ABORTION DEFENSE NETWORK

Know Your State's Abortion Laws

A Guide for Medical Professionals

MISSISSIPPI

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 November 2024

Key Takeaways

Providing contraception, including emergency contraception, is legal.

Providing medical care for pregnancies with no cardiac activity is legal.

Providing information about how to obtain a legal abortion in another state is legal.

Abortion is prohibited under Mississippi law unless:

(1) abortion is necessary to “preserve the mother’s life,” or

(2) the pregnancy was the result of rape and a formal charge of rape has been filed with an appropriate law enforcement official. It is unclear but possible that the rape exception only applies if cardiac activity cannot be detected.

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Definition of Abortion & Contraception

ABORTION

Mississippi law defines "abortion" as "the use or prescription of any instrument, medicine, drug or any other substance or device to terminate the pregnancy of a woman known to be pregnant with an intention 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 dead fetus."[1]

Because Mississippi law excludes the removal of "a dead fetus" from the definition of abortion, miscarriage care is legal as long as the pregnancy has no cardiac activity. With respect to self-managed abortion, it is legal for providers to give medical care during or after a self-managed abortion provided there is no cardiac activity, or if the patient is experiencing a complication that requires an abortion to preserve "the mother's life" (see below). A pregnant person cannot be convicted of a violation of Mississippi's abortion ban for self-managing their abortion because the state's criminal abortion ban(s) explicitly exempt pregnant people from liability.[2]

CONTRACEPTION

Contraception is not illegal in any state in the country. Although Mississippi law does not explicitly exempt contraception from the definition of "abortion," Mississippi's legal definition of abortion only applies to the use or prescription of an "instrument, medicine, drug or any other substance or device to terminate the pregnancy of a woman *known to be pregnant*."[3] By contrast, Mississippi's definitions of "contraceptive procedures" and "contraceptive supplies" refer to "procedure[s]" and "items" that are "designed to *prevent conception*," not terminate an existing pregnancy.[4] Both the definition of abortion and the definition of contraceptive procedures also suggest that emergency contraception, including Plan B, is lawful in Mississippi.

Abortion Bans

Mississippi has several abortion bans with penalties that are either criminal (prison time and/or fines) or civil.[5] Despite containing conflicting terminology, the laws operate together to forbid "perform[ing] or induc[ing]" an abortion "except in the case where necessary for the preservation of the mother's life or where the pregnancy was caused by rape."[6] If the pregnancy was the result of rape, an abortion can be lawfully provided only if "a formal charge of rape has been filed with an appropriate enforcement official."[7] The law defines abortion using the definition provided above.[8] Because of a conflict between the trigger ban and the fetal heartbeat ban, it is possible that a pregnancy resulting from rape can only be terminated *before* a "fetal heartbeat" can be detected, unless the abortion is necessary to preserve the mother's life.[9] For purposes of the law, "fetal heartbeat" means "cardiac activity or the steady and repetitive rhythmic contraction of the fetal heart within the gestational sac."[10]

The Mississippi State Board of Medical Licensure can independently investigate and penalize those who provide abortions after 15-weeks LMP.[11] Additionally, the Mississippi State Board of Medical Licensure can suspend or revoke a medical license following a criminal conviction, including a conviction for a violation of Mississippi's trigger ban.[12] Further, the Mississippi Attorney General has broad authority to manage criminal litigation on behalf of the state,[13] and has explicit statutory authority to investigate those who provide abortions after 15-weeks LMP.[14]

Mississippi's pre-*Roe* abortion ban was enacted in 1952.[15] Among other things, that law made it a misdemeanor to "sell, lend, [or] give[] away . . . any drug or medicine, for causing unlawful abortion."[16]

When a more recent law covers the same conduct as a previous law, the more recent law typically governs. Here, to the extent that the same conduct is covered by both the trigger ban and the pre-*Roe* Ban, the harsher penalty in the trigger ban would apply to that conduct.[17] Mississippi's pre-*Roe* abortion ban contains another provision that prohibits providing information orally "stating when, where, how, of whom, or by what means such article or medicine can be purchased or obtained."[18] Because no other Mississippi law covers this conduct, there is a strong argument that this portion of the pre-*Roe* abortion ban remains in effect today.[19]

