DHBC
Dental Hygiene Board of California

Tuesday, May 27, 2025
Meeting Materials

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS
BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
DENTAL HYGIENE BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1350 Sacramento, CA 95815
P (916) 263-1978 | F (916) 623-4093 | www.dhbc.ca.gov

Notice is hereby given that a public meeting of the
Dental Hygiene Board of California (DHBC) will be held as follows:

DHBC MEETING AGENDA

The DHBC welcomes and encourages public participation in its meetings.
The public may take appropriate opportunities to comment on any issue before the Board at the time the item is heard.

Meeting Date and Time

Tuesday, May 27, 2025
4:00 pm until Adjournment

The DHBC will conduct the meeting in accordance with Government Code section 11123, subdivision (b)(1), via WebEx teleconference for interaction.

Public Access Teleconference Meeting Location

DHBC Headquarters Building
2005 Evergreen Street
1st Floor Lake Tahoe Room 1290
Sacramento, CA 95815

Instructions for WebEx Meeting Participation

The preferred audio connection is via telephone conference and not the microphone and speakers on your computer. The phone number and access code will be provided as part of your connection to the meeting. Please see the instructions attached here to observe and participate in the meeting using WebEx from a Microsoft Windows-based PC. Members of the public may, but are not obligated to, provide their names or personal information as a condition of observing or participating in the meeting. When signing into the WebEx platform, participants may be asked for their name and email address. Participants who choose not to provide their names will be required to provide a unique identifier, such as their initials or another alternative, so that the meeting moderator can identify individuals who wish to make a public comment. Participants who choose not to provide their email address may utilize a fictitious email address in the following sample format: XXXXX@mailinator.com.

For all those who wish to participate or observe the meeting, please log on to the website below. If the hyperlink does not work when clicked on, you may need to highlight the entire hyperlink, then right click. When the popup window opens, click on "Open Hyperlink" to activate it, and join the meeting.

https://dca-meetings.webex.com/dca-meetings/j.php?MTID=m62a8d3a555c05cdc94a1c7392d2ae377

If joining using the link above:

Webinar number: 2493 712 7287
Webinar password: DHBC527

If joining by phone:

+1-415-655-0001 US Toll
Access code: 2493 712 7287
Passcode: 3422527

The meeting will be webcast, provided there are no unforeseen technical difficulties or limitations. To view the webcast, please visit Live Webcasts – Department of Consumer Affairs (thedcapage.blog). The meeting will not be cancelled if webcast is not available. Meeting adjournment may not be webcast if it is the only item that occurs after a closed session.

Members of the Board & Locations

Board Member	Teleconference Meeting Location
Joanne Pacheco, President, RDH Educator Member	Fresno City College 1101 E. University Ave., Room HS 130C Fresno, CA 93741
Naleni “Lolly” Agarwal – Secretary, RDH Member	Newark Public Library Newark Room 37055 Newark Blvd. Newark, CA 94560
Julie Elginer – Public Member	UC Los Angeles (UCLA) 650 Charles E. Young Dr. South Community Science Bldg., Rm. 31-245B Los Angeles, CA 90095
Justin Matthews – Public Member	CSU Monterey Bay (CSUMB) Heron Hall (Bldg. 18 – East Wing Lobby) 3110 Inter-Garrison Rd. Seaside, CA 93955
Sridevi Ponnala, DDS – Dentist Member	Newark Public Library Newark Room 37055 Newark Blvd. Newark, CA 94560

The DHBC welcomes and encourages public participation in its meetings. Please see public comment specifics at the end of this agenda.

The DHBC may act on any item listed on the agenda, unless listed as informational only. All times are approximate and subject to change. Agenda items may be taken out of order to accommodate speakers and to maintain a quorum. The meeting may be cancelled without notice.

Agenda

1. Roll Call & Establishment of Quorum.

2. Public Comment for Items Not on the Agenda.
   [The DHBC may not discuss or act on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting [Government Code sections 11125 & 11125.7(a).]

3. Discussion and Possible Action on New November 2025 Meeting Dates.

4. Discussion and Possible Action and Update on Current Legislation and Legislative Calendar.

   a) Assembly Bill (AB) 224 Bonta: Health care coverage: essential health benefits.
   b) AB 341 Arambula: Oral Health for People with Disabilities Technical Assistance Center Program.
   c) AB 350 Bonta: Health care coverage: fluoride treatments.
   d) AB 371 Haney: Dental coverage.
   e) AB 489 Bonta: Health care professions: deceptive terms or letters: artificial intelligence.
   f) AB 742 Elhawary: Department of Consumer Affairs: licensing: applicants who are descendants of slaves.
   g) AB 873 Alanis: Dentistry: dental assistants: infection control course.
   h) AB 966 Carrillo: Dental Practice Act: foreign dental schools.
   i) AB 980 Arambula: Health care: medically necessary treatment.
   j) AB 1307 Ávila Farías: Licensed Dentists from Mexico Pilot Program.
   k) AB 1418 Schiavo: Department of Health Care Access and Information.
   l) Senate Bill (SB) 62 Menjivar: Health care coverage: essential health benefits.
   m) SB 351 Cabaldon: Health Facilities.
   n) SB 386 Limón: Dental providers: fee-based payments.
   o) SB 470 Laird: Bagley-Keene Open Meeting Act: teleconferencing.
   p) SB 861 Committee on Business, Professions and Economic Development: Committee on Business, Professions and Economic Development. Consumer affairs (Omnibus Bill).

5. Discussion and Possible Action on Amendments to California Code of Regulations (CCR), Title 16, Section 1116.5: Registered Dental Hygienist in Alternative Practice; Physical Facility Registration.

6. Future Agenda Items.

7. Adjournment.

Public comments will be taken on the agenda items at the time the specified item is raised. Government Code section 11125.7 provides the opportunity for the public to address each agenda item during discussion or consideration by the Board prior to the Board taking any action on said item. Members of the public will be provided appropriate opportunities to comment on any issue before the Board, but the Board President may, at their discretion, apportion available time among those who wish to speak. Individuals may appear before the Board to discuss items not on the agenda; however, the Board can neither discuss nor take official action on these items at the time of the same meeting [Government Code sections 11125, 11125.7(a).]

A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting the DHBC at 916-263-1978, via email at dhbcinfo@dca.ca.gov, or by sending a written request to 2005 Evergreen Street, Suite 1350, Sacramento, CA 95815. Providing your request at least five business days prior to the meeting will help to ensure availability of the requested accommodation.

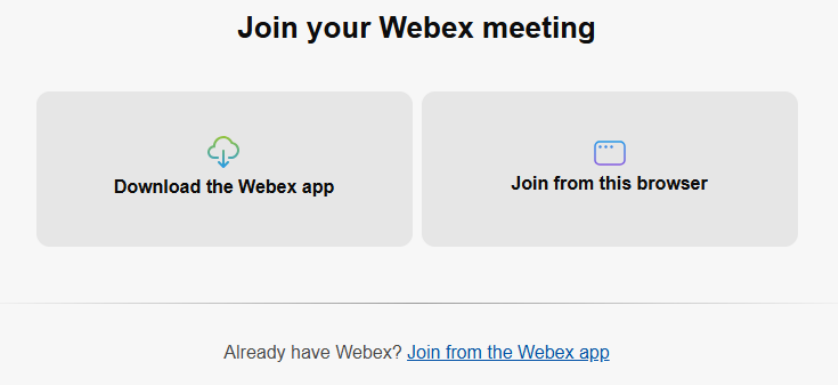
Recommended: Join using the meeting link.

1. Click on the meeting link. This can be found in the meeting notice you received and is on the meeting agenda.

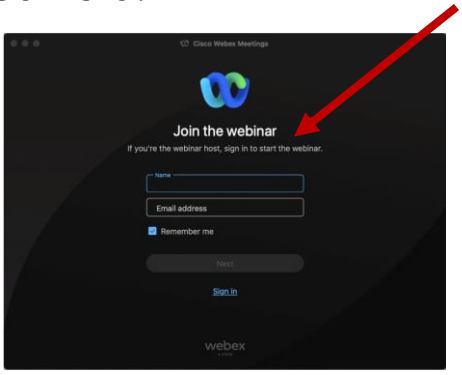
2. If you already have Webex on your device, click the bottom instruction, "Join from the Webex app."

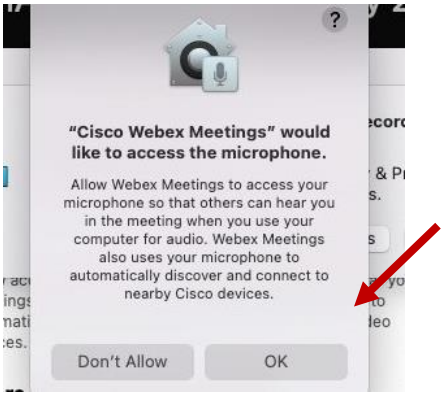
   If you have **not** previously used Webex on your device, your web browser will offer "Download the Webex app." Follow the download link and follow the instructions to install Webex.

   DO NOT click "Join from this browser," as you will not be able to fully participate during the meeting.



3. Enter your name and email address*. Click "Next."
   Accept any request for permission to use your microphone and/or camera.

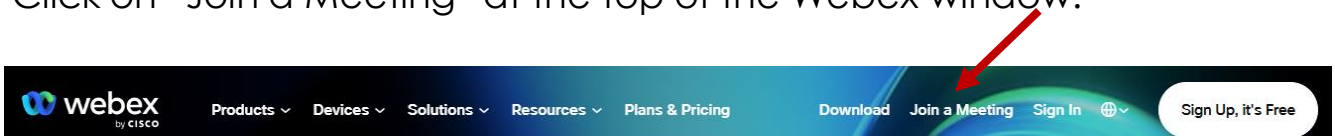




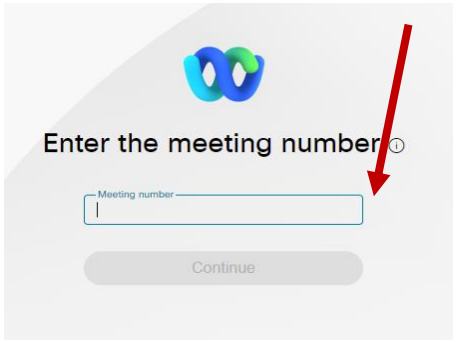
*Members of the public are not obligated to provide their name or personal information and may provide a unique identifier such as their initials or another alternative as well as a fictitious email address like in the following sample format: XXXXX@mailinator.com.

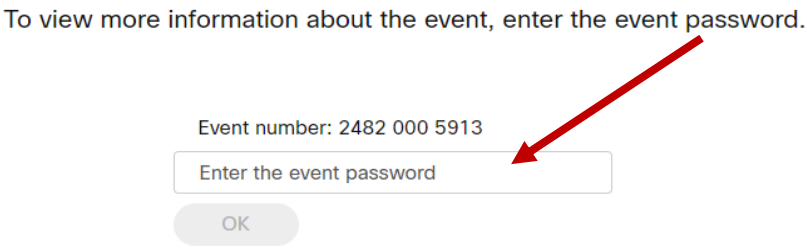
Alternative 1. Join from Webex.com

1 Click on "Join a Meeting" at the top of the Webex window.



2 Enter the meeting/event number and click "Continue." Enter the event password and click "OK." This can be found in the meeting notice you received or on the meeting agenda.





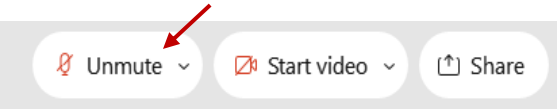
3 The meeting information will be displayed. Click "Join Event."

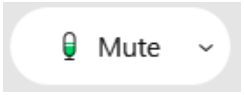
OR

Alternative 2. Connect via Telephone

You may also join the meeting by calling in using the phone number, access code, and passcode provided in the meeting notice or on the agenda.

Microphone control (mute/unmute button) is located at the bottom of your Webex window.





Green microphone = Unmuted: People in the meeting can hear you.

Red microphone = Muted: No one in the meeting can hear you.

Note: Only panelists can mute/unmute their own microphones. Attendees will remain muted unless the moderator invites them to unmute their microphone.

Attendees/Members of the Public

Joined via Meeting Link

The moderator will call you by name and indicate a request has been sent to unmute your microphone. Upon hearing this prompt:

Click the Unmute me button on the pop-up box that appears.

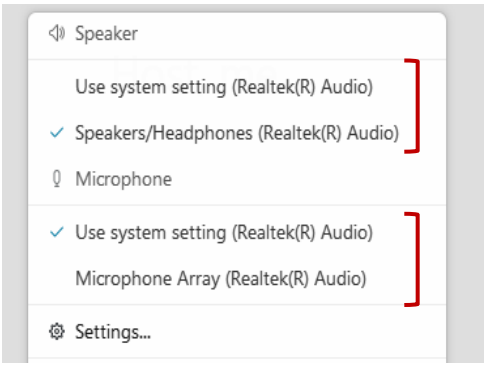
Joined via Telephone (Call-in User)

1. When you are asked to unmute yourself, press *6.
2. When you are finished speaking, press *6 to mute yourself again.

If you cannot hear or be heard

1. Click on the bottom facing arrow located on the Mute/Unmute button at the bottom of the Webex window.

2. From the drop-down menu, select different:
   - Speaker options if you can't hear participants.
   - Microphone options if participants can't hear you.

