ABORTION DEFENSE NETWORK

Know Your State's Abortion Laws

A Guide for Medical Professionals

INDIANA

Since *Roe v. Wade* was overturned in June 2022, medical providers across the country have struggled to understand their state's abortion laws, which contain undefined terms and non-medical language.

Fear and confusion throughout the medical community has led some hospitals to adopt policies that are overly strict or burdensome, causing patients to be denied care in emergencies. While the law remains in flux and some questions have no clear answers, this document aims to provide clarification, where possible, of what conduct is still permitted in your state. Know what your state's law does and does not require, so you can advocate for yourself and your patients.

Last updated August 2025

Key Takeaways

Providing contraception, including emergency contraception, is legal.

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

Providing information about how to obtain a legal abortion in another state is legal.

Abortion is prohibited under Indiana law unless:

(1) necessary "to prevent any serious health risk to the pregnant woman or to save the pregnant woman's life" (litigation seeking clarification of this exception is ongoing),

(2) up to 22 weeks LMP, the fetus is diagnosed with a "lethal fetal anomaly," defined as a condition that "with reasonable certainty" will result in the death of the child within 3 months of birth, or

(3) up to 12 weeks LMP, the pregnancy is the result of rape or incest.

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Definition of Abortion & Contraception

ABORTION

The legal definition of abortion in Indiana is "the termination of human pregnancy with an intention other than to produce a live birth or to remove a dead fetus."[1] This abortion definition includes "abortions by surgical procedures and by abortion including drugs."[2] Indiana defines a "miscarried fetus" as "an unborn child, irrespective of gestational age, who has died from a spontaneous or accidental death before expulsion or extraction from the unborn child's mother, irrespective of the duration of the pregnancy."[3]

The term "dead fetus," while undefined, is generally understood to mean an embryo or fetus that lacks cardiac activity. As a result, treating a missed miscarriage, an incomplete miscarriage, a molar pregnancy, or an ectopic pregnancy is not considered providing an abortion under Indiana law as long as there is no embryonic or fetal cardiac activity present. The Indiana Department of Health has issued guidance stating that treatment of "a missed miscarriage, septic abortion, inevitable miscarriage, ectopic pregnancy, molar pregnancy, or other pregnancy where the fetus has died in-utero" does not require the submission of a terminated pregnancy report.[4] Therefore, the view of the Indiana Department of Health is that treating these conditions does not constitute providing abortion care that needs to be reported. Provided that a miscarriage results in the death of a fetus, Indiana law permits all necessary treatment and medical management.

With respect to self-managed abortion, it is legal for providers to give medical care to a pregnant person who has initiated or recently completed a self-managed abortion. This treatment can lawfully include abortion care provided there is no embryonic or fetal cardiac activity or the patient needs care that would fall within one of the exceptions to Indiana's abortion ban.

CONTRACEPTION

Indiana law permits the provision and use of any contraceptives, including intrauterine devices and birth control implants.[5] Since July of 2023, Indiana also permits pharmacists to directly prescribe and dispense certain hormonal contraceptives to people over the age of eighteen.[6] Indiana law does not explicitly define "emergency contraception." It is a felony in Indiana for a pharmacist to intentionally prescribe a medication to cause an abortion.[7]

Abortion Bans

Total Ban: Indiana has an abortion ban[8] (also known as SB 1 or SEA 1) that states that abortion shall be a criminal act except when provided under certain exceptions.[9] Providing an abortion in violation of the ban is a level 5 felony, and violators are subject to criminal penalties, including imprisonment between one and six years and a fine of up to $10,000.[10] In addition, a physician is subject to license revocation if the Attorney General proves that the physician performed an abortion with the intent to violate Indiana's abortion laws.[11]