Abortion Ban Exceptions

Under Mississippi law, there are certain limited circumstances where an abortion can still be performed. All of Mississippi's abortion bans contain an exception for medical emergencies. The bans each describe medical emergencies in slightly different ways, but the narrowest definition—which would comply with all of the abortion bans—applies when an abortion is "necessary for the preservation" of the pregnant person's life.[20] This medical emergency exception is narrower than the medical emergency exception in Mississippi's fetal heartbeat ban, which permits a provider to provide an abortion if it is necessary *either* to "prevent the death of a pregnant woman or to prevent a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman."[21] However, because that definition is broader than the definition in the trigger ban, providing an abortion that meets the medical emergency exception in the fetal heartbeat ban could be a violation of the trigger ban. Mississippi courts have not yet determined the scope and meaning of this exception or the circumstances when it applies. A physician must inform the pregnant person, "before the abortion if possible," of any medical indications supporting the conclusion that the abortion is necessary to preserve the pregnant person's life.[22]

If a physician has determined that an abortion is necessary to preserve the pregnant person's life, the physician does not need to comply with Mississippi's biased counseling and 24-hour waiting period;[23] for young people under the age of 18, a physician does not need to obtain consent from the parents if, in the physician's "best clinical judgment" an emergency "so complicates the pregnancy as to require an immediate abortion;[24] and the physician does not need to comply with the ban on D&E and intact D&E (sometimes called D&X) abortions, meaning the physician can perform a D&E or D&X procedure if necessary to preserve the pregnant person's life.[25]

However, because these laws do not contain a similar exception for rape, if a physician provides an abortion to a person whose pregnancy is the result of rape before a "fetal heartbeat" can be detected, Mississippi's other abortion restrictions must be followed. Specifically, the physician must obtain consent from the parents of a young person under 18,[26] D&E and D&X procedures are prohibited,[27] and the physician must wait to provide the abortion at least 24 hours after providing information about the risks of abortion and other biased counseling requirements.[28]

EMTALA

A federal law called the Emergency Medical Treatment & Labor Act ("EMTALA") requires emergency abortion care in some cases. EMTALA requires Medicare-participating hospitals with emergency departments (which includes most hospitals), to perform a medical screening to determine whether an emergency medical condition exists of any individual who comes to the emergency department and requests an examination or treatment. Stabilizing medical treatment must be provided to individuals experiencing an emergency medical condition, including people in labor or with emergency pregnancy complications. 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." A person experiencing an emergency medical condition can only be transferred to a different hospital once they are stable or if certain conditions are met such as the medical benefits of transfer outweigh the increased risks to the person experiencing the medical emergency. 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." 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." The stabilizing treatment required by EMTALA can include abortion care in certain circumstances.

The U.S. Department of Health and Human Services ("HHS") reaffirmed these requirements in guidance issued after Roe v. Wade was overturned. That guidance emphasizes that stabilizing treatment required by EMTALA could include abortion care if the examining physician or other qualified medical personnel determines that such treatment is required to stabilize a patient experiencing an emergency medical condition, including a condition that is "likely or certain to become emergent without stabilizing treatment." The guidance made clear those conditions might include, but are not limited to: "ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features." The guidance reiterates that if EMTALA requires the provision of abortion care, then EMTALA expressly preempts any state law prohibiting or restricting access to abortion. Indeed, HHS has recently cited hospitals in Kansas, Missouri and Florida for violating EMTALA by failing to provide abortion care to a patient with PPROM.