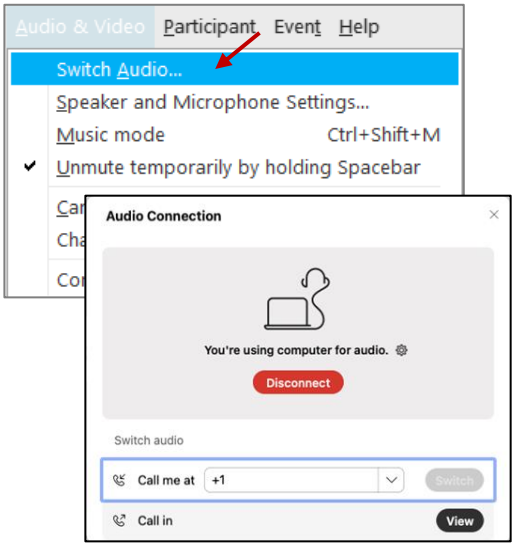


Continue to Experience Issues?

If you are connected by computer or tablet and you have audio issues, you can link your phone to your Webex session. Your phone will then become your microphone and speaker source.

1. Click on "Audio & Video" from the menu bar.

2. Select "Switch Audio" from the drop-down menu.

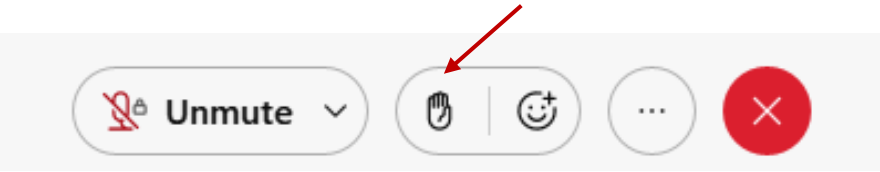


3. Hover your mouse over the "Call In" option and click "View" to show the phone number to call and the meeting login information. You can still un-mute from your computer window.

Hand Raise Feature

Joined via Meeting Link

- Locate the hand icon at the bottom of the Webex window.
- Click the hand icon to raise your hand.
- Repeat this process to lower your hand.



Joined via Telephone (Call-in User)

Press *3 to raise or lower your hand.

Unmuting

Joined via Meeting Link

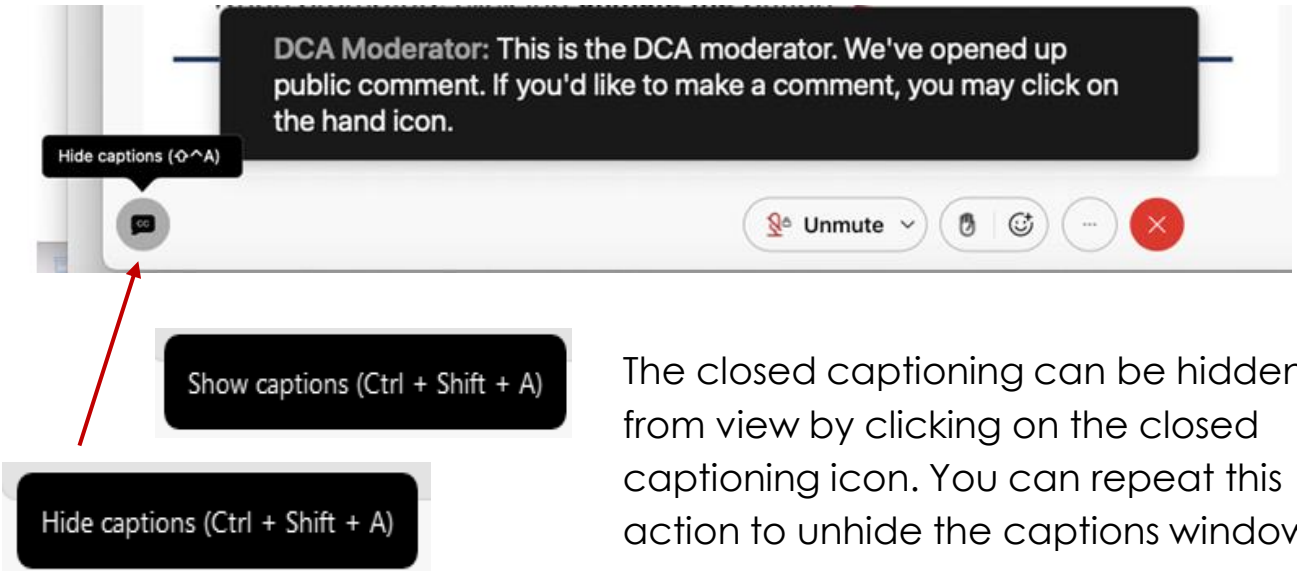
The moderator will call you by name and indicate a request has been sent to unmute your microphone. Upon hearing this prompt:

Click the Unmute me button on the pop-up box that appears.

Joined via Telephone (Call-in User/Audio Only)

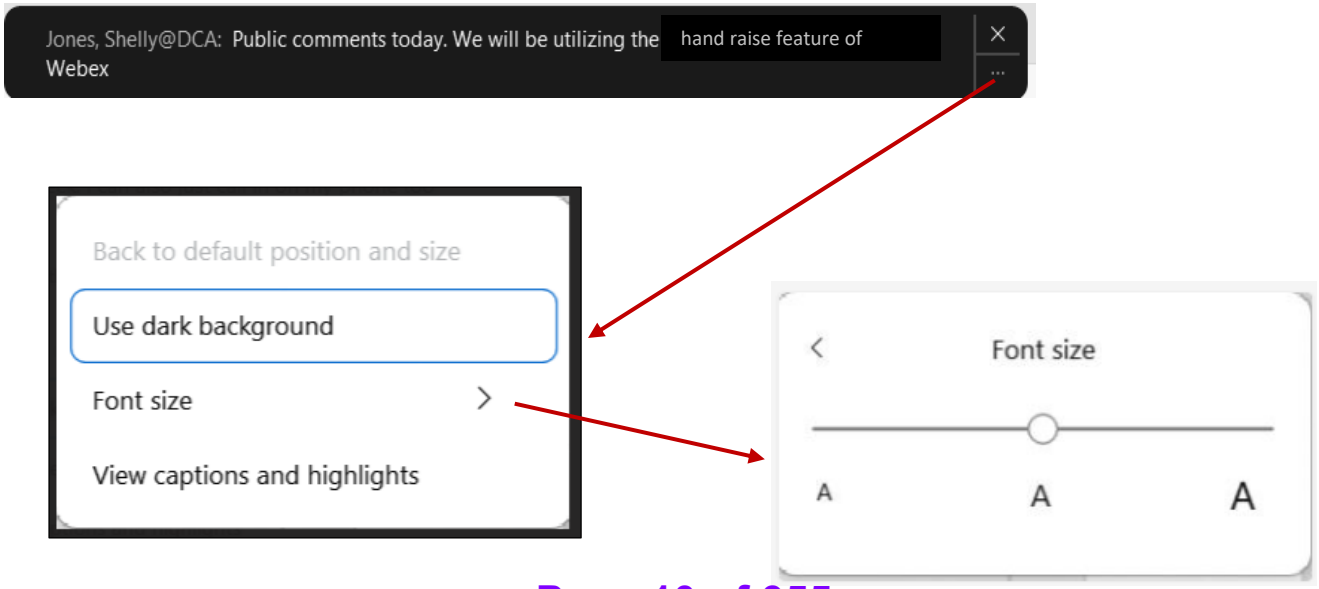
1. When you are asked to unmute yourself, press *6.
2. When you are finished speaking, press *6 to mute yourself again.

Webex provides real-time closed captioning displayed in a dialog box in your Webex window. The captioning box can be moved by clicking on the box and dragging it to another location on your screen.



The closed captioning can be hidden from view by clicking on the closed captioning icon. You can repeat this action to unhide the captions window.

You can view the closed captioning dialog box with a light or dark background or change the font size by clicking the 3 dots on the right side of the dialog box.



DHBC
Dental Hygiene
Board of California

Member	Present	Absent
Julie Elginer		
Sonia “Pat” Hansen		
Sherman King		
Michael Long		
Justin Matthews		
Joanne Pacheco		
Sridevi Ponnala		
Naleni “Lolly” Tribble-Agarwal		

Tuesday, May 27, 2025

Dental Hygiene Board of California

Agenda Item 1.

Roll Call & Establishment of Quorum.

Board Secretary to call the Roll.

Tuesday, May 27, 2025

Dental Hygiene Board of California

Agenda Item 2.

Public Comment for Items Not on the Agenda.

[The Board may not discuss or act on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code Sections 11125 & 11125.7(a).]

DHBC
Dental Hygiene
Board of California

Tuesday, May 27, 2025

Dental Hygiene Board of California

Agenda Item 3.

Discussion and Possible Action on October or November 2025 Board Meeting Dates.

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS
BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
DENTAL HYGIENE BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1350 Sacramento, CA 95815
P (916) 263-1978 | F (916) 623-4093 | www.dhbc.ca.gov

MEMORANDUM

DATE	May 27, 2025
TO	Dental Hygiene Board of California
FROM	Anthony Lum Executive Officer
SUBJECT	**FULL 3: Discussion and Possible Action on New November 2025 Meeting Dates.**

Staff has researched and reviewed the following proposed meeting dates for November 2025 due to several board member schedule conflicts with the currently scheduled November 14-15, 2025, meeting dates as stated at the March 22, 2025, meeting.

These dates plan for 2-day meetings should issues arise for committee(s) to act upon. If there is no need for any Committee action and information for committees will be staff updates only that can be shared with the Board, the date will be reduced to a single 1-day Board meeting to conserve resources. Please review your calendars for any potential date conflicts and discuss with the Board. Staff present the following proposed meeting dates to the Board for approval.

2025

Friday, November 7, 2025 - Saturday, November 8, 2025
Friday, November 21, 2025 - Saturday, November 22, 2025

DHBC
Dental Hygiene
Board of California

Tuesday, May 27, 2025

Dental Hygiene Board of California

Agenda Item 4.

Legislative Update: Bills of Interest and Legislative Calendar:

a) **Assembly Bill (AB) 224 Bonta: Health care coverage: essential health benefits.**
b) **AB 341 Arambula: Oral Health for People with Disabilities Technical Assistance Center Program.**
c) **AB 350 Bonta: Health care coverage: fluoride treatments.**
d) **AB 371 Haney: Dental coverage.**
e) **AB 489 Bonta: Health care professions: deceptive terms or letters: artificial intelligence.**
f) **AB 742 Elhawary: Department of Consumer Affairs: licensing: applicants who are descendants of slaves.**
g) **AB 873 Alanis: Dentistry: dental assistants: infection control course.**
h) **AB 966 Carrillo: Dental Practice Act: foreign dental schools.**
i) **AB 980 Arambula: Health care: medically necessary treatment.**
j) **AB 1307 Ávila Farías: Licensed Dentists from Mexico Pilot Program.**
k) **AB 1418 Schiavo: Department of Health Care Access and Information.**
l) **Senate Bill (SB) 62 Menjivar: Health care coverage: essential health benefits.**
m) **SB 351 Cabaldon: Health Facilities.**
n) **SB 386 Limón: Dental providers: fee-based payments.**
o) **SB 470 Laird: Bagley-Keene Open Meeting Act: teleconferencing.**
p) **SB 861 Committee on Business, Professions and Economic Development: Committee on Business, Professions and Economic Development. Consumer affairs (Omnibus Bill).**

MEMORANDUM

DATE	May 27, 2025
TO	Legislation and Regulatory Committee Dental Hygiene Board of California
FROM	Adina A. Pineschi-Petty DDS Education, Legislative, and Regulatory Specialist
SUBJECT	**FULL 4: Update on Current Legislation as of May 16, 2025**

2025 Legislation	Topic	Status	DHBC Position On 3.22.25
AB 224 Bonta	**Health care coverage: essential health benefits.** Current law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Current law requires a health care service plan contract or health insurance policy to cover the same health benefits that the benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan, offered during the first quarter of 2014, as specified. This bill would express the intent of the Legislature to review California's essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year. The bill would require, commencing January 1, 2027, if the United States Department of Health and Human Services approves a new essential health benefits benchmark plan for the state, as specified, the benchmark plan identified above to include certain additional benefits, including coverage for specified fertility services and specified durable medical equipment. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program.	5.14.25 Assembly Appropriations Suspense File	Watch.

2025 Legislation	Topic	Status	DHBC Position On 3.22.25
AB 341 Arambula	**Oral Health for People with Disabilities Technical Assistance Center Program.** This bill would require the State Department of Developmental Services, no later than July 1, 2027, to contract with a public California dental school or college to administer the Oral Health for People with Disabilities Technical Assistance Center Program to improve dental care services for people with developmental and intellectual disabilities by reducing or eliminating the need for dental treatment using sedation and general anesthesia. The bill would authorize the contracted California dental school or college to partner with a public dental school or college and would require the schools to meet certain criteria relating to location, accreditation, and a demonstrated record of working with regional centers.	5.14.25 Assembly Appropriations Suspense File	Watch.
AB 350 Bonta	**Health care coverage: fluoride treatments.** Under current law, silver diamine fluoride treatments are a covered benefit for eligible children 0 to 6 years of age, inclusive, as specified, and application of fluoride or other appropriate fluoride treatment is covered for children 17 years of age and under. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to provide coverage for the application of fluoride varnish in the primary care setting for children under 21 years of age.	5.7.25 Assembly Appropriations Suspense File	Support.
AB 371 Haney	**Dental coverage.** This bill would require the plan or insurer to pay a noncontracting dental provider directly for covered services if the noncontracting provider submits to the plan or insurer a written assignment of benefits form signed by the enrollee or insured. The bill would require the plan or insurer to provide a predetermination or prior authorization to the dental provider and to reimburse the provider for not less than that amount, except as specified. The bill would require the plan or insurer to notify the enrollee or	5.14.25 Assembly Appropriations Suspense File	Watch.

