**UNITED STATES DISTRICT COURT**
**FOR THE SOUTHERN DISTRICT OF INDIANA**
**INDIANAPOLIS DIVISION**

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| ALL-OPTIONS, INC.; WHOLE WOMAN'S HEALTH ALLIANCE; ALISON CASE, M.D.; WOMEN'S MED GROUP PROFESSIONAL CORP.; WILLIAM MUDD MARTIN HASKELL, M.D.; and PLANNED PARENTHOOD GREAT NORTHWEST, HAWAI'I, ALASKA, INDIANA, AND KENTUCKY, INC., | ) | CASE NO. 1:21-CV-1231 |
| | ) | CIVIL ACTION |
| Plaintiffs, | ) | |
| v. | ) | |
| ATTORNEY GENERAL OF INDIANA, in his official capacity; COMMISSIONER OF THE INDIANA STATE DEPARTMENT OF HEALTH, in her official capacity; MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities; LAKE COUNTY PROSECUTOR, in his official capacity; and MARION COUNTY PROSECUTOR, in his official capacity; MONROE COUNTY PROSECUTOR, in her official capacity; ST. JOSEPH COUNTY PROSECUTOR, in his official capacity; TIPPECANOE COUNTY PROSECUTOR, in his official capacity, | ) | |
| Defendants. | ) | |

## COMPLAINT

Plaintiffs, by and through their undersigned attorneys, bring this complaint against the above-named Defendants and their employees, agents, and successors in office, and in support thereof allege the following:

## PRELIMINARY STATEMENT

1. Abortion is a safe and common medical procedure.

2. Access to abortion is critical to the dignity, equality, bodily integrity, and religious freedom of all people with the capacity for pregnancy.

3. For nearly fifty years, the U.S. Supreme Court has recognized that abortion access is a fundamental component of the liberty protected by the Due Process Clause. *See, e.g.*, *June Med. Servs., L.L.C. v. Russo*, 140 S. Ct. 2103, 2112 (2020) (plurality); *id.* at 2135 (Roberts, CJ., concurring); *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309-10 (2016); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851-53 (1992); *Roe v. Wade*, 410 U.S. 113, 152-54 (1973).

4. Plaintiffs challenge certain provisions of Public Law No. 85-2021, 2021 Ind. Acts ___ (Ex. 1 hereto), and Public Law No. 218-2021, 2021 Ind. Acts ___ (Ex. 2 hereto) (collectively, the "Acts"), which jeopardize the health and safety of abortion patients, obstruct abortion access, and trample on constitutional protections.

5. The "Telehealth Bans," Pub. L. No. 85-2021, §§ 5, 8, 2021 Ind. Acts ___ (codified at Ind. Code §§ 16-34-1-11, 25-1-9.5-0.5); Pub. L. No. 218-2021, § 4(d), Ind. Acts ___ (to be codified at Ind. Code § 16-34-2-1(d)), and "In-Person Dispensing and Consumption Requirement," Pub. L. No. 218-2021, § 4(a)(1), 2021 Ind. Acts ___ (to be codified at Ind. Code § 16-34-2-1(a)(1)), prohibit abortion providers from utilizing telehealth to deliver abortion care, thereby denying abortion patients the benefits of scientific progress and limiting their access to abortion services.

6. The "Abortion Reversal Disclosure Requirement," Pub. L. No. 218-2021, §§ 4(a)(1), 5(a)(1)(C), 2021 Ind. Acts ___ (to be codified at Ind. Code §§ 16-34-2-1(a)(1), 16-34-2-1.1(a)(1)(C)), requires abortion providers to repeatedly tell their patients that "[s]ome evidence suggests" that a medication abortion can be reversed, a bogus claim that may lead some patients to have an abortion based on the mistaken belief that they can later undo its effects.

7. None of these provisions writes on a blank slate. Indiana already requires patients seeking abortions to run a gauntlet of burdensome, demeaning, and medically unnecessary legal requirements. A case challenging related laws banning the use of telehealth in abortion care and requiring that abortion patients be given misleading and scientifically inaccurate information is currently pending in this District. *See Whole Woman's Health Alliance v. Rokita*, 1:18-CV-1904-SEB-MJD (S.D. Ind.). Trial in that case is scheduled to conclude on June 25, 2021, just days before many of the laws challenged in this case are set to take effect.

8. Plaintiffs ask the Court to grant them declaratory and injunctive relief from the challenged provisions of Public Law Nos. 85-2021 and 218-2021 and intend to seek a preliminary injunction against their enforcement while this case proceeds.

**JURISDICTION, VENUE, AND CAUSES OF ACTION**

9. The Court has jurisdiction over Plaintiffs' claims pursuant to 28 U.S.C. § 1331 because this case is a civil action "arising under the Constitution, laws, or treaties of the United States," and 28 U.S.C. § 1343(a)(3) because this case seeks to redress the deprivation of federal constitutional rights under color of state law.

10. Venue is proper in this district pursuant to 28 U.S.C. § 1391(b)(1) because certain Defendants, who are government officers sued in their official capacities, operate and perform their official duties in this district. Venue is also proper pursuant to 28 U.S.C. § 1391(b)(2) because a substantial part of the events and omissions giving rise to Plaintiffs' claims occurred in this district.

11. 42 U.S.C. § 1983 grants Plaintiffs a cause of action to redress the deprivation, under color of state law, of rights secured by the U.S. Constitution.

12. Declaratory relief is authorized by 28 U.S.C. §§ 2201-2202 and Federal Rule of Civil Procedure 57.

## PARTIES

### A. Plaintiffs

13. All-Options, Inc. ("All-Options"), is a nonprofit organization incorporated under Oregon law. Its mission is to provide people with unconditional, judgment-free support concerning pregnancy, parenting, adoption, and abortion. All-Options operates a pregnancy resource center in Bloomington, Indiana, that offers peer counseling, referrals to medical and social service providers, and material goods such as diapers, baby clothes, and toys. In addition, All-Options operates the "Hoosier Abortion Fund," which provides financial assistance to Indiana residents who need help paying for abortion care, and the "Practical Support Network," which connects abortion patients with volunteers willing to drive them to and from their abortion appointments. The challenged laws will increase the cost of abortion care in Indiana, confuse patients about the prospect of abortion reversal, and increase the stigma associated with obtaining an abortion, thereby frustrating All-Options' mission and requiring the organization to divert scarce resources to deal with the laws' impact on its clients—including spending increased time counseling clients and increased money subsidizing the cost of abortion care. All-Options brings this lawsuit on behalf of itself and its clients seeking abortion care in Indiana.

14. Whole Woman's Health Alliance ("WWHA") is a nonprofit organization incorporated under Texas law. Its mission is to provide abortion care in underserved communities and destigmatize abortion. WWHA operates a medical clinic in South Bend, Indiana, that does business under the name Whole Woman's Health of South Bend ("South Bend Clinic"). In 2017, WWHA sought an abortion clinic license for the South Bend Clinic from the Indiana State Department of Health ("Health Department"). Although the Health Department denied WWHA's license application, an order of this Court permits the South Bend Clinic to provide medication abortions. *See Whole Woman's Health All. v. Hill*, 388 F. Supp. 3d 1010, 1013 (S.D. Ind. 2019),

*aff'd as modified*, 937 F.3d 864 (7th Cir. 2019), *cert. denied*, 141 S. Ct. 189 (2020). The South Bend Clinic currently provides medication abortions up to ten weeks of pregnancy, as measured from the first day of a patient's last menstrual period ("LMP"). WWHA brings this lawsuit on behalf of itself, its healthcare providers, and its Indiana abortion patients.

15. Alison Case, M.D., is a physician licensed to practice medicine in Indiana. Dr. Case provides abortion care to patients at the South Bend Clinic. Dr. Case brings this lawsuit on behalf of herself and her Indiana abortion patients.

16. Women's Med Group Professional Corp. ("Women's Med") is a for-profit corporation incorporated under Ohio law. It operates a licensed abortion clinic in Indianapolis, Indiana, that provides aspiration abortions up to thirteen weeks, six days LMP and medication abortions up to ten weeks LMP. Women's Med brings this lawsuit on behalf of itself, its healthcare providers, and its Indiana abortion patients.

17. William Mudd Martin Haskell, M.D., is a physician licensed to practice medicine in Indiana and Ohio. Dr. Haskell owns Women's Med and has served as its Medical Director for more than twenty years. He supervises the medical staff and provides medical care, including abortion care, to patients. Dr. Haskell brings this lawsuit on behalf of himself and his Indiana abortion patients.

18. Planned Parenthood Great Northwest, Hawai'i, Alaska, Indiana, Kentucky, Inc. ("Planned Parenthood"), is a nonprofit organization incorporated under Washington law. Planned Parenthood provides sexual and reproductive health care services including abortion care in a number of states, including Indiana. Planned Parenthood's mission is to provide accessible, affordable, and high-quality evidence-based sexual and reproductive health care. Planned Parenthood provides a wide range of sexual and reproductive health care services to people in

Indiana, including wellness visits (also known as "well-person exams"), cancer screenings, birth control counseling, sexually transmitted infection ("STI") testing and treatment, annual gynecological exams, miscarriage management, and abortion care. Planned Parenthood currently operates four health centers in Indiana that provide medication abortion, which is available to patients up to ten weeks LMP. These four health centers are in Bloomington, Indianapolis, Lafayette, and Merrillville, and all four health centers are licensed abortion clinics. The health centers in Merrillville, Indianapolis, and Bloomington also provide aspiration abortion up to thirteen weeks, six days LMP. Planned Parenthood sues on behalf of itself, its healthcare providers, and its Indiana abortion patients.

**B. Defendants**

19. The Attorney General of Indiana ("Attorney General") is sued in his official capacity and designated by his official title pursuant to Federal Rule of Civil Procedure 17(d). The Attorney General has broad powers to enforce Indiana's criminal laws. *See* Ind. Code § 4-6-1-6; *State v. Harper*, 8 N.E.3d 694, 698 n.4 (Ind. 2014). In addition, the Attorney General is charged with investigating and prosecuting complaints against licensed physicians. The Attorney General maintains an office in this district.

20. The Commissioner of the Health Department ("Commissioner") is sued in her official capacity and designated by her official title pursuant to Federal Rule of Civil Procedure 17(d). The Health Department is responsible for licensing, inspecting, and disciplining medical clinics that provide abortion care. Ind. Code §§ 16-21-2-2.5, 16-21-2-10, 16-21-3-1; 410 Ind. Admin. Code 26-2-8, 26.5-3-8. The Health Department maintains an office in this district.

21. The Members of the Medical Licensing Board of Indiana ("Medical Board") are sued in their official capacities and designated by their official titles pursuant to Federal Rule of Civil Procedure 17(d). The Medical Board is responsible for licensing and disciplining physicians.

Ind. Code §§ 25-0.5-11-1, 25-0.5-11-5, 25-1-9-1, 25-1-9-4, 25-22.5-2-7. The Medical Board maintains an office in this district.

22. The Prosecutors of Lake, Marion, Monroe, St. Joseph, and Tippecanoe Counties ("County Prosecutors") are sued in their official capacities and designated by their official titles pursuant to Federal Rule of Civil Procedure 17(d). They are responsible for enforcing criminal laws in their respective counties. Planned Parenthood's Merrillville clinic is located in Lake County. The Indianapolis clinics operated by Planned Parenthood and Women's Med, respectively, are located in Marion County. Planned Parenthood's Bloomington clinic is located in Monroe County. WWHA's South Bend clinic is located in St. Joseph County. Planned Parenthood's Lafayette clinic is located in Tippecanoe County. The Marion and Monroe County Prosecutors maintain offices in this district.

## ALLEGATIONS

### A. Abortion Care in Indiana

23. Abortion is a common medical intervention. Nearly one in four American women will have an abortion by age forty-five.[1] Between 2015 and 2019, the most recent year for which data are currently available, an average of 7,738 abortions were performed annually in Indiana.[2]

[1] Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014*, 107 Am. J. Pub. Health 1904, 1906–08 (2017).

[2] *See* Indiana State Dep't of Health, Terminated Pregnancy Report 2019 (June 30, 2020) ("Health Dep't 2019 Report") at 2, https://www.in.gov/isdh/files/2019%20Indiana%20Terminated%20Pregnancy%20Report.pdf; Indiana State Dep't of Health, Terminated Pregnancy Report 2018 (June 30, 2019) ("Health Dep't 2018 Report") at 3, https://www.in.gov/isdh/files/2018%20Indiana%20Terminated%20Pregnancy%20Report.pdf; Indiana State Dep't of Health, Terminated Pregnancy Report 2017 (June 30, 2018) ("Health Dep't 2017 Report") at Exec. Summ., https://www.in.gov/isdh/files/2017%20Indiana%20Terminated%20Pregnancy%20Report.pdf; Indiana State Dep't of Health, Terminated Pregnancy Report 2016 (June 30, 2017) ("Health Dep't 2016 Report") at Exec. Summ., https://www.in.gov/isdh/files/2016%20Indiana%20Terminated%20Pregnancy%20Report.pdf; Indiana State Dep't of Health, Terminated Pregnancy Report 2015 (June 30, 2016) ("Health Dep't 2015 Report") at Exec. Summ., https://www.in.gov/isdh/files/2015%20TP%20Report.pdf.

