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California State Assembly

BUSINESS AND PROFESSIONS

MARC BERMAN
CHAIR

Chief Consultant
Robert Sumner

Deputy Chief Consultant
Vincent Chee

Consultant
Kaitlin Curry
Edward Franco

Committee Secretary
Christina Rocha

1020 N Street, Room 379
(916) 319-3301
FAX: (916) 319-3306

AGENDA

Tuesday, June 23, 2026
9 a.m. -- 1021 O Street, Room 1100

BILLS HEARD IN FILE ORDER

1.	SB 758	Umberg	Public health: nitrous oxide.
2.	SB 849	Weber Pierson	Physicians and surgeons: sexual misconduct and offenses: revocation of certificate.
3.	SB 993	Ochoa Bogh	Board of Behavioral Sciences: licensees: notices.
4.	SB 1002	Niello	Out-of-state physicians and surgeons: telehealth: license exemption.
5.	SB 1094	Weber Pierson	Prescription drugs.
6.	SB 1263	McGuire	Contractors: debris removal.
7.	SB 1312	Richardson	Cemeteries.

Date of Hearing: June 23, 2026

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
SB 758 (Umberg) – As Amended January 22, 2026

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

SENATE VOTE: 40-0

SUBJECT: Public health: nitrous oxide

SUMMARY: Prohibits a retailer licensed to engage in the sale of cigarettes or tobacco products from selling nitrous oxide at a retail location.

EXISTING LAW:

1) Establishes the California Department of Tax and Fee Administration (CDTFA) within the Government Operations Agency. (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) Prohibits a retailer licensed under the Cigarette and Tobacco Products Licensing Act of 2003 from selling nitrous oxide, as defined.

2) Provides that for purposes of the bill, a retailer does not include a grocery store or a general retail merchandise store with a grocery department, as defined.

FISCAL EFFECT: According to the Senate Committee on Appropriations, a prior version of this bill would have resulted in unknown, potentially significant costs for the California Department of Public Health for staff positions to conduct inspections, ensure compliance, and conduct investigations.

COMMENTS:

Purpose. This bill is co-sponsored by the *California Narcotic Officers' Association*, the *California League of Cities*, *County of Orange*, and the *Rural County Representatives of California*. According to the author:

> SB 758 aims to address growing public health concerns by regulating a drug that is readily available at gas stations, liquor stores, and tobacco shops. Nitrous oxide has legitimate uses in medicine, dentistry, and food preparation. However, it is also inhaled recreationally by some users, causing long-term neurological effects, paralysis, or even death. Allowing certain retailers to sell nitrous oxide makes the drug dangerously available to recreational users. Cities have already begun passing ordinances to reel in Nitrous Oxide use, but comprehensive legislation at the state level is needed to ensure the safety of all California residents.

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 consumer products already containing a sprayable substance, 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 can be easily purchased at kitchen supply stores and online retailers. These containers are associated with the inappropriate use of nitrous oxide as a recreational drug, commonly referred to as "whippets."

The inhalation of nitrous oxide in order to get high 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 serious health risks associated with the recreational use of nitrous oxide, which can result in serious injury or dangerous activity. Existing law makes it a misdemeanor to possess nitrous oxide with the intent to use it for the purposes of getting high. Additionally, it is a crime to sell, furnish, administer, distribute, give away, or offer nitrous oxide canisters to a person who is under 18 years of age, or to anyone the seller knows intends to use the canisters to get high. Current law also 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.

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 prohibit a retailer who is licensed by the CDTFA to sell cigarettes and tobacco products from selling nitrous oxide. Grocery stores or general retail merchandise stores with a grocery department would be exempted from this prohibition.

Current Related Legislation. SB 936 (Blakespear) would prohibit the sale of specified nitrous oxide products associated with a greater likelihood of being inappropriately used for direct inhalation of nitrous oxide by the purchaser and establishes penalties for the unlawful sale of those nitrous oxide containers. *This bill is pending in the Assembly Committee on Public Safety.*

SB 1314 (Menjivar) would make it a misdemeanor for a person to possess nitrous oxide with the intent to get high, sell nitrous oxide to a minor, or dispense or distribute nitrous oxide knowing it will be ingested or inhaled to get high in an instance that results in serious harm or death. *This bill is pending in the Assembly Committee on Health.*

Prior Related Legislation. AB 1107 (Flora) of 2025 would have authorized the 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 required 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. *This bill died on suspense in the Assembly Committee on Appropriations.*

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 *League of California Cities* writes in support as a co-sponsor:

> Although current law prohibits the sale of nitrous oxide for recreational intoxicating purposes, significant loopholes in the statutory framework allow these products to be easily diverted into the recreational market. For example, nitrous oxide canisters labeled for food preparation are repurposed and resold at various tobacco retail locations. To address this issue, at least twenty-five cities have brought forth ordinances focused on restricting the sale of nitrous oxide in tobacco retail locations that have no real connection to legitimate uses. However, effectively preventing the recreational sale of nitrous oxide will require clear, consistent statewide guidelines.
>
> SB 758 would close the dangerous loophole that allows nitrous oxide to be sold in smoke shops, making it easier for cities to address the troubling proliferation of recreational nitrous oxide related injuries and deaths.

ARGUMENTS IN OPPOSITION:

There is no opposition on file to the current version of the bill.

REGISTERED SUPPORT:

California Narcotic Officers' Association *(Co-Sponsor)*
California League of Cities *(Co-Sponsor)*

County of Orange *(Co-Sponsor)*
Rural County Representatives of California *(Co-Sponsor)*
Arcadia Police Officers' Association
Brea Police Association
Burbank Police Officers' Association
California Association of School Police Chiefs
California Coalition of School Safety Professionals
California Reserve Peace Officers Association
City of Alameda
City of Carlsbad
City of El Cerrito
City of Garden Grove
City of Irvine
City of Lake Forest
City of Paramount
City of Pico Rivera
City of Rocklin
City of San Buenaventura
City of Seal Beach
City of Sunnyvale
City of Tulare
City of Ventura
Claremont Police Officers Association
Corona Police Officers Association
Culver City Police Officers' Association
Fullerton Police Officers' Association
League of California Cities
Los Angeles School Police Management Association
Los Angeles School Police Officers Association
Murrieta Police Officers' Association
Newport Beach Police Association
Palos Verdes Police Officers Association
Placer County Deputy Sheriffs' Association
Pomona Police Officers' Association
Riverside County Sheriff's Office
Riverside Police Officers Association
Riverside Sheriffs' Association

REGISTERED OPPOSITION:

None on file

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

Date of Hearing: June 23, 2026

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
SB 849 (Weber Pierson) – As Amended June 15, 2026

SENATE VOTE: 39-0

SUBJECT: Physicians and surgeons: sexual misconduct and offenses: revocation of certificate

SUMMARY: Requires the Medical Board of California (MBC) and the Osteopathic Medical Board of California (OMBC) to re-revoke any physician and surgeon's license that (1) was reinstated between January 1, 2020, and January 1, 2023, and (2) was initially revoked for specified acts of sexual misconduct with a patient or sexual exploitation, as specified.

EXISTING LAW:

1) Regulates the practice of medicine under the Medical Practice Act and the Osteopathic Act, which establish (1) the MBC to administer and enforce the act as it relates to physicians and surgeons and medicine generally and (2) the OMBC to administer and enforce the provisions of the act as they relate to osteopathic physicians and surgeons. (BPC §§ 2000-2529.8.1)

2) Specifies that protection of the public shall be the highest priority for the MBC and OMBC in exercising their licensing, regulatory, and disciplinary functions, and that whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount. (BPC §§ 2001.1, 2450.1)

3) Prohibits the practice of medicine or conspiring with or aiding or abetting another to practice without a license issued under the Medical Practice Act or other appropriate practice act. (BPC § 2052)

4) Requires the MBC and OMBC to post on their respective websites the current status of their licensees; any revocations, suspensions, probations, or limitations on practice, including those made part of a probationary order or stipulated agreement; historical information regarding probation orders by the board, or the board of another state or jurisdiction, completed or terminated, including the operative accusation resulting in the discipline by the board; and other information about a licensee's status and history. (BPC § 2027)

5) Requires the MBC and OMBC to prioritize their investigative and prosecutorial resources to ensure that physicians representing the greatest threat of harm are identified and disciplined expeditiously. (BPC §2220.05)

6) Provides that a physician licensee whose matter has been heard by an administrative law judge, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the MBC or OMBC, may be subject to license revocation, suspension up to one year, probation and payment of costs for probation monitoring, public reprimand and education, or any other action taken in relation to

discipline as part of an order of probation, as the MBC, OMBC, or an administrative law judge may deem proper. (BPC § 2227)

7) Requires physicians who are on probation for certain offenses, including the commission of any act of sexual abuse, misconduct, or relations with a patient or client to provide their patients with information about their probation status prior to the patient's first visit. (BPC § 2228.1)

8) Requires the MBC and OMBC to automatically revoke the license of any person who has been required to register as a sex offender, with the exception of registrations required following convictions of a misdemeanor for indecent exposure. (Penal Code (PEN) § 290; BPC § 2232)

9) Provides that the conviction of any offense substantially related to the qualifications, functions, or duties of a physician constitutes unprofessional conduct. (BPC § 2236)

10) Automatically suspends a physician's license during any time that the physician is incarcerated after conviction of a felony, as specified. (BPC § 2236.1)

11) Automatically places a physician's license on inactive status during any time that the physician is incarcerated after conviction of a misdemeanor. (BPC § 2236.2)

12) Provides that the revocation, suspension, or other discipline, restriction, or limitation imposed by another state or the federal government upon a license or certificate to practice medicine issued by that state, or the revocation, suspension, or restriction of the authority to practice medicine by any agency of the federal government, that would have been grounds for discipline by the MBC or OMBC, constitutes grounds for disciplinary action for unprofessional conduct against the licensee in this state. (BPC § 2305)

13) Specifies numerous inappropriate activities or violations of the law that constitute unprofessional conduct. (BPC §§ 2237-2318)

14) Authorizes a physician whose license has been surrendered, revoked, suspended, or placed on probation to petition the MBC or OMBC for reinstatement or modification of penalty, including modification or termination of probation, which may be reviewed by a panel. (BPC § 2307)

15) Prohibits, as of January 1, 2023, the MBC and OMBC from reinstating the license of any person under any of the following circumstances:

    a) The person's certificate has been surrendered because the person committed an act of sexual abuse, misconduct, or relations with a patient or sexual exploitation, as specified. (BPC §§ 726, 729(a), 2307(i)(1)(A))

    b) The person's certificate has been revoked based on a finding by the MBC or OMBC that the person committed an act of sexual abuse, misconduct, or relations with a patient or sexual exploitation, as specified. (BPC §§ 726, 729(a), 2307(i)(1)(B))

c) The person was convicted in a court in or outside of this state of any offense that, if committed or attempted in this state, based on the elements of the convicted offense, would have been punishable as one or more of the offenses requiring registration as a sex offender and the person engaged in the offense with a patient or client, or with a former patient or client if the relationship was terminated primarily for the purpose of committing the offense. (PEN § 290; BPC § 2307(i)(1)(C))

d) The person has been required to register as a sex offender, regardless of whether the conviction has been appealed, and the person engaged in the offense with a patient or client, or with a former patient or client if the relationship was terminated primarily for the purpose of committing the offense. (PEN § 290; BPC § 2307(i)(1)(D))

THIS BILL:

1) Requires the MBC and OMBC to automatically re-revoke all licenses that were reinstated after January 1, 2020, if the licenses were previously revoked based on a finding by the MBC that the person committed one of the specified sexual acts that would have precluded the reinstatement after January 1, 2023.

2) Prohibits a person from petitioning the MBC or OMBC for reinstatement or renewal of a license re-revoked under this bill.

3) Authorizes, a licensee subject to re-revocation of their license under this bill to request a hearing within 30 days of the revocation in accordance with the Administrative Procedure Act.

4) Declares that it is the intent of the Legislature that the revocation provisions of this bill have retroactive application.

5) Clarifies that the prohibition against reinstatement of a license for cases where the license was "surrendered because the person committed [specified sexual acts] with a patient… or sexual exploitation" applies when the surrender occurred while the MBC or OMBC accusation alleging the acts was pending.

FISCAL EFFECT: According to the Senate Appropriations Committee analysis of the prior version of this bill (version 97, amended January 5, 2026):

The Medical Board of California (MBC) and Osteopathic Medical Board of California (OMBC) note the process of revoking licenses would add minor and absorbable administrative workload. However, the MBC and OMBC note there is a strong likelihood of litigation that may result in the following significant, unabsorbable costs:

- Total estimated one-time cost to the MBC ranging between $640,000 to $1.66 million (Contingent Fund of the MBC). MBC notes there are four licensees that would be subject to revocation under this bill. Litigation costs average approximately $160,000 per case, with an additional plaintiff cost of $21,000 if the case outcome is unfavorable to MBC. Costs to the MBC may be higher, exceeding $1 million, depending on the appeals process.

- Total Attorney General (AG) costs of up to $1 million to the OMBC, to the extent that OMBC is enjoined in a lawsuit against the MBC challenging the provisions of this bill (OMBC Contingent Fund).

COMMENTS:

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

> The physician-patient relationship involves significant vulnerability and relies on ethical judgment and integrity. When serious misconduct occurs, it calls into question a physician's ability to safely care for patients. This legislation responds by clarifying physician standards to ensure that those entrusted with patient care must continuously meet the responsibility that comes with that role. By centering patient safety, the bill helps restore confidence in the medical profession and ensures patients can rely on their physicians without hesitation. It reflects the Legislature's commitment to protecting the public and maintaining trust in California's healthcare system. Being a physician comes with an immense amount of public trust. This bill affirms that trust by placing patient safety first and upholding the highest expectations and standards for those who practice medicine.

Background. The Medical Practice Act and Osteopathic Act require the MBC and OMBC to enforce the laws relating to the practice of medicine for each of their respective physician license populations. The purpose of enforcement is to ensure that licensees continue to adhere to licensing requirements and protect the public from those that do not.

The boards have a range of enforcement tools to match the severity of any identified practice act violations. For minor violations, the boards may utilize educational letters or issue citations, which may include fines or an order of abatement. For more significant violations, the boards may seek formal disciplinary actions against a license, including probation, suspension, or revocation. Revocation is the highest form of discipline available to a licensing board—the person no longer possesses a license under the jurisdiction of the board.

The boards can initiate formal disciplinary action by referring the matter to the Office of the Attorney General (OAG) to prepare a case for prosecution in an administrative proceeding. For violations that also involve criminal conduct, the DCA's Division of Investigation (DOI) can also refer the case to law enforcement.

Automatic Suspension and Revocation of Licenses. Certain acts and circumstances have been deemed so harmful or such a high risk of harm to patients that the MBC and OMBC are required to automatically suspend or revoke the licenses of any person who commits them. For example, the boards must automatically suspend a license after a conviction of specified felonies, including sexual abuse, misconduct, or relations with a patient. Once the conviction is final, the boards are required to automatically revoke the license.

The MBC and OMBC must also automatically revoke the license of any licensee that has been required to register as a sex offender, regardless of whether the related conviction has been appealed, except when the registration resulted from a misdemeanor for indecent exposure. Physicians subjected to automatic revocation may request a hearing within 30 days of the

revocation. If the relevant conviction is overturned on appeal, the revocation ordered automatically ceases.

License Reinstatement. Except in specified cases, a former physician whose license was revoked, or who surrendered their license while under investigation or while charges were pending, is authorized to petition the MBC and OMBC for reinstatement. Petitions for reinstatement of a license surrendered or revoked for unprofessional conduct may not be filed for at least three years following the date the license was revoked or surrendered, though the MBC and OMBC may, for good cause shown, allow a petition to be submitted after only two years. Petitions include a statement of facts as required by the MBC and must be accompanied by at least two verified recommendations from licensed physicians who have personal knowledge of the activities of the petitioner since the disciplinary penalty was imposed.

Petitions for reinstatement may be heard by a panel of the MBC or OMBC or may be assigned to an administrative law judge. The panel or the administrative law judge may consider all the petitioner's activities since the disciplinary action was taken, the offense for which the petitioner was disciplined, the petitioner's activities during the time the certificate was in good standing, and the petitioner's rehabilitative efforts, general reputation for truth, and professional ability. Once the hearing is completed, the petition for reinstatement is either denied or granted, and may be granted with the imposition of certain terms and conditions.