Other Bans and Restrictions: Indiana law also prohibits both dilation and evacuation ("D&E") procedures[12] and intact D&E procedures (sometimes called D&X procedures),[13] the provision of abortion by telemedicine,[14] and abortions sought for reasons based on the sex, disability, race, color, national origin, or ancestry of the fetus.[15] Indiana's other abortion requirements include: a physician-only requirement;[16] hospital admitting privileges requirement;[17] pre-abortion disclosure requirement, consent and certification requirements;[18] mandatory ultrasound requirement;[19] mandatory 18-hour delay;[20] and additional requirements for medication abortion.[21] Additionally, a physician cannot perform

an abortion on an unemancipated person under the age of 18 without the consent of a parent, legal guardian, or custodian, or unless the young person or the young person's physician is able to obtain a waiver of the requirement from the juvenile court in the county where the young person lives or the abortion will be performed.[22]

Exceptions to Abortion Bans

There are three exceptions to Indiana's abortion ban: (1) abortions throughout pregnancy necessary "to prevent any serious health risk to the pregnant woman or to save the pregnant woman's life;" (2) pregnancies up to 22 weeks LMP where "the fetus is diagnosed with a lethal fetal anomaly;" and (3) pregnancies up to 12 weeks LMP that are the result of rape or incest.

Prevent Serious Health Risk or to Save Patient's Life: Indiana's abortion ban has an exception that applies throughout pregnancy if, "for reasons based upon the professional, medical judgment" of the pregnant person's physician, "reasonable medical judgment dictates that performing the abortion is necessary to prevent any serious health risk to the pregnant woman or to save the pregnant woman's life."[23] The ban defines "serious health risk" as a "serious risk of substantial and irreversible physical impairment of a major bodily function."[24] This definition expressly excludes "psychological or emotional conditions," and it specifies that 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."[25] Before the abortion, the physician must certify in writing that "in the attending physician's reasonable medical judgment, performing the abortion is necessary to prevent any serious health risk to the pregnant woman or to save the pregnant woman's life."[26] There is ongoing litigation about the scope of the exception.[27]

Indiana law similarly defines a "medical emergency" as a condition that, "on the basis of the attending physician's good faith clinical judgment, complicates the medical condition of a pregnant woman so that it necessitates the immediate termination of her pregnancy to avert her death or for which a delay would create serious risk of substantial and irreversible impairment of a major bodily function."[28] In cases of "medical emergency," a physician does not need to comply with certain Indiana abortion requirements, including the requirements for: parental consent for young people under 18; pre-abortion disclosure, consent, and certain certification; mandatory ultrasound; and mandatory 18-hour delay.[29] A medical emergency does not include "a patient's claim or diagnosis that the patient would engage in conduct that would result in the patient's death or substantial physical impairment."[30] Additionally, there is an exception to the D&E ban if "reasonable medical judgment" dictates that the D&E is necessary "to prevent any serious health risk" to the patient or to save the patient's life.[31] There is also an exception to the intact D&E ban if the physician "reasonably believes" that performing an intact D&E "is necessary to save the [patient]'s life" and no other medical procedure would be sufficient.[32]

"Lethal Fetal Anomaly": Indiana's abortion ban also has an exception that applies up to 22 weeks LMP if, "for reasons based upon the professional, medical judgment" of the pregnant person's physician, the fetus has been diagnosed with a lethal fetal anomaly.[33] A lethal fetal anomaly is defined as "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."[34] Before the abortion, the physician must certify in writing "[a]ll facts and reasons supporting the certification."[35] Additional consents are required prior to such an abortion.[36]

Rape and Incest: The last exception to Indiana's abortion ban applies up to 12 weeks LMP if the pregnancy is the result of rape or incest.[37] Before the abortion, the physician must certify in writing that "the abortion is being performed at the woman's request because the pregnancy is the result of rape or incest," and the written certification must include or attach "[a]ll facts and reasons supporting the certification."[38]

