California State Assembly

BUSINESS AND PROFESSIONS

MARC BERMAN
CHAIR

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AGENDA

Tuesday, April 8, 2025
9 a.m. -- 1021 O Street, Room 1100

BILLS HEARD IN FILE ORDER

1.	AB 360	Papan	Physicians and surgeons: menopause surveys.
2.	AB 375*	Nguyen	Medical Practice Act: health care providers: qualified autism service paraprofessionals.
3.	AB 427	Jackson	Social workers: interstate compact.
4.	AB 447	Mark González	Emergency room patient prescriptions.
5.	AB 667	Solache	Professions and vocations: license examinations: interpreters.
6.	AB 742	Elhawary	Department of Consumer Affairs: licensing: applicants who are descendants of slaves.
7.	AB 873	Alanis	Dentistry: dental assistants: infection control course.(Urgency)
8.	AB 957	Ortega	Cigarette and tobacco products: retail sale: pharmacies.
9.	AB 1107*	Flora	Cigarette and Tobacco Products Licensing Act of 2003: nitrous oxide: licensure.
10.	AB 1175	Irwin	Accountants.
11.	AB 1496*	Blanca Rubio	Cannabis task force.

** Proposed for Consent*

Date of Hearing: April 1, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 360 Papan – As Amended March 10, 2025

SUBJECT: Physicians and surgeons: menopause surveys.

SUMMARY: Requires the Medical Board of California (MBC) to develop and administer menopause training surveys, as specified.

EXISTING LAW:

1) Establishes the Medical Practice Act, which provides for the state's licensure and regulation of physicians and surgeons, and the Osteopathic Act, which provides for the state's licensure and regulation of osteopathic physicians and surgeons. (Business and Professions Code (BPC) §§ 2000 *et seq.)*

2) Establishes the MBC within the Department of Consumer Affairs to implement and enforce the Medical Practice Act. (BPC § 2001)

3) Establishes the Osteopathic Medical Board of California (OMBC) to implement and enforce the Osteopathic Act and the Medical Practice Act, when applicable. (BPC § 2701)

4) Specifies that references to the MBC in the Medical Practice Act also refer to the OMBC, as specified. (BPC § 2451)

5) Authorizes the MBC to prepare and provide electronically or by mail to every licensed physician at the time of license renewal a questionnaire containing any questions necessary to establish that the physician currently has no disorder that would impair the physician's ability to practice medicine safely. Requires each licensed physician to complete, sign, and return the questionnaire either electronically or by mail to the MBC as a condition of renewing their license. (BPC § 2425)

6) Requires a licensed physician and surgeon to report to the MBC, immediately upon issuance of an initial license and at the time of license renewal, any specialty board certification they hold that is issued by a member board of the American Board of Medical Specialties or approved by the MBC, their practice status, and information regarding their cultural background and foreign language proficiency. The MBC must provide an option for a licensed physician and surgeon to decline to state their cultural background and foreign language proficiency in the report. Information collected must be aggregated on an annual basis, as specified. (BPC § 2425.3)

7) Requires the MBC, in determining its CE requirements, to consider including a course in menopausal mental or physical health. (BPC § 2191(l))

THIS BILL:

1) Requires the MBC to develop and administer to licensed physicians and surgeons as part of the license renewal process the following menopause training surveys:

   a) An initial survey that includes, but is not limited to, questions concerning the licensed physician and surgeon's training in menopause.

   b) Subsequent surveys that include, but are not limited to, the licensed physician and surgeon's training relating to menopause received since the licensed physician and surgeon submitted the initial survey.

2) Specifies that the purpose of the surveys is for the MBC to assess the extent of training licensed physicians and surgeons have received regarding menopause, menopause symptoms, and the relevant management options available for menopause.

3) Requires the MBC to determine the format of the surveys, which must be conducted anonymously, and authorizes the MBC to develop regulations as necessary.

4) Prohibits the MBC from denying an application for license renewal solely because the applicant failed to complete a survey on menopause.

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

COMMENTS:

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

> [This bill] will require osteopathic and medical doctors to complete a survey about their menopause training when renewing their medical licenses. Each year, over 1 million women in the United States experience menopause, yet there remains a significant gap in understanding the health effects of this natural biological process. With high rates of misdiagnosis and limited data on physician training in this area, this bill seeks to collect comprehensive information on the knowledge and resources available to doctors regarding menopause. By encouraging healthcare professionals to reassess their approach to women's health, identify knowledge gaps, and stay informed on emerging healthcare trends, AB 360 will improve healthcare outcomes for millions of women.

Background.

Medical Board of California. The MBC licenses and regulates physicians and surgeons through the Medical Practice Act. The MBC also has statutory and regulatory authority over licensed midwives, medical assistants, registered polysomnographic trainees, registered polysomnographic technicians, and registered polysomnographic technologists. The MBC's mission is "to protect health care consumers and prevent harm through the proper licensing and regulation of physicians and surgeons and certain allied health care professionals and through the

vigorous, objective enforcement of the Medical Practice Act, and to promote access to quality medical care through the Board's licensing, policy, and regulatory functions."[1]

Physicians and surgeons must renew their licenses every two years, at which time they must complete a physician survey. Under BPC § 2425.3, physicians and surgeons must report their specialty board certificates, if any, practice status (e.g., full-time practice in California), and information regarding their cultural background and foreign language proficiency. As noted on the MBC's website:

> The goal of the survey is to gain a better understanding of the physician workforce in California, to address physician access issues, assist patients to find physicians who will meet their needs, and identify physician shortages. While the Board knows how many licensed physicians reside in the state, there is little information regarding the time that is spent in actual clinical practice, the location, or specialty of that practice. Data collected will increase an understanding of the state's need in the areas of language, numbers of specialists, and other physician workforce characteristics.[2]

Additionally, as a condition of license renewal, the MBC may require licensed physicians and surgeons to complete a questionnaire containing questions that the MBC deems necessary to establish that a licensee is capable of practicing medicine safely.

Menopause. Menopause refers to a singular point in time marking the natural end of a woman's or person assigned female at birth's fertility and is diagnosed after 12 consecutive months without a menstrual cycle.[3] In the United States, the average age of menopause is 52. Perimenopause usually begins in a person's 40s and is the period before menopause in which the ovaries produce less and less estrogen and progesterone, resulting in the end of menstrual periods. Many people experience symptoms such as hot flashes, insomnia, and mood swings, for which there are a variety of treatment options, including hormone therapy, nonhormonal medications, and lifestyle changes. Researchers who studied the impact of menopause symptoms on work outcomes in 2023 estimated an annual loss of $1.8 billion in the United States based on workdays missed due to menopause symptoms.[4] Postmenopause follows menopause and lasts the rest of a person's life. Symptoms may improve during postmenopause, but risks of adverse health conditions such as osteoporosis and heart disease are elevated.

A 2017 survey of 183 postgraduates in family medicine, internal medicine, and obstetrics and gynecology residency programs across the US highlighted knowledge gaps concerning hormone therapy and menopause management strategies.[5] Notably, 20% of respondents (36) reported a

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[1] Medical Board of California, *2023-2027 Strategic Plan*, at 6.
[2] Medical Board of California, *Physician Survey*, https://www.mbc.ca.gov/Licensing/Physicians-and-Surgeons/Renew/Current-Status/Physician-Survey.aspx.
[3] Cleveland Clinic, *Menopause*, https://my.clevelandclinic.org/health/diseases/21841-menopause#overview.
[4] D'Angelo, Stefania et al. "Impact of Menopausal Symptoms on Work: Findings from Women in the Health and Employment after Fifty (HEAF) Study." International journal of environmental research and public health vol. 20, 1 295. 24 Dec. 2022, doi:10.3390/ijerph20010295
[5] Kling, Juliana M et al. "Menopause Management Knowledge in Postgraduate Family Medicine, Internal Medicine, and Obstetrics and Gynecology Residents: A Cross-Sectional Survey." Mayo Clinic proceedings vol. 94, 2 (2019): 242-253. doi:10.1016/j.mayocp.2018.08.033

lack of menopause lectures during residency, and just 6.8% (12) felt adequately prepared to manage menopausal patients. The authors concluded that "investing in the education of future clinicians to ensure evidence-based, comprehensive menopause management for the increasing population of midlife women is a priority."[6]

Moreover, a needs assessment survey completed by 99 of 145 US OBGYN residency program directors in 2022 revealed substantial gaps in education and resources and a strong desire for a standardized menopause curriculum.[7] Fewer than 32% of respondents reported having a menopause curriculum in their residency program, and less than 30% of respondents reported that residents had dedicated time assigned to a menopause clinic. Nearly 84% of respondents agreed that their programs needed more menopause educational resources, and approximately 93% of respondents strongly agreed that there should be a standardized menopause curriculum.

This bill would require the MBC to survey licensees to understand better the level of training they have received related to menopause. This bill requires an initial survey to be completed at every licensee's next license renewal and subsequent surveys each renewal cycle that assess licensees' continuing education and training related to menopause since submitting the initial survey.

Current Related Legislation. *AB 432 (Bauer-Kahan) of 2024* would require physicians with a patient population of 25 percent or more of women to complete a mandatory CE course in perimenopause, menopause, and postmenopausal care, mandates the MBC to require a CE course in menopausal mental or physical health, and requires health care service plan contracts and health insurance policies to cover the evaluation and treatment of perimenopause and menopause, as specified. *AB 432 is pending in this committee.*

Prior Related Legislation. *AB 2467 (Bauer-Kahan) of 2024* would have required a health care service plan contract or health insurance policy, except for a specialized contract or policy that is issued, amended, or renewed on or after January 1, 2025, to include coverage for treatment of perimenopause and menopause. *AB 2467 was vetoed.*

AB 2229 (Wilson), Chapter 706, Statutes of 2024, required comprehensive sexual health education to include instruction and materials on menopause, among other topics related to menstruation.

AB 2270 (Maienschein), Chapter 636, Statutes of 2024, required the MBC, Board of Registered Nursing, Board of Psychology, Physician Assistants Board, and Board of Behavioral Sciences to, in determining their CE requirements, consider including a course in menopausal mental or physical health.

ARGUMENTS IN SUPPORT:

The *California Black Women's Health Project* and *WisePause Wellness* write in support:

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[6] Ibid.
[7] Allen, Jennifer T et al. "Needs assessment of menopause education in United States obstetrics and gynecology residency training programs." Menopause (New York, N.Y.) vol. 30, 10 (2023): 1002-1005. doi:10.1097/GME.0000000000002234

> Menopause, which affects more than 51% of the population and over 1.3 billion women worldwide, is a natural stage of life that is too often misunderstood and misdiagnosed. Many women encounter healthcare providers who lack the necessary training to properly recognize and manage the full spectrum of menopause-related symptoms—from hot flashes and night sweats to mood fluctuations, anxiety, and joint pain. This gap in knowledge frequently results in incorrect diagnoses and delays in treatment. [This bill] would require the Medical Board of California to assess doctors' understanding of both the physical and mental health aspects of menopause as part of their license renewal process. By mandating this survey, the bill encourages healthcare providers to close existing knowledge gaps and offer evidence-based, compassionate care to women during this critical life stage.

ARGUMENTS IN OPPOSITION:

The *California Medical Association* writes in opposition:

> While we appreciate the author's interest in gaining more insight into the extent of menopausal training physicians and surgeons have received, we must regretfully oppose the approach in AB 360, as it misuses California's license renewal process as a menopausal survey tool. California's medical license renewal application is already a costly and administratively burdensome process, and imposing this requirement within the license renewal process would only add to these burdens. Additionally, by expanding the scope and responsibilities of the Medical Board, which is a fee-funded regulatory body, any implementation costs the Medical Board would incur due to the development or administration of this survey will be at the expense of licensees.

POLICY ISSUE(S) FOR CONSIDERATION:

Purpose. This bill would require the MBC to survey licensees to assess their training on menopause but does not require the MBC to do anything with the responses it collects from licensees. Without a prescribed purpose for the data that the MBC collects, it is unclear what use the surveys will be.

Breadth. This bill would require every licensed physician and surgeon to complete initial and subsequent surveys about menopause during license renewal. There are numerous licensees, however, for whom menopause may not be relevant to their medical practice (e.g., pediatricians).

Misuse of the license renewal process. While license renewal is a convenient time to gather information about licensees, requiring licensees to complete a survey to assess their training on a particular health condition does not align with the purpose of license renewal, which is to certify that licensees remain eligible for a license, verify continuing education, and fund the Board's licensing and enforcement programs.

IMPLEMENTATION ISSUES:

Conflicting Requirements. This bill requires that survey completion be tied to license renewal and that the surveys be conducted anonymously. It is unclear how a survey associated with a licensee's renewal could be anonymous.

Frequency of surveys. In addition to requiring licensees to complete an initial survey, this bill would require licensees to complete a subsequent survey each renewal cycle—every two years. Throughout a 30-year career, licensees would be required to complete 15 surveys.

Cost, Workload, and Expertise. As a special fund entity whose revenue is generated solely by fees paid by applicants and licensees, any additional workload for the MBC may increase licensees' renewal costs. The current biennial license renewal fee for a physician's and surgeon's license is $1,206.[8] Additionally, the Board does not have the expertise to develop surveys related to menopause, nor to evaluate the results and provide meaningful policy recommendations.

AMENDMENTS:

To address the aforementioned policy and implementation issues, amend the bill as follows:

In the title, in line 1, strike out "~~Section 2425.5 to the Business and Professions Code,~~", strike out line 2 and insert:

Chapter 6 (commencing with Section 128570) to Part 3 of Division 107 of the Health and Safety Code, relating to public health.

On page 2, before line 1, insert:

SECTION 1. Chapter 6 (commencing with Section 128570) is added to Part 3 of Division 107 of the Health and Safety Code, to read:

Chapter 6. Menopause

128570. (a) The Department of Health Care Access and Information shall work with the Medical Board of California, the Osteopathic Medical Board of California, and state higher education entities to assess both of the following:
(1) Physicians and surgeons' education and training regarding menopause diagnosis and management.
(2) Trends in practice patterns regarding menopause diagnosis and treatment by specialty, region, sex, race or ethnicity, medical practice setting, and experience.
(b) (1) The Department of Health Care Access and Information shall prepare a report to the Legislature on or before January 1, 2027, that does both of the following:
(A) Identifies gaps in medical education and training related to menopause and in menopause diagnosis and management practices among physicians and surgeons.
(B) Recommends state policy needed to improve menopause-related education and training and to improve health outcomes for people who experience menopause.
(2) The report shall be submitted in compliance with Section 9795 of the Government Code.

On page 2, strike out lines 1 to 22, inclusive.

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[8] Medical Board of California, *Physicians and Surgeons Fees*, https://www.mbc.ca.gov/Licensing/Physicians-and-Surgeons/Renew/Current-status/Fees.aspx.

REGISTERED SUPPORT:

ACT3 Convening
Bayer U.S. LLC
Black Women for Wellness Action Project
California Black Health Network
California Black Women's Health Project
California Life Sciences Association
California State Federation of Democratic Women
Citrine Minds, LLC
Claret Circle, LLC
Council of Black Nurses – Los Angeles Chapter
Girls Club of Los Angeles
Healthywomen
Hot or Just Me INC
Hotpause Health
Life in the Pause
Menowar LLC
National Menopause Foundation
Opal and Joy
Pausitive Outlook, LLC.
Perry
Planned Parenthood Affiliates of California
Save a Girl, Save a World
Sistahs Aging with Grace & Elegance
SNAP Productions, Inc.
The Fuchsia Tent LLC
The Metapause
Under the Sisterhood LLC
Wisepause Wellness
Women in the Room Productions and Deep Rooted Entertainment Group
Women's Foundation California
Women’s Caucus of The California Democratic Party
YWCA of San Gabriel Valley
10 Individuals

REGISTERED OPPOSITION:

American College of Obstetricians & Gynecologists - District IX
California Medical Association

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

Date of Hearing: April 8, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 375 (Nguyen) – As Introduced February 3, 2025

SUBJECT: Medical Practice Act: health care providers: qualified autism service paraprofessionals.

SUMMARY: Adds qualified autism service paraprofessionals to the list of health care providers that may provide behavioral health treatment services via telehealth, thus ensuring health plans and insurers cover those services.

EXISTING LAW:

1) Defines "qualified autism service paraprofessional" to mean an unlicensed and uncertified individual who meets all of the following criteria:

   a) Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.

   b) Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.

   c) Meets specified education and training qualification.

   d) Has adequate education, training, and experience, as certified by a qualified autism service provider or an entity or group that employs qualified autism service providers.

   e) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

   (Health and Safety Code § 1374.73(c)(5))

2) Defines "health care provider" to mean any of the following:

   a) A person licensed under the Medical Practice Act or the Osteopathic Act.

   b) An associate marriage and family therapist or marriage and family therapist trainee.

   c) A qualified autism service provider or qualified autism service professional certified by a national entity, as specified.

   d) An associate clinical social worker.

   e) An associate professional clinical counselor or clinical counselor trainee.

   (Business and Professions Code (BPC) § 2290.5(a)(3))

3) Defines "telehealth" as the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. (BPC § 2290.5(a)(6))

4) Requires a health care provider, before the delivery of health care via telehealth, to inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health. (BPC § 2290.5(b))

5) Specify that all laws and regulations governing professional responsibility, unprofessional conduct, and standards of practice that apply to a health care provider under the health care provider's license shall apply to that health care provider while providing telehealth services. (BPC § 2290.5(g))

6) Requires a contract between a health care service plan or health insurer and a health care provider that is issued, amended, or renewed on or after January 1, 2021, to specify that the health plan or health insurer is required to provide coverage for the cost of health care services delivered through telehealth on the same basis and to the same extent that the health plan or health insurer is responsible for coverage for the same service in-person. (Health and Safety Code § 1374.14(a); Insurance Code § 10123.855)

THIS BILL:

1) Revises the definition of "health care provider" for purposes of Division 2 of the Business and Professions Code relating to healing arts to include a qualified autism service paraprofessional certified by a national entity, as specified.

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

COMMENTS:

Purpose. This bill is sponsored by the *Autism Business Association*. According to the author:

> Every child with autism deserves access to the care they need, no matter where they live or their family's financial situation. During the COVID-19 pandemic, we saw firsthand how telehealth broke down barriers and connected families to the behavioral health services their children depend on. But now, those same families are at risk of losing coverage for autism therapy provided by qualified paraprofessionals, just because we haven't made telehealth access permanent. [This bill] makes a simple but critical fix: It ensures that qualified autism service paraprofessionals (QASPs) are formally recognized as health care providers, so the telehealth services they provide are covered. Without this change, families, especially those in rural and underserved communities, face losing access to essential therapy, forcing them into long waitlists or leaving them with no care at all. [This bill] keeps doors open for children with autism, supports working parents, and strengthens California's commitment to accessible, equitable health care.

Background. According to the Centers for Disease Control and Prevention, nearly 1 in 36 children are diagnosed with autism spectrum disorder (ASD), which affects the way they behave, communicate, interact, and learn.[1] While there is no cure for ASD, there are several types of treatment to support daily functioning and quality of life. These include behavioral, developmental, educational, social-relational, pharmacological, and psychological approaches as well as complementary and alternative treatments.[2] Multiple professionals provide treatment, which may be provided at school, in healthcare settings, within the community, at home, or some combination of those settings.

In 2011, SB 946 (Steinberg), Chapter 650, Statutes of 2011 began requiring health plans and health insurance policies to cover behavioral health therapy provided by a qualified autism service provider, a qualified autism service professional supervised by the qualified autism service provider, or a qualified autism service paraprofessional supervised by a qualified autism service provider or professional.

Qualified autism service paraprofessionals must have a high school diploma or the equivalent, have completed 30 hours of competency-based training designed by a certified behavior analyst, and have six months of experience working with developmental disabilities. Alternatively, they may have an associate's degree in either a human, social, or educational services discipline or a degree or certification related to behavior management from an accredited community college or educational institution and have six months of experience working with persons with developmental disabilities.[3] Qualified autism service paraprofessionals are also required to be supervised by a qualified autism service provider or professional, provide treatment and implement services pursuant to a treatment plan developed and approved by a qualified autism service provider, and be employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

Since January 1, 2021, current law has required health care service plans and health insurance policies to cover services provided by a health care provider via telehealth in the same manner as provided for in-person services. While qualified autism service providers and professionals are deemed health care providers in statute, qualified autism service paraprofessionals are not. According to the author's office, Executive Order N-43-2 temporarily required health plans and insurers to cover telehealth services provided by autism service paraprofessionals during the COVID-19 pandemic. However, since the state of emergency was lifted, the author's office reports that one of the largest national health insurance plans has stopped covering telehealth services for behavioral health treatment for individuals with ASD. By expanding the definition of health care provider to include qualified autism service paraprofessionals, this bill would require health plans and health insurance policies to cover telehealth services provided by these providers. The author and sponsor portend that this change will fill gaps and increase access to care for individuals with ASD, particularly for those who live in rural communities or who require services in a language other than English.

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[1] Centers for Disease Control, *Data and Statistics on Autism Spectrum Disorder*, https://www.cdc.gov/autism/data-research/index.html.
[2] Centers for Disease Control, *Treatment and Intervention for Autism Spectrum Disorder*, https://www.cdc.gov/autism/treatment/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/autism/treatment.html.
[3] CCR § 54342

Prior Related Legislation. *AB 2246 (Ramos) of 2024* was identical to this bill. *That bill was held in the Senate Appropriations Committee.*

AB 2449 (Ta) of 2024 would have clarified that the Qualified Applied Behavior Analysis Credentialing Board is also a national entity that may certify a qualified autism service provider and would authorize the certification to be accredited by the American National Standards Institute. *That bill was held in the Senate Appropriations Committee.*

SB 805 (Portantino), Chapter 635, Statutes of 2023, expanded the definition of "qualified autism service professional" to include a psychological associate, an associate marriage and family therapist, an associate clinical social worker, and an associate professional clinical counselor.

SB 562 (Portantino) of 2022 would have, as it relates to this bill, revised the definition of qualified autism service professional and the training requirements for qualified autism service paraprofessional. *That bill was vetoed.*

AB 774 (Aguiar-Curry), Chapter 867, Statutes of 2019, added qualified autism service provider and qualified autism service professional to the definition of health care provider and required health care contracts on or after January 1, 2021, to specify that the health care service plan (health plan) or insurer is required to cover and reimburse diagnosis, consultation, or treatment delivered through telehealth on the same basis and to the same extent as in-person diagnosis, consultation, or treatment.

SB 946 (Steinberg), Chapter 650, Statutes of 2011, required, in part, health plans and health insurance policies to cover behavioral health therapy for autism.

ARGUMENTS IN SUPPORT:

As the sponsor of this bill, the *Autism Business Association* writes in support:

> The increased utilization of telehealth services has been a silver lining during these challenging times, providing essential healthcare and therapeutic interventions. Telehealth has proven to be an extremely effective and convenient mode of service delivery, particularly for families impacted by autism. [This bill] addresses a vital need for the autism community – improving accessibility to care. The provision to include qualified autism service paraprofessionals as providers who can deliver services via telehealth modalities is a progressive step. It aligns with the current healthcare innovation trends and directly tackles care accessibility issues many families face, particularly those living in remote or underserved communities.

REGISTERED SUPPORT:

Alongside ABA
Autism Behavior Services, INC.
Autism Business Association (sponsor)
Autism Society Inland Empire
The Qualified Applied Behavior Analysis Credentialing Board

REGISTERED OPPOSITION:

There is no opposition on file.

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

Date of Hearing: April 8, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 427 (Jackson) – As Amended March 24, 2025

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

SUBJECT: Social workers: interstate compact.

SUMMARY: Codifies the Social Work Licensure Compact (Compact) to facilitate the practice of social work across state lines for licensees who have authorization.

