Date of Hearing: April 29, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1386 (Bains) – As Introduced February 21, 2025

SUBJECT: Health facilities: perinatal services.

SUMMARY: Requires, beginning on an unspecified date, perinatal services to be included as a required basic hospital service. Requires, on or before an unspecified date, the Department of Public Health (DPH) to establish a process to approve or deny a "perinatal service compliance plan" to meet the requirement to provide perinatal services. Requires, on or before an unspecified date, any general acute care hospital (GACH) that does not provide perinatal services to submit a perinatal service compliance plan to DPH, with specified information. Specifically, **this bill**:

1) Requires, beginning _____, perinatal services to also be considered a basic service.

2) Requires, on or before ____, DPH to establish a process to approve or deny a "perinatal service compliance plan" to meet the requirement to provide perinatal services. Requires on or before ____, any GACH that does not provide perinatal services to submit a "perinatal service compliance plan" to DPH including, at a minimum, all of the following:

   a) Maintenance of written transfer agreements with one or more GACHs that provide perinatal services;

   b) A financial report demonstrating the hospital's lack of financial capacity to establish perinatal services;

   c) A description of measures taken to establish perinatal services at the hospital; and,

   d) Other requirements, as determined by DPH.

EXISTING LAW:

1) Licenses and regulates hospitals, including GACHs, by DPH. Permits GACHs, in addition to the basic services all hospitals are required to offer (medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services), to be approved by DPH to offer special services, including, among other services, an emergency department (ED) and maternity services. [Health and Safety Code [HSC] § 1250 and § 1255, *et seq*.]

2) Defines supplemental service to mean an organized inpatient or outpatient service which is not required to be provided by law or regulation. [Title 22, California Code of Regulations, § 70067]

3) Requires a hospital, not less than 120 days prior to eliminating a supplemental service of either an inpatient psychiatric unit or a perinatal unit, to provide public notice of the proposed elimination of the supplemental service, including a notice posted at the entrance to all affected facilities, a notice to all contracted Medi-Cal managed care plans, and a notice to DPH and the board of supervisors of the county in which the hospital is located. Requires the health facility to conduct at least one noticed public hearing within 60 days of providing public notice of the proposed elimination of the supplemental service. [HSC § 1255.25(a)(3)]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, California is facing a maternal health crisis, exacerbated by the alarming trend of hospital maternity ward closures. The author states that this bill is a critical piece of legislation that ensures all communities have access to essential perinatal care by requiring GACHs to maintain maternity services as a basic health care offering. The closure of maternity wards disproportionately affects low-income families and communities of color, forcing expectant mothers to travel long distances for care or rely on emergency rooms ill-equipped for childbirth. Research consistently shows that access to comprehensive maternity care reduces complications, premature births, and maternal mortality—outcomes that are essential for the well-being of California families. The author concludes that this bill not only safeguards maternal and infant health but also strengthens our health care system by supporting the labor and delivery workforce.

2) **BACKGROUND.** In the past decade, more than 50 labor and delivery wards have closed in California hospitals. As a result, large areas of California are without access to birthing facilities or maternity care providers. The absence of access to maternity care has disproportionally impacted California's low-income, Black, Latinx, and Indigenous populations, and those living in rural communities. When maternity wards close, particularly in rural counties, birthing people receive less prenatal care and rates of preterm birth increase. Currently, twelve California counties, most of them rural, do not have any hospitals delivering babies.

   a) **Perinatal units.** With some exceptions, GACHs are required to provide eight basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary. Beyond these basic services, hospitals can be authorized to offer supplemental services, including outpatient services such as emergency services, or inpatient services such as intensive care, cardiovascular surgery, psychiatric units, and perinatal units, among other supplemental services.