Automatic Denial of Reinstatements. In response to a 2021 investigative report published by the *Los Angeles Times* titled "These doctors sexually abused patients. The Medical Board gave them their licenses back"[1] and subsequent reporting, the California Medical Association (CMA) sponsored a bill, AB 1636 (Weber), Chapter 453, Statutes of 2022, to establish the current prohibition against reinstating a license revoked for specified acts of sexual misconduct with patients or sexual exploitation.

The CMA noted that AB 1636 was "intended to remove any obstacles in statute ensuring patients are protected, physicians that commit this egregious conduct are appropriately disciplined, and the integrity of the medical profession is maintained. Physicians are entrusted by their patients to provide care and do no harm." AB 1636 went into effect January 1, 2023, meaning the reinstatement of a license revoked for specified sexual misconduct with a patient or sexual exploitation before that date was not yet prohibited. This bill would retroactively apply the prohibition to licenses reinstated after January 1, 2020. According to the author's background questionnaire:

> AB 1636 went into effect in 2023. A few years prior to the implementation of that measure, the Legislature spoke out against sexual abuse of all forms and granted victims additional rights and protections, including extending the statute of limitations for sexual assault claims and prohibiting nondisclosure agreements in settlement agreements related to workplace sexual harassment.

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[1] Jack Dolan and Brittny Mejia, "These doctors sexually abused patients. The Medical Board gave them their licenses back," *Los Angeles Times*, December 15, 2021, https://www.latimes.com/california/story/2021-12-15/california-medical-board-doctor-patient-sexual-abuse-license-reinstate.

> This bill extends the victim protections implemented by AB 1636 by retroactively applying those protections to a time frame when the State and Legislature became more forceful in their discipline of sexual harassment and misconduct.

Current Related Legislation. AB 2774 (Committee on Business and Professions) is the sunset review bill for the Physical Therapy Board of California (PTBC), which adds specified sex offense registration requirements and convictions to the list of petitions for reinstatement the must deny and extends the PTBC by four years. *AB 2774 is pending in the Senate Business, Professions and Economic Development Committee*.

AB 2775 (Committee on Business and Professions) is the sunset review bill for the Board of Chiropractic Examiners (BCE), which, among other things, authorizes the BCE to automatically revoke a chiropractic license if the licensee is required to register as a sex offender or has been convicted of any offense that, if committed or attempted in this state, would have required the licensee to register as a sex offender, except as specified, and authorizes the BCE to automatically revoke a chiropractic license following a conviction of a serious felony, as defined. *AB 2775 is pending in the Senate Business, Professions and Economic Development Committee*.

Prior Related Legislation. AB 1636 (Weber), Chapter 453, Statutes of 2022, among other things, required the MBC and OMBC to automatically revoke the license of a physician and surgeon who commits specified acts of sexual abuse, misconduct, or relations with a patient and to deny a petition to reinstate a license revoked for those reasons.

AB 1975 (Bermudez), Chapter 756, Statutes of 2004, made various changes relating to the requirement that the MBC revoke the license of licensees required to register as a sex offender and declared the intent of the Legislature for the revocation provisions to apply both retrospectively and prospectively.

AB 236 (Bermudez), Chapter 348, Statutes of 2003, among other things, established the requirement that the MBC automatically revoke the license of any licensee who is required to register as a sex offender, as specified.

ARGUMENTS IN SUPPORT:

The *MBC* and *OMBC* would support this bill if it were amended to instead prospectively expand the types of sexual offenses that result in permanent revocation. In its letter, the *MBC* writes:

> The Board shares your desire to help ensure that patients are protected from physicians who engage in sexual misconduct. The Board believes that sexual misconduct by a physician, regardless of their relationship to the victim, is extremely serious. If the Board's enforcement process or a criminal proceeding proves that someone engaged in sexual misconduct as described in our proposed edits to the bill, that person should not have a medical license in California.
>
> The current approach in [this bill], takes a retrospective approach and attempts to revoke the license of someone who was previously disciplined, and, thereafter, deemed to have met the legal requirements for reinstatement. [This bill] requires the Board to revoke a license of a physician who has not been accused of

committing a new violation of the Medical Practice Act since being reinstated. Consequently, the Board is concerned that, as currently drafted, the Board would be subject to costly litigation that is likely to thwart the aim of your legislation. Instead, the Board asks that you amend [this bill] so that it will do the following:

- Strengthen existing laws that prevent issuance of a license to an applicant who has committed criminal sexual offenses in or outside California, including for the commission of crimes that have been dismissed or expunged following a conviction.
- Mandate license revocation for a licensee who is found by the Board to have committed any act of sexual misconduct or sexual exploitation with a current or former patient or client.
- Prevent someone from seeking reinstatement if their license was revoked (or surrendered by the licensee while a Board accusation was pending against them) due to any act of sexual misconduct or exploitation with a current or former patient or client.
- Prevent someone from seeking reinstatement if their license was revoked because they were convicted of a crime that required them to register as a sex offender, regardless of their relationship to the victim. Establishes a similar requirement for sexual criminal offenses that occurred outside California.

The *OMBC's* letter reiterates the *MBC's* statements and amendment request.

ARGUMENTS IN OPPOSITION:

There is no opposition on file.

IMPLEMENTATION ISSUES:

1) *Constitutionality*. While California courts have held that licensing requirements do not violate constitutional rights unless they are clearly arbitrary,[2] the Sacramento Superior Court has previously ruled that the retroactive mechanism utilized under this bill is structurally unconstitutional under the separation of state legislative, executive, and judicial powers required by article III, section 3 of the California Constitution.[3] In that petition for a writ of

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[2] As long as a licensee is afforded basic procedural due process protections, such as notice and hearing, the California Supreme Court has held that the regulation of licensed professions is inherently constitutional—the licensee has no specific right to practice that outweighs the Legislature's power to protect the public health, safety, and welfare. *Hughes v. Board of Architectural Examiners*, 17 Cal.4th 763, 790 (1998). The Legislature may impose any requirement or prohibition that has a "logical connection of licensees' conduct to their fitness or competence to practice the profession or to the qualifications, functions, or duties of the profession in question." *Clare v. State Bd. of Accountancy*, 10 Cal.App.4th 294, 302 (1992). It may even treat similarly situated licensees completely differently "if any set of facts reasonably can be conceived that would sustain [the distinction]." *Griffiths v. Superior Court*, 96 Cal.App.4th 757, 776 (2002).
[3] *John Doe, M.D. v. Division of Medical Quality of the Medical Board of California*, No. 05CS00467 (Sacramento County Superior Court, March 16, 2006).

mandate, the court found that passing a law to revoke the reinstated licenses of physicians who the MBC had determined to be rehabilitated had the effect of reversing the MBC's decisions. "Such retroactive reversal took over [MBC's] quasi-judicial exercise of discretion, an executive function outside the Legislature's essential law-making function, and violated the separation of powers clause."[4]

The bill at issue in that case, AB 1975 (Bermudez), Chapter 756, Statutes of 2004, was a direct attempt to retroactively apply AB 236 (Bermudez), Chapter 348, Statutes of 2003, to licenses previously reinstated. Among other things, AB 236 required the MBC to automatically revoke the license of any licensee required to register as a sex offender except in specified misdemeanor cases.

AB 1975 did not add any new offenses, conditions, or other justification for the revocation. It just required the MBC and OMBC to revoke the license of any physician required to register as a sex offender since January 1, 1947 (the earliest enactment date of the existing sex offender registration statutes at the time), and to declare the intent of the Legislature for the bill to "apply retrospectively [sic] as well as prospectively" (sec. 2).

The final floor analysis for AB 1975 noted:

> When AB 236 went into effect, it was challenged in federal court by one of the affected physicians. The judge in this case had concerns over its ex-post facto effect and that AB 236 was not written in the same way as other pieces of legislation that were retroactive. MBC subsequently decided not to enforce AB 236 retroactively and the lawsuits against MBC were dropped.
>
> According to an analysis of AB 236, it was the author's intent to make the provisions of AB 236 retroactive. The author's office determined that if a "start date" was added to follow-up legislation (i.e., the 1947 date that California's sex offender registration requirement went into effect), the court could consider that as a basis for applying the provisions of AB 236 retroactively.

While the January 1, 1947, date provided a temporal window for the MBC to apply the AB 236 provisions retroactively, it was ultimately irrelevant to the court's analysis on the separation of powers violation.[5] Instead, the court noted that the Legislature created no exception to the revocation requirement for licensees who the MBC "had determined to be rehabilitated and not a danger to the public before the effective date of [AB 1975],"[6] and in doing so specifically disregarded the MBC's 1995 decision to reinstate the license of the licensee who filed the petition, which was "rendered squarely within the exercise of its then

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[4] *Id*. at 16.
[5] "Here, the Legislature was generally acting within its law-making powers when, in 2003 and 2004, it enacted Business and Professions Code section 2232, directing respondent to revoke the license of any physician required to register as a sex offender since January 1, 1947." *Id*. at 15.
[6] *Id*.

existing, legislatively defined discretion to determine necessary and appropriate license discipline for a physician's commission of a sex offense."[7]

Without any new, substantive justifications for revisiting the MBC's final decision, the court found that the Legislature was simply substituting its rationale after the fact, improperly taking the MBC's role in that instance. As a result, the court granted the petition, dismissing the revocation proceeding against the licensee and declaring the law unconstitutional.

This bill mirrors the structure of AB 1975: it creates a temporal window to retroactively apply the revocation requirement created under AB 1636 (Weber), Chapter 453, Statutes of 2022; declares the intent of the Legislature regarding the retroactive application of the provisions of the bill; and creates no new offenses, conditions, or other substantive justifications for revisiting the MBC's decisions.

According to the MBC's most recent analysis of this bill, "As currently drafted, [this bill] affects only one Board licensee."[8] If that licensee were to file a similar petition in the Sacramento Superior Court, there is nothing under this bill that distinguishes it from AB 1975 for purposes of the prior separation of powers analysis.

2) *Renewal of Surrendered and Revoked Licenses*. This bill prohibits any person from petitioning the MBC for reinstatement or renewal of a license revoked under the retroactive provision of this bill. While a license that is surrendered or revoked is not subject to renewal, the author notes that renewal was included because there continues to be concern regarding physicians who have committed improper sexual acts and potential lack of clarity around their ability to renew their licenses. If this bill passes this Committee, the author may wish to continue to work with the MBC and interested stakeholders to address this area of concern.

AMENDMENTS:

To address the constitutionality issue, amend the bill as follows:

On page 4 the bill, strike lines 29-39 and on page 5, strike lines 1-4.

~~(4) (A) Notwithstanding any other law, if a person's certificate was revoked based on a finding by the board that the person committed an act specified in paragraph (1), and the certificate was subsequently reinstated by the board on or after January 1, 2020, the certificate shall be automatically revoked and the person shall not petition the board for reinstatement or renewal of the certificate.~~

~~(B) Upon revocation of the physician's and surgeon's certificate pursuant to this paragraph, the holder of the certificate may request a hearing within 30 days of the revocation. The proceeding shall be conducted in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code).~~

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[7] *Id*. at 16.
[8] Medical Board of California, "Agenda Item 8P," meeting materials, May 21, 2026, 3, https://www.mbc.ca.gov/About/Meetings/Material/31586/brd-AgendaItem8P-20260521.pdf.

~~(C) It is the intent of the Legislature that this paragraph have retroactive application.~~

REGISTERED SUPPORT:

National Women's Defense League

REGISTERED OPPOSITION:

There is no opposition on file.

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

Date of Hearing: June 23, 2026

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
SB 993 (Ochoa Bogh) – As Amended April 8, 2026

SENATE VOTE: 38-0

SUBJECT: Board of Behavioral Sciences: licensees: notices

SUMMARY: Authorizes the name and license or registration information of Board of Behavioral Sciences (BBS or Board) licensees and registrants to be withheld from clients in acute psychiatric hospitals or correctional settings, except as specified.

EXISTING LAW:

1) Establishes the BBS with the Department of Consumer Affairs to license and regulate licensed marriage and family therapists (LMFTs), clinical social workers (LCSWs), professional clinical counselors (LPCCs), and educational psychologists (LEPs), as well as registered associate marriage and family therapists (AMFTs), clinical social workers (ASWs), and professional clinical counselors (APCCs). (Business and Professions Code (BPC) §§ 4990 *et seq.*)

2) Requires a licensee or registrant to provide a client with a notice prior to initiating psychotherapy services, or as soon as practically possible thereafter, informing them that the BBS receives and responds to complaints regarding services provided by licensees or registrants. (BPC §§ 4980.32(a), 4989.17(a), 4996.75(a), and 4999.71(a))

3) Requires the notice above to include the licensee's or registrant's full name as filed with the Board, the license or registration number, the type of license or registration, and the license or registration expiration date. (BPC §§ 4080.32(b), 4989.17(b), 4996.75(b), and 4999.71(b))

4) Requires delivery of the notice above to the client to be documented. (BPC §§ 4080.32(c), 4989.17(c), 4996.75(c), and 4999.71(c))

5) 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 §§ 4980.31, 4989.48, 4996.7, and 4999.70)

THIS BILL:

1) Authorizes, in the following practice settings, an employing entity or agency of a licensee or registrant to exercise discretion whether to include any or all of the information required in the notice based on individual safety concerns if the setting has an established process by which the client may request and obtain sufficient identification to file a complaint with the BBS, that process is disclosed to the client as part of the notice, and copy of the notice is preserved as part of the client's records:

    a) An acute psychiatric hospital, as defined.

b) A correctional treatment center, as defined.

c) Any setting where mental health services are provided to incarcerated individuals under the jurisdiction of a local, state, or federal correctional authority, including, but not limited to, a state prison, county jail, juvenile detention facility, or other correctional setting operated by, or under contract with, a governmental entity.

2) Specifies that if discretion is exercised, the licensee or registrant is responsible for ensuring the process to request and obtain identification information is in place.

FISCAL EFFECT: Pursuant to Senate Rule 28.8, no significant state costs anticipated.

COMMENTS:

Purpose. This bill is sponsored by the *American Federation of State, County and Municipal Employees, AFL-CIO.* According to the author:

> [This bill] will address serious safety concerns facing mental health professionals working in correctional facilities, acute psychiatric hospitals, and other high-risk settings. Under current law, providers are required to share detailed identifying information with clients prior to delivering services. While it's important for transparency and accountability, the fails to protect licensees who are dealt with the realities of working with incarcerated and high-risk populations, where disclosing this information can expose providers and potentially their families to harassment, threats, or harm. [This bill] offers a balanced solution for these mental health providers by limiting identifying information but still ensuring patients have a clear and accessible process to request the information necessary to file a complaint with the appropriate licensing board. This bill will restore longstanding protections for mental health professionals ensuring that both the incarcerated population and providers are working in the safest environment possible.

Background. The BBS is responsible for licensing, examining, and enforcing professional standards for LMFTs, LCSWs, LEPs, and LPCCs. Additionally, the BBS registers AMFTs, ASWs, and APCCs. Associates have completed the educational requirements for licensure and are in the process of obtaining supervised experience. In total, the Board is responsible for regulatory oversight of more than 148,000 licensees and registrants. Each profession has its own scope of practice, entry-level requirements, and professional settings, with some overlap in areas.

California law used to require licensees to conspicuously display their license in their primary place of practice. However, this requirement was not helpful to clients who receive mental health services exclusively via telehealth. Consequently, SB 1024 (Ochoa Bogh), Chapter 160, Statutes of 2024, limited that requirement to apply only when licensees meet with clients in person. To ensure that all clients are provided with the name and license or registration information for their therapist or LEP, the bill also required licensees and registrants to include that information in a notice to clients.

The proponents of this bill report that since that requirement took effect, therapists have been stalked, harassed, and made to feel unsafe after providing services to incarcerated individuals. This bill would allow employers to withhold a therapist's or LEP's name and license or

registration information from a client in an acute psychiatric hospital or correctional facility based on individual safety concerns. However, the facility must have a process by which clients can request sufficient information about a licensee or registrant to file a complaint with the Board. The process must be disclosed to clients in the notice, and a copy of the notice must be included in clients' records.

