California State Assembly

BUSINESS AND PROFESSIONS

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AGENDA

Tuesday, April 19, 2022
9 a.m. -- 1021 O Street, Room 1100

SPECIAL ORDER OF BUSINESS AT 9:00 A.M.

1.	AB 2098	Low	Physicians and surgeons: unprofessional conduct.

BILLS HEARD IN FILE ORDER

2.	AB 2236	Low	Optometry.
3.	AB 1636	Akilah Weber	Physician's and surgeon's certificate: registered sex offenders.
4.	AB 1704	Chen	Leg-podiatric X-ray equipment: certification or permit exemption.
5.	AB 1885	Kalra	Cannabis and cannabis products: animals: veterinary medicine.
6.	AB 1901	Nazarian	Dog training services and facilities: requirements.
7.	AB 1954	Quirk	Physicians and surgeons: treatment and medication of patients using cannabis.
8.	AB 2060	Quirk	Medical Board of California.
9.	AB 2087	Petrie-Norris	Prescription drugs.
10.	AB 2341	Medina	California Private Postsecondary Education Act of 2009: complaint processing contracts.
11.	AB 2382	Lee	Light pollution control.
12.	AB 2515	Holden	Proprietary and private security services.
13.	AB 2745	Irwin	Real estate broker's license.
14.	AB 2916	McCarty	Contractors: disclosure of letters of admonishment.

Date of Hearing: April 19, 2022

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 2098 (Low) – As Introduced February 14, 2022

SUBJECT: Physicians and surgeons: unprofessional conduct.

SUMMARY: Expressly provides that the dissemination of misinformation or disinformation related to COVID-19 by physicians and surgeons constitutes unprofessional conduct.

EXISTING LAW:

1) Enacts the Medical Practice Act, which provides for the licensure and regulation of physicians and surgeons. (Business and Professions Code (BPC) §§ 2000 *et seq.*)

2) Establishes the Medical Board of California (MBC), a regulatory board within the Department of Consumer Affairs (DCA) comprised of 15 appointed members. (BPC § 2001)

3) Enacts the Osteopathic Act, which provides for the licensure and regulation of osteopathic physicians and surgeons. (BPC §§ 2450 *et seq.*)

4) Establishes the Osteopathic Medical Board of California (OMBC), which regulates osteopathic physicians and surgeons who possess effectively the same practice privileges and prescription authority as those regulated by MBC but with a training emphasis on diagnosis and treatment of patients through an integrated, whole-person approach. (BPC § 2450)

5) Provides that protection of the public shall be the highest priority for both the MBC and the OMBC in exercising their respective 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)

6) 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)

7) Authorizes the MBC to appoint panels of at least four of its members for the purpose of fulfilling its disciplinary obligations and provides that the number of public members assigned to a panel shall not exceed the number of licensed physician and surgeon members. (BPC § 2008)

8) With approval from the Director of Consumer Affairs, authorizes the MBC to employ an executive director as well as investigators, legal counsel, medical consultants, and other assistance, but provides that the Attorney General is legal counsel for the MBC in any judicial and administrative proceedings. (BPC § 2020)

9) Allows the MBC to select and contract with necessary medical consultants who are licensed physicians to assist it in its programs. (BPC § 2024)

10) Empowers the MBC to take action against persons guilty of violating the Medical Practice Act. (BPC § 2220)

11) Requires the Director of Consumer Affairs to appoint an independent enforcement monitor no later than March 1, 2022 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)

12) 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 allegations of gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients receiving the highest priority. (BPC § 2220.05)

13) Clarifies that the MBC is the only licensing board that is authorized to investigate or commence disciplinary actions relating to the physicians it licenses. (BPC § 2220.5)

14) Provides that a 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, may be subject to various forms of disciplinary action. (BPC § 2227)

15) Provides that all proceedings against a licensee for unprofessional conduct, or against an applicant for licensure for unprofessional conduct or cause, shall be conducted in accordance with the Administrative Procedure Act. (BPC § 2230)

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

    a) Violating or aiding in the violation of the Medical Practice Act.

    b) Gross negligence.

    c) Repeated negligent acts.

    d) Incompetence.

    e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician.

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

    g) The failure by a physician, in the absence of good cause, to attend and participate in an investigatory interview by the MBC.

    (BPC § 2234)

17) Provides that a physician shall not be subject to discipline solely on the basis that the treatment or advice they rendered to a patient is alternative or complementary medicine if that treatment or advice was provided after informed consent and a good-faith prior examination; was provided after the physician provided the patient with information concerning conventional treatment; and the alternative complementary medicine did not cause a delay in, or discourage traditional diagnosis of, a condition of the patient, or cause death or serious bodily injury to the patient. (BPC § 2234.1)

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

19) Provides that violating a state or federal law regulating dangerous drugs or controlled substances, constitutes unprofessional conduct. (BPC §§ 2237 – 2238)

20) Provides that self-prescribing of a controlled substance, or the use of a dangerous drug or alcoholic beverages to the extent that it is dangerous or injurious to the physician or any other person, or impairs the physician's ability to practice, constitutes unprofessional conduct. (BPC § 2239)

21) Provides that prescribing, dispensing, or furnishing dangerous drugs without an appropriate prior examination and a medical indication constitutes unprofessional conduct. (BPC § 2242)

22) Provides that the willful failure to comply with requirements relating to informed consent for sterilization procedures constitutes unprofessional conduct. (BPC § 2250)

23) Provides that the prescribing, dispensing, administering, or furnishing of liquid silicone for the purpose of injecting such substance into a human breast or mammary constitutes unprofessional conduct. (BPC § 2251)

24) Provides that the violation of an injunction or cease and desist order relating to the treatment of cancer constitutes unprofessional conduct. (BPC § 2252)

25) Provides that failure to comply with the Reproductive Privacy Act governing abortion care constitutes unprofessional conduct. (BPC § 2253)

26) Provides that the violation of laws relating to research on aborted products of human conception constitutes unprofessional conduct. (BPC § 2254)

27) Provides that the violation of laws relating to the unlawful referral of patients to extended care facilities constitutes unprofessional conduct. (BPC § 2255)

28) Provides that any intentional violation of laws relating to the rights of involuntarily confined inpatients constitutes unprofessional conduct. (BPC § 2256)

29) Provides that the violation of laws relating to informed consent for the treatment of breast cancer constitutes unprofessional conduct. (BPC § 2257)

30) Provides that the violation of laws relating to the use of laetrile or amygdalin with respect to cancer therapy constitutes unprofessional conduct. (BPC § 2258)

31) Provides that failing to give a patient a written summary prior to silicone implants being used in cosmetic, plastic, reconstructive, or similar surgery constitutes unprofessional conduct. (BPC § 2259)

32) Provides that failing to give a patient a written summary prior to collagen injections being used in cosmetic, plastic, reconstructive, or similar surgery constitutes unprofessional conduct. (BPC § 2259.5)

33) Provides that any violation of extraction and postoperative care standards constitutes unprofessional conduct. (BPC § 2259.7)

34) Provides that the removal of sperm or ova from a patient without written consent constitutes unprofessional conduct. (BPC § 2260)

35) Provides that the violation of laws relating to human cloning constitutes unprofessional conduct. (BPC § 2260.5)

36) Provides that knowingly making or signing any certificate related to the practice of medicine which falsely represents the existence or nonexistence of a state of facts constitutes unprofessional conduct. (BPC § 2261)

37) Provides that altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct. (BPC § 2262)

38) Provides that numerous other inappropriate activities or violations of the law constitute unprofessional conduct. (BPC §§ 2263 – 2318)

39) Requires that licensees be given notification of proposed actions to be taken against the licensee by the MBC and be given the opportunity to provide a statement to the deputy attorney general assigned to the case. (BPC § 2330)

THIS BILL:

1) Provides that the dissemination or promotion of misinformation or disinformation related to COVID-19 by a physician and surgeon constitutes unprofessional conduct.

2) Includes false or misleading information regarding the nature and risks of the COVID-19 virus, its prevention and treatment, and the development, safety, and effectiveness of COVID-19 vaccines as types of misinformation or disinformation that could be disseminated.

3) Requires the MBC or OMBC to consider the following factors prior to bringing a disciplinary action against a licensee for disseminating misinformation or disinformation:

    a) Whether the licensee deviated from the applicable standard of care.

    b) Whether the licensee intended to mislead or acted with malicious intent.

    c) Whether the misinformation or disinformation was demonstrated to have resulted in an individual declining opportunities for COVID-19 prevention or treatment that was not justified by the individual's medical history or condition.

d) Whether the misinformation or disinformation was contradicted by contemporary scientific consensus to an extent where its dissemination constitutes gross negligence by the licensee.

4) Defines "physician and surgeon" as a person licensed by either the MBC or the OMBC.

5) Provides that violators of the bill's provisions are not guilty of a misdemeanor.

6) Makes various findings and declarations in support of the bill.

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

COMMENTS:

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

> "AB 2098 is crucial to addressing the amplification of misinformation and disinformation related to the COVID-19 pandemic. Licensed physicians, doctors, and surgeons possess a high degree of public trust and therefore must be held accountable for the information they spread. Providing patients with accurate, science-based information on the pandemic and COVID-19 vaccinations is imperative to protecting public health. By passing this legislation, California will show its unwavering support for a scientifically informed populous to protect ourselves from COVID-19."

Background.

COVID-19 Pandemic and Vaccines. To date, over 984,000 people have died of COVID-19 in the United States, including approximately 90,000 Californians.[1] On March 4, 2020, Governor Gavin Newsom proclaimed a State of Emergency as a result of the impacts of the COVID-19 public health crisis, and on March 19, 2020, the Governor formally issued a statewide "stay at home order," directing Californians to only leave the house to provide or obtain specified essential services. Subsequent guidance from the State Public Health Officer expressly exempted from that order various professionals regulated by the Department of Consumer Affairs (DCA), including physicians and surgeons providing essential care.

On March 30, 2020, Governor Newsom announced an initiative to "expand California's health care workforce and recruit health care professionals to address the COVID-19 surge" and signed Executive Order N-39-20. This executive order established a waiver request process under the DCA and included other provisions authorizing the waiver of licensing, certification, and credentialing requirements for health care providers. Through this waiver process, the DCA issued a series of waivers of law to authorize various healing arts professionals to order and administer COVID-19 vaccines. These waivers aligned with similar authority granted federally under the Public Readiness and Emergency Preparedness (PREP) Act for Medical Countermeasures Against COVID-19.

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[1] Data current as of April 11, 2022; the number of Californians who have died from causes related to COVID-19 has risen 20 percent since this bill was introduced with its current findings and declarations.

Vaccines are regulated and overseen by multiple federal entities responsible for ensuring their safety and efficacy. The federal Food and Drug Administration (FDA) is initially responsible for approving new drugs, determining both that they are safe to administer and that their recommended use is clinically supported. During states of emergency, the FDA may expedite their review through the Emergency Use Authorization (EUA) process to accelerate the availability of new immunizations or treatments. Currently, three vaccines have been approved through the EUA process for COVID-19. These vaccines have additionally been reviewed and found safe by national experts participating in a Western States Scientific Safety Review Workgroup. Data has continued to show that the risks of infection, hospitalization, and death for vaccinated individuals are dramatically lower than for those who have not been vaccinated.[2]

Misinformation and Disinformation. This bill is intended to target three types of false or misleading information relating to the COVID-19 pandemic. First, the language refers to nonfactual information regarding "the nature and risks of the virus"—for example, misleadingly comparing COVID-19 to less serious conditions or inaccurately characterizing the deadliness of the disease. Second, the bill seeks to address false statements regarding its "prevention and treatment"—this would presumably include the promotion of treatments and therapies that have no proven effectiveness against the virus. The third category is for misinformation or disinformation regarding "the development, safety, and effectiveness of COVID-19 vaccines."

Public skepticism and misunderstanding of diseases, treatments, and immunizations is not unique to COVID-19. The earliest known group formed to oppose vaccination programs, the National Anti-Vaccination League, was established in the United Kingdom in 1866 following a series of violent protests against mandatory smallpox immunizations in the Vaccination Act of 1853.[3] In 1918, conspiracy theories were circulated that the Spanish Flu pandemic was a deliberate act of biological warfare, spread through aspirin manufactured by German company Bayer.[4]

What has been historically unprecedented about the dissemination of misinformation and disinformation throughout the COVID-19 pandemic is the omnipresence of media coverage and the prevalence of social media. False information can easily be spread to millions within days or even hours of it being created. It can become challenging for a population already feeling overloaded with complex information to differentiate between thoroughly researched, accurate reporting and information that is oversimplified, unproven, or patently false.[5]

A substantial factor in the spread of false information is a phenomenon known as "confirmation bias." When individuals hold a preexisting belief or suspicion, they will often unconsciously seek out information to validate that predisposition and filter out contradictory evidence.[6] The persistence of modern media exposure and the internet has exacerbated this effect, as information seeming to support virtually any viewpoint or understanding can now easily be found through the use of search engines and social media. Many websites further exacerbate the issue of confirmation bias by algorithmically delivering consistent information to users who have demonstrated a pattern of belief or ideology.

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[2] Dyer, Owen. "COVID-19: Unvaccinated face 11 times risk of death from delta variant, CDC data show." *BMJ (Clinical research ed.)* vol. 374 (2021).
[3] Wolfe, Robert M. "Anti-vaccinationists past and present." *BMJ (Clinical research ed.)* vol. 325 (2002).
[4] Johnson, Norman A. "The 1918 flu pandemic and its aftermath." *Evo Edu Outreach* 11, 5 (2018).
[5] Nelson, Taylor. "The Danger of Misinformation in the COVID-19 Crisis." *Missouri medicine vol. 117*, 6 (2020).
[6] Nickerson, Raymond S. "Confirmation bias: A ubiquitous phenomenon in many guises." *Review of General Psychology*, 2 (1998).

The role of physicians and other health professionals in legitimizing false information during the COVID-19 pandemic has presented serious implications for public safety. For example, the federal Centers for Disease Control and Prevention (CDC) has for decades been recognized as the United States government's primary agency for protecting Americans through expert research and advice related to the control and prevention of communicable disease. The CDC has consistently warned Americans about the threat of COVID-19 and strongly encouraged vaccination. However, throughout the pandemic, many individuals who are predisposed toward skepticism of the government and incredulity toward vaccines have sought to validate those views, despite unambiguous guidance to the contrary from leading health experts.

As a result, health practitioners whose views on COVID-19 and immunization against it are within the extreme minority for their profession are armed with a disproportionately loud voice in the public discourse. Antigovernment cynics and vaccine skeptics cohere to the opinions of those few physicians who will reinforce their beliefs as they seek to appeal to authority in service of their confirmation bias.[7] The effect of this is that a relatively small group of public health contrarians who are licensed as physicians will be afforded the same, if not more, credibility as long-trusted public institutions like the CDC, the FDA, and the American Medical Association, even if those physicians do not specialize in epidemiology or infectious disease prevention.

The incongruity of this reasoning is frequently rationalized in part through conspiracy theories about the medical establishment. This is not novel. When allopathic medicine first achieved dominance during the Progressive Era, there were many who vilified the medical system as financially motivated, accusing "modern medicine men" of oppressing natural therapies in order to profit from a monopoly on health care practice.[8] Other related conspiracy theories frequently involve the United States government, which has been accused of everything from inventing or exaggerating the pandemic to suppressing natural remedies, or even using COVID-19 vaccines as a clandestine method for implanting microchips into Americans.[9]

Role of State Medical Boards. Physicians and surgeons in California are regulated by one of two entities: the Medical Board of California (MBC) or the Osteopathic Medical Board of California (OMBC). The MBC licenses and regulates about 153,000 physicians while the OMBC licenses and regulates slightly over 12,000. Despite receiving different forms of medical education and being overseen by separate boards, the essential scope of practice for these two categories of licensees are virtually identical.

In July of 2021, the Federation of State Medical Boards (FSMB) issued a statement positioned as being "in response to a dramatic increase in the dissemination of COVID-19 vaccine misinformation and disinformation by physicians and other health care professionals on social media platforms, online and in the media." The FSMB warned that physicians who engage in the spread of false information related to COVID-19 were jeopardizing their licenses to practice medicine. While physicians are subject to discipline only by boards located in states where they hold a license, the FSMB's statement was viewed as a serious warning to doctors that they risked disciplinary action if they engaged in spreading inaccurate information.

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[7] Topf, Joel M., and Williams, Paul N. "COVID-19, social media, and the role of the public physician." *Blood Purification* 50.4-5 (2021).
[8] Burrow, JG. *Organized Medicine in the Progressive Era: The Move Toward Monopoly*. Baltimore, MD: Johns Hopkins University Press (1977).
[9] Rubin, Rita. "When Physicians Spread Unscientific Information About COVID-19." *JAMA* 327 (2002).

Following the FSMB's statement, some state medical boards appeared poised to take action against licensees found to be spreading misinformation or disinformation. Tennessee's Board of Medical Examiners adopted the FSMB's statement as their own. However, in response, the state's Republican legislature threatened to disband the board if it sought to take any such action against a physician. Legislation in at least fourteen states has been introduced to prevent medical boards from holding physicians who spread false information accountable in accordance with the FSMB's guidance.[10]

In contrast to legislative action taken in those states, this bill would seek to confirm that in California, physicians who disseminate COVID-19 misinformation or disinformation are indeed subject to formal discipline. The bill would expressly establish that such dissemination would constitute "unprofessional conduct"—a term used prolifically in the Medical Practice Act as a general description of numerous forms of conduct for which disciplinary action may be taken. The MBC or OMBC would be required to consider multiple factors prior to filing an accusation, but would ultimately be authorized to take enforcement action against physicians who have used their licenses to jeopardize public health and safety through the spread of false information.

It is certainly meaningful that this bill would establish as a matter of California law that physicians are subject to discipline for spreading false information. However, it is more than likely that the MBC and OMBC are both already fully capable of bringing an accusation against a physician for this type of misconduct. For example, the Medical Practice Act includes "gross negligence" and "repeated negligent acts" within the meaning of unprofessional conduct, representing situations where the physician deviated from the standard of care in the opinion of the MBC and its expert medical reviewers.

If, for example, a physician were to advise patients to inject disinfectant as a way of treating COVID-19—as former President Trump once did, resulting in a sharp rise in reported incidents of misusing bleach and other cleaning products[11]—disseminating that "misinformation" would almost certainly be considered negligent care subject to discipline. Whether a case of spreading misinformation is sufficient to bring an action for gross negligence would be evaluated using the MBC's expert reviewer guidelines, which provide that "the determining factor is the *degree* of departure from the applicable standard of care." Similarly, it is arguable that spreading "disinformation" as commonly defined would constitute an "act of dishonesty or corruption"—also statutorily included within the Medical Practice Act's meaning of unprofessional conduct.

Those in opposition to this bill have expressed concern that the MBC would overzealously prosecute doctors for expressing views that are outside the mainstream but not indisputably unreasonable based on the physician's research and training. This apprehension cannot easily be reconciled with persistent criticisms levied against the MBC by the Legislature and patient safety advocates, who have repeatedly reproved the board for its underwhelming enforcement activities. Major news editorials have pointed out that the MBC only takes formal disciplinary action in about three percent of cases, and that more than 80 percent of complaints are dismissed without investigation. As the Legislature persists in its admonishment of the MBC for failing to take aggressive action against physicians who commit unprofessional conduct, it would appear dubious that the board would excessively utilize the authority expressly provided by this bill.

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[10] https://www.audacy.com/wccoradio/news/national/laws-are-stopping-medical-boards-from-punishing-doctors
[11] Gharpure, Radhika. "Knowledge and Practices Regarding Safe Household Cleaning and Disinfection for COVID-19 Prevention." *Morbidity and Mortality Weekly Report*, 69 (2020).

It stands to reason that Californians who have demonstrated suspicion toward both the medical establishment and their government would be slow to trust the MBC, with a majority of its members consisting of physicians appointed by the Governor. However, the degree of enmity recently exhibited by physicians and others opposed to COVID-19 prevention policies could be viewed as disturbing. In December of 2021, it was reported that representatives of an anti-vaccination organization called America's Frontline Doctors had stalked and intimidated Kristina Lawson, President of the MBC.[12] This harassment was escalated in April of 2022 when that same organization "released a 21-minute video that depicts Lawson in Nazi regalia, a whip in her hand and swastika on her shoulder, and shows a clip of the garage confrontation validating Lawson's description."[13]

America's Frontline Doctors was founded by Dr. Simone Gold, who holds an active license in California as a physician. Dr. Gold and her organization have vociferously promoted hydroxychloroquine as a COVID-19 treatment, despite evidence increasingly showing it to be ineffective and potentially unsafe.[14] Dr. Gold has engaged in multiple campaigns to stoke public distrust in COVID-19 vaccines, characterizing them as "experimental" despite numerous safety and efficacy trials successfully confirming their safety and efficacy.[15] Dr. Gold spoke at a rally held in conjunction with the attempted insurrection on the United States Capitol on January 6, 2021; she was arrested and subsequently pleaded guilty to a misdemeanor relating to that event.

Despite what would appear to be repeated conduct perpetrated by Dr. Gold involving the dissemination of false information regarding COVID-19, Dr. Gold's license remains active with the MBC and there appears to be no record of any disciplinary action taken against her.[16] Given the air of legitimacy she sustains from her status as a licensed physician, Dr. Gold likely serves as an illustrative example of the type of behavior that the author of this bill seeks to unequivocally establish as constituting unprofessional conduct for physicians in California. Regardless of whether similar authority is already available to the MBC through other enforceable provisions in the Medical Practice Act, it is understandable that the author desires to make this authority explicit and confirm that doctors licensed in California who disseminate misinformation or disinformation should be held fully accountable.

Current Related Legislation. AB 1636 (Weber) would prohibit the MBC from granting or reinstating physician certificates to individuals who commit sexual misconduct and require the MBC to revoke the licenses of physicians to commit such misconduct. *This bill is pending in this committee.*

AB 1767 (Boerner Horvath) would remove licensed midwives from the jurisdiction of the MBC and establish a new board to license and regulate that profession. *This bill is pending in this committee.*

AB 2060 (Quirk) would change the membership composition of the MBC so that a majority of the board consists of public members. *This bill is pending in this committee.*

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[12] https://www.latimes.com/business/story/2021-12-10/covid-anti-vax-confrontations
[13] https://www.latimes.com/business/story/2022-04-06/covid-anti-vaxxers-campaign-against-public-health-advocates-gets-more-extreme
[14] Singh, Bhagteshwar. "Chloroquine or hydroxychloroquine for prevention and treatment of COVID-19." *The Cochrane database of systematic reviews vol. 2*, 2 (2021).
[15] https://www.medpagetoday.com/infectiousdisease/covid19/90536
[16] https://search.dca.ca.gov/details/8002/G/70224/595d067c562f072a5e7b25c913b285cf

Prior Related Legislation. SB 806 (Roth, Chapter 649, Statutes of 2021) extended the sunset date for the MBC until January 1, 2023 and made numerous reforms to the Medical Practice Act.

AB 1909 (Gonzalez) would have provided that performing an examination on a patient for the purpose of determining whether the patient is a virgin constitutes unprofessional conduct. *This bill was not presented for a vote in this committee.*

AB 1278 (Nazarian) would have provided that failing to post an Open Payments database notice constitutes unprofessional conduct. *This bill was held on the Assembly Appropriations Committee's suspense file.*

SB 1448 (Hill, Chapter 570, Statutes of 2018) requires physicians and surgeons, osteopathic physicians and surgeons, podiatrists, acupuncturists, chiropractors and naturopathic doctors to notify patients of their probationary status beginning July 1, 2019.

