

ABORTION-RELATED AMENDMENTS

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House Bill 5711 as enrolled
Public Act 499 of 2012
Sponsor: Rep. Bruce R. Rendon

House Committee: Health Policy
Senate Committee: Judiciary

Second Analysis (2-14-13)

BRIEF SUMMARY: The bill amended various sections of the Public Health Code to address matters related to the performance of abortions. Among other things, the bill does the following:

- Revises the definition of "abortion" and add definitions for "medical abortion" and other terms.
- Adds requirements regarding the disposition of a dead fetus and of fetal remains.
- Requires a mandatory physical examination to be personally performed on a woman by a physician (or other licensed, qualified assistant) prior to the diagnosing and prescribing of a "medical abortion." Other methods of examination, such as by an internet web camera ("telemedicine"), would be prohibited.
- Requires licensing of facilities, including private practice offices, as freestanding surgical outpatient facilities if they publicly advertise outpatient abortion services and perform 120 or more abortions per year.
- Requires screenings for coercion to abort and domestic violence by physicians and others when patients first present at a facility for the purpose of obtaining an abortion. This would include mandatory reporting by a physician to child protective services if a minor patient reported coercion to abort by a person responsible for that minor patient's health or welfare.
- Creates administrative sanctions for providers who violate the provisions pertaining to domestic violence, coercion to abort, and medical abortions and a civil infraction for violations pertaining to final disposition of a dead body or fetal remains.
- Allows DCH to release to LARA, for regulatory purposes only, the reports or contents of the abortion reports completed by a physician for each abortion procedure. Disclosure outside of either agency that would identify a patient, an

abortion provider, or name or address of a facility performing an abortion is prohibited.

- Requires annual reports by DCH to LARA regarding the name and location of each facility performing abortions, the number of abortions and surgical abortions performed, and whether the facility publicly advertises abortion services.

FISCAL IMPACT: The bill has fiscal implications for several state departments, as discussed in more detail later in the analysis. (See Fiscal Information.)

THE APPARENT PROBLEM:

According to Right to Life of Michigan, as detailed in their recently released document "Abortion Abuses and State Regulatory Agency Failure," there has been a long pattern of unethical, illegal, and unsafe practices on the part of abortion providers in the state. They cite incidents of physicians leaving the premises before an abortion is complete or while women are still in recovery, not having emergency equipment on hand or emergency protocols in place to deal with emergent situations, unsterile equipment, easy access by anyone to drugs stored improperly on the premises, improper disposal of medical wastes (including fetal remains, blood, and other bodily fluids), and improper storage and disposal of confidential medical records and patient personal identifiers. Apparently, most providers offering surgical abortions do not have to be licensed as free standing surgical outpatient facilities (FSOF), even though serious complications from abortions, though rare, can happen. Currently, only 4 of the 32 clinics or practices offering surgical abortions in the state are licensed as FSOFs. Even then, the law allows them to waive many of the safety requirements that apply to other FSOFs. In order to ensure women choosing abortions receive services in the cleanest, safest environment, many feel that stricter state oversight is warranted.

In a related matter, ever since a 2010 incident in Delta Township (near Lansing) in which bags containing confidential patient records and the remains of 17 aborted fetuses were reported to have been found in a dumpster outside a women's health clinic, many have called for tighter rules regarding the disposal of fetal remains and confidential patient files and information. According to media reports at the time, because the fetuses had been treated with formaldehyde, authorities investigating the incident determined that the medical waste statutes had not been violated and so there were no grounds for criminal prosecution. Some feel that fetal remains should be disposed of with more dignity.

