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**THE COUNCIL OF THE CITY OF NEW YORK**

**COMMITTEE REPORT OF THE HUMAN SERVICES DIVISION**

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**COMMITTEE ON HEALTH**

**Hon. Lynn Schulman, *Chair***

**COMMITTEE ON HOSPITALS**

**Hon. Mercedes Narcisse, *Chair***

**June 29, 2022**

**Oversight: Maternal Health, Mortality, and Morbidity**

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| **Introduction no. 409** | By Council Members Louis, Hanif, Joseph, Ung, Nurse, Krishnan, Abreu and Restler |
| **Title:** | A Local Law to amend the administrative code of the city of New York, in relation to increasing access to data and maternal mortality and morbidity |
| **Administrative Code:** | Amends subdivision b of section 17-199.3 |
|  |  |
| **Introduction No. 472** | By Council Members Gutiérrez, Louis, Hudson, Hanif, Brooks-Powers, Brewer, Nurse, Ung, Mealy, Velázquez, De La Rosa, Stevens, Menin, Williams, Schulman, Dinowitz, Farías, Sanchez, Richardson Jordan, Cabán, Riley, Avilés, Abreu, Restler and The Speaker (Council Member Adams) (in conjunction with the Brooklyn Borough President) |
| **Title:** | A Local Law in relation to establishing a pilot program in the department of health and mental hygiene to train doulas and provide doula services to residents in all five boroughs |
|  |  |
| **Introduction No. 478** | By Council Members Hudson, Gutiérrez, Louis, Hanif, Brooks-Powers, Nurse, Mealy, Velázquez, De La Rosa, Stevens, Menin, Williams, Schulman, Dinowitz, Farías, Sanchez, Richardson Jordan, Cabán, Riley, Avilés, Abreu, Restler and The Speaker (Council Member Adams) (in conjunction with the Brooklyn Borough President) |
| **Title:** | A Local Law to amend the administrative code of the city of New York, in relation to an outreach and education campaign on the benefits and services provided by doulas and midwives |
| **Administrative Code:** | Adds a new section 17-199.3.2 to title 17 |
|  |  |
| **Introduction No. 482** | By Council Members Louis, Nurse and Abreu |
| **Title:** | A Local Law to amend the administrative code of the city of New York, in relation to requiring the department of health and mental hygiene to report on polycystic ovary syndrome and endometriosis |
| **Administrative Code:** | Adds a new section 17-199.3.2 to title 17 |
|  |  |
| **Introduction No. 490** | By Council Members Menin, Louis, Hudson, Hanif, Nurse and The Speaker (Council Member Adams) |
| **Title:** | A Local Law to amend the administrative code of the city of New York, in relation to the establishment of an office of sexual and reproductive health within the New York city department of health and mental hygiene |
| **Administrative Code:** | Adds a new section 17-199.19 to title 17 |
|  |  |
| **Introduction No. 508** | By Council Members Schulman, Hanif, Brewer, Nurse, Abreu and Louis |
| **Title:** | A Local Law to amend the administrative code of the city of New York, in relation to requiring family building benefits for city employees |
| **Administrative Code:** | Adds a new section 12-141 to chapter 1 of title 12 |
|  |  |
| **Introduction No. 509** | By Council Members Stevens, Louis, Hanif, Brooks-Powers, Nurse and Abreu (in conjunction with the Brooklyn Borough President) |
| **Title:** | A Local Law to amend the administrative code of the city of New York, in relation to a public education and outreach campaign on the risks of caesarean sections |
| **Administrative Code:** | Adds a new section 17-199.3.2 to title 17 |
|  |  |
| **Introduction No. 86****Title:****Administrative Code:****Resolution No. 95** | By Public Advocate Williams, and Council Members Stevens, Hanif, Cabán, Won, Restler, and Yeger (by request of the Bronx Borough President)A Local Law to amend the administrative code of the city of New York, in relation to education about city standards for respectful care at birth, health care proxy forms and patients' rightsAdds a new section 17-200.1 to title 17By Council Members Rivera, Hanif, Riley, Stevens, Won, Nurse and Louis |
| **Title:** | Resolution calling on the New York State Legislature to pass, and the Governor to sign, A217/S2736, relating to informing maternity patients about the risks associated with cesarean section. |
|  |  |
| **Resolution No. 201** | By Council Members Narcisse, Louis, Hanif, Brooks-Powers, Joseph, Nurse, Gutiérrez and Restler |
| **Title:** | Resolution calling upon New York State Legislature to establish full insurance coverage for fertility treatments. |
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| **Resolution No. 205** | By Council Members Rivera, Louis, Hudson, Hanif, Brooks-Powers, Joseph, Nurse, The Speaker (Council Member Adams) and Council Member Restler (in conjunction with the Brooklyn Borough President) |
| **Title:****Resolution No. 244****Title:****Resolution No. 92****Title:** | Resolution calling on the New York State Legislature to pass, and the Governor to sign, legislation making doulas more accessible to individuals with Medicaid and those without health insurance.By Public Advocate Williams, and Council Members Cabán, Hanif, Louis, and GutiérrezResolution calling on the Centers for Disease Control and Prevention to provide expanded funding for the Healthy Start Brooklyn doula program known as By My Side in order to make doulas available to all low-income birthing people in New York City.By Public Advocate Williams and Council Members Hanif, Brewer, Riley, Sanchez, Stevens, Won, Restler, and Nurse (in conjunction with the Brooklyn Borough President)Resolution calling on the United States Congress to pass and President Joseph Biden to sign the Black Maternal Health Momnibus Act of 2021 |

1. **Introduction**

 On June 29, 2022, the Committee on Health, chaired by Council Member Lynn Schulman, and the Committee on Hospitals, chaired by Council Member Mercedes Narcisse, will hold a joint oversight hearing on *Maternal Health, Mortality, and Morbidity*. The Committees will also seek an update on maternal health data, programs, and progress, and will consider 13 pieces of legislation, including 8 bills: Introduction No. 409 (Louis), in relation to increasing access to data and maternal mortality and morbidity; Introduction No. 472 (Gutiérrez), in relation to establishing a pilot program in the department of health and mental hygiene to train doulas and provide doula services to residents in all five boroughs; Introduction No. 478 (Hudson), in relation to an outreach and education campaign on the benefits and services provided by doulas and midwives; Introduction No. 482 (Louis), in relation to requiring the department of health and mental hygiene to report on polycystic ovary syndrome and endometriosis; Introduction No. 490 (Menin), in relation to the establishment of an office of sexual and reproductive health within the New York city department of health and mental hygiene; Introduction No. 508 (Schulman), in relation to requiring family building benefits for city employees; Introduction No. 509 (Stevens), in relation to a public education and outreach campaign on the risks of caesarean sections; and Introduction No. 86 (The Public Advocate), in relation to education about city standards for respectful care at birth, health care proxy forms and patients’ rights. The Committees will also hear Resolution No. 95 (Rivera), calling on the New York State Legislature to pass, and the Governor to sign, A217/S2736, relating to informing maternity patients about the risks associated with cesarean section; Resolution No. 201 (Narcisse), calling upon New York State Legislature to establish full insurance coverage for fertility treatments; Resolution No. 205 (Rivera), calling on the New York State Legislature to pass, and the Governor to sign, legislation making doulas more accessible to individuals with Medicaid and those without health insurance; Resolution No. 244 (The Public Advocate), calling on the Centers for Disease Control and Prevention to provide expanded funding for the Healthy Start Brooklyn doula program known as By My Side in order to make doulas available to all low-income birthing people in New York City; and Resolution No. 92 (The Public Advocate), calling on the United States Congress and President Joseph Biden to sign the Black Maternal Health Omnibus Act of 2021. Witnesses invited to testify include representatives from the NYC Department of Health and Mental Hygiene (DOHMH), NYC Health + Hospitals (H+H), the Greater New York Hospital Association (GNYHA), as well as advocacy groups and organizations, hospitals, nurse and midwife groups, doula organizations, and other interested stakeholders.

1. **Background**
2. *Maternal Mortality in the U.S.*

The ability to protect the health of mothers, birthing people,[[1]](#footnote-1) and babies in childbirth is a basic measure of a society’s development.[[2]](#footnote-2) Yet, more people in the United States (U.S.) die of pregnancy-related complications than in any other developed country, and while the number of reported pregnancy-related deaths has been declining in most of the world,[[3]](#footnote-3) in the U.S., the maternal mortality ratio (MMR) – the number of maternal deaths in a population that occur during a given year per 100,000 live births[[4]](#footnote-4) – has increased compared to similar countries.[[5]](#footnote-5)

**Figure 1: Maternal Deaths Per 100,000 Live Births**[[6]](#footnote-6)



According to the Centers for Disease Control and Prevention (CDC), the MMR in the U.S. has more than doubled since 1987, from 7.2 deaths per 100,000 live births in 1987, to a peak of 18 in 2014, and dropping slightly to 17.3 deaths per 100,000 live births in 2017, the last year with reported data.[[7]](#footnote-7) Data also shows that this trend has worsened in recent years. From 2000 to 2014, the MMR in the U.S. increased by an estimated 26.6 percent.[[8]](#footnote-8) Each year, about 700 American women die from pregnancy-related complications, and about three in five pregnancy-related deaths could be prevented.[[9]](#footnote-9) According to the CDC, severe maternal morbidity (SMM) has also been steadily increasing in recent years, and affected more than 50,000 women in the United States in 2014, the last year with data available nationally.[[10]](#footnote-10) SMM includes unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman’s health.[[11]](#footnote-11)

Additionally, data shows that health inequities significantly impact pregnancy outcomes. According to the CDC, American Indian/Alaska Native and Black women in the U.S. are two to three times more likely to die from complications related to pregnancy than white women.[[12]](#footnote-12) During 2014-2017, the MMR for Black women was 41.7 deaths per 100,000 live births, compared to 13.4 deaths for non-Hispanic white women (or over three times as high).[[13]](#footnote-13) The MMR for non-Hispanic American Indian or Alaska Native women was 28.3 deaths per 100,000 live births, or over two times the rate for white women.[[14]](#footnote-14) Such disparities also affect birth outcomes. Government data suggests that Black infants are more than twice as likely to die as white infants; 11.3 per 1,000 Black babies, compared with 4.9 per 1,000 white babies, a racial disparity that is actually greater than in 1850, 15 years before slavery was abolished in the U.S.[[15]](#footnote-15) Research points to race, rather than educational attainment or income level of the patient, as the cause of such discrepancies.[[16]](#footnote-16) In fact, a Black woman with an advanced degree is more likely to lose her baby than a white woman with less than an eighth-grade education.[[17]](#footnote-17)