ARGUMENTS IN SUPPORT:

The **California Medical Association** (CMA) is sponsoring this bill. According to the CMA: "The COVID-19 pandemic has unfortunately led to increasing amounts of misinformation and disinformation related to the disease including how the virus is transmitted, promoting untested treatments and cures, and calling into question public health efforts such as masking and vaccinations. Many health professionals, including physicians, have been the culprits of this misinformation and disinformation effort." The CMA goes on to argue that "while the MBC may have the ability to discipline licensees for unprofessional conduct under Business and Professions Code section 2234, AB 2098 makes clear that the MBC has the statutory authority to take such actions against physicians that spread COVID-19 misinformation or disinformation."

The **American Academy of Pediatrics, California** is in support of this bill, writing: "Licensed physicians possess a high degree of public trust and therefore have a powerful platform in society. When they choose to spread inaccurate information, physicians contradict their responsibilities and further erode public trust in the medical profession. By passing this bill, California will demonstrate its unwavering support for a scientifically informed populous to protect ourselves from COVID-19."

ARGUMENTS IN OPPOSITION:

A Voice for Choice Advocacy opposes this bill, writing: "While we agree that physicians and surgeons should be disciplined for maliciously sharing misinformation and disinformation, there are already measures in place for the California Medical Board to discipline for such offenses. Furthermore, AB 2098 is overly broad and would be impossible to implement because there is no definition and no established 'standard of care' or 'contemporary scientific consensus' for treating SARS-COV-2/COVID-19."

Californians for Good Governance opposes this bill "based on concerns about its unconstitutional restrictions on free speech." The organization argues that "while the state may be able to claim that providing the public with accurate information regarding Covid-19 is a compelling interest, it cannot possibly argue that the blunt weapon that AB 2098 represents is narrowly tailored to that interest." The organization further states that "in a country such as ours, which was established on the foundation of civil liberties such as free speech, the truth is something hashed out in the marketplace of ideas, rather than dictated by the government."

POLICY ISSUE(S) FOR CONSIDERATION:

Lack of Definitions. The intent of this bill is made clear in the subdivision providing that "it shall constitute unprofessional conduct for a physician and surgeon to disseminate or promote misinformation or disinformation related to COVID-19." However, the terms "misinformation," "disinformation," and "disseminate" are not defined. Provisions outlining what factors the MBC or OMBC must consider prior to bringing a disciplinary action do suggest how false information should be deemed enforceable under the bill, with some of the language taken directly from definitions provided by the CDC on its public guidance regarding misinformation and disinformation.[17] To ensure greater clarity with regards to how this bill should be interpreted and implemented by the MBC and the OMBC within their existing enforcement architecture, the author should consider amendments restructuring the bill to provide for clearer definitions.

Constitutionality. Many of the opposition arguments regarding this bill have revolved around the concept of "free speech" and whether a state law penalizing physicians for conveying information determined to be false is lawful under the United States Constitution. It is certainly true that the First Amendment prohibits laws "abridging the freedom of speech." However, the Supreme Court of the United States has repeatedly confirmed that this constitutional right is not absolute.

A key factor in determining whether a statute like the one proposed in this bill violates the First Amendment is whether the law would in fact regulate professional *speech* as opposed professional *conduct*. The United States Court of Appeals for the Ninth Circuit discussed this distinction extensively in its decision upholding the constitutionality of California's ban on licensed health professionals providing therapies intended to change a patient's sexual orientation or identity.[18] That decision noted that "doctor-patient communications *about* medical treatment receive substantial First Amendment protection, but the government has more leeway to regulate the conduct necessary to administering treatment itself."

To illustrate the critical difference between the regulation of professional speech versus professional conduct, the Ninth Circuit suggested that the issue be viewed "along a continuum." First, the Ninth Circuit stated that "where a professional is engaged in a public dialogue, First Amendment protection is at its greatest. Thus, for example, a doctor who publicly advocates a treatment that the medical establishment considers outside the mainstream, or even dangerous, is entitled to robust protection under the First Amendment—just as any person is—even though the state has the power to regulate medicine."

The Ninth Circuit then suggested that "at the midpoint of the continuum, within the confines of a professional relationship, First Amendment protection of a professional's speech is somewhat diminished." As an example, the decision cited *Planned Parenthood v. Casey*, in which the Supreme Court upheld a requirement that doctors disclose truthful, nonmisleading information to patients about certain risks of abortion. In this case, the Supreme Court ruled that "the physician's First Amendment rights not to speak are implicated, but only as part of the practice of medicine, subject to reasonable licensing and regulation by the State."[19]

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[17] https://www.cdc.gov/vaccines/covid-19/health-departments/addressing-vaccine-misinformation.html
[18] *Pickup v. Brown*, 728 F.3d 1042 (2015).
[19] *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 884 (1992).

The Ninth Circuit ultimately ruled that California's ban on gay conversion therapy fell at the far end of the continuum, in that it consisted of "the regulation of professional conduct, where the state's power is great, even though such regulation may have an incidental effect on speech." The ruling explained that while much of the practice of medicine requires speech to effectuate treatment and therapy in the form of prescriptions, recommendations, and counseling, this is incidental to the regulation of professional conduct, which is the core purpose of all state and federal license requirements. The Supreme Court declined to grant review of the Ninth Circuit's decision, and the California law remains in effect.

A recent decision issued by the Supreme Court in *National Institute of Family and Life Advocates v. Becerra*—which declared that a California law requiring crisis pregnancy centers to make disclosures about pregnancy options was unconstitutional—has frequently been cited as a key precedent for determining whether state laws implicating professional speech are impermissible under the First Amendment.[20] In that decision, the Supreme Court declined to recognize the Ninth Circuit's treatment of "professional speech" as a separate category afforded less protection than other forms of speech. However, the Supreme Court did affirm that "states may regulate professional conduct, even though that conduct incidentally involves speech."

Whether this bill would be considered constitutionally valid would in large part depend on how it is interpreted and enforced. If the MBC or the OMBC were to take action against a physician for statements made to the general public about COVID-19 through social media or at a public protest, a court may find that this speech falls at the end of the spectrum where the First Amendment's protections are strongest. However, if a physician were to be subjected to formal discipline for communications made to a patient under their care in the form of treatment or advice, this would quite likely be considered professional conduct that may be more heavily regulated through the state's police power.

AMENDMENTS:

1) To clarify the meaning of terms used in the bill to align with the boards' existing authority to regulate professional conduct, insert the following provisions to the definitions contained in subdivision (c):

   (3) "Misinformation" means false information that is contradicted by contemporary scientific consensus to an extent where its dissemination constitutes gross negligence by the licensee.

   (4) "Disinformation" means misinformation that the licensee deliberately disseminated with malicious intent or an intent to mislead.

   (5) "Disseminate" means the communication of information from the licensee to a patient under the licensee's care in the form of treatment or advice.

2) To reflect that much of the language currently provided as factors for a board to consider has been relocated to the bill's definitions, strike the current subdivision (b) and insert the following:

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[20] *National Institute of Family and Life Advocates v. Becerra*, 585 U.S. ___ (2018).

(b) Prior to bringing a disciplinary action against a licensee under this section, the board shall consider both whether the licensee departed from the applicable standard of care and whether the misinformation or disinformation resulted in harm to patient health.

3) To add a severability clause to protect the enforceability of the bill following any adverse ruling on the validity of a certain provision or application, insert a new Section 3 as follows:

The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

4) To update statistics in the bill's findings and declarations, amend Section 1 to replace "5,000,000" with "6,000,000 and "75,000" with "90,000."

REGISTERED SUPPORT:

California Medical Association *(Sponsor)*
American Academy of Pediatrics, California
American College of Obstetricians and Gynecologists District IX
California Chapter of the American College of Emergency Physicians
California Podiatric Medical Association
California Rheumatology Alliance
California Society of Anesthesiologists
Children's Specialty Care Coalition
Families for Opening Carlsbad Schools
Numerous individuals

REGISTERED OPPOSITION:

A Voice for Choice Advocacy
California Health Coalition Advocacy
Californians for Good Governance
Catholic Families 4 Freedom CA
Central Coast Health Coalition
Children's Health Defense California Chapter
Concerned Women for America
Depression and Bipolar Support Alliance California
Educate. Advocate.
Frederick Douglass Foundation of California
Homewatch Caregivers of Huntington Beach
Nuremberg 2.0 LTD.
Pacific Justice Institute
Physicians for Informed Consent
Protection of the Educational Rights for Kids
Restore Childhood
Siskiyou Conservative Republicans
Stand Up Sacramento County
Numerous individuals

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

Date of Hearing: April 19, 2022

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 2236 (Low) – As Amended March 17, 2022

SUBJECT: Optometry.

SUMMARY: Updates training requirements for optometric assistants, requires optometrists to stabilize and refer patients with certain conditions to an ophthalmologist, and makes other technical changes to the Optometry Act.

EXISTING LAW:

1) Establishes the California State Board of Optometry (CBO) for the licensure and regulation of optometrists, registered dispensing opticians, contact lens dispensers, spectacle lens dispensers, and nonresident contact lens dispensers. (Business and Professions Code (BPC) §§ 3000 *et seq.*)

2) Establishes the Medical Board of California for the licensure and regulation of physicians and surgeons, including ophthalmologists specializing in the diagnosis and treatment of eye disorders. (BPC §§ 2000 *et seq.*)

3) Makes it unlawful for a person to engage in or advertise the practice of optometry without having first obtained an optometrist license from the CBO. (BPC § 3040)

4) Provides that the practice of optometry includes the prevention, diagnosis, treatment, and management of disorders and dysfunctions of the visual system, as well as the provision of habilitative or rehabilitative optometric services, and specifically authorizes an optometrist who is certified to use therapeutic pharmaceutical agents to diagnose and treat the human eye for various enumerated conditions. (BPC § 3041)

5) Requires an optometrist seeking certification to use therapeutic pharmaceutical agents and diagnose and treat specified conditions to apply for a certificate from the CBO and meet additional education and training requirements. (BPC § 3041.3)

6) Authorizes an assistant in any setting where optometry or ophthalmology is practiced who is acting under the direct responsibility and supervision of a physician and surgeon or optometrist to fit prescription lenses and perform specified services, including performing preliminary subjective refraction procedures in connection with finalizing procedures performed by an ophthalmologist or optometrist, subject to certain conditions, including at least 45 hours of documented training in subjective refraction procedures. (BPC § 2544)

THIS BILL:

1) Provides that the 45 hours of training currently required for optometric assistants who perform preliminary subjective refraction procedures must include the performance of those procedures.

2) Requires an optometrist diagnosing or suspecting angle closure glaucoma to attempt medical stabilization, if possible, and immediately refer the patient to an ophthalmologist.

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

COMMENTS:

Purpose. This bill is sponsored by the **California Optometric Association**.

Background.

Optometry Scope Expansion. In the wake of what many regard to be a physician shortage in California, efforts have been made to expand the scope of practice for optometrists to provide services traditionally reserved for physicians and surgeons specializing in ophthalmology. For example, legislation enacted in recent years have allowed optometrists to treat glaucoma, use therapeutic pharmaceutical agents, employ the use of new drugs and technologies to treat certain conditions, and treat patients with topical and oral therapeutic pharmaceutical agents. These efforts have drawn on the extensive training optometrists receive to empower them to provide additional services and alleviate the need for patients to obtain care from an ophthalmologist.

Acute Closed Angle Glaucoma. Acute angle-closure glaucoma is an ocular emergency that results from a rapid increase in pressure due to a blockage or obstruction of the outflow of aqueous humor (clear fluid in the space towards the front of the eye). The rapid increase in pressure (glaucoma) can damage the optic nerve and eventually lead to blindness. Initial treatment for acute angle-closure glaucoma can include the application of medications or other procedures to reduce intraocular pressure, but ultimately it may require the use of lasers or surgery. This bill would reinsert the authority for optometrists to stabilize the condition and reinsert the requirement that the optometrist immediately refers the patient to an ophthalmologist.

Training for Optometric Assistants. Another recently enacted change to the law expanded the types of procedures that may be performed by optometric assistants, who are unlicensed individuals working under the supervision of an optometrist or an ophthalmologist. Last year, legislation allowed for these assistants to perform preliminary subjective refraction procedures in connection with finalizing subjective refraction procedures performed by an ophthalmologist or optometrist, subject to certain conditions. One of those conditions is a requirement that the assistant have at least 45 hours of documented training in subjective refraction procedures acceptable to the supervising ophthalmologist or optometrist. This bill would specify that this training must include the performance of those procedures.

Current Related Legislation. AB 2574 (Salas) contains provisions similar to those in this bill and additionally corrects an erroneous cross-reference. *This bill is pending in the Assembly Committee on Appropriations.*

Prior Related Legislation. AB 407 (Salas, Chapter 652, Statutes of 2021) expanded and revised the scope of practice for qualified optometrists and optometric assistants to diagnose and treat specified disorders and dysfunctions of the visual system and authorized optometric assistants to perform preliminary subjective refraction procedures under specified conditions.

AB 1467 (Salas and Low) of 2019 would have authorized an optometrist to provide services outlined in a delegation of services agreement between the optometrist and an ophthalmologist. *This bill died in the Senate Committee on Business, Professions, and Economic Development.*

AB 443 (Salas, Chapter 549, Statutes of 2017) expanded the scope of practice for optometrists to include additional procedures including the administration of specific immunizations for optometrists who meet certain training requirements.

SB 1406 (Correa, Chapter 352, Statutes of 2008) expanded the scope of practice for optometrists, including establishing requirements for glaucoma certification and the requirement related to an acute closed-angle attack.

REGISTERED SUPPORT:

None on file.

REGISTERED OPPOSITION:

None on file.

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

Date of Hearing: April 19, 2022

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 1636 (Akilah Weber) – As Amended April 5, 2022

SUBJECT: Physician's and surgeon's certificate: registered sex offenders.

SUMMARY: Requires the Medical Board of California (MBC) to deny an initial license application, automatically revoke a license, or deny a petition to reinstate a license for individuals who have committed acts of sexual abuse, misconduct, or relations with a patient.

EXISTING LAW:

1) Enacts the Medical Practice Act, which provides for the licensure and regulation of physicians and surgeons. (Business and Professions Code (BPC) §§ 2000 *et seq*.)

2) Establishes the MBC, a regulatory board within the Department of Consumer Affairs (DCA) comprised of 15 appointed members, including 7 public members and 8 physicians, subject to repeal on January 1, 2024. (BPC § 2001)

3) 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)

4) Entrusts the MBC with responsibility for all of the following:

   a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

   b) The administration and hearing of disciplinary actions.

   c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

   d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

   e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

   f) Approving undergraduate and graduate medical education programs.

   g) Approving clinical clerkship and special programs and hospitals.

   h) Issuing licenses and certificates under the board's jurisdiction.

   i) Administering the board's continuing medical education program.

   (BPC § 2004)

5) Authorizes the MBC to appoint panels of at least four of its members for the purpose of fulfilling its disciplinary obligations, and requires that a majority of the panel members be physicians. (BPC § 2008)

6) With approval from the Director of Consumer Affairs, authorizes the MBC to employ an executive director as well as investigators, legal counsel, medical consultants, and other assistance, but provides that the Attorney General is legal counsel for the MBC in any judicial and administrative proceedings. (BPC § 2020)

7) Allows the MBC to select and contract with necessary medical consultants who are licensed physicians to assist it in its programs. (BPC § 2024)

8) Requires the MBC to adopt regulations to require its licentiates and registrants to provide notice to their clients or patients that the practitioner is licensed or registered in California by the board, that the practitioner's license can be checked, and that complaints against the practitioner can be made through the board's Internet Web site or by contacting the board. (BPC § 2026)

9) Requires the MBC to post on its Internet Web site the current status of its 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)

10) Empowers the MBC to take action against persons guilty of violating the Medical Practice Act. (BPC § 2220)

1) Requires the Director of Consumer Affairs to appoint an independent enforcement monitor no later than March 1, 2022 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)

11) 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 one or more 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)

12) Clarifies that the MBC is the only licensing board that is authorized to investigate or commence disciplinary actions relating to the physicians it licenses. (BPC § 2220.5)

13) Authorizes the MBC to either deny an application for licensure as a physician and surgeon or to issue a probationary license subject to terms and conditions. (BPC § 2221)

14) Provides that a 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, may be subject to any of the following disciplinary actions:

a) Have their license revoked upon order of the board.

b) Have their right to practice suspended for a period not to exceed one year upon order of the MBC.

c) Be placed on probation and be required to pay the costs of probation monitoring upon order of the MBC.

d) Be publicly reprimanded by the MBC, which may include a requirement that the licensee complete relevant educational courses approved by the MBC.

e) Have any other action taken in relation to discipline as part of an order of probation, as the MBC or an administrative law judge may deem proper.

(BPC § 2227)

15) Enacts the Patient's Right to Know Act of 2018 to require certain healing arts licensees, including physicians, 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 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. (BPC § 2232)

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) 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)

20) 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 in California by the MBC, constitutes grounds for disciplinary action for unprofessional conduct against the licensee in California. (BPC § 2305)

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

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

23) Requires the MBC to set as a goal the improvement of its disciplinary system so that an average of no more than six months will elapse from the receipt of complaint to the completion of an investigation. (BPC § 2319)

24) Requires that licensees be given notification of proposed actions to be taken against the licensee by the MBC and be given the opportunity to provide a statement to the deputy attorney general assigned to the case. (BPC § 2330)

25) Establishes the Osteopathic Medical Board of California (OMBC), which licenses and regulates osteopathic physicians and surgeons who possess effectively the same practice privileges as those regulated by MBC but with a training emphasis on diagnosis and treatment of patients through an integrated, whole-person approach. (BPC § 2450)

26) Limits the authority for most licensing boards under the DCA to deny a new license application to cases where the applicant was formally convicted of a substantially related crime or subjected to formal discipline by a licensing board following, with most offenses older than seven years no longer eligible for license denial. (BPC § 480)

THIS BILL:

1) Requires the MBC to deny an application for licensure as a physician from any applicant who has been required to register as a sex offender, or who was convicted in another state for a crime that would require registration in California, with the exception of registrations required following convictions of a misdemeanor for indecent exposure.

2) Requires the MBC to deny an application for licensure as a physician from any applicant who was formally disciplined by a licensing board in or outside of California for professional misconduct constituting an act of sexual abuse, misconduct, or relations with a patient.

3) Prohibits an applicant from ever reapplying for licensure as a physician if they have previously been denied for any of the above causes.

4) Allows the MBC to automatically revoke a license if the board discovers, after a license is granted, that the applicant's application would have been denied for any of the above causes.

5) Requires the MBC to automatically revoke the license of any physician who has been convicted in another state of a crime that would have required sex offender registration in California.

6) Repeals an exemption from automatic revocation for offenses who have subsequently been relieved of their duty to register as a sex offender in California.

7) Eliminates the ability of a person whose license was revoked before January 1, 2005 following registration as a sex offender to petition a superior court to determine that the individual no longer poses a risk to patients and order the MBC to reinstate their license.

8) Prohibits the MBC from reinstating the license of any person whose license was surrendered or revoked for committing an act of sexual abuse, misconduct, or relations with a patient, or following conviction of a crime requiring registration as a sex offender wherein the person engaged in the offense with a patient or client, with the exception of registration required following conviction of a misdemeanor for indecent exposure

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

COMMENTS:

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

> "This bill will protect patients from criminal sexual misconduct and ensure that any physician who violates a patient's trust cannot be licensed in California."

Background.

Physicians and Surgeons. Physicians and surgeons in California are regulated by one of two entities: the MBC or the OMB. The MBC licenses and regulates about 153,000 physicians while the OMBC licenses and regulates slightly over 12,000. Despite receiving different forms of medical education and being overseen by separate boards, the essential scope of practice for these two categories of licensees are virtually identical. Generally speaking, most provisions governing discipline for unprofessional conduct by the MBC also apply to the OMBC.

Denials of Applications for Licensure. The MBC is responsible for issuing licenses and certificates to physicians and surgeons. The MBC's licensing program ensures licenses are only issued to applicants who meet legal and regulatory requirements and who are not precluded from licensure based on past incidents or activities. Over the four years preceding its last sunset review, the MBC received over 29,000 new physician and surgeon applications.

All applicants must obtain fingerprint criminal record background checks from both the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI) prior to the issuance of a physician's medical license in California from the MBC. The MBC also queries the National Practitioner Databank, a confidential information clearinghouse created by Congress to improve health care quality, protect the public, and reduce health care fraud and abuse in the United States, which contains a record of disciplinary actions taken by other states and jurisdictions. Over the four years preceding the board's most recent sunset review, the MBC denied nine applications for licensure as a physician and surgeon based on criminal history that the Board determined was substantially related to the qualifications, functions, or duties of the profession.

Revocation of Licenses. 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 one or more patients during a course of treatment or an examination. An accusation filed against a physician alleging sexual misconduct must be filed within three years after it is discovered by the MBC, or within 10 years after the act occurs, whichever occurs first. Any proposed decision or decision that contains any finding of fact that a physician engaged in an act of sexual exploitation is required to contain an order of revocation, which cannot be stayed by the administrative law judge.

The MBC is required to automatically revoke the license of any person who has been required to register as a sex offender, regardless of whether the related conviction has been appealed. The only exception to this requirement is for cases where the criminal conviction resulting in registration was a misdemeanor for indecent exposure. Physicians subjected to automatic revocation may request a hearing within 30 days of the revocation. Five years after the automatic revocation and three years after discharge from parole or probation, the individual can petition a superior court to determine that the individual no longer poses a risk to patients and order the MBC to reinstate their license.

License Reinstatement. 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 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 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 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.

Sexual Misconduct by Physicians. In December of 2021, the *Los Angeles Time* published an investigative report as part of an ongoing series of articles and opinion pieces relating to the MBC and its enforcement activities. The article was titled: "These doctors sexually abused patients. The Medical Board gave them their licenses back." [1] The article detailed several cases where a physician committed sexual abuse against a patient, lost their license, but then successfully reinstated to have that license reinstated five or more years later. The *Times* reported that ten physicians who had lost their licenses for sexual misconduct had successfully petitioned for reinstatement since 2013, and that the MBC "reinstated more than half of all sex abusers who sought to get their licenses back, a rate significantly higher than for doctors who lost their licenses for all other reasons."

The *Times* further reported that in response to its criticisms about the reinstatement process, MBC Board President Kristina Lawson conceded that there was "room for improvement" but that the MBC is "bound by state regulations that, among other things, prevent it from deeming some offenses — such as sexual misconduct with a minor — permanently disqualifying." Shortly after the release of the original article, the *Times* published a follow-up piece titled: "*Times'* sex abuse investigation triggers calls for reform of state Medical Board."[2] This article featured the following characterization of Governor Gavin Newsom's response:

> "[A] spokeswoman for the governor, wrote via email: 'Any claims of sexual assault, especially against minors, should be taken seriously.' She called on lawmakers to 'hold people accountable' but did not specify how they should do that. … She also said the governor expects board members to 'use their full authority' to hold doctors accountable but did not say whether he thinks they have done so in the cases cited by The Times."

The California Medical Association (CMA) also provided a response to the *Times* article, stating that it was "abhorrent and intolerable." The CMA spokesperson further commented that "each instance is a flagrant abandonment of what it means to be a doctor and constitutes heinous criminal behavior that should result in the permanent revocation of a license to practice medicine." The CMA spokesperson added: "Any physician who violates a patient's trust and the sanctity of the physician-patient relationship in this way has no place in the medical profession."

