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BILL ANALYSIS

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Senate Bills 818 through 827 (as introduced 4-10-24)
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 & 826)
Senator Sylvia Santana (S.B. 824 & 827)
Committee: Housing and Human Services

Date Completed: 6-18-24

INTRODUCTION

The bills would amend existing and enact new laws governing perinatal care in the State. They would require the Department of Health and Human Services (DHHS) and the Department of Civil Rights (MDCR) to research the status of maternal and perinatal health in the State and provide regular reports on the best methods to address racial and ethnic disparities and improve patient care within the field. They also would prohibit discrimination based on pregnancy or lactating status.

The bills would require insurers covering perinatal care to provide information on malpractice policies related to such care and to cover perinatal services provided in homes or health care facilities. They would require health facilities to stabilize pregnant patients in labor before terminating the patient-provider relationship if that patient refused or denied care. They would allow patient advocate designations to include directives on treatment during pregnancy.

Additionally, the bills would allow the DHHS to provide loan reimbursement and other support to qualified certified nurse midwives working in Health Professional Shortage Areas (HPSA). They would establish a Doula Scholarship Program within the DHHS and require health facilities to allow a pregnant patient's doula to accompany the patient. Finally, they would modify reporting and notification requirements for newborns exposed to alcohol or controlled substances and require the DHHS to develop a safe care plan to address the needs of newborn infants and their parents in these situations.

BRIEF FISCAL IMPACT

The bills would have no fiscal impact on local units of government and an indeterminate negative fiscal impact on the State, mainly stemming from costs to the MDCR and the DHHS. Both Departments would face increased costs due to the need to hire additional full-time equivalents (FTEs) to fulfill the requirements in the bills as well as increased administrative costs related to new reporting requirements. These costs would be significant for the MDCR. Senate Bills 825 and 826 would have the potential for increased costs, but any costs would depend on an appropriation being made to support the Michigan Essential Health Provider Program or the proposed Doula Scholarship Program. The magnitude of the cost would depend on the magnitude of the potential appropriation.

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CONTENT

Senate Bill 818 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 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 comprehensibly 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 would enact the "Biased and Unjust Care Reporting Act" to do the following:

-- **Require the MDCR to collect data using the Patient-reported Experience Measure of Obstetric Racism (PREM-OB) Scale or a similar tool to collect 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.[1]**
-- **Require the MDCR 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).**

Senate Bill 820 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 on the basis of 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.**

Senate Bill 821 would amend the Insurance Code to require an insurer that offered a medical malpractice insurance policy to provide the DHHS with information

[1] The PREM-OB Scale is a survey tool aimed to improve Black birthing experiences and outcomes during childbirth hospitalization and offers measures on humanity, kinship, and racism.

regarding that insurer's policies related to perinatal care services upon the DHHS's request for use in the study required by Senate Bill 818.

Senate Bill 822 would amend the Estates and Protected Individuals Code (EPIC) 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 became effective.

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

Senate Bill 824 would amend the Child Protection Law to do the following:

- **-- Modify a provision requiring certain mandatory reporters to report evidence or suspicion of a newborn infant affected by any amount of alcohol, controlled substance, or metabolite of a controlled substance as a case of child abuse or neglect.**
- **-- Require a mandatory reporter to notify the DHHS of a newborn affected by an amount of alcohol, controlled substance, or metabolite of a controlled substance if the newborn infant's health or welfare were threatened by the parent's substance abuse.**
- **-- Upon notification described above, require the DHHS to develop a plan of safe care to address the needs of newborn infants and the newborn infant's parents and require the plan to provide services during and after pregnancy.**

Senate Bill 825 would amend the 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 HPSA for two years.

