California State Assembly

BUSINESS AND PROFESSIONS

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AGENDA

Tuesday, April 1, 2025
9:30 a.m. -- 1021 O Street, Room 1100

ADOPTION OF COMMITTEE RULES

BILLS HEARD IN FILE ORDER

1.	AB 50	Bonta	Pharmacists: furnishing contraceptives.(Urgency)
2.	AB 481	Blanca Rubio	Healing arts: clinical laboratories: personnel.
3.	AB 489	Bonta	Health care professions: deceptive terms or letters: artificial intelligence.
4.	AB 511*	Chen	Radiologist assistants.
5.	AB 516*	Kalra	Registered veterinary technicians and veterinary assistants: scope of practice.
6.	AB 521*	Carrillo	Contractors State License Board: bond deposits: liability for legal fees and costs.
7.	AB 529*	Ahrens	Pharmacy: declared state of emergency.
8.	AB 559*	Berman	Professions and vocations: contractors: home improvement contracts: prohibited business practices.
9.	AB 586*	Flora	Professional fiduciaries.
10.	AB 631	Lee	Animals: animal shelters: transparency.
11.	AB 659*	Berman	Master of Divinity: physician and surgeon: title.
12.	AB 686*	Berman	Cannabis: appointees: prohibited activities.
13.	AB 867	Lee	Veterinary medicine: cat declawing.
14.	AB 1082	Flora	Nursing: students in out-of-state nursing programs.
15.	AB 1307	Ávila Farías	Licensed Dentists from Mexico Pilot Program.

** Proposed for Consent*

Date of Hearing: April 1, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 50 (Bonta) – As Introduced December 2, 2024

NOTE: This bill is double referred and if passed by this Committee will be re-referred to the Assembly Committee on Health.

SUBJECT: Pharmacists: furnishing contraceptives.

SUMMARY: Expressly authorizes a pharmacist to furnish over-the-counter contraceptives without having to comply with the standardized procedures or protocols that are required for prescription-only hormonal contraceptives.

EXISTING LAW:

1) Prohibits a licensee of a healing arts board from obstructing a patient in obtaining a legally prescribed or ordered drug or device, including emergency contraception drug therapy and self-administered hormonal contraceptives. (Business and Professions Code (BPC) § 733)

2) Authorizes a physician and surgeon, registered nurse, certified nurse-midwife, nurse practitioner, physician assistant, or pharmacist to, within their respective scopes, use a self-screening tool to identify patient risk factors for the use of self-administered hormonal contraceptives by a patient, and, after an appropriate prior examination, prescribe, furnish, or dispense self-administered hormonal contraceptives to that patient. (BPC § 2242.2)

3) Establishes the Pharmacy Law. (BPC §§ 4000 *et seq.*)

4) Establishes the California State Board of Pharmacy (BOP) to administer and enforce the Pharmacy Law, comprised of seven pharmacists and six public members. (BPC § 4001)

5) Defines "pharmacist" as a person to whom a license has been issued by the BOP which is required for any person to manufacture, compound, furnish, sell, or dispense a dangerous drug or dangerous device, or to dispense or compound a prescription. (BPC § 4036)

6) Declares that "pharmacy practice is continually evolving to include more sophisticated and comprehensive patient care activities." (BPC § 4050)

7) Authorizes a pharmacist to initiate a prescription and provide clinical advice, services, information, or patient consultation, as long as the following conditions are met:

   a) The clinical advice, services, information, or patient consultation is provided to a health care professional or to a patient.

   b) The pharmacist has access to prescription, patient profile, or other relevant medical information for purposes of patient and clinical consultation and advice.

   c) Access to medical information and record is secure from unauthorized access.

   (BPC § 4051)

8) Authorizes a pharmacist to do all of the following, among other permissible activities, as part of their scope of practice:

   a) Provide consultation, training, and education to patients about drug therapy, disease management, and disease prevention.

   b) Provide professional information, including clinical or pharmacological information, advice, or consultation to other health care professionals, and participate in multidisciplinary review of patient progress, including appropriate access to medical records.

   c) Order and interpret tests for the purpose of monitoring and managing the efficacy and toxicity of drug therapies in coordination with the patient's provider or prescriber.

   d) Administer immunizations pursuant to a protocol with a prescriber.

   e) Furnish emergency contraception drug therapy, self-administered hormonal contraceptives, HIV preexposure and postexposure prophylaxis, and nicotine replacement products, subject to specified requirements.

   f) Administer drugs and biological products that have been ordered by a prescriber.

   (BPC § 4052)

9) Authorizes a pharmacist to furnish an approved opioid antagonist in accordance with standardized procedures or protocols developed and approved by the BOP and the Medical Board of California, in consultation with stakeholders. (BPC § 4052.01)

10) Authorizes a pharmacist to initiate and furnish preexposure prophylaxis. (BPC § 4052.02)

11) Authorizes a pharmacist to initiate and furnish postexposure prophylaxis. (BPC § 4052.03)

12) Authorizes a pharmacist to perform the following procedures or functions in certain licensed health care facility in accordance with policies, procedures, or protocols developed by health professionals, including physicians, pharmacists, and registered nurses, with the concurrence of the facility administrator:

   a) Ordering or performing routine drug therapy-related patient assessment procedures including temperature, pulse, and respiration.

   b) Ordering drug therapy-related laboratory tests.

   c) Administering drugs and biologicals by injection pursuant to a prescriber's order.

   d) Initiating or adjusting the drug regimen of a patient pursuant to an order or authorization made by the patient's prescriber and in accordance with the policies, procedures, or protocols of the licensed health care facility.

   (BPC § 4052.2)

13) Authorizes a pharmacist to furnish self-administered hormonal contraceptives in accordance with standardized procedures or protocols developed and approved by both the BOP and the Medical Board of California (MBC) in consultation with the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association, and other appropriate entities, and sets additional requirements for the furnishing of self-administered hormonal contraceptives by pharmacists. (BPC § 4052.3)

14) Authorizes a pharmacist to perform skin puncture in the course of performing routine patient assessment procedures. (BPC § 4052.4)

15) Authorizes a pharmacist to initiate, adjust, or discontinue drug therapy for a patient under a collaborative practice agreement with any health care provider with appropriate prescriptive authority. (BPC § 4052.6)

16) Authorizes a pharmacist to independently initiate and administer any vaccine that has been approved or authorized by the federal Food and Drug Administration (FDA) and received a federal Advisory Committee on Immunization Practices individual vaccine recommendation published by the federal Centers for Disease Control and Prevention for persons three years of age and older. (BPC § 4052.8)

17) Authorizes a pharmacist to furnish nicotine replacement products for use by prescription only in accordance with standardized procedures and protocols developed and approved by both the BOP and the Medical Board of California in consultation with other appropriate entities and provide smoking cessation services, under certain conditions. (BPC § 4052.9)

18) Authorizes a pharmacist to furnish up to a 12-month supply of an FDA-approved, self-administered hormonal contraceptive at the patient's request under protocols developed by the BOP. (BPC § 4064.5)

19) Enacts the Contraceptive Equity Act of 2022, which requires specified group health care service plan contracts to include coverage for certain forms of contraception, including point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs, devices, and products at in-network pharmacies without cost-sharing or medical management restrictions. (Health and Safety Code § 1367.25)

THIS BILL:

1) Explicitly allows for a pharmacist to furnish over-the-counter contraceptives in addition to contraceptives requiring a prescription.

2) Clarifies that current law requiring pharmacists to comply with the BOP's standardized procedures or protocols for furnishing self-administered hormonal contraceptives applies only to contraceptives requiring a prescription.

3) Declares that in order to quickly ensure equitable access to over-the-counter birth control for all Californians, it is necessary for the bill to take effect immediately.

FISCAL EFFECT: Unknown; this bill is keyed fiscal by the Legislative Counsel.

COMMENTS:

Purpose. This bill is co-sponsored by *Essential Access Health*, *National Health Law Program*, and *Birth Control Pharmacist*. According to the author:

> AB 50 advances reproductive equity by ensuring Medi-Cal enrollees can access over-the-counter (OTC) contraceptives like O-Pill without a prescription, aligning coverage with private insurance. Despite state laws requiring OTC contraceptive coverage, Medi-Cal only covers OTC contraceptives if prescribed, creating barriers that private insurance holders do not face. Research highlights significant barriers that low-income women face in accessing contraception, including prescription requirements, cost concerns, and limited availability. These challenges contribute to inconsistent contraceptive use and higher rates of unintended pregnancies. Everyone deserves equal access to contraception, regardless of income or insurance type. By eliminating prescription requirements, AB 50 makes birth control more accessible to low-income communities, reducing disparities in reproductive healthcare.

Background.

California State Board of Pharmacy. The BOP is the regulatory body within the Department of Consumer Affairs responsible for overseeing the practice of pharmacy in California. The BOP is currently estimated to regulate over 50,700 pharmacists, 1,300 advanced practice pharmacists, 4,400 intern pharmacists, and 65,700 pharmacy technicians across a total of 32 licensing programs. In addition to regulating professionals, the BOP oversees and licenses pharmacies, clinics, wholesalers, third-party logistic providers, and automated drug delivery systems.

Pharmacist Scope of Practice. California has long faced significant gaps and inequities in its health care workforce. There has historically been a persistent shortage of accessible health professionals overall, which disproportionately impacts communities with concentrated populations of immigrant families and people of color. A recent study found that between 2010 and 2019, the number of primary care physicians in proportion to population remained largely unchanged nationally. Meanwhile, counties with a higher proportion of minorities saw a decline during that period.

In response to these challenges, policymakers have repeatedly turned to pharmacists to help fill the provider gap in parts of the state where primary care providers can be inaccessible but local pharmacies are more readily available. Exercising their training and judgment, pharmacists are often relied upon to administer vaccines, furnish time-sensitive medication, and ensure that there is no delay in care. In 2013, the Legislature enacted Senate Bill 493 (Hernandez), which established an advanced practice pharmacist license and expanded the scope of practice for pharmacists to include additional acts, including independently furnishing specified nicotine replacement products, prescription medications for travel, and hormonal contraceptives.

During the BOP's prior sunset review in 2020-2021, the Committees discussed whether there should be consideration of the BOP transitioning to a standard of care model for pharmacy practice. The BOP established a Standard of Care Ad Hoc Committee, which convened seven meetings and subsequently submitted a report to the Legislature with its findings and recommendations. The BOP concluded that California patients would benefit from pharmacists gaining additional independent authority to provide patient care services, not limited to the traditional dispensing tasks performed at licensed facilities, consistent with their respective education, training, and experience.

The BOP further recommended revisions to certain provisions detailing a pharmacist's authorized scope of practice for specified clinical patient care services and transition to a standard of care model for specified patient care services, where sufficient safeguards are in place to ensure pharmacists retain autonomy to utilize professional judgment in making patient care decisions. Under those conditions, the BOP believes that transitioning to greater use of a standard of care model in the provision of specified patient care services could benefit patients by providing expanded and timely access to patient care. The BOP's Licensing Committee has developed a legislative proposal that would transition many provisions of pharmacist care to a standard of care model in lieu of the current prescriptive model established. As an example, under the BOP's proposed language, a pharmacist would retain the ability to provide hormonal contraception, but would follow a standard of care approach, in lieu of following prescriptive rules established in the BOP's regulation.

Over-the-Counter Contraceptives. In July 2023, the FDA announced its approval of the medication Opill, a norgestrel tablet to prevent pregnancy. Opill was the first daily oral contraceptive approved for use in the United States without a prescription, significantly increasing access by allowing patients to purchase oral contraceptive medicine at local pharmacies over-the-counter. This approval significantly increased availability and access to birth control for women and other patients seeking to prevent pregnancy.

However, the over-the-counter status of Opill has complicated the implementation of related efforts to increase access to contraception, specifically those related to health coverage and reimbursement. In 2022, the Legislature enacted Senate Bill 523 (Leyva), which requires a health care service plan or health insurer to provide point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs, devices, and products at in-network pharmacies without cost sharing or medical management restrictions. Because Medi-Cal generally requires a prescription to reimburse for medications, even those approved as over-the-counter by the FDA, patients are not able to take advantage of this legislation when accessing Opill directly from a pharmacy.

Pharmacists are already authorized to furnish self-administered hormonal contraception, including those requiring a prescription. However, they must do so in accordance with standardized procedures and protocols that can present a barrier to access for patients. To resolve this issue, this bill would clarify that a pharmacist may furnish over-the-counter contraceptives without the standardized procedures or protocols required for prescription-only medications. While the BOP's proposal to transition pharmacy practice to a standard of care model for the practice of pharmacy represents an alternative solution to this issue, this bill would more directly ensure that patients can take advantage of laws intended to ensure access to over-the-counter contraceptives like Opill without imposing the same restrictions and requirements on pharmacists that apply for more serious prescription-only medications.

Current Related Legislation. AB 1503 (Committee on Business and Professions) is the BOP's current sunset review vehicle. *This bill is pending in this committee.*

AB 260 (Aguiar-Curry) would prohibit the BOP from disciplining a pharmacist for dispensing mifepristone or similar drugs. *This bill is pending in the Assembly Committee on Health.*

Prior Related Legislation. SB 524 (Caballero) of 2023 would have authorized a pharmacist to furnish prescription medications pursuant to the result from a test performed by the pharmacist that is used to guide diagnosis or clinical decisionmaking. *This bill died on the Senate Committee on Appropriations suspense file.*

SB 523 (Leyva), Chapter 630, Statutes of 2022 established the Contraceptive Equity Act of 2022, which required a health plan or insurer to provide point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs at in-network pharmacies without cost-sharing.

AB 1064 (Fong), Chapter 655, Statutes of 2021 expanded the authority of a pharmacist to initiate and administer immunizations.

SB 159 (Wiener), Chapter 532, Statutes of 2019 authorized a pharmacist to initiate and furnish HIV preexposure prophylaxis and postexposure prophylaxis.

AB 1264 (Petrie-Norris), Chapter 741, Statutes of 2019 clarified that an "appropriate prior examination" does not require a synchronous interaction between a provider and a patient for purposes of prescribing, furnishing, or dispensing self-administered hormonal contraceptives.

SB 493 (Hernandez), Chapter, 469, Statutes of 2013 increased the scope of practice for pharmacists, including the authority to furnish self-administered hormonal contraception.

ARGUMENTS IN SUPPORT:

Essential Access Health, *National Health Law Program*, and *Birth Control Pharmacist* write jointly in support of this bill as co-sponsors: "Since federal law requires a prescription for Medi-Cal coverage of outpatient medications, Medi-Cal cannot cover OTC birth control without a prescription. As such, when Medi-Cal enrollees want to obtain coverage of OTC birth control, they have to go through the same procedures as if they were obtaining a prescription-only contraceptive at the pharmacy. This includes finding a participating pharmacy with pharmacists that have received the required training to furnish prescription-only birth control methods, filling out a self-screening questionnaire, receiving required counseling (STI prevention, preventive health screenings, etc), and having a summary of the visit sent to their primary care provider. While these procedures are appropriate for prescription-only contraceptives, they are unnecessary for OTC contraceptives and create a burden for both patients and healthcare providers/pharmacists." The co-sponsors argue that "AB 50 provides a clear and practical policy solution to fix a systemic barrier to birth control by ensuring equitable access to OTC methods in communities statewide."

ARGUMENTS IN OPPOSITION:

There is no opposition on file.

POLICY ISSUE(S) FOR CONSIDERATION:

In order to ensure that patients can take advantage of recently enacted coverage expansions for over-the-counter contraceptives like Opill, this bill would expressly provide that the existing restrictions on a pharmacist's authority to furnish self-administered hormonal contraceptives only in accordance with standardized procedures or protocols do not apply to the furnishing of over-the-counter contraceptives, which are already available without a prescription. As part of this clarification, the bill updates various references to self-administered hormonal contraceptives to specify that those laws are in reference to "prescription-only" contraceptives. While these changes are intended to ensure that any restrictions on the furnishing of prescription-only contraception do not apply to over-the-counter products, they may unintentionally excluding those products from laws intended to protect access to contraception.

For example, Section 733 of the Business and Professions Code explicitly prohibits licensed health care providers from obstructing a patient in obtaining emergency contraception drug therapy or self-administered hormonal contraceptives; while this bill's insertion of the phrase "prescription-only" into this subdivision is intended to make terminology consistent with cross-referenced statutes, the effect could be interpreted as no longer applying that protection when the contraception is over-the-counter. Similarly, the addition of the term "prescription-only" to provisions contained in Section 4064.5 could imply that pharmacists would not be allowed to dispense up to a 12-month supply of a contraceptive if it is not prescription-only. The author may wish to clarify that these laws, which are intended to protect and expand access to contraception for patients, apply to both prescription-only and over-the-counter products.

AMENDMENTS:

1) To affirm that current law prohibiting healing arts licensees from obstructing a patient in obtaining contraceptives applies to over-the-counter products, amend Section 1 of the bill so that subdivision (d) reads as follows:

   (d) This section applies to emergency contraception drug therapy, over-the-counter contraceptives, and self-administered prescription-only hormonal contraceptives described in Section 4052.3.

2) To clarify that the existing authority of a pharmacist to furnish up to a 12-month supply of contraceptives applies to over-the-counter products, amend Section 4 of the bill so that paragraph (2) of subdivision (f) reads as follows:

   A pharmacist furnishing an FDA-approved, self-administered prescription-only hormonal contraceptive pursuant to Section 4052.3 under protocols developed by the California State Board of Pharmacy or an over-the-counter contraceptive may furnish, at the patient's request, up to a 12-month supply at one time.

REGISTERED SUPPORT:

Birth Control Pharmacist *(Co-Sponsor)*
Essential Access Health *(Co-Sponsor)*
National Health Law Program *(Co-Sponsor)*
American College of Obstetricians & Gynecologists – District IX
Asian Americans Advancing Justice – Southern California
California Pan – Ethnic Health Network
California Pharmacists Association
California Primary Care Association
California Women's Law Center
Citizens for Choice
Courage California
Disability Rights Education & Defense Fund
Glide
Health Access California
Latino Coalition for a Healthy California
Reproductive Freedom for All California
South Asian Network
The Children's Partnership

Western Center on Law & Poverty
Women's Foundation California

REGISTERED OPPOSITION:

None on file

Analysis Prepared by: Robert Sumner / B. & P. / (916) 319-3301

Date of Hearing: April 1, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 481 (Blanca Rubio) – As Introduced February 10, 2025

SUBJECT: Healing arts: clinical laboratories: personnel.

SUMMARY: Modifies the practice of unlicensed personnel in a licensed clinical laboratory by defining the undefined terms "assist," "assistance," and "supervision and control."

EXISTING LAW:

1) Defines "CLIA" as the federal Clinical Laboratory Improvement Amendments of 1988 and the relevant regulations adopted by the federal Health Care Financing Administration that are also adopted by the California Department of Public Health (CDPH). (Business and Professions Code (BPC) § 1202.5(a))

2) Regulates clinical laboratories and the performance of clinical laboratory tests through the licensing of clinical laboratories and laboratory directors, scientists, and other laboratory personnel under the CDPH and CLIA. (BPC §§ 1200-1327)

3) Defines "clinical laboratory test or examination" means the detection, identification, measurement, evaluation, correlation, monitoring, and reporting of any particular analyte, entity, or substance within a biological specimen for the purpose of obtaining scientific data that may be used as an aid to ascertain the presence, progress, and source of a disease or physiological condition in a human being, or used as an aid in the prevention, prognosis, monitoring, or treatment of a physiological or pathological condition in a human being, or for the performance of nondiagnostic tests for assessing the health of an individual. (BPC § 1206(a)(5))

4) Defines "clinical laboratory" as a place or organization used for the performance of clinical laboratory tests or examinations or the practical application of the clinical laboratory sciences. (BPC § 1206(a)(8))

5) Requires every clinical laboratory to have a laboratory director who is responsible for the overall operation and administration of the clinical laboratory, including (1) administering the technical and scientific operation of a clinical laboratory, the selection and supervision of procedures, the reporting of results, and active participation in its operations to the extent necessary to ensure compliance with state clinical laboratory laws and CLIA, (2) the proper performance of all laboratory work of all subordinates, and (3) employing a sufficient number of laboratory personnel with the appropriate education and either experience or training to provide appropriate consultation, properly supervise and accurately perform tests, and report test results in accordance with the personnel qualifications, duties, and responsibilities described in CLIA and state clinical laboratory laws. (BPC § 1209(d)(1))

6) Defines "direct and constant supervision" as personal observation and critical evaluation of the activity of unlicensed laboratory personnel by a physician and surgeon, or by a clinical laboratory licensee other than a trainee, during the entire time that unlicensed laboratory

personnel are engaged in specified laboratory activities that require additional supervision, education, and training. (BPC §§ 1206(a)(9), 1269)

7) Defines "unlicensed laboratory personnel" as a laboratory aide, histocompatibility technician, cardiopulmonary technician, or other person performing authorized unlicensed activities. (BPC § 1212)

8) Authorizes unlicensed laboratory personnel to perform additional activities in a licensed clinical laboratory under the direct and constant supervision of a physician and surgeon or a clinical laboratory licensee other than a trainee if they meet all of the following criteria:

   a) Have earned a high school diploma, or its equivalent. (BPC § 1269(a)(1))

   b) Have documentation of training appropriate to ensure that the individual has all of the following skills and abilities:

   c) The skills required for proper specimen collection, including patient preparation, labeling, handling, preservation or fixation, processing or preparation, and transportation and storage of specimens. (BPC § 1269(a)(2)(A))

   d) The skills required for assisting a physician and surgeon or a clinical laboratory licensee, other than a trainee, in a licensed clinical laboratory. (BPC § 1269(a)(2)(B))

   e) The skills required for performing preventive maintenance and troubleshooting. (BPC § 1269(a)(2)(C))

   f) A working knowledge of reagent stability and storage. (BPC § 1269(a)(2)(D))

   g) The skills required for assisting in the performance of quality control procedures and an understanding of the quality control policies of the laboratory. (BPC § 1269(a)(2)(E))

   h) An awareness of the factors that influence test results. (BPC § 1269(a)(2)(F))

9) Authorizes unlicensed personnel who meet the specified education and training criteria to perform the following activities under direct and constant supervision:

   a) Biological specimen collection, including patient preparation, labeling, handling, preservation or fixation, processing or preparation, and transportation and storage of specimens. (BPC § 1269(b)(1))

   b) Assisting a physician and surgeon or a clinical laboratory licensee, other than a trainee, in a licensed clinical laboratory. (BPC § 1269(b)(2))

   c) Assisting in preventive maintenance, and troubleshooting. (BPC § 1269(b)(3))

   d) Preparation and storage of reagents and culture media. (BPC § 1269(b)(4))

   e) Assisting in the performance of quality control procedures. (BPC § 1269(b)(5))

10) Authorizes unlicensed personnel to, under the supervision and control of a physician and surgeon or clinical laboratory licensee, perform specimen labeling, handling, preservation or

fixation, processing or preparation, transportation, and storing if they have a high school diploma or its equivalent and documentation of the skills necessary to perform those activities, and. (BPC § 1269(c))

11) Prohibits unlicensed laboratory personnel from doing any of the following:

    a) Recording test results, except they may transcribe results that have been previously recorded either manually by a physician and surgeon or licensed laboratory personnel or automatically by a testing instrument. (BPC § 1269(d)(1))

    b) Performing any part of a test that involves the quantitative measurement of the specimen or test reagent, or any mathematical calculation relative to determining the results or the validity of a test procedure. (BPC § 1269(d)(2))

    c) Performing any phase of clinical laboratory tests or examinations in the specialty of immunohematology beyond initial collection and centrifugation. (BPC § 1269(d)(3))

12) Limits the activities unlicensed laboratory personnel may perform when using the following manual methods:

    a) In the case of qualitative and semi-quantitative "spot, tablet, or stick" tests, the personnel may add the test reagent to the specimen or vice versa, but the results must be read by a physician and surgeon or clinical laboratory licensee. (BPC § 1269(e)(1))

    b) In the case of microbiological tests, the unlicensed laboratory personnel may make primary inoculations of test material onto appropriate culture media, stain slide preparations for microscopic examination, and subculture from liquid media. (BPC § 1269(e)(2))

13) Prohibits unlicensed laboratory personnel from performing the following activities when using any of the following mechanical or electronic instruments:

    a) Standardizing or calibrating the instrument or assessing its performance by monitoring results of appropriate standards and control. (BPC § 1269(f)(1))

    b) Reading or recording test results, except that the personnel may transcribe results that have been previously recorded automatically by a testing instrument. (BPC § 1269(f)(2))

    c) Quantitatively measuring any sample or reagents unless done automatically by the instrument in the course of its normal operation or by the use of previously calibrated and approved automatic syringes or other dispensers. (BPC § 1269(f)(3))

THIS BILL:

1) Authorizes a person to assist in the performance of moderate or high complexity tests in a clinical laboratory if they meet the respective CLIA requirements for moderate or high complexity testing.

2) Defines "assist" or "assistance" as the activities performed by trained and competent personnel who follow specific instruction from a licensed physician and surgeon or personnel

licensed under this chapter, other than a trainee, under direct and constant supervision, and includes the following activities prior to, during, and after the laboratory testing process:

a) Load and unload barcoded specimens and barcoded quality control material onto automated instruments.

b) Load and replenish premeasured reagents and supplies onto automated instruments.

c) Load and unload samples and their byproducts, such as extraction products, onto shakers, incubators, refrigerators, freezers, thermal cyclers, and other automated equipment or instruments.

d) Unload and store reagents from an automated instrument.

e) Move assay from one piece of equipment to the next.

f) Clean and disinfect laboratory equipment.

g) Replacement of consumable laboratory equipment, supplies, and reagents.

h) Activities permissible when assisting a licensed physician and surgeon or licensed clinical laboratory personnel, other than trainees, in a licensed clinical laboratory.

i) Quantitatively measure sample, quality control material, or reagents by the use of previously calibrated and approved automatic syringes, fixed volume pipettes, or other dispensers.

j) Assist with sample dilutions.

3) Defines "supervision and control" to mean direction, management, and awareness of the activity of unlicensed laboratory personnel by a physician and surgeon or by a person licensed under this chapter other than a trainee, who must be physically present in the laboratory and readily available for consultation during the entire time that the unlicensed laboratory personnel are engaged in the duties.

4) Makes other non-substantive, technical changes.

FISCAL EFFECT: Unknown. This bill is keyed fiscal by the Legislative Counsel.

COMMENTS:

Purpose. This bill is co-sponsored by *Quest Diagnostics* and the *California Clinical Laboratory Association*. According to the author, "For over a decade, the shortage of licensed professionals in the clinical laboratory industry has been well-documented but largely ignored. [This bill] takes a practical step toward solving this crisis by allowing federally qualified and trained unlicensed personnel to assist licensed professionals with specific lab tasks. This change won't just help fill critical workforce gaps—it will streamline lab operations, enhance workflow efficiency, and ultimately lead to better patient care and outcomes."

Background. Clinical laboratory testing is the analysis of human specimens, such as fluid, blood, or tissue. An example of a common testing scenario is a physician ordering a blood lipid

panel. When the patient's blood sample is sent to a laboratory, the laboratory extracts the lipids from the blood, tests the lipids using an appropriate analytical method, such as mass spectrometry, and reports the results to the patient or physician. The physician then relies on the results to advise the patient.

Testing performed for medical purposes is highly regulated at both the federal and state levels. The primary intent of the regulation is to minimize the risk of incorrect or unreliable results, which may lead to delays in care or improper diagnoses, among other things.

CLIA. Federally, the Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulates any facility or location where people perform laboratory tests for medical or clinical purposes. CLIA requires these locations to be certified by the Centers for Medicare and Medicaid Services (CMS) as clinical laboratories. At the state level, the California Department of Public Health (CPDH) and respective state health agencies administer CLIA on behalf of CMS.

While CLIA establishes the requirements for federal certification, it also allows states to establish additional or more stringent requirements. In California, clinical laboratories must obtain a state license or registration from CDPH in addition to the federal CLIA certificate. There are also varying levels of certification and licensure depending on the complexity of the tests performed at the laboratory.