Further, there is a concern that some pregnant girls and women are coerced or harassed into choosing an abortion against their wills. Reportedly, the coercion and/or harassment typically comes from the boyfriend or husband, parents, other family members, close friends, and sometimes employers and can range from verbal threats of loss of financial support or living arrangements, ending the relationship, physical violence, or being fired to actual physical harm and in extreme cases, even death to the pregnant female. Abusive boyfriends and spouses have been known to beat to the point of miscarriage a woman who refused to obtain an abortion. Homicide is a leading cause of death of pregnant

women, and many incidents stem from domestic violence situations. Workers and volunteers at crisis pregnancy shelters say that many clients report experiencing undue pressure to choose abortion, whereas they would prefer to carry the baby to term. Underage girls have reported being dragged, sometimes even physically carried, by their parents into abortion clinics against their will. Some who do post-abortion counseling report that when pressured to choose abortion against their will, many women suffer long-term emotional distress and depression that affects their overall quality of life.

Thus, at the initiative of Right to Life of Michigan and other pro-life citizens, legislation was introduced to address these and other concerns.

THE CONTENT OF THE BILL:

House Bill 5711, which became Public Act 499 of 2012, added several new sections to the Public Health Code (PHC) and amended numerous existing provisions related to abortion services (MCL 333.2803 et al.). Public Act 499 takes effect March 31, 2013. A detailed description of the changes to the PHC by PA 499 (hereinafter "the act") follows.

Revised Definition of "Abortion"

The act revised the definition of "abortion" to mean the intentional use of an instrument, drug, or other substance or device to terminate a woman's pregnancy for a purpose other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a ~~(dead)~~ fetus *that has died as a result of natural causes, accidental trauma, or a criminal assault on the pregnant woman*. Abortion does not include the use or prescription of a drug or device intended as a contraceptive. (Highlighting denotes changes.)

Fetal Death Reports

A fetal death occurring in the state must be reported to the state registrar within five days after delivery on a prescribed form. The act includes a stillbirth in the definition of a "fetal death."

If a dead fetus is delivered *in an institution*, the PHC requires the individual in charge (or an authorized representative) to prepare and file the fetal death report. The act clarifies that this requirement pertains to a dead fetus that has completed at least 20 weeks of gestation or weighs at least 400 grams. In addition to filing the fetal death report, the act requires the individual in charge at the institution (or the representative) to follow the protocols in place for the institution in the event of a death occurring after a live birth but before being discharged.

The act revised the definition of "live birth" to mean that term as defined in Section 1 of the Born Alive Infant Protection Act (MCL 333.1071). The term is defined in that act as the complete expulsion or extraction of a *product of conception* from its mother, regardless of the duration of the pregnancy, that after expulsion or extraction, whether or

not the umbilical cord has been cut or the placenta is attached, shows any evidence of life, including, but not limited to, one or more of the following: breathing, a heartbeat, umbilical cord pulsation, and/or definite movement of voluntary muscles.)

"Product of conception," however, is defined in PA 499 to exclude a fetus or fetal body parts and to refer only to tissues or fluids, placenta, umbilical cord, or other uterine contents resulting from a pregnancy.

Reporting Performance of an Abortion

A physician who performs an abortion is required under the PHC to report each procedure to the Department of Community Health (DCH) within seven days after the procedure. The DCH or its employees are prohibited from disclosing to a person or entity outside of the DCH the reports or any content contained in the reports that could identify an individual who underwent an abortion. The act extends the prohibition to include disclosures that could identify the physician who performed the abortion or the name or address of a facility in which an abortion was performed.

The act also permits the DCH to release the reports or their contents to the Department of Licensing and Regulatory Affairs (LARA) for regulatory purposes only. The same prohibitions restricting disclosure of the reports or their content by DCH and its employees and penalties for such actions would apply to LARA and its employees. (A violation is a felony punishable by imprisonment for not more than three years and/or a fine of not more than \$5,000.)

Disposition of Dead Bodies and Fetal Remains Resulting from Abortion

The term "final disposition" was revised to mean the burial, cremation, interment, or other legal disposition of a dead body or fetal remains. (Underlining denotes changes.) The term "dead body" was not revised and means a human body or fetus, or a part of dead human body or fetus, in a condition from which it may reasonably be concluded that death has occurred. The act defines "fetal remains" to mean a dead fetus or part of a dead fetus that has completed at least 10 weeks of gestation or has reached the stage of development that, upon visual inspection, the head, torso, or extremities appear to be supported by skeletal or cartilaginous structures. (The term does not include the umbilical cord or placenta.)