EXISTING LAW:

1) Establishes the Board of Behavioral Sciences (BBS or Board) under the Department of Consumer Affairs (DCA) to license marriage and family therapists, clinical social workers, professional clinical counselors, and educational psychologists and enforce laws designed to protect the public from incompetent, unethical, or unprofessional practitioners. (Business and Professions Code (BCP) §§ 4990; 4990.18)

2) Specifies that protection of the public shall be the highest priority for the Board in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount. (BPC § 4990.16)

3) Establishes the Clinical Social Worker Practice Act to govern the licensure of clinical social workers and the practice of clinical social work. (BPC §§ 4991-4998.5)

4) Defines the practice of social work as a service in which a special knowledge of social resources, human capabilities, and the part that unconscious motivation plays in determining behavior, is directed at helping people achieve more adequate, satisfying, and productive social adjustments. The application of social work principles and methods includes, but is not limited to, counseling and using applied psychotherapy of a nonmedical nature, providing information and referral services, providing or arranging for the provision of social services, explaining or interpreting the psychosocial aspects in the situations of individuals, families, or groups, helping communities to organize, to provide, or to improve social or health services, doing research related to social work, and the use, application and integration of coursework required for licensure. (BPC § 4996.9)

5) Defines “psychotherapy” to mean the use of psychosocial methods within a professional relationship to assist the person or persons to achieve a better psychosocial adaption, to acquire greater human realization of psychosocial potential and adaptation, and to modify internal and external conditions which affect individuals, groups, or communities in respect to behavior, emotions, and thinking, in respect to their intrapersonal and interpersonal processes. (BPC § 4996.9)

6) Specifies that a person engages in the practice of clinical social work when they perform or offer to perform or hold themselves out as able to perform this service for remuneration in any form, including donations. (BPC § 4991.1)

7) Prohibits anyone who is not licensed from using the title "Licensed Clinical Social Worker" (LCSW). Anyone who holds themselves out to be a LCSW without holding a license in good standing is guilty of a misdemeanor. (BPC § 4996(a))

8) Specifies that it is unlawful for any person to practice clinical social work unless they hold a valid, unexpired, and unrevoked license. (BPC § 4996(b))

9) Exempts from the Clinical Social Worker Practice Act any unlicensed or unregistered employee or volunteer working in a governmental entity, school, college, university, or an institution that is both nonprofit and charitable if specified conditions are met. (BPC § 4996.14)

10) Requires every applicant for a license to apply with the Board accompanied by the application fee, as prescribed, and the applicable examination fee, as prescribed. The application must contain information showing that the applicant is qualified for admission to an examination. (BPC § 4992)

11) A registrant or an applicant for licensure as a social worker must pass a California law and ethics exam and a clinical exam. Upon registration with the Board, an associate clinical worker registrant, with the first year of registration, must take the California law and ethics exam. A registrant or an applicant for licensure may take the clinical exam when they have completed all required education and supervised work experience and passed the California law and ethics exam. (BPC § 4992.05)

12) Requires a registrant to complete a minimum of three hours of continuing education in the subject of California law and ethics during each renewal period to be eligible to renew their registration, regardless of whether they have passed the California law and ethics exam. (BPC § 4992.09)

13) Requires applicants to complete 3,000 hours of post-master's degree supervised experience related to the practice of clinical social work, as specified, which may not be gained until the applicant is registered as an associate clinical social worker. (BPC § 4996.23)

14) Requires each applicant for a license to furnish evidence satisfactory to the Board that the applicant complies with all of the following requirements:

    a) Is at least 21 years of age

    b) Has received a master's degree from an accredited school of social work, as defined.

    c) Has had two years of supervised post-master's degree experience, as specified.

    d) Is not subject to the denial of licensure for reasons specified.

    e) Has completed adequate instruction and training on the subject of alcoholism and other chemical substance dependency.

f) Has completed 15 contact hours of coursework in spousal or partner abuse assessment, detection, and intervention.

g) Has completed at least 10 contact hours of training or coursework in human sexuality.

h) Has completed seven contact hours of training or coursework in child abuse assessment and reporting. (BPC § 4996.2)

15) Requires an applicant to have an active registration with the Board as an associate clinical social worker to gain hours of supervised experience. An applicant for registration must have a master's degree from an accredited school or department of social work, not be subject to denial of licensure, and have completed training or coursework in California law and professional ethics, as specified. (BPC § 4996.18)

16) Authorizes the Board to deny an application or suspend or revoke a license or registration, as specified (BPC §§ 4992.3, 4992.33, 4992.35, 4992.36)

17) Requires an applicant for licensure to complete a minimum of 10 contact hours of coursework in aging and long-term care, as specified. (BPC § 4996.25)

18) Requires an applicant for licensure to complete a minimum of six hours of coursework or applied experience under supervision in suicide risk assessment and intervention. (BPC § 4996.27)

19) Requires an applicant for licensure to complete a minimum of three hours of training or coursework in providing mental health services via telehealth. (BPC § 4996.27.1)

20) Requires the Board to assess specified application, examination, licensing, and renewal fees. (BPC § 4996.3)

21) Expires licenses every 24 months and registrations one year after the last day of the month it was issued. As a condition of renewal, licensees and associates apply for renewal, pay a renewal fee, certify compliance with continuing education requirements, and notify the Board whether they have been convicted of a crime, or whether any regulatory or licensing board has taken any disciplinary action after the licensee's or associate's last renewal. (BPC §§ 4996.6, 4996.28)

22) Prohibits the Board from renewing any license unless the applicant certifies to the Board that the applicant has completed at least 36 hours of approved continuing education in the preceding two years, as specified. (BPC 4996.22)

23) Requires a licensee to display their license in a conspicuous place in the licensee's primary place of practice when rendering professional clinical services in person. (BPC § 4996.7)

24) Requires a licensee or registrant to provide a client with a specified notice prior to initiating psychotherapy services. (BPC § 4996.75)

25) Specifies that anyone who violates the Clinical Social Worker Practice Act is guilty of a misdemeanor punishable by imprisonment in county jail for up to six months, a fine up to $1,000, or both. (BPC § 4996.12)

26) Requires a LCSW to retain a client's or patient's health service records for at least seven years from the date therapy is terminated. If the client or patient is a minor, the client's or patient's health service records must be retained for at least seven years from the date the client or patient turns 18. (BPC § 4993)

27) Authorizes a person who holds a license in another jurisdiction of the United States as a clinical social worker to provide clinical social work services in this state for a period not to exceed 30 consecutive days in any calendar year if specified conditions are met. (BPC § 4996.16.1)

28) Authorizes the Board to issue a license to a person who, when submitting an application for a license, holds a license in another jurisdiction of the United States as a clinical social worker at the highest level for independent practice if specified conditions are met. (BPC § 4996.17.1)

THIS BILL:

1) Codifies the entirety of the Compact, including but not limited to provisions that do all of the following:

   a) State that the purpose of the Compact is to facilitate interstate practice of regulated social workers by improving public access to competent social work services and that the Compact preserves the regulatory authority of states to protect public health and safety through the current system of state licensure.

   b) Define terms, including but not limited to "home state," "remote state," and "regulated social worker."

   c) Establish a joint government agency known as the Compact Commission (Commission) and confer upon it enumerated powers and duties, including, but not limited to, the promulgation of reasonable rules to effectively and efficiently implement and administer the purposes and provisions of the Compact.

   d) Authorize each member state's state licensing authority to select one delegate to sit on the Commission. The Commission may recommend the removal or suspension of any delegate from office.

   e) Authorize the Commission to levy on and collect an annual assessment from each member state and impose fees on licensees of member states to whom it grants a multistate license to cover the cost of operations and activities of the Commission and its staff.

   f) Require the Commission to develop, maintain, operate, and use a coordinated data system and require member states to submit specified information for inclusion in the database. Member states contributing information to the data system may designate information that may not be shared with the public without the express permission of the contributing State.

   g) Specify that each delegate is entitled to one vote.

h) Enumerate requirements for member states as a condition of participation in the Compact.

i) Authorize a home state to charge a fee for granting a multistate license.

j) Require an applicant for a multistate license to meet specified requirements.

k) Specifies that the multistate license for a regulated social worker is subject to the renewal requirements of the home state.

l) Require a home state, upon the receipt of an application for a multistate license, to determine the applicant's eligibility for a multistate license. If an applicant is eligible, the home state licensing authority must issue a multistate license authorizing the applicant or registered social worker to practice in all member states.

m) Require the home state licensing authority to designate, upon the issuance of a multistate license, whether the regulated social worker holds a multistate license in the bachelors, masters, or clinical category of social work.

n) Specify that nothing in the Compact affects the requirements established by a member state for issuing a single-state license.

o) Require a multistate license issued by a home state to a resident in that state to be recognized by all compact member states and as authorizing social work practice under a multistate authorization to practice corresponding to each category of licensure regulated in each member state.

p) Specify that nothing in the Compact, nor any rule of the Commission, shall be construed to limit, restrict, or in any way reduce the ability of a member state to enact and enforce laws, regulations, or other rules related to the practice of social work in that state, where those laws, regulations, or other rules are not inconsistent with the provisions of this Compact, or to take adverse action against a licensee's single state license to practice social work in that state.

q) Specify that nothing in the Compact, nor any rule of the commission, limits, restricts, or in any way reduces the ability of a licensee's home state to take adverse action against a licensee's multistate license based upon information provided by a remote state.

r) Authorize a remote state to take adverse action against a licensee's multistate authorization to practice in that state.

s) Specify that a regulated social worker's services in a remote state are subject to that member state's regulatory authority. A remote state may remove a regulated social worker's multistate authorization to practice in the remote state for a specific period of time, impose fines, and take any other necessary actions to protect the health and safety of its citizens.

t) Require a regulated social worker's multistate authorization to practice to be deactivated in all remote states for the duration a multistate license is encumbered. If a multistate authorization to practice is encumbered in a remote state, the regulated social worker's

multistate authorization to practice may be deactivated in that state until the multistate authorization to practice is no longer encumbered.

u) Authorize a remote state to take adverse action against a regulated social worker's multistate authorization to practice only within that member state. Requires the issuing licensing authority to pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state in which the witnesses or evidence are located.

v) Specify that only the home state can take adverse action against a regulated social worker's multistate license.

w) Require a home state to give the same priority and effect to reported conduct received from a member state as it would if the conduct had occurred within the home state.

x) Authorize a member state, if otherwise permitted by state law, to recover from the affected regulated social worker the costs of investigations and dispositions of cases resulting from any adverse action taken against that regulated social worker.

y) Authorize a member state to withdraw from the Compact by enacting a statute repealing the provisions of the Compact and specify that a member state's withdrawal would not take effect until six months after the enactment of the repealing statute.

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

COMMENTS:

Purpose. This bill is sponsored by the *National Association of Social Workers-California Chapter*. According to the author:

> [This bill] will significantly enhance the ability of social workers to provide essential services across state lines. This compact is vital not only for professionals in the field but also for the countless individuals and families who rely on their expertise and support. It is a commitment to improving the social services landscape in California and beyond. By removing barriers and fostering greater mobility for social workers, we are investing in the well-being of our communities and reinforcing the foundation of support that so many depend on.

Background.

Board of Behavioral Sciences. The BBS is responsible for licensing and regulating LCSWs, Licensed Marriage and Family Therapists, Licensed Educational Psychologists, and Licensed Professional Clinical Counselors. Additionally, the Board registers Associate Clinical Social Workers, Associate Marriage and Family Therapists, and Associate Professional Clinical Counselors. Cumulatively, the Board is responsible for the oversight of over 120,000 licensees and registrants, including, as it relates to this bill, roughly 39,500 LCSWs and 19,500 Associate Clinical Social Workers.[1] The Board's licensee population has been rapidly increasing. There were nearly 6,000 more LCSWs in Fiscal Year (FY) 2023-24 than in FY 2020-21. The Board's

[1] Board of Behavioral Sciences, *2025 Sunset Report*, at 36.

mission is to "protect and serve Californians by setting, communicating, and enforcing standards for safe and competent mental health practice."[2] The BBS has the authority to take disciplinary action against Associate Clinical Social Workers and LCSWs who violate the Clinical Social Worker Practice Act. It may cite and fine associates and licensees for minor violations and seek registration/license suspension or revocation for more egregious violations. The board is self-funded through license, application, and examination fees and receives no revenue from the state's General Fund.

California License Requirements and Pathways to Licensure. Applicants for an LCSW license must hold a master's degree in social work from a program accredited by the Council on Social Work Education, complete a minimum of 3,000 hours of post-degree supervised experience, as specified, pass the Board's California Law and Ethics examination and the Association of Social Work Boards' national (clinical) examination, undergo a criminal background check, and pay various fees. Board staff report that the current processing time for an application to take the California Law and Ethics Exam or the Clinical Exam is 53 business days. In FY 2023-24, it took roughly 16 days for the Board to issue an initial LCSW license.[3]

Existing law provides various pathways for out-of-state licensees to practice in California. The federal Servicemembers Civil Relief Act authorizes servicemembers and spouses with a valid license in good standing in another state to practice in California within the same profession if they must relocate to California because of military orders. State law also requires the BBS to expedite applications and waive the application and initial license fees for spouses/domestic partners of active duty servicemembers who hold a license for the same profession in another jurisdiction. Moreover, the BBS must expedite the initial licensure process for honorably discharged military veterans and active military members enrolled in the United States Department of Defense (DOD) SkillBridge program.

Out-of-state social workers may practice in California for up to 30 consecutive days per calendar year if all of the following conditions are met: the license from another jurisdiction is at the highest level for independent clinical practice in the jurisdiction where the license was granted; the license from another jurisdiction is current, active, and unrestricted; the client is located in California when the out-of-state social worker seeks to provide care in California; the client is a current client of the licensee and has an established, ongoing client-provider relationship with the licensee when the client became located in California; the out-of-state social worker informs the client of the limited timeframe of the services and that they are not licensed in California; the social worker provides the client with the Board's website; the social worker informs the client of the jurisdiction in which they are licensed and the type of license held and provides the client with their license number; and the out-of-state licensee provides specific information to the Board before providing services (i.e., name, mailing address, phone number, SSN or ITIN, email, jurisdiction that issued the license, type of license, license number, and the date the person will begin providing services to the person's client).

Out-of-state social workers can also qualify for a LCSW license in California via a streamlined "Licensure by Credential" process if they meet the following criteria: hold an unrestricted license, at the highest level of independent practice, in another U.S. jurisdiction for at least two years; have a master's or doctoral degree from a qualifying accredited or approved institution;

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[2] Board of Behavioral Sciences, *About the Board*, https://www.bbs.ca.gov/about/board_info.html.
[3] Board of Behavioral Sciences, *2025 Sunset Report*, at 47.

complete specific coursework (a 12-hour California law and ethics course, a 15-hour course in California cultures, a 7-hour course in child abuse assessment and reporting, and a 6-hour course in suicide risk assessment and intervention), pass the Board's California Law and Ethics Examination, and pass a criminal history background check. The "Licensure by Credential" process was established via SB 679 (Bates), Chapter 380, Statutes of 2019, after the BBS established a License Portability Committee to review the potential barriers to licensure for out-of-state applicants. According to Board staff, 2,800 out-of-state social workers have successfully applied for licensure using this streamlined approach.

Regulation of Social Work Practice in the United States. According to the Council for State Government (CSG) National Center for Interstate Compacts, in 2022, there were more than 566,000 licensed social workers throughout the United States, a 36% increase since 2012. According to the Association of Social Work Boards, California licensees account for 56% of the total number of licensed social workers nationwide. Unlike California, which licenses social workers at the clinical level, most states license social workers at the bachelor's, master's, and clinical levels, each with its own title, scope, and entry requirements.

Interstate Licensing Compacts. An interstate licensing compact represents a legally binding agreement between multiple states to facilitate cross-state practice for licensed professionals without requiring them to obtain full licensure in each participating state. To participate in such a compact, a state must adopt the model statutory language provided by a compact organization. Typically, practitioners must hold a license in their home state before seeking authorization to practice in a compact member state. California currently does not participate in any licensing compacts related to the healing arts professions.

LCSW Compact. The CSG National Center for Interstate Compacts developed the Compact's model legislation. The DOD funded the effort to support military families by reducing unemployment among military spouses. According to the DOD's Defense-State Liaison Office, 3% of spouses report requiring a social work license.[4]

Under the Compact, a social worker who wants to practice in other Compact member states must apply to their home state licensing authority for a multistate license. To qualify, applicants must hold or be eligible for an active, unencumbered license in their home state. Their home state must verify that the social worker meets the Compact's requirements based on the applicant's license category (bachelor's, master's, or clinical) and issue a multi-state license authorizing them to practice social work in any other Compact member state. A social worker practicing in another Compact member state must abide by that state's laws and regulations. Only the social worker's home state can take adverse action against their multistate license, but member states may revoke a social worker's authorization to practice in their state.

For states to join the compact, they must license and regulate social work in one or more of the following categories: bachelor's, master's, or clinical. Additionally, the state must require licensees to graduate from an accredited social work program corresponding to the license category (Bachelor's or higher for the Bachelor's category and Master's or higher for Master's and Clinical categories). States must also require applicants for a Multistate License to pass a qualifying national exam specified by the Compact's governing body and require applicants for a

[4] The Council of State Governments National Center for Interstate Compacts, *The Social Work Licensure Compact*, https://swcompact.org/wp-content/uploads/sites/30/2023/07/Social-Work-Compact-Legislative-Summit-Slides.pdf.

clinical-category license to complete a period of supervised clinical practice. To maintain their participation in the Compact, states must notify the Compact Commission of disciplinary actions taken against a licensee, comply with the rules of the Commission, implement and utilize a criminal history or background check of applicants for licensure, and provide specified information to the Commission's data system. Applicants must pass the specified qualifying national exam, have an accredited social work degree, and, if applying for the clinical-category multistate license, complete a period of postgraduate supervised clinical practice. They must hold an active, unencumbered license issued by their home state, pay required fees, complete the continuing education requirements of their home state, and agree to abide by the laws, regulations, and scope of practice of the state where the client is located.

On April 12, 2024, the Compact took effect upon the enactment of legislation to join the Compact by a seventh member state. To date, Kansas, Missouri, South Dakota, Washington, Utah, Kentucky, Virginia, Nevada, Arizona, Colorado, North Dakota, Nebraska, Minnesota, Iowa, Louisiana, Mississippi, Alabama, Georgia, Tennessee, Ohio, Connecticut, Rhode Island, Vermont, New Hampshire, and Maine have enacted legislation to join the Compact.[5] Legislation is currently pending in 17 states, including California. The implementation process is expected to take 18 to 24 months before social workers can apply for multistate licenses. The Compact's governing body, a commission of delegates from member states, is currently developing the data system required for member states to communicate licensure and enforcement information.

The CSG National Center for Interstate Compacts suggests there are numerous benefits for including easing mobility for licensees (particularly important relocating military spouses), expanding employment opportunities into new markets, improving continuity of care for clients who are moving, reducing application processing times, enhancing public safety, addressing workforce shortages, and expanding access to qualified social workers.[6]

This bill would require California to join the Compact, which the proponents of this bill would increase access to address workforce shortages, especially in underserved areas, and reduce wait times for services.

Current Related Legislation.

SB 775 (Ashby) is the sunset review vehicle for the BBS and the Board of Psychology and will include various technical changes, statutory improvements, and policy reforms in response to issues raised during the Boards' sunset review processes. *That bill is pending in the Senate Business, Professions, and Economic Development Committee.*

Prior Related Legislation.

AB 1328 (Gipson) of 2023 would have enacted the Cosmetology Licensure Compact to facilitate California's participation in a multistate licensing program whereby cosmetologists can receive reciprocity to practice in other states that have adopted the Cosmetology Licensure Compact and vice versa. *That bill died pending in the Senate Business, Professions, and Economic Development Committee.*

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[5] The Council of State Governments National Center for Interstate Compacts, *Compact Map*, https://swcompact.org/compact-map/.
[6] The Council of State Governments National Center for Interstate Compacts, *Social Work Licensure Compact Fact Sheet*, https://swcompact.org/wp-content/uploads/sites/30/2023/02/Social-Work-Licensure-Compact-Fact-Sheet.pdf.

AB 2051 (Bonta) of 2024 would have, contingent on the Board of Psychology's approval, codified the Psychology Interjurisdictional Compact to facilitate the practice of telepsychology and the temporary in-person, face-to-face practice of psychology across state lines for licensees who have authorization. *That bill died pending in the Senate Business, Professions, and Economic Development Committee.*

AB 2566 (Wilson) of 2024 would have, contingent on the BBS's approval, codified the Counseling Compact to facilitate counseling across state lines for licensees with authorization. *That bill died pending in the Senate Business, Professions, and Economic Development Committee.*

AB 3232 (Dahle) of 2024 would have enacted the Nurse Licensure Compact, under which the Board of Registered Nursing and the Board of Vocational Nursing and Psychiatric Technicians would be authorized to issue a multistate license to practice in all compact states. *That bill died pending in this committee.*

ARGUMENTS IN SUPPORT:

As the sponsor of this bill, the *National Association of Social Workers-California Chapter* writes in support:

> This bill is a crucial step toward addressing our state's escalating mental health needs. Expanding access to licensed social workers from other states can improve service delivery, particularly in underserved and rural communities. Your timely support is essential in advancing this initiative. Supporting [this bill] will help California modernize its licensure process and ensure that more individuals in need of mental health care receive the support they deserve. This bill aligns with our shared objective of improving mental health care access and strengthening the social work workforce to meet emerging demands. Here are key reasons why [this bill] is vital: Closing the Gap in Mental Health Services; Expanding Access to Care in Rural and Underserved Communities; Improving Workforce Mobility; Strengthening Professional Standards; and Reducing Barriers for Diverse Professionals. Your support for [this bill] will not only position California as a leader in addressing our residents' evolving mental health needs but also modernize licensure policies, ensuring California has the workforce and infrastructure to respond to emerging challenges. With your endorsement, we can significantly improve access to care, strengthen the social work profession, and ensure a more equitable future for all Californians.

ARGUMENTS IN OPPOSITION:

One individual writes in opposition:

> I am a CA Licensed LCSW for over 25 years. I think [this bill] really opens consumers up to risk of harm by clinicians outside of CA who will not be familiar with CA Law and Ethics or the diversity of amazing people that make up CA. While the proponents of the compact say it will help with the lack of therapists, I am concerned that these therapists are all remote while many more in-person therapists are needed. I believe that better wages and working conditions for therapists would go along way in increasing the pool of candidates. We have notoriously said no to compacts for a reason! Consumer protection!

POLICY ISSUE(S) FOR CONSIDERATION:

Sufficiency of Existing Laws. Federal and state law currently provide pathways for out-of-state social workers to practice in California temporarily. Moreover, current law requires the Board to expedite the licensure process for honorably discharged veterans, spouses and domestic partners of active duty servicemembers, and some active duty military members. Moreover, the current "licensure-by-credential" pathway offers a streamlined licensure process for all out-of-state social workers, regardless of military affiliation.

Delegation of Authority. By joining the Compact, California would be delegating its authority to a multistate commission to determine and enforce licensing requirements for out-of-state social workers practicing social work in this state.
Fairness for California Licensees. LCSWs licensed by the BBS are required to complete specific education and training requirements. However, out-of-state social workers whose qualifications may be less than what this state has deemed appropriate and necessary for licensure would have the same ability to provide social work services in California. Moreover, it is unclear to what extent, if any, out-of-state licensees may displace California LCSWs.

Consumer Protection. Licensing requirements often vary state by state, which could make Californians susceptible to consumer harm. Out-of-state social workers may have less rigorous requirements. For example, social workers are only responsible for completing continuing education requirements for their home state license. A significant number of states require less continuing education. Additionally, out-of-state licensees with a multistate license would not be required to pass the Board's California laws and ethics exam. It is unknown whether other states require the same coursework in specified subjects that California has deemed necessary for licensure (e.g., child abuse assessment and intervention). Moreover, confusion could be caused by a tri-level licensing scheme (bachelor's, master's, and clinical), each with its own scope of practice. California currently requires all LCSWs to have at least a master's degree.

Disproportionate Influence on Multistate Commission. California would only have one delegate on the commission—the same as every other state—despite contributing a significantly larger licensee population. By a simple majority vote, the Commission would have the ability to make decisions at odds with California's position.

IMPLEMENTATION ISSUES:

Cost. The Compact authorizes the Commission to charge member states an annual assessment and impose fees on licenses of member states with a multistate license to cover the cost of the Commission's operations, activities, and staff. The aggregate annual assessment amount for member states is to be allocated based upon a formula determined by the Commission. Although the Compact allows member states to charge a fee for granting a multistate license, it is presently unknown if such a fee would cover the Board's costs *and* the state's annual assessment for participating in the Compact. If the applicants' fees for a multistate license do not cover that additional expense, it is unclear where the money would come from, as the Board is fully supported by license and renewal fees. Additionally, if such a fee were determined by the number of social workers participating in the Compact from each member state, California could be required to pay a much higher fee than other states. Moreover, the Board would likely incur significant enforcement costs related to California licensees practicing in other member states and out-of-state social workers practicing in this state, only a portion of which would be

recoverable. Because the Board would not be permitted to charge a fee from out-of-state licensees, there is no reimbursement for the Board's added workload.

Workload for the Board. In addition to issuing multistate licenses to LCSW applicants, for which the Board may charge a fee, the BBS would be required to investigate reports of inappropriate conduct by an out-of-state licensee and take appropriate action as it would if such conduct occurred by one of its own licensees. Additionally, the Board would have to investigate and take adverse action against California LCSWs practicing in other member states. Without adequate resources, the Board may be limited in its enforcement capability.

Ease of Leaving a Compact. In the same way legislation is required to join the Compact, so too is legislation to leave the Compact. If California joined and subsequently wanted to leave the Compact, doing so would require additional legislation and would not take effect until six months after the enactment of such a law.

AMENDMENTS:

Amend the bill as follows to make its enactment contingent upon approval by the BBS:

On page 2, after line 18:

(d) (1) A person holds a license under this chapter if they ~~hold~~ *satisfy either of the following requirements:*

(A) The person holds a license under this ~~article or hold a~~ *article.*

(B) The person holds a multistate license or multistate authorization to practice under the Social Work Licensure Compact as set forth in Article 6 (commencing with Section 4998.10).

