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 October 2025

ABORTION DEFENSE NETWORK

MISSISSIPPI

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) “necessary for the preservation of 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 possible that the rape exception only applies if cardiac activity cannot be detected.

Last updated October 2025

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]

While undefined in this statutory section, within the fetal disposition context, a fetus being "dead" is "established by the fact that after such expulsion or extraction the foetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles."[2] 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.[3]

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*."[4] 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.[5] 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

Trigger Ban & "Fetal Heartbeat" Ban: Mississippi has several abortion bans with penalties that are either criminal (prison time and/or fines) or civil, including a "fetal heartbeat" ban enacted in 2019 and a trigger ban that became effective in July 2022.[6] 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."[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]

Pre-*Roe* Ban: 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 an argument that this portion of the pre-*Roe* abortion ban remains in effect today.[19] However, this provision is likely unconstitutional under the First Amendment to the U.S. Constitution.[20]

Abortion Ban Exceptions

Under Mississippi law, there are certain limited circumstances where an abortion can still be performed, including in life-threatening medical emergencies and for pregnancies resulting from rape where a formal charge has been filed with law enforcement.

"Necessary for the Preservation" of Pregnant Person's Life: 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—is the trigger ban's, which applies when an abortion is "necessary for the preservation" of the pregnant person's life.[21] This exception is narrower than the medical emergency exception in Mississippi's fetal heartbeat ban, which permits 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."[22] However, because the fetal heartbeat ban's definition of what constitutes a medical emergency is broader than the definition in the trigger ban, providing an abortion that satisfies 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.[23]

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.[24] 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;[25] 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;[26] and documentation requirements specific to abortion care.[27] 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.[28]

Rape: Mississippi's trigger ban provides that an abortion can lawfully be performed where a pregnancy was caused by rape and "a formal charge of rape has been filed with an appropriate law enforcement official."[29] However, because Mississippi's other abortion laws do not contain a similar exception, if a physician provides an abortion to a person whose pregnancy is the result of rape, Mississippi's other abortion restrictions must be followed. Specifically, the physician must perform the abortion before a "fetal heartbeat" is detected,[30] the physician must obtain consent from the parents

of a young person under 18,[31] D&E and D&X procedures are prohibited,[32] 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.[33]

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.[34] 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."[35] 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."[36]

EMTALA requires stabilizing medical treatment be provided to any individual experiencing an emergency medical condition,[37] including people in labor or with emergency pregnancy complications,[38] unless the individual refuses to consent to such treatment.[39] 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."[40] 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.[41] 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."[42]

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.[43]

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."[44] 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."[45] 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."[46] 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.[47]

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.[48] 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]."[49] 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.[50] 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.[51] Following the change of presidential administrations, the United States dismissed that case entirely. [52]

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.[53] As a result, the Fifth Circuit's decision is final.[54] [55]

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.[56]

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.[57]

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.[58]

Resident Training: The Accreditation Council for Graduate Medical Education ("ACGME") requires that accredited programs provide access to training in the provision of abortion.[59] 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.[60]

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.[61] The only abortion-specific documentation and reporting requirements are:

Abortion 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.[62] The written documentation must include both the "medical condition" and the "medical rationale for the conclusion" that abortion was necessary.[63] The written documentation must be saved in the pregnant person's medical records for at least seven years after the abortion is provided.[64] 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 the pregnancy is the result of rape and an abortion is performed before a fetal heartbeat can be detected, the physician must first "confirm[] that the abortion is not being sought because of the race or sex of the unborn human being or because of the presence or presumed presence of a genetic abnormality and document[] these facts in the maternal patient's chart."[65] As explained above, an abortion may also only be provided in that circumstance if "a formal charge of rape has been filed with an appropriate law enforcement official."[66]

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."[67] The report should not include identifying information about the patient.[68] Providing a report that is known to be false may result in a fine of up to $500 per violation.[69]

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.[70] Medical treatment is defined in the statute to include "hospitalization, laboratory tests, surgery or prescription of drugs."[71] 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.[72]

"Severe Adverse Event" Reporting: If a pregnancy is terminated using abortion medications and the physician knows that the patient experienced a "serious adverse event," as defined by the MedWatch Reporting System, during or after the use of the drug, the physician must report the event to the FDA through the MedWatch Reporting System.[73]

Fetal Death Reporting: Mississippi law requires "each spontaneous fetal death" after 20 weeks LMP or that weighs greater than 350 grams 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."[74] A fetal death report is also required "if either or both the completed weeks of gestation or the weight are unknown."[75] The Mississippi Administrative Code defines "fetal death" as "death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of duration of pregnancy."[76] It 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."[77] Therefore, the fetal death reporting requirements likely do not apply following an abortion, but a report may be required where a physician provides miscarriage care and the weight of the fetal tissue is greater than 350 grams or unknown.

