Legislative Analysis

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ABORTION-RELATED AMENDMENTS

House Bill 5711 as passed by the House
Sponsor: Rep. Bruce R. Rendon
Committee: Health Policy
First Analysis (9-11-12)

BRIEF SUMMARY: The bill would amend various sections of the Public Health Code to address matters related to the performance of abortions. The bill covers the following topics:

- Requirements regarding the disposition of a dead fetus and of fetal remains.
- A mandatory physical examination to be personally performed on a women by a physician prior to the diagnosing and prescribing of a "medical abortion," where that term is defined as an abortion procedure that utilizes a prescription drug or drugs including mifepristone, misoprostol, or ulipristal acetate. Other methods of examination, such as by an internet web camera ("telemedicine"), would be prohibited.
- Mandatory personal liability coverage of at least $1 million for physicians who perform six or more abortions a month and fall under certain other criteria.
- The required licensing of facilities, including private practice offices, as freestanding surgical outpatient facilities if they advertise outpatient abortion services and perform six or more abortions per month.
- (In the previous two paragraphs, the term "abortion" means the intentional use of an instrument, drug, or other substance or device to terminate a woman's pregnancy, with certain exceptions.)
- 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.

FISCAL IMPACT: The bill would have 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 Michigan, and 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. From physicians leaving the premises before an abortion is complete or while women are still in recovery, to not having emergency equipment on hand or emergency protocols in place to deal with emergent situations, to unsterile equipment, easy access by anyone to drugs stored improperly on the premises, and 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, the abortion industry in Michigan appears anything but operating in the best interest of women. Critics say that currently most providers offering surgical abortions do not have to be licensed as free

standing surgical outpatient facilities (FSOF), even though businesses like hemorrhoid removal clinics and facilities doing endoscopic procedures must. An abortion provider does not have to be licensed as an FSOF unless half or more of the patients seen in a year receive an abortion, even though serious complications from abortions, though rare, do 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 the 2010 incident in Delta Township (near Lansing) in which bags containing the remains of 17 aborted fetuses were 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. Apparently, 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.

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 the number one 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.

Legislation has been offered to address these, and other, concerns.

THE CONTENT OF THE BILL:

House Bill 5711 adds several new sections to the Public Health Code (MCL 333.2803 et al.) and amends various existing provisions related to abortion services. The bill would take effect January 1, 2013. A detailed description of the bill follows.

Disposition of Dead Fetus

- If a dead fetus that has completed at least 20 weeks of gestation is delivered *in an institution*, the individual in charge (or an authorized representative) must prepare

and file the fetal death report and make arrangements for the final disposition of the dead fetus in accordance with Section 2848, unless the parents, or parent if the mother is unmarried, expressly requests the responsibility of final disposition, and that disposition does not conflict with any state or federal law, rule, or regulation.

- If a dead fetus that has completed at least 20 weeks of gestation is delivered *outside an institution*, the physician in attendance must file the fetal death report. If a physician becomes aware of a fetal death or miscarriage that has occurred outside an institution, the physician must inform the parents, or parent if the mother is unmarried, that they have a right under state law to determine the final disposition of the dead fetus.

- If a miscarriage occurs outside an institution and a health professional is present or is immediately aware of the miscarriage, then the health professional must inform the parents/parent that they have a right under state law to determine the final disposition of the fetal remains.

- [The term "miscarriage" is defined as the spontaneous expulsion of a nonviable fetus that has completed less than 20 weeks of gestation.]

Disposition of Fetal Remains

- The term "fetal remains" is defined in the bill to refer to a dead fetus or part of a dead fetus that has completed at least 10 weeks of gestation or has reached the state 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 means lawful for other dead bodies, including burial, cremation, or interment. Unless the mother has provided written consent for research on the remains, a physician who performs an abortion must arrange for the final disposition. If the remains are disposed of by cremation, they must be incinerated separately from any other medical waste. However, this would not prohibit the simultaneous cremation of fetal remains with products of conception or other fetal remains resulting from abortions. (The term "products of conception" is defined as any tissues or fluids, placenta, umbilical cord, or other uterine contents resulting from a pregnancy. The term does not include a fetus or fetal body parts.)