(2) This subdivision shall become operative only upon certification by the Director of Consumer Affairs as set forth in subdivision (b) of Section 4998.20.

On page 30, after line 38:

4998.20. *(a)* The board shall comply with the requirements of the compact, as set forth in Section 4998.15, and shall adopt regulations necessary to implement the requirements of the compact.

(b) This article shall become operative only upon certification by the Director of Consumer Affairs that a majority of the board has voted, during a regular meeting, in favor of joining the compact.

(c) The director shall notify the Secretary of State and the Legislative Counsel Bureau of the date of that certification.

To correct an erroneous omission from the Compact model language, amend the bill as follows:

On page 18, after line 32, add:

(e) The Commission shall adopt and provide to the member states an annual report.

REGISTERED SUPPORT:

California Association for Health Services At Home
Harbor Association of Industry and Commerce
National Association of Social Workers-California Chapter (Sponsor)
San Diego Regional Chamber of Commerce
Steinberg Institute
Teladoc Health
The Council for State Governments
46 individuals

REGISTERED OPPOSITION:

One individual

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

Date of Hearing: April 8, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 447 (Mark González) – As Amended March 28, 2025

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

SUBJECT: Healing arts: pharmacy: emergency room patient prescriptions

SUMMARY: Authorizes a prescriber to dispense the unused portion of a dangerous drug to an emergency room patient upon discharge from the hospital under specified conditions; expands the existing licensure exemption for an automated unit dose system (AUDS) to exempt AUDSs used by prescribers to provide doses to emergency room patients under the existing authority to do so when the hospital pharmacy is closed, as specified, or under the authority proposed in this bill.

EXISTING LAW:

1) Regulates pharmaceutical professionals and premises under the Pharmacy Law. (Business and Professions Code (BPC) §§ 4000–4427.8)

2) Establishes the Board of Pharmacy (board) to administer and enforce the Pharmacy Law and delegates to the board the authority to adopt rules and regulations as may be necessary for the protection of the public. (BPC §§ 4001, 4005)

3) Defines "dangerous drug" or "dangerous device" as any drug or device unsafe for self-use in humans or animals and includes any drug or device that by federal or state law can be lawfully dispensed only on prescription. (BPC § 4022)

4) Defines "administer" as the direct application of a drug or device to the body of a patient by injection, inhalation, ingestion, or other means. (BPC § 4016)

5) Defines "dispense," in relevant part, as the furnishing of drugs or devices directly to a patient by a physician or other healing arts professional acting within their scope of practice. (BPC § 4024(b))

6) Prohibits a prescriber from dispensing drugs or dangerous devices to patients in the prescriber's office or place of practice unless all of the following conditions are met:

    a) The dangerous drugs or dangerous devices are dispensed to the prescriber's own patient, and the drugs or dangerous devices are not furnished by a nurse or physician attendant. (BPC § 4170(a)(1))

    b) The dangerous drugs or dangerous devices are necessary in the treatment of the condition for which the prescriber is attending the patient. (BPC § 4170(a)(2))

    c) The prescriber does not keep a pharmacy, open shop, or drugstore, advertised or otherwise, for the retailing of dangerous drugs, dangerous devices, or poisons. (BPC § 4170(a)(3))

d) The prescriber fulfills all of the labeling requirements imposed upon pharmacists, all of the recordkeeping requirements of the Pharmacy Law, and all of the packaging requirements of good pharmaceutical practice. (BPC § 4170(a)(4))

e) The prescriber does not use a dispensing device unless the prescriber personally owns the device and the contents of the device, and personally dispenses the dangerous drugs or dangerous devices to the patient. (BPC § 4170(a)(5))

f) The prescriber, before dispensing, offers to give a written prescription to the patient that the patient may elect to have filled by the prescriber or by any pharmacy. (BPC § 4170(a)(6))

g) The prescriber provides the patient with written disclosure that the patient has a choice between obtaining the prescription from the dispensing prescriber or obtaining the prescription at a pharmacy of the patient's choice. (BPC § 4170(a)(7))

7) Defines "prescriber," for purposes of prescriber dispensing, as a person who holds a physician's and surgeon's certificate, a license to practice optometry, a license to practice naturopathic medicine, a license to practice dentistry, a license to practice veterinary medicine, a certificate to practice podiatry, a certificate to practice as an independent nurse practitioner, or a certificate to practice as a nurse-midwife, and who is duly registered by the Medical Board of California, the Osteopathic Medical Board of California, the California State Board of Optometry, the California Board of Naturopathic Medicine, the Dental Board of California, the Veterinary Medical Board, the Podiatric Medical Board of California, or the Board of Registered Nursing. (BPC § 4170(d))

8) Authorizes a prescriber to dispense a dangerous drug to an emergency room patient if all of the following apply:

a) The hospital pharmacy is closed and there is no pharmacist available in the hospital. (BPC § 4068(a)(1))

b) The dangerous drug is acquired by the hospital pharmacy. (BPC § 4068(a)(2))

c) The dispensing information is recorded and provided to the pharmacy when the pharmacy reopens. (BPC § 4068(a)(3))

d) The hospital pharmacy retains the dispensing information and, if the drug is a controlled substance, reports the information to the Department of Justice. (BPC § 4068(a)(4))

e) The prescriber determines that it is in the best interest of the patient that a particular drug regimen be immediately commenced or continued, and the prescriber reasonably believes that a pharmacy located outside the hospital is not available and accessible at the time of dispensing. (BPC § 4068(a)(5))

f) The quantity of drugs dispensed are limited to that amount necessary to maintain uninterrupted therapy while other pharmacies are not readily available or accessible, but shall not exceed a 72-hour supply. (BPC § 4068(a)(6))

g) The prescriber ensures that the drug label contains all the information required for an ordinary prescription. (BPC § 4068(a)(7))

9) Defines "automated drug delivery system" (ADDS) as a mechanical system that performs operations relative to the storage, dispensing, or distribution of drugs and requires an ADDS to collect and maintain all transaction information to track the movement of drugs in and out of the system. (BPC § 4017.3(a))

10) Defines "automated unit dose system" (AUDS) as a subtype of ADDS used for the storage and retrieval of unit doses of drugs for administration to patients by authorized persons. (BPC § 4017.3(b))

11) Requires that an ADDS be licensed by the board, except as specified. (BPC § 4427.2(a))

12) Exempts an AUDS from licensure if (1) it is operated by a licensed hospital pharmacy, as specified, (2) used solely to provide doses administered to patients while in a licensed general acute care hospital facility, (3) the AUDS complies with all other safety, security, informational, and procedural requirements for an ADDS, and (4) the hospital pharmacy maintains a list of the locations of each AUDS it operates and makes the list available to the board upon request. (BPC § 4427.2(i))

THIS BILL:

1) Authorizes a prescriber to dispense an unused portion of a dangerous drug acquired by the hospital pharmacy to an emergency room patient upon discharge under the following conditions:

   a) The dangerous drug is not a controlled substance.

   b) The dangerous drug has been ordered and administered to the emergency room patient.

   c) Dispensing the unused portion of the dangerous drug is required to continue treatment of the emergency room patient.

2) Expands the existing AUDS licensure exemption for an AUDS used solely to provide doses administered to patients while in a licensed general acute care hospital facility or a licensed acute psychiatric hospital facility to exempt an AUDS used to provide doses to an emergency room patient when the hospital pharmacy is closed or under the authority created by this bill for prescribers to dispense unused portions of administered drugs.

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

COMMENTS:

Purpose. This bill is sponsored by the *California Chapter of the American College of Emergency Physicians (California ACEP).* According to the author:

> Whether due to financial barriers, difficulties reaching medical facilities, or limited time off work, many Californians struggle to obtain the care they need. [This bill] seeks to ease this burden by allowing emergency room patients to take home the remaining doses of non-narcotic medications they started during

treatment. Under this bill, patients will no longer be forced to make an additional trip to a pharmacy to continue essential treatment—reducing both unnecessary expenses and delays in care. This policy will not only save patients time and money, but also help combat excessive medical waste in our healthcare system.

Background.

Dispensing Unused Medications. Ordinarily, hospital emergency room (ER) personnel may not dispense medication to patients for use outside the ER, except under certain circumstances. One such exception authorizes a prescriber (e.g., a physician) to dispense medication to an ER patient when the hospital pharmacy is closed and there is no pharmacist available in the hospital. When dispensing medication pursuant to this authority, the quantity of medication provided may not exceed a 72-hour supply, the prescriber must reasonably believe there is no local pharmacy accessible at the time, and the medication must be labeled with all the information required of a typical pharmacy-issued prescription.

This bill would create an additional authority for prescribers to dispense medication to an ER patient for use outside the hospital. Specifically, it would authorize a prescriber to dispense the unused portion of a medication that was administered to the patient in the ER, provided the medication remains necessary for treatment following discharge.

Because of the existing limitations on prescribers' authority to dispense medication, any unused portion of a multi-use medication must be disposed of when the patient is discharged, even if the medication is necessary for the patient's continued treatment. Instead of allowing the ER patient to take home the unused medication, the prescriber who administered the drug will issue a prescription to be filled at an external pharmacy. According to the author and sponsor, this process causes hospitals to unnecessarily waste usable medication and creates additional inconvenience and expense for patients.

The authority created by this bill is designed specifically for medications contained in multi-use packaging that are difficult or impossible to separate into discrete doses. For example, an inhaler may come in an aerosol container with 30 doses, but an ER patient may only require 3 doses during their ER stay. However, unlike with pills or capsules, there is no way for the hospital pharmacy to separate out 3 aerosol doses to administer to one ER patient and save the remaining 27 doses for other patients. Nor can a prescriber measure out a 72-hour supply of aerosol doses and dispense it to the patient upon discharge under the existing prescriber authority. This bill, therefore, creates a novel pathway for prescribers and hospital pharmacies to dispense portions of necessary medication that would otherwise be disposed of.

Expansion of AUDS Licensure Exemption. To help streamline the processing and distribution of drugs throughout the facility, hospital pharmacies often maintain an automated drug delivery system, or ADDS. An ADDS is an automated cabinet that securely stores medications for ready access by authorized employees. Hospitals may also use a subtype of ADDS known as an automated unit dose system, or AUDS, which specifically dispenses individually-packaged doses for hospital personnel to administer to patients. By packaging and dispensing drugs in single doses, the use of an AUDS can help reduce human error and expedite delivery of medications.

All operators of an ADDS must obtain a license for the system from the Board of Pharmacy (board). However, if an ADDS is an AUDS operated by a licensed hospital pharmacy and is used solely to administer doses to patients in an acute care hospital, the ADDS is exempt from the

licensure requirement. This licensure exemption does not exempt the hospital pharmacy from following all other safety, recordkeeping, reporting, and inspection requirements under the Pharmacy Law—it merely exempts the hospital pharmacy from obtaining a separate license and paying the licensing fee. In Question #22 of its Frequently Asked Questions for ADDSs, the board explains its interpretation that an ADDS is not exempt from licensure if the ADDS is used by a prescriber to dispense medication to an ER patient under the existing prescriber dispensing authority (i.e., when the pharmacy is closed, up to a 72-hour supply). An ADDS used for this purpose, the board states, is not exempt even when it is primarily used for the type of in-hospital administration that would ordinarily render it exempt. The board contends that, because the exemption only applies to ADDSs used *solely* for administration, any use of an ADDS to dispense medication will require the machine to be licensed.

To address the board's interpretation, this bill would expand the licensure exemption to expressly exempt AUDSs used to provide medication to ER patients under existing prescriber dispensing authority or under the proposed authority in this bill.

ARGUMENTS IN SUPPORT:

The sponsor of this bill, the *California Chapter of the American College of Emergency Physicians,* writes in support:

> Patients often present to the emergency department (ED) with conditions that require prescription treatments. These treatments are dispensed from the hospital pharmacy containing more doses than will be used during the ED visit. Frequently, one dose of a multi-use medication, including eye drops, inhalers and liquid antibiotics [is] administered and then the remainder must be disposed of. Under existing law, the remaining doses cannot be sent home with the patient they were prescribed for, and they cannot be used for other patients.
>
> Patients who receive these types of treatments leave the ED with a prescription for the same medication that they must pick up at an outpatient pharmacy to continue treating their condition. In areas where there are no 24-hour pharmacies, this can mean waiting until business hours start and potentially missing treatment doses. Even when readily available, it is an unnecessary, duplicate expense.
>
> Prescription drugs account for approximately 10% of healthcare costs in the U.S. and policies that prevent patients from taking home multiuse drugs contribute to these costs. While emergency department specific data isn't currently available, studies of other care settings have found that as much as 50% of prepared multiuse drugs, including eye drops and inhalers, are discarded instead of being used again or [dispensed] to the patient.
>
> Current California law results in redundant prescriptions, increased cost to the health system, and increased medical waste. [This bill] would allow providers to dispense remaining doses of non-narcotic prescriptions to emergency room patients. Allowing patients to take home the remaining doses of their multiuse medication will reduce unnecessary spending, medical waste, and guarantee timely access to necessary prescriptions.

The *California State Association of Psychiatrists* writes in support:

> [This bill] . . . provides a pragmatic approach to ensuring continuity of care for emergency room patients by allowing the dispensing of unused portions of dangerous drugs upon discharge, under specified conditions.
>
> This bill addresses a critical gap in patient care by authorizing prescribers to dispense non-controlled dangerous drugs acquired by the hospital pharmacy when it is necessary to continue treatment. This is particularly important for vulnerable patients who may face barriers to accessing a pharmacy immediately upon discharge, potentially leading to treatment interruptions and negative health outcomes.
>
> [This bill] maintains appropriate safeguards by excluding controlled substances and ensuring that the prescriber is responsible for any errors or omissions. This balanced approach promotes patient safety while enhancing access to necessary medications, aligning with the goals of improving public health and reducing hospital readmissions.

The *California Medical Association* writes in support:

> This bill addresses flaws in California law which currently result in redundant prescriptions, increased healthcare costs, and excessive medical waste. Allowing patients to take home the remaining doses of their prescribed multi-use medications would reduce unnecessary spending, decrease medical waste, and ensure timely access to necessary treatments. Important safeguards are kept in place, ensuring that a drug must have been ordered and administered to the emergency room patient and that it is required for continued treatment of the patient.
>
> This bill seeks to implement a structured program that allows for the redistribution of certain medications, while ensuring compliance with safety and regulatory standards. This measure will improve health care efficiency, support vulnerable populations, and reduce financial burdens on patients and our health care delivery system.

ARGUMENTS IN OPPOSITION:

There is no opposition on file.

IMPLEMENTATION ISSUES:

Expansion of AUDS Licensure Exemption. This bill is intended to exempt AUDSs that either provide doses for dispensing to ER patients under the existing prescriber authority, or under the new prescriber authority that this bill would create. However, this bill's expanded exemption may not function as intended, as there is an inherent tension between the existing, unchanged exemption language and that of the two prescriber dispensing provisions at issue.

The exemption statute requires, as a threshold matter, that the exempted machine be an AUDS. An AUDS, in turn, is defined as a machine used for storage and retrieval of "unit doses" of drugs for "administration to patients." However, the existing prescriber authority allows a prescriber to

dispense medication. Because an AUDS is defined as a machine used for *administration*, a machine used to occasionally dispense drugs to ER patients may not be classified as an AUDS, and therefore may not qualify for the AUDS exemption.

Under the proposed authority to dispense the unused medication in this bill, the medication must first be administered, which satisfies the "administration" prong of the AUDS definition. However, this bill's provisions specifically contemplate dispensing multi-use medications, while the definition of AUDS is a machine that provides *unit doses*, which are single-use. So, a machine used to provide medication under the proposed authority in this bill may not fit within the definition of an AUDS, and therefore may not qualify for the AUDS licensure exemption. If this bill passes this committee, the author may wish to resolve the tension between the exemption language and the prescriber dispensing authorities both in existing law and within this bill.

AMENDMENTS:

1) To clarify the meaning of "unused portion of a dangerous drug," amend the bill as follows:

   On page 3, between lines 5 and 6, insert:

   (3) The dangerous drug was administered from multi-use packaging and can be self-administered by the patient, including but not limited to, an inhaler, eye drop, ear drop, nose drop or spray, topical product, or liquid product.

2) To standardize labeling requirements with those of an ordinary prescription, amend the bill as follows:

   On page 3, between lines 7 and 8, insert:

   (5) The prescriber shall ensure that the label on the drug contains all the information required by Section 4076.

REGISTERED SUPPORT:

California Chapter of the American College of Emergency Physicians (sponsor)
California State Association of Psychiatrists
California Medical Association
California Emergency Nurses Association
California Hospital Association (if amended)

REGISTERED OPPOSITION:

There is no opposition on file.

Analysis Prepared by: Alexander Diehl / B. & P. / (916) 319-3301

Date of Hearing: April 8, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 667 (Solache) – As Amended April 1, 2025

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

SUBJECT: Professions and vocations: license examinations: interpreters.

SUMMARY: Requires licensing boards within the Department of Consumer Affairs (DCA) and specified certification programs within the Department of Public Health (CDPH) to allow applicants who cannot read, speak, or write in English to use an interpreter when taking examinations required for licensure or certification.

EXISTING LAW:

1) Specifies that whenever any notice, report, statement, or record is required by the Business and Professions Code, it shall be made in writing in the English language unless it is otherwise expressly provided. (Business and Professions Code (BPC) § 11)

2) Provides that the term "board" includes "bureau," "commission," "committee," "department," "division," "examining committee," "program," and "agency." (BPC § 22)

3) Provides that unless otherwise expressly provided, the term "license" means license, certificate, registration, or other means to engage in a business or profession regulated by the Business and Professions Code. (BPC § 23.7)

4) Establishes the DCA within the state Business, Consumer Services, and Housing Agency. (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) States that boards, bureaus, and commissions within the DCA must establish minimum qualifications and levels of competency and license persons desiring to engage in the occupations they regulate, upon determining that such persons possess the requisite skills and qualifications necessary to provide safe and effective services to the public. (BPC § 101.6)

7) Requires boards within the DCA to expedite, and authorizes boards to assist, the initial licensure process for applicants who have been admitted to the United States as a refugee, have been granted asylum by the Secretary of Homeland Security or the Attorney General of the United States, or have a special immigrant visa. (BPC § 135.4)

8) Specifies workforce data that must be collected or requested by healing arts boards within the DCA from applicants for license renewal, including data on languages spoken by applicants. (BPC § 502)

9) Requires both the questions and answers for the examination of applicants for a license to practice dentistry in California to be written in the English language. (BPC § 1630)

10) Requires the Dental Board of California, the Dental Hygiene Board of California, the Medical Board of California, and the Osteopathic Medical Board of California to collect specified information from their respective applicants and licensees, including information regarding each applicant's or licensee's cultural background and foreign language proficiency, if reported by the licensee. (BPC § 1715.5; § 1902.2; § 2425.3; § 2455.2)

11) Requires foreign-trained dentists participating in the Licensed Dentists from Mexico Pilot Program to possess a specified English language comprehension and conversational level and requires employers of dentists in the pilot program to ensure that participants are enrolled in local English-language instruction programs and that the participants attain English-language fluency at a level that would allow the participants to serve the English-speaking patient population when necessary and have the literacy level to communicate with appropriate hospital staff when necessary. (BPC § 1645.4)

12) Prohibits students from being denied admission to a medical degree program or a healing arts residency program based on the student's citizenship or immigration status. (BPC § 2064.3; § 2064.4)

13) Requires foreign-trained physicians participating in the Licensed Physicians from Mexico Program to successfully complete the Test of English as a Foreign Language (TOEFL). (BPC § 2125)

14) Requires all continuing medical education courses for physicians and surgeons to contain curriculum that includes cultural and linguistic competency in the practice of medicine. (BPC § 2190.1)

15) Defines "cultural and linguistic competency" as cultural and linguistic abilities that can be incorporated into therapeutic and medical evaluation and treatment, including direct communication in the patient-client primary language, understanding and applying the roles of culture in health care, and awareness of how health care providers and patients attitudes, values, and beliefs influence and impact professional and patient relations. (BPC § 2198.1)

16) Requires an applicant for licensure as a physical therapist who graduated from an education program outside the United States to successfully complete the TOEFL. (BPC § 2653)

17) Requires all examinations designed to ascertain applicants' fitness to practice the profession of optometry to be conducted in the English language. (BPC § 3053)

18) Requires applicants for licensure under the international medical graduate physician assistant training program to successfully complete the TOEFL. (BPC § 3537.20)

19) Requires the State Board of Barbering and Cosmetology to offer and make available all written materials provided to licensees and applicants in English, Korean, Spanish, and Vietnamese. (BPC § 7312)

20) Requires the Cemetery and Funeral Bureau to examine applicants for a cemetery broker's license on their appropriate knowledge of the English language, including reading, writing, and spelling, and of elementary arithmetic. (BPC § 7651.7)

21) Provides that the first part of the licensing examination for shorthand reporters consists of a section on English. (BPC § 8020.5)

22) Authorizes the Court Reporters Board to examine an applicant for licensure as a shorthand reporter on their knowledge of the English language if the applicant is from a country where the principal language spoken is one other than English. (BPC § 8023.5)

23) Requires the Structural Pest Control Board to examine applicants for licensure on their use and understanding of the English language, including reading and writing. (BPC § 8565)

24) Requires licensed general acute care hospitals to review their policies regarding interpreters for patients with limited-English proficiency and adopt policies for providing language assistance services to patients with language or communication barriers, including procedures for providing the use of an interpreter whenever a language or communication barrier exists. (Health and Safety Code (HSC) § 1259)

25) Requires the CDPH to develop and adopt regulations establishing standards and requirements to provide health care service plan enrollees with appropriate access to language assistance in obtaining health care services, including through translation and interpretation for medical services. (HSC § 1367.04)

26) Requires health care service plans to publish provider directories with information on contracting providers that deliver health care services to the plan's enrollees, including disclosures informing enrollees that they are entitled to language interpreter services, at no cost to the enrollee, and how to obtain interpretation services. (HSC § 1367.27)

27) Provides for the certification of nurse assistants by the CDPH. (HSC §§ 1337 *et seq.*)

28) Provides for the certification of home health aides by the CDPH. (HSC §§ 1725 *et seq.*)

29) Requires the Department of Health Care Access and Information (HCAI) to work with the Employment Development Department, state licensing boards, and state higher education entities to collect specified data, including the diversity of the health care workforce, by specialty, including data on race, ethnicity, and languages spoken. (HSC § 128051)

30) Enacts the Dymally-Alatorre Bilingual Services Act, which generally requires state agencies that provide information or services to a substantial number of members of the public who do not speak English to employ bilingual persons to ensure provision of information and services to the public in the language of non-English-speaking members of the public. (Government Code §§ 7290 *et seq.*)

THIS BILL:

1) Defines "board" as inclusive of any board under the jurisdiction of the DCA.

2) Defines "interpreter" as an individual who satisfies all of the following conditions:

    a) Has not acted as an interpreter for the examination within the year preceding the examination date.

b) Is not licensed and has not been issued the license for which the applicant is taking the examination.

c) Is not a current or former student in an educational program for the license for which the applicant is taking the examination.

d) Is not a current or former student in an apprenticeship or training program for the license for which the applicant is taking the examination.

e) Is not a current or former owner or employee of a school for the license for which the applicant is taking the examination.

3) Beginning July 1, 2026, requires each board to permit applicants for licensure to use an interpreter, if the applicant cannot read, speak, or write in English, to interpret the English written and oral portions of a state-administered or contracted license examination to their preferred language, provided the applicant meets all other requirements for licensure.

4) Prohibits an interpreter from assisting an applicant with any section of an examination that is explicitly intended to test an applicant's English language skills.

5) Prohibits an interpreter from assisting an applicant if an examination is offered in the applicant's preferred language.

6) Prohibits boards from charging an applicant any fee, penalty, or surcharge for the applicant's use of an interpreter.

7) Requires boards to publish information on their websites about the ability of applicants to use an interpreter if the applicant cannot read, speak, or write in English, to interpret the English written and oral portions of a state-administered or contracted license examination to their preferred language, provided the applicant meets all other requirements for licensure.

8) Requires the above information to be posted in English, Spanish, Farsi, Hindi, Chinese, Cantonese, Mandarin, Korean, Vietnamese, Tagalog, and Arabic.

9) Requires boards to include an additional section in a license application that asks an applicant to identify their preferred written, spoken, and signed languages.

10) Requires each board to conduct an annual review of applicants' language preferences that are collected from license applications.

11) Requires boards to annually report on that data to the Assembly Business and Professions Committee and the Senate Committee on Business, Professions, and Economic Development.

12) Establishes similar requirements for certification programs under the CDPH for nurse assistants and home health aides.