All fetal remains resulting from abortions must be disposed of by interment or cremation as those terms are defined in Section 2 of the Cemetery Regulation Act, or by incineration by a person other than a registered cemetery. (Thus, final disposition of non-aborted fetal remains, including from miscarriage, and remains from abortions before 10 weeks would fall under other provisions of the PHC.)

Unless the mother provided written consent for research on the fetal remains under provisions of the PHC, the physician who provides the abortion must arrange for the final disposition of those remains. The act does not require a physician to discuss the final

disposition of fetal remains with the mother prior to performing the abortion, nor does it require a physician to obtain authorization from the mother for the final disposition of the fetal remains upon completion of the abortion.

Authorization for Final Disposition of Dead Fetus and Fetal Remains

Section 2848 of the Public Health Code requires that a funeral director (or person acting as a funeral director) who first assumes custody of a dead body obtain authorization for final disposition of that dead body. In the case of a dead fetus, before final disposition, the PHC requires the funeral director or person assuming responsibility for the final disposition of the fetus (the act added fetal remains) to obtain an authorization for final disposition from the parent/parents. Under the act, this requirement does not apply if the mother has provided written consent for research on the dead fetus under Section 2688 or as otherwise provided in Section 2836 (fetal remains resulting from an abortion, as discussed earlier).

The authorization may allow final disposition to be by a funeral director, the individual in charge of the institution where the fetus was delivered (the act adds miscarried), or an institution or agency authorized to accept donated bodies or fetuses (the act adds fetal remains). The act defines "miscarriage" as the spontaneous expulsion of a nonviable fetus that has completed less than 20 weeks of gestation.

The act also allows the parents or parent (if the mother is unmarried) to direct the final disposition to be interment or cremation under the Cemetery Regulation Act or incineration.

No Religious Service or Ceremony Required

The act says that it does not require a religious service or ceremony as part of the final disposition of fetal remains.

Violations of Fetal Remains and Dead Body Requirements

A person who violates Part 28 of the Code (Vital Records) by failing to dispose of fetal remains resulting from an abortion or by failing to obtain the proper authorization for final disposition of a dead body (which includes a fetus) is responsible for a state civil infraction and may be ordered to pay a civil fine of up to \$1,000 per violation.

Personal Physical Examination by Physician before "Medical Abortion"

A physician (M.D. or D.O.) could not diagnose and prescribe a medical abortion for a patient who is or who is presumed to be pregnant unless the physician or an individual licensed and qualified by education and training first personally performs a physical examination of the patient. A physician could not use other means, such as an internet web camera, to diagnose and prescribe a medical abortion.

A physician must obtain the informed consent of a patient in the manner prescribed under Section 17015 to perform a medical abortion. The physician must be physically present at the location of the medical abortion when the prescription drug used to initiate the medical abortion is dispensed. An individual under the direct supervision of the prescribing physician who is qualified by education and training (under the PHC) could dispense or administer the prescription drug used to initiate the medical abortion.

The term "medical abortion" means an abortion procedure that is not a surgical procedure and that utilizes a prescription drug to induce an abortion. "Prescription drug" means that term as defined in Section 17708 of the PHC. (Section 17708 defines that term to mean a drug dispensed pursuant to a prescription; a drug bearing the federal legend "CAUTION: federal law prohibits dispensing without prescription" or "Rx only"; and/or a drug designated by the board as a drug that may only be dispensed pursuant to a prescription.)

The provisions pertaining to a medical abortion do not create a right to abortion, and a person is prohibited from performing an abortion prohibited by law.

All of the above provisions will sunset on December 31, 2018.

Protocols for Coercion-to-Abort and Domestic Violence Screening

At the time a patient first presents at a private office, freestanding surgical outpatient facility, or other facility or clinic in which abortions are performed for the purpose of obtaining an abortion [whether before or after the 24-hour period described by Section 17015(3)], the physician or qualified person assisting the physician must orally screen the patient for coercion to abort using screening tools to be developed by the DCH. The oral screening could occur before the requirements of Section 17015(3) were met.