1. *Maternal Mortality in New York City*

New York City (NYC) accounts for about 30 of those estimated 700 women who die from pregnancy or childbirth-related causes each year nationally.[[18]](#footnote-18) According to the New York State Department of Health (DOH), the MMR in NYC was 19.8 per 100,000 live births from 2017-2019.[[19]](#footnote-19) Research has illustrated the impact that racial disparities can have on a person’s health outcomes and care in NYC.[[20]](#footnote-20) While about 30 women in NYC die each year of a pregnancy-related cause, statistics indicate that approximately 3,000 women “almost die,” or experience morbidity, during childbirth.[[21]](#footnote-21) Black, non-Latina women are the most likely to experience maternal mortality or maternal morbidity.[[22]](#footnote-22) Additionally, according to a study in the American Journal of Obstetrics and Gynecology, in NYC, Black women are more likely than white women to give birth in hospitals that already have a high rate of severe maternal morbidity or complications.[[23]](#footnote-23) Only 23 percent of Black patients gave birth in the safest hospitals, compared to 63 percent of white patients.[[24]](#footnote-24) At the city level, recent data suggests Black mothers in NYC are 8 to 12 times more likely to die from pregnancy-related causes than white mothers.[[25]](#footnote-25) The Bronx and Brooklyn in particular carry a disproportionate burden of maternal and infant mortality rates.[[26]](#footnote-26) In 2018, residents of Brooklyn had the highest number of both pregnancy-associated and pregnancy-related deaths (14 and 10), followed by the Bronx (10 and 5).[[27]](#footnote-27)

Several factors appear to have a positive influence on outcomes for persons giving birth in NYC. A recent report reveals that women who had doula[[28]](#footnote-28) support were 39 percent less likely to have a caesarean section (C-section), and 15 percent more likely to give birth without needing drugs or labor-inducing techniques.[[29]](#footnote-29) Additionally, a survey regarding doula care in NYC reveals that 72 percent of women reported that their doula helped them communicate their preferences and needs, while 80 percent of those surveyed reported that their doula helped them feel more empowered.[[30]](#footnote-30) Furthermore, 83 percent of the surveyed women reported that having a doula made their labor and birth experience “much better” than if they had not used a doula, and it made them more relaxed before, during, and after birth.[[31]](#footnote-31) However, 88 percent of this cohort reported that cost was an issue when opting to work with a doula.[[32]](#footnote-32) According to DOHMH’s most recent *The State of Doula Care in NYC* report, there are several initiatives to improve access to doula care, in order to address the systemic and interpersonal racism that impacts birthing outcomes in New York City.[[33]](#footnote-33)

1. **COVID-19 and Maternal Health, Mortality, and Morbidity**

Since the COVID-19 outbreak began, healthcare organizations and experts have been addressing its potential effects on maternal health, mortality, and morbidity. For example, in June 2020, the CDC recommended that pregnant women and their families take preventive measures to reduce their risk of contracting COVID-19, as pregnant women were significantly more likely to be hospitalized, admitted to the intensive care unit, and receive mechanical ventilation than non-pregnant women.[[34]](#footnote-34) In November 2020, the CDC reported in a Morbidity and Mortality Weekly Report that pregnant women are also at increased risk of death compared to non-pregnant women.[[35]](#footnote-35) Similar to maternal mortality rates, COVID-19 mortality rates are substantially higher among Black, Latinx, and Native American people than among white or Asian people.[[36]](#footnote-36) The CDC study also suggested that pregnant women who are Hispanic or Black might be disproportionately affected by SARS-CoV-2 infection during pregnancy.[[37]](#footnote-37)

Maternal health disparities are driven by socioeconomic factors, such as where people live and work and access to health care.[[38]](#footnote-38) Given that COVID-19 magnifies existing health disparities, affecting communities of color much more than white communities, it is likely that COVID-19 will also exacerbate existing disparities in maternal mortality rates, which were greater among Black women before the pandemic.[[39]](#footnote-39) Significant shifts in access to healthcare during the pandemic also significantly impacted the ability of Black, Indigenous, and other patients of color to receive adequate healthcare.[[40]](#footnote-40) While some patients found that telehealth has been a blessing, allowing them to see doctors without the need to travel or find childcare, many patients stated that telemedicine made it more difficult to convince providers that they needed to be seen in person, even when they had serious conditions.[[41]](#footnote-41) Furthermore, some patients—especially low-income people and those living in rural areas or on reservations—cannot access telehealth at all because of a lack of internet access or appropriate devices.[[42]](#footnote-42) The pandemic is also exacerbating other inequities Black birthing people face, including the difficulty of even finding a doctor to treat them, as decades of redlining have left cities and towns segregated across America, with communities of color not receiving the same investment as majority-white, suburban neighborhoods.[[43]](#footnote-43) There is also a significant lack of prenatal care in certain areas, which is associated with an increased risk of maternal mortality and morbidity.[[44]](#footnote-44) Moreover, as many pregnancy-related deaths happen in the postpartum period, postpartum follow-up, which was already inconsistent among certain populations before the pandemic began, became almost nonexistent.[[45]](#footnote-45) For example, because of the pandemic, mothers were being discharged so quickly that they did not have adequate information about how to care for their wounds, or how to breastfeed properly, and many mothers were discharged while showing signs of anxiety and depression as they were experiencing social isolation.[[46]](#footnote-46)

The pandemic also introduced a new risk factor for pregnant patients: isolation during birth.[[47]](#footnote-47) Several studies have shown that having a doula or other support person during birth can improve outcomes for birthing people and their babies, and doulas are especially important for Black patients and others who experience discrimination during birth.[[48]](#footnote-48) At the beginning of the COVID-19 pandemic in the U.S., however, many hospitals instituted limits on the number of people who could accompany pregnant people into the delivery room, forcing patients to choose between a partner and a doula.[[49]](#footnote-49) In fact, two major systems in New York City—New York-Presbyterian and Mount Sinai—banned support people from delivery rooms, forcing women to be alone while giving birth.[[50]](#footnote-50) The limits on visitors were intended to conserve personal protective equipment and slow the spread of COVID-19, but when implementing them, hospitals did not consider the disproportionate impact that they could have on Black patients and birthing people.[[51]](#footnote-51)

Former Governor Andrew Cuomo convened a task force of multidisciplinary experts to address the effect of COVID-19 on pregnancy and examine the best approaches to provide mothers with safe alternatives to hospitalization, when appropriate.[[52]](#footnote-52) The COVID-19 Maternity Task Force’s recommendations included testing all pregnant women for the virus and designating doulas as an essential member of the care team, among other suggestions.[[53]](#footnote-53) On April 29, 2020, Governor Cuomo issued an executive order recognizing doulas as essential members of the delivery team, which allows them to be present to support the mother and her family member during labor and delivery.[[54]](#footnote-54)

Tragically, New York City experienced several maternal deaths in hospitals since the onset of the COVID-19 pandemic. Amber Isaac, a 26-year-old Black woman, died on April 21, 2020, shortly after delivering her son, Elias, at Montefiore Medical Center in The Bronx.[[55]](#footnote-55) According to reports, Ms. Isaac studied the disproportionate impact of maternal mortality on Black women throughout her pregnancy, and shortly before her death, she tweeted, “Can’t wait to write a tell all about my experience during my last two trimesters dealing with incompetent doctors at Montefiore.”[[56]](#footnote-56) Shaasia Washington, also a 26-year-old Black woman, died on July 3, 2020, during childbirth at Woodhull hospital, an H+H facility in Brooklyn.[[57]](#footnote-57) According to some reports, Shaasia died while being given an epidural.[[58]](#footnote-58) Hendel Lezer, a 33-year-old orthodox Jewish woman, died on November 19, 2020 in Maimonides Hospital in Brooklyn from complications related to COVID-19, one day after delivering her fifth child.[[59]](#footnote-59) According to reports, Mrs. Lezer’s family and doctor pled with the hospital to treat her with available COVID-19 treatments, but the hospital objected, citing protocol that only patients who contracted the virus less than a week ago could receive the treatment.[[60]](#footnote-60)

1. **Response to Maternal Mortality and Morbidity**
2. *New York City and State Response*

There have been a number of government initiatives addressing maternal mortality and morbidity over the past decade, including during the COVID-19 pandemic. For example, in March 2017, the NYC Council passed the Maternal Mortality Reporting Law, or Local Law 55 of 2017, which requires DOHMH to issue an annual report on maternal mortality, tracking statistics in four areas.[[61]](#footnote-61) The Council then passed Local Law 188 of 2018, which expanded upon these required reporting criteria.[[62]](#footnote-62) In December 2017, DOHMH formally launched a city-specific Maternal Mortality and Morbidity Committee (M3-RC, M3RC, or “the Panel”), composed of up to 45 members, including doctors, nurses, the doula community, researchers, first responders, and experts from various facilities and community based organizations.[[63]](#footnote-63) The M3RC meets every two to three months to conduct a multidisciplinary expert review of every maternal death in the City from both a clinical and a social determinants of health perspective.[[64]](#footnote-64) Additionally, DOHMH and the Fund for Public Health in New York City (FPHNYC) have received two grants from Merck for Mothers to implement severe maternal morbidity projects, with the first resulting in the implementation of the first citywide severe maternal morbidity surveillance system and the second in the launch of the “Reducing Inequities and Disparities in Preventable Severe Maternal Morbidity in New York City Project.”[[65]](#footnote-65) DOHMH has released reports about instances of severe maternal morbidity in New York City, with the latest released in 2016.[[66]](#footnote-66)

In 2018, H+H partnered with DOHMH and the Mayor’s Office to begin implementing a comprehensive maternal care program with the focus of identifying and responding to pregnancy-related morbidity and mortality for women of color, including a maternal medical home and simulation-based programs.[[67]](#footnote-67) Additionally, implicit bias training has occurred within relevant private and public health care facilities across the City.[[68]](#footnote-68)

The NYC Council has held hearings about or related to maternal health outcomes, including mortality and morbidity, in June 2018, September 2019, January 2020, and December 2020.[[69]](#footnote-69) During the last hearing, the Council heard a package of legislation, and eventually passed Local Law 76 of 2021, which required posting information about midwives online.[[70]](#footnote-70) The Council also has a long history of using discretionary funding towards reducing maternal morbidity. In Fiscal 2002, Council launched the Infant Mortality Reduction Initiative, totaling $2.5 million. The goal of the initiative was to promote women’s health before, during, and after pregnancy and to work in areas in the City with the highest infant mortality rates.[[71]](#footnote-71) Starting in Fiscal 2016, the Council began funding the Healthy Women, Healthy Future program initiative, totaling $300,000, a program that supports an array of doula services.[[72]](#footnote-72) Beginning in Fiscal 2017, the two initiatives were grouped together into the Maternal and Child Health Services Initiative.[[73]](#footnote-73) The Council has continued its commitment to these issues and in Fiscal 2021, the Council has designated $1.9 million to the Maternal and Child Health Services Initiative which supports 19 organizations across all five boroughs.[[74]](#footnote-74) In Fiscal 2020, this initiative reached more than 5,408 individuals.[[75]](#footnote-75)

Additionally, beginning in Fiscal 2017 the Council funded the Nurse Family Partnership Initiative for $2 million, which is an evidence-based maternal and early childhood health program that fosters long-term success for first-time mothers, their babies and society.[[76]](#footnote-76) The Council has advocated for expansion of funding for the Nurse Family Partnership and in Fiscal 2019, the Council successfully negotiated $4 million in baseline funding for the program by the Administration.[[77]](#footnote-77) The total budget for Nurse Family Partnership in the Department of Health and Mental Hygiene’s budget is $14 million.

