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MEMORANDUM

DATE	May 15, 2025
TO	Board Members
FROM	Terri Thorfinnson, J.D. Legislative and Regulatory Specialist
RE:	2025 Legislation for consideration and possible recommendations for Positions

2025 Bills Legislative Committee Recommendations for Possible Positions for the Board

AB 54 (Krell) Access Safe Abortion Act

Summary: An act *to add Chapter 25 (commencing with Section 27050) to Division 20 of the Health and Safety Code,* relating to reproductive health.

Existing law sets forth provisions, under the California Constitution, regarding the fundamental right to choose to have an abortion. Existing law, the Reproductive Privacy Act, prohibits the state from denying or interfering with a pregnant person's right to choose or obtain an abortion prior to viability of the fetus, or when the abortion is necessary to protect the life or health of the pregnant person.

This bill, the Access to Safe Abortion Care Act, would make legislative findings about medication abortion, with a focus on use of the drugs mifepristone and misoprostol. The bill would state the intent of the Legislature to enact legislation that would ensure access to medication abortion. Under the bill, the Legislature would reaffirm that it has been, and would continue to be, lawful to cause the delivery of, or mail, ship, take, receive, or otherwise transport, any drug, medicine, or instrument that can be designed or adapted to produce an abortion that is lawful in the State of California.

The bill would set forth provisions regarding the lack of civil or criminal liability, or professional disciplinary action, for accessing or administering mifepristone or misoprostol, among other certain conduct, on or after January 1, 2020, with this provision applied retroactively, as specified.

Assembly Health Committee Bill analysis

Discussion: This bill reaffirms that manufacturers, distributor, authorized health provider, pharmacist shall not be subject to civil or criminal liability for accessing, mailing, shipping, receiving, transporting, distributing, dispensing or administering mifepristone or misoprostol.

Legislative Committee Recommendation: Support.

AB 260 (Aguiar-Curry) Sexual and reproductive health care.

Summary: An act *to amend Sections 2519, 2761, 2878, 4076, and 4521 of, to add Sections 687, 850.3, and 4318 to, and to repeal Section 601 of, the Business and Professions Code, to amend Section 6925 of the Family Code, to amend Sections 1367.21, 1375.61, and 111480 of, and to add Sections 1220.2, 1265.12, and 111376 to, the Health and Safety Code, to amend Sections 10123.195 and 10133.641 of the Insurance Code, to amend Sections 3405 and 4028 of, and to repeal Section 1108 of, the Penal Code, and to amend Sections 220, 1773, and 14132.725 of, and to add Section 14043.8 to, the Welfare and Institutions Code,* relating to sexual and reproductive health care.

(1) The California Constitution provides for the fundamental rights of privacy and to choose to have an abortion. Existing law, the Reproductive Privacy Act, prohibits the state from denying or interfering with a pregnant person's right to choose or obtain an abortion before the viability of the fetus, or when the abortion is necessary to protect the life or health of the pregnant person. Existing law prohibits conditions or restrictions from being imposed on abortion access for incarcerated persons and committed juveniles. Existing laws requiring parental consent for abortion and making assisting in or advertising abortion a crime has been held to be unconstitutional.

This bill would **repeal those unconstitutional provisions and delete obsolete references to criminal abortion penalties**. The bill would make technical changes to provisions authorizing abortion for incarcerated and committed persons.

(2) Existing law, the Sherman Food, Drug, and Cosmetic Law, provides for labeling requirements of drugs and devices. The Pharmacy Law requires a pharmacist to dispense a prescription in a container that is correctly labeled with specified information, including the name of the prescriber and the name address of the pharmacy. A violation of the Pharmacy Law is a misdemeanor.

This bill would authorize the State Department of Public Health to adopt regulations to include or exclude mifepristone and other medication abortion drugs from the requirements of the Sherman Food, Drug, and Cosmetic Law, but would exclude the drugs from those requirements if the drugs are no longer approved by the United States Food and Drug Administration (FDA). The bill would authorize a **pharmacist to dispense mifepristone or other drug used for**

medication abortion without the name of the prescriber or the name and address of the pharmacy, subject to specified requirements. The bill would require the pharmacist to maintain a log, as specified, that is not open to inspection by law enforcement without a subpoena and would prohibit the disclosure of the information to an individual or entity from another state.

The bill would **prohibit criminal, civil, professional discipline, or licensing action against a pharmacist** for manufacturing, transporting, or engaging in specified other acts relating to mifepristone or other medication abortion drugs, and would prohibit the California State Board of Pharmacy from denying an application for licensure or taking disciplinary action against an applicant or licensee for engaging in certain acts relating to mifepristone or other medical abortion drugs. By expanding the scope of a crime under the Pharmacy Law, the bill would impose a state-mandated local program.

(3) Existing law establishes various healing arts boards in the Department of Consumer Affairs that license and regulate various healing arts licensees.

This bill would **prohibit subjecting a healing arts practitioner** who is authorized to prescribe, furnish, order, or administer dangerous drugs **to civil, criminal, disciplinary, or other administrative action** for prescribing, furnishing, ordering, or administering mifepristone or other medication abortion drugs for a use that is different from the use for which that drug has been approved for marketing by the FDA or that varies from an approved risk evaluation and mitigation strategy under federal law, as specified. The bill would state that the laws of another state or federal actions that interfere with the authority of a healing arts practitioner to take specified actions relating to mifepristone or other medication abortion drugs are against the public policy of this state. The bill would prohibit criminal, civil, professional discipline, or licensing actions against an applicant or licensee for manufacturing, transporting, or engaging in certain other acts relating to mifepristone or other medication abortion dru*gs.*

(4) Existing law provides for the licensure and regulation of clinics and health facilities by the State Department of Public Health. This bill would **prohibit criminal, civil, professional discipline, or licensing action against a licensed clinic or health facility for manufacturing, transporting, or engaging in certain other acts relating to mifepristone or other medication abortion drugs that are lawful in California.** The bill would prohibit the department from denying an application for licensure or taking disciplinary action against an applicant or licensee for engaging in certain acts relating to mifepristone or other medical abortion drugs.

(5) Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law regulates the department's certification of enrolled Medi-Cal providers. Under existing law, in-person, face-to-face contact is not required to provide services under the

Medi-Cal program, as specified, but existing law generally prohibits a provider from establishing a new patient relationship with a Medi-Cal beneficiary via asynchronous store and forward, telephonic synchronous interaction, remote patient monitoring, or other virtual communication modalities.

This bill would require the department to update the Medi-Cal provider enrollment requirement and **procedures for remote service providers who offer reproductive health care services exclusively through telehealth modalities, as specified, and to permit the use of a cellular telephone as the primary business phone for reproductive health care providers. The bill would authorize a health care provider to establish a new patient relationship using asynchronous store and forward if the visit is related to reproductive health care services and meets specified requirements.**

(6) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of disability and health insurers by the Department of Insurance. Existing law prohibits a health care service plan contract or a group or individual disability insurance policy or certificate that covers prescription drugs from limiting or excluding coverage of a drug on the basis that the drug is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA.

Existing law prohibits a contract between a health care service plan or health insurer and a health care services provider from containing any term that would result in termination or nonrenewal of the contract or otherwise penalize the provider based on a civil judgment, criminal conviction, or another professional disciplinary action in another state if the judgment, conviction, or professional disciplinary action is solely based on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in California.

Existing law also prohibits a health care service plan or health insurer from discriminating against a licensed provider solely on the basis of a civil judgment, criminal conviction, or another professional disciplinary action in another state if the judgment, conviction, or professional disciplinary action is solely based on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in California.

This bill would prohibit a health care service plan contract or a group or individual disability insurance policy or certificate that covers prescription drugs from limiting or excluding coverage for brand name or generic mifepristone, regardless of its FDA approval status or solely on the basis that the drug is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA or that varies from an approved risk evaluation and

mitigation strategy, except if the state deems it necessary to address an imminent health or safety concern.

The bill would prohibit a plan or insurer from contracting with a health care services provider to terminate or non-renew the contract or otherwise penalize the provider, or from discriminating against a licensed provider, for manufacturing, transporting, or engaging in certain other acts relating to mifepristone or other medication abortion drugs that are lawful in California.

Discussion: This bill makes additional necessary changes to protect women's access to reproductive health care. It anticipates weaknesses in current California law that may be loopholes given the current national politics around access to abortion. One loophole in specific it is closing is the ability of hostile entities turning over the list of prescriptions for mifepristone or other abortion medications to entities such as law enforcement out of state wanting to bring legal actions against California licensed physicians prescribing reproductive health care drugs. In Texas they are hunting down physicians in state and out of state prescribing abortion drugs and arresting women who take these prescriptions. This information is being obtained by the list of prescriptions from pharmacies or health plans that would otherwise by law have to protect this health information as confidential. This bill protects patients seeking reproductive care and physicians providing reproductive care.

It also requires the California Department of Public Health's Food, Drug Administration to adopt regulations to include or exclude mifepristone and other medication abortion drugs from the requirements of the Sherman Food, Drug, and Cosmetic Law, but would exclude the drugs from those requirements if the drugs are no longer approved by the United States Food and Drug Administration (FDA). The bill would authorize a pharmacist to dispense mifepristone or other drug used for medication abortion without the name of the prescriber or the name and address of the pharmacy, subject to specified requirements. The bill would require the pharmacist to maintain a log, as specified, that is not open to inspection by law enforcement without a subpoena and would prohibit the disclosure of the information to an individual or entity from another state. The bill prohibits health plans from excluding any of the medical abortion drugs from coverage. Prohibits disciplinary action against physicians, pharmacists that prescribe or dispense the medical abortion prescriptions.

Assembly Health Committee Bill Analysis

Legislative Committee Recommendation: Support

AB 360 (Papan) Menopause Survey.

Summary: Chapter 6 (commencing with Section 128570) is added to Part 3 of Division 107 of the Health and Safety Code, to read: Chapter 6. Menopause. This bill would require the department

to work with the Medical Board of California, the Osteopathic Medical Board of California, and state higher education entities to assess, among other things, physicians and surgeons' education and training, as specified, relating to menopause diagnosis and treatment. The bill would require the department to prepare a report to the Legislature on or before January 1, 2027, that, among other things, identifies gaps in medical education and training related to menopause and in menopause diagnosis and management practices among physicians and surgeons.