Senate Bill 826 would enact a new law to do the following:

- **-- Establish the Doula Scholarship Program administered by the DHHS and prescribe the Program's eligibility requirements.**
- **-- Allow the DHHS to award a maximum $3,000 scholarship per awardee.**
- **-- Require a scholarship recipient to be working toward the completion of doula training within six months of receiving the funds.**
- **-- Create the Doula Scholarship Fund within the State Treasury.**

Senate Bill 827 would amend the Insurance Code to do the following:

- **-- Require an insurance provider in the State that provided health insurance covering gynecological and pregnancy services to cover those services in a healthcare facility or at a patient's home by a qualified physician, nurse midwife, or midwife.**
- **-- Required the insurance to reimburse a provider in a way that provided for high-quality, cost-effective, evidence-based care, supported efficient payment models, and reduced risks in future pregnancies.**

Senate Bill 818 and Senate Bill 821 are tie barred. Senate Bill 818 is tie-barred to Senate Bill 819 and House Bill 5636. Senate Bills 819, 825, and 827 are also tie-barred to House Bill

5636, which generally would amend the Public Health Code to establish licensing and regulation of freestanding birth centers, among other things.

Senate Bill 818

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 to 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 studies and reports on biased or unjust perinatal care, including studies or reports on instances of obstetric racism and obstetric violence predicated on the PREM-OB Scale or a similar tool.

"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, nontransport 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, the 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 comprehensibly reviewed maternal deaths in the State, facilities 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 a hospital, freestanding birth center licensed under proposed House Bill 5636, freestanding surgical outpatient facility, or other outpatient facility that is licensed or otherwise authorized to operate in the State under Article 17 (Facilities and Agencies) of the Code.

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.
-- In consultation with the Department of Insurance and Financial Services (DIFS), malpractice insurance policies related to perinatal care, including labor and delivery services.
-- In consultation with DIFS, 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.

By 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 clinal settings.[2]

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 819.

Senate Bill 819

Reports on Pregnancy and Postpartum Care

The bill would enact the "Biased and Unjust Care Reporting Act" to require the MDCR to use the PREM-OB Scale or a tool with equivalent validation to receive reports from individuals who

[2] 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.

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.

The MDCR would have to use the patient self-reporting tools described above and other methods to identify incidences of obstetric violence or obstetric racism.

Additionally, the MDCR would have to provide a report 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.

Senate Bill 820

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 residence 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, 2026, a hospital would have to demonstrate to the DHHS, in a form and manner required by the DHHS, that the hospital had a policy that complied with all the following:

-- Allowed a patient who was giving birth to have certain individuals present with the patient while the patient was admitted to the hospital and during the patient's stay at the hospital.
-- Provided the hospital's policy on receiving informed consent to the patient.
-- Provided the hospital's policy 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.

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

Senate Bill 821

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 and the DHHS with information regarding the insurer's malpractice policies related to perinatal care upon the DHHS's request for use in the DHHS's study of perinatal period policies in the State, as proposed by Senate Bill 818.

Senate Bill 822

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.

Senate Bill 823

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 824

Newborn with Presence of Alcohol or Controlled Substance

Under the Child Protection Law, in addition to reporting requirements for child abuse or neglect, child pregnancy, child sexually transmitted infection, or child exposure to methamphetamine production, a mandatory reporter who knows or has reasonable cause to suspect that a newborn infant has any amount of alcohol, a controlled substance, or a metabolite of a controlled substance in his or her body must report that information to the DHHS unless the mandatory reporter knows that the alcohol, controlled substance, metabolite, or symptoms are the result of medical treatment administered to the new born or the newborn's birth parent. The bill would delete these provisions.

(Mandatory reporters under the Law include the following:

-- A physician, dentist, physician's assistant, registered dental hygienist, medical examiner, nurse, person licensed to provide emergency medical care, audiologist, psychologist, physical therapist, physical therapist assistant, occupational therapist, athletic trainer, marriage and family therapist, licensed professional counselor, social worker, licensed master's social worker, licensed bachelor's social worker, registered social service technician, social service technician, a person employed in a professional capacity in any office of the friend of the court, school administrator, school counselor or teacher, law enforcement officer, member of the clergy, or regulated child care provider who has reasonable cause to suspect child abuse or child neglect shall make an immediate report to centralized intake by telephone, or, if available, through the online reporting system, of the suspected child abuse or child neglect.
-- A DHHS employee who is an eligibility specialist, family independence manager, family independence specialist, social service specialist, social work specialist, social work specialist manager or welfare services specialist that has reasonable cause to suspect child abuse or child neglect.)