2025 Legislation	Topic	Status	DHBC Position On 3.22.25
	insured that the provider was paid and that the out-of-network cost may count towards their annual or lifetime maximum.		
AB 489 Bonta	**Health care professions: deceptive terms or letters: artificial intelligence.** Current law provides that a violation of these provisions by a physician shall be subject to the jurisdiction of the Medical Board of California or the Osteopathic Medical Board of California, as appropriate. 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 (AI) or generative artificial intelligence (GenAI) 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 or GenAI technology of certain terms, letters, or phrases that indicate or imply that the advice or care advice, care, reports, or assessments being provided through AI or GenAI is being provided by a natural person with the appropriated health care license or certificate.	5.7.25 Assembly Appropriations Suspense File	Watch.
AB 742 Elhawary	**Department of Consumer Affairs: licensing: applicants who are descendants of slaves.** Current law establishes the Department of Consumer Affairs, which is composed of specified boards that license and regulate various professions. This bill would require those boards to prioritize applicants seeking licensure who are descendants of American slaves once a process to certify descendants of American slaves is established, as specified. 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	5.7.25 Assembly Appropriations Suspense File	New Staff suggests watch.

2025 Legislation	Topic	Status	DHBC Position On 3.22.25
	Regular Session is enacted establishing the Bureau for Descendants of American Slavery.		
AB 873 Alanis	**Dentistry: dental assistants: infection control course.** Current law authorizes the Dental Board of California to review and evaluate all applications for licensure in all dental assisting categories to ascertain whether a candidate meets the appropriate licensing requirements specified by statute and board regulation. Current law establishes the Dental Assisting Council within the Dental Board of California and requires the council to consider all matters relating to dental assistants in the state, as specified, and to make appropriate recommendations to the board and the standing committees of the board in specified areas, including standards and criteria for approval of dental assisting educational programs, courses, and continuing education. Current law requires the board to approve, modify, or reject recommendations by the council within 120 days of submission to the board during full board business. Current law requires that fees relating to the licensing and permitting of dental assistants be established by regulation, subject to certain limitations prescribed by statute. This bill would require that the fee for review of each approval application or reevaluation for a course for instruction in interim therapeutic restoration and radiographic decisionmaking, radiation safety, or infection control that is not accredited by a board-approved agency or the Chancellor's office of the California Community Colleges not exceed $300, and would make conforming changes	4.23.25 Assembly Appropriations Suspense File	Oppose.
AB 966 Carrillo	**Dental Practice Act: foreign dental schools.** Beginning January 1, 2024, existing law requires foreign dental schools seeking approval by the board to complete the international consultative and accreditation process with CODA. Notwithstanding that requirement, existing law maintained the approval of any foreign dental schools whose program was renewed by the board prior to January 1, 2020,	4.8.25 Assembly Business and Professions Committee.	Watch.

2025 Legislation	Topic	Status	DHBC Position On 3.22.25
	through any date between January 1, 2024, and June 30, 2026, through that renewal date. This bill would instead maintain the approval of any foreign dental school whose program was approved by the board prior to January 1, 2024, until the school has been issued a denial of accreditation by CODA and the school does not appeal, the school has been issued a denial by CODA following the completion of the appeals process, or the school withdraws its application for accreditation by CODA, provided the school applies for accreditation on or before January 1, 2026, and updates the board on the accreditation process, as specified. The bill would specify that a graduate of a foreign dental school with this extended approval is eligible for licensure to practice dentistry pursuant to the requirements of the Dental Practice Act, including graduates who were enrolled in the school at the time the extended approval expires, provided they were enrolled on or after July 1, 2025.		
AB 980 Arambula	**Health care: medically necessary treatment.** This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to provide coverage for medically necessary treatment of physical conditions and diseases under the same terms and conditions applied to other medical conditions, as specified. The bill would require the delivery of medically necessary services out of network if those services are not available within geographic and timely access standards. The bill would require a plan or insurer to apply specified clinical criteria and guidelines in conducting utilization review of the covered health care services and benefits for physical conditions and diseases. The bill would authorize the Director of the Department of Managed Health Care or the Insurance Commissioner, as applicable, to assess administrative or civil penalties, as specified, for violation of the requirements relating to utilization review.	4.22.25 Assembly Health	New Staff suggests watch.

2025 Legislation	Topic	Status	DHBC Position On 3.22.25
AB 1307 Ávila Farías	**Licensed Dentists from Mexico Pilot Program.** The Licensed Dentists from Mexico Pilot Program requires the Dental Board of California to issue 3-year nonrenewable permits to practice dentistry to dentists from Mexico who meet specified criteria. This bill would repeal those provisions and replace them with a new Licensed Dentists from Mexico Pilot Program. Under that new program, the bill would require the board to issue a 3-year nonrenewable license to practice dentistry to an applicant that meets specified criteria and require participants in the program to comply with specified requirements. The bill would authorize participants to be employed only by federally qualified health centers that meet specified conditions and would impose requirements on those centers.	4.23.25 Assembly Appropriations Suspense File	New Staff suggests watch.
AB 1418 Schiavo	**Department of Health Care Access and Information.** Current law requires the Department of Health Care Access and Information to establish a health care workforce research and data center to serve as the central source of health care workforce and educational data in the state. Current law requires the department to prepare an annual report to the Legislature that, among other things, identifies education and employment trends in the health care profession and describes the health care workforce program outcomes and effectiveness. This bill would additionally require the department's report to include health care coverage trends for employees subject to waiting periods before receiving employer-sponsored health care coverage, and provide recommendations for state policy necessary to address gaps in health care coverage for those same employees.	4.23.25 Assembly Appropriations Suspense File	New Staff suggests watch.
SB 62 Menjivar	**Health care coverage: essential health benefits.** Current law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage	5.12.25 Senate Appropriations Suspense File	Watch.

2025 Legislation	Topic	Status	DHBC Position On 3.22.25
	for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Current law requires a health care service plan contract or health insurance policy to cover the same health benefits that the benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan, offered during the first quarter of 2014, as specified. This bill would express the intent of the Legislature to review California's essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year. The bill would require, commencing January 1, 2027, if the United States Department of Health and Human Services approves a new essential health benefits benchmark plan for the state, as specified, the benchmark plan to include certain additional benefits, including coverage for specified fertility services and specified durable medical equipment. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program.		
SB 351 Cabaldon	**Health Facilities.** This bill would prohibit a private equity group or hedge fund, as defined, involved in any manner with a physician or dental practice doing business in this state from interfering with the professional judgment of physicians or dentists in making health care decisions and exercising power over specified actions, including, among other things, making decisions regarding coding and billing procedures for patient care services. The bill would prohibit a private equity group or hedge fund from entering into an agreement or arrangement with a physician or dental practice if the agreement or arrangement would enable the person or entity to engage in the prohibited actions described above. The bill would render void and unenforceable specified types of contracts between a physician or dental practice and a private equity group or hedge fund that explicitly or implicitly include any clause barring any provider in that practice from competing with that practice in the event of a termination or resignation, or from disparaging, opining, or commenting on that practice in any	5.12.25 Senate Appropriations Suspense File	Watch.

2025 Legislation	Topic	Status	DHBC Position On 3.22.25
	manner as to any issues involving quality of care, utilization of care, ethical or professional challenges in the practice of medicine or dentistry, or revenue-increasing strategies employed by the private equity group or hedge fund, as specified.		
SB 386 Limón	**Dental providers: fee-based payments.** Would require a health care service plan contract or health insurance policy, as defined, issued, amended, or renewed on and after April 1, 2026, that provides payment directly or through a contracted vendor to a dental provider to have a non-fee-based default method of payment, as specified. The bill, beginning April 1, 2026, would require a health care service plan, health insurer, or contracted vendor to obtain affirmative consent from a dental provider who opts in to a fee-based payment method before the plan or vendor provides a fee-based payment method to the provider. The bill would authorize a dental provider to opt out of a fee-based payment method at any time by providing affirmative consent to the health care service plan, health insurer, or contracted vendor. The bill would require a health care service plan, health insurer, or contracted vendor that obtains affirmative consent to opt in or opt out of fee-based payment to apply the decision to include both the dental provider's entire practice and all products or services covered pursuant to a contract with the dental provider, as specified. The bill would specify that its provisions do not apply if a health care service plan or health insurer has a direct contract with a provider that allows the provider to choose payment methods, including a non-fee-based payment method for services rendered.	4.22.25 Senate Appropriations	New Staff suggests watch.
SB 470 Laird	**Bagley-Keene Open Meeting Act: teleconferencing.** Existing law, the Bagley-Keene Open Meeting Act (Bagley-Keene), authorizes meetings through teleconference subject to specified requirements. This	4.29.25 Senate Appropriations .	New Staff suggests support.

2025 Legislation	Topic	Status	DHBC Position On 3.22.25
	bill extends the January 1, 2026, repeal date for certain provisions in Bagley-Keene until January 1, 2030, authorizing and specifying conditions under which a state body may hold a meeting by teleconference, as specified. AB 470, as currently written, will make the current provisions available until January 1, 2030, allowing the Board to continue with their current processes. With this, the Board may continue to achieve savings and efficiencies by holding board meetings online.		
SB 861 Committee on Business, Professions and Economic Development	**Committee on Business, Professions and Economic Development. Consumer affairs (Omnibus Bill).** Existing law establishes the Dental Hygiene Board of California to license and regulate dental hygienists. Chapter 858 of the Statutes of 2018 created the board out of the former Dental Hygiene Committee of California, as specified. Existing law requires the dental hygiene board to make recommendations to the Dental Board of California regarding dental hygiene scope of practice issues. Existing law also requires the Dental Hygiene Board of California to establish the amount of fees relating to the licensing of dental hygienists and imposes limitations on those fees, including prohibiting the application fee for an original license and the fee for issuance of an original license from exceeding $250. This bill would remove the requirement for the dental hygiene board to make recommendations to the Dental Board of California, as described above. The bill would instead prohibit an application fee from exceeding $100 and an initial licensure fee from exceeding $150. The bill would make technical changes to the provisions regulating dental hygienists by, among other things, correcting references to the dental hygiene board and deleting an obsolete provision affecting the expiration of terms for members of the former Dental Hygiene Committee of California.	5.14.25 Senate Appropriations	New Staff suggests support.

2025 TENTATIVE LEGISLATIVE CALENDAR

COMPILED BY THE OFFICE OF THE SECRETARY OF THE SENATE AND THE OFFICE OF THE ASSEMBLY CHIEF CLERK

Revised October 16, 2024

JANUARY						
S	M	T	W	TH	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

FEBRUARY						
S	M	T	W	TH	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

MARCH						
S	M	T	W	TH	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

APRIL						
S	M	T	W	TH	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

MAY						
S	M	T	W	TH	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

DEADLINES

Jan. 1 Statutes take effect (Art. IV, Sec. 8(c)).

Jan. 6 Legislature Reconvenes (J.R. 51(a)(1)).

Jan. 10 Budget must be submitted by Governor (Art. IV, Sec. 12(a)).

Jan. 20 Martin Luther King, Jr. Day.

Jan. 24 Last day to submit **bill requests** to the Office of Legislative Counsel.

Feb. 17 Presidents' Day.

Feb. 21 Last day for bills to be **introduced** (J.R. 61(a)(1), (J.R. 54(a)).

Mar. 31 Cesar Chavez Day

Apr. 10 **Spring Recess** begins upon adjournment of this day's session (J.R. 51(a)(2)).

Apr. 21 Legislature reconvenes from **Spring Recess** (J.R. 51(a)(2)).

May 2 Last day for **policy committees** to hear and report to **fiscal committees** fiscal bills introduced in their house (J.R. 61(a)(2)).

May 9 Last day for **policy committees** to hear and report to the Floor **nonfiscal** bills introduced in their house (J.R. 61(a)(3)).

May 16 Last day for **policy committees** to meet prior to June 9 (J.R. 61(a)(4)).

May 23 Last day for **fiscal committees** to hear and report to the Floor bills introduced in their house (J.R. 61(a)(5)). Last day for **fiscal committees** to meet prior to June 9 (J.R. 61 (a)(6)).

May 26 Memorial Day.

*Holiday schedule subject to Senate Rules committee approval.

2025 TENTATIVE LEGISLATIVE CALENDAR

COMPILED BY THE OFFICE OF THE SECRETARY OF THE SENATE AND THE OFFICE OF THE ASSEMBLY CHIEF CLERK

Revised October 16, 2024

JUNE						
S	M	T	W	TH	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

June 2 - 6 Floor Session Only. No committees, other than conference or Rules committees, may meet for any purpose (J.R. 61(a)(7)).

June 6 Last day for each house to pass bills introduced in that house (J.R. 61(a)(8)).

June 9 Committee meetings may resume (J.R. 61(a)(9)).

June 15 **Budget Bill** must be **passed** by **midnight** (Art. IV, Sec. 12(c)(3)).

JULY						
S	M	T	W	TH	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

July 4 Independence Day.

July 18 Last day for **policy committees** to meet and report bills (J.R. 61(a)(10)). **Summer Recess** begins upon adjournment of session provided Budget Bill has been passed (J.R. 51(a)(3)).

AUGUST						
S	M	T	W	TH	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

Aug. 18 Legislature reconvenes from **Summer Recess** (J.R. 51(a)(3)).