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

Discussion: The purpose of this bill is to assess the knowledge gap in clinical training related to menopause and make recommendations about addressing this knowledge gap in medical schools, residency training and continuing medical education. This bill requires HCAI to collaborate with Higher Education entities, OMBC and MBC to do this assessment. This bill may undergo further amendments to define the roles and add the existence of a UCLA survey that assesses physician knowledge of menopause. The original bill required the boards to place a link on the online renewals that advertised the survey and had participants connect directly to the survey. OMBC and MBC's role appears to be to assist in distribution, which would involve minimal workload. This assessment would vastly improve the health of women's patients in

menopause and would be worth supporting such an effort.

Assembly Business and Professions Committee Bill Analysis
Legislative Committee Recommendation: Support

AB 432 (Bauer-Kahan) Mandatory CME: Menopause.

Summary: (1) The bill would require *general internists, family physicians, obstetricians and gynecologists, cardiologists, endocrinologists, and neurologists* who have a **patient population**

composed of 25% or more of women to complete at least 10% of their mandatory continuing medical education course in perimenopause, menopause, and postmenopausal care.

(2) This bill would require a health care service plan contract or health insurance policy, except as specified, that is issued, amended, or renewed on or after January 1, 2026, **to include coverage for evaluation and treatment options for perimenopause and menopause**. The bill would **require a health care service plan or health insurer to annually provide clinical care recommendations, as specified, for hormone therapy to all contracted primary care providers who treat individuals with perimenopause and menopause.** Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

BPC section 2190.4.
~~All physicians~~ *general internists, family physicians, obstetricians and gynecologists, cardiologists, endocrinologists, and neurologists* who have a patient population composed of 25 percent or more of *adult* women *under 65 years of age* shall complete a *at least 10 percent of all* mandatory continuing medical education *hours in a* course in perimenopause, menopause, and postmenopausal care.

Discussion: This bill is related to AB 360 because both bills deal with menopause. This bill creates new mandatory CME menopause training. The recent amendments narrow which physicians are subject to this new requirement, eliminating the need to exempt the one's that would not be subject to it. This bill would not only create menopause CME to be created, but it would be the first step in increasing menopause training for physicians and surgeons. It also requires health plans to include coverage for evaluation and treatment options for perimenopause and menopause. Additionally, it requires health plans to annually provide recommendations for hormone therapy to all contracted primary care providers who treat individuals with perimenopause and menopause. The policy proposal is solid and tries to address the knowledge gap among physicians and surgeon related to menopause. This bill would improve women's health and access to appropriate, timely diagnostic and treatment for symptoms that are caused by menopause.

Assembly Business and Professions Committee Analysis
Assembly Health Committee Analysis

Legislative Committee Recommendation: Support

AB 742 (Elhawary) Expedite License Applications for Descendants of Slaves

Summary: This bill would direct the Department of Consumer Affairs to prioritize the license

applications of potential licensees who are descendants of slaves. Special priority would go to descendants of people who were enslaved in the United States. This bill is similar to AB 2862 introduced last year but expands the eligibility to a broader group by the deletion of the word "African" and therefore not limiting it to African American slaves.

American slaves once a process to certify descendants of American slaves is established, as specified would provide for prioritized initial license applications. The bill would make those provisions operative when the certification process is established and would repeal those provisions 4 years from the date on which the provisions become operative or on January 1, 2032, whichever is earlier.

This bill would make these provisions operative only if SB 518 of the 2025–26 Regular Session is enacted establishing the Bureau for Descendants of American Slavery and would make these provisions operative when the certification process is established pursuant to that measure. The bill would repeal these provisions 4 years from the date on which they become operative or on January 1, 2032, whichever is earlier.

Discussion: The wording of this bill is modified from last year's bill AB 2862 that used the words "expedite." In contrast, this bill requires boards to "prioritize" processing of initial license applications for descendants of American slaves. From the Board's perspective there is no daily operations and workload distinction between being required to "prioritize" versus "expedite." The board would be required to process these applications before others not otherwise required to be expedited or prioritized. This prioritization would be added to the five other required expedite categories making this the sixth expedited category for processing license applications. The legislature and Governor raised concerns about the number of expedite categories in existence and more expedite categories being proposed each year.

The intention behind this bill and other expedite categories is that the applicant needs to be prioritized due to special need. The context of bills proposing expedited processing is when Boards have a backlog in processing applications. That was true for OMBC in the past, but with

the online application and being fully staffed for license processing, there is no need to have expedited categories. Typically, depending on whether the applicant provides the board with the required documents for licensure, there is no delay. The delay results from applicant delay in submitting the required documents. Additionally, each expedite category requires documentation that verifies that they are entitled to the expedited processing. Often, applicants don't provide that documentation to avoid delays. Expedite categories also attracts applications that claim eligibility for expedited processing but never provide the documents to verify eligibility.

The Board is also concerned that too many expedite categories will increase processing workload, and not necessarily reduce the application processing time. The board has observed that often expedited applications require more staff time in following up multiple times with the applicant to explain what documents are required and what other documents are missing to complete their application.

The Board estimates that this expedited category could represent 10% of the applications received. Based on approximately 1781 applications received this year, this bill is estimated to generate 171 requests for expedited processing. Each expedited category generates an additional workload of 2-3 hours per expedited application, which would be 342-513 hours for this expedited category. As more expedite categories are created, at some point there will be more applications requiring expedited processing than non-expedited applications. The Board needs another licensing staff person to be able to provide a "concierge" service to expedited applications.

To implement this bill, there would need to be a revision to the online application in breeze and updating the website to advertise the new expedite category and documentation required. It would also require an additional staff workload processing this expedited application category.

This bill addresses the concerns expressed last year that boards have no way to verify whether an applicant is a descendant of American slaves by linking to another bill that SB 518 that would set up a Bureau for Descendants of American slaves. AB 518 would resolve the Board's verification concern and potentially streamline verification of eligibility for this expedite category. However, it is unclear whether it addresses the constitutional concerns raised last session for the prior bill AB 2862. The Senate Judiciary Committee analysis for SB 518 seems to mitigate the constitutional concerns by differentiating race as a whole from a subset of descendants of African American slaves that were harmed and thus concluding the bill does not violate equal protection nor constitute a racial preference.

Assembly Business and Professions Committee Bill Analysis

Legislative Committee Recommendation: Support.

AB 489 (Bonta) AI: Health care professions: deceptive terms or letters: artificial intelligence.

Summary: This bill prohibits the use of AI to pose as a licensed health care provider providing care through telemedicine. An act to add Chapter 15.5 (commencing with Section 4999.8) to Division 2 of the Business and Professions Code, relating to healing arts. This bill would make provisions of law that **prohibit the use of specified terms, letters, or phrases to falsely indicate or imply possession of a license or certificate to practice a health care profession**, as defined, **enforceable against an entity who develops or deploys artificial intelligence technology that**

uses one or more of those terms, letters, or phrases in its advertising or functionality. The bill would prohibit the use by AI technology of certain terms, letters, or phrases that indicate or imply that the advice or care being provided through AI is being provided by a natural person with the appropriated health care license or certificate.

This bill **would make a violation of these provisions subject to the jurisdiction of the appropriate health care profession board, and would make each use of a prohibited term, letter, or phrase punishable as a separate violation. The bill provides the Board with enforcement authority to pursue an injunction or restraining order against the entity in violation of this section.**

Business and Professions Code section 4999.8.

For purposes of this chapter, the following definitions apply:

(a) "Artificial intelligence" or "AI" has the same meaning as set forth in Section 11546.45.5 of the Government Code.

(b) "Generative artificial intelligence" or "Gen AI" has the same meaning as set forth in Section 11549.64 of the Government Code.

(b)For purposes of this chapter, "health

(c) "Health care profession" means any profession that is the subject of licensure or regulation under this division or under any initiative act referred to in this division.

4999.9.

(a) (1) A violation of this chapter is subject to the jurisdiction of the appropriate health care professional licensing board or enforcement agency.

(2) The appropriate health care professional licensing board may pursue an injunction or restraining order to enforce the provisions of this chapter, as authorized by Section 125.5 of the Business and Professions Code.

(3) Nothing in this section limits the authority for a health care professional licensing board or enforcement agency to pursue any remedy otherwise authorized under the law.

(b) Any provision of this division that prohibits the use of specified terms, letters, or phrases to indicate or imply possession of a license or certificate to practice a health care profession,

without at that time having the appropriate license or certificate required for that practice or profession, shall be enforceable against a person or entity who develops or deploys a system or device that uses one or more of those terms, letters, or phrases in the advertising or functionality of an artificial intelligence or generative artificial intelligence system, program, device, or similar technology.

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

(d) Each use of a prohibited term, letter, or phrase shall constitute a separate violation of this chapter.

Discussion: Policy wise when fully matured, this bill is potentially good policy and oversight of AI use in the health care. Particularly, since it is prohibiting the use of AI to pose as a licensed health professional providing care through telemedicine. On its face, the bill would be worth supporting to prohibit the expansion of AI to pose as licensed health professionals and create an AI backstop in the practice of medicine. It appears that the Board would have enforcement authority against the telemedicine entity and the licensee(s) involved in training and/ or using AI to provide telemedicine care. This bill would not target physicians who provide care through telemedicine who appear in video with patient and review any AI generated notes. The ownership, liability and enforcement jurisdiction details may need to be further worked out in the bill. For patient safety and public safety reasons, this bill would be worth supporting to add a backstop to the expansion of AI that pose as telemedicine health providers.

Assembly Business and Professions Committee Bill Analysis
Legislative Committee Recommendation: Support

AB 667 (Solache) Interpreter Paid by Board: Exams: Applications Fiscal Impact

Summary: An act to add Section 41 to the Business and Professions Code, and to add Sections 1337.25 and 1736.3 to the Health and Safety Code, relating to professions and vocations. This bill would, beginning July 1, 2026, require the State Department of Public Health and boards under the jurisdiction of the Department of Consumer Affairs to permit an applicant who cannot read, speak, or write in English to use an interpreter, at no cost to the applicant, to interpret the English verbal and oral portions of the license or certification examination, as applicable, if the applicant meets all other requirements for licensure.

This bill would require an interpreter to satisfy specified requirements, including not having the license for which the applicant is taking the examination. The bill would also require those boards and the State Department of Public Health to post on their internet websites that an applicant may use an interpreter if they cannot read, speak, or write in English and if they meet all other requirements for licensure or certification.

This bill would **require those boards** and the State Department of Public Health to include in their **licensure or certification applications a section that asks the applicant to identify their preferred language and, beginning July 1, 2027, to conduct an annual review of the language preferences of applicants.** The bill would require the State Department of Public Health and those boards, beginning July 1, 2029, and until January 1, 2033, to annually report to specified committees of the Legislature on language preference data.