Instead, under the bill, if a newborn infant were shown to be affected by any amount of alcohol, controlled substance, or metabolite of a controlled substance in the newborn infant's body, a mandatory reporter under the Law would have to notify the DHHS, in a manner prescribed by the DHHS, that the newborn infant was affected by any amount of that substance or metabolite of that substance. The DHHS would have to develop a plan of safe care to address the needs of the newborn infant and the newborn infant's parents and ensure

that the plan of safe care provided services during and after pregnancy as required by the Federal Child Abuse Protection and Treatment Act.[3] If appropriate, as determined by the DHHS, the DHHS would have to develop the plan of safe care in coordination with the hospital where the newborn infant was born.

The notification of a child affected by any amount of alcohol, controlled substance, or metabolite of a controlled substance in the newborn infant's body would have to be made to the DHHS even if that substance or metabolite of that substance in the newborn infant's body were the result of a medical treatment administered to the newborn infant's birth parent. In such an instance where the substance or metabolite of that substance was the result of a known medical treatment administered to the newborn infant or the newborn infant's birth parent a mandatory reporter under the Law would not have to notify the DHHS of suspected child abuse or neglect.

A mandatory reporter under the Law would have to make a report of suspected child abuse or neglect to the DHHS if the following were met:

-- A newborn infant was shown to be affected by any amount of alcohol, controlled substance, or metabolite of a controlled substance in the newborn infant's body.
-- The newborn infant's health or welfare was threatened by the parent's substance abuse.

A mandatory reporter could not make a report of suspected child abuse or neglect to the DHHS if the report were based on only one of the following:

-- A finding of any amount of alcohol, controlled substance, or metabolite of a controlled substance in the newborn infant's body.
-- The person's reasonable suspicion that there was any amount of alcohol, controlled substance, or metabolite of a controlled substance in the newborn infant's body.

Senate Bill 825

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:[4]

-- 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 as proposed by House Bill 5636.

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

[3] Section 5106a of the Child Abuse Prevention and Treatment Act allows for States to receive grants for child abuse or neglect prevention and treatment programs, eligibility is contingent on the development of a plan of safe care for infant newborns affected by substance abuse or withdraw symptoms, or Fetal Alcohol Spectrum Disorder to ensure the safety and wellbeing upon release of care, among other things.
[4] Health resource shortage areas are designated by the United States Department of Health and Human Services as significantly needing additional private health care resources.

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.[5]

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.[6] The bill would specify that this provision also would apply to midwifery programs. "Midwifery program" would mean an accredited program for the training for individuals to become midwives.

Senate Bill 826

Doula Scholarship Program

The bill would enact a new law to create the Doula Scholarship Program to be administered by the DHHS. The DHHS would have to do all the following in implementing the Program:

-- Award scholarships to eligible individuals under the Act.
-- Promulgate rules necessary to administer the Act.
-- Publicize the availability of the Program, in partnership with universities, nonprofit organizations, and other persons.

Under the bill, "doula" would mean an individual who provides continuous physical, emotional, and informational support to a mother before, during, and shortly after childbirth to help the mother achieve a healthy and satisfying childbirth experience.

Scholarship Eligibility

The DHHS could award a scholarship for eligible costs to an individual determined by the DHHS to meet all the following eligibility criteria:

-- Had not been awarded a scholarship under the Act at the time of application submission.
-- Demonstrated a financial hardship through household income or through receipt of financial assistance under the Supplemental Nutrition Assistance Program; the Special Supplemental Food Program for Women, Infants, And Children; the Social Security Administration SSI program; or another program.

[5] 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.

[6] 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.

