Date of Hearing: April 19, 2022

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 1918 (Petrie-Norris) – As Amended March 24, 2022

SUBJECT: California Reproductive Health Service Corps.

SUMMARY: Establishes the California Reproductive Health Service Corps (RHSC) within the Department of Health Care Access and Information (HCAI) to recruit, train, and retain a diverse workforce of reproductive health care professionals to work in underserved areas. Specifically, **this bill**:

1) Establishes the RHSC within HCAI under the supervision of the HCAAI Director of HCAI. Requires the HCAI Director to ensure that adequate staff are provided to effectively administer the RHSC.

2) Requires the California State Loan Repayment Program (SLRP) to support HCAI in establishing the RHSC, and requires the RHSC to do all of the following:

    a) Administer and oversee scholarships and stipends for new reproductive health students, loan repayment for those graduates who have acquired debt from attending a reproductive health professional school in the past, and other types of direct financial support for scholars, in exchange for an appropriate term of obligated service in California at a corps-approved site;
    b) Pay a learning institution, teaching facility, or approved clinical training site directly on behalf of scholar, including for tuition, fees, facility costs, and preceptor time;
    c) Provide an annual payment for education-related costs and a monthly stipend to cover living expenses directly to a scholar. Requires the RHSC to consider family size and numbers of dependents when determining stipend amounts;
    d) Offer existing reproductive health professionals an option for loan forgiveness for each year of service;
    e) Offer scholars stipends or reimbursement for childcare, eldercare, housing, health care coverage with coverage for mental health services, and transportation to eliminate known obstacles of educational completion for scholars;
    f) Requires inclusive scholarships, stipends, and obligated service to be independently assessed for doula education due to the diverse pathways for education, notwithstanding b) through e) above;
    g) Identify and create opportunities for scholars to receive supplemental trainings in comprehensive sexual and reproductive health care, including miscarriage management, aspiration abortion, and medication abortion, through partnerships with and financial support for California-based external partners providing and enabling clinical abortion training in primary care; and,
    h) Create a process for scholars to report unlawful workplace conduct, such as harassment, that impedes the scholar's ability to work in their approved location. Defines "harassment" to mean unwelcome conduct that is based on race, color, sex, including pregnancy, gender identity or stereotyping, and sexual orientation, national origin, religion, age of 40 years and older, physical or mental disability, or genetic information, or reprisal for opposing discrimination or participating in the equal employment opportunity process. States that harassment becomes unlawful if enduring unwelcome or

offensive conduct becomes a condition of employment, involves a tangible employment action, or if the conduct is severe or pervasive enough to create a hostile work environment. Requires, if this conduct is reported and the scholar desires a new placement site, the RHSC to assist the scholar to find a new site to complete their service.

3) Requires RHSC to prioritize the selection of scholars from historically excluded populations and underserved areas, who reflect the patient populations they serve, to ensure greater inclusion and improved diverse representation in the reproductive health services workforce.

4) Requires scholars from historically excluded populations to meet two or more of the following criteria:

    a) Were or currently are homeless;
    b) Were or currently are in the foster care system;
    c) Were eligible for the National School Lunch Program for two or more years as a child;
    d) Do not have or have not had parents or legal guardians who completed a bachelor's degree;
    e) Were or currently are eligible for federal Pell Grants;
    f) Received support from the California Special Supplemental Nutrition Program for Women, Infants, and Children as a parent or child; or,
    g) Grew up in one of the following areas, but only one of which may be used as a criterion for the disadvantaged background definition:

        i) A rural area, as designated by the Rural Health Grants Eligibility Analyzer of the Health Resources and Services Administration (HRSA) of the United States Department of Health and Human Services;
        ii) A health professional shortage area (HPSA), as designated by the HRSA;
        iii) Is a member of a racial or ethnic group that has been shown by the National Science Foundation to be underrepresented in biomedical research and health sciences: Blacks or African Americans, Hispanics or Latinos, American Indians or Alaska Natives, Native Hawaiians, and other Pacific Islanders; or,
        iv) Is an individual with a disability, meaning a person with a physical or mental impairment that substantially limits one or more major life activities, as described in the Americans with Disabilities Act of 1990.

