Senate Bill 29, 30, 32 through 34, 36, and 39 (as passed by the Senate)
Senate Bills 31 and 37 (Substitute S-2 as passed by the Senate)
Senate Bill 38 (Substitute S-1 as passed by the Senate)
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

Date Completed: 6-18-25

RATIONALE

According to the Centers for Disease Control and Prevention (CDC), as of 2021, Black mothers are three times more likely to die from pregnancy related causes than white mothers.[1] These maternal health disparities persist across education and income levels and increase by age.[2] Non-white Hispanic, Native Hawaiian and Pacific Islander, and indigenous mothers also face higher rates of maternal mortality. For example, while the CDC found that 84% of the total pregnancy-related deaths studied between 2017 and 2019 could have been prevented, that number rose to 93% for indigenous mothers.[3] 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. As such, it has been suggested to require the Department of Health and Human Services (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.

CONTENT

Senate Bill 29 would amend the Public Health Code to do the following:

- **Require the 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.**

---

[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.
[2] Hill, Latoya, *et al.*, "Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them", *KFF*, October 25, 2024.
[3] "Pregnancy-Related Deaths: Data From Maternal Mortality Review Committees in 36 U.S. States, 2017–2019", Center for Disease Control. https://www.cdc.gov/maternal-mortality/php/data-research/mmrc-2017-2019.html. Retrieved on 5-15-25; "Pregnancy-Related Deaths Among American Indian or Alaska Native Women: Data From Maternal Mortality Review Committees in 36 U.S. States, 2017–2019", Center for Disease Control. https://www.cdc.gov/maternal-mortality/php/data-research/2017-2019-aian.html. Retrieved on 5-15-25.

-- 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 implement a policy allowing a patient who was giving birth to have present with the patient a doula and the patient's partner or companion.
-- 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 (EPIC) 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 a 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.

Table of Contents

Senate Bill 29

Information on Disparities and Inequities

The Public Health Code requires the DHHS to take certain actions to address racial and ethnic health disparities in the State and to submit to the Legislature, the standing committees pertaining to public health, and the Senate and House Fiscal Agencies an annual report on the status, impact, and effectiveness of those efforts.

The DHHS must develop and implement an effective statewide strategic plan for the reduction of racial and ethnic disparities. The bill also would require this plan to work toward the reduction of inequities.

Additionally, the DHHS must establish a webpage on its website in coordination with the Office of Equity and Minority Health that provides information or links to all the following:

-- Research within minority populations.
-- A resources directory that can be distributed to local organizations interested in minority health.
-- Racial and ethnic specific data, including morbidity and mortality.

Under the bill, the DHHS also would have to include information or links on its website to published, peer-reviewed studies and reports on biased or unjust perinatal care, including studies or reports on instances of obstetric racism and obstetric violence.

"Obstetric racism" would mean that a health facility or agency, health professional, or other person that provides care to a patient during the perinatal period is influenced by the patient's race in making a treatment or diagnostic decision and that decision places the patient's health and well-being at risk. "Health facility or agency" would mean, except as otherwise provided, any of the following:

-- An ambulance operation, aircraft transport operation, non-transport prehospital life support operation, or a medical first response service.
-- A county medical care facility.
-- A freestanding surgical outpatient facility.
-- A health maintenance organization.
-- A home for the aged.
-- A hospital.
-- A nursing home.
-- A facility listed above located in a university, college, or other educational institution.
-- A hospice.
-- A hospice residence.

"Obstetric violence" would mean physical, sexual, emotional, verbal abuse; bullying; coercion, humiliation, or assault, perpetrated by a health care professional on a patient during the perinatal period.

The Code requires the DHHS to provide statistics relevant to the causes, effects, extent, and nature of illness and disability of the people of the State, or a grouping of its people, which may include the incidence and prevalence of various acute and chronic illnesses and infant and maternal morbidity and mortality, among other things. Under the bill, these statistics also would have to include the incidence and prevalence of obstetric violence and obstetric racism.