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

COMMENTS:

Purpose. This bill is co-sponsored by the *California Immigrant Policy Center*, *Immigrants Rising*, and the *Economic Mobility for All Coalition*. According to the author:

> For too long, thousands of Californians have had to compromise on their careers and professional goals due to language barriers. Obtaining a professional license is an important entry point for people to work across a wide spectrum of occupations, from health care providers to accountants and engineers to contractors. Professional licenses not only open the door to further professional development and career growth but also create greater access to higher earning potential and wages, helping individuals achieve economic stability. Efforts to expand access to professional licenses for individuals with limited English proficiency, who disproportionately experience difficult economic conditions, currently exist only in very limited and uneven circumstances.

Background.

Department of Consumer Affairs. The DCA consists of 36 boards, bureaus, and other entities responsible for licensing, certifying, or otherwise regulating professionals in California. As of March 2023, there are over 3.4 million licensees overseen by programs under the DCA, including health professionals regulated by healing arts boards under Division 2 of the Business and Professions Code. Each licensing program has its own unique requirements, with the governing acts for each profession providing for various prerequisites within the application process, typically including specified education, training, and examination requirements.

Health Care Workforce Inequities. There has long been an acknowledged decline in the number of accessible health care providers, which has disproportionately impacted communities with concentrated populations of immigrant families and people of color. For example, a recent study found that between 2010 and 2019, the number of primary care physicians in proportion to population remained largely unchanged nationally, but counties with a high proportion of minorities saw a decline during that period.[1] Additionally, practitioners who are accessible to immigrant communities often do not possess sufficient cultural or linguistic competence to appropriately treat all patients.

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 roughly 40 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.[2] 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."[3]

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[1] Liu M, Wadhera RK. *Primary Care Physician Supply by County-Level Characteristics*, 2010-2019.
[2] https://www.chcf.org/publication/health-workforce-strategies-california
[3] https://ahea.assembly.ca.gov/media/1665

A 2018 study published by the Latino Policy & Politics Initiative at the University of California, Los Angeles (UCLA) 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 health care provider workforce. The UCLA report specifically identified Spanish, Filipino, Thai/Lao, and Vietnamese as underrepresented languages. The report recommended placing an emphasis on language ability in medical school admissions. Since 2006, all continuing medical education courses approved by accrediting associations have been required to contain curriculum that includes cultural and linguistic competency in the practice of medicine.[4]

A similar access gap has been associated with the underrepresentation of culturally and linguistically competent dentists. While 40 percent of California's population is Latino/x, research has found that only 8 percent of the state's dentists are identified as Latino/x or Black.[5] 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.[6]

Compounding these issues of access is a significant lack of diversity among health care practitioners, with several minority groups remaining persistently underrepresented within the healing arts. A recent study of data from the American Community Survey and the Integrated Postsecondary Education Data System found that Black, Hispanic, and Native American people are nationally represented across 10 different health care professions.[7] As a result, minorities seeking to enter these professions face significant systemic obstacles, and patients who are representative of minority groups or immigrant communities often do not have access to practitioners who possess the cultural or linguistic competence to provide appropriate care.

Access to Occupational Licensure for Non-English Speakers. The DCA includes a number of boards that license occupations other than those within the healing arts. A number of reports in recent years have called for reforms to California's licensure scheme, criticizing the state's regulation of occupations and professions as burdensome and complex. The Little Hoover Commission's *Jobs for Californians: Strategies to Ease Occupational Licensing Barriers* advocated for the state to "review its licensing requirements and determine whether those requirements are overly broad or burdensome to labor market entry or labor mobility."[8] Barriers to entry such as licensing fees, education requirements, examinations, conviction disqualifications, and other prerequisites have all been subjected to scrutiny to ensure they are appropriately tailored to what is needed for consumer protection. As a result, efforts have been made to increase access to these professions, particularly among representatives of underrepresented communities such as immigrants and minorities.

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[4] https://latino.ucla.edu/wp-content/uploads/2019/08/The_Patient_Perspective-UCLA-LPPI-Final.pdf
[5] 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
[6] 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
[7] Salsberg, Edward *et al*. "Estimation and Comparison of Current and Future Racial/Ethnic Representation in the US Health Care Workforce." *JAMA network open* vol. 4,3 e213789. 1 March 2021.
[8] Little Hoover Commission. (2023). *Jobs for Californians: Strategies to ease occupational licensing barriers.* https://lhc.ca.gov/report/jobs-californians-strategies-ease-occupational-licensing-barriers/

License Examination and Language Access. Efforts have been specifically made to increase access to a state licensing boards for non-English speakers. The State Board of Barbering and Cosmetology (BBC) complies with the Dymally-Alatorre Bilingual Services Act, which requires state agencies to provide information in languages utilized by the public who accesses information from that particular agency. The BBC translates all its informational materials into Korean, Spanish, and Vietnamese, and the BBC advised during its last sunset review that language access continues to be one of its top priorities. The BBC's licensing unit sends examination admission letters in the applicant's preferred language (English, Korean, Spanish, or Vietnamese). Written examinations are offered in English, Spanish, Vietnamese, and Korean.

Similarly, the Contractors State License Board offers several of its license examinations in Spanish. These include the Law and Business exam, which tests knowledge of regulations and business management, and the B – General Building exam, assessing oversight of construction projects. Trade-specific exams available in Spanish include C-8 – Concrete, C-9 – Drywall, C-15 – Flooring and Floor Covering, C-27 – Landscaping, C-33 – Painting and Decorating, C-54 – Ceramic and Mosaic Tile, C-36 – Plumbing, and C-39 – Roofing.

Not all licensing entities are housed within the DCA. In 2023, the Legislature enacted Assembly Bill 451 (Calderon), which requires the California Department of Insurance to offer the examination for licensure as a life agent, accident and health or sickness agent, property broker-agent, and casualty broker-agent to be provided in English, Spanish, Simplified Chinese, Vietnamese, Korean, and Tagalog. Similarly, the Department of Real Estate offers its examinations for real estate salespersons and brokers in Spanish.

This bill would seek to further expand access to licensure by non-English-speaking applicants by requiring boards under the DCA and specified certification programs under the CDPH to allow for applicants who cannot read, speak, or write in English to utilize an interpreter when taking required examinations. The interpreter would not be allowed to be a student or licensee of the applicable board, and an interpreter would not be allowed to assist applicants on examinations intended to test the applicant's English language skills or examinations offered in the applicant's preferred language. In addition, this bill would require all boards to collect data on each applicant's preferred language, which would then be reported to the appropriate policy committees of the Legislature.

Current Related Legislation. AB 1307 (Ávila Farías) would revise the requirements of the Licensed Dentists from Mexico Pilot Program, including by replacing existing English proficiency requirements with a requirement that applicants successfully complete the TOEFL.

Prior Related Legislation. AB 451 (Calderon), Chapter 136, Statutes of 2023 required the examination for the license for a life agent, accident and health or sickness agent, property broker-agent, and casualty broker-agent to be provided in English, Spanish, Simplified Chinese, Vietnamese, Korean, and Tagalog.

AB 470 (Valencia), Chapter 330, Statutes of 2023 updated continuing medical education standards to further promote cultural and linguistic competency and enhance the quality of physician-patient communication.

AB 2113 (Low), Chapter 186, Statutes of 2020 requires entities under the DCA to expedite applications from refugees, asylees, and special immigrant visa holders.

ARGUMENTS IN SUPPORT:

A letter signed by 64 members of the *Economic Mobility for All Coalition*, including the sponsors of this bill, includes the following arguments in support: "California is home to the largest and most diverse immigrant population in the country. Immigrants make up one in three workers in California, paying $61.8 billion in state and local taxes annually, employing thousands as entrepreneurs, and driving economic growth across industries. However, despite their contributions, many immigrants and individuals with LEP face significant barriers to obtaining professional licenses—an essential step in securing employment in regulated fields such as healthcare, accounting, contracting, and more." The coalition further argues that "California has made strides in expanding language access, but there is still much work to be done. As the state continues to welcome a diverse immigrant and refugee population, including many whose primary language is neither English nor Spanish, it is crucial that we create equitable pathways for career success. Expanding language access in professional licensing examinations is a necessary and overdue step in fostering economic inclusion, strengthening our workforce, and meeting the needs of our communities."

ARGUMENTS IN OPPOSITION:

There is no opposition on file.

POLICY ISSUE(S) FOR CONSIDERATION:

Potential for Examination Subversion. Recent cheating scandals raise legitimate concerns about the risk of interpreters being used to undermine the integrity of license examinations. For example, in July 2019, the California State Board of Pharmacy received credible information that there had been significant public exposure of questions on the California Practice Standards and Jurisprudence Examination for Pharmacists. The test results were invalidated and students were forced to retake the examination. While this bill seeks to address these concerns by prohibiting interpreters from being trained in the profession for which an examination is offered, the author should remain mindful of the need to ensure that there is no risk of applicants subverting license examinations through the use of interpreters.

Interprofessional Communication. As discussed in this analysis, there is an urgent need to increase cultural and linguistic diversity and competence in the health care professions. However, there is the potential for issues to arise if licensed professionals working within the health care system are unable to effectively communicate with one another due to language barriers. Imprecise or unclear communication regarding patient symptoms, medical histories, or treatment plans can lead to misdiagnoses, inappropriate treatments, or even medication errors.

For instance, if, due to language barriers, a nurse misinterprets a physician's prescription instructions, or a pharmacist misunderstands a patient's reported allergy, this could result in administering the wrong medication or dosage, potentially causing harm. Similarly, language barriers could hinder the ability of health care practitioners to effectively communicate with other individuals and entities involved in the delivery of care to patients, such as insurers, regulators, and emergency medical technicians or other first responders. While applicants for healing arts licensure who do not speak English would likely be of significant value to patients who share the same preferred language, a lack of a common language within the health care workforce has the potential to jeopardize patient safety and quality of care. The author should consider narrowing the bill to exclude license examinations for health care professionals.

Conflict with Existing Language Requirements. This bill would allow interpreters to be used only by applicants for licensure who cannot read, speak, or write in English. However, there are notable examples of practice acts that require English-language proficiency to practice. For example, certain professionals licensed by the Court Reporters Board, the Cemetery and Funeral Bureau, and the Physical Therapy Board are all required to demonstrate a level of comprehension of English if that is not their native language. Similarly, a number of laws allowing for the licensure of foreign-trained professionals require those applicants to pass an examination demonstrating English-language proficiency before allowing them to practice.

This bill would specifically prohibit interpreters from being used on an examination explicitly intended to test an applicant's English language skills. However, this raises questions as to how an applicant who cannot read, speak, or write in English would be pass such an examination but be deemed unable to comprehend English for purposes of other examinations, or how they could comply with existing laws requiring proficiency in English. The author may wish to clarify that the requirements of the bill do not apply to any examination for a license for which English language proficiency is required pursuant to law or regulation.

IMPLEMENTATION ISSUES:

Contracted Examinations. This bill would specifically apply to both state-administered and contracted license examinations. Many licensing examinations are not specific to California, but are administered nationally and are typically required for licensure across the country, which facilitates license portability between states. California does not have control over the content or administration of these examinations.

For example, to become licensed as an optometrist in California, applicants must pass both the California Laws and Regulations Exam and a national examination developed by the National Board of Examiners in Optometry (NBEO). Currently, all 50 states, the District of Columbia, and Puerto Rico all use the NBEO Exam for licensure. Because the NBEO is a private organization, it chooses where to offer its examinations, and Part III of the NBEO has historically been administered exclusively at a testing site located in North Carolina. Under this bill, California applicants who cannot read, speak, or write in English would have the right to use an interpreter on the NBEO Exam, but it is unlikely that California would be able to compel the NBEO to comply with this requirement. This bill should likely clarify that it does not apply to national examinations.

In instances where a license examination is specific to California, it may still be the case that a third party is engaged in administering the examination. For example, one prominent testing organization is PSI Services LLC. PSI administers examinations for several boards under the DCA, including trade exams for the California Contractors State License Board and the California Supplemental Examination for the California Architects Board. Applicants for licensure schedule their examinations directly through PSI's website and the examination is taken at a PSI testing location. Another frequently used vendor is Pearson VUE, which administers examinations such as the California Law and Ethics Examination for licensees under the Board of Behavioral Sciences. While these examinations are specifically developed for purposes of licensure in California, they are administered by a third party who may not be able to accommodate interpreters or may not agree to adjust the terms of their contract with the state. The author may further wish to provide that this bill does not apply to examinations administered by third parties pursuant to a contract with boards under the DCA.

AMENDMENTS:

1) To narrow the requirements of the bill to exempt licensed professionals working within the health care system, amend the definition of "board" in Section 1 of the bill to exclude healing arts boards within Division 2 of the Business and Professions Code and strike Sections 2 and 3 from the bill to remove references to certification programs under the CDPH.

2) To resolve potential implementation challenges for examinations administered by third parties, strike the words "or contracted" from subdivision (b) in Section 1 of the bill.

3) To avoid conflicts with existing requirements that specified licensees possess a demonstrated level of comprehension of English, further amend subdivision (b) in Section 1 of the bill as follows:

> *(1)(A) An interpreter shall not assist the applicant with any ~~section of an~~ examination ~~that is explicitly intended to test an applicant's English language skills~~ for a license for which English language proficiency is required pursuant to law or regulation.*

REGISTERED SUPPORT:

California Immigrant Policy Center *(Co-Sponsor)*
Economic Mobility for All Coalition *(Co-Sponsor)*
Immigrants Rising *(Co-Sponsor)*
AdvancED Consulting, LLC
Alliance for a Better Community
AltaMed Health Services
Amigos De Guadalupe Center for Justice and Empowerment
APRIL Parker Foundation
Asian Pacific Islander Small Business Collaborative
Bay Area Medical Academy
Bet Tzedek Legal Services
Binational of Central California
Buen Vecino
Building Skills Partnership
California Healthy Nail Salon Collaborative
California Primary Care Association
Canal Alliance
Central Valley Immigration Integration Collaborative
Central Valley Workers Center
Centro Community Hispanic Association
Children's Institute
Chinese for Affirmative Action
City Heights Community Development Corporation
CLEAN Carwash Worker Center
Democracy at Work Institute
Diversity in Health Training Institute
East Bay Sanctuary Covenant
Education and Leadership Foundation
First Gen Empower
First Graduate

Foundation for California Community Colleges
Hmong Innovating Politics
Inclusive Action for the City
Initiating Change in Our Neighborhoods Community Development Corporation
Inland Coalition for Immigrant Justice
Inland Empire Immigrant Youth Collective
Interfaith Refugee & Immigration Service
International Rescue Committee
LA Cocina
Language Access
LISC San Diego
Los Angeles Economic Equity Accelerator and Fellowship
Loyola Law School Sunita Jain Anti-Trafficking Initiative
Moreno Seeds Foundation
Multicultural Institute
National Immigration Law Center
New Mexico Immigrant Law Center
Nile Sisters Development Initiative
O Community Doulas
On the Move
ORALE: Organizing Rooted in Abolition Liberation and Empowerment
Pars Equality Center
Pre-health Dreamers
Robinson HR & Benefits
Second Harvest of Silicon Valley
Slavic Refugee and Immigrant Services Organization
Small Business Majority
Somali Family Service of San Diego
South Asian Network
Southern California College Attainment Network
Survivors of Torture, International
TODEC Legal Center
Trabajadores Unidos Workers United
UNITE-LA
Upvalley Family Centers of Napa County
Upwardly Global
Veggielution
Vision y Compromiso

REGISTERED OPPOSITION:

None on file

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

Date of Hearing: April 8, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 742 (Elhawary) – As Amended March 13, 2025

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

SUBJECT: Department of Consumer Affairs: licensing: applicants who are descendants of slaves.

SUMMARY: Requires state licensing boards to prioritize applicants seeking licensure who are descendants of American slaves.

EXISTING LAW:

1) Provides that the term "board" includes "bureau," "commission," "committee," "department," "division," "examining committee," "program," and "agency." (Business and Professions Code (BPC) § 22)

2) States that unless otherwise expressly provided, the term "license" means license, certificate, registration, or other means to engage in a business or profession regulated by the Business and Professions Code. (BPC § 23.7)

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

4) Enumerates various regulatory boards, bureaus, committees, and commissions under the DCA's jurisdiction. (BPC § 101)

5) States that boards, bureaus, and commissions within the DCA must establish minimum qualifications and levels of competency and license persons desiring to engage in the occupations they regulate, upon determining that such persons possess the requisite skills and qualifications necessary to provide safe and effective services to the public. (BPC § 101.6)

6) Requires boards within the DCA to expedite, and authorizes boards to assist, the initial licensure process for an applicant who has served as an active duty member of the Armed Forces of the United States and was honorably discharged or who, beginning July 1, 2024, is enrolled in the United States Department of Defense SkillBridge program. (BPC § 115.4)

7) Requires boards within the DCA to expedite the licensure process and waive any associated fees for applicants who hold a current license in another state and who are married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in this state under official active duty military orders. (BPC § 115.5)

8) Requires boards within the DCA to expedite, and authorizes boards to assist, the initial licensure process for applicants who have been admitted to the United States as a refugee, have been granted asylum by the Secretary of Homeland Security or the Attorney General of the United States, or have a special immigrant visa. (BPC § 135.4)

9) Requires the Medical Board of California (MBC), the Osteopathic Medical Board of California (OMBC), the Board of Registered Nursing (BRN), and the Physician Assistant Board (PAB) to expedite the licensure process for applicants who demonstrate that they intend to provide abortions within the scope of practice of their license. (BPC § 870)

10) Requires the MBC to give priority review status to the application of an applicant for a physician's and surgeon's certificate who can demonstrate that they intend to practice in a medically underserved area or serve a medically underserved population. (BPC § 2092)

11) Requests that the Regents of the University of California assemble a colloquium of scholars to draft a research proposal to analyze the economic benefits of slavery that accrued to owners and the businesses, including insurance companies and their subsidiaries, that received those benefits. (Education Code § 92615)

12) Requires the Insurance Commissioner to obtain the names of any slaveholders or slaves described in specified insurance records, and to make the information available to the public and the Legislature. (Insurance Code § 13811)

13) Declares that descendants of slaves, whose ancestors were defined as private property, dehumanized, divided from their families, forced to perform labor without appropriate compensation or benefits, and whose ancestors' owners were compensated for damages by insurers, are entitled to full disclosure. (Insurance Code § 13813)

14) Enacts the Apology Act for the Perpetration of Gross Human Rights Violations and Crimes Against Humanity, with special consideration for African Slaves and their Descendants. (Government Code (GOV) §§ 8301 *et seq.*)

15) Requires the State Controller's Office and the Department of Human Resources, when collecting demographic data as to the ancestry or ethnic origin of persons hired into state employment, to include collection categories and tabulations for Black or African American groups, including, but not limited to, African Americans who are descendants of persons who were enslaved in the United States. (GOV § 8310.6)

THIS BILL:

1) Requires each board under the DCA to prioritize applicants seeking licensure who are descendants of American slaves.

2) Makes the requirements of the bill contingent on the enactment of additional legislation establishing the Bureau for Descendants of American Slavery, and requires an applicant to obtain certification from the Bureau confirming their status as a descendant of an American slave to qualify for prioritization for licensure.

3) Subjects the bill's provisions to repeal four years from the date on which they become operative, or until January 1, 2032, whichever is earlier.

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

COMMENTS:

Purpose. This bill is sponsored by the *California Legislative Black Caucu*s. According to the author: "By prioritizing descendants of slaves when applying for licenses, we hope to increase the number of applicants and recipients of licensure in various businesses and professions where descendants of slaves have often been overlooked and underrepresented. This is one small step in righting the wrongs of the past."

Background.

Expedited Licensure. The DCA consists of 36 boards, bureaus, and other entities responsible for licensing, certifying, or otherwise regulating professionals in California. As of March 2023, there are over 3.4 million licensees overseen by programs under the DCA, including health professionals regulated by healing arts boards under Division 2 of the Business and Professions Code. Each licensing program has its own unique requirements, with the governing acts for each profession providing for various prerequisites including prelicensure education, training, and examination. Most boards additionally require the payment of a fee and some form of background check for each applicant.

The average duration between the submission of an initial license application and approval by an entity under the DCA can vary based on a number of circumstances, including increased workload, delays in obtaining an applicant's criminal history, and deficiencies in an application. Boards typically set internal targets for application processing timelines and seek adequate staffing in an effort to meet those targets consistently. License processing timelines are then regularly evaluated through the Legislature's sunset review oversight process.

The first expedited licensure laws specifically related to the unique needs of military families. The Syracuse University Institute for Veterans and Military Families found that up to 35 percent of military spouses are employed in fields requiring licensure. Because each state possesses its own licensing regime for professional occupations, military family members are required to obtain a new license each time they move states, with one-third of military spouses reportedly moving four or more times while their partner is on active duty. Because of the barriers encountered by military family members who seek to relocate their licensed work to a new state, it is understood that continuing to work in their field is often challenging if not impossible.

In an effort to address these concerns, Assembly Bill 1904 (Block) was enacted in 2012 to require boards and bureaus under the DCA to expedite the licensure process for military spouses and domestic partners of a military member who is on active duty in California. Two years later, Senate Bill 1226 (Correa) was enacted to similarly require boards and bureaus under the DCA to expedite applications from honorably discharged veterans, with the goal of enabling these individuals to quickly transition into civilian employment upon retiring from service.

Statute requires entities under the DCA to annually report the number of applications for expedited licensure that were submitted by veterans and active-duty spouses and partners. For example, in Fiscal Year 2022-23, the MBC received 14 applications from military spouses or partners and 101 applications from honorably discharged veterans subject to expedited processing. In 2023, the federal Servicemembers Civil Relief Act (SCRA) imposed new requirements on states to recognize qualifying out-of-state licenses for service members and their spouses. This new form of enhanced license portability potentially displaces the need for expedited licensure for these applicants.

A decade after the first expedited licensure laws were enacted for military families, the Legislature enacted Assembly Bill 2113 (Low) in 2020 to require licensing entities under the DCA to expedite licensure applications for refugees, asylees, and Special Immigrant Visa holders. The intent of this bill was to address the urgency of allowing those forced to flee their homes to restart their lives upon acceptance into California with refugee status. It is understood that the population of license applicants who have utilized this new expedited licensure program across all DCA entities is, to date, relatively small.

Subsequently in 2022, the Legislature enacted Assembly Bill 657 (Cooper) to add another category of applicants eligible for expedited licensure. This bill required the MBC, OMBC, the BRN, and the PAB to expedite the license application for an applicant who demonstrates that they intend to provide abortions. This bill was passed in the wake of the Supreme Court's decision to overturn *Roe v. Wade*, which led to concerns that with approximately half of all states likely to pursue abortion bans, patients in those states would come to California to receive abortion services, creating a swell in demand for abortion providers. Assembly Bill 657 was passed to ensure that there is an adequate health care provider workforce to provide urgent reproductive care services.

State Efforts to Provide Reparations to Descendants of Slavery. In 2020, the Legislature enacted Assembly Bill 3121 (Weber), which formally established the Task Force to Study and Develop Reparation Proposals for African Americans, with a Special Consideration for African Americans Who are Descendants of Persons Enslaved in the United States. The bill's findings and declarations acknowledged that "more than 4,000,000 Africans and their descendants were enslaved in the United States and the colonies that became the United States from 1619 to 1865." The bill further found that as "a result of the historic and continued discrimination, African Americans continue to suffer debilitating economic, educational, and health hardships," including, among other hardships, "an unemployment rate more than twice the current white unemployment rate."

The Task Force created by AB 3121 was given responsibility for studying and developing reparation proposals for African Americans as a result of slavery and numerous subsequent forms of discrimination based on race. The Task Force was then required to recommend appropriate remedies in consideration of its findings, which were submitted as a report to the Legislature on June 29, 2023. The *California Reparations Report*, drafted with staff assistance from the California Department of Justice, totals over a thousand pages and provides a comprehensive history of the numerous past injustices and persistent inequalities and discriminatory practices. The report also includes a number of recommendations for how the state should formally apologize for slavery, provide compensation and restitution, and address the pervasive effects of enslavement and other historical atrocities.

Chapter 10 of the Task Force's report, titled "Stolen Labor and Hindered Opportunity," addresses how African Americans have historically been excluded from occupational licenses. As discussed in the Task Force's report, "state licensure systems worked in parallel to exclusion by unions and professional societies in a way that has been described by scholars as "particularly effective" in excluding Black workers from skilled, higher paid jobs. White craft unions implemented unfair tests, conducted exclusively by white examiners to exclude qualified Black workers."

The report additionally describes how, as the use of licensure to regulate jobs increased beginning in the 1950s, African American workers continued to be excluded from economic opportunity, in large part due to laws disqualifying licenses for applicants with criminal records, which disproportionately impacted African Americans. This specific issue was previously addressed in California through the Legislature's enactment of Assembly Bill 2138 (Chiu/Low) in 2018, which reduced barriers to licensure for individuals with prior criminal histories by limiting the discretion of most regulatory boards to deny a new license application to cases where the applicant was formally convicted of a substantially related crime or subjected to formal discipline by a licensing board, with nonviolent offenses older than seven years no longer eligible for license denial.