24. People seek abortions for a variety of reasons that are often complex and intersecting. Relevant factors include health, family size, relationship status, financial resources, age, and professional or educational goals.

25. Most abortion patients have prior experience with pregnancy and childbirth. Between 2015 and 2019, more than sixty percent of Indiana abortion patients had previously carried a pregnancy to term, and more than a third had carried two or more pregnancies to term.[3]

26. Nationwide, most abortion patients (sixty-two percent) are religiously affiliated. Fifty-four percent are Christians and eight percent are affiliated with other religious traditions.[4]

27. Three-quarters of abortion patients in the United States are poor or low-income. Nearly half live in households that are below the federal poverty level, and twenty-six percent live in households that earn 100%-199% of the federal poverty level.[5] Currently, the federal poverty level for an individual is an annual income of $12,760, and the federal poverty level for a family of four is an annual income of $26,200.[6]

28. Many Indiana abortion patients must pay for their abortions out of pocket because they lack health insurance coverage for abortion. Indiana prohibits its public health insurance programs from covering abortion except in narrow circumstances. Ind. Code § 16-34-1-2; *Humphreys v. Clinic for Women, Inc.*, 796 N.E.2d 247, 248-49 (Ind. 2003). It also restricts private insurance coverage of abortion care in most circumstances. *See* Ind. Code §§ 16-34-1-8, 27-8-

[3] *See* Health Dep't 2019 Report at 12; Health Dep't 2018 Report at 14; Health Dep't 2017 Report at 13; Health Dep't 2016 Report at 15; Health Dep't 2015 Report at 13.

[4] Jenna Jerman et al., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, Guttmacher Institute 7 (May 2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.

[5] *Id.*

[6] U.S. Dep't of Health and Human Services, *2020 Poverty Guidelines* (Jan. 21, 2020), https://aspe.hhs.gov/2020-poverty-guidelines.

13.4-2. Abortion funds such as the Hoosier Abortion Fund operated by All-Options are only able to provide their clients with a small percentage of the funds needed to pay for abortion care, and they are not able to assist every person in need.

29. Between 2015 and 2019, approximately thirty percent of Indiana abortion patients were Black, and eight percent were Hispanic.[7] People of color face heightened barriers to accessing healthcare and disparities in pregnancy-related health outcomes. For example, Black individuals experience substantially higher rates of maternal mortality and pregnancy-related complications than their White counterparts, even after controlling for income, educational attainment, and maternal health status. People of color are also disproportionately affected by poverty.

30. A significant proportion of people who seek abortion care have abusive partners. Pregnancy is a common trigger for intimate partner violence. People with abusive partners often seek to conceal their pregnancies to avoid or limit further abuse and prevent their partners from interfering with their access to abortion care.

31. Few medical practices offer abortion care in Indiana. Only seven abortion clinics are currently operating in the State. Of those, only five are legally authorized to provide aspiration abortions, and none are legally authorized to provide abortion care after the first trimester of pregnancy.

32. In Indiana, abortion is extremely limited after the first trimester of pregnancy (*i.e.*, the first thirteen weeks of pregnancy as measured by LMP) because of a statute mandating that abortions be performed in a hospital or ambulatory outpatient surgical center after the first

[7] *See* Health Dep't 2019 Report at 10; Health Dep't 2018 Report at 12; Health Dep't 2017 Report at 10; Health Dep't 2016 Report at 10-11; Health Dep't 2015 Report at 9.

trimester. *See* Ind. Code § 16-34-2-1(a)(2)(B). Between 2015 and 2019, only five Indiana hospitals provided abortions, all of which are within a twenty-mile radius of Indianapolis.[8] Collectively, those five hospitals provided 210 abortions during that five-year period, representing just one-half of one percent of the 38,689 abortions provided in Indiana then.[9] No Indiana ambulatory outpatient surgical centers ("ASCs") provided abortion care between 2015 and 2019.[10]

33. In all, only five of Indiana's 92 counties currently have abortion providers. There are no Indiana abortion providers located east of Indianapolis, an area that includes Fort Wayne, Indiana's second-largest city. Likewise, there are no Indiana abortion providers located south of Bloomington, an area that includes Evansville, Indiana's third-largest city.

34. Between 2015 and 2019, individuals from every Indiana county sought abortion care.[11]

35. In Indiana, as nationwide, two methods of abortion are commonly used during the first trimester of pregnancy: medication abortion and aspiration abortion.

36. Medication abortion is typically used to end a pregnancy up to seventy days (*i.e.*, ten weeks) LMP. It involves terminating a pregnancy through a combination of two medications: mifepristone and misoprostol. Mifepristone works by blocking the hormone progesterone, which is necessary to maintain pregnancy, and increasing the efficacy of misoprostol. Misoprostol causes the cervix to open and the uterus to contract and expel its contents, thereby completing the abortion.

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[8] *See* Health Dep't 2019 Report at 15; Health Dep't 2018 Report at 17; Health Dep't 2017 Report at 16; Health Dep't 2016 Report at 19; Health Dep't 2015 Report at 17.

[9] *See* Health Dep't 2019 Report at 15; Health Dep't 2018 Report at 17; Health Dep't 2017 Report at 16; Health Dep't 2016 Report at 19; Health Dep't 2015 Report at 17.

[10] *See* Health Dep't 2019 Report at 15; Health Dep't 2018 Report at 17; Health Dep't 2017 Report at 16; Health Dep't 2016 Report at 19; Health Dep't 2015 Report at 17.

[11] *See* Health Dep't 2019 Report at 17; Health Dep't 2018 Report at 19; Health Dep't 2017 Report at 20; Health Dep't 2016 Report at 24; Health Dep't 2015 Report at 22.

37. The current drug label for Mifeprex—the brand name for mifepristone—was approved by the U.S. Food and Drug Administration ("FDA") in 2016. It sets forth the following regimen for medication abortion, which is typically referred to as the "evidence-based regimen": On day one, the patient takes 200 milligrams of mifepristone orally; twenty-four to forty-eight hours later, the patient takes 800 micrograms of misoprostol buccally (in the cheek pouch); seven to fourteen days later, the patient follows up with a healthcare provider to confirm that the pregnancy has been terminated.[12]

38. The FDA has adopted a Risk Evaluation and Mitigation Strategy ("REMS") for mifepristone that limits how the medication may be distributed. Among other things, the REMS for mifepristone provides that "[m]ifepristone must be dispensed to patients only in certain healthcare settings, specifically clinics, medical offices, and hospitals, by or under the supervision of a certified prescriber."[13] Enforcement of this part of the REMS is currently suspended for the duration of the public health emergency created by the COVID-19 pandemic.[14] When it is in effect, medication abortion patients may only obtain mifepristone at clinics, medical offices, and hospitals unless they are participating in FDA-approved research studies.

39. Aspiration abortion, also called suction curettage, entails the use of suction to empty the contents of the uterus. Although aspiration abortion is sometimes referred to as a surgical procedure, it does not actually constitute surgery because it does not require making an

[12] FDA, Mifeprex Label (2016), https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf.

[13] FDA, Risk Evaluation and Mitigation Strategy (REMS) Single Shared System for Mifepristone 200mg (2019), https://www.accessdata.fda.gov/drugsatfda_docs/rems/Mifepristone_2019_04_11_REMS_Document.pdf.

[14] Letter from Janet Woodcock, Acting FDA Commissioner, to Maureen G. Phipps, CEO, Amer. Coll. of Obstetricians & Gynecologists (Apr. 12, 2021), ECF No. 155-1, *Amer. Coll. Of Obstetricians & Gynecologists v. U.S. Food & Drug Admin.*, No. 8:20-CV-1320-TDC (D. Md. Apr. 26, 2021).

incision in the patient's body. Instead, a hollow curette is inserted into the uterus through the patient's cervix. At the other end of the curette, a hand-held syringe or an electric device is applied to create suction and remove the products of conception from the uterus. The procedure typically takes less than ten minutes to complete. This abortion method is used in the first and early second trimester of pregnancy.

40. A Committee of the National Academies of Sciences, Engineering, and Medicine ("National Academies") recently issued a Consensus Study Report on the Safety and Quality of Abortion Care in the United States after surveying the relevant literature. It concluded that abortion in the United States is safe; serious complications of abortion are rare; and abortion does not increase the risk of long-term physical or mental health disorders.[15]

41. The Committee assessed the quality of abortion care based on six factors: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. It concluded that the quality of abortion care depends to a great extent on geography. In particular, it found that "[i]n many parts of the country, state regulations have created barriers to optimizing each dimension of quality care."[16]

42. In a 2016 decision striking down a pair of Texas abortion restrictions, the U.S. Supreme Court likewise concluded that abortion is safe and complications from abortion are rare. *See Whole Woman's Health*, 136 S. Ct. at 2311, 2315. Indeed, the Supreme Court found that abortion is safer than many other procedures commonly performed in outpatient settings. *See id.* at 2315. It also recognized that unnecessary regulation may diminish the quality of care that patients receive. *See id.* at 2318.

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[15] Nat'l Acads. of Scis., Eng'g, and Med., *The Safety and Quality of Abortion Care in the United States* 1–16 (2018) ("Nat'l Acads. Report"), https://doi.org/10.17226/24950.

[16] *Id.* at 10.

43. Notably, abortion entails significantly less medical risk than carrying a pregnancy to term and giving birth.[17] Every pregnancy-related complication is more common among those who give birth than among those having abortions. This is not surprising given that pregnancies ending in abortion are substantially shorter than those ending in childbirth and thus entail less time for pregnancy-related complications to occur; many serious pregnancy-related complications such as pregnancy-related hypertension, gestational diabetes, and placental abnormalities occur later in pregnancy; and nearly one-third of U.S. births occur by cesarean delivery, a major abdominal surgery that entails significant risk. In addition, while evidence shows that abortion does not increase a person's risk of mental illness, post-partum depression follows childbirth in at least fifteen percent of pregnancies.

**B. The Acts**

***i. Public Law No. 85-2021***

44. Public Law No. 85-2021 was enacted on April 20, 2021, and took immediate effect. It amends Indiana laws concerning telehealth.

45. It replaces the term "telemedicine" with the term "telehealth" throughout the Indiana Code. *See generally* Pub. L. No. 85-2021, 2021 Ind. Acts ___.

46. In addition, it relaxes Indiana's regulation of telehealth in several ways, including by authorizing the provision of telehealth services by telephone, Pub. L. No. 85-2021, §§ 4, 16(b), 28, 31, 2021 Ind. Acts ___ (codified at Ind. Code §§ 16-18-2-348.5, 25-1-9.5-6(b), 27-8-34-5, 27-13-1-34); and eliminating certain restrictions on the prescription of controlled substances by

[17] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216–17 (2012).

telemedicine, Pub. L. No. 85-2021, § 18(b), 2021 Ind. Acts ___ (codified at Ind. Code § 25-1-9.5-8(b)).

47. Nevertheless, Public Law 85-2021 contains two provisions that prohibit abortion providers from delivering abortion care through telehealth, using the following language: "Telehealth 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." Pub. L. No. 85-2021, §§ 5, 8, 2021 Ind. Acts ___ (codified at Ind. Code §§ 16-34-1-11, 25-1-9.5-0.5).

48. As used in Public Law No. 85-2021, § 5, 2021 Ind. Acts ___ (codified at Ind. Code § 16-34-1-11), "telehealth" means "a specific method of delivery of services, including medical exams and consultations and behavioral health evaluations and treatment, including those for substance abuse, using technology allowed under IC 25-1-9.5-6 to allow a provider to render an examination or other service to a patient at a distant location." Ind. Code § 16-18-2-348.5.

49. As used in Public Law No. 85-2021, § 8, 2021 Ind. Acts ___ (codified at Ind. Code § 25-1-9.5-0.5), "telehealth" means "the delivery of health care services using interactive electronic communications and information technology, in compliance with the federal Health Insurance Portability and Accountability Act (HIPAA) including: (1) secure videoconferencing; (2) store and forward technology; or (3) remote patient monitoring technology; between a provider in one (1) location and a patient in another location." Ind. Code § 25-1-9.5-6(a). "The term does not include the use of the following unless the practitioner has an established relationship with the patient: (1) Electronic mail[;] (2) An instant messaging conversation[;] (3) Facsimile[;] (4) Internet questionnaire[; or] (5) Internet consultation." Ind. Code § 25-1-9.5-6(b).

50. The Medical Board may impose disciplinary sanctions on licensed physicians who violate the Telehealth Bans set forth in Public Law No. 85-2021, *see* Ind. Code § 25-1-9-4(a)(1)(3),

and the Health Department may impose disciplinary sanctions on licensed abortion clinics and hospitals that permit, aid, or abet violations, Ind. Code § 16-21-3-2(2).