"Coercion to abort" means an act committed with the intent to coerce an individual to have an abortion, which act is prohibited by Section 213A of the Michigan Penal Code. (Note: House Bill 4799, which would have created Section 213A to make it a criminal offense to coerce a woman into having an abortion, was not enacted. Therefore, Section 213A does not yet exist.)

If a patient discloses coercion to abort or that she is the victim of domestic violence that does not include coercion to abort, the physician or qualified person assisting the physician would be required to follow the protocols developed by the department under Section 17015(11) of the PHC.

If a patient under 18 years old discloses domestic violence or coercion to abort by an individual responsible for her health or welfare, the physician or qualified person assisting the physician would have to report that fact to a local child protective services office.

A private office, freestanding surgical outpatient facility, or other facility or clinic in which abortions are performed must post a notice stating that it is illegal for anyone to

coerce a woman into seeking an abortion (Note: House Bill 4799, which would have made it illegal to coerce a woman into seeking an abortion, was not enacted). The notice must be posted in a conspicuous place in an area of the facility accessible to patients, employees, and visitors. Publications containing information about violence against women must be made available in an area accessible to patients, employees, and visitors.

The above provisions would not create a right to abortion and a person could not perform an abortion prohibited by law.

Revisions to the Informed Consent Provisions

Section 17015 of the PHC prohibits a physician from performing a lawful abortion without the patient's informed written consent, given freely and without coercion to abort. The provision also requires certain conduct on the part of the physician or the qualified person assisting the physician not less than 24 hours before the abortion is performed, such as confirming that the patient is pregnant. Among numerous revisions, the act added to these duties a requirement to provide the patient with a physical copy of the prescreening summary on the prevention of coercion to abort. This new requirement could be fulfilled by a patient accessing the Internet website maintained and operated by the DCH in the same manner as receiving other required informed consent materials.

Acknowledgment and Consent Form Changes

The PHC requires the DCH to develop, draft, and print an acknowledgment and consent form that must be signed by a patient prior to obtaining an abortion. The act changed the timeframe for when the acknowledgement and consent form is required to be obtained. Instead of requiring the form to be signed *before performing an abortion*, the act would require the physician or qualified person assisting the physician to obtain the patient's signature on the acknowledgment and consent form and provide a physical copy of the signed form to the patient *after the expiration of the 24-hour informed consent period but before performing the abortion*.

Before obtaining the patient's signature on the acknowledgement and consent form, a physician personally and in the presence of the patient would have to confirm with the patient that the mandatory coercion-to-abort screening had been performed.

The act also requires the form to state that the authorization for the procedure is done *voluntarily and willfully*. The form would also have to include the following line: *I understand that it is illegal for anyone to coerce me into seeking an abortion*. (As noted earlier, the bill that would have specifically made this conduct illegal was not enacted.)

Sanctions Against Health Professionals

LARA may investigate activities related to the practice of a health profession by a licensee, a registrant, or an applicant for licensure or registration and report its findings to

the appropriate disciplinary subcommittee. The disciplinary subcommittee is authorized to impose administrative sanctions for certain violations.

Under the act, a violation of the requirements pertaining to the coercion-to-abortion and domestic violence screenings and medical abortions would carry the same penalties imposed for violations of the informed consent provisions. Sanctions could include license or registration denial, revocation, probation, suspension, or limitation, or a reprimand, fine, or restitution.