Unlicensed Laboratory Personnel. One area where California is more stringent than CLIA is the use of unlicensed laboratory personnel. CLIA and state law both require the performance of clinical laboratory tests to be performed by licensed personnel such as physician pathologists, clinical laboratory scientists, and medical laboratory technicians. They also require the tests to be performed under the overall direction of a licensed laboratory director. The laboratory director is responsible for everything that goes on in the laboratory, including the development of policies and procedures, training of personnel, quality of test results, and anything else required under CLIA and state law. The laboratory director must document compliance with every requirement for CDPH auditing purposes.

Where CLIA and state law differ is the use of unlicensed personnel. Other than the restrictions on who may perform laboratory tests, CLIA is silent on unlicensed laboratory personnel, including the non-testing tasks they can perform and their qualifications. In states without requirements on unlicensed personnel, the laboratory director would determine the level of training necessary to perform the tasks assigned.

In comparison, California law limits the use of unlicensed personnel to specific tasks and dictates the level of supervision required for those tasks. It also requires specific training that must be documented. For more advanced tasks, including assisting licensed personnel in their duties, the unlicensed personnel must be under direct and constant supervision. Direct and constant supervision means the personnel is both personally observable to and receiving critical evaluation from the supervisor the entire time that they are assisting. Specified lesser tasks, such as labeling or transport, must be performed under the supervision and control of a licensee.

However, the tasks included under "assisting" are not defined, so it is not clear what is allowed or whether there are limits to what unlicensed personnel can do when assisting. "Supervision and control" is also not defined. This bill would define both terms, specifying the tasks included in the term "assist" and that "supervision and control" means indirect supervision with a supervisor onsite and available for consultation.

Test Complexity. The requirements for CLIA certification, licensure, and required personnel vary depending on the complexity of the laboratory tests performed. Clinical laboratories or other testing sites need to know whether each test system used is waived, moderate, or high complexity. In general, the more complicated the test, the more stringent the requirements, including increased training and licensing of laboratory personnel.

The FDA determines the complexity of laboratory tests under CLIA. Waived tests are simple tests with a low risk of an incorrect result. They include tests listed in the CLIA regulations, tests cleared by the FDA for home use, and tests approved for a waiver by the FDA using the CLIA criteria. Tests not classified as waived are assigned a moderate or high complexity category based on seven criteria given in the CLIA regulations, including ease of use, the knowledge required, and the types of materials tested. For commercially available FDA-cleared or approved tests, the test complexity is determined by the FDA during the pre-market approval process.

Under federal and California law, anyone providing direct care may perform a waived test in a federally certified laboratory or as part of a nondiagnostic health assessment program under the overall direction of a laboratory director, unless otherwise limited. In applying for a CLIA certificate of waiver, the laboratory director must list the types of analytes to be tested, the tests performed, and the test manufacturer.

This bill would clarify that persons assisting with moderate complexity testing or high complexity testing must meet the federal CLIA requirements for moderate complexity testing or high complexity testing respectively.

Prior Related Legislation. AB 1741 (Waldron) of 2023 was similar to this bill, modifying the practice of unlicensed personnel in a licensed clinical laboratory by defining undefined terms and adding additional authorized tasks and training requirements. *AB 1741 was vetoed by Governor Newsom, who wrote:*

> This bill would revise training requirements for unlicensed laboratory personnel, change the scope of work authorized, and clarify the level of supervision required.
>
> While I appreciate the author's intent to address the licensed workforce shortage in labs and improve testing capacity, this bill contains a provision that could enable unlicensed laboratory personnel to perform tasks that exceed their level of training, posing a danger to the health and safety of Californians. As a result, this bill could conflict with the Clinical Laboratory Improvement Act, a federal law that prohibits individuals who do not meet the specified education and training requirements from performing any aspect of the analytical phase of testing.
>
> I encourage the author and stakeholders to work with the Department of Public Health on a solution that ensures that personnel performing specified testing have the skills necessary to reliably receive accurate results.
>
> For these reasons, I cannot sign this bill.

SB 334 (Pan), Chapter 144, Statutes of 2019, required CDPH to develop a medical laboratory technician to clinical laboratory scientist pathway to allow work experience in a lab to count towards licensure as a clinical laboratory scientist by January 1, 2022.

ARGUMENTS IN SUPPORT:

The *California Clinical Laboratory Association* (co-sponsor) writes in support, "Supporting this bill is essential for improving the efficiency and accessibility of clinical laboratory testing in California. By allowing qualified individuals to assist with testing under the supervision of licensed professionals, this bill ensures that the state's laboratories can better manage increasing workloads without compromising accuracy or patient safety. The bill's provision for clear supervision and control, requiring licensed personnel to be physically present and readily available, provides an extra layer of assurance the assistance is performed correctly. Additionally, aligning state regulations with the federal Clinical Laboratory Improvement Amendments (CLIA) standards ensures that California's laboratory practices meet the highest national standards, while fostering a more flexible, well-supported workforce. This will ultimately improve the quality and timeliness of critical diagnostic testing across the state."

Quest Diagnostics (co-sponsor) writes in support:

> There is an acute shortage of licensed clinical laboratory scientists in California that is adversely impacting California laboratories' abilities to meet testing demand in a timely manner. These staffing challenges have been recognized by the California Department of Public Health's Lab Field Services Clinical Laboratory Technology Advisory Committee (CLTAC), which issued a *Report on Challenges to California's Laboratory Workforce Capacity* in 2022, at which time they estimated the vacancy rate for Clinical Laboratory Scientists, who are qualified to perform diagnostic testing, to be at 20%.
>
> The laboratory workforce shortage impacts all types of testing conducted by clinical labs and delays patients access to their results. [This bill] allows unlicensed personnel to assist with a specified subset of tasks under the supervision of licensed personnel within the lab. In doing so, this allows licensed personnel to focus on critical tasks that are in line with their area of expertise.
>
> Expanding the tasks that unlicensed laboratory personnel can perform under the supervision of licensed personnel will make a significant impact to alleviate the workforce shortage, improve testing capacity, increase patient access to testing and results, and introduce a pathway to employment within the clinical laboratory industry.
>
> [This bill] mitigates the effects of the clinical laboratory workforce shortage, increasing testing capacity to improve the cycle time to report test results so patients and physicians can make informed and timely health care decisions and protect public health.

The *California Society of Pathologists (CSP)* writes in support:

> Clinical laboratories across the state, including those in hospitals, labs, and independent settings, are experiencing critical staffing challenges, particularly among Clinical Laboratory Scientists. These shortages have been exacerbated by workforce retirements, limited licensure pathways, and a lack of training opportunities to support the next generation of laboratory professionals. The COVID-19 pandemic made these vulnerabilities starkly visible, prompting

emergency Executive Orders and subsequent legislative action in AB 269 (Berman) in 2023 to temporarily align state practices with federal CLIA standards.

[This bill] builds on this approach by aligning state law with the Clinical Laboratory Improvement Amendments of 1988 (CLIA). It authorizes trained personnel to assist in moderate and high complexity testing in clinical laboratories so long as they meet federal CLIA qualifications, even if they do not hold a California-specific license. This narrowly tailored flexibility will help relieve workforce bottlenecks while maintaining high standards of safety and oversight.

These changes provide a modernization and clarification of how trained support personnel can contribute safely and effectively within today's highly automated and team-based laboratory environments.

The CSP believes [this bill] strikes the right balance between flexibility and oversight and will help address pressing operational needs without compromising patient care.

ARGUMENTS IN OPPOSITION:

The *California Nurses Association*, *Engineers & Scientists of California*, *Local 20 IFPTE*, *Service Employees International Union*, *California State Council* (SEIU California), and *United Food and Commercial Workers* write:

…we are opposed unless amended to [this bill]. [This bill] would allow unlicensed individuals who meet federal standards under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) to assist in performing moderate and high complexity laboratory tests. This assistance includes tasks that require training and education to perform safely, of which this bill undermines. As a result, we fear that the enactment of [this bill] would compromise patient safety and the quality of healthcare services.

Our organizations represent workers in laboratories across California or in medical systems. We would be the first to tell you that errors in handling specimens or preparing tests can lead to inaccurate results, which might affect medical diagnoses and treatments. Additionally, while the bill requires supervision by a licensed professional, it only mandates that the supervisor be physically present and available for consultation. This could lead to situations where unlicensed personnel perform critical steps without direct oversight, increasing the risk of mistakes. Even though these assistants are not directly analyzing test results, errors in preparing or processing specimens could lead to incorrect data, ultimately leading doctors to misdiagnose or mistreat patients or tests needing to be repeated

We have requested the following amendments, which would address our concerns, but still achieve the sponsors' goals of improving efficiency in laboratories across the state:

1) Clarification that "extraction" in (3) must be performed by a clinical laboratory scientist, but otherwise the unlicensed personnel would be okay to assist.

2) Eliminate (9) and (10), which allow unlicensed professionals to "quantitively measure sample" and "assist with sample dilutions." We feel that these tasks are too complex for unlicensed personnel, who lack the training or education to perform these safely.

3) Add back in the following supervision language that the sponsors agreed to in AB 1741, which clarifies that a laboratory director maintains responsibility and licensure implications for any delegated supervision or training: “The laboratory director shall maintain responsibility for the performance of unlicensed laboratory personnel and any delegated supervision or training of the unlicensed personnel.”

4) Require, at a minimum, a phlebotomist certificate is needed for unlicensed personnel to perform the work specified in [this bill]. This ensures that the training of unlicensed personnel is standardized across employers, not on a case-by-case basis.

5) Explicitly specify in statute the tests unlicensed personnel can assist with. This follows the process established by allowing unlicensed personnel to perform and interpret waived COVID-19 tests (such as many rapid antigen tests) if they are working under the oversight of a licensed healthcare professional and the facility has the appropriate CLIA waiver. We support similar clarity, instead of an ambiguous list of tasks specified in statute.

6) Finally, if the bill is relaxing the "supervision and control" standard so that it's no longer "direct," we would ask for a quantifiable ratio of licensed to unlicensed professionals. We believe that a 1:3 ratio is appropriate to ensure that patient safety is not compromised in lieu of employer profit.

The *California Association for Medical Laboratory Technology* (CAMLT) writes in opposition:

> CAMLT is opposed to [this bill] because it would significantly lower California’s rigorous standards for laboratory personnel. The bill would allow unlicensed individuals to perform moderate or high complexity testing under CLIA (federal standards) instead of California standards if they are supervised by a licensed person. This expansion of activities for unlicensed personnel would directly compromise the accuracy of test results and potentially jeopardize the health and safety of patients in California.
>
> Specifically, the laboratory testing and activities that would be impacted by the bill include:
>
> 1) Assisting a CLS or MLT with the analytical phase of testing: This activity is equivalent to performing tests without a license or supervision. It is impossible for licensed personnel to provide direct and constant supervision

(line of sight supervision) to unlicensed personnel while simultaneously performing tests themselves.

2) Quantitatively measuring sample, quality control material, or reagents: This crucial step is essential for test performance and accuracy.

3) Correctly diluting or manipulating samples: This is another vital aspect of accurate and reliable test results.

CAMLT strongly believes that maintaining the current requirements for laboratory personnel is essential for ensuring the highest quality and accuracy of test results.

POLICY ISSUES FOR CONSIDERATION:

1) *Employer Influence.* Under CLIA and state law, the laboratory director is responsible for the overall direction of a laboratory. However, the opposition raises concerns about employer influence over a supervisor tasked with supervising an unlicensed person, such as requiring a supervisor to supervise more personnel than they can handle or supervising someone unqualified, resulting in incorrect test results and liability for the supervisor.

2) *Supervision and Control*. Opposition to this bill raises concerns over the relaxing of "supervision and control" to less than "direct." However, existing law does not define supervision and control. Based on the way the existing duties are separated, with fewer and more menial tasks allowed under supervision and control, it suggests that it means something less, which would necessarily be something less than direct.

   A prior bill on this issue, AB 1741 (Waldron) of 2023 would have allowed additional tasks under supervision and control that currently require direct supervision, but this bill does not change the permissible tasks.

3) *Required Training*. Opposition raises concerns over whether on-the-job training as required by CLIA and state law is sufficient to perform the tasks included under this bill. Supporters of the bill argue that it is in the best interest of the laboratory director and the laboratory as a whole to ensure personnel are qualified and trained and that CDPH will perform inspections that review the personnel qualification and training documentation. Opposition further argues that, for laboratories that favor efficiency, CDPH oversight may be insufficient and there should be additional state oversight of personnel, such as through a phlebotomy certificate issued by the CDPH, which includes standards for training, examination, and continuing education. While components of phlebotomy education (such as blood draws) are not applicable to personnel who do not perform phlebotomy, there may be subject areas or continuing education requirements that can be applied if the bill passes this committee.

4) *Complexity of Tasks*. Opposition raises concerns over the complexity of certain tasks for unlicensed personnel, regardless of how much training they may receive (short of what is required for a license). Specifically, they point out the performance of extractions of byproducts, quantitively measuring samples, and assisting with sample dilutions.

5) *Difficulties with Supervision*. Opposition raises concerns about the difficulty of supervising while performing tests. Existing law addresses this issue. If a supervisor is unable to

appropriately supervise while performing the test, they may tell the supervisee, who is personally observable during the entire time that they are engaged in these duties, to stop. Alternatively, they may wait until the supervisee is done.

IMPLEMENTATION ISSUES:

1) *Circular References*. This bill defines "assist," but includes a cross-reference to the act of assisting as well as the act of assisting with sample dilutions within the definition.

2) *Orphan Definitions*. This bill defines "assist" and "supervision and control" in two separate places, even though the chapter has a section specifically for definitions. If this bill passes this committee, the author may wish to combine the definitions in one section or move them to the existing definitions section (BPC § 1206).

AMENDMENTS:

1) To narrow the application of the definition of "assist" to unlicensed personnel and to be consistent with the existing verbiage, amend the bill as follows:

   On page 2 of the bill, line 13:

   ~~(c)~~ *For purposes of Section 1269,* "Assist" or ~~"Assistance"~~ *"assisting"* means activities performed by trained and competent personnel who follow specific instruction from a licensed physician and surgeon or personnel licensed under this chapter, other than a trainee, under direct and constant supervision, and includes the following activities prior to, during, and after the laboratory testing process:

2) To address concerns regarding extractions and make a technical change to be inclusive of various form factors for equipment, amend the bill as follows:

   On page 2, lines 23-25:

   ~~(3)~~ *(c)* Load and unload samples and their ~~byproducts, such as extraction products,~~ *byproducts into or* onto shakers, incubators, refrigerators, freezers, thermal cyclers, and other automated equipment or instruments.

3) To avoid circular cross-reference, amend the bill as follows:

   On page 3, strike lines 4-5:

   ~~(8) Activities permissible under paragraph (2) of subdivision (b) of Section 1269.~~

4) To address concerns regarding quantitative measurements and sample dilutions, amend the bill as follows:

On page 3, lines 6-9:

~~(9) Quantitatively measure sample.~~ *(h) Transfer samples,* quality control material, or reagents by the use of previously calibrated and approved automatic syringes, fixed volume pipettes, or other dispensers.

~~(10) Assist with sample dilutions.~~

5) To address concerns regarding the sufficiency of training for the tasks outlined, amend the bill as follows:

On page 3, line 34:

(F) ~~An awareness~~ *A working knowledge* of the factors that influence test results.

(b) Training for unlicensed personnel includes, but is not limited to, reading and understanding of the procedures, receiving verbal instruction on how the task is performed by licensed personnel, and directly observing the task performed by licensed personnel.

(c) Prior to performing any of the activities identified in subdivision (d) unlicensed personnel shall, under direct and constant supervision, demonstrate the skills and ability to satisfactorily perform the task.

6) To limit the reference to CLIA requirements to unlicensed personnel, amend the bill as follows:

On page 3, before line 35:

(d) In addition to the requirements of this section, an unlicensed person assisting in the performance of moderate complexity testing in a clinical laboratory shall meet the requirements under the CLIA for moderate complexity testing.

(e) In addition to the requirements of this section, an unlicensed person assisting in the performance of high complexity testing in a clinical laboratory shall meet the requirements under CLIA for high complexity testing.

On page 2, lines 3-12:

~~(a) Notwithstanding subdivision (b) of Section 1206.5, a person may assist in the performance of moderate complexity testing in a clinical laboratory if they meet the requirements under the federal Clinical Laboratory Improvement Amendments of 1988 (42 U.S.C. Sec. 263a) for moderate complexity testing.~~

~~(b) Notwithstanding subdivision (c) of Section 1206.5, a person may assist in the performance of high complexity testing in a clinical laboratory if they meet the requirements under the federal Clinical Laboratory Improvement Amendments of 1988 (42 U.S.C. Sec. 263a) for high complexity testing~~.

7) To clarify the laboratory director is ultimately responsible for unlicensed personnel, amend the bill as follows:

   On page 5, after line 17, insert:

   (l) The laboratory director shall designate the supervisor and shall maintain overall responsibility for the supervision and performance of the unlicensed laboratory personnel.

REGISTERED SUPPORT:

California Clinical Laboratory Association (co-sponsor)
Quest Diagnostics Incorporated (co-sponsor)
California Society of Pathologists
Laboratory Corporation of America (LABCORP)
Myriad Genetics
Valley Industry and Commerce Association (VICA)
Veracyte

REGISTERED OPPOSITION:

California Nurses Association (unless amended)
California Association for Medical Laboratory Technology
California State Council of Service Employees International Union (unless amended)
Engineers and Scientists of California, IFPTE Local 20, AFL-CIO (unless amended)
United Food and Commercial Workers (unless amended)

Analysis Prepared by: Vincent Chee / B. & P. / (916) 319-3301

Date of Hearing: April 1, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 489 (Bonta) – As Introduced February 10, 2025

NOTE: This bill is double referred and if passed by this Committee will be re-referred to the Assembly Committee on Privacy and Consumer Protection.

SUBJECT: Health care professions: deceptive terms or letters: artificial intelligence.

SUMMARY: Extends the enforceability of existing title protections for various licensed health care professions to expressly apply against a person or entity who develops or deploys artificial intelligence (AI) technology.

EXISTING LAW:

1) Defines "artificial intelligence" as an engineered or machine-based system that varies in its level of autonomy and that can, for explicit or implicit objectives, infer from the input it receives how to generate outputs that can influence physical or virtual environments. (Government Code § 11546.45.5)

2) Requires a health facility, clinic, physician's office, or office of a group practice that uses generative AI (GenAI) to generate written or verbal patient communications pertaining to patient clinical information to provide a disclaimer that the communication was generated by GenAI and instructions on how to contact a human. (Health and Safety Code § 1339.75)

3) Requires a developer of a GenAI system or service to publicly disclose specific information related to the system or service's training data. (Civil Code § 3111)

4) Establishes the Department of Consumer Affairs (DCA) within the Business, Consumer Services, and Housing Agency. (Business and Professions Code (BPC) § 100)

5) Enumerates various regulatory boards, bureaus, committees, and commissions under the DCA's jurisdiction, including healing arts boards under Division 2. (BPC § 101)

6) Makes it unlawful for any healing arts licensee to publically communicate a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of or likely to induce, directly or indirectly, the rendering of professional services in connection with the professional practice or business for which they are licensed. (BPC § 651)

7) Restricts the use of the title "nurse" to persons licensed under the Nursing Practice Act or the Vocational Nursing Practice Act, with exceptions. (BPC § 680)

8) Restricts the use of the title "chiropractor" to persons licensed under the Chiropractic Initiative Act. (BPC § 1000)

9) Restricts the use of the title "dentist" to persons licensed under the Dental Practice Act. (BPC § 1625)

10) Restricts the use of the title "registered dental hygienist" to persons licensed under the Dental Practice Act. (BPC § 1958)

11) Restricts use of the titles "doctor" or "physician" to persons licensed under the Medical Practice Act or the Osteopathic Initiative Act, with specified exceptions. (BPC § 2054)

12) Restricts the use of the titles "podiatrist," "doctor of podiatric medicine," or "foot specialist" to persons licensed as podiatric doctors under the Medical Practice Act. (BPC § 2474)

13) Restricts the use of the title "licensed midwife" to persons licensed as licensed midwives under the Medical Practice Act. (BPC § 2511)

14) Restricts the use of the title "athletic trainer" to persons certified by the Board of Certification for the Athletic Trainer. (BPC § 2529.8.1)

15) Restricts the use of the titles "audiologist," "hearing clinician," or "hearing therapist" to persons licensed by the Speech-Language Pathologists and Audiologists and Hearing Aid Dispensers Licensure Act. (BPC § 2530.3)

16) Restricts the use of the title "occupational therapist" to persons licensed under the Occupational Therapy Practice Act. (BPC § 2570.18)

17) Restricts the use of the title "dietician" to persons meeting certain criteria. (BPC § 2585)

18) Restricts the use of the title "perfusionist" to persons meeting certain criteria. (BPC § 2590)

19) Restricts the use of the title "physical therapist" to persons licensed under the Physical Therapy Practice Act. (BPC § 2630)

20) Restricts the use of the title "registered nurse" to persons licensed under the Nursing Practice Act. (BPC § 2732)

21) Restricts the use of the title "psychologist" to persons licensed under the Psychology Licensing Law. (BPC § 2903)

22) Restricts the use of the title "optometrist" to persons licensed under the Optometry Practice Act. (BPC § 3040)

23) Restricts the use of the title "physician assistant" to persons licensed under the Physician Assistant Practice Act. (BPC § 3503)

24) Restricts the use of the title "naturopathic doctor" to persons licensed under the Naturopathic Doctors Act. (BPC § 3661)

25) Restricts the use of the titles "respiratory care practitioner" or "inhalation therapist" to persons licensed under the Respiratory Care Practice Act. (BPC § 3760)

26) Restricts the use of the title "certified massage therapist" to persons certified under the Massage Therapy Act. (BPC § 4611)

27) Restricts the use of the title "board certified music therapist" to persons certified pursuant to the Music Therapy Act. (BPC § 4611)

28) Restricts the use of the title "veterinarian" to persons licensed under the Veterinary Medicine Practice Act. (BPC § 4826)

29) Restricts the use of the title "acupuncturist" to persons licensed under the Acupuncture Licensure Act. (BPC § 4935)

30) Restricts the use of the title "marriage and family therapist" to persons licensed under the Licensed Marriage and Family Therapist Practice Act. (BPC § 4980)

31) Restricts the use of the title "licensed clinical social worker" to persons licensed under the Clinical Social Worker Practice Act. (BPC § 4996)

32) Restricts the use of the title "professional clinical counselor" to persons licensed under the Clinical Social Worker Practice Act. (BPC § 4999.82)

33) Provides that corporations and other artificial legal entities shall have no professional rights, privileges, or powers under the Medical Practice Act. (BPC § 2400)

34) Makes it unlawful for any person to make or disseminate any statement in the advertising of services, professional or otherwise, which is untrue or misleading. (BPC § 17500)

35) Authorizes the Director of Consumer Affairs, Attorney General, or any city attorney, county counsel, or district attorney to seek an immediate termination or modification of any advertising claim that is false or misleading and disseminate information concerning the veracity of the claims or why the claims are misleading to consumers. (BPC § 17508)

THIS BILL:

1) Provides that any provision of the laws governing the regulation of healing art licensees that prohibits the use of specified terms, letters, or phrases to indicate or imply possession of a license or certificate to practice a health care profession, without at that time having the appropriate license or certificate required for that practice or profession, shall be enforceable against a person or entity who develops or deploys a system or device that uses one or more of those terms, letters, or phrases in the advertising or functionality of an artificial intelligence system, program, device, or similar technology.

2) Prohibits the use of a term, letter, or phrase in the advertising or functionality of an AI system, program, device, or similar technology that indicates or implies that the care or advice being offered through the AI technology is being provided by a natural person in possession of the appropriate license or certificate to practice as a health care professional.

3) Specifies that each use of a prohibited term, letter, or phrase constitutes a separate violation.

4) Defines certain terms for purposes of the bill.

FISCAL EFFECT: Unknown; this bill is keyed fiscal by the Legislative Counsel.

COMMENTS:

Purpose. This bill is co-sponsored by *SEIU California* and the *California Medical Association*. According to the author:

> The rapid rise of AI systems has sparked a wide range of opinions about their impact on society. However, one thing is certain— AI is advancing faster than the laws and regulations needed to protect Californians. Artificial intelligence (AI) systems have reached a point where they can produce natural-sounding language, and are trained on a vast amount of information, including health-related information. This powerful capability enables it to convincingly mimic a health professional. Without proper safeguards in place, this capability can pose a danger to consumers in both health care and non-health care settings. Californians deserve transparency and protection from misrepresentation, and AI technologies must be developed and deployed responsibly to prevent such misrepresentation. For instance, consumers should be able to trust that a "nurse advice" telephone line or chat box is staffed by a licensed human nurse. AB 489 fills an emerging need by codifying a clear, enforceable prohibition on automated systems misrepresenting "themselves" as health professionals.

Background.

Professional Title Protection. Title protection is one of the forms of regulation of professional services that can be imposed by the Legislature to protect patients and consumers by reserving the use of words, terms, initials, and titles for individuals who have met certain requirements to demonstrate competence. As described in the context of the Legislature's "sunrise review" process, title protection is frequently included as part of a licensing act, where only persons who meet predetermined standards are allowed to work at an occupation. When licensure is required for a profession, both the scope of practice and the use of titles describing that title are protected.[1]

As a less restrictive alternative to licensure, the Legislature will sometimes grant recognition to persons who obtain a voluntary certification or registration relating to an unlicensed profession by providing them with exclusive use of specified titles. In many cases, this title protection is limited to the use of terms such as "certified" or "licensed" in association with terms related to the profession. However, some specific terms, such as "dietician" or "athletic trainer," are reserved for individuals who have obtained a voluntary certification or met other requirements despite there being no requirement to obtain a license to practice that profession.

General provisions governing health professional licensing boards make it unlawful for any healing arts licensee to publically communicate any false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of rendering professional services in connection with their licensed practice. Statute specifically prohibits a licensee from using "any professional card, professional announcement card, office sign, letterhead, telephone directory listing, medical list, medical directory listing, or a similar professional notice or device if it includes a statement or claim that is false, fraudulent, misleading, or deceptive." Practitioners may advertise that they are certified or that they limit their practice to specific fields; however, the term "board certified" reserve for physicians certified by an American Board of Medical Specialties member board.

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[1] https://abp.assembly.ca.gov/sites/abp.assembly.ca.gov/files/reports/SunriseProcessDescriptionAsm.pdf

Additionally, Section 17500 of the Business and Professions Code broadly prohibits false advertising of a product or service. Specifically, this law makes it unlawful for any person to make any statement or advertisement with intent to perform services, professional or otherwise, that is untrue or misleading. While this code section covers a wide range of false advertisements by sellers of goods or services, its provisions would be applicable to health care licensees.

Unlawful use of a title is enforced by regulatory entities, including healing arts boards, consistent with the process for enforcement against unlicensed practice. Typically, these types of violations of a practice act constitute a misdemeanor. Many boards also possess the authority to cite and fine violators, or to engage in other actions to compel compliance with the law. The unauthorized use of professional titles in advertising can also form the basis for prosecutions against individuals or entities for false advertising or unfair business practices.

Artificial Intelligence. The recent acceleration in the evolution of AI technologies has elicited a great deal of attention from policymakers, and this has been especially true when the technology is deployed in a health care setting. The integration of AI into health care practice raises both legal and ethical concerns, particularly when AI is used to supplant or influentially augment clinical judgment by practitioners. Additionally, concerns have been voiced that AI technologies have the potential to displace human medical professionals in the future, which could have detrimental effects on both the health care workforce and for patients.[2]

A significant component of these concerns relates to the use of potential for AI systems to imitate licensed health care providers. AI-powered diagnostic tools, chatbots, and virtual assistants are increasingly capable of providing what resembles medical advice, which can blur the lines between machine-generated guidance and professional medical consultation from a trained human professional. Meanwhile, there is uncertainty as to whether existing laws that restrict the use of professional titles to licensed individuals are enforceable against non-human AI programs or those who develop or deploy them. This has led to challenges in ensuring that AI systems do not mislead patients by presenting communications as coming from qualified professionals, especially since those communications are not subject to oversight by a licensing board.