This bill was subsequently introduced by the author in an effort to ensure that the MBC will no longer allow physicians who were determined to have committed sexual misconduct involving patients to practice. It does this by limiting the MBC's discretion at three stages by requiring:

1) Mandatory denial of applications for initial licensure for applicants who were previously convicted of, or disciplined for, sexual offenses and sexual misconduct;

2) Automatic license revocation for practicing physicians who commit sexual misconduct involving a patient; and

3) A lifetime prohibition against reinstatement for physicians whose licenses were revoked or surrendered due to sexual misconduct involving a patient.

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[1] https://www.latimes.com/california/story/2021-12-15/california-medical-board-doctor-patient-sexual-abuse-license-reinstate

[2] https://www.latimes.com/california/story/2021-12-16/medical-board-reaction-story

Current Related Legislation. AB 2060 (Quirk) would change the membership composition of the MBC so that a majority of the board consists of public members. *This bill is pending in this committee.*

AB 2098 (Low) would expressly provide that the dissemination of misinformation or disinformation related to COVID-19 by physicians and surgeons constitutes unprofessional conduct. *This bill is pending in this committee.*

Prior Related Legislation. SB 806 (Roth, Chapter 649, Statutes of 2021) extended the sunset date for the MBC until January 1, 2023 and made numerous reforms to the Medical Practice Act.

SB 1448 (Hill, Chapter 570, Statutes of 2018) requires physicians and surgeons, osteopathic physicians and surgeons, podiatrists, acupuncturists, chiropractors and naturopathic doctors to notify patients of their probationary status beginning July 1, 2019.

ARGUMENTS IN SUPPORT:

The **California Medical Association** (CMA) is sponsoring this bill, citing the *Los Angeles Times* reporting. The CMA explains that "AB 1636 is 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. For these reasons, CMA is proud to sponsor AB 1636."

The **Consumer Protection Policy Center** (CPPC), an advocacy organization based at the University of San Diego School of Law, supports this bill. According to the CPPC: "The patient-doctor relationship is based on trust, and patients in this relationship are in a particularly vulnerable situation. No physician or surgeon who has engaged in sexual misconduct requiring registration as a sex offender should be allowed to return to practice, thus allowing their patients to become their prey."

ARGUMENTS IN OPPOSITION:

The **Alliance for Constitutional Sex Offense Laws** opposes this bill, writing: "It appears that the basis of AB 1636 is the myth that everyone convicted of a sex offense poses a current danger to society regardless of how long ago the offense took place. This myth has been debunked by studies and reports issued by academia as well as by government organizations." The Alliance goes on to point out that "AB 1636 is inconsistent with legislation recently passed by the California legislature that defines and limits the authority of licensing boards (AB 2138) as well as allows courts to remove from the sex offender registry individuals who do not pose a current danger (Senate Bill 384)."

POLICY ISSUE(S) FOR CONSIDERATION:

Inconsistency with Fair Chance Licensing Act. In 2018, Assembly Bill 2138 (Chiu/Low, Chapter 995, Statutes of 2018) was signed into law, going into effect on July 1, 2020. The bill made substantial reforms to the application process for individuals with criminal records seeking licensure from a board or bureau under the DCA. Under AB 2138, an application may only be denied on the basis of prior misconduct if the applicant was formally convicted of a substantially related crime or was subject to formal discipline by a licensing board.

AB 2138 was introduced following persistent criticisms of how boards and bureaus under the DCA used their broad discretion to deny licensure to applicants with criminal histories. In its report *Unlicensed & Untapped: Removing Barriers to State Occupational Licenses for People with Records*, the National Employment Law Project (NELP) discusses the draconian nature of barriers to occupational entry based on criminal history. NELP's report refers to "a lack of transparency and predictability in the licensure decision-making process and confusion caused by a labyrinth of different restrictions" in regulatory schemes across the country.

One of the key reforms made by AB 2138 was language providing for a seven-year "washout" for prior misconduct. Under the bill, a criminal conviction or formal disciplinary action may only be cause for denial if it occurred within seven years prior to the application. This provision does have several exceptions—for example, all serious and violent felonies can be cause for an application denial with no limitations. Certain boards are authorized to deny an application for specified financial crimes regardless of age. Finally, criminal convictions for which the applicant was required to register as a sex offender were exempted from the washout; however, this exemption does not include Tier 3 sex offenses, which are the collection of offenders who may be required to register but who present the lowest risk to the public.

This bill would amend a section within the Medical Practice Act that specifically outlines how the MBC may deny an application for licensure. However, that section was preempted by AB 2138's changes to Section 480 of the Business and Professions Code, which is a statute universally governing how most entities under the DCA must handle review of license applications for individuals with criminal histories. The language in this bill would therefore be out of alignment with existing law and would arguably reverse progress made toward providing economic opportunity to individuals who committed misconduct prior to receiving the privileges of licensure.

Rather than amending an outdated statute within the Medical Practice Act, the author should consider instead making any changes to Section 480 that are considered to frustrate the intent of the bill, which is to prevent individuals who commit serious sexual misconduct from practicing medicine. For example, while Section 480 allows for serious sexual offenses older than seven years to be cause for disqualification of an application, there are currently no exemptions to the washout period for prior discipline. The author may wish to consider creating a similar exception to the language of AB 2138 for instances where past misconduct resulting in disciplinary action involved sexual misconduct with a patient.

AMENDMENTS:

To reconcile the bill with the provisions of AB 2138 and allow for the MBC and OMBC to deny licensure to applicants who were previously subjected to any formal discipline for sexual misconduct involving a patient, strike the current Section 1 from the bill and instead insert the following provision into paragraph (2) of subdivision (a) in Section 480:

> *Formal discipline that occurred earlier than seven years preceding the date of application may be grounds for denial of a license only if the formal discipline was for conduct that, if committed in this state by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2, would have constituted an act of sexual abuse, misconduct, or relations with a patient pursuant to Section 726 or sexual exploitation as defined in subdivision (a) of Section 729.*

REGISTERED SUPPORT:

California Medical Association *(Sponsor)*
American Academy of Pediatrics, California
American College of Obstetricians and Gynecologists District IX
California Academy of Family Physicians
California Rheumatology Alliance
California Society of Anesthesiologists
California State Association of Psychiatrists
Consumer Protection Policy Center, University of San Diego School of Law

REGISTERED OPPOSITION:

Alliance for Constitutional Sex Offense Laws

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

Date of Hearing: April 19, 2022

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 1704 (Chen) – As Amended April 18, 2022

NOTE: This bill is double referred and previously passed the Assembly Committee on Health as amended on a 12-1-2 vote. The amendments are reflected in this analysis but will not be reflected in the bill until April 18, 2022.

SUBJECT: Leg-podiatric X-ray equipment: certification or permit exemption.

SUMMARY: Creates an alternate permit process for unlicensed personnel to perform X-ray imaging under the supervision of a licensed podiatrist.

EXISTING LAW:

1) Regulates the practice of podiatric medicine under the Medical Practice Act, and establishes the Podiatric Medical Board of California (PMBC) to administer and enforce the provisions of the act relating to the practice of podiatric medicine. (BPC §§ 2460-2499.8)

2) Defines "podiatric medicine" as the diagnosis, medical, surgical, mechanical, manipulative, and electrical treatment of the human foot, including the ankle and tendons that insert into the foot, and the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot. (BPC § 2472(b)).

3) Prohibits the practice of podiatric medicine without obtaining a doctor of podiatric medicine (DPM) license from the PMBC or a physician's and surgeon's license. (BPC §§ 2052, 2472, 2474)

4) Regulates radiologic technology under the Radiology Technology Act to protect the public and radiation workers from excessive or improper exposure to ionizing radiation. (Health and Safety Code (HSC) §§ 27, 106965-107120, 114840-114896)

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

6) Authorizes limited permits for conducting radiologic technology limited to the performance of certain procedures or the application of X-rays to specific areas of the human body, including leg-podiatry radiography. (HSC § 114870(c)(1))

7) Requires the California Department of Public Health (CDPH) to appoint a certification committee to assist, advise, and make recommendations for the establishment of regulations necessary to ensure the proper administration and enforcement of radiologic technology certification. (HSC § 114855)

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

9) Exempts specified individuals from the radiologic certification and permitting requirements, including the following:

   a) Healing arts licensees. (HSC § 106975(a))

   b) A licensed dentist; or a person who, under the supervision of a licensed dentist, operates only dental radiographic equipment for the sole purpose of oral radiography and has passed the required course by the Dental Board of California (DBC). (HSC § 106975(e))

10) Regulates the practice of dentistry under the Dental Practice Act and establishes the DBC to administer and enforce the act. (BPC § 1600-1976)

11) Requires the DBC to approve a radiation safety course that includes theory and clinical application in radiographic technique and requires DBC to require the courses to be taught by persons qualified in radiographic technique and to adopt regulations specifying the qualifications for course instructors. (BPC § 1656(a))

THIS BILL:

1) Authorizes the PMBC to issue a person a limited permit in leg-podiatric radiography that exempts the permittee from existing radiologic certification and permitting requirements if the following are met:

   a) Completion of a course in radiation safety and radiologic technology jointly approved by the PMBC and the Radiologic Health Branch of the CDPH that complies with all of the following:

      i) The course includes theory and clinical application in radiographic techniques specific to the operation of leg-podiatric x-ray equipment.

      ii) The course, if online, requires additional in-person clinical training as necessary.

      iii) The course includes a minimum of 100 hours of education.

   b) The person has satisfied the eligibility requirements established in regulation by the CDPH.

2) Requires, no later than July 1, 2023, the PMBC and the Radiologic Health Branch of the CDPH to jointly approve and make available at least one course that complies with the requirements specified under this bill.

3) Specifies that a permit in leg-podiatric radiography authorizes the holder to operate leg-podiatric x-ray equipment in a podiatric office only while under the supervision of a certified supervisor and operator who is a licensed DPM.

4) Clarifies that this bill does not increase the scope of practice of a doctor of podiatric medicine or authorize the holder of the permit to perform x-rays beyond the foot, ankle, tibia, and fibula.

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

COMMENTS:

Purpose. This bill is sponsored by the *California Podiatric Medical Association*. According to the author, "This bill will create an alternate pathway for trained Podiatric [medical assistants] to take a comprehensive course/exam, certified by the [PMBC], to perform x-rays on specialized podiatric x-ray equipment with built in safety features, specific to the foot and ankle. This bill will enable our doctors to have more narrow, and specialized training for their desired fields."

Background. Currently, unlicensed personnel (medical assistants) may perform X-rays imaging under the supervision of a licensed DPM if they obtain a limited X-ray permit (or higher level of certification) from the CDPH. This bill would additionally allow them to obtain a permit from the PMBC if they meet specified coursework.

Doctors of Podiatric Medicine. "Podiatric medicine" means all medical treatment of the foot, ankle, and tendons that insert into the foot, including diagnosis, surgery, and the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot. Therefore, a DPM's scope of practice is similar to that of a physician and surgeon who specializes in the foot and ankle. However, unlike a physician and surgeon, whose scope is only limited by the licensee's area of competence, a DPM's scope is limited by the license to the foot and ankle.

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

Under the act, CDPH certifies individuals as radiologic technologists in diagnostic, therapeutic, and mammographic X-ray use; certifies and permits licensed medical, osteopathic, podiatric, and chiropractic doctors to use diagnostic or therapeutic X-rays within their scope of professional license; and approves schools that provide the training courses for non-licensee certificate or permit. These certificate or permit holders cannot use diagnostic or therapeutic X-rays unless that person has been certified or granted a permit, and is acting under the supervision of a licentiate of the healing arts.

The categories of limited permits include chest radiography, dental laboratory radiography, extremities radiography, leg-podiatric radiography, skull radiography, and torso-skeletal radiography.

Leg-Podiatric Radiography. This bill authorizes a person to obtain a limited leg-podiatric radiography permit from the PMBC in addition to the one offered by CDPH. Currently, a leg-podiatric radiography permit authorizes radiography of the knee, tibia, fibula, ankle, and foot. According to CDPH, there are currently 57 limited permit X-ray technicians who hold a leg-podiatric radiography permit. However, other certified and permitted individuals may perform leg-podiatric X-ray, such as those who hold an extremity X-ray technician permit (2,674) or certified radiologic technologists (27,634).

Safety Considerations in Leg-Podiatric Radiography Permits. The risks of X-ray imaging stem from the use of ionizing radiation (a form of radiation that has enough energy to potentially cause damage to DNA). Risk factors include the radiosensitivity of body organs, the nature and complexity of procedures to be performed, the radiation safety protection problems associated with X-ray procedures, the types of patients to be X-rayed (e.g., ambulatory, geriatric, pediatric,

bedridden, non-ambulatory), whether contrast media is used for a procedure, the types of facilities (e.g., hospitals, surgery centers, physician or podiatry offices) and equipment to be encountered (e.g., radiographic, fluoroscopic, portable, mobile and computerized tomography equipment, and ancillary medical equipment such as IV pumps, contrast injectors, etc.), and the types of imaging systems used.

Prior Related Legislation. AB 356 (Chen), Chapter 459, Statutes of 2021, authorized CDPH to issue a physician and surgeon or DPM a one-time, temporary permit authorizing them to operate or supervise the operator or fluoroscopic X-ray equipment if certain conditions are met.

ARGUMENTS IN SUPPORT:

The *California Podiatric Medical Association* (sponsor) writes in support:

> Due to the reality of time management in a typical podiatric practice, it is difficult or impossible for podiatrists to take our own x-rays. To ensure patients receive the immediate care they need, podiatrists seek assistance from individuals to perform the in-office x-ray. These individuals, or "podiatric" medical assistants, are unique to other technicians who perform x-rays as their primary duty is chairside assisting, while the secondary duty is to take foot and ankle x-rays. In many ways, this is very similar to a dental practice, where the dental assistant performs a variety of chairside duties, but also takes dental x-rays.
>
> Additionally, the x-ray equipment used in podiatrist office is unique and specialized. Like dental, these are "low dose" x-ray tubes, mounted on standing platforms, providing the podiatrist with weight bearing images. Apart from fractures, nearly all other aspects of podiatric evaluation rely on weight bearing images, and it is not appropriate to use full size table units (which are common most other imaging centers) for vast majority of podiatric care.
>
> To accommodate this practice, a podiatric-specific limited x-ray permit category (known as "leg-podiatric") was made available, allowing podiatric medical assistants to become certified. Once certified, a limited podiatric XT technician can take x-rays under the direction of a licensed podiatrist who holds an X-ray Supervisor and Operator permit. Unfortunately, this existing process that allows these individuals to obtain a limited permit specific to podiatry has become untenable, as there are currently no schools in California offering or willing to offer courses specific to podiatry and all the other permit options are beyond the scope of podiatry. This situation has resulted in fewer and fewer podiatric medical assistants certified to take x-rays, creating a circumstance that harms individual and small group practices' ability to provide proper patient care.
>
> To alleviate the existing barriers to education and to accommodate the specialize podiatric setting, [this bill] provides a solution that will enable these individuals, particularly those already working in a podiatric office, to be trained and permitted to assist podiatrists in taking x-rays.

ARGUMENTS IN OPPOSITION:

The *California Radiological Society (CRS)* opposed the January 26, 2022 version of this bill. As noted above, the amendments adopted by the Assembly Committee on Health will not be in print by the publication of this analysis, but they will be in print on April 18, 2022. Those amendments have addressed many of the CRS' concerns and they no longer oppose this bill. However, they still are concerned that this bill would "bifurcate the regulatory oversight of this type of x-ray away from the RHB to a new process to be developed by the [PMBC]."

The *California Society of Radiologic Technologists (CSRT)* remains opposed to this bill after the April 18, 2022, amendments recommended by the Assembly Committee on Health, writing, "We oppose [this bill] as it bifurcates the current system of regulation of ionizing radiation by removing one element and starting a process within an entity that has no experience. This change would put California citizens and patients at greater risk as the individuals administering the diagnostic or therapeutic would not have the training and educational background that radiologic technologists in California are required to have in order to perform diagnostic or therapeutic X-rays.

REGISTERED SUPPORT:

California Podiatric Medical Association (sponsor)
Podiatric Medical Board of California

REGISTERED OPPOSITION:

California Society of Radiologic Technologists

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

Date of Hearing: April 19, 2022

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 1885 (Kalra) – As Introduced February 8, 2022

SUBJECT: Cannabis and cannabis products: animals: veterinary medicine.

SUMMARY: Authorizes a veterinarian to recommend the use of cannabis for use on an animal for potential therapeutic effect or health supplementation purposes, and requires the Veterinary Medical Board to adopt and publish guidelines by January 1, 2024 for veterinarians to follow when recommending cannabis.

EXISTING LAW:

1) Establishes the Veterinary Medical Board (Board) under the jurisdiction of the Department of Consumer Affairs, responsible for licensing and regulating veterinarians, registered veterinary technicians, veterinary assistant substance controlled permit holders, and veterinary premises. (Business and Professions Code (BPC) § 4800 *et seq*.)

2) Requires a veterinarian, each time they initially prescribe, dispense, or furnish a dangerous drug in an outpatient setting, to offer to provide to the client responsible for the animal patient, a consultation, as specified. (BPC § 4829.5)

3) Prohibits a licensee from dispensing or administering cannabis or cannabis products to an animal patient. (BPC § 4884(a))

4) States that, notwithstanding any other law and absent negligence or incompetence, a licensed veterinarian shall not be disciplined by the Board solely for discussing the use of cannabis on an animal for medical purposes. (BPC § 4884(b))

5) Required the Board on or before January 1, 2020 to adopt guidelines for veterinarians to follow when discussing cannabis within the veterinarian-client-patient relationship and post the guidelines on the Board's website. (BPC § 4884(c))

6) Authorizes the Board to deny, revoke, or suspend a license or registration or asses a fine for:

    a. Accepting, soliciting, or offering any form of remuneration from or to a cannabis licensee if the veterinarian or his or her immediate family have a financial interest with the cannabis licensee;

    b. Discussing cannabis with a client while the veterinarian is employed by, or has an agreement with, a cannabis license;

    c. Distributing any form of advertising for cannabis in California. (BPC § 4883(p), 4883(q), and 4883(r))

7) Establishes the Medicinal and Adult-Use Cannabis Regulation and Safety Act (MAUCRSA) to regulate the cultivation, distribution, transport, storage, manufacturing, processing, and sale of both medicinal and adult-use cannabis. (BPC § 26000 *et seq*.)

8) Defines "cannabis product" as cannabis that has undergone a process whereby the plant material has been transformed into a concentrate, including, but not limited to, concentrated cannabis, or an edible or topical product containing cannabis or concentrated cannabis and other ingredients (BPC § 26001(i) and Health and Safety Code (HSC) § 11018.1)

9) Defines "edible cannabis product" as a cannabis product that is intended to be used, in whole or in part, for human consumption, excluding food products, as specified. Further clarifies that an edible cannabis product is not considered food. (BPC § 26001(t))

10) Defines "cannabis concentrate" as cannabis that has undergone a process to concentrate one or more active cannabinoids, thereby increasing the product's potency. (BPC § 26001(h))

11) States that the Department of Cannabis Control (DCC) must promulgate regulations governing the licensing of cannabis manufacturers and standards for the manufacturing, packaging, and labeling of all manufactured cannabis products. (BPC § 26130 (a))

THIS BILL:

1) Prohibits the Board from disciplining a veterinarian solely for recommending the use of cannabis on an animal for potential therapeutic effects or health supplementation purposes.

2) Requires the Board, on or before January 1, 2024, to adopt and publish on its website guidelines for veterinarians to follow when recommending cannabis within the veterinarian-client-patient relationship.

3) Specifies that the Board may deny, revoke, or suspend a license if a veterinarian is recommending cannabis use with a client while the veterinarian is employed by, or has an agreement with, a cannabis licensee.

4) Amends the definition of a "cannabis product" to include cannabis products intended for use on an animal.

5) Amends the definition of "edible cannabis product" to include cannabis products intended for consumption by an animal.

6) Clarifies that a cannabis concentrate or edible cannabis product is not considered a processed pet food.

7) States that if a cannabis product is intended for use on an animal, the product shall confirm with any additional relevant standards established by the DCC.

8) Defines an animal, for the purpose of MAUCRSA, to include any member of the animal kingdom except for food animals and livestock.

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

COMMENTS:

Purpose. This is an author-sponsored bill. According to the author, "Californians have greater access to cannabis than ever before and many pet owners are already looking to use cannabis-derived CBD to provide therapeutic benefits to their pets. Preliminary research has found that

derivatives of cannabis can be used to address pain, anxiety, inflammation, nausea, loss of appetite and seizures in animals. Therefore, pet owners should be able to seek recommendations from veterinary medical professionals who can better inform their decision to use cannabis on their pets and educate them on safe and responsible application. [This bill] also ensures that these products are accessible to consumers in a regulated market."

Background. *The Medicinal and Adult-Use Cannabis Regulation and Safety Act*. In 1996, California voters approved Proposition 215, known as the Compassionate Use Act, which legalized the use of medicinal cannabis in the state. In October 2015, Governor Jerry Brown signed a legislative package made of AB 243 (Wood, Chapter 688, Statutes of 2015), AB 266 (Bonta, Cooley, Jones-Sawyer, Lackey, and Wood, Chapter 689, Statutes of 2015), and SB 643 (McGuire, Chapter 719, Statutes of 2015) – collectively referred to as the Medical Cannabis Regulation and Safety Act (MCRSA) – which established California's first comprehensive regulatory framework for medicinal cannabis. In 2016, California voters subsequently approved Proposition 64, the Adult Use of Marijuana Act (AUMA), which aimed to legalize the recreational use of cannabis in the state by 2018. In June 2017, AUMA and MCRSA were combined to form one system for the regulation of cannabis, known as MAUCRSA.

Currently, MAUCRSA is applicable to both recreational and medicinal products. However, it does not specifically address cannabis products intended for use on animal patients. This bill amends the definitions of "cannabis products" and "edible cannabis products" under MAUCRSA to include products that are intended for use on, or consumption by, animals. The bill mandates that cannabis products intended for animals must conform to any additional regulatory standards established by the DCC and other entities involved in regulatory and oversight responsibilities.

Veterinary Medicine. Licensed veterinarians provide health care to several types of animals, from domestic companions such as dogs, cats, rabbits, birds, hamsters and snakes, to agricultural livestock such as cattle, poultry, fish, goats, pigs, and horses. Similar to human medicine, there are recognized specialties within the veterinary profession, including surgery, internal medicine, microbiology, pathology and more. In California, the practice of veterinary medicine is regulated under the Veterinary Practice Act (Act), a set of laws outlining the licensure requirements, scope of practice, and responsibilities of licensed veterinary professionals. The Act is enforced by the Board, a state regulatory agency under the umbrella of the Department of Consumer Affairs which is responsible for the licensing, examination, and enforcement of professional standards of the veterinary profession. In order to obtain a license as a veterinarian, a candidate must generally graduate from an accredited postsecondary institution recognized by the Board, as well as pass a national examination, a state examination, and an examination testing the knowledge of the laws and regulations related to the practice of veterinary medicine in California.

Except under certain circumstances, state law requires a licensed veterinarian to establish a veterinarian-client-patient relationship (VCPR) prior to providing treatment of therapy for an animal. Generally, VCPR is established when the animal owner has authorized the veterinarian to assume responsibility for making medical judgements regarding the health of the animal; when the veterinarian has sufficient knowledge of the animal to initiate at minimum a preliminary diagnosis of potential medical conditions; and when the veterinarian has assumed responsibility for making medical judgements and has communicated with the client a course of treatment appropriate for the animal.