5) Requires a scholar to do all of the following:

    a) Agree to complete abortion training as part of their health care education with the intent to provide, or participate on a team that provides, reproductive health services with the inclusion of medical abortion or procedural abortion and miscarriage management;
    b) Commit to working at a corps-approved site in one of the following areas or with one of the following populations:

        i) A HPSA, as designated by the HRSA;
        ii) A medically underserved area (MUA) or with a medically underserved population (MUP), as mapped by the HRSA;
        iii) A maternity care desert, as designated by the March of Dimes;
        iv) A rural area, as designated by the federal Centers for Medicare and Medicaid Services;

v) A California county identified to have no abortion services;
vi) An area that is more than 50 miles from abortion services; and,
vii) An area where the majority of patients are covered under the Medi-Cal program.

c) Agree, in writing, that if the scholar fails to complete the period of obligated service at a corps-approved site, they will be in breach of contract.

6) Notwithstanding 5) b) above, authorizes a scholar or a site to petition the RHSC for approval of a site based on the reproductive health needs of specific communities or populations or the area's specific linguistic needs.

7) Allows a scholar to transfer to a new site to complete their service with the authorization of the RHSC. Requires the RHSC to define the criteria for transfer eligibility. Requires the RHSC, under certain defined conditions, including those described in 2) c) above, to assist the scholar to find a new approved site.

8) Requires, when a scholar is employed at a RHSC-approved site, the scholar to be subject to the personnel system of that entity.

9) Requires the RHSC to work with the California Department of Insurance (CDI) to establish a malpractice insurance fund to support its work. Requires the fund to do all of the following:

a) Offer coverage for reproductive health care professionals to work independently across the state;
b) Offer coverage for reproductive health care professionals in service or retired reproductive health care professionals who wish to work or teach part time; and
c) Offer coverage to permit medical and nursing students or medical residents to train in a variety of settings.

10) Requires HCAI to conduct an evaluation five years after implementation to assess the impact and effectiveness of the RHSC. Requires the evaluation to include all of the following:

a) The number of health care providers from underrepresented racial, ethnic, socioeconomic, and geographic backgrounds that have completed the RHSC program;
b) The number of scholars and corps graduates who are practicing in underserved areas;
c) The geographic areas served by scholars and corps graduates and geographic placement gaps that persist;
d) The provider types utilizing the corps; and,
e) The number of scholars and corps graduates who have integrated abortion care into their practices.

11) Requires HCAI to report its findings to the Legislature on or before January 1, 2029.

12) Defines the following terms for purposes of this bill:

a) "Corps" means the RHSC;
b) "Reproductive health" means health services relating to abortion care, sexual health counseling, contraception, sexually transmitted infections, reproductive tract infections,

HIV, gynecology, perinatal care, midwifery care, gender affirming care, and gender-based violence prevention;

c) "Reproductive health care professionals" means medical doctors, licensed midwives, certified nurse-midwives, nurse practitioners, registered nurses, physician's assistants, doulas, licensed vocational nurses, and medical assistants; and,
d) "Scholar" means a person in the RHSC who is a student who has been accepted in a school or a program on a part-time or full-time basis that graduates reproductive health care professionals or who is an existing reproductive health professional who desires more training and professional development in abortion care to provide this service.

13) Makes finding and declarations as follows:

a) That it is the intent of the Legislature to ensure the growth of a network of clinicians trained in abortion and sexual and reproductive health care and that these clinicians must reflect California's diverse racial, ethnic, linguistic, socioeconomic, and geographic diversity;
b) That there are significant economic barriers to entering the health care workforce, as prospective students must take on significant amounts of debt to complete their education;
c) While some educational programs for physicians, nurse practitioners, certified nurse-midwives, and physician assistants do provide didactic instruction in abortion care and miscarriage management, hands-on training to develop proficiency is limited; and,
d) That it is the intent of the Legislature to ensure a diverse pool of health care providers are trained to provide a full range of sexual and reproductive health services, with emphasis on abortion care, by creating and funding a grant program for abortion training and for providers serving medically underserved populations.