Discussion: This bill requires the boards to pay for interpreters for licensing exams and

applications if otherwise qualified. One specified distinction related to exams is that the bill could only cover state exams administered by the boards and not national exams. OMBC does not offer state or board created or administered exams for purposes of this bill and thus the requirement for providing paid interpreters would not apply to OMBC. However, the reference to also requiring interpreters for the licensing applications would apply to OMBC.

OMBC does not create, administer any licensing exams. All relevant exams are created and administered as national exams by the National Board of Osteopathic Examiners (NBOME). This bill would not have jurisdiction to require the California base board to pay for national exams offered by NBOME. The nature of Osteopathic Medical training is that the U.S. is the only country that trains its osteopathic physicians and surgeons to be equivalent to M.D.s clinical training. So, only U.S. trained osteopathic graduates are eligible to take the national boards and apply for state licensure. In contrast, that is not true for the Medical Board of California which allows foreign trained medical students to be eligible for residency training and state licensure.

The other requirement is that OMBC would have to add questions on the online license application that asks for the person's preferred language. This question is likely to cause confusion with OMBC applicants because all applicants speak fluent English otherwise, they would not have been able to comprehend medical school or residency training, national board exams.

Overall, paid interpreters are expensive and would cost more per application in which an interpreter is utilized than the revenue the board takes in for application fees. This policy poses huge risk to public safety to facilitate non-English speakers to practice medicine with the untranslatable details involved in clinical medicine and prescriptions. This bill facilitates the high risks to patient safety that non-English speakers pose to overall public safety. Other non-health care professions may benefit from this bill, but policy wise it does not make sense to

include physicians in this bill. The Legislative Committee recommends an oppose unless amended to exempt OMBC from this bill. **Note recent amendment exempt OMBC and other healing arts boards as recommended by the Assembly Business and Professions Committee.**

Assembly Business and Professions Committee Bill Analysis

Legislative Committee Recommendation: Oppose Unless Amended. Request OMBC be amended out of the bill.

AB 876 (Flora) Nurse Anesthetists Scope of Practice Expansion.

Summary: This bill originally proposed to expand the scope of practice for nurse anesthetists to be allowed to practice medicine exempt from physician supervision and peer review protocols.

The bill proposed Certified Nurse Anesthetists (CNAs) do not have to adhere to health facility protocols and standards of care. The bill's most recent amendments (April 23, 2025) remove all of the proposed language to expand the scope of practice and attempts to codify existing law and an advisory opinion. *The bill would state that the provisions of the Nurse Anesthetists Act are declaratory of existing law and of an advisory opinion set forth in specified case law.*

Discussion: The prior version of the bill would have essentially elevated nurse anesthetists to the level of licensed physicians and surgeons. The justification for this is the unsubstantiated claim that rural areas often lack enough anesthesiologists so nurse anesthetists would provide anesthesia instead of anesthesiologists. This would have been a dangerous scope of practice expansion for public safety. The proposed expansion would have been reckless and would endanger patient safety in the hands of less qualified and less competent providers and would constitute the practice of medicine restricted to physicians and surgeons.

Practice of Nursing vs. Practice of Medicine

In the mid 1970's, the Legislature caused confusion when they tried to acknowledge the overlap in the nursing and physician training and tried to bring clarity to the scope of practice for CNAs. However, existing laws failed to define medical terminology and interpret it accurately and what that meant scope of practice wise for CNAs. The result was a vague statute that did not definitively define the scope of practice for CNAs with respect to physician supervision. Instead of better defining the law, the issue was decided in court which resulted in a misinterpretation of the medical terminology "ordered by physician" that in turn led to CNAs performing anesthesia without physician supervision. Even though this was occurring, the law was not definitive, so this bill intended to provide that clarity. But, even with the recent amendments the law is vague and has provisions that conflict with each other. Chapter 6 and Article 7 pertain to the practice of nursing, not the practice of medicine. The central question to
be answered is whether it is truly the Legislature's intention to allow CNAs to perform

anesthesiology without physician supervision and practice medicine? Just because they are amending the Nursing Act, and the Nurse Anesthetist Act does not mean the Legislature
supports Nurse Anesthetists practicing medicine. This matter of semantics may essentially allow CNAs to practice medicine.

Background*:* To understand this bill, it is important to know the history to put this bill into context. *In order for hospitals, ambulatory surgical centers, and critical access hospitals to receive reimbursement under Medicare when a certified registered nurse anesthetist (CRNA) administers anesthesia, federal regulations 395*395 require that the CRNA must be supervised by a physician. (42 C.F.R. §§ 482.52(a)(4) (2011), 416.42(b)(2) (2011), 485.639(c)(2) (2011).) However, other federal regulations provide that a state's governor has the discretion to make a request on behalf of the state to opt out of the physician supervision requirement after concluding, among other things, that the opt out is "consistent with State law." (42 C.F.R. §§ 482.52(c)(1) (2011),*

*416.42(c)(1) (2011), 485.639(e)(1) (2011).) On June 10, 2009, former Governor Arnold Schwarzenegger (the Governor) exercised his discretion under federal law and opted California out of the federal physician supervision Medicare reimbursement requirement. (*Society of Anesthesiologists v. Brown (2012) 204 Cal App. 4th 390).

At the federal level, there are billing codes for non-physician anesthesia that are used by nurse anesthetist to bill for their anesthesiology services. Non-physician anesthesiology billing accounts for one third of all federal billing for that code. So, nurse anesthetists are already being used to be the primary providers of anesthesiology around the country. The determination of scope of practice is determined by state law. A small number of states have authorized such scope of practice. California has not specifically defined their scope in statute to allow them to provide anesthesiology services without physician supervision—instead this was partially accomplished to the court decision reference above and partially achieved through the Governor exercising his discretion to opt out. The statute remains vague and contradictory.

The scope of practice in California relies on a court decision that interpreted the law to not require physician supervision as part of the scope of practice for CNAs. Case law, not specific statutory provisions define CNAs scope of practice to not require physician supervision to perform anesthesiology. However, CNAs are only authorized to perform anesthesiology if approved by the health facility and upon order of a physician who provides the prescription for specific medication. Without a clear definition between nursing and practicing medicine with regard to CNAs, the scope of practice for CNAs is unfinished and in limbo. This bill is an attempt to add specific scope of practice language to the CNA and Nursing statutes to authorize their independent scope of practice.

The bill tries to leverage an unsubstantiated allegation of a shortage of anesthesiologists in rural areas to justify this scope of practice expansion. The problem with this expansion is that it ignores the fact that physicians have far more in-depth clinical training in general and in anesthesiology with residency specialty training that can take upwards of 7 years or more in addition to medical school. Nurse anesthetist training is not equivalent to physician training and for that reason, authorizing nurse anesthetists to replace physicians poses a significant risk and threat to public safety.

According to the California Society of Anesthesiologists, in 2024, state and federal investigators at Doctors Medical Center and Stanislaus Surgical Hospital uncovered shocking instances of patient harm due to this model of nurse anesthetists providing unsupervised anesthesiology during surgery. This is consistent with other studies of hospital care provided by non-physicians resulting in greater preventable deaths because non-physicians cannot adequately identify and diagnose patient symptoms that are emergencies and require not only immediate but the appropriate treatment to prevent death. Patent harm is the risk of giving into alleged physician shortages by filling the gaps with non-physicians. Expanding the scope of lesser trained and less

competent providers will usher in more non-physician care because it costs the health care system and insurance less so its prevalence will explode if this bill is signed into law.

Overarching Policy Concerns

The main policy concern is that anesthesiology is the practice of medicine. The Board objects to allowing CNAs to perform anesthesiology without physician supervision and that it constitutes the practice of medicine which is reserved exclusively for physicians and surgeons. Even current law supports this position: BPC section 2833.5 states: **"Except as provided in BPC section 2725 and this section, the practice of nurse anesthetists does not confer the authority to practice medicine or surgery.** The Board objects to allowing CNAs to perform anesthesiology without physician supervision and that it constitutes the practice of medicine which is reserved exclusively for physicians and surgeons. The bill needs to amend in physician supervision and define the meaning of the medical term "ordered by physician" to require physician supervision.

The overarching policy question not acknowledged is that fact that the case law misinterpreted the medical terminology meaning of "order by Physician" to not mean supervision of CNAs is required. Additionally, the statutes continue with the tradition of vague references to scope of practice based on the case law and not the plain meaning of the existing statutory terminology with the end result being that this bill essentially authorizes CNAs to practice medicine without physician supervision. Under the CMS billing rules for anesthesiology, state law defines scope of practice for CNAs. The problem is that California is unsettled; it does not definitively define the scope of practice for CNAs with respect to physician supervision.

All bills are an opportunity to revisit existing law and revise it. So, now as we evaluate the newly amended language, it is an opportunity for the Legislature to add the words "physician supervision," which has not yet been done to this bill. This bill presents the Legislature with the opportunity to correct the interpretation by the case law and in doing so protect patient and public safety and prevent premature deaths.

Case Law Misinterpretation of BPC section 2725 Medical term Order by Physician.

The interpretation of the law relies on a specific case law decision Society of Anesthesiologists v. Brown (2012) 204 Cal App. 4th 390, which interpreted existing statutes, specifically BPC section 2725, at the time as not requiring physician supervision because it did not specifically include the words "physician supervision." The court order relied exclusively on strict statutory construction that interprets BPC section 2725 (b) (2) to not require physician supervision simply because the words physician supervision was not spelled out as a requirement. What the judge in that case misinterpreted is that existing language "ordered by a physician" is a medical term that also includes physician supervision of CNAs. The standard of care defines an order by a physician as including physician supervision of the CNAs in this case. The statute includes the words "ordered by physician" and that should have been enough to imply or interpret physician supervision of CNAs is required.

CNAs are not authorized to perform anesthesiology without a physician order. The court's decision relied on statutory construction: i.e. if the Legislature intended to require physician supervision, they would have added it to the law at the time. The court misinterpreted the standard of care definition of "ordered by physician" finding that terminology did not imply or require physician supervision. The court ignored safety concerns raised and decided based on strict statutory construction. Since then, the law has remained vague on the scope of practice for CNAs.

Unpacking Recent Amendments.

The recent amendments attempt to limit the scope of practice expansion language, which was deleted, and the bill attempts to affirms current law. However, it shifts the amendments from amending BPC section 2725 to amending sections 2826, 2827, and 2833.6. While the characterization of recent amendment claims to codify existing law, the amendments do alter current law so as written the bill misrepresents the impact and interpretation of the amendments as not altering the scope of practice of CNAs.