      Perinatal units are defined in regulations as a maternity and newborn service of the hospital for the provision of care during pregnancy, labor, delivery, postpartum, and neonatal periods with appropriate staff, space, equipment and supplies. The regulations pertaining to perinatal units establish a number of staffing requirements, including the following:

      i) A physician certified or eligible for certification by the American Board of Obstetrics and Gynecologists or the American Board of Pediatrics must have overall responsibility of the unit. If a physician with those qualifications is not available, a physician with training and experience in obstetrics and gynecology or pediatrics is permitted to administer the service, while a physician with the necessary qualifications provides consultation at a frequency that will assure high quality service;

      ii) The physician must be responsible for providing continuous obstetric, pediatric, anesthesia, laboratory, and radiologic coverage, among other requirements;

iii) One registered nurse on duty on each shift must be assigned to the labor and delivery suite, with sufficient additional trained personnel to assist the family, monitor and evaluate labor and assist with the delivery;

iv) One registered nurse must be on duty for each shift assigned to the antepartum and postpartum areas; and,

v) A registered nurse who has had training and experience in neonatal nursing must be responsible for the nursing care in the nursery.

b) Recent increase in maternity unit closures. On November 15, 2023, *CalMatters* published an investigative report focusing on the increase in maternity unit closures in California, titled "*As Hospitals Close Labor Wards, Large Stretches of California Are Without Maternity Care*." According to this report, from 2012 to 2019, at least 19 hospitals stopped offering labor and delivery services (six of those were because the hospitals closed completely). In an acceleration, 16 more closed maternity services from 2020 to 2022. By the time of publication, 11 more had announced maternity closures in 2023, including one hospital that closed completely (Madera Community Hospital). CalMatters reported that after El Centro Regional Medical Center closed its maternity service in January of 2023, Imperial County was left with only one hospital doing births for the approximately 2,500 babies born every year in Imperial County. In total, according to CalMatters analysis, at least 46 California hospitals have shut down or suspended labor and delivery since 2012, and 27 of those have taken place in the last three years. Twelve rural counties do not have any hospitals delivering babies, and Latino and low-income communities have been hit hardest by losses. CalMatters noted that the closures come as the country and state contend with a maternal mortality crisis, with pregnancy-related deaths reaching a ten-year high in 2020 in California.

The CalMatters report stated that hospital administrators cite a number of reasons for the closures, including high costs, labor shortages, and declining birth rates. In the past 30 years, the number of births have dropped by half in California, and the birth rate is at its lowest level on record. CalMatters noted that the trend is not unique to California, with labor and delivery units closing across the country. Many closures result from hospital systems consolidating maternity care into one location, which hospitals argue can help maintain staff training and provide a higher level of care. According to CalMatters, labor and delivery units are often the second-most expensive department for hospitals to run, second only to emergency rooms. The report quoted a health researcher as stating that obstetrics units are often unprofitable for hospitals to operate.

c) Maternity care in California. According to the California Health Care Foundation's 2023 Health Care report, "Maternity Care in California," access to quality maternal care is essential for positive birth outcomes. In California, 46,000 women age 15 to 44 live in counties with no hospitals with obstetrics care or birth centers, and an additional 76,000 live in counties with only one hospital with obstetrics care or a birth center. Fifty-one thousand women age 18 to 44 live in counties with fewer than 29 obstetricians or certified nurse midwives per 10,000 births.

In 2021, births to Latina/x mothers and birthing people made up nearly half of all births in the state, at just under 200,000 births. About three in 10 births in California were to mothers or birthing people born outside the US.

California's pregnancy-related mortality rate has fluctuated since 2009. It increased by 45% from 2019 to 2020, possibly due to COVID-19. About one in four deaths occurred on the day of delivery between 2018 and 2020. A recent Centers for Disease Control and Prevention analysis found that more than four in five pregnancy-related deaths were preventable. Between 2009 and 2020, the pregnancy-related mortality rate for Black mothers and birthing people was three to four times higher than the rate for mothers and birthing people of other races/ethnicities. This variation cannot be explained by factors such as age, income, education, and health insurance coverage. Research shows that implicit bias and racism are key causes of disparate outcomes for Black mothers and birthing people.