EXISTING LAW:

1) Establishes HCAI, (formerly the Office of Statewide Health Planning and Development) to, among other functions, collect, analyze, and publish data regarding healthcare workforce and health professions training, identify areas of health workforce shortages, and provide scholarships, loan repayments, and grants to students, graduates, and institutions providing direct patient care in areas of unmet need.

2) Establishes the Song-Brown Program within HCAI to increase the number of students and residents receiving quality primary care education and training in areas of unmet need throughout California.

3) Establishes the Health Professions Education Fund within HCAI to provide loans to students. Authorizes HCAI to receive private donations and specifies that all money in the fund is continuously appropriated to HCAI.

4) Establishes the health care workforce research and data center within HCAI to serve as the central source of health care workforce and educational data in the state.

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal Committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, reproductive freedom is under assault in this country. California has long been a strong leader in protecting reproductive rights, but many Californians lack access to reproductive care: 40% of California's counties don't have a single abortion provider. The Future of Abortion Council has made myriad suggestions to protect and expand abortion access in California, and this bill will fulfill one of their critical policy recommendations: to create the RHSC in HCAI. A RHSC will improve our healthcare education pipeline by recruiting, training, and retaining a diverse workforce of medical professionals – from Doctors to Nurses to Licensed Midwives – trained in abortion and sexual and reproductive healthcare and assigned to teams in underserved areas across our state. The author states that the RHSC will invest in training our future reproductive healthcare workforce with scholarships, loan repayment, living wage stipends, and vital wrap-around services to ensure that Members can achieve their educational goals. Importantly, the RHSC is dedicated to addressing the systemic barriers that historically excluded populations face. The author concludes that we know how vital it is that medical professionals reflect those they are serving – and these medical professionals will reflect California's diverse racial, ethnic, and linguistic communities.

2) **BACKGROUND.** While abortion is normal and a common healthcare procedure, many healthcare professionals receive little to no training in abortion care during their time as students. Abortion is common and safer than carrying a pregnancy to term. All forms of abortion are safe, and the only limits to safety are limits to access. Abortion is among the most common procedures performed among women. One in four U.S. women will have an abortion in their lifetime: 18% of U.S. pregnancies (excluding miscarriages) end in abortion. Most abortions occur early in pregnancy: nearly 90% in the first 12 weeks. White patients account for 39% of abortion procedures, Black patients 28%, Hispanic patients 25%, and patients of other races and ethnicities 9%.

   a) **Abortion Access in California.** According to a 2017 Guttmacher Institute study, "Abortion Incidence and Service Availability in the United States," one in four women will need an abortion in her lifetime. 40% of California counties do not have an abortion provider, meaning there is a misdistribution of trained providers concentrated in metropolitan areas. Many Californians already struggle to obtain the full spectrum of reproductive health care. The number of providers and clinics providing abortion has declined in recent years and California saw an 18% decline from 2014 to 2017. The number of providers decreases with increasing gestational age: 95% offer abortion to eight weeks, 34% to 20 weeks, and 16% to 24 weeks. Half of the 58 counties in the state lack a facility that provides 400 or more abortions California's gap in access will only get more pronounced when patients from out of state come seeking care**.**

   b) **Abortion training.** Abortion is normal and a common healthcare procedure, yet many healthcare professionals receive no or limited training in abortion care while in school. Only 6% of national family medicine programs guarantee their residents abortion training, and in nursing and midwifery, abortion training is even less accessible. Only 6% of national Family Medicine programs guarantee their residents abortion training, and within nursing, midwifery, and other healthcare professions, abortion training is even less accessible. Nineteen percent of Family Medicine programs in California offer opt-out

abortion training as part of their residency program. California has 64 Family Medicine programs, of those 12 offer opt-out abortion training.