There have also been a number of initiatives taken at the State level. In January 2018, Governor Cuomo announced a proposal to create a State Maternal Mortality Review Board (“Board”) to review of each maternal death.[[78]](#footnote-78) The New York State Department of Health (DOH) convenes a Board of diverse experts to conduct a confidential review of each maternal death, determining whether death was preventable, and to identify recommendations.[[79]](#footnote-79) On April 23, 2018, the Governor announced a series of additional new initiatives focused on maternal mortality and disparate racial outcomes, including another taskforce, a pilot to expand Medicaid to cover doula services, a best practices summit, and a call for enhanced training for medical students.[[80]](#footnote-80) The Taskforce on Maternal Mortality and Disparate Racial Outcomes (the Taskforce) met three times between June and December 2018, and members of the Taskforce submitted recommendations to the Governor on ways to reduce racial disparities and preventable maternal mortality and morbidity.[[81]](#footnote-81) The doula pilot faced implementation issues and failed to get off the ground.[[82]](#footnote-82)

In response to issues arising during the COVID-19 pandemic, the State created a COVID-19 Maternity Task Force.[[83]](#footnote-83) On April 29, 2020, the State announced that the Governor accepted the Task Force’s recommendations in full, which included measures to diversify birthing site options and support patient choice; extend the period of time a healthy support person can accompany a mother post-delivery; mandate testing of all pregnant New Yorkers; ensure equity in birthing options; create an educational campaign; and review the impact of COVID-19 on pregnancy and newborns with special emphasis on reducing racial disparities in maternal mortality.[[84]](#footnote-84) Included in the final recommendation was a plan for DOH to host weekly statewide interactive webinars addressing the management of maternity care during the pandemic, as needed, as part of a collaboration with the New York State Perinatal Quality Collaborative in partnership with the American College of Obstetrics and Gynecology District II, including a webinar on obstetrical care and implicit bias within the context of the COVID-19.[[85]](#footnote-85)

Under the current Mayoral Administration, Mayor Eric Adams announced the creation of a new doula program, as well the expansion of a Midwifery Initiative and the expansion of a maternal health care services program.[[86]](#footnote-86) The Citywide Doula Initiative will provide free access to doulas for birthing families and focus on 33 neighborhoods with the greatest social needs.[[87]](#footnote-87) According to the Mayor’s Press Release, “the Midwifery Initiative will be expanded to all 38 public and private birthing facilities citywide and will allow DOHMH, for the first time, to gather data on births and care with midwives; create partnerships with midwife organizations, private practices, and community members; and develop a report on midwives in New York City.”[[88]](#footnote-88) Additionally, the Maternity Hospital Quality Improvement Network (MHQIN) will be expanded across all 38 birthing facilities across the city in an effort to improve maternal care at local hospitals and birthing centers.[[89]](#footnote-89)

1. *Medical Community Response and Best Practices*

The medical community has done a great deal to respond to the maternal mortality crisis, including creating organizations, conducting studies, holding panel discussions, task forces, and seminars, and coming up with best practices and recommendations to improve maternal outcomes.[[90]](#footnote-90) On a national level, the Surgeon General, via the United States Department of Health and Human Services (HHS), issued a list of recommendations for healthcare providers in January 2020, which include[[91]](#footnote-91):

* **Collect and evaluate your key maternal safety data** for hypertension, hemorrhage, infections, primary C-section rate and opioid addiction. Every hospital should have a systematic approach to reviewing maternal health complications, acting on the data as appropriate and implementing improvement strategies. It is also important to ensure risk-appropriate care is provided to both high- and low-risk patients to decrease unnecessary interventions and improve screening and detection of complications.
* **Examine care disparities in your maternal population**. Break down your data by place, race, ethnicity and other variables appropriate to your organization and community. Analyze the data over a period of years to help identify disparities and opportunities for improvement in areas, including addressing social determinants of health and maternal health, both prior to and after delivery.
* **Next, engage mothers and their families as advocates for themselves and others.** Empower them to be vocal about their care, and ensure that you have strong referral networks and interventions.
* **Partner with clinicians and stakeholders in your community.**Engage healthcare providers, community and tactical partners, and other stakeholders in these efforts so that together we can improve maternal health and the well-being of babies and families.

**The American Medical Association (AMA) supports and recommends similar data-based solutions to improve maternal outcomes,**[[92]](#footnote-92) and also has committed to advocacy efforts to address maternal health outcomes.[[93]](#footnote-93) On a clinical level, the Society for Maternal-Fetal Medicine proposes recommendations to improve clinical care for providers, healthcare systems, and medical systems,[[94]](#footnote-94) and how to approach the work in an anti-racist way.[[95]](#footnote-95) The American College of Obstetricians and Gynecologists have also issued recommendations to specifically address racial and ethnic disparities in obstetrics and gynecology.[[96]](#footnote-96)

In New York City, doctors and the medical community have also worked to address maternal health outcomes outside the formal hospital and healthcare setting. For example, Dr. Taraneh Shirazian, an Obstetrician/Gynecologist at NYU Langone founded the non-profit Saving Mothers, which operates around the world and in New York City in underserved areas using low-cost, high-impact programs for women that aim to decrease death in pregnancy and delivery.[[97]](#footnote-97) In 2020, Saving Mothers created a program in New York City called “mPOWHER,” which teaches community health workers how to identify high-risk patients in the home, how to talk about complications, teach about medical risk in pregnancy, and teach pregnant women how to communicate with their physicians to help ensure their health is prioritized in the health care system.[[98]](#footnote-98)

1. **Fertility Equity in NYC**

On January 1, 2020, a new state law went into effect, which requires large group (more than 100 employees) insurance policies, including New York City’s insurance policy, and contracts that provide medical, major medical, or similar comprehensive-type coverage and are delivered or issued for delivery in New York to cover three cycles of in vitro fertilization (IVF) used in the treatment of infertility:[[99]](#footnote-99)

Every large group policy delivered or issued for delivery in … [New York State] that provides medical, major medical or similar comprehensive-type coverage shall provide coverage for three cycles of in-vitro fertilization used in the treatment of infertility. Coverage may be subject to annual deductibles and coinsurance, including copayments, as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given policy. For purposes of this item, a “cycle” is defined as either all treatment that starts when: preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing in-vitro fertilization using a fresh embryo transfer; or medications are administered for endometrial preparation with the intent of undergoing in-vitro fertilization using a frozen embryo transfer.[[100]](#footnote-100)

Ancillary treatments and services including egg freezing and storage may also be covered.[[101]](#footnote-101)

State law prohibits insurers providing the required IVF coverage from discriminating “based on an insured’s … personal characteristics, including … sex, sexual orientation, marital status or gender identity.”[[102]](#footnote-102) Although the State’s requirement of some IVF treatment is relatively progressive,[[103]](#footnote-103) many plan participants who need such services to build families are essentially excluded from coverage.[[104]](#footnote-104) Coverage is conditioned on obtaining an infertility diagnosis, which State law defines as: [[105]](#footnote-105)

[A] disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after twelve months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female thirty-five years of age or older.[[106]](#footnote-106)

The State’s definition operates to exclude IVF coverage for couples who require it to produce a baby, but who do not have an infertility diagnosis.[[107]](#footnote-107) Critics of this test for coverage cite its discriminatory effect on single adults and same-sex couples who necessarily cannot or will not attempt to obtain a diagnosis for purposes of obtaining coverage.[[108]](#footnote-108)

Moreover, a host of other treatments and services related to family building, including gamete and embryo freezing, surrogacy and adoption, are often not covered under State-approved and City-contracted health plans as treatments for participants who, whether by virtue of a biological condition or of their family makeup, cannot build a family through sexual intercourse.[[109]](#footnote-109) New York City’s plan, Emblem Health/GHI-CBP, does not provide coverage for treatment/services related to: sperm donation when the donor is not a plan participant; “elective” egg and sperm freezing; certain egg retrievals; surrogacy; and adoption.[[110]](#footnote-110) In April, 2022, a same-sex couple sued New York City, alleging that the City discriminated against them by not covering IVF services for them under the City’s health insurance plan.[[111]](#footnote-111)

1. **Conclusion**

The Committees on Health and Hospitals seek to examine issues relating to maternal mortality and morbidity in NYC, with a particular focus on the experience of birthing people of color and their babies. This will also include an examination of the City’s reports on maternal mortality and access to doulas, which were prepared pursuant to Local Laws 187 and 188 of 2018. Moreover, the Committees are interested in how rates of maternal mortality and morbidity have been impacted by the COVID-19 pandemic as well as how the City is working to mitigate any factors that threaten to further exacerbate racial inequities among birthing people of color. The Committees are also interested in learning what steps the City must take to improve outcomes for birthing people of color and their babies. Lastly, the Committees are interested in hearing testimony on the proposed legislation.

1. **legislation**
2. *Analysis of Int. No. 409*

Int. No. 409 would require DOHMH to post the annual Maternal Mortality and Morbidity report on its website. The proposed legislation would take effect immediately after becoming law.

1. *Analysis of Int. No. 472*

This bill would require DOHMH to establish a doula pilot program to: 1) train doulas and 2) provide professional, no-cost doula services to residents of all five boroughs. This bill would also require DOHMH commissioner to submit a report to the Mayor and the Speaker of the City Council on the merits of the pilot program. The proposed legislation would take effect immediately after becoming law.

1. *Analysis of Int. No. 478*

This bill would require DOHMH to conduct an education and outreach campaign about the services offered by doulas and midwives; to increase awareness of efforts to improve access to such services and share information about free and low-cost resources related to such services by January 31, 2023, and by January 31 every five years thereafter. It would also require DOHMH to submit to the Mayor and City Council Speaker, and post online, by May 31, 2023, and by May 31 every five years thereafter, a report describing the methods of outreach used to comply with this section. The proposed legislation would take effect 120 days after becoming law.

