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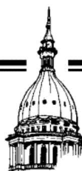

BILL ANALYSIS

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House Bill 5711 (Substitute H-1 as reported without amendment)
Sponsor: Representative Bruce R. Rendon
House Committee: Health Policy
Senate Committee: Judiciary

Date Completed: 8-14-12

CONTENT

The bill would amend the Public Health Code to do the following in regard to abortions:

- **-- Require a physician or qualified person assisting a physician to screen a patient orally regarding coercion to abort at the time she first presented at a facility for an abortion.**
- **-- Require a physician or assistant to take certain actions if the patient disclosed that she was the victim of domestic violence or coercion to abort.**
- **-- Require a facility in which abortions were performed to post and make available information regarding violence against women and coercion to abort.**
- **-- Require the Department of Community Health (DCH) to develop, draft, and print or make available information regarding domestic violence and coercion to abort.**
- **-- Require the DCH to develop, draft, and print screening and training tools regarding coercion to abort.**
- **-- Require a physician or assistant to give an abortion patient a physical copy of the prescreening summary on prevention of coercion to abort, at least 24 hours before the physician performed the abortion.**
- **-- Require a physician to confirm with the patient that the coercion-to-abort screening was performed, before she signed an acknowledgment and consent form.**
- **-- Prohibit a physician from diagnosing and prescribing a medical abortion (a procedure that uses a prescription drug), without first personally performing a physical examination of the patient.**
- **-- Require a physician to be physically present at the location of a medical abortion and at the time any prescription drug was dispensed or administered during a medical abortion.**
- **-- Require a physician to maintain at least $1.0 million worth of professional liability coverage if he or she performed six or more abortions per month and met certain other conditions regarding liability or professional disciplinary sanctions.**
- **-- Include violations of several proposed requirements among the grounds for professional disciplinary sanctions.**

The bill also would do the following in regard to fetal remains or a dead fetus:

- **-- Require all fetal remains resulting from abortions to be disposed of by means lawful for other dead bodies, including burial, cremation, or interment.**
- **-- Require fetal remains resulting from an abortion to be incinerated separately from other medical waste, if they were disposed of by cremation.**

- **Require arrangements for the disposition of a dead fetus delivered in an institution to be made according to requirements for authorization for the final disposition of a body, unless the parent or parents requested responsibility for final disposition.**
- **Require notice to the parent or parents that they had a right to determine the final disposition of a dead fetus or fetal remains, in the case of a fetal death or miscarriage outside an institution.**
- **Require a funeral director, or another person responsible for the final disposition, to obtain authorization from the parents or parent before final disposition of fetal remains resulting from a miscarriage (as currently required for a dead fetus).**
- **Require a funeral director, individual in charge of an institution, or another person making the final disposition of a dead fetus or fetal remains to take into account the express wishes of the parent or parents.**
- **Provide that a person who failed to dispose of fetal remains resulting from an abortion as required, or failed to obtain the proper authorization for final disposition of a dead body, would be responsible for a State civil infraction, and prescribe a maximum fine of $1,000 per violation.**

In addition, the bill would require a private practice office to be licensed as a freestanding surgical outpatient facility if the facility advertised outpatient abortion services and performed six or more abortions per month.

The bill would take effect on January 1, 2013.

Coercion to Abort

Screening for Coercion. Under the bill, at the time a patient first presented at a private office, freestanding surgical outpatient facility, or other facility or clinic in which abortions were performed, for the purpose of obtaining an abortion, the physician or qualified person assisting the physician would have to screen the patient orally for coercion to abort. The screening would have to use the screening tools developed by the DCH under the bill.

If a patient disclosed that she was the victim of domestic violence that did not include coercion to abort, or if she disclosed coercion to abort, the physician or assistant would have to follow the protocols developed by the DCH.

If a patient who was under 18 disclosed domestic violence or coercion to abort by an individual responsible for her health or welfare, the physician or assistant would have to report that to a local child protective services office.

Before performing an abortion, a physician would have to comply with the requirements described above.

A private office, freestanding surgical outpatient facility, or other facility or clinic in which abortions were performed would have to post the notice required by the bill in a conspicuous place in an area of its facility that was accessible to patients, employees, and visitors. The facility also would have to make publications that contained information about violence against women available in an area of the facility that was accessible to patients, employees, and visitors.

These provisions would not create a right to abortion, and a person could not perform an abortion that was prohibited by law.

Notice & Training Materials. The bill would require the DCH to take the actions described below 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 successor organization, and the American Medical Association.