Prior Related Legislation. SB 1024 (Ochoa Bogh), Chapter 160, Statutes of 2024, as it relates to this bill, required licensees and registrants to provide a mandatory notice to clients, including their full name, license or registration number, the type of license, and the license or registration expiration date, upon initiation of psychotherapy services.

SB 373 (Menjivar) of 2023, as it relates to this bill, would have prohibited the BBS from disclosing a licensee's or registrant's full address online and instead required the Board to disclose the licensee's or registrant's city, state, or zip code. *SB 373 was vetoed.*

AB 630 (Arambula and Low), Chapter 229, Statutes of 2019, required psychotherapy providers who provide services under a BBS license, registration, or exemption to give clients a notice disclosing where complaints against the provider may be filed and made various technical, clarifying, and conforming changes.

ARGUMENTS IN SUPPORT:

As the sponsor of this bill, the *American Federation of State, County and Municipal Employees, AFL-CIO* writes in support:

> Recent changes to law under SB 1024 (Chapter 160, Statutes of 2024) requiring mental health providers to disclose detailed personal identifying information, including full name and license details to patients, were well-intentioned in improving transparency, particularly in telehealth settings. However, in correctional and secure psychiatric environments, these requirements can unintentionally expose therapists to significant risks. Mental health providers working with incarcerated populations often treat individuals with complex behavioral health needs, including those with histories of violence. Requiring routine disclosure of personally identifying information in these settings creates the potential for misuse of that information, placing not only the providers, but also their families, at risk. [This bill] allows employers in correctional and specified psychiatric settings to limit the routine disclosure of identifying information, while still ensuring that patients have a clear and accessible process to obtain the information necessary to file complaints with the appropriate licensing board. This preserves accountability while mitigating unnecessary risk.

ARGUMENTS IN OPPOSITION:

One individual writes in opposition:

> I understand and share the bill's underlying concern: providers working in correctional facilities, acute psychiatric hospitals, and similar high-risk settings face real safety risks, and the legislature is right to take that seriously. However, as currently drafted, the bill's mechanism does not achieve its stated safety purpose and may create accountability gaps

without meaningfully protecting providers. The bill allows employing entities to omit a licensee's name, license number, license type, and expiration date from the required client notice based on individual safety concerns. The problem is that all of this information is already publicly accessible. The BBS maintains a public license lookup database searchable by a provider's first and last name. Additionally, California law requires licensees to maintain a public address of record with the board. This means that if a client receives a notice containing only a provider's name, or learns a provider's name by any other means, they can immediately locate the provider's license details and address through the BBS public database. Withholding license information from the client notice provides no meaningful barrier to someone determined to locate a provider. In short, the bill imposes new administrative burdens, creates a murky accountability structure that places responsibility on individual licensees of institutional processes they do not control, and does not address the actual mechanism by which provider information becomes accessible.

POLICY ISSUES:

Efficacy. While this bill would prevent the name and license or registration information of a therapist or LEP from being proactively provided to clients at psychiatric hospitals or correctional facilities, those clients may request such information to file a complaint with the BBS. With the full name or license or registration number of a therapist or LEP, a client may access any other information about a licensee or registrant that is publicly available on the Board's website, including an address. Therefore, this bill may not provide a wholesale solution to the concerns raised by the author and proponents.

IMPLEMENTATION ISSUES:

Conflicting Responsibility and Liability. First, this bill authorizes the employing entity or agency to exclude a licensee's or registrant's identifying information from the client notice. Because licensees and registrants are ultimately responsible for providing the notice to clients, the author may wish to clarify that a licensee or registrant may exclude identifying information in the required notice if authorized by the employing entity or agency.

Second, this bill makes licensees and registrants responsible for ensuring that a psychiatric hospital or correctional facility has a process in place for clients to request sufficient identifying information to file a complaint with the Board. This requirement is intended to prevent licensees and registrants from withholding identifying information from a notice without confirming that a psychiatric hospital or correctional facility has such a process in place. However, this bill already requires such a process to be identified in the notice whenever identifying information is withheld. Requiring the process to be included in the client notice arguably satisfies the goal of ensuring that a licensee or registrant has confirmed that the psychiatric hospital or correctional facility has a process in place for clients to request the information needed to file a complaint.

REGISTERED SUPPORT:

American Federation of State, County and Municipal Employees, AFL-CIO (Co-sponsor)
American Federation of State, County and Municipal Employees Council 57
California Baptist Capitol Ministry

County Behavioral Health Directors Association

REGISTERED OPPOSITION:

One individual

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

Date of Hearing: June 23, 2026

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
SB 1002 (Niello) – As Amended June 15, 2026

SENATE VOTE: 35-0

SUBJECT: Out-of-state physicians and surgeons: telehealth: license exemption

SUMMARY: Expands existing law, which narrowly allows for out-of-state physicians to provide care via telehealth without a license to California patients who have an immediately life-threatening disease or condition, by allowing for those out-of-state physicians to continue to provide care to those patients in perpetuity after that disease or condition is in remission and no longer immediately life-threatening.

EXISTING LAW:

1) Establishes the Medical Board of California (MBC) within the DCA to license and regulate physicians and surgeons under the Medical Practice Act. (BPC §§ 2000 *et seq.*)

2) Establishes the Osteopathic Medical Board of California (OMBC) within the DCA to license and regulate physicians and surgeons under the Osteopathic Act, who possess the same privileges as licensees regulated by the MBC. (BPC §§ 2450 *et seq.*)

3) Provides that provisions of the Medical Practice Act apply to the OMBC to the extent they are consistent with the Osteopathic Act, unless otherwise provided. (BPC § 2452)

4) Provides that protection of the public shall be the highest priority for the MBC in exercising its licensing, regulatory, and disciplinary functions, and that whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount. (BPC § 2001.1)

5) Entrusts the MBC with responsibility for, among other things, the enforcement of the disciplinary and criminal provisions of the Medical Practice Act; the administration and hearing of disciplinary actions; carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge; suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions; and reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board. (BPC § 2004)

6) Requires the MBC to adopt regulations to require its licensees to provide notice to their clients or patients that the practitioner is licensed in California by the MBC. (BPC § 2026)

7) Requires the MBC to post on its website the current status of its licensees and any prior history of discipline. (BPC § 2027)

8) Provides that it is a criminal offense for any person to practice medicine or advertise themselves as practicing medicine within the scope of the Medical Practice Act without a valid license as a physician and surgeon. (BPC § 2052)

9) Prohibits any person who does not have a valid, unrevoked, and unsuspended certificate as a physician and surgeon from the MBC from using the words "doctor" or "physician" or otherwise implying that they are a physician and surgeon. (BPC § 2054)

10) Requires the MBC to give priority review status to applicants who practice in a medically underserved area or serve a medically underserved population. (BPC § 2092)

11) Authorizes the MBC to take action against all persons guilty of violating the Medical Practice Act. (BPC § 2220)

12) Previously required the Director of DCA to appoint an independent enforcement monitor to monitor the MBC's enforcement efforts, with specific concentration on the handling and processing of complaints and timely application of sanctions or discipline imposed on licensees and persons in order to protect the public. (BPC § 2220.01)

13) Requires the MBC to prioritize its investigative and prosecutorial resources to ensure that physicians representing the greatest threat of harm are identified and disciplined expeditiously, with the following allegations being handled on a priority basis and with the first paragraph receiving the highest priority:

    a) Gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to patients, such that the physician represents a danger to the public.

    b) Drug or alcohol abuse by a physician involving death or serious bodily injury to a patient.

    c) Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances, or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith prior examination of the patient and medical reason therefor.

    d) Repeated acts of clearly excessive recommending of cannabis to patients for medical purposes, or repeated acts of recommending cannabis to patients for medical purposes without a good faith prior examination of the patient and a medical reason for the recommendation.

    e) Sexual misconduct with one or more patients during a course of treatment or an examination.

    f) Practicing medicine while under the influence of drugs or alcohol.

    g) Repeated acts of clearly excessive prescribing, furnishing, or administering psychotropic medications to a minor without a good faith prior examination of the patient and medical reason therefor.

    (BPC § 2220.05)

14) Requires that any complaint determined to involve quality of care, before referral to a field office for further investigation, shall be reviewed by a qualified medical expert and shall include the review of the following:

    a) Relevant patient records.

    b) The statement or explanation of the care and treatment provided by the physician.

    c) Any additional expert testimony or literature provided by the physician.

    d) Any additional facts or information requested by the medical expert reviewers that may assist them in determining whether there was a departure from the standard of care.

    (BPC § 2220.08)

15) Enacts the Patient's Right to Know Act of 2018, which requires specified healing arts licensees, including physicians and surgeons, who are on probation for certain offenses to provide their patients with information about their probation status prior to the patient's first visit. (BPC § 2228.1)

16) Requires the MBC to take action against any licensee who is charged with unprofessional conduct, including, but not limited to, the following:

    a) Violations of the Medical Practice Act.

    b) Gross negligence.

    c) Repeated negligent acts.

    d) Incompetence.

    e) Acts of dishonesty or corruption that are substantially related to the practice of medicine.

    f) Any action or conduct that would have warranted the denial of a certificate.

    g) Failure to attend and participate in an interview by the MBC.

    (BPC § 2234)

17) Provides that the conviction of any offense substantially related to the qualifications, functions, or duties of a physician constitutes unprofessional conduct. (BPC § 2236)

18) Automatically suspends a physician's license during any time that the physician is incarcerated after conviction of a felony. (BPC § 2236.1)

19) Provides that numerous inappropriate activities or violations of the law constitute unprofessional conduct. (BPC §§ 2237 – 2318)

20) Authorizes health care practitioners to provide services via telehealth in compliance with certain standardized requirements and definitions, their professional practice act, and the regulations adopted by their regulatory board pursuant to that practice act. (BPC § 686)

21) Authorizes the MBC to establish a pilot program to expand the practice of telehealth in California. (BPC § 2028.5)

22) Allows for the prescribing, dispensing, or furnishing of dangerous drugs without a synchronous interaction between the patient and the licensee through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care. (BPC § 2242)

23) 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))

24) Provides 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))

25) Enacts the David Hall Act, which allows for an eligible patient with an immediately life-threatening disease or condition, as defined in the Right to Try Act, to consent to receive telehealth care services from a physician and surgeon who is licensed in another state but not in California whose medical expertise is that of the eligible patient's illness. (BPC § 2052.5)

26) Enacts the Right to Try Act, which provides that an investigational drug, biological product, or device that is not yet approved by the United States Food and Drug Administration (FDA) available to patients with a serious or immediately life-threatening disease, when that patient has considered all other treatment options currently approved by the FDA, has been unable to participate in a relevant clinical trial, and for whom the investigational drug has been recommended by the patient's primary physician and a consulting physician. (Health and Safety Code §§ 111548 *et seq.*)

THIS BILL:

1) Expands the definition of "eligible patient" for purposes of the David Hall Act to allow a patient who previously had an immediately life-threatening disease or condition but who is now in remission to continue to receive care for that condition with the previously established eligible out-of-state physician and surgeon.

2) Allows for patients who are able to participate in the clinical trial nearest to their home for their immediately life-threatening disease or condition to receive care via telehealth from a previously established eligible out-of-state physician and surgeon if their immediately life-threatening disease or condition is in remission.

FISCAL EFFECT: Pursuant to Senate Rule 28.8, negligible state costs.

COMMENTS:

Purpose. This bill is sponsored by the *California Senior Legislature*. According to the author:

> SB 1002 ensures that some of California's most vulnerable patients, individuals who once faced an immediately life threatening diagnosis, do not lose access to the out of state physicians who were essential to their survival and long term remission. These patients sought specialized care beyond California's borders when time was critical, and through that process established a successful, trusted patient provider relationship that resulted in their improved prognosis. For these survivors, continuity of care is central to maintaining their health. Yet under current law they would no longer have the option for telehealth with that out-of-state provider. By allowing that continued access and removing travel related barriers to care, this bill ensures that these survivors can maintain their health through continued telehealth follow-up care.

Background.

Regulation of Physicians and Surgeons. Physicians and surgeons in California are regulated by one of two entities: the MBC or the OMBC. The MBC licenses and regulates about 153,000 physicians under the Medical Practice Act. The OMBC licenses and regulates slightly over 12,000 under the Osteopathic Act. Generally speaking, most provisions governing discipline for unprofessional conduct by the MBC also apply to the OMBC.

The majority of the MBC's staff and resources are dedicated to its enforcement program. The MBC receives approximately 10,000 complaints per year. Statute requires the MBC to prioritize the investigation of certain complaints, including sexual misconduct with a patient.

All physicians and surgeons who practice in California are required to hold an active license from either the MBC or the OMBC. Any person who practices or attempts to practice, or who advertises or holds themselves out as practicing, any system or mode of treating the sick or afflicted in California, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without a valid, unrevoked, or unsuspended certificate as a physician and surgeon in California or without being otherwise authorized to perform the act, is guilty of a crime. There are only a limited number of exceptions to this general prohibition against the unlicensed practice of medicine.

Telehealth. California first formally recognized telehealth in 1996 when the Legislature enacted SB 1665 (Thompson), the Telemedicine Development Act. This bill set standards for the use of what was then called "telemedicine" by health care practitioners and insurers. The bill prohibited insurers from requiring face-to-face contact between a health care practitioner and patient for services appropriately provided through telemedicine. The bill also exempted out-of-state practitioners from the Medical Practice Act when consulting either within California or across state lines, with a licensed practitioner in California; however, it prohibited the out-of-state practitioner from having ultimate authority over the care or primary diagnosis of a patient in California.

Much of the Telemedicine Development Act was repealed and replaced in 2011 through AB 415 (Logue), which established the Telehealth Advancement Act to facilitate the advancement of telehealth as a service delivery mode in managed care and the Medi-Cal Program. The following year, AB 1733 (Logue), the Telehealth Advancement Act, expanded the use of telehealth while expressly requiring a health care practitioner who provides services via telehealth to comply with the revised requirements of the Telehealth Advancement Act, as well as any additional requirements contained in the practice act relating to the practitioner's licensed profession and any regulations adopted by the practitioner's licensing board pursuant to that practice act. The bill also updated a number of statutes to replace the term "telemedicine" with "telehealth."

The vernacular shift from "telemedicine" to "telehealth" reflects a general consensus among policymakers that telehealth is not itself a form of medicine, but simply a tool to deliver health care outside a traditional office visit. In California there is no distinction between in-person care and telehealth in terms of either the standard of care or the expectations of a physician-patient relationship. Legally speaking, a physician or other practitioner is deemed to have provided care in whichever geographic place the patient is in at the time of receiving care. For example, if a physician in Illinois is giving medical advice to a patient in California through a telehealth platform, the state considers the physician to be practicing medicine in California. As such, that physician would need a license from the MBC or the OMBC to lawfully provide that care, regardless of whether they are physically within the borders of the state.

Under the Medical Practice Act, a patient wishing to receive care from a physician outside California typically has the following options. First, the patient can physically travel to a state where that physician is licensed. Next, pursuant to the Telemedicine Development Act, a patient's physician who is licensed in California can consult with an out-of-state physician via telehealth, as long as the California-licensed physician is ultimately responsible for the care. Finally, the out-of-state physician can apply for and obtain a license in California from the MBC.

Patients with Terminal Diseases. In 2016, the Legislature enacted the Right to Try Act, which authorized the manufacturer of an investigational drug, biological product, or device not yet approved by the FDA to make that investigational drug available to a patient with a serious or immediately life-threatening disease. The patient must have considered all other treatment options currently approved by the FDA and been unable to participate in a relevant clinical trial. The investigational drug must also have been recommended by the patient's primary physician and a consulting physician. Notwithstanding the provisions of the Right to Try Act, terminally ill patients were still limited by the Medical Practice Act's requirement that a physician and surgeon located outside California must be licensed by the MBC or OMBC to deliver care to California patients via telehealth.

David Hall Act. In 2023, the Legislature passed AB 1369 (Bauer-Kahan), formally referred to as the David Hall Act. The author of that bill contended that the existing options for receiving care from an out-of-state physician were insufficient for patients who have a disease or condition that is immediately life-threatening when a physician outside California is the only person qualified to give specialty care to a patient with a rare, terminal disease. For these patients, it is arguably impractical, if not impossible, for them to travel to another state, and there is not sufficient time for the out-of-state license to go through the California licensing process.