In its discussion of issues relating to professional licensure, the Task Force concludes by stating that "while AB 2138 represents progress, other schemes remain in California which continue to have a racially discriminatory impact." The Task Force then provides several recommendations on how the Legislature could "expand on AB 2138." This includes a recommendation in favor of "prioritizing African American applicants seeking occupational licenses, especially those who are descendants [of slavery]."

On January 31, 2024, the California Legislative Black Caucus announced the introduction of the 2024 Reparations Priority Bill Package, consisting of a series of bills introduced by members of the caucus to implement the recommendations in the Task Force's report. Assembly Bill 2862 (Gipson) was introduced to implement the Task Force's recommendation that boards be required to prioritize African American applicants seeking licenses, especially applicants who are descended from a person enslaved in the United States. However, this bill ultimately did not pass the Senate Committee on Business, Professions, and Economic Development.

The following year, the California Legislative Black Caucus announced its "Road to Repair 2025 Priority Bill Package," which it described as "not only about acknowledging the past, but also a commitment to build a more just and equitable future by addressing the systemic barriers that Black Californians continue to face." This bill, included as part of that package, is similar to Assembly Bill 2862 from the prior session. However, this bill replaces references to African American applicants with a requirement that boards prioritize "descendants of American slaves."

Because there is currently no established way to prove this status, the bill's requirements are contingent on the Legislature also enacting Senate Bill 518 (Weber Pierson), which would establish a Bureau for Descendants of American Slavery. Once this Bureau has implemented a process for certifying descendants of American slaves, certified applicants would qualify for prioritization under the bill. This requirement would be similar to existing expedited licensure processes for military families, refugee applicants, and abortion providers. While this bill would only represent a single step in what could be considered a long journey toward addressing the malignant consequences of slavery and systemic discrimination, the author believes it would meaningfully address the specific impact those transgressions have had on African Americans seeking licensure in California.

Current Related Legislation. AB 7 (Bryan) would allow higher education institutions in California to grant descendants of American chattel slavery preferential consideration for admission, to the extent that it does not conflict with federal law. *This bill is pending in the Assembly Committee on Higher Education.*

AB 57 (McKinnor) would designate a share of Home Purchase Assistance Funds for first-time home buyers who are descendants of American chattel slavery. *This bill is pending in the Assembly Committee on Judiciary.*

SB 437 (Weber Pierson) would require the California State University to conduct independent research and issue a report on scientific methods for verifying an individual's genealogical connection to enslaved ancestors in the United States. *This bill is pending in the Senate Committee on Judiciary.*

SB 518 (Weber Pierson) would establish the Bureau of Descendants of American Slavery. *This bill is pending in the Senate Committee on Governmental Organization.*

Prior Related Legislation. AB 2862 (Gipson) of 2024 would have required state licensing boards under the (DCA to prioritize African American applicants seeking licenses, especially applicants who are descended from a person enslaved in the United States. *This bill died in the Senate Committee on Business, Professions, and Economic Development*.

SB 1403 (Bradford) of 2024 would have established a California American Freedmen Affairs Agency. *This bill died on the Assembly Floor inactive file.*

AB 657 (Cooper), Chapter 560, Statutes of 2022 requires specified boards under the DCA to expedite applications from applicants who demonstrate that they intend to provide abortions.

AB 3121 (Weber), Chapter 319, Statutes of 2020 established the Task Force to Study and Develop Reparation Proposals for African Americans, with a Special Consideration for African Americans Who are Descendants of Persons Enslaved in the United States.

AB 2113 (Low), Chapter 186, Statutes of 2020 requires entities under the DCA to expedite applications from refugees, asylees, and special immigrant visa holders.

AB 2138 (Chiu/Low), Chapter 995, Statutes of 2018 reduced barriers to licensure for individuals with prior criminal convictions.

SB 1226 (Correa), Chapter 657, Statutes of 2014 requires entities under the DCA to expedite applications from honorable discharged veterans.

AB 1904 (Block), Chapter 399, Statutes of 2012 requires entities under the DCA to expedite applications from military spouses and partners.

ARGUMENTS IN SUPPORT:

The *Greater Sacramento Urban League* supports this bill, writing: "For generations, Black Californians have faced systemic discrimination in licensing processes, limiting their ability to enter high-demand professions and contribute fully to California's workforce. The historical impacts of racial bias, mass incarceration, and unjust restrictions on licensing have disproportionately affected descendants of enslaved people, creating economic disparities that persist today. AB 742 takes a critical step toward correcting these injustices by ensuring that licensing boards prioritize applications from descendants of enslaved individuals and eliminate arbitrary waiting periods that delay their ability to enter the workforce."

ARGUMENTS IN OPPOSITION:

Pacific Legal Foundation opposes this bill, writing: "As currently drafted, AB 742 does not offer its ostensible race-based eligibility criteria as a remedy to specific instances of discrimination in state licensing. While the Task Force report prompting the legislation references state laws restricting individuals with certain criminal convictions from obtaining licenses that are more likely to impact African American workers, it makes no mention of any laws explicitly excluding or limiting African Americans from receiving a license. The justification for AB 742's race-based licensing thus amounts to addressing societal discrimination, which is insufficient as a compelling interest."

POLICY ISSUE(S) FOR CONSIDERATION:

Creation of Additional Expedited Licensure Processes. When expedited licensure was first established as a process in California, it was intended to address unique issues relating to military families who move frequently and can often not afford to wait to qualify for a new license each time they relocate to a new state. The addition of refugee and asylee applicants was intended to respond to a growing international refugee crisis by providing similar benefits to a small number of applicants whose relocation to California was presumably abrupt and who would need to rebuild their professions. In that same spirit, the extension of expedited licensure to abortion care providers was aimed at preparing for a potential influx of demand for those services in the wake of the Supreme Court's decision to overturn longstanding protections for reproductive rights.

Several pieces of legislation have been subsequently introduced to establish new expedited licensure requirements for additional populations of applicants. Each of these proposals has arguably been meritorious, as were each of the measures previously signed into law. However, there is potentially a cause for concern that as the state contemplates adding more categories of license applicants to the growing list of applications that must be expedited by entities within the DCA, the value of expediting each applicant type becomes diluted and non-expedited applications could become unduly delayed.

If the Legislature intends to extend expedited licensure requirements to new demographics of applicants—which the author of this bill has argued cogently in favor of doing—attention should be paid to the impact that all these proposals ultimately have in their totality. The Legislature should also subsequently revisit the need for expedited licensure requirements that were established in particular contexts and determine if they are still needed, which could be achieved by the addition of sunset clauses. This bill would arguably address this issue by subjecting the provisions of the bill to sunset four years after their effective date.

Constitutionality. In June of 2023, the Supreme Court of the United States issued its ruling in *Students for Fair Admissions v. Harvard*, in which it decided that the Equal Protection Clause of the Fourteenth Amendment prohibits universities from positively considering race as a factor in admissions. This decision strongly suggests an antagonistic position within the current composition of the Supreme Court when reviewing policies that seek to improve equitable access to opportunity or providing redress to representatives of racial groups that have been subjected to discrimination and marginalization. The likelihood of this bill's provisions surviving a strict scrutiny examination by the Supreme Court will be more thoroughly discussed when this bill is re-referred to the Assembly Committee on Judiciary.

REGISTERED SUPPORT:

Greater Sacramento Urban League

REGISTERED OPPOSITION:

California Landscape Contractor's Association
Pacific Legal Foundation
17 Individuals

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

Date of Hearing: April 8, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 873 (Alanis) – As Introduced February 19, 2025

SUBJECT: Dentistry: dental assistants: infection control course.

SUMMARY: Removes the requirement that an unlicensed dental assistant (DA) complete an 8-hour infection control course approved by the Dental Board of California (DBC) prior to providing specified services, instead allowing DAs to provide the services but requiring those who have been in continuous employment for 90 days or more to take the infection control course within a year of the date of employment, and deletes other provisions related to the infection control course.

EXISTING LAW:

1) Regulates the practice of dentistry under the Dental Practice Act and establishes the DBC within the Department of Consumer Affairs to administer and enforce the act. (Business and Professions Code (BPC) §§ 1600-1976)

2) Defines "dentistry" as the diagnosis or treatment, by surgery or other method, of diseases and lesions and the correction of malpositions of the human teeth, alveolar process, gums, jaws, or associated structures; and such diagnosis or treatment may include all necessary related procedures as well as the use of drugs, anesthetic agents, and physical evaluation. (BPC § 1625)

3) Establishes a Dental Assisting Council within the DBC to consider all matters relating to DAs, registered dental assistants (RDAs), and registered dental assistants in extended functions (RDAEFs), and make appropriate recommendations to the DBC and its standing committees. (BPC § 1742)

4) Defines "alternative dental assisting program" as a program offered by an institution of secondary or postsecondary education that has a current accreditation from the Commission on Dental Accreditation or is accredited or approved by an agency recognized by the United States Department of Education or State Department of Education, including career health and technical education programs, regional occupation centers or programs, or apprenticeship programs registered by the State Department of Education or Division of Apprenticeship Standards of the Department of Industrial Relations in allied dental programs, and through which a certificate of completion from the program serves as a pathway component for licensure as a registered dental assistant. (BPC § 1741(a)

5) Defines "basic supportive dental procedures" as procedures that have technically elementary characteristics, are completely reversible, and are unlikely to precipitate potentially hazardous conditions for the patient being treated. (BPC §§ 1741(b), 1750(a))

6) Defines "dental assistant" as an individual who may perform, without a license, basic supportive dental procedures. (BPC § 1750(j))

7) Defines “direct supervision” to mean the supervision of dental procedures based on instructions given by a licensed dentist, who must be physically present in the treatment facility during the performance of those procedures. (BPC § 1741(k))

8) Defines “general supervision” as supervision of dental procedures based on instructions given by a licensed dentist but not requiring the physical presence of the supervising dentist during the performance of those procedures. (BPC § 1741(l))

9) Authorizes DAs to perform the following basic supportive dental procedures and specifies the level of supervision required:

    a) Under the general supervision and according to the order, control, and full professional responsibility of a licensed dentist:

        i) Extraoral duties specified by the supervising licensee that meet the definition of a basic supportive dental procedure, including a procedure that requires the use of personal protective equipment, laboratory functions, and sterilization and disinfection procedures. (BPC § 1750.1(a)(1))

        ii) Operate dental radiography equipment for oral radiography if the DA has completed a DBC-approved course in radiation safety, although an erroneous cross-reference points to the requirements for coronal polishing. (BPC § 1750.1(a)(2))

        iii) Perform intraoral and extraoral photography. (BPC § 1750.1(a)(3))

    b) Under the direct supervision and according to the order, control, and full professional responsibility of a licensed dentist:

        i) Apply nonaerosol and noncaustic topical agents, including all forms of topical fluoride. (BPC § 1750.1(b)(1))

        ii) Take intraoral impressions for all nonprosthodontic appliances. (BPC § 1750.1(b)(2))

        iii) Take facebow transfers and bite registrations. (BPC § 1750.1(b)(3))

        iv) Place and remove rubber dams or other isolation devices. (BPC § 1750.1(b)(4))

        v) Place, wedge, and remove matrices for restorative procedures. (BPC § 1750.1(b)(5))

        vi) Remove postextraction dressings after inspection of the surgical site by the supervising licensed dentist. (BPC § 1750.1(b)(6))

        vii) Perform measurements for the purposes of orthodontic treatment. (BPC § 1750.1(b)(7))

        viii) Cure dental materials with a light curing device. (BPC § 1750.1(b)(8))

        ix) Examine orthodontic appliances. (BPC § 1750.1(b)(9))

        x) Place and remove orthodontic separators. (BPC § 1750.1(b)(10))

xi) Remove ligature ties and archwires. (BPC § 1750.1(b)(11))

xii) After adjustment by the dentist, examine and seat removable orthodontic appliances and deliver care instructions to the patient. (BPC § 1750.1(b)(12))

xiii) Remove periodontal dressings. ((BPC § 1750.1(b)(13))

xiv) Remove sutures after inspection of the site by the dentist. (BPC § 1750.1(b)(14))

xv) Place patient monitoring sensors. (BPC § 1750.1(b)(15))

xvi) Adjust the flow of nitrous oxide and oxygen gases if deemed necessary and directed by the supervising dentist who shall be present in the operatory directly supervising the adjustment. (BPC § 1750.1(b)(16))

xvii) Extraoral functions specified by the supervising dentist that meet the definition of basic supportive dental procedures, including patient monitoring, placing monitoring sensors, taking of vital signs, or other extraoral procedures related to the scope of their practice. (BPC § 1750.1(b)(17))

xviii) Administer or assist in the administration of oxygen in response to a medical emergency. (BPC § 1750.1(b)(18))

10) Specifies that the supervising licensed dentist is responsible for determining the competency of a DA to perform any basic supportive dental procedures. (BPC § 1750(b))

11) Specifies that the employer of a DA is responsible for ensuring that the DA has passed a DBC-approved eight-hour course in infection control prior to performing any basic supportive dental procedures involving potential exposure to blood, saliva, or other potentially infectious materials. (BPC § 1750(c))

12) Establishes the following regarding DA infection control courses:

a) Defines “a course in infection control” as one that has as its main purpose providing theory and clinical application in infection control practices and principles where the protection of the public is its primary focus. (BPC § 1755(a))

b) Requires an unlicensed DA who is not enrolled in a DBC-approved program for registered dental assisting or an alternative dental assisting program to complete one of the following infection control certification courses:

i) A DBC-approved eight-hour course, with six hours being didactic instruction and two hours being laboratory instruction. (BPC § 1755(b)(1))

ii) A DBC-approved eight-hour course, with six hours of didactic instruction and at least two hours of laboratory instruction using video or a series of video training tools, all of which may be delivered using asynchronous, synchronous, or online learning mechanisms or a combination thereof. (BPC § 1755(b)(2))

c) Requires a course to establish specific instructional objectives. Instruction must provide the content necessary for students to make safe and ethical judgments regarding infection control and asepsis. (BPC § 1755(c))

d) Requires objective evaluation criteria to be used for measuring student progress. Students must be provided with specific performance objectives and the evaluation criteria that will be used for didactic testing. (BPC § 1755(d))

e) Requires didactic instruction to include, at a minimum, all of the following as they relate to Division of Occupational Safety and Health, known as Cal/OSHA, regulations and the DBC's Minimum Standards for Infection Control:

   i) Basic dental science and microbiology as they relate to infection control in dentistry. (BPC § 1755(e)(1))

   ii) Legal and ethical aspects of infection control procedures. (BPC § 1755(e)(2))

   iii) Terms and protocols specified in Section 1005 of Title 16 of the California Code of Regulations regarding the minimum standards for infection control. (BPC § 1755(e)(3))

   iv) Principles of modes of disease transmission and prevention. (BPC § 1755(e)(4))

   v) Principles, techniques, and protocols of hand hygiene, personal protective equipment, surface barriers and disinfection, sterilization, sanitation, and hazardous chemicals associated with infection control. ((BPC § 1755(e)(5))

   vi) Principles and protocols of sterilizer monitoring and the proper loading, unloading, storage, and transportation of instruments to the work area. (BPC § 1755(e)(6))

   vii) Principles and protocols associated with sharps management. (BPC § 1755(e)(7))

   viii) Principles and protocols of infection control for laboratory areas. (BPC § 1755(e)(8))

   ix) Principles and protocols of waterline maintenance. 1755(e)(9))

   x) Principles and protocols of regulated and nonregulated waste management. 1755(e)(10))

   xi) Principles and protocols related to injury and illness prevention, hazard communication, general office safety, exposure control, postexposure requirements, and monitoring systems for radiation safety and sterilization systems. 1755(e)(11))

f) Requires the issuance of a certificate of completion to students who pass the course.

THIS BILL:

1) Amends the requirement on the employer of an unlicensed DA to ensure that the DA completes a DBC-approved, eight-hour course in infection control from "prior to performing" services to "within a year of the date of employment."

2) Limits the requirement to the employer of a DA who has been in continuous employment for 90 days or more.

3) Deletes the provisions specifying the DA infection control course requirements.

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

COMMENTS:

Purpose. This bill is sponsored by the *California Dental Association*. According to the author, "[This bill] aims to address critical issues faced by dental assistants and the dental workforce shortage across California. Our bill proposes to repeal the strict timing requirement for unlicensed dental assistants to complete the 8-hour infection control course and replace it with a 90-day window. This window will provide dental assistants more flexibility when trying to begin work in the dental industry. Looking out for those in underserved and rural areas is crucial, and this bill not only allows dental assistants to begin working earlier but also helps patients access necessary and timely care."

Background. DAs are one of three types of dental practitioners that assist licensed dentists, the other two being RDAs and RDAEFs. RDAs and RDAEFs are licensed by the DBC and can perform relatively complex services. DAs are unlicensed and may perform "basic supportive dental procedures," which are procedures that are elementary from a technical standpoint, are completely reversible, and are unlikely to result in hazardous conditions for the patient.

DAs are not licensed, so they are indirectly regulated by the DBC through requirements on their dentist employers. Dentist employers are responsible for the services provided by their DA employees, so they must provide proper training and oversight. They must also document compliance with all relevant requirements. When there is an adverse event, the employing or supervising dentist's license may be subject to discipline by the DBC.

DA Training. In addition to any training needed to successfully incorporate a DA into a dental practice, employers of DAs also have statutorily and regulatorily required training requirements. The Dental Practice Act specifies that DA employers are responsible for DAs completing a DBC-approved two-hour course on the Dental Practice Act and maintaining certification in basic life support issued by the American Red Cross, the American Heart Association, the American Safety and Health Institute, the American Dental Association's Continuing Education Recognition Program, or the Academy of General Dentistry's Program Approval for Continuing Education.

The act also requires DA employers to ensure DA employees complete a DBC-approved eight-hour course in infection control that meets various statutory requirements prior to performing any service that involves potential exposure to blood, saliva, or other potentially infectious materials. This bill, for purposes of the Dental Practice Act, would instead allow DAs to begin providing those services prior to completing the infection course, except that those employed for 90 days or more must take the infection control course within a year of the date of employment. This bill would not modify other requirements related to infection control training, such as those required by the Division of Occupational Safety and Health.

Prior Related Legislation. AB 2242 (Carrillo) of 2024 would have made numerous changes to the education, scope of practice, and regulation of dental auxiliaries, including dental assistants,

orthodontic assistants, and registered dental assistants. *AB 2242 died pending a hearing in the Assembly Business and Professions Committee.*

SB 1453 (Ashby), Chapter 483, Statutes of 2024, which was the DBC's sunset review bill,[1] contained, among other things, provisions substantially similar to those in AB 2242 (Carrillo) of 2024 and the infection control requirements being amended under this bill.

AB 481 (Carrillo) of 2023 was substantially similar to AB 2242 (Carrillo) of 2024. *AB 481 was held on the Senate Appropriations Committee suspense file*.

AB 2276 (Carrillo) of 2022 would have authorized unlicensed dental assistants to polish teeth and apply dental sealants. *AB 2276 was held on the Assembly Appropriations Committee suspense file*.

ARGUMENTS IN SUPPORT:

The *California Dental Association* (sponsor) writes in support:

> Dental practices across California are struggling to hire unlicensed dental assistants due to new statutory barriers. Currently, newly hired unlicensed dental assistants must complete an in-person, eight-hour infection control course before they can begin working in a dental office—a requirement that replaced the previous one-year completion window following the 2024 dental board sunset review.
>
> Both unlicensed medical and dental assistants must complete basic infection control training as required by Cal/OSHA. However, Unlike medical assistants, who can begin working after completing their required training, unlicensed dental assistants must now also take a separate, state-mandated eight-hour infection control course before starting their roles. This is despite also receiving general onboarding and supervision from their dentist, who is ultimately responsible for ensuring the office complies with state-mandated infection control protocols. While there is no question about the value of this training, allowing a 90-day window to complete the course would provide new dental assistants with valuable on-the-job experience, enabling them to better understand and retain the intensive training.
>
> Additionally, some dentists may prefer to have their dental staff complete the in-person course format. The limited availability of in-person courses—especially in rural and underserved areas already struggling with workforce shortages—creates significant hiring delays. As a result, some candidates pursue jobs in other industries, further reducing the dental workforce. This challenge not only worsens staffing shortages in dental practices but also limits patient access to care.

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[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 DBC's 2024 Sunset Review, accessible at: https://abp.assembly.ca.gov/jointsunsethearings.

ARGUMENTS IN OPPOSITION:

The *Dental Assisting Alliance* is opposed to this bill unless it is amended, writing:

> Current law requires that an unlicensed dental assistant take an 8-hour infection control course prior to "potential exposure to blood and other potentially infectious materials." This aligns with OSHA regulations that require appropriate training "At the time of initial assignment to tasks where occupational exposure may take place". [This bill] would allow an unlicensed dental assistant up to 90 days to take a Dental Board approved infection control course. That is unacceptable.
>
> The impetus to the sponsor's proposal allowing 3 months in which to work as a dental assistant without the necessary training in infection control is due to the perceived lack of courses within a reasonable distance to those who live in remote areas of California. This erroneous assumption is negated by three facts:
>
> - Courses are available within a 40–50-mile radius of any county in California,
> - Several course providers will travel to the dental office to complete the hands-on lab and evaluation portion of the course (while the didactic portion of the course is available virtually),
> - [AB 1453 (Ashby), Chapter 483, Statutes of 2024], which passed last year, provides for a virtual only option for this 8-hour infection control course.
>
> For the reasons stated above, there is no potential obstacle for compliance or delay in taking the course "prior to potential exposure to blood and OPIM" as current law requires, and we respectfully oppose unless amended [to this bill].

POLICY ISSUES FOR CONSIDERATION:

Timing of 8-hour Infection Control Course. Prior to the passage of the DBC's prior sunset review bill, SB 1453 (Ashby), Chapter 483, Statutes of 2024, the Dental Practice Act required long-term employees to complete the infection control course and other specified courses within one year of employment:

> (c) The employer of a dental assistant shall be responsible for ensuring that the dental assistant who has been in continuous employment for 120 days or more, has already successfully completed, or successfully completes, all of the following within a year of the date of employment:
>
> (1) A board-approved two-hour course in the Dental Practice Act.
>
> (2) A board-approved eight-hour course in infection control.
>
> (3) A course in basic life support offered by an instructor approved by the American Red Cross or the American Heart Association, or any other course approved by the board as equivalent and that provides the student the opportunity to engage in hands-on simulated clinical scenarios.

> (d) The employer of a dental assistant shall be responsible for ensuring that the dental assistant maintains certification in basic life support.

That sunset bill, which took effect this year on January 1, 2025, removed the infection control requirement from that section, instead requiring any employee, regardless of the time they have been employed, to take the 8-hour course prior to performing any supportive dental procedures that involve risk of exposure to infectious materials.

Opponents of this bill argue that the 8-hour course being taken prior to performing services is extremely important for public safety. However, the DBC has not reported a large number of issues related to the timing of the training. Even if the timing of the training requirement was reverted to some period of time after a DA is employed, employers would still have to comply with the training requirements related to bloodborne pathogens promulgated by the Division of Occupational Safety and Health, known as Cal/OSHA (Californa Code of Regulations, Title 8, §§ 5193).

The bloodborne pathogens requirements apply to all places of work where there is occupational exposure to blood or other potentially infectious materials (OPIM). Occupational exposure is defined as "reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties."

The requirements specify that the training be provided “at the time of initial assignment to tasks where occupational exposure may take place” and at least annually after that. The training must include, at a minimum, all of the following:

1) *Copy and Explanation of Standard*. An accessible copy of the regulatory text of the bloodborn pathogens standard and an explanation of its contents.

2) *Epidemiology and Symptoms*. A general explanation of the epidemiology and symptoms of bloodborne diseases.

3) *Modes of Transmission*. An explanation of the modes of transmission of bloodborne pathogens.

4) *Employer's Exposure Control Plan*. An explanation of the employer's exposure control plan and the means by which the employee can obtain a copy of the written plan.

5) *Risk Identification*. An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and OPIM.

6) *Methods of Compliance*. An explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, administrative or work practice controls and personal protective equipment.

7) *Decontamination and Disposal*. Information on the types, proper use, location, removal, handling, decontamination and disposal of personal protective equipment.

8) *Personal Protective Equipment*. An explanation of the basis for selection of personal protective equipment.

9) *Hepatitis B Vaccination*. Information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge.

10) *Emergency*. Information on the appropriate actions to take and persons to contact in an emergency involving blood or OPIM.

11) *Exposure Incident*. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident, the medical follow-up that will be made available and the procedure for recording the incident on the Sharps Injury Log.

12) *Post-Exposure Evaluation and Follow-Up*. Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident.

13) *Signs and Labels*. An explanation of the signs and labels and/or color coding.

14) *Interactive Questions and Answers*. An opportunity for interactive questions and answers with the person conducting the training session.

