provisions

MEDICAL LIABILITY SPECIAL REPORT

PRACTICING POST-ROE

Post-Roe Info Center

TALKING POINTS

Our primary focus is providing healthcare liability support to our insureds impacted by *Dobbs v. Jackson Women's Health Organization*. If you or your clients have questions or concerns, there are multiple avenues to get assistance.

Call ProAssurance toll-free: **800-282-6242**

Risk Management questions or concerns:

- Risk Management Consultant line: **844-223-9648**, select option 1
- Email RiskAdvisor@ProAssurance.com

To report a claim, or the possibility of a claim, contact the Claims department:

- ProAssurance: **877-778-2524** or email ClaimsIntake@ProAssurance.com
- NORCAL: **800-416-0791** or email ReportOfClaim@NORCAL-Group.com
- Find additional claims reporting instructions at ProAssurance.com/report-a-claim

A Word on Our Issue

Introducing our Post-Roe Info Center

The U.S. Supreme Court's decision to overturn *Roe v. Wade* raises significant regulatory, compliance, and practical issues for healthcare providers, health systems, and those entities that insure them. As state laws are enacted, challenged, and modified over the coming months, the implications for ProAssurance's insureds, your clients, will undoubtably change.

As it stands now, the laws of each state offer a patchwork of different abortion prerequisites, exceptions, restrictions, and penalties for illegal abortions. And there are severe penalties, both civil and criminal, directed primarily at the healthcare providers performing abortions.

We are committed to keeping our insureds informed and protecting their practice of medicine.

When discussing abortion services—medical or surgical in nature—attention must be paid to the basic premise that medical professional liability insurers cannot shield physicians from liability for illegal acts. Therefore, knowing the permissible scope of abortion services in each state is paramount and will require the involvement of a dedicated attorney from that state. Decisions made by healthcare providers in contravention of state law may indeed preclude coverage under their professional liability policy.

We are cataloguing information on this topic as it develops in our Post-Roe Info Center, at ProAssurance.com/Post-Roe. This webpage will evolve, with the goal of highlighting many of the pressing issues affecting providers who now practice in a post-Roe world.

We appreciate your assistance in directing your clients to this resource, and the ProAssurance team, as questions arise. If you are receiving questions from your insureds on how these legal changes affect their practice, our team is readily available to help. Please feel encouraged to forward or use the contact information on the previous page—or call your Business Development or Underwriting representative for assistance.

Thank you.

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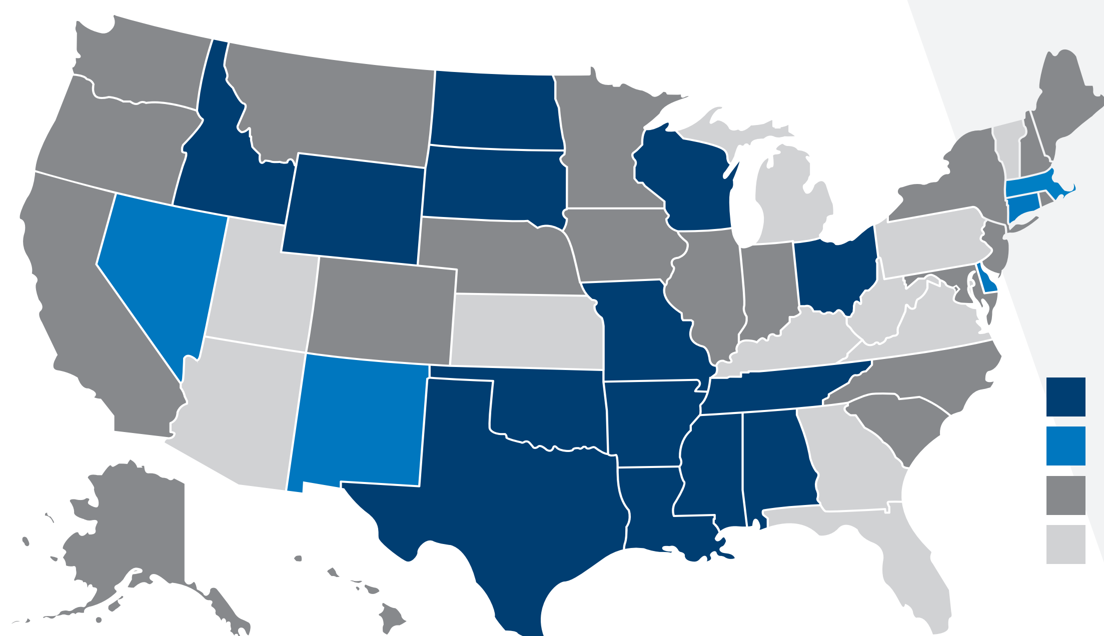
ProAssurance. Treated Fairly

__ProVisions__ is ProAssurance's monthly agent magazine. If you or your colleagues do not receive the digital version, email __AskMarketing@ProAssurance.com__. Please include names and email addresses for everyone who would like to subscribe.

