

To: IHA Members

From: Laura Brown, Deputy General Counsel

Date: August 8, 2022

Re: Senate Enrolled Act 1 – Indiana’s Updated Abortion Framework

Late in the evening of August 5, 2022, Governor Holcomb signed [Senate Enrolled Act \(“SEA”\) 1](#) into law, which updates Indiana’s abortion framework in light of the U.S. Supreme Court’s *Dobbs v. Jackson Women’s Health Organization* opinion. The provisions of SEA 1 are effective **September 15, 2022**, and highlights of the new law are outlined below.

This memorandum is provided as guidance only and does not constitute legal advice. Therefore, we encourage all members to review policies and procedures in light of the new SEA 1 framework, as well as the Centers for Medicare and Medicaid Services’ (“CMS”) [recent memorandum](#) reinforcing obligations under the Emergency Medical Treatment and Labor Act (“EMTALA”) specific to pregnant patients and those who are experiencing pregnancy loss.

I. Lawful Abortions under SEA 1

Under the new framework of SEA 1, abortions may only be provided in hospitals licensed under Indiana Code (“IC”) 16-21 and ambulatory outpatient surgical centers (“ASC”) that have a majority ownership by a hospital licensed under IC 16-21¹ for the following reasons:

- A) Serious Health Risk or Life of Pregnant Woman:** At any point in a woman’s pregnancy, an abortion is lawful if a physician determines, based on reasonable medical judgment, that “the abortion is necessary to prevent any serious health risk to the pregnant woman or to save the pregnant woman’s life.”² The term “serious health risk” means that in reasonable medical judgment, a condition exists that has complicated the mother’s medical condition and necessitates an abortion to prevent death or a serious risk of substantial and irreversible physical impairment of a major bodily function. The term does not include psychological or emotional conditions. A medical condition may not be determined to exist based on a claim or diagnosis that the woman will engage in conduct that she intends to result in her death or in physical harm.³ The term “reasonable medical judgment” is undefined in Indiana Code.

An abortion performed to prevent a serious health risk or to save the pregnant woman’s life *before* the earlier of the viability of the fetus or twenty (20) weeks postfertilization must be performed by a physician in a hospital or ASC.⁴ An abortion performed for this reason *after* the viability of the fetus or twenty (20) weeks postfertilization may only be performed in a hospital.⁵ The woman submitting to the abortion must file her consent with the physician; however,

¹ IC 16-18-2-14(c).

² IC 16-34-2-1(a)(1)(A)(i) and IC 16-34-2-1(a)(3)(A).

³ IC 16-18-2-327.9.

⁴ IC 16-34-2-1(a)(1)(B).

⁵ IC 16-34-2-1(a)(3)(C).

consent is not required if in the judgement of the physician, the abortion is necessary to preserve the life of the woman.⁶ Prior to the abortion being performed, the physician must certify in writing to the hospital or ASC that in the physician's reasonable medical judgement, performing the abortion is necessary to prevent any serious health risk to the pregnant woman or to save the pregnant woman's life. All facts and reasons supporting the certification shall be set forth by the physician in writing and attached to the certificate.⁷

- B) Lethal Fetal Anomaly:** Before the earlier of the viability of the fetus or twenty (20) weeks postfertilization, an abortion is lawful if, based on the professional, medical judgement of the physician, the fetus is diagnosed with a lethal fetal anomaly.⁸ The term "lethal fetal anomaly" means a fetal condition diagnosed before birth that, if the pregnancy results in a live birth, will with reasonable certainty result in the death of the child not more than three (3) months after the child's birth.⁹ However, an abortion may still be provided for a lethal fetal anomaly if after viability of the fetus or twenty (20) weeks postfertilization, the lethal fetal anomaly poses a serious health risk to the pregnant woman, and an abortion is provided subject to requirements for an abortion to prevent a serious health risk after viability of the fetus or twenty (20) weeks postfertilization, as outlined above.