1. *Analysis of Int. No. 482*

This bill would require DOHMH to report on the number of individuals diagnosed with polycystic ovary syndrome and endometriosis at each hospital in the City, including the race or ethnicity and age group of such individuals broken down by percentage. The report would also include whether each hospital has staff specializing in polycystic ovary syndrome or endometriosis diagnosis and treatment, and if so, the total number of such staff. The proposed legislation would take effect 30 days after becoming law.

1. *Analysis of Int. No. 490*

This bill would create an office of sexual and reproductive health within DOHMH. Such office would be required to provide outreach, education, and support to adults and adolescents, especially low-income individuals and those without health insurance, regarding issues related to sexual and reproductive health, including but not limited to: contraception, including a broad range of methods such as long-acting reversible contraception; preconception health services; abortion services; family planning services; counseling and testing for HIV; testing and treatment for sexually transmitted infections; routine screening for breast and cervical cancer; and health education in community settings to promote reproductive health, to prevent unintended pregnancy, and to promote access to reproductive and preventive health services. The office would also make referrals to affordable and accessible services related to contraception, abortion, family planning, breast and cervical cancer screenings, and counseling, testing, and treatment for HIV and sexually transmitted infections, and conduct research on sexual and reproductive health disparities across New York City. The proposed legislation would take effect one year after becoming law.

1. *Analysis of Int. No. 508*

This bill would require the City to establish a family building benefit for City employees intended to cover some or all of the costs of assisted reproduction and adoption for City employees without conditioning reimbursement on an infertility diagnosis. In implementing such benefits, the City would be prohibited from discriminating on the basis of marital or partnership status. The proposed legislation would take effect immediately after becoming law.

1. *Analysis of Int. No. 509*

This bill would require DOHMH to create a public education and outreach campaign on the risks of caesarean sections. As part of the campaign, DOHMH would create and disseminate written materials to the public and to locations such as doctor offices and hospitals. This bill would also require DOHMH to annually report on such campaign to the Mayor and the Speaker of the Council and post such report on its website. The proposed legislation would take effect immediately after becoming law.

1. *Analysis of Int. No. 86*

This bill would require that the Department of Health and Mental Hygiene undertake a public education campaign in facilities that provide obstetric and gynecological care through the Department to inform patients about the city standards for respectful care at birth, health care proxy forms, the right to be free from discrimination related to pregnancy, childbirth, or a related medical condition, the right to be free from discrimination due to caregiver status, the right to reasonable accommodations in the workplace including lactation accommodations, paid sick and safe leave, temporary schedule changes, temporary disability insurance, the family and medical leave act of 1993 and New York’s paid family leave program. The campaign would distribute posters, flyers, forms and other written material to patients. The bill would also invite the New York City Health and Hospitals Corporation to distribute and post such materials at locations under its jurisdiction.

Int. No. 409

By Council Members Louis, Hanif, Joseph, Ung, Nurse, Krishnan, Abreu and Restler

A Local Law to amend the administrative code of the city of New York, in relation to increasing access to data and maternal mortality and morbidity

Be it enacted by the Council as follows:

Section 1. Subdivision b of section 17-199.3 of the administrative code of the city of New York, as amended by local law 188 of the year 2018, is amended to read as follows:

b. No later than September 30, 2022, and no later than September 30 annually thereafter, the department shall post on its website, submit to the speaker and publish in a machine-readable format in the annual summary of vital statistics the most recent calendar year data available regarding maternal mortality in New York City, to the extent such data is made available to the department, on an individual-person level, anonymized to comply with privacy considerations, including but not limited to the health insurance portability and accountability act (HIPAA), including, but not be limited to:

§ 2. This local law takes effect immediately.

Session 12

BM

LS # 5197

4/11/22 12:00pm

Session 11

BM

LS 16059 & 16060

Int 2179

Int. No. 472

By Council Members Gutiérrez, Louis, Hudson, Hanif, Brooks-Powers, Brewer, Nurse, Ung, Mealy, Velázquez, De La Rosa, Stevens, Menin, Williams, Schulman, Dinowitz, Farías, Sanchez, Richardson Jordan, Cabán, Riley, Avilés, Abreu, Restler and The Speaker (Council Member Adams) (in conjunction with the Brooklyn Borough President)

A Local Law in relation to establishing a pilot program in the department of health and mental hygiene to train doulas and provide doula services to residents in all five boroughs

Be it enacted by the Council as follows:

Section 1. a. Definitions. For the purposes of this local law, the following terms have the following meanings:

Commissioner. The term “commissioner” means the commissioner of health and mental hygiene.

Department. The term “department” means the department of health and mental hygiene.

Doula. The term “doula” means: (i) a trained person who provides continuous physical, emotional, and informational support to a pregnant person and the family before, during, or shortly after childbirth, for the purpose of assisting a pregnant person through the birth experience; or (ii) a trained person who supports the family of a newborn during the first days and weeks after childbirth, providing evidence-based information, practical help, and advice to the family on newborn care, self-care and nurturing of the new family unit.

§ 2. No later than October 1, 2022, the commissioner shall establish a pilot program for training doulas and providing professional, no-cost doula services to residents of neighborhoods in all five boroughs. The commissioner shall determine the standard used to determine which neighborhoods will be included in the pilot and the standard for how many visits each doula shall provide, provided that each program participant is provided with the option of having at least two visits with a doula. Such pilot shall include no fewer than 50 doulas. Participating doulas shall be trained on, at minimum, the practical roles and responsibilities of a doula. Such training shall be designed in consultation with community members and may include additional topics including, but not limited to, trauma-informed care, perinatal mood and anxiety disorders, respectfully navigating the hospital environment, and support services available to low-income birthing people and their families. Within such pilot program, where a birthing person presents to the department with a possible developmental, intellectual or physical disability, the department shall assess whether such person is receiving any supportive services related to the perceived disability and coordinate with the doula to ensure that appropriate services are provided.

§ 3. Such pilot program shall continue until January 1, 2024 and may continue past that date at the discretion of the commissioner.

§ 4. No later than October 30, 2023, the commissioner shall submit to the mayor and the speaker of the council and post online a report on such pilot program. The report shall include, but not be limited to: (i) the number of doulas trained through the pilot, disaggregated by type of doula if they identify with a subsector of the field; (ii) an overview of topics covered in such doula training; (iii) the number of individuals served by doulas involved in the pilot; (iv) a list of the zip codes that such individuals live in; (v) an evaluation of the benefits of the pilot and how such benefits were measured or evaluated; (vi) an overview of challenges or lessons learned from the pilot, and (vii) recommendations as to whether and how such pilot program should continue or be expanded.

§ 5. This local law takes effect immediately.

BM

LS 8366/9393

5/27/22 1:00p

Int. No. 478

By Council Members Hudson, Gutiérrez, Louis, Hanif, Brooks-Powers, Nurse, Mealy, Velázquez, De La Rosa, Stevens, Menin, Williams, Schulman, Dinowitz, Farías, Sanchez, Richardson Jordan, Cabán, Riley, Avilés, Abreu, Restler and The Speaker (Council Member Adams) (in conjunction with the Brooklyn Borough President)

A Local Law to amend the administrative code of the city of New York, in relation to an outreach and education campaign on the benefits and services provided by doulas and midwives

Be it enacted by the Council as follows:

Section 1. Chapter 1 of title 17 of the administrative code of the city of New York is amended by adding a new section 17-199.3.2 to read as follows:

§ 17-199.3.2 Education and outreach campaign on the benefits of doulas and midwives. a. Definitions. For the purposes of this section, the following terms have the following meanings:

Doula. The term “doula” means: 1. a trained person who provides continuous physical, emotional, and informational support to a pregnant person and the family before, during or shortly after childbirth, for the purpose of assisting a pregnant person through the birth experience; or 2. a trained person who supports the family of a newborn during the first days and weeks after childbirth, providing evidence-based information, practical help, and advice to the family on newborn care, self-care and nurturing of the new family unit.

Midwife. The term “midwife” means an individual who is licensed or certified to practice midwifery in New York state.

b. Education and outreach. No later than January 31, 2023, and by January 31 every five years thereafter, the department shall conduct an education and outreach campaign for birthing people, healthcare workers, health and safety advocates, community organizations, women’s rights advocates, reproductive health rights advocates, and other populations the department deems relevant, in all five boroughs. Such campaign should highlight the services offered by doulas and midwives, increase awareness of the evidence-based benefits of such services, any efforts to improve access to such services and share information about free and low-cost resources related to such services in New York city. Such campaign shall also include, but not be limited to, distribution of educational materials, outreach utilizing social media, radio and television, public service announcements and both in-person and online events, such as educational workshops or forums. Any written materials disseminated by the department pertaining to such campaign shall be made available in the top ten languages most commonly spoken within the city as determined by the department of city planning.

c. Reporting. No later than May 31, 2023, and by May 31 every five years thereafter, the department shall submit to the mayor and speaker of the council, and post online, a report describing the methods of targeted outreach used to comply with this section.

§ 2. This local law takes effect 120 days after it becomes law.

BM

LS 7334 / 8273

5/27/22 12:00p

Int. No. 482

By Council Members Louis, Nurse and Abreu

A Local Law to amend the administrative code of the city of New York, in relation to requiring the department of health and mental hygiene to report on polycystic ovary syndrome and endometriosis

Be it enacted by the Council as follows:

Section 1. Chapter 1 of title 17 of the administrative code of the city of New York is amended by adding a new section 17-199.3.2 to read as follows:

§ 17-199.3.2 Report on polycystic ovary syndrome and endometriosis. a. No later than March 1, 2023, and annually thereafter, the department shall submit to the speaker of the council and post on the department’s website a report on diagnosed cases of polycystic ovary syndrome and endometriosis in hospitals. To the extent such information is available to the department, such report shall include, but need not be limited to, the following information for the preceding calendar year for each hospital in the city:

1. The total number of individuals who were diagnosed with polycystic ovary syndrome, including the age group and race or ethnicity of such individuals by percentage;

2. The total number of individuals who were diagnosed with endometriosis, including the age group and race or ethnicity of such individuals by percentage; and

3. Whether each such hospital has staff that specialize in polycystic ovary syndrome or endometriosis diagnosis and treatment, and if so, the total number of such staff.

b. Information required to be reported pursuant to this section shall be reported in a manner that does not violate any applicable provision of federal, state or local law relating to the privacy of personally identifiable information.

§ 2. This local law takes effect 30 days after it becomes law.