Review of Maternal Statewide Mortality

Under the bill, the DHHS would have to maintain a team that comprehensively reviewed maternal deaths in the State, facilitated best practices for sharing data regarding maternal deaths, coordinated meetings with maternal mortality review teams throughout the country, and participated in regional or national maternal mortality review activities.

As used above, "health facility" would mean an ambulance operation, aircraft transportation operation, non-transport prehospital life support operation, or medical first response service; a county medical care facility; a freestanding surgical outpatient facility; a health maintenance organization; a home for the aged; a hospital; a nursing home; a facility described above located in a university, college, or other educational institution; a hospice or hospice residence; or a freestanding birth center other outpatient facility that is licensed or otherwise authorized to operate in the State under Article 17 (Facilities and Agencies) of the Code.[4]

The DHHS would have to study the use of research evidence in policies related to the perinatal period in the State, including all the following:

-- The public payment systems and the systems' policies related to labor and delivery services.
-- The malpractice insurance policies related to perinatal care, including labor and delivery services.
-- The private payment systems and the systems' policies related to labor and delivery services.

The bill would allow the DHHS to contract with a third-party to complete the study.

By January 1, 2026, using the implementation science framework, the DHHS would have to report to the Legislature's standing committees concerned with health policy the results of the study described above.

Beginning January 1, 2026, and every three years following, the DHHS would have to submit a report to the same committees on all the following:

-- A list of the most preventable causes of maternal mortality that the DHHS identified as having the greatest impact on the pregnant and postpartum population in the State.
-- In consultation with the Michigan Perinatal Care Quality Collaborative (PQC), a list of recommendations for best practices and quality improvement in clinical settings that could reduce the incidence of pregnancy related-deaths, maternal mortality, and morbidity in prenatal, perinatal, and postnatal clinical settings.[5]

[4] Public Act 252 of 2024 will add Part 207 (Freestanding Birth Centers) to Article 17 of the Code to prescribe their licensure and regulation and will take effect April 1, 2025.

[5] The DHHS oversees the PQC, which is comprised of nine regional PQCs and is part of the National PQC; members include health care professionals, community partners, families, faith-based organizations, Great Start Collaboratives and home visiting agencies, all focused on addressing outcomes related to clinical care, as well as environment, socioeconomic factors, and health-related behavior.

The bill would require the DHHS to incorporate in the report any findings from the MDCR under the "Biased and Unjust Care Reporting Act" proposed by Senate Bill 30.

Senate Bill 30

Reports on Pregnancy and Postpartum Care

The bill would enact the "Biased and Unjust Care Reporting Act" to require the DHHS to use a validated tool to receive reports from individuals who were pregnant or in the postpartum period and who received gynecological or perinatal care that did not meet at least one of the following:

-- Was provided in a manner that was culturally congruent, unbiased, and just.
-- Maintained dignity, privacy, and confidentiality.
-- Prevented harm or mistreatment.
-- Met requirements for informed consent.

"Validated tool" would mean a written or oral survey instrument that can demonstrate empirical evidence for reliability and validity.

The DHHS would have to use the validated tool and other methods to identify incidences of obstetric violence or obstetric racism.

Additionally, the DHHS would have to provide a report that contained de-identified data on the incidence and prevalence of obstetric violence and obstetric racism to the Governor, the Legislature's standing committees concerned with public health, the DHHS Director, and the LARA Director. The report could not contain a health facility or agency, health professional, or other person that provided care to a patient during the perinatal period's identifying information.

"De-identified data" would mean health information that does not identify an individual and there is no reasonable basis to believe the health information can be used to identify an individual.

Senate Bill 31 (S-2)

Patient or Resident General Standards of Care

Under the Public Health Code, a licensed health facility or agency that provides services directly to patients or residents must adopt a policy describing a patient's or resident's rights and responsibilities. The facility must treat patients and residents according to the policy.

Among other requirements, the policy must include that a patient or resident is entitled to refuse treatment to the extent provided by law and to be informed of the consequences of that refusal. If a refusal of treatment prevents a health facility or agency or its staff from providing appropriate care according to ethical and professional standards, the relationship with the patient or resident may be terminated upon reasonable notice. Under the bill, if the patient or resident were pregnant and in labor at the health facility, the facility would have to stabilize the patient or resident before terminating the relationship as described above.