Aug. 29 Last day for **fiscal committees** to meet and report bills to the Floor. (J.R. 61(a)(11)).

SEPTEMBER						
S	M	T	W	TH	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

Sept. 1 Labor Day.

Sept. 2-12 Floor Session Only. No committees, other than conference or Rules committees, may meet for any purpose (J.R. 61(a)(12)).

Sept. 5 Last day to **amend** on the Floor (J.R. 61(a)(13)).

Sept. 12 Last day for **each house to pass bills** (J.R. 61(a)(14)).
Interim Study Recess begins at end of this day's session (J.R. 51(a)(4)).

*****Holiday schedule subject to Senate Rules committee approval.

IMPORTANT DATES OCCURRING DURING INTERIM STUDY RECESS

2025

Oct. 12 Last day for Governor to sign or veto bills passed by the Legislature on or before Sept. 12 and in the Governor's possession after Sept. 12 (Art. IV, Sec.10(b)(1)).

2026

Jan. 1 Statutes take effect (Art. IV, Sec. 8(c)).

Jan. 5 Legislature reconvenes (J.R. 51(a)(4)).

AMENDED IN ASSEMBLY APRIL 23, 2025

CALIFORNIA LEGISLATURE—2025–26 REGULAR SESSION

ASSEMBLY BILL No. 224

Introduced by Assembly Member Bonta

January 9, 2025

An act to amend Section 1367.005 of the Health and Safety Code, and to amend Section 10112.27 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 224, as amended, Bonta. Health care coverage: essential health benefits.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service ~~plans.~~ *plans and makes a willful violation of the act a crime.* Existing law requires the Department of Insurance to regulate health insurers. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Existing law requires a health care service plan contract or health insurance policy to cover the same health benefits that the benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan, offered during the first quarter of 2014, as specified.

This bill would express the intent of the Legislature to review California's essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year. ~~The bill would limit the applicability of the current benchmark plan benefits to plan years on or~~

~~before the 2027 plan year.~~ *The bill would require, commencing January 1, 2027, if the United States Department of Health and Human Services approves a new essential health benefits benchmark plan for the state, as specified, the benchmark plan identified above to include certain additional benefits, including coverage for specified fertility services and specified durable medical equipment. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program.*

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: ~~no~~ *yes*.

The people of the State of California do enact as follows:

SECTION 1. It is the intent of the Legislature to review California's essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year.

SEC. 2. Section 1367.005 of the Health and Safety Code is amended to read:

1367.005. (a) An individual or small group health care service plan contract issued, amended, or renewed on or after January 1, 2017, shall include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act (PPACA) and as outlined in this section. For purposes of this section, "essential health benefits" means all of the following:

(1) Health benefits within the categories identified in Section 1302(b) of PPACA: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

(2) (A) ~~For plan years on or before the 2027 plan year,~~ *The* health benefits covered by the Kaiser Foundation Health Plan Small Group HMO 30 plan (federal health product identification number 40513CA035) as this plan was offered during the first quarter of 2014, as follows, regardless of whether the benefits are specifically referenced in the evidence of coverage or plan contract for that plan:

(i) Medically necessary basic health care services, as defined in subdivision (b) of Section 1345 and Section 1300.67 of Title 28 of the California Code of Regulations.

(ii) The health benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in the following sections: Sections 1367.002, 1367.06, and 1367.35 (preventive services for children); Section 1367.25 (prescription drug coverage for contraceptives); Section 1367.45 (AIDS vaccine); Section 1367.46 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha-fetoprotein testing); Section 1367.6 (breast cancer screening); Section 1367.61 (prosthetics for laryngectomy); Section 1367.62 (maternity hospital stay); Section 1367.63 (reconstructive surgery); Section 1367.635 (mastectomies); Section 1367.64 (prostate cancer); Section 1367.65 (mammography); Section 1367.66 (cervical cancer); Section 1367.665 (cancer screening tests); Section 1367.67 (osteoporosis); Section 1367.68 (surgical procedures for jaw bones); Section 1367.71 (anesthesia for dental); Section 1367.9 (conditions attributable to diethylstilbestrol); Section 1368.2 (hospice care); Section 1370.6 (cancer clinical trials); Section 1371.5 (emergency response ambulance or ambulance transport services); subdivision (b) of Section 1373 (sterilization operations or procedures); Section 1373.4 (inpatient hospital and ambulatory maternity); Section 1374.56 (phenylketonuria); Section 1374.17 (organ transplants for HIV); Section 1374.72 (mental health parity); and Section 1374.73 (autism/behavioral health treatment).

(iii) Any other benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in those statutes.

(iv) The health benefits covered by the plan that are not otherwise required to be covered under this chapter, to the extent required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22,

1367.24, and 1367.25, and Section 1300.67.24 of Title 28 of the California Code of Regulations.

(v) Any other health benefits covered by the plan that are not otherwise required to be covered under this chapter.

(B) If there are any conflicts or omissions in the plan identified in subparagraph (A) as compared with the requirements for health benefits under this chapter that were enacted prior to December 31, 2011, the requirements of this chapter shall be controlling, except as otherwise specified in this section.

(C) Notwithstanding subparagraph (B) or any other provision of this section, the home health services benefits covered under the plan identified in subparagraph (A) shall be deemed to not be in conflict with this chapter.

(D) For purposes of this section, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) shall apply to a contract subject to this section. Coverage of mental health and substance use disorder services pursuant to this paragraph, along with any scope and duration limits imposed on the benefits, shall be in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), and all rules, regulations, or guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

(E) Commencing January 1, 2027, if the United States Department of Health and Human Services approves a new essential health benefits benchmark plan for the State of California pursuant to submissions to the department made on behalf of the state in 2025 for this purpose, the benchmark plan described in subparagraph (A) shall additionally include all of the following benefits:

(i) Services to evaluate, diagnose, and treat infertility that include all of the following:

(I) Artificial insemination.

(II) Three attempts to retrieve gametes.

(III) Three attempts to create embryos.

(IV) Three rounds of pretransfer testing.

(V) Cryopreservation of gametes and embryos.

(VI) Two years of storage for cryopreserved embryos.

(VII) Unlimited storage for cryopreserved gametes.

(VIII) Unlimited embryo transfers.

(IX) Two vials of donor sperm.

(X) Ten donor eggs.

(XI) Surrogacy coverage for the services described above.

(XII) Health testing of the surrogate for each attempted round of covered services.

(ii) All of the following durable medical equipment:

(I) Mobility devices, including, but not limited to, walkers and manual and power wheelchairs and scooters.

(II) Augmented communications devices, including, but not limited to, speech-generating devices, communications boards, and computer applications.

(III) Continuous positive airway pressure machines.

(IV) Portable oxygen.

(V) Hospital beds.

(iii) (I) An annual hearing exam.

(II) One hearing aid per ear every three years.

(3) With respect to habilitative services, in addition to any habilitative services and devices identified in paragraph (2), coverage shall also be provided as required by federal rules, regulations, and guidance issued pursuant to Section 1302(b) of PPACA. Habilitative services and devices shall be covered under the same terms and conditions applied to rehabilitative services and devices under the plan contract. Limits on habilitative and rehabilitative services and devices shall not be combined.

(4) With respect to pediatric vision care, the same health benefits for pediatric vision care covered under the Federal Employees Dental and Vision Insurance Program vision plan with the largest national enrollment as of the first quarter of 2014. The pediatric vision care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any vision services covered under the plan identified in paragraph (2).

(5) With respect to pediatric oral care, the same health benefits for pediatric oral care covered under the dental benefit received by children under the Medi-Cal program as of 2014, including the provision of medically necessary orthodontic care provided pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009. The pediatric oral care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any dental or orthodontic services covered under the plan identified in paragraph (2).

(b) Treatment limitations imposed on health benefits described in this section shall be no greater than the treatment limitations imposed by the corresponding plans identified in subdivision (a), subject to the requirements set forth in paragraph (2) of subdivision (a).

(c) Except as provided in subdivision (d), this section does not permit a health care service plan to make substitutions for the benefits required to be covered under this section, regardless of whether those substitutions are actuarially equivalent.

(d) To the extent permitted under Section 1302 of PPACA and any rules, regulations, or guidance issued pursuant to that section, and to the extent that substitution would not create an obligation for the state to defray costs for any individual, a plan may substitute its prescription drug formulary for the formulary provided under the plan identified in subdivision (a) if the coverage for prescription drugs complies with the sections referenced in clauses (ii) and (iv) of subparagraph (A) of paragraph (2) of subdivision (a) that apply to prescription drugs.

(e) A health care service plan, or its agent, solicitor, or representative, shall not issue, deliver, renew, offer, market, represent, or sell any product, contract, or discount arrangement as compliant with the essential health benefits requirement in federal law, unless it meets all of the requirements of this section.

(f) This section applies regardless of whether the plan contract is offered inside or outside the California Health Benefit Exchange created by Section 100500 of the Government Code.

(g) This section does not exempt a plan or a plan contract from meeting other applicable requirements of law.

(h) This section does not prohibit a plan contract from covering additional benefits, including, but not limited to, spiritual care services that are tax deductible under Section 213 of the Internal Revenue Code.

(i) Subdivision (a) does not apply to any of the following:

(1) A specialized health care service plan contract.

(2) A Medicare supplement plan.

(3) A plan contract that qualifies as a grandfathered health plan under Section 1251 of PPACA or any rules, regulations, or guidance issued pursuant to that section.

(j) This section shall not be implemented in a manner that conflicts with a requirement of PPACA.

(k) An essential health benefit is required to be provided under this section only to the extent that federal law does not require the state to defray the costs of the benefit.

(*l*) This section does not obligate the state to incur costs for the coverage of benefits that are not essential health benefits as defined in this section.

(m) A plan is not required to cover, under this section, changes to health benefits that are the result of statutes enacted on or after December 31, 2011.

(n) (1) The department may adopt emergency regulations implementing this section. The department may, on a one-time basis, readopt any emergency regulation authorized by this section that is the same as, or substantially equivalent to, an emergency regulation previously adopted under this section.

(2) The initial adoption of emergency regulations implementing this section and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(3) The initial adoption of emergency regulations implementing this section made during the 2015–16 Regular Session of the Legislature and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(4) The director shall consult with the Insurance Commissioner to ensure consistency and uniformity in the development of regulations under this subdivision.

(5) This subdivision shall become inoperative on July 1, 2018.

(o) For purposes of this section, the following definitions apply:

(1) "Habilitative services" means health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings, or both. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the plan contract.

(2) (A) "Health benefits," unless otherwise required to be defined pursuant to federal rules, regulations, or guidance issued pursuant to Section 1302(b) of PPACA, means health care items or services for the diagnosis, cure, mitigation, treatment, or prevention of illness, injury, disease, or a health condition, including a behavioral health condition.

(B) "Health benefits" does not mean any cost-sharing requirements such as copayments, coinsurance, or deductibles.

(3) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(4) "Small group health care service plan contract" means a group health care service plan contract issued to a small employer, as defined in Section 1357.500.

SEC. 3. Section 10112.27 of the Insurance Code is amended to read:

10112.27. (a) An individual or small group health insurance policy issued, amended, or renewed on or after January 1, 2017, shall include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act (PPACA) and as outlined in this section. This section shall exclusively govern the benefits a health insurer must cover as essential health benefits. For purposes of this section, "essential health benefits" means all of the following:

(1) Health benefits within the categories identified in Section 1302(b) of PPACA: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services

and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

(2) (A) ~~For plan years on or before the 2027 plan year,~~ *The* health benefits covered by the Kaiser Foundation Health Plan Small Group HMO 30 plan (federal health product identification number 40513CA035) as this plan was offered during the first quarter of 2014, as follows, regardless of whether the benefits are specifically referenced in the plan contract or evidence of coverage for that plan:

(i) Medically necessary basic health care services, as defined in subdivision (b) of Section 1345 of the Health and Safety Code and Section 1300.67 of Title 28 of the California Code of Regulations.

(ii) The health benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in the following sections of the Health and Safety Code: Sections 1367.002, 1367.06, and 1367.35 (preventive services for children); Section 1367.25 (prescription drug coverage for contraceptives); Section 1367.45 (AIDS vaccine); Section 1367.46 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha-fetoprotein testing); Section 1367.6 (breast cancer screening); Section 1367.61 (prosthetics for laryngectomy); Section 1367.62 (maternity hospital stay); Section 1367.63 (reconstructive surgery); Section 1367.635 (mastectomies); Section 1367.64 (prostate cancer); Section 1367.65 (mammography); Section 1367.66 (cervical cancer); Section 1367.665 (cancer screening tests); Section 1367.67 (osteoporosis); Section 1367.68 (surgical procedures for jaw bones); Section 1367.71 (anesthesia for dental); Section 1367.9 (conditions attributable to diethylstilbestrol); Section 1368.2 (hospice care); Section 1370.6 (cancer clinical trials); Section 1371.5 (emergency response ambulance or ambulance transport services); subdivision (b) of Section 1373 (sterilization operations or procedures); Section 1373.4 (inpatient hospital and ambulatory maternity); Section 1374.56 (phenylketonuria); Section 1374.17 (organ transplants for HIV); Section 1374.72 (mental health parity); and Section 1374.73 (autism/behavioral health treatment).

(iii) Any other benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in those statutes.

(iv) The health benefits covered by the plan that are not otherwise required to be covered under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, to the extent otherwise required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22, 1367.24, and 1367.25 of the Health and Safety Code, and Section 1300.67.24 of Title 28 of the California Code of Regulations.

