HIPAA: Can the Privacy Rule Save the Patient-Physician Relationship in a Post-*Dobbs* World?

Lance S. Lee*

With the repealing of Roe v. Wade *and the elimination of abortion as a constitutionally guaranteed right, new statutes have been passed all throughout the United States prohibiting abortions, with some states encouraging private citizens to report those who "aid and abet" abortions in the state. These statutes come into direct conflict with medical ethical obligations, which, in turn, damage the patient-physician relationship by instilling in patients a fear that their physician will report their friends and family and bring a lawsuit under those statutes. This Note analyzes the effects of the repealing of Roe v. Wade and considers how the Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically the Privacy Rule, maintains the patient-physician relationship and allows patients to be candid with their health-care providers without fear that their physician will voluntarily disclose information and bring a lawsuit against them or their friends and family. This Note also briefly considers what expansions of HIPAA or privacy laws in the United States may help garner more protections for those seeking abortions, such as the passing of policies within private health-care organizations to ensure such information is classified as Protected Health Information (PHI) and thus protected under HIPAA.*

* Lance S. Lee, J.D., UCI Law, Class of 2023; B.A., UCI, Class of 2019. The research for this Note was concluded in April of 2023 and this Note was written that following May. As such, any developments after April 2023 were not included in this Note's analysis.

INTRODUCTION

The United States is now in a somewhat dystopian future for women's[1] reproductive rights. On June 24, 2022, the Supreme Court overturned *Roe v. Wade*[2] in its decision under *Dobbs v. Jackson Women's Health Organization*.[3] This opened the door for states to ban abortion outright and, as a result, just weeks after the decision, trigger bans in thirteen states went into effect, making abortion illegal. As of April 2023, twenty-eight states have determined abortions are not legally protected; however, it is unclear whether these states will make abortions illegal outright.[4] These laws have greatly impacted the patient-physician relationship, forcing physicians to balance providing candid medical advice and the patient's values or health against the "labyrinth of legal requirements" imposed.[5] These laws also come into direct conflict with the ethical obligations physicians are expected to uphold, which places the welfare of the patient first and foremost.[6]

However, despite these attacks on patient privacy, patients seeking abortions should not fear being candid with their physicians when determining the best medical care for themselves because patients may have a limited safeguard through the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Although HIPAA allows providers to disclose Protected Health

1. Although the author acknowledges there may be some dispute over the usage of the term "woman," the author understands that some individuals seeking reproductive care do not identify as female. For the purposes of this Note, as all relevant cases have referred to and considered only pregnant "women," this terminology will be used throughout to conform to the language of these cases.

2. 410 U.S. 113 (1973), *overruled by* Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022).

3. 597 U.S. 215 (2022).

4. *See After Roe Fell: Abortion Laws by State*, CTR. FOR REPROD. RTS., https://reproductiverights.org/maps/abortion-laws-by-state/ [https://perma.cc/58FJ-ZHZN] (last visited Jun. 13, 2024).

5. *See* Selena Simmons-Duffin, *For Doctors, Abortion Restrictions Create an 'Impossible Choice' When Providing Care*, NPR (June 24, 2022, 4:26 PM), https://www.npr.org/sections/health-shots/2022/06/24/1107316711/doctors-ethical-bind-abortion/ [https://perma.cc/C3M3-UJLF].

6. *See* CODE OF PRO. ETHICS OF THE AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS: CODE OF CONDUCT 2, AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS (2018); AMA CODE OF MED. ETHICS § 1.1.1, AM. MED. ASS'N (2016).

Information (PHI) without patient authorization as evidence of a crime on the premises, the Privacy Rule prohibits physicians from voluntarily disclosing PHI to law enforcement or other agencies, thus barring physicians from acting as private citizens in bringing lawsuits against those that aid the patient receiving an abortion.[7] By barring voluntary disclosures, HIPAA should instill physicians with the trust and confidence of their patients, thus protecting the patient-physician relationship. These protections, although limited in scope, may also be expanded in the future either by legislative reforms or guidance by health care providers to their clinicians.

Part I of this Note will provide a review of *Dobbs v. Jackson*, beginning with an introduction to the facts underlying the commencement of the litigation and its subsequent procedural history. The Note will then discuss a history of the legalities of abortion laws from common law to the commencement of proceedings, culminating in a discussion of the Supreme Court's holding on the issue. Part II will explore the consequences of the Supreme Court's decision in overturning *Roe v. Wade* and its progeny, particularly revolving around the patient-physician relationship. The Note will also look at state statutes that have been passed because of *Roe*'s repeal, including statutes encouraging private citizens to report those who aided an individual in obtaining an abortion. Part III will introduce background information on HIPAA, including an explanation of the Privacy Rule and what it mandates of physicians' confidentiality requirements regarding PHI. Finally, Part IV will explore some potential uses of HIPAA's Privacy Rule to provide some kind of shelter at least insofar as prohibiting physicians from using PHI to bring complaints against abortion patients via state-encouraged reporting statutes as well as point to a few steps that may be taken to expand those protections.

I. HISTORY AND BACKGROUND OF *DOBBS V. JACKSON*

A. Facts

In 2018, the Mississippi Legislature passed the "Gestational Age Act,"[8] which prohibits abortion after fifteen weeks' gestation unless the mother has a "medical emergency" or there is a "severe fetal abnormality."[9] According to the statute, a medical emergency is defined as a

> condition in which . . . an abortion is necessary to preserve the life of a pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition

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7. *See* Rebecca Pifer, *No 'Slam Dunk Fix' in HIPAA Privacy Law to Protect Abortion Patients*, HEALTHCARE DIVE (August 5, 2022), https://www.healthcaredive.com/news/hipaa-privacy-law-abortion/627319/ [https://perma.cc/NY7N-8NBR]; *see also* Carmel Shachar, *HIPAA, Privacy, and Reproductive Rights in a Post-*Roe *Era*, 328 JAMA 417, 417 (2022) (noting without a warrant or similar document providing an obligation to disclose, clinicians and health care centers should not disclose to avoid violating HIPAA).