51. Indiana law already prohibits licensed physicians and other "prescribers" from using telemedicine to prescribe "an abortion inducing drug." Ind. Code § 25-1-9.5-8(a)(4); *see also* Ind. Code § 25-1-9.5-4 (definition of prescriber). That provision is being challenged in *Whole Woman's Health Alliance v. Rokita*, 1:18-CV-1904-SEB-MJD (S.D. Ind.).

***ii. Public Law No. 218-2021***

52. Public Law No. 218-2021 was enacted on April 29, 2021, and is scheduled to take effect on July 1, 2021.

53. It imposes numerous restrictions on the provision of abortion care in Indiana.

54. Plaintiffs' challenge focuses on two sets of restrictions: (1) the Telehealth Ban and In-Person Dispensing and Consumption Requirement; and (2) the Abortion Reversal Disclosure Requirement.

55. The Telehealth Ban set forth in Public Law No. 218-2021 provides that: "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." Pub. L. No. 218-2021, § 4(d), Ind. Acts ___ (to be codified at Ind. Code § 16-34-2-1(d)).

56. Knowing or intentional violation of this Telehealth Ban constitutes a felony. Ind. Code § 16-34-2-7(a). In addition, the Medical Board may impose disciplinary sanctions on licensed physicians who violate it, Ind. Code § 25-1-9-4(a)(1)(3), and the Health Department may impose disciplinary sanctions on licensed abortion clinics and hospitals that permit, aid, or abet violations, Ind. Code. § 16-21-3-2(2).

57. The In-Person Dispensing and Consumption Requirement provides that: "A physician must dispense the abortion inducing drug in person and have the pregnant woman

consume the drug in the presence of the physician." Pub. L. No. 218-2021, § 4(a)(1), 2021 Ind. Acts ___ (to be codified at Ind. Code § 16-34-2-1(a)(1)). For purposes of this requirement, "'in person' does not include the use of telehealth or telemedicine services." Ind. Code § 16-34-2-1(a)(1).

58. Knowing or intentional violation of the In-Person Dispensing and Consumption Requirement constitutes a felony. Ind. Code § 16-34-2-7(a). In addition, the Medical Board may impose disciplinary sanctions on licensed physicians who violate the In-Person Dispensing and Consumption Requirement, Ind. Code § 25-1-9-4(a)(1)(3), and the Health Department may impose disciplinary sanctions on licensed abortion clinics and hospitals that permit, aid, or abet violations, Ind. Code. § 16-21-3-2(2).

59. Indiana law already requires a physician to conduct an "in-person" examination "before prescribing or dispensing an abortion-inducing drug." Ind. Code § 16-34-2-1(a)(1). That provision is being challenged in *Whole Woman's Health Alliance v. Rokita*, 1:18-CV-1904-SEB-MJD (S.D. Ind.).

60. These in-person requirements function as *de facto* bans on using telehealth to provide medication abortion.

61. The Abortion Reversal Disclosure Requirement mandates that the following statement be made to an abortion patient on two separate occasions: "Some evidence suggests that the effects of Mifepristone may be avoided, ceased, or reversed if the second pill, Misoprostol, has not been taken. Immediately contact the following for more information at (insert applicable abortion inducing drug reversal Internet web site and corresponding hotline number)." Pub. L. No. 218-2021, §§ 4(a)(1), 5(a)(1)(C), 2021 Ind. Acts ___ (to be codified at Ind. Code §§ 16-34-2-1(a)(1), 16-34-2-1.1(a)(1)(C)).

62. First, "the physician who is to perform the abortion, the referring physician or a physician assistant . . ., an advance practice registered nurse . . ., or a certified nurse midwife . . . to whom the responsibility has been delegated by the physician who is to perform the abortion or the referring physician" must provide the statement to an abortion patient both "orally and in writing" "[a]t least eighteen (18) hours before the abortion." Ind. Code § 16-34-2-1.1(a)(1)(C).

63. Failure to provide the statement at this time is punishable as a Class A infraction. Ind. Code § 16-34-2-7(c); *see generally* Ind. Code § 34-28-5-4(a) ("A judgment of up to ten thousand dollars ($10,000) may be entered for a violation constituting a Class A infraction."). In addition, the Medical Board may impose disciplinary sanctions on licensed physicians who fail to comply with this portion of the Abortion Reversal Disclosure Requirement, Ind. Code § 25-1-9-4(a)(1)(3), and the Health Department may impose disciplinary sanctions on licensed abortion clinics and hospitals that permit, aid, or abet violations, Ind. Code § 16-21-3-2(2). Further, consent to an abortion is statutorily abrogated if this portion of the Abortion Reversal Disclosure Requirement is not satisfied. *See* Ind. Code § 16-34-2-1.1(a).

64. Other pre-abortion disclosure requirements, as well as the requirement that such disclosures be made in person, are being challenged in *Whole Woman's Health Alliance v. Rokita*, 1:18-CV-1904-SEB-MJD (S.D. Ind.).

65. Second, "[a] physician shall also provide" the required statement "orally and in writing" at the time an abortion patient is discharged from a healthcare facility. Pub. L. No. 218-2021, § 4(a)(1), 2021 Ind. Acts ___ (to be codified at Ind. Code § 16-34-2-1(a)(1)).

66. Failure to provide the statement at this time is punishable as a felony. Ind. Code § 16-34-2-7(a). In addition, the Medical Board may impose disciplinary sanctions on licensed physicians who fail to comply with this portion of the Abortion Reversal Disclosure Requirement,

Ind. Code § 25-1-9-4(a)(1)(3), and the Health Department may impose disciplinary sanctions on licensed abortion clinics and hospitals that permit, aid, or abet violations, Ind. Code. § 16-21-3-2(2).

67. Public Law No. 218-2021 provides no information about the "abortion inducing drug reversal Internet web site and corresponding hotline number" referenced in the statement that abortion providers are required to make to their patients.

**C. Impact of the Challenged Requirements**

***i. Telehealth Bans and In-Person Dispensing and Consumption Requirement***

68. Outside Indiana, abortion providers have been using telemedicine to provide medication abortion since 2008.

69. In site-to-site telemedicine, a patient visits an abortion clinic and uses telemedicine technology to communicate with a practitioner who is at a different location.

70. In direct-to-patient telemedicine, a patient who is at home or another non-clinical location uses telemedicine technology to communicate with a practitioner. When the REMS for mifepristone was fully enforced, direct-to-patient telemedicine was only permissible in connection with FDA-approved research studies.

71. Providing medication abortion through telemedicine is as safe and effective as in-person treatment.

72. A 2011 study of medication abortion in Iowa found that the success rates for telemedicine patients and in-person patients were similar: 98.7% for telemedicine patients and 96.9% for in-person patients.[18] Likewise, there was no significant difference in the occurrence of

[18] Daniel Grossman, et al., *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine*, 118 Obstetrics & Gynecology 296, 296-303 (2011), doi: 10.1097/AOG.0b013e318224d110.

adverse events among telemedicine patients compared to in-person patients. A subsequent study, published in 2017, compared the safety of medication abortion provided in person and by telemedicine in Iowa over a seven-year period.[19] The study encompassed 8,765 medication abortions performed via telemedicine and 10,405 medication abortions performed in person. It found no significant difference in success rate or the prevalence of adverse events between telemedicine and in-person patients.

73. A 2019 systematic review of evidence regarding the use of telemedicine to provide medication abortion found that the practice is safe, effective, and well-liked by both patients and providers.[20] It further found that clinical outcomes for medication abortion via telemedicine, including the rates of unsuccessful abortion, hospitalization, and blood transfusions, are comparable to those reported for medication abortion in person.

74. Before suspending enforcement of the REMS' requirement that mifepristone be dispensed in clinics, medical offices, or hospitals, the FDA reviewed the medical literature concerning direct-to-patient telemedicine for medication abortion as well as its own data concerning adverse events following medication abortion. It found no evidence to suggest that permitting medication abortion patients to obtain mifepristone by mail or through a pharmacy poses serious safety concerns.[21]

75. The American College of Obstetricians and Gynecologists ("ACOG") has concluded that "[m]edication abortion can be provided safely and effectively by telemedicine with

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[19] Dan Grossman & Kate Grindlay, *Safety of Medical Abortion Provided Through Telemedicine Compared with In Person*, 130 Obstetrics & Gynecology 778, 778-82 (2017), doi:10.1097/aog.0000000000002212.

[20] Margit Endler, et al., *Telemedicine for Medical Abortion: A Systematic Review*, 126 BJOG 1094, 1094-1102 (2019), doi: 10.1111/1471-0528.15684.

[21] *See* Letter from Janet Woodcock, Acting FDA Commissioner, to Maureen G. Phipps, CEO, Amer. Coll. of Obstetricians & Gynecologists (Apr. 12, 2021), ECF No. 155-1, *Amer. Coll. Of Obstetricians & Gynecologists v. U.S. Food & Drug Admin.*, No. 8:20-CV-1320-TDC (D. Md. Apr. 26, 2021).

a high level of patient satisfaction, and telemedicine improves access to early abortion care, particularly in areas that lack a health care practitioner."[22] Likewise, the National Academies has concluded that "[t]here is no evidence that the dispensing or taking of mifepristone tablets requires the physical presence of a clinician . . . to ensure safety or quality."[23]

76. Outside the abortion context, Indiana has authorized a dramatic expansion in the use of telemedicine in recent years. In 2015, Indiana enacted a law requiring health insurance policies to provide coverage for telemedicine services on the same terms as they provide coverage for healthcare services delivered in person. *See* Pub. L. No. 185-2015, §§ 25-27, 2015 Ind. Acts 2102-04 (codified at Ind. Code §§ 27-8-34-1 to 27-8-34-7, 27-13-1-34, 27-13-7-22). In 2016, Indiana enacted a law broadly authorizing healthcare providers to use telemedicine to treat patients and prescribe medications. *See* Pub. L. No. 78-2016, § 2, 2016 Ind. Acts 711-15 (codified at Ind. Code §§ 25-1-9.5-1 to 25-1-9.5-12). In 2017, Indiana enacted a law authorizing prescribers to prescribe controlled substances via telemedicine.[24] *See* Pub. L. No. 150-2017, § 7, 2017 Ind. Acts 1430-31 (codified in relevant part at Ind. Code § 25-1-9.5-8). Apart from abortion-inducing drugs and certain opioids, Indiana law does not prohibit practitioners from prescribing any medications via telemedicine, Ind. Code § 25-1-9.5-8, and it does not prohibit practitioners from prescribing

[22] Am. Coll. of Obstetricians & Gynecologists, *Medication Abortion Up to 70 Days of Gestation: ACOG Practice Bulletin, Number 225*, 136 Obstetrics & Gynecology e31, e35 (2020) ("ACOG Practice Bulletin on MAB"), doi: 10.1097/AOG.0000000000004082.

[23] Nat'l Acads. Report at 79.

[24] On its face, the law exempts certain opioids. *See* Ind. Code § 25-1-9.5-8(a)(3)(B). The exemption is currently suspended by a pandemic-related executive order permitting "DEA-registered practitioner[s] to issue prescriptions for all schedule II-IV controlled substances to patients for whom they have not conducted an in-person medical evaluation" provided that certain minimal safeguards are satisfied. Ind. Exec. Order No. 20-13 (Mar. 30, 2020), https://www.in.gov/gov/files/Executive-Order-20-13-Medical-Surge.pdf.

mifepristone and misoprostol for purposes other than inducing an abortion, *see* Ind. Code § 16-18-2-1.6.

77. Today, healthcare providers throughout Indiana utilize telemedicine to deliver a wide variety of services to patients, including services that are far more complex than medication abortion. For example, the St. Joseph Health System, whose hospitals are licensed by the Health Department, has a telemedicine program aimed at improving care for acute stroke patients. Beacon Health System, whose hospitals are licensed by the Health Department, operates a telemedicine program to serve patients with urgent care needs. Indiana University Health, whose hospitals are licensed by the Health Department, uses telemedicine to deliver various services to patients, including follow-up care to kidney transplant patients.

78. Indiana practitioners also provide a broad range of reproductive healthcare via telemedicine, including contraceptive care, infertility treatment, diagnosis and treatment of sexually transmitted infections, and prenatal care.

79. The risks of medication abortion are similar in magnitude to the risks of taking commonly prescribed and over-the-counter medications such as antibiotics and nonsteroidal anti-inflammatory drugs ("NSAIDs").[25]

80. The same evidence-based regimen of mifepristone and misoprostol used for medication abortion is also used to treat patients experiencing a miscarriage. Neither the Telehealth Bans nor the In-Person Dispensing and Consumption Requirement apply in that context.

[25] Nat'l Acads. Report at 79.

81. Abortion clinics throughout Indiana—including those operated by WWHA, Women's Med, and Planned Parenthood—would utilize telemedicine to provide medication abortion if the law permitted them to do so.

82. That would enable patients to obtain abortions earlier in pregnancy, which would reduce the medical risks they face from both pregnancy and abortion as well as the risk of violence or interference by an abusive partner or family member.