The Department would have to develop, draft, and print or make available in printable format, in nontechnical English, Arabic, and Spanish, a notice that would have to be posted in facilities and clinics. The notice would have to be at least 8.5 inches by 14 inches, be printed in at least

44-point type, and contain at least all of the following:

-- A statement that "it is illegal under Michigan law to coerce a woman to have an abortion".
-- A statement that "help is available if a woman is being threatened or intimidated; is being physically, emotionally, or sexually harmed; or feels afraid for any reason".
-- The telephone number of at least one domestic violence hotline and one sexual assault hotline.

The Department also would have to 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, contained the information required in the notice described above and notified the patient that an oral screening for coercion to abort would be conducted before she gave written consent to obtain an abortion.

In addition, the DCH would have to develop, draft, and print screening and training tools and accompanying training materials to be used by a physician or qualified person assisting the physician while performing the coercion-to-abort screening. The screening tools would have to instruct the physician or assistant to do at least 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, or any other individual had engaged in coercion to abort and coerced her into seeking an abortion.
-- Orally ask the patient if an individual was 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.

The DCH also would have to develop, draft, and print protocols and accompanying training materials to be used by a physician or a qualified person assisting the physician if a patient disclosed during the screening that coercion to abort or domestic violence, or both, was occurring. The protocols would have to instruct the physician or assistant to do at least all of the following:

-- Follow the proposed screening requirements.
-- Assess the patient's current level of danger.
-- Explore safety options with the patient.
-- Give the patient referral information regarding law enforcement and domestic violence and sexual assault support organizations.
-- Document any referrals in the patient's medical record.

24-Hour & Consent Requirements. The Public Health Code lists actions that a physician or a qualified person assisting a physician must take at least 24 hours before the physician performs an abortion. The bill would include in that list providing the patient with a physical copy of the prescreening summary on prevention of coercion to abort.

Before obtaining a patient's signature on an acknowledgment and consent form, a physician must do certain things personally and in the presence of the patient, including giving her the physician's name, and informing the patient of her right to withhold or withdraw her consent to an abortion at any time before the abortion is performed. The bill also would require the physician to confirm with the patient that the coercion-to-abort screening was performed.

For purposes of the 24-hour requirements, "abortion" means 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. The bill, instead of referring to a dead fetus, would refer to a fetus that has died as a result of natural causes, accidental trauma, or a criminal assault on the pregnant woman. This definition also would apply under the bill's coercion-screening requirement and medical abortion restrictions.

Medical Abortion

The bill would prohibit a physician from diagnosing and prescribing a medical abortion for a patient who was or was presumed to be pregnant, without first personally performing a physical examination of the patient. A physician could not use other means, including an internet web camera, to diagnose and prescribe a medical abortion.

A physician would have to obtain the patient's informed consent, as required by the Code, to perform a medical abortion. The physician would have to be physically present at the location of the medical abortion and at the time any prescription drug was dispensed or administered during a medical abortion. The prescribing physician would have to provide direct supervision of the dispensing or administering of a prescription drug during a medical abortion, but an individual under the prescribing physician's direct supervision, who was qualified by education and training as provided in the Code, 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 unless the physician satisfied all the criteria established by Federal law or guideline that a physician must satisfy in order to take that action.

The bill specifies that these provisions would not create a right to an abortion and a person could not perform an abortion that was prohibited by law.

"Medical abortion" would mean an abortion procedure that uses a prescription drug or drugs, including mifepristone, misoprostol, or ulipristal acetate.

"Federal law or guideline" would mean any U.S. law, rule, or regulation or any drug approval letter, including the use of medication guides and patient agreements as described in a drug approval letter of the U.S. Food and Drug Administration that governs or regulates the use of prescription drugs for the purpose of inducing abortions.

Liability Coverage

The bill would amend Part 170 (Medicine) and Part 175 (Osteopathic Medicine and Surgery) to require certain physicians to maintain professional liability coverage of at least $1.0 million, or provide equivalent security as determined by the Department of Licensing and Regulatory Affairs (LARA), for the purpose of compensating a woman suffering from abortion complications caused by the physician's gross negligence or malpractice. The requirement would apply to a physician who performed six or more abortions per month and met any of the following:

-- He or she was found liable for damages in two or more civil lawsuits in the preceding seven years related to harm caused by abortions that he or she performed.
-- The disciplinary subcommittee had imposed one or more sanctions against the physician's license in the preceding seven years for unprofessional, unethical, or negligent conduct.
-- The physician operated, or had supervisory authority over, an office or facility in which abortions were performed and that office or facility was found to be noncompliant with health and safety requirements during a follow-up inspection after previous inspections had formally identified the compliance failures and necessary corrective actions.

If the disciplinary subcommittee found that a physician subject to the requirement failed to maintain at least $1.0 million in liability coverage, it immediately would have to limit the physician's license to prohibit him or her from performing abortions until he or she met the requirement.