8. MISS. CODE ANN. § 41-41-191 (2023). This Note will refer to this law as "the Mississippi Law."

9. MISS. CODE ANN. § 41-41-191(4)(b) (2023).

> arising from the pregnancy itself, or when the continuation of the pregnancy will create a serious risk of substantial and irreversible impairment of a major bodily function.[10]

A "severe fetal abnormality" is defined as a "life-threatening physical condition that . . . regardless of the provision of life-saving medical treatment, is incompatible with life outside the womb."[11] Any physicians who provided an abortion after fifteen weeks gestation outside of the two limited exceptions are subject to professional sanctions, such as a suspension of their license to practice medicine or a total revocation pursuant to an action by the Board of Medical Licensure.[12] The Mississippi Legislature based its post-fifteen-week abortion ban on abortion laws from the international community[13] as well as several medical findings.[14] As part of the medical findings the legislature incorporated regarding prenatal development, the legislature noted that abortion "carries significant physical and psychological risks" to pregnant women.[15] Additionally, the legislature makes an effort to list potential medical complications in its justification of the Mississippi law, including but not limited to, pelvic infections, blood clots, and heavy bleeding or hemorrhaging.[16] The Mississippi law also deemed the usual methods of an abortion procedure after fifteen weeks' pregnancy to be a "barbaric practice" that is "dangerous for the maternal patient, and demeaning to the medical profession."[17] As if to emphasize its conclusion, the legislature includes sensationalist language in its description of the procedure, such as describing the procedure as using instruments to "crush and tear" the unborn child during the abortion.[18]

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10. *Id.* § 41-41-191(3)(j).
11. *Id.* §41-41-191(3)(h).
12. *Id.* § 41-41-191(6).
13. *Id.* § 41-41-191(2)(a). The legislature states that the United States is one of seven nations in the world that permits nontherapeutic or elective abortion-on-demand after the twentieth week of gestation and that seventy-five percent of all nations do not permit abortion after twelve weeks gestation except to save life and preserve the physical health of the mother. This statistic seems to be used to guide the legislature in bringing the abortion laws into accordance with the majority of nations; however, the weight placed on other countries' views on reproductive rights should be limited when considering the heightened importance of individual rights guaranteed and directly embedded into the bedrock of American society. For example, throughout history, only fifteen constitutions in nine countries "ever included an explicit right to bear arms." Brennan Weiss, James Pasley & Azmi Haroun, *Only 3 Countries in the World Protect the Right to Bear Arms in Their Constitutions: The US, Mexico, and Guatemala*, BUSINESS INSIDER (Nov. 22, 2022, 12:50 PM), https://www.businessinsider.com/2nd-amendment-countries-constitutional-right-bear-arms-2017-10 [https://perma.cc/5GEY-NR39]. And currently, as of Nov. 22, 2022, only three countries have a constitutional right to own a gun: the United States, Mexico, and Guatemala. *Id.* That means, of the 195 recognized countries in the world, about 98.5% do not have a constitutional right to own a gun. Does that mean the United States should follow that trend and repeal the Second Amendment? As we have seen in recent years, the answer seems to be an emphatic "no," but that is a discussion for a different note.
14. MISS. CODE ANN. § 41-41-191(2)(b).
15. *Id.* § 41-41-191(2)(b)(ii).
16. *Id.* § 41-41-191(2)(b)(iv).
17. *Id.* § 41-41-191(2)(b)(i)(8).
18. *Id.*

B. Procedural History

Respondents, Jackson Women's Health Organization (Organization), an abortion clinic—in fact, the only abortion clinic in Mississippi—and one of the Organization's physicians, challenged the Mississippi law in federal district court, alleging that the law violated previous Supreme Court precedents establishing a constitutional right to abortion via *Roe v. Wade* and *Planned Parenthood of Se. Pa. v. Casey*.[19] The District Court for the Southern District of Mississippi agreed, first granting a temporary restraining order blocking the Mississippi law[20] before subsequently granting summary judgment for respondents, permanently enjoining the Mississippi Law on the basis that such a prohibition violated the Fourteenth Amendment's Due Process Clause.[21]

When the issue was brought to the Fifth Circuit Court of Appeals, the district court's holdings were affirmed.[22] In affirming the district court's decision, the Fifth Circuit distinguished between a regulation on abortion prior to viability and a per se unconstitutional ban on pre-viability abortions. The court noted that a regulation on pre-viability abortions would be lawful if the regulation did not impose an undue burden on the woman's right to an abortion but determined that the Mississippi law was a per se ban and thus in violation.[23] On petition, the Supreme Court granted certiorari limited to the question of whether "all pre-viability prohibitions on elective abortions are unconstitutional."[24]

*C. Brief History of the Legality of Abortion Pre-*Dobbs

Traditionally, abortion laws have depended in part on the stage of development a fetus is in at the time of evacuation, typically determined by whether the fetus was "quickened."[25] Under these definitions, any abortion prior to the

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19. Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 215 (2022).

20. Jackson Women's Health Org. v. Currier, 349 F. Supp. 3d 536 (S.D. Miss. 2018), *aff'd sub nom*; Jackson Women's Health Org. v. Dobbs, 945 F.3d 265 (5th Cir. 2019), *rev'd and remanded by* Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022).

21. *Dobbs*, 597 U.S. at 215; *see also* U.S. CONST. amend. XIV, § 1 ("No state shall . . . deprive any person of life, liberty, or property, without due process of law . . . .").

22. Jackson Women's Health Org. v. Dobbs, 945 F.3d 265, 269 (5th Cir. 2019), *rev'd and remanded by* Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022).

23. *Id.* Only two months after the Fifth Circuit affirmed the District Court's decision, the Fifth Circuit again decided on another Mississippi law that was even stricter, prohibiting physicians from performing abortions after a fetus's heartbeat was detected. This law was passed shortly after the original *Dobbs* temporary restraining order was ordered. MISS. CODE ANN. § 41-41-34.2 (2021). The District Court similarly ordered a preliminary injunction against the fetal heartbeat prohibition, which the Fifth Circuit affirmed. *See* Jackson Women's Health Org. v. Dobbs, 951 F.3d 246, 248 (5th Cir. 2020) (per curiam) ("[A]fter [the Court] held that the 15-week ban is unconstitutional, Mississippi conceded that the fetal heartbeat law must also be.").

24. Dobbs v. Jackson Women's Health Org., 141 S.Ct. 2619 (mem.) (2021); *see also Dobbs*, 597 U.S. at 233.

25. *See* Roe v. Wade, 410 U.S. 113, 133–35 (1973), *overruled by* Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022) (noting the varying determinations of a "quick fetus" as when the fetus first had recognizable movement in utero, typically from the sixteenth to eighteenth week of pregnancy

quickened fetus was undisputedly not murder and not "an indictable offense."[26] Additionally, even the abortion of a quick fetus was not considered a felony. In fact, Blackstone had even noted that although abortion after quickening had once been considered manslaughter, modern law "took a less severe view."[27] Similarly, common law precedents seemed to also come to the conclusion that post-quickening abortions were never established as a common-law crime.[28]

It was not until 1803 that England first criminalized abortion, making abortion of a quick fetus a capital crime while providing lesser penalties for the "felony of [an] abortion before quickening, and thus preserved the 'quickening' distinction."[29] On the other hand, "by 1840, . . . only eight American states had statutes dealing with abortion."[30] However, after the Civil War, legislation began to replace the common law, and by the end of the 1950s, a large majority of jurisdictions in the United States banned abortion under every circumstance unless it was done to save or preserve the life of the mother.[31]

It would not be until the early 1970s, in the seminal case on abortion laws, *Roe v. Wade*, that the Supreme Court first recognized a woman's fundamental right to an abortion, albeit with some limitations.[32] In *Roe*, an anonymous single woman under the pseudonym "Jane Roe" sought declaratory judgment that the criminal abortion statutes of Texas were facially unconstitutional and also sought an injunction against the enforcement of those statutes.[33] In Justice Blackmun's majority opinion, the Court opined one of the Court's most controversial rulings in history by determining that the Constitution guaranteed a fundamental right to personal privacy via the First, Fourth, Fifth, Ninth, and Fourteenth Amendments,[34] building off of notable cases like *Terry v. Ohio*,[35] *Griswold v. Connecticut*,[36] and *Loving v. Virginia*.[37] The Court specifically noted that this right of privacy, "whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action," extended to "a woman's decision whether or not to terminate her pregnancy."[38]

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before later considering philosophical and Christian theological justifications to when a fetus "animated").