Other Legal Requirements: Every abortion performed in Indiana under an exception must occur in hospitals or in ambulatory outpatient surgical centers that are majority-owned by a hospital.[39] Further, every abortion performed after 22 weeks LMP: (1) must occur in a hospital having "premature birth intensive care units, unless compliance with this requirement would result in an increased risk to the life or health of the pregnant person and (2) have a second physician present.[40] Additionally, Indiana requires certain consents and certifications before an abortion. Physicians must obtain written consent from the pregnant person.[41] However, consent is not required if, "in the judgment of the physician the abortion is necessary to preserve the life of the [pregnant person]."[42] Prior to an abortion, the physician must certify in writing the specific exception upon which the physician is relying, and attach all facts and reasons supporting that certification.[43]

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

EMTALA requires stabilizing medical treatment be provided to any individual experiencing an emergency medical condition,[47] including people in labor or with emergency pregnancy complications,[48] unless the individual refuses to consent to such treatment.[49] 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."[50] 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.[51] 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."[52]

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.[53]

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."[54] 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."[55] 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." [56] 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.[57]

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.[58] 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]."[59] 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.[60] 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.[61] Following the change of presidential administrations, the United States dismissed that case entirely. [62]

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.[63] As a result, the Fifth Circuit's decision is final.[64] [65]

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.[66]

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.[67]

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.[68]

Resident Training: The Accreditation Council for Graduate Medical Education (ACGME) requires that accredited programs provide access to training in the provision of abortion.[69] 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.[70]

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.[71] 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.

In addition to the certifications required when an exception to the abortion ban is being used (discussed above), the only abortion-specific documentation and reporting requirements are:

Abortion Reporting: Under Indiana law, a physician or hospital must report all abortions to the Indiana Department of Health ("IDOH") by submitting a terminated pregnancy report ("TPR"). IDOH guidance states that "[t]reatment of a missed miscarriage, septic abortion, inevitable miscarriage, ectopic pregnancy, molar pregnancy, or any pregnancy where the fetus has died in-utero" does not require a terminated pregnancy report.[72]

For patients 16 years or older, providers are required to submit the TPR within 30 calendar days of the abortions.[73] For patients less than 16 years old, the provider must submit the TPR to IDOH and separately, by email, to the Indiana Department of Child Services ("DCS") within 3 days after the abortion.[74]

In September 2024, a district court ruled that TPRs are not public records.[75] However, IDOH subsequently reached a settlement with an anti-abortion group which would have allowed IDOH to nonetheless release TPRs to the public. A district court recently blocked IDOH from releasing these reports while litigation proceeds.[76]

Complication Reporting: Indiana law requires physicians to report certain abortion complications to the IDOH.[77] The abortion complications form asks providers to report the method of termination, and, if medication was used, whether medication was "obtained by a mail order or internet source."[78] The form gives providers the option of responding "Not Disclosed." The abortion complication reporting requirements do not include the patient's identity.[79]

Alleged or Suspected "Coerced Abortion" Reporting: Indiana law requires mandatory reporters to immediately report "every instance of alleged or suspected coerced abortion."[80] This provision does not define what constitutes a "coerced abortion" or when this reporting requirement is triggered. However, for all abortions performed in the state, Indiana law requires a physician, physician assistant, advanced practice registered nurse, or certified midwife to "verbally ask the pregnant woman if she is being coerced to have

an abortion" at least 18 hours before the abortion is performed.[81] If the provider "has specific and credible information" that the pregnant person is being coerced into having an abortion, there is a 24-hour delay after a coerced abortion report is made before the abortion can be performed. Thus, a provider likely must make a report only if they have "specific and credible" information that an abortion is coerced.