Sanctions

The Code allows LARA to investigate activities related to the practice of a health profession by a licensee, a registrant, or an applicant for licensure or registration. The Department must report its findings to the appropriate disciplinary subcommittee. If it finds that certain grounds exist, the disciplinary subcommittee must proceed with sanctions. The grounds include a violation of 24-hour screening requirements for performing an abortion. The bill also

would allow sanctions for the following violations:

-- Failing to screen for coercion to abort.
-- Failing to perform a physical exam before administering a medical abortion.
-- Failing to secure $1.0 million in liability coverage, if required.

The sanction for failing to screen for coercion or failing to perform a physical exam before a medical abortion could be denial, revocation, restitution, probation, suspension, limitation, reprimand, or a fine.

The sanction for failing to secure the required $1.0 million liability coverage would be an immediate limitation of the physician's license to prohibit him or her from performing abortions until he or she met the liability coverage requirement.

<u>Surgical Facility Licensure</u>

The Code requires LARA to promulgate rules to differentiate a freestanding surgical outpatient facility (FSOF) from a private office of a physician or other health professional. The Department must specify in the rules that a facility, including a private practice office, must be licensed as an FSOF if 50% or more of the patients annually served at the facility undergo an abortion.

The bill, instead, would require LARA to specify in the rules that a facility, including a private practice office, would have to be licensed as an FSOF if the facility publicly advertised outpatient abortion services and performed six or more abortions per month.

Under the Code, the rules must include standards for an FSOF in which 50% or more of the patients annually served in the facility undergo an abortion. The Department also may modify or waive one or more of the rules regarding construction or equipment standards, or both, for such an FSOF. Under the bill, those provisions would refer to a private practice office or FSOF that publicly advertised outpatient abortion services and performed six or more abortions per month.

Under Part 222 (Certificates of Need) of the Code, a health facility required to be licensed as an FSOF under rules promulgated by LARA (for facilities where at least 50% of the patients undergo an abortion) is not required to obtain a certificate of need in order to be granted a license as a an FSOF. Under the bill, that would apply to a health facility required to be licensed as an FSOF due to the performance of abortions at the facility. Such a health facility would be subject to Part 222, however, for the services performed at the facility other than abortions.

<u>Final Disposition of Fetal Remains</u>

<u>Report of Fetal Death</u>. Under Section 2834 of the Public Health Code, a fetal death occurring in Michigan must be reported to the State Registrar within five days of delivery. If a dead fetus is delivered in an institution, the individual in charge of the institution or an authorized representative must prepare and file the report. Under the bill, this would apply if the fetus had completed at least 20 weeks of gestation. The person filing the report also would have to make arrangements for the final disposition of the dead fetus in accordance with Section 2848 (which the bill would amend, as described below), unless the parents, or parent if the mother were not married, expressly requested the responsibility of final disposition, and that disposition did not conflict with State or Federal law, rule, or regulation.

Currently, if a dead fetus is delivered outside an institution, the attending physician must prepare and file the report. Under the bill, this would apply if the fetus had completed at least 20 weeks of gestation. Also, if a physician became aware of a fetal death or miscarriage that had occurred outside an institution, he or she would have to inform the parents, or parent in the case of an unmarried mother, that they or she had a right under State law to determine the final disposition of the dead fetus or fetal remains.

Also, under Section 2834, if a fetal death occurs without medical attendance at or after the delivery or if the medical examiner requires an inquiry, the attendant, mother, or other person who knows of the death must notify the medical examiner, who must investigate the cause and prepare and file the report.

The bill provides that Sections 2834 and 2848 would not apply to a miscarriage that

occurred outside an institution, except as otherwise specifically provided.

Under the bill, if a miscarriage occurred outside an institution and a health professional were present or immediately aware of the miscarriage, the health professional would have to inform the parents, or the parent in the case of an unmarried mother, of their or her right under State law to determine the final disposition of the fetal remains.

The Code defines "institution" as a public or private establishment that provides inpatient medical, surgical, or diagnostic care or treatment or nursing, custodial, or domiciliary care to two or more unrelated individuals, including an establishment to which individuals are committed by law.

"Fetal death" means the death of a fetus that has completed at least 20 weeks of gestation or weighs at least 400 grams. The bill specifies that "fetal death" would include a stillbirth.

"Final disposition" means the burial, cremation, or other disposition of a dead body or fetus. The bill would define the term as the burial, cremation, interment, or other legal disposition of a dead body or fetal remains.

The bill would define "fetal remains" as 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 at which, upon visual inspection, the head, torso, or extremities appear to be supported by skeletal or cartilaginous structures. The term would not include the umbilical cord or placenta.

"Miscarriage" would mean the spontaneous expulsion of a nonviable fetus that has completed less than 20 weeks of gestation.