Sec 1: Amendments to BPC section 2826

The amendments to BPC section 2826 restore this section to its original version by deleting prior amendments that added: ~~"Nurse Anesthetists means a certified registered nurse anesthetist, CRNA, nurse anesthesiologist or anesthetists.~~ This amendment prevents expanding the scope for CNAs by adding different titles. This is a good amendment.

Sec 2: Amendments to BPC section 2827.

(a) The utilization of a nurse anesthetist to provide anesthesia services in an acute care facility shall be approved by the acute care facility administration and the appropriate committee, and at the discretion of the physician, dentist or podiatrist. If a general anesthetic agent is administered in a dental office, the dentist shall hold a permit authorized by Article 2.7 (commencing with Section 1646) of Chapter 4 or, commencing January 1, 2022, Article 2.75 (commencing with Section 1646) of Chapter 4.

(b) In an acute care facility or outpatient setting where the nurse anesthetist has been credentialed to provide anesthesia, or in a dental office where the dentist holds a permit authorized by Article 2.75 (commencing with Section 1646) of Chapter 4, the anesthesia services shall include preoperative, intraoperative, and postoperative care and pain management for patients receiving anesthesia ordered by a physician, dentist, or podiatrist that are provided within the scope of practice of the nurse anesthetist. A nurse anesthetist is authorized to provide direct and indirect patient care services, including administration of medications and therapeutic agents necessary to implement a treatment, for disease prevention, or a rehabilitative regimen ordered by, and within the scope of practice of, a physician, dentist, podiatrist, or clinical psychologist. An order entered on the chart or medical record of a patient shall be the authorization for the nurse anesthetist to select the modality of anesthesia for the patient and to

abort or modify the modality of anesthesia for the patient during the course of care. Ordering and administering controlled substances and other drugs preoperatively, intraoperatively, and postoperatively shall not constitute a prescription, as that term is defined in Section 1300.01 of Title 21 of the Code of Federal Regulations.
(c) In an acute care facility or outpatient setting where the nurse anesthetist has been credentialed to provide anesthesia, anesthesia services may also encompass services performed outside of the perioperative period in accordance with Section 2725, including, but not limited to:
(1) Selecting and administering medication, therapeutic treatment, medication-assisted treatment, and adjuvants to psychotherapy in accordance with paragraph (2) of subdivision (b) of Section 2725.
(2) Providing emergency, critical care, and resuscitation services.
(3) Performing advanced airway management.
(4) Performing point-of-care testing.
(5) In accordance with the policies of the facility or office, initiating orders for functions authorized under Section 2725 and this article to registered nurses and other appropriate staff, as required, to provide preoperative and postoperative care related to the anesthesia service.

Existing law only had only one paragraph. This amendment adds major scope of practice amendments with subsection (b) and (c) and expands the reference to include Chapter 4 on dentistry that includes BPC sections 1646-1646.13. Just this reference is misleading and vague because while there is reference to unspecified personnel assisting dentists within Chapter 4

there is no mention of the type of staff who can assist a dentist in proving deep sedation except a physician trained in anesthesiology. Both the dentist and the physician must apply and receive a dental permit to perform the deep sedation. By statutory construction, there is no specific role defined in dental sedation or that they are eligible for a dental deep sedation permit. Adding reference to Chap 4 is changing the law to imply CNAs can provide dental deep sedation without dental or physician supervision under current law, when Chap.4 specifies no such role for CNAs. The only mention of CNAs is in their respective chapter 6 and Article 7 related to CNAs.

Section 2827 has major amendments that add significant scope of practice specificity and relies on the court case reference to BPC section 2725 to authorize administration of anesthesia without physician supervision. If this were truly a codification of current law, there should not be new language proposed as reflected by detailed amendments to BPC 2827 (b). **All of subsection (b) is new language and thus new scope of practice details expanding CNAs scope of practice.**

Every word added that does not include the words physician supervision is essentially adding new law, and not codifying current law. The details added to BPC section 2827 (highlighted in yellow) go beyond existing law; and in doing so essentially reaffirm CNAs can perform anesthesiology without physician supervision.

Why this matters is because the interpretation of what constitutes current law regarding the Certified Nurse Anesthetist (CNA's) scope of practice in part relies on case law that misinterpreted supervision not being required due to the word physician supervision not specifically being added to the statute. Statutory wording matters and when interpreted by the courts, they default to strict statutory construction of the meaning of the words that are specified and do not imply words that do not appear in the statute, and they are not experts in medical terminology and standard of care.

It should be noted that the words "ordered by physician" is added to section 2827 is because CNAs cannot perform anesthesiology without orders from a physician. The order from the physician facilitates CNAs obtaining the prescription because they do not have prescription authority. The amendment amends the word "requested" because that is not a clinical or medical term and replaces it with "order" by physician which is a medical term that has meaning. That meaning is that CNAs are required to be supervised by physicians. It is factually inaccurate that the courts interpreted "order" as not to require physician supervision. The legislature needs to correct that by adding the words physician supervision through this chapter and Article 7 to clarify the issue.

Sec 3: BPC section 2833.6 amendments

The bill amends BPC section 2833.6 shown below in italics. Existing law states: **"This chapter is not intended to address the scope of practice of, and nothing in this chapter shall be construed to restrict, expand, alter, or modify the existing scope of practice of, a nurse anesthetist."** The amendment to BPC 2833.6**.** is:

~~"This chapter is not intended to address the scope of practice of, and nothing in this chapter~~ *Nothing in this article* shall be construed to restrict, expand, alter, or modify the existing scope of practice of, a nurse anesthetist. *anesthetist and is declaratory of existing law and the advisory opinion as set forth in California Society of Anesthesiologists v. Brown (2012) 204 Cal.App.4th 390.*

The wording in yellow represent the new proposed language that is being added. Let's unpack the first amendment swapping out the wording "**This chapter is not intended to address the scope of practice, and nothing in this chapte**r" …for **"nothing in this article**." What is different? The words "address scope of practice" is deleted which eliminates the original legislative intent which was to not address the scope of practice by this chapter [Chapter 6 includes sections 2700-2838.6] The Chapter reference includes the Nursing Scope and the Article 7 [sections 2825-2833.6]. Why did they change the wording and reference to Chapter versus Article 7? This amendment excludes Section 2725 (b) (2) the basis of the case law that the court interpreted as allowing CNAs to perform anesthesia without physician supervision. So, it's sets up a truism that the bill is not changing the scope within Article 7 because the scope is defined in section 2725 (b) (2) a section not located in Article 7. This amendment misrepresents what the purpose of this

amendment is: codify existing law. This first part of the amendment is amending current law that does not need amending to truly be codifying existing law— the amendment adds new language that changes the law.

The second part of the amendment to this section includes adding the reference to the case law, which would codify the case law interpretation of the existing law. The case law is incorrect and should not be codified. The statutory language needs to be clarified to reflect the true meaning of the medical term ordered by physician to include supervision is required.

Conclusion.
The amendments have one thing in common which is to add reference to section 2725 throughout and claim it is codifying existing language. However, by adding that section to sections that did not reference that section changes the meaning and essentially amends in scope the practice expansion provided by the court's interpretation of section 2725. These amendments conflict with the claim that no changes have been made to the scope of practice and only codifies existing law. The claim that section 2833.6 does not change the scope of practice is not true—it does change the scope of practice by virtue of statutory construction adding a reference to a section related to scope of practice.

This entire bill is misleading and hides the fact that it does change the scope of practice for CNAs. The consequence is to actually codify the change in scope of practice to allow CNAs to practice medicine without physician supervision.

There is no reason to codify existing law nor existing case law—its redundant. In adding the reference to case law, this bill is codifying a point in time ruling that can be altered by legislation. To codify a ruling that was based solely on statutory construction is not a justifiable or sound basis for codifying what may amount to a statutory drafting error with significant public safety consequences. It is a missed opportunity to protect public safety by not adding "physician supervision."

Legislative Committee Recommendation: Oppose.

AB 1215 (Flora) Hospital Membership: Peer Review, Assessment Expansion of Non-Physicians

Summary: This bill would expand the required provisions related to organizations to include **dentists, podiatrists, clinical psychologists, nurse practitioners, nurse anesthetists, nurse midwives, and other health care professionals, as specified.** The bill would expand the required provisions related to membership of medical staff to additionally include dentists, podiatrists, clinical psychologists, nurse practitioners, nurse anesthetists, and nurse midwives, as specified.

The act makes unprofessional conduct subject to discipline by the board the regular practice of medicine in a specified hospital having 5 or more physicians and surgeons on the medical staff without required provisions governing the operation of the hospital relating to records and to the organization, membership, and self-governance of the medical staff.

The act makes unprofessional conduct subject to discipline by the board the regular practice of medicine in a specified hospital having less than 5 physicians and surgeons on the medical staff without required provisions governing the operation of the hospital relating to records and to the membership of the medical staff. The act includes in the organization provisions licensed physicians and surgeons, as specified, and in the membership provisions physicians and surgeons, and other licensed practitioners, as specified.

BPC section 2282.

The regular practice of medicine in a licensed general or specialized hospital having five or more physicians and surgeons on the medical staff, which does not have rules established by the board of directors thereof to govern the operation of the hospital, which rules include, among other provisions, all the following, constitutes unprofessional conduct:

(a) Provision for the organization of physicians and ~~surgeons~~ *surgeons, dentists, podiatrists, clinical psychologists, nurse practitioners, nurse anesthetists, nurse midwives, and other health care professionals* licensed to practice in this state who are permitted to practice in the hospital into a formal medical staff with appropriate officers and bylaws and with staff appointments on an annual or biennial basis.

(b) Provision that membership on the medical staff shall be restricted to physicians and ~~surgeons~~ *surgeons, dentists, podiatrists, clinical psychologists, nurse practitioners, nurse anesthetists, nurse midwives,* and other licensed practitioners competent in their respective fields and worthy in professional ethics. In this respect the division of profits from professional fees in any manner shall be prohibited and any such division shall be cause for exclusion from the staff.

(c) Provision that the medical staff shall be self-governing with respect to the professional work performed in the hospital; that the medical staff shall meet periodically and review and analyze at regular intervals their clinical experience; and the medical records of patients shall be the basis for such review and analysis.

(d) Provision that adequate and accurate medical records be prepared and maintained for all patients.

SEC. 2.

Section 2283 of the Business and Professions Code is amended to read:

2283.