Fetal Death Reporting: Indiana law requires a physician, physician assistant, or advanced practice registered nurse to file a "certificate of death or stillbirth with the local health officer of the jurisdiction in which the death occurred."[82] "Stillbirth" is defined as "a birth after twenty (20) weeks of gestation that is not a live birth."[83] A certificate of stillbirth is not required before 22 weeks LMP.[84] Although the law does not separately define the term "death," a "dead body" is defined as "a lifeless human body or parts or bones of the human body from the condition of which it reasonably may be concluded that death recently occurred."[85] Because the fetal death certificate process does not mention abortions performed after 22 weeks LMP, it would seem that Indiana's other reporting requirements that are specific to abortion—including the terminated pregnancy reports—supersede the requirement of a death certificate in the case of an abortion. However, in some cases of miscarriage management where a death is deemed a "stillbirth," a fetal death certificate may be required under the law.

Other Mandatory Reporting: All other general mandatory reporting also applies for abortion patients.[86] 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 DCS or law enforcement.[87] Additionally, if a provider is required to make a report in their capacity as a staff member of a hospital, they must also report to an individual in charge of the hospital or that individual's designated agent.

Electronic Medical Records: Many electronic medical record systems (EMRs) allow healthcare providers to securely share patient records across healthcare institutions.[88] While EMRs have settings that allow patients to choose how and when their records are shared, hospital systems often instead use their EMR's default settings that widely share patient records. Though often done for continuity of care purposes, these settings may put abortion providers and patients (or patients obtaining other sensitive care) at risk, and many patients do not know their records are shared in this way.[89]

The federal government has taken steps to address this concern by issuing a HIPAA rule that became effective on June 25, 2024.[90] The rule prohibits the use or disclosure of protected health information (PHI) if sought to conduct an investigation into or impose liability on any person solely for seeking, obtaining, providing, or facilitating lawful reproductive healthcare, or identifying any person for these purposes.[91] A provider who receives a request to disclose PHI potentially related to reproductive care must obtain an attestation from the requestor that the request is not for a prohibited purpose.[92] The attestation is required when the request is for: law enforcement purposes, disclosures to coroners and medical examiners, judicial and administrative proceedings, and health oversight activities.[93] If the abortion care – self-managed or otherwise – was provided by someone else, the rule allows a provider to assume it was provided lawfully unless 1) the patient tells them otherwise or 2) the attestation provides evidence of unlawfully provided care.[94] The rule only applies to healthcare providers who are subject to HIPAA.[95] Though several states are challenging this rule in litigation, it currently remains in place as these cases move forward.[96]

Separate from HIPAA, interoperability rules that

penalize certain information blocking may apply when a healthcare provider uses EMRs.[97] Because of this, we encourage you to discuss alternative EMR settings and information blocking exceptions that may be available with your institution's compliance officers, counsel, and/or technology officers.[98]

Counseling & Referral

Speech about abortion is legal in Indiana. Medical professionals in Indiana can thus (1) provide accurate options counseling, including about abortion; (2) refer patients to medical providers in states where abortion is legal; and (3) refer patients to medical providers in Indiana for abortion care that is lawful in Indiana pursuant to the abortion ban's exceptions.

Medication Abortion

Indiana law defines an "abortion inducing drug" as any "medicine, drug, or substance prescribed or dispensed with the intent of terminating a clinically diagnosable pregnancy with the knowledge that the termination will, with reasonable likelihood, cause the death of the fetus," including the use of "off-label" drugs that are known to have abortion inducing properties."[99] If an abortion is permissible under the abortion ban's exceptions, abortion medications may be provided by a physician up to 10 weeks LMP and must be ingested in the presence of the physician.[100]

Disposition of Fetal Tissue Remains

Indiana law requires health care facilities to comply with requirements related to the disposition of fetal remains. Specifically, a health care facility that has possession of embryonic or fetal remains is responsible for disposition—which must be done through interment or cremation.[101] They must also attain burial transit permits for the remains.[102] Any information on the permits that may be used to identify the pregnant person is confidential and must be redacted from any public records. These requirements also apply to fetal or embryonic tissue remains resulting from natural miscarriage or stillbirth,[103] though patients may arrange for the final disposition of fetal remains if they so choose.[104] In the case of an abortion, the pregnant patient must inform the hospital or ambulatory surgical center in writing of her decisions regarding disposition.[105]

Medical facilities are responsible for enforcing the law, and violations are subject to civil penalties.[106]

Need legal advice?