Notwithstanding EMTALA's clear requirements with respect to emergency abortion, there is ongoing litigation relating to attempts by state officials in Idaho and Texas to restrict hospitals from complying with their federal legal obligations. In 2022, a federal district court in Idaho issued a preliminary injunction ensuring that Idaho's abortion ban could not be enforced to prohibit health-saving emergency abortions required under EMTALA. The U.S. Supreme Court temporarily stayed that injunction, allowing Idaho to enforce its abortion ban even in cases where abortion care is required under EMTALA. But, in June 2024, the Supreme Court lifted that stay and restored the preliminary injunction. In other words, Idaho may not currently enforce its abortion ban to prohibit health-saving abortions required under EMTALA. In July 2024, following that order, HHS issued a statement reiterating that EMTALA requires hospitals to provide emergency abortion care when it is necessary stabilizing treatment. Meanwhile, HHS had asked the U.S. Supreme Court to review a Fifth Circuit decision that affirmed a lower court decision temporarily blocking federal enforcement of HHS' guidance in Texas and as to other plaintiffs in that case. HHS petitioned the Supreme Court to reverse the preliminary injunction. However, in October 2024, the Supreme Court declined to review the Fifth Circuit's decision, meaning the guidance is still blocked in Texas.

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.[29]

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.[30]

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.[31]

Resident Training: The Accreditation Council for Graduate Medical Education ("ACGME") requires that accredited programs provide access to training in the provision of abortion.[32] 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.[33]

Documentation & Reporting

Generally, state law does not require documentation of irrelevant or non-medical information in patient charts. Nor does it require reporting patients who receive abortions out of state or self-manage their own abortion to law enforcement.[34] The only abortion-specific documentation and reporting requirements are:

Documentation: If an abortion is necessary to preserve the life of the pregnant person, the physician must "declare in writing, under penalty of perjury, that the medical procedure was necessary, to the best of the person's reasonable medical judgment, to prevent the death" of the pregnant person.[35] The written documentation must include both the "medical condition" and the "medical rationale for the conclusion" that abortion was necessary.[36] The written documentation must be saved in the pregnant person's medical records for at least seven years after the abortion is provided.[37] Quoting the language of the statute when documenting a patient case—e.g. "the abortion is necessary for the preservation of the mother's life"—may be helpful.

If an abortion is performed before a fetal heartbeat can be detected and the pregnancy is the result of rape, there is no documentation requirement. However, as explained above, an abortion may only be provided in that circumstance if "a formal charge of rape has been filed with an appropriate law enforcement official."[38]

Some hospitals may impose additional documentation requirements for abortions performed as medical emergencies, including attestations by multiple physicians and/or approvals by an ethical review board. While intended to insulate the hospital from liability, these are not legal requirements.

Abortion Reporting: Mississippi law requires physicians to report abortions performed under an exception to the Mississippi State Department of Health. The reports must include the date of the abortion, the "[s]pecific method of abortion," whether the "race of, sex of, or the presence or presumed presence of any genetic abnormality in the unborn human being had been detected at the time of the abortion," a statement confirming that the abortion was not provided because of the fetus's sex,

race, or genetic abnormality, and any "[p]robable health consequences of the abortion."[39] The report should not include identifying information about the patient.[40] Providing a report that is known to be false may result in a fine of up to $500 per violation.[41]

Complication Reporting: If a physician "has a reasonable basis to believe" that a patient who "comes under the physician's professional care *and* requires medical treatment" has experienced a complication that is "a primary, secondary, or tertiary result of an induced abortion," the physician must file a written report with the state Department of Health.[42] Medical treatment is defined in the statute to include "hospitalization, laboratory tests, surgery or prescription of drugs."[43] Therefore, unless a patient requires medical treatment, there is no obligation to make a report, even if a physician believes that a patient has had an abortion. If a patient does require medical treatment for a complication that was the result of an abortion, the report must be anonymous, contain information about the treatment and condition, and filed within thirty days of the discharge or death of the patient.[44]

Fetal Death Reporting: Mississippi law requires "spontaneous fetal deaths (stillbirths and miscarriages)" to be reported by the "person in charge of the institution" or that person's "designated representative," if the "dead fetus was delivered in an institution or enroute thereto."[45] The Mississippi Administrative Code defines "stillbirth" as "an unintended, intrauterine fetal death occurring in this state after a gestational age of not less than twenty (20) completed weeks, or a weight of 350 grams or more."[46] Therefore, the fetal death reporting requirements likely do not apply to abortions, but may apply in instances where a physician provides miscarriage treatment.