Under the Act, veterinarians can prescribe and administer drugs or medications, but are explicitly prohibited under state law from dispensing or administering cannabis or cannabis products to an animal patient. In addition, the Federal Drug Enforcement Administration (DEA), which has enforcement authority over federal controlled substance regulations, continue to classify cannabis, tetrahydrocannabinol, and other cannabinoids as a Schedule I controlled substances. As such, the DEA does not give health care practitioners, including veterinarians, the authority to possess administer, dispense, recommend, or prescribe cannabis products. In human health care, this issue has led to policy discussions distinguishing between prescribing and recommending cannabis products. For example, the Medical Board of California published in 2017 guidelines for the recommendation of cannabis for medicinal purposes on human patients.

Veterinary Guidelines for Discussing Cannabis Use on Animals. In 2018, the legislature enacted AB 2215 (Kalra, Chapter 819, Statutes of 2018), which authorized veterinarians to "discuss" the use of cannabis on an animal patients for medicinal purposes. The bill also required the Board to adopt and publish guidelines for veterinarians to follow when discussing cannabis within the veterinarian-client-patient-relationship (VCPR) on or before January 1, 2020. In 2019, the Board approved and made available on its website "Guidelines for Veterinarian Discussion of Cannabis within the Veterinarian-Client-Patient Relationship." Among other items, the guidelines state that:

• A veterinarian should document that an appropriate VCPR is established prior to discussing cannabis with the animal-owner client.

• A documented physical examination and collection of relevant clinical history is required, and should include both subjective and objective data and must obtained prior to discussing cannabis for medical purpose.

• The discussions should be evaluated in accordance with accepted standards of practice as they evolve over time. This documentation may include advice about potential risks of the medical use of cannabis, including the variability of quality, source, safety, and testing of cannabis products; the side effects and signs of overdose of toxicity; and the lack of clinical research regarding dose, toxicity, and efficacy.

AB 2215 also enacted a number of conflict of interest provisions, and authorized the Board to take disciplinary actions against veterinarians accepting, soliciting, or offering any form of remuneration from or to a cannabis licensee if the veterinarian or his or her immediate family have a financial interest with the cannabis licensee. AB 2215 also prohibited a veterinarian from discussing cannabis with a client while the veterinarian is employed by, or has an agreement with, a cannabis licensee, and prohibited a veterinarian from distributing any form of advertising for cannabis in California.

Current Related Legislation.

AB 384 (Kalra, 2021): Almost identical legislation to AB 1885 (Kalra), with the exception of the implementation date and urgency clause. Would have made clear and authorized a veterinarian to recommend cannabis use by an animal for potential therapeutic effect of health supplementation purposes. Also would have required the Board to adopt and publish guidelines by January 1, 2023 for veterinarians to follow when recommending cannabis. Also amended the definition of a "cannabis product" and "edible cannabis product" under the Medicinal and Adult-

Use Cannabis Regulation and Safety Act to include cannabis products intended for use on, or consumption by, an animal.

Prior Related Legislation.

AB 2215 (Kalra, Chapter 819, Statutes of 2018): Prohibits the Board from disciplining, or denying, revoking, or suspending the license of, a licensed veterinarian solely for discussing the use of cannabis on an animal for medicinal purposes, absent negligence or incompetence. Required the board to adopt guidelines for these discussions on or before January 1, 2020, and would require the board to post the guidelines on its Internet Web site. Authorized the board to revoke or suspend a veterinarian license, or to assess a fine, for accepting, soliciting, or offering any form of remuneration from or to a Medicinal and Adult-Use Cannabis Regulation and Safety Act (MAUCRSA) licensee if the veterinarian or his or her immediate family has a financial interest, as defined.

SB 627 (Galgiani, 2019): Would have required the Board to adopt guidelines for veterinarians to follow when recommending cannabis within the veterinarian-client-patient relationship. Would have authorized a licensed veterinarian to discuss the use of medicinal cannabis or cannabis products on an animal patient and, after guidelines are adopted, allows a veterinarian to recommend the use of medicinal cannabis or cannabis products under certain conditions. Would have adjusted other cannabis-related statutes to accommodate medicinal use on an animal patient by adults who are 21 years of age and older.

ARGUMENTS IN SUPPORT:

The California Veterinary Medical Association writes in support: "What we have learned since the passage of AB 2215-Kalra (2018) is that more and more pet owners are purchasing cannabis products for their pets and are then bringing them in to the veterinary hospital, seeking help from their veterinarian regarding dosing questions. This is a very common scenario in veterinary practices and veterinarians would like to have the ability to look at the product, discuss the potential impact of the product on the animal, and then suggest a safe dose, if applicable. Without the guidance of a veterinary medical professional, the animal-owning client is left to make his or her own "guesstimate" regarding dosing; or more troubling, they might seek dosing information from a cannabis dispensary clerk. The veterinary medicine community is very active in its exploration of the impact of cannabis in pets through its work with our national association, continuing education opportunities with leading experts, and medical reports. As we continue to monitor the issue, AB 1885 becomes an important next step in bringing clinical discussions between veterinarians and their animal-owning pets together in a safe setting, to contemplate reasonable recommendations for usage."

The California Cannabis Industry Association (CCIA) write in support that it "is pleased to support of AB 1885 (Kalra), which prohibits the Board from disciplining a veterinarian for recommending cannabis for animals for potential therapeutic effect or health supplementation purposes and requires the Board to adopt guidelines for veterinarians to follow when recommending cannabis by January 1, 2024. AB 1885 further permits the manufacture and sale of cannabis pet products as prescribed under the Medicinal and Adult Use Cannabis Regulation and Safety Act (MAUCRSA) and requires that cannabis products intended for animals comply with concentration and other standards adopted by regulations of the Department of Cannabis Control."

ARGUMENTS IN OPPOSITION:

None on file.

POLICY ISSUE(S) FOR CONSIDERATION:

As noted in this analysis, clinical research on the use of cannabis on animal patients is still nascent. While available studies are considered promising and continue to make important breakthroughs, the veterinary medical community has not yet reached a broad consensus on the appropriate use, potential side effects, and other medical considerations related to cannabis treatments.

REGISTERED SUPPORT:

Best Friends Animal Society
The California Cannabis Industry Association (CCIA)
The California Veterinary Medical Association (CVMA)
California NORML
Good Farmers Great Neighbors
The Parent Company
VetCBD
Woman United for Animal Welfare (WUFAW)

REGISTERED OPPOSITION:

None on file.

Analysis Prepared by: Annabel Smith / B. & P. / (916) 319-3301

Date of Hearing: April 19, 2022

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 1901 (Nazarian) – As Amended March 24, 2022

SUBJECT: Dog training services and facilities: requirements.

SUMMARY: Establishes requirements for dog trainers, dog training facilities, and dog training facility operators, and requires dog trainers to disclose in writing certain information to a purchaser of dog training services, including whether the trainer is licensed or certified by an animal training organization.

EXISTING LAW:

1) Establishes procedures, as administered by the State Department of Public Health (CDPH), for the care and maintenance of pets boarded at a pet boarding facility, including, but not limited to, sanitation, provision of enrichment for the pet, health of the pet, and safety. (Health and Safety Code (HSC) §§ 122380 – 122388)

THIS BILL:

1) Applies the same standards that currently exist for pet boarding facilities to dog trainers, dog training facilities, and dog training facility operators.

2) Defines "dog trainer" or "trainer" as a person, firm, partnership, corporation, or other association that sells, offers, or provides dog training services on the premises of the person, firm, partnership, corporation, or other association.

3) Defines "dog training facility" as any lot, building, structure, enclosure, or premises, or a portion thereof, whereupon dogs are trained at the request of, and in exchange for compensation provided by, their owner; a dog training facility may be on the same premises as a dog boarding facility.

4) Requires a dog trainer to deliver to a purchaser of dog training services a written disclosure containing all of the following:

    a. The trainer's name and address.

    b. Whether the trainer is licensed or certified by any animal training organization.

    c. The trainer's training techniques and whether they use negative reinforcement or shock collars.

    d. A written training plan describing the nature and goals of the training.

    e. A record of any injury sustained by dogs in their care.

5) Provides that the required written disclosure shall be signed by the trainer certifying the accuracy of the statement, and by the purchaser of the training services acknowledging receipt of the statement; however, all medical information shall be made orally.

6) Requires a dog trainer to maintain a written record on the health, status, and disposition of each dog trained at the training facility for a period of at least one year after the completion of training.

7) Prohibits a dog trainer from failing to do any of the following:

    a. Maintain facilities where the dogs are kept or trained in a sanitary condition.

    b. Provide dogs with adequate nutrition, when needed, and potable water.

    c. Provide adequate space appropriate to the age, size, weight, and breed of dog.

    d. Provide dogs with a rest board, floormat, or similar device that can be maintained in a sanitary condition.

    e. Provide dogs with adequate socialization and exercise, as appropriate during the course of the training.

    f. Wash hands before and after handling an infectious or contagious dog.

    g. Provide veterinary care without delay when necessary.

8) Provides that each dog training facility operator shall be responsible for all of the following:

    a. Ensuring that the entire dog training facility, including all equipment therein, is structurally sound and maintained in good repair.

    b. Ensuring that pests do not inhabit any part of the facility in a number large enough to be harmful, threatening, or annoying to the dogs.

    c. Ensuring the containment of dogs within the facility, and, in the event that a dog escapes, making reasonable efforts to immediately capture the escaped dog.

    d. If an escaped dog has not been captured despite reasonable efforts, ensuring that all material facts regarding the dog's escape are reported to the local agency for animal control and to the purchaser.

    e. Ensuring that the facility's interior building surfaces, including walls and floors, are constructed in a manner that permits them to be readily cleaned and sanitized.

    f. Ensuring that light, by natural or artificial means, is distributed in a manner that permits routine inspection and cleaning, and the proper care and maintenance of the dogs.

    g. Maintaining an area in the facility for isolating sick dogs from healthy dogs.

9) Sets minimum standards for permanent or fixed and temporary enclosures where dog training occurs.

10) Requires a dog training facility operator to comply with specified care requirements, including the use of training methods that will not hurt or injure a dog.

11) Requires a dog training facility operator to provide each purchaser with additional written information describing facility operations and schedules, and requires that any material deviations from those practices must be disclosed to the purchaser as appropriate.

12) Requires animal control officers to issue a single notice to correct any violations and subjects operators who violate the same provision multiple times within five years to infractions or misdemeanors.

13) Subjects a trainer who violates the requirements of the bill to a civil penalty of up to $1,000 or a 30-day prohibition from training dogs, or both; for the second offense, a civil penalty of up to $2,500 or a 90-day prohibition, or both; for a third offense, a civil penalty of up to $5,000, or a six month prohibition or both; for a fourth and subsequent offenses, a civil penalty of up to $10,000 or a year-long prohibition from training dogs, or both.

FISCAL EFFECT: Unknown. This bill has been keyed fiscal by Legislative Counsel.

COMMENTS:

Purpose. This bill is author-sponsored. According to the author: "For over 15,000 years, humans and canines have had a special, mutually beneficial relationship. Up to and including today, this relationship has developed and grown to the point that dogs hold an incredibly important place in our society. Due to this bond, dogs have taken a prominent role in our society. We bring dogs into our homes and families while allowing them to serve in our law enforcement and our armed forces. As a result, we owe to our canine companions to ensure when we entrust them with a dog trainer, we have ample regulations in place to protect them. By creating these regulations on dog trainers, facility operators and giving an animal control officer enforcement powers, we are giving our animals a level of protection that does not exist now."

Background.

Over the past four years, there have been multiple reports relating to incidents of harm and death of dogs in the care of dog training facilities. All reported incidents involve a dog boarding service and overnight stays by an animal in a fixed/enclosed facility. Additionally, there have been incidents of fraud, embezzlement, and theft of animals also reported by pet owners. In Contra Costa County alone, there have been reported incidents of at least two dogs who died while under the care of dog trainers. Other trainers are accused of leaving their dogs malnourished and taking money for services never completed.

This bill is intended to address these reports of incidents involving dogs in training facilities. It would mimic requirements currently in place for pet boarding facilities. The author believes that imposing similar requirements on dog training facilities would help reduce the number of incidents where dogs are harmed during training.

Current Related Legislation. AB 1881 (Santiago): Would enact the Dog and Cat Bill of Rights and require every public animal control agency or shelter, society for the prevention of cruelty to animals shelter, humane society shelter, or rescue group to post a copy of the Dog and Cat Bill of Rights, subject to a civil penalty.

ARGUMENTS IN SUPPORT:

Social Compassion in Legislation writes in support of the bill: "Social Compassion in Legislation is proud to support the introduction of the Dog Trainer Disclosure Act, Assembly Bill 1901 (Nazarian). This bill will provide transparency and disclosure for dog owners who are purchasing the services of dog trainers. It would require that dog trainers offer basic but pertinent information to consumers before buying the services. For example, they must provide the trainer's name, address, certification status, techniques, dog training philosophy, and civil judgments related to the dog trainer's services. We, unfortunately, find far too many examples of dogs being harmed and injured by dog trainers who, if forced to disclose some basic information, consumers would stay away from. A lack of regulations for dog trainers is a severe issue that AB 1901 addresses by requiring simple disclosure. Although just a first step, this bill is critical for protecting dogs and dog owners."

ARGUMENTS IN OPPOSITION:

American Kennel Club writes in opposition: "The training for these events is as varied as the activities themselves. This is in addition to the thousands of organized training classes on basic obedience, dog handling and care held in every county in the state. While a few programs encompass overnight care, the vast majority are brief sessions, often lasting an hour or less, where owners and their dogs gather in a variety of venues that include community/recreation centers, schools, dog clubs, training centers, and public parks – just to name a few. Training classes are not the same as boarding kennel situations, and as such, many of the requirements in AB 1901 are not practical or appropriate. This includes requirements for food, resting mats, enrichment, and daily activity and personnel schedules. In addition, with terms such as "negative training" not being defined, it could include a humane but firm verbal command with a misbehaving dog or dog that would potentially come into harm. With so many vague and broad-reaching requirements, it is highly likely that many trainers – particularly dog clubs and community volunteers who offer low-cost dog training to the public – will simply choose to longer offer classes. Loss of affordable opportunities for the public to participate in dog training classes would be a significant and detrimental loss to the state and have a critical negative impact on public safety."

San Diego Humane Society writes in opposition: "Our chief concern with AB 1901 is its vague nature. Dog training is a complex industry and assistance to pet owners is offered in a variety of forms including board and train, private trainers, canine sport trainers, class trainers, and more. While it appears that the intent of this bill is to protect pet owners and pets from mistreatment and inhumane practices for board and train type activities, this bill will adversely impact independent dog trainers that do not have a facility or those trainers who own a facility but only offer short private sessions or group classes. This bill would require dog training facility operators, such as San Diego Humane Society to provide 'daily enrichment,' to dogs during the duration of a short one-hour class or private consultation. Training itself can be considered a form of enrichment that benefits a dog's behavior health. Furthermore, it would be unlawful for a dog trainer to fail to provide a resting board or floormat to a dog during these short session training class or private consultations. Pet owners are encouraged to provide these items themselves during these training activities, however they are not necessary for such a short duration if required to be given by the dog trainer, this will add financial burden for acquiring these items, transportation of these items, and up keep. Further, we appreciate the desire for trainers to be transparent about the techniques they will use to change the dog's behavior and

avoid any methods of training that would cause pain or injury, however, we are unsure as to why the bill singles out 'negative reinforcement' and 'shock collars.' We suspect the appropriate term you're seeking is 'positive punishment' because this would mean you are adding an aversive stimulus to decrease the likelihood of a behavior, such as a shock collar. For professionals in the industry, the section is confusing and demonstrates a lack of understanding in behavior science because the application of operant conditioning principles is complex."

POLICY ISSUE(S) FOR CONSIDERATION:

This bill attempts to align a similar standard of care to dog trainers, dog training facilities, and dog training facility operators. However, there are questions surrounding how this would help the health and safety of pet training services. There are already various environments dog trainers operate within. For example, these environments include recreation centers, schools, dog clubs, training centers, and public parks. This bill, as currently drafted, may unintentionally result in untrained or undertrained dogs that risk being surrendered. Dog training program locations are conducted in various types of structures and locations that may be owned privately (client's home), commercially (dog training facility, mall, restaurant, hospitals, etc.) or government (parks and/or buildings) and do not all require overnight boarding. Thus, it is imperative that different dog training delivery systems be cleanly delineated and standards suitable to each be applied

This bill is including and categorizing all dog training facilities into one category, which may result in the unintentional consequences for dogs, their owners, and access to effective and financially reasonable training services for communities. While similar, dog training classes and boarding kennel facilities are distinctly different and, therefore, need clear standards within the industry.

AMENDMENTS:

1) To narrow the bill to only require written disclosures to purchasers of dog training, strike all of the bill's provisions except those contained in the proposed Section 122395.2 and corresponding definitions.

2) To ensure safe pet training services and proper disclosure to the consumer, amend the proposed disclosure requirement so as to read:

   A dog trainer shall disclose in writing certain information to a purchaser of dog training services, including:

   1. *The trainer's name and address;*
   2. *Whether the trainer is licensed or certified by an animal training organization;*
   3. *The trainer's training techniques and philosophy;*
   4. *A written training plan describing the nature and goals of the training;*
   5. *Require a dog trainer to disclose in writing any civil judgements related to the care of an animal by their services.*

3) Clarify that this written disclosure made pursuant to this section shall be signed by the trainer certifying the accuracy of the statement, and by the purchaser of the training services acknowledging receipt of the statement.

REGISTERED SUPPORT:

Social Compassion in Legislation

REGISTERED OPPOSITION:

Black Brant Group Fred Harpster
California Waterfowl Association
California Houndsmen for Conservation
Cal-Ore Wetland and Waterfowl Council
California Hawking Club
Congressional Sportmen's Foundation
Four Paws to Freedom
Inland Valley Retriever
NorCal Guides Association
San Diego County Wildlife Federation
Tulare Basin Wetlands Association

Analysis Prepared by: Annabel Smith / B. & P. / (916) 319-3301

Date of Hearing: April 19, 2022

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 1954 (Quirk) – As Introduced February 10, 2022

SUBJECT: Physicians and surgeons: treatment and medication of patients using cannabis.

SUMMARY: Prohibits a physician and surgeon from denying treatment or medication to a qualified patient using medicinal cannabis, as specified.

EXISTING LAW:

1) Regulates the practice of medicine by physicians and surgeons under the Medical Practice Act and establishes the Medical Board of California (MBC) to administer and enforce the act. (Business and Professions Code (BPC) §§ 2000-2529.6)

2) Authorizes a physician to recommend cannabis for medical purposes under the Compassionate Use Act of 1996, which protects patients and their primary caregivers from criminal prosecution or sanction for obtaining and using marijuana for medical purposes upon the recommendation of a physician. (Health and Safety Code (HSC) § 11362.5)

3) Outlines various requirements related to recommending medical cannabis, including making it unprofessional conduct to recommend medical cannabis without an appropriate prior examination. (BPC §§ 2525-2529.6)

4) Requires the MBC to consult with the California Marijuana Research Program, known as the Center for Medicinal Cannabis Research on developing and adopting medical guidelines for the appropriate administration and use of medical cannabis. (BPC § 2525.1)

5) Defines "qualified patient" as a person who is qualified for protection under the Compassionate Use Act of 1996 to use and cultivate cannabis for medical purposes. (HSC §§ 11362.5(d); 11362.7(f))

6) Prohibits a hospital, physician and surgeon, procurement organization, or person from denying a potential recipient of an anatomical gift based solely upon the potential recipient's status as a qualified patient, or based solely upon a positive test for the use of medical cannabis by the potential recipient, except to the extent that the qualified patient's use of medical cannabis has been found by a physician and surgeon, following a case-by-case evaluation of the potential recipient, to be medically significant to the provision of the anatomical gift. (HSC § 7151.36(a))

THIS BILL:

1) Defines "qualified patient" as having the same meaning as defined under the HSC provisions relating to the Compassionate Use Act of 1996.

2) Prohibits a physician and surgeon from denying treatment or medication to a qualified patient based solely on a positive drug screen for tetrahydrocannabinol (THC) or report of medical cannabis use, except to the extent that the qualified patient's use of medical cannabis has

been found by a physician and surgeon, following a case-by-case evaluation of the patient, to be medically significant to the treatment or medication.

3) Specifies that the use of medical cannabis that has been recommended by a licensed physician and surgeon does not constitute the use of an illicit substance in the evaluation performed under this bill.

4) Specifies that no physician and surgeon may be punished, or denied any right or privilege, for having administered treatment or medication to a qualified patient within the requirements of this bill.

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

COMMENTS:

Purpose. This bill is sponsored by The *California Chapter of the National Organization for the Reform of Marijuana Laws (California NORML)*. According to the author, "Recent research is increasingly highlighting the medical utility of cannabis, especially in the treatment of chronic pain. Medicinal cannabis is being used by almost 2 million Californians and has the potential to significantly improve patient quality of life. However, patients who use medicinal cannabis may be denied healthcare services solely based on a positive THC test. Doctors, too, are unclear about their liability prescribing treatments such as opioids to medicinal cannabis users. [This bill] specifies that physicians cannot deny treatment or medication to a qualified patient based solely on a positive drug screen for THC, except when medically indicated. It further clarifies that medicinal cannabis use does not constitute the use of an illicit substance for the purpose of treatment evaluation. The bill also shields physicians from liability and repercussions for treating or prescribing medication to qualified patients."

Background. Under California law, the use and cultivation of medicinal cannabis has been legal since 1996, and the cultivation and non-medical use of cannabis has been legal since 2016. While physician recommendations are no longer necessary to consume cannabis in California, many patients still obtain these recommendations and obtain additional state law protections, including those relating to organ donations and the ability of the terminally ill to consume cannabis in certain health facilities. To qualify, a physician must determine that the person's health would benefit from its use in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which cannabis provides relief.

Medicinal Cannabis. Medicinal cannabis refers to the use of cannabis and cannabis products for health care purposes. Also known as "marijuana" or "marihuana," cannabis is the general term for processed cannabis plants. Cannabis plants are processed in many ways, providing for a variety of inhalable, ingestible, and other mediums. Cannabis plants contain more than 100 cannabinoids, but two are of particular interest for medical purposes: tetrahydrocannabinol (THC) and cannabidiol (CBD). THC is the primary psychoactive substance leading to an altered mental state (high). CBD is also psychoactive but does not tend to alter a person's mental state.

In 1999, after medicinal cannabis was legalized in California, the Institute of Medicine of the National Academies of Sciences, Engineering, and Medicine issued a report stating that scientific data indicate the "potential therapeutic value of cannabinoid drugs, primarily THC, for pain relief, control of nausea and vomiting, and appetite stimulation." The report went on to state that

the psychological effects of cannabinoids, such as anxiety reduction, sedation, and euphoria can influence their potential therapeutic value.

In January 2017, the National Academies of Sciences, Engineering, and Medicine published *The Health Effects of Cannabis and Cannabinoids*, a review of the scientific research on cannabis published since 1999, considering more than 10,000 scientific abstracts to reach nearly 100 conclusions. This review found evidence to support that patients who were treated with cannabis or cannabinoids were more likely to experience significant reductions in pain symptoms. It also found benefits for multiple sclerosis-related muscle spasms, and preventing and treating chemotherapy-induced nausea and vomiting. Along with certain benefits, the review of the science suggested cannabis is likely to increase the risk of developing schizophrenia and other psychoses, and that with greater frequency of cannabis use, there is an increased likelihood of developing riskier cannabis use.

Legal Status of Cannabis. According to the National Conference of State Legislatures, 33 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands have authorized some form of cannabis use, California being the first with the passage of the Compassionate Use Act (Proposition 215) in 1996. Still, at the federal level cannabis is classified as a Schedule I substance under the Uniform Controlled Substances Act. Schedule I substances are considered to have no accepted medical use and a high potential for dependency, which makes the distribution of cannabis a federal offense.