This document should not be construed as legal advice. If you need individualized legal advice, please contact the Abortion Defense Network, where you will be matched with a pro bono attorney.

The Abortion Defense Network is managed by the Lawyering Project in partnership with the American Civil Liberties Union, Center for Reproductive Rights (CRR), National Women's Law Center (NWLC), and Resources for Abortion Delivery (RAD).

ACLU

CENTER for REPRODUCTIVE RIGHTS

THE LAWYERING PROJECT

NATIONAL WOMEN'S LAW CENTER
Justice for Her. Justice for All.

RAD RESOURCES FOR ABORTION DELIVERY

References

[1] IND. CODE § 16-18-2-1.
[2] *Id.* "'Abortion inducing drug' means a medicine, drug, or substance prescribed or dispensed with the intent of terminating a clinically diagnosable pregnancy with the knowledge that the termination will, with reasonable likelihood, cause the death of the fetus. The term includes the off-label use of a drug known to have abortion inducing properties if the drug is prescribed with the intent of causing an abortion." *Id.* § 16-18-2-1.6.
[3] IND. CODE § 16-21-11-2; *see also* IND. CODE § 16-18-2-237.1.
[4] Ind. Dep't of Health, Guidance Regarding the Submission of Terminated Pregnancy Reports ("IDOH TPR Submission Guidance") (Aug. 22, 2023), https://www.in.gov/health/cshcr/files/TPR-Submission-Guidance-2023-Aug-22.pdf.
[5] IND. CODE § 12-15-47-1.
[6] IND. CODE § 25-26-25-4.
[7] *Id.* § 25-26-25-9(b).
[8] S. B. Senate Enrolled Act 1(ss), 122nd Gen. Assemb., Spec. Sess. (Ind. 2023) (enacted), https://iga.in.gov/pdf-documents/122/2022ss1/senate/bills/SB0001/SB0001.06.ENRH.pdf.
[9] IND. CODE § 16-34-2-1(a).
[10] *Id.* § 16-34-2-7(a); *id.* § 35-50-2-6(b).
[11] *Id.* § 25-22.5-8-6(b)(2).
[12] *Id.* § 16-34-2-1(c).
[13] *Id.* § 16-34-2-1(b).
[14] *Id.* § 16-34-2-1(d), *id.* § 16-34-1-11.
[15] *Id.* § 16-34-4-1 et seq.
[16] *Id.* § 16-34-2-4.5; *id.* § 16-34-2-1(a)(1)(A).
[17] *Id.* § 16-34-2-4.5.
[18] *Id.* §§ 16-34-2-1(a)(1)(C)-(D), (a)(2)(B), (a)(3)(B); *id.* § 16-34-2-1.1.
[19] *Id.* § 16-34-2-1.1(a)(5), (a)(3)(B).
[20] *Id.* § 16-34-2-1.1(a)-(c).
[21] *Id.* § 16-34-2-1(a)(1).
[22] *Id.* § 16-34-2-4 (b)-(d).
[23] *Id.* § 16-34-2-1(a)(1)(A)(i), (a)(3)(A).
[24] *Id.* § 16-18-2-327.9.
[25] *Id.*
[26] *Id.* § 16-34-2-1(a)(1)(E)(i).
[27] *See Anonymous Plaintiff 1 v. Individual Members of the Medical Licensing Board of Indiana*, Cause No. 49D01-2209-PL-031056; *Planned Parenthood N.W. Haw., Alaska, Ind., Ky. v. Members of the Med. Licensing Bd. of Ind.,* Cause No. 53-C06-2208-PL-001756.
[28] IND. CODE § 16-18-2-223.5.
[29] *See* IND. CODE. §§ 16-34-2-4(k) (stating that Indiana's parental consent law does not apply where "there is an emergency need for a medical procedure to be performed to avert the pregnant minor's death or a substantial and irreversible impairment of a major bodily function"), 16-34-2-1.1(a) (describing pre-abortion disclosure, consent and certification requirement, mandatory ultrasound requirement and mandatory 18-hour delay as