The regular practice of medicine in a licensed general or specialized hospital having less than five physicians and surgeons on the medical staff, which does not have rules established by the board

of directors thereof to govern the operation of the hospital, which rules include, among other provisions, all of the following, constitutes unprofessional conduct:
(a) Provision that membership on the medical staff shall be restricted to physicians and ~~surgeons~~ *surgeons, dentists, podiatrists, clinical psychologists, nurse practitioners, nurse anesthetists, nurse midwives,* and other licensed practitioners competent in their respective fields and worthy in professional ethics. In this respect the division of profits for professional fees in any manner shall be prohibited and any such division shall be cause for exclusion from the staff.
(b) Provision that adequate and accurate medical records be prepared and maintained for all patients.

Discussion: This bill proposes to expand the professions beyond physician who can be a member of the health facility and peer review committees. The bill proposes to expand membership to dentists, podiatrists, clinical psychologists, nurse practitioners, nurse anesthetists, nurse midwives, and other health care professionals. This proposed expansion poses unnecessary risks to public and patient safety. There is no equivalence with respect to training between physicians and all other professions. Physicians clinical training is more intensive and comprehensive beyond in any given procedure. Physicians are trained to diagnose emergencies and treatment them to save lives. All other allied professions have inferior clinical training.

This bill proposes to treat non-physicians as equals in competency and decision-making and peer review when they are not equivalent in their own training and competency. The reason that hospital memberships and peer review committees are limited to physicians is because they are the most qualified to evaluate competency among physician and non-physician staff. They are the only profession who is trained to evaluate safety and competency for any surgical procedure and set policy regarding staffing and competency. To expand the membership to non-physicians poses huge risks for patient and public safety. The policy considerations for this proposal are a matter of competency and public safety. This is a dangerous bill with huge implications for overall quality of care and patient safety.

Legislative Committee Recommendation: Oppose.

SB 508 (Valladares) Telemedicine License Exemption Expansion

Summary: SB 508, as introduced, Valladares. Out-of-state physicians and surgeons: telehealth: license exemption. Amends BPC 2052.5

Existing law, the Medical Practice Act, establishes the Medical Board of California within the Department of Consumer Affairs and sets forth its powers and duties relating to the licensure

and regulation of the practice of medicine by physicians and surgeons. Existing law generally prohibits the practice of medicine without a physician's and surgeon's certificate issued by the board.

Existing law authorizes a health care provider to deliver health care via telehealth to a patient pursuant to specified protocols and conditions. Existing law defines "telehealth" as the delivery of health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care, and that telehealth includes synchronous interactions and asynchronous store and forward transfers.

Existing law authorizes a person licensed as a physician and surgeon in another state, as specified, to deliver health care via telehealth to an eligible patient, as defined. Existing law defines "eligible patient" as a person who, among other requirements, has a life-threatening disease or condition, as defined, and has not been accepted to participate in the clinical trial nearest to their home for the immediately life-threatening disease or condition, as specified, or in the medical judgment of a physician and surgeon, as defined, it is unreasonable for the patient to participate in that clinical trial due to the patient's current condition and state of disease.

The prior version of the bill would expand the life-threatening disease requirement of an eligible patient to include a person who has been diagnosed with any stage of cancer and would provide that cancer patients are not subject to the clinical trial requirement, as specified.

Discussion: This bill proposes to expand the license exemption for telemedicine practice on California patients with life-threatening conditions. The original version was written more broadly to expand the life-threatening condition to any stage of cancer. This would have created a gaping licensure exemption for telemedicine physicians treating California based cancer patients. The Business and Professions Committee recommended the author narrow the scope to delete cancer that was too broad and instead allow for continued care to California patients by an out of state physician providing care through telemedicine to patients even after they are no longer in a life-threatening condition.

While the scope of the license exemption was seemingly narrowed from all cancer to allow a continuation of non-urgent care to the same patients that originally sought treatment from out of state physicians for their life-threatening conditions, it has significantly expanded the justification for continued care by an out of state physicians not required to be licensed in California to treat a California patient even when their condition is no longer life threatening. This is an unnecessary expansion of license exemption for non-life-threatening care by an out of state physicians unlicensed in California. Once you create an exemption it opens the door for more expansion of the exemption and thus, we are seeing with this bill the slippery slope of license exemption for telemedicine out of state physician being allowed to practice medicine on

California patients without a California license. And, telemedicine by definition does not include physical examination of the patient that is required for treatment of most serious, and life-threatening conditions so it also exempts out of state physicians from the adhering to the standard of care for medical treatment. It continues to be a bad policy that keeps getting worse.

A quick reminder, this license exemption means that the Board lacks enforcement jurisdiction for such patient complaints if patients are harmed. Patients are on their own without any legal remedies because the Board lacks jurisdiction over the out of state physician and the patient lacks jurisdiction to sue the out of state physician. This lack of a remedy and oversight is the justification for licensure.

Senate Business and Professions and Economic Development Committee Bill Analysis
Legislative Committee Recommendation: Oppose.

SB 641 (Ashby) States of Emergency: Waivers and Exemption

Summary: An act to amend Sections 122, 136, and 10176 of, and to add Sections 108.1, 136.5, 7058.9, and 10089 to, the Business and Professions Code, relating to professions and vocations, and declaring the urgency thereof, to take effect immediately.

This bill would authorize **boards** under the jurisdiction of the Department of Consumer Affairs to waive the application of certain provisions of the licensure requirements that the board or department is charged with enforcing for licensees and applicants impacted by a declared federal, state, or local emergency or whose home or business is located in a declared disaster area, including certain examination, fee, and continuing education requirements.

The bill would exempt impacted licensees of boards from, among other requirements, the payment of duplicate license fees. The bill would **require all applicants and licensees** of boards under the Department of Consumer Affairs **to provide the board or department with an email address.** The bill would prohibit a contractor licensed pursuant to the Contractors State License Law from engaging in private debris removal unless the contractor has one of specified license qualifications or as authorized by the registrar of contractors during a declared state of emergency or for a declared disaster area. This bill would declare that it is to take effect immediately as an urgency statute.

Senate Business, Professions and Economic Development Committee Analysis

Discussion: This bill would authorize the Board to waiver or exempt licensees from statutory requirements in the event of a declared local, state or federal emergency. This authority would require a declaration of emergency, but it would authorize the Board to waiver or exempt

licensees' requirements who live and work in declared disaster areas. Waivers and exemption include:
(1) Examination eligibility and timing requirements.
(2) Licensure renewal deadlines.
(3) Continuing education completion deadlines.
(4) License display requirements.
(5) Fee submission timing requirements.
(6) Delinquency fees.

In past years, this authority was exercised by the Governor and later delegated to the DCA Director. Lawsuits claiming some emergency authority was illegal because only the Legislature

can delegate such authority. This bill does that by authorizing the Board to respond immediately in the case of a disaster to exempt or waiver statutory requirements for licensees impacted by disaster. This would settle legal argument for such authority and allow the board to act immediately in a disaster.

In the past, emails were not required to be provided to the Board by applicants. This bill specifically requires applicants provide the Board emails. This will facilitate the Board's ability to contact licensees and applicants in an emergency.

Legislative Committee Recommendation: Support

AB 460 (Chen) Radiologic technologists: venipuncture: direct supervision.

Summary: This bill would revise that definition to require the licensed physician and surgeon to either be physically present within the facility and immediately available to intervene or available immediately via telephone or other real-time audio *and video* communication with access to the patient's electronic medical records and have the ability to intervene through standing orders or protocols. *The bill would require the facility to have safety protocols and personnel onsite capable of responding to adverse events at the physician's direction.* By changing the scope of direct supervision for purposes of these provisions, the violation of which is a crime, the bill would impose a state-mandated local program.

Existing law, the Radiologic Technology Act, provides for the certification and regulation of radiologic technologists by the State Department of Public Health and makes a violation of the act or regulation of the department adopted pursuant to the act a misdemeanor. Existing law authorizes a radiologic technologist to perform venipuncture in an upper extremity, as specified, under the direct supervision of a licensed physician and surgeon. Existing law defines direct supervision for purposes of that provision to mean the direction of procedures by a licensed physician and surgeon who is physically present and available within the facility when the

procedures are performed to provide immediate medical intervention prevent or mitigate injury to the patient in the event of adverse reaction.

Discussion: This bill relaxes the requirement of direct physician supervision to allow availability through telemedicine video and that the facility has safety protocols for adverse reaction emergencies to mitigate the lack of presence of the supervising physician and anticipate the procedures to be followed. This policy shift is in response to the growing use of telemedicine that can facilitate a direct conversation with a physician not physically present in the room where the procedure is being performed. The addition for facilities having safety protocols is a good addition that you might expect to already exist but may not. There is a risk to public safety in not having the supervising physician physically present. Additionally, if the safety protocols are not effective in explaining next steps or the technician is unable to perform the protocols telemedicine creates an unnecessary risk to public safety. Given the potential for emergency situation, telemedicine is not appropriate. The American Society of Radiologists raised concerns that radiology assistants are not trained to deal with emergencies and would need an onsite physician available. The committee addressed this concern by requiring the safety protocols have an onsite physician to handle the emergencies if needed.

Central to this bill is determining whether telemedicine is appropriate for direct supervision in the case of an emergency. Telemedicine was never created to replace in person required care and supervision and it should not be expanded as this bill does to allow direct supervision to be performed through video telemedicine. The radiology assistants have already raised their concern over not being trained to handle emergencies and did not support the expansion of direct supervision to include telemedicine. While the committee amendments tried to address and mitigate these concerns, the reality is that telemedicine does not replace the required need for direct supervision in this instance.

In the context of pushes to expand the convenience of telemedicine, it poses unnecessary risks to patient and public safety to entertain that telemedicine can replace direct supervision in the event of an emergency. Telemedicine is not and never should be a replacement for direct, in person supervision, particularly in the light of the potential for emergencies such as reaction to dye or contract substances given to a patient through I.V. for particular radiological imaging. This is a dangerous expansion of telemedicine that poses harm to patients and public safety.

Assembly Health Committee Analysis 3.28.2025

Recommendation: Oppose.

AB 967 (Valencia) Physicians and surgeons: licensure: expedite fee.

Summary: This bill would require the Medical Board of California to expedite the licensure process for an applicant who submits an application that is accompanied by an expedite fee fixed

by the board. The bill would require the board to fix the expedite fee at an amount equal to the cost of expediting the licensure process, but not to exceed $250, as specified.

Existing law requires a board to expedite the licensure process for certain applicants, including an applicant who has a specified relationship with an active-duty member of the Armed Forces of the United States, as prescribed, and holds a current license in another state, district, or territory of the United States in the profession or vocation for which the applicant seeks a license from the board.