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.[78] This includes reporting of sexual abuse of young people, child abuse or neglect, and human trafficking.[79]

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.[80] 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.[81, 82]

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.[83] 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.[84]

Counseling & Referral

Speech about abortion is legal in Mississippi. While the pre-*Roe* ban prohibits writing or printing any card, circular, pamphlet, advertisement, or notice of any kind or providing information orally "stating when, where, how, of whom, or by what means such article or medicine can be purchased or obtained,"[85] U.S. Supreme Court precedent suggests this part of the statute is unconstitutional,[86] and many similar statutes in other states have been struck down.[87] Medical professionals in Mississippi can thus (1) provide accurate options counseling, including about abortion, and (2) refer patients to medical providers in states where abortion is legal.

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."[88] Mississippi prohibits anyone other than a physician from prescribing, selling, administering, or otherwise providing an "abortion-inducing" drug.[89] 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.[90] 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.[91] 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.[92]

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.[93]

Disposition of Fetal Tissue Remains

Mississippi law permits, but does not require, a physician to "authorize disposition of [fetal tissue] by incineration, cremation, burial or other sanitary method approved by the state board of health."[94] 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.[95] 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.[96] Mississippi law also permits the State Board of Health to establish additional rules and regulations for the disposition of fetal tissue.[97] For purposes of these requirements, fetal tissue does not include "placenta or connective tissue."[98]

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] MISS. CODE ANN. § 41-41-45(1).
[2] *Id.* § 41-39-1.
[3] *See id.* § 41-41-45(4).
[4] *Id.* § 41-41-45(1) (emphasis added).
[5] *Id.* § 41-42-3(c), (d) (emphasis added).
[6] *Id.* § 41-41-45 (trigger ban); *id.* § 97-3-3 (pre-*Roe* ban, arguably not in effect); *id.* § 97-3-5 (pre-*Roe* helpers ban); *id.* § 41-41-34.1 ("fetal heartbeat" ban).
[7] *Id.* § 41-41-45(2).
[8] *Id.* § 41-41-45(1).
[9] *See id.* § 41-41-34.1(2).
[10] *Id.* § 41-41-34.1(1)(a).
[11] *Id.* § 41-41-191(6).
[12] *See id.* § 73-25-29.
[13] *Id.* § 7-5-1.
[14] *Id.* § 41-41-191(7).
[15] *Id.* § 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] *See Bigelow v. Virginia*, 421 U.S. 809 (1975); *see also Weeks v. Connick*, 733 F. Supp. 1036, 1039 (E.D. La. 1990) (denying a motion to vacate a permanent injunction against a Louisiana statute banning abortion-related advertising) ("In *Bigelow* the Supreme Court expressly recognized a First Amendment right to advertise abortion services.").
[21] MISS. CODE ANN. § 41-41-45(2).
[22] *Id.* § 41-41-34.1(2)(b)(i).
[23] While Mississippi's abortion bans do not explicitly contain an exception for abortion care necessary to treat an ectopic pregnancy, untreated ectopic pregnancies are often life-threatening, and therefore such abortion care could be provided in accordance with Mississippi's medical emergencies exception.
[24] *Id.* § 41-41-37.

[25] *Id.* § 41-41-33(1).
[26] *Id.* §§ 41-41-155(1), 41-41-73(1).
[27] *Id.* § 41-41-407(1) (confirmation, documentation, and reporting that abortion is not sought on account of race, sex, or genetic abnormality not required in cases of medical emergency).
[28] *Id.* § 41-41-57.
[29] *Id.* § 41-41-45(2)–(3).
[30] *See id.* § 41-41-34.1.
[31] *Id.* § 41-41-57.
[32] *Id.* §§ 41-41-155, 41-41-73.
[33] *Id.* § 41-41-33(1).
[34] EMTALA, 42 U.S.C. § 1395dd(a).
[35] EMTALA, 42 U.S.C. § 1395dd(e)(1)(A).
[36] EMTALA, 42 U.S.C. § 1395dd(e)(1)(B).
[37] EMTALA, 42 U.S.C. § 1395dd(b)(1)(A).
[38] EMTALA, 42 U.S.C. § 1395dd(e)(1).
[39] EMTALA, 42 U.S.C. § 1395dd(b)(2).
[40] EMTALA, 42 U.S.C. § 1395dd(e)(3)(A).
[41] 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).
[42] EMTALA, 42 U.S.C. § 1395dd(c)(1)(B)–(c)(2)(A).
[43] 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.
[44] Kennedy Letter.
[45] Kennedy Letter.
[46] *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.).
[47] Center for Reproductive Rights, *Complaints Against Texas Hospitals for Denying Emergency Care for Ectopic Pregnancies*, (updated May 8, 2025).
[48] *St. Luke's Health System, LTD. v. Labrador*, No. 1:25-cv-00015, ECF No. 1 (D. Idaho Jan 14, 2025).
[49] *St. Luke's Health System, LTD v. Labrador*, No. 1:25-cv-00015, ECF No. 49 at 59 (D. Idaho Mar. 20, 2025).
[50] *United States v. Idaho*, 623 F. Supp. 3d 1096, 1117 (D. Idaho 2022).
[51] *Moyle v. United States*, 144 S. Ct. 2015 (June 27, 2024) (per curiam).
[52] *Idaho v. United States*, No. 1:22-cv-00329, ECF No. 182 (D. Idaho Mar. 5, 2025).
[53] *Becerra v. Texas*, No. 23-1076 (U.S. Oct. 7, 2024) (denying certiorari).
[54] *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).
[55] 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.

