Catholic Med. Ass'n v. Dep't of Health & Hum. Servs.*, No 3:25-cv-00048, ECF No. 1 (M.D. Tenn. Jan. 10, 2025), but the plaintiff voluntarily dismissed that action on June 3, 2025.

[38] 42 C.F.R. §§ 482.13(a)(1), (b)(1), (b)(2).

[39] Nat'l Women's Law Ctr., *Know Your Rights: Existing Laws May Protect Health Care Professional Who Provide or Support Abortion from Discrimination in Employment* (Feb. 9, 2023).

[40] MCL § 600.2912.

[41] Accreditation Council for Graduate Med. Educ., *ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology* (Sept. 3, 2025).
[42] 42 U.S.C. § 238n.
[43] There is no reason to report a self-managed abortion to the police. Fact sheets from If/When/How with additional detail, including some state-specific fact sheets, are available here. If/When/How adds state-specific fact sheets to their website as they are finalized.
[44] MCL §§ 333.2834, 333.2803(4) (defining "fetal death" as "the death of a fetus that has completed at least 20 weeks of gestation or weighs at least 400 grams. Fetal death includes a stillbirth. The definition of fetal death must conform in all other respects as closely as possible to the definition recommended by the federal agency responsible for vital statistics").
[45] MCL § 333.2834(3).
[46] MCL § 333.2834(4).
[47] MCL § 333.2834(5).
[48] MCL § 333.2898.
[49] MCL § 333.2834(1).
[50] MCL § 333.17015a.
[51] Fact sheets from If/When/How with a comprehensive list of the state-specific mandatory reporting requirements that apply for all abortion procedures are available here.
[52] MCL §§ 722.622, 750.411.
[53] MCL § 722.623.
[54] For example, an EMR may employ a tool that securely shares information among healthcare institutions that use the same EMR (e.g., from one hospital system to another) and allows robust sharing among affiliated healthcare institutions (e.g., a Texas hospital treating a patient may be able to see the patient's records from an Illinois hospital within the same health system).
[55] For example, if a patient travels from a ban state to an access state for abortion care or obtains an abortion in the ban state under an exception, then later obtains any type of healthcare at a different provider that uses the same EMR, the patient's records may be automatically shared with the second provider. If the second provider believes that the care violated the state's abortion ban, they may report it to authorities.
[56] Some states have taken steps to address vulnerabilities in information sharing, specifically for abortion and gender-affirming care. For example, Maryland and California, among other states, have enacted laws that restrict disclosure of abortion-related records and require EMRs to develop tools to limit or prohibit such disclosure. *See, e.g.,* H.B. 812, 445th Leg., Reg. Sess. (Md. 2023), A.B. 352, 2023 Leg., Reg. Sess. (Cal. 2023).
While the federal government under the Biden administration created additional HIPAA protections related to the disclosure of reproductive health care records by issuing a HIPAA Reproductive Health Rule, in 2025, a federal district court vacated the rule nationwide and the requirements of the rule are no longer in effect (except for the notice of privacy practices provisions related to substance use disorder treatment records, which go into effect on February 16, 2026). HIPAA Privacy Rule to Support Reproductive Health Care Privacy, 89 Fed. Reg. 32976 (2024) (modifying 45 C.F.R. §§ 160, 164), *Purl v. U.S. Dep't of Health & Hum. Servs.*, No. 2:24-cv-228-Z (N.D. Tex. Jun 18, 2025) (vacating the majority of the rule). All HIPAA protections that were in place prior to this rule remain in place.
[57] Many of these setting options are quite broad, blocking not only a subsequent provider's access to more "sensitive" information, but also to less sensitive information that is critical to continuity of care. For this reason, many patients may not want to limit access to their records.
[58] E.g., healthcare institutions must comply with interoperability rules that penalize certain information blocking (though exceptions are available). *See* 21st Century Cures Act: Interoperability, Information Blocking and the ONC Health IT Certification Program, 85 Fed. Reg. 25642 (May 1, 2020) (amending 45 C.F.R. §§ 170, 171), 21st Century Cures Act: Establishment of Disincentives for Health Care Providers That Have Committed Information Blocking, 89 Fed. Reg. 54662 (July 1, 2024) (amending 42 C.F.R. §§ 171 414, 425, 495). *See also* Health Data, Technology, and Interoperability:

Protecting Care Access, 89 Fed. Reg. 102512 (Dec. 17, 2024) (adding 45 C.F.R. § 171.206 to except information blocking practices intended to reduce potential exposure to legal action based on lawful reproductive health care provision, subject to certain conditions). Not all healthcare providers are currently subject to the disincentives included in the 2024 rule. However, the Centers for Medicare & Medicaid Services (CMS) may apply disincentives to certain hospitals and merit-based incentive payment system (MIPS) eligible clinicians.

[59] MCL § 333.16285. Providers may prescribe medication within the scope of their practice via telehealth. *Id.*

[60] MCL § 333.2836 (repealed 2023).

[61] MCL § 333.2848 (describing a fetus as "delivered or miscarried," terms that do not apply to abortion).