Existing law establishes the Medical Board of California to enforce the licensing and regulatory provisions relating to physicians and surgeons. Existing law imposes various fees on applicants for licensure of physicians and surgeons, including an application and processing fee of $625 to be paid by an applicant for a certificate based on reciprocity, and an applicant for a certificate based upon written examination, as specified. Under existing law, all moneys paid to and received by the board are required to be paid into the State Treasury and credited to the Contingent Fund of the Medical Board of California. Existing law requires moneys in that fund to be available, upon appropriation by the Legislature, as provided.

SECTION 1.

Section 2438 is added to the Business and Professions Code, to read:

2438.

(a) The board shall expedite the licensure process for an applicant who submits an application that is accompanied by an expedite fee fixed by the board.

(b) The board shall fix the expedite fee at an amount equal to the cost of expediting the licensure process for applicants applying under subdivision (a), but the fee shall not exceed two hundred fifty dollars ($250).

(c) (1) This section does not change any existing licensure requirements.

(2) An applicant applying for expedited licensure under subdivision (a) shall meet all applicable statutory and regulatory licensure requirements.

(d) This section does not require an applicant applying for expedited licensure pursuant to Sections 115.4, 115.5, 135.4, 870, and 2092 to pay the expedite fee established in subdivision (a).

Discussion: This bill appears to exclude OMBC and only apply to offering up to $250 fee for an applicant's request for the Board to expedite the initial license application. The bill is sponsored by the California Medical Association as a way to address the physician shortage in California. While it is a worthy intention to address the physician shortage in California that is otherwise

driving a dangerous trend towards expanding scope of practice for non-physicians, it may not be the solution to the problem it purports.

The nature of application processing has significantly changed for OMBC with the physician and surgeon application being online. There are no more applications being lost in the mail or keying application delays. So, the bulk of the processing is waiting for the various required documents to arrive at the Board to complete the application. Waiting for required documents: transcripts, COMLEX exam scores, fingerprint clearance, certification of completion of 12 months of postgraduate training from training programs are what takes up the bulk of the processing time and causes the delays in completion and issuance of applications. In this context, adding an expedite fee would not eliminate these delays in receiving the required documents.

Additionally, in the past and prior to the physician and surgeon application be available online, the Board was inadequately staffed and there were application processing backlogs. Now, the processing time for initial licensing completed applications ranges from 3 days to 30 days. For incomplete applications that the Board is waiting for required documents longer than 30 days. In this context, expediting more applications does not impact the delays in receiving a license.

Currently, those applicants for initial license that hold a Postgraduate Training License (PTL) are already in a position to have their licenses expedited by virtue of only needing one required document to complete their physician and surgeon application. The PTL application already all but one of the required documents for licensure unless they claim eligibility for an expedited processing then they would need that additional verification of expedite eligibility document in addition to certification of completion of 12 months of residency training.

The Board estimates that 50% of initial applications are from out of state including licensed and unlicensed applicants. The other 50% of application are from instate Postgraduate Training License holders. This bill would currently apply to both instate and out of state applicants not otherwise claiming eligibility for expedite processing based on a statutory mandate. The Board receives 1700 initial applications per year. This means that 50% of applicants already enjoy expedited processing because they hold a Postgraduate Training License (PTL). So, the potential for new expedited licensure proposed by this bill would be from the remaining 50% of out of state licensed or unlicensed applicants. The Assembly Business and Professions Committee suggested amendments that would narrow the eligibility to only out of state applicants.

Expedite. Historically, the expedite categories were merited by some special need or attribute of the license applicant: military, military spouse, rural or medically underserved communities, refugee/asylum, abortion provider. This bill proposes an on demand expedite category based on paying an expedite fee to process the application faster. This money category would be open to every applicant, who is not otherwise eligible for the existing expedite categories, and anyone who can afford to pay the fee. On its face, this expedite fee would not bring the relief this bill is seeking: to solve the alleged physician and surgeon shortage in California.

The policy issue of expansion of the number of statutorily mandated expedite categories was discussed last session and the expedite bills were vetoed. The reason is because many believe that we are at the tipping point with respect to expanding the number of expedited categories beyond the point where expedited status becomes meaningless and the expedite workload dilutes the original intention of expedited status because now the majority or all applicants become eligible for expedite status. If everyone is eligible for expedited processing, the Board's current staff capacity cannot support the increased workload of expediting all applications.

Both the Assembly and Senate Business and Professions Committees have highlighted the policy of creating expedited categories and placed sunset clauses in all expedite bills to allow the Legislature to evaluate whether there is a need for any of some of the existing expedite categories. So, policy wise does it makes sense to give this issue space for the Legislature to ponder without adding to the list of expedite categories? Or does it make sense to frame this policy using a different lens of no merit expedite category that this bill proposes?

Equity. The Assembly Business and Professions Committee analysis highlights the equity issue in creating an expedite fee that would lead to the inequity of only those applicants that can pay the expedite fee would be entitled to expedited processing of their license applications. As a matter of policy this expedited fee would create inequity among the pool of applicant who cannot afford or choose not to pay the expedite fee resulting in only affluent applicants receiving expedited processing of their license application. This built-in inequity would undermine the intention of the current expedite categories that have a basis for providing expedited services. If the purpose of expedite categories is to only allow ones with a good justification, then this bill undermines that policy intention.

Concierge Services. Under the current structure of the Board, it is staffed to review, evaluate and verify eligibility for licensure. It is not staffed to provide extra contact and assistance to applicants. Expedite applications, however, require the staff to provide extra contact and follow-up with applicants to ensure they realize their application remains incomplete. These expedited categories generate increased workload for staff who have to not only verify they meet the licensure requirements with the required documents but also receive the required document verifying they are in fact eligible for expedite licensure processing. In most case, the staff has to follow-up for not only the license required documents but also the documents verifying their expedite status category. This extra verification for expedite generates additional workload than for non-expedited applications. The Board has observed that a fraction of the expedited requests actually provide documentation of their eligibility, but nonetheless adds additional workload in either case. This waiting period for required documents is at the heart of the delays in processing and issuing licenses, which the expedited categories do not solve.

The Board cannot absorb the additional workload that on-demand expedited processing would require and would need at least 1 fulltime PY. However, if the purpose of expedited services is to provide a concierge type service for applicants, the Board would need to provide them with

more follow-up and communication related to keep them apprised of the status of the application and what deficiencies are outstanding. Providing concierge services is what is hinted at by proposing an expedite fee. If applicants simply want better more interactive services, then facilitating that concierge service through an expedite fee would provide just that. **The concierge services would not solve the physician shortage, but it would improve the license application experience for applicants—maybe that is what is needed.**

To entertain this bill, the Board would need to be added to the bill, the bill only applies to MBC. If the author and bill sponsors are serious about facilitating the Board to ramp up its staff to meet the increased demand for expedited services on demand (concierge services), the bill would need to include position authority for additional staff for OMBC to create this concierge application service. As proposed, the maximum fee of $250 expedite fee would cover the cost of the Board hiring a dedicated concierge staff to implement an on-demand fee based expedited processing. **The Board cannot absorb this on demand workload without additional staff.**

Without the additional staff, the Board, as mentioned above, is not set up to provide concierge services for applications—that type of service is beyond the Board's current staffing. In approaching this in the alternative, everyone probably prefers extra assistance and maybe applicants would enjoy having access to concierge services when they apply for their initial license. As proposed, the maximum fee of $250 expedite fee would cover the cost of the Board hiring a dedicated concierge staff. The Board would need ongoing position authority added to the bill without appropriate because the cost of the concierge staff would be funded by the expedite fee. The implementation would be contingent on receiving the position authority and authorization through regulations to charge an expedite fee which would require delayed implementation to accomplish.

Assembly Business and Professions Committee Analysis

Recommendation: Support if amended?

WATCH LIST BILLS

AB 50 Pharmacists: furnishing contraceptives.

Summary: An act to amend Sections 733, 4052, 4052.3, and 4064.5 of the Business and Professions Code, relating to healing arts, and declaring the urgency thereof, to take effect immediately. This bill would limit the application of those requirements to self-administered hormonal contraceptives that are prescription-only and would authorize a pharmacist to furnish over-the-counter contraceptives without following those standardized procedures or protocols. The bill would additionally authorize a pharmacist to furnish up to a 12-month supply at one time of over-the-counter contraceptives at the patient's request. The bill would make related conforming changes.

Exiting law requires a pharmacist, when furnishing self-administered hormonal contraceptives, to follow specified standardized procedures or protocols developed and approved by both the board and the Medical Board of California in consultation with the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association, and other appropriate entities. Existing law requires those standardized procedures or protocols to require that the patient use a self-screening tool that will identify related patient risk factors and that require the pharmacist to refer the patient for appropriate follow-up care, as specified. Existing law requires the pharmacist to provide the recipient of the drug with a standardized factsheet that includes the indications and contraindications for use of the drug, the appropriate method for using the drug, the need for medical follow-up, and other appropriate information. Existing law authorizes a pharmacist furnishing an FDA-approved, self-administered hormonal contraceptive pursuant to the above-described protocols to furnish, at the patient's request, up to a 12-month supply at one time.

This bill would declare that it is to take effect immediately as an urgency statute.

Discussion: This bill is part of the package of bills to protect access to reproductive health care from hostile federal or out of state laws. The bill provides prescription hormones shall be furnished by pharmacists without adhering to the standardized procedures or protocols for prescription only self-administered hormone contraceptives. Since this bill regulates pharmacists furnishing contraceptives, it is on the watch list rather than recommended for a position.

Recommendation: Watch.

AB 346 (Nguyen) In-home supportive services: licensed health care professional certification.

Summary: AB 346. An act to amend Sections 12300.1 and 12309.1 of the Welfare and Institutions Code, relating to in-home supportive services. This bill defines "licensed health care professional" for those purposes to mean any person who engages in acts that are the subject of licensure or regulation under specified provisions of the Business and Professions Code or under any initiative act referred to in those specified provisions. The bill would also clarify that as a condition of receiving paramedical services, an applicant or recipient is required to obtain a certification from a licensed health care professional, as specified.

Existing law provides for the county-administered In-Home Supportive Services (IHSS) program,

under which qualified aged, blind, and disabled persons are provided with specified services in order to permit them to remain in their own homes and avoid institutionalization. Existing law defines supportive services for purposes of the IHSS program to include those necessary

paramedical services that are ordered by a licensed health care professional, which persons could provide for themselves, but for their functional limitations. Existing law requires an applicant for, or recipient of, in-home supportive services, as a condition of receiving these services, to obtain a certification from a licensed health care professional declaring that the applicant or recipient is unable to perform some activities of daily living independently, and that without services to assist the applicant or recipient with activities of daily living, the applicant or recipient is at risk of placement in out-of-home care, and defines a licensed health care professional to mean an individual licensed in California by the appropriate California regulatory agency, acting within the scope of their license or certificate as defined in the Business and Professions Code.