In January 2025, California Attorney General Rob Bonta issued a "legal advisory on the application of existing California law to artificial intelligence in healthcare." The advisory noted that "California's professional licensing laws provide additional standards to which licensed medical professionals must adhere" and that "only human physicians (and other medical professionals) are licensed to practice medicine in California; California law does not allow delegation of the practice of medicine to AI." The Attorney General's advisory further opined that "using AI or other automated decision tools to make decisions about patients' medical treatment, or to override licensed care providers' determinations about what a patient's medical needs are, may violate California's ban on the practice of medicine by corporations and other 'artificial legal entities' … in addition to constituting an 'unlawful' or 'unfair' business practice under the Unfair Competition Law."[3]

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[2] Parikh, R. B., Teeple, S., & Navathe, A. S. (2024). *Artificial intelligence and the future of work in healthcare: The role of trust and acceptance.* NPJ digital medicine, 6(1), 111. https://doi.org/10.1177/23779608241245220

[3] California Department of Justice. (2024). *Application of existing California laws to artificial intelligence in healthcare* (Legal Advisory). https://tinyurl.com/AGadvisory

AI Psychotherapy. In the background paper for the Board of Psychology's most recent sunset review oversight hearing, Issue #13 discussed how AI is specifically changing the field of psychology.[4] The background paper questioned what regulatory changes may be necessary to protect consumers and ensure the ethical use of AI-driven tools in psychotherapy practice. As discussed in the sunset review background paper, AI has the potential to transform the field of psychology, from the provision of psychotherapy to research. While AI innovations, such as chatbots (e.g., Wysa and Woebot) and tools that automate notetaking (e.g., Mental Note AI and TherapyFuel), can improve consumer access and affordability and lessen the administrative burden on psychologists, there are numerous questions outstanding about safety, privacy, reliability, and equity. The dangers of AI-generative chatbots have been the subject of increased scrutiny and are at the center of two lawsuits.

In a letter to the Federal Trade Commission (FTC), the American Psychological Association (APA) expressed its "grave concerns about "entertainment" chatbots that purport to serve as companions or therapists. The letter highlighted concerns that some technologies available to the public lack appropriate safeguards, adequate transparency, or the warning and reporting mechanisms necessary to ensure appropriate use and access by appropriate users.[5] The APA urged the FTC to investigate "the prevalence and impacts of deceptive practices employed by AI-generative chatbots and other AI-related technologies like Character.ai, Replika, and other companies for developing and perpetuating AI-generated characters that engage in misrepresentations and for engaging in deceptive trade practices, passing themselves off as trained mental health providers, and potentially causing harm to the public."

As reported by the *New York Times*, a lawsuit against Character.ai has been filed by the mother of a Florida teen who died by suicide after interacting with a chatbot claiming to be a licensed psychologist.[6] A second lawsuit was initiated by the parents of a Texas teen with autism grew hostile and violent towards them during a period of time when he was interacting with a chatbot claiming to be a psychologist. According to *The Washington Post*, he had also begun harming himself and lost 20 pounds.[7]

Although the dangers of these chatbots are well documented, they are popular. Some of Character.ai's chatbots have had more than one million conversations with users. In its letter to the FTC, the APA argues that:

> Given that the fundamental purpose of professional licensing is consumer protection, there is a compelling legal argument that the same prohibitions contained in professional licensing laws restricting unqualified individuals from referring to themselves as a "psychologist" or "physician" or other licensed professional and attempting to conduct themselves in that way ought to apply these non-human chatbots as well.

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[4] https://abp.assembly.ca.gov/media/1241
[5] Letter from Arthur C. Evans, Chief Executive Officer, American Psychological Association to Federal Trade Commission (Dec. 20, 2024), https://www.apaservices.org/advocacy/generative-ai-regulation-concern.pdf
[6] Ellen Barry, *Human Therapists Prepare for Battle Against A.I. Pretenders,* The New York Times (Feb. 24, 2025), https://www.nytimes.com/2025/02/24/health/ai-therapists-chatbots.html
[7] Nitasha Tiku, *An AI companion suggested he kill his parents. Now his mom is suing.* The Washington Post (Dec. 13, 2024), https://www.washingtonpost.com/technology/2024/12/10/character-ai-lawsuit-teen-kill-parents-texas

This bill would address general concerns about the integration of AI technologies in health care practice settings, and specific concerns about the growing popularity of AI chatbots engaged in psychotherapy, by expressly applying existing title protections to the advertising or functionality of an AI system, program, device, or similar technology. The bill would additionally prohibit the use of any term, letter, or phrase in the advertising or functionality of an AI system, program, device, or similar technology that indicates or implies that the care or advice being offered through the AI technology is being provided by a natural person in possession of the appropriate license or certificate to practice as a health care professional. While it could be argued that existing law could be interpreted to prohibit the types of behaviors addressed by the bill as unfair business practices or the unlicensed practice of medicine, this bill would make the applicability of existing protections explicit for purposes of AI technologies, which would clarify both requirements for compliance and options for enforcement.

Current Related Legislation. SB 579 (Padilla) would require the Secretary of the Government Operations Agency to appoint a mental health and AI working group to evaluate identified issues and determine the role of AI in mental health settings. *This bill is pending in the Senate Committee on Appropriations.*

SB 775 (Ashby) is the current sunset review vehicle for the Board of Psychology and the Board of Behavioral Sciences. *This bill is pending in the Senate Committee on Business, Professions, and Economic Development.*

Prior Related Legislation. SB 1451 (Ashby), Chapter 481, Statutes of 2024 updated existing restrictions on the use of the words "doctor" or "physician" or similar terms by individuals not licensed as physicians and surgeons.

AB 2013 (Irwin), Chapter 817, Statutes of 2024 required a developer of a GenAI system or service to publicly disclose specific information related to the system or service's training data.

AB 3030 (Calderon), Chapter 848, Statutes of 2024, required specified health care providers to disclose the use of a GenAI tool when it is used to generate communications to a patient pertaining to patient clinical information.

ARGUMENTS IN SUPPORT:

SEIU California and the *California Medical Association* (CMA) write jointly in support as co-sponsors of the bill: "AB 489 provides state health professions boards with clear authority to enforce title protections when AI systems or similar technologies, such as internet-based chatbots, misrepresent themselves as health professionals. The bill makes entities that develop and deploy AI systems responsible for any violations of existing title protections and explicitly prohibits AI systems from misrepresenting themselves as human health professionals." SEIU California and CMA argue that "AB 489 is a commonsense step to guarding against these dangers and ensuring that AI technologies are developed and deployed responsibly in healthcare settings. By prohibiting AI systems from misrepresenting themselves as licensed health professionals, this bill protects patients from deception and potential harm."

ARGUMENTS IN OPPOSITION:

There is no opposition on file.

REGISTERED SUPPORT:

California Medical Association *(Co-Sponsor)*
SEIU California *(Co-Sponsor)*
American College of Obstetricians & Gynecologists – District IX
California Academy of Child and Adolescent Psychiatry
California Alliance of Child and Family Services
California Association of Orthodontists
California Dental Association
California Orthopedic Association
California Psychological Association
California Radiological Society
California Retired Teachers Association
CFT – a Union of Educators & Classified Professionals, AFT, AFL-CIO
County Behavioral Health Directors Association
Kaiser Permanente
National Union of Healthcare Workers
Oakland Privacy
Steinberg Institute

REGISTERED OPPOSITION:

None on file

Analysis Prepared by: Robert Sumner / B. & P. / (916) 319-3301, Kaitlin Curry / B. & P. / (916) 319-3301

Date of Hearing: April 1, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 511 (Chen) – As Introduced February 10, 2025

SUBJECT: Radiologist assistants.

SUMMARY: Prohibits a person from holding themselves out as a radiologist assistant (RA) or using the RA title or any other term to imply or to suggest that the person is an RA unless the person meets specified requirements.

EXISTING LAW REGARDING RADIOLOGY PROFESSIONALS:

1) Regulates the practice of medicine under the Medical Practice Act and establishes the Medical Board of California to administer and enforce the act. (BPC §§ 2000-2529.6)

2) Prohibits the practice, attempt to practice, advertisement of, or holding out as practicing any system or mode of treating the sick or afflicted, or diagnosis, treatment, operation for, or prescription for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of doing so a valid, unrevoked, or unsuspended medical license or being otherwise authorized under state law to perform the medical act. (BPC § 2052)

3) Regulates the practice of nursing under the Nursing Practice Act and establishes the Board of Registered Nursing to administer and enforce the act, including the licensure of registered nurses and the certification of nurse practitioners (NPs). (BPC §§ 2700-2838.4)

4) Regulates the practice of physician assistants (PAs) under the Physician Assistant Practice Act and establishes the Physician Assistant Board to administer and enforce the act. (BPC §§ 3500-3545).

5) Regulates radiologic technology under the Radiology Technology Act to protect the public and radiation workers from excessive or improper exposure to ionizing radiation and requires the California Department of Public Health (CDPH) to administer and enforce the act. (Health and Safety Code (HSC) §§ 27(f), 106965-107115, 114840-114896)

6) Prohibits any person from administering or using diagnostic or therapeutic X-rays on human beings unless that person has been certified as a radiologic technologist (RT) or granted a permit as specified, is acting within the scope of that certification or permit, and is acting under the supervision of a licentiate of the healing arts. (HSC § 106965)

7) Authorizes CDPH to deny, revoke, or suspend certificates and permits, as specified. (HSC § 107070)

8) Establishes civil and misdemeanor penalties for violations of the Radiologic Technology Act. (HSC § 107075)

9) Requires the CDPH to appoint a Radiologic Technology Certification Committee to assist, advise, and make recommendations for the establishment of regulations necessary to ensure

the proper administration and enforcement of radiologic technology certification. (HSC §§ 114850(b), 114855)

10) Specifies the composition of the certification committee, including six physicians, 3 of whom are certified in radiology, two certified RTs, one radiological physicist, one podiatrist, and one chiropractor. (HSC § 114860)

EXISTING LAW REGARDING NEW REGULATION OF A PROFESSION:

1) Establishes requirements and procedures for legislative oversight of the formation of new state boards and categories of licensed of professional practice. (Government Code (GOV) §§ 9148-9148.8)

2) Defines "license" as a license, certificate, registration, or other means to engage in a business or profession regulated under the BPC unless otherwise expressly provided. (BPC §§ 23.7, 1000, 3600)

3) Requires, before consideration by the Legislature of legislation creating a new state board or legislation creating a new category of licensed professional, that the author or sponsor of the legislation develop a plan for the establishment and operation of the proposed state board or new category of licensed professional. (GOV § 9148.4)

4) The plan must include all of the following:

   a) A description of the problem that the creation of the specific state board or new category of licensed professional would address, including the specific evidence of need for the state to address the problem. (GOV § 9148.4 (a))

   b) The reasons why this proposed state board or new category of licensed professional was selected to address this problem, including the full range of alternatives considered and the reason why each of these alternatives was not selected. (GOV § 9148.4(b))

   c) Alternatives that shall be considered include, but are not limited to, the following:

      i) No action taken to establish a state board or create a new category of licensed professional. (GOV § 9148.4(b)(1))

      ii) The use of a current state board or agency or the existence of a current category of licensed professional to address the problem, including any necessary changes to the mandate or composition of the existing state board or agency or current category of licensed professional. (GOV § 9148.4(b)(2))

      iii) The various levels of regulation or administration available to address the problem. (GOV § 9148.4(b)(3))

      iv) Addressing the problem by federal or local agencies. (GOV § 9148.4(b)(4))

   d) The specific public benefit or harm that would result from the establishment of the proposed state board or new category of licensed professional, the specific manner in which the proposed state board or new category of licensed professional would achieve this benefit and the specific standards of performance which shall be used in reviewing

the subsequent operation of the board or category of licensed professional. (GOV § 9148.4(c))

e) The specific source or sources of revenue and funding to be utilized by the proposed state board or new category of licensed professional in achieving its mandate. (GOV § 9148.4(d))

f) The necessary data and other information required in this section shall be provided to the Legislature with the initial legislation and forwarded to the policy committees in which the bill will be heard. (GOV § 9148.4(e))

5) Authorizes the appropriate policy committee of the Legislature to evaluate the plan prepared in connection with a legislative proposal to create a new state board and provides that, if the appropriate policy committee does not evaluate a plan, then the Joint Sunset Review Committee shall evaluate the plan and provide recommendations to the Legislature. (GOV § 9148.8)

THIS BILL:

1) Makes various findings and declarations regarding RAs.

2) Prohibits a person from holding themselves out to be an RA, or use the title of "radiologist assistant," or any other term, to imply or to suggest that the person is an RA, unless the person meets all of the following requirements:

a) The person has passed the RA examination administered by the American Registry of Radiologic Technologists, the radiology practitioner assistant examination administered by the Certification Board for Radiology Practitioner Assistants, or another examination offered by a successor or comparable entity that has been determined by the CDPH to evaluate the knowledge and skills necessary to ensure the protection of the public and has been approved by the CDPH.

b) The person maintains current registration with the American Registry of Radiologic Technologists, the Certification Board for Radiology Practitioner Assistants, or a successor or comparable entity.

c) The person is certified or permitted to conduct radiologic technology in this state or possesses an RA license from another state that licenses RAs.

3) Requires an RA to work only under the supervision of a radiologist.

4) Prohibits an RA from functioning in their capacity as an RA independent of a supervising radiologist.

5) Prohibits an RA from interpreting images, making diagnoses, or prescribing medications or therapies.

6) Authorizes an RA to administer prescribed drugs only as directed by a supervising radiologist or their designee.

7) Authorizes an RA to communicate and document initial clinical and imaging observations or procedures only to a radiologist for the radiologist's use.

8) Authorizes an RA to communicate a supervising radiologist's report to an appropriate health care provider consistent with the American College of Radiology guideline for communicating diagnostic imaging findings.

9) Authorizes a supervising radiologist to delegate to an RA, as the radiologist determines appropriate to the RA's competence, those tasks or services that a radiologist usually performs and is qualified to perform.

10) Specifies that the provisions of this bill do not affect any existing duties for a radiologic technologist or any existing requirements for the supervision of a radiologic technologist.

11) Specifies that a violation of the provisions of this bill do not constitute a misdemeanor violation of the Radiologic Technology Act.

FISCAL EFFECT: Unknown. This bill is keyed fiscal by the Legislative Counsel.

Comments:

Purpose. This bill is sponsored by the *American Registry of Radiologic Technologists*. According to the author, "[This bill] builds off the Legislature's previous work to ensure patient safety and uphold the dignity of work in healthcare settings. This bill codifies protections to safeguard the Radiologist Assistant (RA) position, and builds out a framework to ensure the longevity of this role in the years to come."

Background. According to the sponsor, an RA is a medical radiographer who is certified by the American Registry of Radiologic Technologists (ARRT) as a Registered Radiologist Assistant (RRA) or by the Certification Board for Radiology Practitioner Assistants (CBRPA) as a Radiology Practitioner Assistant (RPA) to perform radiology services under the supervision of a radiologist. RAs can perform patient assessment, patient management, and certain imaging procedures, including fluoroscopy, but not image interpretation. Currently in California, RAs are certified as RTs and required to hold a license as a certified diagnostic RT and an RT fluoroscopy permit.

RAs must obtain a minimum of a bachelor's degree for RPA certification and a master's or higher for an RRA certification, complete an RA educational program approved by either the ARRT or the CBRPA, pass an examination offered by the relevant organization, and obtain and maintain the certificate. The RA training goes beyond what is required for RTs, preparing RAs to become advanced practice RTs or radiologist extenders.

Radiologic Technologists. RTs work with ionizing radiation and their education, training, and experience requirements are designed to prevent excessive and improper exposure to ionizing radiation. RTs generally obtain a two-year associate's degree in Radiologic Technology. After obtaining their degree, students are eligible to take the California examination for a diagnostic or therapeutic radiologic technology certificate. They are also eligible to take the national examination for a therapeutic radiologic technology certificate. Both examinations, state and national, are administered by the ARRT. Successful passage of an examination qualifies an RT to

X-ray any part of the body. Those who obtain California state certification may also apply for additional certificates, such as the RT Fluoroscopy Permit or the Mammographic Radiologic Technology Certificate if they the requirements. RTs may also become certified in radiation therapy technology through the ARRT. According to the American Society of Radiologic Technologists, RTs practice in hospitals, clinics, and physician's offices across many specialties, from prenatal care to orthopedics.

Radiology. Radiographers perform the imaging aspect of radiology. Radiology is a branch of medicine that uses imaging technology to diagnose and treat disease. The primary medical practitioner of radiology is the radiologist. Radiologists are physician and surgeons who specialize in diagnosing and treating injuries and diseases using radiology, including medical imaging procedures like X-rays, computed tomography (CT), magnetic resonance imaging (MRI), nuclear medicine, positron emission tomography (PET), and ultrasound. Podiatrists and chiropractors also perform radiology within their scope of practice.

Radiologic Technology Act. The Radiologic Technology Act was enacted to protect the public from excessive or improper exposure to ionizing radiation via X-rays. It requires that any individual who uses X-rays on humans for diagnostic or therapeutic purposes meet certain standards of education, training, and experience.

Ionizing radiation is a form of radiation that has enough energy to potentially cause damage to DNA. Risk factors for harm include the radiosensitivity of body organs, the nature and complexity of procedures to be performed, the radiation safety protection problems associated with X-ray procedures, the types of patients to be X-rayed (e.g., ambulatory, geriatric, pediatric, bedridden, non-ambulatory), whether contrast media is used for a procedure, the types of facilities (e.g., hospitals, surgery centers, physician or podiatry offices) and equipment to be encountered (e.g., radiographic, fluoroscopic, portable, mobile and computerized tomography equipment, and ancillary medical equipment such as infusion pumps or contrast injectors), and the types of imaging systems used.

The Radiologic Health Branch (RHB) of the CDPH administers and enforces the Radiologic Technology Act, including the education, training, and licensing requirements. It also administers the meetings of the Radiologic Technology Certification Committee (RTCC). RTCC assists, advises, and makes recommendations for ensuring proper administration and enforcement of the act.

Prior Related Legislation. AB 3097 (Chen) of 2024 was substantially similar to this bill. *AB 3097 was held on the Assembly Appropriations Committee suspense file.*

SB 377 (Hertzberg) of 2022 was substantially similar to this bill. *SB 377 was held on the Senate Appropriations Committee suspense file,*

SB 480 (Archuleta), Chapter 336, Statutes of 2020, before being amended to address a different subject, would have established the RA Advisory Committee under the Medical Board of California to identify the appropriate training, qualifications, and scope of practice for individuals assisting radiologists.

AB 352 (Eng) of 2012 would have established title protection for certified RAs. *AB 352 died pending a hearing in the Assembly Business, Professions and Consumer Protection Committee*.

AB 623 (Lieu) of 2007 would have established an RA certificate program under the CDPH. *AB 623 was held on the Appropriations Committee suspense file.*

SB 700 (Aanestad) of 2005 would have established an RA certificate program under the CDPH. *SB 700 died pending a hearing in the Senate Business, Professions and Economic Development Committee.*

ARGUMENTS IN SUPPORT:

The *American Registry of Radiologic Technologists* (sponsor) writes in support:

> Today, 31 states license, accept, or otherwise recognize the RA. Federal agencies and state governments continue to agree that RAs greatly increase hospital efficiency, improve access to patient care (especially in rural areas), while providing the highest levels of radiation safety. Other than a radiologist, no other practitioner gets as much specialized training in radiology services and radiation safety as the RA.
>
> The fact is, RAs extend the reach of the radiologist and free [them] to focus on those services only the radiologist can provide such as performing complex procedures, consulting with their referring primary care colleagues, interpreting images, and generally diagnosing and treating patients. What's more, RAs help alleviate physician burnout.
>
> As the need for more highly trained medical personnel in the state increases, it is imperative the state keep pace with the rest of the country and recognize the RA profession so they can operate in the state and provide high quality medical care to all Californians.

The *American Society of Radiologic Technologists* (ASRT) writes in support, "ASRT applauds the introduction of [this bill]. By requiring radiologist assistants to hold a credential through a nationally recognized credentialing organization and be registered by the state under [this bill], California is taking a critical step to ensure Californians receive safe, high-quality care."

The *California Radiological Society* writes in support, "RAs in California are not allowed to practice according to their training since there is currently no recognition of the advanced level practitioner. [This bill] would create that opportunity and allow radiology groups to incorporate these professionals into their practice to delegate tasks under their supervision. It would help address the growing issue of workforce capability, complexity of radiology/ imaging practice with the volume of images to be reviewed. This limited delegation of appropriate duties would help address the workload and workforce issues."

ARGUMENTS IN OPPOSITION:

There is no opposition on file.

SUNRISE REVIEW:

When there are proposals for new or expanded regulation of an occupation, legislators and administrative officials are expected to weigh arguments regarding the necessity of the proposed

regulation, determine the appropriate level of regulation (e.g., registration, certification, or licensure), and select a set of standards (education, experience, examinations). As a result, the Legislature uses a process known as "sunrise" to review and assess the proposals.

The process includes a questionnaire and a set of evaluative scales to be completed by the group supporting regulation. The questionnaire is an objective tool for collecting and analyzing information needed to arrive at accurate, informed, and publicly supportable decisions regarding the merits of regulatory proposals.

The Need for Sunrise. New regulatory and licensing proposals are generally intended to assure the competence of specified practitioners in different occupations. However, these proposals have resulted in a proliferation of licensure and certification programs, which are often met with mixed support. Proponents argue that regulation benefits the public by assuring competence and an avenue for consumer redress. Critics argue that regulation benefits a profession more than it benefits the public.

Sunrise helps distill those arguments by: (1) placing the burden of showing the necessity for new regulations on the requesting groups; (2) allowing the systematic collection of opinions both pro and con; and (3) documenting the criteria used to decide upon new regulatory proposals.

Sunrise has been in law since 1990, but recent studies continue to support the need for the process. Specifically, those studies show that, while licensing and other forms of regulation may increase employment opportunities and raise wages, they can also have negative or unintended economic impacts, such as shortages of practitioners or increased costs for services.[1]

In response to concerns over the growing number of professions requiring a license, the White House issued a report in 2015, *Occupational Licensing: A Framework for Policymakers*. The report agreed that, while licensing offers important protections to consumers and can benefit workers, there are also substantial costs, and licensing requirements may not always align with the skills necessary for the profession being licensed. Specifically, the report found:

> There is evidence that licensing requirements raise the price of goods and services, restrict employment opportunities, and make it more difficult for workers to take their skills across State lines. Too often, policymakers do not carefully weigh these costs and benefits when making decisions about whether or how to regulate a profession through licensing. In some cases, alternative forms of occupational regulation, such as State certification, may offer a better balance between consumer protections and flexibility for workers.

Levels of Regulation. If a review of the proponents' case indicates that regulation is necessary to protect public health, safety, and welfare, then a determination must be made regarding the

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[1] See generally, Morris M. Kleiner, *Reforming Occupational Licensing Policies*, Discussion Paper 2015-01 (The Hamilton Project, Brookings Institution, March 2015); Michelle Natividad Rodriguez and Beth Avery, *Unlicensed & Untapped: Removing Barriers to State Occupational Licenses for People with Records* (National Employment Law Project, April 2016); *Jobs for Californians: Strategies to Ease Occupational Licensing Barriers,* Report #234 (Little Hoover Commission, 2016); Dick M. Carpenter II, Lisa Knepper, Kyle Sweetland, and Jennifer McDonald, *License to Work: A National Study of Burdens from Occupational Licensing*, 2nd Edition (Institute for Justice, November 2017); Adam Thierer and Trace Mitchell, *Occupational Licensing Reform and the Right to Earn a Living: A Blueprint for Action* (Mercatus Center/George Mason University April 2020).

appropriate level of regulation. As noted above, the public is often best served by minimal government intervention. The definitions and guidelines below are intended to facilitate the selection of the least restrictive level of regulation that will adequately protect the public interest.

Level I: Strengthen existing laws and controls. The choice may include providing stricter civil actions or criminal prosecutions. It is most appropriate where the public can effectively implement control.

Level II: Impose inspections and enforcement requirements. This choice may allow inspection and enforcement by a state agency. These should be considered where a service is provided that involves a hazard to the public health, safety, or welfare. Enforcement may include recourse to court injunctions and should apply to the business or organization providing the service, rather than the individual employees.

Level III: Impose registration requirements. Under registration, the state maintains an official roster of the practitioners of an occupation, recording also the location and other particulars of the practice, including a description of the services provided. This level of regulation is appropriate where any threat to the public is small.

Level IV: Provide an opportunity for certification. Certification is voluntary; it grants recognition to persons who have met certain prerequisites. Certification protects a title: non-certified persons may perform the same tasks but may not use "certified" in their titles. Usually, an occupational association is the certifying agency, but the state can be one as well. Either can provide consumers a list of certified practitioners who have agreed to provide services of a specified quality for a stated fee. This level of regulation is appropriate when the potential for harm exists and when consumers have a substantial need to rely on the services of practitioners.

Level V: Impose licensure requirements. Under licensure, the state allows persons who meet predetermined standards to work at an occupation that would be unlawful for an unlicensed person to practice. Licensure protects the scope of practice and the title. It also provides for a disciplinary process administered by a state control agency. This level of regulation is appropriate only in those cases where a clear potential for harm exists and no lesser level of regulation can be shown to adequately protect the public.

Sunrise Criteria and Questions. Central to the sunrise process are nine sunrise criteria, which were developed in coordination with the Department of Consumer Affairs to provide a framework for evaluating the need for regulation. These criteria are:

1) Unregulated practice of the occupation in question will harm or endanger the public health, safety or welfare.
2) Existing protections available to the consumer are insufficient.
3) No alternatives to regulation will adequately protect the public.
4) Regulation will alleviate existing problems.
5) Practitioners operate independently, making decisions of consequence.
6) The functions and tasks of the occupation are clearly defined.
7) The occupation is clearly distinguishable from other occupations that are already regulated.
8) The occupation requires knowledge, skills, and abilities that are both teachable and testable.
9) The economic impact of regulation is justified.

The criteria were used to develop the sunrise questionnaire noted above and help legislators and administrators answer three policy questions:

1) Does the proposed regulation benefit the public health, safety, or welfare?
2) Will the proposed regulation be the most effective way to correct existing problems?
3) Is the level of the proposed regulation appropriate?

Sunrise Analysis. The following analysis is based on the above criteria and corresponding questions and answers provided by the author, sponsor of the bill, and applicant group in the sunrise questionnaire. The applicant group is the *California Coalition for Radiologist Assistants* (CCRA). According to the CCRA, "We are a coalition of the California Society of Radiologic Technologists, including the [Society of Radiology Physician Extenders (SRPE)], the [American Registry of Radiologic Technologists (ARRT)], and [American Society of Radiologic Technologists (ASRT)]."

Criteria 1. Unregulated practice of RAs will harm or endanger the public health, safety, or welfare. While RAs are not specifically regulated as RAs, all aspects of the RA practice proposed under this bill are regulated in other ways. The lower levels of RA practice are regulated through the certification of RTs, and the higher levels of practice are regulated through the licensure of physicians, physician assistants, and nurse practitioners. If harm is occurring, the practitioner causing the harm will have their license or certificate disciplined. Unlicensed radiology practice, particularly at the higher level of an RA, is also highly unlikely, as the radiological procedures often require expensive and sophisticated equipment and the results would ultimately have to be interpreted by a radiologist or other authorized licensee.

As a result, the applicants acknowledge that there is not currently a significant public demand for the regulation of RAs on the basis of harm, nor is there significant demand generally outside of the radiology community. Instead, they argue that the regulation of RAs will help carve out a regulatory space to practice, increasing public exposure to services specific to RAs and creating additional demand. The applicants specifically note, "The basis for the application is the attempt to improve efficiency and reduce the cost to consumers."

Of the conceptual harms, the applicants note the following:

- "Fluoroscopy and CT scans use radiation for image-guided [procedures] are dangerous in unqualified hands. The more skilled a practitioner is in using these procedures, the less a consumer will be exposed to radiation."

- "There is always the risk of burns from over-radiation, but also, long term risks include cancers that are not easily traceable to radiation. The [radiologic] technologist unqualified in performing an RA's tasks would also risk misdiagnosis of disease."

- "RAs are highly specialized in their area of expertise and have specific training in radiation safety, equipment operation, and all the things needed to prevent patient harm."