Additionally, the Code prohibits an owner, operator, and governing body of a licensed hospital from discriminating because of race, religion, color, national origin, age, or sex in the operation of the hospital, including employment, patient admission and care, room assignment, and professional or nonprofessional selection and training programs. The bill specifies that the term "sex" would include pregnancy or lactating status.

Hospital Policy on Transfer and Delivery

Under the bill, beginning January 1, 2027, a hospital would have to have a policy that complied with all the following:

-- Subject to the provisions described below and unless otherwise prohibited by law, allowed a patient who was giving birth to have certain individuals present with the patient from the time the patient was admitted to the hospital and through the duration of the patient's stay at the hospital.
-- Provided the hospital's policy on receiving informed consent from the patient.
-- Provided the hospital's process on receiving a pregnant patient's information from a health professional who initiated transfer of the patient's care to the hospital.

The bill specifies that the policy would have to allow a patient's partner or spouse and a doula to be present with the patient during the patient's stay. If the patient did not have a partner or spouse, or the patient's partner or spouse were not available, the policy would have to allow the patient to have present a doula and a companion of the patient. "Doula" would mean an individual who provides nonclinical physical, emotional, and informational support to an individual who is pregnant before, during, and after the individual's pregnancy.

Additionally, the policy would have to specify that if the health professional that initiated a pregnant patient's transfer to a hospital were a midwife, the process would have to require the hospital to accept the standard form described in Section 17107 if the form were provided to the hospital for the patient or accept any information that the midwife was required to provide to the hospital under Section 17117. (Generally, Section 17117 and 17107 of the Code require the Board of Licensed Midwifery to establish the duties a midwife must perform in an emergency transfer to a hospital and specify that a midwife must establish a patient-specific protocol for the transfer of care to a physician or to a hospital including a form to collect information on a patient whose care was transferred, respectively.)

If the health professional initiating the transfer were a certified nurse midwife, the process would have to require the hospital to accept any information the certified nurse midwife provided. "Certified nurse midwife" would mean an individual who was licensed as a registered professional nurse under Part 172 (Nursing) and who has been granted a specialty certification in the health profession specialty field of nurse midwifery by the Michigan Board of Nursing.

Exemptions for Exclusion

A hospital could limit or otherwise exclude an individual from being present with a patient who was giving birth under any of the following circumstances:

-- A declared public health emergency, public health risk, or infection control risk, that required the limiting or excluding of the individual.
-- The individual assaulted another individual on the premises of the hospital.
-- Any other circumstance that existed in which the hospital determined that limiting or excluding the individual was necessary to protect the public health or safety, or to protect the health and safety of at least one individual on the premises of the hospital.

If a hospital limited or otherwise excluded an individual who was a doula from being present as described above, the hospital would have to document the reason for the doula's exclusion and allow for an alternative individual who would not otherwise be excluded as described above to be present with the patient.

The bill also would allow the DHHS to promulgate rules to implement the bill's policy requirements described above.

Senate Bill 32

Malpractice Insurance Policies on Perinatal Care

The Insurance Code requires the DIFS Director, after consultation with associations representative of physician interests and with authorized insurers writing malpractice insurance for physicians in the State, to prescribe the rating classifications for use by insurers in writing malpractice insurance for physicians.

The bill would require an insurer that offered a medical malpractice insurance policy to provide DIFS with information regarding the insurer's malpractice policies related to perinatal care annually at a date as determined by the DIFS Director, in a manner determined by DIFS. Within 60 days after DIFS received the insurer's information, DIFS would have to submit the information to the DHHS for the purpose of the DHHS's study of perinatal period policies, as proposed by Senate Bill 29.

Senate Bill 33

Patient Advocate Designation of Treatment While Pregnant

Generally, EPIC allows an individual at least 18 years of age or older and of sound mind at the time that a patient advocate designation is made to designate another individual to exercise powers concerning the first individual's care, custody, and medical or mental health treatment, among other things. The designation may include a statement on the individual's desires regarding those powers.