JEF

LS # 9356

5/25/2022 9:34am

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| Int. No. 490 By Council Members Menin, Louis, Hudson, Hanif, Nurse and The Speaker (Council Member Adams) A Local Law to amend the administrative code of the city of New York, in relation to the establishment of an office of sexual and reproductive health within the New York city department of health and mental hygiene Be it enacted by the Council as follows: Section 1. Chapter 1 of title 17 of the administrative code of the city of New York is amended by adding a new section 17-199.19 to read as follows:§ 17-199.19 Office of sexual and reproductive health. a. The department shall establish an office of sexual and reproductive health. Such office shall have the power and duty to: 1. Provide outreach, education, and support to adults, and adolescents, especially low-income individuals and those without health insurance, regarding issues related to sexual and reproductive health, including but not limited to:(a) Contraception, including a broad range of methods such as long-acting reversible contraception;(b) Preconception health services;(c) Abortion services;(d) Family planning services;(e) Counseling and testing for HIV;(f) Testing and treatment for sexually transmitted infections;(g) Routine screening for breast and cervical cancer; and(h) Health education in community settings to promote reproductive health, to prevent unintended pregnancy, and to promote access to reproductive and preventive health services.2. Make referrals to affordable and accessible services related to contraception, abortion, family planning, breast and cervical cancer screenings, and counseling, testing, and treatment for HIV and sexually transmitted infections.3. Conduct research on sexual and reproductive health disparities across New York city.§ 2. This local law takes effect 1 year after it becomes law. HKALS #90965/26/22 |

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| Int. No. 508 By Council Members Schulman, Hanif, Brewer, Nurse, Abreu and Louis A Local Law to amend the administrative code of the city of New York, in relation to requiring family building benefits for city employees Be it enacted by the Council as follows: Section 1. Chapter 1 of title 12 of the administrative code of the city of New York is amended by adding a new section 12-141 to read as follows:§ 12-141 Family building benefits for city employees. a. Definitions. For purposes of this section, the following terms have the following meanings:“Adoption.” The term “adoption” includes the range of services available to adults who intend to adopt a child, including agency and legal services related to the adoption of a child.“Assisted reproduction.” The term “assisted reproduction” includes the range of services and technologies to assist adults who intend to become parents, including, but not necessarily limited to: egg and sperm donation and preservation; in vitro fertilization; intrauterine insemination; surrogacy; and agency and legal services related to such services and technologies, as well as the establishment of parentage of a child.“City employee.” The term “city employee” means a person who: is employed by a department or agency of the city; and is paid out of the city treasury; and is employed under terms prescribing a work week regularly consisting of twenty or more hours during the fiscal year; and is not employed by the board of education.b. The city shall offer family building benefits to city employees for the purpose of defraying the costs of assisted reproduction and adoption. Such benefits shall reimburse city employees for some or all of such costs when another city-provided health insurance plan does not cover them. The office of labor relations may enter into contracts with companies providing insurance coverage for such services and technologies for the purpose of meeting the requirements of this section.   c. The city shall not discriminate on the basis of marital or partnership status in meeting the requirements of this section. Family building benefits offered to city employees pursuant to this section shall not condition eligibility for such benefits on an infertility diagnosis. d. This section does not affect the mayor’s authority to bargain with certified employee organizations pursuant to chapter 3 of title 12 of the administrative code.§ 2. This local law takes effect immediately. NCLS #92615/18/21   |

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| Int. No. 509 By Council Members Stevens, Louis, Hanif, Brooks-Powers, Nurse and Abreu (in conjunction with the Brooklyn Borough President) A Local Law to amend the administrative code of the city of New York, in relation to a public education and outreach campaign on the risks of caesarean sections Be it enacted by the Council as follows:            Section 1. Chapter 1 of title 17 of the administrative code of the city of New York is amended by adding a new section 17-199.3.2 to read as follows:§ 17-199.3.2 Caesarean section risks. a. Definitions. For purposes of this section, the following terms have the following meanings:Caesarean section. The term “caesarean section” means the surgical procedure in which a baby is delivered through an incision in the abdomen of the mother.Relevant agencies. The term “relevant agencies” means the department of social services, the mayor’s office to end domestic and gender-based violence, the New York city health and hospitals corporation and any other agency that the department deems relevant.Relevant organization. The term “relevant organization’ means a community-based organization that serves a population that the department deems relevant to the campaign required by subdivision b of this section.b. Public education and outreach campaign. Beginning no later than 90 days after the effective date of the local law that created this section, and continuing thereafter, the department, in collaboration with the relevant agencies and the relevant organizations, shall conduct a public education and outreach campaign to inform the public about the risks of a caesarean section to a pregnant person and a newborn. Such campaign shall include, but need not be limited to, the following:1. Creating culturally appropriate written materials, including, but not limited to, pamphlets, posters and flyers, in the designated citywide languages as defined in section 23-1101;2. Posting such materials on the websites of the department, the relevant agencies and the relevant organizations;3. Having employees of the relevant agencies and the relevant organizations distribute such materials to their clients and patients; and4. Providing such materials to locations, including, but not limited to, doctor offices, hospitals and relevant organizations for such locations to disseminate such materials to their clients and patients.c. Report. The department shall submit a report on the campaign required by subdivision b of this section beginning no later than one year after the effective date of the local law that created this section and annually thereafter. The commissioner shall submit such report to the mayor and the speaker of the council and post such report on the department’s website. Such annual report shall include, but need not be limited to, the following information:1. The number of public education and outreach efforts as required by subdivision b; 2. A list of each such effort with each separate row referencing a unique effort and providing the following information about such effort set forth in separate columns:(a) The agency or the organization that conducted such effort;(b) The approximate number of individuals provided information during such effort;(c) The specific population, if any, reached during such effort; and(d) The information disseminated during such effort; and3. Any recommendations to improve such efforts and the plans to implement such recommendations.§ 2. This local law takes effect immediately.NLBLS #92595/17/2022 |

Int. No. 86

By the Public Advocate (Mr. Williams) and Council Members Stevens, Hanif, Cabán, Won, Restler and Yeger (by request of the Bronx Borough President)

A Local Law to amend the administrative code of the city of New York, in relation to education about city standards for respectful care at birth, health care proxy forms and patients’ rights

Be it enacted by the Council as follows:

Section 1. Chapter 1 of title 17 of the administrative code of the city of New York is amended by adding a new section 17-200.1 to read as follows

§ 17-200.1 Respectful care at birth, health care proxy; public education. a. The commissioner shall engage in public education efforts as necessary to inform health care providers and patients about the city’s standards for respectful care at birth; health care proxy forms; the right to be free from discrimination in relation to pregnancy, childbirth or a related medical condition; the right to reasonable workplace accommodations and New York’s paid family leave. Such efforts shall include, but need not be limited to:

1. An outreach initiative to distribute posters, flyers, online materials, and other written materials to all facilities where obstetric and gynecological care is provided through the department containing information about standards for respectful care at birth; health care proxy forms and their uses; the right to be free from discrimination related to pregnancy, childbirth or a related medical condition; the right to be free from discrimination related to caregiver status; the right to reasonable workplace accommodations including lactation accommodations, paid sick and safe leave, temporary schedule changes, temporary disability insurance, the family and medical leave act of 1993 and New York’s paid family leave program. The department shall develop such materials in consultation with the New York city commission on human rights, the department of consumer and worker protection, and community based organizations with expertise in the workplace rights of pregnant workers. Such materials shall be developed with a focus on equity. The department shall distribute blank health care proxy forms as part of such initiative.

2. An invitation to the New York city health and hospitals corporation to participate in the posting and distribution of such posters, flyers, forms, online materials, and other written materials to patients seeking or receiving obstetric and gynecological care.

b. Nothing in this section shall be construed as requiring the acceptance or display of any such materials by any private entity.

§ 2. This local law takes effect 120 days after it becomes law.

Session 12

NAB

LS #4536

2/17/22

Session 11

JG

LS #14831

Int. #2370-2021

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| Res. No. 95 Resolution calling on the New York State Legislature to pass, and the Governor to sign, A217/S2736, relating to informing maternity patients about the risks associated with cesarean section. By Council Members Rivera, Hanif, Riley, Stevens, Won, Nurse and Louis Whereas, According to the American College of Obstetricians and Gynecologists (ACOG), a cesarean birth is the delivery of a baby through incisions made in the abdomen and uterus; andWhereas, According to ACOG, a cesarean birth may be performed if there are certain concerns about the fetus, problems with the placenta, if the birthing parent has certain medical conditions, and for other reasons; andWhereas, While cesarean sections can be medically needed, for low risk pregnancies and those who do not medically require a cesarean section, there are benefits to having a vaginal birth; and Whereas, According to the Mayo Clinic, cesarean sections include risks for both the birthing parent and baby; andWhereas, Babies born by scheduled cesarean section are more likely to develop transient tachypnea, a breathing problem marked by abnormally fast breathing during the first few days after birth, and, rarely, babies may experience a surgical injury; andWhereas, Risks for birthing parents include infection, postpartum hemorrhage, blood clots, wound infection, surgical injury, and other issues; andWhereas, Individuals who have a cesarean section also require time to recover and additional postpartum care; andWhereas, Cesarean sections also impact the birthing parent’s future maternal health; andWhereas, Individuals who have a cesarean section face a higher risk of potentially serious complications in a subsequent pregnancy, such as cesarean scar on the uterus rupturing during a future vaginal birth; andWhereas, According to the New York State Taskforce on Maternal Mortality and Disparate Racial Outcomes, the cesarean delivery rate in the U.S. has risen to over 30 percent, and, when compared to vaginal deliveries, cesarean deliveries carry overall higher rates of maternal mortality; andWhereas, According to the Task Force’s report, from 2012-2014, 66 percent of prenatal related deaths in New York State involved a cesarean section; andWhereas, According to the New York City 2008-2012 Severe Maternal Morbidity report, maternal morbidity is a continuum from mild adverse effects to life-threatening events or death; andWhereas, According to the report, the severe maternal morbidity rate was higher among people with a primary or repeat cesarean (474.1 and 492.3 per 10,000 deliveries, respectively), compared to those with a vaginal birth (109.8 per 10,000 deliveries) or vaginal birth after a cesarean (172.7 per 10,000 deliveries); andWhereas, Although it is difficult to differentiate between morbidity caused by cesarean delivery versus morbidity requiring a cesarean delivery, cesarean sections may have a higher risk of maternal morbidity; andWhereas, According to the Centers for Disease Control and Prevention, in 2020 the cesarean delivery rate in New York State was 33.6 percent, the twelfth highest rate in the country; andWhereas, It is increasingly important to ensure that all individuals giving birth are informed of the risks associated with cesarean births; andWhereas, A217/S2736, sponsored by Senator Julia Salazar and Assembly Member Amy Paulin, amends the public health law, in relation to informing maternity patients about the risks associated with cesarean section; andWhereas, The bill would require maternal health providers to supply individuals with a planned cesarean and those who undergo an unplanned cesarean with a standardized written communication about cesarean sections; andWhereas, Such written communication would include, but not be limited to, potential maternal injuries, potential injuries to the fetus, the impact of a cesarean delivery may have on future pregnancies and deliveries, and the circumstances in which cesarean delivery may be necessary to save the life of the parent or fetus; andWhereas, The information would be developed by the Commissioner based on consultations with appropriate health care professionals, providers, consumers, educators, and patients, including the ACOG and the New York State Association of Licensed Midwives; andWhereas, Such a law would ensure the universal dissemination of information to improve the health and safety of New York’s birthing parents and newborns; now, therefore, be itResolved, That the Council of the City of New York calls on the New York State Legislature to pass, and the Governor to sign, A217/S2736, relating to informing maternity patients about the risks associated with cesarean section. Session 12EBLS 509503.04.2022 Session 11EBLS 15869Res. 1499-2020 |