An abortion performed if the fetus is diagnosed with a lethal fetal anomaly must be performed by a physician in a hospital or ASC, if performed before the viability of the fetus or twenty (20) weeks postfertilization.¹⁰ The woman submitting to the abortion must file her consent with the physician; however, consent is not required if in the judgement of the physician, the abortion is necessary to preserve the life of the woman.¹¹ Prior to the abortion being performed, the physician must certify in writing to the hospital or ASC that the fetus has been diagnosed with a lethal fetal anomaly. All facts and reasons supporting the certification shall be set forth by the physician in writing and attached to the certificate.¹²

- C) Rape or Incest:** During the first ten (10) weeks of postfertilization, an abortion is lawful if the pregnancy is the result of rape or incest.¹³ The term "rape or incest" is defined to mean sexual intercourse with another person if the other person is related to the person biologically as a parent, child, grandparent, grandchild, sibling, aunt, uncle, niece, or nephew; rape, as defined by [IC 35-42-4-1](#); child molesting, as defined by [IC 35-42-4-3](#); child seduction, as defined by [IC 35-42-4-7](#); or sexual misconduct with a minor, as defined by [IC 35-42-4-9](#); even if a person has not been charged with or convicted of any of the latter acts or offenses.¹⁴

⁶ IC 16-34-2-1(a)(1)(C).

⁷ IC 16-34-2-1(a)(1)(E)(i).

⁸ IC 16-34-2-1(a)(1)(A)(ii).

⁹ IC 16-25-4.5-2.

¹⁰ IC 16-34-2-1(a)(1)(B).

¹¹ IC 16-34-2-1(a)(1)(C).

¹² IC 16-34-2-1(a)(1)(E)(ii).

¹³ IC 16-34-2-1(a)(2)(A).

¹⁴ IC 16-18-2-306.7.

An abortion performed if the pregnancy is the result of rape or incest must be performed by a physician in a hospital or ASC.¹⁵ The woman submitting to the abortion must file her consent with the physician; however, consent is not required if in the judgement of the physician, the abortion is necessary to preserve the life of the woman.¹⁶ Further, consent by the parent, legal guardian, or custodian for an abortion for an unemancipated pregnant minor is not required if the minor is pregnant as the result of rape or incest by a parent, legal guardian, or custodian.¹⁷ Prior to the abortion being performed, the physician must certify in writing to the hospital or ASC that after proper examination, the abortion is being performed at the woman's request because the pregnancy is the result of rape or incest. All facts and reasons supporting the certification shall be set forth by the physician in writing and attached to the certificate.¹⁸

The framework for providing abortion inducing drugs remains the same, although like surgical abortions, they may only be provided in hospitals or ASCs going forward. Further, the requirement for physicians who perform an abortion to have admitting privileges has been updated to also apply to physicians who perform an abortion using an abortion inducing drug.¹⁹

The informed consent provisions of [IC 16-34-2-1.1](#), as well as the provisions for performing an abortion after the earlier of the time a fetus is viable or twenty (20) weeks postfertilization under [IC 16-34-2-3](#), including the requirement that the abortion be performed in a hospital having a premature birth intensive care unit and in the presence of a second physician, remain unchanged.

Please note, the language of SEA 1 is clear that the new framework does not apply to in vitro fertilization.²⁰ Further, the definition of “abortion” was not altered and means “the termination of human pregnancy with an intention other than to produce a live birth or to remove a dead fetus.”²¹ Accordingly, miscarriage management is not considered an abortion and does not fall under the framework of SEA 1.

II. Reports under SEA 1

SEA 1 also made several changes to Indiana’s reporting structure. Going forward, every health care provider who performs an abortion, including the provision of abortion inducing drugs, will be required to include the reason for the abortion in the report required under [IC 16-34-2-5](#).²²

The Indiana Department of Health’s public report on the statistics from the reports submitted on abortions provided will now be compiled on a quarterly basis, rather than a yearly basis as well.²³ IHA expects the legislature to review the quarter four (4) report for 2022 as the legislature convenes for the 2023 legislative session.

¹⁵ (IC 16-34-2-1(a)(2)(C).

¹⁶ IC 16-34-2-1(a)(2)(B).

¹⁷ IC 16-34-2-4(a).

¹⁸ IC 16-34-2-1(a)(2)(D).

¹⁹ IC 16-34-2-4.5.

²⁰ IC 16-34-1-0.5

²¹ IC 16-18-2-1.

²² IC 16-34-2-5(a)(19).

²³ IC 16-34-2-5(e).

