

To: IHA Members

From: Laura Brown, Deputy General Counsel

Date: August 30, 2022

Re: Senate Enrolled Act 1 – Commonly Asked Questions

Since the passage of [Senate Enrolled Act \(“SEA”\) 1](#), the provisions of which are effective September 15, 2022, several commonly asked questions have emerged and are summarized here. This document is not comprehensive and does not constitute legal advice. IHA strongly recommends that hospitals consult legal counsel to resolve any questions and ensure ongoing compliance with state and federal laws and regulations.

1. Question: How is the term “serious health risk” defined?

- 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 (See IC 16-18-2-327.9). The term “reasonable medical judgment” is undefined in Indiana Code. Please note, a substantial and irreversible physical impairment of a major bodily function is not required to first occur for there to be a “serious health risk.” There instead must be *a serious risk of such an impairment* for the term “serious health risk” to apply.

2. Question: How is the term “lethal fetal anomaly” defined?

- 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 (See IC 16-25-4.5-2).

3. Question: How is the term “rape or incest” defined?

- 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 (See IC 16-18-2-306.7).

4. **Question: What is required to “certify” that an abortion is being performed to prevent a serious health risk or to save the pregnant woman's life; as a result of the fetus being diagnosed with a lethal fetal anomaly; or at the woman's request because the pregnancy is the result of rape or incest?**
- SEA 1 requires a physician to certify in writing to the hospital or ambulatory outpatient surgical center the reason for the abortion prior to the abortion being performed, and “all facts and reasons supporting the certification shall be set forth by the physician in writing and attached to the certificate” (See IC 16-34-2-1(a)(1)(E), IC 16-34-2-1(a)(2)(D), and IC 16-34-2-1(a)(3)(E)). SEA 1 is not more specific about what must be included in the “certificate,” but a reasonable interpretation of the use of the word “certificate” indicates that more than normal documentation is required.
 - IHA has created a sample certificate, entitled the “Abortion Certification Form,” for physicians and hospitals to utilize. Please note, the Abortion Certification Form does not constitute legal advice or guarantee compliance with Indiana laws and regulations. The use of the Abortion Certification Form is voluntary. IHA, as well as individual members, may modify or update this sample certificate as we work through implementation, but due to the law's September 15th effective date, IHA is providing this document as a starting point.
5. **Question: How are ectopic pregnancies addressed under the framework of SEA 1?**
- SEA 1 does not specifically address ectopic pregnancies. However, ectopic pregnancies are permitted to be terminated if the fetus does not have a fetal heartbeat (“Scenario #1”). If the fetus does have a fetal heartbeat, termination would be permitted to prevent a serious health risk or to save the pregnant woman's life at any point in the pregnancy, or if the fetus is diagnosed with a lethal fetal anomaly before the earlier of viability or twenty (20) weeks postfertilization (“Scenario #2”).
 - More specifically to Scenario #1, the term “abortion” means “the termination of human pregnancy with an intention other than to produce a live birth or **to remove a dead fetus**. The term includes abortions by surgical procedures and by abortion inducing drugs” (See IC 16-18-2-1). If in the case of an ectopic pregnancy the fetus **does not have** a heartbeat, the fetus would be considered to be dead, and the removal of the dead fetus would be permitted, as such a procedure would not fall under the definition of an “abortion.” A Terminated Pregnancy Report (“TPR”) would not be required to be filed.
 - More specifically to Scenario #2, if in the case of an ectopic pregnancy the fetus **does have** a heartbeat, an abortion would be permitted if termination of the ectopic pregnancy is necessary to prevent a serious health risk or to save the pregnant woman's life at any point in the pregnancy, or if before the earlier of viability or twenty (20) weeks postfertilization, the fetus is diagnosed with a lethal fetal anomaly. **The physician would need to first make either of those determinations based on the physician's reasonable medical judgement, and both would fall under the definition of “abortion,” thereby requiring a TPR to be filed.**
 - Any pregnancy termination should be made on a case-by-case basis, with appropriate documentation included in the patient's medical record.

6. Question: How is “Plan B,” or emergency contraception, treated under the framework of SEA 1?

- SEA 1 does not specifically address the provision of Plan B or emergency contraception generally. The term “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” (See IC 16-18-2-1.6). As such, Plan B would be permitted under SEA 1 so long as it is provided prior to the pregnancy being clinically diagnosable (i.e., detectable through a pregnancy test or blood sample).

7. Question: Are miscarriage care or in vitro fertilization procedures impacted under SEA 1?

- As stated above, the term “abortion” does not include the removal of a dead fetus. Accordingly, the framework of SEA 1 does not impact miscarriage care. Further, SEA 1 is clear that the abortion framework does not apply to in vitro fertilization (See IC 16-34-1-0.5).

