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 July 2024

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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) abortion is 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 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, a "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 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 this 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]

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. 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."[36]

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.[37] 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.[38] Additionally, Indiana requires certain consents and certifications before an abortion. Physicians must obtain written consent from the pregnant person.[39] However, consent is not required when, in the judgment of the physician, the abortion is necessary to preserve the life of the pregnant person.[40] 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.[41]

EMTALA

A federal law called the Emergency Medical Treatment & Labor Act (EMTALA) requires emergency abortion care in some cases. EMTALA requires Medicare-participating hospitals with emergency departments (which is most hospitals), to provide medical screening[42] and stabilizing medical treatment to individuals experiencing an emergency medical condition,[43] including people in labor or with emergency pregnancy complications.[44] 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."[45] A person experiencing an emergency medical condition can only be transferred to a different hospital once they are stable or if certain conditions are met such as the medical benefits of transfer outweigh the increased risks to the person experiencing the medical emergency.[46] 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 . . . ."[47] EMTALA defines medical emergency 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."[48] The stabilizing treatment required by EMTALA can include abortion care in certain circumstances.

HHS reaffirmed these requirements in guidance issued after *Roe v. Wade* was overturned. That guidance emphasizes that stabilizing treatment required by EMTALA could include abortion care if the examining physician or other qualified medical personnel determines that such treatment is required to stabilize a patient experiencing an emergency medical condition, including a condition that is "likely or certain to become emergent without stabilizing treatment."[49] The guidance made clear those conditions might include, but are not limited to: "ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features."[50] The guidance reiterates that if EMTALA requires the provision of abortion care, then EMTALA expressly preempts any state law prohibiting or restricting access to

abortion.[51] Indeed, HHS has recently cited hospitals in Kansas, Missouri and Florida for violating EMTALA by failing to provide abortion care to a patient with preterm premature rupture of membranes ("PPROM").[52]

Notwithstanding EMTALA's clear requirements with respect to emergency abortion, there is ongoing litigation relating to attempts by state officials in Idaho and Texas to restrict hospitals from complying with their federal legal obligations. In 2022, a federal district court in Idaho issued a preliminary injunction ensuring that Idaho's abortion ban could not be enforced to prohibit health-saving emergency abortions required under EMTALA. While that injunction was temporarily stayed by the U.S. Supreme Court, that stay was lifted in June 2024 and the preliminary injunction restored while the case continues in the lower courts.[53] In July 2024, following that order, HHS issued a statement reiterating that EMTALA requires hospitals to provide emergency abortion care when it is necessary stabilizing treatment.[54] Meanwhile, HHS has asked the U.S. Supreme Court to review a Fifth Circuit decision that affirmed a lower court decision temporarily blocking federal enforcement of HHS' guidance in Texas. HHS has petitioned the Supreme Court to reverse the preliminary injunction.[55] The government's petition will be considered by the Supreme Court in the next term.

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.[56]

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.[57]

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.[58]

Resident Training: The Accreditation Council for Graduate Medical Education (ACGME) requires that accredited programs provide access to training in the provision of abortion.[59] 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.[60]

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.[61] 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.[62]

For patients 16 years or older, providers are required to submit the terminated pregnancy reports within 30 calendar days of the abortions.[63] For patients less than 16 years old, the provider must submit the TPR within 3 days after the abortion to the IDOH and separately, by email, to the Indiana Department of Child Services (DCS).[64]

Complication Reporting: Indiana law requires physicians to report certain abortion complications to the IDOH.[65] 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."[66] The form gives providers the option of responding "Not Disclosed." The abortion complication reporting requirements do not include the patient's identity.[67]

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."[68] "Stillbirth" is defined as "a birth after twenty (20) weeks of gestation that is not a live birth."[69] 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."[70] Because the fetal death certificate process does not mention abortions, 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.[71] 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 Indiana Department of Child Services ("DCS") or law enforcement. To report suspected child abuse or neglect, providers may contact law enforcement or call the DCS Child Abuse and Neglect Hotline.[72] 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.[73]

Electronic Medical Records: Many electronic medical record systems (EMRs) allow healthcare providers to securely share patient records across healthcare institutions.[74] 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.[75]