On the frequency of harms, the applicants note, "There are examples of radiation burns and over-radiation, but are often [settled] out of court… Harm is more likely to occur to the consumer when other providers are practicing procedures that they rarely or infrequently perform. The

risks from providers who do not have the extensive education and clinical training that RA's have, are greatly increased."

While the applicants did provide examples of harm from over-radiation, the two case examples are media articles covering investigations into the harm, which do not go into enough detail to determine whether any particular type of practitioner was the cause of the harm.

Another potential data point would be CDPH enforcement. While this bill does not require the CDPH to regulate the certification of RAs, it does amend the RT Act, which CDPH is required to enforce. The CDPH has previously stated (in the context of SB 377 (Hertzberg) of 2022, which was identical to this bill) that it annually conducts an average of three enforcement actions on similar scope of practice issues.

Criteria 2. Existing protections available to the consumer are insufficient. As noted above, this sunrise application is primarily about providing pathways for RAs to practice. However, while RAs are not specifically licensed, they can currently practice as RTs or theoretically as PAs or NPs who completed multiple pathways for training. As a result, the applicants argue "that there is a lack of clarity both for the consumer and the provider."

Criteria 3. No alternatives to regulation will adequately protect the public. Applicants argue that the following non-governmental avenues are insufficient:

1) Code of ethics: "ARRT has an active ethics enforcement program and California patients would benefit from it. If the RA does not become licensed, then RAs will journey to states where their employers can be paid by Medicare and Medicaid (at least 60% of patients) for RA performed tests and procedures"

2) Codes of practice enforced by professional associations:

    a) "Standards of Practice are developed, published, and adopted by the American Society of Radiologic Technologists… and the Certification Board for Radiology Practitioner Assistants that outline acceptable practice for the RAs. There is no enforcement mechanism for those unless there is a state statute that references them."

    b) "The Rules of Ethics are enforced by the ARRT and CBRPA. When a rule of ethics violation happens in a state, it is usually reported to the state's licensing agency, the oversight board, or advisory committee. Those agencies or boards notify ARRT. It is not usual to see something like this come from an individual that is not related to the state agencies that oversee licensure."

The applicants do not make arguments for the inadequacy of dispute-resolution mechanisms such as mediation or arbitration, recourse to currently applicable law, or regulation of those who employ or supervise practitioners.

Criteria 4. Regulation will mitigate existing problems. According to the applicants, the primary problems that would be addressed are quality and access to care. According to the applicants, "The public's best chance for high quality patient care and radiation safety is to recognize educationally prepared and clinically competent providers." As a specific example, they cite that

"at Memorial Sloan Kettering Cancer Center show, patient satisfaction scores are noticeably higher when radiology departments employ RAs."

The applicants argue that this bill would also increase access to radiology services by establishing a workforce of radiologist extenders, creating an avenue for reducing the workload of radiologists. Specifically, they write:

> For non-critical access hospitals in rural areas that frequently have less than 5 radiologists on staff, employing an RA could increase the availability of times that fluoroscopy procedures and minor procedures could be performed. The smaller facilities must limit the number of these types of procedures they can do each day that require a radiologist because the radiologists need to spend most of their time interpreting images. With the RA, the facilities could open up more time slots for these procedures.
>
> Rural hospitals with limited radiologist coverage often manage multiple modalities. Typically, only one radiologist is assigned to fluoroscopy and minor procedures, but they still must perform all the regular interpretations. In these settings, radiology departments are only able to schedule regular fluoroscopy and minor procedures for 1-2 hours per day and patients have to wait for the next available time slot. With an RA, these facilities can do those procedures for 6-7 hours a day, greatly improving rural access to care.

Criteria 5. Practitioners operate independently, making decisions of consequence. While RAs operate under the supervision of radiologists, their function is to extend the reach of the radiologist's practice and independently exercise judgement in delegated duties. According to the applicants, "Nearly every action that an RA takes is a professional judgment such as: how much radiation is needing to be used, needle placement for lumbar puncture, etc…. One example would be the use of fluoroscopy (high levels of radiation) generally involving image guided procedures."

Criteria 6. Functions and tasks of the occupation are clearly defined. The functions and tasks of RAs are well established via the existing voluntary certification requirements and radiology practice generally, although the day to day practice of any individual RA will depend on the supervising radiologist. This model is similar to PAs under practice agreements or NPs under standardized procedures, although the scope of practice is much broader for PAs and NPs.

Criteria 7. The occupation is clearly distinguishable from other occupations that are already regulated. As noted above, RTs, NPs, and PAs theoretically cover the range of services RAs provide, although RTs would not reach the upper end of services and CDPH does not issue fluoroscopy permits to NPs. In addition, NPs and PAs, like physician radiologists, begin as generalists so would likely need to seek additional training in radiology.

Criteria 8. The occupation requires possession of knowledge, skills, and abilities that are both teachable and testable. Based on the information provided by the applicants and as discussed above, the RA education, examination, and certification process are well established. This career pathway is utilized in other states where RAs are licensed.

Criteria 9. The economic impact of regulation is justified. This bill would only have a financial impact on those who wish to use the title RA and practice as specified under the bill. For those who already fill the practice space the proposed RA would practice in (e.g. RTs, NPs, or PAs), there would be no change unless they wanted to use the title but did not meet the certification requirements under the bill. For those who already meet the requirements of the bill, there would be no impact. The only impact would be to those who currently use the title RA and do not meet the requirements under this bill, although it is unclear how much that is occurring. There may be some inadvertent or otherwise non-objectionable usage, such as an unlicensed medical assistant or RT whose position at work is titled "RA," but that situation can likely be remedied by the employer.

POLICY ISSUES FOR CONSIDERATION:

Sunrise Review. As noted above, the criteria and the sunrise questionnaire are intended to assist policymakers in answering the following questions:

1) *Does the proposed regulation benefit the public health, safety, or welfare?* Based on the information provided by the author, sponsor, applicant group, and supporters, there is demand for RAs in radiology practice, and RAs extending the functions of radiologists may help with workforce issues. However, the sponsor's last estimate (2022) was that there were about 73 RAs in California and 660 RAs nationwide. The sponsor and supporters hope that state recognition, additional practice authority, and the potential to bill Medicare will increase interest in the profession.

2) *Will the proposed regulation be the most effective way to correct existing problems?* This is unclear. The reason RAs are unable to practice to the higher end of their training is that the existing licensing structure of medicine and radiologic technology precludes them from doing so. The approach under this bill is to carve out functions in that regulated practice space and authorize RAs to perform them. There may be other approaches that are conceptually different (i.e. do not create new regulatory requirements on an occupation) that have not been explored, but they would likely require more comprehensive changes to other licensing structures or move the bill outside the jurisdiction of this committee. One option might be authorizing the facilities where radiology is performed to allow more advanced practices under specified circumstances.

3) *Is the level of the proposed regulation appropriate?* When discussing the original proposal (AB 3097 (Chen) of 2024) the author and sponsors agreed to a lower level of regulation, from licensure (Level V) to voluntary certification and title protection (Level IV). It is unclear if a lower level of regulation would achieve the goals of the bill. Strengthening existing laws (Level I), imposing inspections and enforcement requirements (Level II), and establishing a registry without certification or title protection requirements (Level III) are focused on reducing consumer harm, which is not the primary goal of this bill. Registration would also not authorize more advanced practice, and would unnecessarily require more state resources as all RAs are registered with their certifying entities.

IMPLEMENTATION ISSUES:

Definition of Radiologist. This bill requires RAs to be supervised by radiologists but does not define the term "radiologist." While the title "radiologist" is understood to mean a physician who

specializes in radiology, there are varying levels of specialty, such as board certification and fellowships. On the other hand, a physician interpreting radiological images in a rural area would be acting in the capacity of a radiologist. Similar logic applies to a doctor of podiatric medicine who is permitted by the RHB to perform radiology. If this bill passes this committee, the author may wish to consider defining radiologist for purposes of who may supervise an RA.

REGISTERED SUPPORT:

American Registry of Radiologic Technologists (sponsor)
American Society of Radiologic Technologists
California Radiological Society

REGISTERED OPPOSITION:

There is no opposition on file.

Analysis Prepared by: Vincent Chee / B. & P. / (916) 319-3301

Date of Hearing: April 1, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 516 (Kalra) – As Introduced February 10, 2025

SUBJECT: Registered veterinary technicians and veterinary assistants: scope of practice

SUMMARY: Authorizes registered veterinary technicians (RVTs) and veterinary assistants to perform animal health care services not otherwise prohibited by law or regulation, including on animals housed in public or private animal shelters, humane societies, or societies for the prevention of cruelty to animals.

EXISTING LAW:

1) Provides for the regulation of veterinary medicine under the Veterinary Medicine Practice Act (Act) and prohibits the practice unlicensed of veterinary medicine. (Business and Professions Code (BPC) §§ 4800-4917)

2) Establishes the Veterinary Medical Board (VMB) within the Department of Consumer Affairs (DCA) to license and regulate the veterinary medicine profession. (BPC § 4800)

3) Declares it is unlawful to practice veterinary medicine in California unless the individual holds a valid, unexpired, and unrevoked license issued by the VMB. (BPC § 4825)

4) Provides that an individual practices veterinary medicine, surgery, and dentistry, and the various branches thereof, when the practitioner does any one of the following:

    a) Represents oneself as engaged in the practice of veterinary medicine, veterinary surgery, or veterinary dentistry in any of its branches.

    b) Diagnoses or prescribes a drug, medicine, appliance, application, or treatment of whatever nature for the prevention, cure, or relief of a wound, fracture, bodily injury, or disease of animals.

    c) Administers a drug, medicine, appliance, application, or treatment for the prevention, cure, or relief of a wound, fracture, bodily injury, or disease of animals, as specified.

    d) Performs a surgical or dental operation upon an animal.

    e) Performs any manual procedure for the diagnosis of pregnancy, sterility, or infertility upon livestock or Equidae.

    f) Collects blood from an animal for the purpose of transferring or selling that blood and blood component products to a licensed veterinarian at a registered premise.

    g) Uses any words, letters, or titles in such connection or under such circumstances as to induce the belief that the person using them is engaged in the practice of veterinary medicine, veterinary surgery, or veterinary dentistry, as specified.

    (BPC § 4826)

5) Permits a veterinarian to authorize an RVT to act as an agent of the veterinarian for the purpose of establishing the veterinarian-client-patient relationship to administer preventive or prophylactic vaccines or medications for the control or eradication of apparent or anticipated internal or external parasites, subject to certain conditions, including:

    a) Vaccines must be administered in a registered veterinary premises at which the veterinarian is physically present.

    b) If working at a location other than a registered veterinary premises, the veterinarian is in the general vicinity or available by telephone and is quickly and easily available. The RVT shall have necessary equipment and drugs to provide immediate emergency care.

    c) The RVT examines the animal patient and administers vaccines in accordance with written protocols and procedures established by the veterinarian.

    d) The veterinarian and RVT sign and date a statement containing an assumption of risk by the veterinarian for all acts of the RVT related to patient examination and administration of vaccines, short of willful acts of animal cruelty, gross negligence, or gross unprofessional conduct on behalf of the RVT.

    e) The veterinarian and RVT sign and date a statement containing authorization for the RVT to act as an agent of the veterinarian until such date as the veterinarian terminates authorization.

    f) Before the RVT examines or administers vaccines to the animal patient, the RVT informs the client orally or in writing that they are acting as an agent of the veterinarian.

    g) Signed statements between the veterinarian and RVT must be retained by the veterinarian for the duration of the RVT's work as an authorized agent and until three years from the date of termination of their relationship with the veterinarian.

    (BPC § 4826.7(b))

6) Requires all veterinarians engaged and employed as veterinarians by the state, or a county, city, corporation, firm, or individual to secure a license issued by the VMB. (BPC § 4828)

7) Requires the VMB to adopt regulations delineating animal health care tasks and an appropriate degree of supervision required for those tasks that may be performed solely by an RVT or licensed veterinarian. (BPC § 4836(a))

8) Permits the VMB to additionally adopt regulations establishing animal health care tasks that may be performed by a veterinary assistant, an RVT or a licensed veterinarian. (BPC § 4836(b))

9) Requires the VMB to establish an appropriate degree of supervision by an RVT or a licensed veterinarian over a veterinary assistant for any authorized tasks and provides that the degree of supervision for any of those tasks shall be higher than, or equal to, the degree of supervision required when an RVT performs the task. (BPC § 4836(b))

10) Authorizes the VMB to revoke or suspend the certificate of registration of an RVT, as specified. (BPC § 4837)

11) Prohibits an individual from using the title "RVT," "veterinary technician," or using the initials "RVT" without meeting the requirements of an RVT. (BPC § 4839.5)

12) Defines "direct supervision" as the supervisor physically present at the location where animal healthcare professionals provide care and tasks which are expected to be conducted quickly and are easily available. (California Code of Regulations (CCR), tit. 16, § 2034(e))

13) Defines "indirect supervision" as the supervisor not being physically present at the location where animal healthcare tasks, treatments, procedures, etc. are to be performed, but has given either written or oral instructions ("direct orders") for treatment of the animal and the animal has been examined by a veterinarian in a manner consistent with appropriate delegated animal health care task and that the animal is not anesthetized, as defined. (CCR, tit. 16, § 2034(f))

14) Authorizes RVTs and veterinary assistants to perform those animal health care services prescribed by law under the supervision of a veterinarian licensed or authorized to practice. (BPC § 4840(a))

15) Specifies that an RVT may perform animal health care services on impounded animals by a state, county, city, or city and county agency pursuant to the direct order, written order, or telephonic order of a veterinarian licensed or authorized to practice in California. (BPC § 4840(b))

16) Permits an RVT to apply for registration from the federal Drug Enforcement Administration to allow the direct purchase of sodium pentobarbital for the performance of euthanasia, without the supervision or authorization of a licensed veterinarian. (BPC § 4840(c))

17) Prohibits an RVT from performing the following functions or activities that represent the practice of veterinary medicine, requires the knowledge, skill, and training of a licensed veterinarian:

    a) Surgery;

    b) Diagnosis and prognosis of animal diseases; and

    c) Prescribing drugs, medications, or appliances.

    (BPC § 4840.2)

18) Allows an RVT to perform the following procedures under the direct supervision of a licensed veterinarian:

    a) Induce anesthesia;

    b) Perform dental extractions;

    c) Suture cutaneous and subcutaneous tissues, gingiva, and oral mucous membranes;

d) Create a relief hole in the skin to facilitate placement of an intravascular catheter; and

e) Drug compounding from bulk substances.

(CCR, tit. 16 § 2036(b))

19) Authorizes an RVT to perform the following procedures under indirect supervision of a licensed veterinarian:

a) Administer controlled substances;

b) Apply casts and splints;

c) Provide drug compounding from non-bulk substances.

(CCR, tit. 16 § 2036(c))

20) Prohibits veterinary assistants and veterinary assistant controlled substance permit (VACSP) holders from performing animal healthcare tasks specified to RVTs, except that a VACSP holder may administer a controlled substance under the direct or indirect supervision of a veterinarian. (CCR, tit. 16 § 2036.5(a))

21) Authorizes VACSP holders and veterinary assistants to perform auxiliary animal health care tasks under the direct or indirect supervision of a veterinarian, or under the direct supervision of an RVT, and specifies that the degree of veterinary supervision shall be higher than or equal to the degree of supervision required when an RVT performs the same task. (CCR, tit. 16 § 2036.5(b))

THIS BILL:

1) Authorizes RVTs and veterinary assistants to perform animal health care services not otherwise prohibited by law under the supervision of a licensed veterinarian.

2) Extends the ability for RVTs and veterinary assistants to perform animal health care services not otherwise prohibited by law, pursuant to a direct, written, or telephonic order of a licensed veterinarian, to animals housed in public or private animal shelters, humane societies, or societies for the prevention of cruelty to animals.

3) Clarifies that RVTs may perform dental care procedures, including tooth extractions, under the supervision of a licensed veterinarian.

FISCAL EFFECT: Unknown; this bill is keyed fiscal by the Legislative Counsel.

COMMENTS:

This bill is co-sponsored by the *San Francisco SPCA, California Veterinary Medical Association,* and the *San Diego Humane Society*. According to the author:

> Registered Veterinary Technicians (RVTs) and veterinary assistants are versatile professionals who are allowed to undertake any work task that they are not explicitly forbidden from performing by law. For RVTs specifically, this means that they are allowed

to engage in any task that does not constitute surgery, diagnosis, prognosis, or prescription of medication. However, the regulations governing RVT and veterinary assistant job tasks do not clearly convey this fact, instead creating and perpetuating the misconception that these staff are limited to small, exhaustive lists of duties. Unfortunately, this misconception has spread widely, discouraging many veterinarians from fully utilizing their staff. This results in inefficient veterinary practices, which exacerbate California's ongoing veterinary care shortage. AB 516 will address this issue by clarifying that RVTs and veterinary assistants can carry out any task that they are not forbidden from performing by law, ensuring that veterinarians and their staff can work to their full capacity.

Background.

Veterinarians, RVTs and Veterinary Assistants. In order to practice veterinary medicine and provide healthcare to a variety of animals, veterinarians must secure a license through the VMB. A licensed California veterinarian is authorized to engage in the practice of veterinary medicine, surgery, veterinary dentistry, and related health procedures for the benefit of an animal's general health and wellbeing. Veterinarians are trained and licensed to diagnose, prescribe medication and provide treatment for the animal's health and improvement to the animal's quality of life. Veterinarians are extensively trained, satisfied academic requirements, and provide health care for various animals. Veterinarians receive specific healthcare training as it applies to animals and understanding the nature for the prevention, cure, or relief of a wound, fracture, bodily injury, or disease of animals. In order to practice veterinary medicine in California, an applicant must graduate from a degree program offered by an accredited postsecondary institution or institutions approved by the VMB, pass a national veterinarian examination, and pass an examination provided by the VMB to test the knowledge of the laws and regulations related to the practice of veterinary medicine in California.

RVTs serve a crucial role in the veterinary workforce by providing vital supportive health-related tasks. These health tasks involve drawing blood and conducting laboratory tests, operating radiographic equipment, administering medication, as well as countless other health related procedures. RVTs may perform certain advanced tasks under the direct supervision of a veterinarian, such as the induction of anesthesia, creation a relief hole in the skin to facilitate placement of an intravascular catheter, application casts and splints, performance of dental extractions, suturing of cutaneous and subcutaneous tissues, and more. The VMB's regulations have also stipulated that an RVT may perform a variety of procedures under indirect supervision of a licensed veterinarian. These procedures include the act of administering controlled substances and performing certain routine animal health care tasks.

To qualify for registration as an RVT, three pathways to licensure are available. The first requires graduation from an AVMA accredited RVT program or a VMB-approved RVT program. The second pathway, also known as the "alternate route," requires candidates to complete a combination of 20 semester units, or 30 quarter units or 300 hours of specific education and 4,416 hours of directed clinical practice experience completed in no less than 24 months under the direct supervision of a California licensed veterinarian. Upon completion of first two pathways, candidates must then take a national examination. The third pathway, known as the "Out-of-State Registrant" pathway, is for applicants who are licensed as an RVT in another state, have passed the national examination, and have obtained at least 4,416 hours of directed clinical practice, under the direct supervision of a veterinarian in the 24 months preceding their application.

Veterinary assistants support the delivery of animal healthcare services by performing animal care and administrative tasks under the supervision of a licensed veterinarian or RVT. Veterinary assistants are not licensed or registered by the VMB, and their duties are limited to non-medical or minimally invasive animal care tasks that do not require the clinical judgment or advanced training of veterinarians or RVTs. Common responsibilities include feeding, bathing, and exercising animals, sterilizing surgical and medical equipment, maintaining clean and sanitary conditions in animal care areas, and assisting veterinarians and RVTs during procedures by handling and restraining animals. Veterinary assistants may also provide basic monitoring of animal vital signs and observe animal behavior for changes in condition, reporting concerns to the supervising veterinarian or RVT. Training for veterinary assistants varies and may include on-the-job experience or completion of a certificate program; however, aside from general instruction requirements for certain tasks such as operation radiographic equipment, there is no formal licensing or certification requirement governed by the VMB for veterinary assistants to perform their designated duties.

In 2016, recognizing the need for expanded access to compounded drugs in the veterinary setting, the Legislature established the Veterinary Assistant Controlled Substances Permit (VACSP). Individuals who possess a VACSP are able to perform the functions of a veterinary assistant, but are also approved by the Board to obtain and administer controlled substances. VACSP holders must be at least 18 years of age and must not have been convicted of a state or federal felony controlled substance violation. The VMB conducts a background check to verify VACSP requirements are met. Once the VACSP has been issued, the permit holder is required to establish and maintain a supervisory relationship with a licensed veterinarian.

Expanded Roles for RVTs and Veterinary Assistants. In recent years, there have been efforts to expand the role that RVTs play in the veterinary field, not only to address disparities in veterinary care but to offer further career advancement for experienced RVTs or veterinary assistants that may not have the desire or ability to pursue a full DVM career. Last year the Legislature permitted veterinarians to authorize RVTs to act as an agent of the veterinarian for purposes of establishing a client relationship or administering certain vaccines with the passage of SB 669 (Cortese, Chapter 882, Statutes of 2023). Additionally, in 2021 the VMB promulgated regulations permitting RVTs to perform certain tasks under the direct supervision of a veterinarian, including drug compounding from bulk substances. The regulations also clarified that RVTs may complete other tasks under indirect supervision of a veterinarian, such as the application of casts and splints. These expansions of scope to include less demanding tasks are intended to bridge the gap between the shortage of veterinary professionals and the rising demand for veterinary care.

Nevertheless, veterinary and animal welfare stakeholders—such as the sponsors of this legislation—stated that adoption of these additional tasks and responsibilities among RVTs has been mixed. Stakeholders report that some veterinarians are reticent to authorize certain tasks to RVTs and assistants that are allowed under regulation, such as dental extractions. In other cases, RVTs report hesitance to assume duties now authorized under law or regulation, such as establishing a VCPR for purposes of vaccination, as they are not educated on these statutory and regulatory changes to their profession. As a result, there is concern that some RVTs and veterinary assistants are not performing the full breadth of tasks authorized under their profession, perpetuating care shortages in certain veterinary settings such as shelters. This legislation, which the author states was crafted in consultation with veterinary professionals and animal welfare organizations alike, seeks to clarify that RVTs and veterinary assistants are

allowed to perform tasks that are not explicitly prohibited in statute or regulation and thus encourage greater adoption of these crucial auxiliary and supportive tasks by professionals in the veterinary setting.

Current Related Legislation. AB 867 (Lee) would prohibit a person from performing a declawing or similar procedures on any cat or other animal unless the person is licensed as a veterinarian in California and the veterinarian is performing the declawing for a therapeutic purpose, as defined. *This bill is pending in this committee.*

AB 1502 (Committee on Business and Professions) would extend the sunset date for the California Veterinary Medical Board (VMB) to a future date, as well enact related changes as part of the Joint Legislative Sunset Review process. *This bill is pending in this committee.*

SB 687 (Ochoa-Bogh) would prohibit a chiropractor who is not under the supervision of a veterinarian from practicing animal chiropractic, as defined, without being registered as an animal chiropractic practitioner by the State Board of Chiropractic Examiners and satisfying certain requirements. *This bill is pending consideration in the Senate Business, Professions, and Economic Development Committee.*

Prior Related Legislation. AB 2133 (Kalra) of 2024 would have authorized registered veterinary technicians to perform cat neuter surgery, subject to specified conditions. *This bill was held in the Assembly Committee on Appropriations.*

AB 1535 (Committee on Business and Professions) Chapter 631, Statutes of 2021 enacted various changes to the regulation of veterinarians, RVTs, Veterinary Assistant Controlled Substances Permit (VACSP) holders, veterinary schools, and veterinary premises, stemming from the joint sunset review oversight of the Veterinary Medical Board (Board) by the Assembly Committee on Business and Professions and the Senate Committee on Business, Professions, and Economic Development.

SB 1347 (Galgiani) from 2020 would have expanded exemptions to the practice of veterinary medicine to include specified functions performed at a shelter, as defined, by an employee or volunteer who has obtained specified training. *This bill was held in the Assembly Committee on Appropriations.*

ARGUMENTS IN SUPPORT:

A broad coalition of supporters of this bill, including the bill's co-sponsors, write the following: "Veterinary technicians and assistants play a critical role in providing care to animals across California, supporting veterinarians in shelters, clinics, and hospitals. Under existing law, RVTs are permitted to perform any duty that does not constitute surgery, diagnosis, prognosis, or prescription of medication. However, current regulations are structured in a way that has led to misinterpretation, causing unnecessary and artificial limitations on the scope of practice for RVTs and veterinary assistants. This has resulted in the underutilization of these skilled professionals, exacerbating the ongoing veterinary care shortage in California." The coalition further writes that "AB 516 provides a straightforward solution by affirming that RVTs and veterinary assistants may perform any task not explicitly prohibited by law, allowing veterinary teams to operate more efficiently and effectively."

ARGUMENTS IN OPPOSITION:

There is no opposition on file.

REGISTERED SUPPORT:

California Veterinary Medical Association *(Co-Sponsor)*
San Diego Humane Society *(Co-Sponsor)*
San Francisco SPCA *(Co-Sponsor)*
Act 2 Rescue
American Kennel Club
Best Friends Animal Society
California Animal Welfare Association
Carmel Police Department
City of Sacramento
County of San Diego Animal Services
Friends of the Alameda Animal Shelter
Forgotten Felines of Sonoma County
Humane Society of Imperial County
Humane World For Animals
Inland Valley Humane Society & SPCA
Joybound People & Pets
Marin Humane
Napa County Animal Shelter
Nine Lives Foundation
NorCal Boxer Rescue
NorCal German Shorthaired Pointer Rescue
Palo Alto Humane
Peninsula Humane Society & SPCA
Pets In Need
San Gabriel Valley Humane Society
Santa Barbara Humane
Santa Cruz County Animal Shelter
Social Compassion in Legislation
Stray Cat Alliance
The Dancing Cat
Town of Apple Valley Animal Services
Valley Humane Society, Inc.
Woody Cat Rescue

REGISTERED OPPOSITION:

None on file

Analysis Prepared by: Edward Franco / B. & P. / (916) 319-3301, Robert Sumner / B. & P. / (916) 319-3301

Date of Hearing: April 1, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 521 (Carrillo) – As Introduced February 10, 2025

NOTE: This bill is double referred and if passed by this Committee will be re-referred to the Assembly Judiciary Committee.

SUBJECT: Contractors State License Board: bond deposits: liability for legal fees and costs.

SUMMARY: Shields the Contractors State License Board (CSLB) from liability for legal fees in civil claims involving a contractor's cash deposit in lieu of surety bond.

EXISTING LAW:

1) Establishes, until January 1, 2029, the CSLB under the Department of Consumer Affairs (DCA) to implement and enforce the Contractors State License Law (License Law). (Business and Professions Code (BPC) §§ 7000 *et seq.*)

2) Authorizes the CSLB to appoint a registrar of contractors to be the executive officer and secretary of the CSLB. (BPC § 2011)

3) Requires an applicant for licensure to qualify in regard to their experience and knowledge, as specified. (BPC § 7068)

4) Requires a contractor's bond to be executed by an admitted surety in favor of the State of California, in a form acceptable to the registrar and filed with the registrar by the licensee or applicant. (BPC § 7071.5)

5) Requires an applicant or licensee, as a condition of licensure, to file or have on file a contractor's bond in the sum of $25,000. (BPC § 7071.6(a))

6) Authorizes the CSLB to require, as a condition of licensure, an applicant to post a contractor's bond in the sum of $50,000 until the time that the license is renewed if the applicant has been subject to certain specified disciplinary actions. (BPC § 7071.6(d))

7) Requires an applicant or licensee, as a condition of licensure as a limited liability company, to file or have on file a surety bond in the sum of $100,000. The bond must be executed by an admitted surety in favor of the State of California, in a form acceptable to the registrar, and file with the registrar by the applicant or licensee. The bond is for the benefit of any employee damaged by their employer's failure to pay wages, interest on wages, or fringe benefits and is intended to serve as an additional safeguard for workers employed by or contracted to work for a limited liability company. (BPC § 7071.6.5)

8) Requires, as condition of licensure following the revocation of a license for violating the License Law, an applicant or licensee to file or have on file a contractor's bond in a sum to be fixed by the registrar, based on the seriousness of the violation, but shall not be less than $25,000 nor more than $250,000.