Abortion in Your State

Multiple states have new limits, or pending court challenges and other conflicts, which affect abortion and contraceptive access. This will continue to change as issues move through the legislative and judicial process. Starnes Davis Florie LLC provided an initial state survey on abortion laws, which we will continue to update.

At right, we have featured states with recent changes, or issues on the ballot in upcoming elections. Get the full report with the latest information at ProAssurance.com/Post-Roe.



Alabama

Following the *Dobbs* ruling, the injunction on the 2019 Human Life Protection Act was lifted by Alabama Attorney General and the abortion ban contained within the Act went into immediate effect.

Arkansas

Abortion care was further restricted as a result of *Dobbs*. *Dobbs* triggered The Arkansas Human Life Protection Act, which is an almost-total abortion ban, with the exception to save the life of the mother in a medical emergency, to save/preserve the health of the unborn child, spontaneous abortion, and ectopic pregnancy.[1] There is no rape or incest exception.

Louisiana

Automatically once *Dobbs* was handed down, a trigger ban criminalized all abortions except to prevent death of the mother or to avert serious permanent impairment of a life-sustaining organ of the mother. There is no current exception for rape or incest. This trigger ban, however, has been temporarily blocked by the filing of a lawsuit by abortion providers. The court heard arguments July 8, 2022. A decision is still pending. Presently, all Louisiana abortion clinics have ceased to provide abortion services. There also is pending legislation that would amend the ban to remove the following scenarios from the definition of abortion: (1) removal of ectopic pregnancies, (2) the use of methotrexate to treat an ectopic pregnancy, and (3) the removal of a medically futile fetus.

Massachusetts

On June 24, 2022, the governor signed Executive Order No. 600, which protects access to reproductive healthcare services by banning state agencies from assisting other states' investigation into businesses or people for receiving/delivering abortion services that are legal in Massachusetts.

Michigan

Governor Gretchen Whitmer filed a lawsuit requesting the Michigan Supreme Court declare the pre-*Roe* laws unconstitutional, but the Court has not yet acted. There could also be a constitutional amendment to protect the right to abortion on the November ballot.

Mississippi

After *Dobbs*, Mississippi's trigger ban went into effect. Mississippi now bans all abortions except to save the life of the mother, or in cases of rape or incest that have been reported to law enforcement.[2] After being challenged in court, the trigger ban is currently in effect.

Missouri

Missouri's abortion ban contained a trigger ban that criminalized all abortions except in cases of medical emergency, which took effect on June 24, 2022. Abortions in Missouri can only be performed in cases of medical emergency, or a decision, based on reasonable medical judgment, that abortion of the pregnancy is necessary to avert the death of the pregnant woman and/or to avoid "serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman."[3]

Nevada

Abortion rights have been expanded since *Dobbs*. On June 28, 2022, Governor Steve Sisolak signed Executive Order 2022-08 entitled "Protecting Access to Reproductive Health Services in Nevada." This Order protects abortion patients and providers from other states' prosecution, providers from professional discipline, and bars state agencies from aiding other states' investigations. Anti-abortion advocates have hinted at proposing laws that require waiting periods, mandatory counseling, and/or requiring parental notification/consent for minors in the future.

New Mexico

On June 27, 2022, the governor signed Executive Order 2022-107 Protecting Access to Reproductive Health Care Services in New Mexico, which solidified the right to abortion in the state. More guarantees to abortion access, such as state funding and protection for out-of-state patients, may be enacted during the next legislative sessions. New Mexico is home to the only independent clinics in the U.S. that perform third trimester abortions without conditions, and the legal climate post-*Dobbs* is unlikely to affect that.

Ohio

An Ohio law that was previously enjoined took effect on June 24, 2022. The law criminalizes abortions after a heartbeat is detected (6 weeks) but does not apply to abortions to prevent the death or "serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman." It requires a physician who performs an abortion to document that the procedure is necessary to prevent the death/substantial impairment of major bodily function of the mother, specify the mother's medical condition, and the medical rationale behind the procedure. The physician is required to maintain a copy of the documentation for at least seven years from its creation.