Other Mandatory Reporting: All other general mandatory reporting to the Department of Family and Protective Services, local law enforcement, etc., also applies for abortion patients.[47] This includes reporting of sexual abuse of young people, child abuse or neglect, and human trafficking.[48]

Electronic Medical Records: Many electronic medical record systems ("EMRs") allow healthcare providers to securely share patient records across healthcare institutions.[49] While EMRs have settings that allow patients to choose how and when their records are shared, hospital systems often instead use their EMR's default settings that widely share patient records. Though often done for continuity of care purposes, these settings 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.[50]

The federal government has taken steps to address this concern by issuing a new HIPAA rule, effective June 25, 2024.[51] The rule prohibits the use or disclosure of protected health information ("PHI") if sought to conduct a criminal, civil, or administrative investigation into or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating lawful reproductive healthcare, or identifying any person for these purposes.[52] A provider who receives a request for disclosure of PHI potentially related to reproductive care must obtain a signed attestation from the requestor that the request is not for a prohibited purpose.[53] The attestation is required when the request is for: law enforcement purposes, disclosures to coroners and medical examiners, judicial and administrative proceedings, and health oversight activities.[54] If the abortion care—self-managed or otherwise—was provided by someone else, a provider is allowed to assume the care was provided lawfully unless 1) the patient tells them otherwise or 2) the attestation provides evidence of unlawfully provided care.[55]

The new rule only applies to healthcare providers who are subject to HIPAA. Separate from HIPAA,

interoperability rules may apply when a healthcare provider uses EMRs.[56] Because of this, we encourage you to discuss alternative EMR settings and information blocking exceptions with your institution's compliance officers, counsel, and/or technology officers, who may be able to offer customized solutions.[57]

Medication Abortion

Mississippi has additional rules that apply specifically to abortion medications. Practically speaking, now that abortion is largely prohibited in Mississippi, these rules only apply to abortions that are necessary to preserve the life of the pregnant person or where the pregnancy is the result of rape that the pregnant person has reported to law enforcement and no "fetal heartbeat" has been detected.

Mississippi law defines "abortion-inducing drug" as "a medicine, drug or any other substance prescribed or dispensed with the intent of terminating the clinically diagnosable pregnancy of a woman to cause the death of the unborn child."[58] Mississippi prohibits anyone other than a physician from prescribing, selling, administering, or otherwise providing an "abortion-inducing" drug.[59] Additionally, before providing abortion medications, the physician must first physically examine a patient and document the gestational age and intrauterine location of the pregnancy in the patient's chart.[60] If abortion medications are provided, they must be administered in the same room of and in the presence of the physician who prescribed the medication, and the physician must provide the patient with a copy of the drug's final printed label.[61] Finally, the physician must have a signed contract with a physician who has hospital admitting privileges and gynecological/surgical privileges and can provide follow-up care in the event that the physician is not available, and the physician must schedule a follow-up appointment with the patient approximately fourteen days after administration of the medications.[62]

Failure to comply with these requirements will result in both criminal and civil liability for the physician, but the pregnant person is explicitly exempt from liability.[63]

Disposition of Fetal Tissue Remains

Mississippi law permits, but does not require, a physician to "authorize disposition of [fetal issue] by incineration, cremation, burial or other sanitary method approved by the state board of health."[64] Alternatively, the patient may make a written request that the tissue be delivered to them for disposal in accordance with the state board of health.[65] Unless the "mother of the dead foetus or her spouse" provides consent, fetal tissue may not be disposed of less than forty-eight hours after its removal or acquisition.[66] Mississippi law also permits the State Board of Health to establish additional rules and regulations for the disposition of fetal tissue.[67]

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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), If/When/How: Lawyering for Reproductive Justice, National Women's Law Center (NWLC), and Resources for Abortion Delivery (RAD).