Discussion: This bill is requiring that as a condition for receiving paramedical services for conditions that the patient is capable of performing that they get certified by a licensed health care provider that they in fact need paramedical services to perform specified functions. This would not impact the Board.

Recommendation: Watch.

AB 408 (Berman) Physician Health and Wellness Program

Summary: This is a MBC sponsored bill to establish their Physician Health and Wellness Program for licensees under the board to receive treatment. Licensees include physicians and surgeons and licensed midwives.

Discussion: Among the program design revisions is to not contract with recovery contractors that other boards, including OMBC, under DCA utilize. Instead, it creates a non-profit that runs the program. It also exempts voluntary enrollees from being subject to the requirements of the Uniform Standards for Substance Abusing Licensees. It allows entrance into the program either voluntarily or pursuant to disciplinary order. This bill does not apply to OMBC. OMBC has a long-established Diversion Program that contracts with a third party to evaluate, provide appropriate treatment and case management monitoring.

Assembly Business and Professions Committee Analysis

Recommendation: Watch.

AB 447 (González) Emergency Room (ER) Patient Prescriptions

Summary: This bill would, notwithstanding any other law, authorize a prescriber to dispense an unused portion of a dangerous drug acquired by the hospital pharmacy to an emergency room patient upon discharge under certain conditions, including that the dangerous drug is not a

controlled substance and that dispensing the unused portion of the dangerous drug is required to continue treatment of the patient.

Existing law authorizes a prescriber to dispense a dangerous drug, including a controlled substance, to an emergency room patient if specified requirements are met, including that the dangerous drug is acquired by the hospital pharmacy.

Existing law requires an automated drug delivery system (ADDS) that is installed, leased, owned, or operated in California to be licensed by the board. Existing law exempts an automated unit dose system (AUDS), a type of ADDS, from licensure if the AUDS is used solely to provide doses administered to patients while in a licensed general acute care hospital facility or a licensed acute psychiatric hospital facility if the licensed hospital pharmacy owns or leases the AUDS and owns the dangerous drugs and dangerous devices in the AUDS.

This bill would also exempt from licensure an AUDS that is used to provide doses administered to emergency room patients in accordance with specified requirements.

Discussion: This bill marries the issue of emergency room patients that can't afford prescriptions or there are no pharmacies available and emergency rooms treating patients with drugs that once opened cannot be used again. It would allow the patient to be discharged with the remaining unused portion of the treatment medication administered in the ER. The safety feature is that the unused drugs can only be dispensed to the same patient who the drug was administered as treatment. It seems like a commonsense idea that needed some statutory backstops due to the nature of prescriptions and potential for abuse.

Assembly Business and Professions Committee Analysis

Recommendation: Watch.

AB 479 (Tangipa) Criminal Procedure: Vacatur Relief: Findings of Harm

Summary: An act to amend Section 236.15 of the Penal Code, relating to criminal procedure. This bill would require the court, before it may vacate the conviction, to make findings regarding the impact on the public health, safety, and welfare, if the petitioner holds a license, as defined, and the offense is substantially related to the qualifications, functions, or duties of a licensee. **The bill would require a petitioner who holds a license to serve the petition and supporting documentation on the applicable licensing entity and would give the licensing entity 45 days to respond to the petition for relief.**

Existing law allows a person who was arrested or convicted of a nonviolent offense while they were a victim of intimate partner violence, or sexual violence, to petition the court, under penalty of perjury, for vacatur relief. Existing law requires, in order to receive that relief, that the petitioner establish, by clear and convincing evidence, that the arrest or conviction was the direct

result of being a victim of intimate partner violence or sexual violence that demonstrates the petitioner lacked the requisite intent. Existing law authorizes the court to vacate the conviction if it makes specified findings.

Discussion: This bill would require the court before vacating a conviction to make a finding regarding the impact on public health, safety and welfare in the petitioner holds a license (not limited to physicians) and the offense is substantially related to the qualifications or duties of the licensee. Requiring the court to evaluation the public safety risk would make this part of the court order to vacate and would allow boards to obtain information on the licensee's behavior.

The bill requires the petitioner to notify the Board of the pending order to vacate the conviction and the Board would have 45 days to respond. This would require the Board to set up a system for responding to such a notice within 45 days. BRN is the sponsor of this bill and indicated that they had a petitioner have their conviction vacated for child pornography and the petitioner was allowed to continue to practice. This would be another enforcement tool for boards.

Assembly Public Safety Committee Analysis

Recommendation: Watch.

AB 485 (Ortega) Labor Commissioner: unsatisfied judgments: nonpayment of wages

Summary: This bill would require a state agency, if an employer in an industry that is also required to obtain a license or permit from that state agency is found to have violated the unsatisfied judgment provision, to deny a new license or permit or the renewal of an existing license or permit for that employer. The bill would also require the Labor Commissioner, upon finding that an employer is conducting business in violation of that provision, to notify the applicable state agency with jurisdiction over that employee's license or permit.

Existing law establishes the Division of Labor Standards Enforcement, under the direction of the Labor Commissioner, within the Department of Industrial Relations and sets forth its powers and duties regarding the enforcement of labor laws. Existing law authorizes the Labor Commissioner to investigate employee complaints and to provide for a hearing in any action to recover wages, penalties, and other demands for compensation, as specified. take various actions against an employer with respect to unpaid wages.

Existing law generally prohibits an employer with an unsatisfied final judgment for nonpayment of wages from continuing to conduct business in California, unless that employer has obtained a bond from a surety company and filed that bond with the Labor Commissioner, as prescribed. Under existing law, if an employer in the long-term care industry that is also required to obtain a license from the State Department of Public Health or the State Department of Social Services has violated the above provision governing unsatisfied judgments (unsatisfied judgment provision), either of those departments may deny a new license or the renewal of an existing

license for that employer. Existing law further requires the Labor Commissioner, upon finding that an employer in the long-term care industry is violating the unsatisfied judgment provision, to notify those departments.

Discussion: This bill creates the authority for the Board to deny an initial license or not renew an existing license until the judgement is satisfied. This is similar to non-payment of child support law that prevents a license from being renewed if the board is notified of an outstanding child support judgement. This bill is trying to deter such non-payment of employee wages.

Assembly Labor and Employment Committee Analysis

Recommendation: Watch.

AB 985 (Aherns) Assistance Anesthesiologist Scope of Practice

Summary: This bill, the Anesthesiologist Assistant Practice Act, would make it unlawful for any person to hold themselves out as an anesthesiologist assistant, as defined, unless they meet specified requirements. The bill would make it an unfair business practice to violate these provisions. The bill would require an anesthesiologist assistant to work under the direction and supervision of an anesthesiologist and would require the anesthesiologist to be physically present on the premises, and immediately available, to oversee and take responsibility for medical services rendered by the anesthesiologist assistant. The bill would authorize an anesthesiologist assistant, under the supervision of an anesthesiologist, to assist in developing and implementing an anesthesia care plan for a patient.

Assembly Business and Professions Committee Analysis

Discussion: This bill has been amended to be a title act that protects the usage of the title and create a new profession recognized in California: Certified Anesthesiology Assistants (CAA). Currently, there is no board in charge of overseeing this new profession which would have to be created through a legislative sunrise process detailed in Government Code 9148.The bill does

not identify a board or scope of practice. According to the Assembly Business and Professions Committee Analysis Certified Anesthesiology Assistants are recognized to practice under the direct supervision of Anesthesiologists in 19 states and the District of Columbia.

The California Society of Anesthesiologists, the bill's sponsor, is proposing this bill as a safe solution to the alleged shortage of Anesthesiologists in rural areas. This bill sets up Certified Anesthesiologists Assistants (CAA) to become part of the anesthesiology team to work with physician anesthesiologists in performing anesthesiology. The hospital peer review would assess their competence and authorize their participation on the anesthesiology team. In concept, they

would be only authorized to practice under the direct, in person, supervision of an anesthesiologist.

According to the California Society of Anesthesiologists recognizing Certified Anesthesiology Assistants in California as a way to create a supervised "extender" for anesthesiology teams. Currently, there is no Board that oversees Certified Anesthesiology Assistants. A Board and scope of practice has yet to be identified and developed.

The theme and problem driving all scope of practice bills is to address the shortage of physicians. However, central to any scope of practice consideration is safety and training to practice safely. Through the years, there have been many scope of practice expansions for allied health professions that once studied indicate allied health professionals are not trained to adequately detect emergencies and as a result, patients under their care die prematurely. One of the consequences of scope of practice expansions is that hospitals and health systems increasingly employ allied health professionals to replace physicians. The main point to consider is that no other profession is trained as thoroughly and extensively as physicians, which means that no other profession can be substituted for physician care and supervision when it comes to patient care.

This bill is not fully developed for as a scope of practice bill, so it is premature to seriously consider taking a position on. For this reason, it is recommended to be a watch.

Recommendation: Watch.

AB 511 (Chen) Radiologist assistants.

Summary: This bill would prohibit a person from holding themselves out as a radiologist assistant unless the person meets certain requirements, including that they have passed the radiologist assistant examination, as specified, and that they maintain current registration with prescribed entities. The bill would require a radiologist assistant to work only under the supervision of a radiologist and would prohibit a radiologist assistant from functioning in that capacity independent of a supervising radiologist. The bill, among other things, would authorize a radiologist assistant to communicate and document initial clinical and imaging observations or procedures only to a radiologist for the radiologist's use. The bill would authorize a supervising radiologist to delegate to a radiologist assistant, as the radiologist determines appropriate to the assistant's competence, those tasks or services that a radiologist usually performs and is qualified to perform. The bill would provide that a violation of its provisions does not constitute a misdemeanor.

Existing law, the Radiologic Technology Act, prohibits a person from administering or using diagnostic or therapeutic X-rays on human beings in this state, unless that person either qualifies for a specified exemption or has been certified or granted a permit by the State Department of

Public Health, as specified, is acting within the scope of that certification or permit, and is acting under the supervision of a healing arts licensee. A person who violates a provision of the Radiologic Technology Act or regulation of the department adopted pursuant to that act is guilty of a misdemeanor.

Assembly Business and Professions Committee Analysis

Discussion: This bill makes it illegal for any one to hold themselves out as a radiology assistant if not licensed. The bill also requires direct supervision by a radiologist and prohibits radiology assistants from practicing without direct supervision of radiologist.