83. Permitting telemedicine abortion would reduce the number of abortion patients who are delayed past ten weeks LMP, when medication abortion is no longer available in Indiana. It would also reduce the number of patients who are delayed past the first trimester, when Indiana abortion clinics are no longer permitted to provide abortion care. *See* Ind. Code § 16-34-2-1(a)(2).

84. For some patients, using telemedicine would meaningfully reduce the cost of obtaining abortion care.

85. Absent relief from the Court, the Telehealth Bans and In-Person Dispensing and Consumption Requirement will irreparably harm Plaintiffs and the abortion patients whose interests they represent, including by denying abortion patients the benefits of scientific progress, delaying their access to abortion care, and violating their constitutional rights.

***ii. Abortion Reversal Disclosure Requirement***

86. There is no credible or reliable scientific evidence that "the effects of mifepristone can be avoided, ceased, or reversed."

87. The evidence-based regimen for medication abortion has a failure rate of approximately 2.6%. That means that, in approximately 2.6% of cases, patients will continue to be pregnant despite completing the regimen. Taking mifepristone alone—not followed by misoprostol—has a substantially higher failure rate.

88. No medical intervention has been shown to avoid, cease, or reverse the effects of mifepristone or increase the likelihood that a medication abortion will fail.

89. Upon information and belief, the Act's contention that "[s]ome evidence suggests that effects of Mifepristone may be avoided, ceased, or reversed . . ." is based on an experimental treatment proposed by California physicians George Delgado and Mary Davenport, who have alleged that they can reverse the effects of mifepristone by administering large doses of the hormone progesterone to abortion patients. Upon information and belief, certain other practitioners have also experimented with this practice. While there is no consensus on the protocol for administering this so-called "abortion reversal" treatment, some practitioners have experimented with weekly progesterone injections, in some cases until the end of pregnancy, as well as oral and vaginal routes of progesterone administration.

90. The safety and efficacy of this experimental treatment is unknown. It has never been tested in animals, and the only clinical trial involving human subjects had to be halted early due to safety concerns after one-quarter of the participants experienced severe hemorrhage.

91. So-called "abortion reversal" treatment is opposed by leading medical organizations. ACOG has concluded that "[t]here is no evidence that treatment with progesterone after taking mifepristone increases the likelihood of the pregnancy continuing," but "limited available evidence suggests that use of mifepristone alone without subsequent administration of misoprostol may be associated with an increased risk of hemorrhage."[26] The American Medical Association ("AMA") opposes legislation requiring physicians to tell their patients about abortion reversal experiments and has sued to block a North Dakota requirement similar to the Abortion Reversal Disclosure Requirement challenged here. *See Am. Med. Ass'n v. Stenhjem*, 412 F. Supp.

[26] ACOG Practice Bulletin on MAB at e33.

3d 1134 (D.N.D. 2019) (preliminarily enjoining enforcement of an abortion reversal disclosure requirement).

92. After reviewing the available evidence, the National Academies found that claims that the effects of mifepristone can be reversed are based primarily on a case series report of patients "who did not receive standardized doses or formulations of the medications (i.e., mifepristone or progesterone)."[27] It noted that "[c]ase series are descriptive reports that are considered very low-quality evidence for drawing conclusions about a treatment's effects."[28]

93. The statement that "[s]ome evidence suggests that the effects of Mifepristone may be avoided, ceased, or reversed if the second pill, Misoprostol, has not been taken" is untruthful and misleading because no credible or reliable scientific evidence supports the conclusion that the effects of mifepristone can be avoided, ceased, or reversed under any circumstances.

94. Absent a legal mandate, the abortion-provider Plaintiffs would not initiate a conversation about abortion reversal experiments with their patients.

95. The abortion-provider Plaintiffs consistently counsel their patients that they must be firm in their decision to have an abortion before beginning the medication abortion regimen. The Abortion Reversal Disclosure Requirement undermines this message, requiring Plaintiffs in the same breath to tell their patients that the effects of mifepristone can be avoided, ceased, or reversed. This disclosure threatens to encourage some patients who are not firm in their decision to proceed with a medication abortion nevertheless, based on the mistaken belief that it could later be blocked or reversed. The irreparable harm that would result is manifest.

[27] Nat'l Acads. Report at 54 (citation omitted).

[28] *Id.* (citation omitted).

96. Further, compliance with the Abortion Reversal Disclosure Requirement would violate fundamental norms of the informed consent process.

97. Obtaining a patient's informed consent prior to performing a medical intervention is a key ethical and legal duty of medical practitioners.

98. The foundational ethical principle guiding informed consent is respect for persons, commonly referred to as autonomy. This principle requires practitioners to enable their patients to make voluntary choices about medical interventions based on relevant and scientifically accurate information.

99. The Abortion Reversal Disclosure Requirement undermines patient autonomy by mandating that patients be given irrelevant and scientifically inaccurate information about unproven claims that a medication abortion can be reversed. Accordingly, compliance with the Abortion Reversal Disclosure Requirement would require practitioners to violate a key ethical duty to their patients.

100. By requiring practitioners to provide untruthful, misleading, and irrelevant information, the Abortion Reversal Disclosure Requirement would also undermine patients' trust in their healthcare providers.

101. The Abortion Reversal Disclosure Requirement singles out abortion patients and providers for disfavored treatment. No other healthcare providers are required to inform their patients about experimental medical interventions, the safety and efficacy of which are wholly unsupported by reliable scientific evidence, and no other patients are required to receive such information as a condition of treatment. Similarly, no other healthcare providers are required to give their patients untruthful, misleading, or irrelevant information, and no other patients are required to receive such information as a condition of treatment. *See Spar v. Cha*, 907 N.E.2d 974,

984 (Ind. 2009) (explaining that "physicians have a duty to disclose to their patients information *material* to a proposed course of treatment" (emphasis added)); *id.* ("A physician must disclose the facts and risks of a treatment which a reasonably prudent physician would be expected to disclose under like circumstances, and which a reasonable person would want to know.").

102. Absent relief from the Court, the Abortion Reversal Disclosure Requirement will irreparably harm Plaintiffs and the abortion patients whose interests they represent, including by violating their constitutional rights, undermining patient trust in and goodwill for the abortion-provider Plaintiffs, and encouraging patients who are not firm in their decisions to end their pregnancies to begin the medication abortion regimen nevertheless.

## CLAIMS

### COUNT I
### (Free Speech)

103. The allegations of paragraphs 1 through 102 are incorporated as though fully set forth herein.

104. The Abortion Reversal Disclosure Requirement compels speech by abortion providers in violation of the Free Speech Clause of the First Amendment.

### COUNT II
### (Substantive Due Process)

105. The allegations of paragraphs 1 through 102 are incorporated as though fully set forth herein.

106. The Telehealth Bans impose an undue burden on access to pre-viability abortion in violation of the Due Process Clause of the Fourteenth Amendment.

107. The In-Person Dispensing and Consumption Requirement imposes an undue burden on access to pre-viability abortion in violation of the Due Process Clause of the Fourteenth Amendment.

108. The Abortion Reversal Disclosure Requirement requires the provision of untruthful or misleading information to pre-viability abortion patients in violation of the Due Process Clause of the Fourteenth Amendment.

**COUNT III**
**(Equal Protection)**

109. The allegations of paragraphs 1 through 102 are incorporated as though fully set forth herein.

110. The Telehealth Bans deny equal protection of the laws to abortion patients and providers in violation of the Equal Protection Clause of the Fourteenth Amendment.

111. The In-Person Dispensing and Consumption Requirement denies equal protection of the laws to abortion patients and providers in violation of the Equal Protection Clause of the Fourteenth Amendment.

112. The Abortion Reversal Disclosure Requirement denies equal protection of the laws to abortion patients and providers in violation of the Equal Protection Clause of the Fourteenth Amendment.

## REQUEST FOR RELIEF

WHEREFORE, Plaintiffs respectfully request that the Court:

a. Declare the Telehealth Bans unconstitutional and permanently enjoin their enforcement;

b. Declare the In-Person Dispensing and Consumption Requirement unconstitutional and permanently enjoin its enforcement;

c. Declare the Abortion Reversal Disclosure Requirement unconstitutional and permanently enjoin its enforcement;

d. Award Plaintiffs attorneys' fees and costs pursuant to 42 U.S.C. § 1988; and

e. Grant such other and further relief as the Court may deem just, proper, and equitable.

Dated: May 18, 2021

Respectfully submitted,

/S/ *Stephanie Toti*

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*Motion for admission *pro hac vice* forthcoming

# Exhibit 1

First Regular Session of the 122nd General Assembly (2021)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2020 Regular Session of the General Assembly.

# SENATE ENROLLED ACT No. 3

AN ACT to amend the Indiana Code concerning professions and occupations.

*Be it enacted by the General Assembly of the State of Indiana:*

SECTION 1. IC 12-7-2-190.3, AS ADDED BY P.L.204-2013, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 190.3. **(a) "Telehealth activities", for purposes of IC 12-15-5-11, has the meaning set forth in IC 12-15-5-11(a).**

**(b)** "Telehealth services", for purposes of IC 12-15-5-11, has the meaning set forth in ~~IC 12-15-5-11(a).~~ **IC 12-15-5-11(b).**

SECTION 2. IC 12-7-2-190.4 IS REPEALED [EFFECTIVE UPON PASSAGE]. ~~Sec. 190.4. "Telemedicine services", for purposes of IC 12-15-5-11, has the meaning set forth in IC 12-15-5-11(b).~~

SECTION 3. IC 12-15-5-11, AS AMENDED BY P.L.150-2017, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 11. (a) As used in this section, "telehealth ~~services"~~ **activities"** means the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, and information across a distance.

(b) As used in this section, ~~"telemedicine~~ **"telehealth** services" has the meaning set forth for ~~"telemedicine"~~ **"telehealth"** in IC 25-1-9.5-6.

(c) The office shall reimburse a Medicaid provider who is licensed as a home health agency under IC 16-27-1 for telehealth ~~services.~~

**activities.**

(d) The office shall reimburse the following Medicaid providers for medically necessary ~~telemedicine~~ **telehealth** services:

(1) A federally qualified health center (as defined in 42 U.S.C. 1396d(l)(2)(B)).

(2) A rural health clinic (as defined in 42 U.S.C. 1396d(l)(1)).

(3) A community mental health center certified under IC 12-21-2-3(5)(C).

(4) A critical access hospital that meets the criteria under 42 CFR 485.601 et seq.

(5) A provider, as determined by the office to be eligible, providing a covered ~~telemedicine~~ **telehealth** service.

(e) The office may not impose any distance restrictions on providers of telehealth ~~services~~ **activities** or ~~telemedicine~~ **telehealth** services. Before December 31, 2017, the office shall do the following:

(1) Submit a Medicaid state plan amendment with the United States Department of Health and Human Services that eliminates distance restrictions for telehealth ~~services~~ **activities** or ~~telemedicine~~ **telehealth** services in the state Medicaid plan.

(2) Issue a notice of intent to adopt a rule to amend any administrative rules that include distance restrictions for the provision of telehealth ~~services~~ **activities** or ~~telemedicine~~ **telehealth** services.

**(f) Subject to federal law, the office may not impose any location requirements concerning the originating site or distant site in which a telehealth service is provided to a Medicaid recipient.**

**(g) A Medicaid recipient waives confidentiality of any medical information discussed with the health care provider that is:**

**(1) provided during a telehealth visit; and**

**(2) heard by another individual in the vicinity of the Medicaid recipient during a health care service or consultation.**

~~(f)~~ **(h)** The office shall implement any part of this section that is approved by the United States Department of Health and Human Services.

~~(g)~~ **(i)** The office may adopt rules under IC 4-22-2 necessary to implement and administer this section.

SECTION 4. IC 16-18-2-348.5, AS ADDED BY P.L.185-2015, SECTION 15, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 348.5. ~~"Telemedicine",~~ **"Telehealth",** for purposes of **IC 16-34-1 and** IC 16-36-1, means a specific method of delivery of services, including medical exams and consultations and behavioral health evaluations and treatment, including those for

substance abuse, using ~~videoconferencing~~ ~~equipment~~ **technology allowed under IC 25-1-9.5-6** to allow a provider to render an examination or other service to a patient at a distant location. ~~The term does not include the use of the following:~~

~~(1) A telephone transmitter for transtelephonic monitoring.~~

~~(2) A telephone or any other means of communication for the consultation from one (1) provider to another provider.~~

SECTION 5. IC 16-34-1-11 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 11. Telehealth 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.**

SECTION 6. IC 16-36-1-15, AS ADDED BY P.L.185-2015, SECTION 17, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 15. A health care provider (as defined in IC 16-18-2-163(a)) may not be required to obtain a separate additional written health care consent for the provision of ~~telemedicine~~ **telehealth** services.

SECTION 7. IC 25-1-2-10, AS ADDED BY P.L.121-2018, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 10. (a) As used in this section, "board" means any of the following boards:

(1) The medical licensing board of Indiana.
(2) The Indiana state board of nursing.
(3) The state board of dentistry.
(4) The behavioral health and human services licensing board.
(5) The state psychology board.
(6) The Indiana board of pharmacy.