Under SEA 1, the Statewide Maternal Mortality Review Committee (“Committee”) will also be required to study how changes in the state’s abortion laws affect maternal mortality in Indiana.²⁴ SEA 1 extended the Committee until June 30, 2027; the Committee was previously set to expire on June 30, 2025.²⁵

III. Enforcement under SEA 1

The legislature did not increase criminal penalties under SEA 1, but unlawful abortions remain a Level 5 felony under the current regulatory framework.²⁶ Further, the Medical Licensing Board will now be required to revoke a physician’s license if, after appropriate notice and an opportunity for a hearing, the attorney general proves by a preponderance of the evidence that the physician provided an unlawful abortion.²⁷

SEA 1 does make clear that a pregnant woman should not be criminalized for committing an unlawful act with the intent to terminate her pregnancy, but the language is not applicable and is not a defense to a physician performing an unlawful abortion.²⁸

Finally, SEA 1 provides that the criminal act of feticide, which is a Level 3 felony under [IC 35-42-1-6](#), does not apply to the pregnant mother whose pregnancy is terminated; (2) a person who in good faith provides medical treatment to a pregnant woman that results in the accidental or unintentional termination of the pregnancy; or (3) a physician licensed under IC 25-22.5 who, upon the request of a pregnant woman, performs a medical procedure to terminate her pregnancy, even if the procedure is not authorized under [IC 16-34-2-1](#).²⁹

IV. EMTALA Memorandum

With the expectation that several states would update their legal and regulatory frameworks on abortion following the *Dobbs* opinion, CMS recently issued [QSO 22-22](#) to reinforce the obligations under EMTALA specific to pregnant patients and those who are experiencing pregnancy loss.

The EMTALA statute requires that all patients receive an appropriate medical screening examination to determine whether an emergency medical condition (“EMC”) exists; stabilizing treatment if the hospital determines the individual has an EMC; and transfer to another hospital if the individual requests the transfer or the medical benefits of the transfer outweigh the risks (i.e., the hospital does not have the capability to stabilize the condition). QSO 22-22 outlines the following requirements related to screening, stabilizing treatment, and transfers:

A) Emergency Medical Conditions: The QSO states “the determination of whether an [EMC] exists is made by the examining physician(s) or other qualified medical personnel of the hospital,” and an “EMC includes medical conditions with acute symptoms of sufficient severity that, in the absence of immediate medical attention, could place the health of a person (including pregnant patients) in serious jeopardy, or result in a serious

²⁴ IC 16-50-1-3(b)(2).

²⁵ IC 16-50-1-12.

²⁶ IC 16-34-2-7.

²⁷ IC 25-22.5-8-6(b)(2).

²⁸ IC 35-41-3-12.

²⁹ IC 35-42-1-6(a).

impairment or dysfunction of bodily functions or any bodily organ.”³⁰ The QSO states “[EMCs] involving pregnant patients may include, but are not limited to: ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features.”³¹

B) Stabilizing Treatment: The QSO states “[t]he EMTALA statute requires that stabilizing treatment prevent material deterioration and compels hospitals and physicians to act prior to the patient’s condition declining.”³² Further, the QSO states that if “qualified medical personnel determine that the patient’s condition, such as an ectopic pregnancy, requires stabilizing treatment to prevent serious jeopardy to the patient’s health (including a serious impairment or dysfunction of bodily functions or any bodily organ or a threat to life), the qualified medical personnel is required by EMTALA to provide the treatment.” Finally, the QSO notes that “[s]tabilizing treatment could include medical and/or surgical interventions (e.g., methotrexate therapy, dilation and curettage (D&C), removal of one or both fallopian tubes, anti-hypertensive therapy, etc.).”³³

C) Transfers: The QSO clarifies that a “hospital cannot cite State law or practice as the basis for transfer.”³⁴ Hospitals that are not capable of handling high-risk deliveries or infants often have written transfer agreements with facilities capable of handling high-risk cases, but the hospital must first meet the screening, treatment, and transfer requirements of EMTALA.

D) Hospital’s Obligation: The QSO states that a “hospital’s EMTALA obligation ends when a physician or qualified medical person has made a decision: [t]hat no [EMC] exists (even though the underlying medical condition may persist); [t]hat an [EMC] exists and the individual is appropriately transferred to another facility; or [t]hat an [EMC] exists and the individual is stabilized or admitted to the hospital for further stabilizing treatment.”³⁵ The QSO also states that “any state that has a more restrictive definition of [EMC] or that has a definition that directly conflicts with any definition above is preempted by the EMTALA statute.”³⁶

While this memorandum is provided as guidance only, we encourage all members to review their policies and procedures in light of the new SEA 1 framework and CMS’s recent EMTALA memorandum to ensure examinations, any treatment, and transfers, if a transfer is deemed necessary, are provided in accordance with both state and federal law. If you have any questions, please contact Laura Brown at L.brown@ihaconnect.org.

³⁰ “Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss (QSO-21-22-Hospitals UPDATED JULY 2022),” Page 3.

³¹ *Id.* At 4.

³² *Id.*

³³ *Id.*

³⁴ *Id.*

³⁵ *Id.* At 4-5.

³⁶ *Id.* At 5.