Recommendation: Watch.

SB 679 (Weber-Pierson) Requires Health Facilities/ Peer Review Committees 805 reporting to include race and gender

Summary: This bill creates a new code section 805.3 that requires health facilities that are required to report terminations and revocation of privileges, to report the data by race and gender and report it to the Civil Rights Department and the Board. The Civil Rights Department would be required to publish the de-identified information on their website and create a report to the Legislature.

Senate Business and Professions & Economic Development Committee Analysis

Discussion: The bill requires health facilities and peer review committees to report 805 data by race and gender to the Civil Rights Department and the Board. It appears that the enhanced data would also have to be reported to the Board, so the Board would have to add those additional data fields in their record keeping. It is the Civil Rights Department that is required to submit the report to the Legislature. As written, it does not appear to require any additional breeze codes.

Recommendation: Watch.

AB 1037 (Elhawary) Public Health: Overdose Treatment by Non-Physicians

Summary: The bill makes several changes to current law. "First, expands existing authorization of a licensed health care provider to prescribe an opioid antagonist to include those at risk of experiencing any overdose, rather than specifically an opioid-related overdose and to those who are in a position to help a person at risk of any overdose. Second, it removes the requirement that those who receive and possess opioid antagonists receive training. Given the fact that there is virtually no risk of harm from administering naloxone to a person who is not experiencing an opioid overdose and the lifesaving effect that administration has on a person who is experiencing an overdose, this seems appropriate. Third, the bill authorizes a person at risk of an overdose, or a person in a position to assist them, to possess an opioid antagonist and subsequently dispense

or distribute the opioid antagonist to a person at risk of an overdose or another person in a position to assist a person at risk of an overdose." (Assembly Judiciary Committee Analysis 4/29/2025)

Existing law requires that a person who receives an opioid antagonist pursuant to a standing order or otherwise possesses an opioid antagonist receive training, as specified. Existing law provides that a person who is trained in the use of an opioid antagonist and acts with reasonable care and in good faith is not subject to professional review, liable in a civil action, or subject to criminal prosecution.

Assembly Judiciary Committee Analysis

Assembly Health Committee Analysis

Discussion: This bill is a Public Health response to the drug overdose epidemic and the availability of opioid antagonists such as Naloxone (Narcan) that can revive a person experiencing an overdose. Currently, only trained professionals can administer such a drug. Typically, lay people can be liable for harm caused by acting as a "good Samaritan" to assist someone in an emergency such as car accidents or drug overdoses. However, since Naloxone can by available without a prescription, policy wise exempting untrained people from liability for administering the drug in an emergency overdose scenario may save more lives because if friends or family members have the drug handy, they could administer it in an emergency to save the person's life.

Naloxone is safe even when administered to someone who is not overdosing. The bill attempts to loosen the liability for good Samaritans to try to save the life of someone that has overdose. Despite efforts to curb the epidemic of drug overdoses, it remains an epidemic and it makes sense to entertain such an exemption. The intent of this bill is to increase access to life saving overdose treatment, which also makes sense. The exemption is narrow, so it targets the drug overdose Public Health scenario only.

The law enforcement community opposes this bill rejecting the basis of the bill as "Harm Reduction" and characterizes it a facilitation of more illegal drug use.

Recommendation: Watch.

AB 1186 (Patel) Data Collection: race and ethnicity: minimum categories

Summary: This bill, subject to a specified exception, would require any state agency, board, or commission that directly or by contract collects demographic data on the ethnic origin, ethnicity, or race of Californians to collect data on at least the 9 instead of 7 minimum categories on race and ethnicity, as defined, as well as at least the top 9 largest detailed categories, categories, and prescribed write-in options, as provided. The bill would require compliance with these provisions by January 1, 2029. The

The bill would establish, within the Demographic Research Unit, the position of the Chief Statistician of California, who would be required to, among other things, standardize collection of demographic data across state agencies, as provided. The bill would require the Chief Statistician of California and the Demographic Research Unit within the Department of Finance to oversee implementation of these provisions and provide technical assistance. The

The bill would also require, on or before January 1, 2027, and annually thereafter, each state agency, board, or commission required to comply with the bill's provisions to submit a report to the Legislature and the Assembly Committee on Governmental Organization on compliance with these provisions, as provided. The bill would require data collected pursuant to this section to be made available to the public in accordance with state and federal law, except for personal identifying information, as specified. *The bill would prohibit an agency* from disclosing personal identifying information to any federal agency unless the disclosure is expressly required by federal law.

Assembly Judiciary Committee Analysis

Discussion: This bill attempts to add more minimum data categories to aggregate state demographic data. It requires the Board and others to comply by 2029. The problem for the Board is that the only race and ethnicity data collection the Board collects is through the physician survey and the demographic information is voluntary by law. The survey is mandated but within the survey the demographics data is voluntary. The physician survey has a lot of race and ethnicity categories and a fill-in option so it may not need any revisions, but the fact that demographic data is optional remains an obstacle for using the data for meaningful research and data analysis.

The Board has observed that if the demographics are not required, physicians don't complete it. As a result, for research and data analysis purposes, only the surveys with completed demographics can be used for research purposes. Under current law, the demographic data on the physician survey is voluntary, and physicians can choose not to have their gender, race and ethnicity or language spoken disclosed. It is unclear whether this bill would override the voluntary nature of the physician survey demographic data collection. As the Assembly Judiciary Committee points out the bill needs to define the pathway for Board's to seem exemption from this proposed data collection and report to the Legislature. This bill also requires the establishment of the Chief Statistician of California position within the Department of Finance, which unless it's an administrative priority, may not survive.

If the Board is exempt from this bill, it would not impact the Board fiscally or IT wise. However, if the Board is required to proactively apply for an exempt, DCA may consider collectively facilitating applying for such an exemption. If the Board must collect the data, analyze it and report to the Legislature it would be a significant fiscal and IT impact for the Board. This bill would not be absorbable, and the Board would need either an exemption or additional staff with statistical expertise that could analyze the data and create a report to the Legislature.

Given the Board's mission and small size, ramping up staff wise to collect, analyze and report demographics data on its licensees would be a burden that would outweigh the benefit to the public--" the basis for an exemption.

Recommendation: Watch.

SB 387 Residency Accreditation Eligibility Revision: Faculty Permit

Summary: This bill would modify the requirements for a National Cancer Institute-designated comprehensive cancer center to qualify as an academic medical center by, instead, requiring the facility to train 25 resident or fellow physicians annually and exempting the facility from the Western Association of Schools and Colleges accreditation requirement.

The Medical Practice Act authorizes a person who meets certain eligibility requirements to apply to the board for a special faculty permit, which authorizes the holder to practice medicine without a physician's and surgeon's certificate only within a medical school itself, in any affiliated institution of the medical school, or in an academic medical center and any affiliated institution in which the permitholder is providing instruction as part of the medical school's or academic medical center's educational program and for which the medical school or academic medical center has assumed direct responsibility. Existing law defines "academic medical center" for these purposes as a facility that meets certain requirements. Among those requirements, existing law requires the facility to train a minimum of 250 resident physicians annually and to be accredited by both the Western Association of Schools and Colleges and the Accreditation Council for Graduate Medical Education.

Senate Business and Professions and Economic Development Committee Analysis

Discussion: The function of a faculty permit is to waiver licensure qualifications for foreign trained physicians. This does not apply to OMBC because foreign trained Osteopaths are ineligible for licensure. The relevance is a proposed modification to accreditation standards.

Recommendation: Watch.

SB 470 (Laird) Bagley-Keene Open Meeting Act: teleconferencing

Summary: This bill extends the current Open Meetings Act rules until January 1, 2030. The current rules would have sunset January 1, 2026.

Discussion: The intent of the bill is not to let the current law sunset. The fact that all this bill does is retain the current rules is an indication that for now this is as flexible as the Legislature is willing to approve. The author wants to at least cement this compromise until 2030.

Recommendation: Watch.

SB 518 (Weber-Pierson) Descendants of enslaved persons: reparation: certify descendants.

Summary: This bill would establish the Bureau for Descendants of American Slavery within the Department of Justice, under the control of the director, who would be appointed by the Attorney General and confirmed by the Senate. The bill would require the bureau, as part of its duties, to determine how an individual's status as a descendant would be confirmed. The bill would also require proof of an individual's descendant status to be a qualifying criterion for benefits authorized by the state for descendants. To accomplish these goals, the bill would require the bureau to be comprised of a Genealogy Division, a Property Reclamation Division, an Education and Outreach Division, and a Legal Affairs Division.

The bill would, upon appropriation, impose specified duties on the Property Reclamation Division to accept, review, and investigate applications, to determine whether an applicant is a dispossessed owner, and, if so, to determine whether and what type of property or just compensation is warranted, as defined and specified. In this regard, the bill would require a local entity, upon a determination that issuing property or just compensation is warranted, to recommend publicly held properties suitable as compensation and to provide compensation in accordance with the division's determination. By imposing new duties on local entities, this bill would impose a state-mandated local program.

Senate Judiciary Committee Analysis

Discussion: This bill proposes to establish the Bureau for Descendants of African American Slavery within the Department of Justice. This bureau would certify that a person is a descendant of African American Slavery. This bill, in part, is the vehicle to address the concerns raised last year about expediting licensing for descendants of African American Slaves, but it also creates the framework for "Reparation." This bill would certify whether someone is a descendant of African American slaves. The bill AB 472 to expedite licensure applications for descendants of American Slaves are tied to the passage of this bill SB 518, which means that if SB 518 is not signed into law, then AB 472 would not be signed into law. This certification would resolve one of the concerns with how the Board would determine the eligibility for expedite purposes and what documentation would be required to be verified.

Although this bill is linked to AB 472, the definition of American Slave differs. AB 472 has broader language that is not limited to African American Slaves rather it deleted African and just has American Slaves, which would include broader ethic and racial categories of eligibility for expedited licensing. In comparison, SB 518 under their definition of "Descendants" is limited to descendants of African American slaves. So, the certifying bureau would only certify African American Slave descendants not the broader universe of American Slaves.

The Senate Judiciary Committee Analysis has a more refined constitutional analysis of SB 518 stating that it does not violate the equal protection clause because it is not based on race it is based on a narrow group of descendants of slaves that were harmed, not all African Americans.

The bill also lays the fiscal foundation for this new bureau to be funded by "Reparations Funds.**"** While this bill is related to AB 472, it goes into much more details that involve reparation that is beyond the Board's scope. For this reason, it is recommended to be a watch.

Recommendation: Watch.