The federal government has taken steps to address this concern by issuing a new HIPAA rule, effective June 25, 2024.[76] The rule prohibits the use or disclosure of protected health information (PHI) if sought to conduct a criminal, civil, or administrative

investigation into or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating lawful reproductive healthcare, or identifying any person for these purposes.[77] A provider who receives a request for disclosure of PHI potentially related to reproductive care must obtain a signed attestation from the requestor that the request is not for a prohibited purpose.[78] 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.[79] If the abortion care—self-managed or otherwise—was provided by someone else, a provider is allowed to assume the care was provided lawfully unless 1) the patient tells them otherwise or 2) the attestation provides evidence of unlawfully provided care.[80]

The new rule only applies to healthcare providers who are subject to HIPAA. Separate from HIPAA, interoperability rules may apply when a healthcare provider uses EMRs.[81] Because of this, we encourage you to discuss alternative EMR settings and information blocking exceptions with your institution's compliance officers, counsel, and/or technology officers, who may be able to offer customized solutions.[82]

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 "abortion-inducing drugs" 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."[83] 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.[84]

Disposition of Fetal Tissue Remains

Indiana law requires hospitals and ambulatory surgical centers to comply with requirements related to the disposition of fetal remains. Specifically, a hospital or ambulatory surgical center that has possession of embryonic or fetal remains is responsible for disposition which must be done through interment or cremation[85] They must also attain burial transit permits for the remains.[86] Any information on the permits that may be used to identify the pregnant person is confidential and must be redacted from any public records. In the case of an "abortion induced by an abortion inducing drug," the pregnant person must inform the hospital or ambulatory surgical center whether the fetus will be returned for disposition.[87]

Neither of the above provisions apply to fetal and embryonic tissue remains resulting from natural miscarriage or stillbirth, though patients may arrange for the final disposition of miscarriage remains if they so choose. Neither provision puts any requirements on patients. Medical facilities are responsible for enforcing the law and violations are subject to civil penalties.

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Need legal advice?

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

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

References

[1] 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." *Id.* § 16-18-2-1.6.; "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.*
[3] IND. CODE § 16-21-11-2; *see also* IND. CODE § 16-18-2-237.1.
[4] Ind. Dept. 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), 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), 16-34-1-11.
[15] *Id.* §§ 16-34-4-1– 9.
[16] *Id.* §§ 16-34-2-4.5, 16-34-2-1(a)(1)(A).
[17] *Id.* § 16-34-2-4.5.
[18] *Id.* §§ 16-34-2-1(a)(1)(C)-(D), 16-34-2-1(a)(2)(B), 16-34-2-1(a)(3)(B), 16-34-2-1.1.
[19] *Id.* §§ 16-34-2-1.1(a)(5), 16-34-2-1.1(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] IND. CODE §§ 16-34-2-1(a)(1)(A)(i), 16-34-2-1(a)(3)(A).
[24] *Id.* § 16-18-2-327.9.