The requirements also specify that the person conducting the training must be knowledgeable in the subject matter covered by the elements contained in the training program as it relates to the workplace that the training will address.

IMPLEMENTATION ISSUES:

Dental Board Approval of New Infection Control Courses. The DBC, which would support this bill if amended, writes that this bill would repeal the infection control provisions establishing a new dental assistant infection control course that could be completed electronically. Specifically:

> As described in the Board's November 2024 meeting materials (Agenda Item 27.e.), Board staff identified numerous concerns when preparing to implement Board approval of the new infection control course created in BPC section 1755. Following the Board's November 2024 meeting, the Board's Dental Assisting Council Infection Control Working Group met with various stakeholders, including CDA and the Dental Assisting Alliance, to determine the best pathway to implement this new course that maintains consumer protection through appropriate course instruction while improving course access to unlicensed dental assistants in rural areas.
>
> The Board recommends the following amendments to resolve the urgent implementation issues with the infection control and radiation safety courses:
>
> - Amend BPC section 1725 to add new subdivision (l) to establish preexisting application fees
>
> - Amend BPC section 1755 (infection control course), subdivision (b), to allow an unlicensed dental assistant, who previously took or wants to take a Board-approved education program's infection control course currently authorized in regulation or an eight-hour infection control course currently authorized in

regulation, to use any of those infection control courses to satisfy the infection control course requirement, in effect providing legacy compliance for those individuals who have already completed the infection control course prior to January 1, 2025, when BPC section 1755 went into effect.

- Add new BPC section 1755, new subdivisions (c) and (d), to establish course application, laboratory instruction, and Board approval process requirements, based on existing course application regulations.

- Add new BPC section 1755, subdivision (g), to limit the use of the electronic infection control courses solely to unlicensed dental assistants, so that all registered dental assistant (RDA) license, orthodontic assistant, and dental sedation permit applicants would continue to take the eight-hour infection control course offered by an education program or infection control course provider under regulation. Currently, BPC section 1755 creates a disparity in the infection control course requirement for RDA applicants – subdivision (a) provides that an unlicensed dental assistant not enrolled in a Board approved program or alternative dental assisting program (two of the five pathways for RDA licensure) have to take the new infection control course with six hours of didactic instruction and two hours of laboratory instruction (no in-person supervised clinical instruction). The Board has received comment from dental assisting stakeholders that clinical instruction on infection control is extremely important for public safety; such instruction on the use of personal protective equipment (PPE) and instrument cleaning, disinfection, and sterilization cannot be effectively taught through electronic means. The Board has not received any information on why some RDA applicant pathways should be required to receive clinical instruction and other pathways should not. Since RDAs perform many more dental procedures involving infectious materials, many of which are not directly supervised, than unlicensed dental assistants, the Board believes RDAS and other dental assisting permitholders should receive effective clinical instruction on Infection control. The issue communicated to the Board was the need to improve access by unlicensed dental assistants to infection control courses: the proposed amendments would accomplish this by allowing three different infection control courses, including the new electronic course, while maintaining consumer protection by requiring RDA license and dental assisting permit applicants to receive clinical instruction.

Dental Board Implementation of Other Sunset Review Recommendations. The DBC also requested additional amendments, writing:

> During the Board's February 2025 meeting, the Board approved a legislative proposal to resolve the implementation concerns with BPC section 1755, along with various other provisions to clarify the dental assisting statutes amended by SB 1453. The Board also approved several other legislative proposals at its November 2024 and February 2025 meetings to better clarify other SB 1453 implementation issues. Board staff have been in continued discussions with stakeholders on these issues, and CDA has expressed willingness to incorporate additional amendments to the bill.

If this bill passes this committee, the author may wish to continue working with the DBC on its additional proposals.

AMENDMENTS:

1) To reduce the timeframe that a DA must complete the infection control course and apply the requirement to all DAs regardless of length of employment, amend the bill as follows:

   On page 2 of the bill, lines 15-23:

   (c) The employer of a dental assistant shall be responsible for ensuring that a dental assistant ~~who has been in continuous employment for 90 days or more, has already completed, or successfully completes,~~ *has successfully completed* a board-approved eight-hour course in infection control ~~within a year of the date of employment.~~ *within 90 days from the date of first employment at the dental office.*

2) To incorporate the DBC's implementation language allowing for the approval of additional infection control courses, amend the bill as follows:

   On page 4, beginning with line 8:

   Section 1755 of the Business and Professions Code is amended to read:

   1755. (a) A course in infection control is one that has as its main purpose providing theory and clinical application in infection control practices and principles where the protection of the public is its primary focus. *The board shall approve only those courses that adhere to the minimum requirements of this section and applicable regulations adopted by the board.*

   (b) ~~An unlicensed dental assistant not enrolled in a board-approved program for registered dental assisting or an alternative dental assisting program as defined in subdivision (a) of Section 1741, shall complete one of the following infection control certification courses:~~ *An eight-hour infection control course taken for compliance with the requirements of paragraph (c) of Section 1750 shall be one of the following:*

   ~~(1) A board-approved eight-hour course, with six hours being didactic instruction and two hours being laboratory instruction.~~

   (1) A board-approved eight-hour infection control course provided by a board-approved registered dental assisting education program.

   (2) An eight-hour infection control course approved by the board pursuant to Section 1070.6 of Title 16 of the California Code of Regulations.

   (*3*~~2~~) A board-approved eight-hour course, with six hours of didactic instruction and at least two hours of laboratory instruction using video or a series of video training tools, all of which may be delivered using asynchronous, synchronous, or online learning mechanisms or a combination thereof.

(c) A provider of an infection control course offered to students for compliance with paragraph (3) of subdivision (b) shall submit an application on a form furnished by the board for board approval to offer the course, the applicable fee specified in Section 1725, and all of the following:

(1) The course name, course provider name, course director name, business address, telephone number, and email address shall be identified in the application for board approval.

(2) Proof that the course director possesses a valid, active, and current license issued by the board or the Dental Hygiene Board of California.

(*3*~~c~~) *A detailed course outline, in writing, that clearly states the curriculum subject matter, hours of didactic and laboratory instruction, and* specific instructional objectives. Instruction shall provide the content necessary for students to make safe and ethical judgments regarding infection control and asepsis.

(*4*~~d~~) Objective evaluation criteria shall be used for measuring student progress. Students shall be provided with specific performance objectives and the evaluation criteria that will be used for ~~didactic testing~~*course examination*.

(5) Proof that course instructors have experience in the instruction of California Division of Occupational Safety and Health (Cal/OSHA) regulations (Cal. Code Regs., Title 8, Sections 330-344.85) and the board's Minimum Standards for Infection Control (Cal. Code Regs., Title 16, Section 1005).

(*6*~~e~~) *Documentation of d*idactic instruction ~~shall~~*that* include<u>s</u>, at a minimum, all of the following as they relate to Cal/OSHA regulations, as set forth in Sections 300 to 344.85, inclusive, of Title 8 of the California Code of Regulations, and the board's Minimum Standards for Infection Control, as set forth in Section 1005 of Title 16 of the California Code of Regulations:

(*A*~~1~~) Basic dental science and microbiology as they relate to infection control in dentistry.

(*B*~~2~~) Legal and ethical aspects of infection control procedures.

(*C*~~3~~) Terms and protocols specified in Section 1005 of Title 16 of the California Code of Regulations regarding the minimum standards for infection control.

(*D*~~4~~) Principles of modes of disease transmission and prevention.

(*E*~~5~~) Principles, techniques, and protocols of hand hygiene, personal protective equipment, surface barriers and disinfection, *instruments and devices,* sterilization, sanitation, and hazardous chemicals associated with infection control.

(*F*~~6~~) Principles*,* ~~and~~ protocols*, and procedures* of sterilizer monitoring and the proper loading, unloading, storage, and transportation of instruments to work area.

(*G*~~7~~) Principles, ~~and~~ protocols, *and procedures* associated with sharps management.

(*H*~~8~~) Principles, ~~and~~ protocols, *and procedures* of infection control for laboratory areas.

(*I*~~9~~) Principles, ~~and~~ protocols, *and procedures* of waterline maintenance.

(*J*~~10~~) Principles, ~~and~~ protocols, *and procedures* of ~~regulated and nonregulated~~ *contaminated medical* waste management *occurring in the dental healthcare setting*.

(*K*~~11~~) Principles, ~~and~~ protocols, *and procedures* related to injury and illness prevention, hazard communication, general office safety, exposure control, postexposure requirements, and monitoring systems for radiation safety and sterilization systems.

(7) Documentation of laboratory instruction that includes, at a minimum, demonstrations in the following areas, as they relate to Cal/OSHA regulations, as set forth in Sections 300 to 344.85, inclusive, of Title 8 of the California Code of Regulations, and the board's Minimum Standards for Infection Control, as set forth in Section 1005 of Title 16 of the California Code of Regulations:

(A) Apply hand cleansing products and perform hand cleansing techniques, protocols, and procedures.

(B) Apply, remove, and dispose of patient treatment gloves, utility gloves, overgloves, protective eyewear, masks, and clinical attire.

(C) Utilize instruments, surfaces, and situations where contamination is simulated, without actual contamination, from bloodborne and other pathogens being present.

(D) Apply the appropriate techniques, protocols, and procedures for the preparation, sterilization, and storage of instruments including, at a minimum, application of personal protective equipment, precleaning, ultrasonic cleaning, rinsing, sterilization wrapping, internal or external process indicators, labeling, sterilization, drying, storage, and delivery to work area.

(E) Preclean and disinfect contaminated operatory surfaces and devices, and properly use, place, and remove surface barriers.

(F) Maintain sterilizer including, at a minimum, proper instrument loading and unloading, operation cycle, spore testing, and handling and disposal of sterilization chemicals.

(G) Apply work practice controls as they relate to the following classification of sharps: anesthetic needles or syringes, orthodontic wires, and broken glass.

(H) Apply infection control protocol and procedures for the following laboratory devices: impressions, bite registrations, and prosthetic appliances.

(I) Perform waterline maintenance, including use of water tests and purging of waterlines.

(J) Perform techniques for safe handling and disposal of contaminated regulated medical waste.

(8) Written laboratory protocols that comply with the board's Minimum Standards for Infection Control (Cal. Code Regs., Title 16, Section 1005) and other federal, state, and local requirements governing infection control. The course shall provide these protocols to all students and course instructors to ensure compliance.

(9) A written examination that reflects the curriculum content, which may be administered at intervals throughout the course as determined by the course director and shall be successfully completed by each student prior to issuing the certificate of completion described in subdivision (e).

(d) For infection control courses offered to students for compliance with paragraph (3) of subdivision (b), all of the following applies:

(1) The board or its designee may approve, provisionally approve, or deny approval of the course after it evaluates all components of the course. Provisional approval shall expire one year from the date of provisional approval or upon subsequent board approval or denial, whichever occurs first. Provisional approval shall be limited to those courses that substantially comply with all existing standards for full approval. A course given provisional approval shall immediately notify each student of such status. If the board provisionally approves or denies approval of a course, the specific reasons therefore shall be provided by the board to the course director in writing within 90 days after such action.

(2) A board-approved course shall be re-evaluated approximately every seven years, but may be subject to re-evaluation and inspection by the board at any time to ensure compliance with this section.

(3) The board may withdraw approval at any time that it determines the course does not meet the requirements of this section.

(4) The course director shall actively participate in and be responsible for the administration of the course and each of the following requirements:

(A) Maintaining for a period of not less than five years copies of curricula, program outlines, objectives, and grading criteria, and copies of course instructor credentials, licenses, and certifications, and individual student records, including those necessary to establish satisfactory completion of the course.

(B) Informing the board of any major change to the course (including closure), course provider name, course director, business contact information, or course content within 10 days of the change.

(C) Ensuring that all course instructors meet the requirements set forth in this section.

(5) Prior to enrolling a student, the course shall provide notification to the prospective student of the computer or communications technology necessary to participate in didactic and laboratory instruction.

(6) The course shall provide technological assistance to students, as needed, to participate in didactic and laboratory instruction.

(7) The course shall ensure completion of didactic instruction by the student prior to the student's participation in laboratory instruction.

(*e*~~f~~) Upon successful completion of the course, students shall receive a certificate of completion as defined in subdivision (e) of Section 1741. *The certificate of completion shall state the statutory authority under paragraph (1), (2), or (3) of subdivision (b) for which the course has been approved.*

(f) Course records shall be subject to inspection by the board at any time.

(g) A course taken pursuant to paragraph (3) of subdivision (b) shall not satisfy completion of an infection control course required for licensure as a registered dental assistant or permit as an orthodontic assistant or dental sedation assistant.

(*h*~~g~~) The board may adopt regulations to implement this section.

3) To incorporate the DBC's sunset review implementation language codifying existing fees (CCR, tit. 16, § 1022(p)-(v)) relating to DA courses, amend the bill as follows:

On page 2, before line 1, insert:

Section 1725 of the Business and Professions Code is amended to read:

1725. The amount of the fees prescribed by this chapter that relate to the licensing and permitting of dental assistants shall be established by regulation and subject to the following limitations:

(a) The application fee for an original license shall not exceed two hundred dollars ($200).

(b) The fee for examination for licensure as a registered dental assistant shall not exceed the actual cost of the examination.

[…]

(l) The fee for review of each approval application or reevaluation for a course provided pursuant to Sections 1753.52, 1754.5, and 1755 that is not accredited by a board-approved agency or the Chancellor's office of the California Community Colleges shall be three hundred dollars ($300).

REGISTERED SUPPORT:

California Dental Association (sponsor)
California Association of Orthodontists
California Society of Pediatric Dentistry
CPCA Advocates, Subsidiary of the California Primary Care Association

REGISTERED OPPOSITION:

The California Dental Assisting Alliance (unless amended)

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

Date of Hearing: April 8, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 957 (Ortega) – As Introduced February 20, 2025

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

SUBJECT: Cigarette and tobacco products: retail sale: pharmacies.

SUMMARY: Prohibits a pharmacy from engaging in the sale of cigarettes or tobacco products.

EXISTING LAW:

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

2) 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)

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

4) Defines "pharmacy" as an area, place, or premises licensed by the BOP in which the profession of pharmacy is practiced and where prescriptions are compounded. (BPC § 4037)

5) 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)

6) Provides that no person shall conduct a pharmacy in the state unless they have obtained a license from the BOP, and requires a separate license for each of the premises of any person operating a pharmacy in more than one location. (BPC § 4110)

7) Requires each pharmacy to designate a pharmacist-in-charge, subject to approval by the BOP, who is responsible for a pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy. (BPC § 4113)

8) Provides that the BOP shall take action against any licensee who is guilty of unprofessional conduct, with various specific examples provided. (BPC § 4301)

9) Enacts the Cigarette and Tobacco Products Licensing Act of 2003 to provide for the licensing of manufacturers, importers, distributors, wholesalers, and retailers of cigarettes and tobacco products. (BPC §§ 22970 *et seq.*)

10) Provides for specified application requirements for a retailer to obtain a license from the California Department of Tax and Fee Administration (CDTFA) to engage in the sale of cigarettes or tobacco products and specifies causes for denial of a license, including the conviction of specified felonies. (BPC § 22973.1)

THIS BILL:

1) Provides that a pharmacy shall not engage in the retail sale of cigarettes or tobacco products, as those terms are defined in the Cigarette and Tobacco Products Licensing Act.

2) Prohibits the CDTFA from issuing a license to a retailer to engage in the sale of cigarettes or tobacco products if the retailer is a licensed pharmacy.

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

COMMENTS:

Purpose. This bill is co-sponsored by the *American Cancer Society Cancer Action Network*, the *American Heart Association*, the *Campaign for Tobacco-Free Kids*, and the *American Lung Association*. According to the author:

> California has made so much progress in the fight to prevent needless deaths caused by tobacco, and AB 957 is the next step. As a state we've removed smoking rooms from restaurants, increased age requirements, banned flavored tobacco products, and more. But still, every year, 40,000 Californians will die because of smoking and tobacco consumption and $13.29 billion dollars will be spent on smoking-related health care costs. We need to do more. AB 957 will end the sale of tobacco products in pharmacies. Pharmacies are different from other retailers. Patients trust pharmacies to promote health and prevent harm. Selling a product like tobacco which is known to cause serious illnesses contradicts pharmacists' oath to 'do no harm.' A 2023 survey showed 67.8% of Californians agreed that pharmacies and drug stores should not sell tobacco products. Banning tobacco sales in pharmacies would help realign these establishments with their core health-promoting values, reinforcing a commitment to public health.

Background.

Pharmacy Law. The BOP is the regulatory body responsible for overseeing the practice of pharmacy in California. The BOP currently licenses over 50,700 pharmacists, 1,300 advanced practice pharmacists, 4,400 intern pharmacists, and 65,700 pharmacy technicians across 32 licensing programs. The BOP also oversees and licenses pharmacies, clinics, wholesalers, third-party logistic providers, and automated drug delivery systems.

The BOP has its own enforcement staff, which includes field inspectors responsible for conducting investigations and inspections of pharmacies. The BOP's policy is to inspect all pharmacies at least once every four years. A total of 2,969 inspections were completed during Fiscal Year 2023-24. As of July 1, 2024, 80 percent of all licensed pharmacies have received a routine inspection within the last four years; out of the BOP's 6,091 licensed pharmacies, only 317 have never been inspected either through a routine inspection or inspection for another reason, such as investigation of a complaint.

While each individual pharmacy location maintains its own separate license, the BOP was recently given authority to bring an action for fines for repeated violations of materially similar provisions of the Pharmacy Law within five years by three or more pharmacies operating under common ownership or management within a chain community pharmacy. For each third and following violation, an administrative fine may be imposed of up to $100,000 per violation.

Additionally, the BOP may bring an action against a chain community pharmacy operating under common ownership or management for fines not to exceed $150,000 for any violation of the Pharmacy Law demonstrated to be the result of a written policy or which was expressly encouraged by the common owner or manager.

Restriction of Cigarette and Tobacco Sales. According to the federal Centers for Disease Control and Prevention, smoking causes cancer, heart disease, stroke, lung diseases, diabetes, and chronic obstructive pulmonary disease. The government has an established policy goal in preventing tobacco use, and there are multiple federally funded campaigns to not just educate consumers about tobacco health considerations, but to discourage smoking and encourage cessation. In California, the Department of Public Health's California Tobacco Control Program states that its focus is to make tobacco "less desirable, less acceptable and less accessible." The California Department of Education similarly provides assistance to schools, school districts, and county offices of education regarding the prevention and cessation of tobacco use.

The Stop Tobacco Access to Kids Enforcement Act (STAKE Act) prohibits the sale of tobacco products to individuals under 21 years old and requires tobacco retailers to post age restriction warning signs. It also enforces compliance through undercover youth decoy operations, imposes fines for violations, and mandates licensing requirements for sellers. The STAKE Act further prohibits advertising of tobacco products on any outdoor billboard located within 1,000 feet of any public or private elementary school, junior high school, or high school, or public playground.

Tobacco-Free Pharmacy Laws. In recent years there have been efforts to prohibit the sale of tobacco products in pharmacies, with advocates arguing that such sales contradicted the core mission of pharmacists to promote health and wellness among their patients.[1] The American Pharmacists Association (APhA) has formally adopted the following policy statement:

1) APhA urges pharmacies and facilities that include pharmacies to discontinue the sale of tobacco products.

2) APhA urges the federal government and state governments to limit participation in government-funded prescription programs to pharmacies that do not sell tobacco products.

3) APhA urges state boards of pharmacy to discontinue issuing and renewing licenses to pharmacies that sell tobacco products and to pharmacies that are in facilities that sell tobacco products.

4) APhA urges colleges of pharmacy to only use pharmacies that do not sell tobacco products as experience sites for their students.

5) APhA urges the Accreditation Council for Pharmacy Education (ACPE) to adopt the position that college-administered pharmacy experience programs should only use pharmacies that do not sell tobacco products.

6) APhA urges pharmacists and student pharmacists who are seeking employment opportunities to first consider positions in pharmacies that do not sell tobacco products.

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[1] Wang, Teresa W. *et al.* "Attitudes Toward Prohibiting Tobacco Sales in Pharmacy Stores Among U.S. Adults." *American journal of preventive medicine* vol. 51,6 (2016)

Many countries, including the United Kingdom, Australia, and most of the provinces and territories of Canada, prohibit the sale of tobacco products in pharmacies. The State of New York began prohibiting the sale of tobacco and vape products in pharmacies beginning in May 2020.[2] California law does place some restrictions on where cigarettes and tobacco products may be sold; for example, the Medicinal and Adult Use Cannabis Regulation and Safety Act prohibits cannabis retailers from selling tobacco products on their licensed premises, and the STAKE Act generally prohibits the sale of tobacco products by self-service display or through a vending machine. However, California law does not currently prohibit the sale of cigarettes or tobacco products in pharmacies.

Meanwhile, local governments have implemented their own restrictions on the sale of cigarettes and tobacco products. In 2008, San Francisco became the first city in the country to ban the sale of tobacco products in pharmacies. This local ordinance was challenged in court by the tobacco company Philip Morris USA, who argued that the ban was unconstitutional under the First Amendment because it would result in the company being unable to advertise in drugstores; however, this argument was unsuccessful. A second lawsuit was brought by Walgreens, who argued that the bill unconstitutionally discriminated against pharmacies while allowing other large retailers and grocery stores to continue to sell tobacco products; this litigation was also ultimately defeated upon appeal. San Francisco would subsequently broaden its ban in 2010 to include big box stores and grocery stores.[3]

Following the success of San Francisco's ban, a number of other jurisdictions passed ordinances to similarly restrict the sale of tobacco products in California, including the City of Richmond and the unincorporated area in Santa Clara County in 2010, and Marin County and the City of Berkeley in 2014. Research has found that cities that pass tobacco-free pharmacy laws are associated with a greater reduction of tobacco retailer density over time.[4] Additionally, in 2014, CVS Health announced that it would be the first major pharmacy chain in the United States to voluntarily stop selling tobacco products in all of its stores.

This bill would impose a statewide ban on the sale of cigarettes and tobacco products in pharmacies. The bill would prohibit pharmacies from engaging in the retail sale of cigarettes or tobacco products under the Pharmacy Law. Additionally, the bill would make licensed pharmacies ineligible for licensure under the Cigarette and Tobacco Products Licensing Act. The author and sponsors contend that this statewide prohibition will further California's longstanding efforts to reduce tobacco use and improve public health.

Current Related Legislation. AB 762 (Irwin) would prohibit the sale of disposable, battery-embedded vapor inhalation devices. *This bill is pending in the Assembly Committee on Environmental Safety and Toxic Materials.*

Prior Related Legislation. SB 94 (Committee on Budget and Fiscal Review), Chapter 27, Statutes of 2017 established a unified system for the regulation of cannabis which included a prohibition against cannabis retailers selling tobacco products.

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[2] Public Health Law Article 13-F Section 1399-MM-2
[3] "Ordinance 245-10: Banning the Sale of Tobacco Products in Pharmacies." City and County of San Francisco. 28 September 2010. http://www.sfbos.org/ftp/uploadedfiles/bdsupvrs/ordinances10/o0245-10.pdf
[4] Jin, Yue *et al*. "Tobacco-Free Pharmacy Laws and Trends in Tobacco Retailer Density in California and Massachusetts." *American journal of public health* vol. 106,4 (2016)

ARGUMENTS IN SUPPORT:

The *American Cancer Society Cancer Action Network*, the *American Heart Association*, the *American Lung Association*, and the *Campaign for Tobacco-Free Kids* write jointly in support of this bill, writing: "The success of tobacco-free pharmacy policies has already been demonstrated across 256 municipalities and two states. After CVS voluntarily stopped selling tobacco products in 2014, studies documented decreased cigarette pack sales and increased nicotine patch purchases in states where the chain had a significant presence – clear evidence that such policies can positively impact public health outcomes. Academic medical professionals recognize the importance of addressing tobacco use, with 98.5% of pharmacist school faculty including tobacco cessation training in their curricula. It is time for our pharmacy practices to align with this professional education by eliminating the sale of products that directly contradict healthcare principles. Making pharmacies tobacco-free would help realign these establishments with their core health-promoting values, promote cessation and reinforce a commitment to public health."

ARGUMENTS IN OPPOSITION:

There is no opposition on file.

IMPLEMENTATION ISSUES:

The language of this bill amending the Pharmacy Law would simply prohibit a pharmacy from engaging in the retail sale of cigarettes or tobacco products without further specificity. Under state law, a pharmacy license is required for any area, place, or premises in which the profession of pharmacy is practiced or prescriptions are compounded. Statute provides that this "includes, but is not limited to, any area, place, or premises described in a license issued by the board wherein controlled substances, dangerous drugs, or dangerous devices are stored, possessed, prepared, manufactured, derived, compounded, or repackaged, and from which the controlled substances, dangerous drugs, or dangerous devices are furnished, sold, or dispensed at retail." The BOP does not typically inspect activities taking place outside a licensed pharmacy.