-- Completed a signed application stating intent to become a doula in the State and provided proof of residency in the State.
-- Met any other standards establish by the DHHS' rules.

"Eligible costs" would mean the costs of doula training, including the costs of books, workshop fees, examination fees, and membership fees. "Financial hardship" would mean insufficient financial resources to complete doula training without financial assistance. "Doula training" would mean the training an individual completes to become a doula and that is approved by the Michigan Doula Advisory Council within the DHHS.

An individual could apply for a scholarship by completing an application on a form provided by the DHHS.

Under the Act, an individual could not receive more than $3,000 as a scholarship award and could not receive more than one Doula Scholarship Program award.

Within six months of receiving a scholarship, the individual would have to be working toward the completion of doula training or have completed doula training. The individual would have to provide the DHHS with documentation demonstrating such information. The DHHS would have to accept any of the following as documentation:

-- A letter from a health care professional who verified the individual was serving as a doula and the health care professional worked with the individual.
-- A letter from a client who received services from the individual acting as the client's doula.
-- Any other documentation the DHHS determined was sufficient to demonstrate that the individual was working toward, or had completed, doula training.

If an individual were not able to demonstration the information described above to the DHHS, the DHHS would have to seek repayment of the award.

Doula Scholarship Fund

The Act would create the Doula Scholarship Fund within the State Treasury. The State Treasure could receive money or other assets from any source to deposit into the Fund and would have to direct investment of the Fund. The State Treasurer would have to credit to the fund, interest and earnings from Fund investments. Money in the Fund at the close of the Fiscal Year would have to remain in the Fund and would not lapse into the General Fund.

The DHHS would be the administrator of the Doula Scholarship Fund for auditing purposes and the DHHS only could expend money from the Fund, upon appropriation, for the purpose of providing Program scholarships.

Senate Bill 827

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 would have to provide coverage in a health facility or agency or an individual's home by a physician, nurse midwife, or licensed midwife acting within the scope of that individual's license or specialty certification. The bill would require the insurer to reimburse all eligible providers within the scope of the provider's practice in a manner that did all the following:

-- Promoted high-quality, cost-cost effective, and evidence-based care.
-- Promoted high-value, evidence-based payment models.

-- Prevented risk in subsequent pregnancies.

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)
722.623a (S.B. 824)
333.2701 et al. (S.B. 825)
Proposed MCL 500.3406cc (S.B. 827)

FISCAL IMPACT

Senate Bill 818

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 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 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

The bill would have a significant fiscal impact on the MDCR. The MDCR 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 type and level of detail included in these undertakings. It is likely that most of the cost of the development and administration of these reporting tools and programs would be absorbed by existing appropriations, but it is possible that an additional FTE could be needed, depending on the level of engagement with these tools. The estimated annual cost of an FTE is $137,500.

Senate Bill 820

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

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 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 824

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

Senate Bill 825

The bill will 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 (MCL) 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 into, assuming a flat appropriation level in future fiscal years. A recent funding history of the Michigan Essential Health Provider Program is shown below.

Fiscal Year	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[c]	N/A[d]	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]The amounts in this row reflect the Executive, Senate, and House proposed funding level.
[d]Unavailable until the close of the Fiscal Year.

Senate Bill 826

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 promulgation of rules to implement the scholarship program. Costs related to administering the scholarship program once established would depend on the necessary time investment. If the administration of the program could be supported using existingFTEs and resources, the DHHS would incur no costs; however, if the administration of the scholarship program required one or more additional FTEs, the average annual cost incurred by the DHHS would be approximately $137,500 per FTE, which includes salary and benefits.

Actual expenditures from the fund to support the scholarship program created in the bill would depend on appropriation, therefore the impact on the DHHS would depend on how much funding was made available through an appropriation.

The bill would have no fiscal impact on the Department of Treasury. Based on the level of estimated revenue likely to be appropriated to the Fund, ongoing costs associated with administration and investment would be less than $100. Current appropriations would be sufficient to carry out these activities.

Senate Bill 827

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

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