Senate Fiscal Agency
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BILL ANALYSIS

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Senate Bills 818 and 819 (Substitute S-2 as reported by the Committee of the Whole)
Senate Bills 820 and 821 (Substitute S-1 as reported by the Committee of the Whole)
Senate Bills 822, 823, and 825 (as reported by the Committee of the Whole)
Sponsor: Senator Erika Geiss (S.B. 818 & 819)
Senator Mary Cavanagh (S.B. 820 & 821)
Senator Sarah Anthony (S.B. 822 & 825)
Senator Stephanie Chang (S.B. 823)
Committee: Housing and Human Services

**CONTENT**

Senate Bill 818 (S-2) would amend the Public Health Code to do the following:

-- Require the Department of Health and Human Services (DHHS) to include in its statewide strategic plan for the reduction of racial and ethnic disparities a plan to reduce inequities.
-- Require the DHHS to include on its website links and information of published peer-reviewed studies and reports on biased or unjust perinatal care, including studies or reports on instances of obstetric racism and obstetric violence.
-- Require the DHHS to provide statistics on the incidence and prevalence of obstetric violence and obstetric racism.
-- Require the DHHS to maintain a team to review statewide maternal deaths.
-- Require the DHHS to study policies concerning perinatal labor and delivery services in the State and submit a report on the study to the Legislature by January 1, 2026.
-- By January 1, 2026, and every three years following, require the DHHS to report to the Legislature causes of maternal mortality and best practices to reduce maternal mortality and morbidity in the State.

Senate Bill 819 (S-2) would enact the "Biased and Unjust Care Reporting Act" to do the following:

-- Require the DHHS to collect data using a validated tool and analyze reports from pregnant or postpartum individuals that received care that was not culturally congruent, unbiased and just, did not prevent harm, did not maintain dignity and confidentiality, or did not meet informed consent requirements.
-- Require the DHHS to report the prevalence of care described above to the Governor, the Legislature, the DHHS Director, and the Director of the Department of Licensing and Regulatory Affairs (LARA).
-- Prohibit the DHHS report from containing identifying information of a maternal care provider.

Senate Bill 820 (S-1) would amend the Public Health Code to do the following:

-- Require a health facility to stabilize a patient or resident who was pregnant and in labor before ending the patient or resident relationship upon the patient or resident's refusal or denial of care.
-- Prohibit an owner, operator, or governing body of a hospital from discriminating based on an individual's pregnancy or lactating status.

-- By January 1, 2026, require a hospital to demonstrate to the DHHS that the hospital had a policy allowing a patient who was giving birth to have present with the patient a doula and the patient's partner or a companion of the patient.
-- By January 1, 2026, require a hospital to demonstrate to the DHHS that the hospital had a policy on informed consent.
-- By January 1, 2026, require a hospital to demonstrate to the DHHS that the hospital had a policy on receiving a pregnant patient's information upon a transfer, including a transfer initiated by a midwife or certified nurse midwife.
-- Specify that a hospital could exclude a doula or a midwife from being present with a patient during instances in which the hospital determined limiting an individual was necessary to protect public health, among other things.

Senate Bill 821 (S-1) would amend the Insurance Code to do the following:

-- Require an insurer that offered a medical malpractice insurance policy to provide the Department of Insurance and Financial Services (DIFS) with information about that insurer's policies related to perinatal care services annually.
-- Require DIFS to submit the information received from insurers to the DHHS upon request for use in the study required by Senate Bill 818 (S-2) within 60 days of receipt.

Senate Bill 822 would amend the Estates and Protected Individuals Code to allow a patient advocate designation to include a statement on which life-sustaining treatment the patient would desire or not desire if the patient were pregnant at the time the designation took effect.

Senate Bill 823 would amend the Elliot-Larson Civil Rights Act to specify discrimination based on "sex" would include pregnancy or lactating status.

Senate Bill 825 would amend Part 27 (Michigan Essential Health Provider Recruitment Strategy) of the Public Health Code to allow a midwife who attended a midwifery program to participate in the DHHS's health provider loan repayment program, which generally provides loan repayment to professionals who meet the program's obligations, including participation in full-time, primary healthcare services at an eligible nonprofit located in an Health Professional Shortage Area for two years.

Senate Bill 818 is tie-barred to Senate Bill 819, Senate Bill 821, and House Bill 5636. Senate Bill 819 is tie-barred to House Bill 5636. Generally, House Bill 5636 would amend the Public Health Code to establish licensing and regulation of freestanding birth centers, among other things. Senate Bill 821 is tie-barred to Senate Bill 818.

MCL 333.2227 et al. (S.B. 818)
333.20201 et al. (S.B. 820)
500.2434 (S.B. 821)
700.5507 (S.B. 822)
37.2301 (S.B. 823)
333.2701 et al. (S.B. 825)

## BRIEF RATIONALE

According to the Centers for Disease Control and Prevention, as of 2021, Black mothers are three times more likely to die from pregnancy related causes than white mothers.[1] Some people believe that the State has not done enough to address health disparities for mothers of color, specifically regarding informed consent and providing equitable healthcare. It has

[1] "Working Together to Reduce Black Maternal Mortality.", Center for Disease Control. https://www.cdc.gov/womens-health/features/maternal-mortality.html Retrieved 10-17-24.

been suggested to require the DHHS and healthcare providers to study and address maternal healthcare disparities to reduce inequity and improve maternal outcomes in the State.