26. *Id.* at 132.
27. *Id.* at 135.
28. *Id.*
29. *Id.* at 136.
30. *Id.* at 138–39.
31. Roe v. Wade, 410 U.S. at 139.
32. *See id.* at 155.
33. *Id.* at 120.
34. *Id.* at 152.
35. 392 U.S. 1 (1968) (regarding the Fourth and Fifth Amendments).
36. 381 U.S. 479 (1965) (regarding the Ninth Amendment).
37. 388 U.S. 1 (1967) (regarding privacy rights that extended to activities relating to marriage–here, privacy). *See also* Griswold v. Connecticut, 381 U.S. 479 (1965) (extending privacy right to contraception); Eisenstadt v. Baird, 405 U.S. 438 (1972) (extending privacy right to family relationships); Prince v. Massachusetts, 321 U.S. 158 (1944) (extending privacy right to child rearing and education).
38. *Roe*, 410 U.S. at 153.

The Court in *Roe* also made note of challenges women could face when considering an unexpected pregnancy or even an unwanted child. Some notable considerations included psychological harm, mental and physical health deterioration, and even social stigmas attached to single mothers.[39] Despite these considerations, the Court also considered the government's "important interests in safeguarding health, in maintaining medical standards, and in protecting potential life."[40] Acknowledging these "important interests," the Court noted that at some point during a pregnancy, the "respective interests become sufficiently compelling to sustain regulation of the factors that govern abortion decision," thus stating that the privacy right was not absolute.[41]

To balance these interests between a woman's purported privacy rights and the government's "important interests," the *Roe* Court adopted the trimester framework.[42] Under this framework, the Court noted the "present medical knowledge" to determine that the "compelling" point was at approximately the end of the first trimester.[43] Citing the fact that first-trimester mortality could be less than mortality in normal childbirth, the *Roe* Court determined that state governments could not ban or regulate first-trimester abortions.[44] However, from that point, it followed "from and after [the end of the first trimester], a State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health."[45] It also followed that, upon reaching viability at the beginning of the third trimester, states could "go so far as to proscribe abortion" due to their "important and legitimate interest in potential life," except when it was necessary to preserve the life of the mother.[46] As a result of this framework, the Court determined that the Texas criminal abortion statutes at issue violated the Due Process Clause of the Fourteenth Amendment because they prohibited elective abortions in the first and second trimesters.[47]

The *Roe* framework would largely remain untouched for nearly two decades until the Court abandoned the trimester framework entirely in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.[48] In *Casey*, five provisions of the Pennsylvania Abortion Control Act of 1982, as amended in 1988 and 1989, were challenged by five abortion clinics and one physician.[49] The five provisions imposed informed

39. *Id.*

40. *Id.* at 154.

41. *Id. See also* Jacobson v. Massachusetts, 197 U.S. 11 (1905) (refusing to recognize an unlimited right to do with one's body as one pleases regarding vaccination); Buck v. Bell, 274 U.S. 200 (1927) (refusing to recognize an unlimited right to do with one's body as one pleases regarding sterilization).

42. *Roe*, 410 U.S. at 163.

43. *Id.*

44. *Id.*

45. *Id.*

46. *Id.*

47. *Id.* at 163–164.

48. 505 U.S. 833 (1992) (plurality opinion), *overruled by* Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022).

49. *Id.* at 844–45.

consent requirements on women seeking abortions, notification requirements to husbands (for married women) and parents (for minors), and several reporting requirements on facilities providing abortion services.[50] In their deliberations of whether to overturn the previously successful *Roe v. Wade*, the Justices considered several factors, such as whether *Roe*'s central rule was workable, whether subsequent legal or medical developments found the existing precedent to be obsolete, and whether the precedent could be removed without serious inequity to those who relied upon it.[51]

In the plurality, five justices determined that the rule of *stare decisis* required the Court to adhere to the "essential holding of *Roe v. Wade*" and reaffirmed the decision.[52] In reaffirming the central holding of *Roe*, the Court illuminated the Due Process Clause's protections regarding a woman's ability to receive an abortion before viability.[53] Justices O'Connor, Kennedy, and Souter, who delivered the opinion of the Court, went a step further in announcing that the Due Process Clause was only triggered where state regulation imposed an "undue burden" on a woman's ability to make that abortion decision.[54] The Court cited *Maher v. Roe*, which explained that "*Roe* did not declare an unqualified 'constitutional right to an abortion'" and that "the right protects the woman from unduly burdensome interference with her freedom to decide."[55] This undue burden standard simply asks whether a "regulation [on abortion] has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus."[56] In applying this framework, Justices O'Connor, Kennedy, and Souter determined that the Pennsylvania statute was violative of the Due Process Clause because its requirement that pregnant women notify their husbands granted their husbands veto power over their abortion, thus potentially discouraging women from obtaining an abortion.[57] The Court noted that the statute's requirement meant "in a large fraction of the cases . . . it will operate as a substantial obstacle to a woman's choice to undergo an abortion. It is an undue burden, and therefore invalid."[58]

Casey's undue burden standard would remain the gold standard for yet another two decades before the Court heard and subsequently decided on *Whole Woman's Health v. Hellerstedt*.[59] The *Hellerstedt* Court held a Texas statute in violation of the undue burden standard when the statute required abortion physicians to have admitting privileges at a hospital less than thirty miles away and for abortion

50. *Id.* at 833.
51. *Id.* at 855.
52. *Id.* at 846.
53. *See id.* at 874 (plurality opinion) (clarifying that a State may prohibit abortions post-viability and, at all times, had a legitimate interest in protecting maternal and fetal health).
54. *Id.*
55. Maher v. Roe, 432 U.S. 464, 473–74 (1977).
56. *Casey*, 505 U.S. at 877.
57. *Id.* at 897.
58. *Id.* at 895.
59. 579 U.S. 582 (2016), *abrogated by* Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022).