- (This 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 PCH requires the funeral director or person assuming responsibility for the final disposition of the fetus (the bill would add fetal remains) to obtain an authorization for final disposition from the parent/parents. Under the bill, this requirement would not apply if the mother had provided written consent for research on the dead fetus under Section 2688.

  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 bill would add miscarriage), or an institution or agency authorized to accept donated bodies or fetuses (the bill would add fetal remains).

- The bill newly specifies that the funeral director, individual in charge of the institution, or other person making the final disposition must take into account the express wishes of the parent/parents if those wishes do not conflict with any state or federal law, rule, or regulation.

No Religious Service or Ceremony Required

- The bill specifies 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 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 could not diagnose and prescribe a medical abortion for a patient without first personally performing 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.

- Under the bill, a physician must obtain the informed consent of a patient in the manner prescribed under Sec.17015 to perform a medical abortion. The physician must be physically present at the location of the medical abortion and at the time any prescription drug is dispensed or administered during a medical abortion. The prescribing physician must provide direct supervision of dispensing or administering of a prescription drug during a medical abortion. 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 during a medical abortion.

- A physician could not give, sell, dispense, administer, otherwise provide, or prescribe a prescription drug to an individual for the purpose of inducing an abortion in the individual unless the physician satisfies all the criteria established by federal law or guideline that a physician must satisfy in order to give, sell, dispense, administer, otherwise provide, or prescribe a prescription drug for inducing an abortion.

- (As noted earlier, the term "medical abortion" refers to an abortion procedure that utilizes a prescription drug or drugs, including mifepristone, misoprostol, or ulipristal acetate, marketed under the name "Ella." This appears to cover both what are generally known as the "abortion pill" and the newer "morning-after" pill "Ella" that is available only by prescription, and not "Plan B", an older emergency contraception available without a prescription.

- The bill specifies that this section does not create a right to abortion.

- A health professional regulated under the PCH who did not comply with the above requirements may be subject to an investigation and may incur administrative sanctions that could include license or registration denial, revocation, suspension, limitation, or probation as well as a reprimand, fine, or order for restitution.

Professional Liability Coverage

- A physician who performs six or more abortions per month and meets any of several other listed criteria must maintain professional liability coverage of at least $1 million, or provide equivalent security as determined by the Department of Licensing and Regulatory Affairs, for the purpose of compensating a woman suffering from abortion complications caused by gross negligence or malpractice. The criteria are:

  (1) has been found liable for damages in two or more civil lawsuits in the preceding seven years related to harm caused by abortions he or she performed;

  (2) the disciplinary subcommittee has imposed one or more sanctions against his/her license for unprofessional, unethical, or negligent conduct in the preceding seven years; or

  (3) operates, or has supervisory authority over, an office or facility where abortions are performed and that office or facility was found during a follow-up inspection to be noncompliant with health and safety requirements after previous

inspections had formally identified the compliance failures and the corrective actions needed.

- If a disciplinary subcommittee finds that a physician is in violation of the paragraph above, it shall immediately limit the physician's license to prohibit the physician from performing abortions until the physician is in compliance.

Licensing as Freestanding Surgical Outpatient Facility

- The Department of Licensing and Regulatory Affairs would be required to specify in rules that a facility, including a private practice office, must be licensed under Article 17 of the Health Code as a freestanding surgical outpatient facility (FSOF) if that facility advertises outpatient abortion services and performs six or more abortions per month. Such a facility would not require a certificate of need to be granted a license. Presumably, for the purpose of determining whether the requirement to be licensed as FSOF would apply, the monthly total of either surgical abortions or medical abortions, or any combination, would be counted.

  (Currently, under this section of the Health Code this licensing requirement applies to a facility, including a private practice office, where 50% or more of the patients served annually undergo an abortion.)