References

[1] MISS. CODE ANN. § 41-41-45(1).
[2] *See id.* § 41-41-45(4).
[3] *Id.* § 41-41-45(1) (emphasis added).
[4] MISS. CODE ANN. § 41-42-3(c), (d) (emphasis added).
[5] MISS. CODE ANN. § 41-41-45 (trigger ban); MISS. CODE ANN. § 97-3-3 (pre-*Roe* ban, arguably not in effect); *id.* § 97-3-5 (pre-*Roe* helpers ban); MISS. CODE ANN. § 41-41-34.1 (de facto 6-Week Ban).
[6] MISS. CODE ANN. § 41-41-45(2).
[7] *Id.* § 41-41-45(3).
[8] *Id.* § 41-41-45(1).
[9] *Id.* § 41-41-34.1(2)(a).
[10] *Id.* § 41-41-34.1(1)(a).
[11] *Id.* § 41-41-191(6).
[12] *See* MISS. CODE ANN. § 73-25-29.
[13] MISS. CODE ANN. § 7-5-1.
[14] MISS. CODE ANN. § 41-41-191(7).
[15] MISS. CODE ANN. § 97-3-3(1).
[16] *Id.* § 97-3-5. The pre-*Roe* ban also forbids providing an abortion by any means, unless the abortion is "necessary for the preservation of the mother's life" or the "pregnancy was caused by rape." *Id.* § 97-3-3(1). The law makes such conduct a felony. *Id.* Because the trigger ban covers the same conduct in its entirety and was enacted after the pre-*Roe* ban, the trigger ban likely implicitly repealed this part of the pre-*Roe* ban as well.
[17] *See, e.g.*, *Russell v. State*, 169 So. 654, 656 (Miss. 1936) ("It is not to be assumed that the Legislature intended to have two statutes upon the same subject, embracing the same elements of crime, and make the crime in one a misdemeanor, and in the other a felony."). Under Mississippi law, a later-enacted statute repeals an earlier statute by implication "[w]here the Legislature in a later act covers the entire scheme dealt with in former acts," even if there is "some difference in the provisions of the two statutes." *Id.* In particular, if a later statute changes the penalty for the same conduct from a misdemeanor into a felony, or vice versa, the Mississippi legislature has held that there is a repeal by implication. *Id.* However, repeals by implication are disfavored, and will not be found if there is "reasonable ground to hold to the contrary." *State v. Wood*, 187 So. 2d 820, 826 (Miss. 1966).