9) Specifies that if the qualifying individual is neither the proprietor, a general partner, nor a joint licensee, the qualifying individual must file or have on file a qualifying individual's bond in the sum of $25,000. This bond is in addition to, and cannot be combined with, any contractor's bond. Neither the responsible managing officer of a corporation nor the qualifying individual for a limited liability company is required to file or have on file a qualifying individual's bond if they own at least 10% of the voting stock of the corporation or at least a 10% membership interest in the limited liability company. (BPC § 7071.9)

10) Specifies that a qualifying individual's bond must be executed by an admitted surety insurer in favor of the State of California, in a form acceptable to the registrar and filed with the registrar by the qualifying individual. The qualifying individual's bond is for the benefit of a homeowner contracting for home improvement; a property owner contracting for the construction of a single-family dwelling; a person damaged as a result of a willful and deliberate violation of the license law, or by the fraud of the licensee in the execution or performance of a construction contract; an employee of the licensee; or a person or entity to which a portion of the compensation of an employee is paid. (BPC § 7071.10)

11) Requires each person licensed by the CSLB and subject to any bond requirement by the License Law to maintain the requisite bond from an admitted surety insurer or as deposited (lawful money or cashier's check) with the registrar in the appropriate amount. (BPC § 7071.4(a))

12) Prohibits the CSLB from accepting any alternatives in lieu of a bond or deposit beginning January 1, 2019. (BPC § 7071.4(e)(1))

13) Specifies that if the CSLB is notified in writing of a civil action against the deposit, the deposit or any portion thereof must not be released for any purpose, except as determined by the court. (BPC § 7071.4(c)(1))

14) Specifies that legal fees may not be charged by the CSLB against any alternative given in lieu of a bond filed with the registrar before January 1, 2019, or deposited with the registrar. (BPC § 7071.4(c)(1))

15) Specifies that a licensee who fails to maintain a sufficient bond as required by the License Law is subject to license suspension or revocation. (BPC § 7071.15)

16) Specifies that a deposit given instead of a bond has the same force and effect, is treated the same, and is subject to the same conditions, liability, and statutory provisions, including provisions for increase and decrease of amount, as the bond. (Code of Civil Procedure (CCP) § 995.730)

17) Authorizes liability on a bond to be enforced by civil action and requires the principal and the sureties to be joined as parties to the action. (CCP § 996.430)

THIS BILL:

1) Exempts CSLB from liability for legal fees or costs in any civil action against any deposit, regardless of when it was filed with the registrar.

FISCAL EFFECT: Unknown. This bill is keyed fiscal by the Legislative Counsel.

COMMENTS:

Purpose. This bill is sponsored by the *Contractors State License Board*. According to the author:

> Protecting CSLB from being held liable for attorney's fees in the event of civil litigation is crucial for the success of our state's infrastructure and housing goals. By maintaining CSLB's focus on licensing and consumer protection, we ensure that resources are directed toward verifying qualified contractors and maintaining public trust. This protection helps streamline the regulatory process, enabling us to continue building the roads, homes, and important infrastructure projects that are essential to our state's growth and prosperity.

Background. The CSLB is responsible for the implementation and enforcement of the License Law, which governs the licensure, practice, and discipline of contractors in California. A license is required for construction projects valued at $1,000 or more, including labor and materials. The CSLB issues licenses to business entities and sole proprietors. Each license requires a qualifying individual (a "qualifier") who satisfies the experience and examination requirements for licensure and directly supervises and controls construction work performed under the license.

A $25,000 contractor's bond must be filed with the CSLB as a condition of licensure. In addition to a contractor's bond, a $25,000 qualifying individual's bond is required if the qualifier is a responsible managing employee (i.e., not the sole owner, general partner, or joint licensee) or if the qualifier is a responsible managing officer, manager, or member who does not own at least 10% of the voting stock or equity of the corporation or limited liability company for which they are the qualifier. Lastly, a disciplinary bond is required before the reinstatement or reissuance of a license previously revoked for violating the License Law. The CSLB's registrar is authorized to determine the disciplinary bond amount between $25,000 and $250,000 based on the seriousness of the violation(s).

Bonds are for the benefit of consumers, employees, and other contractors who may be harmed by an applicant or licensee. Unlike insurance, a bond does not protect the contractor from financial loss if a violation of the License Law results in damages. Instead, the surety compensates the damaged party, but the contractor must reimburse the surety. Sureties generally require a signed indemnity agreement and an annual premium in exchange for a bond, and must be licensed through the California Department of Insurance.

Current law allows applicants and licensees to satisfy the aforementioned bond requirements by providing a cash deposit to the CSLB (i.e., cashier's check or bank-certified check) in lieu of a surety bond. The CSLB is prohibited from releasing any portion of the cash deposit for any purpose except as instructed by a judge. Although the law treats cash deposits the same as surety bonds, the CSLB is not a surety. Nonetheless, a recent appellate court decision in *Karton v. Ari Design & Construction*, *Inc.,* which extended liability for attorney fees to the defendant's surety company, exposes CSLB to liability for attorney fees in civil cases relating to a licensee's cash deposit. Before *Karton*, a surety's exposure to attorney fees was understood to be capped at the bond amount (which is to be repaid by the contractor). Now, the CSLB, whose revenue is wholly generated by licensing and renewal fees, must, at great expense, interplead every case or risk being held liable for litigation costs, including attorney fees. Before *Karton*, the CSLB's legal expenses were minimal as the Board only had to pay the Office of the Attorney General to monitor the case and notify the CSLB whom to release the funds to.

There are approximately 300 cash deposits on file with CSLB for which the CSLB could be liable for attorney fees.[1] The CSLB reasons that it should not be responsible for attorney fees for holding a cash deposit because CSLB is not a surety, does not issue or profit from bonds, and has no discretion to release cash deposits without a court order.[2] This bill would shield CSLB from liability for attorney fees in civil claims involving a contractor's cash deposit.

Prior Related Legislation.

AB 2677 (Chen) of 2024 would have limited a license surety's liability to the penal sum of the bond. *That bill was vetoed.*

AB 3126 (Brough), Chapter 925, Statutes of 2018, repealed the CSLB's authority to accept a deposit in lieu of a bond, beginning January 1, 2019, unless the deposit is cash or a cashier's check, as specified, and requires all other existing alternatives for a deposit in a lieu of a bond to be replaced with a surety bond or cash or a cashier's check deposit by January 1, 2020.

ARGUMENTS IN SUPPORT:

As the sponsor of this bill, the *CSLB* writes in support:

> [This bill] expressly provides that CSLB is not liable for attorney fees in civil claims where a contractor has made a cash deposit in lieu of maintaining a contractor's bond. As you are aware, the contractor's bond is for the benefit of consumers, employees, or other contractors who may be damaged from defective construction or violations of Contractors State License Law. Unlike surety companies, CSLB does not issue bonds, make a profit from them, or have the authority to release cash deposits without a court order. This potential liability undermines the purpose of cash deposits, which are simply an alternative for contractors who do not wish to use a surety company but still need to fulfill the bonding requirement for licensure.

REGISTERED SUPPORT:

Contractors State License Board (Sponsor)

REGISTERED OPPOSITION:

There is no opposition on file.

Analysis Prepared by: Kaitlin Curry / B. & P. / (916) 319-3301

[1] Contractors State License Board, *March 14, 2025, Board Meeting Materials*, at 76.
[2] Ibid.

Date of Hearing: April 1, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 529 (Ahrens) – As Introduced February 11, 2025

SUBJECT: Pharmacy: declared state of emergency.

SUMMARY: Increases the existing statutory duration for which the California State Board of Pharmacy (Board) may extend waivers of pharmacy laws and regulations beyond the termination of a declared emergency from 90 days to 120 days.

EXISTING LAW:

1) Establishes the Pharmacy Law. (Business and Professions Code (BPC) §§ 4000 *et seq.*)

2) Establishes the Board to administer and enforce the Pharmacy Law, comprised of seven pharmacists and six public members. (BPC § 4001)

3) Provides that protection of the public shall be the highest priority for the Board in exercising its licensing, regulatory, and disciplinary functions. (BPC § 4001.1)

4) Authorizes the Board to adopt rules and regulations as may be necessary for the protection of the public. (BPC § 4005)

5) Prohibits a pharmacist from furnishing a dangerous drug without a prescription from a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor, with certain exceptions. (BPC § 4059)

6) Authorizes the Board to waive application of any provisions of the Pharmacy Law or its own application during a declared federal, state, or local emergency and for up to 90 days following the termination of that declared emergency. (BPC § 4062)

THIS BILL:

1) Extends the period of time that the Board is authorized to continue waiving provisions of the Pharmacy Law or its regulations following the termination of a declared emergency from 90 days to 120 days.

FISCAL EFFECT: Unknown; this bill is keyed fiscal by the Legislative Counsel.

COMMENTS:

Purpose. This bill is sponsored by the author. According to the author:

> Whether our communities in California are facing devastating wildfires, a global pandemic, or another emergency, it is critical that they maintain access to the medication they need. The Board of Pharmacy has shown its ability to act quickly to waive provisions of law necessary to protect patients and preserve crucial pharmacy services. AB 529 will provide the Board with greater flexibility to keep these waivers in place when they are still needed.

Background. During a declared federal, state, or local emergency, the Pharmacy Law currently authorizes the Board to "waive application of any provisions of [the Pharmacy Law] or the regulations adopted pursuant to it if, in the Board's opinion, the waiver will aid in the protection of public health or the provision of patient care." Section 8558 of the Government Code broadly defines a "state of emergency" as follows:

> [The] duly proclaimed existence of conditions of disaster or of extreme peril to the safety of persons and property within the state caused by conditions such as air pollution, fire, flood, storm, epidemic, riot, drought, cyberterrorism, sudden and severe energy shortage, electromagnetic pulse attack, plant or animal infestation or disease, the Governor's warning of an earthquake or volcanic prediction, or an earthquake, or other conditions, other than conditions resulting from a labor controversy or conditions causing a "state of war emergency," which, by reason of their magnitude, are or are likely to be beyond the control of the services, personnel, equipment, and facilities of any single county, city and county, or city and require the combined forces of a mutual aid region or regions to combat, or with respect to regulated energy utilities, a sudden and severe energy shortage requires extraordinary measures beyond the authority vested in the Public Utilities Commission.

For example, on March 4, 2020, Governor Gavin Newsom proclaimed a State of Emergency as a result of the impacts of the COVID-19 pandemic. Following the Governor's emergency declaration, the Board established a waiver request process through which licensees and members of the public may request a waiver of law. This process enabled the Board to grant either site-specific waivers or more general "broad waivers." The Board delegated authority to its President to review and make final determinations on all waiver approvals, which could then be granted for up to 90 days with authority to extend waivers for two additional 90-day periods.

Between March 2020 and November 2020, the Board granted approximately 300 site-specific waivers along with 21 broad waivers, which typically included conditions for use and recordkeeping requirements to demonstrate compliance with the conditions. In addition, one broad waiver provided authority for the Board to reinstate a license under specified conditions or extend an intern license that would have otherwise expired. As of July 1, 2020, the Board had extended 692 intern licenses and reinstated 194 licenses.

In addition to the Board's actions during the COVID-19 pandemic, the Board frequently uses its authority to waive provisions of law during natural disasters. For example, during devastating wildfires such as the Tubbs Fire in 2017, the Camp Fire in 2018, and the Dixie Fire in 2021, the Board issued waivers allowing pharmacists to provide emergency refills, temporary relocation of pharmacies, and mobile pharmacy operations. Similar waivers have been granted during large earthquakes, severe storms and floods, and prolonged power outages.

While the Pharmacy Law only allows these waivers to be granted during a declared emergency, the Board is given discretion to maintain a waiver following the termination of the emergency for up to 90 days "if, in the Board's opinion, the continued waiver will aid in the protection of the public health or in the provision of patient care." This bill would extend that authority to allow waivers to remain in effect for up to 120 days following the termination of a declared emergency. The author contends that this flexibility has been thoroughly justified throughout the various emergencies that California has faced in recent years, ranging from the COVID-19 pandemic to the catastrophic wildfires that have struck Southern California and other regions of the state over the past year.

Current Related Legislation. AB 1503 (Committee on Business and Professions) is the Board's current sunset review vehicle. *This bill is pending in this committee.*

Prior Related Legislation. AB 690 (Aguiar-Curry), Chapter 679, Statutes of 2019 established qualifications for a pharmacy technician working at a remote dispensing site pharmacy and allows for a pharmacy license to be transferred in a declared state of emergency.

SB 569 (Stone), Chapter 705, Statutes of 2019 provided the Board with discretion to authorize pharmacists to fill prescriptions for controlled substances regardless of whether there is a valid prescription form for that drug during a declared emergency.

ARGUMENTS IN SUPPORT:

Mental Health America of California writes in support of this bill: "A state of emergency can arise in various forms, including epidemics, power outages, extreme weather, and natural disasters such as floods, earthquakes, and wildfires. During such emergencies the availability of resources and public services become scarce, such as access to healthcare services and medication. During times of great stress, Individuals may develop, or experience heightened, mental health challenges increasing the need for these vital services. While the Board of Pharmacy may currently waive provisions of the pharmacy law for up to 90 days after the end of a state of emergency to allow mobile clinics and pharmacies to operate, it can take more than 90 days to rebuild a community and for any sense of normalcy to return. This bill would allow for an additional 30 days for a total of 120 days expanding access to care and medications as communities transition from crisis intervention to rehabilitation."

ARGUMENTS IN OPPOSITION:

No opposition on file.

REGISTERED SUPPORT:

Mental Health America of California

REGISTERED OPPOSITION:

None on file

Analysis Prepared by: Robert Sumner / B. & P. / (916) 319-3301

Date of Hearing: April 1, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 559 (Berman) – As Amended March 27, 2025

NOTE: This bill is double referred and if passed by this Committee will be re-referred to the Assembly Judiciary Committee.

SUBJECT: Professions and vocations: contractors: home improvement contracts: prohibited business practices.

SUMMARY: Expands the definition of "home improvement" to include accessory dwelling units (ADUs) on residentially zoned property, thereby subjecting the construction of ADUs to specific contract and payment rules, and enhances penalties for violations that result in consumer financial harm, as specified.

EXISTING LAW:

1) Establishes, until January 1, 2029, the Contractors State License Board (CSLB) under the Department of Consumer Affairs (DCA) to implement and enforce the Contractors State License Law (License Law), which includes the licensing and regulation of contractors and home improvement salespersons. (Business and Professions Code (BPC) §§ 7000 *et seq.*)

2) Authorizes the Board to appoint a registrar of contractors to be the executive officer and secretary of the CSLB. (BPC § 2011)

3) Exempts from the License Law a work or operation on one undertaking or project by one or more contracts if the aggregate price for labor, materials, and all other items is less than $1,000 that work or operation being considered of casual, minor, or inconsequential nature, and the work or operation does not require a building permit. (BPC § 7048)

4) Requires the CSLB to promulgate regulations covering the assessment of civil penalties that consider the gravity of the violation, the good faith of the licensee or applicant for licensure being charged, and the history of previous violations. Except as otherwise provided, prohibits the CSLB from assessing a civil penalty that exceeds $8,000. Specifies that the CSLB may assess a civil penalty up to $30,000 for specified violations (e.g., willful or deliberate disregard and violation of state and local building laws; aiding or abetting an unlicensed person to violate the License Law; entering into a contract with an unlicensed person; and committing workers' compensation fraud). (BPC § 7099.2)

5) Specifies that abandonment without legal excuse of any construction project or operation engaged in or undertaken by the licensee as a contractor constitutes a cause for disciplinary action. (BPC § 7107)

6) Defines "home improvement" to mean the repairing, remodeling, altering, converting, or modernizing of, or adding to, residential property, as well as the reconstruction, restoration, or rebuilding of a residential property that is damaged or destroyed by a natural disaster for which a state of emergency is proclaimed by the Governor, or for which an emergency or major disaster is declared by the President of the United States, and includes, but is not

limited to, the construction, erection, installation, replacement, or improvement of driveways, swimming pools, including spas and hot tubs, terraces, patios, awnings, storm windows, solar energy systems, landscaping, fences, porches, garages, fallout shelters, basements, and other improvements of the structures or land which is adjacent to a dwelling house. "Home improvement" also means installing home improvement goods or furnishing home improvement services. (BPC § 7151(a))

7) Defines "home improvement contract" to mean an agreement, whether oral or written, or contained in one or more documents, between a contractor and an owner or between a contractor and a tenant for the performance of a home improvement, and includes all labor, services, and materials to be furnished and performed thereunder. "Home improvement contract" also means an agreement, whether oral or written, or contained in one or more documents, between a salesperson, whether or not they are a home improvement salesperson, and an owner or a tenant which provides for the sale, installation, or furnishing of home improvement goods or services. (BPC § 7151.2)

8) Identifies the projects for which a home improvement contract is required, outlines the contract requirements, and lists the items that shall be included in the contract or may be provided as an attachment. (BPC § 7159)

9) Sets forth the following requirements for home improvement contracts and specifies that failure to comply is cause for discipline by the CSLB:

   a) The contract shall be in writing and shall include the agreed contract amount in dollars and cents. The contract amount shall include the entire cost of the contract, including profit, labor, and materials, but excluding finance charges.

   b) If there is a separate finance charge between the contractor and the person contracting for home improvement, the finance charge shall be set out separately from the contract amount.

   c) If a downpayment will be charged, the downpayment shall not exceed $1,000 or 10 percent of the contract amount, whichever amount is less.

   d) If, in addition to a downpayment, the contract provides for payments to be made prior to completion of the work, the contract shall include a schedule of payments in dollars and cents specifically referencing the amount of work or services to be performed and any materials and equipment to be supplied.

   e) Except for a downpayment, the contractor shall neither request nor accept payment that exceeds the value of the work performed or material delivered. The prohibition extends to advance payment in whole or in part from any lender or financier for the performance or sale of home improvement goods or services.

   f) Upon any payment by the person contracting for home improvement, and prior to any further payment being made, the contractor shall, if requested, obtain and furnish to the person a full and unconditional release from any potential lien claimant claim or mechanics lien for any portion of the work for which payment has been made. The person contracting for home improvement may withhold all further payments until these releases are furnished.

g) If the contract provides for a payment of a salesperson's commission out of the contract price, that payment shall be made on a pro rata basis in proportion to the schedule of payments made to the contractor by the disbursing party, as specified.

h) A contractor furnishing a performance and payment bond, lien and completion bond, or a bond equivalent or joint control covering full performance and payment is exempt from paragraphs (c), (d), and (e) above, and need not include specified information as part of the contract. A contractor furnishing these bonds, bond equivalents, or a joint control approved by the registrar may accept payment prior to completion. If the contract provides for a contractor to furnish joint control, the contractor shall not have any financial or other interest in the joint control. Notwithstanding any other law, a licensee shall be licensed in this state in an active status for not less than two years prior to submitting an Application for Approval of Blanket Performance and Payment Bond as provided in Section 858.2 of Title 16 of the California Code of Regulations as it read on January 1, 2016.

(BPC § 7159.5(a))

10) Specifies that a violation of paragraphs (a), (c), and (e) above is a misdemeanor punishable by a fine of not less than $100 nor more than $5,000, or by imprisonment in county jail not exceeding one year, or by both that fine and imprisonment. If a violation occurs in a location damaged by a natural disaster for which a state of emergency is proclaimed by the Governor or for which an emergency or major disaster is declared by the President of the United States, the court must impose the maximum fine.

11) Specifies that any person who violates the requirements in (5) above as part of a plan or scheme to defraud an owner or tenant of a residential or nonresidential structure, in connection with the offer or performance of repairs for the structure for damage caused by a natural disaster, shall be ordered by the court to make full restitution to the victim based on the person's ability to pay, as specified. For natural disasters for which a state of emergency is proclaimed by the Governor or for which an emergency or major disaster is declared by the President of the United States, a court may impose a fine of $500 to $25,000, in addition to full restitution and imprisonment, based on the defendant's ability to pay. (BPC § 7159.5(c))

12) Defines ADU as an attached or a detached residential dwelling unit that provides complete independent living facilities for one or more persons and is located on a lot with a proposed or existing primary residence. An ADU must include permanent living, sleeping, eating, cooking, and sanitation provisions on the same parcel where the single-family or multifamily dwelling is or will be situated. (Government Code § 66313(a))

THIS BILL:

1) Expands the definition of "home improvement" to include the construction, erection, installation, replacement, or improvement of an ADU on residentially zoned property.

2) Specifies that a licensee, or their agent or salesperson, who requests or accepts a downpayment, progress payment, or some combination of the two, in violation of the License Law, resulting in financial loss to a consumer greater than 10 percent of the contract amount is subject to revocation of their license and a civil penalty of at least $10,000.

3) Specifies that an unlicensed person who is subject to licensure by CSLB, or their agent or salesperson, who requests or accepts a downpayment, progress payment, or some combination of the two, in violation of the License Law, resulting in financial loss to a consumer greater than 10 percent of the contract amount is subject to citation and a civil penalty of at least $10,000.

4) Deletes an obsolete operative date and makes other technical and conforming changes.

FISCAL EFFECT: Unknown. This bill is keyed fiscal by the Legislative Counsel.

COMMENTS:

Purpose. This bill is sponsored by the *Contractors State License Board*. According to the author:

> A recent high-profile case in which a contractor defrauded consumers out of hundreds of thousands of dollars for uncompleted ADUs shed light on the need to strengthen payment rules for ADUs and toughen penalties for crooked contractors. AB 559 responds directly to the more than 400 complaints received by the Contractors State License Board by prohibiting ADU builders from charging more than a $1,000 downpayment and accepting payment for work or materials that have not been completed or delivered. AB 559 will also stiffen penalties for violating these rules.

Background. The CSLB is responsible for the implementation and enforcement of the License Law, which governs the licensure, practice, and discipline of contractors in California. A license is required for construction projects valued at $1,000 or more, including labor and materials. The CSLB issues licenses to business entities and sole proprietors. Each license requires a qualifying individual (a "qualifier") who satisfies the experience and examination requirements for licensure and directly supervises and controls construction work performed under the license.

The CSLB is authorized to take disciplinary action against licensed and unlicensed contractors who have violated the License Law and is empowered to use an escalating scale of penalties, ranging from citations and fines (referred to as civil penalties) to license suspension and revocation. The CSLB recently revoked the license of Anchored Tiny Homes, a Sacramento-based ADU builder, after it received more than 400 complaints, primarily from consumers alleging that they paid for ADUs that were never completed. Unlike new construction, home improvement projects are subject to contract and payment rules to protect consumers from unscrupulous contractors. For example, contractors are prohibited from requesting or accepting progress payments that exceed the value of the work completed or the cost of materials delivered. Existing law does not expressly include ADUs in the definition of home improvement, so while Anchored Tiny Homes did not contest the revocation of their license, another contractor could argue that contracts for ADUs are not subject to the same payment restrictions, thus illuminating the need to clarify existing law.

This bill would include ADUs in the definition of "home improvement," in the same way that swimming pools, fences, and garages are, therefore subjecting the construction of ADUs to stricter contract and payment rules. Additionally, this bill would boost the CSLB's enforcement capability by subjecting a contractor to automatic license revocation (or citation if the individual is unlicensed) and a $10,000 fine if they request or accept a downpayment or progress payment for work and materials that are not performed or supplied, resulting in a consumer's financial

loss greater than 10 percent of the contract amount. In doing so, this bill will help protect homeowners and tenants from being scammed and potentially losing their hard-earned savings.

Prior Related Legislation. *SB 757 (Limón), Chapter 249, Statutes of 2021,* added the installation of solar energy improvements to the definition of "home improvement."

SB 1189 (McGuire), Chapter 364, Statutes of 2020, revised the definition of "home improvement" to include the reconstruction, restoration, or rebuilding of a residential property that is damaged or destroyed by a natural disaster for which a state of emergency is proclaimed by the Governor or for which an emergency or major disaster is declared by the President of the United States.

SB 601 (McGuire), Chapter 403, Statutes of 2023 required, in part as it related to this bill, that the courts to impose the maximum fine when a contractor violates home improvement contract requirements in a declared disaster area.

AB 2622 (Juan Carrillo), Chapter 240, Statutes of 2024, authorized a person who does not have a contractor's license to both advertise for and perform construction work or a work of improvement if the total cost of labor, materials, and all other items, is less than $1,000, and if specified conditions are met.

ARGUMENTS IN SUPPORT:

As the sponsor of this bill, the *CSLB* writes in support:

> With the demand for the construction of accessory dwelling units (ADU) rising in recent years, CSLB has received a significant increase in the number of consumer-filed complaints against contractors for failing to complete ADU construction projects. Most of the complaints allege considerable financial harm because the contractor abandoned the project after requesting and accepting payment for work that was not completed and materials that were not delivered. This bill strengthens consumer protection by adding ADUs to the existing definition of "Home Improvement" in Contractors State License Law and increasing penalties on contractors who violate progress payment provisions resulting in consumer harm. These amendments clarify that contractors engaging in ADU construction projects are subject to progress payment rules and will discourage contractors from failing to complete construction projects despite receiving payment.

REGISTERED SUPPORT:

Contractors State License Board (Sponsor)
California Low-Income Consumer Coalition

REGISTERED OPPOSITION:

There is no opposition on file.

Analysis Prepared by: Kaitlin Curry / B. & P. / (916) 319-3301

Date of Hearing: April 1, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 586 (Flora) – As Introduced February 12, 2025

NOTE: This bill is double referred and if passed by this Committee will be re-referred to the Assembly Judiciary Committee.

SUBJECT: Professional fiduciaries.

SUMMARY: Authorizes licensed professional fiduciaries to form professional corporations, requires licensees to notify the Professional Fiduciaries Bureau (PFB) if serving under a professional fiduciary corporation, and clarifies the limits on who a superior court may appoint to specified fiduciary positions.

EXISTING LAW:

1) Regulates and licenses professional fiduciaries under the Professional Fiduciaries Act. (Business and Professions Code (BPC) §§ 6500-6592)

2) Establishes the PFB within the Department of Consumer Affairs to administer and enforce the Professional Fiduciaries Act. (BPC § 6510)

3) Prohibits a person from acting or holding themselves out to the public as a professional fiduciary unless licensed as a professional fiduciary, except as specified. (BPC § 6530)

4) Defines a "professional fiduciary" as the following:

    a) A person who acts as a guardian or conservator of the person, the estate, or the person and estate, for two or more individuals at the same time who are not related to the professional fiduciary or to each other. (BPC § 6501(f)(1)(A))

    b) A personal representative of a decedent's estate, as defined in the Probate Code, for two or more individuals at the same time who are not related to the professional fiduciary or to each other. (BPC § 6501(f)(1)(B), Probate Code (PROB) § 58(a))

    c) A person who acts as a trustee, agent under a durable power of attorney for health care, or agent under a durable power of attorney for finances, for more than three individuals, at the same time. (BPC § 6501(f)(2))

5) Authorizes the formation of professional corporations under the Moscone-Knox Professional Corporation Act. (Corporations Code (CORP) §§ 13400-13410)

6) Defines "professional services" as any type of professional services that may be lawfully rendered pursuant to a license, certification, or registration authorized by the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act. (CORP § 13401(a))

7) Defines "professional corporation" as a corporation that is engaged in rendering professional services in a single profession pursuant to a certificate of registration issued by the governmental agency regulating the profession as provided in the Moscone-Knox

Professional Corporation Act and that in its practice or business designates itself as a professional or other corporation as may be required by statute. (CORP § 13401(b))

8) Prohibits a superior court from appointing a person to carry out the duties of a professional fiduciary, or permitting a person to continue those duties, unless the person holds a valid, unexpired, unsuspended license as a professional fiduciary, is exempt from the definition of "professional fiduciary", or is exempt from the licensing requirements of Professional Fiduciaries Act. (PROB § 2340)

THIS BILL:

1) Authorizes licensed fiduciaries to organize professional fiduciary professional corporations under the Professional Fiduciaries Act.

2) Adds professional fiduciary corporations to the definition of "professional fiduciary" under the Professional Fiduciaries Act and the PROB.