c) **Workforce diversity.** According to the California Future Workforce Commission (Commission), by 2030, communities of color will make up over 65% of California's population, yet they are severely under-represented in the health workforce and educational pipeline. Latinos are California's largest single ethnic group and are projected to reach 41.5% of the population by 2030. Given that these groups will make up the majority of California's working-age population, the Commission notes that action is needed to ensure that more of them become health professionals.

d) **Professional Liability Insurance (malpractice insurance).** This bill requires the RHSC established by this bill to work with CDI to establish a malpractice insurance fund to support its work. Malpractice insurance is essential for healthcare professionals. However, according to a 2011 study in the *American Journal of Public Health*, "Medical Liability Insurance as a Barrier to the Provision of Abortion Services in Family Medicine," the cost and availability of liability insurance is a barrier for those who are trained and want integrate abortion services into their practice, but can't due to the limitations of their insurance policy which will not provide coverage and keeps them from offering this essential form of care. Although abortion and miscarriage management is regularly covered in polices for those who provide obstetrics, it not part of policies for family care, primary care doctors, internists, adolescent medicine and some advanced practitioners. Supplemental insurance, known as a rider, needed for performing first trimester and/or medical abortion, costs approximately $7,000. Factors influencing the premium include: the percentage of the practice that is abortions (the higher the percentage, the higher the premium); relative experience of the physician (the newer the physician, the higher the premium); and, the trimester in which the abortion is performed (if only performing first trimester abortions, the lower the premium).

   Most commonly, malpractice policies are purchased by healthcare facilities or medical practices on behalf of their employees. Universities provide malpractice on behalf of students in order for them to gain hands-on medical/nursing skills in medical facilities and clinical practices.

   In the state of Washington, malpractice insurance is offered by the State as part of the Volunteer and Retired providers program, allowing providers to continue to offer their services to the community as volunteers.

e) **HCAI loan and scholarship programs.** HCAI works to increase and diversify California's healthcare workforce through the Healthcare Workforce Development Division (HWDD) by providing scholarships and loan repayments to health professional students and graduates who provide direct patient care in those communities. Existing loan repayment and scholarship programs at HCAI are as follows:

   i) **Loan repayments programs.** Loan repayment programs offer financial support to health professionals who agree to provide direct patient care in medically underserved areas (for a qualified facility). Eligibility guidelines and criteria vary by program**.** HCAI administers the following loan repayment programs:

(1) Allied Healthcare Loan Repayment Program (AHLRP). AHLRP is funded by the County Medical Services Program (CMSP) Governing Board. Eligible applicants may receive loan repayments of up to $16,000 in exchange for a 12-month service obligation practicing and providing direct patient care at one of the CMSP-contracted provider locations or facilities in any of the 35 CMSP-designated counties.

(2) Bachelor of Science Nursing Loan Repayment Program (BSNLRP). BSNLRP is funded through a $10 surcharge for renewal and licensure fees of Registered Nurses (RNs) in California. Eligible applicants may receive loan repayments of up to $10,000 in exchange for a 12-month service obligation practicing and providing direct patient care in an underserved community. The purpose of this program is to increase the number of appropriately trained RNs providing direct patient care in a qualified facility in California.

(3) SLRP. The SLRP increases the number of primary care physicians, dentists, dental hygienists, physician assistants, nurse practitioners, certified nurse midwives, pharmacists, and mental/behavioral health providers by providing loan repayments to professionals practicing in HPSAs.

(4) County Medical Services Program Loan Repayment (CMSP) Program. The CMSP Loan Repayment Program assists with the repayment of qualified educational loans for primary care healthcare professionals and dentists who provide healthcare services at an approved site located in the 35 CMSP counties.