[56] 42 C.F.R. § 482.13(a)(1), (b)(1), (b)(2).

[57] 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/.

[58] MISS. CODE ANN. § 15-1-36.

[59] Accreditation Council for Graduate Med. Educ., *ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology* (Sept. 3, 2025).

[60] 42 U.S.C. § 238n.

[61] 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.

[62] MISS. CODE ANN. § 41-41-34.1(2)(b)(ii); *see also* MISS. CODE ANN. § 41-41-57 (parental consent requirements for abortions performed on a young person do not apply in a medical emergency; the physician "shall state in the medical record of the abortion the medical indications on which his judgment was based.").

[63] MISS. CODE ANN. § 41-41-34.1(2)(b)(ii).

[64] *Id.*

[65] *Id.* § 41-41-407(1).

[66] *Id.* § 41-41-45(3).

[67] *Id.* § 41-41-407(3).

[68] *Id.* § 41-41-407(4).

[69] *Id.* § 41-41-191(6)(b).

[70] *Id.* § 41-41-77(1) (emphasis added).

[71] *Id.* § 41-41-76(b).

[72] *Id.* § 41-41-77(1)-(2); *id.* § 41-41-78.

[73] *Id.* § 41-41-109.

[74] 15 MISS. CODE R. §§ 5-85-5.2.2, 5-85-5.1.1.

[75] *Id.* § 5-85-5.2.1.

[76] *Id.* § 5-85-1.3.1(10).

[77] *Id.* § 5-85-1.3.1(25).

[78] 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.

[79] MISS. CODE ANN. § 43-21-353.

[80] 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).

[81] 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.

[82] 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.

[83] 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.

[84] 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.

[85] MISS. CODE ANN. § 97-3-5.

[86] *See Bigelow v. Virginia*, 421 U.S. 809, 811–13 (1975); *see also Weeks v. Connick*, 733 F. Supp. 1036, 1039 (E.D. La. 1990) (denying a motion to vacate a permanent injunction against a Louisiana statute banning abortion-related advertising) ("In *Bigelow* the Supreme Court expressly recognized a First Amendment right to advertise abortion services.").

[87] *See, e.g.*, *Meadowbrook Women's Clinic, P.A. v. Minnesota*, 557 F. Supp 1172, 1178 (D. Minn. 1983) (holding that a Minnesota statute banning abortion-related advertising is unconstitutional) ("If the statute is designed to prevent illegal transactions . . . the statute is overbroad since it prevents the dissemination of information concerning clearly legal activities."); *Planned Parenthood Ass'n v. Fitzpatrick*, 401 F. Supp. 554, 578 (E.D. Pa. 1975) (holding that a statutory provision prohibiting solicitation or advertising of abortion services violated the First Amendment), *aff'd sub nom Franklin v. Fitzpatrick*, 428 U.S. 901 (1976); *Associated Students for Univ. of Cal. at Riverside v. Attorney General of U.S.*, 368 F. Supp. 11, 23-24 (C.D. Cal. 1973) (holding that federal statutory provisions prohibiting the use of mail to distribute information concerning abortion or unsolicited advertisements of birth control devices violated the First Amendment); *Mitchell Fam. Plan., Inc. v. City of Royal Oak*, 335 F. Supp. 738, 741-42 (E.D. Mich. 1972) (holding that a municipal ordinance making it unlawful to advertise any means by which an abortion could be procured or any information concerning the procuring of an abortion was unconstitutionally overbroad since the statute failed to distinguish between legal and illegal abortions); *Atlanta Coop. News Project v. U.S. Postal Serv.*, 350 F. Supp. 234, 239 (N.D. Ga. 1972) (holding that a federal statute prohibiting the mailing of any writing giving information directly or indirectly as to how, where, or from whom an abortion could be obtained, was unconstitutional as a prior restraint of protected First Amendment communications).

[88] MISS. CODE ANN. § 41-41-105(a).

[89] *Id.* § 41-41-107(1).

[90] *Id.* § 41-41-107(2).

[91] *Id.* § 41-41-107(3)–(4).

[92] *Id.* § 41-41-107(5)–(6).

[93] *Id.* §§ 41-41-111, 41-41-113.

[94] *Id.* § 41-39-1.

[95] *Id.*

[96] *Id.*

[97] *Id.* § 41-39-3.

[98] *Id.* § 41-39-1.