Coercion-to-Abort and Domestic Violence Materials

The DCH, after considering the standards and recommendations of the Joint Commission on Accreditation of Healthcare Organizations, the Michigan Domestic and Sexual Violence Prevention and Treatment Board, the Michigan Coalition to End Domestic and Sexual Violence (or a successor organization), and the American Medical Association, would have to:

- Develop, draft, and print (or make available in printable format), in nontechnical English, Arabic, and Spanish, a notice that is required to be posted in facilities and clinics. The notice would have to be at least 8.5 inches by 14 inches and be printed in at least 44-point type and must contain at a minimum all of the following: (1) a statement that it is illegal under Michigan law to coerce a woman to have an abortion (Note: No such specific law yet exists as House Bill 4799 was not enacted); (2) a statement that help is available if a woman is being threatened or intimidated; physically, emotionally, or sexually harmed; or feels afraid for any reason; and (3) the telephone number of at least one domestic violence hotline and one sexual assault hotline.
- Develop, draft, and print (or make available in printable format), in nontechnical English, Arabic, and Spanish, a prescreening summary on prevention of coercion to abort that, at a minimum, contains the information listed in the paragraph above, and notifies the patient that an oral screening for coercion to abort will be conducted before she gives written consent to obtain an abortion.
- Develop, draft, and print screening and training tools and accompanying training materials to be used by a physician or a qualified person assisting the physician while performing the required coercion-to-abortion screening. The screening tools would have to instruct the physician or qualified person to orally communicate information to the patient regarding coercion to abort and to document the findings from the coercion-to-abortion screening in the patient's medical record.
- Develop, draft, and print protocols and accompanying training materials to be utilized by a physician or a qualified person assisting a physician if a patient discloses coercion to abort or that domestic violence is occurring, or both, during the coercion-to-abortion screening. The protocols must instruct the physician or qualified person assisting the physician to do, at a minimum, all the following:

- Follow the screening requirements of Section 17015a as applicable.
- Assess the patient's current level of danger and explore safety options.
- Provide referral information regarding law enforcement and sexual assault support organizations.
- Document any referrals in the patient's medical record.

Licensing as Freestanding Surgical Outpatient Facility

Under Public Act 499, the Department of Licensing and Regulatory Affairs (LARA) is required to specify in rules that a facility, including a private practice office of a physician, must be licensed under Article 17 of the Health Code as a freestanding surgical outpatient facility (FSOF) if that facility publicly advertises outpatient abortion services and performs 120 or more surgical abortions per year. Such a facility would not require a certificate of need to be granted a license. However, a facility would be subject to CON provisions for services performed at the facility other than abortions. (This provision replaces a requirement for a facility, including a private practice office, to be licensed as an FSOF if 50% or more of the patients served annually underwent an abortion.)

Further, under certain conditions, the PHC permits LARA to modify or waive one or more departmental rules regarding construction or equipment standards relating to FSOFs that provide abortion services. The act amended the provision to apply the waiver only to an FSOF that performs 120 or more surgical abortions per year and that publicly advertises outpatient abortion services, but only if the FSOF was in existence and operating on December 31, 2012, (instead of March 10, 2000) and if the department determined that existing (or proposed modifications to) construction or equipment conditions are adequate to preserve the health and safety of patients and employees without meeting the specific requirements of the rules. (The latter condition was unchanged by the act.)

"Publicly advertises" would mean using directory or Internet advertising including yellow pages, white pages, banner advertising, or electronic publishing.

"Surgical abortion" would mean an abortion that is not a medical abortion as defined in the act.

Report by DCH to LARA

The act requires DCH, by January 15 of each year, to provide all of the following information to LARA:

- From data received by DCH from physicians through the abortion reporting requirements: the name and location of each facility at which abortions were performed during the immediately preceding calendar year; the total number of abortions performed at that facility location during the immediately preceding

calendar year; and the total number of surgical abortions performed at that facility location during the immediately preceding calendar year.

- Whether a facility at which surgical abortions were performed in the immediately preceding calendar year publicly advertised abortion services.

Other Definitions

The definition of "pathological waste", which does include products of conception, was revised to exclude a fetus or fetal body parts. Pathological waste is included in the definition of "medical waste."

"Products of conception" is defined in the act as any tissues or fluids, placenta, umbilical cord, or other uterine contents resulting from a pregnancy, but does not include a fetus or fetal body parts.