AB 1369 allowed patients to consent to receive care via telehealth directly from an out-of-state physician who is not licensed in California only under specified circumstances where the patient has not been accepted to participate in the clinical trial nearest to their home, or, in the medical judgment of their primary physician, it is unreasonable for the patient to participate in that clinical trial due to the patient's current condition and stage of disease. Under the David Hall Act, the eligible patient's disease or condition must be immediately life-threatening, as defined in the Right to Try Act, and the out-of-state physician must possess a license in good standing from another state and have medical expertise in the eligible patient's illness. While the criteria for eligibility under the David Hall Act is substantially limiting, the author contended that it would effectively enable patients with rare, terminal diseases to receive urgent specialized care.

This bill would expand the David Hall Act by allowing an out-of-state physician to continue to practice medicine in California via telehealth without a California license when their patient previously met the eligibility criteria of having an immediately life-threatening disease or condition but is now in remission. A patient in remission would also be eligible to continue receiving care from their out-of-state physician even if they are able to participate in the clinical trial nearest to their home for their immediately life-threatening disease or condition. While the patient's condition would no longer be urgent or life-threatening, there is no requirement that the care ever transition to compliance with the Medical Practice Act, regardless of how long the patient continues to receive care for that condition.

Prior Related Legislation. SB 508 (Valladares) of 2025 was substantially similar to this bill. *This bill was amended to deal with an unrelated topic after a hearing in this committee was canceled at the request of the author.*

AB 1369 (Bauer-Kahan), Chapter 837, Statutes of 2023 authorized an eligible out-of-state physician and surgeon to practice medicine in California without a California license if the practice is limited to delivering health care via telehealth to an eligible patient who has an immediately life-threatening disease or condition.

AB 1668 (Calderon), Chapter 684, Statutes of 2016 enacted the Right to Try Act.

AB 415 (Logue), Chapter 547, Statutes of 2011 enacted the Telehealth Advancement Act.

SB 1665 (Thompson), Chapter 864, Statutes of 1996 enacted the Telemedicine Development Act.

ARGUMENTS IN SUPPORT:

The *California Senior Legislature* (CSL) is the sponsor of this bill. The CSL writes in support: "Current law appropriately permits certain out-of-state physicians to provide telehealth services to patients with life-threatening conditions. However, once a condition moves into remission, older adults may face unnecessary barriers to maintaining continuity of care. Disrupting an established physician-patient relationship at this critical stage can create medical risk, emotional stress, and avoidable health system costs." The CSL further writes: "SB 1002 is a modest but meaningful step toward ensuring that older adults can maintain trusted medical relationships without unnecessary disruption."

AARP California writes in support of this bill: "Under current law, once a patient's condition enters remission, their eligibility for this out-of-state telehealth pathway ends—even if they still need ongoing monitoring, medication management, and follow-up with the same specialist who treated their condition. This has meant that patients have been faced with a choice between traveling out of state for continuing care or severing a trusted provider relationship. For many Californians, especially older adults, and those on fixed incomes, this is not a real choice." AARP California further writes: "SB 1002 extends AB 1369 to patients now in remission, and removes the requirement that these patients must have been denied participation in a clinical trial. It ensures that patients who developed a relationship with an out-of-state provider under AB 1369 can meet via telehealth with the provider who may have played a significant role in their recovery."

ARGUMENTS IN OPPOSITION:

The *Medical Board of California* (MBC) opposes this bill, writing: "Any eligible physician may obtain a license from the Board and be authorized to treat patients in this state via telehealth. Also, current law authorizes an out-of-state physician to consult with a Board-licensed physician provided they do not have ultimate authority over the care or primary diagnosis of a patient located in California." The MBC further writes: "Licensure is a vital form of consumer protection and ensures that physicians practicing in California have met the relevant statutory requirements to treat patients in this state. Without the requirement for licensure, the Board would be unaware of those who are treating patients in this state and would be unable to take disciplinary action against a physician who fails to treat their California patients within the standard of care."

The *California Medical Association* writes in opposition to this bill: "This bill dangerously expands upon a narrow exception intended for people with life threatening diseases who have not been accepted into a clinical trial in their home state by allowing physicians and surgeons not licensed in California to practice medicine in California. One of the primary responsibilities of The Medical Board of California is to protect health care consumers by ensuring that physicians and surgeons are appropriately regulated to maintain high medical care standards. To qualify for a California Physician and Surgeon License from the MBC, applicants must meet several critical requirements: medical education, postgraduate training, and examinations. In addition, the MBC has a process for screening out-of-state physicians who wish to obtain a Temporary License."

POLICY ISSUES:

Lack of Oversight and Patient Safety Concerns. When AB 1369 was originally considered by this Committee, the analysis included the following policy issue for consideration:

> While the author's argument for this bill is cogent, there remain unresolved questions as to what administrative recourse would be available to a patient if an out-of-state physician violates the standard of care in the provision of services to that patient via telehealth. Because under the terms of the bill, the MBC would have no authority over the physician, there would likely be no ability for the board to take disciplinary action or other measures to protect the public. At the same time, it is unclear whether the regulatory board within the state where the physician is licensed would have jurisdiction if the care is deemed to not have occurred within that state.

When a physician provides health care services to a patient via telehealth, the care is deemed to take place in the jurisdiction where the patient is when they receive those services. Correspondingly, in that scenario, the Medical Practice Act and other California laws to protect patients and ensure quality of care apply, and the out-of-state physician is subject to oversight and enforcement by the MBC in California, not by a regulatory board in their home state. This is why an out-of-state physician who provides care via telehealth to a California patient must typically obtain a license from the MBC. Alternatively, the patient may travel to the state where the physician is licensed, or another physician who is licensed in California may consult with the out-of-state physician while remaining ultimately responsible for the patient's care.

Under the David Hall Act, an out-of-state physician can provide care to a California patient without a license from the MBC, meaning that there is conceivably no state agency with jurisdiction over that care. While the out-of-state physician is required to possess a license in good standing in another state with no history of prior discipline, there is no process by which either the patient or any California regulator would become aware if the out-of-state physician were to lose their license or be otherwise subjected to discipline. In the instance where the out-of-state physician harms the California patient or engages in unprofessional conduct, there is no administrative remedy available, nor any process in place for the out-of-state physician's home state regulator to become aware of that misconduct even if it had jurisdiction.

Notwithstanding these considerations, AB 1369 was narrowly tailored to a specific population of patients for whom the urgency and importance of receiving care from an out-of-state specialist exceeded the risks of harm associated with the unlicensed practice of medicine. For patients with an immediately life-threatening disease or condition, it is not reasonable to expect them to travel to another state or to wait for the out-of-state physician to become licensed in California. While the patient's California-licensed physician can consult with the out-of-state physician, this option may not be appropriate for the type of highly specialized care required by the patient. Further, in the same spirit that the Right to Try Act was enacted, it is arguably absurd to tell a patient who is imminently at risk of perishing due to their disease or condition that they may not utilize every possible chance of receiving life-saving care because their health and safety might be jeopardized through a lack of bureaucratic oversight. The exception to the state's licensing requirements is justified by both the seriousness and urgency of the patient's condition.

However, none of these circumstances would apply to patients who would qualify under the expanded provisions of this bill. A patient who previously had an immediately life-threatening disease or condition but who is now in remission is not so necessarily unable to travel. Similarly, a disease or condition that is in remission is arguably no longer so urgent as to preclude the out-of-state physician from seeking licensure in California if it is truly necessary that the patient continue to be directly under their care.

Additionally, this bill does not place any limitation on how long a patient in remission may remain eligible under the David Hall Act, meaning a patient who previously had an immediately life-threatening disease or condition in childhood could continue to receive care from an unlicensed physician for decades without any state licensing board ever having oversight over the scope of that care. Rather than maintaining a narrow exception to the Medical Practice Act for an inherently time-limit period of crisis for a patient whose critical condition has manifested undeniable exigency, this bill would remove basic regulatory safeguards for patients indefinitely.

This proposal is particularly worrisome in light of the substantial probability that many of the patients who are likely to qualify under this bill are elderly or impaired by illness, rendering them particularly susceptible to harm by bad actors.

Providing for continuity of care is certainly a meritorious goal. However, it is not a policy priority that overwhelms the significant public protection imperatives implicated in professional licensure. The author should consider other policies to increase access to care for seniors and other vulnerable patient populations that do not perilously expand intentionally narrow exceptions to licensure under current law.

REGISTERED SUPPORT:

California Senior Legislature *(Sponsor)*
60 Plus Association
AARP California
ALS Association
American Association of Senior Citizens
American Cancer Society Cancer Action Network
Association for Frontotemporal Degeneration
ATA Action
Barry Goldwater Institute for Public Policy Research
California Academy of Family Physicians
California Association for Nurse Practitioners
California Health Coalition Advocacy
Community Oncology Alliance
Everylife Foundation for Rare Diseases
Family Caregiver Alliance
Institute for Justice
National Vehicle Residency Coalition
Pacific Legal Foundation
R Street Institute
U.S. Pain Foundation

REGISTERED OPPOSITION:

Association of Northern California Oncologists
California Medical Association
Medical Board of California
Medical Oncology Association of Southern California
Osteopathic Medical Board of California

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

Date of Hearing: June 23, 2026

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
SB 1094 (Weber Pierson) – As Amended April 8, 2026

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

SENATE VOTE: 38-0

SUBJECT: Prescription drugs

SUMMARY: Expands the authority for a pharmacist to substitute a biosimilar for a prescribed biological product and authorizes health plans and insurers to require their enrollees to try an AB-rated generic equivalent, biosimilar, or interchangeable biological product of a reference product that was previously approved for coverage by the plan under specified conditions.

EXISTING LAW:

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

2) Establishes the California State Board of Pharmacy (BOP) within the Department of Consumer Affairs to administer and enforce the Pharmacy Law. (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) Authorizes the BOP to adopt rules and regulations as may be necessary for the protection of the public. (BPC § 4005)

5) Defines "pharmacist" as a natural person to whom a license has been issued by the BOP which is required for any person to manufacture, compound, furnish, sell, or dispense a dangerous drug or dangerous device, or to dispense or compound a prescription; allows a pharmacist to authorize the initiation of a prescription consistent with the accepted standard of care. (BPC § 4036; § 4051)

6) Declares pharmacist practice to be a dynamic, patient-oriented health service that applies a scientific body of knowledge to improve and promote patient health by means of patient-care activities to optimize appropriate drug use, drug-related therapy, disease management and prevention, and communication for clinical and consultative purposes and that pharmacist practice is continually evolving to include more sophisticated and comprehensive patient care activities. (BPC § 4050)

7) Authorizes a pharmacist to perform specified functions and provide specified services as part of their scope of practice, including furnishing certain medications, performing certain procedures, administering drugs and biological products, ordering and interpreting tests, and providing consultation, training, and education to patients. (BPC § 4052)

8) Authorizes a pharmacist filling a prescription order for a drug product may select a different form of medication with the same active chemical ingredients of equivalent strength and duration of therapy as the prescribed drug product when the change will improve the ability of the patient to comply with the prescribed drug therapy. (BPC § 4052.5)

9) Prohibits the furnishing of any dangerous drug or device, except upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor. (BPC § 4059)

10) Authorizes a pharmacist to refill a prescription for a dangerous drug or dangerous device without the prescriber's authorization if the prescriber is unavailable to authorize the refill and if, in the pharmacist's professional judgment, failure to refill the prescription might interrupt the patient's ongoing care and have a significant adverse effect on the patient's well-being, subject to additional requirements. (BPC § 4064)

11) Authorizes a pharmacist filling a prescription order for a drug product prescribed by its trade or brand name to select another drug product with the same active chemical ingredients of the same strength, quantity, and dosage form, and of the same generic drug name as determined by the United States Adopted Names (USAN) and accepted by the federal Food and Drug Administration (FDA), of those drug products having the same active chemical ingredients. (BPC § 4073)

12) Authorizes a pharmacist filling a prescription order for a prescribed biological product may select an alternative biological product only if all of the following:

    a) The alternative biological product is interchangeable.

    b) The prescriber does not personally indicate "Do not substitute," or words of similar meaning.

    (BPC § 4073.5(a))

13) Requires a pharmacist who is substituting an interchangeable biosimilar for a prescribed biological product to make an entry of the product provided to the patient, including the name of the biological product and the manufacturer, within five days. (BPC § 4073.5(b))

14) Prohibits a pharmacist from substituting an interchangeable biosimilar for a prescribed biological product if the prescriber personally indicates, either orally or in his or her own handwriting, "Do not substitute," or words of similar meaning. (BPC § 4073.5(e))

15) Provides that selection of an interchangeable biosimilar is within the discretion of the pharmacist and that the pharmacist shall assume the same responsibility for substituting the biological product as would be incurred in filling a prescription for a biological product prescribed by name. (BPC § 4073.5(f))

16) Defines "interchangeable" as a biological product that the FDA has determined meets certain standards, or has been deemed therapeutically equivalent by the FDA as set forth in the latest addition or supplement of the Approved Drug Products with Therapeutic Equivalence Evaluations. (BPC § 4073.5(j))

THIS BILL:

1) Authorizes a pharmacist filling a prescription order for a prescribed biological product to select an alternative biological product that is biosimilar to the prescribed reference product that has not determined to be interchangeable by the FDA.

2) Defines "biosimilar" and "reference product" as having the same meaning as those terms are used in federal law.

3) Updates the requirement that the BOP post a link on its website to the current list of biological products determined by the FDA to be interchangeable to require a link to the FDA's Purple Book Database of Licensed Biological Products.

4) Amends provisions of law that prohibit a health care service plan contract or health insurance policy from limiting or excluding coverage for an enrollee's or insured's previously covered drug to allow for a provider to prescribe another drug covered by a plan or insurer that is medically appropriate for the enrollee or insured and allows for generic or biosimilar drug substitutions.

5) Authorizes a health care service plan or insurer to require an enrollee or insured to try an AB-rated generic equivalent of a brand name drug, a biosimilar, or interchangeable biological product of a reference product that was previously approved for coverage by the plan if all of the following conditions are met:

   a) The prescriber has not personally indicated "Do not substitute," or words of similar meaning.

   b) The net cost to the plan or insurer of the substitute is lower than the brand name or reference product.

   c) An enrollee's or insured's cost sharing is based on the net cost of the drug or biological product.

   d) An enrollee's or insured's cost sharing is the same or less than the cost sharing of the brand name drug or reference product.

   e) The plan or insurer provides at least 30 days' advance notice to the enrollee or insured and prescribing provider of a substitution requirement prior to requiring an enrollee or insured to try a substitute.

6) Provides that an enrollee or insured who is required to try a substitute or the enrollee's prescribing provider may request an exception.

7) Requires a plan or insurer to provide the Department of Managed Health Care with information related to the proportion of prescription substitutions that resulted in reduced cost sharing as well as information about the factors affecting when an enrollee's or insured's cost sharing is not reduced and the impact of substitutions resulting from that authority on premiums.

FISCAL EFFECT: Pursuant to Senate Rule 28.8, negligible state costs.

COMMENTS:

Purpose. This bill is sponsored by the *California Association of Health Plans*. According to the author:

> A majority of Californians report health care costs rising faster than their income, causing many to delay or avoid care. One driver of rising health insurance premiums is prescription drug spending, which has increased 72% since 2017. Biological products are particularly expensive: though only 5% of prescriptions, they account for about half of all drug spending. Expanding the use of lower-cost alternatives, like generics and biosimilars, could help reduce pharmaceutical spending and lower insurance premiums. Despite no clinically meaningful differences in safety, purity, or potency, biosimilars are often significantly cheaper than their reference biologic. Furthermore, competition between biosimilars and brand-name biologics helps drive prices down overall. Despite their potential savings, biosimilars remain underused. This bill encourages the use of lower cost biosimilars when available by: (1) allowing pharmacists to substitute a reference biologic with a biosimilar unless the prescribing provider indicates otherwise; and (2) allowing health plans to require patients currently using brand-name products to try therapeutically equivalent generics or biosimilars when those alternatives are available at the same or lower cost and the prescriber has not indicated otherwise. As Californians face a health care affordability crisis, addressing underlying cost drivers such as the high price of prescription drugs is an important step toward reducing overall health care costs.