Oklahoma

Oklahoma has a trigger ban that took effect June 24, 2022, which resurrects an older pre-*Roe* abortion ban. The resurrected law prohibits abortion at all stages of fetal development except to save the life of the mother.

Tennessee

Tennessee has a trigger ban which took effect on July 25, 2022. It criminalizes providers of abortions at any stage of pregnancy, except to prevent the death of the mother or "serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman." This does not include the mother's mental health. There is also no current exception for rape or incest, but some legislators are hoping to add an exception for child sex victims. Until the trigger ban goes into effect, Tennessee will implement a "heartbeat ban," which essentially bars abortions after about six weeks of pregnancy.

Wyoming

Abortion care has been further restricted post-*Dobbs*. Wyoming has a trigger law, which bans abortions after viability except when necessary to preserve the woman from a serious risk of death or of substantial and irreversible physical impairment of a major bodily function, in cases of incest, and in cases of sexual assault. There is no exception for psychological or emotional conditions. A physician or other person performing an illegal abortion can face felony charges and imprisonment up to 14 years.

References

1. Ark. Code Ann. § 5-61-301, et seq.
2. Miss. Code Ann. § 41-41-45
3. Mo. Ann. Stat. § 188.015

Tracking Patients Seeking Access Across State Lines

New Challenges for Telemedicine

At the forefront of many providers' minds is the future of telemedicine in the context of providing abortion services. ProAssurance will likely face questions from insureds about whether, and in what circumstances, they can provide medication abortion services via telemedicine and how the provisions of those services may affect their coverage.

The intersection of telemedicine and abortion generally involves "medication abortion services." In a medication abortion, patients who are within the first 70 days or up to 10 weeks after the first day of a missed period can terminate their pregnancy by ingesting a two-drug regimen (mifepristone and misoprostol). Mifepristone blocks a pregnancy-supporting hormone to terminate the pregnancy, while misoprostol causes uterine contractions to expel the pregnancy. This regimen is an FDA-approved protocol for abortion and has become increasingly popular in recent years, comprising more than half of the abortions in the U.S. in 2020.

Last year, the FDA made it easier for healthcare providers to prescribe the drugs used in medication abortions by lifting the requirement that patients see their doctors in-person before being prescribed mifepristone, the first of the two drugs used in the regimen. The FDA's actions allowed patients to obtain abortion medication without going into their physical doctor's offices, or even seeing their own doctor. Many patients turned to telemedicine to consult with a certified doctor online or over the phone and get a prescription mailed by a licensed pharmacy.

Access to medication abortion hinges not only on the FDA's decision but also on the abortion-specific regulations that are on the books in many states (or soon will be). While some states have directly banned telemedicine abortions, other state regulations—including ultrasound and counseling requirements, waiting periods, and specific in-person dispensing mandates—also play a role in limiting the feasibility of using telehealth for medication abortion. Currently, at least 19 states have specifically banned telemedicine visits for abortion while other states have legislation on the horizon to curtail access to it. Even without an outright ban on telemedicine visits for abortion, if a state bans or restricts abortions, those laws will generally cover telemedicine abortion as well.

Developing an understanding of the state law where the provider is located versus the state law where the patient is located is paramount. For the most part, the law of the state where the patient is located will govern the telemedicine interaction. Providers that offer abortion pills through telehealth into states that have banned the procedure could likely face legal consequences. For example, a healthcare provider based in New York, where abortion is legal, that offers a medication abortion through telehealth to a patient in Alabama would be subject to Alabama's state law and could face criminal penalties and medical license revocation.[1]

Conversely, if the provider is located in a state that bans abortions and attempts to offer a medication abortion to a patient in a non-banned state, there is still the very real potential that the provider's home state or its medical licensure commission could initiate an investigation and prosecute the provider. For the time being, providers living in states that ban abortion should refrain from engaging in any medication abortion services, regardless of where the patient lives or is located.

Until the law is more fleshed out, the prudent course of action for using telemedicine to provide a medication abortion is to do so only in situations where both the provider and the patient are in states that allow abortions. Even in those situations, the following practice pointers should be considered:

Confirm the state's licensure practices.

Most states require that before a physician can provide telemedicine services, they must obtain a license to practice medicine in the state where the patient is located. Make sure the insured is aware of the licensure requirements for any state they are seeking to practice telemedicine in.

Confirm the state's telemedicine laws.

Some states that allow abortion in general may still have specific laws that restrict the use of telemedicine in prescribing abortion-inducing medications or may require an in-person encounter before prescribing a medication (abortion-inducing or not). Insureds should be familiar with a state's specific telemedicine laws before conducting telemedicine in that state.