d) Nine Basic Services? As noted in existing law, and a) of the Background, above, hospitals are required to provide eight basic services. This bill would add perinatal services as a basic service at a date uncertain and would require DPH to define criteria for hospitals' compliance plans. This would require DPH to promulgate regulations through the standard regulations process, which DPH estimates would take about three years to complete. If a hospitals' compliance plan was not approved, DPH would most likely require the hospital to submit a plan of correction detailing how it planned to meet the compliance plan requirement. If DPH did not approve the hospital's plan of correction, or a subsequently revised compliance plan, the hospital would be required to provide perinatal services. Since this bill would make perinatal services a required basic service, DPH would be compelled to suspend or revoke the license of the hospital if it did not provide the service and did not have an exemption.

DPH would also need to revise its licensure and re-licensure surveys to reflect the addition of perinatal services to the required basic services. DPH would inspect a hospitals' perinatal service during all periodic surveys.

3) SUPPORT. The California Nurses Association/National Nurses United (CNA) is the sponsor of this bill and states that hospitals are the backbone of comprehensive perinatal services in our communities, providing specialized expertise, staffing, and resources to manage high-risk pregnancies and to handle complications during the birthing process. Yet, there are no guardrails to ensure all communities have access to basic and essential maternity services. Despite nearly 98% of all births in California occurring in a hospital, perinatal services are considered only a supplemental service and consequently not protected under state law. CNA contends that the lack of statutory protections for perinatal services has allowed hospitals to selectively close these vital services based on profit maximization and that the result has been a systemic erosion of hospital-based maternity care in California, disproportionately affecting vulnerable populations and exacerbating health disparities.

CNA argues that the burden of hospital maternity service closures has fallen most heavily on low-income families, rural communities, and communities of color, with closures primarily of for-profit hospitals that predominantly service low-income Black and Latino communities. The closure of hospital maternity wards in California's rural communities has led to increased travel distances for expectant mothers, with 6.4% of women in the state residing more than 30 minutes away from a birthing hospital. CNA points to research that shows that there is a direct correlation between obstetric unit closures and increased rates of severe maternal morbidity, particularly for Black and Latino mothers. Black women in California already face a maternal mortality rate nearly four times higher than their white counterparts, and the

elimination of hospital-based maternity services only deepens these inequities. This pattern of closures has effectively created a two-tiered system of maternity care, where wealthier communities retain access to hospital-based perinatal services while low-income and rural communities – predominantly communities of color – are left to navigate a landscape of diminished and fragmented care, a form of medical redlining that endangers the lives of mothers and infants.

CNA states that this bill seeks to correct the crisis in access to comprehensive maternity care by reclassifying perinatal services as a mandatory component of hospital care under current law. For GACHs that currently provide perinatal services, this bill would require that the hospital maintains these services as a basic service. Hospitals that have closed their labor and delivery units, or do not currently provide these services, must submit a compliance plan to DPH detailing solutions to ensure continued access to maternity care. CNA concludes that this bill will hold hospitals accountable to their communities and prevent financially-motivated decisions to close maternity services that come at the expense of maternal and infant health.

4) **OPPOSE UNLESS AMENDED.** The California Hospital Association (CHA) is opposed to this bill unless it is amended and states that three primary factors are behind California's reduced capacity for hospital deliveries: lower birth volume, workforce shortages, and hospitals' financial instability. CHA argues that this bill, which would require perinatal services (those provided by Labor & Delivery (L&D) units) to be offered at all California hospitals, fails to acknowledge any of these factors.

   CHA contends that maintaining labor and L&D services is particularly challenging in areas with low birth volumes and significant workforce shortages. Many regions in California — especially lower-income communities — face a severe lack of OB/GYNs, with eight counties having no licensed OB/GYNs at all. These workforce constraints make it difficult — especially for hospitals facing significant financial distress — to ensure the specialized, around-the-clock staffing needed to safely operate an L&D unit.