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| Res. No. 201 Resolution calling upon New York State Legislature to establish full insurance coverage for fertility treatments. By Council Members Narcisse, Louis, Hanif, Brooks-Powers, Joseph, Nurse, Gutiérrez and Restler Whereas, Fertility, broadly speaking, is the ability to produce offspring through reproduction or the reproductive process; andWhereas, Infertility is a medical condition recognized by the World Health Organization and the American Society for Reproductive Medicine, that affects about 9% of American men and 10% of American women; andWhereas, According to the Centers for Disease Control and Prevention, 1 in 8 couples have difficulty getting pregnant or sustaining a pregnancy; andWhereas, Infertility affects a broad spectrum of prospective parents, no matter what race, religion, sexual orientation, or economic status; andWhereas, Same-sex couples, uncoupled adults, and asexual adults, among others, uniquely experience fertility and infertility challenges; andWhereas, According to the Center for Reproductive Rights, fertility implicates and affects multiple human rights, including the rights to plan the timing and spacing of children, benefit from scientific progress, health, sexual and reproductive health, and non-discrimination; andWhereas, According to Columbia University Medical Center, infertility cuts across socioeconomic, racial, ethnic and religious lines,and cost is the number one barrier to seeking family building assistance, as 46% of affected people lack insurance coverage for treatment of infertility; andWhereas, According to the Center for Reproductive Rights, issues of infertility can create devastating social stigma rooted in harmful stereotypes, particularly for same-sex couples and individuals seeking fertility care and treatments; andWhereas, The price for fertility treatment ranges between $10,000 to $20,000 per attempt at conception through In Vitro fertilization (IVF), according to American Society for Reproductive Medicine, keeping the possibility of a child out of reach for many; andWhereas, As of January, 2020, New York Insurance Law §§ 3221(k)(6)(C) and 4303(s)(3) requires large group insurance policies and contracts that provide medical, major medical, or similar comprehensive-type coverage in New York to cover three cycles of IVF used in the treatment of infertility; andWhereas, The existing state law provides up to three IVF cycles to people who are insured through an employer with over 100 employees who provides qualifying coverage; andWhereas, The existing state law also provides medically necessary fertility preservation treatments for people facing infertility caused by medical intervention or conditions; andWhereas, The existing state law prohibits the delivery of insurance coverage from discriminating based on age, sex, sexual orientation, marital status, or gender identity; andWhereas, There are still limitations and mandates that exclude many New Yorkers from these services such as (1) People on Medicaid; (2) People who receive their health insurance from the Exchange in New York; (3) Employees of small companies of fewer than 100 employees; (4) Employees of companies that self-insure with over 1,000 employees; (5) and People with health insurance provided by the Federal government; andWhereas, Although the State’s requirement for some IVF coverage is relatively progressive, many plan participants who need such services to build families are excluded from coverage due to the requirement for  an infertility diagnosis; andWhereas, The State’s requirement for an infertility diagnosis operates to exclude IVF coverage for couples and individuals who do not have an infertility diagnosis, particularly, same-sex couples, uncoupled adults, asexual adults, and others; andWhereas, Many of other treatments and services related to family building, particularly those services most often utilized for family planning by same-sex couples, uncoupled adults, and asexual adults, including gamete and embryo freezing surrogacy, and adoption; andWhereas, According to Kaiser Family Foundation, the high cost and limited coverage of fertility services make this care inaccessible to many low income people, communities of color, LTBQ+ populations, and other marginalized groups who may need it, but are unable to afford it; andWhereas, Broadening the definition and understanding of infertility and guaranteeing fair distribution of fertility treatments is imperative so that everyone has an equal opportunity to plan their families, regardless of gender, race, or sexual orientation; andWhereas, It is time for New York State to guarantee insurance coverage for all fertility treatments to achieve greater equity, and fulfill a fundamental human right to basic reproductive essential health care; now, therefore be itResolved, That the Council of the City of New York calls upon New York State Legislature to establish full insurance coverage for fertility treatments.VM4/25/2022LS#9260 |

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| Res. No. 205 Resolution calling on the New York State Legislature to pass, and the Governor to sign, legislation making doulas more accessible to individuals with Medicaid and those without health insurance. By Council Members Rivera, Louis, Hudson, Hanif, Brooks-Powers, Joseph, Nurse, The Speaker (Council Member Adams) and Council Member Restler (in conjunction with the Brooklyn Borough President)                      Whereas, According to DONA International, a doulais a trained professional who provides continuous physical, emotional, and informational support to a pregnant person and the family before, during, and shortly after childbirth; and                     Whereas, Doulas have proven to be beneficial to pregnant people and their health; andWhereas, Doulas act as important advocates, facilitating communication between providers and patients, providing culturally-competent and language-appropriate care to immigrant communities and communities of color they serve; and                     Whereas, According to the New York City Department of Health and Mental Hygiene’s (DOHMH’s) report *The State of Doula Care in NYC 2019*(“doula report”), doula care has been associated with lower rates of Cesarean birth, preterm birth, low birthweight, and postpartum depression, as well as with increased rates of breastfeeding, and greater patient satisfaction with maternity care; andWhereas, A 2017 report published by Cochrane reveals that people who had doula support were 39 percent less likely to have a caesarean section and 15 percent more likely to give birth without needing drugs or labor-inducing techniques; andWhereas, According to Choices in Childbirth, a survey regarding doula care in New York City reveals that 72 percent of people reported that their doula helped them communicate their preferences and needs, while 80 percent of those surveyed reported that their doula helped them feel more empowered; andWhereas, 83 percent of survey respondents reported having a doula made their labor and birth experience “much better” than if they had not used a doula, and it made them more relaxed before, during, and after birth; andWhereas, 88 percent of this cohort reported that cost was an issue when opting to work with a doula; andWhereas, According to DOHMH’s doula report, the average cost of birth-doula services was $1,550 per client among doulas surveyed for the report, with a range of $225 to $5,000; andWhereas, Doula services are generally not covered by Medicaid or private insurance; andWhereas, Doula care should be more accessible, especially given the maternal mortality and morbidity rates in New York City as well as the inequitable health outcomes for people of color and infants of color, specifically those who are Black; andWhereas, Of the 21 pregnancy-related deaths in New York City in 2017, 11 were of people who were Black and six were of people who were Latina, accounting for nearly every pregnancy-related death; and  Whereas, In New York City in 2017, the rate of severe maternal morbidity was highest among Black people (457.2 per 10,000 births), followed by people of other or multiple race(s) (399.6), people who are Latina (313.7), Asian/Pacific Islander (225.4), and, last, people who are white (187.9); andWhereas, By expanding access to doulas, New York City could better tackle these insidious inequities; andWhereas, Doulas face barriers providing care to all those who need it; andWhereas, According to DOHMH’s doula report, among doulas surveyed, 9 of every 10 have turned clients away, for reasons including clients’ living outside their coverage area (47 percent), being already booked with other families (43 percent), and clients’ being unable to afford their fee (37 percent); andWhereas, New York State considered legislation to include doula services in Medicaid coverage; andWhereas, In April 2018, New York State announced the launch of a Medicaid pilot program to cover doula services; andWhereas, This legislation and pilot were extremely controversial in the doula community for numerous reasons; andWhereas, The Medicaid pilot program was discontinued in Brooklyn because of lack of doula participation due to many flaws with the program; andWhereas, One of the crucial flaws in the program was the inadequate reimbursement rate for doula services; andWhereas, For a Medicaid doula program to operate and become sustainable, reimbursement rates must be sufficient to allow doulas to support themselves and their families and to increase doula participation in the program; andWhereas, DOHMH’s doula report on doula care provides numerous recommendations for stakeholders to improve access to doulas; andWhereas, Recommendations fall within four key components, including increasing access for underserved communities, making hospital environments more welcoming of doulas, amplifying community voices to help expand access to doula services, and improving data collection; andWhereas, The New York State Legislature should consider these recommendations, and should develop legislation, in collaboration with doulas and people with lived experience, in order to best understand the most effective and significant ways to expand access to doula services; now, therefore, be it,Resolved, The Council of the City of New York calls on the New York State Legislature to pass, and the Governor to sign, legislation making doulas more accessible to individuals with Medicaid and those without health insurance Session 12LS 8087EB/VM5/26/2022 Session 11LS 13225EBRes. 1239-2020 |

Res. No. 244

Resolution calling on the Centers for Disease Control and Prevention to provide expanded funding for the Healthy Start Brooklyn doula program known as By My Side in order to make doulas available to all low-income birthing people in New York City.

By the Public Advocate (Mr. Williams) and Council Members Cabán, Hanif, Louis and Gutiérrez

                     Whereas, The New York City Department of Health and Mental Hygiene (DOHMH) describes doulas as trained birth assistants who provide non-medical support to birthing parents and their partners before, during and after a child’s birth; and

                     Whereas, The By My Side (BMS) birth support program is administered through Healthy Start Brooklyn, a federally-funded program based in the City’s DOHMH Center for Health Equity, that provides free doula services to low-income birthing parents in Brooklyn who disproportionately face the risks of infant mortality, low birthweight, preterm birth and other challenges; and

Whereas, The BMS program’s mission is also to encourage breastfeeding among low-income and immigrant parents, and educate through the use of doula services, thereby promoting the nutrients necessary for a healthy baby’s brain growth and nervous system development; and

Whereas, According to the Cochrane Collaboration Review, a compilation of data from multiple peer-reviewed and evidenced-based studies, continuous labor supports provided by birth doulas has been scientifically proven to shorten labor by 41 minutes on average, reduce the risk of cesarean section delivery by 25 percent and has increased the likelihood of spontaneous vaginal births by eight percent; and

Whereas, DOHMH has reported doula services lead to improved birthing outcomes, with instrumental vaginal births or induced labor less likely and a reduced need for pain medications; and

Whereas; Additionally, doulas services lead to experiencing a more successful initiation of breastfeeding and self-reported positive experience in giving birth which facilitates better parent-baby bonding; and

Whereas, The DOHMH State of Doula Care in NYC 2021 Report clearly stated that while doulas alone cannot solve the inequities in birth outcomes that are the result of centuries of structural and medical racism nationwide, doulas do provide a positive health benefit in facilitating improved birth outcomes, particularly while working to eliminate racial inequities and decrease maternal deaths while reducing life-threatening complications related to childbirth; and

Whereas, Additional funding from the Centers for Disease Control and Prevention (CDC) would allow the expansion of the DOHMH’s BMS birth support program to serve low-income birthing parents in all five boroughs who are also part of a demographic that disproportionally face the risks of infant mortality, preterm birth, low birthweight and other challenges; now, therefore, be it,

Resolved, The Council of the City of New York calls on Centers for Disease Control and Prevention to provide expanded funding for the Healthy Start Brooklyn doula program known as By My Side in order to make doulas available to all low-income birthing people in New York City.