This raises some logistical questions as to how the BOP would enforce the prohibition contained in this bill. For example, it is unclear whether a grocery store that has a licensed pharmacy on the same premises would be prohibited from selling cigarettes or tobacco products in a separate part of the store where the practice of pharmacy is not taking place. It is similarly unclear whether the prohibition would apply to a retailer that subleases space within its store to an independently licensed pharmacy.

When the State of New York enacted its ban, it specified that the sale of tobacco and vape products was prohibited "in a pharmacy or in a retail establishment that contains a pharmacy." New York further provides that the prohibition "shall not apply to any other business that owns or leases premises within any building or other facility that also contains a pharmacy or a retail establishment that contains a pharmacy." The author may wish to include similar clarifications within this bill, consistent with the author's intent.

REGISTERED SUPPORT:

American Cancer Society Cancer Action Network *(Co-Sponsor)*
American Heart Association *(Co-Sponsor)*
American Lung Association *(Co-Sponsor)*

Campaign for Tobacco-Free Kids *(Co-Sponsor)*

REGISTERED OPPOSITION:

None on file

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

Date of Hearing: April 8, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 1107 (Flora) – As Introduced February 20, 2025

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

SUBJECT: Cigarette and Tobacco Products Licensing Act of 2003: nitrous oxide: licensure.

SUMMARY: Empowers the California Department of Tax and Fee Administration (CDTFA) to deny, suspend, or revoke a license for a retailer to sell cigarettes or tobacco products if the retailer has been convicted of violating laws criminalizing the unlawful sale of nitrous oxide, and requires the court to order the suspension of the business license, for a period of up to one year, for a retailer that repeatedly violates those laws.

EXISTING LAW:

1) Establishes the CDTFA within the Government Operations Agency, vested with responsibilities and powers previously assigned to the State Board of Equalization. (Government Code §§ 15570 *et seq.*)

2) Enacts the Cigarette and Tobacco Products Licensing Act of 2003 to provide for the licensing of manufacturers, importers, distributors, wholesalers, and retailers of cigarettes and tobacco products. (Business and Professions Code (BPC) §§ 22970 *et seq.*)

3) Provides for specified application requirements for a retailer to obtain a license to engage in the sale of cigarettes or tobacco products and specifies causes for denial of a license, including the conviction of specified felonies. (BPC § 22973.1)

4) Specifies causes for suspension or revocation of a retailer's license to engage in the sale of cigarettes or tobacco products by the CDTFA, including violations of laws relevant to the scope of the license. (BPC § 22980.3)

5) Provides that any person who possesses nitrous oxide with the intent to breathe, inhale, ingest for the purposes of causing intoxication, elation, euphoria, dizziness, stupefaction, or dulling of the senses, or for the purposes of changing, distorting, or disturbing the audio, visual, or mental processes, or who is intentionally under the influence of nitrous oxide, is guilty of a misdemeanor punishable by imprisonment in county jail for up to six months, by a fine not to exceed $1,000, or by both imprisonment and a fine. (Penal Code (PEN) § 381b)

6) Defines "nitrous oxide" as N2O, dinitrogen monoxide, dinitrogen oxide, nitrogen oxide, or laughing gas; states that every person who sells, furnishes, administers, distributes, or gives away, or offers to sell, furnish, distribute, or give away a device, canister, tank, or receptacle either exclusively containing nitrous oxide, or exclusively containing a chemical compound containing nitrous oxide to a person under 18 years of age is guilty of a misdemeanor punishable by imprisonment in a county jail for up to six months, by a fine not to exceed $1,000, or by both imprisonment and a fine; requires the court to consider ordering community service as a condition of probation. (PEN § 381c)

7) Makes it a misdemeanor punishable by imprisonment in a county jail for up to six months, by a fine not to exceed $1,000, or both, for any person to dispense or distribute nitrous oxide to a person knowing or having reason to believe that the nitrous oxide will be ingested or inhaled by the person for the purposes of causing intoxication, euphoria, dizziness, or stupefaction, and that person proximately cause great bodily injury or death to themselves or any other person. (PEN § 381d)

8) Requires a person who distributes or dispenses nitrous to record each transaction involving nitrous oxide in a physical written document, which both that person and the purchaser must sign, and which that person must make available during normal business hours to members of law enforcement or to the California State Board of Pharmacy. (PEN § 381e(a))

9) Specifies that the following the document used to record each transaction shall inform the purchaser of all of the following:

   a) The inhalation of nitrous oxide may be hazardous to your health;

   b) That it is a violation of state law to possess nitrous oxide or any substance containing nitrous oxide with the intent to breathe, inhale, or ingest it for the purpose of intoxication;

   c) That it is a violation of state law to knowingly distribute or dispense nitrous oxide or any substance containing nitrous oxide, to a person who intends to breathe, ingest, or inhale it for the purpose of intoxication.

   (PEN § 381e(b))

10) Exempts from these requirements any person who administers nitrous oxide for the purpose of providing medical or dental care, if administered by a licensed medical or dental provider or at the direction or under the supervision of a licensed practitioner. (PEN § 381e(c))

11) Exempts from these requirements the sale of nitrous oxide contained in food products for use as a propellant. (PEN § 381e(d))

12) Exempts from these requirements the sale of nitrous oxide by a wholesaler licensed by the California State Board of Pharmacy or a specified manufacturer. (PEN § 381e(e))

THIS BILL:

1) Makes conviction of specified misdemeanors relating to the unlawful sale of nitrous oxide a cause for denial of a license from the CDTFA for a retailer to engage in the sale of cigarettes or tobacco products.

2) Makes conviction of specified misdemeanors relating to the unlawful sale of nitrous oxide a cause for suspension or revocation of a retailer's license to engage in the sale of cigarettes or tobacco products by the CDTFA.

3) Requires the court to order the suspension of the business license, for a period of up to one year, of a person who knowingly violates laws criminalizing the unlawful sale of nitrous oxide after having previously been convicted of those laws, unless the owner of the business license can demonstrate a good faith attempt to prevent those violations.

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:

> AB 1107 aims to highlight the growing concern of flavored nitrous oxide misuse and the urgent need for stronger enforcement measures. AB 1107 addresses this issue by ensuring that businesses violating nitrous oxide distribution laws face meaningful consequences, including license suspension and ineligibility for new licenses. The FDA has also issued an advisory warning consumers about the dangers of inhaling nitrous oxide, underscoring the serious health risks associated with these products. By targeting repeat offenders and restricting access to these hazardous substances, this legislation promotes public safety, particularly for young people who are most vulnerable to inhalant misuse.

Background. Nitrous oxide, or dinitrogen monoxide, is a gaseous chemical compound. Often referred to as "laughing gas," nitrous oxide has long been used as a form of anesthesia in surgical and dental procedures. It is also commonly used in motor racing as a rapid-burning fuel for internal combustion engines (referred to in that setting as "NOS.") Nitrous oxide has been approved by the World Health Organization's Expert Committee on Food Additives as a propellant for food since 1985. The gas is used in aerosol containers to deliver culinary substances through a spray that turns into a foam upon being propelled, such as with cooking sprays and whipped cream. Nitrous oxide works particularly well for this purpose because of its interaction with food ingredients and its effectiveness for turning liquids into foamy sprays.

While most consumers interact with nitrous oxide through its use in consumer products already containing the substance intended to be sprayed, pure nitrous oxide may be purchased separately in bulbs or canisters for purposes of recharging dispensers that can then be loaded with home-made whipped products. A popular brand of whipped cream chargers is marketed as "Whip-It!" and is available at kitchen supply stores and online retailers.

The issue this bill seeks to address is the use of these nitrous oxide canisters as a recreational drug. Most commonly referred to as "whippets," inspired by the popular brand name product, the inhalation of nitrous oxide is also sometimes called "hippy crack," "nitro," "laughing gas," "the epiphany drug," "nangs," or "chargers." Typically, the user will inflate a balloon with a charging canister and then inhale it, with the gas operating as a dissociative hallucinogen, producing a sense of euphoria. Recreational use of nitrous oxide is not a new phenomenon; affluent members of English society were known to have so-called "laughing gas parties" hosted by chemist Humphry Davy, who is credited with originally discovering the compound.

There are numerous health risks associated with the recreational use of nitrous oxide and there have been various reports of individuals who become serious injured or engage in dangerous activity as a result of being high on the gas, including a constituent of the author's. For this reason, existing law makes it a misdemeanor crime for any person to possess nitrox oxide with the intent to use it for the purposes of getting high. It is also a crime to sell, furnish, administer, distribute, give away, or offer nitrous oxide canisters to a person under 18 years of age, or to anyone the seller knows intends to use the canisters to get high,. Finally, the law currently requires a person who dispenses or distributes nitrous oxide to record each transaction in a document signed by both the seller and the buyer, which must inform the buyer that recreational use of nitrous oxide is both a crime and dangerous.

Beyond these legal restrictions, nitrous oxide canisters are legal to purchase and sell for legitimate reasons and are not federally regulated as a controlled substance. It has been contended that while many stores sell nitrous oxide for its intended use—to dispense whipped cream through an aerosol device—it is very unlikely that a consumer who purchases the product from a shop primarily selling cigarettes or tobacco products intends to use the canisters for any purpose other than getting high. However, it has also been noted that nitrous oxide can be purchased from myriad other retailers that are arguably less regulated, including online retailers that do not necessarily engage in age verification or other protections against abuse.

Existing law makes it a crime to engage in certain unlawful conduct relating to the sale of nitrous oxide. First, it is a misdemeanor to sell, furnish, administer, distribute, or give away a device, canister, tank, or receptacle either exclusively containing nitrous oxide or exclusively containing a chemical compound mixed with nitrous oxide, to a person under 18 years of age. The defendant can raise a defense that they honestly and reasonably believed that the minor involved in the offense was at least 18 years of age. Beginning in 2010, the court is required to order the suspension of the business license, for a period of up to one year, of a person who knowingly violates this misdemeanor after having been previously convicted of a violation of the same crime.

Additional provisions of law make it a misdemeanor for a retailer to dispense or distribute nitrous oxide to a person who the retailer knows or should know is going to use the nitrous oxide in violation of the law, and that person proximately causes great bodily injury or death to themselves or another person. Retailers are also required to record each transaction involving the dispensing or distribution of nitrous oxide and to make specified disclosures to purchasers, and a violation of required confidentiality relating to information obtained from purchasers is also punishable as a misdemeanor. Unlike the prohibition on sales of nitrous oxide to minors, repeated violations of these additional restrictions and requirements are not subject to mandatory suspension of a business license. This bill would add that language to both of these laws.

The Cigarette and Tobacco Products Licensing Act of 2003 contains provisions governing the CDTFA's process for licensing and overseeing retailers engaged in the sale of cigarettes and tobacco products. Current law provides that specific violations of the law are cause for the CDTFA to deny an application for an initial or renewed license, and that a license can be suspended or revoked for specified causes. This bill would add violations of laws relating to the sale of nitrous oxide, including the aforementioned criminal prohibitions, to the offenses that can result in a license denial, suspension, or revocation by the CDTFA against a retailer.

Prior Related Legislation. SB 193 (Nielsen) of 2019 would have criminalized the sale of nitrous oxide by a tobacco retailer and requires the court to order the suspension of the retailer's business license if convicted. *This bill died on suspense in the Assembly Committee on Appropriations.*

SB 631 (Nielsen) of 2017 would have prohibited a retailer of tobacco products or tobacco-related products from selling or offering to sell nitrous oxide, and made a violation punishable by a civil penalty not to exceed $2,500. *This bill died in Assembly Committee on Judiciary.*

AB 1735 (Hall), Chapter 458, Statutes of 2014 made it a misdemeanor for any person to dispense or distribute nitrous oxide to a person knowing or having reason to believe that the nitrous oxide will be ingested or inhaled by the person for the purposes of causing intoxication, and that person proximately cause great bodily injury or death to themselves or any other person.

AB 1015 (Torlakson), Chapter 266, Statures of 2009 made it a misdemeanor to sell or furnish to a person under 18 years of age a canister or device containing nitrous oxide, or a chemical compound mixed with nitrous oxide.

ARGUMENTS IN SUPPORT:

The *County Health Executives Association of California* supports this bill, writing: "Although it is illegal for tobacco retailers to knowingly sell nitrous oxide to individuals intending to use it for recreational purposes, the current fines and penalties are ineffective in preventing these sales. The growing popularity of nitrous oxide has led to an increase in sales by tobacco retailers. AB 1107 aims to enhance enforcement, urging tobacco retailers to maintain proper documentation for sales and ensure that nitrous oxide is not sold for recreational drug use."

ARGUMENTS IN OPPOSITION:

There is no opposition on file.

REGISTERED SUPPORT:

County Health Executives Association of California
County of Humboldt

REGISTERED OPPOSITION:

None on file

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

Date of Hearing: April 8, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 1175 (Irwin) – As Introduced February 21, 2025

SUBJECT: Accountants.

SUMMARY: Phases in new education and experience standards for a certified public accountant (CPA) license and authorizes out-of-state CPA license holders to practice public accountancy in California under a practice privilege if the state that issued their license has comparable licensure requirements, as defined.

EXISTING LAW:

1) Establishes the California Board of Accountancy (CBA or Board) within the Department of Consumer Affairs (DCA) to implement and enforce the California Accountancy Act. (Business and Professions Code (BPC) §§ 5000 *et seq.*)

2) Authorizes the CBA to designate an executive officer until January 1, 2029. (BPC § 5015.6)

3) Provides that a person shall be deemed to be engaged in the practice of public accountancy if they perform certain acts, make certain representations, or render accounting services to the public and clients for compensation. (BPC § 5051)

4) Specifies that the CPA license shall be granted by the Board to any person who meets the requirements, has not committed acts or crimes constituting grounds for denial of a license, and files an application for licensure on a form provided by the Board. (BPC § 5080)

5) Specifies that an applicant for an authorization to be admitted to the examination for a CPA license must not have committed acts or crimes constituting grounds for denial of a license, meet one of the educational requirements, and file the application prescribed by the Board. This application is not be considered filed unless all required supporting documents, fees, and the fully completed board-approved application form are received in the Board office or filed by mail, as specified. (BPC § 5081)

6) Requires an applicant for a CPA license to have successfully passed an examination on subjects the Board deems appropriate, and in the form and manner that the Board deems appropriate. The Board may, by regulation, prescribe the methods for applying for and conducting the examination, including methods for grading and determining a passing grade. (BPC § 5082)

7) Authorizes the Board to issue a CPA license to any applicant who is a holder of a current, active, and unrestricted CPA license issued under the laws of any state, if the Board determines that the standards under which the applicant received the license are substantially equivalent to the standards of education, examination, and experience established under the California Accountancy Act and the applicant has not committed acts or crimes constituting grounds for denial. (BPC § 5087)

8) Authorizes any individual who is the holder of a current and valid license as a CPA issued under the laws of any state and who applies to the Board for a license as a CPA to, until the time the application for a license is granted or denied, practice public accountancy in this state only under a practice privilege, except that the individual is not disqualified from a practice privilege during the period the application is pending by virtue of maintaining an office or principal place of business, or both, in this state. The Board may by regulation provide for exemption, credit, or proration of fees to avoid duplication of fees. The Board may in particular cases waive any of the requirements regarding the circumstances in which the various parts of the examination were to be passed for an applicant from another state. (BPC § 5088)

9) Requires an applicant for the CPA license to comply with the education, examination, and experience requirements as set forth in the California Accountancy Act. (BPC § 5090)

10) Repeals the following educational requirements on January 1, 2014, unless the educational requirements in ethics study and accounting study, as specified, are reduced or eliminated, at which time the educational requirements become operative again:

    a) An applicant for the CPA license must present satisfactory evidence that the applicant has completed a baccalaureate or higher degree conferred by a college or university, as specified, the total educational program to include a minimum of 24 semester units in accounting subjects and 24 semester units in business-related subjects.

    b) An applicant for the CPA license shall pass an examination prescribed by the Board.

    c) The applicant shall show, to the satisfaction of the Board, that the applicant has had two years of qualifying experience, as specified.

    (BPC § 5092)

11) Specifies that to qualify for the CPA license, an applicant must meet the following education, examination, and experience requirements and authorizes the Board to adopt regulations as necessary to implement them:

    a) An applicant for admission to the CPA examination must present satisfactory evidence that the applicant has completed a baccalaureate or higher degree conferred by a degree-granting university, college, or other institution of learning, as specified. The applicant must have completed at least 150 semester units of college education, including a minimum of 24 semester units in accounting subjects, 24 semester units in business-related subjects, 10 units of ethics study, and 20 units of accounting study, as specified.

    b) An applicant for the CPA license must pass an examination prescribed by the Board.

    c) An applicant must show, to the satisfaction of the Board, that the applicant has had one year of qualifying experience, as specified. The Board may, by regulation, allow experience in academia to be qualifying.

    (BPC § 5093(a)–d))

12) Specifies that applicants completing education at a college or university in another state shall be deemed to meet the education requirements for a CPA license if the Board determines that the education is substantially equivalent to the education standards in this state. (BPC § 5093(e))

13) Authorizes the Board to admit an applicant to the CPA examination before the applicant completes the education requirements if the applicant is enrolled in a degree-granting university, college, or other institution of learning and is within 180 days of completing the educational requirements. Within 240 days of submitting an application, the applicant must provide the Board with satisfactory evidence that they have completed the educational requirements. (BPC § 5093.5)

14) Requires, at a minimum, an applicant's education to be from an accredited degree-granting university, college, or other institution of learning, as specified. (BPC § 5094(b))

15) Specifies that education from a college, university, of other institution of learning located outside of the United States may be qualifying provided it is deems to be equivalent education. (BPC § 5094(c))

16) Requires an applicant for licensure as a CPA to complete 10 semester units or 15 quarter units of ethics study, including the following:

    a) A minimum of three semester units or four quarter units in courses at an upper division level or higher devoted to accounting ethics, accountants' professional responsibilities, auditing, or fraud unless the course was completed at a community college, in which case it need not be completed at the upper division level or higher.

    b) A maximum of 7 semester units or 11 quarter units in the following subjects: business, government, and society; business law; corporate governance; corporate social responsibility; ethics; fraud; human resources management; business leadership; legal environment of business; management of organizations; morals; organizational behavior; professional responsibilities; or auditing.

    c) A maximum of three semester units or four quarter units in courses taken in philosophy, religion, or theology, as specified.

    d) A maximum of one semester unit of ethics study for completion of a course specific to financial statement audits.

    (BPC § 5094.3)

17) Requires the Board to, by regulation, adopt guidelines for accounting study to be included as part of the education required. "Accounting study" means independent study or other academic work in accounting, business, ethics, business law, or other academic work relevant to accounting and business to enhance students' competency as practitioners. (BPC § 5094.6)

18) Specifies that to be authorized to sign reports on attest engagements, a licensee shall complete a minimum of 500 hours of experience, satisfactory to the Board, in attest services, as specified. (BPC § 5095(a))

19) Authorizes an individual whose principal place of business is not in California and who has a valid and current license, certificate, or permit to practice public accountancy from another state to, subject to conditions and limitations, engage in the practice of public accountancy in this state under a practice privilege without obtaining a certificate or license if the individual satisfies one of the following:

    a) The individual has continually practiced public accountancy as a certified public accountant under a valid license issued by any state for at least 4 of the last 10 years.

    b) The individual has a license, certificate, or permit from a state determined by the Board to have education, examination, and experience qualifications for licensure substantially equivalent to this state's qualifications.

    c) The individual possesses education, examination, and experience qualifications for licensure that have been determined by the board to be substantially equivalent to this state's qualifications.

    (BPC § 5096(a))

20) Requires an individual who is exercising the practice privilege in California to, in part, comply with the provisions of the California Accountancy Act, Board regulations, and other laws, regulations, and professional standards applicable to the practice of public accountancy by the licensees of this state and to any other laws and regulations applicable to individuals practicing under practice privileges in this state, except the individual deems, to have met the continuing education requirements and the ethics examination requirements of this state when the individual has met the examination and continuing education requirements of the state in which the individuals holds the valid license, certificate, or permit on which the substantial equivalency is based. (BPC § 5096(d)(2))

21) Requires the Board to consult the Public Company Accounting Oversight Board and the United States Securities and Exchange Commission at least once every six months to identify out-of-state licensees who may have disqualifying conditions or who may be obliged to cease practice, and to disclose whether those out-of-state licensees are lawfully permitted to exercise the privilege. (BPC § 5096.4(a))

22) Requires the Board to add an out-of-state licensee feature to its license lookup tab of the home page of its website that allows consumers to obtain information about an individual whose principal place of business is not in this state and who seeks to exercise a practice privilege in this state, that is at least equal to the information that was available to consumers through its home page through the practice privilege form previously filed by out-of-state licensees. (BPC § 5096.20(a))

23) Requires, if the Board determines, that allowing individuals from a particular state to practice in this state pursuant to a practice privilege violates the Board's duty to protect the public, the Board must require out-of-state individuals licensed from that state to file a notification form and pay applicable fees, as specified. (BPC § 5096.21(a))

24) Requires an individual whose principal place of business is in a state subject to an action of the Board to, prior to practicing, submit a notification form to the Board, as specified, and

pay a fee equal to the reasonable administrative costs, as established by the Board. (BPC § 5096.22(a))

25) Specifies that individuals who, at the time of the enactment of California Accountancy Act, held CPA licenses heretofore issued under the laws of this state are not to be required to secure additional licenses, but are otherwise subject to all the provisions California Accountancy Act; and such licenses heretofore issued shall, for all purposes, be considered licenses under the California Accountancy Act and subject to the provisions hereof. (BPC § 5086)

THIS BILL:

1) Defines "comparable licensure requirements" to mean another state requires passage of the examination required by the Board and has education and experience requirements, when considered collectively, that meet or exceed the standards established by the Board.

2) Authorizes an applicant for authorization to be admitted to the examination for a CPA license to submit their application electronically.

3) Repeals the requirement that in order for an out-of-state CPA license holder to obtain a CPA license in California, the Board must determine that the licensing standards in that other state are substantially equivalent to the education, examination, and experience standards required for licensure in California. Instead requires that the other state have "comparable licensure requirements," as defined.

4) Repeals obsolete licensing requirements for applicants prior to January 1, 2014.

5) Sunsets existing licensing requirements on January 1, 2029.

6) Requires an applicant for admission to the CPA examination to, beginning, July 1, 2026, meet the educational requirements by presenting satisfactory evidence that the applicant has completed one of the following:

   a) The applicant was conferred a board-recognized baccalaureate or advanced accounting degree. The Board may recognize accounting degrees conferred by United States institutions of higher education that require the completion of an accounting concentration of courses, as specified.

   b) The applicant was conferred a baccalaureate or advanced degree not recognized by the Board and completed an accounting concentration of courses. The Board must establish be regulation an accounting concentration of courses required to be completed to satisfy the requirements.

   c) The applicant is enrolled in a dual degree program that confers a baccalaureate degree upon the conferral of a master's degree. Satisfactory evidence must include, but not be limited to, all of the following: a statement that the applicant is enrolled and in good standing in a dual degree program, as specified; the date the applicant completed all educational requirements for a baccalaureate degree, the degrees to be conferred, and the applicant is enrolled in an institution of higher education and is within 180 days of completing the education requirement, and within 240 days of submitting an application

to qualify for the examination, the applicant provides the Board with satisfactory evidence that they have completed the educational requirement.

7) Requires an applicant seeking CPA licensure to, beginning July 1, 2026, show, to the satisfaction of the Board, completion of two years of qualifying experience and passage of the CPA examination

8) Specifies that an advanced degree in an accounting-related subject may be substituted for one year of experience.

9) Authorizes the Board to, by regulation, accept the completion of Board-recognized certificate or training programs as a substitute for a portion of the otherwise required amount of experience. An applicant may only receive credit for substitution of the experience requirement with an advanced degree or board-recognized certificate or training programs, but not both.

10) Authorizes the Board to, by regulation, allow experience in academia to count towards an applicant's minimum experience.

11) Clarifies that for education outside of the United States to be qualifying, it must be from a degree-granting college, university, or other institution of learning.

12) Specifies that colleges, universities, or other institutions of learning that provide qualifying education shall be referenced as "institutions of higher education."

13) Requires the Board to adopt emergency regulations to establish policies and procedures to address, at a minimum, all of the following:

    a) Requirements for an accounting-related degree to be recognized by the Board as satisfying the educational requirements.

    b) Requirements for an accounting concentration of courses that must set a minimum number of semester units and quarter unit equivalents that includes accounting, business, and ethics college courses.

    c) Criteria and procedures for Board recognition of specified certificates that may count toward qualifying experience. At a minimum, the criteria shall require the certificate to be offered by a United States institution of higher education.

    d) Requirements for an advanced degree in an accounting-related subject that may be substituted for one year of qualifying experience.

14) Authorizes the Board to, by regulation, require the completion of specified job tasks to be authorized to sign reports on attest engagements.