FISCAL INFORMATION:

Community Health

HB 5711 as enrolled establishes additional requirements for the Department of Community Health to develop and maintain new protocols, screening and training tools, notices for public posting and other information for providers and the public related to the Informed Consent for Abortion Law and website, and to provide abortion report information to the Department of Licensing and Regulatory Affairs for regulatory purposes. These responsibilities will require a modest amount of staff time and related costs annually to develop, maintain, and carry out.

Related to the responsibility for final disposition of fetal remains, the bill may have a fiscal impact on public facilities and providers. Any civil fine revenue collected from violators related to the disposal of fetal remains will be provided to public and county law libraries pursuant to the Revised Judicature Act.

Licensing and Regulatory Affairs

PA 499 would have a significant fiscal impact on the Bureau of Health Systems (BHCS) to the extent that additional abortion providers would require licensure as freestanding outpatient surgical facilities (FSOF).

Under the Public Health Code (1978 PA 368), the Bureau of Health Care Services (BHCS) is required to inspect freestanding surgical outpatient facilities (FSOF) annually to ensure compliance with applicable state laws and rules. Previously, healthcare facilities, including private practices, which annually provide abortion services for at least 50% of their patients, require licensure as a FSOF. However, due to previous confidentiality requirements, the Department of Community Health (DCH) was unable to share data with the BHCS regarding the number of abortions provided by particular

facilities; thus abortion providers had to self-identify in order to become licensed as a FSOF. There were four abortion providers licensed as FSOFs during 2012.

Under PA 499, healthcare facilities, including private practices, which advertise surgical abortion services and perform 120 or more surgical abortions per year, would require licensure as a FSOF. PA 499 amends the Public Health Code to permit DCH to share abortion data with the BHCS for regulatory purposes and directs DHS to provide the BHCS with data pertaining to the number of abortions performed at facilities and whether that facility publicly advertises.

Under PA 499, based on DCH induced-abortion data, the BHCS estimates that an additional 16 abortion providers in the state would require licensure as a FSOF. The current fee per license for FSOFs is \$238 annually, which is insufficient to cover the expenses of licensure and inspection of FSOFs. Currently these fees generate \$28,560 annually while the expense of licensing and inspecting FSOFs is approximately \$201,500. Sixteen additional FSOFs would generate an additional \$3,808 which would be inadequate to support the additional expenses of licensure and inspection.

In the FY 12-13 omnibus budget, the Legislature appropriated an addition \$530,000 of GF/GP for the inspection of FSOFs. This amount coincides with the amount recommended in BHCS' Sec. 731 fee report for additional funding to inspect all FSOFs. However, the BHCS also recommend triennial inspections rather than annual and this amount was calculated to support the expenses of triennial inspections, therefore it would have to be approximately tripled to support annual inspections.

State Civil Infraction Fine Revenue

Any additional civil fine revenue collected from new infractions would benefit local libraries.

ARGUMENTS:

For:

Public Act 499 represents a compromise that addresses some concerns raised by Right to Life of Michigan. Some important provisions of the act include the following:

- The act is clear as to the final disposition of fetal remains from abortion procedures, as well as from miscarriages. All fetal remains resulting from an abortion at 10 weeks or later (and for those showing some skeletal formation) will have to be interred, cremated, or incinerated (i.e., by a medical waste company). Final disposition of non-aborted fetal remains (10 weeks or later) or dead fetuses of any gestational age, including stillborns and miscarriages, would require parental authorization but could include interment, cremation, or incineration. In addition, the act is also clear that the treatment of products of conception, defined to include the placenta and umbilical cord, among other things, will be regulated under the Medical Waste Regulatory Act. These revisions are expected to treat

the remains of dead fetuses with dignity and to prevent any future occurrences of aborted fetuses being tossed into dumpsters.