(5) Licensed Mental Health Services Provider Education Program (LMHSPEP). LMHSPEP is funded through a $20 surcharge for renewal and licensure fees of psychologists, marriage and family therapists, and licensed clinical social workers in California. Eligible applicants may receive loan repayments of up to $15,000 in exchange for a 24-month service obligation practicing and providing direct client care in a publicly funded mental health facility, a nonprofit mental health facility, a mental health professions shortage area, a veteran's, correctional, or a county facility or in the public mental health system. The purpose of this program is to increase the number of appropriately trained mental healthcare professionals providing direct care in a qualified facility in California.

(6) Licensed Vocational Nurse Loan Repayment (LVNLRP). LVNLRP is funded through a $5 surcharge for renewal and licensure fees of Vocational Nurses (LVN) in California. Eligible applicants may receive loan repayments of up to $6,000 in exchange for a 12-month service obligation practicing and providing direct patient care in an underserved community. The purpose of this program is to increase the number of appropriately trained LVNs providing direct patient care in a qualified facility in California.

(7) Steven M. Thompson Physician Corps Loan Repayment Programs (STLRP). STLRP was established in 2003 to increase access to healthcare and promote the retention of primary care physicians in MUAs of California. STLRP is funded through a $25 surcharge for renewal of allopathic physician licenses in California and through the Managed Care Administrative Fines and Penalties Fund. There is an advisory committee of seven members, with two members appointed by the

California Medical Association. Physicians and surgeons can receive up to $105,000 in exchange for providing direct patient care in a MUA for a minimum of three years.

ii) **Scholarship programs.** Scholarship programs though the HWDD provide students with support to finance their education while accepted or enrolled in a health professions program. Students can apply and may be awarded in exchange for a period of direct patient service to a medically underserved community upon completion of their education. These scholarship programs include:

(1) **Allied Healthcare Scholarship Program (AHSP).** AHSP is funded through grants, donations, and special funds. Eligible applicants may receive up to $8,000 in exchange for a 12-month service obligation practicing and providing direct patient care in an underserved community. The purpose of this program is to increase the number of appropriately trained allied professionals providing direct patient care in a qualified facility in California

(2) **Vocational Nurse Scholarship Program (VNSP).** VNSP is funded through a $5 surcharge for renewal and licensure fees of Vocational Nurses (VN) in California. Eligible applicants may receive up to $4,000 in exchange for a 12-month service obligation practicing and providing direct patient care in an underserved community. The purpose of this program is to increase the number of appropriately trained VNs providing direct patient care in a qualified facility in California.

(3) **LVN to Associate Degree Nursing (ADN) Scholarship Program.** LVN to ADN is funded through a $10 surcharge for renewal and licensure fees of RN) in California. Eligible applicants may receive up to $8,000 in exchange for a 12-month service obligation practicing and providing direct patient care in an underserved community. The purpose of this program is to increase the number of appropriately trained nurses providing direct patient care in a qualified facility in California.

(4) **Associate Degree Nursing Scholarship Program (ADNSP).** ADNSP is funded through a $10 surcharge for renewal and licensure fees of RNs in California. Eligible applicants may receive up to $8,000 in exchange for a 12-month service obligation practicing and providing direct patient care in an underserved community. The purpose of this program is to increase the number of appropriately trained nurses providing direct patient care in a qualified facility in California.

(5) **Bachelor of Science Nursing Scholarship Program (BSNSP).** BSNSP is funded through a $10 surcharge for renewal and licensure fees of RNs in California. Eligible applicants may receive up to $10,000 in exchange for a 12-month service obligation practicing and providing direct patient care in an underserved community. The purpose of this program is to increase the number of appropriately trained nurses providing direct patient care in a qualified facility in California.