Coercion to Abort and Domestic Violence Screening

- The bill would amend sections of the Public Health Code that deal with abortion informed consent requirements in order to require a physician or qualified person assisting the physician to do coercion-to-abort and domestic violence screening, and would require the Department of Community Health to produce information, screening tools, and protocols related to coercion-to-abort and domestic violence.

- 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, the physician or other qualified person assisting the physician, would have to orally screen the patient for coercion-to-abort using the screening tools developed by the Department of Community Health.

- 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 Code.

- If a patient under 18 years old discloses domestic violence or coercion to abort by an individual responsible for the health or welfare of the minor, the physician or qualified person assisting 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. The notice would have to be posted in a conspicuous place in an area of the facility that is accessible to patients, employees, and visitors. Publications containing information about violence against women would also have to be made available in an area accessible to patients, employees, and visitors.

- A physician, as part of the informed consent process, would have to confirm with a patient seeking an abortion that the mandatory coercion-to-abort and domestic violence screening had been performed. The physician or person assisting the physician, not less than 24 hours before that physician performs an abortion, must provide the patient with a physical copy of a prescreening summary on the prevention of coercion to abort.

- A health professional regulated under the PCH, and in particular a physician, who did not comply with the above requirements may be subject to an investigation and may incur administrative sanctions that could include license or registration denial, revocation, suspension, limitation, or probation as well as a reprimand, fine, or order for restitution.

- The Department of Community Health, after considering the standards and recommendations of the Joint Commission on Accreditation of Healthcare Organizations, the Michigan Domestic Violence Prevention and Treatment Board, the Michigan Coalition Against 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; (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-abort screening. The screening tools would have to instruct the physician or person assisting the physician to do, at a minimum, all of the following:

  -- Orally inform the patient that coercion to abort is illegal and is grounds for a civil action, but clarifying that discussions about pregnancy options, including personal or intensely emotional expressions about those options, are not necessarily coercion to abort and illegal.

  -- Orally ask the patient if her husband, parents, siblings, relatives, or employer, the father or putative father of the fetus, the parents of the father or putative father of the fetus, or any other individual has engaged in coercion to abort and coerced her into seeking an abortion.

  -- Orally ask the patient if an individual is taking harmful actions against her, including intimidating her, threatening her, physically hurting her, or forcing her to engage in sexual activities against her wishes.

  -- Document the findings from the coercion-to-abort 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-abort screening. The protocols would need to 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 amended by House Bill 5711), as applicable.

  -- Assess the patient's current level of danger.

  -- Explore safety options with the patient.

  --Provide referral information to the patient regarding law enforcement and domestic violence and sexual assault support organizations.

  -- Document any referrals in the patient's medical record.

<u>Acknowledgment and Consent Form Changes</u>

- Currently, the DCH is required to develop, draft, and print an acknowledgment and consent form that must be signed by a patient prior to obtaining an abortion.

The bill would require 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*.

- The physician or qualified person assisting the physician would have 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.

FISCAL INFORMATION:

Community Health

HB 5711 as passed by the House would establish additional requirements for the Department of Community Health (DCH) 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. These responsibilities will require a modest amount of staff time and related costs annually to develop and maintain.

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 would be provided to public and county law libraries pursuant to the Revised Judicature Act.

Licensing and Regulatory Affairs

HB 5711 would have a significant fiscal impact on the Bureau of Health Systems (BHS) within the Department of Licensing and Regulatory Affairs (LARA) 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 BHS is required to inspect FSOFs annually to ensure compliance with applicable state laws and rules. Currently, healthcare facilities, including private practice offices, which annually provide abortion services for at least 50% of their patients require licensure as a FSOF. There are currently four abortion providers licensed as FSOFs. Under HB 5711, healthcare facilities, including private practices, which advertise abortion services and perform at least six abortions per month, including the prescribing of drugs to induce abortion, would require licensure as a FSOF.

