

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.

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.

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 Bans and Restrictions on Abortion

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 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.¹⁶ Stabilizing medical treatment must be provided to individuals experiencing an

emergency medical condition,¹⁷ including people in labor or with emergency pregnancy complications.¹⁸ 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.”¹⁹ 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 outweighing the increased risks to the person experiencing the emergency medical condition.²⁰ 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.”²¹ 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.”²² 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.”²³ 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.”²⁴ 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.²⁵ Indeed, since *Dobbs*, HHS has cited hospitals in Kansas, Missouri, and Florida for violating EMTALA by failing to provide abortion care to patients with PPROM or other life-threatening pregnancy conditions.²⁶

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.

In 2022, in *United States v. Idaho*, the federal government sued Idaho and obtained a preliminary injunction ensuring that Idaho’s abortion ban could not be enforced to prohibit health-saving emergency abortions required under EMTALA.²⁷ After temporarily staying that injunction,²⁸ the U.S. Supreme Court lifted the stay and restored the preliminary injunction in June 2024.²⁹

Following the change of presidential administrations, the United States dismissed its case, effectively eliminating the injunction entered in that case.³⁰ By that time, however, a hospital system had filed a separate lawsuit and obtained a temporary restraining order, and subsequently a preliminary injunction, effectively maintaining the status quo, meaning that Idaho still cannot enforce its abortion ban in circumstances where EMTALA would require abortion care.³¹

Meanwhile in Texas, the U.S. Supreme Court refused to review a Fifth Circuit decision that affirmed a lower court decision blocking federal enforcement of HHS’ 2022 EMTALA guidance in Texas and as to other plaintiffs in that case. As a result, the Fifth Circuit’s decision affirming the permanent injunction against the 2022 EMTALA guidance is final. This means HHS may not enforce the 2022 guidance in Texas or against any member

of the American Association of Pro-Life OBGYNs (AAPLOG) or Christian Medical & Dental Associations (CMDA).^{32,33}

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.³⁴

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.³⁵

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.³⁶

Resident Training: The Accreditation Council for Graduate Medical Education (ACGME) requires that accredited programs provide access to training in the provision of abortion.³⁷ 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.³⁸

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.³⁹ 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 law does not require providers to report abortions that they perform.

Complication Reporting: Michigan law does not require providers to report abortion complications that they treat.

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.⁴⁰

If a fetal death occurs inside an institution, the individual in charge of the institution or an authorized representative must file the report.⁴¹ If a fetal death occurs outside an institution, the physician in attendance must file the report.⁴² 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.⁴³ The medical examiner must also investigate the cause and prepare and file a fetal death report if inquiry into the fetal death is required.⁴⁴

Fetal deaths must be reported to the state registrar within 5 days of the death or becoming aware of the death.⁴⁵

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.⁴⁶ 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.⁴⁷ In Michigan, this includes reporting of sexual abuse of young people, child abuse, vulnerable adult abuse, and injuries inflicted by violent means.⁴⁸ Under Michigan law, a pregnancy is not considered grounds for reasonable suspicion of abuse or neglect unless it occurs in a minor younger than 12.⁴⁹

Electronic Medical Records: Many electronic medical record systems (EMRs) allow healthcare providers to securely share patient records across healthcare institutions.⁵⁰ 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.⁵¹

The federal government has taken steps to address this concern by issuing a HIPAA rule that became effective on June 25, 2024.⁵² The rule prohibits the use or disclosure of protected health information (PHI) if sought to conduct an investigation into or impose liability on any person solely for seeking,

obtaining, providing, or facilitating lawful reproductive healthcare, or identifying any person for these purposes.⁵³ A provider who receives a request to disclose PHI potentially related to reproductive care must obtain an attestation from the requestor that the request is not for a prohibited purpose.⁵⁴ 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.⁵⁵ If the abortion care – self-managed or otherwise – was provided by someone else, the rule allows a provider to assume it was provided lawfully unless 1) the patient tells them otherwise or 2) the attestation provides evidence of unlawfully provided care.⁵⁶ The rule only applies to healthcare providers who are subject to HIPAA.⁵⁷ Though several states are challenging this rule in litigation, it currently remains in place as these cases move forward.⁵⁸

Separate from HIPAA, interoperability rules that penalize certain information blocking may apply when a healthcare provider uses EMRs.⁵⁹ Because of this, we encourage you to discuss alternative EMR settings and information blocking exceptions that may be available with your institution's compliance officers, counsel, and/or technology officers.⁶⁰

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.⁶¹ 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.⁶² 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.⁶³ 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 in order to obtain clarity on this question. If you have questions about on this issue, you should contact your hospital's general counsel or reach out to 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 \(CRR\)](#), [If/When/How: Lawyering for Reproductive Justice](#), [National Women's Law Center \(NWLC\)](#), and [Resources for Abortion Delivery \(RAD\)](#).



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\(b\)\(1\)\(A\)](#).

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

¹⁹ [EMTALA, 42 U.S.C. § 1395dd\(e\)\(3\)\(A\)](#).

²⁰ [EMTALA, 42 U.S.C. § 1395dd\(c\)\(2\)](#) (requiring hospitals to use “qualified personnel and transportation equipment” when making a permitted transfer under EMTALA, among other requirements).

²¹ [EMTALA, 42 U.S.C. § 1395dd\(c\)\(1\)\(B\)—\(c\)\(2\)\(A\)](#).

²² [EMTALA, 42 U.S.C. § 1395dd\(e\)\(1\)](#).