(6) **Advanced Practice Healthcare Scholarship Program (AHPSP).** AHPSP is funded through grants, donations, and special funds. Eligible applicants may receive up to $25,000 in exchange for a 12-month service obligation practicing and providing direct patient care in an underserved community. The purpose of this program is to increase the number of appropriately trained advanced practice

healthcare professionals providing direct patient care in a qualified facility in California.

f) **The Song-Brown Program**. The Song Brown Program, also housed in HCAI, funds institutions that train primary care health professionals to provide healthcare in California's MUAs. Competitive proposals demonstrate a commitment to Song-Brown goals and demonstrated success in meeting the three statutory priorities: i) attracting and admitting underrepresented groups in medicine and those from underserved communities; ii) training students in underserved areas; and, iii) placing graduates in underserved areas. Gynecology and Obstetric specialties are included in the Song Brown Program.

g) **HPSAs.** The U.S. Department of Health and Human Services uses HPSAs to identify areas, population groups, or facilities within the United States that are experiencing a shortage of health care professionals. There are geographic HPSAs and population HPSAs. Geographic HPSAs have a shortage of services for the entire population within an established geographic area. Population HPSAs have a shortage of services for a specific population subset within an established geographic area. Frequently designated Population HPSAs include people who are Medicaid eligible, low income, migrant farmworkers, Native American or Alaskan Native, and people experiencing homelessness.

h) **MUA/Ps.** MUAs and MUPs identify geographic areas and populations with a lack of access to primary care services. These designations help establish health maintenance organizations or community health centers. MUAs have a shortage of primary care health services within geographic areas such as:

i) A whole county;
ii) A group of neighboring counties;
iii) A group of urban census tracts; or,
iv) A group of county or civil divisions.

MUPs have a shortage of primary care health services for a specific population subset within a geographic area. These groups may face economic, cultural, or language barriers to health care. Some examples include:

i) People experiencing homelessness;
ii) People who are low-income;
iii) People who are eligible for Medicaid;
iv) Native Americans; and.
v) Migrant farm workers.

i) **Primary Care Shortage Areas (PCSAs).** In 2004, the California Healthcare Workforce Policy Commission (Commission) adopted formal criteria for designating PCSAs using primary care physician counts and demographic data. During the June 2019 policy meeting, the Commission voted to modify the criteria to include weighted counts of family nurse practitioners and physician assistants. HCAI refreshed the PCSA designations by applying the updated criteria to the most recently available data. Using the updated criteria and data, the methodology would designate 268 of California's Medical Service Study Areas as PCSAs

j) **Governors budget proposal on health care workforce.** The Budget includes a one-time $1.7 billion investment over three years in care economy workforce development—across both the Labor and Workforce Development Agency (Labor Agency) and California Health and Human Services Agency (CHHSA)—that will create more innovative and accessible opportunities to recruit, train, hire, and advance an ethnically and culturally inclusive health and human services workforce, with improved diversity, wages, and health equity outcomes. The Care Economy investments will be jointly coordinated by the Labor Agency and CHHSA through the CHHSA/ HCAI Health Workforce Education and Training Council.

k) **Governor's 2022 Budget funding proposal for reproductive health.** To protect the right to safe and accessible reproductive health care services, the 2022 Budget proposes a number of actions to maintain and improve availability of these essential services including:

   i) **Increasing Flexibilities.** The Medi-Cal program provides comprehensive family planning and reproductive health services. To increase flexibility for Medi-Cal providers to provide clinically appropriate medication abortion services, the Department of Health Care Services (DHCS) will modify its existing billing requirements to remove requirements for in-person follow up visits and ultrasounds, if not clinically indicated;
   ii) **Family Planning, Access, Care and Treatment (PACT) HPV Vaccine Coverage.** The Budget includes $8 million ($4.6 million General Fund) in 2022-23 and ongoing to add the human papillomavirus vaccine as a covered benefit under the Family PACT program, effective July 1, 2022;
   iii) **Clinical Infrastructure.** To support California's clinical infrastructure of reproductive health care services, the Budget includes one-time funding of $20 million General Fund within HCAI to provide scholarships and loan repayments to a variety of health care provider types that commit to providing reproductive health care services;
   iv) **Capital Infrastructure.** The Budget includes one-time funding of $20 million in grant funding to HCAI to assist reproductive health care facilities in securing their physical and information technology infrastructure and to enhance facility security; and,
   v) **Covered California Subsidies.** The Budget includes $20 million General Fund in 2022-23 for Covered California to support the One-Dollar Premium Subsidy program which subsidizes the cost of Covered California consumers for health plans due to federal policy concerning abortion coverage.