In October 2009, the Obama Administration sent a memo to federal prosecutors encouraging them not to prosecute people who distribute cannabis for medical purposes per state law. In August 2013, the U.S. Department of Justice provided an update to its cannabis enforcement policy after Colorado and Washington voted to legalize the non-medical use of cannabis. This memo, known as the "Cole Memorandum," stated that while cannabis remains illegal federally, the Department of Justice expects states like Colorado and Washington to create "strong, state-based enforcement efforts…and will defer the right to challenge their legalization laws at this time."

However, in January 2018, then U.S. Attorney General Sessions issued a "Marijuana Enforcement Memorandum" that rescinded the Cole Memorandum, and permitted federal prosecutors to decide how to prioritize enforcement of federal marijuana laws, weighing "all relevant considerations, including federal law enforcement priorities set by the Attorney General, the seriousness of the crime, the deterrent effect of criminal prosecution, and the cumulative impact of particular crimes on the community." While the Biden Administration has yet to issue a follow-up memo, Congress has passed a law, known as the Rohrabacher-Farr amendment, that prohibits the U.S. Department of Justice from spending funds to interfere with the implementation of state medical cannabis laws.

Further discussions are also occurring at the federal level. On March 24, 2022, the U.S. Senate passed the "Cannabidiol and Marihuana Research Expansion Act" which would take several steps toward gathering data on the safety and medical efficacy of cannabis and cannabidiol, opening the door to federally-sanctioned medical research. It would also specify that it is not a violation of the federal Controlled Substances Act for a State-licensed physician to discuss the known potential harms and benefits of specified types of cannabis as a treatment with (1) the patient or guardian of the patient if the patient is an adult or (2) the guardian of a patient if the patient is a child.

Current Related Legislation. SB 988 (Hueso), which is pending in the Senate, would repeal the requirement that health facilities comply with drug and medication requirements applicable to Schedule II, III, and IV drugs, and be subject to enforcement actions by the California Department of Public Health when permitting patient use of medicinal cannabis.

Prior Related Legislation. SB 311 (Hueso), Chapter 384, Statutes of 2021, requires specified health care facilities to allow terminally ill patients to use medical cannabis within the facility, subject to certain restrictions.

AB 258 (Levine), Chapter 51, Statutes of 2015, prohibits the denial of a potential organ donor recipient based on the recipient's status as a qualified patient or based solely upon a positive test for the use of medical cannabis unless the use is found by the patient's physician and surgeon, following a case-by-case evaluation of the potential recipient, to be medically significant to the provision of the anatomical gift.

ARGUMENTS IN SUPPORT:

California NORML (sponsor) writes in support:

> California NORML has heard innumerable complaints from chronic pain patients who say that physicians or clinics have denied them treatment with prescription opioids or other medications for no other reason than using or testing positive for medical marijuana…. However, chronic pain patients in many instances cannot fully rely on cannabis for pain management, necessitating some reliance on opioids or other prescription drugs.
>
> In California, many health plans, health systems, and hospitals require patients to sign agreements not to use illicit or controlled substances for the duration of their prescribed opioid treatment and agree to drug testing…. An online survey by [California NORML] of nearly 600 patients found that 18.5% of respondents have been denied prescription medications due to their use of cannabis. Existing law does not specify whether healthcare providers who prescribe opioids may refuse to do so exclusively on the grounds of a positive test for [THC] or its metabolites. In its 2016 guidelines for prescribing opiates for chronic pain, the Centers for Disease Control recommended that patients not be dismissed from care based on a urine test for THC because this could have adverse consequences for patient safety. We have heard of cases where patients have resorted to street drugs after being denied opioid prescriptions.
>
> Many physicians are wrongly under the impression that they cannot prescribe opioid medications to patients who test positive for cannabis, resulting in hundreds of chronic pain patients who are unfairly denied access to quality-of-life or life-saving medications.

ARGUMENTS IN OPPOSITION:

The *California Medical Association (CMA)* writes in opposition, "This legislation in its current form prohibits a physician from denying treatment to a patient solely based on a positive drug test for [THC]. This limits a physician's ability to make medical decisions; this type of restriction on physicians could lead to negative patient health outcomes and burdensome liability risk.

Cannabis is still federally prohibited and there has been few studies conducted or published on how THC interacts with other medications. Additionally, this bill is overly broad, particularity the term 'medically significant' not being clearly defined. CMA believes that this bill is premature, strips physicians of critical medical decision making and puts physicians at risk of being non-compliant with Federal law."

IMPLEMENTATION ISSUES:

Health System, Plan, and Facility Policies. This bill would require a physician and surgeon to provide treatment or medication to a qualified patient using medicinal cannabis if there is no determination that the qualified patient's use of medicinal cannabis would be medically significant to the treatment or medication. However, the sponsor also reports that there are health systems, health plans, and health facilities that may be establishing policies that prohibit physicians and surgeons from providing certain medications and treatments, such as opioids, to cannabis users who also suffer from chronic pain.

This bill would require a physician and surgeon operating under a blanket policy established by a health system or other relevant entity to violate that policy if the physician does not find a medically significant interaction with the treatment or medication. While the bill specifies that the physician and surgeon may not be denied any right or privilege or otherwise punished for doing so, it is unclear what the effect practical effect of this requirement would be, or what effects it may have on the entity imposing the policy.

If this bill passes this Committee, the author and sponsor may wish to work with the Assembly and Senate Committees on Health and relevant stakeholders to ensure this bill would not create unintended conflicts and whether there is a more direct route to addressing the issue of blanket policies established by health systems.

AMENDMENTS:

Definition of Medical Significance. While "medical significance" is used on other areas of law, it is not currently defined. To provide additional direction to physicians and surgeons and make clarifying changes, the bill should be amended as follows:

1) On page 2 of the bill, lines 3-9:

> (a) A physician and surgeon shall not *automatically* deny treatment or medication to a qualified patient based solely on a positive drug screen for tetrahydrocannabinol (THC) or report of medical cannabis use, *without first completing a case-by-case evaluation of the patient that includes, but is not limited to,* ~~except to the extent~~ *a determination* that the qualified patient's use of medical cannabis ~~has been found by a physician and surgeon, following a case-by-case evaluation of the patient, to be~~ *is* medically significant to the treatment or medication.

2) On page 2, lines 16-18:

(d) For purposes of this section, *the following terms have the following meanings:* ~~"qualified~~

(1) "Medically significant" means that a physician and surgeon has made a clinical determination that may include, but is not limited to, any of the following:

(A) The treatment or medication is contraindicated or is likely, or expected, to cause an adverse reaction or physical or mental harm to the qualified patient if administered or used in conjunction with THC or medical cannabis, based on the known clinical characteristics of the patient and the known characteristics and history of the patient's treatment or medication regimen.

(B) The treatment or medication is expected to be ineffective based on the known clinical characteristics of the qualified patient and the known characteristics and history of the patient's treatment or medication regimen.

(C) The treatment or medication, when administered or used in conjunction with THC or medical cannabis, is not clinically appropriate for the qualified patient because the treatment or medication is expected to do any of the following, as determined by a physician and surgeon:

(i) Worsen a comorbid condition.

(ii) Decrease the capacity to maintain a reasonable functional ability in performing daily activities.

(iii) Pose a significant barrier to adherence to, or compliance with, the qualified patient's drug regimen or plan of care.

(D) Any other clinically or medically relevant determination.

(2) "Qualified patient" has the same meaning as defined in Section 11362.7 of the Health and Safety Code.

REGISTERED SUPPORT:

California NORML
Americans for Safe Access
California Cannabis Industry Association
Origins Council
129 Individuals

REGISTERED OPPOSITION:

California Medical Association

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

Date of Hearing: April 19, 2022

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 2060 (Quirk) – As Introduced February 14, 2022

SUBJECT: Medical Board of California.

SUMMARY: Changes the membership composition of the Medical Board of California (MBC) so that a majority of the board consists of public members who are not practicing physicians.

EXISTING LAW:

1) Enacts the Medical Practice Act, which provides for the licensure and regulation of physicians and surgeons. (Business and Professions Code (BPC) §§ 2000 *et seq.*)

2) Establishes the MBC, a regulatory board within the Department of Consumer Affairs (DCA) comprised of 15 appointed members, including seven public members and eight physicians, subject to repeal on January 1, 2024. (BPC § 2001)

3) 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)

4) Entrusts the MBC with responsibility for all of the following:

   a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

   b) The administration and hearing of disciplinary actions.

   c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

   d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

   e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

   f) Approving undergraduate and graduate medical education programs.

   g) Approving clinical clerkship and special programs and hospitals.

   h) Issuing licenses and certificates under the board's jurisdiction.

   i) Administering the board's continuing medical education program.

   (BPC § 2004)

5) Provides that all members of the MBC must have been citizens of California for five years preceding their appointment; requires all non-public members of the MBC to be actively licensed physicians; prohibits any member from owning any interest in any medical school; and requires that four of the physician members hold faculty appointments in a clinical department of an approved medical school in California, but not more than four members may hold full-time appointments to the faculties of such medical schools. (BPC § 2007)

6) Authorizes the MBC to appoint panels of at least four of its members for the purpose of fulfilling its disciplinary obligations, and requires that a majority of the panel members be physicians. (BPC § 2008)

7) Establishes four-year terms for members of the MBC and provides that each appointing authority has the power to fill its vacancies for the unexpired term. (BPC § 2010)

8) Allows each appointing power to remove its board members for neglect of duty, incompetency, or unprofessional conduct. (BPC § 2011)

9) Provides that the MBC shall elect a president, a vice president, and a secretary from its members. (BPC § 2012)

10) Authorizes the MBC to establish advisory committees consisting of physicians in good standing and members of the public with interest or knowledge of a subject matter assigned to the committee, who are not required to be members of the MBC. (BPC § 2015.5)

11) Requires the MBC and each committee or panel to keep an official record of all their proceedings. (BPC § 2017)

12) With approval from the Director of Consumer Affairs, authorizes the MBC to employ an executive director as well as investigators, legal counsel, medical consultants, and other assistance, but provides that the Attorney General is legal counsel for the MBC in any judicial and administrative proceedings. (BPC § 2020)

13) Allows the MBC to select and contract with necessary medical consultants who are licensed physicians to assist it in its programs. (BPC § 2024)

14) Empowers the MBC to take action against persons guilty of violating the Medical Practice Act. (BPC § 2220)

15) Authorizes the MBC to delegate its authority to conduct investigations and inspections and to institute proceedings to its executive director or other personnel, but prohibits the MBC from delegating its authority to take final disciplinary action against a licensee. (BPC § 2224)

16) Provides that a 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, is subject to various forms of discipline. (BPC § 2227)

17) Provides that all proceedings against a licensee for unprofessional conduct, or against an applicant for licensure for unprofessional conduct or cause, shall be conducted in accordance with the Administrative Procedure Act, and defines “agency itself” as including any panel appointed by the MBC for purposes of that Act. (BPC § 2230)

18) Provides that numerous other inappropriate activities or violations of the law constitute unprofessional conduct. (BPC §§ 2236 – 2318)

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

20) Requires that licensees be given notification of proposed actions to be taken against the licensee by the MBC and be given the opportunity to provide a statement to the deputy attorney general assigned to the case. (BPC § 2330)

21) Allows the MBC and the Attorney General to establish panels or lists of experts as necessary to assist them in their respective duties. (BPC § 2332)

22) Requires that all proposed decisions and interim orders of the Medical Quality Hearing Panel within the Office of Administrative Hearings shall be transmitted to the executive director of the MBC to be acted on by the full board or a panel. (BPC § 2335)

23) Requires the MBC to adopt rules to govern the conduct of oral argument following nonadoption of a proposed decision. (BPC § 2336)

THIS BILL:

1) Changes the composition of the MBC to consist of eight public members and seven physician members.

2) Provides that the first position held by a licensed physician that becomes vacant on or after January 1, 2023, shall be converted to a public member position to implement the bill.

3) Updates language in statute to require members of the board to have been residents, rather than citizens, of California for five years.

4) Changes the number of physician members on the MBC required to hold faculty appointments from four to three.

5) Prohibits any panel established for the purpose of fulfilling the MBC's disciplinary obligations from being comprised of more physician members than public members.

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

COMMENTS:

Purpose. This bill is sponsored by the **Medical Board of California**. According to the author:

> "Consumer protection boards should be composed of a majority of people who are members of the public, rather than those of the profession they regulate. It is a feature that should be included on all boards. Over the last few years, consumer advocates have called for a public member majority, rather than physician member majority, on the Medical Board of California. AB 2060 responds to the requests of consumer advocates to establish a public member majority for the Medical Board of California and will strengthen the public's trust in this important institution."

Background.

Medical Board of California. The first Medical Practice Act in California was enacted in 1876. Early iterations of the MBC consisted of members either appointed directly by professional medical societies or who were appointed from lists of names provided by these societies. In 1901, the Act was completely rewritten and a Board of Examinations was established, comprised of nine members; the membership was increased to 11 in 1907. In 1976, significant changes were made to the Act to create MBC much as it exists today, as well as adjustments to MBC's composition. The prior board's 11 members originally included only one non-physician member; the MBC's membership was increased to 19 members, including seven public members. The MBC underwent more structural change in 2008 with the elimination of its Divisions of Licensing and Medical Quality and the creation of a unified board with membership set at 15.

Today, the MBC is still comprised of 15 members: eight physicians and seven public members. All eight professional members and five of the public members are appointed by the Governor. One public member of the MBC is appointed by the Senate Committee on Rules and one public member is appointed by the Speaker of the Assembly. Current law requires that four of the physician members hold faculty appointments in a clinical department of an approved medical school in the state, but no more than four members may hold full-time appointments to the faculties of such medical schools. The MBC meets about four times per year.

The MBC has jurisdiction over physicians and surgeons, as well as special program registrants/organizations and special faculty permits which allow those who are not MBC licensees but meet licensure exemption criteria outlined in the Medical Practice Act to perform duties in specified settings. The MBC also has statutory and regulatory authority over licensed midwives, medical assistants, registered polysomnographic trainees, registered polysomnographic technicians, registered polysomnographic technologists, research psychoanalysts, and student research psychoanalysts. The MBC also approves accreditation agencies that accredit outpatient surgery settings and issues Fictitious Name Permits to physicians practicing under a name other than their own.

Board Composition Issues. The MBC's most recent sunset review background paper outlined a number of issues and posed questions relating to the continued operation of the board. These issues were subsequently discussed during multiple oversight hearings held by the Senate Committee on Business, Professions, and Economic Development and the Assembly Committee on Business and Professions in early 2021. The first issue in this paper posed the question: *Does MBC's composition need to be updated to include additional members of the public?*

This issue is similar to those that have been raised for the majority of regulatory boards that have undergone sunset review since 2015, when the Supreme Court of the United States issued a ruling in *North Carolina State Board of Dental Examiners v. Federal Trade Commission*.[1] As discussed in the MBC's sunset review background paper, this case originated when 2010 when the Federal Trade Commission (FTC) brought an administrative complaint against the North Carolina State Board of Dental Examiners for exclusion of non-dentists from the practice of teeth whitening. The FTC alleged that the board's decision was an uncompetitive and unfair method of competition under the Federal Trade Commission Act. This opened the board to lawsuits and substantial damages from affected parties.

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[1] *North Carolina State Board of Dental Examiners v. Federal Trade Commission*, 574 U.S. 494 (2015)

The North Carolina board was composed of six licensed, practicing dentists and two public members. The practice of teeth whitening was not addressed in the statutes comprising the Dental Practice Act. Instead of initiating a rulemaking effort to clarify the appropriate practice of teeth whitening, the board sent cease-and-desist letters to non-dentists in the state offering teeth whitening services. The board argued that the FTC's complaint was invalid because the board was acting as an agent of North Carolina, and according to state-action immunity, one cannot sue the state acting in its sovereign capacity for anticompetitive conduct. A federal appeals court sided with the FTC, and the board appealed to the Supreme Court.

In February 2015, the Court agreed with the FTC and determined that the board was not acting as a state agent and could be sued for its actions. The Court ruled, "Because a controlling number of the board's decision-makers are active participants in the occupation the board regulates, the board can invoke state-action antitrust immunity only if it was subject to active supervision by the State, and here that requirement is not met." The Court was not specific about what may constitute "active participants" or "active supervision." However, the Court did say that "active supervision" requires "that state officials have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy," and that "the supervisor must review the substance of the anticompetitive decision, not merely the procedures followed to produce it."

In October 2015, the FTC released a staff guidance, *Active Supervision of State Regulatory Boards Controlled by Market Participants* in order to better explain when active supervision of a state regulatory board would be required, in order for a board to invoke the state action defense. The guidance also aimed to highlight what factors are relevant when determining if the active supervision requirement has been satisfied. The FTC states that active supervision includes the ability of a state supervisor to review the substance of the anticompetitive decision and have the power to veto or modify a decision. The state supervisor may not be an active market participant. In addition, the FTC states that active supervision must precede the implementation of the alleged anticompetitive restraint.

The FTC states that the guidance addresses only the active supervision requirement of the state action defense, and antitrust analysis is fact-specific and context-dependent. This means that although a state action defense might not be applicable in a certain case, this does not mean that the conduct of a regulatory board necessarily violates federal antitrust laws.

On October 22, 2015, the Assembly Committee on Business and Professions and the Senate Committee on Business, Professions, and Economic Development held a joint informational hearing to explore the implications of the Court decision on the DCA's professional regulatory boards and consider recommendations. In response to the Court's decision, State Senator Jerry Hill requested an opinion from the Office of Attorney General Kamala Harris (AG). The AG released the following:

> "*North Carolina Dental* has brought both the composition of licensing boards and the concept of active state supervision into the public spotlight, but the standard it imposes is flexible and context-specific. This leaves the state with many variables to consider in deciding how to responds. Whatever the chosen response may be, the state can be assured that North Carolina Dental's 'active state supervision' requirement is satisfied when a non-market-participant state official has and exercises the power to substantively review a board's action and determines whether the action effectuates the state's regulatory policies."

North Carolina State Board of Dental Examiners v. FTC placed limitations on the immunity of regulatory boards controlled by active market participants. This is because individuals who are directly affected by their own rulemaking may not be able to detect their biases, purposefully or inadvertently placing their benefit over those of the public. Or, as the Supreme Court stated, "Dual allegiances are not always apparent to an actor."

The potential appearance of bias has been repeatedly raised as a concern as news reports and media publications have criticized the MBC's enforcement activities for failing to aggressively prosecute physicians guilty of misconduct. On July 6, 2021, the *Los Angeles Times* editorial board published a piece titled: "Put non-physicians in charge of the state medical board."[2] The piece pointed out that the MBC only takes formal disciplinary action in about three percent of cases, and that more than 80 percent of complaints are dismissed without investigation. The *Times* argued that while "changing the board's balance of power and boosting its budget won't necessarily lead to more effective enforcement and fewer instances of bad doctors continuing to practice," it would still be beneficial to "give the public more confidence that the board is focused on protecting healthcare consumers, not healthcare providers."

Following the MBC's multiple sunset review oversight hearings, SB 806 (Roth), the board's sunset extension vehicle, was briefly amended to reconstitute the board composition as a public member majority by adding two additional public members appointed by the Legislature. However, this language was subsequently removed from the bill only eight days later, and the bill never received a vote with that provision included. Advocates for associations representing licensed physicians strongly opposed the language during the time that it was in print, arguing that it would undermine the MBC's ability to regulate the practice of medicine by applying the standard of care.

This bill similarly proposes to change the composition of the MBC to feature a public member majority; however, it would achieve this reform by exchanging the next vacated physician member seat for a new public member appointment. The bill includes several corresponding changes to accommodate the reduction in the number of physician members. Finally, this bill would also require that the majority of members appointed to any panel established by the MBC for the purpose of fulfilling its disciplinary obligations be public members, which was not previously proposed in the MBC's sunset legislation.

Current Related Legislation. AB 1636 (Weber) would prohibit the MBC from granting or reinstating physician certificates to individuals who commit sexual misconduct and require the MBC to revoke the licenses of physicians to commit such misconduct. *This bill is pending in this committee.*

AB 1767 (Boerner Horvath) would remove licensed midwives from the jurisdiction of the MBC and establish a new board to license and regulate that profession. *This bill is pending in this committee.*

AB 2098 (Low) would expressly provide that disseminating misinformation or disinformation relating to COVID-19 treatments or immunizations constitutes unprofessional conduct. *This bill is pending in this committee.*

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[2] https://www.latimes.com/opinion/story/2021-07-06/california-medical-board-reform

Prior Related Legislation. SB 806 (Roth, Chapter 649, Statutes of 2021) extended the sunset date for the MBC until January 1, 2023 and made numerous reforms to the Medical Practice Act.

ARGUMENTS IN SUPPORT:

This bill is sponsored by the **Medical Board of California**. According to the MBC, "the Board has come under increasing scrutiny by the Legislature and other stakeholders. In 2021, the Legislature evaluated the Board through the processes of sunset review and, for several Board members, confirmation by the California State Senate. During some of those proceedings, the Board received questions and comments expressing concern that the Board has lost the trust of the public. Further, we regularly receive comments from consumers and advocates who question the Board's priorities and commitment to its mission." The MBC argues that "AB 2060 provides the Legislature the opportunity to take a meaningful step to reassure the public that the Board has appropriate priorities by changing the Board's composition from physician-member majority to public-member majority."

Consumer Watchdog also supports this bill, writing: "Due to a public outcry led by the media, a whistleblower, a legislative sunset review that showcased the need for reform, and consumers who have effectively testified how the Medical Board failed them, the call for reform of the Medical Board has escalated to a fever pitch. The public's call for reform begins with the institution of a public board member majority." While Consumer Watchdog argues that much more significant reform to the MBC is needed, it states that "reconstituting the Board with a public member majority is the crucial first step to achieving that change and restoring the public's confidence that the Board represents them."

ARGUMENTS IN OPPOSITION:

The **California Orthopaedic Association** opposes this bill, writing: "Having physicians on the Board means that other physicians charged with misconduct who risk losing their right to practice are judged by a jury of their peers – other physicians. Medical professionals are more qualified than are non-doctors to evaluate whether a clinical standard of care was followed in a particular case. Additionally, medical professionals are more likely to be able to judge whether a physician is spreading misinformation, due to their ability to be able to clinically evaluate the information. Public members on the Board just do not have the clinical training to make these decisions."

POLICY ISSUE(S) FOR CONSIDERATION:

Debatable Efficaciousness. While the Court's decision in *North Carolina State Board of Dental Examiners v. FTC* initially suggested that there may be substantial ramifications for state licensing policymaking, to date, there has been no meaningful litigation against public bodies established under California law. This is likely attributable in part to key distinctions between the facts of that case and California's administrative structure for its regulatory programs. While the MBC is a board overseeing the practice of medicine on which a majority of members are physicians, numerous differences between the MBC's regulatory activities and the facts of the *NC Dental* case make the likelihood of similarly successful antitrust litigation substantially improbable.

For example, while the North Carolina State Board of Dental Examiners is considered an "agency of the State," its eight-member board featured six practicing dentists and one practicing

dental hygienist, all of whom were elected by practicing licensees within the profession. A single public member was appointed by the Governor to the board. By contrast, the MBC has thirteen members, of which only a narrow majority of eight are practicing physicians, all of whom were appointed by the Governor without direct involvement from any professional association or society.

Further, the oversight provided by the Department of Consumer Affairs uniquely confirms the presence of "active state supervision" for purposes of *NC Dental*. The MBC is considered only semiautonomous, with much of its rulemaking and disciplinary activity subject to involvement by multiple other governmental entities. The Department of Consumer Affairs has also worked to ensure that members are adequately trained in certain procedures to ensure an adequate record of deliberation for purposes of defense against any potential allegations of antitrust.