Under the bill, a patient advocate designation also could include a statement on which life-sustaining treatment the patient would desire or not desire if the patient were pregnant at the time the patient advocate designation became effective. The bill would specify that the patient's pregnancy status would not change or limit that right.

Under EPIC, the acceptance of a designation as a patient advocate must include certain statements confirming that the designation is effective only when the patient is unable to make decisions and does not allow for decisions that the patient may not make themselves.

Additionally, the designation must include a statement that the patient advocate designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient's death. The bill would delete this provision. Instead, the designation would have to include a statement or substantially similar statement that the patient advocate designation could be used to direct which life-sustaining treatment the patient would desire or not desire if the patient were pregnant at the time the patient advocate designation became effective.

Patient Advocate Authority

Generally, a patient advocate has the authority, rights, and responsibility to follow a patient's desires and cannot exercise powers concerning the patient's care that the patient could not have exercised on the patient's own behalf if that individual were able to participate in the decision. The advocate can make decisions about withholding treatment, hospice care, and mental health treatment.

Specifically, the designation of a patient advocate cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant and that would result in a pregnant patient's death. Under the bill, this provision would not apply after the bill's effective date.

Senate Bill 34

Sex Based Discrimination

Generally, ELCRA prohibits discrimination in employment, public accommodations and public services, educational facilities, and housing and real estate based on religion, race, color, national origin, age, sex, height, weight, familial status, marital status, or gender identity or expression. The bill specifies that the term "sex" would include pregnancy or lactating status.

Senate Bill 36

Midwifery Program Support

Under the Public Health Code, the DHHS may cooperate with a certified midwifery service to support the placement of certified nurse midwives in health resource shortage areas. The bill would modify this provision to specify that to support the placement of certified nurse midwives *or midwives* in health resource shortage areas, the DHHS could cooperate with any of the following:[6]

-- A certified nurse midwifery service.
-- An association representing midwives or certified nurse midwives from the State.
-- An association representing midwives and certified nurse midwives from the State who attend births in homes in licensed freestanding birth centers.

Midwifery Addition to the Essential Health Provider Repayment Program

Generally, the DHHS must administer an essential health provider repayment program for designated professionals who have incurred a debt or expense because of a loan taken to attend medical school, dental school, or specified programs. The bill would make eligible for the program a designated professional who incurred a debt or expense as a result of a loan taken to attend a midwifery program.[7]

Additionally, the DHHS must report certain information biannually to the House and Senate DHHS appropriations subcommittees, the House and Senate Fiscal Agencies, the Governor, the State Health Planning Council, and the Public Health Advisory Council on the status of the Michigan Essential Health Provider Strategy for the preceding two years. The bill would delete the requirement of the DHHS to notify the State Health Planning Council.

Among other things, the report must contain an assessment of whether the amount of debt or expense repayment an individual may receive under Section 2705(3) is sufficient to facilitate the placement and retention of designated professionals in health resource shortage areas, or whether that maximum amount should be adjusted to reflect changes in tuition costs for students enrolled in medical schools, dental schools, nursing programs, or physician's assistant programs.[8] The bill would specify that this provision also would apply to

---

[6] Health resource shortage areas are designated by the United States Department of Health and Human Services (USDHHS) as significantly needing additional private health care resources.

[7] The Michigan Essential Health Provider Strategy, known as the Michigan State Loan Repayment Program, assists employers in recruiting and retaining health providers by providing loan repayment to those who meet the Program's obligations, including participation in full-time, primary healthcare services at an eligible nonprofit located in an HPSA for two years.

[8] Under Section 2705(3) of the Public Health Code, in any year of a debt or expense repayment program, the maximum amount of a debt or expense repayment is $40,000 per year. The maximum amount of debt or expense repayment the DHHS may pay on behalf of a designated professional is $300,000, paid over a period of 10 years or more.

midwifery programs. "Midwifery program" would mean an accredited program for the training for individuals to become midwives.