3) Designates the PFB as the governmental agency regulating professional fiduciary corporations for purposes of the Moscone-Knox Professional Corporation Act.

4) Authorizes the PFB to promulgate regulations regarding professional fiduciary corporations.

5) Exempts professional fiduciary corporations from the requirement to obtain a certificate of registration under the Moscone-Knox Professional Corporation Act.

6) Requires professional fiduciary corporation and shareholders, officers, directors, and employees rendering professional services who are licensed fiduciaries to comply with the Moscone-Knox Professional Corporation Act, the Professional Fiduciaries Act, and all other statutes and regulations that pertain to professional corporations.

7) Requires each director, shareholder, and officer of a professional fiduciary corporation to be licensed in accordance with the Professional Fiduciaries Act.

8) Requires any individual providing professional fiduciary services on behalf of a professional fiduciary corporation to be a licensee.

9) Specifies that a licensee serving as an officer, director, shareholder, or employee of a professional fiduciary corporation is not exempt from discipline.

10) Requires the name of a professional fiduciary corporation and any name under which it renders professional services to contain, and be restricted to, a name of one or more former, present, or prospective shareholders

11) Specifies that any income of a professional fiduciary corporation attributable to professional services rendered while a shareholder is a disqualified person, as defined in the Moscone-Knox Professional Corporation Act, shall not accrue to the benefit of that shareholder or their shares in the corporation.

12) Requires each professional fiduciary professional corporation to provide to the PFB, upon request, a corporation-wide report consisting of all of the following information:

a) The full name, license number, address, and telephone number for any licensee contained in the name of the corporation.

b) The full names and license numbers of all officers, directors, shareholders, and licensed employees of the corporation.

c) The corporation entity number as issued by the Secretary of State and current statement of information filed with the Secretary of State.

d) A client log containing all of the following:

i) A list of all case names, whether the cases are court supervised or noncourt supervised, the date the corporation was appointed, and the managing professional fiduciary on the case.

ii) The court location and case number for each case that is supervised by a court.

iii) The aggregate managed asset value of all matters under the management of the corporation.

13) Specifies that the corporation-wide report is not a public record and may not be disclosed to the public pursuant to the California Public Records Act, except in any of the following circumstances:

a) In the course of any disciplinary proceeding by the PFB after the filing of a formal accusation.

b) In the course of any legal action to which the PFB is a party.

c) In response to an official inquiry from a state or federal agency.

d) In response to a subpoena or summons enforceable by order of a court.

e) When otherwise specifically required by law.

14) Specifies that the failure of a registrant of a professional fiduciary corporation with the Secretary of State to submit the corporation-wide report within 60 days of the request shall be considered unprofessional conduct as a violation, that each registrant with the Secretary of State is subject to discipline, and that the professional fiduciary professional corporation is subject to suspension or revocation by the Secretary of State.

15) Specifies that the failure of a representative of a professional fiduciary corporation to respond to an inquiry from the PFB related to the corporation may subject the corporation to disciplinary action.

16) Requires licensed fiduciaries to annually report, and for the PFB to maintain on file for court purposes, whether, in each case, the licensee is serving under a professional fiduciary corporation.

17) Defines “fiduciary positions” that a superior court may not appoint a non-licensed fiduciary or other exempt person to as a guardian, conservator, personal representative, trustee, or other

officer and makes a conforming change regarding the appointment of professional fiduciary corporations and the responsible person under the corporation.

18) Makes a declaration regarding the necessity of the Public Records Act exemption.

FISCAL EFFECT: Unknown. This bill is keyed fiscal by the Legislative Counsel.

COMMENTS:

Purpose. This bill is sponsored by the *Professional Fiduciary Association of California*. According to the author, "[This bill] protects consumers first, by requiring the members of a professional fiduciary professional corporation to possess a license, second, by subjecting the corporation as an entity to regulation by the Professional Fiduciaries Bureau, and third, by requiring the entities to comply with the requirements of the Moscone Knox Professional Corporations Act."

Background. In general, fiduciaries are individuals who have been granted another individual's confidence and trust. Those who are paid to handle fiduciary duties for clients, such as conservators, guardians, trustees, personal representatives of a decedent's estate, and agents under durable power of attorney, are considered professional fiduciaries and require a license.

Because a license is required to provide professional fiduciary services, and corporations and other business entities are not able to obtain a license under existing law, corporations and other business entities are prohibited from providing professional services.

However, according to the sponsor, there are situations in which unlicensed corporate entities can be designated as professional fiduciaries. For example, the Probate Code is silent as to whom a testator may name as successor trustee in the context of a trust, where the trustee's appointment is determined by the testator's stated wishes as opposed to a court appointment. Therefore, there is no restriction on the entity the testator may name as a trustee, regardless of the licensing status of the members of that entity.

This bill attempts to address the problem by authorizing the formation of professional fiduciary corporations under the Moscone-Knox Professional Corporation Act, limiting the corporate provision of fiduciary services to professional fiduciary corporations, limiting the membership of professional fiduciary corporations to licensed fiduciaries, and requiring licensees to report whether they were providing services under a professional fiduciary corporation to the PFB.

Prior Related Legislation. AB 2148 (Low) of 2024 was similar to this bill except that it would have required the PFB to issue a certificate of registration to professional fiduciary corporations. *AB 2148 was held on the Senate Appropriations Committee suspense file.*

ARGUMENTS IN SUPPORT:

The *Professional Fiduciary Association of California* (sponsor) writes in support:

> This legislation resolves issues that have been identified which courts, attorneys and licensed Professional Fiduciaries acknowledge exist in current law:
>
> - Although the Probate Code does not specifically authorize the court to appoint entities (other than financial institutions) in representative capacities, courts

have approved petitions seeking the appointment of professional fiduciary entities (as opposed to an individual professional fiduciary being appointed).

- Because no restriction exists as to whom a testator may name as Executor of their Will or Trustee of their Trust, Testators are naming fiduciary entities to serve in various representative capacities.

- Though the Business and Professions Code provides the Bureau with authority to license and regulate individuals, the Professional Fiduciary Bureau does not currently have statutory authority to license or regulate either a fiduciary entity or the members acting on behalf of that entity.

- In the scenario of an entity serving in a representative capacity, depending on the type of entity, the extent of liability on the part of the entity can be limited leaving consumers vulnerable.

[This bill] would close the existing "loopholes" in state law by authorizing Professional Fiduciaries to form Professional Corporations, enabling those Professional Corporations to be named and/or appointed by the court to serve in fiduciary capacities (guardian, conservator, personal representative of a decedent's probate estate, or trustee of a trust). While these Professional Corporations would not be required to register with the Professional Fiduciaries Bureau, these Corporations would, much like individuals, be subject to the Bureau's oversight and discipline.

ARGUMENTS IN OPPOSITION:

There is no opposition on file.

IMPLEMENTATION ISSUES:

Typo. On page 9 of the bill, in line 25, the bill contains the word "ore" when it appears to mean "or." If this bill passes this committee, the author may wish to address this issue.

REGISTERED SUPPORT:

Professional Fiduciary Association of California (sponsor)

REGISTERED OPPOSITION:

There is no opposition on file.

Analysis Prepared by: Vincent Chee / B. & P. / (916) 319-3301

Date of Hearing: April 1, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 631 (Lee) – As Introduced February 13, 2025

SUBJECT: Animals: animal shelters: transparency.

SUMMARY: Requires animal shelters, as defined, to post on the internet the number of animals taken in, the source of intake, and the outcomes for all animals, as specified, and update this information at least once per month.

EXISTING LAW:

1) Governs the operation of animal shelters by, among other things, setting a minimum holding period for stray dogs, cats, and other animals, and requiring animal shelters to ensure that those animals, if adopted, are spayed or neutered and, with exceptions, microchipped. (Food and Agricultural Code (FAC) §§ 30501 *et seq.*; § 31108.3; §§ 31751 *et seq.*; §§ 32000 *et seq.*)

2) Defines "animal shelter" as a public animal control agency or shelter, society for the prevention of cruelty to animals shelter, humane society shelter, or rescue group. (FAC § 30503.5)

3) Requires that a shelter hold a stray dog for a specified period prior to adoption or euthanasia of a dog, scan the dog for a microchip that identifies the owner of that dog, and make reasonable efforts to contact the owner and notify them that their dog is impounded and is available for redemption. (FAC § 31108)

4) Requires that a shelter hold a stray cat for a specified period prior to adoption or euthanasia, scan the cat for a microchip that identifies the owner of that cat, and make reasonable efforts to contact the owner and notify them that their cat is impounded and is available for redemption. (FAC § 31752)

5) Requires that a rabbit, guinea pig, hamster, potbellied pig, bird, lizard, snake, turtle, or tortoise that is impounded in a shelter be held for the same period of time, under the same requirements of care, and with the same opportunities for redemption and adoption, as cats and dogs. (FAC § 31753)

6) Requires all public animal shelters, shelters operated by societies for the prevention of cruelty to animals, and humane shelters that perform public animal control services, to provide the owners of lost animals and those who find lost animals with all of the following:

    a) Ability to list the animals they have lost or found on "Lost and Found" lists maintained by the animal shelter.

    b) Referrals to animals listed that may be the animals the owners or finders have lost or found.

    c) The telephone numbers and addresses of other animal shelters in the same vicinity.

    d) Advice as to means of publishing and disseminating information regarding lost animals.

e) The telephone numbers and addresses of volunteer groups that may be of assistance in locating lost animals.

(FAC § 32001)

7) Requires all public and private animal shelters to keep accurate records on each animal taken up, medically treated, or impounded, which shall include all of the following information and any other information required by the Veterinary Medical Board of California:

a) The date the animal was taken up, medically treated, euthanized, or impounded.

b) The circumstances under which the animal was taken up, medically treated, euthanized, or impounded.

c) The names of the personnel who took up, medically treated, euthanized, or impounded the animal.

d) A description of any medical treatment provided to the animal and the name of the veterinarian of record.

e) The final disposition of the animal, including the name of the person who euthanized the animal or the name and address of the adopting party. These records shall be maintained for three years after the date on which the animal's impoundment ends.

(FAC § 32003)

8) Provides that it is the policy of the state that no adoptable animal should be euthanized if it can be adopted into a suitable home. (Penal Code § 599d; Civil Code § 1834.4)

THIS BILL:

1) Requires animal shelters to post on its internet website, or a third-party internet website that is conspicuously linked on its internet website, all of the following information:

a) The number of animals taken in with separate categories for dogs, cats, and other animals;

b) The source of intake separated by category, including, but not limited to, stray animals, surrendered by owner, or transferred from another animal shelter; and

c) The outcomes for all animals separated by category, including, but not limited to, returned to owner, adopted, transferred to another organization, euthanized, died in care, or dead upon arrival.

2) Requires the information to be publicly accessible for at least five years, and specifies that the information shall be updated at least once per month.

3) Encourages, but does not require, animal shelters with local contracts for animal care to make the data available in a downloadable spreadsheet format that may include, but is not limited to, a comma-separated values file or a tab-separated values file and that is compatible with a spreadsheet software application that is widely used at the time of the posting.

FISCAL EFFECT: Unknown. This bill is keyed fiscal by the Legislative Counsel.

COMMENTS:

Purpose. This bill is sponsored by *Social Compassion in Legislation.* According to the author:

> The official state pet is the "Shelter Pet." This bill will help provide important data about shelter animals so that resources are better optimized to find more pets their forever homes. State, local jurisdictions, and nonprofits invest hundreds of millions of dollars in our shelter system to save animals' lives. Yet the data these entities rely on to direct these resources is no longer available. This transparency will ensure that the state and other entities are able to direct funding efficiently to shelters with the greatest need, while also giving policymakers a more complete picture of the pet overpopulation problem to make informed policy decisions.

Background. From 1995 to 2016, the California Department of Public Health (CDPH) collected and reported data consistent with the disclosures required by this bill. However, these reports were based on data voluntarily submitted from public animal shelters alongside mandated reporting on rabies infection and vaccination. This voluntary reporting included data on the number of licensed dogs and cats adopted from their shelters, the number of rabies vaccines administered, intake rates for dogs and cats, euthanasia, and more. In 2017, the CDPH stopped collecting and reporting data on shelter euthanasia.

In recent years, the author and sponsor have put forward bills to explicitly require the CDPH to collect and report these data points from local governments. In addition, the CDPH would also be required to collect data on the number of domestic dogs and cats discharged by local animal control authorities, including, but not limited to: the number reclaimed by owner, adopted, relinquished to a rescue organization, euthanized, died, or transferred to another shelter. Last year's iteration—AB 2012 (Lee)—would also have authorized the CDPH to contract these data collection and reporting requirements to a California-accredited veterinary school. These prior efforts to require that CDPH collect and report animal data have received bipartisan support in this Committee but have nevertheless stalled in the Assembly Appropriations Committee due to administrative cost concerns.

This year, instead of making the CDPH or another state entity responsible for collecting and posting specified animal welfare data, the bill requires animal shelters to post the data themselves and update it monthly. Notably, the bill defines "animal shelters" according to Food and Agricultural Code § 30503.5, which encompasses "a public animal control agency or shelter, society for the prevention of cruelty to animals shelter, humane society shelter, or rescue group." In other words, all public and private organizations that work in the adoption and rescue of animals would be required to post information specified under this bill, not just those that are publicly funded. This bill would allow animal shelters that do not have their own website to post information on a third-party website, such as petfinder.com. Moreover, the bill encourages animal shelters with local contracts for animal care to post the data as a downloadable spreadsheet. The author contends that this bill is necessary to know how many cats and dogs are euthanized in this state and where, which would help inform decisions about where to prioritize grant funding.

Current Related Legislation.

AB 1482 (Essayli) would, among other things, require an animal shelter to provide public notice regarding the adoption availability of any animal and require the Department of Food and Agriculture (CDFA) to conduct a study on certain topics, including overcrowding of state animal shelters. The bill would also make changes and additions to state law pertaining to dog breeders. *AB 1482 is pending consideration in this Committee.*

Prior Related Legislation.

AB 2012 (Lee) of 2024 would have required the CDPH to collect specified data from public animal shelters as part of their annual rabies control activities reporting, and authorized the CDPH to contract out this requirement to a California accredited veterinary school. *That bill was held on suspense in the Assembly Committee on Appropriations.*

AB 2265 (McCarty) of 2024 would have, among other things, required that all animal shelters provide public notice at least 24 hours before a dog or cat is scheduled to be euthanized, to be posted daily on their internet website or Facebook page, and that the notice be physically affixed on the kennel of a dog to cat scheduled to be euthanized, as well as mandated time certain that a dog or cat must be spayed or neutered by an animal shelter upon being given to a foster. *That bill was held on suspense in the Assembly Committee on Appropriations.*

SB 1459 (Nguyen) of 2024 would have, among other things, required public animal control agencies and shelters to publish and update specified data on their internet website beginning January 1, 2026. *That bill was held on suspense in the Assembly Committee on Appropriations*.

AB 332 (Lee) from 2023 would have required the CDPH to collect and report specified data as part of their rabies control program. *That bill was held in the Senate Appropriations Committee.*

AB 595 (Essayli) of 2023 would have required animal shelters to provide 72 hours public notice before euthanizing any dog, cat, or rabbit with information that includes information about the animal and that it is subject to euthanasia, and would have required the CDFA to conduct a study on animal shelter overcrowding and the feasibility of a statewide database for animals scheduled to be euthanized. *That bill was held on suspense in the Assembly Committee on Appropriations.*

AB 2723 (Holden), Chapter 549, Statutes of 2022, established additional requirements for various types of public animal shelters related to microchip registration and the release of dogs and cats.

AB 588 (Chen), Chapter 430, Statutes of 2019, required any shelter or rescue group in California to disclose when a dog with a bite history when it is being adopted out.

ACR 153 (Santiago), Chapter 72, Statutes of 2018, urged communities in California to implement policies that support the adoption of healthy cats and dogs from shelters by 2025.

AB 2791 (Muratsuchi), Chapter 194, Statutes of 2018, permitted a puppy or kitten that is reasonably believed to be unowned and is impounded in a shelter to be immediately made available for release to a nonprofit animal rescue or adoption organization before euthanasia.

SB 1785 (Hayden), Chapter 752, Statutes of 1998, established that the State of California's policy is that no adoptable animal should be euthanized if it can be adopted into a suitable home.

ARGUMENTS IN SUPPORT:

As the sponsor of this bill, *Social Compassion in Legislation* writes in support:

> Public and private animal shelters regularly partner with rescues to take animals as fosters, help to facilitate adoptions, and to assist with medical care for the animals. Understanding the intake and outcome data from these rescues is necessary if the public and lawmakers are to have a full grasp of the scope of the animal overpopulation problem in California. It is estimated that our local and state governments spend over $400 million on operating animal shelters. That figure does not include the incalculable millions spent by nonprofit rescue organizations who pull dogs, cats, and various other animals from shelters before they are euthanized in order to save their lives and find them a loving home. Nor does it include the $50 million dollars combined in 2021 and 2022 the state funded to UC Davis to support our state's animal shelters efforts to reduce euthanasia rates, in addition to the approximately $500,000 granted out annually through the Pet Lover's License Plate Fund and the Prevention of Animal Homelessness and Cruelty Voluntary Tax Contribution Fund, combined, for spay and neuter programs. Despite these figures, stakeholders statewide do not have a complete picture of the pet overpopulation problem. [This bill] will give stakeholders visibility into the numbers of animals entering and exiting our state's animal shelters and rescues, while helping to ensure funds are spent effectively and efficiently. Additionally, this data will give lawmakers a better picture of the pet overpopulation problem as they move forward with legislative solutions, as well as ensure animal shelter and rescue data is available in the unfortunate event of a zoonotic disease outbreak.

ARGUMENTS IN OPPOSITION:

There is no opposition on file.

POLICY ISSUE(S) FOR CONSIDERATION:

Purpose. This bill requires animal shelters to regularly report specified data on the number of animals in their care but does not prescribe a use for the data. While it is the author's intent that the data inform state policy and steer the administration of the grants, no entity has been tasked to aggregate and analyze the data.

IMPLEMENTATION ISSUE(S) FOR CONSIDERATION:

Workload and feasibility. This bill would require animal shelters to post specified information on their website or a third-party website every month. A few stakeholders have indicated that they would support this bill if amended to reduce the frequency of the reporting requirement from monthly to quarterly and to exempt organizations that do not maintain a website. The author has agreed to amend the bill to require quarterly reporting in lieu of monthly reporting.

AMENDMENTS:

To limit the frequency with which animal shelters must update the information on their website or a third-party website, amend the bill as follows:

On page 2, after line 16:

> (c) The information required to be posted pursuant to subdivision (b) shall be made publicly accessible, be updated on the animal shelter's internet website or third-party internet website at least once per *quarter* ~~month~~, and remain publicly accessible for at least five years.

REGISTERED SUPPORT:

Animal Politics with Ed Boks
Animal Wellness Action
Berkeley Animal Rights Center
Better Together Forever
California Association of Licensed Investigators
Compassionate Bay
Feline Lucky Adventures
Giantmecha Syndicate
Greater Los Angeles Animal Spay Neuter Collaborative
Latino Alliance for Animal Care Coalition
Leaders for Ethics, Animals, and the Planet (LEAP)
NY 4 Whales
Project Minnie
Seniors Citizens for Humane Education and Legislation
Social Compassion in Legislation
Start Rescue
Students Against Animal Cruelty Club - Hueneme High School
Women United for Animal Welfare
489 individuals

REGISTERED OPPOSITION:

There is no opposition on file.

Analysis Prepared by: Edward Franco / B. & P. / (916) 319-3301

Date of Hearing: April 1, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 659 (Berman) – As Introduced February 14, 2025

SUBJECT: Master of Divinity: physician and surgeon: title.

SUMMARY: Clarifies that a person who has earned a Master of Divinity degree but not a medical degree may not display titles highlighting the title "MD" or "M.D." in a way that makes it unclear that the title is an "MDiv" or "M.D.i.v."

EXISTING LAW:

1) Regulates the practice of medicine under the Medical Practice Act and the Osteopathic Act. (BPC §§ 2460-2499.8; Osteopathic Act, California Proposition 20 (1922))

2) Establishes the Medical Board of California and the Osteopathic Medical Board of California to administer and enforce the acts. (BPC §§ 2001, 2450)

3) Prohibits the practice of medicine, including using drugs or devices, severing or penetrating tissue, or using any other method in the treatment of diseases, injuries, deformities, or other physical and mental conditions without a physician and surgeon or osteopathic physician and surgeon license, unless authorized by a license granted under some other law. (BPC §§ 2051, 2052, 2453)

4) Makes it a misdemeanor to use in an advertisement, such as a business card, the words "doctor" or "physician," the letters or prefix "Dr.," the initials "M.D.," "D.O.," or any other terms or letters indicating or implying that the user is a physician and surgeon, physician, surgeon, or practitioner, or that the user is entitled to practice medicine, or to represent or hold themselves out as a physician and surgeon, physician, surgeon, or practitioner under the terms of any other law, without being a licensed physician and surgeon. (BPC § 2054)

THIS BILL:

1) Prohibits a person who has earned a Master of Divinity from displaying the title "MDiv" or "M.D.i.v." in a communication or advertisement relating to the person's practice unless the title is clearly distinguishable from the title "MD" or "M.D."

2) Specifies that prohibited displays include, but are not limited to, using different colors, fonts, or font sizes in a way that makes the "MD" or "M.D." more prominent than the "iv" or "i.v."

3) Provides that a person who violates the provisions of this bill will not be subject to the misdemeanor criminal penalties in the Medical Practice Act.

FISCAL EFFECT: Unknown. This bill is keyed fiscal by the Legislative Counsel.

COMMENTS:

Purpose. This bill is sponsored by the author. According to the author, "This bill simply clarifies that a professional who is not a physician but holds a Master of Divinity degree, which is

abbreviated as MDiv, may not make the "MD" overly prominent or obscure the "iv" in a way that makes it look like an MD."

Background. Existing law prohibits the use of the letters MD, an abbreviation for a medical degree, in advertisements, such as window signs or business cards, in a way that may mislead consumers into believing the user is a physician if the user is not licensed as a physician. This bill clarifies that this prohibition applies even when the MD is a legitimate part of another type of degree, specifically the Master of Divinity Degree. A Master of Divinity is a degree that is focused on theological or religious subject areas and offered by institutions operated by religious organizations.

Prior Related Legislation. SB 1451 (Ashby), Chapter 481, Statutes of 2024, among numerous other things, added "D.O." to the prohibition against the use of "Dr." and "M.D." and prohibited the use of terms or letters in a healthcare setting that would lead a reasonable patient to determine that the person is a licensed "M.D." or "D.O."

AB 765 (Wood) of 2023 would have enacted the California Patient Protection, Safety, Disclosure, and Transparency Act, prohibiting a person who is not licensed as a physician and surgeon to use any medical specialty title, as specified, or any titles, terms, letters, words, abbreviations, description of services, designations, or insignia indicating or implying that the person is licensed to practice under the Medical Practice Act.

AB 1564 (Low) of 2023 was identical to this bill. *AB 1564 died pending a hearing in the Assembly Appropriations Committee*.

REGISTERED SUPPORT:

There is no support on file.

REGISTERED OPPOSITION:

There is no opposition on file.

Analysis Prepared by: Vincent Chee / B. & P. / (916) 319-3301

Date of Hearing: April 1, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 686 (Berman) – As Introduced February 14, 2025

SUBJECT: Cannabis: appointees: prohibited activities.

SUMMARY: Extends current prohibitions against state cannabis officials having specified financial interests or relationships within the licensed cannabis industry to additional appointed officials within the Department of Cannabis Control (DCC).

EXISTING LAW:

1) Enacts the Medicinal and Adult-Use Cannabis Regulation and Safety Act (MAUCRSA) to provide for a comprehensive regulatory framework for the cultivation, distribution, transport, storage, manufacturing, processing, and sale of medicinal and adult-use cannabis. (Business and Professions Code (BPC) §§ 26000 *et seq.*)

2) Establishes the DCC within the Business, Consumer Services, and Housing Agency (BCSH) (previously established as the Bureau of Cannabis Control, the Bureau of Marijuana Control, the Bureau of Medical Cannabis Regulation, and the Bureau of Medical Marijuana Regulation), for purposes of administering and enforcing MAUCRSA. (BPC § 26010)

3) Provides the DCC with authority for issuing various types of cannabis licenses including subtypes for cultivation, manufacturing, testing, retail, distribution, and microbusiness; requires each licensee except for testing laboratories to clearly designate whether their license is for adult-use or medicinal cannabis. (BPC § 26050)

4) Requires the Governor to appoint the director of the DCC, subject to confirmation by the Senate and under the direction and supervision of the BCSH Secretary. (BPC § 26010.5(a))

5) Allows for every power granted to or duty imposed upon the director of the DCC to be exercised or performed in the name of the director by a deputy or assistant director or chief, subject to conditions and limitations that the director may prescribe. (BPC § 26010.5(b))

6) Expressly authorizes the Governor to appoint a chief deputy director, a deputy director of equity and inclusion, and either a deputy director of legal affairs or a chief counsel to the DCC. (BPC § 26010.5(c))

7) Establishes the Cannabis Control Appeals Panel (CCAP) within BCSH, which consists of one member appointed by the Senate Committee on Rules, one member appointed by the Speaker of the Assembly, and three members appointed by the Governor; requires the Governor's appointees to each reside in a different county; and specifies that each member of the panel may be removed by their appointing authority. (BPC § 26040)

8) Prohibits either the director of the DCC or any member of CCAP from any of the following:

    a) Receiving any commission or profit whatsoever, directly or indirectly, from any person applying for or receiving any license or permit under MAUCRSA.

b) Engaging or having any interest in the sale or any insurance covering a licensee's business or premises.

c) Engaging or having any interest in the sale of equipment for use upon the premises of a licensee engaged in commercial cannabis activity.

d) Knowingly soliciting any licensee for the purchase of tickets for benefits or contributions for benefits.

e) Knowingly requesting any licensee to donate or receive money, or any other thing of value, for the benefit of any person whatsoever.

(BPC § 26011)

THIS BILL:

1) Extends the existing prohibitions against the director of the DCC or a member of CCAP profiting from having any of the specified financial interests or relationships with the licensed cannabis industry to also apply to other DCC executives appointed by the director under MAUCRSA.

FISCAL EFFECT: Unknown; this bill is keyed fiscal by the Legislative Counsel.

COMMENTS:

Purpose. This bill is sponsored by the author, who is Chair of the Assembly Committee on Business and Professions. According to the author:

> Californians rely on state cannabis officials to fairly and unbiasedly administer and enforce our cannabis laws. This is why existing law prohibits the Director of the Department of Cannabis Control, or any member of the Cannabis Control Appeals Panel, from financially benefiting from the cannabis industry or from accepting gifts from licensees. AB 3054 will strengthen this law by extending those same prohibitions to other influential officials within the Department of Cannabis Control.

Background.

Brief History of Cannabis Regulation in California. Consumption of cannabis was first made lawful in California in 1996 when voters approved Proposition 215, or the Compassionate Use Act. Proposition 215 protected qualified patients and caregivers from prosecution relating to the possession and cultivation of cannabis for medicinal purposes, if recommended by a physician. This regulatory scheme was further refined by SB 420 (Vasconcellos) in 2003, which established the state's Medical Marijuana Program. After several years of lawful cannabis cultivation and consumption under state law, a lack of a uniform regulatory framework led to persistent problems across the state. Cannabis's continued illegality under the federal Controlled Substances Act, which classifies cannabis as a Schedule I drug ineligible for prescription, generated periodic enforcement activities by the United States Department of Justice. Threat of action by the federal government created persistent apprehension within California's cannabis community.

After several prior attempts to improve the state's regulation of cannabis, the Legislature passed the Medical Marijuana Regulation and Safety Act—subsequently retitled the Medical Cannabis Regulation and Safety Act (MCRSA)—in 2015. MCRSA established, for the first time, a comprehensive statewide licensing and regulatory framework for the cultivation, manufacture, transportation, testing, distribution, and sale of medicinal cannabis. While entrusting state agencies to promulgate extensive regulations governing the implementation of the state's cannabis laws, MCRSA fully preserved local control. Under MCRSA, local governments may establish their own ordinances to regulate medicinal cannabis activity. Local jurisdictions could also choose to ban cannabis establishments altogether.