Based on induced abortion data from DCH, the BHS estimates that an additional 16 abortion providers in the state would require licensure as a FSOF under HB 5711. The current fee per license for FSOFs is $238 annually which is insufficient to cover the full 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.[1]

HB 5711 would also have an indeterminate fiscal impact on the Bureau of Health Professions (BHP) within LARA to the extent that the BHP would be required to determine whether an abortion provider meeting certain criteria maintains professional liability insurance of $1,000,000. Under current law, physicians are not required to maintain professional liability insurance in order to obtain licensure in the state.

State Civil Infraction Fine Revenue

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

ARGUMENTS:

For:

Critics of abortion practices say that due to weak laws and poor oversight by governmental authorities, many abortion providers do not follow proper safety protocols and engage in practices that are disrespectful of women and disrespectful of their aborted fetuses. Because abortion laws are weak, data on abortion-related deaths and injuries are suspected as being underreported. That being said, deaths and serious complications have occurred in Michigan. Some abortion providers have received license sanctions and fines for unsafe practices, but for the most part, the actions have been little more than slaps on the wrists. The bill would address several ongoing issues that without change could jeopardize the health and safety of women seeking abortions in Michigan.

- The bill is clear as to the final disposition of fetal remains from abortion procedures, as well as from miscarriages. The remains would simply be treated in the same manner as for dead bodies, and be given the same respect and dignity accorded under law.

- Final disposition for fetal remains from abortions would not be overly burdensome for abortion providers. The bill would require burial, cremation, interment, or other legal disposition of a dead body only for remains from fetuses of at least 10 weeks of gestational age (and for those showing some skeletal formation). Since cremation includes incineration, something readily available for any medical practice generating medical waste, it should not be difficult or present a financial obstacle for providers to arrange. In addition, the bill is also clear that the treatment of products of conception, defined to include the placenta

[1] In the FY 2012-13 omnibus budget, the Legislature appropriated an addition $530,000 of GF/GP revenue for the inspection of FSOFs under existing statutory requirements. This amount coincides with the amount recommended in BHS' Sec. 731 fee report for additional funding to inspect all FSOFs. However, the BHS also recommends triennial, rather than annual, inspections. This amount was calculated to support the expenses of triennial inspections. It would, therefore, have to be approximately tripled to support annual inspections, with additional funds needed to implement HB 5711.

and umbilical code, among other things, will be regulated under the Medical Waste Regulatory Act. What the bill will help prevent, however, is the tossing of aborted fetuses into dumpsters.

- By changing the criteria triggering licensing as a free standing outpatient facility (FSOF), 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 enactment, 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. With enactment, facilities would have to meet exacting medical care standards that will improve patient safety and outcomes.

- Requiring abortion providers to screen for coercion will better 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 a pregnant woman into doing something she may regret and feel guilt for the rest of her life. In addition, requiring abortion providers to screen for domestic violence and provide information about contacting a law enforcement agency and available domestic violence shelters and support organizations could reduce incidents of domestic violence related to unplanned pregnancies by getting women at risk into safe places.

- The bill would ensure that a woman losing her baby to miscarriage would have an opportunity for input on the final disposition of her baby's remains, and that the remains would be disposed of in a respectful manner. This involvement and assurance the final disposition was in accordance with her wishes can be an important part of the grieving process.

- The bill would require physicians with a pattern of negligence or administrative sanctions to carry additional liability insurance. If a woman was injured by a physician with a poor safety record, the insurance would help cover her claims.

Against:

Critics say that this bill is an attempt by opponents of abortion to regulate abortion out of existence. Moreover, they say, the bill has several problematic, vague, and/or incorrect references and provisions.

- For instance, a physician would be required to inform a patient before an abortion that coercion to abort is illegal and grounds for a civil action. However, the substitute bill does not create a civil action, nor would any of the current companion bills.