facilities to meet the same minimum health and safety standards as ambulatory surgical centers.[60] When applying *Casey*'s undue burden standard, the Court determined that the court of appeals' articulation of the standard was incorrect.[61] The court of appeals had determined a state law regulating abortion to be constitutional if "(1) it does not have the purpose of effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus; and (2) it is reasonably related to . . . a legitimate state interest."[62] Instead, the *Hellerstedt* Court adopted a balancing test that considered "the burdens a law imposes on abortion access together with the benefits those laws confer."[63] Through the use of this balancing test, the Court determined that the Texas statute did not meet the undue burden standard, concluding that "neither of these provisions confers medical benefits sufficient to justify the burdens upon access." The Court further determined that each provision placed "a substantial obstacle in the path of women seeking a previability abortion," thus constituting an undue burden.[64] For six years, this balancing test set forth by *Hellerstedt* would prevail until June 24, 2022, the Supreme Court's controversial opinion in *Dobbs v. Jackson*.

D. The End of Roe v. Wade

After nearly five decades of abortion protections, the Supreme Court repealed *Roe* and its progeny, stripping women of their right to abortion—a right that was determined to be Constitutionally granted since 1973.[65] Justice Alito delivered the opinion of the Court, joined by Justices Thomas, Gorsuch, Kavanaugh, and Barrett, first explaining that the "critical question" was "whether the Constitution, properly understood, confers a right to obtain an abortion."[66] In answering this question, the Court noted the Constitution made no "express reference" to abortion rights.[67] Additionally, the Court noted that previous precedent held that state regulation of abortion is not a sex-based classification and therefore is not subject to heightened scrutiny as a protected classification.[68]

Next, the Court addressed whether abortion was "deeply rooted in [our] history and tradition" and whether it is "essential to our Nation's 'scheme of ordered liberty.'"[69] The Court elaborated that the Fourteenth Amendment's Due

60. *Id.* at 589.
61. *Id.* at 607.
62. *Id.* (quoting Whole Woman's Health v. Cole, 790 F.3d 563, 572 (5th Cir.), *modified*, 790 F.3d 598 (5th Cir. 2015)).
63. *Id.*
64. *Id.* at 591.
65. *See* Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022). *See also* Roe v. Wade, 410 U.S. 113 (1973), *overruled by* Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022).
66. *Dobbs*, 597 U.S. at 234.
67. *Id.* at 235.
68. *Id.* at 236.
69. *Id.* at 237.

Process Clause provides two types of substantive rights[70]: the first being the rights guaranteed by the first eight amendments, and the second (the category at issue in *Dobbs*) being a "select list of fundamental rights that are not mentioned anywhere in the Constitution."[71] In determining whether a right falls in either category, the Court considered history and tradition and the Nation's "scheme of ordered liberty."[72] As part of its analysis of history and tradition, the Court noted that even under common law, abortion was a crime at least after "quickening."[73] Additionally, the Court noted that even in the United States, abortion at any stage of pregnancy was criminalized in three-quarters of the states at the time the Fourteenth Amendment was adopted.[74] The Court went on to explain that this was true until *Roe* and therefore "liberty" under the Fourteenth Amendment would not recognize abortion as a fundamental right in the nature, history, or traditions of the United States. The Court stated *Roe* "ignored or misstated" this history before delving into the history of abortion laws.[75]

In considering the Nation's "scheme of ordered liberty," the Court also stated that "the people of the various states" may evaluate the interests of a woman who wants an abortion and the interests of "potential life" differently.[76] To support this stance, the Court noted that in some states, voters might believe abortion rights should be more extensive than what *Roe* and *Casey* provided for, while voters in other states might want to impose tighter restrictions.[77] Using this conception, the Court concluded the Nation's understanding of "ordered liberty" does not prevent the people's elected representatives from deciding how abortion should be regulated, thus providing that abortion laws should be state regulated instead of Constitutionally granted via *Roe* and its progeny.[78]

The Court also shut down appeals to a broader "right to autonomy" and attempts to define one's "concept of existence" as a broader entrenched right by comparing abortion rights and rights to autonomy to "illicit drug use, [or] prostitution," which do not have any claims to being deeply rooted in history.[79] Further, the Court distinguished the right to abortion from other rights recognized in *Roe* and *Casey* regarding, inter alia, the right to marriage and the right to contraceptives;[80] focusing the opinion on the life of an "unborn human being"[81] and opining that abortion destroys "potential life."

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70. *Id.*
71. *Id.*
72. *Id.*
73. *Id.* at 242. See *supra* Part I.C for a discussion of the "quickening" standard.
74. *Dobbs*, 597 U.S. at 241.
75. *Id.* at 241–52; see *supra* Part I.C for a brief history of abortion legality.
76. *Id.* at 256.
77. *Id.*
78. *Id.*
79. *Id.* at 257.
80. *See id.* at 256–57 (listing several cases *Casey* relied upon in affirming *Roe*).
81. *See id.* at 257.

So then, with the *Dobbs* Court's conclusion that *Roe* and its progeny have been wrong about the standard for the past fifty years, what is the standard? According to the Court, rational basis review is the appropriate standard since procuring an abortion is not a fundamental constitutional right.[82] This allows for states to regulate abortion for "legitimate reasons," and as the Court says, when such regulations are challenged, courts cannot "substitute their social and economic beliefs for the judgment of legislative bodies."[83] Additionally, laws regulating abortions must be entitled to a "strong presumption of validity" like other health and welfare laws and must be sustained if there is a rational basis for which the legislature could have thought to serve legitimate state interests.[84] The Court names as legitimate interests

> respect for and preservation of prenatal life at all stages of development . . . the protection of maternal health and safety; the elimination of particularly gruesome or barbaric medical procedures; the preservation of the integrity of the medical profession; the mitigation of fetal pain; and the prevention of discrimination on the basis of race, sex, or disability.[85]

By using these claimed legitimate interests, the Court claims the Mississippi law is justified as the legitimate state interests of "protecting the life of the unborn"[86] and preventing a "barbaric practice, dangerous for the maternal patient"[87] provide a rational basis, precluding the respondents' constitutional challenge.[88]

II. POST-*DOBBS* CONSEQUENCES

In the aftermath of *Dobbs*, the overruling of *Roe* eliminated the federal constitutional right to abortion, allowing states to severely restrict or even ban abortion outright. In fact, as some scholars have noted, as of November of 2022, "the Center for Reproductive Rights estimates that twenty-six out of fifty states" may have done so already, with possibly more to come.[89] Immediately after the decision, twelve states banned abortion from the point of conception with extremely limited exceptions, and additional states banned abortion at other points early in pregnancy.[90] Additionally, abortion bans and restrictions may impact access to the full range of reproductive health care, regardless of an individual's desired pregnancy outcome.[91]

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82. *Id.* at 300. *See also id.* at 233–64 (presenting the bulk of the Court's analysis regarding its decision not to find a constitutional right in the Constitution's text or the Nation's history).