(v) Any other health benefits covered by the plan that are not otherwise required to be covered under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(B) If there are any conflicts or omissions in the plan identified in subparagraph (A) as compared with the requirements for health benefits under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code that were enacted before December 31, 2011, the requirements of Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code shall control, except as otherwise specified in this section.

(C) Notwithstanding subparagraph (B) or any other provision of this section, the home health services benefits covered under the plan identified in subparagraph (A) shall not be in conflict with Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(D) For purposes of this section, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) shall apply to a policy subject to this section. Coverage of mental health and substance use disorder services pursuant to this paragraph, along with any scope and duration limits imposed on the benefits, shall be in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

(E) Commencing January 1, 2027, if the United States Department of Health and Human Services approves a new essential health benefits benchmark plan for the State of California pursuant to submissions to the department made on behalf of the state in 2025 for this purpose, the benchmark plan described in

subparagraph (A) shall additionally include all of the following benefits:

(i) Services to evaluate, diagnose, and treat infertility that include all of the following:

(I) Artificial insemination.

(II) Three attempts to retrieve gametes.

(III) Three attempts to create embryos.

(IV) Three rounds of pretransfer testing.

(V) Cryopreservation of gametes and embryos.

(VI) Two years of storage for cryopreserved embryos.

(VII) Unlimited storage for cryopreserved gametes.

(VIII) Unlimited embryo transfers.

(IX) Two vials of donor sperm.

(X) Ten donor eggs.

(XI) Surrogacy coverage for the services described above.

(XII) Health testing of the surrogate for each attempted round of covered services.

(ii) All of the following durable medical equipment:

(I) Mobility devices, including, but not limited to, walkers and manual and power wheelchairs and scooters.

(II) Augmented communications devices, including, but not limited to, speech-generating devices, communications boards, and computer applications.

(III) Continuous positive airway pressure machines.

(IV) Portable oxygen.

(V) Hospital beds.

(iii) (I) An annual hearing exam.

(II) One hearing aid per ear every three years.

(3) With respect to habilitative services, in addition to any habilitative services and devices identified in paragraph (2), coverage shall also be provided as required by federal rules, regulations, or guidance issued pursuant to Section 1302(b) of PPACA. Habilitative services and devices shall be covered under the same terms and conditions applied to rehabilitative services and devices under the policy. Limits on habilitative and rehabilitative services and devices shall not be combined.

(4) With respect to pediatric vision care, the same health benefits for pediatric vision care covered under the Federal Employees Dental and Vision Insurance Program vision plan with the largest national enrollment as of the first quarter of 2014. The pediatric

vision care services covered pursuant to this paragraph shall be in addition to, and shall not replace, any vision services covered under the plan identified in paragraph (2).

(5) With respect to pediatric oral care, the same health benefits for pediatric oral care covered under the dental benefit received by children under the Medi-Cal program as of 2014, including the provision of medically necessary orthodontic care provided pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009. The pediatric oral care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any dental or orthodontic services covered under the plan identified in paragraph (2).

(b) Treatment limitations imposed on health benefits described in this section shall be no greater than the treatment limitations imposed by the corresponding plans identified in subdivision (a), subject to the requirements set forth in paragraph (2) of subdivision (a).

(c) Except as provided in subdivision (d), this section does not permit a health insurer to make substitutions for the benefits required to be covered under this section, regardless of whether those substitutions are actuarially equivalent.

(d) To the extent permitted under Section 1302 of PPACA and any rules, regulations, or guidance issued pursuant to that section, and to the extent that substitution would not create an obligation for the state to defray costs for any individual, an insurer may substitute its prescription drug formulary for the formulary provided under the plan identified in subdivision (a) if the coverage for prescription drugs complies with the sections referenced in clauses (ii) and (iv) of subparagraph (A) of paragraph (2) of subdivision (a) that apply to prescription drugs.

(e) A health insurer, or its agent, producer, or representative, shall not issue, deliver, renew, offer, market, represent, or sell any product, policy, or discount arrangement as compliant with the essential health benefits requirement in federal law, unless it meets all of the requirements of this section. This subdivision shall be enforced in the same manner as Section 790.03, including through the means specified in Sections 790.035 and 790.05.

(f) This section applies regardless of whether the policy is offered inside or outside the California Health Benefit Exchange created by Section 100500 of the Government Code.

(g) This section does not exempt a health insurer or a health insurance policy from meeting other applicable requirements of law.

(h) This section does not prohibit a policy from covering additional benefits, including, but not limited to, spiritual care services that are tax deductible under Section 213 of the Internal Revenue Code.

(i) Subdivision (a) does not apply to any of the following:

(1) A policy that provides excepted benefits as described in Sections 2722 and 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91).

(2) A policy that qualifies as a grandfathered health plan under Section 1251 of PPACA or any binding rules, regulations, or guidance issued pursuant to that section.

(j) This section shall not be implemented in a manner that conflicts with a requirement of PPACA.

(k) An essential health benefit is required to be provided under this section only to the extent that federal law does not require the state to defray the costs of the benefit.

(*l*) This section does not obligate the state to incur costs for the coverage of benefits that are not essential health benefits as defined in this section.

(m) An insurer is not required to cover, under this section, changes to health benefits that are the result of statutes enacted on or after December 31, 2011.

(n) (1) The commissioner may adopt emergency regulations implementing this section. The commissioner, on a one-time basis, may readopt any emergency regulation authorized by this section that is the same as, or substantially equivalent to, an emergency regulation previously adopted under this section.

(2) The initial adoption of emergency regulations implementing this section and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(3) The initial adoption of emergency regulations implementing this section made during the 2015–16 Regular Session of the Legislature and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(4) The commissioner shall consult with the Director of the Department of Managed Health Care to ensure consistency and uniformity in the development of regulations under this subdivision.

(5) This subdivision shall become inoperative on July 1, 2018.

(o) This section does not impose on health insurance policies the cost sharing or network limitations of the plans identified in subdivision (a) except to the extent otherwise required to comply with this code, including this section, and as otherwise applicable to all health insurance policies offered to individuals and small groups.

(p) For purposes of this section, the following definitions apply:

(1) "Habilitative services" means health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings, or both. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the policy.

(2) (A) "Health benefits," unless otherwise required to be defined pursuant to federal rules, regulations, or guidance issued pursuant to Section 1302(b) of PPACA, means health care items or services for the diagnosis, cure, mitigation, treatment, or prevention of illness, injury, disease, or a health condition, including a behavioral health condition.

(B) "Health benefits" does not mean any cost-sharing requirements such as copayments, coinsurance, or deductibles.

(3) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(4) "Small group health insurance policy" means a group health insurance policy issued to a small employer, as defined in subdivision (q) of Section 10753.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O

Date of Hearing: April 29, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 224 (Bonta) – As Amended April 23, 2025

SUBJECT: Health care coverage: essential health benefits.

SUMMARY: Requires, beginning January 1, 2027, if the United States Department of Health and Human Services (HHS) approves a new essential health benefits (EHBs) benchmark plan for the State of California (state) pursuant to the submission by the state, the existing EHB benchmark plan to additionally include coverage for hearing aids, durable medical equipment (DME), and infertility benefits, as specified. Specifically, **this bill**:

1) Requires, beginning January 1, 2027, if HHS approves a new EHB benchmark plan for the state pursuant to submissions to HHS made by the state in 2025 for this purpose, the existing EHB benchmark plan to additionally include the following benefits:

    a) Services to evaluate, diagnose, and treat infertility that include all of the following:

        i) Artificial insemination;

        ii) Three attempts to retrieve gametes;

        iii) Three attempts to create embryos;

        iv) Three rounds of pre-transfer testing;

        v) Cryopreservation of gametes and embryos;

        vi) Two years of storage for cryopreserved embryos;

        vii) Unlimited storage for cryopreserved gametes;

        viii) Unlimited embryo transfers;

        ix) Two vials of donor sperm;

        x) Ten donor eggs;

        xi) Surrogacy coverage for the services described above; and,

        xii) Health testing of the surrogate for each attempted round of covered services.

    b) All of the following DME:

        i) Mobility devices, including, but not limited to, walkers and manual and power wheelchairs and scooters;

        ii) Augmented communications devices, including, but not limited to, speech generating devices, communications boards, and computer applications;

iii) Continuous positive airway pressure machines;

iv) Portable oxygen; and,

v) Hospital beds.

c) An annual hearing exam and one hearing aid per ear every three years.

EXISTING LAW:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 and the California Department of Insurance (CDI) to regulate health insurers. [Health and Safety Code (HSC) § 1340, *et seq*., and Insurance Code (INS) § 106, *et seq*.]

2) Establishes California's EHB benchmark under the federal Patient Protection and Affordable Care Act (ACA) as the Kaiser Small Group Health Maintenance Organization contract. Establishes existing California health insurance mandates and the 10 ACA mandated benefits. [HSC § 1367.005 and INS § 10112.27]

3) Specifies EHBs in the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and, pediatric services, including oral and vision care. [HSC § 1367.005 and INS § 10112.27]

4) Defines “basic health care services” as all of the following:

a) Physician services, including consultation and referral;

b) Hospital inpatient services and ambulatory care services;

c) Diagnostic laboratory and therapeutic radiologic services;

d) Home health services;

e) Preventive health services;

f) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. Basic health care services includes ambulance and ambulance transport services provided through the 911 emergency response system; and,

g) Hospice care. [HSC § 1345]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, the ACA requires health plans sold in the individual and small group markets to offer a comprehensive package of items and services, known as EHBs. The author states that under this federal legislation each state has

the authority to choose its benchmark EHB plan, which details the EHBs that must be included in the scope of benefits for each health plan. The author continues that California's current EHB benchmark plan does not include coverage for a variety of benefits – such as hearing aids, infertility treatment or DME. In order to change California's EHBs, the author notes that the state was required to update its existing benchmark plan through a review process, which included an actuarial analysis and stakeholder process. The author continues that in order for new benefits to be in place for the 2027 plan year, the state must notify the federal government of its intention and proposed plan by May of this year. The author concludes that California has completed its review process and is now in the process of submitting a proposal to the federal government to add hearing aids, infertility treatment, and DME to California's EHB benchmark plan. This bill will codify these new EHBs if that proposal is approved.

2) BACKGROUND.

a) ACA & EHBs. Signed into law by President Obama in 2010, the ACA marked a significant overhaul of the U.S. health care system. According to the Kaiser Family Foundation, prior to the passage of the ACA high rates of uninsurance were prevalent due to unaffordability and exclusions based on preexisting health conditions. Additionally, insured people faced extremely high out-of-pocket costs and coverage limits. With the goal of addressing these issues, the ACA built upon the existing health insurance system and made significant changes to Medicare, Medicaid, and the employer-sponsored plan system. This impacted all aspects of the health system, from insurers, providers, state governments, employers, taxpayers, and consumers.

The ACA established EHBs, which are ten categories of services that plans are required to cover: (1) ambulatory patient services (outpatient care); (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and, (10) pediatric services, including dental and vision care.

The ACA helps consumers shop for and compare health insurance options in the individual and small group markets by promoting consistency across plans, protecting consumers by ensuring that plans cover a core package of items that are equal in scope to benefits offered by a typical employer plan, and limit out of pocket expenses. Federal rules outline health insurance standards related to the coverage of EHBs and the determination of actuarial value (AV) – (which represents the share of health care expenses the plan covers for a typical group of enrollees), while providing significant flexibility to states to shape how EHBs are defined. Taken together, EHBs and AV significantly increase consumers' ability to compare and make an informed choice about health plans.

b) California's initial EHB benchmark plan selection process. HHS defines EHBs based on state-specific EHB benchmark plans and gives each state the authority to choose its "benchmark" plan. California chose the Kaiser Small Group HMO plan in 2012, and last reviewed it in 2015.

c) **Updating EHBs.** HHS issued final rules in 2018 and 2019, which provided flexibility for states by allowing three new options for the EHB benchmark plan, in addition to the option of retaining the current EHB benchmark plan. Beginning with the 2020 plan year, states could: (1) select an EHB benchmark plan used by another state for the 2017 plan year; (2) replace one or more of the ten EHB categories in the state's EHB benchmark plan with the same category or categories of EHBs from another state's 2017 EHB benchmark plan; or, (3) otherwise select a set of benefits that would become the state's EHB benchmark plan. At a minimum, the EHB benchmark plan must provide a scope of benefits equal to or greater than a typical employer plan. Furthermore, a new "generosity test" required that EHBs not exceed the generosity of the most generous among the set of ten previous 2017 benchmark comparison plan options. According to the Centers for Medicare & Medicaid Services (CMS) website, for plan years between 2020 and 2025, nine states updated their EHB benchmark plans.