(b) As used in this section, "license" means:

(1) an unlimited license, certificate, or registration;
(2) a limited or probationary license, certificate, or registration;
(3) a temporary license, certificate, registration, or permit;
(4) an intern permit; or
(5) a provisional license;

issued by the board regulating the profession in question.

(c) As used in this section, "practitioner" means an individual who holds a license under any of the following:

(1) IC 25-14-1.
(2) IC 25-22.5-5.
(3) IC 25-23.
(4) IC 25-23.6.
(5) IC 25-26.

(6) IC 25-27.5.

(7) IC 25-33.

(d) To allow for programmatic and policy recommendations to improve workforce performance, address identified workforce shortages, and retain practitioners, beginning January 1, 2019, every practitioner who is renewing online a license issued by a board must include the following information related to the practitioner's work in Indiana under the practitioner's license during the previous two (2) years:

(1) The practitioner's specialty or field of practice.

(2) The following concerning the practitioner's current practice:

(A) The location or address.

(B) The setting type.

(C) The average hours worked weekly.

(D) The health care services provided.

(3) The practitioner's education background and training.

(4) For a practitioner ~~that is a prescriber~~ (as defined in ~~IC 25-1-9.5-4),~~ **IC 25-1-9.5-3.5),** whether the practitioner delivers health care services through ~~telemedicine~~ **telehealth** (as defined in IC 25-1-9.5-6).

(e) The Indiana professional licensing agency shall do the following:

(1) Include notification with a practitioner's license renewal notice that the practitioner must submit the information required under subsection (d) if the practitioner renews the license online.

(2) Compile the information collected under this section into an annual report. The report may not contain any personal identifying information and the report must be compliant with the federal Health Insurance Portability and Accountability Act (HIPAA).

(3) Post the annual report compiled under this subsection on the agency's Internet web site.

(4) Submit the annual report compiled under this subsection to the following:

(A) The office of Medicaid policy and planning.

(B) The department of workforce development.

(C) The commission on improving the status of children in Indiana (IC 2-5-36).

(D) The legislative council in an electronic format under IC 5-14-6.

(E) The office of the attorney general.

SECTION 8. IC 25-1-9.5-0.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS

[EFFECTIVE UPON PASSAGE]: **Sec. 0.5. Telehealth 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.**

SECTION 9. IC 25-1-9.5-1, AS AMENDED BY P.L.150-2017, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 1. (a) This chapter does not prohibit a provider, prescriber, insurer, **practitioner,** or patient from agreeing to an alternative location of the patient, provider, **practitioner,** or prescriber to conduct ~~telemedicine.~~ **telehealth.**

(b) This chapter does not supersede any other statute concerning a provider or prescriber who provides health care to a patient.

SECTION 10. IC 25-1-9.5-2, AS AMENDED BY P.L.150-2017, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2. As used in this chapter, "distant site" means a site at which a ~~prescriber~~ **practitioner** is located while providing health care services through ~~telemedicine.~~ **telehealth.**

SECTION 11. IC 25-1-9.5-2.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 2.5. As used in this chapter, "health care services" includes the following:**

**(1) Assessment, diagnosis, evaluation, consultation, treatment, and monitoring of a patient.**

**(2) Transfer of medical data.**

**(3) Patient health related education.**

**(4) Health administration.**

SECTION 12. IC 25-1-9.5-3, AS ADDED BY P.L.78-2016, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 3. As used in this chapter, "originating site" means any site at which a patient is located at the time health care services through ~~telemedicine~~ **telehealth** are provided to the individual.

SECTION 13. IC 25-1-9.5-3.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 3.5. As used in this chapter, "practitioner" means an individual who holds an unlimited license to practice as any of the following in Indiana:**

**(1) An athletic trainer licensed under IC 25-5.1.**

**(2) A chiropractor licensed under IC 25-10.**

**(3) A dental hygienist licensed under IC 25-13.**

**(4) The following:**

**(A) A dentist licensed under IC 25-14.**

**(B) An individual who holds a dental residency permit**

**issued under IC 25-14-1-5.**

**(C) An individual who holds a dental faculty license under IC 25-14-1-5.5.**

**(5) A diabetes educator licensed under IC 25-14.3.**

**(6) A dietitian licensed under IC 25-14.5.**

**(7) A genetic counselor licensed under IC 25-17.3.**

**(8) The following:**

**(A) A physician licensed under IC 25-22.5.**

**(B) An individual who holds a temporary permit under IC 25-22.5-5-4.**

**(9) A nurse licensed under IC 25-23.**

**(10) An occupational therapist licensed under IC 25-23.5.**

**(11) Any behavioral health and human services professional licensed under IC 25-23.6.**

**(12) An optometrist licensed under IC 25-24.**

**(13) A pharmacist licensed under IC 25-26.**

**(14) A physical therapist licensed under IC 25-27.**

**(15) A physician assistant licensed under IC 25-27.5.**

**(16) A podiatrist licensed under IC 25-29.**

**(17) A psychologist licensed under IC 25-33.**

**(18) A respiratory care practitioner licensed under IC 25-34.5.**

**(19) A speech-language pathologist or audiologist licensed under IC 25-35.6.**

**(20) A veterinarian licensed under IC 25-38.1.**

SECTION 14. IC 25-1-9.5-4, AS AMENDED BY P.L.247-2019, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4. As used in this chapter, "prescriber" means any of the following:

(1) A physician licensed under IC 25-22.5.

(2) A physician assistant licensed under IC 25-27.5 and granted the authority to prescribe by the physician assistant's collaborating physician in accordance with IC 25-27.5-5-4.

(3) An advanced practice registered nurse licensed and granted the authority to prescribe drugs under IC 25-23.

(4) An optometrist licensed under IC 25-24.

(5) A podiatrist licensed under IC 25-29.

**(6) A dentist licensed under IC 25-14.**

**(7) A veterinarian licensed under IC 25-38.1.**

SECTION 15. IC 25-1-9.5-5, AS AMENDED BY P.L.150-2017, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 5. As used in this chapter, "store and forward" means the transmission of a patient's medical information from an

originating site to the ~~prescriber~~ **practitioner** at a distant site without the patient being present.

SECTION 16. IC 25-1-9.5-6, AS ADDED BY P.L.78-2016, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 6. (a) As used in this chapter, ~~"telemedicine"~~ **"telehealth"** means the delivery of health care services using **interactive** electronic communications and information technology, **in compliance with the federal Health Insurance Portability and Accountability Act (HIPAA),** including:

(1) secure videoconferencing;

(2) ~~interactive audio-using~~ store and forward technology; or

(3) remote patient monitoring technology;

between a provider in one (1) location and a patient in another location.

(b) The term does not include the use of the following **unless the practitioner has an established relationship with the patient:**

~~(1) Audio-only communication.~~

~~(2) A telephone call.~~

~~(3)~~ **(1)** Electronic mail.

~~(4)~~ **(2)** An instant messaging conversation.

~~(5)~~ **(3)** Facsimile.

~~(6)~~ **(4)** Internet questionnaire.

~~(7) Telephone consultation.~~

~~(8)~~ **(5)** Internet consultation.

**(c) The term does not include a health care service provided by an employee of a practitioner who is performing a health care service listed in section 2.5(2), 2.5(3), or 2.5(4) of this chapter under the direction of the practitioner.**

SECTION 17. IC 25-1-9.5-7, AS AMENDED BY P.L.129-2018, SECTION 26, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 7. (a) A ~~prescriber~~ **practitioner** who:

**(1)** provides health care services through ~~telemedicine~~ **telehealth; or**

**(2) directs an employee of the practitioner to perform a health care service listed in section 2.5(2), 2.5(3), or 2.5(4) of this chapter;**

shall be held to the same standards of appropriate practice as those standards for health care services provided at an in-person setting.

(b) ~~A prescriber may not use telemedicine, including issuing a prescription, for an individual who is located in Indiana unless a provider-patient relationship between the prescriber and the individual has been established.~~ A ~~prescriber~~ **practitioner** who uses ~~telemedicine~~ **telehealth** shall, if such action would otherwise be required in the

provision of the same health care services in a manner other than ~~telemedicine,~~ **telehealth,** ensure that a proper provider-patient relationship is established. The provider-patient relationship by a ~~prescriber~~ **practitioner** who uses ~~telemedicine~~ **telehealth** must at a minimum include the following:

(1) Obtain the patient's name and contact information and:

(A) a verbal statement or other data from the patient identifying the patient's location; and

(B) to the extent reasonably possible, the identity of the requesting patient.

(2) Disclose the ~~prescriber's~~ **practitioner's** name and disclose ~~whether the prescriber is a physician, physician assistant, advanced practice registered nurse, optometrist, or podiatrist.~~ **the practitioner's licensure, certification, or registration.**

(3) Obtain informed consent from the patient.

(4) Obtain the patient's medical history and other information necessary to establish a diagnosis.

(5) Discuss with the patient the:

(A) diagnosis;

(B) evidence for the diagnosis; and

(C) risks and benefits of various treatment options, including when it is advisable to seek in-person care.

(6) Create and maintain a medical record for the patient. ~~and,~~ **If a prescription is issued for the patient, and** subject to the consent of the patient, **the prescriber shall** notify the patient's primary care provider of any prescriptions the prescriber has issued for the patient if the primary care provider's contact information is provided by the patient. The requirements in this subdivision do not apply when any of the following are met:

(A) The ~~prescriber~~ **practitioner** is using an electronic health record system that the patient's primary care provider is authorized to access.

(B) The ~~prescriber~~ **practitioner** has established an ongoing provider-patient relationship with the patient by providing care to the patient at least two (2) consecutive times through the use of ~~telemedicine~~ **telehealth** services. If the conditions of this clause are met, the ~~prescriber~~ **practitioner** shall maintain a medical record for the patient and shall notify the patient's primary care provider of any issued prescriptions.

(7) Issue proper instructions for appropriate follow-up care.

(8) Provide a ~~telemedicine~~ **telehealth** visit summary to the patient, including information that indicates any prescription that

is being prescribed.

**(c) The medical records under subsection (b)(6) must be created and maintained by the practitioner under the same standards of appropriate practice for medical records for patients in an in-person setting.**

**(d) A patient waives confidentiality of any medical information discussed with the practitioner that is:**

**(1) provided during a telehealth visit; and**

**(2) heard by another individual in the vicinity of the patient during a health care service or consultation.**

**(e) An employer may not require a practitioner, by an employment contract, an agreement, a policy, or any other means, to provide a health care service through telehealth if the practitioner believes that providing a health care service through telehealth would:**

**(1) negatively impact the patient's health; or**

**(2) result in a lower standard of care than if the health care service was provided in an in-person setting.**

**(f) Any applicable contract, employment agreement, or policy to provide telehealth services must explicitly provide that a practitioner may refuse at any time to provide health care services if in the practitioner's sole discretion the practitioner believes:**

**(1) that health quality may be negatively impacted; or**

**(2) the practitioner would be unable to provide the same standards of appropriate practice as those provided in an in-person setting.**

SECTION 18. IC 25-1-9.5-8, AS AMENDED BY P.L.52-2020, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 8. (a) A prescriber may issue a prescription to a patient who is receiving services through the use of ~~telemedicine~~ **telehealth** if the patient has not been examined previously by the prescriber in person if the following conditions are met:

(1) The prescriber has satisfied the applicable standard of care in the treatment of the patient.

(2) The issuance of the prescription by the prescriber is within the prescriber's scope of practice and certification.

(3) The prescription:

(A) meets the requirements of subsection (b); and

(B) is not for an opioid. However, an opioid may be prescribed if the opioid is a partial agonist that is used to treat or manage opioid dependence.

(4) The prescription is not for an abortion inducing drug (as

defined in IC 16-18-2-1.6).

(5) If the prescription is for a medical device, including an ophthalmic device, the prescriber must use ~~telemedicine~~ **telehealth** technology that is sufficient to allow the provider to make an informed diagnosis and treatment plan that includes the medical device being prescribed. However, a prescription for an ophthalmic device is also subject to the conditions in section 13 of this chapter.

(b) Except as provided in subsection (a), a prescriber may issue a prescription for a controlled substance (as defined in IC 35-48-1-9) to a patient who is receiving services through the use of ~~telemedicine,~~ **telehealth,** even if the patient has not been examined previously by the prescriber in person, if the following conditions are met:

(1) The prescriber maintains a valid controlled substance registration under IC 35-48-3.

(2) The prescriber meets the conditions set forth in 21 U.S.C. 829 et seq.

~~(3) The patient has been examined in person by a licensed Indiana health care provider and the licensed health care provider has established a treatment plan to assist the prescriber in the diagnosis of the patient.~~

~~(4) The prescriber has reviewed and approved the treatment plan described in subdivision (3) and is prescribing for the patient pursuant to the treatment plan.~~

**(3) A practitioner acting in the usual course of the practitioner's professional practices issues the prescription for a legitimate medical purpose.**

**(4) The telehealth communication is conducted using an audiovisual, real time, two-way interactive communication system.**

(5) The prescriber complies with the requirements of the INSPECT program (IC 25-26-24).