Background.

California State Board of Pharmacy. The BOP is the regulatory body responsible for overseeing pharmacies and pharmacist practice in California. As of 2025, the BOP is estimated to regulate over 50,700 pharmacists, 1,300 advanced practice pharmacists, 4,400 intern pharmacists, and 65,700 pharmacy technicians across 32 distinct licensing programs. In addition to regulating professionals, the BOP licenses and oversees pharmacies, clinics, wholesalers, third-party logistic providers, and automated drug delivery systems.

As one of approximately three dozen boards and bureaus under the Department of Consumer Affairs, the BOP plays an important role in the regulatory ecosystem that oversees the healing arts. In the face of persistent concerns such as the opioid crisis, the BOP is empowered to ensure that dangerous drugs and controlled substances are dispensed and furnished only under lawful circumstances. Under regulations enforced by the BOP, pharmacists are tasked with a corresponding responsibility for ensuring that the prescriptions they fill are legitimate and not for purposes of abuse.

Entrusted with administering and enforcing the state's Pharmacy Law, statute provides that "protection of the public shall be the highest priority for the California State Board of Pharmacy 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."

Pharmacist Scope of Practice. California has long faced significant gaps and inequities in its health care workforce. There has historically been a persistent shortage of accessible health care providers overall, which disproportionately impacts communities with concentrated populations of immigrant families and people of color. A recent study found that between 2010 and 2019, the number of primary care physicians in proportion to population remained largely unchanged nationally. Meanwhile, counties with a higher proportion of minorities saw a decline during that period.[1]

In response to these challenges, policymakers have repeatedly turned to pharmacists to help fill the provider gap in parts of the state where primary care providers can be inaccessible but local pharmacies are more readily available. Data cited by the BOP indicates that while 20 percent of Californians live in areas designated as primary care health professional shortage areas, only 6 percent of Californians live in areas designated as pharmacy deserts. Exercising their training and judgment, pharmacists are often relied upon to administer vaccines, furnish time-sensitive medication, and ensure that there is no delay in care. In 2013, the Legislature enacted SB 493 (Hernandez), which established an advanced practice pharmacist license and expanded the scope of practice for pharmacists to include additional acts, including independently furnishing specified nicotine replacement products, prescription medications for travel, and hormonal contraceptives.

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

The BOP further recommended revisions to certain provisions detailing a pharmacist's authorized scope of practice for specified clinical patient care services and transition to a standard of care model for specified patient care services, where sufficient safeguards are in place to ensure pharmacists retain autonomy to utilize professional judgment in making patient care decisions. Under those conditions, the BOP argued that transitioning to greater use of a standard of care model in the provision of specified patient care services could benefit patients by providing expanded and timely access to patient care. The BOP's Licensing Committee developed a legislative proposal to transition many provisions of pharmacist practice to a standard of care model in lieu of the existing prescriptive model.

Much of the BOP's proposed language was ultimately enacted through AB 1503 (Berman), the BOP's sunset bill, in 2025. The bill defined "accepted standard of care" for purposes of the Pharmacy Law. Consistent with that standard, current law now provides pharmacists with broader authority to engage in activities and services that they believe are in the best interest of a patient, including furnishing specified medications without a prescription, ordering and interpreting laboratory tests, and initiating and administering immunizations.

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[1] Liu M, Wadhera RK. *Primary Care Physician Supply by County-Level Characteristics*, 2010-2019.

Biologics and Biosimilars. Biological products, often referred to as biologics, are therapeutic medications derived from living organisms or their components, such as proteins, cells, tissues, or microorganisms. While traditional small molecule drugs are synthesized through chemical processes, biologics are produced using complex biological systems and are often used to treat chronic, serious, or life-threatening conditions such as cancer, rheumatoid arthritis, inflammatory bowel disease, diabetes, and multiple sclerosis. Common examples include monoclonal antibodies such as Humira (adalimumab), Keytruda (pembrolizumab), and insulin products. Because biologics are manufactured from living sources, they are generally more complex and difficult to reproduce than conventional pharmaceuticals. The FDA defines biologics as products made from natural and living sources and notes that their complexity often requires specialized manufacturing and regulatory oversight.[2]

A biosimilar is a biologic product that is highly similar to an original FDA-approved biologic, referred to as the reference product. According to the FDA, "it is both normal and expected for both biosimilars and original biologics to have minor differences between batches of the same medication. This means that biologics cannot be copied exactly, and that is why biosimilars are not identical to their original biologic." The FDA further explains that "biosimilars must have no clinically meaningful differences from their original biologic, and as a result, "biosimilars provide the same treatment benefits and have the same risks as the original biologic." The FDA states that biosimilars are just as safe and effective as their reference product.[3]

While all biosimilars are rigorously and thoroughly evaluated by the FDA to confirm that they are as safe and effective as their original biologic, some biosimilars may go through an additional process to be designated by the FDA as "interchangeable." The Biologics Price Competition and Innovation Act, enacted in 2010 as part of the Patient Protection and Affordable Care Act, authorizes the FDA to designate certain biosimilars as "interchangeable" if they meet additional statutory requirements demonstrating that it can be expected to produce the same clinical result as the reference product in any given patient and, when administered more than once, that switching between the biosimilar and reference product does not create additional risk. A company must specifically request that the FDA approve its biosimilar as interchangeable; the FDA states that in some cases, companies do not make this request for various business reasons.[4]

Pharmacist Substitution of Biologics. The Biologics Price Competition and Innovation Act included language stating that the interchangeability designation for biosimilars was intended to mean "that the biological product may be substituted for the reference product without the intervention of the health care provider who prescribed the reference product." Legislation has since been enacted in all 50 states to allow for this manner of substitution. In 2013, AB 1139 (Lowenthal) and SB 598 (Hill) were introduced to authorize California pharmacists to substitute an interchangeable biosimilar when filling a prescription for a prescribed biologic; while SB 598 was passed by the Legislature, it was vetoed by Governor Jerry Brown.

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[2] "Biosimilars Basics for Patients." *U.S. Food and Drug Administration*, https://www.fda.gov/drugs/biosimilars/biosimilars-basics-patients
[3] "Biosimilar and Interchangeable Biologics: More Treatment Choices." *U.S. Food and Drug Administration*, https://www.fda.gov/consumers/consumer-updates/biosimilar-and-interchangeable-biologics-more-treatment-choices
[4] "9 Things to Know About Biosimilars and Interchangeable Biosimilars." *U.S. Food and Drug Administration*, https://www.fda.gov/drugs/things-know-about/9-things-know-about-biosimilars-and-interchangeable-biosimilars

Governor Brown's veto message declared his support for amending the Pharmacy Law to allow interchangeable biosimilars to be substituted for biologic drugs, once these interchangeable drugs are approved by the FDA. However, the Governor appeared hesitant to support language in the bill requiring pharmacists to notify prescribers when a biosimilar has been substituting, noting that "this requirement, which on its face looks reasonable, is for some reason highly controversial" and that while doctors supported the notification requirement, "CalPERS and other large purchasers warn that the requirement itself would cast doubt on the safety and desirability of more cost-effective alternatives to biologics." Governor Brown further argued that physician notification was premature given that the FDA had not yet established its standards for biosimilars to be designated as interchangeable.

In 2015, SB 671 (Hill) was introduced to authorize a pharmacist to substitute an interchangeable biosimilar when filling a prescription for a prescribed biologic. The bill expressly prohibited substitution when the prescriber indicated "do not substitute" or words to that effect on the prescription, and required information regarding the substitution to be entered into an electronic records system product within five days. The bill also required the BOP to maintain a link on its website to the list of interchangeable biological products recognized by the FDA.

SB 671 was supported by pharmaceutical manufacturers and medical specialists for its notification requirements and limited authority for substitution. However, the bill was opposed by health plans, insurers, and pharmacy benefit managers, who argued that the bill "creates doubt about the safety of biosimilar drugs by placing notification requirements on drugs that have been available in international markets for over a decade." The opposition believed that restricting the authority to substitute biosimilars and placing new administrative burdens on pharmacists would impede cost savings, discourage substitution, and cause patients to question the effectiveness and safety of biosimilars. Despite this opposition, SB 671 was signed into law.

The market for biologics and biosimilars has grown substantially in the years following the enactment of SB 671 in 2015, at which time one biosimilar had been approved by the FDA. In March 2024, the FDA announced that it had approved 50 biosimilars for 15 different biologics.[5] Two years later, that number has grown to over 80 biosimilars approved by the FDA for use in the United States. The FDA has publicly supported efforts to increase the development and use of biosimilars as a way to reduce treatment costs and promote competition, citing statistics that biologics represent five percent of prescriptions but 51 percent of drug spending.[6]

The FDA has issued new draft guidance intended to streamline the approval process for biosimilars. Additionally, public statements issued by the FDA have minimized the distinction between interchangeable biosimilars and biosimilars without that designation. The director of the FDA's Office of Therapeutic Biologics and Biosimilars has stated: "Both biosimilars and interchangeable biosimilars meet the same high standard of biosimilarity for FDA approval and both are as safe and effective as the reference product."[7]

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[5] Woodcock, Janet, and Sarah Yim. "A Milestone in Facilitating Development of Safe and Effective Biosimilars." *FDA Voices*, *U.S. Food and Drug Administration*, July 2023.
[6] "FDA Proposes to Ease Testing Rules to Speed Up Biosimilar Drug Development." *Reuters*, March 2026.
[7] "FDA Updates Guidance on Interchangeability." *U.S. Food and Drug Administration*, https://www.fda.gov/drugs/drug-alerts-and-statements/fda-updates-guidance-interchangeability

When the BOP submitted its proposed language to establish a standard of care practice model for pharmacists as part of its sunset review in 2025, it included language to expand the authority of a pharmacist to "perform therapeutic interchanges." Earlier iterations of AB 1503 would have repealed the biosimilar substitution provisions of the Pharmacy Law enacted through SB 671 and instead more broadly authorized interchanges including, but not limited to, "use of biosimilars, different dosage forms, drugs within the same drug classification, and generic substitutions intended to optimize patient care." The bill would have required patient consent and would have prohibited a pharmacist from performing a therapeutic interchange when the prescriber had indicated "do not substitute" on the prescription or when medical literature does not support the change.

The therapeutic interchange language in AB 1503 was opposed by organizations representing physicians and pharmaceutical manufacturers. Letters of opposition specifically opposed the expansion of biosimilar substitutions and the repeal of the language enacted through SB 671, arguing that "it would be a grave mistake to replace those carefully vetted and negotiated provisions with the broad language currently contained in AB 1503." The language authorizing pharmacists to perform therapeutic interchange was subsequently removed from the BOP's sunset bill in the Senate.

This bill would similarly expand the authority of a pharmacist to select an alternative biological product when filling a prescription for a prescribed biologic by removing the requirement that the biologic being substituted be designated as interchangeable by the FDA. The bill would not repeal or substantially amend the language enacted through SB 671, including provisions providing for prescriber notification. The bill would additionally update the requirement that the BOP post a link on its website to the FDA's list of approved interchangeable biosimilars to require a link to be posted to the FDA's Purple Book Database of Licensed Biological Products.

Health Plans and Insurers. In addition to the section of this bill amending the Pharmacy Law, this bill would amend the Knox-Keene Health Care Service Plan Act of 1975 and provisions of the Insurance Code related to health insurers. Existing law prohibits a health plan or insurer from limiting or excluding coverage for a previously approved drug. This bill would authorize health plans and insurers to require an enrollee or insured to try an AB-rated generic equivalent of a brand name drug, a biosimilar, or interchangeable biological product of a reference product that was previously approved for coverage by the plan.

Certain conditions must be met for a health plan or insurer to require substitution of a drug; for example, the prescriber would retain the express authority to indicate "do not substitute" on the prescription. The bill would also require that the net cost to the plan or insurer of the substitute be lower than the brand name or reference product and would specify cost sharing. A health plan or insurer would additionally be required to provide at least 30 days' advance notice to the enrollee or insured and prescribing provider of a substitution requirement prior to requiring an enrollee or insured to try a substitute. Finally, this bill would require health plans and insurers to submit information relating to the proportion of prescription substitutions resulting from the bill that resulted in reduced cost sharing as well as information about the factors affecting when an enrollee's cost sharing is not reduced, along with information regarding the impact on premiums.

Provisions in this bill relating to health plans and insurers are within the jurisdiction of the Committee on Health, which would be re-referred the bill upon passage by this Committee.

Prior Related Legislation. AB 1503 (Berman), Chapter 196, Statutes of 2025 extended the sunset date for the BOP and made additional changes to the Pharmacy Law.

SB 671 (Hill), Chapter 545, Statutes of 2015 authorized a pharmacist to substitute an alternative biological product when filling a prescription for a prescribed biological product if the biosimilar has been designated as interchangeable with the reference product by the FDA.

SB 598 (Hill) of 2023 would have authorized a pharmacist to substitute an FDA-approved interchangeable biosimilar for a prescribed biologic. *This bill was vetoed by the Governor.*

AB 1139 (Lowenthal) of 2013 would have authorized a pharmacist to substitute an FDA-approved interchangeable biosimilar for a prescribed biologic. *This bill did not receive a hearing in this committee.*

ARGUMENTS IN SUPPORT:

The *California Association of Health Plans* (CAHP) is the sponsor of this bill. CAHP writes:

> SB 1094 will remove existing barriers by allowing health plans and pharmacies to substitute lower-cost biosimilars for high-cost brand-name biologics, regardless of the 'interchangeable' designation. Furthermore, the bill ensures transparency by requiring health plans to provide data to the DMHC demonstrating the resulting consumer affordability benefits. Without this legislative change, Californians will remain locked into higher-priced brand-name products, even when safe, lower-cost alternatives are available.

Blue Shield of California supports this bill, writing:

> [Senate Bill 1094] will make access to lower cost, equally safe and effective biosimilar medications available to consumers right at the pharmacy, maintaining all existing consumer protections and the sanctity of the doctor-patient relationship. This is necessary because access to these medications is locked behind state law created intentionally to allow only certain types of so-called 'interchangeable' biosimilars to be substituted automatically, functionally creating a niche market without any benefit to consumers. The Food and Drug Administration (FDA) has repeatedly stated that there is no safety distinction between a biosimilar, an interchangeable biosimilar, or the reference (or branded) product – it's a distinction without a difference – except it costs multiple times more than the alternative AND patients have no choice on what they must buy.

Health Access California also supports this bill, writing:

> Prescription drugs are a significant driver of high health care costs for consumers. The Department of Managed Health Care recently reported that prescription drug expenses for large group health plans increased nearly 10 percent from 2024 to 2025. With prescription drug expenses making up nearly 18% of large group health care premiums, ensuring that consumers have access to more affordable prescription drugs is critical to their access to care, and controlling escalating health care premiums.

> That's why ensuring that consumers have access to safe alternatives like biosimilars is important. A biosimilar and its original biologic are made from the same types of sources and have the same treatment benefits and risks. They have no clinically meaningful differences. However, biosimilars can be made available at a lower cost than the original biologics or brand name drug.

ARGUMENTS IN OPPOSITION:

The *California Rheumatology Alliance* opposes this bill, writing:

> For many rheumatology patients, finding an effective biologic requires multiple failures of other treatments. Allowing pharmacists to make a medical decision to substitute biological products without the direct, proactive consent of the treating physician can lead to unintentional switches, increased immunogenicity, and loss of efficacy. SB 1094 would also allow insurers to demand that patients switch to a biosimilar or interchangeable product as a condition of coverage, even if they have been stable on a reference product. This switching ignores individual patient history and mandates that physicians spend valuable time navigating prior authorizations to maintain the treatment plan that works.