- The act is silent regarding the fetal remains from a medical abortion, but since medical abortions are generally only performed up to nine weeks (63 days) and completed at home, it appears that the act's requirements for final disposition of fetal remains (which are triggered for fetuses 10 weeks and later) would not pertain to the remains from a medical abortion.
- The act ensures that a woman losing her baby to miscarriage has an opportunity for input on the final disposition of her baby's remains. This involvement and assurance that the final disposition was in accordance with her wishes can be an important part of the grieving process.
- The act revises the criteria that would trigger licensure as a freestanding surgical outpatient facility; only surgical abortions, and not medical abortions, would be counted when making a determination if licensure as an FSOF were required. Therefore, a private practice that only performed medical abortions would not need to be licensed as an FSOF.

For:

According to Futures Without Violence (formerly Family Violence Prevention Fund), "a significant proportion of women seeking abortions have a history of lifetime or current IPV." ("IPV" means intimate partner violence and includes threatening or acting violent if the partner doesn't comply with the perpetrators wishes regarding contraception or the decision whether to terminate or continue a pregnancy.) Nationally, between 14 percent and 25.7 percent of women seen at abortion clinics report experiencing physical and/or sexual IPV in the previous year. Women and teens who seek abortions are almost three times more likely to have been victimized by an intimate partner in the past year as compared to women who continue their pregnancies. (From the manual "Addressing Intimate Partner Violence Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic, and Reproductive Health Care Settings" by Futures Without Violence.)

Therefore, requiring abortion providers to screen for coercion to abort will protect a woman's right to choose. Whether to carry a baby to term or to abort is a decision a woman will be affected by throughout her lifetime. It is one thing to offer advice or admonition, another thing to bully or physically assault a pregnant woman into doing something she may regret and feel guilty over for the rest of her life.

In addition, according to "The Facts on Reproductive Health and Partner Abuse", also by Futures Without Violence, up to one in 12 pregnant women are battered and "homicide is the second leading cause of traumatic death for pregnant and recently pregnant women in the U.S., accounting for 31 percent of maternal injury deaths." Requiring abortion providers to screen for domestic violence and provide information about options such as domestic violence shelters and support organizations could reduce incidents of domestic violence related to unplanned pregnancies by getting women at risk into safe places.

Response:

According to Futures Without Violence, the "relationship between violence and continuing or terminating a pregnancy is bidirectional." Where some women aren't allowed to continue their pregnancies if they want to, others who want to terminate their pregnancies are also not allowed to. Often, these latter pregnancies are a result of contraception sabotage or forced unprotected sex by an abusive partner who uses sex and/or pregnancy as a means of controlling the woman. Legislation therefore should focus on *all* forms of intimate partner violence, not just on whether the woman experienced coercion to abort.

Further, the act requires an abortion provider to call child protective services (CPS) if a minor requesting an abortion discloses either domestic violence or coercion to abort by a parent or other person responsible for that minor's health or welfare. However, mandatory reporter laws already require all physicians (and numerous other professionals) to report suspected child abuse or neglect to the Department of Human Services. Child abuse includes threatened harm through injury and neglect includes threatened harm to a child's health or welfare by failing to provide adequate food, clothing, shelter, or medical care. Since this has long been law, perhaps increasing physician awareness as to how the mandatory reporting laws may apply in situations in which a minor seeks an abortion would be more constructive than seeming to single out abortion providers with an additional requirement.

For:

By changing the criteria for licensure as a freestanding surgical outpatient facility (FSOF) from 50 percent of the patients served annually undergoing abortions to 120 or more surgical abortions performed annually, the act will require more abortion providers to be licensed as FSOFs. This will better ensure that procedure rooms in facilities or private practice offices that offer surgical abortion services will be sanitary, follow safe practices regarding the transmission of blood borne illnesses and infections, and have appropriate medical staff and equipment on the premises should a complication arise. It means that most, if not all, of the providers offering surgical abortions will have to follow the same health and safety protocols as other medical providers offering comparable procedures (e.g., use of anesthesia, generating medical wastes, risks associated with invasive procedures and medication reactions, sterilization of equipment, infection, etc.). They will also be subject to inspections by the state.