Disposition of Remains from Abortion. The bill would add Section 2836 to the Public Health Code to require all fetal remains resulting from abortions to be disposed of by means lawful for other dead bodies, including burial, cremation, or interment. Unless the mother had given written consent for research on the fetal remains in accordance with the Code, a physician who performed an abortion would have to arrange for the final disposition of the fetal remains resulting from an abortion. If fetal remains resulting from an abortion were disposed of by cremation, they would have to be incinerated separately from any other medical waste. The fetal remains could be cremated, however, with products of conception or other fetal remains resulting from an abortion.

The bill states that Section 2836 would not require a physician to discuss the final disposition of the fetal remains with the mother before performing the abortion, or to obtain the mother's authorization for the final disposition of the remains upon completing the abortion.

"Products of conception" would mean that term as defined in Section 13807 (which the bill would amend).

Authorization for Final Disposition. Under Section 2848 of the Code, a funeral director who first assumes custody of a dead body must obtain authorization for the final disposition of the body within 72 hours after death occurred or the body was found. Before final disposition of a dead fetus, irrespective of the duration of pregnancy, the funeral director or person assuming responsibility for final disposition must obtain from the parents or parent, as applicable, an authorization for final disposition. The authorization may allow final disposition by a funeral director, the individual in charge of the institution where the fetus was delivered, or an institution or agency authorized to accept donated bodies or fetuses.

Under the bill, the provisions concerning a fetus would apply unless written consent for research were obtained in accordance with the Code. A funeral director or person assuming responsibility would have to obtain parental authorization before final disposition of either a dead fetus or fetal remains resulting from a miscarriage. The authorization could allow final disposition by a funeral director, the individual in charge of the institution where the fetus was delivered or miscarried, or an institution or agency authorized to accept fetal remains.

The bill would require the funeral director, individual in charge of the institution, or other person making the final disposition to take into account the express wishes of the parents, or parent in the case of an

unmarried mother, as long as those wishes did not conflict with any State or Federal law, rule, or regulation.

The bill states that Section 2848, as amended, would not require a religious service or ceremony as part of the final disposition of fetal remains.

Violations & Fine. Under the bill, a person who failed to dispose of fetal remains resulting from an abortion as prescribed in Section 2836, or failed to obtain the proper authorization for final disposition of a dead body as provided in Section 2848, would be responsible for a State civil infraction as provided under the Revised Judicature Act. The person could be ordered to pay a maximum civil fine of $1,000 per violation.

Products of Conception. Part 138 of the Code, which also is known as the Medical Waste Regulatory Act, governs the disposal of medical waste, which includes pathological waste. In Section 13807, the definition of "pathological waste" includes products of conception.

The bill would define "products of conception" as any tissues or fluids, placenta, umbilical cord, or other uterine contents resulting from a pregnancy. The term would not include a fetus or fetal body parts.

MCL 333.2803 et al.

Legislative Analyst: Patrick Affholter

FISCAL IMPACT

The bill would have a significant and negative fiscal impact on the Department of Licensing and Regulatory Affairs. Under the bill, medical providers that performed six or more abortions per month would have to be licensed as a freestanding surgical outpatient facility (FSOF) and undergo annual inspection by the Bureau of Health Systems (BHS). Under current law, a provider must be licensed only if more than 50% of its patients receive an abortion. According to abortion data from the Department of Community Health, an additional 16 providers would be required to receive FSOF licensure under the bill.

Currently, FSOFs are required to pay a $238 annual fee for licensure. To the extent that the DCH figures are accurate, the bill would result in an additional $3,808 annually for the BHS. In a 2012 report, however, the BHS indicated that for a self-sustaining FSOF licensing program, FSOF license fees would need to be $4,653 for each facility annually, assuming the licenses were renewed annually but on-site inspections were conducted only triennially. Under current law, inspections of FSOFs are required annually, and the BHS has estimated that the inspection of these additional 16 facilities would cost about $9,700 each in the first year, and $5,700 per year thereafter. Since each of the new FSOFs would annually generate only $238, the bill would cost the BHS, in total, about $151,000 for the first year, and $87,000 per year after the first.

The bill also would introduce some unknown new costs to the Bureau of Health Professions related to verifying whether certain providers that perform abortions maintained professional liability insurance of at least $1.0 million.

In addition, any person who failed to dispose of fetal remains as prescribed by the bill would be responsible for a State civil infraction and would be subject to a civil fine of not more than $1,000. Revenue from these fines would benefit public libraries.

Finally, the DCH would incur some minor administrative costs from the following:

-- Updating abortion consent forms used by providers.
-- Creating notices to be posted in facilities that provide abortions.
-- Developing a prescreening summary for the prevention of coerced abortions.
-- Developing training tools for providers to use in screening for coercion.

These administrative costs would be borne by existing DCH resources.

Fiscal Analyst: Josh Sefton

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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.