ABORTION DEFENSE NETWORK

Know Your State's Abortion Laws

A Guide for Medical Professionals

ALABAMA

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.

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Key Takeaways

Providing contraception, including emergency contraception, is legal.

Providing medical care for ectopic pregnancies (including cesarean scar ectopic pregnancies) and pregnancies with no cardiac activity is legal.

Abortion is prohibited under Alabama law unless:

(1) in the physician's reasonable medical judgment, a serious health risk or medical emergency exists; or

(2) the fetus has a lethal anomaly which will cause it to be stillborn or to die shortly after birth.

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Definition of Abortion & Contraception

ABORTION

The word "abortion" is defined in Alabama law as the "use or prescription of any instrument, medicine, drug, or any other substance or device with the intent to terminate the pregnancy of a woman known to be pregnant with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child."[1] The following are excluded from the definition of abortion: (1) a procedure, e.g., treatment for miscarriage, intended to remove a dead embryo or fetus (generally understood to mean no fetal or embryonic cardiac activity is detected); (2) the termination of an ectopic pregnancy, defined as a "pregnancy resulting from either a fertilized egg that has implanted or attached outside the uterus or a fertilized egg implanted inside the cornu of the uterus";[2] and (3) the termination of a pregnancy when the fetus has a lethal anomaly, defined as a "condition from which [a fetus] would die after birth or shortly thereafter or be stillborn."[3, 4]

There is no specific crime of self-managed abortion in Alabama law, and Alabama's abortion ban explicitly exempts the pregnant person from civil or criminal liability.[5]

Because it is not provided with "the intent to terminate the pregnancy of a woman known to be pregnant,"[6] post-abortion care regardless of where or how the abortion was obtained, by definition is not prohibited under Alabama law and, indeed, may be required under federal law (see the discussion of EMTALA below).

CONTRACEPTION

Contraception is not illegal in any state in the country, including Alabama.

Abortion Ban

Alabama law makes it "unlawful for any person to intentionally perform or attempt to perform an abortion."[7] The only exception is for abortions that are "necessary in order to prevent a serious health risk to the" pregnant person, as set forth below.[8] An abortion performed in violation of the ban is a Class A felony, punishable by "imprisonment" for "not more than 99 years or less than 10 years."[9] An attempted abortion is a Class C felony, punishable by "imprisonment" for "not more than 10 years or less than one year and one day."[10]

Abortion Ban Exception & Exclusions

Alabama's abortion ban contains only one exception, i.e., to prevent a "serious health risk." Alabama's abortion ban also excludes from the definition of abortion terminations of pregnancy in certain circumstances.

"Serious Health Risk": The current ban contains an exception for when "an attending physician licensed in Alabama determines that an abortion is necessary in order to prevent a serious health risk" to the pregnant person.[11] That determination must be confirmed in writing by a second physician licensed in Alabama within 180 days of the abortion,[12] and "no physician confirming the serious health risk" "shall be criminally or civilly liable for those actions."[13] Furthermore, the confirmation "shall be prima facie evidence for a permitted abortion."[14] (The confirmation requirement does not apply in a medical emergency, as defined below.)

Alabama law defines a "serious health risk" as a condition that, in reasonable medical judgment, so complicates her medical condition that it necessitates the termination of her pregnancy to avert her death or to avert serious risk of substantial *physical* impairment of a major bodily function.[15] Except as described below, a serious health risk

"does not include a condition based on a claim that the woman is suffering from an emotional condition or a mental illness which will cause her to engage in conduct that intends to result in her death or the death of" the fetus or embryo.[16]

A serious health risk based on mental illness may exist if "a second physician who is licensed in Alabama as a psychiatrist, with a minimum of three years of clinical experience, examines the woman and documents that the woman has a diagnosed serious mental illness and because of it, there is reasonable medical judgment that she will engage in conduct that could result in her death or the death of" the fetus or embryo.[17] "If the mental health diagnosis and likelihood of conduct is confirmed . . . , and it is determined that a termination of the [pregnant person's] pregnancy is medically necessary to avoid the conduct, the termination may be performed," but it may only be "performed by a physician licensed in Alabama in a hospital . . . to which he or she has admitting privileges."[18]

Medical Emergencies: The ban "shall not apply to a physician licensed in Alabama performing a termination of a pregnancy or assisting in performing a termination of a pregnancy due to a medical emergency."[19] A "medical emergency" is defined as a "condition which, in reasonable medical judgment, so complicates the medical condition of the pregnant woman that her pregnancy must be terminated to avoid a serious health risk."[20]

A physician may perform an abortion for a serious health risk or in a medical emergency even if the patient previously attempted to self-manage their abortion.