[18] MISS. CODE ANN. § 97-3-5.
[19] Repeals by implication are generally disfavored, and will only be found if "there is a plain and manifest repugnancy between the two statutes." *Pons v. State*, 49 Miss. 1, 4 (Miss. 1873). Further if there is a conflict between two statutes, the former statute is "repealed [only] to the extent of the repugnancy." *Id.* Mississippi has other laws on the books that ban abortion at fifteen weeks LMP, *see* MISS. CODE ANN. § 41-41-191(4), and twenty weeks LMP, *see id.* § 41-41-137. There is a strong argument that both laws are still in effect. The fifteen-week ban specifically provides that "[i]t is not the intention of this section to make lawful an abortion that is otherwise unlawful." MISS. CODE ANN. § 41-41-191(8). Further, "[a]n abortion that complies with this section, but violates any other state law, is unlawful. An abortion that complies with another state law, but violates this section is unlawful." *Id.* Likewise, the twenty-week ban explains that the law "may not be construed to repeal, by implication or otherwise, any other provision of Mississippi law," and that an abortion that complies with the ban but violates another law is "unlawful," as is an abortion that "complies with another state law" but violates the twenty-week ban. *Id.* § 41-41-147.
[20] MISS. CODE ANN. § 41-41-45(2).
[21] *Id.* § 41-41-34.1(2)(b)(i).
[22] *Id.* § 41-41-37.
[23] *Id.* § 41-41-33(1).
[24] *Id.* § 41-41-57.
[25] *Id.* §§ 41-41-155(1), 41-41-73(1).
[26] *Id.* § 41-41-57.
[27] *Id.* §§ 41-41-155(1), 41-41-73(1).
[28] *Id.* § 41-41-33(1).
[29] 42 C.F.R. §§ 482.13(a)(1), (b)(1), (b)(2).
[30] Know Your Rights: Existing Laws May Protect Health Care Professional Who Provide or Support Abortion from Discrimination in Employment, NAT'L WOMEN'S LAW CTR. (Feb. 9, 2023), https://nwlc.org/resource/know-your-rights-existing-laws-may-protect-health-care-professionals-who-provide-or-support-abortion-from-discrimination-in-employment/.
[31] MISS. CODE ANN. § 15-1-36.
[32] Accreditation Council for Graduate Med. Educ., *ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology*, ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC. (effective July 1, 2022), https://www.acgme.org/globalassets/pfassets/programrequirements/220_obstetricsandgynecology_2023.pdf.
[33] 42 U.S.C. § 238n.
[34] 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.
[35] MISS. CODE ANN. § 41-41-34.1(2)(b)(ii).
[36] *Id.*
[37] *Id.*
[38] *Id.* § 41-41-45(3).
[39] *Id.* § 41-41-407(3).
[40] *Id.* § 41-41-407(4).
[41] *Id.* § 41-41-191(6)(b).
[42] *Id.* § 41-41-77(1) (emphasis added).
[43] *Id.* § 41-41-76(b).
[44] *Id.* § 41-41-77(1)-(2); *id.* § 41-41-78.
[45] 15 MISS. CODE R. §§ 5-85-.2.2, 5-85-5.1.1.
[46] *Id.* § 5-85-1.3.1(25).
[47] 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.
[48] MISS. CODE ANN. § 43-21-353.

[49] For example, one EMR, Epic, uses a tool called Care Everywhere to securely share information between health care institutions (e.g., from one hospital system to another) and allows robust sharing within a single institution (e.g., a Texas hospital treating a patient may be able to see the patient's records from an Illinois hospital within the same system).
[50] 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.
[51] 89 Fed. Reg. 32976 (amending 45 C.F.R. §§ 160, 164). Although effective on June 25, 2024, compliance with this rule is not required until December 23, 2024, except for the applicable requirements for revising Notice of Policy Practices (as required by 45 CFR 164.520), which must be complied with by February 16, 2026.
[52] 42 U.S.C. § 164.502(a)(5)(iii). *See also HIPAA Privacy Rule Final Rule to Support Reproductive Health Care Privacy: Fact Sheet*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.hhs.gov/hipaa/for-professionals/special-topics/reproductive-health/final-rule-fact-sheet/index.html (content last reviewed April 22, 2024).
[53] 42 U.S.C. § 164.509. HHS released a model attestation, available here: https://www.hhs.gov/sites/default/files/model-attestation.pdf.
[54] 42 U.S.C. §§ 164.509(a), 164.512(d)-(g).
[55] 42 U.S.C. § 164.502(a)(5)(iii)(C).
[56] 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). 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. HHS intends to expand disincentives to other groups of health care providers in future rulemaking.
[57] In the past year, states and the federal government have taken steps to address these vulnerabilities, specifically for abortion and gender-affirming care. Maryland and California have passed bills that restrict disclosure of abortion-related records and require EMRs to develop tools to limit or prohibit such disclosure. As these laws are implemented, the landscape for how electronic abortion records are handled may change.
[58] MISS. CODE ANN. § 41-41-105(a).
[59] *Id.* § 41-41-107(1).
[60] *Id.* § 41-41-107(2).
[61] *Id.* § 41-41-107(3)–(4).
[62] *Id.* § 41-41-107(5)–(6).
[63] *Id.* §§ 41-41-111, 41-41-113.
[64] MISS. CODE ANN. § 41-39-1.
[65] *Id.*
[66] *Id.*
[67] *Id.* § 41-39-3.