- The definition for "medical abortion" includes a procedure using ulipristal acetate (Ella). However, Ella is not intended to be used to induce abortions. Ella was approved in August of 2010 by the Federal Drug Administration as a prescription emergency contraception. Like Plan B, the older non-prescription emergency contraception, Ella prevents or delays ovulation. According to a recent *New York Times* article, an FDA spokeswoman was quoted as saying "emerging data on Plan B suggest that it does not inhibit implantation. Less is known about Ella. However, some data suggest it also does not inhibit implantation." ("Abortion Qualms on Morning-After Pill May Be Unfounded", June 5, 2012). Live births have occurred for both drugs when taken after fertilization has occurred.

- The definitions for several terms, including "fetal remains" and "products of conception", as well as basing gestational age on conception, would be out of sync with accepted medical definitions and practices. For example, "products of conception" is accepted as including fetal tissue, whereas the bill would exclude it. Basing gestational age on conception is not widely recognized within medicine according to medical societies, and could create ambiguity about when compliance with the bill's requirements regarding fetal disposition would be triggered. Basing administrative sanctions and civil infractions on terms that differ from medical training and practice is confusing and could inadvertently "catch" medical professionals and hospital staff who are not the intended targets.

- 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 wishes of the parents for final disposition must be taken into consideration. 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.

- Abortion providers who <u>publicly advertise</u> outpatient abortion services and who perform six or more a month would have to be licensed as a freestanding surgical

outpatient facility. However, it is not clear what "publicly advertise" would mean: TV or radio commercials, Yellow Pages, Internet website, sign on the side of a bus, etc.? If a provider only did abortions by "word of mouth," would he or she not have to be licensed regardless of how many abortions were performed?

- Requiring an abortion provider to screen for coercion would only provide an illusion of safety. In reality, the legislation could have the unintended effect of putting many women at more risk for injury from domestic violence. Abusers tend to escalate the level of violence whenever they feel they are losing control. If they discovered their partner or girlfriend was about to go to the police or a shelter, it is likely they would increase the violence to whatever level they felt was necessary to obtain compliance. It has been well documented that batterers often engage in retaliation after being arrested and then released, as they feel that they have done no wrong. Therefore, many women may not be truthful as to the level of coercion or domestic violence they are experiencing if they are afraid it will escalate, rather than relieve, their current situation.

- If the bill goes forward, it should be amended to protect a woman from coercion or harassment whether she chooses to have an abortion or chooses not to. It is wrong to protect one choice and not the other, especially since the U.S. Constitution does give women the right to choose for themselves.

- Some have expressed concerns over costs to taxpayers (via state services) of having to bury or cremate the remains of every aborted fetus over nine weeks of gestation. If the mother were indigent, the institution, provider, or county medical examiner (if in possession of the fetal remains), may be able to seek reimbursement from the Department of Human Services through its grant program to help with indigent burials. If so, this could be a significant cost to the state, and therefore taxpayers.

- Some worry that if seen to place overly burdensome requirements on physicians, the bill 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.

POSITIONS:

Representatives from the following associations and organizations offered testimony, written or oral, or indicated support for the bill on 6-7-12:

Right to Life of Michigan
Citizens for Traditional Values
Michigan Catholic Conference

Representatives from the following associations and organizations offered testimony, written or oral, or indicated opposition for the bill on 6-7-12:
Michigan Health & Hospital Association
Michigan - National Organization of Women (NOW)
ACLU of Michigan
American Congress of Obstetricians and Gynecologists
Michigan State Medical Society (MSMS)
OB-GYN Chair, University of Michigan
Planned Parenthood of Michigan
Planned Parenthood of West & Northern Michigan
Planned Parenthood Mid and South Michigan
Northland Family Planning
American Association of University Women (AAUW)
MSU Law Students for Reproductive Justice
Michigan Unitarian Universalist Social Justice Network (MUUSJN)
Oakland/Macomb - NOW

Legislative Analyst: Susan Stutzky
Chris Couch
Fiscal Analyst: Sue Frey
Paul Holland
Erik Jonasson