required "[e]xcept in the case of a medical emergency"), 16-34-2-1(a)(1)(C) (stating that "if in the judgment of the physician the abortion is necessary to preserve the life of the woman, her consent is not required"); *see also id.* § 16-34-2-1(a)(2)(B), (a)(3)(B).

[30] IND. CODE § 16-34-2-0.5.

[31] *Id.* § 16-34-2-1(c).

[32] *Id.* § 16-34-2-1(b).

[33] *Id.* § 16-34-2-1(a)(1)(A)(ii). Indiana law refers to the "postfertilization age of the fetus," which is approximately two weeks less than gestational age.

[34] *Id.* § 16-25-4.5-2.

[35] *Id.* § 16-34-2-1(a)(1)(E)(ii).

[36] *Id.* § 16-34-2-1.1(b)-(c).

[37] *Id.* § 16-34-2-1(a)(2).

[38] *Id.* § 16-34-2-1(a)(2)(D).

[39] *Id.* § 16-34-2-1(a)(1)(B), (a)(2)(C).

[40] *Id.* § 16-34-2-3. The requirements for the second physician's role are provided within the statute.

[41] *Id.* § 16-34-2-1(a)(1)(C).

[42] *Id.*

[43] *Id.* § 16-34-2-1(a)(1)(E), (a)(2)(D), (a)(3)(E); *see also* IDOH, Guidance Regarding the Regulatory Implementation of Senate Enrolled Act 1 (Aug. 22, 2023) ("For a patient who receives an abortion on or after August 21, 2023, documentation should be included in the patient's medical record that demonstrates compliance with the Indiana Code, including listing the reason for the abortion.").

[44] EMTALA, 42 U.S.C. § 1395dd(a).

[45] EMTALA, 42 U.S.C. § 1395dd(e)(1)(A).

[46] EMTALA, 42 U.S.C. § 1395dd(e)(1)(B).

[47] EMTALA, 42 U.S.C. § 1395dd(b)(1)(A).

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

[49] EMTALA, 42 U.S.C. § 1395dd(b)(2).

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

[51] 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).

[52] EMTALA, 42 U.S.C. § 1395dd(c)(1)(B)–(c)(2)(A).

[53] 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.

[54] Kennedy Letter.

[55] Kennedy Letter.

[56] *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.).

[57] Center for Reproductive Rights, *Complaints Against Texas Hospitals for Denying Emergency Care for Ectopic Pregnancies*, (updated