Senate Bill 37 (S-2)

The bill would amend the Insurance Code to require an insurer that delivered, issued for delivery, or renewed in the State a health insurance policy that provided coverage for perinatal and gynecological services at an in-network facility to provide coverage in a health facility or agency or an individual's home by an in-network physician, certified nurse midwife, or licensed midwife acting within the scope of that individual's license or specialty certification.

"Certified nurse midwife" would mean an individual who was licensed as a registered professional nurse under Part 172 (Nursing) of the Public Health Code, who has been granted a specialty certification in the health professional field of nurse midwifery by the Michigan Board of Nursing under the Code.

"Midwife" would mean an individual licensed under Part 171 (Midwifery) of the Public Health Code to engage in the practice of midwifery.

"Physician" would mean a physician licensed under Part 170 (Medicine) or Part 175 (Osteopathic Medicine and Surgery) of the Public Health Code to engage in the practice of medicine or osteopathic medicine.

"Health facility" would mean any of the following:

-- An ambulance operation, aircraft transport operation, non-transport prehospital life support operation, or a medical first response service.
-- A county medical care facility.
-- A freestanding surgical outpatient facility.
-- A health maintenance organization.
-- A home for the aged.
-- A hospital.
-- A nursing home.
-- A facility listed above located in a university, college, or other educational institution.
-- A hospice.
-- A hospice residence.

Senate Bill 38 (S-1)

The Social Welfare Act prescribes specific services that may be covered under HMP health insurance plans, such as hospital services and physician services. The bill would amend the Act to allow Medicaid eligible individuals to receive perinatal and gynecological services if the DHHS applied to the USDHHS for an amendment to the HMP to include the services as prescribed below.

The DHHS would have to do all the following in implementing the bill's provisions:

-- Ensure that the services were provided by a perinatal or gynecological professional who was licensed, registered, or otherwise authorized to practice in the State, including health professionals working in facilities governed by Part 207 (Freestanding Birth Centers) of the Public Health Code.
-- Monitor and track contracted health plans for compliance in this area and consider that compliance in any health plan incentive programs.
-- Pay the same rate to a perinatal or gynecological professional working in a freestanding birth center licensed under Part 207 in a manner that promoted high-quality, cost-

effective, and evidence-based care, promoted high-value, evidence-based payment models, and prevented risk in subsequent pregnancies.

Senate Bill 39

The bill 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 in a residence or other off-site location through telemedicine. The DHHS would have to amend its rules for fee-for-service and medical assistance managed care plans regarding reimbursement to allow reimbursement for remote ultrasound procedures and remote fetal nonstress tests using established current procedural terminology (CPT) codes for these procedures when the patient was in a residence or other off-site location from the patient's provider and the same standard of care was met.

Under the bill, remote ultrasounds would be reimbursable only when the provider used digital technology as follows:

-- To collect medical and other forms of health data from a patient and electronically transmitted that data securely to a health care provider in a different location for interpretation and recommendation.
-- In a manner that complied with the Health Insurance Portability and Accountability Act and was approved by the United States Food and Drug Administration (FDA).

Remote fetal nonstress tests would be reimbursable only if the following conditions were met:

-- The requirements for ultrasound reimbursement described above.
-- They had a place of service modifier for at-home monitoring with remote monitoring solutions that were cleared by the FDA for on-label use for monitoring fetal heart rate, maternal heart rate, or uterine activity.

The DHHS would have to adopt and publish guidelines to implement the bill's provisions.

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)
722.623a (S.B. 35)
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)

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 reintroductions of Senate Bills 818 through 823 and Senate Bills 825 through 827 of the 2023-2024 Legislative Session, respectively. 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.