Changing the Board's composition to a public member majority would therefore not necessarily decrease the MBC's risk of exposure to litigation in a significant way. A more assertable benefit would be the removal of perceived bias exhibited by a controlling majority of board members. The theory of "regulatory capture" posits that government agencies are often at risk of gradually becoming ideologically motivated by the needs of an interest group, rather than the interest of the public, through the accumulation of influence exerted by a regulated constituency.[3] The MBC has been charged with similar allegations, as the seemingly infrequent occurrence of formal discipline against licensees has been correlated with the physicians who make up a majority of its board members.

While the Legislature has consistently criticized the MBC's underwhelming enforcement program and patient safety advocates have blamed identified shortcomings as the result of the medical profession's lobbying influence, no evidence has been provided that would unequivocally establish such a link. Supporters of this bill have been unable to produce any examples of an action taken by the MBC in which a narrow majority of professional members overwhelmed the dissent of the public member minority by a single vote. While certainly professional members have a tendency to be more active participants in debate generally on licensing boards, this would remain true even if that demographic's representation were reduced, with a vocal and persuasive minority still potentially dominating discourse. It should also be noted that with even public members representing a one-vote majority on the MBC, nothing would prevent a quorum from being established when a majority of those in attendance are physician members.

The strongest argument for reconstituting the MBC with a public member majority, therefore, is essentially in service of removing the *appearance* of undue influence by physicians on the board. That is not to say that such a benefit would be trivial; the public's perception of government, particularly for agencies like the MBC who are entrusted with protecting patients and consumers, is certainly meaningful, and it is arguable that even superficial reform to the MBC would help replace trust in the body as a regulator acting on behalf of the people. This argument is cogently made in multiple letters submitted in support of the bill. However, those who expect reform of the MBC's membership composition to existentially reshape the board's activities in a dramatic fashion should reevaluate whether that is likely to occur as a result of this bill, when the immediate value of the change may prove to be more symbolic than consequential.

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[3] Dal Bó, Ernesto (2006). "Regulatory capture: A review." *Oxford Review of Economic Policy*. 22 (2): 203–225.

Impact on Standard of Care Assessments. Out of the twenty healing arts boards placed under the Department of Consumer Affairs, all but four of them feature a majority of professional members.[4] This tradition is in large part because of the nature of health professional regulation, particularly with boards that follow a "standard of care" model of discipline. When the MBC is determining whether to bring an accusation against a licensee for misconduct following a complaint or adverse event, the motivating question is not whether the physician adhered to the letter of the law. The threshold question in many cases is: did the physician follow the appropriate standard of care, acting reasonably at the time in accordance with their training?

It is only logical that the individuals best situated to judge whether a medical professional met the expected standard of care would be fellow professionals. This is why the earliest forms of qualification in the healing arts were essentially self-regulatory bodies consisting of members of professional societies. When state agencies took over these functions, the perspectives of those within the profession retained their voice through the appointment of professional board members. While most boards feature nearly as many members appointed from the disinterested public to offset any potential bias, the prevailing concept has long been that health professionals charged with failing to meet the expectations of their license should be held accountable foremost by their peers.

There are a number of ways the MBC assesses whether a licensee failed to meet the standard of care beyond the presence of professional members on the board. Any complaint determined to involve quality of care is required to be reviewed by "medical experts with the pertinent education, training, and expertise to evaluate the specific standard of care issues raised by the complaint." These medical reviewers are themselves physicians, who advise the board on whether there was a deviation in the standard of care. Expert witnesses are utilized frequently in disciplinary hearings and are required to produce evidence of their credentials.

These disciplinary functions are largely delegated by the MBC as a whole to one of two panels that review proposed decisions and settlements. The Medical Practice Act allows these panels to act on behalf of the full board in various matters relating to disciplinary proceedings. To ensure that those charged with approving, modifying, or rejecting these outcomes fully appreciate the methodology for establishing and assessing the standard of care, statute requires that a majority of those serving on these disciplinary panels must be appointed from among the MBC's physician members.

In addition to reforming the MBC's board composition as a whole, this bill would also change statute to require instead that disciplinary panels be made up primarily of lay persons. While this would appear consistent with the intent of the bill, there could be significant issues with delegating responsibilities directly related to standard of care assessments primarily to those who do not have the education and training to evaluate those assessments. It may be prudent to provide the MBC with flexibility to allow these panels to remain constituted with a majority of physician members in some cases. While the panels would ultimately remain subservient to the board as a whole and therefore the MBC's disciplinary activities would still be overseen by a public member majority, allowing for this discretion would ensure that the MBC continues to carry out its disciplinary functions with the appropriate consideration of medical standards.

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[4] The California Acupuncture Board, Board of Behavioral Sciences, and Bureau of Vocational Nursing and Psychiatric Technicians each have a one-member public majority; the Respiratory Care Board has an equal number of licensee and public members, in addition to a physician member.

AMENDMENTS:

To provide the MBC with flexibility to determine whether any of its disciplinary panels should retain their physician-majority memberships, amend Section 3 in the bill so that Section 2008 would be amended as follows:

> The board may appoint panels from its members for the purpose of fulfilling the obligations established in subdivision (c) of Section 2004. Any panel appointed under this section shall at no time be comprised of ~~*less*~~ *fewer* than four members ~~*and the number of public members assigned to the panel shall not exceed the number of licensed physician and surgeon members assigned to the panel*~~. Each panel shall annually elect a chair and a vice chair.

REGISTERED SUPPORT:

Medical Board of California *(Sponsor)*
A Voice for Choice Advocacy
Consumer Protection Policy Center
Consumer Watchdog

REGISTERED OPPOSITION:

California Orthopaedic Association

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

Date of Hearing: April 19, 2022

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 2087 (Petrie-Norris) – As Amended March 24, 2022

SUBJECT: Prescription drugs.

SUMMARY: Restates that it is unlawful to dispense or furnish a prescription drug, or advertise the ability to do so, without a valid license to do so and authorizes enforcement of violations of existing law by private right of action.

EXISTING LAW:

1) Regulates the dispensing and furnishing of prescription drugs under various healing arts practice arts and makes it unlawful to furnish or dispense a prescription drug without a relevant license, including, but not limited to, the Medical Practice Act, the Nursing Practice Act, the Pharmacy Law, the Dental Practice Act, the Optometric Practice Act, the Physician Assistant Practice Act, the Naturopathic Doctors Act, and the Veterinary Medicine Practice Act. (BPC §§ 2000-2028.5, 2700-2828.4, 4000-4427.8, 1600-1976, 3000-3167, 3500-3545, 3610-3686, 4800-4920.8)

2) Defines "furnish" as supplying a drug by any means, by sale or otherwise. (BPC § 4026)

3) Defines "dispense" as the furnishing of drugs or devices:

    a) Upon prescription from a physician, dentist, optometrist, podiatrist, veterinarian, or naturopathic doctor. (BPC § 4024(a))

    b) Upon an order to furnish drugs or transmit a prescription from a certified nurse-midwife, nurse practitioner, physician assistant, naturopathic doctor, or pharmacist. (BPC § 4024(a))

    c) Directly to a patient by a physician, dentist, optometrist, podiatrist, or veterinarian, or by a certified nurse-midwife, nurse practitioner, naturopathic doctor, or physician assistant. (BPC § 4024(b))

4) Defines "drug" as any of the following:

    a) Articles recognized in the official United States Pharmacopoeia, official National Formulary or official Homeopathic Pharmacopoeia of the United States, or any supplement of any of them. (BPC § 4024(a))

    b) Articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in humans or other animals. (BPC § 4024(b))

    c) Articles (other than food) intended to affect the structure or any function of the body of humans or other animals. (BPC § 4024(c))

    d) Articles intended for use as a component of any article specified above. (BPC § 4024(d))

5) Defines "dangerous drug and device" as any drug or device unsafe for self-use in humans or animals, and includes the following:

   a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import. (BPC § 4022(a))

   b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a ____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order the use of the device. (BPC § 4022(b))

   c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished under the regulations promulgated by the Board of Pharmacy. (BPC § 4022(c))

6) Makes it a misdemeanor, as specified, for any person to knowingly and unlawfully dispense or furnish a dangerous drug or dangerous device, or anything that looks like a dangerous drug or dangerous device, or who knowingly owns, manages, or operates a business that dispenses or furnishes a dangerous drug or dangerous device or thing that looks like a dangerous drug or dangerous device, without a license to dispense or furnish these products. (HSC § 11352.1)

7) Establishes penalties and remedies for unfair competition, including any unlawful, unfair, or fraudulent business act or practice and unfair, deceptive, untrue, misleading, or false advertising. (BPC §§ 17200-17210, 17500)

THIS BILL:

1) Restates that it is unlawful to dispense or furnish a prescription drug, or advertise the ability to do so, unless licensed to do so as required under existing law.

2) Restates that violations of the existing laws specified under this bill are enforceable under the respective existing laws.

3) Establishes an undefined private right of action to enforce violations of existing licensing laws specified under this bill.

4) Authorizes the recovery of attorney's fees to a prevailing party in the private right of action brought under this bill.

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

COMMENTS:

Purpose. This bill is sponsored by *Jarrod's Law, Inc*. According to the author:

> Too many vulnerable patients are being recruited into addiction treatment facilities that are not properly staffed to meet patient needs. Unscrupulous recovery centers churn vulnerable patients through their facilities for profit, resulting in avoidable relapses and tragic deaths.

> [This bill]—also known as Jarrod's Law—will ensure patient protection by requiring proper training and licensing for employees of addiction treatment centers. Specifically, this bill clarifies that, if a business is earning money housing people in recovery for both mental and physical health needs, and if that business has an employee distribute or store prescription drugs for patients, both the business and employee must be properly licensed. This will ensure that the level of care provided by treatment centers matches the needs of their clients.
>
> Jarrod's Law will stop exploitative treatment centers from furnishing prescription drugs, or advertising their ability to do so, without a proper license. It will also empower patients, family members, and our local communities to hold bad actors accountable through civil action. This will protect patients and neighborhoods by raising the standard of care in the addiction treatment and mental health recovery industries.

Background. Existing law makes it unlawful to give out prescription drugs without a license to do so. It also makes it unlawful to advertise the ability to give out prescription drugs without a license. Individuals or businesses that violate those laws are subject to criminal and administrative penalties.

Further, existing law establishes a system of licensure of facilities under the Department of Health Care Services, Department of Public Health, and Department of Social Services for the treatment of behavioral and mental health disorders, including substance use disorder.

There are also additional criminal and civil penalties for unfair business practices under the Unfair Competition Law (BPC §§ 17200-17210, 17500). That law prohibits misrepresentations, including the ability to provide a service needing a license without a license, and establishes a private right of injunctive relief for individuals who have "suffered an injury in fact" and have "lost money or property as a result of the unfair competition."

This bill would establish a new, undefined private right of action, and accompanying attorney's fees, to allow for additional private enforcement of licensing laws.

Prior Related Legislation. AB 920 (Petrie-Norris) of 2019 would have required outpatient alcoholism or drug abuse recovery or treatment program that provides services to the public and is not otherwise licensed under existing law to be licensed by the Department of Health Care Services, except as specified. That bill was vetoed by Governor Newsom who stated:

> This bill would eliminate an existing voluntary outpatient certification program. Beginning January 1, 2021, it would attempt to require an outpatient substance use disorder (SUD) recovery or treatment services facility which is not licensed under existing law, to obtain licensure from the Department of Health Care Services (DHCS) to provide SUD services. The bill attempts to do this by replacing references to program certification in existing Health and Safety Code references to program licensure.
>
> I am supportive of the Legislature's intent to license all SUD recovery and treatment services. However, developing a new licensing schema is a significant undertaking, and would require a significant departure from the bill as enrolled. This bill would need to be revised to provide adequate statutory authority for

> DHCS to effectively monitor and ensure compliance with outpatient licensure requirements. In addition, establishing the associated administrative oversight is not without significant cost. After reviewing this bill, it is clear that a substantial amount of work is still needed to develop a program that my administration can implement.

SB 325 (Hill) of 2019 would have required the Department of Consumer Affairs (DCA) on or before July 1, 2020, to conduct a sunrise review for the licensing of alcohol or drug counselors and required the Department of Health Care Services (DHCS), beginning January 1, 2021, to license an outpatient alcohol or other substance use disorder recovery or treatment services program that provides those services to the public and is not otherwise licensed, as specified.

AB 724 (Benoit) of 2008 would have defined a sober living home which is defined as a residential property which is operated as a cooperative living arrangement to provide an alcohol and drug-free environment for persons recovering from alcoholism or drug abuse, or both, who seek a living environment in which to remain clean and sober, and which meets other specified requirements.

ARGUMENTS IN SUPPORT:

Jarrod’s Law (sponsor) writes in support:

> California has poor and minimal regulation and oversight of private, for-profit addiction treatment. Operators advertise over the internet to recruit addicts from other states in order to obtain a profitable income stream from their clients' private health insurance plans. Initially, addicts may be housed in state licensed detox facilities, increasingly with clinical services provided sporadically but without continuous oversight of anyone trained in clinical healthcare. When insurance no longer pays for detox level services, addicts are then transitioned to therapy in commercial centers and shuffled into lodging in what the state defines as "Recovery Residences," commercially operated houses that have no government oversight whatsoever. Nevertheless, all manner of services are provided to the recovering addict residing in a Recovery Residence, many of which require a license and exceed reasonable accommodations.
>
> The City of Dana Point has pursued a strategy in which it sues operators claiming to manage Recovery Residences as purely peer supportive environments. Through disclosure in these suits, virtually all of the Recovery Residence operators have been determined to have engaged in services that require a license, despite posing otherwise.
>
> One such service is the distribution of an addict's prescribed medication. In early recovery, addicts are frequently not trusted to remember or store their own medications, including those for treatment of co-occur ring disorders such as anxiety or depression, in part due to the risk to other addicts in the same residence who might find the medication and use i t. Increasingly, the state legislature is pushing Medication Assisted Treatment, technically low dose narcotics, into addiction treatment housing as well. These medications, even if managed by a supervisor, can be ground up and snorted to obtain a high from which the addict might overdose, representing a threat to all who live in the home.

> State law refers to the requirement for a license to engage in medication distribution under some substance use treatment circumstances but has not clearly addressed the requirement on residential properties operated by businesses affiliated with commercial treatment. It is imperative that employees supervising and distributing medication on these properties be trained appropriately as would be required if their employer had a license.
>
> [This bill] clarifies an important point of law. No one in an employment capacity should be distributing a prescribed medication without the business having a license to do so. To perform this service without a license, as regularly takes place in Recovery Residences, is a violation of current treatment licensing intent and represents a threat to the health of people whom the law should clearly protect.

ARGUMENTS IN OPPOSITION:

None on file.

POLICY ISSUES FOR CONSIDERATION:

Private Right of Action. This bill would create a private right of action for a violation of existing licensing requirements. A private right of action is the right to sue in court as a private citizen, rather than a public entity (such as the attorney general, a district attorney, or other public attorney). Existing licensing requirements are currently enforced by licensing entities and public attorneys who can seek penalties for behavior that rises to the level of prosecution.

Standing. This bill establishes a private right of action, but does not specify who may bring a suit under the private right of action (known as standing). For civil actions, remedies are usually based on harm or the potential for harm. Because this bill does not specify who may bring the private right of action suit, this bill would allow anyone, even if not harmed by the unlawful behavior, to bring a suit under the bill.

Remedies. This bill establishes a private right of action, but does not specify what remedies are available under that private right of action (it is unclear what the plaintiff can win in the action).

AMENDMENTS:

1) *Erroneous Cross References*. Currently, the bill makes erroneous cross references to cannabis provisions when the intent is to reference existing prohibitions against the unlicensed furnishing and dispensing of dangerous drugs. Therefore, the bill should be amended to correct the cross reference:

   On page 2 of the bill, lines 7-8:

   > (a) It is unlawful to operate a business where an employee dispenses or furnishes a prescription drug without both the business and the employee having a valid license authorizing the business and employee to dispense or furnish the prescription drug, as specified in Section ~~11362.1~~*11352.1* of the Health and Safety Code and pursuant to the statutory or regulatory requirements of the licensure scheme under which the business or person is licensed.

(b) It is unlawful for a business to advertise or act as if they have a license to dispense or furnish a prescription drug without having a valid license to do so, as required under Section ~~11362.1~~ *11352.1* of the Health and Safety Code.

2) *Clarity on Private Right of Action*. As noted above, this bill lacks a definition of the newly created private right of action. In addition, the Consumer Attorneys of California would support this bill if it is amended to only allow attorney's fees to a prevailing plaintiff, rather than any party to the action.

While this bill and amendments being recommended would benefit from a hearing in the Assembly Committee on Judiciary, the author has agreed to address the standing, remedy, and attorney's fees issues through Committee amendments that would (1) limit standing to those injured by the unlawful behavior, (2) limit the remedy to an injunction or other order appropriate to the suit, and (3) award attorney's fees to a successful plaintiff:

(c) This section may be enforced in accordance with the licensing scheme under which the business or person is licensed, such as revoking the license of the business or *person.* ~~person, or by a private right of action.~~

(d) A person who receives services in violation of this article, or the person's parent, spouse, child, sibling, next of kin, guardian, successor in interest, or personal representative may bring a civil action for an injunction or other appropriate order. The prevailing ~~party in a private right of action~~ *plaintiff in that action* may recover *reasonable* attorney's fees.

(e) The remedies established by this article are in addition to the remedies established under other laws.

~~(d)~~ *(f)* For purposes of this ~~section, "dispense" has the same meaning as defined in Section 4024.~~ *section, the following definitions apply:*

(1) "Dispense" has the same meaning as defined in Section 4024.

(2) "Furnish" has the same meaning as defined in Section 4026.

REGISTERED SUPPORT:

Jarrod's Law (sponsor)
Advocates for Responsible Treatment
The Purpose of Recovery

REGISTERED OPPOSITION:

None on file.

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

Date of Hearing: April 19, 2022

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 2341 (Medina) – As Introduced February 16, 2022

NOTE: This bill is double referred and passed out of the Assembly Higher Education Committee on April 2, 2022, by of a vote of 11-0-1.

SUBJECT: California Private Postsecondary Education Act of 2009: complaint processing contracts.

SUMMARY: Authorizes a public institution of higher education, as defined, to contract with the Bureau of Private Postsecondary Education (BPPE) to review and, as appropriate, act on complaints concerning the institution.

EXISTING LAW:

Federal law.

1) Specifies that an institution, as described, is legally authorized by a State if the State has a process to review and appropriately act on complaints concerning the institution including enforcing applicable State laws, and the institution meets specified provisions. (34 Code of Federal Regulations § 600.9)

State law.

1) Enacts the California Private Postsecondary Education Act to provide for the regulation and oversight of private postsecondary schools, subject to repeal on January 1, 2023. (Education Code (EDC) §§ 94800 *et seq.*)

2) Establishes the BPPE within the Department of Consumer Affairs to regulate private postsecondary educational institutions under the California Private Postsecondary Education Act. (EDC § 94820)

3) Authorizes an independent institution, as defined, to execute a contract with BPPE for BPPE to review, and, as appropriate, act on complaints concerning the institution, in accordance with federal regulations. (EDC § 94874.9(b))

4) Provides that the execution of a contract by BPPE with an institution shall constitute establishment by the state of that institution to offer programs beyond secondary education, including programs leading to a degree or certificate, in accordance with federal regulations. (EDC § 94874.9(c))

5) Provides that BPPE shall use a standard form contract. (EDC § 94874.9(d))

6) Specifies that a contract meet minimum requirements, as specified. (EDC § 94874.9(e)(1)(A)-(D))

7) Provides that BPPE may terminate a contract if an institution is no longer an independent institution of higher education, as defined, or fails to comply with the provisions of the contract. (EDC § 94874.9(f))

8) Requires all moneys collected by BPPE that relate to a contract to be deposited in the Private Postsecondary Education Administration Fund. (EDC § 94874.9(g))

9) Requires BPPE to maintain on its website both of the following:

   a) The provisions of the standard form contract.

   b) A list of institutions with which BPPE has executed a contract.

   (EDC § 94874.9(h))

10) Requires BPPE to report specified information to the Director of Finance and the Legislature regarding implementation. (EDC § 94874.9(i))

11) Provides that notwithstanding any other law, the Department of General Services, at the request of BPPE, may exempt contracts from any laws, rules, resolutions, or procedures that are otherwise applicable to public contracts that the Department of General Services administers. (EDC § 94874.9(j))

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

13) Requires an out-of-state private postsecondary educational institution (other than a nonpublic higher education institution that grants undergraduate degrees, graduate degrees, or both, formed as nonprofit corporation and accredited by an agency recognized by the United States Department of Education) to register with the BPPE, pay a fee, provide evidence of accreditation, evidence that the institution is approved to operate in the state where the institution maintains its main administrative location, and a copy of the institution's catalog and sample enrollment agreement. Requires these institutions to comply with Student Tuition Recovery Fund requirements and disclosures. Prohibits an institution from operating in California for failure to comply with the registration requirements. Establishes the validity of a BPPE registration for two years. (EDC § 94801.5)

14) Defines "public institution of higher education" to mean any of the following:

   a) An institution of public education, including the University of California, California State University, or a district or campus of the California Community College system.

   b) An institution operated by the United States government, a state, as defined, a local government, as *defined*, or Indian tribal government, as defined.

   c) An institution that is an instrumentality of a state or local government if it meets all of the following:

      i) The institution's employees are government employees.

ii) The institution's liabilities are payable to the same degree as if they were liabilities of the state or local government, in the state or local government jurisdiction where the institution is formed.

iii) The institution is subject to the same financial oversight and open public records laws as the state or local government, in the state or local government jurisdiction where the institution is formed.

(EDC § 94858.5)

THIS BILL:

1) Authorizes a public institution of higher education, as defined, to contract with BPPE to review and, as appropriate, act on complaints concerning the institution.

2) Provides that moneys paid by a public institution of higher education, as defined, shall support costs incurred by BPPE to perform activities pursuant to the contract with that institution so that fees collected by BPPE from other institutions are not used to support those costs.

3) Provides that the execution of a contract by BPPE with a public institution of higher education, as defined, does not, in and of itself, qualify the institution for participation in the Cal Grant Program.

4) Makes various technical and conforming changes.

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

COMMENTS:

Purpose. This bill is sponsored by *Arizona State University*. According to the author, "Student access to federal financial aid programs is critical for students to achieve their educational goals. While California has a clear path for many higher education institutions to offer federal aid to their students, legislation is needed to authorize public institutions established by another state that have a physical location in California as part of their meeting the federal regulations. [This bill] will therefore rectify the loophole in state policy, allowing California students who attend any public institutions in California to access their federal financial aid. Specifically, [this bill] authorizes the Bureau of Private Postsecondary Education to enter a contract with a public institution of higher education established by another state. We should not deny federal financial aid to deserving students because of their decision an accessible institution that aligns with their goals."

Background.

BPPE and the California Private Postsecondary Education Act (Act). BPPE is responsible for oversight of private postsecondary educational institutions that have a physical presence in California and enforcing the Act, which prohibits false advertising and inappropriate recruiting and requires disclosure of specific information about the educational programs being offered, graduation and job placement rates, and licensing information. Specifically, the Act directs BPPE to, in part, review and approve private postsecondary educational institutions; establish

minimum operating standards to ensure educational quality; provide an opportunity for student complaints to be resolved; and ensure private postsecondary educational institutions offer accurate information to prospective students about school and student performance. BPPE also investigates and combats unlicensed activity, conducts research and outreach to students and postsecondary educational institutions, and administers the Student Tuition Recovery Fund (STRF). STRF provides financial support to students that have suffered from an economic loss due to a school closure or other factors affecting the student's education.