Document the location of the patient.

Have the patient confirm both in writing and orally their physical location at the time of the interaction, including the city and state. The provider should clearly document the patient's response in the chart.

Use caution if the patient's physical location is different from their home state.

Post *Dobbs*, many patients who live in states that ban abortions may travel across state lines into a state that allows abortions to participate in a call or videoconference with a telemedicine provider. Those patients may leave their state and take virtual appointments in their car and then have the abortion pills mailed to a P.O. box or other address near the state border. Though currently untested, there could be a scenario where a provider is investigated or prosecuted for prescribing a medication abortion to a patient who lives in a banned state but traveled outside the state lines for the telemedicine interaction.

Reference

1. Several states, including California, Connecticut, and Delaware, are considering (or have already enacted) legislation that would protect physicians and patients from out-of-state civil actions and/or allow physicians and patients to recover legal costs for the same. The legality of these statutes has not yet been challenged in courts.

This information was provided to ProAssurance by the Starnes Davis Florie LLP law firm.

EMERGENCY CONTRACEPTION

There is much debate in the public realm about whether contraceptives—in particular emergency contraceptives such as Plan B (levonorgestrel) and Ella (ulipristal acetate)—will be considered abortion-inducing medications that violate state laws banning abortion. Current thinking is that ProAssurance insureds should lawfully be able to prescribe and dispense these emergency contraceptives in most states.

Emergency contraceptive drugs, by and large, *prevent* rather than *terminate* a pregnancy. Plan B works by preventing the release of an egg from the ovary or preventing fertilization of the egg by sperm. Ella works by preventing or delaying the release of an egg from the ovary. Both Plan B and Ella may also work by changing the lining of the uterus to prevent development of a pregnancy. It is unlikely that these mechanisms of "prevention" would run afoul of state abortion statutes, given that most current statutes define abortion as "termination" of an existing pregnancy. In Alabama, for instance, the Human Life Protection Act makes it unlawful to "use or [prescribe] any instrument, medicine, drug, or any other substance or device with the intent to terminate the pregnancy of a woman known to be pregnant with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child." (Ala. Code § 26-23H-3)

However, each state law will define the term "abortion" differently. Moreover, every drug acts differently and may have potential abortive effects if taken improperly, at the wrong time, or in the wrong setting. Therefore, care must be taken to review both the prescribing information for the specific drug being considered and the applicable state law before making a determination in any given situation.

Additionally, many of the statutes banning abortions require "intent" on the part of the provider to terminate the pregnancy. With emergency contraceptives, there generally is no intent to terminate an existing pregnancy—the intent is to prevent a potential pregnancy. This lack of intent should provide further reassurance as to the lawfulness of prescribing emergency contraceptives such as Plan B and Ella.

Presently, there is very little in the way of official legal rulings on how each state's law will address emergency contraceptives. Without the benefit of judicial guidance, providers should continue to rely on their training, education, and experience with respect to prescribing emergency contraceptives. If a provider is concerned about the legality of prescribing a specific emergency contraceptive, the following practice pointers could be communicated:

Review the drug's package insert. What does it say about Indications, Usage, and Precautions?

Plan B's package insert, for instance, states that it is "indicated for prevention of pregnancy following unprotected intercourse or a known or suspected contraceptive failure." It further states that Plan B "is not effective in terminating an existing pregnancy." However, some emergency contraceptive drugs can also be used to terminate an existing pregnancy. If the drug labeling is unclear or explicitly acknowledges the drug can terminate an existing pregnancy, providers in states that ban abortions should consult with legal counsel before prescribing that drug as an emergency contraceptive.

Document the intent and the purpose of treatment.

In addition to normal documentation of the risks of treatment and the provider's medical decision-making, a specific entry in the record explaining the provider's intent is recommended. An entry in the record that the drug was prescribed to prevent a potential pregnancy from occurring will be useful if the prescription is ever questioned.

Is the drug one that should be taken within a certain time period following intercourse?

If so, the provider should document his/her conversations with the patient about when they had intercourse and their instructions for the timing of treatment. Some drugs may have the potential to terminate an existing pregnancy if taken outside the recommended time window. If there is potential for termination of a pregnancy based on when the treatment is given, the provider should counsel the patient about this risk, document the conversation, and document their intent and instructions to the patient to take the drug at the proper time.

Is the drug being prescribed for an indication other than pregnancy prevention?