   In April of 2024, new rules were finalized for EHB benchmark updates through the HHS Notice of Benefit and Payment Parameters for 2025. For plan years beginning on or after January 1, 2026, the federal government approved three revisions to the standards for state selection of EHB-benchmark plans to address long-standing requests from states to improve, and reduce the burden of, the EHB benchmark plan update process. First, states are allowed to consolidate the options for changing EHB benchmark plans, meaning a state may select a set of benefits that would become the state's EHB benchmark plan. Second, the generosity standard was removed and a revised typicality standard was introduced. Under this typicality standard a state's new EHB benchmark plan must demonstrate that it provides a scope of benefits that is equal to the scope of benefits of a typical employer plan in the state. The scope of benefits of a typical employer plan in the state would be defined as any scope of benefits that is as or more generous than the scope of benefits in the state's least generous typical employer plan, and as or less generous than the scope of benefits in the state's most generous typical employer plan. Third, the requirement for states to submit a formulary drug list as part of their documentation to change EHB-benchmark plans unless the state changes its prescription drug EHBs was removed.

d) **California's process.** On June 27, 2024, DMHC held a public meeting to discuss California's EHBs and the process for updating the benchmark plan. At that meeting, DMHC shared the timeline and introduced consultants who explained the federal rules and recently approved and proposed EHB benchmark changes from other states. A second stakeholder meeting was held on January 28, 2025. At this meeting the Wakely Consulting Group (Wakely) presented an actuarial analysis that identified the benefit allowance and potential options and prices for a proposed benchmark plan. Through a typicality test following current CMS standards, Wakely determined that California's proposed benchmark plan can impact benefit costs (which is what the plan pays for the service plus member cost share) that range between 1.06% to 2.23%. This means that the value of the benefit additions cannot exceed 2.23%. Wakely further estimated the pricing of a suite of proposed benefits that potentially could be added, including hearing aids, DME, wigs, chiropractic, infertility, and adult dental. Altogether the cost of these benefits, with the exception of adult dental would add 1.63% to 3.48% cost. These benefits exceed the allowed cost impact range by 0.57% to 1.25%. This meant choices had to be made to narrow the set of proposed benefits to be covered. A joint legislative hearing was held on February 11, 2024 to provide the Assembly and Senate Health

Committees with information about the analysis and options that may be considered for updating the EHB benchmark plan.

On March 28, 2025, DMHC announced California's intent to submit a proposal to the federal government to add three new benefits to the state's EHB benchmark plan: hearing aids, durable medical equipment, and infertility treatment. Notification from DMHC to HHS must take place by May 7, 2025 for the new benchmark to go into effect for the January 1, 2027 plan year. If the proposed EHB benchmark is approved by CMS, legislation to codify the new benchmark plan will be necessary. This bill and SB 62 (Menjivar) have been introduced to codify any benchmark changes that may come out of this process.

e) **Cost impacts to patients.** It should be noted that premiums may increase as a result of setting a new benchmark plan. Individuals who are eligible for premium subsidies may be shielded from premium increases, but those not eligible for subsidies will feel the full impact of any premium increase. Covered California announced individual insurance market rates for the 2025 coverage year indicating the preliminary statewide weighted average rate change for the 2025 coverage year is 7.9%. Northern and Central valley regions are seeing higher premium increases and the Monterey, San Benito and Santa Cruz county region are seeing the highest average increase at 15.7%. The region with the lowest average increase is San Bernardino and Riverside with 5.3%. San Francisco and Bay Area regions, Los Angeles and San Diego are seeing average premium increases in the 7 to 8% range. Orange County is seeing an average premium increase of 9.6%.

f) **ACA subsidies.** The ACA also provides federal subsidies for those who qualify, referred to as Advanced Premium Tax Credits (APTCs), to help offset the costs to purchase individual market health insurance purchased through federal or state marketplaces (or health benefit exchanges). According to Covered California, the state's health benefit exchange, in June of 2024, approximately 1.5 million Californians received an average of $519 per member per month in APTCs (this translates to $9.7 billion on an annualized basis). Approximately 19% comes from the federal Inflation Reduction Act enhanced subsidies, which are set to expire at the end of 2025. For 2024, these enhanced APTCs were roughly $1.8 billion.

g) **Defrayal of mandate costs**. Under the ACA, if states require plans to cover services beyond those defined as EHBs in law, states must pay the costs of those benefits, either by paying the enrollee directly or by paying the qualified health plan (offered through Covered California). States adopting a new benchmark plan or revising the existing plan will not result in triggering defrayal. This is the process the Legislature and Administration are currently engaged in.

3) **SUPPORT.** The Western Center on Law and Poverty (WCLP) supports this bill, stating that the current benchmark creates a significant gap in services due to its lack of coverage for DME. WCLP continues that as a result, many Californians do not have access to the wheelchairs, hearing aids, oxygen equipment or other DME that they need because private health plans in California's individual and small group markets regularly exclude or limit coverage of this equipment. WCLP notes that without adequate coverage, people go without medically necessary devices, obtain inferior ones that put their health and safety at risk, or turn to publicly-funded health care programs for help.

SEIU California supports this bill, citing the inclusion of infertility services as an EHB. SEIU California argues that this bill moves our health care delivery system forward for those seeking to start or grow their family. SEIU California notes that with 7 out of 10 of their members identifying as women and 60% as women of color, this bill is personal for many. SEIU California continues that for their members, like the physician residents and interns united in SEIU CIR, who may train and study for decades before being financially stable to consider a family, this bill is particularly important. SEIU states that with 1 in 4 physicians with wombs experiencing infertility, this allows them the reassurance that they can fulfill their professional vision while honoring their personal family vision, too.

4) **SUPPORT IF AMENDED.** The California Dental Association (CDA) writes to ask that this bill be amended to include adult dental in California's EHB plan. CDA understands the challenges with including adult dental coverage as highlighted in the benefit review analysis and is aware that adult dental is not included in the draft plan under current consideration. However, CDA urges the legislature to consider adding adult dental at the earliest opportunity as oral healthcare is not a luxury, it is a core component of overall health.

5) **CONCERNS.** The California Association of Health Plans (CAHP) and Association of California Life and Health Insurance Companies (ACLHIC) understand the intent to enhance healthcare coverage for Californians, but believe that proceeding with this bill now is premature and warrants a delay to allow for a more thorough review and consultation on several critical issues. CAHP and ACLHIC's primary concern lies with the potential premium impact and affordability for consumers. CAHP and ACLHIC also state that the federal uncertainty surrounding the future of healthcare funding also necessitates a delay in considering this legislation.

6) **RELATED LEGISLATION.**

   a) SB 62 (Menjivar) is substantially similar to this bill. SB 62 is pending in the Senate Health Committee.

7) **PREVIOUS LEGISLATION.**

   a) AB 2914 (Bonta) of 2024 expressed the intent of the Legislature to review California's EHB benchmark plan and establish a new EHB plan for the 2027 plan year. AB 2914 was moved to the inactive file on the Senate floor.

   b) AB 2753 (Ortega) of 2024 would have included as coverage of existing EHB rehabilitative and habilitative services and devices, DME services, and repairs, if appropriately prescribed or ordered by a health professional, and prohibits a health care service plan (health plan) or health insurance policy from subjecting coverage of DME and services to financial or treatment limitations. AB 2753 defined DME to mean devices that are designed for repeated use, and that are used for the treatment or monitoring of a medical condition or injury in order to help a person to partially or fully acquire, improve, keep, or learn, or minimize the loss of, skills and functioning of daily living. AB 2753 was held on the Assembly Appropriations suspense file.

   c) SB 729 (Menjivar) Chapter 930, Statutes of 2024, requires a health plan contract or policy of disability insurance sold in the large group market (employers with more than 100 covered individuals) to provide coverage for the diagnosis and treatment of infertility

and fertility services, including services of a maximum of three completed oocyte retrievals with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine (ASRM) using single embryo transfer when recommended and medically appropriate. A signing message from the Governor stated:

"I am signing Senate Bill 729, which will require a large group health plan to provide coverage for infertility and fertility services, including in vitro fertilization (IVF), with a maximum of three completed oocyte retrievals and unlimited embryo transfers, beginning July 1, 2025, and delay its implementation for CalPERS until July 1, 2027.

California is a reproductive freedom state. As a national leader for increasing access to reproductive health care and protecting patients and providers, including those under assault in other states, I want to be clear that the right to fertility care and IVF is protected in California. In many other states, this is not the case. I wholeheartedly agree that starting a family should be attainable for those who dream to have a child - inclusive of LGBTQ+ families. There is a better way to strengthen IVF coverage across California's health care delivery system, and the state has already begun this work. In January of this year, we started the process of updating the state's "benchmark" plan, which will set a new standard for commercial insurance health coverage. The services under evaluation specifically include infertility treatment and IVF. The state's proposed benefit design will be released later this year and adopted by the Legislature by May 2025. I expect that IVF coverage will be included in the benchmark plan proposal adopted next spring, but may differ from the one in this bill. As a part of that process, I request that the Legislature change the effective date of this measure from July 1, 2025 to January 1, 2026, upon their return in January to allow an evaluation of the costs and benefit design in this bill within that broader context."

d) SB 1290 (Roth) of 2024 was substantially similar to AB 2914. SB 1290 was moved to the inactive file on the Assembly floor.

e) SB 635 (Menjivar) of 2023 would have required health aid coverage for enrollees or insureds under 21 years of age. Governor Newsom vetoed SB 635, stating in part, that the Department of Health Care Services has developed a comprehensive plan to increase provider participation and program enrollment for the Hearing Aid Coverage for Children Program.

f) AB 1157 (Ortega) of 2023 was substantially similar to AB 2753 (Ortega). AB 1157 was held in Senate Appropriations Committee.

REGISTERED SUPPORT / OPPOSITION:

Support

American Society for Reproductive Medicine
California State Council of Service Employees International Union (SEIU California)
Children's Specialty Care Coalition
Indivisible CA: Statestrong
National Association of Pediatric Nurse Practitioners

Resolve: the National Infertility Association
Western Center on Law & Poverty

Opposition

None on file

Analysis Prepared by: Riana King / HEALTH / (916) 319-2097

AMENDED IN ASSEMBLY MAY 1, 2025

CALIFORNIA LEGISLATURE—2025–26 REGULAR SESSION

ASSEMBLY BILL No. 341

Introduced by Assembly Member Arambula

January 28, 2025

An act to add Article 9 (commencing with Section 4698.50) to Chapter 6 of Division 4.5 of the Welfare and Institutions Code, relating to developmental services.

LEGISLATIVE COUNSEL'S DIGEST

AB 341, as amended, Arambula. Oral Health for People with Disabilities Technical Assistance Center Program.

Existing law, the Lanterman Developmental Disabilities Services Act, requires the State Department of Developmental Services to contract with regional centers to provide services and supports to individuals with developmental disabilities, including intellectual disabilities and other conditions, and their families. Under existing law, the regional centers purchase needed services and supports for individuals with developmental disabilities through approved service providers, or arrange for their provision through other publicly funded agencies. Existing law defines "services and supports for persons with developmental disabilities" to mean specialized services and supports or special adaptations of generic services and supports directed toward the alleviation of a developmental disability, or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with a developmental disability, or toward the achievement and maintenance of an independent, productive, and normal life. Under existing law, specialized medical and dental care are included within that definition.

This bill would require the department, no later than July 1, 2027, to contract with a public California dental school or college to administer the Oral Health for People with Disabilities Technical Assistance Center Program to improve dental care services for people with developmental and intellectual disabilities by reducing or eliminating the need for dental treatment using sedation and general anesthesia. The bill would authorize the contracted California dental school or college to partner with a public ~~or private~~ dental school or college, and would require the schools to meet certain criteria relating to location, accreditation, and a demonstrated record of working with regional centers. The bill would require the contracted school or partnership, among other responsibilities, to identify up to 10 regional centers to participate, provide practical experience, systems development, and expertise in relevant subject areas, to train, monitor, and support regional center and oral health personnel, and to collect and analyze program data with the support of participating regional centers and oral health providers. The bill would require the department to submit an annual report of the collected data to the Legislature, and to provide guidance and establish protocols to support the program, among other things. The bill also would specify regional center duties, including identifying consumers who can benefit from the program, and establishing vendor agreements with interested oral health professionals.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) People with intellectual and developmental disabilities are often referred for dental treatment that relies on the use of sedatives and general anesthesia. This leads to longer wait times and increased costs. Because of this, people with intellectual and developmental disabilities are more likely to lack access to dental care and are disproportionately at risk of developing chronic dental illnesses.

(b) Chronic conditions associated with delayed dental care include depression, cardiovascular disease, respiratory infection, and adverse pregnancy outcomes.

(c) New developments in dental materials, dental procedures, and dental treatment delivery systems have created alternatives to the use of sedation and general anesthesia for people with intellectual and developmental disabilities. These improvements can reduce risk, wait times, and cost, which all improve patient outcomes.

(d) Unfortunately, these alternatives are not widely available to those in need because of a lack of trained practitioners, policy barriers, and systemic deficiencies in payment and other support systems for practitioners who otherwise might provide care to this vulnerable population.

SEC. 2. Article 9 (commencing with Section 4698.50) is added to Chapter 6 of Division 4.5 of the Welfare and Institutions Code, to read:

Article 9. Oral Health for People with Disabilities Technical Assistance Center Program

4698.50. (a) No later than July 1, 2027, the State Department of Developmental Services shall contract with a public California dental school or college to administer the Oral Health for People with Disabilities Technical Assistance Center Program. The purpose of the program is to improve dental care services for people with developmental and intellectual disabilities by reducing or eliminating the need for dental treatment using sedation and general anesthesia.

(b) The contracted California dental school or college may partner with a public ~~or private~~ dental school or college. The contracted school or resulting partnership shall collectively meet both of the following qualifications:

(1) All partner public ~~or private~~ schools shall be located in California and be approved by the Dental Board of California or the Commission on Dental Accreditation of the American Dental Association.

(2) Lead faculty at one or more schools shall demonstrate having developed and implemented at regional centers, community-based dental care programs that have achieved all of the following:

(A) Successfully used teledentistry-supported systems to bring dental care to people with developmental disabilities in community settings.

(B) Successfully reduced the number of people needing dental care using sedation or general anesthesia.