Not long after the Legislature enacted MCRSA, California voters passed Proposition 64, the Adult Use of Marijuana Act (AUMA). The passage of the AUMA legalized cannabis for non-medicinal adult use in a private home or licensed business; allowed adults 21 and over to possess and give away up to approximately one ounce of cannabis and up to eight grams of concentrate; and permitted the personal cultivation of up to six plants. The proponents of the AUMA sought to make use of much of the regulatory framework and authorities set out by MCRSA while making a few notable changes to the structure still being implemented.

In the spring of 2017, SB 94 (Committee on Budget and Fiscal Review) was passed to reconcile the distinct systems for the regulation, licensing, and enforcement of legal cannabis that had been established under the respective authorities of MCRSA and the AUMA. The single consolidated system established by the bill—known as the Medicinal and Adult-Use Cannabis Regulation and Safety Act (MAUCRSA)—created a unified series of cannabis laws. On January 16, 2019, the state's three cannabis licensing authorities—the Bureau of Cannabis Control, the California Department of Food and Agriculture, and the California Department of Public Health—officially announced that the Office of Administrative Law had approved final cannabis regulations promulgated by the three agencies respectively.

In early 2021, the Department of Finance released trailer bill language to create a new Department with centralized authority for cannabis licensing and enforcement activities. This new department was created through a consolidation of the three prior licensing authorities' cannabis programs. As of July 1, 2021, the Department has been the single entity responsible for administering and enforcing the majority of MAUCRSA. New regulations went into effect on January 1, 2023 to effectuate the organizational consolidation and make other changes to cannabis regulation.

Cannabis Control Appeals Panel. CCAP is a quasi-judicial entity charged with reviewing licensing decisions issued by the DCC. CCAP currently consists of five members: three appointed by the Governor, one by the Senate Committee on Rules, and one by the Speaker of the Assembly. Each member appointed by the Governor is required to be a resident of a different county from the other two at the time of their initial appointment. Each member of CCAP may be removed by their appointing authority.

Ensuring Disinterested Cannabis Authorities. Per MAUCRSA, the DCC is overseen by a director appointed by the Governor, subject to confirmation by the Senate. Both the director of the DCC and any of the appointed members of CCAP are prohibited by law from engaging in specified activities to ensure that they are not financially motivated in the execution of their responsibilities as overseers of the state's licensed cannabis industry. Specifically, MAUCRSA provides that neither the director not a CCAP member may do any of the following:

a) Receive any commission or profit whatsoever, directly or indirectly, from any person applying for or receiving any license or permit under MAUCRSA.

b) Engage or have any interest in the sale or any insurance covering a licensee's business or premises.

c) Engage or have any interest in the sale of equipment for use upon the premises of a licensee engaged in commercial cannabis activity.

d) Knowingly solicit any licensee for the purchase of tickets for benefits or contributions for benefits.

e) Knowingly request any licensee to donate or receive money, or any other thing of value, for the benefit of any person whatsoever.

The director of the DCC is authorized to employ and appoint employees and to delegate their powers and duties to a deputy director, assistant director, or chief. MAUCRSA then expressly authorizes the Governor to appoint a chief deputy director, a deputy director of equity and inclusion, and either a deputy director of legal affairs or a chief counsel to the DCC. These additional appointed officials arguably exercise significant influence over the DCC's activities and are similarly trusted to oversee the cannabis industry. This bill intends to recognize this influence by extending the same conflict of interest provisions that apply to the director of DCC and members of CCAP to these additional appointees.

Prior Related Legislation. AB 3054 (Berman) of 2024 was substantially similar to this bill. *This bill died on the Senate inactive file.*

SB 94 (Committee on Budget and Fiscal Review), Chapter 27, Statutes of 2017 combined AUMA and MCRSA into a unified system for the regulation of cannabis, MAUCRSA.

REGISTERED SUPPORT:

None on file.

REGISTERED OPPOSITION:

None on file.

Analysis Prepared by: Robert Sumner / B. & P. / (916) 319-3301

Date of Hearing: April 1, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 867 (Lee) – As Amended March 24, 2025

SUBJECT: Veterinary medicine: animal declawing.

SUMMARY: Prohibits a person from performing a declawing or similar procedures on any cat unless the person is licensed as a veterinarian in California and the veterinarian is performing the declawing for a therapeutic purpose, as defined.

EXISTING LAW:

1) Establishes the Veterinary Medicine Practice Act for the regulation and oversight of licensed veterinarians by the Veterinary Medical Board of California (VMB). (Business and Professions Code (BPC) §§ 4800 et seq.)

2) States that a person practices veterinary medicine whenever they perform a surgical or dental operation upon an animal. (BPC § 4826)

3) Prohibits a local government from prohibiting a licensed healing arts professional from engaging in any act or performing any procedure that falls within the professionally recognized scope of practice of that licensee. (BPC § 460)

4) Provides that every person who maliciously and intentionally maims, mutilates, tortures, or wounds a living animal, or maliciously and intentionally kills an animal, is guilty of a crime. (Penal Code (PEN) § 597)

5) Prohibits an individual from performing, or arranging for the performance of, surgical claw removal, declawing, onychectomy, or tendonectomy on any cat that is a member of an exotic or native wild cat species, with the exception of procedures performed solely for a therapeutic purpose. (PEN § 597.6)

6) Prohibits property managers from refusing to rent real property to an individual who refuses to declaw or devocalize an animal. (Civil Code § 1942.7)

7) Provides for the general regulation of cats, with specific requirements and prohibitions placed on public animal control agencies, shelters, and rescue groups. (Food and Agricultural Code §§ 31751 *et seq.*)

THIS BILL:

1) Prohibits a person from performing a declawing on any cat unless both of the following conditions are satisfied:

   a) The person is licensed as a veterinarian in California, and

   b) The veterinarian is performing the declawing for a therapeutic purpose.

2) Defines “declawing” as any of the following:

a) An onychectomy, dactylectomy, phalangectomy, partial digital amputation, or any other surgical procedure in which a portion of a cat's paw is amputated to remove the animal's claw,

b) A tendonectomy, or surgical procedure in which the tendons of a cat's limbs, paws, or toes are cut or modified so that the claws cannot be extended, or

c) Any other procedure that prevents the normal functioning of a cat's claws.

3) Defines a "therapeutic purpose" as a medically necessary procedure to address an existing or recurring infection, disease, injury, or abnormal condition in the claws, nail bed, or toe bone, which jeopardizes the cat's health.

4) Excludes a procedure performed for a cosmetic or aesthetic purpose or to make the cat convenient to keep or handle from the definition of "therapeutic purpose."

5) Requires that, if a veterinarian determines that declawing is necessary for a therapeutic purpose, the veterinarian shall prepare and file a written statement with the VMB setting forth the purpose for performing the procedure and providing the date on which the procedure was performed, and shall also provide a copy of that statement to the owner of the cat.

6) Makes violation of this law subject to discipline by the VMB, which shall make a determination as to whether or not to impose penalties, including, but not limited to, fines, suspension of license, or revocation of license.

7) Clarifies that nothing in the bill shall be interpreted to preempt any local ordinance prohibiting declawing procedures, nor any penalties imposed for a violation of such an ordinance.

FISCAL EFFECT: Unknown; this bill is keyed fiscal by the Legislative Counsel.

COMMENTS:

Purpose. This bill is sponsored by the *Paw Project*. According to the author:

> Cat declawing, the amputation of the first knuckle of each cat's toes, is an outdated, cruel, and unethical surgical procedure that results in lifelong disfigurement and pain. Many countries have already outlawed this inhumane practice. AB 867 shows the nation and world that California does not endorse surgical mutilation performed electively on healthy cats for human convenience. This bill safeguards the welfare of cats by protecting them from the harmful and barbaric surgical procedure of declawing.

Background.

Cat Declawing. Speaking generally, "declawing" refers to any procedure intended to prevent an animal from using its claws, through removal of either the claws or the animal's ability to use them. Onychectomy involves removing an animal's claws through a surgery that may include the amputation of bone through nail trimmers, scalpels, or lasers. Tendonectomy is a procedure performed for a similar purpose in which a cat's tendons are severed to prevent a cat from extending its claws.

According to recent data, an estimated 20-24% of cats in the United States have been declawed. Declawing is performed on domesticated cats to prevent the animal from scratching humans or other animals, as well as furniture and other possessions within a home. Studies indicate that many individuals who declaw their cats would likely give up their pets if the scratching were allowed to continue, and surveys have demonstrated that pet owners believe their relationships with their cats improve following declawing. However, the author of a prior related bill previously provided data suggesting the relinquishing of cats has decreased in cities that banned declawing.

Notwithstanding the asserted benefits of declawing domesticated cats, there have long been criticisms that declawing is inherently inhumane toward cats when done purely for the convenience of an owner. There is an assumption that declawing is a painful or uncomfortable procedure for cats, though the extent to which this is true remains to be a matter of medical consensus. Complications can also arise as a result of the procedure, as with any other invasive surgery performed on an animal.

In January of 2020, the American Veterinary Medical Association (AVMA) revised its formal policy regarding the declawing of domestic cats. Previously, the AVMA focused on encouraging client education prior to consideration of declawing procedures, citing scientific data indicating that cats that have destructive scratching behavior are more likely to be euthanatized or abandoned. The new policy continues to defer to a veterinarian's professional judgment, while more strongly discouraging elective declawing. The full text of the statement is as follow:

> The AVMA discourages the declawing (onychectomy) of cats as an elective procedure and supports non-surgical alternatives to the procedure. The AVMA respects the veterinarian's right to use professional judgment when deciding how to best protect their individual patients' health and welfare. Therefore, it is incumbent upon the veterinarian to counsel the owner about the natural scratching behavior of cats, the alternatives to surgery, as well as the details of the procedure itself and subsequent potential complications. Onychectomy is a surgical amputation and if performed, multi-modal perioperative pain management must be utilized.

Historically, the overall lack of scientific consensus as to what constitutes an appropriate clinical context for claw removal, as well as a lack of moral consensus about whether the procedure should be generally prohibited on a humanitarian basis, has led to active debates in various local jurisdictions, as well as within foreign governments. Australia, Austria, Brazil, Croatia, Germany, Ireland, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom have all banned declawing in some way. Meanwhile, Los Angeles, San Francisco, Berkeley, Burbank, Culver City, West Hollywood, Santa Monica, and Beverly Hills have all banned declawing.

However, in 2008, legislation was introduced in California in response to concerns about local governments enacting their own local ordinances to carve away portions of licensed veterinary scope of practice authorized at the state level. Following litigation by the California Veterinary Medical Association (CVMA) against the City of West Hollywood over its local ban on declawing, the CVMA sponsored AB 2427 (Eng) of 2008 to expressly state that it is unlawful for a locality to prevent a healing arts licensee from engaging within the licensed scope of their practice. Supported by a broad range of healing arts professional associations beyond veterinary medicine, this bill effectively stopped the trend of local governments banning declawing within their jurisdictions.

Existing law within the Veterinary Medicine Practice Act already prohibits any non-veterinarian from performing surgical procedures, including declaw procedures. The measure before this committee would prohibit any person, regardless of whether they are a licensed veterinarian, from performing an onychetomy, tendonectomy, or similarly disruptive procedures on a cat. Violations would be subject to specified civil penalties. Only a "therapeutic purpose," as defined, would allow a licensed veterinarian to perform the procedures, and only a cat's physical medical condition would provide that justification. The veterinarian would not be allowed to perform a procedure for a cosmetic or aesthetic purpose or to make the cat convenient to keep or handle.

Current Related Legislation. AB 1502 (Committee on Business and Professions) is the VMB's current sunset review vehicle. *This bill is pending in this committee.*

Prior Related Legislation. AB 2954 (Wendy Carrillo) of 2024 would have prohibited any person from performing declawing on any cat except for a therapeutic purpose. *This bill died in this committee.*

AB 2606 (Wendy Carrillo) of 2022 would have prohibited any person from performing declawing on any cat except for a therapeutic purpose. *This bill died in the Senate Committee on Business, Professions, and Economic Development*.

SB 585 (Stern) of 2021 would have prohibited an individual from declawing a cat except for a therapeutic purpose and imposed a penalty for a violation. *This bill died in the Senate Committee on Business, Professions, and Economic Development.*

AB 1230 (Quirk) of 2019 would have prohibited a veterinarian from performing a declawing on any cat or any other animal except for a therapeutic purpose. *This bill died in this committee.*

SB 1441 (Stern) of 2018 would have prohibited a person from performing the surgical declawing of a domestic cat. *This bill died in the Senate Public Safety Committee*.

ARGUMENTS IN SUPPORT:

The *Paw Project* is sponsoring this bill, writing: "Declawing is a series of amputations of all or most of the last bone of each of an animal's toes and performed to prevent unwanted scratching. Declawing removes an integral part of an animal's anatomy and subjects animals to the risks of pain, infection, behavioral changes, and lifelong lameness. Safe and effective alternatives to declawing include simple training, nail caps, and other established deterrent methods."

ARGUMENTS IN OPPOSITION:

The *California Veterinary Medical Association* (CVMA) opposes this bill, writing: "While this bill is aimed at prohibiting veterinarians from performing a surgical declawing procedure on cats under certain circumstances, it would—if passed—have a far-reaching and precedential impact on a veterinarian's ability to practice veterinary medicine." CVMA states that it is "deeply concerned that the veterinary profession is being singled out among our fellow healing arts professionals with legislation proposing to ban specific medical and surgical procedures in statute, which is a dangerous precedent."

POLICY ISSUE(S) FOR CONSIDERATION:

Interference with Professional Judgement. This bill's opposition points out that legislation specifically prohibiting a healing arts licensee from engaging in a procedure that the licensee is trained to perform is exceptionally rare. While many procedures are frequently discouraged or reserved for only certain situations, statute generally provides licensees with the discretion to determine whether the procedure is appropriate based on the specifics of the situation. This tendency to avoid "legislating the practice of medicine" is rooted in the common denominator for most healing arts regulation, in which practitioners are not expected to follow step-by-step directions outlined in statute when engaged in clinical practice, but are instead entrusted with freedom to exercise their judgement, as guided by extensive education and training. However, this bill does leave it up to each individual veterinarian to determine whether there is a therapeutic purpose for declawing from the perspective of the animal patient, which arguably retains the appropriate level of deference to professional judgment.

REGISTERED SUPPORT:

The Paw Project *(Co-Sponsor)*
Animal Legal Defense Fund *(Co-Sponsor)*
Castillo Animal Veterinary Corp
Cat Town
City of West Hollywood
Conference of California Bar Associations
Crooked Tails Senior Rescue
Democrats for the Protection of Animals
Humane Veterinary Medical Alliance
Humane World for Animals
Michelson Center for Public Policy
Our Honor
Patricia H. Ladew Foundation
SNAP CATS
Social Compassion in Legislation
VCA Canada
West Radiologic Services
42 individuals

REGISTERED OPPOSITION:

California Veterinary Medical Association

Analysis Prepared by: Robert Sumner / B. & P. / (916) 319-3301, Edward Franco / B. & P. / (916) 319-3301

Date of Hearing: April 1, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 1082 (Flora) – As Introduced February 20, 2025

SUBJECT: Nursing: students in out-of-state nursing programs.

SUMMARY: Authorizes an unlicensed nursing student who is enrolled in an out-of-state distance education nursing program to provide supervised nursing services that are incidental to the course of study for purposes of gaining clinical experience.

EXISTING LAW:

1) Regulates the practice of nursing under the Nursing Practice Act. (Business and Professions Code (BPC) §§ 2700-2838.4)

2) Establishes the Board of Registered Nursing (BRN) within the Department of Consumer Affairs (DCA) to administer and enforce the Nursing Practice Act until January 1, 2027. (BPC § 2701)

3) Prohibits the practice of nursing without holding a license which is in an active status issued under the Nursing Practice Act, except as otherwise provided, and specifies that every licensee may be known as a registered nurse (RN) and use the title "R.N." (BPC § 2732)

4) Requires an applicant for licensure as an RN to complete the education requirements established by the BRN in a program in this state approved by the BRN or in a school of nursing outside of this state which, in the opinion of the BRN, offers an education that meets the BRN's requirements. (BPC § 2736)

5) Defines "an approved school of nursing" or "an approved nursing program" as one that (1) has been approved by the BRN, (2) gives the course of instruction approved by the BRN, covering not less than two academic years, (3) is affiliated or conducted in connection with one or more hospitals, and (4) is an institution of higher education. (BPC § 2786(a))

6) Requires the BRN to determine by regulation the required subjects of instruction for licensure as an RN and (1) include the minimum units of theory and clinical experience necessary to achieve essential clinical competency at the entry level of an RN and (2) require all programs to provide clinical instruction in all phases of the educational process, except as specified. (BPC § 2786(c))

7) Authorizes a student to render nursing services if those services are incidental to the course of study of one of the following:

    a) A student enrolled in a BRN-approved pre-licensure program or school of nursing. (BPC § 2729(a))

    b) A nurse licensed in another state or country taking a BRN-approved continuing education course or a post-licensure course. (BPC § 2729(b))

8) Requires a nursing program to obtain approval from the BRN for the use of any agency or facility for clinical experience, and requires the program to take into consideration the impact that an additional group of students would have on students of other nursing programs already assigned to the agency or facility. (California Code of Regulations, Title 16, § 1427)

9) Prohibits an institution of higher education or a private postsecondary school of nursing, or an entity affiliated with the institution or school of nursing, from making a payment to any clinical agency or facility in exchange for clinical experience placements for students enrolled in a nursing program offered by or affiliated with the institution or private postsecondary school of nursing, as specified. (BPC § 2786.4)

10) Defines an "out-of-state private postsecondary educational institution" as a private entity without a physical presence in this state that offers distance education to California students for an institutional charge, regardless of whether the institution has affiliated institutions or institutional locations in California. (Education Code § 94850.5)

THIS BILL:

1) Authorizes a student who is a resident of this state and enrolled in a pre-licensure distance education nursing program based at an out-of-state private postsecondary educational institution to provide nursing services to gain clinical experience in a clinical setting if the following are met:

    a) The program is accredited by a programmatic accreditation entity recognized by the United States Department of Education.

    b) The BRN has not otherwise approved the program.

    c) The student placement does not impact any students already assigned to the agency or facility.

    d) The program does not make payments to any clinical agency or facility in exchange for clinical experience placements for students enrolled in a nursing program offered by or affiliated with the institution or private postsecondary school of nursing.

    e) The program qualifies graduates for licensure under the Nursing Practice Act.

    f) The program maintains minimum faculty to student ratios required of BRN-approved programs for in-person clinical experiences.

    g) The program pays a one-time fee of $100 to the BRN for each student who participates in clinical experience placements in the state.

2) Requires a student providing services under this bill to be supervised by an RN while rendering nursing services.

3) Prohibits a clinical agency or facility from offering clinical experience placements to an out-of-state private postsecondary educational institution if the placements are needed to fulfill the clinical experience requirements of an in-state student enrolled in a BRN-approved nursing program.

4) Specifies that, for purposes of the authorization under this bill, "out-of-state private postsecondary educational institution" means a private entity without a physical presence in this state that offers distance education to California students for an institutional charge, regardless of whether the institution has affiliated institutions or institutional locations in California.

FISCAL EFFECT: Unknown. This bill is keyed fiscal by the Legislative Counsel.

COMMENTS:

Purpose. This bill is sponsored by the *Nightingale Education Group*. According to the author, "This bill will provide flexibility for nursing students while addressing the state's nursing shortage by potentially retaining more students within California. This bill acknowledges the challenges faced by California nursing students enrolled in out-of-state distance learning programs and offers a solution to enable them to complete their clinical education within the state. By permitting supervised clinical rotations within California healthcare institutions, the bill aims to support the educational needs of these students while addressing the state's nursing shortage."

Background. Nursing education generally contains two components, classroom theory and clinical experience. Clinical experience is supervised, hands-on experience providing patient care, providing an opportunity to apply theory to practice. In California, both theory and clinical experience are required for licensure as an RN.

To allow students to gain clinical experience, existing law exempts students from licensing requirements while providing nursing services through a BRN-approved education program. There is no exemption for students enrolled in non-BRN-approved nursing education programs, including students who live in California but attend distance-learning nursing education programs based in other states.

However, students who attend out-of-state programs must have their education evaluated for equivalency with state requirements, including clinical experience. Those who do not meet the requirements will be denied or considered deficient and required to complete additional remedial education or training.

As a result, the in-state students enrolled in non-BRN-approved distance programs must move to other states during their course of study to obtain the required clinical experience if they wish to immediately qualify for licensure in California upon graduation. This bill seeks to avoid requiring those students to move or travel by expanding the license exemption, though specifically limited to students enrolled in non-BRN-approved distance education nursing programs that are also accredited.

BRN. The BRN is a licensing entity within DCA and is responsible for administering and enforcing the Nursing Practice Act, which is the chapter of laws that establishes the BRN and outlines the regulatory framework for the practice, licensing, education and discipline of RNs and advanced practice registered nurses. The BRN is also one of the few licensing boards that actively approve and regulate educational programs that offer the degrees necessary for licensure. In-state programs that offer a course of instruction leading to an RN license must seek approval from the BRN to operate. As of March 2025, the BRN's website (https://www.rn.ca.gov/education/enrolldata.shtml) reports a total of 200 approved RN programs, including 108 Associate Degree in nursing (ADN) programs, 74 Bachelor of Science in nursing (BSN) programs, and 18 Entry-level Master's (ELM) programs.

Prior Related Legislation. AB 2578 (Flora) of 2024 was identical to this bill except that AB 2578 would have required the out-of-state school to submit annual reports to the BRN. *AB 2578 was held on the Senate Appropriations Committee suspense file.*

SB 1015 (Cortese), Chapter 776, Statutes of 2024, required the Board of Registered Nursing (BRN) to study and recommend standards regarding how approved schools of nursing or nursing programs manage or coordinate clinical placements and to annually collect, analyze, and report information related to management of coordination of clinical placements.

SB 1042 (Roth) of 2024 would have required health facilities and clinics to work with representatives from nursing schools and programs, upon request, to meet the clinical placement needs of the school or program; requires nursing schools and programs to report specified clinical placement data to the BRN; required the BRN to assist schools or programs in finding clinical placement slots; and required health facilities and clinics to report specified clinical placement data to the Department of Health Care Access and Information (HCAI). *SB 1042 was held on the Assembly Appropriations Committee suspense file.*

AB 1292 (Flora) of 2023 was substantially similar to this bill. *AB 1292 was held on the Assembly Appropriations Committee suspense file*.

AB 1577 (Low) of 2023 would have required hospitals that offer pre-licensure clinical training slots to work in good faith with community college nursing programs to meet their clinical training needs. *AB 1577 died pending a hearing in the Senate Health Committee*.

AB 2684 (Berman), Chapter 413, Statutes of 2022, which was the BRN's 2022 Sunset Review bill,[1] made several changes to address the lack of clinical placements, including establishing a lower 500 minimum number of clinical experience hours, authorizing clinical placements to take place in the academic term immediately following theory, prohibiting nursing schools and programs from paying for clinical placements, and requiring the BRN to utilize data from

[1] The sunset review process provides an opportunity for the DCA, the Legislature, the boards, and interested parties and stakeholders to discuss the performance of the boards, and make recommendations for improvements. Each year, the Assembly Business and Professions Committee and the Senate Business, Professions, and Economic Development Committee hold joint sunset review oversight hearings to review the boards and bureaus. For more information, see the background paper on the BRN's 2022 Sunset Review, accessible at: https://abp.assembly.ca.gov/jointsunsethearings.

available regional or individual institution databases in collecting information related to the number of clinical placement slots available to nursing students.

AB 2288 (Low), Chapter 282, Statutes of 2020, in response to the COVID-19 pandemic, authorized the director of an approved nursing program, during a state of emergency, to make requests to the BRN for the following: 1) the use of a clinical setting without meeting specified requirements; 2) the use of preceptorships without having to maintain specified written policies; 3) the use of clinical simulation up to 50% for medical-surgical and geriatric courses; 4) the use of clinical simulation up to 75% for psychiatric-mental health nursing, obstetrics, and pediatrics courses; and 5) allowing clinical placements to take place in the academic term immediately following theory.

AB 1015 (Blanca Rubio), Chapter 591, Statutes of 2021, required the BRN to incorporate regional forecasts into its biennial analyses of the nursing workforce, develop a plan to address regional areas of shortage identified by its nursing workforce forecast, as specified, and annually collect, analyze, and report information related to the number of clinical placement slots that are available and the location of those clinical placement slots within the state.

ARGUMENTS IN SUPPORT:

Nightingale Education Group (sponsor) writes in support:

> Under the current nursing regulations, the reality for many California residents is that they are forced, while enrolled in distance education programs domiciled outside of California, to fulfill clinical experiential learning requirements in other states, where they are required to relocate for several weeks each semester to fulfill the mandatory on-ground practical components of their education. This creates a costly and cumbersome reality where students must travel at their own expense, leaving their families, homes, and employment, for weeks at a time every semester for the duration of their nursing program. Additionally, during these travel rotations these students are developing relationships with, and actively being recruited by, healthcare facilities in other states who offer compelling benefits to relocating, thus worsening California's nursing shortage.
>
> The Covid-19 pandemic elevated the nursing shortage to crisis levels, with UCSF recently reporting that the state's hospitals are short the equivalent of more than 40,000 full-time nurses, and as the state’s population ages, the shortage is often felt more urgently in non-hospital settings such as long-term care/skilled nursing, dialysis, outpatient clinics, etc. While myriad California residents are ready and willing to meet this shortage by training to become nurses, many California nursing education programs are not able to meet the demand of incoming applicants. The San Francisco Chronicle recently reported on the extreme exclusivity of many of the state's nursing programs in a time of staffing crisis, stating that multiple University of California campuses (UC Irvine and UCLA) have an acceptance rate of only 1%, which as the article stated, is "...even more selective than getting into Yale" (6.53% acceptance rate). Now is not the time for more exclusive enrollments, now is the time to create greater access to this much needed profession.

For many California nursing education program applicants, work schedules, family life, finances, and other priorities now make distance nursing education their only option. Unfortunately, many other students have chosen not to pursue their education at all because options in their local areas are either severely limited or non-existent. [This bill] would allow these students to enroll in readily available blended distance education programs (online education + local on-ground experiential learning), offered by colleges and universities across the country that provide education opportunities meeting the students' lifestyle and financial needs.

Distance education provides many benefits for California nursing students including, open enrollment without waiting lists or lottery systems, less expensive education costs relative to traditional on-site counterparts, substantial savings on gas, car maintenance, room and board, and childcare, and many others. In addition to the personal benefits for students, the economic benefits experienced by communities when residents stay and work at local businesses during school and after graduation are immeasurable. Rural communities are especially affected by economic pressures, and due to cost and space constraints, traditional on-site colleges and universities are simply not able to meet the needs of these cities and towns. Distance education programs provide much-needed workforce development options for under-served communities, especially for critical services such as nursing and healthcare.

ARGUMENTS IN OPPOSITION:

The *Board of Registered Nursing* writes in opposition for two reasons:

1) Program oversight:

…every state has its own unique NPA that sets the framework for how nurses are prepared and able to practice within that state. This includes different standards and rules related to nursing education, licensure, scope of practice, and discipline. Out of state nursing programs are eligible to receive the same Board approval that is granted to in state schools. Doing so would allow out of state programs to have their students to conduct clinicals in California.

Instead, the bill would require the out of state programs to be accredited by a programmatic accreditation entity recognized by the United States Department of Education. This is problematic for two reasons. First is that, unlike program approval, program accreditation does not ensure that a nursing program adheres to pertinent laws and regulations. Program accreditation is a voluntary process in which a private, nonprofit organization evaluates a nursing program from a national perspective to see if they meet general standards of the profession, they do not check for compliance with state law.

Second, the US Department of Education is charged with recognizing accrediting agencies and the standards they use to evaluate programs. However, the President of the United States signed an Executive Order to close the Department of

Education and return authority over education to the States and local communities. Closing the Department of Education will leave accrediting bodies without any type of oversight unless and until California establishes a mechanism for providing oversight at some point in the future.