Some emergency contraceptives also have non-contraceptive uses. For instance, Ella can also be used to treat uterine fibroids. In situations where a provider is prescribing an emergency contraceptive for a non-contraceptive reason, special care in documenting the prescription should be exercised. The record should reflect specifically why the drug is being prescribed, what medical condition warranted the use of the drug, and that extensive discussions with the patient were held regarding the potential contraceptive effect of the drug.

This information was provided to ProAssurance by the Starnes Davis Florie LLP law firm.

Ectopic Pregnancies

A common question from insureds in the wake of *Dobbs* is whether—and to what extent—ectopic pregnancies are affected by the enactment of various state abortion bans. Based on present information, the *Dobbs* ruling should not change the way healthcare practitioners care for and treat ectopic pregnancies. Healthcare practitioners should continue to follow evidence-based medicine and utilize normal medical and surgical options to address ectopic pregnancies, just as they would pre-*Dobbs*.

According to The American College of Obstetricians and Gynecologists (ACOG), an ectopic pregnancy occurs when a fertilized egg grows outside of the uterine cavity—with more than 90% of ectopic pregnancies occurring in a fallopian tube. ACOG notes that a tubal ectopic pregnancy will never be a viable pregnancy. It cannot move or be moved to the uterus. As the pregnancy grows, it can cause the structure where it is implanted to rupture, which can, in turn, cause major internal bleeding and require urgent surgery. The primary methods to treat an ectopic pregnancy include medication (commonly methotrexate) and surgery.

Presently, no abortion laws seek to criminalize the removal of ectopic pregnancies. In fact, even in states with stringent abortion bans, ectopic pregnancies are commonly excluded from the definition of "abortion" or are otherwise exempted. For example, in Alabama, the law states an "abortion" specifically "does not include a procedure or act to terminate the pregnancy of a woman with an ectopic pregnancy[.]"[1] Similarly, in Arkansas, an act is not an abortion if it is "performed with the purpose to … remove an ectopic pregnancy[.]"[2] In states that explicitly exempt ectopic pregnancies, providers should not fear prosecution and should continue to perform medical and surgical removal of ectopic pregnancies in a manner consistent with their education, training, and the standard of care.

Even if the state does not explicitly exclude ectopic pregnancies from its definition of abortion, all states currently have some form of a "medical emergency" or "life/health of the mother" exception to their abortion law. These exceptions generally allow abortion when it is deemed medically necessary to prevent the death of the patient or to avert serious risk of substantial and irreversible physical impairment to the patient. For example, Nebraska's law bans abortion after 20 weeks except in cases where a physician has made a reasonable medical judgment that the patient "has a condition which so complicates her medical condition as to necessitate the abortion of her pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function."[3] Given the serious and life-threatening nature of ectopic pregnancy, it should either be considered a "medical emergency" or a permissible procedure to preserve the life or health of the patient.

There have been reports of providers waiting until the patient becomes medically unstable before removing an ectopic pregnancy out of fear of prosecution under the state's abortion ban. However, current laws that ban abortion should not alter the clinical realities of ectopic pregnancy management or the medical decision-making of healthcare professionals. Delaying or withholding treatment for an ectopic pregnancy can lead to death. If reasonable clinical judgment indicates the ectopic pregnancy poses a risk to the patient's life, then reasonably prompt action in response to the individual circumstances should be taken.

The following practice pointers for providers are particularly relevant in the context of ectopic pregnancies:

Document the medical condition.

Make the record clear that the patient has an ectopic pregnancy, the location where it implanted (if able to be determined), and identify the tools used to make the diagnosis (i.e., ultrasound, pelvic exam, blood tests, etc.).

Document your discussion of the risks and benefits with the patient.

Except in emergency cases, the chart should reflect—at minimum—that you discussed the risks attendant with continuing an ectopic pregnancy (e.g., rupture, bleeding, injury to organs, and death). Careful documentation of your communications with the patient about the harm that can/will result if the ectopic pregnancy is not removed is paramount. If a discussion detailing the non-viability of the ectopic pregnancy occurred, document that as well.

Document the purpose of the procedure and your intent.

The record should reflect that the purpose of the procedure is to remove a non-viable/ectopic pregnancy. Phrases such as "medically necessary" and "in my reasonable medical judgment" should be used where appropriate. Additionally, document your intent for performing either medical or surgical removal. Identifying your specific intent to prevent harm to the patient using phrases such as "to reasonably avoid tubal rupture and avert internal bleeding" and/or "emergently avoid maternal death" will be particularly helpful.

Code the procedure properly.