83. *Id.* at 300.

84. *Id.* (citing Heller v. Doe, 509 U.S. 312, 319–20 (1993)).

85. *Dobbs*, 597 U.S. at 301 (citation omitted).

86. MISS. CODE ANN. § 41-41-191(2)(b)(i) (2021).

87. *Id.* § 41-41-91(2)(b)(i)(8).

88. *Dobbs*, 597 U.S. at 301.

89. Risa Kaufman, Rebecca Brown, Catalina Martínez Coral, Jihan Jacob, Martin Onyango, & Katrine Thomasen, *Global Impacts of* Dobbs v. Jackson Women's Health Organization *and Abortion Regression in the United States*, 30 SEXUAL & REPROD. HEALTH MATTERS, 2022, at 1. *See also After Roe Fell: Abortion Laws by State, supra* note 4.

90. Kaufman, et al., *supra* note 89.

91. *Id.* at 2.

Physicians are already facing issues in providing candid medical advice, finding conversations with pregnant patients beginning to focus more on the "labyrinth of legal requirements" rather than the patient's values or health.[92] As a result, physicians in states that restrict abortion are facing an "impossible choice between upholding their ethical obligations and following the law."[93] As one physician in Texas noted, "[e]very single day I have a conversation with a patient in which I say, 'Abortion would be a really safe and valid option for you and I'm so sorry that I can't do it here.'"[94] Additionally, others have commented on the apparent paradoxical conflict between the laws and medical ethics because such laws ask physicians to "deprioritize" their patients and act in "medically harmful" ways or risk facing penalties such as losing one's license, fines, or even criminal sanctions.[95] As a result, physicians are put in the position of "just standing there" watching a patient "get sicker and sicker" instead of risking themselves being exposed to criminal liability.[96]

Beyond the sanctions physicians risk, these laws also have dire consequences that undermine the patient-physician relationship. According to the American College of Obstetricians and Gynecologists *Code of Professional Ethics*, "the welfare of the patient must form the basis of all medical judgments" and obstetricians and gynecologists should "exercise all reasonable means to ensure that the most appropriate care is provided to the patient."[97] This general rule is also present in the American Medical Association's *Code of Medical Ethics*, requiring physicians "to place patients' welfare above the physician's own self-interest or obligations to others."[98] By instituting these abortion regulations, lawmakers have interfered with the patient-physician relationship and even posed "grave dangers" to patient well-being by encouraging, even mandating, a physician to subordinate the patient's welfare to their own interests in order to avoid criminal liability.[99]

At the heart of the medical system is the patient-physician relationship and at the core of the patient-physician relationship is "the ability to counsel frankly and confidentially" about any medical issues or concerns based on the patient's medical interests with the best available scientific evidence.[100] Yet, even with the core of

92. Simmons-Duffin, *supra* note 5.

93. *Id. See also* Brief for American College of Obstetricians and Gynecologists, American Medical Ass'n, American Academy of Family Physicians, American Academy of Nursing, American Academy of Pediatrics, American Ass'n of Public Health Physicians, et al. as Amici Curiae Supporting Respondents at 26, Dobbs v. Jackson Women's Health Organization, 142 S. Ct. 2228 (2022) (No. 19–1392) [hereinafter ACOG Amicus Brief].

94. Simmons-Duffin, *supra* note 5.

95. *Id.*

96. *Id.*

97. AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *supra* note 6, at 2.

98. AM. MED. ASS'N, *supra* note 6.

99. ACOG Amicus Brief, *supra* note 93, at 27.

100. *Id.* at 28 (citing AM. MED. ASS'N, PATIENT-PHYSICIAN RELATIONSHIPS, CODE OF MED ETHICS OP. 1.1.1) ("The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.").

medical ethics revolving around the patient-physician relationship, some states have now passed egregious statutes that have been coined "bounty hunter laws," which incentivize citizens with a cash "bounty" if they succeed in bringing a lawsuit against anyone who has helped a person get an abortion.[101] The Texas version, known as Senate Bill 8, which inspired Idaho and Oklahoma to follow along with this type of enforcement mechanism, is officially codified as Texas Health and Safety Code § 171.208.[102] Statutes like § 171.208 encourage private citizens, but not "an officer or employee of a state or local governmental entity," to bring a civil action against someone who "aids or abets" an abortion.[103] If the suit is successful, the statute instructs courts to award plaintiffs "not less than $10,000" for each abortion that the defendant aided or abetted[104] as well as costs and attorney's fees.[105] Although the people who receive the abortion cannot be sued under these laws, according to the statute, those who "aid or abet" individuals receiving the abortion may.[106] Physicians and abortion providers, people who drive a pregnant woman to a clinic, and even people who help raise money to fund an abortion may all be sued.[107]

At first, it would seem these bounty hunter laws would not actually affect the patient-physician relationship since the person receiving the abortion cannot be sued under these statutes; however, these statutes technically encourage physicians, as private citizens, to bring lawsuits against anyone named by the pregnant woman when she consults with her physician regarding her choice to receive an abortion.[108] As such, a strict reading of the statute would mean that if a woman mentioned she was seeking an abortion in a routine checkup with her physician, the physician could bring suit against the pregnant woman's partner who plans to drive her to the clinic, against family members the pregnant woman mentions that send her money to cover the expenses of the abortion, or even against the physician conducting the abortion. This of course, directly challenges the core of the patient-physician relationship to "counsel frankly and confidentially" about any medical issues based on the patient's medical interests[109] and even strains people's willingness to discuss their medical needs with their physicians for fear that it may result in their friends and family

101. Emma Bowman, *As States Ban Abortion, the Texas Bounty Law Offers a Way to Survive Legal Challenges*, NPR (July 11, 2022), https://www.npr.org/2022/07/11/1107741175/texas-abortion-bounty-law [https://perma.cc/M76T-UBW7].

102. *Id.*, TEX. HEALTH & SAFETY CODE ANN. § 171.208 (West 2022) (awarding $10,000 for a successful suit). *See also* IDAHO CODE ANN. § 18-8807 (West 2022), *amended by* 2023 Idaho Laws Ch. 310 (H.B. 242) (awarding $20,000 for a successful suit against the medical professional who performed the abortion); OKLA. STAT. ANN. tit. 63, § 1-745.39 (West 2022) (awarding $10,000 for a successful suit).

103. TEX. HEALTH & SAFETY CODE ANN. § 171.208(a)(2) (West 2022).

104. *Id.* at § 171.208(b)(2).

105. *Id.* at § 171.208(b)(3).