State Authorization. Postsecondary institutions with a physical presence in a state must be authorized by that state in order to operate and be eligible for certain federal financial aid (e.g. Pell Grant). A postsecondary institution is legally authorized by a state if, in part, the state has a process to review and appropriately act on complaints concerning the institution. The governing boards of the University of California, California State University, and California Community College systems fulfill this role on behalf of students attending in-state, public colleges and universities in California. BPPE administers complaint handling for private for-profit postsecondary institutions. Independent colleges and universities may contract with BPPE for complaint processing, and this bill would similarly authorize a public university to contract with BPPE for complaint handling.

Need for the bill. Arizona State University (ASU) recently opened a new campus known as the ASU California Center in downtown Los Angeles. As described on ASU's website, "The ASU California Center provides students from all of ASU's campuses the opportunity to make connections within Los Angeles and engage industries through jobs and internships. The new location also helps expand access to higher education for California students and life-long learners through undergraduate and graduate degree programs, executive education, workshops and seminars." In order for students to be eligible for federal financial aid, which may make programs offered at the ASU California Center more appealing to prospective students, ASU must receive state authorization, which requires there to be a process for investigating and acting on complaints levied against ASU. This bill would allow ASU to contract with BPPE for this purpose.

Prior Related Legislation.

AB 1097 (Santiago) of 2021, as introduced, would have, in part, allowed a student who is a California resident attending a public institution of higher education, as specified, to receive an initial Cal Grant award if the student is enrolled at a branch or other location of the institution that is physically located in the state.

SB 802 (Roth), Chapter 552, Statutes of 2021, extends the sunset date for the Bureau for Private Postsecondary Education (BPPE) until January 1, 2023 and makes additional technical changes, statutory improvements, and policy reforms in response to issues raised during the BPPE's sunset review oversight process.

AB 70 (Berman), Chapter 153, Statutes of 2020, prohibits the Bureau from approving an exemption or handling complaints for a nonprofit institution that the AG determines does not meet specified criteria of a nonprofit corporation.

AB 1344 (Bauer-Kahan), Chapter 520, Statutes of 2019, requires that out-of-state institutions registering with the BPPE, either at the time of registration, or within 30 days if currently registered, to notify the BPPE if specific actions are taken against the institution.

SB 81 (Committee on Budget and Fiscal Review), Chapter 22, Statutes of 2015, authorized private colleges and universities to operate in the state and set up a complaint process for students through BPPE.

ARGUMENTS IN SUPPORT:

As the sponsor of this bill, *Arizona State University* writes in support, "ASU has deep ties to California, including the more than 18,000 Californians who are ASU students in Arizona and the nearly 52,000 who are ASU alumni. We have a new home at the ASU California Center, located at the historic Herald Examiner building in downtown Los Angeles. This presence will allow California students to complete their education at ASU while staying in the state by facilitating access to top-ranked undergraduate and graduate degree programs. It will also allow ASU to advance innovative transdisciplinary projects and connect our students with high-demand careers in the region. ASU's execution of a contract with the Bureau is necessary for us to demonstrate state authorization to the United States Department of Education. Currently, California has a clear path for many higher education institutions, including private for-profit institutions and independent institutions, to meet these federal "state authorization" requirements and thereby offer federal aid to their students. Because ASU, a public university, is not a private independent or for-profit institution and therefore is not within the current jurisdiction of the Bureau, students enrolling in-person at our new center in Los Angeles cannot receive federal financial aid, including Pell Grants, until this legislation is enacted. For our students, as for any student, access to federal aid is a critical support as they work to achieve their educational goals."

The *Central City Association of Los Angeles* writes in support: "By providing this authorization, AB 2341 will support affordability for California students who want to complete their higher education at a public institution in California. The bill, if enacted, will help students at those institutions through federal financial aid options, like critical Pell Grants."

ARGUMENTS IN OPPOSITION:

None on file.

POLICY ISSUE(S) FOR CONSIDERATION:

Precedent. This committee is only aware of one out-of-state university with a physical campus in California. However, additional schools may be more inclined to establish a campus in California if their students were eligible to receive federal financial aid. The Committee may wish to consider the potential impact of additional out-of-state universities operating within California.

IMPLEMENTATION ISSUES:

Ability to act on complaints. Federal regulations specify that in order for a postsecondary institution to receive state authorization the state must have a process to review *and appropriately act* on complaints concerning the institution. Because BPPE does not have any authority over postsecondary institutions that it does not approve or regulate, BPPE has limited

ability to act on complaints beyond referring them to the institutions that are subject the complaints or other agencies (such as accrediting agencies). It is unclear whether this process provides the level of consumer protection envisioned by state authorization requirements. This bill would allow a new category of postsecondary institutions (out-of-state public universities establishing campuses in California) to contract with BPPE for complaint handling even though BPPE can do little to provide recourse for those students.

Complaint filing. If this bill is signed into law, ASU students wishing to file a complaint about the university would have two different processes for doing so depending on where their program is offered. Students attending ASU in-person in Arizona or online would file complaints with ASU, whereas students participating in a program offered at the ASU California Center would file complaints through BPPE. The author may wish to consider what steps could be taken to ensure that students are aware of the complaint process available to them so that students do not face undue delay or burden while attempting to file a complaint.

REGISTERED SUPPORT:

Arizona State University *(Sponsor)*
Central City Association of Los Angeles
Los Angeles Latino Chamber of Commerce

REGISTERED OPPOSITION:

None on file.

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

Date of Hearing: April 19, 2022

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 2382 (Lee) – As Amended March 31, 2022

SUBJECT: Light pollution control.

SUMMARY: Requires state agencies, as defined, to ensure that an outdoor lighting fixture, as defined, that is installed on a building or structure that is owned, leased, or managed by a state agency is shielded, as defined, turned off manually or automatically, or motion activated between 11 p.m. and sunrise, beginning July 1, 2023.

EXISTING LAW:

1) Establishes the California Building Standards Commission (CBSC) within the Department of General Services and requires any building standards adopted or proposed by state agencies to be submitted to, and approved by, the CBSC prior to codification into the California Building Standards Code. (Health and Safety Code §§ 18901 *et seq*.)

2) Requires the State Energy Resources Conservation and Development Commission to adopt, among other regulations, lighting and other building design and construction standards that increase efficiency in the use of energy for new residential and nonresidential buildings to reduce the wasteful, uneconomic, inefficient, or unnecessary consumption of energy, including energy associated with the use of water, and to manage energy loads to help maintain electrical grid reliability. (Public Resources Code §§ 25000 *et seq*.)

THIS BILL:

1) States that the Legislature finds and declares that the purpose of this chapter is to regulate outdoor night lighting to preserve and enhance the state's dark sky while promoting safety for people, birds, and other wildlife, conserving energy, reducing our carbon footprint, and preserving the aesthetic qualities of the night sky.

2) Defines "department" to mean the Department of General Services.

3) Defines "outdoor lighting fixture" to mean an outdoor artificial illuminating device, whether permanent or portable, including, but not limited to, artificial illuminating devices installed on a building or structure and used for illumination or advertisement, including, but not limited to, searchlights, spotlights, and floodlights, used for architectural lighting, parking lot lighting, landscape lighting, billboards, or street lighting.

4) Defines "shield" to mean to cover in a manner that light rays emitted by the fixture, either directly from the lamp or indirectly from the fixture, are projected below a horizontal plane running through the lowest point on the fixture where the light is emitted.

5) Defines "state agency" to mean a state agency as defined in Government Code Section 11000.

6) Requires, on and after July 1, 2023, a state agency to ensure that between the hours of 11 p.m. and sunrise, an outdoor lighting fixture that is installed on a building or structure that is owned, leased, or managed by the state agency is any of the following:

   a) Shielded.

   b) Extinguished by an automatic or manual shutoff device.

   c) Motion activated with a duration of fewer than 15 minutes and equipped with an automatic shutoff device.

7) Exempts all of the following from the requirement in (6) above.

   a) Outdoor lighting fixtures on advertisement signs on interstate highways and federal primary highways.

   b) Navigational lighting systems at airports and other lighting necessary for aircraft safety pursuant to the requirements of the Federal Aviation Administration, including, but not limited to, lighting placed on communication towers or wind turbines.

   c) Outdoor lighting fixtures that are necessary for worker safety, including, but not limited to, lights at agricultural facilities, and industrial, manufacturing, or commercial sites.

   d) Emergency lighting that is used by police, firefighters, correctional personnel, or medical personnel and that is in operation as long as the emergency exists.

   e) Outdoor lighting regulated pursuant to federal law, rule, or regulation that preempts state law.

   f) Lighting intended for tunnels and roadway underpasses.

   g) Outdoor lighting used for programs, projects, or improvements of a state agency relating to construction, reconstruction, improvement, or maintenance of a street or highway.

   h) Outdoor lighting used for construction or major renovation of state agency buildings, structures, and facilities.

   i) Street light fixtures if the shielding is unavailable from the manufacturer.

   j) Incandescent fixtures of 150 watts or fewer and other sources of fewer than 70 watts, including, but not limited to, seasonal and decorative lighting.

8) Requires the department to do all of the following:

   a) Develop educational materials to encourage the reduction of light pollution.

   b) Develop educational materials regarding compliance with the requirements of this chapter, including examples of conforming lighting fixtures that conform to the requirements specified in Section 11902 and the exemptions provided pursuant to Section 11903.

c) Make educational materials developed pursuant to subdivisions (a) and (b) available to the public.

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

COMMENTS:

Purpose. This bill is jointly sponsored by *Audubon California*, the *Santa Clara Valley Audubon Society*, the *National Park Conservation Association*, and the *American Bird Conservancy*. According to the author, "Increased light pollution throughout California and globally is disrupting the circadian rhythms and migratory patterns of animals, which is harming our ecosystems. According to the National Audubon Society, 80% of birds that migrate do so at night using the dark skies to help them navigate to and from their breeding grounds. In addition to disrupting circadian rhythms, excessive artificial light at night (ALAN) can also disorient birds, which can result in fatal collisions. To address this issue, [this bill] will require all outdoor lighting fixtures on state buildings and structures to have an external shield to direct light to where it is needed or be equipped with a shutoff device. This sensible reform promotes safety for migratory birds, ecosystems, and people."

Background.

Light pollution. Light pollution, which has been found to have adverse effects on human health and wildlife, is caused by increasingly large urban areas and the excessive and inefficient use of lights. Light pollution is characterized by sky glow (brighter sky in urban areas), light trespass (shining of lights in unneeded or unwanted areas), and glare (brightness resulting in visual discomfort).

Light pollution was first recognized as a problem by astronomers in the 1970s upon discovery that thousands of stars and other objects in space could not be seen as clearly despite the use of powerful equipment. In suburbs and cities where a few thousand stars should be visible at night, only a few hundred or a few dozen, respectively, can be seen.

In addition to obscuring stars, light pollution can directly impact human health by interfering with natural circadian rhythms caused by a decrease in the amount of melatonin produced in the body. Sleep disorders, depression, cancer, and other adverse health conditions have been linked to circadian disruption.

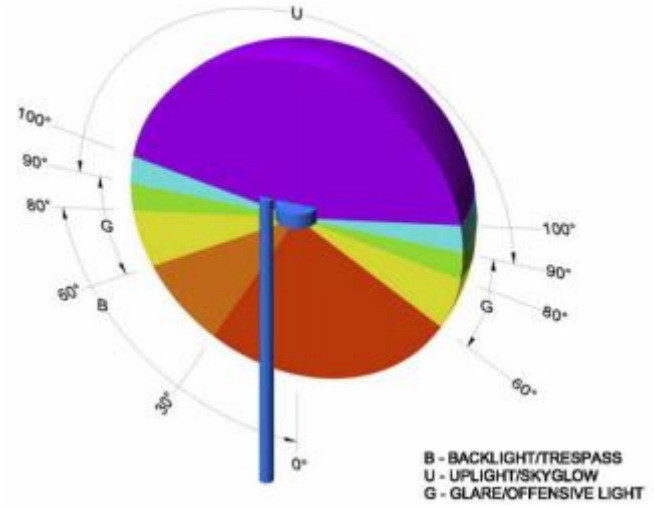
Similarly, wildlife are also subject to adverse impacts of light pollution. Studies have demonstrated that light pollution can alter the behavior of wildlife, often resulting in the death or decline of species such as turtles, birds, fish, reptiles, and other wildlife.

Light pollution has also been known to impact the ability for the military to conduct nighttime trainings, which is done to simulate combat situations. In 2007, Texas, at the request of the military, began to regulate the use of outdoor lighting in counties with several military bases and more than one million residents.

California Green Building Standards Code (CALGreen). In 2007, the CBSC developed green building standards to help the state achieve its greenhouse gas reduction goals. CALGreen is the first-in-the-nation mandated green building standards code and includes regulations for energy efficiency, water efficiency and conservation, material conservation and resource efficiency, and

environmental quality. CBSC is authorized to propose CALGreen standards for non-residential structures and any others that are not under the jurisdiction of another state agency. CALGreen Section 5.106.8 currently imposes specific light pollution reduction standards for non-residential buildings. Outdoor lighting systems must be designed and installed to prevent light escaping in unwanted or unnecessary directions from an outdoor light fixture. Specifically the light produced may not exceed the allowable backlight (light directed behind the fixture), uplight (light directed above the horizontal plane of the fixture), and glare (light emitted at high angles that cause a glare) (BUG) ratings per lighting zone. See Figure 1. Lighting zones range from natural environments with extremely limited outdoor lighting to urban areas with extensive use of outdoor lighting. CALGreen specifies that if a local ordinance is more stringent than the CALGreen requirements, the building owner must comply with the local ordinance. CalGreen currently exempts a variety of light fixtures, including but limited to those used for aviation; landscaping; temporary use outdoors; sports and athletic fields, and children's playgrounds; tunnels, bridges, stairs, and ramps; and lighting for industrial sites. CALGreen also exempts emergency lighting; building façade meeting specified requirements; and some custom lighting features.

Figure 1: Backlight, Uplight, and Glare



Source: California Energy Commission

Other states. Nineteen states, the District of Columbia, and Puerto Rico have enacted laws to reduce light pollution. "Dark skies" laws typically require outdoor lighting fixtures to be shielded so that light is emitted downwards only, to use low-glare or low-wattage lightbulbs, or to be restricted during certain hours.

Current Related Legislation.

AB 1710 (Lee) of 2022 states that "It is the intent of the Legislature to enact legislation relating to the regulation of residential and outdoor light-emitting diodes (LED) fixtures that create artificial light pollution at night, which causes harmful environmental and public health effects."

ARGUMENTS IN SUPPORT:

The *Midpeninsula Regional Open Space*, *Save the Bay*, *Hills for Everyone*, *Green Foothills*, *Friends of Harbors, Beaches and Parks*, *Defenders of Wildlife*, the *Citizens Committee to Complete the Refuge*, *California Institute for Biodiversity*, the *Open Space Authority of Santa Clara Valley*, and the *Santa Clara Valley Audubon Society* each write in support of this bill:

"Artificial Light at Night (ALAN) has increased to unprecedented levels globally and in California. This has resulted in a disruption to circadian rhythms in plants and animals, which harm our ecosystems.

"Excessive night light attracts nocturnal-migratory birds and diverts them from safe migration routes to human environments, where they are more susceptible to collisions with buildings and other human-made structures. A study found that reducing indoor artificial night light by half can result in roughly 60% fewer bird collisions. Insects are attracted to light as well, and when caught in a light plume of a light fixture, they circle around it until they die or the light is extinguished.

"According to the National Audubon Society, 70% of bird species migrate each year. And of those birds, 80% migrate at night, using the night sky to help them navigate to and from their breeding grounds. Every day in the U.S., at least one million birds die due to building or structure collisions related to ALAN. This past year in New York City, 200 birds were found dead on the street after a mass collision with a high-rise building.

"Excessive artificial night lighting also has detrimental effects on humans. Teens and adolescents who live in areas that have high levels of ALAN are more likely to have mood and anxiety disorders, and interrupted sleep patterns.

"Lastly, the International Dark Sky Association estimates that at least 30% of all outdoor lighting in the United States alone is wasted – primarily by lights that aren't covered. That wasted light totals $3.3 billion in lost electricity costs and the release of 21 million tons of carbon dioxide per year. It is time to reverse this trend and protect our night sky and biosphere."

ARGUMENTS IN OPPOSITION:

None on file.

POLICY ISSUE(S) FOR CONSIDERATION:

Applicability to existing outdoor lighting fixtures. This bill would require each state agency to retrofit or replace every non-conforming outdoor lighting fixture affixed to a building or structure owned, leased, or managed by the state agency. To limit costs and resource constraints, the author may wish to amend the bill to limit the applicability of the requirements to new installations and replacements of outdoor lighting fixtures.

IMPLEMENTATION ISSUES:

Compatibility with CALGreen. This bill exempts incandescent fixtures of 150 watts or fewer and other sources of fewer than 70 watts, including, but not limited to, seasonal and decorative lighting. Watts refer to the amount of power a lighting fixture consumers, whereas lumens refer

to the amount of light produced by the lighting fixture. Because lighting fixtures with the same wattage may produce different amounts of light, the author may wish to replace references to watts with lumens, which, importantly, is the same metric that CALGreen uses.

More broadly, the author may wish to consider working within the existing framework of CALGreen's regulations to avoid the possibility of conflicting requirements for state agencies.

Lessee Lessor Arrangements. This bill would apply to any outdoor lighting fixture that is installed on a building or structure that is owned, *leased*, or managed by the state agency. As a lessee, a state agency may not have the authority to make changes to lighting fixtures affixed to privately owned buildings or structures. Rather, as a lessee, a state agency would have to rely on the owner to make the changes, which likely would not occur until after the lease is renegotiated. As such, the author may wish to consider exempting outdoor lighting fixtures affixed to privately owned buildings or structures that are leased by state agencies.

In contrast, this bill would also apply to buildings and properties that are owned by a state agency and leased to non-state agency. The author may wish to consider the bill's potential impact on buildings and structures that are subject to public-private partnerships.

Enforcement. While this bill directs state agencies to adhere to specified outdoor lighting requirements, there is no mechanism for enforcement.

Education. This bill requires the Department of General Services to develop educational materials to encourage the reduction of light pollution, including providing examples of conforming lighting fixtures. Notably, there is not a repository with information regarding conforming lighting fixtures. The author may wish to amend the bill to require collaboration between the California Energy Commission and the Building Standards Commission, which share subject matter expertise in this area.

AMENDMENTS:

To limit the applicability of the bill to future installations and replacements of outdoor lighting fixtures, amend Government Code Section 11903 to read as follows:

> 11902. Except as specified in Section 11903~~, on and after July 1, 2023,~~ a state agency shall ensure that between the hours of 11 p.m. and sunrise, an outdoor lighting fixture that is installed *or replaced* on a building or structure *on or after January 1, 2023* that is owned, leased, or managed by the state agency is any of the following:

REGISTERED SUPPORT:

American Bird Conservancy
California Institute for Biodiversity
Citizens Committee to Complete the Refuge
Cornell Lab of Ornithology
Defenders of Wildlife
Friends of Harbors, Beaches and Parks
Green Foothills
Hills for Everyone
Midpeninsula Regional Open Space District

Santa Clara Valley Audubon Society
Santa Clara Valley Open Space Authority
Save the Bay

REGISTERED OPPOSITION:

None on file.

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

Date of Hearing: April 19, 2022

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 2515 (Holden) – As Amended March 29, 2022

SUBJECT: Proprietary and private security services.

SUMMARY: SUMMARY: Revises requirements for obtaining a baton permit and carrying a baton, and requires a person registered as a proprietary private security employer to deliver a written report to the Department of Consumer Affairs (DCA) describing the circumstances surrounding any physical altercation with a member of the public by a registered proprietary private security officer while on duty and while acting within the course and scope of their employment within 7 business days after the qualifying incident.

EXISTING LAW:

1. Establishes the Bureau of Security and Investigative Services (BSIS) within the DCA, which licenses and regulates the private security industry, private investigators, locksmiths, repossessors, and alarm companies. (Business and Professions Code (BPC) §§ 7512 *et seq.*)

2. Existing law establishes the Private Security Services Act, which provides for the BSIS's regulation of Private Patrol Operators (PPO) who employ private security guards and security patrolpersons. (BPC §§ 7580 *et seq.*)

3. Establishes the Proprietary Security Services Act, which provides for the BSIS's regulation of proprietary private security employers and officers. (BPC §§ 7574 *et seq.*)

4. Requires BSIS to issue a firearms permit to an applicant is a licensed under the Private Investigator (PI) Act, the Private Security Services Act, or the Alarm Company Act, as specified, when specified conditions are met and when they have determined that carrying and use of a firearm presents no apparent threat to public safety. (BPC §§ 7542.2, 7583.23, 7596.3)

5. Prohibits a private patrol officer from failing to properly maintain accurate and current records of proof of completion be each employee of the licensee of the course in the training of the power to arrest, the security officer skills training, and the annual practice and review, as specified. An employee's completion of the course of training in the exercise of the power to arrest must be certified before the employee is placed at a duty station. Violation of this provision results in a fine of $500. (BPC §§ 7583.2, 7587.8)

6. Requires a person entering the employ of a licensee as a security guard or a security patrolperson to complete a course in the exercise of the power to arrest before being assigned to a duty location. (BPC § 7583.6)

7. Requires a person registered pursuant to the Private Security Services Act to complete at least 32 hours of training in security officer skills within six months from the date the registration card is issued and that that 16 of the hours must be completed within 30 days of the registration card issuance. (BPC § 7583.6)

8. Requires a course provider to issue a certificate to a security guard upon satisfactory completion of a required course and authorizes a PPO to provide additional training programs and courses. Requires a registrant who is unable to provide their employer the certificate to complete 16 hours or the training within 30 days of the registrant's employment date and the 16 remaining hours within six months of the registrant's employment date. (BPC § 7583.6)

9. Requires the DCA to develop and approve by regulation a standard course and curriculum for skills training and authorizes the course of training to be administered, tested, and certified by any licensee, organization, or school approved by the DCA. Requires the DCA to consult with consumers, labor organizations, and subject matter experts to do so. (BPC § 7583.6)

10. Requires a PPO licensee, on and after January 1, 2005, to annually provide each registered employee with 8 hours of review or practice of security officer skills, as described, and to maintain records of such training. (BPC § 7583.6)

11. Prohibits a security guard or security patrolperson who is employed by a licensed PPO from being issued a registration card before the instructor of the exercise of the power to arrest course properly certifies that the employee has been taught and the certificate has been sent to the DCA. (BPC § 7583.8)

12. Requires a potential security guard employee, before accepting employment by a PPO, to apply for registration as a security guard and to obtain fingerprint cards for submission to the Department of Justice (DOJ) for use as specified. (BPC § 7583.9)

13. Requires a PPO licensee to maintain supplies of applications and fingerprint cards that shall be provided by the bureau upon request. (BPC § 7583.9)

14. Requires a security guard employee, on their first day, to display to the client their registration card if it is feasible and practical and requires the employee to display their card upon the request of the client. (BPC § 7583.9)

15. Requires the application for a security guard registration who is employed by a PPO to be verified and include information about the employee, employer, and the employer's certification that the employee received a course in the exercise of the power to arrest. (BPC § 7583.10)

16. Requires a PPO licensee to be responsible for ascertaining that their employees who are subject to registration are currently registered or have made proper application for registration and prohibits a PPO licensee from employing a person whose registration has expired or been revoked, denied, suspended, or canceled. (BPC § 7583.19)

17. Permits a PPO registrant to present evidence of renewal to substantiate a continued registration for up to 90 days after the date of expiration if the renewed registration card has not been delivered prior to the expiration date of the prior registration. (BPC § 7583.20)

THIS BILL:

1. Commencing January 1, 2024, revises and recasts the requirements for obtaining a baton permit and carrying a baton.

2. Requires the BSIS to issue baton permits to applicants who meet specified conditions, including that a certified baton training instructor has attested under penalty of perjury that the applicant has successfully completed a baton training course.