15) Deletes the requirement that an individual have continually practice public accountancy as a CPA in another state for at least 4 of the last 10 years, have a license, certificate, or permit from a state that the Board has determined has substantially equivalent education, examination, and experience standards for licensure, or possess education, examination, and experience qualifications for licensure that the Board has determined to be substantially equivalent to this state's qualifications for a CPA licensed in another state to engage in the

practice of public accountancy in this state under a practice privilege without obtaining a certificate or license.

16) Requires the Board to consider whether a state has in place and implements comparable licensure requirements when the Board determines or redetermines that allowing individuals from a particular state to practice in this state pursuant to a practice privilege violates the Board's duty to protect the public.

17) Requires an individual whose principal place of business is in a state that the Board has determined that allowing individuals from that state to practice in this state pursuant to a practice privilege violates the Board's duty to protect the public to indicate on a specified notification form that they have continually practiced public accountancy as a CPA under a current and active license issued by any state for at least 4 of the last 10 years or that they have passed the uniform CPA examination and completed education that included a baccalaureate degree or higher with an accounting concentration and at least one year of general accounting experience.

18) Deletes various obsolete provisions and implementation dates 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 *California Board of Accountancy.* According to the author:

> California is experiencing a shortage of accountants as the demand for CPA services outpaces the number of new CPAs entering the profession. This has placed a strain on current CPAs, their clients and the public interest. [This bill] will create more inclusive, flexible, and affordable licensure pathways for aspiring accountants. This bill modifies educational requirements for CPA applicants and will also allow CPAs licensed in other states to practice accounting in California while maintaining high standards and strong consumer protections. This will ensure there is a steady flow of qualified accountants able to meet market demands.

Background.

California Board of Accountancy. The CBA has regulated the public accounting profession in California for over 120 years. Its mission is "to protect consumers by ensuring only qualified licensees practice public accountancy in accordance with applicable professional standards."[1] The Board achieves this mission primarily through its ability to issue licenses. There are collectively more than 115,000 certified public accountants (CPAs), public accountants (PAs), and accounting firms (i.e., partnerships, corporations, and out-of-state firms) licensed or registered in California.

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[1] California Board of Accountancy, *Functions and History of the CBA*, https://www.dca.ca.gov/cba/about/history.shtml.

CPA Pipeline Shortage. The Association of International Certified Professional Accountants' (AICPA) 2023 Trends Report reveals a significant decline of individuals on the path to becoming licensed CPAs.[2] Since 2016, there has been a 37% decline in the number of candidates taking the CPA exam. Moreover, the number of college graduates with a bachelor's or master's degree in accounting has dropped by 18.2% since the 2015-16 academic year. In December 2022, the Wall Street Journal reported that more than 300,000 accountants and auditors left their jobs in the preceding two years, a 17% decline.[3] In the Fiscal Year 2022-23, the number of initial license applications received by the Board reached a 10-year low.[4]

During the Board's 2024 sunset review, the Board reported that there has been a steady decline in the number of individuals entering the CPA profession and expressed concern about whether there will be a sufficient number of licensed CPAs to meet consumer demand. The Board at that time anticipated that failure to meet consumer demand could result in higher costs for consumers and fees for licensees and that there could be an increase in unlicensed activity.

In July 2023, AICPA formed a National Pipeline Advisory Group to facilitate national conversations about the future of the profession. Additionally, the National Association of State Boards of Accountancy (NASBA) established a Professional Licensure Task Force in October 2023. The Task Force discussions have centered on the history of the current education model; the education required under foreign Mutual Recognition Agreements; and other experiential learning models such as the Experience, Learn and Earn3 (ELE) that might be equivalent to 30 semester units at a college/university, but would not be shown on a college/university transcript. Moreover, the California Society of CPAs recently started a California Pipeline Advisory Group to assist in the evaluation of potential changes to the CPA licensure framework.

A 2023 report by Edge Research, commissioned by the Center for Audit Quality, indicates that the 150-unit requirement is one of the most significant barriers to pursuing a degree in accounting. Among business students, the 150 unit requirement was the third most cited reason for not choosing accounting as their major, preceded only by lack of interest and higher starting salaries for other majors. Moreover, among accounting majors, the 150-unit requirement presented an even bigger barrier for Black and Hispanic students. The cost and time to fulfill the 150-unit requirement were identified as the biggest obstacle among students who had decided not to pursue CPA licensure or who were undecided. Even among those planning to pursue licensure, 75% said the cost was an obstacle, with 31% seeing the cost as a major obstacle, and 74% said the additional time was an obstacle, with 20% saying it was a major obstacle. Black and Hispanic students indicated that cost and time to complete 150 units were major obstacles to becoming a CPA at higher rates than their White counterparts.

New research demonstrates that the 150-unit rule did not "measurably improve CPA service quality but did create additional barriers to entry for minority candidates."[5] Following the implementation of the 150-unit requirement, the researchers noted a decrease in the number of

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[2] Islam, Sam. "Addressing the CPA Shortage with International Talent." The CPA Journal, Apr. 2025, www.cpajournal.com/2025/04/02/addressing-the-cpa-shortage-with-international-talent/.
[3] Ellis, Lindsay. "Why so Many Accountants Are Quitting." WSJ, 28 Dec. 2022, www.wsj.com/articles/why-so-many-accountants-are-quitting-11672236016.
[4] California Board of Accountancy, *Report on Long-Term Licensing Data Trends*, at 7.
[5] Vereckey, Betsy. ""150-Hour Rule" for CPA Certification Causes a 26% Drop in Minority Entrants | MIT Sloan." Mitsloan.mit.edu, 10 Apr. 2024, mitsloan.mit.edu/ideas-made-to-matter/150-hour-rule-cpa-certification-causes-a-26-drop-minority-entrants.

candidates who passed the national CPA exam and found no evidence that the additional year of education (30 units) reduces disciplinary actions involving CPAs for professional violations, tax fraud, and other misconduct. However, the authors found a 14% overall decline in CPA licensure nationally following the adoption of the 150-unit rule. Licensure among minorities dropped by 26% compared with nonminorities.

In another study, economists found that reducing the education requirement from 150 to 120 units is associated with a roughly 25% increase in candidates attempting the CPA exam for the first time.[6] Additionally, they found that reducing the education requirement does not change the CPA exam pass rates or scores and acts as a barrier to entry rather than improving the quality of CPAs.

Education, Examination, and Experience Requirements. In 2001, the Legislature provided two pathways to licensure for a CPA license. Pathway 1, which sunset in 2014 (or in 2016 for applicants that satisfied the exam requirement by December 31, 2013), required a bachelor's degree with a minimum of 24 semester units in accounting and 24 semester units in business-related subjects, plus two years of general accounting subjects and passage of the Uniform CPA Examination developed by the AICPA. Pathway 2, modeled after the national Uniform Accountancy Act (UAA), established the current 150 unit requirement, with 24 semester units in accounting and 24 semester units in business-related subjects, plus one year of general accounting experience and passage of the CPA exam. Since then, legislation has added greater specificity to the unit requirement.

Today, applicants for the CPA license must complete a total of 150 semester units, as follows:

- 24 semester units of accounting subjects (i.e., accounting, auditing, taxation, financial reporting, financial statement analysis, and external & internal reporting);
- 24 semester units of business-related subjects (i.e., business administration, finance, marketing, economics);
- 20 semester units of accounting study (i.e., independent study or other academic work in accounting, business, ethics, business law, or other academic work relevant to accounting and business to enhance students' competency as practitioners); and
- 10 semester units of ethics study, as prescribed in statute.

Because the average bachelor's degree is 120 semester units, applicants must earn an advanced degree or take additional courses at a community college to make up the difference in units. The additional units do not have to be related to accounting. Anecdotally, some applicants take elective courses to meet the 150-unit threshold.

Given the current prescriptive nature of the unit requirements, the Board must verify that each individual applicant has taken the required number and type of courses as required by law. This bill would amend the education and experience requirements for a CPA license in California by eliminating the 150-unit requirement and instead requiring an individual to complete a bachelor's degree in accounting and two years of supervised experience. These changes would make it so

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[6] Stephenson, Frank, and Brian Meehan. "Reducing a Barrier to Entry: The 120/150 CPA Licensing Rule." The Center for Growth and Opportunity at Utah State University, 7 Jan. 2021, www.thecgo.org/research/reducing-a-barrier-to-entry-the-120-150-cpa-licensing-rule/.

the Board would not need to verify each applicant's coursework, although if an applicant's degree was in a subject other than accounting, the applicant would need to fulfill a specific number of units in accounting-related coursework.

In a 2024 survey conducted by the Board, accounting firm partners/hiring managers indicated that they would be more interested in hiring an entry-level CPA who has a bachelor's degree with two years of experience than a an entry-level CPA who had an advanced degree with one year of general experience and more than 63% agreed that an applicant with a bachelor's degree in accounting should fully meet the educational requirements for licensure so long as they complete two years of general accounting experience.

The NASBA, along with the AICPA, have proposed new changes to the UAA similar to those proposed by this bill. The exposure draft released for public comment on March 4, 2025, offers three pathways to licensure: a post-baccalaureate degree with an accounting concentration, one year of experience, and the CPA Exam (the current requirements for a CPA license in California), a baccalaureate degree with an accounting concentration supplemented by an additional 30 semester credits, one year of experience, and the CPA Exam (another option for meeting the current requirements for a CPA license in California), or a baccalaureate degree with an accounting concentration, two years of experience, and the CPA Exam (the requirements for a CPA license in California, as proposed by this bill).

Practice Privilege. Before July 1, 2013, licensed CPAs from other states were required to notify the Board and pay a fee before providing public accounting services in California. Senate Bill 1405 (De León), Chapter 411, Statutes of 2012, established California's "mobility law," allowing any CPA whose principal place of business is located outside California and who holds a valid and current license, certificate, or permit to practice public accountancy from another state, to practice public accountancy in California under a practice privilege (commonly referred to as mobility), without giving notice or paying a fee, provided one of the following conditions is met:

- They have continually practiced public accountancy as a CPA under a valid license issued by any state for at least four of the last 10 years.
- They hold a valid license, certificate, or permit to practice public accountancy from a state determined by the Board to be substantially equivalent to the licensure qualifications in California.
- They possess education, examination, and experience qualifications which have been determined by the Board to be substantially equivalent to the licensure qualifications in California.

That bill also required the Board to convene a stakeholder group to determine whether licensees' practice privilege adequately protects the public. In its 2017 Mobility Stakeholder Group (MSG) Annual Report, the MSG expressed support for and confidence in the state's practice privilege provisions, having determined that NASBA's Guiding Principles of Enforcement, which are the foundation for other state board's enforcement programs, are equivalent to those in California. Additionally, the MSG ensured that the licensing entities in other states had to make each of their licensee's disciplinary history publicly available online. The MSG held its final meeting in November 2019 and was disbanded during the Board's 2024 sunset review.

This bill would allow an out-of-state CPA license holder to practice public accountancy in this state so long as the state that issued their license has "comparable licensure requirements,"

meaning the issuing state requires passage of the same licensure exam and has education and experience requirements that, when considered collectively, meet or exceed California's standards. Individuals from states deemed not to have comparable licensure requirements would be required to submit a notification form to the Board and testify that they have continually practiced public accounting for 4 of the preceding 10 years or longer or meet California's education, examination, and experience requirements. The proponents of this bill purport that this change is necessary to avoid implications to mobility caused by modifying the education and experience requirements for licensure. The changes, they argue, allow flexibility for individual jurisdictions to adjust their licensure requirements as needed without disrupting out-of-state CPAs' ability to practice in California. The aforementioned UAA exposure draft similarly suggests transitioning from mobility based on substantial equivalency to individual licensing criteria.

Current Related Legislation. *SB 788 (Niello)* would exempt a person or firm, including the firm's partners, shareholders, owners, or employees, that is authorized to practice public accountancy pursuant to the California Accountancy Act, from the requirements of the Tax Preparation Act. *That bill is pending in the Senate Business, Professions, and Economic Development Committee.*

Prior Related Legislation.

AB 3251 (Committee on Business and Professions), Chapter 586, Statutes of 2024, extended the sunset date for the Board by four years and enacted technical changes, statutory improvements, and policy reforms in response to issues raised during the Board's sunset review.

ARGUMENTS IN SUPPORT:

As the sponsor of this bill, the *California Board of Accountancy* writes in support:

> The bill will enhance the requirements to become a licensed Certified Public Accountant in California and modernize existing mobility provisions. This measure would provide a simplified, clear, and flexible pathway to licensure. It will create options to reduce the cost and time needed for education, offering better access into the profession for California's diverse population, and will assist in ensuring California consumers can access the accounting services they need. The legislation will also provide the CBA and other regulatory stakeholders more flexibility to consider alternative licensure pathways without concern over how they might impact cross-border practice. It will ensure consumer access to services while increasing consumer safeguards by authorizing the CBA to remove a state from the mobility program if it believes the state is jeopardizing its consumer protection mission.

ARGUMENTS IN OPPOSITION:

There is no opposition on file.

POLICY ISSUE(S) FOR CONSIDERATION:

Emergency Regulation Authority. This bill contains language requiring the Board to adopt emergency regulations to implement the new alternative license qualifications and requirements. While emergency rulemaking can be appropriate and needed to address urgent issues, the

abbreviated timeline for public input diminishes transparency and stakeholder engagement. The Office of Administrative Law describes emergency rulemaking as a process intended to respond to "a situation that calls for immediate action to avoid serious harm to the public peace, health, safety, or general welfare." While it is the understandable intent of this author that the bill's provisions be implemented as soon as possible, the bill itself does not contain an urgency clause, and there is no indication that the typical public notice and review need to be forfeited to avoid harm. Going forward, the author may wish to reconsider the appropriateness of language requiring emergency rulemaking, which this committee typically does not support without demonstration of urgency as a matter of policy.

IMPLEMENTATION ISSUES:

License Mobility. Moving away from the 150-unit requirement has the potential to disrupt mobility for Californians who qualify for licensure under the new educational requirements. However, applicants for licensure would, until January 1, 2029, have the option to qualify for licensure under the current 150-unit pathway. Moreover, Board staff report that more than a dozen states are moving away from the 150-unit requirement and/or mobility based on substantial equivalency, and more may do so if the exposure draft if the UAA is adopted.

AMENDMENTS:

To correct a drafting error, amend the bill as follows:

On page 20, after line 15:

> (3) Deemed to have appointed the regulatory agency of the state ~~that issued the individual has identified as their~~ *in which the* principal place of business *identified by the individual is located, as* the individual's agent on whom ~~notice,~~*notices,* subpoenas, or other process may be served in any action or proceeding by the board against the individual.

REGISTERED SUPPORT:

California Board of Accountancy (Sponsor)
California Society of Certified Public Accountants

REGISTERED OPPOSITION:

There is no opposition on file.

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

Date of Hearing: April 8, 2025

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 1496 (Blanca Rubio) – As Introduced February 21, 2025

SUBJECT: Cannabis task force.

SUMMARY: Reestablishes a prior task force on state and local regulation of commercial cannabis activity and expands the membership of the task force to include representatives of tribal governmental entities.

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 Department of Cannabis Control (DCC) within the Business, Consumer Services, and Housing Agency (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) Requires the DCC to convene an advisory committee to advise the department on the development of standards and regulations pursuant to MAUCRSA, which is required to include representatives of labor organizations. (BPC § 26014)

4) Establishes grounds for disciplinary action against cannabis licensees, including knowing violations of any state or local law, ordinance, or regulation conferring worker protections or legal rights on the employees of a licensee. (BPC § 26030)

5) Authorizes the DCC to issue a citation to a licensee or unlicensed person for violating MAUCRSA or regulations adopted pursuant to MAUCRSA, and allows the DCC to assess an administrative fine of up to $5,000 per violation by a licensee and up to $30,000 per violation by an unlicensed person. (BPC § 26031.5)

6) Prohibits a person or entity from engaging in commercial cannabis activity without a state license issued by the DCC pursuant to MAUCRSA. (BPC § 26037.5)

7) 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)

8) Prohibits the DCC from approving an application for a state cannabis license if approval of the license will violate the provisions of any local ordinance or regulation. (BPC § 26055)

9) Provides that state cannabis laws do not supersede or limit the authority of a local jurisdiction to adopt and enforce local ordinances to regulate cannabis businesses. (BPC § 26200)

10) Establishes the California Cannabis Equity Act, enacted to ensure that persons most harmed by cannabis criminalization and poverty be offered assistance to enter the cannabis industry. (BPC §§ 26240 *et seq.*)

11) Provides California with criminal jurisdiction and civil adjudicatory jurisdiction over tribal lands within its borders, but not civil regulatory jurisdiction. (Public Law 83-280)

THIS BILL:

1) Reinstates provisions of MAUCRSA that were repealed effective January 1, 2025 establishing a task force on state and local regulation of commercial cannabis activity.

2) Provides that the purpose of the task force is to promote communication between state and local entities engaged in the regulation of commercial cannabis activity and facilitate cooperation to enforce applicable state and local laws.

3) Establishes the membership of the task force to include representatives from all of the following entities:

   a) The DCC.

   b) The California Department of Tax and Fee Administration.

   c) The Department of Fish and Wildlife.

   d) The State Water Resources Control Board.

   e) The Department of the California Highway Patrol.

   f) The Labor and Workforce Development Agency.

   g) The Department of Justice.

   h) All local jurisdictions and tribal governmental entities regulating commercial cannabis activity that opt to participate in the task force, which may send one or more specified representatives.

4) Requires the task force to meet twice each fiscal year, through teleconference or similar means to facilitate remote participation, for discussions to be convened and led by the DCC.

5) Provides that discussion topics may include, but need not be limited to, enforcement against the illicit market, social equity programs, state licensing requirements, and labor and workforce compliance.

6) Exempts meetings of the task force from the requirements of the Bagley-Keene Open Meeting Act or the Ralph M. Brown 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:

> Since its legalization, California's recreational cannabis market has been hindered by the presence of unlicensed illicit cannabis growers and sellers. After an initial boom, the cannabis market is currently in a precarious position, with licensed growers and retailers struggling to operate at a sustainable level. The illicit cannabis market takes away business and valuable customers from the legal market, reducing legal profits and in turn reducing general fund money generated by the cannabis industry. These illegal cannabis operations not only undermine the legal market but also prey on marginalized communities, leading to the exploitation of workers and contributing to labor trafficking. Re-establishing and expanding the task force is critical for continuing efforts to combat the illicit cannabis market and ensure that unregulated cannabis does not infiltrate our communities. In 2024 alone, the Cannabis Task Force was instrumental in removing over $500 million worth of illegal cannabis, confiscating firearms, and executing multiple arrests in the process. These efforts demonstrate the importance of maintaining a well-supported and comprehensive approach to tackling the illicit cannabis trade.

Background.

Brief History of Cannabis Regulation in California. Consumption of cannabis was first made lawful in California in 1996 when voters approved Proposition 215, 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. 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.

Local Regulation of Cannabis. When Proposition 64 was approved by the voters, it preserved the provisions of MCRSA that provided local control to cities and counties to decide whether to allow cannabis activity within their jurisdictions. Language included in MAUCRSA authorized the state's cannabis licensing authorities to issue four month "temporary licenses" to applicants, which could be extended in 90-day increments. These temporary licenses allowed businesses to engage in commercial cannabis activity under state approval while local governments commenced with establishing their own local authorization processes and reviewing applications for local approval. Temporary licenses were issued without any fees and temporary licensees did not have access to the state's track and trace system.

While the intent of MAUCRSA was to transition businesses to full annual licensure no later than December 31, 2018—at which time temporary license authority was scheduled to expire—many local jurisdictions struggled to launch their approval programs. For example, by August of 2018, Humboldt County regulators had received 2,376 permit applications and only approved 240. Some jurisdictions issued temporary or provisional local permits, but had not completed the full process for local permitting. To transition away from temporary licensure while local authorization issues remained unresolved, the Legislature passed SB 1459 (Cannella) in 2018, which instead established a "provisional license" scheme. Unlike temporary licenses, provisional license holders must pay a fee, comply with track and trace requirements, and meet additional responsibilities under MAUCRSA.

As of 2022, the DCC reported that approximately 70 percent of licenses in California remained provisional. The authority to issue and renew provisional licenses was originally scheduled to sunset on January 1, 2020; this was subsequently extended with the provisional licensing program ultimately sunsetting on January 1, 2026. Specific expiration dates and deadlines were applied to provisional licensees and applicants based on the size and nature of the business, and new requirements for certain applicants to submit documentation regarding lake or streambed alteration agreement were enacted. Beginning January 1, 2025, the DCC is no longer authorized to renew provisional licenses with the exception of locally verified equity retail licenses.

The 2022-23 Budget Act required the DCC to submit a report to the Legislature on the condition and health of the cannabis industry in the state. This report was presented to the Legislature in March 2025 and discussed in a joint informational hearing. In its transmittal letter, the DCC argued that "California has made significant progress since launching licensed cannabis sales in 2018" while conceding that "the legal industry continues to face persistent challenges."

The DCC's report indicated that as of July 2024, 46 percent of cities and counties in California allow at least one type of commercial cannabis activity. This means that 54 percent of cities and counties do not currently allow any type of cannabis business. The DCC further reported that 57 percent of cities and counties do not allow any retail cannabis businesses within their jurisdictions.

Tribal Governments and Cannabis. A document issued by the United States Attorney General in 2013 known as the "Cole memorandum" indicated that the existence of a strong and effective state regulatory system, and a cannabis operation's compliance with such a system, could allay the threat of federal enforcement interests. Federal prosecutors were urged under the memo to review cannabis cases on a case-by-case basis and consider whether a cannabis operation was in compliance with a strong and effective state regulatory system prior to prosecution. The memo was followed by a "Policy Statement Regarding Marijuana Issues in Indian Country" (referred to as the "Wilkinson memorandum"), which essentially extended the Cole memorandum to tribal lands contained within the borders of states that possess strong and effective state regulatory systems for cannabis, and that effectively comply with that regulatory system.

Both the Cole and Wilkinson memoranda were rescinded by Attorney General Jeff Sessions in January of 2018. In March 2022, a coalition of nine United States senators sent a letter to then-Attorney General Merrick Garland, urging the Department of Justice to respect tribal sovereignty and cease enforcement of the Controlled Substances Act on tribal lands where cannabis activities are legalized by the tribes. The letter emphasized that tribal governments should have the right to determine their own cannabis policies without federal interference.

Neither the AUMA nor MAUCRSA included any language expressly authorizing recognized Indian tribes to engage in licensed cannabis activity within California. In the text of the regulations originally promulgated to implement MAUCRSA, a cannabis licensee "that may fall within the scope of sovereign immunity that may be asserted by a federally recognized tribe or other sovereign entity must waive any sovereign immunity defense that the applicant or licensee may have." The regulations' prohibited on cannabis delivery to publicly owned lands also "applies to land held in trust by the United States for a tribe or an individual tribal member unless the delivery is authorized by and consistent with applicable tribal law."

It is generally accepted that members of a recognized Indian tribe may engage in cannabis activities on tribal land as long as this activity does not intermix with the market outside that tribal land and any involved individuals are exempted from the state's cannabis license requirements through a claim of sovereign immunity. However, this has led to frustration among several tribes that wish to engage in the state's growing regulated industry without having to waive sovereign immunity, as required by regulations. One barrier to allowing tribal members to engage in licensed activities on tribal lands is that Public Law 280 does not allow the state's licensing authorities to enter that tribal land to engage in civil regulatory enforcement, meaning a tribe's compliance with MAUCRSA could not be monitored and confirmed without a waiver of sovereign immunity.

Additionally, even to the extent that members of a tribe do not themselves intend to engage in regulated cannabis activities, they remain unable to lease any part of their land for cannabis cultivation to a California licensee, as tribal land is not technically within a local government capable of authorizing the activity locally under the state's scheme for dual-licensure. Meanwhile, tribal governments also see significant adverse impacts from the illicit cannabis market, including environmental damage and other criminal activity.

State and Local Task Force. The 2022-23 Budget Act established a task force to promote communication between state and local entities engaged in the regulation of commercial cannabis activity and facilitate cooperation to enforce applicable state and local laws. The author of this bill previously authored earlier legislation that expanded the task force to include additional representatives of state agencies engaged in the enforcement of civil rights and labor rights. However, the task force formally sunset on January 1, 2025.

This bill would reestablish the task force, placing recently repealed language back into MAUCRSA. Additionally, this bill would add representatives of tribal governments to the task force, with the intent of improving collaboration and communication between those entities and state and local governments. The author believes that this task force was a demonstrated success and that its operation should continue as California continues to work toward its goal of facilitating a successful legal cannabis industry within the state.

Prior Related Legislation. AB 993 (Rubio), Chapter 822, Statutes of 2023 expanded the membership of the task force on state and local regulation of commercial cannabis activity to include representatives of the Civil Rights Department and the Department of Industrial Relations.

AB 195 (Committee on Budget), Chapter 56, Statutes of 2022 originally established the task force on state and local regulation of commercial cannabis activity.

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

REGISTERED SUPPORT:

None on file

REGISTERED OPPOSITION:

None on file

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