106. *See id.* at § 171.208(a) (authorizing suits only against people who perform (§ 171.208(a)(1)) or "aid or abet" (§ 171.208(a)(2)) abortions). *See also* Bowman, *supra* note 101.

107. Bowman, *supra* note 101.

108. *See* TEX. HEALTH & SAFETY CODE ANN. § 171.208(a)–(b) (West 2022).

109. ACOG Amicus Brief, *supra* note 93, at 28.

being sued.[110] Though the statutes seem to implicate a physician may be able to bring suit, pregnant women may be able to rely on one potential safeguard when consulting their physicians to ensure they are able to receive the proper care—HIPAA.[111]

III. THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

On August 21, 1996, HIPAA, was signed into law.[112] Originally created to "improve the portability and accountability of health insurance coverage," HIPAA proposed several measures that ensured continuity of coverage between jobs, guaranteed coverage for employees with preexisting conditions, and prevented "job lock"—a scenario in which plan members stayed in a job to avoid losing health benefits.[113] Due to these measures increasing costs for health insurers, Congress enacted further measures to prevent waste, fraud, and abuse in health insurance and health care to deflect increased costs being passed onto plan members and employers and to simplify the administration of health insurance transactions.[114] Because an increasing number of health insurance transactions were done electronically, standards to safeguard health information when it was maintained or transmitted electronically were developed alongside standards for the privacy of individually identifiable health information.[115] These standards eventually resulted in the publication of the Security and Privacy Rules that form the basis of an individual's HIPAA protections.[116]

After HIPAA was signed into law, the U.S. Department of Health and Human Services (HHS) set about creating the first Privacy Rule.[117] The first proposed Privacy Rule was published in November of 1999; however, the finalized version would not be published until August 2002, and would not become effective until April 14, 2003.[118] The Privacy Rule defines PHI, stipulates permissible uses and disclosures, lists the circumstances in which authorization is required, and gives individuals rights over their PHI.[119]

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110. *See generally* Robert Barnes, Caroline Kitchener & Amber Phillips, *Can a Texas Resident be Sued for Getting an Abortion Out of State? The Post Answers Questions About the Ban*, THE WASHINGTON POST (September 8, 2021), https://www.washingtonpost.com/politics/2021/09/08/questions-texas-abortion-law/ [https://perma.cc/SG9K-RXRY] (answering questions in a Q&A format about the abortion ban and bounty hunter provision of Senate Bill 8, including questions from readers of The Washington Post with concerns about who may be sued as a result).

111. *See* Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104–191, 110 Stat. 1936.

112. *Id.*

113. *HIPAA History*, HIPAA J. (2023), https://www.hipaajournal.com/hipaa-history/ [https://perma.cc/GSN7-HF8B] (last visited Jun. 13, 2024).

114. *Id.*

115. *Id.*

116. *Id.* For the purposes of this Note, the author is focusing specifically on the Privacy Rule.

117. *Id.*

118. *HIPAA History*, *supra* note 113.

119. *Id.*

A. The Privacy Rule

The Privacy Rule is part of the HIPAA Administrative Simplification Regulations, which were regulations developed with the objective of encouraging "the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information."[120] In working towards this objective, HHS was instructed to introduce rules that would standardize transactions between health care providers and health plans (the Administrative Requirements) to promote "the confidentiality of health information, protect it from reasonably anticipated threats, and prevent unauthorized uses and disclosures . . . ."[121] However, before understanding exactly what "confidential information" is protected by the Privacy Rule, it is important to note that not all organizations are required to comply with every HIPAA Rule.[122] Under HIPAA, health plans, health-care clearinghouses, and health-care providers that conduct electronic transactions listed in the Administrative Requirements are required to comply with the Privacy Rule, which are referred to as "Covered Entities."[123] In addition to Covered Entities, Business Associates may also be required to comply with the Privacy Rule depending on the nature of the service provided for or on behalf of a Covered Entity.[124]

If an organization is required to comply with the Privacy Rule, the Privacy Rule protects PHI by stipulating when uses and disclosures are required, permitted, or subjected to an individual's authorization.[125] PHI is an individually identifiable health information relating to "an individual's past, present, or future physical or mental condition, treatment for the condition, or payment for the treatment" along with "individually identifiable non-health information maintained in the same 'designated record set.'"[126] There are only two occasions when uses and disclosures are required under HIPAA:(1) when an individual exercises their access rights and (2) when access is required by HHS' Office for Civil Rights (OCR) during an investigation or compliance review.[127] Permissible uses and disclosures are those that are necessary for treatment, payment, or health care operations; those required by law or for public health services; and those necessary to avoid a serious threat to health and safety.[128] Among these permitted disclosures are some required by state laws such as mandatory reports of abuse, neglect, or domestic abuse, and other permissible disclosures may

120. *HIPAA Privacy Rule*, HIPAA J. (2023), https://www.hipaajournal.com/hipaa-privacy-rule/ [https://perma.cc/XB63-Y4VA] (last visited Jun. 13, 2024). *See also* 45 C.F.R. pt. 160; 45 C.F.R. pt. 162; 45 C.F.R. pt. 164.

121. *HIPAA Privacy Rule*, *supra* note 120.

122. *Id.*

123. *Id.*

124. See *id.* for a nonexhaustive list of some of the exceptions that are common.

125. *Id.*

126. *Id. See also infra* Part III.B for a more robust discussion on what exactly is considered PHI.

127. *Id.*

128. *Id.*

be required during "emergency incidents."[129] Other than these required or permitted disclosures, all other uses and disclosures of PHI require authorization by the individual who is the subject of the PHI or their personal representative.[130]

Should an organization violate the Privacy Rule, an individual may bring a complaint to HHS' OCR, which will review and investigate if there was a violation. During the investigation, the Covered Entity must disclose whatever PHI necessary, and in cases where OCR finds willful neglect, civil monetary penalties may be imposed.[131]

B. What is Protected Health Information (PHI)?

Many sources define PHI as "the identifiers that have to be removed from a designated record set before any health information remaining in the designated record set is no longer "individually identifiable," but this is incorrect.[132] As defined under the General HIPAA Provisions, "health information" is any information, including genetic information, that:

> (1) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.[133]Additionally, "individually identifiable health information" is health information including demographic information collected from an individual that is created or received by health-care provider, health plan, employer, or health-care clearinghouse that identifies the individual or can be used to identify the individual.[134] Finally, the General HIPAA Provisions define PHI as individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.[135]

While the definitions provided in the General HIPAA Provisions are a good baseline, these definitions also do not provide a full definition as HIPAA identifiers must also be accounted for. As one journal asked, "[S]ince when has a license plate number had anything to do with an individual's health?"[136] HIPAA identifiers are typically stored in a designated record set, which, defined by the statute, is any group of medical and/or billing records maintained by or for a Covered Entity used