(C) Demonstrated improved oral health in community settings as the result of meeting the achievements described in subparagraphs (A) and (B).

(c) In administering the Oral Health for People with Disabilities Technical Assistance Center Program, the contracted school or partnership shall do all of the following:

(1) Identify up to 10 regional centers to participate in the program.

(2) Provide practical experience, systems development, and expertise in relevant subject areas.

(3) Enlist dental offices and clinics to participate and establish teams of community-based allied personnel and dentists to work with each participating regional center.

(4) Design, implement, and support customized operational systems in each community in conjunction with the local oral health community and regional center personnel.

(5) Provide initial and ongoing training, monitoring, and support for participating oral health personnel, including, but not limited to, dental offices and clinics, and dentists and allied dental personnel.

(6) Provide initial and ongoing training, monitoring, and support for participating regional center personnel.

(7) Monitor and support the ongoing improvement and sustainability of operational systems at each regional center.

(8) Organize and direct a statewide advisory committee and learning community.

(9) Collect and analyze program data with the support of participating regional centers and oral health providers.

(d) The department shall submit to the Legislature an annual report of the data described in paragraph (9) of subdivision (c), in accordance with Section 9795 of the Government Code.

(e) To implement this section, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Part 2 (commencing with Section

10100) of Division 2 of the Public Contract Code, and the review or approval of the Department of General Services.

4698.51. Participating regional centers shall do all of the following:

(a) Designate a lead person at each regional center with responsibility for duties related to this article.

(b) Establish vendor agreements with interested oral health professionals.

(c) Identify people with intellectual and developmental disabilities who can benefit from the program, especially those who are already experiencing long wait times for dental care using sedation or general anesthesia, or those who are likely to experience long wait times in the future.

(d) Collect and store social, medical, and consent history and information necessary for a referral to a participating oral health professional.

(e) Facilitate referrals to participating oral health professionals.

(f) Monitor program and individual patient activity and progress.

4698.52. (a) The department shall do all of the following:

(1) Establish procedures for regional center directors, or their designees, to participate in the program.

(2) Provide guidance and establish protocols to support the program, including detailed clarification of payment for the various components of the program, workflow, and purchase-of-service authorizations and payments.

(3) Provide guidance for regional centers regarding the use of specialized therapeutic services payments.

(4) Provide guidance and technical assistance for regional centers to streamline the vendorization process for dental professionals.

(5) Allow regional centers to aggregate and publish anonymized results data.

(b) The department may consult and share information with other state entities as necessary to implement this article.

(c) The department may adopt other rules and regulations necessary to implement this article.

O

Date of Hearing: April 29, 2025

ASSEMBLY COMMITTEE ON HUMAN SERVICES
Alex Lee, Chair
AB 341 (Arambula) – As Introduced January 28, 2025

SUBJECT: Oral Health for People with Disabilities Technical Assistance Center Program

SUMMARY: Requires the Department of Developmental Services (DDS) to contract with a public California dental school or college to administer the Oral Health for People with Disabilities Technical Assistance Center Program (Program) to improve dental care services for people with developmental and intellectual disabilities. Specifically, **this bill**:

1) Specifies that, by July 1, 2027, DDS must contract with a public California dental school or college to administer the Oral Health for People with Disabilities Technical Assistance Center Program. The purpose of the Program is to improve dental care services for people with developmental and intellectual disabilities by reducing or eliminating the need for dental treatment using sedation and general anesthesia.

2) Specifies that the contracted California dental school or college may partner with a public or private dental school or college. The contracted school or resulting partnership must collectively meet both of the following qualifications:

    a) All partner public or private schools shall be located in California and be approved by the Dental Board of California or the Commission on Dental Accreditation of the American Dental Association; and,

    b) Lead faculty at one or more schools shall demonstrate having developed and implemented at regional centers, community-based dental care programs that have achieved all of the following:

        i) Successfully used teledentistry-supported systems to bring dental care to people with developmental disabilities in community settings;

        ii) Successfully reduced the number of people needing dental care using sedation or general anesthesia; and,

        iii) Demonstrated improved oral health in community settings as the result of meeting the achievements, as described in i) and ii) above.

3) Requires that, in administering the Program, the contracted school or partnership must do all of the following:

    a) Identify up to 10 regional centers to participate in the program;

    b) Provide practical experience, systems development, and expertise in relevant subject areas;

c) Enlist dental offices and clinics to participate and establish teams of community-based allied personnel and dentists to work with each participating regional center;

d) Design, implement, and support customized operational systems in each community in conjunction with the local oral health community and regional center personnel;

e) Provide initial and ongoing training, monitoring, and support for participating oral health personnel, including, but not limited to, dental offices and clinics, and dentists and allied dental personnel;

f) Provide initial and ongoing training, monitoring, and support for participating regional center personnel;

g) Monitor and support the ongoing improvement and sustainability of operational systems at each regional center;

h) Organize and direct a statewide advisory committee and learning community; and,

i) Collect and analyze program data with the support of participating regional centers and oral health providers.

4) Specifies that DDS must submit to the Legislature an annual report of the data in 3) i) above.

5) Declares that, to implement this section, DDS may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to these provisions are exempt from specified provisions in existing law related to the California State Contracts Register, contracting by state agencies, and the review or approval of the Department of General Services.

6) Requires participating regional centers to have the following program responsibilities:

a) Designate a lead person at each regional center with responsibility for duties related to the program;

b) Establish vendor agreements with interested oral health professionals;

c) Identify people with intellectual and developmental disabilities who can benefit from the program, especially those who are already experiencing long wait times for dental care using sedation or general anesthesia, or those who are likely to experience long wait times in the future;

d) Collect and store social, medical, and consent history and information necessary for a referral to a participating oral health professional;

e) Facilitate referrals to participating oral health professionals; and,

f) Monitor program and individual patient activity and progress.

7) Requires DDS to do all of the following:

   a) Establish procedures for regional center directors, or their designees, to participate in the program;

   b) Provide guidance and establish protocols to support the program, including detailed clarification of payment for the various components of the program, workflow, and purchase-of-service authorizations and payments;

   c) Provide guidance for regional centers regarding the use of specialized therapeutic services payments; and,

   d) Provide guidance and technical assistance for regional centers to streamline the vendorization process for dental professionals.

8) Authorizes DDS to consult and share information with other state entities, as necessary.

9) Authorizes DDS to adopt regulations as necessary to implement this bill.

EXISTING LAW:

1) Establishes an entitlement to services for individuals with developmental disabilities under the Lanterman Developmental Disabilities Services Act (Lanterman Act). (Welfare and Institutions Code [WIC] § 4500 *et seq*.)

2) Grants all individuals with developmental disabilities, among all other rights and responsibilities established for any individual by the United States Constitution and laws and the California Constitution and laws, the right to treatment and habilitation services and supports in the least restrictive environment. (WIC § 4502)

3) Establishes a system of nonprofit regional centers throughout the state to identify needs and coordinate services for eligible individuals with developmental disabilities and requires DDS to contract with regional centers to provide case management services and arrange for or purchase services that meet the needs of individuals with developmental disabilities, as defined. (WIC § 4620 *et seq.*)

FISCAL EFFECT: Unknown, this bill has not been analyzed by a fiscal committee.

COMMENTS:

Background: *Lanterman Developmental Disabilities Act* originally became statute in 1969. The Lanterman Act provides entitlement to services and supports for individuals three years of age and older who have a qualifying developmental disability. Qualifying disabilities include autism, epilepsy, cerebral palsy, intellectual disabilities, and other conditions closely related to intellectual disabilities that require similar treatment. To qualify, an individual must have a disability that is substantial that began before they attained 18 years of age and is expected to be lifelong. There are no income-related eligibility criteria. Direct responsibility for implementation of the Lanterman Act's service system is shared by DDS and a statewide network of 21 regional centers, which are private, community-based nonprofit entities, that contract with DDS to carry out many of the state's responsibilities.

As of August 2023, the 21 regional centers served 459,395 consumers, providing services such as: information and referral; assessment and diagnosis; counseling; lifelong individualized planning and service coordination; purchase of necessary services included in the individual program plan (IPP); resource development; outreach; assistance in finding and using community and other resources; advocacy for the protection of legal, civil, and service rights; early intervention services for at risk infants and their families; genetic counseling; family support; planning, placement, and monitoring for 24-hour out-of-home care; training and educational opportunities for individuals and families; and, community education about developmental disabilities. Regional centers services vary at each location. One location might offer one program and the next might offer what they consider an alternative or offer nothing comparable. Geographically, regional centers' spending also varies.

Dental Care for Individuals with Developmental Disorders. Dental services are coordinated through regional centers just like other services. Most regional centers employ a "dental coordinator." Dental coordinators are responsible for expanding the network of dental providers willing to serve DDS consumers, helping providers with the Medi-Cal Dental Program administration, conducting consumer case reviews, helping individual consumers find providers, training consumers and residential care providers on oral hygiene, and coordinating desensitization.

Regional center consumers receive less dental services than the general population which causes more complex dental problems due to neglect of addressing early problems. According to the Legislative Analyst's Office on Improving Access to Dental Services for Individuals with Developmental Disabilities,

> *"The oral health of individuals with developmental disabilities is worse on average than the oral health of the general population on several key factors. For example, they have higher rates and increased severity of periodontal disease, much higher rates of untreated cavities, and more missing and decaying teeth. (One study in Massachusetts found that patients with developmental disabilities average 6.7 missing teeth, whereas the Centers for Disease Control and Prevention estimate the general population averages 3.6 missing teeth.) Compared to the general population, patients with developmental disabilities are more likely to have missing teeth than to have teeth with fillings. This could be due, for example, to situations where their decaying teeth are more likely to be extracted than restored with fillings. Some oral health problems stem directly from the particular disability itself. For example, mouth breathing among individuals with Down syndrome can lead to a dry mouth, which makes it more difficult to wash away bacteria and can result in increased risk of gum disease."*

Dentists and dental hygienists receive limited training in school and through continuing education courses on how to serve individuals with developmental disabilities. This contributes to the lack of access. According to a dental association, there are only 14 dental schools and surgery centers in California that can handle special needs patients.

A 2022 CalMatters article, *"'Like Torture': For Californians with Special Needs, Getting to See a Dentist Can Take Years"* by Kristen Hwang found that, "One of the primary reasons it's so difficult to find a dentist is that most don't accept Medi-Cal, the state health plan for its poorest residents, which a majority of people with disabilities rely on. In 2021, about 36% of active licensed dentists in the state accepted Medi-Cal."

Author's Statement: According to the Author, "People with disabilities should have access to quality and timely dental care to prevent dental disease. Access to preventative dental care is critical for the prevention of chronic illness. Deferred or avoided oral health treatment is linked not only to tooth decay, but depression, cardiovascular disease, diabetes, respiratory infection, and adverse pregnancy outcomes. People with complex medical, physical, cognitive, or behavioral health challenges are the most vulnerable to delayed dental care. These people often require extra time and attention for routine and preventative care. Unfortunately, there are not enough oral health providers with the expertise to serve these patients effectively. This has led many people with disabilities to be placed on waitlists that are months or years long or to simply go without routine dental care. [This bill] establishes the Oral Health for People with Disabilities Technical Assistance Center to provide training and educational materials to expand the use of alternative methods for providing oral health services for people with disabilities that are not currently widely understood."

Double referral: For timing purposes, this bill was previously heard in the Assembly Committee on Higher Education on April 8, 2025, and was approved on a 10-0 vote.

Equity Implications: Dental health and oral hygiene are important at all stages of life since they support human functions like breathing, speaking, and eating. Poor dental health can lead to infections in the bloodstream and heart disease. *This bill* is attempting to create equity by considering the special needs of someone with a developmental disability.

Amendments: The Author has agreed to take the following amendments:

(b) The contracted California dental school or college may partner with a public ~~**or private**~~ dental school or college. The contracted school or resulting partnership shall collectively meet both of the following qualifications:

(1) All partner public ~~**or private**~~ schools shall be located in California and be approved by the Dental Board of California or the Commission on Dental Accreditation of the American Dental Association.

RELATED AND PRIOR LEGISLATION:

AB 2510 (Arambula) of 2024, was substantially similar to this bill. *AB 2510 was held on the Assembly Committee on Appropriations suspense file.*

AB 649 (Wilson) of 2023, would have permitted regional centers to purchase services that would otherwise be available from other specified means when a consumer or a consumer's representative chooses not to pursue coverage despite eligibility. *AB 649 was held on the Assembly Committee on Appropriations suspense file.*

AB 1957 (Wilson), Chapter 314, Statutes of 2022, added additional data points to the set of data that DDS and regional centers must report. These additional data mostly relate to services that were cut during the pandemic and recently restored, including social recreation, camping, educational services, and nonmedical therapies such as art, dance, and music. AB 1957 also added untimely translations of an IPP in a threshold language to be included in the set of data.

AB 1 X2 (Thurmond), Chapter 3, Statutes of 2016, second extraordinary session, authorized the Service Access and Equity grant program through which $11 million in ongoing General

Fund resources for DDS was provided to assist regional centers in reducing purchase of service disparities.

REGISTERED SUPPORT / OPPOSITION:

Support

The Arc and United Cerebral Palsy California Collaboration (Sponsor)
Association of Regional Center Agencies
California Association of Orthodontists
California Dental Association
California Dental Hygienists' Association
California Disability Services Association
Children's Choice Dental Care
Pediatric Day Health Care Coalition

Opposition

None on file.