LS 5212

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5/24/22

Res. No. 92

Resolution calling on the United States Congress to pass and President Joseph Biden to sign the Black Maternal Health Momnibus Act of 2021

By the Public Advocate (Mr. Williams) and Council Members Hanif, Brewer, Riley, Sanchez, Stevens, Won, Restler and Nurse (in conjunction with the Brooklyn Borough President)

Whereas, The rate of maternal mortality in the United States more than doubled between 1990 and 2014 and the United States is the only developed country in the world whose rates continue to rise according to studies published in Obstetrics and Gynecology; and

Whereas, Over 700 women a year in the United States die of complications related to pregnancy and two-thirds of those deaths are preventable, with 50,000 women suffering from Severe Maternal Morbidity defined as life threatening complications of pregnancy according to the Centers for Disease Control and Prevention; and

Whereas, Rising maternal mortality and morbidity rates disproportionately impact Black women, who are up to three times more likely to die due to a complication from child birth than white women, regardless of other factors such as their level of educational attainment or income, according to United States Department of Health and Human Services research on maternal mortality disparities; and

Whereas, In New York State, the maternal mortality rate for black women was 51.6 deaths per 100,000 live births, compared to 15.9 deaths per 100,000 live births for white women from 2014-2016, according to the New York State Taskforce on Maternal Mortality and Disparate Racial Outcomes report from March 2019; and

Whereas, In New York City, Black women are three times more likely than white women to suffer from Severe Maternal Morbidity according to a New York City Department of Health and Mental Hygiene report on Severe Maternal Morbidity; and

Whereas, The Black Maternal Momnibus Act of 2021 H.R.959/S.346 sponsored by Rep. Lauren Underwood (D-IL-14) and Sen. Cory Booker (D-NI) is a package that includes nine individual pieces of legislation to address the immense racial and ethnic disparities in maternal healthcare in the United States; and

Whereas, The Social Determinants for Moms Act H.R.943/S.851 sponsored by Rep. Lucy McBath (D-GA-6) and Sen. Richard Blumenthal (D-CT) approves the disbursement of grant funding for further research and study on social determinants of maternal health such as transportation, housing and environmental factors; and

Whereas, The Kira Johnson Act H.R.1212 sponsored by Rep. Alma Adams (D-NC-12) and named for a 39-year-old active, otherwise healthy Black woman who passed away in 2016 from a preventable complication shortly after delivering her second son, would expand funding for community based organizations working to improve maternal health outcomes for Black women; and

Whereas, The Protecting Moms Who Served Act H.R.958/S.796 sponsored by Rep. Lauren Underwood (D-IL-14) and Sen. Tammy Duckworth (D-IL) would commission a study on maternal health outcomes among veterans with an emphasis on ethnic and racial disparity; and

Whereas, The Perinatal Workforce Act H.R.945/S.287 sponsored by Rep. Gwen Moore (D-WI-4) and Tammy Baldwin (D-WI) would establish grant funding under the Public Services Act for accredited schools that educate and train certified nurse-midwives and other perinatal healthcare providers in order to expand and diversify the maternity care workforce; and

Whereas, The Data to Save Moms Act H.R.925/S.347 sponsored by Rep. Sharice Davids (D-KS-3) and Sen. Tina Smith (D-MN) would improve data collection processes and quality measures of maternal health outcomes; and

Whereas, The Moms MATTER Act H.R.909/S.484 sponsored by Rep. Lisa Blunt Rochester (D-DE-At Large) and Sen. Kirsten Gillibrand (D-NY) would address the mental health and substance use disorder needs of mothers through the promotion of evidence-based programs that improve outcomes; and

Whereas, The Justice for Incarcerated Moms Act H.R.948/S.341 sponsored by Rep. Ayanna Presley (D-MA-7) and Sen. Cory Booker (D-NJ)  would support incarcerated women by promoting better care in corrections facilities and would help to end the utilization of shackling in state and local prisons by attaching federal funding to prohibitions on the use of restraints on pregnant women; and

Whereas, The Tech to Save Moms Act H.R.937/S.893 sponsored by Rep. Eddie Bernice Johnson (D-TX-30) and Sen. Bob Menendez (D-NJ) would invest in digital tools like telehealth to improve maternal health outcomes in underserved areas; and

Whereas, The IMPACT to Save Moms Act H.R.950/S.334 sponsored by Rep. Janice Schakowsky (D-IL-09) and Sen. Bob Casey (D-PA) would help to promote better access to care through the continuity of health insurance coverage for the duration of labor, delivery and postpartum care; and

Whereas, The Maternal Health Pandemic Response Act H.R.8027/S.4769 sponsored by Rep. Lauren Underwood (D-IL-14) and Sen. Elizabeth Warren (D-MA) would make targeted investments to advance safe and maternity care and improve data collection, monitoring, and research on maternal health outcomes during the COVID-19 pandemic and beyond; and

Whereas, The Protecting Moms and Babies Against Climate Change Act H.R.957/S.423 sponsored by Rep. Lauren Underwood (D-IL-14) and Sen. Ed Markey (D-MA) would address climate change-related risks, make investments to initiatives that aim to reduce levels of and exposure to extreme heat, air pollution, and other environmental threats to pregnant people, new moms, and their infants, and

Whereas, The Maternal Vaccination Act H.R.951/S.345 sponsored by Representative Terri A. Sewell (D-AL-07) and Sen. Tim Kaine (D-VA) would provide funding for programs to increase maternal vaccination rates, protecting both new moms and their babies; and

Whereas, The Black Maternal Health Momnibus Act of 2021 would make critical investments in policies that would help to end preventable maternal mortality and to close the racial and ethnic disparities in maternal healthcare; now, therefore, be it

Resolved, That the Council of the City of New York calls on the United States Congress to pass and President Joseph Biden to sign the Black Maternal Health Momnibus Act of 2021.