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129. *HIPAA Privacy Rule*, *supra* note 120.
130. *Id.*
131. *Id.*
132. *What is Protected Health Information?*, HIPAA J. (March 12, 2023), https://www.hipaajournal.com/what-is-protected-health-information/ [https://perma.cc/5HLX-RPUQ] (last visited Jun. 14, 2024).
133. 45 C.F.R. § 160.103 (2014).
134. *Id.*
135. *Id.*
136. *What is Protected Health Information?*, *supra* note 132.

in whole or in part to make decisions about an individual.[137] Any individually identifiable health information created or received by a Covered Entity is a designated record set and qualifies for Privacy Rule protections.[138] This also includes any items of individually identifiable non-health information maintained in the designated record set for that patient that identifies the individual.[139] This means that should a designated record set contain a patient's name, diagnosis, treatment, payment details, and license plate number, the license plate number will be considered PHI even though it is non-health information.[140] This general rule applies to any identifiers listed under the statute if those identifiers are maintained in the same designated record as PHI.[141]

Thus, if a patient were to consult their physician about the means by which she would obtain an abortion, including the names of drivers, the physician performing the procedure, or even any family or friends that have donated to help aid in the cost of the abortion, and the physician subsequently were to maintain that information in the designated record set, that information would become PHI under HIPAA's Privacy Rule and thus qualify for the Privacy Rule's protections.

IV. HIPAA BARS PHYSICIANS FROM DISCLOSING PHI VOLUNTARILY

As we can see, HIPAA is certainly not a "slam dunk fix" in protecting those who receive abortions given providers are allowed to report abortion data in response to a court order or summons.[142] However, HIPAA *may* be used to protect the patient-physician relationship by barring physicians from voluntarily disclosing PHI, like by bringing a lawsuit against those that "aid and abet" abortions in Texas under their bounty hunter law.

In the wake of the Supreme Court's repealing of *Roe v. Wade*, HIPAA was thrust into the limelight as a potential safeguard, causing many physicians and health organizations to question whether HIPAA required them to disclose patients' abortion records.[143] In June of 2022, HHS' OCR released guidance materials.[144] The

137. 45 C.F.R. § 164.501 (2013).

138. *What is Protected Health Information?*, *supra* note 132.

139. *Id.*

140. *Id.*

141. See 45 C.F.R. § 164.514 (2013) for a full list of identifiers. However, it should be noted that the list was created more than twenty years ago and does not include email addresses, social media handles, LGBTQ status, and Medicare Beneficiary Identifiers, which may be something Congress should address within the coming years as modern ways of identifying individuals becomes increasingly easier through the internet and social media.

142. *See* Pifer, *supra* note 7. *See also* Carmel Shachar, *HIPAA, Privacy, and Reproductive Rights in a Post-*Roe *Era*, 328 JAMA 417, 417 (2022) (explaining the ability for clinicians to report upon receiving a warrant or similar document).

143. *See generally* Allie Reed, *Abortion Patients Have a Limited Privacy Shield: HIPAA Explained*, BL (May 18, 2022, 2:25 AM), https://news.bloomberglaw.com/health-law-and-business/abortion-patients-have-a-limited-privacy-shield-hipaa-explained [https://perma.cc/QD2L-LYJ4] (discussing how HIPAA could operate as a legal privacy shield shortly after the *Dobbs* decision).

144. *See HIPAA Privacy Rule and Disclosures of Information Relating to Reproductive Health Care*, U.S. DEP'T OF HEALTH & HUM. SERVS. (June 29, 2022), https://www.hhs.gov/hipaa/for-profe

guidance restates that regulated entities (Covered Entities) can "use or disclose PHI, without an individual's signed authorization, *only* as expressly permitted or required by the Privacy Rule."[145] The Privacy Rule permits, *but does not require*, covered entities to disclose PHI without the individual's authorization when such disclosure is required by another law and the disclosure complies with that law's requirements.[146] The guidance clarifies that this permission to disclose PHI as "required by law" is limited to "a mandate contained in law that compels an entity to make a use or disclosure of PHI and that is enforceable in a court of law" and that those disclosures are restricted to the relevant requirements of such law.[147]

Additionally, the June 2022 guidance also stipulates the requirements for disclosures for law enforcement purposes. Covered Entitles are permitted *but not required* to disclose PHI about an individual for law enforcement purposes "pursuant to process and as otherwise required by law" under certain conditions.[148] These instances are typically when responding to a law enforcement request made through a court order or a court-ordered warrant, or a subpoena or summons.[149] HHS' OCR clarifies that in the absence of a mandate enforceable in a court of law, the permission to disclose PHI for law enforcement purposes *does not permit* disclosure to law enforcement where a hospital or health care provider's workforce member *chose* to report an individual's abortion or other reproductive health care.[150]

What this guidance means is physicians should not be voluntarily disclosing PHI, in our case, information given by the patient, in bringing lawsuits against the people named by the patient. Indeed, since there are currently no states with mandatory reporting laws requiring providers to report to law enforcement the "suspicion (or confirmation)" of a person's attempt at abortion, reporting a patient to law enforcement is a HIPAA violation "absent a specific requirement in the law."[151] This, in turn, brings us back to the crux of this Note. Although pregnant women thinking about an abortion may fear their health-care providers bringing a lawsuit against them or their loved ones in obtaining an abortion, thus straining the patient-physician relationship, under these HIPAA protections, there may be a narrow safe harbor that both physicians and patients may rely on.

Yes, HIPAA is a narrow statute in that it is concerned "only with PHI found in electronic health records" that are "maintained by covered entities,"[152] but as

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ssionals/privacy/guidance/phi-reproductive-health/index.html [https://perma.cc/LYW5-SM93].

145. *Id.*

146. *Id.* (citing 45 C.F.R. § 164.512(a)(1) (2016)).

147. *HIPAA Privacy Rule and Disclosures of Information Relating to Reproductive Health Care*, *supra* note 144 (citing 45 C.F.R. § 164.512(a)(1) (2016)).

148. *Id.* (citing 45 C.F.R. § 164.512(f)(1) (2016)).

149. *Id.*

150. *Id.* This is true whether the workforce member initiated the disclosure to law enforcement or the workforce member disclosed PHI at the request of law enforcement.

151. Jamila Perritt & Jill E. Adams, *Don't Report Your Abortion Patients to Law Enforcement*, MEDPAGE TODAY (Nov. 5, 2022), https://www.medpagetoday.com/opinion/second-opinions/101581 [https://perma.cc/7W3V-7W4M].