Legislative Analyst: Eleni Lionas

## FISCAL IMPACT

### Senate Bill 818 (S-2)

The bill would have an indeterminate negative fiscal impact on the DHHS and no impact on local units of government. The DHHS would incur minor administrative costs resulting from the requirement that it maintain links to peer-reviewed published studies and reports on biased or unjust perinatal care on a DHHS webpage as well as include statistics related to the incidence and prevalence of obstetric violence and obstetric racism on the DHHS's health information system.

The DHHS also could face increased personnel costs resulting from the requirement that the DHHS maintain a maternal death review team. On average the cost incurred by a department for each additional full-time equivalent (FTE) is approximately $137,500 annually, for salary and benefits. The total cost of the bill would depend on the number of new FTEs necessary to adequately staff the maternal death review team.

The bill would require the DHHS to complete a one-time study of policies related to the perinatal period as well as a report every three years on the most preventable causes of maternal mortality and recommendations to address those causes. One-time costs for similar studies range from $100,000 to $250,000. For the report required every three years, the DHHS would face minor administrative costs that could be absorbed by any additional appropriations to support the maintenance of a maternal death review team.

### Senate Bill 819 (S-2)

The bill would have a negative fiscal impact on the DHHS and no fiscal impact on local units of government. The DHHS would incur costs for the development and receipt of reports and reporting tools as described under the bill. The magnitude of these costs would depend on the complexity of any IT systems or reporting tools necessary to implement the requirements of the bill, as well as the number of new FTEs necessary to adequately set-up and maintain the reporting tool. On average the cost incurred by a department for each additional FTE is approximately $137,500 annually, for salary and benefits.

### Senate Bill 820 (S-1)

The bill would have an indeterminate minor negative fiscal impact on the DHHS and no impact on local units of government. The DHHS could face minor administrative costs resulting from the promulgation of rules to implement the requirements of the bill and the creation of a form for hospitals to report required information. These costs could be borne by existing appropriations.

### Senate Bill 821 (S-1)

The bill would not have a fiscal impact on the State or local governmental units.

### Senate Bill 822

The bill would not have a fiscal impact on the State or local governmental units.

**Senate Bill 823**

The bill likely would not have a significant fiscal impact on the Michigan Department of Civil Rights (MDCR). It is possible that the MDCR would experience some additional resource demands due to the expansion of the definition, but the volume of these complaints and related activity likely would not require additional appropriations or personnel.

**Senate Bill 825**

The bill would have no fiscal impact on the DHHS or local units of government. The number of loan repayment contracts that the DHHS enters with eligible medical providers under Michigan Compiled Laws 333.2705 is limited by the yearly appropriation to the Michigan Essential Health Provider Program. Expanding the definition of eligible schooling to include a midwifery program would increase the potential pool of applicants but would have no impact on the number of contracts that the DHHS could enter, assuming a flat appropriation level in future fiscal years. A recent funding history of the Michigan Essential Health Provider Program is shown below.

Recent Funding History of the Michigan Essential Health Provider Program

| Fiscal Year (FY) | Provider Contracts | Gross | Federal | Private | GF/GP |
|---|---|---|---|---|---|
| FY 2013-2014 | 92 | $2,491,300 | $1,236,300 | $255,000 | $1,000,000 |
| FY 2014-2015 | 104 | 3,591,300 | 1,236,300 | 855,000 | 1,500,000 |
| FY 2015-2016 | 69 | 3,591,300 | 1,236,300 | 855,000 | 1,500,000 |
| FY 2016-2017 | 67 | 3,591,300 | 1,236,300 | 855,000 | 1,500,000 |
| FY 2017-2018 | 86 | 3,591,300 | 1,236,300 | 855,000 | 1,500,000 |
| FY 2018-2019 | 84 | 3,591,300 | 1,236,300 | 855,000 | 1,500,000 |
| FY 2019-2020 | 126 | 4,519,600 | 1,236,300 | 855,000 | 2,428,300 |
| FY 2020-2021 | 91 | 3,519,600 | 1,236,300 | 855,000 | 1,428,300 |
| FY 2021-2022 | 80 | 3,519,600 | 1,236,300 | 855,000 | 1,428,300 |
| FY 2022-2023[a] | 271[b] | 13,519,600 | 1,236,300 | 855,000 | 11,428,300 |
| FY 2023-2024 | 82 | 3,519,600 | 1,236,300 | 855,000 | 1,428,300 |
| FY 2024-2025 | N/A[c] | 3,519,600 | 1,236,300 | 855,000 | 1,428,300 |

[a]The FY 2022-23 budget included $10.0 million Gross and General Fund/General Purpose in the One-Time Appropriations Unit to expand the Program to behavioral health services providers.
[b]Of the 271 contracts, 192 are funded through the one-time appropriation while the remaining 79 are funded through the ongoing appropriation.
[c]Unavailable until the close of the Fiscal Year.

Date Completed: 11-5-24

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