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

The bills would bring equity and accountability to Michigan's maternal healthcare systems. Firstly, they would require the DHHS to collect and analyze data on obstetric violence and obstetric racism, as well as reports from pregnant or postpartum individuals who did not receive proper care. They also would require the DHHS to maintain the Maternal Mortality Review Committee, which reviews statewide maternal deaths. Lastly, the bills would require DIFS to collect and transmit to the DHHS information on insurers' medical malpractice insurance policies related to perinatal care services. Requiring the DHHS and DIFS to gather and analyze this data would allow them to implement policies and solutions to reduce disparities in care. This data collection also would bring transparency to the State's health systems. Testimony before the Senate Committee on Housing and Human Services during the 2023-2024 Legislative Session indicated that pregnant individuals of color may distrust the medical system due to institutional obfuscation and a lack of resources, among other reasons. The bills' promotion of data would make the State's health systems more transparent and trustworthy.

Additionally, the bills would reduce disparities in the State's maternal healthcare systems by involving pregnant patients and their families in their care. According to testimony during the 2023-2024 Legislative Session, obstetric racism may manifest as institutional deafness, with doctors, nurses, and other staff ignoring or discounting patients' wishes and feelings. The bills would address this issue in several ways. Firstly, Senate Bill 31 (S-2) would require hospitals to allow a laboring patient's doula and partner or companion to accompany the patient during birth. The presence of doulas during birth may lead to better outcomes for birthing patients, as their work is associated with fewer cesarean sections, shorter labor, and greater satisfaction with the birthing experience.[9] Allowing a patient's partner, companion, or doula to accompany a birthing patient also would allow them to advocate for patients in a likely unfamiliar environment. Senate Bill 33 would allow a patient advocate to decide whether to withhold or withdraw lifesaving treatment for a pregnant patient, according to the pregnant patient's wishes. In other words, the bill would give patient advocates the power to carry out a pregnant patient's wishes, ensuring that the patient's voice was heard under dire circumstances. While all birthing patients would benefit from this support and information, the benefit would likely be greatest for birthing patients of color.

Senate Bill 34 also would reduce inequality overall by protecting individuals regardless of pregnancy or lactating status. Pregnant and lactating individuals may face discrimination and harassment in the workplace. Workers in low-wage fields may be at greater risk. While Title VII of the Civil Rights Act, the Americans with Disabilities Act, the Pregnant Workers Fairness Act, and the Break Time for Nursing Mothers Act generally protect individuals from discrimination related to pregnancy and lactating status, testimony before the Senate Committee on Housing and Human Services during the 2023-2024 Legislative Session indicated that these laws do not cover all pregnant and lactating individuals and may be broadly unenforceable. The bills would provide equity to pregnant and lactating individuals at the State level, ensuring that violations would be punishable and workers protected. Overall, the bills would make the State's health systems more equitable and accountable by requiring the collection of certain data; giving pregnant patients, especially patients of color, and their families a greater voice in their medical care; and prohibiting discrimination related to pregnancy or lactating status.

Response: Senate Bills 29 and 30 may not capture the full scope of obstetric racism. In 2023, the DHHS found that, out of the women who reported having induced an abortion,

[9] Robles-Fradet, Alexis, and Mara Greenwald, "Doula Care Improves Health Outcomes, Reduces Racial Disparities and Cuts Cost", *National Health Law Program*, August 8, 2022.

53.3% were black women, compared to 35% of white women.[10] Reportedly, doctors may pressure pregnant patients of color to terminate their pregnancies more than white women. The DHHS should investigate this issue to determine whether pregnant patients of color are at risk of coercion to terminate a pregnancy.

Supporting Argument

The bills would reduce harmful outcomes, including death, for birthing individuals in a variety of ways. Firstly, some pregnant individuals may opt to give birth at home instead of a hospital to alleviate expenses or for personal reasons. A pregnant individual also may choose to give birth in a community health center, where care may be more culturally congruent, unbiased, and just due to community participation. Senate Bill 37 (S-2) would require a health insurance provider that covered gynecological and pregnancy services to provide in-network coverage of those services in a health facility or agency or patient's home by an in-network physician, certified nurse midwife, or a qualified midwife. In other words, under the bill, an insurance provider could not discriminate against payers who chose not to deliver in a hospital.