**(6) All other applicable federal and state laws are followed.**

(c) A prescription for a controlled substance under this section must be prescribed and dispensed in accordance with IC 25-1-9.3 and IC 25-26-24.

SECTION 19. IC 25-1-9.5-9, AS AMENDED BY P.L.150-2017, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 9. (a) A ~~prescriber~~ **practitioner** who is physically located outside Indiana is engaged in the provision of health care services in Indiana when the ~~prescriber.~~ **practitioner:**

(1) establishes a provider-patient relationship under this chapter

with; or

(2) determines whether to issue a prescription under this chapter for;

an individual who is located in Indiana.

(b) A ~~prescriber~~ **practitioner** described in subsection (a) may not establish a provider-patient relationship under this chapter with or issue a prescription under this chapter for an individual who is located in Indiana unless the ~~prescriber~~ **practitioner** and the ~~prescriber's~~ **practitioner's** employer or the ~~prescriber's~~ **practitioner's** contractor, for purposes of providing health care services under this chapter, have certified in writing to the Indiana professional licensing agency, in a manner specified by the Indiana professional licensing agency, that the ~~prescriber~~ **practitioner** and the ~~prescriber's~~ **practitioner's** employer or ~~prescriber's~~ **practitioner's** contractor agree to be subject to:

(1) the jurisdiction of the courts of law of Indiana; and

(2) Indiana substantive and procedural laws;

concerning any claim asserted against the ~~prescriber,~~ **practitioner,** the ~~prescriber's~~ **practitioner's** employer, or the ~~prescriber's~~ **practitioner's** contractor arising from the provision of health care services under this chapter to an individual who is located in Indiana at the time the health care services were provided. The filing of the certification under this subsection shall constitute a voluntary waiver by the ~~prescriber,~~ **practitioner,** the ~~prescriber's~~ **practitioner's** employer, or the ~~prescriber's~~ **practitioner's** contractor of any respective right to avail themselves of the jurisdiction or laws other than those specified in this subsection concerning the claim. However, a ~~prescriber~~ **practitioner** that practices predominately in Indiana is not required to file the certification required by this subsection.

(c) A ~~prescriber~~ **practitioner** shall renew the certification required under subsection (b) at the time the ~~prescriber~~ **practitioner** renews the ~~prescriber's~~ **practitioner's** license.

(d) A ~~prescriber's~~ **practitioner's** employer or a ~~prescriber's~~ **practitioner's** contractor is required to file the certification required by this section only at the time of initial certification.

SECTION 20. IC 25-1-9.5-10, AS AMENDED BY P.L.150-2017, SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 10. (a) A ~~prescriber~~ **practitioner** who violates this chapter is subject to disciplinary action under IC 25-1-9.

(b) A ~~prescriber's~~ **practitioner's** employer or a ~~prescriber's~~ **practitioner's** contractor that violates this section commits a Class B infraction for each act in which a certification is not filed as required by section 9 of this chapter.

**SEA 3 — Concur**

SECTION 21. IC 25-1-9.5-11, AS AMENDED BY P.L.28-2019, SECTION 11, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 11. A pharmacy does not violate this chapter if the pharmacy fills a prescription for an opioid and the pharmacy is unaware that the prescription was written or electronically transmitted by a prescriber providing ~~telemedicine~~ **telehealth** services under this chapter.

SECTION 22. IC 25-1-9.5-12, AS ADDED BY P.L.78-2016, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 12. The Indiana professional licensing agency may adopt policies or rules under IC 4-22-2 necessary to implement this chapter. Adoption of policies or rules under this section may not delay the implementation and provision of ~~telemedicine~~ **telehealth** services under this chapter.

SECTION 23. IC 25-1-9.5-13, AS ADDED BY P.L.52-2020, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 13. (a) As used in this section, "HIPAA" refers to the federal Health Insurance Portability and Accountability Act.

(b) A prescriber may not issue a prescription for an ophthalmic device unless the following conditions are met:

(1) If the prescription is for contact lenses or eyeglasses, the patient must be at least eighteen (18) years of age but not more than fifty-five (55) years of age.

(2) The patient must have completed a medical eye history that includes information concerning the following:

(A) Chronic health conditions.

(B) Current medications.

(C) Eye discomfort.

(D) Blurry vision.

(E) Any prior ocular medical procedures.

(3) The patient must have had a prior prescription from a qualified eye care professional that included a comprehensive in person exam that occurred within two (2) years before the initial use of ~~telemedicine~~ **telehealth** for a refraction under subdivision (5)(A).

(4) If the patient desires a contact lens prescription, at the discretion of the eye care professional, that patient must have had a prior contact lens fitting or evaluation by a qualified eye care professional that occurred within two (2) years before the initial use of ~~telemedicine~~ **telehealth** for a refraction under subdivision (5)(A).

**SEA 3 — Concur**

(5) The patient:

(A) may not use ~~telemedicine~~ **telehealth** more than two (2) consecutive times within two (2) years from the date of the examination that occurred under subdivision (3) for a refraction without a subsequent in person comprehensive eye exam; and

(B) must acknowledge that the patient has had a comprehensive eye exam as required under clause (A) before receiving an online prescription.

(6) The patient may allow the prescriber to access the patient's medical records using an appropriate HIPAA compliant process.

(7) The prescriber must ensure that the transfer of all information, including the vision test and prescription, comply with HIPAA requirements.

(8) The prescriber must use technology to allow the patient to have continuing twenty-four (24) hour a day online access to the patient's prescription as soon as the prescription is signed by the prescriber.

SECTION 24. IC 25-1-9.5-14 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 14. Nothing in this chapter requires an individual to provide or use telehealth.**

SECTION 25. IC 25-1-9.5-15 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 15. If a veterinarian is required to establish a veterinarian-client-patient relationship to perform a health care service, the veterinarian shall ensure that a proper veterinarian-client-patient relationship is established, as defined in IC 25-38.1-1-14.5, when providing the service using telehealth.**

SECTION 26. IC 25-22.5-2-7, AS AMENDED BY P.L.249-2019, SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 7. (a) The board shall do the following:

(1) Adopt rules and forms necessary to implement this article that concern, but are not limited to, the following areas:

(A) Qualification by education, residence, citizenship, training, and character for admission to an examination for licensure or by endorsement for licensure.

(B) The examination for licensure.

(C) The license or permit.

(D) Fees for examination, permit, licensure, and registration.

(E) Reinstatement of licenses and permits.

(F) Payment of costs in disciplinary proceedings conducted by the board.

(2) Administer oaths in matters relating to the discharge of the board's official duties.

(3) Enforce this article and assign to the personnel of the agency duties as may be necessary in the discharge of the board's duty.

(4) Maintain, through the agency, full and complete records of all applicants for licensure or permit and of all licenses and permits issued.

(5) Make available, upon request, the complete schedule of minimum requirements for licensure or permit.

(6) Issue, at the board's discretion, a temporary permit to an applicant for the interim from the date of application until the next regular meeting of the board.

(7) Issue an unlimited license, a limited license, or a temporary medical permit, depending upon the qualifications of the applicant, to any applicant who successfully fulfills all of the requirements of this article.

(8) Adopt rules establishing standards for the competent practice of medicine, osteopathic medicine, or any other form of practice regulated by a limited license or permit issued under this article.

(9) Adopt rules regarding the appropriate prescribing of Schedule III or Schedule IV controlled substances for the purpose of weight reduction or to control obesity.

(10) Adopt rules establishing standards for office based procedures that require moderate sedation, deep sedation, or general anesthesia.

(11) Adopt rules or protocol establishing the following:

(A) An education program to be used to educate women with high breast density.

(B) Standards for providing an annual screening or diagnostic test for a woman who is at least forty (40) years of age and who has been determined to have high breast density.

As used in this subdivision, "high breast density" means a condition in which there is a greater amount of breast and connective tissue in comparison to fat in the breast.

(12) Adopt rules establishing standards and protocols for the prescribing of controlled substances.

(13) Adopt rules as set forth in IC 25-23.4 concerning the certification of certified direct entry midwives.

(14) In consultation with the state department of health and the office of the secretary of family and social services, adopt rules

under IC 4-22-2 or protocols concerning the following for providers that are providing office based opioid treatment:

(A) Requirements of a treatment agreement (as described in IC 12-23-20-2) concerning the proper referral and treatment of mental health and substance use.

(B) Parameters around the frequency and types of visits required for the periodic scheduled visits required by IC 12-23-20-2.

(C) Conditions on when the following should be ordered or performed:

(i) A urine toxicology screening.

(ii) HIV, hepatitis B, and hepatitis C testing.

(D) Required documentation in a patient's medical record when buprenorphine is prescribed over a specified dosage.

(15) Adopt rules as set forth in IC 25-14.5 concerning the certification of certified dietitians.

(b) The board may adopt rules that establish:

(1) certification requirements for child death pathologists;

(2) an annual training program for child death pathologists under IC 16-35-7-3(b)(2); and

(3) a process to certify a qualified child death pathologist.

(c) The board may adopt rules under IC 4-22-2 establishing guidelines for the practice of ~~telemedicine~~ **telehealth** in Indiana. Adoption of rules under this subsection may not delay the implementation and provision of ~~telemedicine~~ **telehealth** services by a provider under IC 25-1-9.5.

SECTION 27. IC 25-33-3 IS REPEALED [EFFECTIVE UPON PASSAGE]. (Telepsychology).

SECTION 28. IC 27-8-34-5, AS ADDED BY P.L.185-2015, SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 5. ~~(a)~~ As used in this chapter, ~~"telemedicine~~ **"telehealth** services" means health care services delivered by use of ~~interactive audio, video, or other electronic media,~~ **technology allowed under IC 25-1-9.5-6,** including the following:

(1) Medical exams and consultations.

(2) Behavioral health, including substance abuse evaluations and treatment.

~~(b) The term does not include the delivery of health care services by use of the following:~~

~~(1) A telephone transmitter for transtelephonic monitoring.~~

~~(2) A telephone or any other means of communication for the consultation from one (1) provider to another provider.~~

**SEA 3 — Concur**

SECTION 29. IC 27-8-34-6, AS ADDED BY P.L.185-2015, SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 6. (a) A policy must provide coverage for ~~telemedicine~~ **telehealth** services in accordance with the same clinical criteria as the policy provides coverage for the same health care services delivered in person.

(b) Coverage for ~~telemedicine~~ **telehealth** services required by subsection (a) may not be subject to a dollar limit, deductible, or coinsurance requirement that is less favorable to a covered individual than the dollar limit, deductible, or coinsurance requirement that applies to the same health care services delivered to a covered individual in person.

(c) Any annual or lifetime dollar limit that applies to ~~telemedicine~~ **telehealth** services must be the same annual or lifetime dollar limit that applies in the aggregate to all items and services covered under the policy.

(d) A separate consent for ~~telemedicine~~ **telehealth** services may not be required.

**(e) If a policy provides coverage for telehealth services via:**

**(1) secure videoconferencing;**

**(2) store and forward technology; or**

**(3) remote patient monitoring technology;**

**between a provider in one (1) location and a patient in another location, the policy may not require the use of a specific information technology application for those services.**

SECTION 30. IC 27-8-34-7, AS ADDED BY P.L.185-2015, SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 7. This chapter does not do any of the following:

(1) Require a policy to provide coverage for a ~~telemedicine~~ **telehealth** service that is not a covered health care service under the policy.

(2) Require the use of ~~telemedicine~~ **telehealth** services when the treating provider has determined that ~~telemedicine~~ **telehealth** services are inappropriate.

(3) Prevent the use of utilization review concerning coverage for ~~telemedicine~~ **telehealth** services in the same manner as utilization review is used concerning coverage for the same health care services delivered to a covered individual in person.

SECTION 31. IC 27-13-1-34, AS ADDED BY P.L.185-2015, SECTION 26, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 34. ~~(a) "Telemedicine~~ **"Telehealth** services"

means health care services delivered by use of ~~interactive audio, video, or other electronic media,~~ **technology allowed under IC 25-1-9.5-6,** including the following:

(1) Medical exams and consultations.

(2) Behavioral health, including substance abuse evaluations and treatment.

~~(b) The term does not include the delivery of health care services by use of the following:~~

~~(1) A telephone transmitter for transtelephonic monitoring.~~

~~(2) A telephone or any other means of communication for the consultation from one (1) provider to another provider.~~

SECTION 32. IC 27-13-7-22, AS ADDED BY P.L.185-2015, SECTION 27, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 22. (a) An individual contract or a group contract must provide coverage for ~~telemedicine~~ **telehealth** services in accordance with the same clinical criteria as the individual contract or the group contract provides coverage for the same health care services delivered to an enrollee in person.

(b) Coverage for ~~telemedicine~~ **telehealth** services required by subsection (a) may not be subject to a dollar limit, copayment, or coinsurance requirement that is less favorable to an enrollee than the dollar limit, copayment, or coinsurance requirement that applies to the same health care services delivered to an enrollee in person.