Make sure you and any relevant staff know the proper codes for ectopic pregnancies and utilize them appropriately.

Document why the procedure is needed at the present time.

In most cases, ectopic pregnancies are treated as soon as possible to avoid rupture. Identifying the rationale for why it is medically necessary to move forward with the procedure *at the present time* may help ward off allegations that you performed the procedure "too soon" or before harm was "imminent."

Consult an attorney in your state that is familiar with the statutory language that governs abortions.

The particular wording of each state's abortion law will differ. Working with legal counsel to understand the exact phrasing contained in your state's laws can help improve your medical documentation. For instance, some states may allow abortions to avert a "serious risk." Practitioners would be wise to use terms in their medical charting that match and track the terminology in the state's laws when appropriate.

Rely on your medical training and clinical judgment.

While the current legal climate invites fear and speculation, providers should focus on making reasonable medical judgments that are guided by their medical education, training, and previous experience.

References

1. Ala. Code § 26-23H-3(1)
2. A.C.A. § 5-61-403(1)
3. Neb. Rev. St. § 28-3, 106

Federally Qualified Healthcare Facilities

Some insureds may question the role of federally qualified health care facilities (FQHC) in the provision of abortions, both in states that allow abortions and those that ban it. FQHCs are outpatient clinics that qualify for specific reimbursement systems under Medicare and Medicaid. They include Health Center Program award recipients, which receive grant funding from the Health Resources & Services Administration (HRSA) to provide primary care services in underserved areas.

Under present federal regulations, FQHCs must stay in compliance with all applicable federal, state, and local laws. Further, abortions cannot be directly or indirectly funded by federal funds—they are considered outside the scope of the health center grant. Because federal funds cannot be put toward providing abortions and all FQHCs are required to follow applicable state and local laws, if the FQHC is in a state where abortions are prohibited, the FQHC cannot provide abortions. If the FQHC is in a state where abortions are legal, they can provide abortions so long as they do not use federal funds. In other words, the FQHC seeking to provide abortions in a state where it is legal must be financially self-sustaining and will need to fiscally separate out supplies and time used to provide abortions. Given that many FQHC patients have limited ability to pay for services and that there are limited sources of reimbursement for abortions, it is likely that few FQHCs are performing abortions, even in those states where they are permitted.

This information was provided to ProAssurance by the Starnes Davis Florie LLP law firm.

Document Retention and Destruction

The Initial Question

Shortly after the *Dobbs* decision, our Risk Management consultants were contacted by a physician whose patient requested destruction of the medical records related to an abortion she had 20 years ago. The patient and physicians were located in a state that restricts abortion to six weeks but has legislation pending to ban the procedure. This scenario raises questions regarding a provider's record retention and destruction obligations.

Risk Management Considerations

First, while federal and state laws and regulations outline when medical records may be destroyed, nothing obligates a provider to accommodate a patient's request to destroy medical records—including those related to abortion procedures. In the preceding scenario, more than a decade had passed from the last treatment date; thus, destruction of the entire medical record was permissible. The provider's decision to dispose of the records came only after consideration of the controlling regulations and did not emanate from a legal obligation to honor the patient's request.

All medical records should be treated the same regarding retention and destruction. Prematurely destroying medical records, even if done at a patient's request, could violate local laws and regulations. Most states have requirements for physicians and hospitals to maintain patient records for a specific period. Your record retention policy should comply with your state's retention period requirements. Numerous online resources, including HealthIT.gov, maintain lists of state-by-state regulations.

Disposing of medical records in an untimely manner, or in a manner inconsistent with your practice's policy, could hinder the defense of a professional negligence claim. Unfortunately, retention periods are not easily defined in the context of a medical malpractice allegation. For example, some states apply a "discovery rule" to the statute of limitations for medical liability actions, meaning the limitations period does not begin until a patient discovers or should have discovered their injury is related to medical treatment received.

Because states do not have uniform record retention requirements or statutes of limitation, ProAssurance generally recommends that organizations retain adult patient records for 10 years from the date of the last treatment. Records for minors should be retained either 10 years from the date of the last visit or until the minor reaches the age of majority for that state, plus the applicable statute of limitations, whichever period is longer.

ProAssurance recommends that your organization consistently follow all aspects of your record retention policy for all medical records and destroy records only after exceeding the policy's recommended retention period.

This essay was provided by the ProAssurance Risk Management department.