²³ Ctrs. for Medicare & Medicaid Servs., [Reinforcement of EMTALA Obligations Specific to Patients who are Pregnant or are Experiencing Pregnancy Loss](#) (updated July 2022).

²⁴ *Id.*

²⁵ *Id.*; see also [EMTALA, 42 U.S.C. § 1395dd\(f\)](#) (“The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.”).

²⁶ Ctrs. for Medicare & Medicaid Servs., [Freeman Health System—Freeman West, Statement of Deficiencies and Plan of Correction](#) (April 10, 2023); Ctrs. for Medicare & Medicaid Servs., [University of Kansas Hospital, Statement of Deficiencies and Plan of Correction](#) (April 10, 2023); Caroline Kitchener & Dan Diamond, [She filed a complaint after being denied an abortion. The government shut her down](#), Washington Post (Jan. 19, 2024), (“Biden officials also confirmed one additional case that the administration had determined violated EMTALA involving a woman who presented at two hospitals in Florida with a life-threatening pregnancy condition in December 2022.”); Press Release, U.S. Dep’t of Health and Human Servs., [HHS Secretary Xavier Becerra Statement on EMTALA Enforcement](#) (May 1, 2023).

²⁷ [United States v. Idaho](#), 623 F. Supp. 3d 1096, 1117 (D. Idaho 2022).

²⁸ [Idaho v. United States](#), 144 S. Ct. 541 (Jan. 5, 2024) (mem.).

²⁹ [Moyle v. United States](#), 144 S. Ct. 2015 (June 27, 2024) (per curiam).

³⁰ [Idaho v. United States](#), No. 1:22-cv-00329, [ECF No. 182](#) (D. Idaho Mar. 5, 2025).

³¹ [St. Luke’s Health System, Ltd. v. Labrador](#), No. 1:25-cv-00015, [ECF No. 33](#) (D. Idaho Mar. 4, 2025).

³² Ctrs. for Medicare & Medicaid Servs., [Emergency Medical Treatment & Labor Act \(EMTALA\)](#), (last modified Dec. 6, 2024).

³³ A separate challenge to the guidance was filed by the Catholic Medical Association in Tennessee, Complaint, [Catholic Med. Ass’n v. Dep’t of Health & Human Servs.](#), No. 3:25-cv-00048, [ECF No. 1](#) (M.D. Tenn. Jan. 10, 2025), but the federal government has not yet responded.

³⁴ 42 C.F.R. §§ 482.13(a)(1), (b)(1), (b)(2).

³⁵ 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).

³⁶ MCL § 600.2912.

³⁷ Accreditation Council for Graduate Med. Educ., [ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology](#) (July 1, 2023).

³⁸ [42 U.S.C. § 238n](#).

³⁹ 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.

⁴⁰ [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”).

⁴¹ [MCL § 333.2834\(3\)](#).

⁴² [MCL § 333.2834\(4\)](#).

⁴³ [MCL § 333.2834\(5\)](#).

⁴⁴ [MCL § 333.2898](#).

⁴⁵ [MCL § 333.2834\(1\)](#).

⁴⁶ [MCL § 333.17015a](#).

⁴⁷ 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](#).

⁴⁸ [MCL §§ 722.622, 750.411](#).

⁴⁹ [MCL § 722.623](#).

⁵⁰ For example, one EMR, Epic, uses a tool called Care Everywhere to securely share information between healthcare 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 that within the same system).

⁵¹ 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.

⁵² Compliance with this rule is required after 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.

⁵³ [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. (content last reviewed April 22, 2024).

⁵⁴ [42 U.S.C. § 164.509](#). The U.S. Department of Health & Human Services (HHS) recently released a model attestation, available here: www.hhs.gov/sites/default/files/model-attestation.pdf.

⁵⁵ [42 U.S.C. §§ 164.509\(a\), 512\(d\)-\(g\)\(1\)](#).

⁵⁶ [42 U.S.C. § 164.502\(a\)\(5\)\(iii\)](#).

⁵⁷ American Medical Association, [HIPAA Privacy Rule to Support Reproductive Health Care Privacy AMA Drafted Summary of Regulatory Changes in Final Rule](#) (April 26, 2024) (last visited June 27, 2024).

⁵⁸ [Tennessee v. U.S. Dept. of Health & Human Servs.](#), No. 3:25-cv-00025 (E.D. Tenn. Jan. 17, 2025); [Texas v. U.S. Dept. of Health & Human Servs.](#), No. 5:24-cv-00204-H (N.D. Tex. Sept. 4, 2024); [Missouri v. U.S. Dept. of Health & Human Servs.](#), No. 4:25-cv-00077 (E.D. Mo. Jan. 17, 2025); [Purl v. U.S. Dept. of Health & Human Servs.](#), ___ F. Supp. 3d. ___ (N.D. Tex. Dec. 22, 2024) (enjoining the 2024 HIPAA Rule as to Dr. Purl only).

⁵⁹ [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.

⁶⁰ In addition to the federal government, some states have taken steps to address vulnerabilities in this information sharing, specifically for abortion and gender-affirming care. For example, in 2023, Maryland and California passed bills that restrict disclosure of abortion-related records and require EMRs to develop tools to limit or prohibit such disclosure.

⁶¹ [MCL § 333.16285](#). Providers may prescribe medication within the scope of their practice via telehealth. *Id.*

⁶² [MCL § 333.2836](#) (repealed 2023).

⁶³ [MCL § 333.2848](#) (describing a fetus as “delivered or miscarried,” terms that do not apply to abortion).