Secondly, the bills would increase access to midwives. Senate Bill 36 would allow a midwife-in-training to participate in the DHHS's health provider loan repayment program. The bill would alleviate barriers to entry into the field, allowing more individuals to pursue training. Growing the midwife population would, in turn, lead to better health outcomes for pregnant individuals. Similar to doulas, midwife care is associated with fewer interventions, cesarean deliveries, preterm births, and labor inductions.[11] Additionally, one-third of Michigan's counties are reported to lack access to obstetric care. As midwives may be more flexible and mobile, they could bring the benefits of obstetric care to counties that lacked it. Erasing barriers to entry for midwifery would increase healthy, happy deliveries across the State.

Additionally, individuals in labor who opt to deliver with the aid of a midwife or doula but must be transferred to the hospital may face complications. Testimony before the Senate Committee on Housing and Human Services during the 2023-2024 Legislative Session indicated that the disconnect between midwives, doulas, and hospital healthcare systems may delay critical care for patients. Senate Bill 31 (S-2) would require a hospital to develop a policy for receiving a pregnant patient's information upon such a transfer. The bill would integrate these systems to provide the best outcomes for patients.

Further, protecting lactating individuals from discrimination also would contribute to their health. Pumping and breastfeeding benefits lactating individuals, reducing their risk for reproductive-related cancers, type 2 diabetes, and high blood pressure.[12] Individuals prohibited from expressing may face illness and infections as a result. Additionally, the discrimination and harassment, including sexual harassment, a lactating individual may face may negatively affect a lactating individual's mental health. Ensuring that lactating individuals could pump and breastfeed in peace would lead to better health outcomes.

The bills also would ensure that pregnant patients and their families could make informed decisions. Senate Bill 31 (S-2) would require a hospital to record its method of receiving a patient's informed consent, ensuring that individuals could make decisions with full knowledge of the potential consequences of treatment or the lack thereof. Overall, the bills would benefit pregnant individuals by requiring insurance to cover births conducted in a non-hospital health facility, such as a birthing center, or at-home; increasing access to midwives, smoothing the

[10] "Number and Percent of Reported Induced Abortions by Race or Hispanic Ancestry of Woman, Michigan Residents, 2023", https://vitalstats.michigan.gov/osr/abortion/Abortrace.asp. Retrieved on 5-22-25.
[11] Combellick, Joan, *et al.*, "Midwifery care during labor and birth in the United States", *American Journal of Obstetrics and Gynecology*, Volume 228, Issue 5, May 2023.
[12] "Five great benefits of breastfeeding", Center for Disease Control. https://www.cdc.gov/breastfeeding/features/breastfeeding-benefits.html. Retrieved 5-27-25.

transition from home or birth center to hospital; protecting lactating individuals; and requiring hospitals to implement policies regarding informed consent.

Supporting Argument

By investing in maternal healthcare, the bills would contribute to the State's economy. Michigan's population has stagnated in the past decades. Since 1980, the State's population has only grown 8.8% (as of 2021). Between 1980 and 2020, the population of residents aged 19 or younger decreased 22%, while the population aged 20 to 34 decreased 18%.[13] The State is losing more people, especially young people, than it attracts. The State's stagnating population harms the economy. It puts Michigan at a competitive disadvantage and results in tax base and revenue loss. It also harms the State's political representation. To combat these issues, the Growing Michigan Together Council set a goal that Michigan would be a top-10 state for population growth by 2050. To achieve this goal, and contribute to the economy, the State should invest in maternal healthcare. Testimony before the Senate during the 2023-2024 Legislative Session indicated that women and other individuals seeking to start families consider the cost and safety of doing so. By making maternal healthcare more accessible and safer, the State could attract prospective parents. The bills would send a message that Michigan is a great place to have a family and so potentially reverse its population stagnation.

Additionally, by investing in midwives and community birth centers, the State could grow cost-effectively. A 2019 report by the University of Minnesota's School of Public Health found that, by increasing the percentage of pregnancies with midwife-led care from 8.9% to 15% by 2023, the United States could save $1.0 billion in costs. If the percentage increased to 20% by 2027, the United States could save $4.9 billion.[14] While the study examined the United States as a whole, Michigan could see significant cost-savings as well by increasing access to midwife care.