News & Updates

Medical groups join to denounce legislative interference with healthcare, abortion

More than 75 healthcare organizations have joined to denounce legislative interference in the patient-physician relationship now that the U.S. Supreme Court has overturned the 1973 landmark case *Roe v. Wade*. Federal and state laws put physicians in what has been described as an "impossible situation," but they aim to work with legislators on policies.

(Medical Economics)

HIPAA won't protect you if prosecutors want your reproductive health records

With *Roe v. Wade* now overturned, patients are wondering whether federal laws will shield their reproductive health data from law enforcement, or legal action more broadly. The answer, currently, is no. If there's a warrant, court order, or subpoena for the release of those medical records, then a clinic could be required to hand them over.

(STAT News)

Now hovering in the background during a risky pregnancy: the doctor's legal team

Physicians in states where new abortion bans are leaning heavily on lawyers to decide when to terminate life-threatening pregnancies without violating state laws. That can sometimes delay care in emergency situations in which a few minutes make a big difference.

(NBC News)

Abortion bans could leave close to half of U.S. obstetrics residents with inadequate training

The overturn of *Roe v. Wade* opens questions on how medical programs can be accredited when a procedure required to be taught is illegal where they are based. Accreditation rules require training in abortions for residents, who may need it for treating miscarriages and other complications, doctors say.

(USA Today)

HHS affirms abortion services covered by federal emergency care law

Emergency medical services include abortion services, according to the U.S. Department of Health and Human Services (HHS). The federal department announced new guidance to physicians across the country about the Emergency Medical Treatment and Active Labor Act (EMTALA). HHS Secretary Xavier Becerra reaffirmed the federal law protects providers when offering legally mandated, life- or health-saving abortion services in emergency situations.

(Medical Economics)

Risk Management Learning System Upgrade

On August 22, we will be upgrading our learning management system. Your clients will need to complete any seminars they have started by August 21 to avoid losing their progress in the transition. This upgrade will not change the method for accessing or completing CME content going forward.

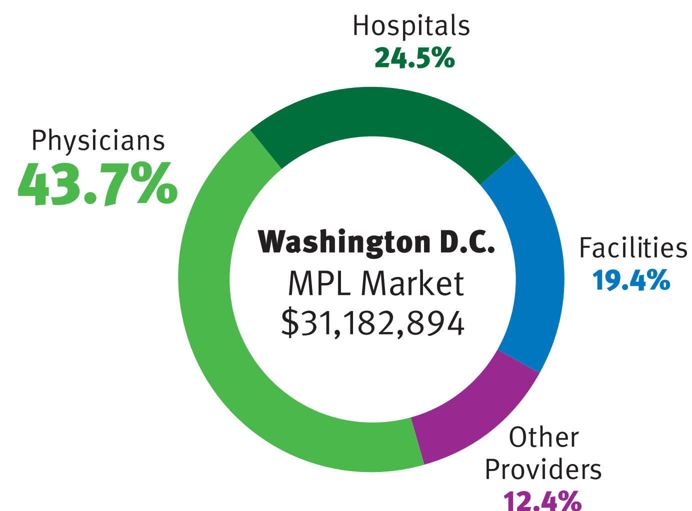
If you have questions or your clients need additional assistance, the Risk Management team is available at 844-223-9648 or RiskAdvisor@ProAssurance.com.

NORTHEAST REGION

MPL State Profile

Washington D.C.

- PRA New Business Paper
- 46 2021 Rank in MPL Market
- 1 **2021 ProAssurance Industry Rank**



One Party or All Party Consent

Washington D.C. has one party consent.

In D.C. it is a criminal offense to use any device to record communications whether it's wire, oral or electronic without the consent of at least one person taking part in the communication. There is a caveat in that recording is allowed to take place if there is no reasonable expectation of privacy such as a public place such as a street or park.

Telemedicine Regulations

Medicaid Reimbursement: Medicaid is required to cover healthcare services appropriately delivered through telehealth if the same services would be covered when delivered in person. Medicaid enrolled providers are eligible to deliver telemedicine services at the same rate as in-person consultations.

Licensure Compact(s): Member of the Interstate Medical Licensure Compact, Member of Physical Therapy Compact, Member of the Psychology Interjurisdictional Compact

Consent Requirements: Must obtain and document patient consent, except when providing interpretive services.

Abortion Law

Pre-*Dobbs*: D.C. has statutorily protected the right to abortion at all stages of pregnancy. However, D.C. law prohibits using local funds to pay for abortions for Medicaid patients.

Post-*Dobbs*: Abortion care in D.C. is unlikely to change due to *Dobbs*.

See D.C. Code § 2-1401.06; United States v. Vuitch, 402 U.S. 62 (1971).