2) Clinical impaction:

Board members also expressed concern with the negative impact this bill would have on California's already strained supply of clinical placements. The bill sponsor alone has thousands of California residents enrolled in their nursing programs. Given that that is only one of numerous out of state programs that would be eligible to have their students conduct clinical placements in California under this bill, the potential for clinical displacement is significant.

The bill states that a clinical agency or facility cannot schedule a clinical experience placement with an out-of-state private postsecondary educational institution if the placement is needed to fulfill the clinical experience requirements of an in-state student enrolled in a board-approved nursing program. However, the Board does not have any jurisdiction over health facilities and would not be able to monitor or enforce compliance with this provision.

There are various reasons why a California resident may choose to enroll in an out of state private distance education program, including a more flexible schedule that better accommodates their and their family's unique needs. Residents also may choose to enroll in out of state nursing programs because they are unable to get into their local nursing programs in a timely fashion due to long wait lists. One of the key contributors to these long wait lists is the limited supply of clinical placements. Clinical impaction is so severe in parts of the state that the Board has had to deny new nursing programs, new campus locations and reduce enrollment increase requests to mitigate the displacement of current students.

Allowing out of state nursing programs to grow and utilize clinical placements in California without going through the same upfront Board approval process that our in-state nursing programs must go through creates an unfair advantage and impedes the ability of in-state programs to grow and reduce those same waitlists for California residents.

POLICY ISSUES FOR CONSIDERATION:

1) *Lack of Clinical Placements*. During the BRN's 2022 Sunset Review, both this committee and the Senate Business, Professions and Economic Development Committee raised, and continue to work on, the issue of the availability of clinical placements for nursing students. The availability of student placements for clinical experiences is based on the willingness of clinical facilities, such as hospitals or clinics, to accept and teach students.

While there are no requirements that clinical facilities accept students, many willingly accept students because it is necessary for the workforce and can help with recruitment. However, the facilities must have staff that is qualified to teach and supervise students. As a result,

clinical placements are often difficult to find, and currently, clinical placement availability is severely lacking. Unfortunately, students who are unable to obtain their clinical placements before the end of the term either have to drop out or receive an incomplete. Under either circumstance, the student would have to repeat the course.

This bill may complicate that problem by authorizing nursing students who are enrolled in out-of-state distance education programs to compete for already limited clinical placements. To reduce the chance that a student enrolled in an in-state program is displaced from a clinical placement, this bill contains language previously recommended by this committee requiring clinical facilities to give preference to students enrolled in an in-state program.

2) *Education Quality*. The BRN and stakeholders argue that out-of-state schools may not meet the standards of in-state schools that require BRN approval. However, there are already California students enrolled in out-of-state programs, and these students must be approved by the BRN as meeting California requirements. Once approved, they must still pass the licensing exam, the NCLEX. If the BRN finds them deficient, they must take approved remedial courses before they may take the NCLEX.

   Similarly, students who have attended a program in another state and obtained a license in that state can obtain a California license after the BRN reviews their education when applying for a license by endorsement. As a result, the only difference between the California nursing students affected by this bill and students and nurses who apply to the BRN is that they are located in California.

3) *Federal Accreditation*. This bill would only apply to students enrolled in out-of-state nursing programs that are accredited by a programmatic accreditation entity recognized by the United States Department of Education. As the BRN notes, there is an executive order that aims to close the department. While closing the department would require an act of Congress, that act is also a possibility. However, if that were to happen, and a nursing program was accredited by an accreditor no longer recognized by the department because the department did not exist, then that program would not be able to use the exception under this bill.

4) *Fairness*. The BRN and stakeholders argue that granting the benefit under this bill to out-of-state nursing programs, which do not have to pay a $40,000 fee to obtain BRN approval or go through the rigorous approval process, is not fair to approved in-state nursing programs.

5) *Enforceability*. The BRN and stakeholders note that this bill contains various conditions and prohibitions but does not designate an agency to enforce them. However, it is possible to seek a court order to enforce the law through an injunction (Code of Civil Procedure §§ 525-526; BPC §§17200-17210).

IMPLEMENTATION ISSUES:

Timing. The BRN is scheduled for its sunset review next year. If this bill passes this committee, the author may wish to include a sunset date that aligns with the BRN's sunset date, January 1, 2027, so the impacts of this bill can be discussed through the end of the legislative session and whether the exception granted under this bill should be extended.

REGISTERED SUPPORT:

Nightingale Education Group (sponsor)

REGISTERED OPPOSITION:

American Federation of State, County and Municipal Employees, AFL-CIO
Association of California Nurse Leaders
Board of Registered Nursing
CA Organization of Associate Degree Nursing Directors South
California Association of Associated Degree Nursing
California Association of Colleges of Nursing
California Nurses Association
California State University, Office of the Chancellor

Analysis Prepared by: Vincent Chee / B. & P. / (916) 319-3301

Date of Hearing: April 1, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 1307 (Ávila Farías) – As Introduced February 21, 2025

SUBJECT: Licensed Dentists from Mexico Pilot Program.

SUMMARY: Reestablishes the Licensed Dentists from Mexico Pilot Program and revises various requirements contained within the existing pilot program relating to the temporary state licensure of dental professionals from Mexico.

EXISTING LAW:

1) Establishes the Dental Practice Act. (Business and Professions Code (BPC) §§ 1600 *et seq.*)

2) Establishes the Dental Board of California (DBC) within the Department of Consumer Affairs to administer and enforce the Dental Practice Act. (BPC § 1601.1)

3) Establishes the Licensed Dentists from Mexico Pilot Program, previously established as a component of the Licensed Physicians and Dentists Pilot Program, which requires the DBC to issue a three-year nonrenewable permit to practice dentistry to no more than 30 dentists from Mexico who meet specified criteria. (BPC § 1645.4)

4) Requires dentists in the pilot program to meet one of the following sets of requirements:

    a) Be a graduate from the National Autonomous University of Mexico School of Faculty Dentistry (Facultad de Odontología); meet all criteria for licensure in Mexico, including a minimum grade point average, specified English language comprehension, passage of a general examination, and passage of an oral interview; and enroll and complete an orientation program that focuses on coursework including pharmacology, pathology, infection control, and sedation techniques, all taught by California dental school instructors, along with introductions to health care systems in California and community clinic operations.

    b) Graduate within the three-year period before enrollment in the program, from a foreign dental school that has received provisional approval or certification by November 2003 from the DBC under the Foreign Dental School Approval Program; enroll and satisfactorily complete an orientation program that focuses on the health care system and community clinic operations in California; and enroll and satisfactorily complete a course taught by an approved foreign dental school on infection control approved by the DBC.

    (BPC § 1645.4(e))

5) Limits employment of dentists in the pilot program to nonprofit community health centers. (BPC § 1645.4(f))

6) Sets the fee for a three-year nonrenewable permit at $548. (BPC § 1645.4(g))

7) Requires the DBC to terminate a three-year nonrenewable permit if the DBC determines that either the permit was issued by mistake or a complaint has been received against the permitholder that warrants termination pending an investigation. (BPC § 1645.4(h))

8) Requires dentists in the pilot program to apply for a three-year visa and Social Security number (SSN) within 14 days of receiving a permit and to provide the SSN within 10 days of obtaining it, and prohibits the participant from engaging in the practice of dentistry until these conditions are met. (BPC § 1645.4(i))

9) Provides that all applicable employment benefits, salary, and policies provided by nonprofit community health centers to their current employees shall be provided to medical and dental practitioners from Mexico participating in this pilot program, and that nonprofit community health centers must provide malpractice insurance coverage. (BPC § 1645.4(j))

10) Requires an evaluation of the program commencing 12 months after implementation, performed by a California dental school or independent consultant, and requires that evaluation to include specified issues including the quality of care and impact on cultural and linguistic services. (BPC § 1645.4(k))

11) Provides that the costs for administering the pilot program shall be secured from philanthropic entities. (BPC § 1645.4(l))

12) Requires program applicants to be responsible for working with the governments of Mexico and the United States in order to obtain the necessary three-year visa required for program participation. (BPC § 1645.4(m))

THIS BILL:

1) Repeals existing law establishing the Licensed Dentists from Mexico Pilot Program and replaces it with new provisions, with no specified cap on the number of participating dentists.

2) Expands eligibility to graduates from any dental program accredited by Consejo Nacional de Educación Odontológica, A.C. or Comités Interinstitucionales para la Evaluación de la Educación Superior.

3) Requires certification from the Asociación Dental Mexicana confirming competency in specific clinical experiences.

4) Requires completion of the Test of English as a Foreign Language (TOEFL) or the Occupational English Test (OET) with specific scores.

5) Revises the requirements of the orientation program to include broader topics such as medical ethics and managed care standards.

6) Limits employment to federally qualified health centers (FQHCs) that meet accreditation and quality assurance requirements and that have at least one health professional shortage area or dental professional shortage area within their service area.

7) Establish the fee for a three-year nonrenewable license at $1,002, which includes a Controlled Substance Utilization Review and Evaluation System (CURES) fee.

8) Requires evidence of a visa application, but allows practice while waiting for a SSN, with a 10-day deadline upon receipt.

FISCAL EFFECT: Unknown; this bill is keyed fiscal by the Legislative Counsel.

COMMENTS:

Purpose. This bill is sponsored by the author. According to the author:

> California is home to one of the largest dentist workforces in the nation, yet over 2.7 million Californians live in areas that have limited access to dental health professionals. The majority of which live in rural, low-income communities that are predominantly Latino. AB 1307 expands access to dental health professional by establishing the Licensed Dentists from Mexico Pilot Program, allowing 30 qualified dentists from Mexico to obtain a time-limited license and visa to practice in federally qualified health centers. These dentists must meet rigorous educational, licensing, and language standards to ensure high-quality, culturally competent care. This bill is modeled after a successful physician pilot program and reflects our state's commitment to health equity. AB 1307 offers a targeted, cost-neutral solution to reduce disparities and improve oral health outcomes for some of California's most vulnerable populations.

Background.

Health Care Workforce Inequities. There has long been an acknowledged decline in the number of accessible primary care physicians, which has disproportionately impacted communities with concentrated populations of immigrant families and people of color. A recent study found that between 2010 and 2019, the number of primary care physicians in proportion to population remained largely unchanged nationally, and that counties with a high proportion of minorities saw a decline during that period.[1] Additionally, physicians who are accessible to immigrant communities often do not possess the linguistic or cultural competence to appropriately treat all patients. A 2018 study published by the Latino Policy & Politics Initiative at the University of California, Los Angeles found that while nearly 44 percent of the California population speaks a language other than English at home, many of the state's most commonly spoken languages are underrepresented within the physician workforce.[2]

Research cited by the California Health Care Foundation (CHCF) in its 2021 report "Health Workforce Strategies for California: A Review of the Evidence" found that while 39 percent of Californians identified as Latino/x in 2019, only 14 percent of medical school matriculants and 6 percent of active patient care physicians in California were Latino/x.[3] In February 2024, the Assembly Committee on Health held an informational hearing on diversity in California's health care workforce. The background paper for the hearing concluded that "it is well-documented that physicians from minority backgrounds are more likely to practice in Health Profession Shortage Areas and to care for minority, Medicaid, and uninsured people than their counterparts."[4]

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[1] Liu M, Wadhera RK. *Primary Care Physician Supply by County-Level Characteristics*, 2010-2019.
[2] https://latino.ucla.edu/wp-content/uploads/2019/08/The_Patient_Perspective-UCLA-LPPI-Final.pdf
[3] https://www.chcf.org/publication/health-workforce-strategies-california
[4] https://ahea.assembly.ca.gov/media/1665

Mexico Pilot Programs. The concept of allowing professionals from Mexico to temporarily practice in California was first proposed in 1998 by the Clinica de Salud del Valle de Salinas (CSVS), an FQHC in Monterey County. As described in reporting by the CHCF, "the clinic was having a hard time finding enough physicians to work in Salinas, let alone doctors who spoke Spanish and understood the culture." CSVS's chief executive officer worked with a policy consultant to develop and advocate for the proposal, which reportedly received "pushback from some California medical school officials, physicians, and the California Medical Association."[5]

In 2000, the Legislature enacted Assembly Bill 2394 by Assemblymember Marco A. Firebaugh, sponsored by the California Hispanic Healthcare Association. As amended in the Senate, the bill established the Task Force on Culturally and Linguistically Competent Physicians and Dentists. The bill briefly included language that would have created a Doctors and Dentists from Mexico Exchange Pilot Program; however, this language was subsequently removed from the bill. Instead, a Subcommittee of the Task Force, chaired by the Director of Health Services, was charged with examining "the feasibility of establishing a pilot program that would allow Mexican and Caribbean licensed physicians and dentists to practice in nonprofit community health centers in California's medically underserved areas."

AB 2394 required the Subcommittee to make its report to the full Task Force by March 1, 2001, and then the full Task Force was required to forward the report to the Legislature, with any comments, by April 1, 2001. The practicality of this timeline was questioned by the Senate Committee on Business and Professions; the committee analysis noted that the Subcommittee was only allotted three months after the effective date of the bill to deliver its report to the Task Force. This due date was considered even more challenging in view of the fact that the sponsor of the bill had indicated a desire that the Subcommittee visit Mexico as part of its study.

In 2001, Assemblymember Firebaugh introduced Assembly Bill 1045, again sponsored by the California Hispanic Health Care Association. The bill initially proposed to simply require that the Subcommittee's recommendations be incorporated into the Medical Practice Act by statute—despite the fact that those recommendations had not yet been made. As predicted, the Subcommittee's report had not been accomplished by the dates prescribed in the prior bill. When AB 1045 was first considered by the Assembly Committee on Health, the first meeting of the Subcommittee was scheduled to take place days later on May 10, 2001. Additional amendments to the bill proposed to push out the Subcommittee's deadline to report to the Task Force until June 15, 2001, with the final report due on August 15, 2001. AB 1045 subsequently stalled following passage to the Senate, remaining pending in the Senate Committee on Business and Professions with multiple hearings postponed over the course of the following year.

In the meantime, the Subcommittee finally met on July 10, 2001. During this meeting, the Subcommittee discussed comments and proposals it had received from seven organizations, including the California Medical Association, the California Dental Association, the Medical Board of California, the California Hispanic Health Care Association, the California Latino Medical Association, the Latino Coalition for a Healthy California, and the chief executive officer of CSVS (the FQHC in Monterey County). The proposal submitted by the California Hispanic Health Care Foundation comprised of language creating a Licensed Doctors and Dentists from Mexico Pilot Program that was briefly amended into AB 1045 (and removed just two days later). The draft proposal was subsequently revised based on comments from CSVS.

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[5] https://www.chcf.org/blog/doctors-mexico-treat-farmworkers-rural-california

The Subcommittee compared each proposal in an element matrix and then discussed potential models for a pilot program during its meeting. According to the Subcommittee meeting minutes:

> Although many members agreed on a number of the proposed elements, there was significant disagreement upon the time frame for implementing a pilot project, the temporary or permanent nature of licensure, education requirements for licensure, placements of doctors and dentists who participate in a pilot project, and how to determine cultural linguistic competency.

After extensive discussion of the different proposals and the identified areas of disagreement, it was eventually determined that the Subcommittee should disband, with members arguing that "the Subcommittee has come as far as it can with decisions and proposals." A decision was made to simply forward the element matrix and the various proposals to the full Task Force without making any specific recommendation for adoption.

The chairs of the Task Force subsequently submitted the Subcommittee's report to the Legislature on September 7, 2001. The report's cover letter noted that while its transmittal fulfilled the Task Force's commitment to forward the Subcommittee's report, the contents of the report were still being discussed by the full Task Force and the submission did not constitute adoption of the report or any recommendations by the Task Force. As a result, no conclusive recommendations were ever submitted to the Legislature for consideration, but rather a collection of unresolved discussion topics and conflicting proposals.[6]

Amendments were ultimately made to AB 1045 in May 2002 that reflected the revised language proposed to the Subcommittee by the California Hispanic Health Care Association, the bill's sponsor. By the time AB 1045 was heard by the Senate Committee on Business and Professions in August 2002, it had been amended several additional times but was still formally opposed by the California Medical Association, the California Dental Association, and the Federation of State Medical Boards, all of whom raised concerns that the proposed pilot program could result in undertrained, lower quality health care providers being allowed to practice in California. The committee analysis noted that further amendments were needed to clarify the author's intent and resolve outstanding questions about how the program would be implemented.

Despite the opposition to the legislation, AB 1045 ultimately passed the Legislature and was signed into law by Governor Gray Davis on September 30, 2002. The final amended version of the bill repealed the statute establishing the Subcommittee and established the Licensed Physicians and Dentists from Mexico Pilot Program. The bill allowed up to 30 physicians and 30 dentists from Mexico to participate in the program for three-year periods—a compromise from the 150 physicians and 100 dentists that were previously proposed. Participants in the pilot program were required to hold a license in good standing in Mexico, pass a board review course, complete a six-month orientation program, and enroll in adult English-as-a-second-language (ESL) classes. The bill additionally required the Medical Board of California (MBC) and DBC to provide oversight, in consultation with other entities, to provide oversight of these entities and submit reports to the Legislature.

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[6] A copy of the Subcommittee's report is available for review in the Government Publications section of the California State Library.

While AB 1045 was enacted in 2002, its vision was not effectuated for over two decades. This substantial delay is attributable to several factors. First, the bill required that the pilot program could only be implemented "if the necessary amount of nonstate resources are obtained" and that "General Fund moneys shall not be used for these programs." Sponsors of the bill would have to secure private philanthropic donations to fund the pilot program. Additionally, the bill required the identification of medical schools and hospitals that would accept foreign physicians, which was reportedly a challenging task.[7]

Supporters of the pilot program ultimately succeeded in overcoming the administrative hurdles to implementing AB 1045. Philanthropic dollars were collected and placed into a Special Deposit Fund to support the MBC's implementation of the bill, with $333,000 from that fund appropriated in the Budget Act of 2020. Similar funding has continued to be appropriated in subsequent budget bills, with an estimated $498,000 in philanthropic funds appropriated in Fiscal Year 2023-24 and $299,000 appropriated in Fiscal Year 2024-25.

Physicians from Mexico finally started serving patients under the pilot program in August 2021, beginning with physicians working at San Benito Health Foundation in August 2021. Additional physicians subsequently began serving patients at CSVS in Monterey County, Altura Centers for Health in Tulare County. From January to November 2023, additional physicians from Mexico began serving patients in the Alta Med Health Corporation in Los Angeles and Orange Counties.

Early in the implementation of the pilot program, some barriers were identified in the process through which physicians from Mexico receive approval to participate in the pilot program. As noncitizens, applicants typically would not have an individual taxpayer identification number (ITIN) or social security number (SSN), which is required by all regulatory boards, including the MBC, as a condition of receiving a license. However, applicants typically cannot apply to receive a visa and accompanying SSN without proof that they may legally work in California, which they cannot demonstrate without a license from the MBC. To resolve this issue, Assembly Bill 1395 (Garcia) was signed into law in 2023 to resolve this issue for physicians who had been unable to finalize their participation in the pilot program.

Another issue identified was that some physicians from Mexico were unable to practice for significant portions of the three-year period to which their license was limited due to factors outside their control. To address this issue, language was included in SB 815 (Roth), the MBC's sunset bill, to authorize an extension of a license when the physician was unable to work due to a delay in the visa application process beyond the established time line by the federal Customs and Immigration Services. The MBC was also authorized to extend a license if the physician was unable to treat patients for more than 30 days due to an ongoing condition, including pregnancy, serious illness, credentialing by health plans, or serious injury. These extensions allowed those physicians from Mexico more time to serve patients under the pilot program.

The first annual progress report on the pilot program was submitted to the Legislature by the University of California, Davis in August of 2022. The report found that many patients had substantially positive experiences communicating with their doctor, and frequently felt welcome. While the overall efficacy of the pilot program was still under review, initial reports appeared positive.

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[7] Quintanilla, Esther. "In California, doctors from Mexico help fill the need for some patients. 'As good as any doctor.'" *Valley Public Radio*, September 28, 2023.

UC Davis submitted its second annual progress report on the pilot program to the Legislature in October of 2023. As stated in the report summary, the goal of the evaluation was to provide recommendations on the pilot program and opine on "whether it should be continued, expanded, altered, or terminated." The report summary concluded with a finding that the pilot program "has strong positive feedback from all. Physicians integrated seamlessly, making healthcare more accessible, and increasing patient trust. Staff reported excellent patient care processes and a supportive environment." The report further concluded that physicians in the program "demonstrated a solid understanding of California Medical Standards."

With early assessments of the pilot program producing undeniably positive findings, the original supporters of AB 1045 introduced new legislation in 2024 to revise and expand the program for physicians from Mexico, making a number of changes from the version that was negotiated back in 2001. AB 2860 (Garcia) extended the licenses of physicians currently participating in the pilot program by an additional three years and revised the requirements that physicians from Mexico must meet both prior to coming to California and upon arrival. The bill then allowed a newly codified Licensed Physicians from Mexico Program to gradually expand over fifteen years, with increases every four years to eventually reach a maximum of no more than 220 physicians from Mexico in the program, including up to 40 psychiatrists, commencing January 1, 2041.

Licensed Dentists from Mexico Pilot Program. In addition to making revisions to the Licensed Physicians from Mexico Program, AB 2860 reestablished the component of the prior pilot program relating to dentists from Mexico as the Licensed Dentists from Mexico Pilot Program. To date, no dentists from Mexico have been able to participate in the pilot program, with supporters of the program prioritizing physicians in the early stages of implementation. The intent of AB 2860 was to begin the process of allowing dentists to participate in a recodified pilot program within the Dental Practice Act.

While prior efforts to implement a pilot program for temporarily licensing health professionals from Mexico focused on California's primary care provider shortage, the state is facing a comparably urgent crisis in regards to its dental health professional workforce. While California has historically had the highest number of dentists per capita in the United States, the state nevertheless has struggled with dental care accessibility. Approximately 2.2 million Californians reside in areas designated as dental health professional shortage areas.[8]

This access gap is exacerbated by the underrepresentation of linguistically and culturally competent dentists; while 40 percent of California's population is Latino/x, research has found that only 8% of the state's dentists are identified as Latino/x or Black.[9] The lack of Spanish-speaking dental professionals contributes to persistent access failures for vulnerable communities in California such as farmworkers. The Farmworker Health Survey conducted by researchers at the University of California, Merced found that only 35 percent of farmworkers had visited the dentist in the past year.[10]

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[8] University of California Office of the President. *Dentistry in California: Workforce and Access to Care*. https://www.ucop.edu/uc-health/reports-resources/profession-specific-reports/dentistry1.pdf

[9] UCLA Center for Health Policy Research. *Barriers to Accessing Dental Care for Low-Income Californians*. https://healthpolicy.ucla.edu/newsroom/blog/report-identifies-barriers-accessing-dental-care-low-income-californians

[10] UC Merced, *Farmworker Health Study: Assessing the Health and Well-Being of California's Farmworkers*. February 2023. https://clc.ucmerced.edu/sites/clc.ucmerced.edu/files/page/documents/fwhs_report_2.2.2383.pdf

To enable the Licensed Dentists from Mexico Pilot Program to begin accepting applicants and deploying dentists to serve high-need populations in the state, this bill would replace existing statute establishing the pilot program with a substantially similar law. Among other changes, the bill would expands program eligibility to include graduates from any dental program accredited by Consejo Nacional de Educación Odontológica, A.C. or Comités Interinstitucionales para la Evaluación de la Educación Superior. The bill would also require certification from the Asociación Dental Mexicana to confirm competency in specified clinical experiences.

There is currently no limit to the number of dentists from Mexico who could participate in the pilot program under this bill. Dentists in the pilot program would be limited to practicing in FQHCs that meet accreditation and quality assurance requirements and that have at least one health professional shortage area or dental professional shortage area within their service area. Just as with prior pilot program implementations, all costs for administering the pilot program will be fully paid for by funds provided by philanthropic foundations. Once this funding is secured and the DBC has established its framework for the program, the author believes that a dental professional workforce will become available to low-access communities in California, with the likely added benefit of linguistic and cultural competency for practitioners who are expected to routinely engage with Spanish-speaking and immigrant patient populations.

Current Related Legislation. AB 966 (Carrillo) would allow graduates of foreign dental schools previously approved by the DBC but not approved by the Commission on Dental Accreditation (CODA) to remain eligible for licensure while the school is going through the CODA approval process. *This bill is pending in this committee.*

Prior Related Legislation. AB 2860 (Garcia), Chapter 246, Statutes of 2024 reestablished the Licensed Physicians and Dentists from Mexico Pilot Program as the distinct Licensed Physicians from Mexico Program and Licensed Dentists from Mexico Pilot Program and revised various requirements contained within the existing pilot program relating to the temporary state licensure of medical professionals from Mexico.

AB 2864 (Garcia), Chapter 247, Statutes of 2024 required the MBC to extend the licenses of physicians participating in the Licensed Physicians and Dentists from Mexico Pilot Program by an additional three years.

AB 1395 (Garcia) Chapter 205, Statutes of 2023 required the MBC to issue a license to applicants for participation in the Licensed Physicians and Dentists from Mexico Pilot Program who did not possess federal documentation but otherwise meet the pilot program's requirements, and authorizes the MBC to extend a pilot program participant's license under certain conditions.

AB 1396 (Garcia) of 2023 was substantially similar to AB 1395. *This bill died in the Assembly Committee on Appropriations.*

AB 1045 (Firebaugh) Chapter 1157, Statutes of 2002 established the Licensed Physicians and Dentists from Mexico Pilot Program.

AB 2394 (Firebaugh), Chapter 802, Statutes of 2000 created the Task Force on Culturally and Linguistically Competent Physicians and Dentists and required its subcommittee to examine the feasibility of establishing a pilot program that would allow Mexican and Caribbean licensed physicians and dentists to practice in nonprofit community health centers in California's medically underserved areas.

ARGUMENTS IN SUPPORT:

CPCA Advocates, the advocacy affiliate of the California Primary Care Association, writes in support of this bill: "In March 2024, California had 30,280 active dentists, one of the most in the US, yet we also had 532 dental health professional shortage areas (DHPSA), in which 2.7 million Californians reside, creating massive inequities in healthcare, often on the basis of class and race. California's Latino population is over 40%, and in 2021 approximately 10.4 million Californians spoke Spanish as their first language. Yet California's academic and professional institutions in dentistry have not structurally addressed the cultural and linguistic barriers for such a large portion of our population to access dental care. AB 1307 builds on the success of a sister program that is bringing physicians from Mexico to provide care to needy Californians across the state."

ARGUMENTS IN OPPOSITION:

The *California Dental Association* (CDA) has taken an "oppose unless amended" position on this bill, citing concerns that have been raised by the DBC. CDA specifically identifies six concerns that the DBC has raised "that require further clarification and revision to ensure public safety and compliance with existing regulations." CDA further writes: "Given the complexity of these issues, and considering the Board is in a period of leadership transition, we remain optimistic that the bill's author and sponsors will work collaboratively to address these concerns. It is critical that any changes to dental licensure maintain high competency and safety standards while ensuring consistency with existing regulations."

POLICY ISSUE(S) FOR CONSIDERATION:

Existing law limits active participation in the pilot program to no more than 30 dentists from Mexico, and the author of this bill has indicated that the intent is for the reestablished authority for the program to continue to cap the number of participants. However, there does not appear to be language in this bill setting a participation limit. As this appears to be an inadvertent omission, the author may wish to reinsert prior language that limits participation in the pilot program to no more than 30 dentists from Mexico practicing at a time.

AMENDMENTS:

To restore the current limitation that no more than 30 dentists from Mexico participate in the pilot program at a given time, insert the following language into subdivision (b) in Section 2:

> *The board shall accept 30 participating dentists. The board shall also maintain an alternate list of program applicants. If an active program participant leaves the program for any reason, a participating dentist from the alternate list shall be chosen to fill the vacancy.*

REGISTERED SUPPORT:

Altamed Health Services Corporation
Ampla Health
California Primary Care Association
Clinica De Salud Del Valle De Salinas
Clinica Monseñor Oscar A. Romero

Clinicas De Salud Del Pueblo,
Golden Valley Health Centers
JWCH Institute Inc. – Wesley Health Centers
Ole Health
Petaluma Health Center
Sac Health
Truecare

REGISTERED OPPOSITION:

California Dental Association

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