Session 12

CGR

LS #4537

3/10/2022

Session 11

NO

LS #14,832

Res. No. 1717

1. The Committees center that not just women give birth, and will include gender expansive and inclusive language within the report, aside from when quoting a source directly. However, doing so does not negate the fact that, while the majority of people receiving maternal health are women/mothers, there are populations that are impacted who do not identify as women or mothers. [↑](#footnote-ref-1)
2. MacDorman MF, Declercq E, Cabral H, Morton C., *Is the United States Maternal Mortality Rate Increasing? Disentangling trends from measurement issues*, Obstetrics and gynecology (2016), 447-455, *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5001799/pdf/nihms810951.pdf. [↑](#footnote-ref-2)
3. World Health Organization, Trends in Maternal Mortality: 1990 to 2015 (2015), *available at* https://apps.who.int/iris/bitstream/handle/10665/194254/9789241565141\_eng.pdf;jsessionid=A5BCC05853070F3E0AAADCC3FB3CB6EB?sequence=1. [↑](#footnote-ref-3)
4. *See* Roosa Tikkanen, Munira Z. Gunja, Molly FitzGerald, and Laurie Zephyrin, Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries (Nov. 18, 2020), available at https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries; World Health Organization, *Maternal mortality ratio (per 100 000 live births)* (last visited June 17, 2022), available athttps://www.who.int/data/gho/indicator-metadata-registry/imr-details/26 (The World Health Organization (WHO) defines maternal death as “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes”). [↑](#footnote-ref-4)
5. *See* “Table 2. Estimates of maternal mortality ratio (maternal mortality ratio, deaths per 100 000 live births), number of maternal deaths, and lifetime risk by United Nations MDG regions, 2008;” *see also* “Annex 3. Comparison of 1990, 1995, 2000, 2005, and 2008 estimates of maternal mortality ratio (maternal mortality ratio, deaths per 100 000 live births) by country,” World Health Organization, et al., Trends in maternal mortality: 1990 to 2008 (2010), 18, 28-32, *available at* http://apps.who.int/iris/bitstream/handle/10665/44423/9789241500265\_eng.pdf;jsessionid=E07455C2099CB48EE28744F5BAAA2C34?sequence=1. [↑](#footnote-ref-5)
6. Calpurnyia Roberts, *Bronx Infant and Maternal Health Summit*, Neighborhood Health Action Centers (June 21, 2018), citing Kassebaum et. al (2016). [↑](#footnote-ref-6)
7. Centers for Disease Control and Prevention, Pregnancy Mortality Surveillance System (last visited June 17, 2022), *available at* <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm>. [↑](#footnote-ref-7)
8. M. MacDorman, E. Declercq, H. Cabral, C. Morton, *Is the United States Maternal Mortality Rate Increasing? Disentangling Trends from Measurement Issues*, Obstetrics and Gynecology 447-455 (2016), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5001799/pdf/nihms810951.pdf. [↑](#footnote-ref-8)
9. Centers for Disease Control and Prevention, *Pregnancy Related Deaths*, available at <https://www.cdc.gov/vitalsigns/maternal-deaths/index.html>. [↑](#footnote-ref-9)
10. Centers for Disease Control and Prevention, *Severe Maternal Morbidity in the United States*, available at <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html>. [↑](#footnote-ref-10)
11. *Id.* [↑](#footnote-ref-11)
12. Centers for Disease Control and Prevention, *Infographic: Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016*, available at <https://www.cdc.gov/reproductivehealth/maternal-mortality/disparities-pregnancy-related-deaths/infographic.html> [↑](#footnote-ref-12)
13. Centers for Disease Control and Prevention, Pregnancy Mortality Surveillance System (last visited June 17, 2022), *available at* https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm. [↑](#footnote-ref-13)
14. *Id.* [↑](#footnote-ref-14)
15. Linda Villarosa, *Why America’s Black Mothers Are in a Life-or-Death Crisis*, New York Times (Apr. 11, 2018), *available at* https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html; *See also* J.D.B. De Bow, *Mortality Statistics of the Seventh Census of the United States 1850* (last visited Nov 25, 2020), *available at* https://babel.hathitrust.org/cgi/pt?id=uc2.ark:/13960/t4qj7qt8w;view=1up;seq=40 (showing that the government started to track vital statistics related to mortality, disaggregating info by sex and race, in 1850). [↑](#footnote-ref-15)
16. *Id.* (explicitly making this point and explaining, “by the late 1990s, other researchers were trying to chip away at the mystery of the black-white gap in infant mortality. Poverty on its own had been disproved to explain infant mortality, and a study of more than 1,000 women in New York and Chicago, published in The American Journal of Public Health in 1997, found that black women were less likely to drink and smoke during pregnancy, and that even when they had access to prenatal care, their babies were often born small.… Though it seemed radical 25 years ago, few in the field now dispute that the black-white disparity in the deaths of babies is related not to the genetics of race but to the lived experience of race in this country”). [↑](#footnote-ref-16)
17. Centers for Disease Control and Prevention, *Infographic: Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016*, available at <https://www.cdc.gov/reproductivehealth/maternal-mortality/disparities-pregnancy-related-deaths/infographic.html> [↑](#footnote-ref-17)
18. The top causes of U.S. pregnancy-related deaths in 2011 were cardiovascular disease, 15.1 percent; non-cardiovascular disease, 14.1 percent; infection or sepsis, 14 percent; and hemorrhage, 11.3 percent. *See* Robin Fields, *New York City Launches Committee to Review Maternal Deaths*, ProPublica (Nov. 15, 2017), *available at* https://www.propublica.org/article/new-york-city-launches-committee-to-review-maternal-deaths; Linda Villarosa, *Why America’s Black Mothers and Babies Are in a Life-or-Death Crisis,* New York Times (Apr. 11, 2018), available at https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html. [↑](#footnote-ref-18)
19. New York State Department of Health, *New York State Community Health Indicator Reports (CHIRS),* Oct. 2021, <https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/chir_dashboard/chir_dashboard&p=it&ind_id=Ib33#pagetitle>. [↑](#footnote-ref-19)
20. *See* Nancy Krieger, Maureen Benjamins, Alyash A. Sewell, Presentation: *Prioritizing Equity video series: Research and data for health equity*, Amer. Med. Assoc. (Nov. 20, 2020), *available at* https://www.ama-assn.org/delivering-care/health-equity/prioritizing-equity-video-series-research-and-data-health-equity; Benjamin Retelus, et. al., *Racial Disparities in COVID-19 Hospitalization and In-hospital Mortality at the Height of the New York City Pandemic* 18(1) 1, 1 (Sep. 18, 2020), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7500250/. [↑](#footnote-ref-20)
21. *See* New York City Department of Health and Mental Hygiene, *Severe Maternal Morbidity in New York City, 2008-2012* (2016), *available at* http://www1.nyc.gov/assets/doh/downloads/pdf/data/maternal-morbidity-report-08-12.pdf. [↑](#footnote-ref-21)
22. *Id.* [↑](#footnote-ref-22)
23. Jamila Taylor, Cristina Novoa, Katie Hamm, and Shilpa Phadke, *Eliminating Racial Disparities in Maternal and Infant Mortality*, Center for American Progress (May 2, 2019), *available at* <https://www.americanprogress.org/issues/women/reports/2019/05/02/469186/eliminating-racial-disparities-maternal-infant-mortality/>*; See* March of Dimes, Nowhere to Go: Maternity Care Deserts Across the U.S. (2018), *available at* <https://www.marchofdimes.org/materials/Nowhere_to_Go_Final.pdf>; National Partnership for Women and Families, *Black Women’s Maternal Health: A Multifacted Approach to Addressing Persistent and Dire Health Disparities* (April 2018*), available at* <http://www.nationalpartnership.org/research-library/maternal-health/black-womens-maternal-health-issue-brief.pdf>; *See also* Elizabeth A. Howell, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61(2) Clin Obstet Gynecol. 387, 387 (Jun. 1, 2019), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5915910/. [↑](#footnote-ref-23)
24. CNN*, Childbirth is Killing Black Women in the U.S., and Here’s Why*, CNN (Nov. 15, 2017), *available at* https://www.cnn.com/2017/11/15/health/black-women-maternal-mortality/index.html; Rates were also high among Puerto Rican and other Latina women compared to White non-Latina women and overall when examining other risk factors. *Pregnancy-Associated Mortality in New York City, 2006-2010* (2015), *available at* https://www1.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report.pdf. [↑](#footnote-ref-24)
25. Data received by the City Council in mandated reports. [↑](#footnote-ref-25)
26. New York City Department of Health and Mental Hygiene, *Pregnancy-Associated Mortality in New York City, 2018*, January 2022, available at <https://www1.nyc.gov/assets/doh/downloads/pdf/data/maternal-mortality-annual-report-2021.pdf> [↑](#footnote-ref-26)
27. *Id.* [↑](#footnote-ref-27)
28. A *doula* is a trained professional who provides continuous physical, emotional and informational support to a pregnant person and the family before, during, and shortly after childbirth. [↑](#footnote-ref-28)
29. Bohren MA, Hofmeyr GJ, Sakala C, Fukuzawa RK and Cuthbert A., *Continuous support for women during childbirth*, 7(1) Cochrane Database of Systematic Reviews (2017). [↑](#footnote-ref-29)
30. “Doula Care in New York City: Advancing the Goals of the Affordable Care Act.” *Choices in Childbirth*, 28 Oct. 2014, https://choicesinchildbirth.org/wp-content/uploads/2014/10/Doula-Report-10.28.14.pdf. [↑](#footnote-ref-30)
31. *Id.* [↑](#footnote-ref-31)
32. *Id*. The average fee for doula services in NYC is $1200, which includes one prenatal visit, labor support, and a postpartum follow up visit. However, fees can range from $150 to $2800 per birth depending on experience. [↑](#footnote-ref-32)
33. New York City Department of Health and Mental Hygiene, *The State of Doula Care in NYC 2021,* available at <https://www1.nyc.gov/assets/doh/downloads/pdf/csi/doula-report-2021.pdf> [↑](#footnote-ref-33)
34. Sascha Ellington, et al., *Characteristics of Women of Reproductive Age with Laboratory-Confirmed*

*SARS-CoV-2 Infection by Pregnancy Status — United States, January 22–June 7, 2020*, Morbidity and Mortality Weekly Report, Jun. 26, 2020, <https://www.cdc.gov/mmwr/volumes/69/wr/mm6925a1.htm?s_cid=mm6925a1_w>. [↑](#footnote-ref-34)
35. Laura D. Zambrano, et al., *Update: Characteristics of Symptomatic Women of Reproductive Age with Laboratory-Confirmed SARS-CoV-2 Infection by Pregnancy Status — United States, January 22–October 3, 2020*, Morbidity and Mortality Weekly Report, Nov. 2, 2020, <https://www.cdc.gov/mmwr/volumes/69/wr/mm6944e3.htm?s_cid=mm6944e3_w>. [↑](#footnote-ref-35)
36. American Hospital Association, *COVID-19: Maternal and Child Health During COVID-19*, Jul. 2020, <https://www.aha.org/system/files/media/file/2020/05/COVID-19-Maternal-Guidelines_rev6.pdf>. [↑](#footnote-ref-36)
37. Sascha Ellington, et al., *Characteristics of Women of Reproductive Age with Laboratory-Confirmed*

*SARS-CoV-2 Infection by Pregnancy Status — United States, January 22–June 7, 2020*, Morbidity and Mortality Weekly Report, Jun. 26, 2020, <https://www.cdc.gov/mmwr/volumes/69/wr/mm6925a1.htm?s_cid=mm6925a1_w>. [↑](#footnote-ref-37)
38. Harvard T.H. Chan School of Public Health, *COVID-19 may increase maternal mortality disparities in U.S.*, <https://www.hsph.harvard.edu/news/hsph-in-the-news/covid-19-may-increase-maternal-mortality-disparities-in-u-s/> (last accessed Dec. 2, 2020). [↑](#footnote-ref-38)
39. *Id.* [↑](#footnote-ref-39)
40. Anna North, *America is failing Black moms during the pandemic*, Vox, Aug. 10, 2020, <https://www.vox.com/2020/8/10/21336312/covid-19-pregnancy-birth-black-maternal-mortality>. [↑](#footnote-ref-40)
41. *Id.* [↑](#footnote-ref-41)
42. *Id.* [↑](#footnote-ref-42)
43. *Id.* [↑](#footnote-ref-43)
44. *Id.* [↑](#footnote-ref-44)
45. *Id.* [↑](#footnote-ref-45)
46. Emily Bobrow, *She Was Pregnant With Twins During Covid. Why Did Only One Survive?*, New York Times, Aug. 9, 2020, <https://www.nytimes.com/2020/08/06/nyregion/childbirth-Covid-Black-mothers.html>. [↑](#footnote-ref-46)
47. Anna North, *America is failing Black moms during the pandemic*, Vox, Aug. 10, 2020, <https://www.vox.com/2020/8/10/21336312/covid-19-pregnancy-birth-black-maternal-mortality>. [↑](#footnote-ref-47)
48. *Id.* [↑](#footnote-ref-48)
49. *Id.* [↑](#footnote-ref-49)
50. Katie Van Syckle & Christina Caron, ‘*Women Will Not Be Forced to Be Alone When They Are Giving Birth’*, New York Times, Mar. 28, 2020, <https://www.nytimes.com/2020/03/28/parenting/nyc-coronavirus-hospitals-visitors-labor.html>. [↑](#footnote-ref-50)
51. Anna North, *America is failing Black moms during the pandemic*, Vox, Aug. 10, 2020, <https://www.vox.com/2020/8/10/21336312/covid-19-pregnancy-birth-black-maternal-mortality>. [↑](#footnote-ref-51)
52. American Hospital Association, *COVID-19: Maternal and Child Health During COVID-19*, Jul. 2020, <https://www.aha.org/system/files/media/file/2020/05/COVID-19-Maternal-Guidelines_rev6.pdf>. [↑](#footnote-ref-52)
53. *Id.* [↑](#footnote-ref-53)
54. New York State Executive Order No. 202.25: Continuing Temporary Suspension and Modification of Laws Relating to the Disaster Emergency. [↑](#footnote-ref-54)
55. “A Pregnant Woman Tweeted Concerns About a Bronx Hospital. She Died Days Later,” The City, Apr. 27, 2020, available at <https://www.thecity.nyc/health/2020/4/27/21247056/a-pregnant-woman-tweeted-concerns-about-a-bronx-hospital-she-died-days-later>. [↑](#footnote-ref-55)
56. *Id*. [↑](#footnote-ref-56)
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