Lethal Fetal Anomalies: As noted above, the current ban explicitly excludes from the definition of an abortion the termination of a pregnancy where the fetus has a "lethal anomaly."[21] The statute defines a "lethal anomaly" as a "condition from which an unborn child would die after birth or shortly thereafter or be stillborn."[22] Alabama law does not otherwise specify fetal conditions that would meet this definition.

Ectopic Pregnancies: As noted above, the current ban explicitly excludes from the definition of abortion the termination of an ectopic pregnancy. An ectopic pregnancy is defined as "[a]ny pregnancy resulting from either a fertilized egg that has implanted or attached outside the uterus or a fertilized egg implanted inside the cornu of the uterus."[23] The law provides that, unless expressly stated otherwise, the term "abortion" in Alabama law and regulations shall not include a procedure to terminate an ectopic pregnancy.[24] Requirements for the documentation and reporting of gestational age as well as fetal death reporting requirements do not apply to the termination of an ectopic pregnancy.[25]

Other Abortion Restrictions

The ban repeals as "null and void" any prior statute or regulation governing abortion that is "in conflict with or antagonistic to this chapter."[26] However, the ban does not specify which of Alabama's numerous laws regulating abortion are "in conflict with or antagonistic to" the current prohibition on abortion. We encourage anyone seeking to provide abortion care in Alabama to reach out to the Abortion Defense Network, linked at the end of this document.

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.[27] 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."[28] 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."[29]

EMTALA requires stabilizing medical treatment be provided to any individual experiencing an emergency medical condition,[30] including people in labor or with emergency pregnancy complications,[31] unless the individual refuses to consent to such treatment.[32] 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."[33] 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.[34] 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."[35]

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.[36]

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."[37] 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."[38] 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."[39] 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.[40]

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.[41] 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]."[42] 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.[43] 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.[44] Following the change of presidential administrations, the United States dismissed that case entirely. [45]

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.[46] As a result, the Fifth Circuit's decision is final.[47] [48]

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.[49]

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.[50]

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.[51]

Resident Training: The Accreditation Council for Graduate Medical Education (ACGME) requires that accredited programs provide access to training in the provision of abortion.[52] 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.[53]

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.[54] 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.

Alabama law requires a "report of induced termination of pregnancy for each induced termination of pregnancy which occurs," which must be filed "no later than 10 days after the last day of the month during which the procedure was performed." 22-9A-13.

Other Mandatory Reporting: All other general mandatory reporting also applies for abortion patients. This includes reporting of sexual abuse of young people, child abuse, and vulnerable adult abuse. Providers must immediately report suspected child abuse or neglect to the law enforcement when they reasonably believe a child or a vulnerable adult has suffered abuse, to be followed by a written report.[55]

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.[56] 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.[57, 58]

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.[59] 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.[60]

Counseling & Referral

Speech about abortion is legal in Alabama. After the Supreme Court issued its ruling in *Dobbs*, the Alabama Attorney General made public statements suggesting he could use Alabama's criminal laws to prosecute those who help pregnant Alabamians access legal abortion care out of state. In response, health care providers and an abortion fund sued in federal district court. In March of 2025, the district court issued a final ruling declaring that the use of Alabama's criminal laws to prosecute people for speech intended to assist Alabamians seeking to cross state lines to obtain abortion care where it is legal would violate the First Amendment. *See Yellowhammer Fund v. Marshall*, No. 2:23CV450-MHT, 2025 WL 959948, at *1 (M.D. Ala. Mar. 31, 2025). Medical professionals and others in Alabama can thus (1) provide accurate options counseling, including about abortion, and (2) provide information, including specific recommendations, as to where and how to access legal abortion care.