3. Prohibits a licensee, a qualified manager of a licensee, or a security guard from carrying a baton in the course of their employment unless they are wearing a uniform, are carrying a valid baton permit issued by the bureau, and are carrying a valid license, qualified manager certificate, or security guard registration card.

4. Makes those provisions inapplicable to a qualified law enforcement officer, as defined, who meets specified conditions.

5. Provides for the expiration of a baton permit two years from the date of issuance and would specify requirements for renewing a baton permit.

6. Requires a peace officer exempt from obtaining a baton permit who applies for registration as a security guard to submit a letter of approval from their primary employer authorizing the peace officer to carry a baton while working as a security guard or security officer.

7. Adds baton permit fees to the list of fees required to be paid by off-duty peace officers working as security guards or security officers.

8. Makes conforming and other changes relating to baton permits and baton permit holders, including requiring disciplinary review committees to perform specified functions relating to baton permit holders.

9. Requires a person registered as a proprietary private security employer to deliver to the director a written report describing the circumstances surrounding any physical altercation by a registered proprietary private security officer with a member of the public while on duty and while acting within the course and scope of their employment within seven business days after the qualifying incident.

10. The report shall include, but not be limited to, a description of any injuries or damages incurred, the identity of all participants, and whether a police investigation was conducted.

11. The failure to deliver a report to the director shall be subject to a fine of $2,500.

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

Purpose.

This bill is authored-sponsored. According to the author: “Last year, I introduced and Governor Newsom signed AB 229, which stipulates that private patrol operators must report within seven business days any incidents involving physical altercation with a member of the public requiring

any type of first aid or other medical attention, and any physical use of force or violence on any person while on duty. However, there is nothing in existing law that requires proprietary private security employers to adhere to the same requirements. It is imperative that we hold proprietary private security employers to the same standards as private patrol operators. Additionally, AB 2515 provides greater accountability by requiring that the Bureau of Security and Investigative Services issue baton permits. This ensures that students attending Bureau-certified baton training facilities are not being overcharged for their participation."

Background.

Using a baton has the potential to cause great bodily injury and can be a deadly weapon. The initial baton training teaches students the acceptable target areas to strike with a baton and explains the vital areas to avoid. Current law, however, does not require a permit holder to complete any refresher training to ensure the permit holder possesses a minimum level of proficiency in the use and situational suitability for deploying a baton or impact weapon.

During the BSIS's 2019 sunset review hearing, multiple conflicts in current law were recognized as major consumer protection issues that should be addressed. This bill would make it clear that a Baton Permit may be associated with a sole owner of a sole ownership licensee, a partner of a partnership licensee, a qualified manager of a licensee, and a security guard registrant. This bill would clarify conflicting reporting requirements in current law, which has been an ongoing concern during multiple sunset review hearings.

Further, according to the author, training standards for security guards are administered through regulation, but use of force standards are not clearly defined in statute. Since there is no standard use of force standard, each private security firm is left to establish its own guidance. The author cites: "The Golden 1 Center is an arena owned by the City of Sacramento and operated by a private entity, the Sacramento Downtown Arena, LLC. Universal Protection Service, LP, is a Pennsylvania Limited Partnership that was doing business in Sacramento. Universal Protection Service, LP, provides uniformed private security in Sacramento under the name, Allied Universal Security Service. Universal Protection Service, LP is licensed by the State of California Bureau of Security and Investigative Services (BSIS) as a private patrol operator.

Mario Matthews was a Mexican-American, who worked as a warehouse worker. According to a lawsuit filed by his parents, on July 2, 2019, at around 3:30 a.m., after attending an outdoor concert held following two NBA exhibition games, Mario entered the Golden 1 Center through a propped-open door, which was part of the main entrance. Video surveillance showed Mario running around the court and dribbling as if he was playing basketball. Two Universal Protection Security personnel began chasing Mario and eventually detained him.

The lawsuit alleges that Mario was slammed face-first into a wall, tackled and restrained face-down on the floor. His hands were handcuffed behind his back and the two security personnel got on top of his back. One security guard used his right knee to apply pressure to the side of Mario's neck for approximately four and a half minutes. In addition to the initial two Universal Protection Security personnel, a third security officer placed himself on Mario's back.

After approximately ten minutes, several Sacramento Police Department officers arrived and used maximum restraints; they tied his legs together with one strap and another strap around his waist. For a total of 20 minutes, Mario was facedown with as many as four people on top of him.

Mario became unresponsive and was taken to the hospital. He passed away two days later. The lawsuit claims that the Sacramento County Coroner acknowledged that restraint was a cause of Mario's death. Additionally, the coroner's pathologist noted deep bruising of Mario's back as a result of the weight and pressure that had been placed on him. Mario weighed 125 pounds.

Prior Related Legislation.

AB 229 (Holden, Chapter 697, Statutes of 2021): Prohibits a person required to be registered as a security guard from carrying or using a firearm or baton unless the security guard is an employee of a private patrol operator, licensee or an employee of the state or a political subdivision of the state, and would require the course in the carrying and the use of firearms to include training in the appropriate use of force.

SB 609 (Glazer, Chapter 377, Statutes of 2019): Makes various changes to the operations of the Bureau of Security and Investigative Services (BSIS), including prohibiting BSIS from issuing firearms permits to applicants under 21 years of age, consolidating the Private Investigator (PI) Fund and the Private Security Services (PSS) Fund, increasing certain fees within the PI Act, and ensuring Legislative review of BSIS by January 1, 2024.

SB 1196 (Hill, Chapter 800, Statutes of 2016): Sunset extension bill for the BSIS. subjects the Bureau of Security and Investigative Services (BSIS) to review by the appropriate committees of the Legislature, and makes various changes to provisions in the Alarm Company Act, Locksmith Act, Private Investigator Act, Private Security Services Act, Proprietary Security Services Act, and Collateral Recovery Act to improve the oversight, enforcement and regulation by the BSIS of licensees under each Act; adds a sunset review date for the Bureau of Real Estate (CalBRE) and Bureau of Real Estate Appraisers (BREA), and makes various changes to provisions in the Real Estate Law and the Real Estate Appraisers' Licensing and Certification Law to improve the oversight, enforcement and regulation by the CalBRE and BREA, and makes other technical changes.

ARGUMENTS IN SUPPORT:

California Association of Licensed Security Agencies (CALSAGA) writes in support: "AB 2515 harmonize the reporting requirements amongst the security industry. Existing law requires a person licensed as a private patrol operator, as defined, to deliver to the director of the Department of Consumer Affairs the circumstances surrounding the discharge of any firearm, or physical altercation with a member of the public while on duty, by a licensee or any officer, partner or employee of a licensee while acting within the course and scope of their employment within the 7 business days after the qualifying incident. When a private patrol operator fails to deliver a report to the director a fine of $2,500 is imposed, and under AB 2515 the same fine for proprietary private security officers would also be imposed. CALSAGA is supportive of aligning the requirements for both proprietary private security officers and private patrol operators as it creates balance and consistency throughout the security industry."

ARGUMENTS IN OPPOSITION:

None on file.

REGISTERED SUPPORT:

California Association of Licensed Security Agencies (CALSAGA)

REGISTERED OPPOSITION:

None on file.

Analysis Prepared by: Annabel Smith / B. & P. / (916) 319-3301

Date of Hearing: April 19, 2022

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 2745 (Irwin) – As Introduced February 18, 2022

SUBJECT: Real estate broker's license.

SUMMARY: Updates the Broker license qualifications by allowing a Master's Degree in real estate to be the equivalent of two-year's general non-licensed real estate experience, and by requiring all non-licensed general real estate experience to be conducted within the last five years of applying for a broker's license.

EXISTING LAW:

1) Establishes the Department of Real Estate (DRE) in the Business, Consumer Services, and Housing Agency. (Business and Professions Code (BPC) § 10004)

2) Establishes the Real Estate Law, which provides for the licensing and regulation of real estate professionals by the DRE. (BPC §§ 10000 *et seq.*)

3) Requires an applicant for an original real estate broker's license to demonstrate to the Real Estate Commissioner that they have held a real estate salesperson's license for at least two years and qualified for the renewal of their real estate salesperson status, within the five-year period immediately prior to the date of their application for the broker's license, and during such time was actively engaged in the business of real estate salesperson. (BPC §§ 10150 – 10165.6)

THIS BILL:

1) Requires non-licensed real estate experience to be conducted within the five-year period immediately prior to the date of their application for the broker's license.

2) Allows a Master's Degree in real estate to be the equivalent of two-year's general non-licensed real estate experience.

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

COMMENTS:

Purpose. This is an author-sponsored bill. According to the author: "Real estate brokers are trusted to ensure consumer protection laws, overseeing that all real estate transactions under their supervision are lawful and complete. Given that the real estate industry continues to expand and evolve, it is of the utmost importance that licensed brokers have the necessary education, training, and experience to enter into the profession. AB 2745 will ensure consumer protection by raising the professional and educational standards for licensed real estate brokers."

Background.

Research reveals sixty colleges or universities currently offer an advanced degree in real estate, however, not all are solely master's degrees in real estate. This includes universities offering a master of real estate, as well as those offering a master of business administration with a specialization in real estate, etc. Currently the Department of Real Estate only recognize Pepperdine University's master of real estate program, because it is the only university with an articulation agreement with the Department.

While current law allows unlicensed applicants with a Bachelor's degree in real estate to meet the requirements to apply for a broker's license, applicants with a Master's Degree in real estate cannot count their degree towards the general non-licensed experience requirement. In these instances, it has been up to the DRE to decide whether to accept a Master's Degree, with past commissioners refusing to count this degree as experience.

As a result, in 2021 the DRE developed a new legal interpretation to allow Masters Degrees to be counted as non-licensed general experience if the DRE and the university entered into an articulation agreement on a case bases. Currently, only one university, Pepperdine University, has this articulation agreement with the Department of Real Estate. Aside from these changing legal interpretations, there is also a current disparity between the timeframe in which a non-licensed applicant and an applicant with a licensed salesperson experience must complete their general equivalent experience.

For an applicant with licensed salesperson experience, they must apply for their broker's license within the five year period prior to the date of their application. However, a non-licensed applicant with general experience does not have a time frame as to when they would need to have acquired this experience prior to applying for their broker's license, creating disparity between the experience needed for a licensed and non-licensed applicant.

As the real estate industry continues to evolve, licensed brokers have the necessary education, training, and/or experience to enter the profession. Brokers are responsible not only for their own license, but also for the supervision of real estate agents. To ensure the State's consumer protection initiatives, it is necessary that licensed brokers have the necessary skills to operate within the profession.

Prior Related Legislation.

SB 726 (Breed, Chapter 826, Statutes of 1949) placed Business and Professions Code Section 10150.6 in the Real Estate Law, allowing either a college degree with course specialization in real estate or two years of equivalent non-licensed experience in lieu of two years of licensed real estate salesperson experience to qualify for the real estate broker's examination.

AB 931 (Chapter 549, Statutes of 1961) adjusted the experience requirement for broker licensure to require that the applicant's two-years of licensed salesperson experience occur within the five-year period immediately prior to the date of application for the broker's exam. Prior to AB 931, there was no timeframe requirement.

AB 1718 (Hill, Chapter 193, Statutes of 2012) specified that a four year degree from a college or university could only be considered as equivalent to two years' of licensed real estate salesperson experience for purposes of qualifying to sit for the broker's examination, if that degree included

a major or minor in real estate. Prior to this bill, statute allowed for graduation from a four-year college or university course to suffice, provided the course included specialization in real estate.

SB 226 (Negrete McLeod, 2007) would have required the Department of Real Estate to adopt regulations to establish educational criteria that constitute "specialization in real estate" under Business and Professions Code Section 10150.6. This bill was vetoed by Governor Schwarzenegger.

AB 1963 (Leslie, 2006,) would have repealed the four-year college degree as a substitute for the two years' sales experience requirement. This bill was vetoed by Governor Schwarzenegger.

REGISTERED SUPPORT:

None on file.

REGISTERED OPPOSITION:

None on file.

Analysis Prepared by: Annabel Smith / B. & P. / (916) 319-3301

Date of Hearing: April 19, 2022

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 2916 (McCarty) – As Amended March 24, 2022

SUBJECT: Contractors: disclosure of letters of admonishment.

SUMMARY: As proposed to be amended, would require the Contractors State License Board (CSLB) to disclose for one or two years a complaint against a licensee that is resolved by a letter of admonishment.

EXISTING LAW:

1) Establishes the CSLB under the Department of Consumer Affairs (DCA) to license and regulate contractors and home improvement salespersons. (Business and Professions Code (BPC) §§ 7000 *et seq*.)

2) Requires the CSLB in consultation with the Director of DCA to appoint a registrar of contractors (Registrar) and sunsets the CSLB and its authority to appoint a registrar on January 1, 2024, as specified. (BPC § 7011)

3) Authorizes the Registrar of CSLB to investigate the actions of any applicant, contractor, or home improvement salesperson within the state and may deny the licensure or the renewal of licensure of, or cite, temporarily suspend, or permanently revoke any license or registration if the applicant, licensee, or registrant, is guilty of or commits any one or more of the acts or omissions constituting causes for disciplinary action. (BPC § 7090)

4) Requires the Registrar to make available to the public the date, nature, and status of all complaints on file against a licensee that do either of the following:

   a) Have been referred for accusation; or

   b) Have been referred for investigation, after a determination by CSLB enforcement staff, that a probable violation has occurred, and have been reviewed by a supervisor, and involve allegations that if proven would present a risk of harm to the public and would be appropriate for suspension or revocation of the contractor's license or criminal prosecution.

   (BPC § 7124.6(a))

5) Requires the CSLB to create a disclaimer to accompany the disclosure stating that the complaint is an allegation in addition to any other information the board determines would be relevant to a person evaluating the complaint. (BPC § 7124.6(b))

6) Provides that a complaint resolved in favor of the contractor shall not be subject to disclosure. (BPC § 7124.6(c)(1))

7) Specifies that a complaint resolved by issuance of a letter of admonishment, as specified, shall not be deemed resolved in favor of the contractor for above disclaimer requirement

and a letter of admonishment issued to a licensee shall be disclosed for a period of one year from the date of service, as specified. (BPC § 7124.6(c)(2))

8) Requires the Registrar to make available to the public the date, nature, and disposition of all legal actions, subject to the following:

   a) Limits the disclosure of legal actions for citations from the date of issuance for five years after the date of compliance if no additional disciplinary actions have been taken against the licensee during that period;

   b) Limits the disclosure of accusations that result in suspension, stayed suspension, or stayed revocation of the contractor's license from the date accusation is filed for seven years if no additional disciplinary actions have been taken against the licensee during that period; and

   c) All revocations that are not stayed shall be disclosed indefinitely from the effective date of the revocation.

   (BPC § 7124.6(d)-(e))

9) Provides that if, upon investigation, the Registrar has probable cause to believe that a licensee, registrant, or applicant has committed acts or omissions that are grounds for denial, suspension, or revocation of a license or registration, the Registrar, or their designee, may issue a letter of admonishment to an applicant, licensee, or registrant in lieu of issuing a citation. (BPC § 7099.9(a))

10) Specifies that the letter of admonishment shall be in writing and shall describe in detail the nature and facts of the violation, including a reference to the statutes or regulations violated. The letter of admonishment shall inform the licensee, registrant, or applicant that within 30 days of service of the letter of admonishment the licensee, registrant, or applicant may do either of the following:

   a) Submit a written request for an office conference to the Registrar to contest the letter of admonishment. Upon a timely request, the Registrar, or their designee, shall hold an office conference with the licensee, registrant, or applicant and, if applicable, their legal counsel or authorized representative.

   b) Comply with the letter of admonishment and, if required, submit a written corrective action plan to the Registrar documenting compliance. If an office conference is not requested pursuant to this section, compliance with the letter of admonishment shall not constitute an admission of the violation noted in the letter of admonishment.

   (BPC § 7099.9(b))

11) Requires the letter of admonishment to be served upon the licensee, registrant, or applicant personally or by certified mail at their address of record with the board. If the licensee, registrant, or applicant is served by certified mail, service shall be effective upon deposit in the United States mail. (BPC § 7099.9(c))

12) Requires the licensee, registrant, or applicant to maintain and have readily available a copy of the letter of admonishment and corrective action plan, if any, for at least one year from the date of issuance of the letter of admonishment. (BPC § 7099.9(d))

13) Provides that the issuance of a letter of admonishment shall not be construed as a disciplinary action or discipline for purposes of licensure or the reporting of discipline for licensure. (BPC § 7099.9(f))

14) Prohibits the board from issuing a letter of admonishment when any one of the following factors is present:

    a) The licensee, registrant, or applicant was unlicensed at the time of the violation.

    b) The licensee, registrant, or applicant has a history of the same or similar violations.

    c) The violation resulted in financial harm to another.

    d) The victim is an elder or dependent adult, as defined.

    e) The violation is related to the repair of damage caused by a natural disaster.

    (BPC § 7099.9(g))

15) Authorizes the board to adopt regulations to further define the circumstances under which a letter of admonishment may be issued. (BPC § 7099.9(h))

THIS BILL:

1) Would require CSLB to disclose for two years complaints against a licensee that are resolved by a letter of admonishment.

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

COMMENTS:

Purpose. This bill is sponsored by the author. According to the author, "Consumer protection is best served when members of the public have access to records of disciplinary actions taken by the Contractor State License Board. Furthermore, businesses and contractors are incentivized to comply with laws and regulations and correct violations more quickly if evidence of disciplinary actions is on record and available to the public, rather than protected from disclosure. [This bill] increases the period of disclosure for letters of admonishment from one year to two years -- providing consumer protection and greater transparency."

Background.

CSLB and the Contractors' State License Law. CSLB is responsible for implementing and enforcing the Contractors' State License Law, the laws and regulations related to the licensure, practice, and discipline of the construction industry in California. All businesses and individuals who construct or alter, or offer to construct or alter, any building, highway, road, parking facility, railroad, excavation, or other structure in California must be licensed by CSLB if the total cost, including both labor and materials, of one or more contracts on the project is $500 or more.

Contractors' licenses are to be issued to individual owners, partnerships, corporations, and limited liability companies. CSLB also registers and regulates home improvement salespersons (HIS). As of March 1, 2022, there were 234,020 active licensed contractors and 24,051 HIS registrants in California.

CSLB Enforcement Tools. CSLB has a variety of enforcement tools at its disposal. For very minor violations, CSLB may issue an advisory notice, which is not publically disclosed. For more egregious violations, CSLB may issue an administrative citation, which may include a corrective order and require the licensee to pay a civil penalty and/or restitution to an injured party. Citations must be publically disclosed from the date of issuance and for five years after compliance. For the most serious violations, CSLB may file an accusation to revoke or place on probation a contractor's license. Accusations must be publically disclosed from the date the accusation was filed and for seven years after the accusation has been settled. Accusations that are not stayed must be publically disclosed indefinitely.

Letters of admonishment. In 2018, the Legislature authorized CSLB to issue a letter of admonishment to applicants, licensees, or registrants if, upon investigation, there is probable cause to believe that they committed acts or omissions that are grounds for denial, suspension, or revocation of a license or registration. An intermediate form of corrective action, letters of admonishment are reserved for minor violations. Nonetheless, contractors must comply with the terms outlined in the letter of admonishment or contest it in writing. Appeals are handled internally by CSLB without a formal hearing process. A complaint resolved by issuance of a letter of admonishment is not to be deemed resolved in favor of the contractor. Although a letter of admonishment is not considered formal disciplinary action, it may be used to support formal disciplinary action in the future. Moreover, a letter of admonishment must be publically disclosed for one year.

In 2021, CSLB issued 310 letters of admonishment. The most common violations cited were conviction of a non-violence misdemeanor criminal offence (28 percent), violation of a statute or regulation including permit requirements (16 percent), and failure to meet home improvement contract requirements (17 percent).

Prior Related Legislation.

SB 486 (Monning) Chapter 308, Statutes of 2017, authorizes the Contractors State License Board (CSLB) to issue letters of admonishment to an applicant, licensee, or registrant rather than issuing a citation and set specific conditions for issuing letters.

SB 1474 (Senate Business, Professions and Economic Development), Chapter 312, Statutes of 2020, repealed and recast the provisions of SB 486 (Monning) Chapter 308, Statutes of 2017 in a new code section.

AB 569 (Grayson), Chapter 94, Statutes of 2021, authorizes the Contractors State License Board to issue a Letter of Admonishment in lieu of a citation for multiple violations at a time.

ARGUMENTS IN SUPPORT:

The *Contractors State License Board* (CSLB), which has taken a support as proposed to be amended position on the bill, writes: "After the March 24th amendments, Board staff met with the author's office and committee staff on additional amendments. Namely, that CSLB must consider the gravity of the violation, the good faith of the contractor, and the history of previous violations, in determining whether an LOA should be publicly disclosed for one or two years in each case. Once these amendments are in print, CSLB will immediately provide the committee with a support position letter."

ARGUMENTS IN OPPOSITION:

The *Housing Contractors of California* write in opposition: "Housing Contractors of California is very appreciative of the efforts by the Contractors State License Board and its Registrar, David Fogt; to provide fair enforcement of construction standards. The Letter of Admonishment process is beneficial to the industry, and the workings of the CSLB. It allows CSLB resources to pursue the truly bad actors, who don't cooperate with investigators; and don't actively resolve issues, to the citation process, with 5 years disclosure. Both employers and the CSLB spend significant resources when an issue goes to citation; the letter of admonishment allows for a compromise without expending limited resources.

"There can be reasonable disputes between CSLB investigators and contractors over construction methods and practices. CSLB also has no way to differentiate on its website between a contractor who shows one letter of admonishment or citation while doing $300,000 of revenue annually; versus another contractor who has one letter of admonishment or citation while doing $300 million of annual revenue. That is unfair, but we don't have an alternative.

"That is why posting a letter of admonishment for 2 years is not fair, nor helpful to the process of enforcement."

POLICY ISSUE(S) FOR CONSIDERATION:

Appeals. SB 486 (Monning), Chapter 308, Statutes of 2017, authorized CSLB to issue a letter of admonishment in lieu of a citation so that minor violations could be addressed in a more expedient and cost-effective manner. Increasing the duration of public disclosure may incentivize more applicants, licensees, and registrants to appeal a letter of admonishment, thereby reducing the financial and staff-resource savings envisioned when that bill was enacted.

AMENDMENTS:

To allow CSLB to determine whether a letter of admonishment is subject to disclosure for one year, as is required by currently law, or for two years, amend paragraph (2) of subdivision (b) to read as follows:

> (2) A complaint resolved by issuance of a letter of admonishment pursuant to Section 7099.9 shall not be deemed resolved in favor of the contractor for the purposes of this section. A letter of admonishment issued to a licensee shall be disclosed for a period of *either* one year *or two years* from the date of service described in subdivision (c) of Section 7099.9. *For the limited purposes of this subparagraph, the determination regarding the one- or two-year*

disclosure shall be made based on the factors enumerated in subdivision (a) of Section 7099.2.

As amended, CSLB would be required to consider the following factors in determining whether to publically disclose a letter of admonishment on its website for one or two years: the gravity of the violation; the good faith of the licensee or applicant for licensure being charged, and the history of previous violations.

REGISTERED SUPPORT:

Contractors State License Board *(as proposed to be amended)*

REGISTERED OPPOSITION:

Housing Contractors of California

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