(c) Any annual or lifetime dollar limit that applies to ~~telemedicine~~ **telehealth** services must be the same annual or lifetime dollar limit that applies in the aggregate to all items and services covered under the individual contract or the group contract.

(d) This section does not do any of the following:

(1) Require an individual contract or a group contract to provide coverage for a ~~telemedicine~~ **telehealth** service that is not a covered health care service under the individual contract or group contract.

(2) Require the use of ~~telemedicine~~ **telehealth** services when the treating provider has determined that ~~telemedicine~~ **telehealth** services are inappropriate.

(3) Prevent the use of utilization review concerning coverage for ~~telemedicine~~ **telehealth** services in the same manner as utilization review is used concerning coverage for the same health care services delivered to an enrollee in person.

(e) A separate consent for ~~telemedicine~~ **telehealth** services may not be required.

**(f) If a policy provides coverage for telehealth services via:**

**(1) secure videoconferencing;**

**(2) store and forward technology; or**

**(3) remote patient monitoring technology;**

**between a provider in one (1) location and a patient in another location, the policy may not require the use of a specific information technology application for those services.**

SECTION 33. **An emergency is declared for this act.**

President of the Senate

President Pro Tempore

Speaker of the House of Representatives

Governor of the State of Indiana

Date: _____ Time: _____

**SEA 3 — Concur**

# Exhibit 2

First Regular Session of the 122nd General Assembly (2021)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2020 Regular Session of the General Assembly.

# HOUSE ENROLLED ACT No. 1577

AN ACT to amend the Indiana Code concerning health.

*Be it enacted by the General Assembly of the State of Indiana:*

SECTION 1. IC 16-18-2-225.8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 225.8. "Mental health provider", for purposes of IC 16-36-1.5 and **IC 16-34-1-4,** has the meaning set forth in IC 16-36-1.5-2.

SECTION 2. IC 16-18-2-267 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 267. "Parental consent", for purposes of IC 16-34, means the **notarized** written consent of the parent or legal guardian of an unemancipated pregnant woman less than eighteen (18) years of age to the performance of an abortion on the minor pregnant woman **or for the final disposition of the aborted fetus by interment in compliance with IC 23-14-54 or cremation through a licensee (as defined in IC 25-15-2-19) and in compliance with IC 23-14-31.**

SECTION 3. IC 16-34-1-4, AS AMENDED BY P.L.72-2019, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 4. No:

(1) physician;

(2) nurse;

(3) physician assistant;

(4) pharmacist; ~~or~~

(5) employee or member of the staff of a hospital or other facility in which an abortion may be performed; **or**

**(6) mental health provider;**

shall be required to perform an abortion, to prescribe, administer, or dispense an abortion inducing drug, **to provide advice or counsel to a pregnant woman concerning medical procedures resulting in, or intended to result in, an abortion,** ~~or~~ to assist or participate in ~~the~~ medical procedures resulting in, or intended to result in an abortion, **or to handle or dispose of aborted remains,** if that individual objects to such procedures on ethical, moral, or religious grounds.

SECTION 4. IC 16-34-2-1, AS AMENDED BY P.L.93-2019, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 1. (a) Abortion shall in all instances be a criminal act, except when performed under the following circumstances:

(1) Except as prohibited in IC 16-34-4, during the first trimester of pregnancy for reasons based upon the professional, medical judgment of the pregnant woman's physician if:

(A) the abortion is performed by the physician;

(B) the woman submitting to the abortion has filed her consent with her physician. However, if in the judgment of the physician the abortion is necessary to preserve the life of the woman, her consent is not required; and

(C) the woman submitting to the abortion has filed with her physician the written consent of her parent or legal guardian if required under section 4 of this chapter.

However, an abortion inducing drug may not be dispensed, prescribed, administered, or otherwise given to a pregnant woman after ~~nine (9) weeks~~ **eight (8) weeks** of postfertilization age. ~~unless the Food and Drug Administration has approved the abortion inducing drug to be used for abortions later than nine (9) weeks of postfertilization age.~~ **A physician must dispense the abortion inducing drug in person and have the pregnant woman consume the drug in the presence of the physician.** A physician shall examine a pregnant woman in person before prescribing or dispensing an abortion inducing drug. ~~In accordance with FDA guidelines,~~ The physician shall provide the pregnant woman with a copy of the manufacturer's instruction sheets and require that the pregnant woman sign the manufacturer's patient agreement form. **A physician shall also provide, orally and in writing, along with other discharge information, the following statement: "Some evidence suggests that the effects of Mifepristone may be avoided,**

**ceased, or reversed if the second pill, Misoprostol, has not been taken. Immediately contact the following for more information at (insert applicable abortion inducing drug reversal Internet web site and corresponding hotline number)."** The physician shall retain a copy of the signed patient agreement form, and the signed physician's agreement form required by the manufacturer, in the patient's file. As used in this subdivision, "in person" does not include the use of telehealth or telemedicine services.

(2) Except as prohibited by IC 16-34-4, after the first trimester of pregnancy and before the earlier of viability of the fetus or twenty (20) weeks of postfertilization age, for reasons based upon the professional, medical judgment of the pregnant woman's physician if:

(A) all the circumstances and provisions required for legal abortion during the first trimester are present and adhered to; and

(B) the abortion is performed in a hospital or ambulatory outpatient surgical center (as defined in IC 16-18-2-14).

(3) Except as provided in subsection (b) or as prohibited by IC 16-34-4, at the earlier of viability of the fetus or twenty (20) weeks of postfertilization age and any time after, for reasons based upon the professional, medical judgment of the pregnant woman's physician if:

(A) all the circumstances and provisions required for legal abortion before the earlier of viability of the fetus or twenty (20) weeks of postfertilization age are present and adhered to;

(B) the abortion is performed in compliance with section 3 of this chapter; and

(C) before the abortion the attending physician shall certify in writing to the hospital in which the abortion is to be performed, that in the attending physician's professional, medical judgment, after proper examination and review of the woman's history, the abortion is necessary to prevent a substantial permanent impairment of the life or physical health of the pregnant woman. All facts and reasons supporting the certification shall be set forth by the physician in writing and attached to the certificate.

(b) A person may not knowingly or intentionally perform a partial birth abortion unless a physician reasonably believes that:

(1) performing the partial birth abortion is necessary to save the mother's life; and

(2) no other medical procedure is sufficient to save the mother's life.

(c) A person may not knowingly or intentionally perform a dismemberment abortion unless reasonable medical judgment dictates that performing the dismemberment abortion is necessary:

(1) to prevent any serious health risk to the mother; or

(2) to save the mother's life.

**(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.**

SECTION 5. IC 16-34-2-1.1, AS AMENDED BY P.L.77-2020, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 1.1. (a) An abortion shall not be performed except with the voluntary and informed consent of the pregnant woman upon whom the abortion is to be performed. Except in the case of a medical emergency, consent to an abortion is voluntary and informed only if the following conditions are met:

(1) At least eighteen (18) hours before the abortion and in the private, not group, presence of the pregnant woman, the physician who is to perform the abortion, the referring physician or a physician assistant (as defined in IC 25-27.5-2-10), an advanced practice registered nurse (as defined in IC 25-23-1-1(b)), or a certified nurse midwife (as defined in IC 34-18-2-6.5) to whom the responsibility has been delegated by the physician who is to perform the abortion or the referring physician has informed the pregnant woman orally and in writing of the following:

(A) The name of the physician performing the abortion, the physician's medical license number, and an emergency telephone number where the physician or the physician's designee may be contacted on a twenty-four (24) hour a day, seven (7) day a week basis.

(B) That follow-up care by the physician or the physician's designee (if the designee is licensed under IC 25-22.5) is available on an appropriate and timely basis when clinically necessary.

(C) The nature of the proposed procedure or information concerning the abortion inducing drug **that includes the following statement: "Some evidence suggests that effects of Mifespristone may be avoided, ceased, or reversed if the second pill, Misoprostol, has not been taken. Immediately contact the following for more information at (insert applicable abortion inducing drug reversal Internet web**

**site and corresponding hotline number)."**

(D) Objective scientific information of the risks of and alternatives to the procedure or the use of an abortion inducing drug, including:

(i) the risk of infection and hemorrhage;

(ii) the potential danger to a subsequent pregnancy; and

(iii) the potential danger of infertility.

(E) That human physical life begins when a human ovum is fertilized by a human sperm.

(F) The probable gestational age of the fetus at the time the abortion is to be performed, including:

(i) a picture of a fetus;

(ii) the dimensions of a fetus; and

(iii) relevant information on the potential survival of an unborn fetus;

at this stage of development.

(G) That objective scientific information shows that a fetus can feel pain at or before twenty (20) weeks of postfertilization age.

(H) The medical risks associated with carrying the fetus to term.

(I) The availability of fetal ultrasound imaging and auscultation of fetal heart tone services to enable the pregnant woman to view the image and hear the heartbeat of the fetus and how to obtain access to these services.

(J) That the pregnancy of a child less than fifteen (15) years of age may constitute child abuse under Indiana law if the act included an adult and must be reported to the department of child services or the local law enforcement agency under IC 31-33-5.

(K) That Indiana does not allow a fetus to be aborted solely because of the fetus's race, color, national origin, ancestry, sex, or diagnosis or potential diagnosis of the fetus having Down syndrome or any other disability.

(2) At least eighteen (18) hours before the abortion, the pregnant woman will be informed orally and in writing of the following:

(A) That medical assistance benefits may be available for prenatal care, childbirth, and neonatal care from the county office of the division of family resources.

(B) That the father of the unborn fetus is legally required to assist in the support of the child. In the case of rape, the information required under this clause may be omitted.

(C) That adoption alternatives are available and that adoptive parents may legally pay the costs of prenatal care, childbirth, and neonatal care.

(D) That there are physical risks to the pregnant woman in having an abortion, both during the abortion procedure and after.

(E) That Indiana has enacted the safe haven law under IC 31-34-2.5.

(F) The:

(i) Internet web site address of the state department of health's web site; and

(ii) description of the information that will be provided on the web site and that are;

described in section 1.5 of this chapter.

(G) For the facility in which the abortion is to be performed, an emergency telephone number that is available and answered on a twenty-four (24) hour a day, seven (7) day a week basis.

(H) On a form developed by the state department and as described in IC 16-34-3, that the pregnant woman has a right to determine the final disposition of the remains of the aborted fetus.

(I) On a form developed by the state department, that the pregnant woman has a right, after a surgical abortion, to:

(i) dispose of the remains of the aborted fetus by interment in compliance with IC 23-14-54, or cremation through a licensee (as defined in IC 25-15-2-19) and in compliance with IC 23-14-31; or

(ii) have the health care facility or abortion clinic dispose of the remains of the aborted fetus by interment in compliance with IC 23-14-54, or cremation through a licensee (as defined in IC 25-15-2-19) and in compliance with IC 23-14-31, and ask which method of disposition will be used by the health care facility or abortion clinic.

(J) On a form developed by the state department:

(i) that a pregnant woman, after an abortion induced by an abortion inducing drug, will expel an aborted fetus; and

(ii) the disposition policy of the health care facility or the abortion clinic concerning the disposition of the aborted fetus. The disposition policy must allow the pregnant woman to return the aborted fetus to the health care facility or abortion clinic for disposition by interment in compliance

with IC 23-14-54, or cremation through a licensee (as defined in IC 25-15-2-19) and in compliance with IC 23-14-31.

(K) On a form developed by the state department, information concerning any counseling that is available to a pregnant woman after having an abortion.

The state department shall develop and distribute the forms required by clauses (H) through (K).

(3) The pregnant woman certifies in writing, on a form developed by the state department, before the abortion is performed, that:

(A) the information required by subdivisions (1) and (2) has been provided to the pregnant woman;

(B) the pregnant woman has been offered by the provider the opportunity to view the fetal ultrasound imaging and hear the auscultation of the fetal heart tone if the fetal heart tone is audible and that the woman has:

(i) viewed or refused to view the offered fetal ultrasound imaging; and

(ii) listened to or refused to listen to the offered auscultation of the fetal heart tone if the fetal heart tone is audible; and

(C) the pregnant woman has been given a written copy of the printed materials described in section 1.5 of this chapter.

(4) At least eighteen (18) hours before the abortion and in the presence of the pregnant woman, the physician who is to perform the abortion, the referring physician or a physician assistant (as defined in IC 25-27.5-2-10), an advanced practice registered nurse (as defined in IC 25-23-1-1(b)), or a certified nurse midwife (as defined in IC 34-18-2-6.5) to whom the responsibility has been delegated by the physician who is to perform the abortion or the referring physician has provided the pregnant woman with a color copy of the informed consent brochure described in section 1.5 of this chapter by printing the informed consent brochure from the state department's Internet web site and including the following information on the back cover of the brochure:

(A) The name of the physician performing the abortion and the physician's medical license number.

(B) An emergency telephone number where the physician or the physician's designee may be contacted twenty-four (24) hours a day, seven (7) days a week.

(C) A statement that follow-up care by the physician or the physician's designee who is licensed under IC 25-22.5 is available on an appropriate and timely basis when clinically

necessary.