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).

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] Ala. Code § 26-23H-3(1).
[2] Ala. Code § 26-23H-3(2).
[3] Ala. Code § 26-23H-3(3).
[4] Accordingly, the current definition of abortion reads in full: "The use or prescription of any instrument, medicine, drug, or any other substance or device with the intent to terminate the pregnancy of a woman known to be pregnant with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. The term does not include these activities if done with the intent to save the life or preserve the health of an unborn child, remove a dead unborn child, to deliver the unborn child prematurely to avoid a serious health risk to the unborn child's mother, or to preserve the health of her unborn child. The term does not include a procedure or act to terminate the pregnancy of a woman with an ectopic pregnancy, nor does it include the procedure or act to terminate the pregnancy of a woman when the unborn child has a lethal anomaly." Ala. Code § 26-23H-3(1).
[5] Ala. Code § 26-23H-5.
[6] Ala. Code § 26-23H-3(1).
[7] Ala. Code § 26-23H-4(a).
[8] Ala. Code § 26-23H-4(b).
[9] Ala. Code § 13A-5-6(a)(1).
[10] Ala. Code § 13A-5-6(a)(3).
[11] Ala. Code § 26-23H-4(b).
[12] *Id.*
[13] *Id.*
[14] *Id.*
[15] Ala. Code § 26-23H-3(6).
[16] *Id.*
[17] *Id*
[18] *Id.*
[19] Ala. Code § 26-23H-7.
[20] Ala. Code § 26-23H-3(4).
[21] Ala. Code § 26-23H-3(3).
[22] *Id.*
[23] Ala. Code § 26-23H-3(2).
[24] Ala. Code § 26-23D-1(b).

[25] Ala. Code § 26-23D-1(c).
[26] Ala. Code § 26-23H-8.
[27] EMTALA, 42 U.S.C. § 1395dd(a).
[28] EMTALA, 42 U.S.C. § 1395dd(e)(1)(A).
[29] EMTALA, 42 U.S.C. § 1395dd(e)(1)(B).
[30] EMTALA, 42 U.S.C. § 1395dd(b)(1)(A).
[31] EMTALA, 42 U.S.C. § 1395dd(e)(1).
[32] EMTALA, 42 U.S.C. § 1395dd(b)(2).
[33] EMTALA, 42 U.S.C. § 1395dd(e)(3)(A).
[34] 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).
[35] EMTALA, 42 U.S.C. § 1395dd(c)(1)(B)–(c)(2)(A).
[36] 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.
[37] Kennedy Letter.
[38] Kennedy Letter.
[39] *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.).
[40] Center for Reproductive Rights, *Complaints Against Texas Hospitals for Denying Emergency Care for Ectopic Pregnancies*, (updated May 8, 2025).
[41] *St. Luke's Health System, LTD. v. Labrador*, No. 1:25-cv-00015, ECF No. 1 (D. Idaho Jan 14, 2025).
[42] *St. Luke's Health System, LTD v. Labrador*, No. 1:25-cv-00015, ECF No. 49 at 59 (D. Idaho Mar. 20, 2025).
[43] *United States v. Idaho*, 623 F. Supp. 3d 1096, 1117 (D. Idaho 2022).
[44] *Moyle v. United States*, 144 S. Ct. 2015 (June 27, 2024) (per curiam).
[45] *Idaho v. United States*, No. 1:22-cv-00329, ECF No. 182 (D. Idaho Mar. 5, 2025).
[46] *Becerra v. Texas*, No. 23-1076 (U.S. Oct. 7, 2024) (denying certiorari).
[47] *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).
[48] 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.
[49] 42 C.F.R. §§ 482.13(a)(1), (b)(1), (b)(2).
[50] 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/.
[51] Ala. Code § 6-5-548(a).

[52] Accreditation Council for Graduate Med. Educ., *ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology* (Sept. 3, 2025).
[53] 42 U.S.C. § 238n.
[54] 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.
[55] Ala. Code § 26-14-3; Ala. Code § 38-9-8.
[56] 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).
[57] 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.
[58] 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 went 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.
[59] 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.
[60] 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.