152. Shachar, *supra* note 142, at418.

discussed above, if physicians were to properly store and maintain the information within the designated record set, that information would be considered PHI.[153] Once classified PHI, HHS' OCR has been very clear that outside of permissive disclosure as "required by law" or "pursuant to process," the permission to disclose PHI is *not* a voluntary one.[154] By relying on this relatively small safe harbor, the patient-physician relationship may just well be saved in our post-*Dobbs* world by instilling a patient with trust and confidence to be candid with their physicians about their medical needs regarding reproductive health, knowing that the physician is barred from volunteering that information under HIPAA and thus barred from bringing a lawsuit against the patient's friends and family who provide support during the process.

Although the protections HIPAA provides are relatively small in scope and though HIPAA certainly is not the immovable shield as some commenters have hoped for,[155] there is an abundance of potential changes that should be considered to protect pregnant women in the coming years. For example, as some have noted, the best solution would be for Congress to "address gaps" within privacy laws and HIPAA to resolve "concerns related to reproductive rights."[156] Another, albeit small, step could be for health care providers to enact policies for their clinicians to accurately maintain information in a patient's designated record set. By doing so, the information would then be protected by HIPAA as PHI and thus would bar the clinician from voluntarily disclosing that information. However, one complication in this route would be that storing more information within the designated record set also allows law enforcement agencies access to more information when, or if, a proceeding is brought against the patient and a warrant for that information is obtained.[157] Additionally, some have pointed to medical groups and experts releasing best practices for health-care entities, ensuring providers know that HIPAA does not mandate disclosure on its own and any forced disclosures by court mandate should be as narrow as possible to protect the privacy of the patients.[158]

CONCLUSION

Although the United States no longer recognizes the constitutional right to abortion,[159] resulting in some states passing anti-abortion and bounty-hunter laws

153. *See generally What is Protected Health Information?*, *supra* note 132.

154. *See generally HIPAA Privacy Rule and Disclosures of Information Relating to Reproductive Health Care*, *supra* note 144.

155. *See* Reed, *supra* note 143. *See also* Pifer, *supra* note 7 (contemplating HIPAA's potential protections post-Dobbs); Shachar, *supra* note 143 (noting HIPAA's possible protections against reporting).

156. Pifer, *supra* note 7.

157. *See* U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 144.

158. *See* Maggie Jo Buchanan & Nadia Stovicek, *Using HIPAA to Protect Patient Privacy and Fight Abortion Criminalization*, CTR. FOR AM. PROGRESS (Aug. 17, 2022), https://www.americanprogress.org/article/using-hipaa-to-protect-patient-privacy-and-fight-abortion-criminalization/ [https://perma.cc/8U5Y-3SBE].

159. *See* Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022).

that affect the patient-physician relationship,[160] women seeking abortion should not be intimidated from consulting with their physicians about their entire medical needs. Although bounty-hunter laws were enacted, HIPAA provides for a safe harbor that prevents physicians from voluntarily disclosing an individual's PHI, thus preventing physicians from bringing lawsuits under those bounty-hunter laws.[161] This safe harbor potentially saves the patient-physician relationship in our post-*Dobbs* world by instilling trust and confidence in one's health care providers. Additionally, there are steps that may be taken to expand these protections in the future, such as Congress "addressing gaps"[162] between HIPAA and privacy laws, or health-care providers giving their clinicians all the information needed to understand their disclosure rules and potentially what information to store in a patient's designated record set to receive HIPAA protections.[163]

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160. *See* TEX. HEALTH & SAFETY CODE ANN. § 171.208 (West 2021); IDAHO CODE ANN. § 18-8807 (West 2022), *amended by* 2023 Idaho Laws Ch. 310 (H.B. 242); OKLA. STAT. ANN. tit. 63, § 1-745.39 (West 2022).

161. *See supra* Part III; Part IV.

162. Pifer, *supra* note 7.

163. In fact, months after the research and original drafting of this Note, some states like California signed into law new bills related to abortion regulations, such as California Assembly Bill 352 (AB 352) and Assembly Bill 254 (AB 254), which were signed into law on September 27, 2023. In a November 2023 Insight by prominent law firm McDermott, Will, and Emery (MWE), MWE attorneys noted the key takeaways to California's new reproductive privacy laws that create complexities for health information sharing, attempting to mitigate the risk of out-of-state prosecution of individuals seeking abortions. *See* Daniel F. Gottlieb, Alya Sulaiman & Reuben Bank, *California's New Reproductive Privacy Laws AB 352 and AB 254 Create Complexities for Health Information Sharing*, MWE (Nov. 17, 2023), https://www.mwe.com/insights/californias-new-reproductive-privacy-laws-ab-352-and-ab-254-create-complexities-for-health-information-sharing/ [https://perma.cc/M4S3-3ZJ4]. Additionally, on April 22, 2024, the Health and Human Services Office for Civil Rights (OCR) announced a new final rule, enhancing privacy protections related to reproductive health care. HIPAA Privacy Rule to Support Reproductive Health Care Privacy, 89 Fed. Reg. 32,977 (Apr. 26, 2024) (to be codified at 45 C.F.R. pts. 160, 164). The final rule amends HIPAA's Privacy Rule to establish new limits on the use and disclosure of PHI. OCR, citing the *Dobbs* decision, asserted the rule change is necessary to ensure that "individuals are not afraid to seek reproductive healthcare." *Id.* at 32,977. The OCR observed several concerns relating to the use and disclosure of certain PHI related to reproductive healthcare, including potential harm caused by disclosing such information for non-health-care purposes, such as to "conduct an investigation against, or to impose liability upon, an individual or another person who receives or delivers reproductive healthcare." *Id.* at 33,022. As discussed in this Note, these situations may chill an individual's "wiliness to seek lawful healthcare treatment" or even chill an individual's wiliness "to provide full information to their health care providers when obtaining that treatment." As a result, as it relates to this Note, OCR's new final rule "prohibits the use or disclosure of PHI when it is sought to investigate or impose liability on individuals, health care providers, or others who seek, obtain, provide, or facilitate reproductive health care that is lawful under the circumstances in which such health care is provided, or to identify persons for such activities." IPAA Privacy Rule to Support Reproductive Health Care Privacy, 89 Fed. Reg. at 33,025. Although this final rule is effective sixty days after the publication in the Federal Register, OCR extended the compliance date to February 16, 2026. *See* HIPAA Privacy Rule to Support Reproductive Health Care Privacy, 89 Fed. Reg. 32976 (April 26, 2024) (to be codified at 45 C.F.R. pts. 160, 164). *See also* Joseph J. Lazzarotti, *New HIPAA Final Rule Imposes Added Protections for Reproductive Health Care Privacy*, JACKSON LEWIS: WORKPLACE PRIVACY, DATA MANAGEMENT & SECURITY REPORT (Apr. 23, 2024), https://www.workplaceprivacyreport.com/2024/04/articles/hipaa/new-hipaa-final-rule-imposes-added-protections-for-reproductive-health-care-privacy/ [https://perma.cc/86N2-ZA3P] (summarizing the HIPAA final rule found in 89 FR 32976).