The *Biotechnology Innovation Organization* (BIO) opposes this bill unless amended to "allow automatic substitution of non-interchangeable biosimilars only upon the initial dispensing of a prescription, but not for patients on an established course of treatment." BIO further writes:

> It should also be clear that *this bill would not treat biosimilars more like generic drugs*. A common misconception exists that approval of a "traditional" or "small molecule" generic drug automatically means that the generic is substitutable without physician intervention at the pharmacy. That is not the case, and it conflates the standards for approval of a drug with the standard for dispensing it to patients. Even generic drugs are not substitutable by operation of law—FDA makes an assessment of therapeutic equivalence as a part of the approval process for a generic product. In fact, there are many generic drugs that were approved for marketing by the FDA without being substitutable at the pharmacy counter. To treat non-interchangeable biosimilars as interchangeable in California would be a big departure from the way FDA regulates small molecule drugs because, unlike for generic drugs, FDA would not have the flexibility to decide whether any given biosimilar should be substitutable at the pharmacy or not.

Amgen also opposes this bill, writing:

> For complex biologics, a default opt-out standard does not provide the same patient protections as affirmative prescriber involvement. When a prescriber determines that continuity, device familiarity, training, or patient-specific considerations matter, the law should not place the burden on that prescriber to preemptively block automatic substitution across all cases. Patient protection is stronger when substitution without prescriber intervention is limited to products that FDA has designated interchangeable.

POLICY ISSUES:

Disruption of Effective Treatments. As articulated in opposition comments from specialist physicians, patients who use biologic therapies often live with complex conditions that require long-term management and highly individualized treatment approaches, such as Crohn's disease, rheumatoid arthritis, and psoriasis. For these types of conditions, identifying a medication that can effectively and sustainably manage symptoms and slow disease progression can be challenging. Additionally, a biologic that works very well for one patient may not work for another patient with the same diagnosis. For example, two patients with rheumatoid arthritis may both be prescribed a TNF inhibitor such as Humira, but while one patient may experience improvement, the other may need a different biologic that targets another biological pathway.

This bill would authorize a pharmacist to substitute any biosimilar for a prescribed biologic even if the patient has been taking that prescribed biologic for a very long time and even if that biologic was prescribed after an extensive trial-and-adjustment process to identify a successful therapeutic solution for that patient. This could mean that a stable patient on a consistent treatment regimen could abruptly have their biologic switched out for a biosimilar that is less effective, or not effective at all. This interruption in therapy could have both short-term and long-term consequences; in some cases, the originally prescribed biologic may no longer be as effective even once the patient is switched back.

While there are cogent reasons to support allowing pharmacists to select an alternative biologic product for patients that would be more affordable or accessible, this conceivable benefit must be weighed against the potential impact on patients who are managing chronic conditions who could be destabilized by having their medication substituted. The author should consider amendments to ensure that prescribers are notified when a patient who is currently taking a biologic as part of an ongoing treatment regimen is subject to having that biologic substituted for a non-interchangeable biosimilar as a result of the expanded authority provided by this bill. This notification would enable those prescribers to indicate "do not substitute" on the patient's prescription if needed and if they have not already done so.

Potential for Actions against Prescribers. This bill would fully retain the authority of a physician or other prescriber to indicate "do not substitute" on a prescription for a biologic, which ostensibly protects patients who could suffer from a substitution. However, stakeholders have raised concerns that health plans and pharmacy benefit mangers could pressure those physicians through repeated requests for prior authorization, proof of adverse reactions or failure, or submissions of the clinical rationale for decisions, which could burden physicians and delay care. The author should consider amendments to ensure that prescribers who indicate "do not substitute" on prescriptions are not subject to inappropriate consequences.

REGISTERED SUPPORT:

California Association of Health Plans *(Sponsor)*
AFSCME District Council 36
American GI Forum Education Foundation of Santa Maria, CA
American Muslims for Sustainability
Blue Shield of California
California Academy of Family Physicians

California African American Chamber of Commerce
California Chamber of Commerce
California Hispanic Chambers of Commerce
Clergy and Laity United for Economic Justice
Coalition of LA Probation Unions
Community Church
Corinthian Baptist Church
CPCA Advocates, Subsidiary of the California Primary Care Association
CVS/Caremark Corporation
Ephesian Baptist Church
First Union Baptist Church
Good News Missionary Baptist Church
Hardesty LLC
Health Access California
Los Angeles Civil Rights Association
Mahoney Entertainment
Oakland Youth First Scotlan Youth & Family Center
Parchester First Baptist Church
Pharmaceutical Care Management Association
San Diego Regional Chamber of Commerce
Santa Clara County Probation Peace Officer's Union, AFSCME Local 1587
SEIU California
Shalom International Outreach
The Sperantia Foundation
West Oakland Job Resource Center
Three individuals

REGISTERED OPPOSITION:

Amgen
Biocom
Biotechnology Innovation Organization
California Dermatology Advocacy Network
California Rheumatology Alliance
California Society of Dermatology & Dermatologic Surgery
Osteopathic Physicians and Surgeons of California
U.S. Pain Foundation

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

Date of Hearing: June 23, 2026

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
SB 1263 (McGuire) – As Amended June 15, 2026

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

SENATE VOTE: 36-0

SUBJECT: Contractors: debris removal

SUMMARY: Prohibits a contractor from engaging in debris removal on residential property that is damaged or destroyed by a natural disaster, as specified, unless they hold a specific license from the Contractors State License Board (CSLB or Board), have passed a CSLB Hazardous Substance Removal Certification examination, and comply with Department of Industrial Relations' Hazardous Waste Operations and Emergency Response (HAZWOPER) requirements.

EXISTING LAW:

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

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

3) Specifies that willful or deliberate disregard and violation of the building laws of the state constitutes a cause for disciplinary action against a licensee. (BPC § 7110)

4) Makes it a misdemeanor for any person to advertise for construction or work of improvement unless that person holds a valid license in the classification so advertised, except that a licensed building or engineering contractor may advertise as a general contractor. A violation is punishable by a fine of not less than $700 and not more than $1,000, in addition to any other punishment imposed for a violation. (BPC § 7027.1)

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

6) Establishes four branches of contracting business in the following classifications:

   a) General engineering contracting (A).

   b) General building contracting (B1).

   c) Residential remodeling contracting (B2).

   d) Specialty contracting (C).

(BPC § 7055)

7) Defines an A – General Engineering Contractor as those whose principal contracting businesses are in connection with fixed works requiring specialized engineering knowledge and skill, including the following divisions or subjects: irrigation, drainage, water power, water supply, flood control, inland waterways, harbors, docks and wharves, shipyards and ports, dams and hydroelectric projects, levees, river control and reclamation works, railroads, highways, streets and roads, tunnels, airports and airways, sewers and sewage disposal plants and systems, waste reduction plants, bridges, overpasses, underpasses and other similar works, pipelines and other systems for the transmission of petroleum and other liquid or gaseous substances, parks, playgrounds and other recreational works, refineries, chemical plants and similar industrial plants requiring specialized engineering knowledge and skill, powerhouses, powerplants and other utility plants and installations, mines and metallurgical plants, land leveling and earthmoving projects, excavating, grading, trenching, paving and surfacing work and cement and concrete works in connection with the above-mentioned fixed works. (BPC § 7056)

8) Defines a B1 – General Building Contractor as those whose principal contracting businesses are in connection with any structure built, being built, or to be built, for the support, shelter, and enclosure of persons, animals, chattels, or movable property of any kind, requiring in its construction the use of at least two unrelated building trades or crafts, or to do or superintend the whole or any part thereof. (BPC § 7057)

9) Defines a C – Specialty Contractor as those whose operations involve performance of construction work requiring special skill and whose principal contracting business involves the use of specialized building trades or crafts. (BPC § 7058)

10) Prohibits contractors licensed in one classification from contracting in the field of any other classification unless they are also licensed in that classification or are permitted to do so. (16 CCR § 830)

11) Defines the scope under which each specialty contractor classification may perform contracting work (16 CCR §§ 832.02, 832.4-832.17, 832.20-832.23, 832.26-832.29, 832.31-832.36, 832.38, 832.39, 832.42, 832.43, 832.45-832.47, 82.49-832.51, 832.53-832.55, 832.57, 832.60-832.62)

THIS BILL:

1) Prohibits a contractor from engaging in debris removal, including muck out and ash out, on residential property that is damaged or destroyed by a natural disaster for which a state of emergency is declared by the Governor or for which an emergency or major disaster is declared by the President of the United States, unless the contractor has one of the following licenses or classifications:

    a) A - General Engineering Contractor.

    b) B - General Building Contractor.

    c) C-12 –Specialty Contractor Classification for Earthwork and Paving and

    d) C-21 –Specialty Contractor Classification for Building Moving/Demolition.

2) Provides that during a declared federal or state emergency or for a declared disaster area due to a natural disaster, any contractor licensee authorized to perform debris removal must have passed a Hazardous Substance Removal Certification examination administered by the CSLB and comply with HAZWOPER requirements.

3) Specify that the restrictions for debris removal, including muck out and ash out, pursuant to this bill shall no longer apply after any needed debris removal, including muck out or ash out, is deemed completed or finalized within the requirements of the local permitting agency, irrespective of whether an emergency proclamation or disaster declaration is still in effect.

4) Defines "debris" as debris from, or located on, a residential property as a result of a natural disaster. "Debris" does not include any materials unrelated to the declared emergency or disaster.

FISCAL EFFECT: Pursuant to Senate Rule 28.8, no significant state costs anticipated.

COMMENTS:

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

> As California faces increasingly destructive natural disasters, safe debris removal and disposal are essential components of disaster recovery. Improper handling of hazardous debris can create significant risks to public health, worker safety, and the environment. [This bill] clarifies who is authorized to conduct debris removal in declared disaster areas—including muck-out and ash-out operations—and requires that all who perform this work possess hazardous substance removal certifications and comply with HAZWOPER standards. These crucial safeguards will help ensure appropriate clearing of disaster sites while protecting workers and impacted communities.

Background. The CSLB is responsible for implementing and enforcing the License Law, which governs the licensure, practice, and discipline of contractors in California. A license is required for construction projects valued at $1,000 or more, including labor and materials. The CSLB issues licenses to business entities and sole proprietors. Each license requires a qualifying

individual (a "qualifier") who satisfies the experience and examination requirements for licensure and directly supervises and controls construction work performed under the license. The CSLB issues four types of licenses: "A" General Engineering Contractor; "B" General Building Contractor; "B-2" Residential Remodeling Contractor; and "C" Specialty Contractor, of which there are more than 40 classifications. Each licensing classification (i.e., electrical) authorizes a specific type of construction work. The CSLB is authorized to take disciplinary action against licensed and unlicensed contractors who have violated the License Law and is empowered to impose an escalating range of penalties, from citations and fines to license suspension or revocation.

In the aftermath of the Eaton and Palisades wildfires in Los Angeles County in 2025, the first step in rebuilding was a two-phase hazardous-waste cleanup and debris-removal process. In total, more than 2.5 million tons of debris were removed from more than 9,000 properties. In the first phase, the United States Environmental Protection Agency (EPA) removed hazardous waste such as batteries, fertilizers and pesticides, paints and oils, cleaners and solvents, and propane tanks and other pressurized products from all residential properties at no cost to homeowners.[1] In some instances, hazardous waste removal was deferred until phase two debris removal.

During phase two, property owners could elect to participate in a federally funded, government-sponsored program or to hire a private contractor.[2] If homeowners opted in for free debris removal, the United States Army Corps of Engineers removed structural debris, including damaged foundations, hazardous trees, asbestos, ash, contaminated soil, and destroyed vehicles.[3] Those who opted out were required to arrange for and pay for debris removal themselves. Property owners were required to hire a certified consultant to check their property for asbestos, hire a licensed, specialized contractor to remove debris, and obtain a fire debris removal permit from Los Angeles County. Los Angeles County debris removal permits were issued to contractors with an A General Engineering Contractor, B General Building Contractor, C-12 Earthwork and Paving, and C-21 Building Moving/Demolition license.[4]

Moreover, contractors were required to hold the CSLB Hazardous Substance Removal Certification. Under current law, contractors who perform hazardous substance removal work at specific sites must pass the Hazardous Substance Removal Certification examination to add the certification to their existing license.[5] The examination is developed by the CSLB in consultation with the Division of Occupational Safety and Health, the State Water Resources Control Board, the Department of Toxic Substances Control, and an advisory committee composed of two representatives of hazardous substance removal workers in California, two general engineering contractors in California, and two representatives of insurance companies in California who are selected by the Insurance Commissioner. The examination covers safe removal, transport, and disposal of hazardous materials, but not the identification of hazardous substances.

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[1] Cleanup and debris removal, State of California, https://www.ca.gov/lafires/help-for-you/rebuild-your-house/cleanup-debris-removal/ (last visited June 19, 2026).
[2] Debris Removal, LA Country Recovers, https://recovery.lacounty.gov/debris-removal/ (last visited June 19, 2026).
[3] Cleanup and debris removal, State of California, https://www.ca.gov/lafires/help-for-you/rebuild-your-house/cleanup-debris-removal/ (last visited June 19, 2026).
[4] Contractors State License Board, *Disaster Debris 2025* (2025), https://www.cslb.ca.gov/Resources/MediaRoom/Disaster%20Debris%202025.pdf.
[5] Bus. and Prof. Code § 7058.7.

Los Angeles County also required contractors' employees to complete 40 hours of HAZWOPER training. Current Cal/OSHA health and safety standards cover employees performing fire cleanup work, including ash, soot, and debris removal, and require employers to provide mandated hazard training and proper protective equipment. According to the CSLB, more than 1,500 contractors met the debris removal contract requirements established by Los Angeles County.

This bill codifies those requirements. Specifically, this bill prohibits a contractor from engaging in debris removal on residential property that is damaged or destroyed by a natural disaster for which a state of emergency is declared by the Governor or for which an emergency or major disaster is declared by the President of the United States, unless the contractor has an A General Engineering Contractor, B General Building Contractor, C-12 Earthwork and Paving, or C-21 Building Moving/Demolition license. Additionally, the contractor must obtain Hazardous Substance Removal Certification from CSLB and comply with HAZWOPER standards. This bill is double-referred to the Assembly Emergency Management Committee.

Prior Related Legislation. SB 641 (Ashby) of 2025, as it relates to this bill, would have prohibited a contractor from engaging in debris removal unless the contractor has an A-General Engineering Contractor, B – General Building Contractor, C-12 Earthwork and Paving, or C-21 Building Moving/Demolition license; allowed CSLB to authorize additional classification to perform debris removal during a declared emergency or declared disaster area due to a natural disaster; and required any licensee authorized to perform debris removal to have passed the CSLB's hazardous substance certification examination and completed HAZWOPER training. *SB 641 was vetoed due to other provisions.*

ARGUMENTS IN SUPPORT:

The *Associated General Contractors* write in support:

> This bill provides important benefits to licensed contractors by clarifying eligibility requirements and reinforcing the value of proper licensure and training. By requiring contractors engaged in debris removal to hold specific classifications, [this bill] helps ensure that qualified professionals are prioritized for this critical work, protecting both public safety and the integrity of the contracting industry. The bill's requirement for hazardous substance certification and compliance with established safety standards strengthens workforce preparedness. Contractors who invest in proper training and certification will be better positioned to compete for debris removal contracts, while also operating under clearer regulatory expectations during emergency response situations. [This bill] also promotes fairness by creating a more level playing field. By limiting participation to appropriately licensed and certified contractors, the bill helps reduce unqualified or opportunistic operators entering disaster zones, thereby supporting reputable contractors who adhere to industry standards.

ARGUMENTS IN OPPOSITION:

The *Southern California Contractors Association (SCCA)* writes in opposition:

> [This bill] generally contains two provisions. The first requires a specific contractors license for debris removal in a declared disaster area. SCCA has no concerns with this provision. The second requires hazardous waste operations and emergency response (HAZWOPER) training for any contractor that "performs debris removal" in a declared disaster area. This requirement is unnecessary. SCCA contractors have a long history of performing soil mitigation and debris removal in declared disaster areas. Our members worked on soil mitigation and debris removal after the Camp Fire in 2017 and most recently the Palisades Fire in 2025. Our contractor members have sent hundreds of workers through the 40 hour HAZWOPER training. Additionally, SCCA contractors frequently work for Caltrans and other agencies removing non-hazardous debris due to mudslides. [This bill's] requirement for HAZWOPER training for non-hazardous debris is entirely unnecessary.