3) **SUPPORT.** Training in Early Abortion for Comprehensive Healthcare (TEACH) is the sponsor of this bill and states that it will fund the development of abortion training within schools, clinical sites, and training programs to build their capacity to provide hands-on abortion training, miscarriage management, and sexual and reproductive healthcare curriculum, allowing for full integration of these services as essential parts of primary and reproductive healthcare. TEACH states that by creating an innovative malpractice insurance fund, this bill will allow existing providers, recent graduates, and retirees to continue to teach, train, and provide comprehensive, equitable healthcare to California's underserved communities.

The California Nurse Midwives Association states in support of this bill, that while abortion is normal and a common healthcare procedure, many healthcare professionals receive little to no training in abortion care during their time as students. Without diverse and sustained educational and training pathways, California's workforce of healthcare professionals cannot acquire the necessary skills to refer, counsel, educate or provide comprehensive sexual and reproductive healthcare, including abortion care to underserved communities in California.

4) **OPPOSITION.** The California Catholic Conference (CCC) is opposed to this bill and states that nationally, most low-income people identify as prolife, and 68% of Latinos and African Americans support restricting abortion to the first trimester or ending it entirely. Clinicians from these communities do not want to perform abortions and should not be coerced into abortion training against their consciences, with their scholarships hanging in the balance. CCC states that there is no lack of access to abortion in California. The state already funds abortions through tax dollars, with over 400 facilities performing abortions, and abortions offered by nurse practitioners, nurse midwives, physician assistants, via telehealth, on college campuses, and through a dozen sources by mail. On the other hand, doctors in overwhelmed metros like Riverside, LA, and Sacramento are assisting at hundreds of births per year, while several rural California counties have no obstetrician or gynecologist at all. CCC concludes that women in maternity care deserts and HRSAs don't need more abortion providers, but more doctors who can safely deliver their infant.

5) **RELATED LEGISLATION.**

a) AB 1666 (Bauer-Kahan) declares that a law of another state that authorizes a person to bring a civil action against a person who receives or seeks, performs or induces, or aids or abets the performance of an abortion is contrary to the public policy of this state. AB 1666 is pending a vote on the Assembly Floor.

b) AB 2091 (Mia Bonta) prohibits compelling a person to identify or provide information that would identify an individual who has sought or obtained an abortion in a state, county, city, or other local criminal, administrative, legislative, or other proceeding. AB 2091 is pending a hearing in the Assembly Judiciary Committee.

c) AB 2134 (Akilah Weber) establishes the California Reproductive Health Equity Program within HCAI to ensure abortion and contraception services are affordable for and accessible to all patients and to provide financial support for safety net providers of these services. AB 2134 is pending a hearing in the Assembly Health Committee.

d) AB 2223 (Wicks) prohibits a person from being subject to civil or criminal liability, or otherwise deprived of their rights, based on their actions or omissions with respect to their pregnancy or actual, potential, or alleged pregnancy outcome or based solely on their actions to aid or assist a pregnant person who is exercising their reproductive rights. AB 2223 is pending a hearing in the Assembly Health Committee.

e) AB 2320 (C. Garcia), requires, until January 1, 2028, DHCS, to establish and administer a pilot program to direct funds to community health clinics that provide reproductive health care services in five counties that agree to participate. AB 2320 is pending a hearing in the Assembly Health Committee.

f) SB 245 (Lena Gonzalez) Chapter 11, Statutes of 2022, eliminates cost sharing in abortion services.

g) SB 1142 (Caballero and Skinner) requires CHHSA, or an entity designated by the agency, to establish an internet website where the public can find information on abortion services in California. Requires CHHSA to also develop, implement, and update as necessary, a statewide educational and outreach campaign to inform the public on how to access abortion services in the state. SB 1142 is pending a hearing in the Senate Health Committee.