   CHA notes that when considering solutions to maintaining L&D services in hospitals, any approach must address the factors underlying access challenges and recognize that every community is unique and requires a resolution tailored to its needs. Legislation requiring every hospital to open a labor and delivery unit is not feasible and would only come at the cost of other services being cut — especially for the more than 50% of California hospitals that lose money every day caring for patients.

   CHA has offered amendments, including:

   a) The establishment of a statewide Obstetrical Coverage Program and a Statewide Obstetrical Nurse Staffing Pool to ensure equitable access to specialized care in communities unable to support an OB/GYN practice or hospital-based maternity unit; and,

   b) Requirements that health plans, including all Medi-Cal managed care plans, reimburse GACHs for perinatal services at rates sufficient to cover direct and indirect costs of providing those services.

5) RELATED LEGISLATION.

a) SB 32 (Weber Pierson) would require, on or before July 1, 2027, the Department of Managed Health Care, the Department of Insurance, and the Department of Health Care Services (DHCS) to consult together and with stakeholders to develop and adopt standards for the geographic accessibility of perinatal units to ensure timely access for enrollees and insureds, as specified. The bill's provisions would become inoperative on July 1, 2033, and be repealed on January 1, 2034. SB 32 is currently pending in the Senate Health Committee.

b) SB 669 (McGuire) would establish a 5-year pilot project to allow critical access and individual and small system rural hospitals to establish standby perinatal medical services, as defined. The bill would require a hospital, to qualify for participation in the pilot project, to meet specified requirements, including, among others, that the hospital (1) be greater than 60 minutes from the nearest hospital providing full maternity services, (2) not have closed a full maternity or labor and delivery department within the past 3 years, and (3) agree to provide routine labor and delivery services or have an agreement with a freestanding birth center. SB 669 is pending in the Senate Health Committee.

6) PREVIOUS LEGISLATION.

a) AB 1895 (Weber) of 2024 would have required a GACH that operates a perinatal unit and determines those services are at risk of closing in the next six months to report specified information to the Department of Health Care Access and Information (HCAI). Would have required HCAI, DPH, and DHCS to assess the potential impact to the community and develop recommendations for how to resolve the perinatal units' challenges. AB 1895 was vetoed by Governor Newsom, who stated in part, "…current law already requires hospitals to provide public notice in advance of a supplemental service elimination, and much of the information in the proposed community impact report is duplicative. Further, this bill creates costly administrative burdens for the state that are unlikely to change hospitals' business decisions."

b) SB 1300 (Cortese), Chapter 894, Statutes of 2024, extends the public notice requirement, when a health facility eliminates or closes either inpatient psychiatric services or perinatal services, from 90 days prior to elimination of the service to 120 days; expands the notice of closure to include data on the patients served and a justification for the decision to eliminate services; and requires the hospital to hold a public hearing within 60 days of providing the notice.

c) Senate Bill 413 (Beilenson), Chapter 1201, Statutes of 1973, among other provisions, established standards for licensure of GACHs, including the 8 basic services a hospital is required to maintain.

7) POLICY COMMENT. As noted by the author, sponsors, and opposition to this bill, access to maternity care in California is rapidly decreasing, placing birthing people in immediate jeopardy of adverse outcomes. While agreement on the scope of the problem is universal, proposed solutions differ widely. Making the conversations even more difficult, the State is facing a potential budget shortfall in the billions of dollars, not even accounting for looming federal cuts to health care spending. Moving forward, the stakeholders are encouraged to engage in long-term and meaningful conversations as to how access to safe birthing options

in California can be preserved, and even expanded, in creative and cost effective ways. The author is also encouraged to engage with stakeholders to establish an implementation date for the bill that promotes safe and accessible maternal care.

REGISTERED SUPPORT / OPPOSITION:

Support

California Nurses Association/National Nurses United (sponsor)
Black Women for Wellness Action Project
California Federation of Labor Unions, AFL-CIO
California Pan - Ethnic Health Network

Opposition

None on file

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