May 8, 2025).
[58] *St. Luke's Health System, LTD. v. Labrador*, No. 1:25-cv-00015, ECF No. 1 (D. Idaho Jan 14, 2025).
[59] *St. Luke's Health System, LTD v. Labrador*, No. 1:25-cv-00015, ECF No. 49 at 59 (D. Idaho Mar. 20, 2025).
[60] *United States v. Idaho*, 623 F. Supp. 3d 1096, 1117 (D. Idaho 2022).
[61] *Moyle v. United States*, 144 S. Ct. 2015 (June 27, 2024) (per curiam).
[62] *Idaho v. United States*, No. 1:22-cv-00329, ECF No. 182 (D. Idaho Mar. 5, 2025).
[63] *Becerra v. Texas*, No. 23-1076 (U.S. Oct. 7, 2024) (denying certiorari).
[64] *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).
[65] 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.
[66] 42 C.F.R. §§ 482.13(a)(1), (b)(1), (b)(2).
[67] 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/.
[68] IND. CODE § 34-18-8-1 et seq.
[69] Accreditation Council for Graduate Med. Educ., *ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology*, ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC. (effective July 1, 2022), https://www.acgme.org/globalassets/pfassets/programrequirements/220_obstetricsandgynecology_2023.pdf.
[70] 42 U.S.C. § 238n.
[71] 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.
[72] Ind. Dep't of Health, Guidance Regarding the Submission of Terminated Pregnancy Reports ("IDOH TPR Submission Guidance") (Aug. 22, 2023), https://www.in.gov/health/cshcr/files/TPR-Submission-Guidance-2023-Aug-22.pdf.
[73] IND. CODE § 16-34-2-5(b).
[74] *Id.* As set forth in the Indiana State Department of Health's August 22, 2023, guidance, TPRs for patients under 16 years old should be submitted to DCS by email at dcshotlinereports@dcs.in.gov. IDOH TPR Submission Guidance.
[75] Order Granting Motion to Dismiss, Voices for Life v. Ind. Dep't of Health, No. 49D02-2405-MI-019876 (Ind. Cnty. Ct. Sept. 10, 2024).
[76] Special Findings of Fact, Conclusions of Law, and Order Issuing Preliminary Injunction, Bernard v. Ind. State Health Comm'r, No. 49D13-2502-PL-006359 (Ind. Cnty. Ct. Mar. 24, 2025). There is also another case seeking to enjoin the enforcement of Indiana's TPR law on the basis of federal preemption that is currently pending. Complaint, *Scifres v. Ind. State Health Comm'r*, No. 1:24-CV-2262 (S.D. Ind. Dec. 23, 2024).
[77] IND. CODE § 16-34-2-4.7.
[78] Ind. Dep't of Health, Abortion Complications Reporting Form; IND. CODE § 16-34-2-4.7(e).
[79] *See* IND. CODE § 16-34-2-4.7(e).
[80] IND. CODE § 16-34-6-6.

[81] *Id.* § 16-34-2-1.1.
[82] *Id.* § 16-37-3-3.
[83] *Id.* § 16-18-2-341.
[84] *Id.* § 16-34-3-4(f); *id.* § 16-21-11-6(c).
[85] *Id.* § 16-37-3-1.
[86] 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.
[87] IND. CODE §§ 31-33-5-1, 31-33-5-4. To report suspected child abuse or neglect, providers may contact law enforcement or call the DCS Child Abuse and Neglect Hotline. Ind. Dep't of Child Serv., Indiana Child Abuse and Neglect Hotline, https://www.in.gov/dcs/contact-us/child-abuse-and-neglect-hotline/.
[88] For example, one EMR, Epic, uses a tool called Care Everywhere to securely share information between healthcare institutions (e.g., from one hospital system to another) and allows robust sharing within a single institution (e.g., a Texas hospital treating a patient may be able to see the patient's records from an Illinois hospital that within the same system).
[89] 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.
[90] Although effective on June 25, 2024, compliance with this rule was required on December 23, 2024, except for the applicable requirements for revising Notice of Policy Practices (as required by 45 CFR 164.520), which must be complied with by February 16, 2026.
[91] 42 U.S.C. § 164.502(a)(5)(iii). *See also HIPAA Privacy Rule Final Rule to Support Reproductive Health Care Privacy: Fact Sheet*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.hhs.gov/hipaa/for-professionals/special-topics/reproductive-health/final-rule-fact-sheet/index.html (content last reviewed April 22, 2024).
[92] 42 U.S.C. § 164.509. The U.S. Department of Health & Human Services (HHS) recently released a model attestation, available here: https://www.hhs.gov/sites/default/files/model-attestation.pdf.
[93] 42 U.S.C. §§ 164.509(a), 512(d)-(g)(1).
[94] 42 U.S.C. § 164.502(a)(5)(iii).
[95] American Medical Association, *HIPAA Privacy Rule to Support Reproductive Health Care Privacy AMA Drafted Summary of Regulatory Changes in Final Rule* (April 26, 2024), https://www.ama-assn.org/system/files/summary-regulatory-changes-final-rule-reproductive-health-information.pdf (last visited June 27, 2024).
[96] *Tennessee v. U.S. Dept. of Health & Human Servs.*, Case No. 3:25-cv-00025 (E.D. Tenn. Jan. 17, 2025); *Texas v. U.S. Dept. of Health & Human Servs.*, Case. No. 5:24-cv-00204-H (N.D. Tex. Sept. 4, 2024); *Purl v. U.S. Dept. of Health & Human Servs.*, Case No. 2:24-cv-00228-Z (N.D. Tex. Dec. 22, 2024) (enjoining the 2024 HIPAA Rule as to Dr. Purl only).
[97] 21st Century Cures Act: Interoperability, Information Blocking and the ONC Health IT Certification Program, 85 Fed. Reg. 25642 (May 1, 2020) (amending 45 C.F.R. §§ 170, 171), 21st Century Cures Act: Establishment of Disincentives for Health Care Providers That Have Committed Information Blocking, 89 Fed. Reg. 54662 (July 1, 2024) (amending 42 C.F.R. §§ 171 414, 425, 495). Not all healthcare providers are currently subject to the disincentives included in the 2024 rule. However, the Centers for Medicare & Medicaid Services (CMS) may apply disincentives to certain hospitals and merit-based incentive payment system (MIPS) eligible clinicians. HHS intends to expand disincentives to other groups of health care providers in future rulemaking.
[98] In addition to the federal government, some states have taken steps to address vulnerabilities in this information sharing, specifically for abortion and gender-affirming care. For example, in 2023, Maryland and