Without such standards in place, women are put at risk of death or serious harm when there are no crash carts or trained medical professionals on hand to resuscitate them if they have a reaction to anesthesia, no emergency transport on hand if they experience heavy bleeding or other medical emergency, improper sterilization of equipment that exposes them to blood borne infections such as HIV or hepatitis or infections that could leave them infertile, medical assessments and performance of some procedures left to nonmedical personnel with no direct physician supervision, among other things. Regulation as an FSOF means a facility would have to meet exacting medical care standards that will improve patient safety and outcomes.

Response:

For licensure as an FSOF to be triggered, the facility must perform an average of 10 surgical abortions a month and publicly advertise those outpatient services. It would appear that a facility could circumvent the licensure requirement, regardless of how many surgical abortions it performed in a year, if it opted to forgo advertising and rely on word of mouth or even referrals from other agencies or medical providers.

For:

By January 15, 2014, the Department of Community Health must begin to provide annually to the Department of Licensing and Regulatory Affairs information gathered from the abortion reports required of abortion providers when a procedure is performed. This may enable LARA to determine if an abortion provider meets the criteria requiring licensure as a freestanding surgical outpatient facility (FSOF). Previously, this information was not shared between the two agencies. The act makes it clear in Section 2835 that though DCH may share information contained in the abortion reports with LARA, it is for regulatory purposes only. Employees from both agencies are prohibited from publicly disclosing any information that could identify the patient, the physician who performed the abortion, or the facility where the abortion was performed. A violation is a felony punishable by up to three years in prison and/or a substantial fine.

Against:

The act has several problematic, vague, and/or incorrect references and provisions.

- For instance, the definition of "coercion to abort" says that it is illegal to coerce a woman to abort under a provision of the Michigan Penal Code and patients must be told that it is a crime, but the bill that would have created that crime was not enacted.
- The definition of "live birth" is now out of sync with the definition of "products of conception." "Live birth" requires assessment of products of conception for signs of life, such as a beating heart or blood pulsating through the umbilical cord. Yet, where accepted medical definitions include fetal tissue and fetuses as products of conception, Public Act 499 excludes it. "Products of conception" under the act refers just to fluids and tissues that are not part of the fetus. Amniotic fluid won't be breathing or have a heartbeat, nor will an umbilical cord that is detached from a fetus. Thus, the new definition of "products of conception" potentially renders the definition of "live birth" meaningless.
- All of the provisions pertaining to medical abortions, including the definition of the term and a requirement for a woman to first undergo a physical examination by a physician or individual licensed and qualified by education and training (most likely a physician's assistant or nurse practitioner) would be eliminated by the end of 2018. Reportedly, the only provision meant to be sunsetted was the prohibition on using telemedicine on the part of a physician to conduct a physical examination of the patient seeking the abortion or to satisfy the requirement to be present onsite when the abortifacient was first dispensed. The sunset was

acknowledging the expected advancements in telemedicine that would render such physicals by remote means acceptable.

- The provisions regarding final disposition of fetal remains and authorization for final disposition appear to grant more rights and consideration to mothers who miscarry than for women who choose an abortion. Under Section 2836, the physician performing an abortion does not have to obtain authorization for the final disposition of the dead fetus or fetal remains from the mother, nor even discuss the matter with her (presumably authorization would be made by the institution, if needed). Yet, under Section 2848, final disposition for a dead fetus or fetal remains from a miscarriage must have parental authorization (unless the mother provided written consent for the remains to be donated for research) and the parents may direct the final disposition. Though in early stage abortions most women may prefer not to think about the disposition of the fetal remains, it can be quite different in the case of later term abortions performed to save the life of the mother or performed due to the fetus' medical condition. These women may have bonded to their unborn and should have the same protections and considerations given to women who miscarried or delivered a stillborn baby.
- Some worry that if seen to place overly burdensome requirements on physicians, the act could have a chilling effect on OB/GYNs from locating in the state. Northern Michigan already lacks adequate numbers of OB/GYNs for ready access by residents. It is in the best interest of women in the state to attract quality physicians with high patient outcomes, not discourage them with onerous requirements.

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■ This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.