6) PREVIOUS LEGISLATION. SB 1301 (Sheila Kuehl), Chapter 385, Statutes of 2002, enacts the Reproductive Privacy Act, which provides that every individual possesses a fundamental right of privacy with respect to reproductive decisions, including the fundamental right to choose or refuse birth control, and the fundamental right to choose to bear a child or obtain an abortion.

7) DOUBLE REFERRAL. This bill is double referred; upon passage in this Committee, this bill will be referred to the Assembly Committee on Higher Education.

8) SUGGESTED AMENDMENTS.

a) Workplace conduct. This bill requires the RHSC to create a process for scholars to report unlawful workplace conduct. However the approved location where the scholar is working should have its own policies in place, and neither the RHSC or HCAI would have first-hand knowledge of the alleged conduct, potentially opening the state up liability. This bill also states the scholar employed at a corps approved site is subject to the personnel system of that entity, making the first provision duplicative. The Committee may wish to strike the requirement for RHSC to create a process to unlawful workplace conduct to RHSC from the bill

b) Malpractice insurance. This bill requires the RHSC established by this bill to work with CDI to establish a malpractice insurance fund to support its work. The language requiring the CDI to "work with" the RHSC to establish a fund for medical malpractice insurance is extremely vague, and could be interpreted to mean that CDI is actively involved in the financial responsibility for managing a large fund; creating policy coverage, limits, exclusions; and administering claims. Essentially, this is running an insurance company, which would be an extensive undertaking and most likely constitutes a conflict of interest. The Committee may wish to strike this requirement from the bill.

c) Term of service. As currently drafted, this bill authorizes the RHSC to determine what is an "appropriate term of obligated service." The Committee may wish to amend this bill to require the term of obligated service to be three years.

d) Reporting requirements. This bill requires HCAI to conduct an evaluation five years after implementation to assess the impact and effectiveness of the RHSC. The Committee may wish to amend this bill to require the report to also include the number of applicants to the RHSC, and how many awardees do not meet their service requirement, by provider type.

9) POLICY COMMENTS.

a) SLRP not appropriate entity to oversee the RHSC. The SLRP is a federally funded program and has limitations imposed on the types of clinicians and the types of practice settings HCAI is allowed to award. Therefore, requiring the SLRP to administer the RHSC would limit the types of clinicians this bill aims to assist. The activities included in this bill are broad, and there are several existing HCAI workforce programs that could be used to implement the bill provisions. This includes the Steven Thompson Physician Loan Repayment Program, Allied Healthcare Loan Repayment/Scholarship Program, Nursing Loan Repayment/Scholarship Program, and Advanced Practice Scholarship Program. The author should work with HCAI to identify the appropriate entity to administer the RHSC.

b) Additional stipends for living expenses. This bill requires RHSC to offer scholars stipends or reimbursement for childcare, eldercare, housing, health care coverage with coverage for mental health services, and transportation to eliminate known obstacles of educational completion for scholars. State loan and scholarship programs do not traditionally cover these types of expenses, and it is unclear how the RHSC would decide what is a valid expense, how to track them, or, in the event a scholar did not finish their "service obligation" how, or whether, the money would be returned to the RHSC. The author may wish to work with HCAI to clarify this process moving forward.

REGISTERED SUPPORT / OPPOSITION:

Support

Training in Early Abortion for Comprehensive Healthcare (sponsor)
Access Reproductive Justice
Actions
American College of Obstetricians and Gynecologists District IX
American Nurses Association/California
Black Women for Wellness Action Project
California Academy of Family Physicians
California Latinas for Reproductive Justice
California Nurse Midwives Association
Citizens for Choice
Essential Access Health
NARAL Pro-Choice California
National Council of Jewish Women- San Francisco Bay Area Section
National Health Law Program
Nurses for Sexual & Reproductive Health
Physicians for Reproductive Health
Planned Parenthood Affiliates of California
Reproductive Health Access Project
Urge: Unite for Reproductive & Gender Equity
Women's Foundation California
Women's Health Specialists

Opposition

California Catholic Conference
Right to Life League

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