Further, prohibiting discrimination based on pregnancy or lactation status would keep more parents in the workforce. Some employers may construe short-term absences as evidence that an employee may not prioritize their work.[15] Pregnant and lactating employees often need short-term breaks, such as to attend doctors' appointments or to pump. Long-term absences, such as maternity leave, may cause pregnant employees to miss promotion and growth opportunities. Federal law prohibits discrimination against pregnant workers; however, testimony before the Senate Committee on Housing and Human Services during the 2023-2024 Legislative Session indicated that pregnant and lactating employees still face discrimination and harassment while working. The State should enact Senate Bill 34 to further protect workers from discrimination and harassment based on pregnancy and lactation status. Overall, the bills would contribute to the State's economy by supporting Michigan workers and their family planning choices.

Supporting Argument

The bills would provide Michigan children with better health outcomes. Firstly, integrating doula and midwife care into the State's medical systems may reduce instances of preterm births. According to the CDC, fetal development continues into the final weeks of pregnancy. Children born before 37 weeks of pregnancy may face life-threatening complications. In 2022, 14% of infant deaths across the United States resulted from preterm birth and low birth weight.[16] A 2016 study by the University of Minnesota School of Public Health found that pregnant individuals in states with higher rates of midwife-assisted births had a 13% lower

---

[13] *Growing Michigan Together Council Report*, pp. 13-14, December 14, 2023.

[14] Kozhimannil, Katy B., *et al.*, "Policy Brief: More Midwife-Led Care could Generate Cost Savings and Health Improvements", *University of Minnesota School of Public Health*, November 2019.

[15] Ferguson Melhorn, Stephanie, "Data Deep Dive: Women in the Workforce", *U.S. Chamber of Commerce*, June 26, 2024.

[16] "Preterm Birth", CDC. https://www.cdc.gov/maternal-infant-health/preterm-birth/index.html. Retrieved 5-27-25.

chance of preterm birth and an 11% lower chance of delivering a low-birth-weight infant.[17] Increasing access to doula and midwife care could reduce preterm delivery and, as a result, infant mortality.

Secondly, prohibiting discrimination based on lactating status also would contribute to healthy children. Breastfeeding provides infants with important nutrition and comfort and protects them from short- and long-term illnesses, due to the antibodies passed from parent to child. For this reason, many health systems and professionals recommend infants be exclusively breastfed for their first six months. As infants grow older and are introduced to new foods, breastmilk may be used to supplement their diet. Despite the importance of breastfeeding, lactating individuals may face discrimination and harassment in public, especially in the workplace. Reportedly, lactating individuals may be denied breaks to pump or feed or privacy when doing so. These difficulties may reduce a lactating individual's milk supply or push a lactating individual to wean the individual's infant earlier than recommended. By prohibiting discrimination and harassment against lactating individuals and investing in doula care and midwifery the State would support infant health.

Opposing Argument
Some individuals do not support the termination of pregnancy under any circumstance because of religious, cultural, or personal beliefs and so oppose Senate Bill 33. The bill would allow a patient advocate to decide whether to withhold or withdraw lifesaving treatment for a pregnant patient, according to a pregnant patient's wishes. Withdrawing or withholding lifesaving treatment from a pregnant patient may be considered termination, as the death of a pregnant patient also results in the death of the patient's unborn child. Currently, a patient advocate may decide whether to withhold or withdraw treatment for an individual; however, the law prohibits a patient advocate from making such a decision when the patient is pregnant. The law should remain unchanged.

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.

[17] Plain, Charlie, "Study finds states with midwifery-friendly laws have more midwife-attended births and better birth outcomes", *University of Minnesota School of Public Health*, March 24, 2026.

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.

Fiscal Analyst: Ellyn Ackerman
Bobby Canell
Nathan Leaman
John P. Maxwell
Elizabeth Raczkowski
Jaymie Tibbits

SAS\S2526\s29sb
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.