(5) At least eighteen (18) hours before an abortion is performed and at the same time that the pregnant woman receives the information required by subdivision (1), the provider shall perform, and the pregnant woman shall view, the fetal ultrasound imaging and hear the auscultation of the fetal heart tone if the fetal heart tone is audible unless the pregnant woman certifies in writing, on a form developed by the state department, before the abortion is performed, that the pregnant woman:

(A) does not want to view the fetal ultrasound imaging; and

(B) does not want to listen to the auscultation of the fetal heart tone if the fetal heart tone is audible.

**A pregnant woman must be advised, prior to the pregnant woman's decision concerning fetal ultrasound imaging, that an ultrasound image of the fetus will be provided to the pregnant woman to keep at no charge to the pregnant woman if the fetal ultrasound is performed.**

(b) This subsection applies to a pregnant woman whose unborn child has been diagnosed with a lethal fetal anomaly. The requirements of this subsection are in addition to the other requirements of this section. At least eighteen (18) hours before an abortion is performed on the pregnant woman, the physician who will perform the abortion shall:

(1) orally and in person, inform the pregnant woman of the availability of perinatal hospice services; and

(2) provide the pregnant woman copies of the perinatal hospice brochure developed by the state department under IC 16-25-4.5-4 and the list of perinatal hospice providers and programs developed under IC 16-25-4.5-5, by printing the perinatal hospice brochure and list of perinatal hospice providers from the state department's Internet web site.

(c) If a pregnant woman described in subsection (b) chooses to have an abortion rather than continuing the pregnancy in perinatal hospice care, the pregnant woman shall certify in writing, on a form developed by the state department under IC 16-25-4.5-6, at least eighteen (18) hours before the abortion is performed, that the pregnant woman has been provided the information described in subsection (b) in the manner required by subsection (b).

**(d) For any abortion performed under this article, the physician who is to perform the abortion, the referring physician or a physician assistant (as defined in IC 25-27.5-2-10), an advanced practice registered nurse (as defined in IC 25-23-1-1(b)), or a certified nurse midwife (as defined in IC 34-18-2-6.5) to whom the**

**responsibility has been delegated by the physician who is to perform the abortion or the referring physician shall include, or ensure the inclusion of, a copy of a pregnant woman's ultrasound report in the pregnant woman's patient file.**

SECTION 6. IC 16-34-2-4, AS AMENDED BY P.L.173-2017, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 4. (a) No physician shall perform an abortion on an unemancipated pregnant minor less than eighteen (18) years of age without first having obtained from one (1) of the parents, a legal guardian, or a custodian accompanying the unemancipated pregnant minor:

(1) the **notarized** written consent of the parent, legal guardian, or custodian of the unemancipated pregnant minor;

(2) government issued proof of identification of the parent or the legal guardian or custodian of the unemancipated pregnant minor; and

(3) some evidence, which may include identification or other written documentation that provides an articulable basis for a reasonably prudent person to believe that the person is the parent or legal guardian or custodian of the unemancipated pregnant minor.

The physician shall keep records of the documents required under this subsection in the unemancipated pregnant minor's medical file for at least seven (7) years.

(b) A minor:

(1) who objects to having to obtain the written consent of her parent or legal guardian or custodian under this section; or

(2) whose parent or legal guardian or custodian refuses to consent to an abortion;

may petition, on her own behalf or by next friend, the juvenile court in the county in which the pregnant minor resides or in which the abortion is to be performed, for a waiver of the parental consent requirement under subsection (a) and the parental notification requirement under subsection (d). A next friend may not be a physician or provider of abortion services, representative of the physician or provider, or other person that may receive a direct financial benefit from the performance of an abortion.

(c) A physician who feels that compliance with the parental consent requirement in subsection (a) would have an adverse effect on the welfare of the pregnant minor or on her pregnancy may petition the juvenile court within twenty-four (24) hours of the abortion request for a waiver of the parental consent requirement under subsection (a) and

the parental notification requirement under subsection (d).

(d) Unless the juvenile court finds that it is in the best interests of an unemancipated pregnant minor to obtain an abortion without parental notification following a hearing on a petition filed under subsection (b) or (c), a parent, legal guardian, or custodian of a pregnant unemancipated minor is entitled to receive notice of the emancipated minor's intent to obtain an abortion before the abortion is performed on the unemancipated pregnant minor. The attorney representing the unemancipated pregnant minor shall serve the notice required by this subsection by certified mail or by personal service and provide the court with documentation of the attorney's good faith effort to serve the notice, including any return receipt for a certified mailing. The court shall retain the documentation provided in the confidential records of the waiver proceedings held under this section.

(e) The juvenile court must rule on a petition filed by a pregnant minor under subsection (b) or by her physician under subsection (c) within forty-eight (48) hours of the filing of the petition. Before ruling on the petition, the court shall consider the concerns expressed by the pregnant minor and her physician. The requirement of parental consent under this section shall be waived by the juvenile court if the court finds that the minor is mature enough to make the abortion decision independently or that an abortion would be in the minor's best interests. The juvenile court shall waive the requirement of parental notification under subsection (d) if the court finds that obtaining an abortion without parental notification is in the best interests of the unemancipated pregnant minor. If the juvenile court does not find that obtaining an abortion without parental notification is in the best interests of the unemancipated pregnant minor, the court shall, subject to an appeal under subsection (g), order the attorney representing the unemancipated pregnant minor to serve the notice required under subsection (d).

(f) Unless the juvenile court finds that the pregnant minor is already represented by an attorney, the juvenile court shall appoint an attorney to represent the pregnant minor in a waiver proceeding brought by the minor under subsection (b) and on any appeals. The cost of legal representation appointed for the minor under this section shall be paid by the county.

(g) A minor or the minor's physician who desires to appeal an adverse judgment of the juvenile court in a waiver proceeding under subsection (b) or (c) is entitled to an expedited appeal, under rules to be adopted by the supreme court.

(h) All records of the juvenile court and of the supreme court or the

court of appeals that are made as a result of proceedings conducted under this section are confidential.

(i) A minor who initiates legal proceedings under this section is exempt from the payment of filing fees.

(j) This section 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 of the pregnant minor, and the attending physician certifies this in writing.

(k) A physician receiving parental consent under subsection (a) shall execute an affidavit for inclusion in the unemancipated pregnant minor's medical record. The affidavit must contain the following information:

(1) The physician's name.

(2) Certification that, to the physician's best information and belief, a reasonable person under similar circumstances would rely on the information provided by the unemancipated pregnant minor and the unemancipated pregnant minor's parent or legal guardian or custodian as sufficient evidence of identity and relationship.

(3) The physician's signature.

(l) A person who, with intent to avoid the parental notification requirements described in subsection (a), falsely claims to be the parent or legal guardian or custodian of an unemancipated pregnant minor by:

(1) making a material misstatement while purportedly providing the written consent described in subsection (a)(1); or

(2) providing false or fraudulent identification to meet the requirement described in subsection (a)(2);

commits a Level 6 felony.

SECTION 7. IC 16-34-2-5, AS AMENDED BY P.L.205-2018, SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 5. (a) Every health care provider who performs a surgical abortion or provides, prescribes, administers, or dispenses an abortion inducing drug for the purposes of inducing an abortion shall report the performance of the abortion or the provision, prescribing, administration, or dispensing of an abortion inducing drug on a form drafted by the state department, the purpose and function of which shall be the improvement of maternal health and life through the compilation of relevant maternal life and health factors and data, and a further purpose and function shall be to monitor all abortions performed in Indiana to assure the abortions are done only under the authorized provisions of the law. For each abortion performed and abortion

inducing drug provided, prescribed, administered, or dispensed, the report shall include, among other things, the following:

(1) The age of the patient.

(2) Whether a waiver of consent under section 4 of this chapter was obtained.

(3) Whether a waiver of notification under section 4 of this chapter was obtained.

(4) The date and location, **including the facility name and city or town, where the:**

**(A) pregnant woman:**

**(i) provided consent; and**

**(ii) received all information;**

**required under section 1.1 of this chapter; and**

**(B)** ~~the~~ abortion was performed or the abortion inducing drug was provided, prescribed, administered, or dispensed.

(5) The health care provider's full name and address, including the name of the physicians performing the abortion or providing, prescribing, administering, or dispensing the abortion inducing drug.

(6) The city and county where the pregnancy termination occurred.

(7) The age of the father, or the approximate age of the father if the father's age is unknown.

(8) The patient's county and state of residence.

(9) The marital status of the patient.

(10) The educational level of the patient.

(11) The race of the patient.

(12) The ethnicity of the patient.

(13) The number of the patient's previous live births.

(14) The number of the patient's deceased children.

(15) The number of the patient's spontaneous pregnancy terminations.

(16) The number of the patient's previous induced terminations.

(17) The date of the patient's last menses.

(18) The physician's determination of the gestation of the fetus in weeks.

(19) Whether the patient indicated that the patient was seeking an abortion as a result of being:

(A) abused;

(B) coerced;

(C) harassed; or

(D) trafficked.

(20) The following information concerning the abortion or the provision, prescribing, administration, or dispensing of the abortion inducing drug:

(A) The postfertilization age of the fetus (in weeks).

(B) The manner in which the postfertilization age was determined.

(C) The gender of the fetus, if detectable.

(D) Whether the fetus has been diagnosed with or has a potential diagnosis of having Down syndrome or any other disability.

(E) If after the earlier of the time the fetus obtains viability or the time the postfertilization age of the fetus is at least twenty (20) weeks, the medical reason for the performance of the abortion or the provision, prescribing, administration, or dispensing of the abortion inducing drug.

(21) For a surgical abortion, the medical procedure used for the abortion and, if the fetus was viable or had a postfertilization age of at least twenty (20) weeks:

(A) whether the procedure, in the reasonable judgment of the health care provider, gave the fetus the best opportunity to survive;

(B) the basis for the determination that the pregnant woman had a condition described in this chapter that required the abortion to avert the death of or serious impairment to the pregnant woman; and

(C) the name of the second doctor present, as required under IC 16-34-2-3(a)(3).

(22) For a nonsurgical abortion, the precise drugs provided, prescribed, administered, or dispensed, and the means of delivery of the drugs to the patient.

(23) For a nonsurgical abortion, that the manufacturer's instructions were provided to the patient and that the patient signed the patient agreement.

(24) For an early pre-viability termination, the medical indication by diagnosis code for the fetus and the mother.

(25) The mother's obstetrical history, including dates of other abortions, if any.

(26) Any preexisting medical conditions of the patient that may complicate the abortion.

(27) The results of pathological examinations if performed.

(28) For a surgical abortion, whether the fetus was delivered alive, and if so, how long the fetus lived.

(29) Records of all maternal deaths occurring at the location where the abortion was performed or the abortion inducing drug was provided, prescribed, administered, or dispensed.

(30) The date the form was transmitted to the state department and, if applicable, separately to the department of child services.

(b) The health care provider shall complete the form provided for in subsection (a) and shall transmit the completed form to the state department, in the manner specified on the form, within thirty (30) days after the date of each abortion. However, if an abortion is for a female who is less than sixteen (16) years of age, the health care provider shall transmit the form to the state department of health and separately to the department of child services within three (3) days after the abortion is performed.

(c) The dates supplied on the form may not be redacted for any reason before the form is transmitted as provided in this section.

(d) Each failure to complete or timely transmit a form, as required under this section, for each abortion performed or abortion inducing drug that was provided, prescribed, administered, or dispensed, is a Class B misdemeanor.

(e) Not later than June 30 of each year, the state department shall compile a public report providing the following:

(1) Statistics for the previous calendar year from the information submitted under this section.

(2) Statistics for previous calendar years compiled by the state department under this subsection, with updated information for the calendar year that was submitted to the state department after the compilation of the statistics.

The state department shall ensure that no identifying information of a pregnant woman is contained in the report.

(f) The state department shall:

(1) summarize aggregate data from all data submitted under this section; and

(2) submit the data, before July 1 of each year, to the United States Centers for Disease Control and Prevention for its inclusion in the annual Vital Statistics Report.

SECTION 8. IC 16-34-5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]:

**Chapter 5. Miscellaneous Provisions**

**Sec. 1. (a) The state department shall consider the results of an abortion clinic inspection when making a determination concerning the renewal of an abortion clinic license.**

**(b) The state department may not renew the license of an abortion clinic until any noncompliance discovered during the course of an inspection is remedied in a manner prescribed by the state department under 410 IAC 26-2-8.**

**Sec. 2. (a) During the course of an abortion clinic's annual inspection, the state department shall randomly select and review patient files to ensure compliance with inspection form requirements and IC 16-34-2-1.1(d). The number of files selected and reviewed under this subsection shall be consistent with applicable administrative state department provisions concerning patient file inspections.**

**(b) An abortion clinic's failure to comply with IC 16-34-2-1.1(d) shall constitute an inspection violation for purposes of section 1(b) of this chapter.**

Speaker of the House of Representatives

President of the Senate

President Pro Tempore

Governor of the State of Indiana

Date: _____ Time: _____