California passed bills that restrict disclosure of abortion-related records and require EMRs to develop tools to limit or prohibit such disclosure.

[99] IND. CODE § 16-18-2-1.6.

[100] *Id.* § 16-34-2-1(a); *id.* § 16-34-2-1(d) ("Telehealth and telemedicine may not be used to provide any abortion, including the writing or filling of a prescription for any purpose that is intended to result in an abortion.")

[101] *Id.* § 16-34-3-4(a) ("A hospital or ambulatory outpatient surgical center having possession of an aborted fetus shall provide for the final disposition of the aborted fetus. The burial transit permit requirements of IC 16-37-3 apply to the final disposition of an aborted fetus, which must be interred or cremated."); *id.* § 16-21-11-6(b) ("A health care facility having possession of a miscarried fetus shall provide for the final disposition of the miscarried fetus. The burial transit permit requirements under IC 16-37-3 apply to the final disposition of the miscarried fetus, which must be cremated or interred."); *id.* § 16-21-11-2 (defining "miscarried fetus" as "an unborn child, irrespective of gestational age, who has died from a spontaneous or accidental death before expulsion or extraction from the unborn child's mother, irrespective of the duration of the pregnancy."); *id.* § 16-21-11-1 (defining "health care facility" as: 1) a hospital, 2) a birthing center, or 3) any other medical facility). These statutory provisions make clear that a certificate of stillbirth is not required for an aborted or miscarried fetus that has a "gestational age of less than twenty (20) weeks." *Id.* § 16-34-3-4(f); § 16-21-11-6(c).

[102] IND. CODE § 16-34-3-4.

[103] *Id.* § 16-21-11-2 ("'[M]iscarried fetus' means an unborn child, irrespective of gestational age, who has died from a spontaneous or accidental death before expulsion or extraction from the unborn child's mother, irrespective of the duration of the pregnancy."); *see also* IDOH, Fetal Remains Disposition Letter (Dec. 28, 2022).

[104] *See id.* § 16-21-11-4, § 16-21-11-5, § 16-21-11-6.

[105] *Id.* § 16-34-3-2(b), (e); *id.* § 16-34-2-1.1(a)(2)(J).

[106] IND. CODE § 16-34-3-4(e).