[25] *Id.*
[26] IND. CODE § 16-34-2-1(a)(1)(E)(ii).
[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(j) (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)(B) (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] IND. CODE § 16-34-2-1(a)(1)(A)(ii).
[34] IND. CODE § 16-25-4.5-2.
[35] IND. CODE § 16-34-2-1(a)(1)(E)(ii).
[36] IND. CODE § 16-34-2-1(a)(2).
[37] IND. CODE § 16-25-2-1(a)(1)(B)-(a)(2)(C).
[38] IND. CODE § 16-34-2-3. The requirements for the second physician's role are provided within the statute.
[39] *Id.* § 16-34-2-1(a)(1)(C).
[40] *Id.*
[41] *Id.* § 16-34-2-1(a)(1)(E),(a)(3)(E),(a)(2)(D).
[42] EMTALA, 42 USC § 1395dd(c)(1)(A).
[43] EMTALA, 42 USC § 1395dd(b)(1)(A).
[44] EMTALA, 42 USC § 1395dd(e)(1).
[45] EMTALA, 42 U.S.C. § 1395dd(e)(3)(A).
[46] EMTALA, 42 USC § 1395dd(c)(2) (requiring hospital to use "qualified personnel and transportation equipment" when making a permitted transfer under EMTALA, among other requirements).
[47] EMTALA, 42 USC § 1395dd(c)(1)(B)-(c)(2)(A).
[48] EMTALA, 42 U.S.C. § 1395dd(e)(1).
[49] CMS, Reinforcement of EMTALA Obligations Specific to Patients who are Pregnant or are Experiencing Pregnancy Loss (updated July 2022).
[50] *Id.*
[51] *Id.*; *see also* EMTALA, 42 U.S.C. § 1395dd(f) ("The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.").
[52] CMS, Freeman Health System—Freeman West, Statement of Deficiencies and Plan of Correction (April 10, 2023); CMS, University of Kansas Hospital, Statement of Deficiencies and Plan of Correction (April 10, 2023); HHS Secretary Xavier Becerra Statement on EMTALA Enforcement (May 1, 2023).
[53] *Moyle v. United States*, No. 23-726, slip op. (U.S. June 27, 2024) (per curiam).
[54] Press Release, U.S. Dep't of Health and Human Servs., Biden-Harris Administration Reaffirms Commitment to EMTALA Enforcement (July 2, 2024), https://www.hhs.gov/about/news/2024/07/02/biden-harris-administration-reaffirms-commitment-emtala-enforcement.html.
[55] *Texas v. Becerra*, No. 23-10246, 2024 WL 20069 (5th Cir. Jan. 2, 2024), *petition for cert. filed* (U.S. Apr. 1, 2024) (No. 23-1076).
[56] 42 C.F.R. §§ 482.13(a)(1), (b)(1), (b)(2).
[57] 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/.
[58] IND. CODE § 34-18-8-1 *et seq.*

[59] Accreditation Council for Graduate Med. Educ., *ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology*, ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC. (Sept. 17, 2022), https://www.acgme.org/globalassets/pfassets/programrequirements/220_obstetricsandgynecology_9-17-2022_tcc.pdf.
[60] 42 U.S.C. § 238n.
[61] 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.
[62] Ind. Dept. 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.
[63] IND. CODE § 16-34-2-5(b).
[64] *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.
[65] IND. CODE § 16-34-2-4.7.
[66] Ind. Dept. of Health, Abortion Complications Reporting Form; *see also* IND. CODE § 16-34-2-4.7(e)(8).
[67] *See* IND. CODE § 16-34-2-4.7.
[68] IND. CODE § 16-37-3-3.
[69] IND. CODE § 16-18-2-341.
[70] IND. CODE § 16-37-3-1.
[71] 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. CODE § 31-33-5-4; Ind. Dept. of Child Serv., Indiana Child Abuse and Neglect Hotline, https://www.in.gov/dcs/contact-us/child-abuse-and-neglect-hotline/.
[73] IND. CODE §§ 31-33-5-1, 31-33-5-4, 31-33-5-2.5.
[74] For example, one EMR, Epic, uses a tool called Care Everywhere to securely share information between health care 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 within the same system).
[75] 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.
[76] Although effective on June 25, 2024, compliance with this rule is not required until 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.
[77] 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).
[78] 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.
[79] 42 U.S.C. §§ 164.509(a), 512(d)-(g)(1).
[80] 42 U.S.C. § 164.502(a)(5)(iii).
[81] 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. The U.S. Department of Health and Human Services intends to expand disincentives to other groups of health care providers in future rulemaking.
[82] In the past year, states and the federal government have taken steps to address these vulnerabilities, specifically for abortion and gender-affirming care. Maryland and California have passed bills that restrict disclosure of abortion-related records and require EMRs to develop tools to limit or prohibit such disclosure. As these laws are implemented, the landscape for how electronic abortion records are handled may change.

[83] IND. CODE § 16-18-2-1.6.
[84] IND. CODE § 16-34-2-1(a).
[85] *Id.* § 16-34-3-4(a); *see* § 16-18-2-128.7 (defining "fetus" as "an unborn child, irrespective of gestational age or the duration of the pregnancy"). The fetal tissue statute also makes clear that a certificate of stillbirth is not required for "an aborted fetus with a gestational age of less than twenty weeks of age. IND. CODE § 16-34-3-4(f).
[86] IND. CODE § 16-34-3-4.
[87] *Id.* §§ 16-34-3-2(b), 16-34-3-2 (e); 16-34-2-1.1(2)(J).