Prejudgment Interest

- **Tort actions rate:** Prejudgment interest is neither authorized nor forbidden by statute. However, a court may award interest, in its discretion, if needed to make the plaintiff whole.
  - Do Id.; Burke v. Groover, Christie & Merritt, P.C., 26 A.3d 292 (D.C. 2011).
- **Accrual date:** From the date needed to make the plaintiff whole.
  - D.C. Code § 15–109.
- **Postjudgment Contract and Tort Actions Rate:** If not specified by contract, "70% of the rate of interest set by the Secretary of the Treasury pursuant to section 6621 of the Internal Revenue Code of 1986 ... rounded to the nearest full percent, or if exactly 1/2 of 1%, increased to the next highest full percent; provided, that a court of competent jurisdiction may lower the rate of interest under this subsection for good cause shown or upon a showing that the judgment debtor in good faith is unable to pay the judgment."
  - D.C. Code § 28-3302.
- **Accrual date:** The date of judgment
  - D.C. Code § 15-109; Bell v. Westinghouse Elec. Co., 507 A.2d 548 (D.C. 1986).

Tort Laws

- **Limits on damages for pain and suffering:** None
- **Limits on contingent attorney fees:** None
- **Reform of collateral source rule:** None
- **Periodic payment of future damages:** None
- **Statute of limitations:** 3 years from discovery
  - §12-301 (1963)

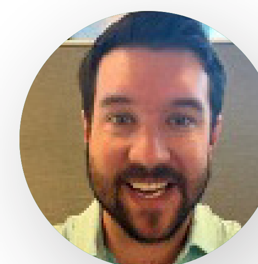
New What's the Risk video—Service Animals

What happens when a patient shows up at your facility with a dog and claims that it is a service animal?

Do you allow the animal in the waiting room with your other patients? Do you have the right to ask the patient why they require this animal? You soon find out that the dog is actually an emotional support animal. So now what? In this video, Tina Santos, Regional Manager, Risk Management, reviews the difference between service animals and emotional support animals.

Watch the latest *Two Minutes: What's the Risk? Service Animals* video from our Risk Management team.

ProAssurance Welcomes Robert Crotty



We are pleased to announce that Robert Crotty has joined ProAssurance as a Business Development Representative for the Southeast Region.

Raised in Louisville, Kentucky, Robert graduated from the University of Louisville and currently resides in Tampa, Florida. He got his start in insurance in 2017 and most recently worked for Chubb Insurance as an Underwriting Account Representative.

Robert has responsibility for managing the flow of critical communications to our agents and brokers regarding our new business goals, product development, and other resources available to support a continuing ProAssurance competitive marketplace advantage. He will collaborate with Underwriting and other functional areas on renewal accounts, assuring the highest level of service possible to our agent and broker partners. The Southeast Region includes Tennessee, North Carolina, South Carolina, Mississippi, Georgia, Alabama, and Florida.

You can reach Robert directly at 904-309-8122 and RobertCrotty@ProAssurance.com.

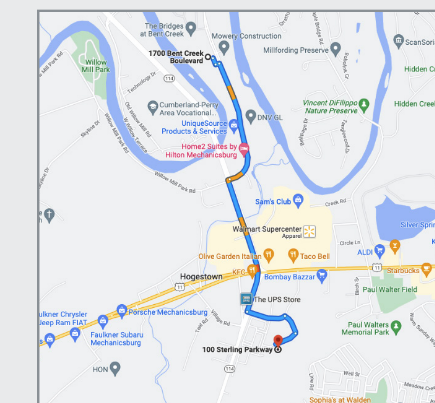
Please join us in welcoming Robert to ProAssurance and wishing him success in his new role.

Our PA Office Is Moving...

September 6, 2022 the Mechanicsburg, PA office will be relocated:

FROM
1700 Bent Creek Blvd
Suite 160
Mechanicsburg, PA 17050

TO
100 Sterling Parkway
Suite 205
Mechanicsburg, PA 17050



Phone numbers for all employees who report to this office will remain the same.

To subscribe or see previous issues, visit ProAssurance.com/ProVisions.

IMPORTANT

Please Remove All References to NORCAL Mutual on Your Agency Websites

As part of the demutualization process, NORCAL Mutual was renamed NORCAL Insurance Company, or NORCAL—referred to as NORCAL or NORCAL Group in running text. To clarify that the organization is no longer a mutual, please update any references to NORCAL on your website.

If you need updated logos, flyers, or other sales materials, email AskMarketing@ProAssurance.com.

Thank you!