POLICY ISSUES:

HASWOPER Training. As noted above, the Southern California Contractors Association asserts that the HAZWOPER training requirement is unnecessary for the removal of non-hazardous debris. However, it is unclear whether many natural disasters, as specified by this bill, require non-hazardous debris removal. The author may wish to continue working with stakeholders to determine if this requirement is overbroad.

IMPLEMENTATION ISSUES:

Natural Disasters. Subdivision (a) prohibits a contractor from engaging in debris removal on residential property that is damaged or destroyed by *a natural disaster for which a state of emergency is declared by the Governor, or for which an emergency or major disaster is declared by the President of the United States,* unless they hold a specific contractor license. Subdivision (b) further requires that during *a declared federal or state emergency or for a declared disaster area due to a natural disaster*, a contractor authorized to perform debris removal must have additional certification and training. The differences in wording between the two subdivisions create confusion and risk establishing different requirements under varying circumstances. For clarity, the author may wish to strike the natural disaster language in (b) and cross-reference (a).

Definition of "Debris." This bill defines "debris" as "debris from, or located on, a residential property as a result of a natural disaster," and "does not include materials unrelated to the declared emergency or disaster." As this definition is circular, the author may with to further define "debris."

Definition of "Debris Removal." This bill prohibits individuals from engaging in the undefined act of "debris removal," except as specified. The author may wish to define "debris removal."

Local Permitting Requirements. Although it is the author's intent to limit the applicability of this bill to debris removal requiring a permit from the local permitting agency, as currently drafted, that limitation is unclear. Subdivision (c) currently states that the restrictions shall no longer apply after any needed debris removal is deemed completed or finalized *within the requirements of the local permitting agency*, irrespective of whether an emergency proclamation or disaster declaration is still in effect. The author may wish to more clearly state that the bill only applies when a permit is required for debris removal resulting from a natural disaster.

Hazardous Trees. In a letter of concern, the California Special Districts Association writes that "there have been instances, such as the Park Fire, where in rural and wooded areas, hazard trees must be removed as part of the process of recovery and clean up to allow access to and ingress and egress into communities and homes in disaster areas[…] In some scenarios burned, dead trees pose a hazard to traffic, emergency response, and ingress to homes – including those on private or residential property can hinder recovery and clean up. Delays in felling hazard trees and risks of tree falls can necessitate road closures and further delay recovery and clean up." This bill would not permit a C-49 Tree and Palm Contractor to remove hazardous trees on residential property after a natural disaster. Parts of the state that are heavily forested and have limited contractor availability rely on C-49 Tree and Palm Contractors for vegetation management and tree removal. C-49 Tree and Palm Contractors plant, maintain, and remove trees and palms. Their duties include pruning, stump grinding, and tree, palm, or limb guying. The author may wish to allow C-49 Tree and Palm Contractors to engage in debris removal, to the extent that they are performing tree-related work within the scope of the license classification.

AMENDMENTS: The author may wish to consider amending the bill as follows to improve clarity and add C-49 Tree and Palm Contractors:

(a) Notwithstanding Section 40520 of the Public Resources Code, a contractor shall not engage in debris removal, including muck out and ash out, on residential property that is damaged or destroyed by a natural disaster for which a state of emergency is declared by the Governor, pursuant to Section 8625 of Government Code, or for which an emergency or major disaster is declared by the President of the United States, unless the contractor has one of the following licenses or classifications:

(1) A - General Engineering Contractor.

(2) B - General Building Contractor.

(3) C-12 - Earthwork and Paving. ~~and~~

(4) C-21 - Building Moving/Demolition.

(5)(A) C-49 – Tree and Palm, to the extent permitted by the license classification.

(B) Debris removal pursuant to this paragraph shall be limited to tree service and removal only.

(b) ~~During a declared federal or state emergency or for a declared disaster area due to a natural disaster, any~~ *Any* licensee authorized to perform debris removal pursuant to this section shall have passed an approved hazardous substance certification examination pursuant to Section 7058.7 and shall comply with the hazardous waste operations and emergency response requirements pursuant to Section 5192 of Title 8 of the California Code of Regulations.

(c) This section shall apply when a permit is required for debris removal resulting from a natural disaster as described in subdivision (a), and ~~The~~ *the* restrictions for debris removal,

including muck out and ash out, pursuant to this section shall no longer apply after any needed debris removal, including muck out or ash out, is deemed completed or finalized *by* ~~within the requirements of~~ the local permitting agency, irrespective of whether an emergency proclamation or disaster declaration is still in effect.

(d) For the purposes of this section, "debris" means debris from, or located on, a residential property as a result of a natural disaster. "Debris" does not include any materials unrelated to the declared emergency or disaster.

(e) "Debris removal" means appropriate identification, encapsulation, transportation, and disposal of debris.

REGISTERED SUPPORT:

Associated General Contractors, California Chapters
Contractors State License Board

REGISTERED OPPOSITION:

Southern California Contractors Association (unless amended)

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

Date of Hearing: June 23, 2026

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
SB 1312 (Richardson) – As Amended June 18, 2026

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

SENATE VOTE: 38-0

SUBJECT: Cemeteries

SUMMARY: Establishes a process for an endowment care cemetery to be declared abandoned by, and have its title transferred to, a local government, which shall be responsible for ongoing care and management of the cemetery unless that responsibility is transferred to another entity.

EXISTING LAW:

1) Establishes the Cemetery and Funeral Act, which provides for the licensing and oversight of 14 professional categories within the death care industry. (Business and Professions Code (BPC) §§ 7600 *et seq.*)

2) Establishes the Cemetery and Funeral Bureau (Bureau) within the Department of Consumer Affairs (DCA) to administer and enforce the Cemetery and Funeral Act. (BPC § 7602)

3) Exempts religiously-affiliated cemeteries, public cemeteries, and private or fraternal burial parks not exceeding 10 acres in area and established prior to September 19, 1939 from the Bureau's licensing requirements. (BPC § 7612.2)

4) Requires each licensed cemetery authority file with the Bureau an annual written report with the following information:

    a) The number of square feet of grave space and the number of crypts and niches sold or disposed of under endowment care by specific periods;

    b) The amount collected and deposited in both the general and special endowment care funds segregated as to the amounts for crypts, niches, and grave space by specific periods as set forth either on the accrual or cash basis at the option of the cemetery authority;

    c) A statement showing separately the total amount of the general and special endowment care funds invested in each of the investments authorized by law and the amount of cash on hand not invested, which statement shall actually show the financial condition of the funds;

    d) A statement showing separately the location, description, and character of the investments in which the special endowment care funds are invested.

e) A statement showing the transactions entered into between the corporation or any officer, employee, or stockholder thereof and the trustees of the endowment care funds with respect to those endowment care funds, including dates, amounts of the transactions, and a statement of the reasons for those transactions.

(BPC § 7612.6)

5) Requires cemetery authorities requesting a change of filing date of the endowment care fund report to file a petition with the Bureau prior to the close of the year. (BPC § 7612.7)

6) Requires the Bureau to conduct a study to obtain information to determine if the endowment care fund levels of each licensee's cemetery are sufficient to cover the cost of future maintenance. (BPC § 7612.11)

7) Required that the Bureau, on or before March 1, 2026, convene a workgroup composed of interested stakeholders including representatives from the cemetery industry, local government representatives, public cemeteries, and legislative staff, to discuss options for ensuring continued care, maintenance, and embellishment of abandoned cemeteries, including the possibility of requiring counties to assume responsibility for maintenance, irrigation, public works, and burial services for cemeteries located within their boundaries that become abandoned; required the Bureau to submit a report to the Legislature no later than June 1, 2026. (BPC § 7612.12)

8) Requires that 90 days following the cancellation, surrender, or revocation of a certificate of authority, the Bureau shall take title of any endowment care funds of the cemetery authority, take possession of all necessary books, records, property, and assets, and act as conservator over the management of the endowment care funds. (BPC § 7613.11)

9) Declares that upon finding by a court that a cemetery manager of a private cemetery has ceased to perform their duties due to a lapse, suspension, surrender, abandonment or revocation of their license, the court shall appoint a temporary manager to manage the cemetery property. (BPC § 7653.9)

10) Authorizes a cemetery authority to place its cemetery under endowment care and establish, maintain, and operate an endowment care fund. (Health and Safety Code (HSC) § 8725)

11) Requires the principal of all funds for endowment care to be invested and the income only to be used for the care, maintenance, and embellishment of the cemetery in accordance with the provisions of law and the resolutions, bylaws, rules, and regulations or other actions or instruments of the cemetery authority and for no other purpose. (HSC § 8726)

12) Establishes minimum amounts which an endowment care cemetery must deposit into its endowment care fund at the time of, or not later than, completion of the initial sale of internment space in the cemetery. (HSC § 8738)

13) Authorizes a city or county that determines an abandoned cemetery threatens or endangers the health, safety, comfort, or welfare of the public to dedicate such abandoned cemetery as a pioneer memorial park and take over maintenance of the cemetery. (HSC §§ 8825 – 8829)

THIS BILL:

1) Authorizes a city, county, or city and county to, by resolution of its governing board, formally declare the abandonment of a cemetery if all of the following circumstances have occurred:

   a) The certificate of authority of the cemetery has been canceled, surrendered, abandoned, or revoked for at least one year.

   b) The Bureau has conserved the endowment care fund.

   c) At least one of the following circumstances are met:

      i) The Bureau has imposed citations or disciplinary actions for maintenance deficiencies or mismanagement of the endowment care fund of the cemetery.

      ii) Local authorities have imposed citations or notices.

      iii) Nonpayment of property taxes have resulted in a lien on the cemetery property.

      iv) Local authorities have performed maintenance on the cemetery property to protect public health, safety, or welfare.

      v) There has been limited access or no access to the cemetery property for families and visitors.

      vi) The owner of the cemetery property has voluntarily abandoned the property.

   d) Any of the following circumstances have occurred:

      i) The cemetery has not made any sales for at least one year.

      ii) There has not been any interments for at least one year.

      iii) There is little to no remaining inventory or cemetery plots.

2) Requires written notice to be provided to the owner of the cemetery property 90 days prior to, and upon, declaration of abandonment, as specified.

3) Provides that the title of an abandoned endowment care cemetery shall transfer to the local government that declared the cemetery abandoned and shall be recorded with the county.

4) Requires the local government to keep a record of and honor all prior and outstanding contracts for burial entered into by the prior cemetery authority.

5) Exempts the local government from liability for any of the following:

   a) Any debts, obligations, taxes, fines, or judgments of the previous owner, except as provided.

b) Harm, loss, or damages for any actions performed by the prior owner of the cemetery property for a period of three years while the property is returned to a safe condition.

c) Failure to provide any missing paperwork or contracts.

6) Provides that a local government shall not be required to return the property to the prior owner of the cemetery property.

7) Authorizes the local government to transfer the care and management of an abandoned endowment care cemetery to another licensed cemetery owner, which would have a period of five years to become compliant with the minimum maintenance standards.

8) Authorizes the local government to transfer the care and management of an abandoned endowment care cemetery to a cemetery entity exempt from licensure, which would be required to keep a record of and honor all prior and outstanding contracts for burial entered into by the prior cemetery authority.

9) Provides that if another licensed cemetery owner or cemetery exempt from licensure does not assume ownership of an abandoned endowment care cemetery, the local government shall have authority over the endowment care fund and shall be responsible for ongoing care, maintenance, and embellishment of the cemetery and performance of any prepaid burial obligations.

10) Allows for the person or entity caring for and managing an abandoned endowment care cemetery to initiate a petition to form a public cemetery district or join an existing public cemetery district.

11) Authorizes the endowment care fund of an abandoned endowment care cemetery to be disbursed to the person or entity caring for and managing the cemetery to conserve and protect the fund.

12) Requires a court that determines that a required certificate of authority of a cemetery has lapsed or has been suspended, surrendered, abandoned, or revoked to do all of the following:

a) Name the Bureau conservator to conserve the endowment care and special care funds.

b) Take actions as it deems appropriate pursuant to relevant provisions of the Cemetery and Funeral Act.

c) Authorize interments for decedents who have a right of interment through a preneed contract.

d) Take actions as it deems appropriate to ensure the continued care, maintenance, and embellishment of the property.

e) Pursue the transfer of the entirety or portions of the property ownership to one or more nonprofit, business, or governmental entities.

13) Authorizes the Bureau to establish abbreviated requirements for the operation and maintenance of the property or portions of the property as it deems appropriate for its planned use and in recognition of the limited financial viability of the property.

14) Exempts the new owner to which a property is transferred and any individual serving as a temporary manager from liability for the debts, obligations, taxes, fines, or judgments of the previous owner.

15) Provides that the certificate of authority is abandoned if the court determines that for an extended and unreasonable period of time one or more of the following has occurred and that the health, safety, comfort, or welfare of the public is threatened or endangered:

    a) Unresponsiveness to the public.

    b) Inability of the community to access and visit the property.

    c) Failure to perform authorized interments.

    d) Nonpayment of property taxes.

    e) Serious violation of the maintenance standards.

    f) A city or county declaration of abandonment.

    g) Unavailability of special care or endowment care funds.

16) Revises the timeline for a cemetery authority to file an annual written report to the Bureau regarding its properties under endowment care to require that written report to be filed every three or five years.

17) Strikes the limitation on the Bureau approving a petition to change the filing date of the endowment care fund report to no more than 12 months.

18) Expressly authorizes the Bureau to establish an advisory committee to assist it in engaging consumers and licensees in its regulatory activities.

19) Provides that if the Bureau establishes an advisory committee, the advisory committee shall include at least one member from each of the following groups:

    a) Licensed representatives of the death care industry.

    b) Members of the public.

    c) Representatives of local governments.

20) Defines various terms for purposes of the bill.

FISCAL EFFECT: Pursuant to Senate Rule 28.8, negligible state costs.

COMMENTS:

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

> This bill is very personal to my constituents and families in my district. Lincoln Memorial Park Cemetery in Carson City that was founded in 1934 has become abandoned by the owner and manager since 2023, due to health care issues. Since then the cemetery has been subject to vandalism, theft and desecration of burial plots. There are 187 private cemeteries in the State of California that are subject to abandonment. However, when cemeteries lose owners, they are without protection.

Background.

Cemetery and Funeral Bureau. The Bureau was established in 1995 when the previously distinct Cemetery Board and Board of Funeral Directors and Embalmers were merged into a consolidated program under the DCA. As a bureau under the DCA, the Bureau is charged with administering and enforcing the Cemetery and Funeral Act. A voluntarily established Advisory Committee, comprised of representatives of both the industry and the public, assists the Bureau in engaging consumers and licensees in its regulatory activities.

The Bureau oversees 14 different professional categories within the so-called "death care" industry, with approximately 11,315 licensees currently active with the Bureau. The Bureau's licensing program includes funeral establishments and directors; embalmers and apprentice embalmers; cremated remains disposers, crematories, crematory managers, and hydrolysis facilities; cemetery managers, brokers, branches, and salespersons; and certain private, nonreligious cemeteries. Beginning in 2027, the Bureau will also license reduction facilities. The Bureau is additionally tasked with the fiduciary responsibility of overseeing more than three billion dollars in funds held and invested by funeral establishments and cemeteries, including endowment care funds and preneed trust funds.

The Bureau plays a vital role in protecting consumers from fraud, negligence, and other misconduct in the course of obtaining cemetery and funeral services, a time when consumers are frequently grieving and vulnerable to dishonest dealings. In its enforcement of the Cemetery and Funeral Act, the Bureau is authorized to inspect any premises in which the business of a funeral establishment, reduction facility, cemetery, or crematory is conducted; where embalming is practiced; or where human remains are stored. The Bureau is then empowered to take disciplinary action against a licensee for violations of the law. The Cemetery and Funeral Act declares that protection of the public shall be the Bureau's highest priority.

It is important to note that the Bureau's authority is exclusively over privately-owned cemeteries. Public cemeteries, those owned by religious corporations, and cemeteries established prior to 1939 with under 10 acres who do not collect an endowment care fund, are exempt from Bureau oversight. Of the hundreds, if not thousands, of cemeteries within the state of California, the Bureau only regulates 192 licensed cemeteries operated by private business owners, the majority of which are opened to the public for burials. For those cemeteries that are licensed, the Bureau is entrusted with ensuring that the remains of loved ones are treated with dignity and respect in perpetuity.

