Senate Fiscal Agency
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BILL ANALYSIS

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Senate Bills 29, 30, 32 through 36, and 39 (as reported by the Committee of the Whole)
Senate Bills 31 and 37 (Substitute S-2 as reported by the Committee of the Whole)
Senate Bill 38 (Substitute S-1 as reported by the Committee of the Whole)
Sponsor: Senator Erika Geiss (S.B. 29 & 30)
Senator Mary Cavanagh (S.B. 31 & 32)
Senator Sarah Anthony (S.B. 33, 36, & 39)
Senator Stephanie Chang (S.B. 34)
Senator Sylvia Santana (S.B. 37 & 38)
Committee: Housing and Human Services

CONTENT

Senate Bill 29 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 30 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 providers.

Senate Bill 31 (S-2) 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, 2027, require a hospital to have 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.

-- Require a hospital to have a policy on informed consent.
-- Require a hospital to have 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 an individual from being present with a patient during instances in which the hospital determined that limiting an individual was necessary to protect public health, among other things.

Senate Bill 32 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 29 within 60 days of receipt.

Senate Bill 33 would amend the Estates and Protected Individuals Code to do the following:

-- 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.
-- Delete a provision prohibiting a patient advocate from deciding to withhold or withdraw treatment that would result in a pregnant patient's death.

Senate Bill 34 would amend the Elliot-Larson Civil Rights Act to specify discrimination based on "sex" would include pregnancy or lactating status.

Senate Bill 36 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 37 (S-2) would amend the Insurance Code to require an insurance provider in the State that provided health insurance covering gynecological and pregnancy services to provide in-network coverage of those services whether in a healthcare facility or at a patient's home by an in-network physician, certified nurse midwife, or a qualified midwife.

Senate Bill 38 (S-1) would amend the Social Welfare Act to allow a Medicaid eligible individual to receive perinatal and gynecological services if the DHHS applied to the United States Department of Health and Human Services to provide such services under the Healthy Michigan Plan (HMP).

Senate Bill 39 would amend the Social Welfare Act to require the DHHS to provide coverage under the HMP for ultrasound procedures and fetal nonstress tests performed remotely or through telemedicine.

Senate Bills 29 and 32 are tie-barred. Senate Bill 29 is also tie-barred to Senate Bill 30.

MCL 333.2227 et al. (S.B. 29); 333.20201 et al. (S.B. 31); 500.2434 (S.B. 32)
700.5507 & 700.5509 (S.B. 33); 37.2201 & 37.2301 (S.B. 34);333.2701 et al. (S.B. 36)
Proposed MCL 500.3406cc (S.B. 37)
400.109 9 (S.B. 38)
Proposed MCL 400.109q (S.B. 39)

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 been suggested to require the DHHS, the Michigan Department of Civil Rights (MDCR), and healthcare providers to study and address maternal healthcare disparities to reduce inequity and improve maternal health outcomes throughout the State.

PREVIOUS LEGISLATION

(This section does not provide a comprehensive account of previous legislative efforts on this subject matter.)

Generally, Senate Bills 29 through 37 are respectively reintroductions of Senate Bills 818 through 823 and Senate Bills 825 through 827 of the 2023-2024 Legislative Session. Senate Bills 818 through 823 and Senate Bill 825 passed the Senate and were discharged from the House Committee on Health Policy but received no further action. Senate Bills 826 and 827 received testimony in the Senate Committee on Housing and Human Services but received no further action. Senate Bills 38 and 39 are reintroductions of Senate Bills 1057 and 1058 of the 2023-2024 Legislative Session. Senate Bills 1057 and 1058 passed the Senate and were referred to the House Committee on Government Operations but received no further action.

Legislative Analyst: Eleni Lionas

FISCAL IMPACT

Senate Bill 29

The bill would have an indeterminate negative fiscal impact on the DHHS and no fiscal 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 $138,900 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.

[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.

Senate Bill 30

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 upon 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 $138,900 annually, for salary and benefits.

Senate Bill 31 (S-2)

The bill would have an indeterminate minor negative fiscal impact on LARA and no impact on local units of government. The Department could face minor administrative costs resulting from the promulgation of rules to implement the bill's requirements. These costs could be borne by existing appropriations.

Senate Bill 32

The bill would have no fiscal impact on State or local government.

Senate Bill 33

The bill would have no fiscal impact on State or local government.

Senate Bill 34

The bill likely would not have a significant fiscal impact on the 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. Other State departments, agencies, and bodies could experience minor cost increases, but these most likely would be accommodated by existing appropriations.

Senate Bill 36

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 (GF/GP) 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.

Senate Bill 37 (S-2)

The bill would have no fiscal impact on State or local government.

Senate Bill 38 (S-1)

The bill could have an uncertain fiscal impact on the Medicaid program within the DHHS. There would be no fiscal impact on local units of government. Michigan's Medicaid program provides coverage for perinatal and gynecological services provided by a physician and certified nurse midwives. Michigan Medicaid does not provide coverage for perinatal and gynecological services provided by a licensed midwife.

The fiscal impact on the State is uncertain as the bill's inclusion of coverage for perinatal and gynecological services provided by a licensed midwife at the same rate for the same services currently paid to perinatal care or gynecological professionals is not covered under current policy within the Michigan Medicaid program. It is unclear if there is care currently offered by licensed midwives to eligible Medicaid recipients and being paid for out-of-pocket by currently eligible Medicaid recipients. To the extent that perinatal and gynecological care demand is moved from the current provider array to an expanded provider array, there would be no net increase in cost to Michigan's Medicaid program as one care provider is being substituted in place for another. To the extent that this expansion increased the amount of perinatal and gynecological care provided, there would be an increase in Medicaid costs.

Senate Bill 39

The bill could have an uncertain fiscal impact on the Medicaid program within the DHHS. There would be no fiscal impact on local units of government.

According to the most recent version available of the Medicaid Provider Manual (July 1, 2024): "The Maternity Outpatient Medical Services (MOMS) program covers outpatient pregnancy-related services for the unborn child…
The following services are covered consistent with current MOMS policy:

- Radiology and ultrasound"

The fiscal impact on the State is uncertain as the bill's inclusion of coverage for ultrasound procedures and fetal nonstress tests performed remotely in a residence or other off-site location through telemedicine may not be covered under current policy within the Michigan Medicaid program. To the extent that the coverage described in the bill was more extensive than current practices within the DHHS, there could be a fiscal cost to the State.

Date Completed: 4-17-25

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