8. Question: Where may an abortion, including the provision of abortion inducing drugs, take place under SEA 1?

- SEA 1 requires any abortion to be performed in a hospital licensed under IC 16-21 or an ambulatory outpatient surgical center that has a majority ownership by a hospital licensed under IC 16-21. The term “abortion” includes both surgical procedures and the provision of abortion inducing drugs. As such, effective September 15th, an abortion inducing drug may only be provided in a hospital licensed under IC 16-21 or an ambulatory outpatient surgical center that has a majority ownership by a hospital licensed under IC 16-21.
- Please note, an abortion provided after the earlier of the viability of the fetus or twenty (20) weeks postfertilization that is necessary to prevent any serious health risk to the pregnant woman or to save the pregnant woman’s life, whether the abortion is provided via a surgical procedure or an abortion inducing drug, may only be performed in a hospital licensed under IC 16-21, and not in an ambulatory outpatient surgical center.

9. Question: Generally, when is a TPR required to be filed?

- A TPR must be filed after each abortion, meaning “the termination of human pregnancy with an intention other than to produce a live birth or to remove a dead fetus. The term includes abortions by surgical procedures and by abortion inducing drugs” (See IC 16-18-2-1). Physicians are required to submit a TPR to the Indiana Department of Health (“IDOH”) within thirty (30) days after the date of an abortion for patients sixteen (16) years of age and older and within three (3) days after the date of an abortion for patients who are less than sixteen (16) years of age. For patients who are less than sixteen (16) years of age, the TPR must also be submitted separately to the Indiana Department of Child Services (“DCS”). For all patients, the TPR should be retained in the patient’s medical file as well.

- Additionally, a person's duty to immediately report child abuse or neglect through an oral or written report to DCS or law enforcement when the person has reason to believe a child is a victim of child abuse or neglect is separate and distinct from the TPR requirement, which may or may not involve circumstances of child abuse or neglect. This reporting requirement applies even when a pregnancy termination is not performed. DCS maintains a child abuse and neglect hotline at 1-800-800-5556 for oral reports of child abuse or neglect and an email address at dcshotlinereports@dcs.in.gov for written reports of child abuse or neglect.

10. Question: How are TPRs filed?

- TPRs should be submitted electronically through IDOH's Database for Registering Indiana's Vital Events ("DRIVE"). Instructions for submitting a TPR through DRIVE can be found [here](#). ***A best practice may be for all practicing OBGYNs to proactively register for DRIVE, so that TPRs can be timely filed if necessary.***

11. Question: What is expected to change on the TPR form as a result of SEA 1?

- IDOH is expected to update the TPR form by September 15th to have providers include the reason for the abortion. An ICD 10 code will also be required if the abortion was to prevent a serious health risk or to save the life of the pregnant woman or the fetus was diagnosed with a lethal fetal anomaly.

12. Question: Are hospitals updating their internal policies and procedures in light of the passage of SEA 1?

- All hospitals are encouraged to review and update their policies and procedures to determine what services will be offered related to pregnancy terminations and to ensure the requirements of the Emergency Medical Treatment and Labor Act ("EMTALA") are met at all times. As a reminder, the federal Centers for Medicare and Medicaid Services 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). A hospital cannot cite state law or practice as the basis for transfer.
- While QSO 22-22 has been [preliminarily enjoined](#) as it applies to Texas and the members of the American Association of Pro Life Obstetricians and Gynecologists and the Christian Medical and Dental Association, QSO 22-22 is still in effect as applied to Indiana.

13. Question: What are the penalties associated with an unlawful abortion?

- The new abortion framework will be under the criminal penalties currently in law. The relevant penalties associated with violations of Indiana's abortion requirements are as follows:

- Unlawful abortion: Level 5 felony (See IC 16-34-2-7(a))
- Requirements in the case of a minor: Class A misdemeanor (See IC 16-34-2-7(b))
- Voluntary and informed consent requirements: Class A infraction (See IC 16-34-2-7(c))
- SEA 1 revised the Medical Licensing Board's (MLB) discretion when adjudicating a licensure complaint related to abortion. Under SEA 1, the MLB "**shall revoke** the license of a physician if, after appropriate notice and an opportunity for a hearing, the attorney general proves by a **preponderance of the evidence** that the physician performed an abortion in violation" of the new framework (See IC 25-22.5-8-6(b)(2)). It is important to note that the determination of whether such burden of proof has been satisfied will be made by the MLB.

If you have any questions, please contact Laura Brown at Lbrown@ihaconnect.org.