Endowment Care Funds. A licensed cemetery's endowment care fund is comprised of consumer deposits for each space sold within the cemetery, and the accumulated income generated on those deposits from investments. Investment decisions must be conservative and are limited under the Cemetery and Funeral Act. Only the accumulated income portion of the fund may be spent on the care, maintenance, and embellishment of the cemetery.

The Cemetery and Funeral Act authorizes Bureau oversight of an endowment care fund, including requirements regarding the number of days deposits must be made into the fund, proper and allowable investments, mandated annual independent audits of funds, and annual reporting to the Bureau. The Act also allows the Bureau to take possession of the fund and act as the conservator under certain conditions, including if there is probable cause to believe that irreparable loss and injury to the endowment care funds of a cemetery authority has occurred, or may occur, unless the Bureau takes immediate action. As part of reforms enacted in the Bureau's 2024 sunset bill, the Bureau was further granted authority to conserve an endowment care fund when a previously licensed cemetery becomes unlicensed due to abandonment, cancellation, surrender, or revocation of the license, and also authorized the Bureau to conserve the endowment care fund when a cemetery authority voluntarily surrenders the fund to the Bureau. According to the Bureau, some cemeteries have voluntarily surrendered their endowment care funds to the Bureau to avoid the annual audit costs as they transition to fewer employees and limited public access hours.

Each year, a cemetery authority must submit a written report with the Bureau that includes a detailed accounting of its endowment care activities and fund management. It must include the number of grave spaces, crypts, and niches sold under endowment care, the amounts collected and deposited into general and special endowment care funds, detailed statements of fund investments and financial condition, and disclosures of any transactions involving fund trustees and affiliated parties. The report must be verified by corporate officers and accompanied by an independent audit of the endowment and special care funds signed by a public accountant. This bill would revise the timeline for cemeteries to submit this report.

Cemetery Abandonment. Issue #8 in the Bureau's 2024 sunset review background paper discussed the topic of abandoned cemeteries and posed the question of what steps could be taken to ensure that older cemeteries are appropriately and respectfully maintained by another entity after they have been abandoned. This topic had been discussed during prior sunset reviews, when the Committees cited the example of a cemetery in Southern California where grave markers were allowed to become overgrown with dirt and grass and minimum maintenance standards were not met. In its response to this issue, the Bureau indicated that it would continue to work with all licensed cemeteries to ensure they are adhering to maintenance standards and practice a progressive discipline model if needed to bring them into compliance.

AB 180 (Bonilla, Chapter 395, Statutes of 2015) directed the Bureau to conduct a study to obtain information to determine if the endowment care levels of each cemetery the Bureau licenses are sufficient to cover the cost of future maintenance. The 2017 Endowment Care Sufficiency Study found that at least 43 licensed cemeteries have an underfunded endowment care fund with limited spaces to sell. The report concluded that, although endowment care cemeteries deposit at least the minimum amounts required by law, there is still a substantial statewide shortfall.

The report found that some cemeteries deposited more than the minimum amount required by law, but it was still found that statewide the costs of maintaining California's privately-owned cemeteries exceeded the income generated from the cemeteries' endowment care trusts. The study pointed out that for at least 21 of the licensed cemeteries, endowment care income appeared to be sufficient to cover the long-run costs of maintaining the endowment care spaces they have already sold, but for the large majority of licensed cemeteries, the endowment care income was not sufficient to cover the endowment care spaces they have already sold, and long-run sufficiency will require more significant trust growth.

There are two distinct drivers of the problem: older cemeteries have limited spaces remaining to sell and endowment funds are inadequate to perpetually maintain cemeteries that have since sold all available plots. Because these cemeteries are private businesses, properties that no longer generate revenue become abandoned if they cannot be sold, or they are abandoned following disciplinary measures by the Bureau, including revocation of a license. The result is an unlicensed, abandoned cemetery where the resting places of the dead are not treated with dignity.

A recent example of the devastation this situation can cause is the cancelation of the license and subsequent abandonment of Lincoln Memorial Park Cemetery in Carson, California, part of the author's district. In August 2023, the Bureau began receiving information from the public that the cemetery had closed its gates. Upon investigation, the Bureau confirmed that the cemetery was no longer being maintained by the cemetery manager and cemetery authority, who requested cancelation of their licenses. The community was devastated as public access for family members had been limited and there was no local entity to oversee new internments of loved ones who had passed away who had previously purchased a plot in the cemetery. Neither the City of Carson nor Los Angeles County were able to assist in providing ongoing care to the abandoned cemetery.

Responsibility for Abandoned Cemeteries. Currently, when a private cemetery that has not interred more than 10 human bodies in the preceding five years threatens or endangers the health, safety, comfort, or welfare of the public, statute allows (but does not require) a city or county to declare that cemetery abandoned. The abandoned cemetery is then declared a pioneer memorial park and is maintained by the city or county. This statute, however, only applied to those abandoned cemeteries that never collected endowment care funds—in other words, cemeteries established prior to 1939.

The Act only provides for two options for maintenance by a private cemetery by an entity other than the licensee. One statute authorizes a court to appoint a temporary licensed cemetery manager to manage the property and serve prepaid internments, or the county if there is no appointed temporary manager. The Bureau states that typically when a cemetery is within city limits, a county will not utilize this section and defer to the city (as occurred with Lincoln Memorial Park Cemetery). Statute additionally allows a city or county to perform maintenance within a cemetery when its license has been revoked, suspended, or not renewed. This law only applies to maintenance necessary to protect the health and safety of the public. In other words, while dry weeds creating a fire hazard would be addressed, the law does not provide for cosmetic upkeep to grounds and embellishments, which while not a matter of safety are important for communities whose families are interred in the cemetery.

In the above cases, local governments are not *required* to take action following the abandonment of a cemetery, but are merely *permitted* to under certain circumstances. The Bureau has pointed out that when a cemetery is proposed to be created, the local government in which it will be situated has to authorize and zone a parcel of land as cemetery property with approval to intern decedents. Local authorities are responsible for determining whether a piece of property within their communities will be dedicated as cemetery property, and local governments know that there is no guarantee a private cemetery business will remain active forever.

In its 2024 sunset review report, the Bureau suggested that the Legislature consider amending current statute to vest the responsibility of perpetual care with the jurisdiction that authorized the underlying use upon abandonment of a cemetery, contending that local governments—who initially permitted and zoned the private cemetery with full knowledge that they may eventually cease private operations—should ultimately be responsible for the cemetery's perpetual care. Such a mandate, however, would conceivably create challenges with local governments who argue that a lack of resources would not allow them to successfully assume responsibility for all private cemeteries within their boundaries.

Recognizing that the importance of this issue necessitates a thorough discussion of all potential options, AB 3254 (Berman, Chapter 589, Stats. of 2024) required the Bureau, by July 1, 2027, to convene a workgroup comprised of representatives from the cemetery industry, county government, and other interested stakeholders to discuss options for ensuring continued care, maintenance, and embellishment of abandoned cemeteries, including the possibility of requiring counties to assume responsibility for cemeteries located within their boundaries that become abandoned. The Bureau was required to report on the workgroup's discussions and recommendations no later than January 1, 2028 in advance of its next sunset review.

Arguing that the increasingly squalid condition of abandoned cemeteries in her district and throughout the state requires urgent action, the author of this bill introduced SB 777 in 2025 to address the issue of abandoned cemeteries. Initial iterations of the bill would have established a new process whereby local governments assume control of abandoned endowment care cemeteries, funded via a new grant program administered by the Bureau with money collected as part of an increase to every fee under the Bureau's jurisdiction. SB 777 received significant opposition from cemetery stakeholders and representatives of local government, and committee analysis noted that it would be appropriate to allow the Bureau to complete its workgroup discussions and provide its recommendations on an accelerated timeline. SB 777 was subsequently amended to require the workgroup to convene no later than March 1, 2026, and to provide a summary of its discussions and its recommendations to the Legislature by June 2026.

The Bureau's workgroup held an in-person meeting on January 21, 2026. During this meeting, members "noted a practical risk of counties assuming the responsibility of maintenance of abandoned cemeteries. If a county invests significant resources to maintain a neglected private cemetery, the property's value may increase, allowing the private owner to sell and keep the benefit without reimbursing the county. This creates an illogical incentive for property owners to defer maintenance and shifts costs to the public." According to the Bureau, the argument was made that "local governments are neither designed nor resourced to provide ongoing upkeep for privately owned property. Clear statutory direction is needed to avoid unintended fiscal burdens on counties and to ensure private owners remain accountable for maintenance obligations."

The Bureau's workgroup identified three main areas of focus to aid in the continued care of abandoned cemeteries:

- Defining abandonment
- Title transfer to a new entity
- Ongoing funding for maintenance, access, and burials for those who have already purchased plots

The Bureau formally submitted its report to the Legislature on June 1, 2026. In the conclusion of its report, the Bureau acknowledged that "unlicensed and abandoned cemeteries present complex challenges requiring coordination and strong partnerships among the Bureau, local authorities, and communities statewide." The Bureau's report included a number of recommendations, which were developed in coordination with its workgroup. In its conclusion, the Bureau recommended:

- Advancing prevention strategies in partnership with licensees, local governments, and the Legislature to reduce the risk of cemetery abandonment.

- Continuing to conserve and protect the endowment care trust funds and pursue legislative authority to allow income disbursement to qualified entities, such as non-profits.

- Revisions to the law to authorize local governmental entities to formally declare abandonment.

- Releasing the endowment care trust fund to the local authority if no licensee or nonprofit assumes ownership, making the local entity responsible for ongoing care and prepaid burial obligations.

This bill would now seek to implement the Bureau's recommendations. First, it would formally define an "abandoned endowment care cemetery" and establish a mechanism for a city, county, or city and county to declare an endowment care cemetery to be abandoned when specified conditions are met. Once a cemetery has been declared abandoned, the local government that made the declaration would be responsible for ongoing care, maintenance, and embellishment of the cemetery and performance of any prepaid burial obligations, unless that responsibility is transferred to the operator of another cemetery. The person or entity caring for and managing an abandoned endowment care cemetery would also have the option of seeking to form or join a public cemetery district.

Mt. Tamalpais Cemetery. Beginning in 2022, the Bureau began taking enforcement actions against the owner of an endowment care cemetery in San Rafael for failing to adequately maintain the property and properly manage its endowment care trust. It was subsequently determined that millions of dollars from the trust had been diverted into inappropriate investments and personal expenses rather than cemetery care and maintenance. In 2025, the Bureau revoked the cemetery's license and issued cease-and-desist orders to stop conducting cemetery operations. Additionally, the Bureau seized $52 million in endowment care funds that are reserved for the care and maintenance of the four cemeteries under the control of the cemetery owner.

However, while the cemetery owner no longer had a license to operate a cemetery business, they still maintained ownership and possession of the land where the cemetery was located, which remained an active burial site. Meanwhile, the cemetery grounds continued to fall into disrepair, with reports of overgrown vegetation, obscured headstones, gopher damage, deteriorating infrastructure, and a lack of regular maintenance. These poor conditions have caused understandable grief and dismay for the families of those interred at the cemetery, including members of synagogues who had long utilized the cemetery for religious burials.

Because the owner of the cemetery in San Rafael never willingly relinquished their license or title to the cemetery property, the cemetery would not necessarily be considered "abandoned" in the traditional sense. However, the failure of the cemetery to maintain a minimum standard of care implicates the same concerns for health and safety as well as the dignity of those interred. Additionally, many individuals pre-purchased plots on the land, desiring to be laid to rest alongside family members. The County of Marin has characterized the current state of the dispute with this cemetery as "a serious gap in California's regulatory framework for private cemeteries when ownership fail but operations continue" and has sought to resolve the situation as part of the broader solution to abandoned cemetery issues.

This bill would provide that when a court determines that a cemetery's certificate of authority has lapsed or has been suspended, surrendered, abandoned, or revoked, the court shall name the Bureau as the conservator of the endowment care fund and take specified actions to take actions as it deems appropriate to ensure the continued care, maintenance, and embellishment of the property. A cemetery's certificate of authority would be deemed abandoned if the court determines that certain circumstances have persisted for an extended and unreasonable period of time and that the health, safety, comfort, or welfare of the public is threatened or endangered. These circumstances would include unresponsiveness to the public, inability of the community to access and visit the property, and serious violations of maintenance standards. These provisions of the bill are specifically tailored to address the circumstances of the San Raphael cemetery situation and would provide courts with a mechanism to provide relief to local stakeholders and families.

Advisory Committees. The Bureau currently regularly convenes a seven-member Advisory Committee, which consists of four representatives of the death care industry and three members of the public, all of whom are appointed for two-year terms by the Bureau Chief. According to the Bureau, the purpose of having an Advisory Committee is so that timely issues, such as barriers to licensure or changes in the profession, can be brought to the Bureau's attention. The Advisory Committee is also consulted when the Bureau is exploring potential changes in law, regulation, or policy, such as its recent increase in license fees.

While the value of the Advisory Committee is cogently stated, its existence is currently not recognized in statute. The Bureau established the Advisory Committee voluntarily on its own initiative and there is no legal requirement that the Advisory Committee be continued in the future. While there is no indication that the Bureau's current leadership would ever consider disbanding the Advisory Committee, there has been discussion of potential benefits to codifying it within the Act. This bill would prove that if the Bureau establishes an Advisory Committee, the advisory committee shall include at least one member from each of the specified groups, including representatives of local governments.

Prior Related Legislation. SB 777 (Richardson), Chapter 658, Statutes of 2025 expedites the requirement for the Bureau to convene a workgroup, and provide a report, to discuss options for ensuring continued care of abandoned endowment care cemeteries.

AB 3254 (Berman), Chapter 589, Statutes of 2024 extended the sunset date for the Bureau and required the Bureau to convene a workgroup of interested stakeholders to make recommendations relating to abandoned cemeteries.

ARGUMENTS IN SUPPORT:

The *Marin County Board of Supervisors* supports this bill, writing: "The County of Marin has been grappling firsthand with the consequences of an abandoned private endowment care cemetery at Mt. Tamalpais Cemetery in San Rafael. Mt. Tamalpais is a 150-year-old cemetery that remains an active burial site for families with pre-purchased plots. Following years of financial mismanagement, operational failures, and neglect, the Cemetery and Funeral Bureau revoked the cemetery's license in 2025 and assumed control of its endowment care fund. Despite these actions, the cemetery remains in a state of severe deterioration, with overgrown vegetation, damaged gravesites, public safety concerns, and little to no ongoing maintenance. Unlike other abandoned cemeteries in the state, Mt. Tamalpais continues to conduct burials while lacking a licensed cemetery operator, creating a uniquely challenging situation for families and regulators alike." The County of Marin further writes: "Marin County is grateful to Senator Richardson and her office for taking a leadership role on this difficult issue."

ARGUMENTS IN OPPOSITION:

The *California Special Districts Association* (CDSA) writes in opposition: "SB 1312 would create a process whereby a city, county, or city and county can, by majority vote, transfer an abandoned private endowment care cemetery to various entities, including public cemetery districts. Similarly, SB 1312 creates a process whereby a court may intervene in practically the same way. Neither of these processes involve the express, affirmative consent of the public cemetery district to shoulder the significant undertaking involved in taking over an abandoned cemetery. Without taking into consideration the judgment of the public cemetery district, these provisions of SB 1312 threaten to dramatically upset the financial viability of a public cemetery district. To address these concerns, we believe that SB 1312 should be amended such that in no case should any entity be able to unilaterally assign stewardship, ownership, responsibility, care, management, maintenance, or embellishment of an abandoned endowment care cemetery without the express, affirmative consent of the public cemetery district."

IMPLEMENTATION ISSUES:

The language in this bill was based on the recommendations contained in the report submitted by the Bureau on June 1, 2026. Subsequently, on June 16, 2026, the Bureau submitted language to the author drafted to implement its recommendations; however, this language was not received in time to incorporate into recent amendments to this bill. While there are not substantive policy conflicts between the Bureau's proposed language and the language currently in this bill, the author should work with the Bureau to reconcile any drafting differences to ensure that the policy of the bill can be effectively implemented.

REGISTERED SUPPORT:

Marin County Board of Supervisors

REGISTERED OPPOSITION:

California Special Districts Association

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