Analysis Prepared by: Alexandria Smith / HUM. S. / (916) 319-2089

AMENDED IN ASSEMBLY APRIL 24, 2025

CALIFORNIA LEGISLATURE—2025–26 REGULAR SESSION

ASSEMBLY BILL No. 350

Introduced by Assembly Member Bonta

January 29, 2025

An act to add Section 1367.73 to the Health and Safety Code, to add Section 10120.45 to the Insurance Code, and to amend Section 14132 of the Welfare and Institutions Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 350, as amended, Bonta. Health care coverage: fluoride treatments.

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's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law sets forth specified coverage requirements for health care service plan contracts and health insurance policies.

Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which health care services are provided to low-income individuals. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes a schedule of benefits under the Medi-Cal program and provides for various services, including certain dental services, that are rendered by Medi-Cal enrolled providers. Under existing law, silver diamine fluoride treatments are a covered benefit for eligible children 0 to 6 years of age, inclusive, as specified, and

application of fluoride or other appropriate fluoride treatment is covered for children 17 years of age and under.

This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to provide coverage *without cost sharing* for the application of fluoride varnish in the primary care setting for children under 21 years of age. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program.

This bill would make the application of fluoride or other appropriate fluoride treatment, including fluoride varnish, a covered benefit under the Medi-Cal program for children under 21 years of age. The bill would require the State Department of Health Care Services to establish and promulgate a policy governing billing and reimbursement for the application of fluoride varnish, as specified.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1367.73 is added to the Health and Safety Code, to read:

1367.73. (a) A health care service plan contract issued, amended, or renewed on or after January 1, 2026, shall provide coverage for the application of fluoride varnish in the primary care setting for children under 21 years of ~~age.~~ *age, to be billed as a medical benefit, and shall not impose a deductible, coinsurance, copayment, or other cost-sharing requirement for that coverage.*

(b) Subdivision (a) does not diminish a plan's responsibility under the federal Patient Protection and Affordable Care Act (Public Law 111-148) to cover services that are assigned either a grade of A or a grade of B by the United States Preventive Services Task Force for all populations subject to that recommendation.

SEC. 2. Section 10120.45 is added to the Insurance Code, to read:

10120.45. (a) A health insurance policy issued, amended, or renewed on or after January 1, 2026, shall provide coverage for the application of fluoride varnish in the primary care setting for children under 21 years of ~~age.~~ *age, to be billed as a medical benefit, and shall not impose a deductible, coinsurance, copayment, or other cost-sharing requirement for that coverage.*

(b) Subdivision (a) does not diminish an insurer's responsibility under the federal Patient Protection and Affordable Care Act (Public Law 111-148) to cover services that are assigned either a grade of A or a grade of B by the United States Preventive Services Task Force for all populations subject to that recommendation.

SEC. 3. Section 14132 of the Welfare and Institutions Code is amended to read:

14132. The following is the schedule of benefits under this chapter:

(a) Outpatient services are covered as follows:

Physician, hospital or clinic outpatient, surgical center, respiratory care, optometric, chiropractic, psychology, podiatric, occupational therapy, physical therapy, speech therapy, audiology, acupuncture to the extent federal matching funds are provided for acupuncture, and services of persons rendering treatment by prayer or healing by spiritual means in the practice of any church or religious denomination insofar as these can be encompassed by federal participation under an approved plan, subject to utilization controls.

(b) (1) Inpatient hospital services, including, but not limited to, physician and podiatric services, physical therapy, and occupational therapy, are covered subject to utilization controls.

(2) For a Medi-Cal fee-for-service beneficiary, emergency services and care that are necessary for the treatment of an emergency medical condition and medical care directly related to the emergency medical condition. This paragraph does not change the obligation of Medi-Cal managed care plans to provide emergency services and care. For the purposes of this paragraph, "emergency services and care" and "emergency medical condition" have the same meanings as those terms are defined in Section 1317.1 of the Health and Safety Code.

(c) Nursing facility services, subacute care services, and services provided by any category of intermediate care facility for the developmentally disabled, including podiatry, physician, nurse

practitioner services, and prescribed drugs, as described in subdivision (d), are covered subject to utilization controls. Respiratory care, physical therapy, occupational therapy, speech therapy, and audiology services for patients in nursing facilities and any category of intermediate care facility for persons with developmental disabilities are covered subject to utilization controls.

(d) (1) Purchase of prescribed drugs is covered subject to the Medi-Cal List of Contract Drugs and utilization controls.

(2) Purchase of drugs used to treat erectile dysfunction or any off-label uses of those drugs are covered only to the extent that federal financial participation is available.

(3) (A) To the extent required by federal law, the purchase of outpatient prescribed drugs, for which the prescription is executed by a prescriber in written, nonelectronic form on or after April 1, 2008, is covered only when executed on a tamper resistant prescription form. The implementation of this paragraph shall conform to the guidance issued by the federal Centers for Medicare and Medicaid Services, but shall not conflict with state statutes on the characteristics of tamper resistant prescriptions for controlled substances, including Section 11162.1 of the Health and Safety Code. The department shall provide providers and beneficiaries with as much flexibility in implementing these rules as allowed by the federal government. The department shall notify and consult with appropriate stakeholders in implementing, interpreting, or making specific this paragraph.

(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in subparagraph (A) by means of a provider bulletin or notice, policy letter, or other similar instructions without taking regulatory action.

(4) (A) (i) For the purposes of this paragraph, nonlegend has the same meaning as defined in subdivision (a) of Section 14105.45.

(ii) Nonlegend acetaminophen-containing products, including children's acetaminophen-containing products, selected by the department are covered benefits.

(iii) Nonlegend cough and cold products selected by the department are covered benefits.

(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in subparagraph (A) by means of a provider bulletin or notice, policy letter, or other similar instruction without taking regulatory action.

(e) Outpatient dialysis services and home hemodialysis services, including physician services, medical supplies, drugs, and equipment required for dialysis, are covered, subject to utilization controls.

(f) Anesthesiologist services when provided as part of an outpatient medical procedure, nurse anesthetist services when rendered in an inpatient or outpatient setting under conditions set forth by the director, outpatient laboratory services, and x-ray services are covered, subject to utilization controls. This subdivision does not require prior authorization for anesthesiologist services provided as part of an outpatient medical procedure or for portable x-ray services in a nursing facility or any category of intermediate care facility for the developmentally disabled.

(g) Blood and blood derivatives are covered.

(h) (1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance of a complete artificial denture, are covered, subject to utilization controls. The utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are necessary to prevent a significant disability or to replace previously furnished prostheses that are lost or destroyed due to circumstances beyond the beneficiary's control. Notwithstanding the foregoing, the director may by regulation provide for certain fixed artificial dentures necessary for obtaining employment or for medical conditions that preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities administered by the department's California Children's Services program.

(2) For persons 21 years of age or older, the services specified in paragraph (1) shall be provided subject to the following conditions:

(A) Periodontal treatment is not a benefit.

(B) Endodontic therapy is not a benefit except for vital pulpotomy.

(C) Laboratory processed crowns are not a benefit.

(D) Removable prosthetics shall be a benefit only for patients as a requirement for employment.

(E) The director may, by regulation, provide for the provision of fixed artificial dentures that are necessary for medical conditions that preclude the use of removable dental prostheses.

(F) Notwithstanding the conditions specified in subparagraphs (A) to (E), inclusive, the department may approve services for persons with special medical disorders subject to utilization review.

(3) Paragraph (2) shall become inoperative on July 1, 1995.

(i) Medical transportation is covered, subject to utilization controls.

(j) Home health care services are covered, subject to utilization controls.

(k) (1) Prosthetic and orthotic devices and eyeglasses are covered, subject to utilization controls. Utilization controls shall allow replacement of prosthetic and orthotic devices and eyeglasses necessary because of loss or destruction due to circumstances beyond the beneficiary's control. Frame styles for eyeglasses replaced pursuant to this subdivision shall not change more than once every two years, unless the department so directs.

(2) Orthopedic and conventional shoes are covered when provided by a prosthetic and orthotic supplier on the prescription of a physician and when at least one of the shoes will be attached to a prosthesis or brace, subject to utilization controls. Modification of stock conventional or orthopedic shoes when medically indicated is covered, subject to utilization controls. If there is a clearly established medical need that cannot be satisfied by the modification of stock conventional or orthopedic shoes, custom-made orthopedic shoes are covered, subject to utilization controls.

(3) Therapeutic shoes and inserts are covered when provided to a beneficiary with a diagnosis of diabetes, subject to utilization controls, to the extent that federal financial participation is available.

(*l*) Hearing aids are covered, subject to utilization controls. Utilization controls shall allow replacement of hearing aids necessary because of loss or destruction due to circumstances beyond the beneficiary's control.

(m) Durable medical equipment and medical supplies are covered, subject to utilization controls. The utilization controls

shall allow the replacement of durable medical equipment and medical supplies when necessary because of loss or destruction due to circumstances beyond the beneficiary's control. The utilization controls shall allow authorization of durable medical equipment needed to assist a disabled beneficiary in caring for a child for whom the disabled beneficiary is a parent, stepparent, foster parent, or legal guardian, subject to the availability of federal financial participation. The department shall adopt emergency regulations to define and establish criteria for assistive durable medical equipment in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(n) Family planning services are covered, subject to utilization controls. However, for Medi-Cal managed care plans, utilization controls shall be subject to Section 1367.25 of the Health and Safety Code.

(o) Inpatient intensive rehabilitation hospital services, including respiratory rehabilitation services, in a general acute care hospital are covered, subject to utilization controls, when either of the following criteria are met:

(1) A patient with a permanent disability or severe impairment requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to develop function beyond the limited amount that would occur in the normal course of recovery.

(2) A patient with a chronic or progressive disease requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to maintain the patient's present functional level as long as possible.

(p) (1) Adult day health care is covered in accordance with Chapter 8.7 (commencing with Section 14520).

(2) Commencing 30 days after the effective date of the act that added this paragraph, and notwithstanding the number of days previously approved through a treatment authorization request, adult day health care is covered for a maximum of three days per week.

(3) As provided in accordance with paragraph (4), adult day health care is covered for a maximum of five days per week.

(4) As of the date that the director makes the declaration described in subdivision (g) of Section 14525.1, paragraph (2) shall become inoperative and paragraph (3) shall become operative.

(q) (1) Application of fluoride, or other appropriate fluoride treatment as defined by the department, and other prophylaxis treatment for children under 21 years of age are covered.

(2) Paragraph (1) includes the application of fluoride varnish in the primary care setting, *to be billed as a medical benefit,* for children under 21 years of age.

(3) The department shall establish and promulgate a billing policy that allows a Medi-Cal enrolled provider who is authorized to apply and bill for the application of fluoride varnish to be reimbursed for that service, if the fluoride varnish is physically applied by a person who is both of the following:

(A) Employed by the Medi-Cal enrolled provider or working in a contractual relationship with the Medi-Cal provider.

(B) Otherwise authorized under law, including under Section 104762 or 104830 of the Health and Safety Code, to apply fluoride varnish.

(4) All dental hygiene services provided by a registered dental hygienist, registered dental hygienist in extended functions, and registered dental hygienist in alternative practice licensed pursuant to Sections 1753, 1917, 1918, and 1922 of the Business and Professions Code may be covered as long as they are within the scope of Denti-Cal benefits and they are necessary services provided by a registered dental hygienist, registered dental hygienist in extended functions, or registered dental hygienist in alternative practice.

(r) (1) Paramedic services performed by a city, county, or special district, or pursuant to a contract with a city, county, or special district, and pursuant to a program established under former Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code by a paramedic certified pursuant to that article, and consisting of defibrillation and those services specified in subdivision (3) of former Section 1482 of the article.

(2) A provider enrolled under this subdivision shall satisfy all applicable statutory and regulatory requirements for becoming a Medi-Cal provider.

(3) This subdivision shall be implemented only to the extent funding is available under Section 14106.6.

(s) (1) In-home medical care services are covered when medically appropriate and subject to utilization controls, for a beneficiary who would otherwise require care for an extended period of time in an acute care hospital at a cost higher than in-home medical care services. The director shall have the authority under this section to contract with organizations qualified to provide in-home medical care services to those persons. These services may be provided to a patient placed in a shared or congregate living arrangement, if a home setting is not medically appropriate or available to the beneficiary.

(2) As used in this subdivision, "in-home medical care service" includes utility bills directly attributable to continuous, 24-hour operation of life-sustaining medical equipment, to the extent that federal financial participation is available.

(3) As used in this subdivision, in-home medical care services include, but are not limited to:

(A) Level-of-care and cost-of-care evaluations.

(B) Expenses, directly attributable to home care activities, for materials.

(C) Physician fees for home visits.

(D) Expenses directly attributable to home care activities for shelter and modification to shelter.

(E) Expenses directly attributable to additional costs of special diets, including tube feeding.

(F) Medically related personal services.

(G) Home nursing education.

(H) Emergency maintenance repair.

(I) Home health agency personnel benefits that permit coverage of care during periods when regular personnel are on vacation or using sick leave.

(J) All services needed to maintain antiseptic conditions at stoma or shunt sites on the body.

(K) Emergency and nonemergency medical transportation.

(L) Medical supplies.

(M) Medical equipment, including, but not limited to, scales, gurneys, and equipment racks suitable for paralyzed patients.

(N) Utility use directly attributable to the requirements of home care activities that are in addition to normal utility use.

(O) Special drugs and medications.

(P) Home health agency supervision of visiting staff that is medically necessary, but not included in the home health agency rate.

(Q) Therapy services.

(R) Household appliances and household utensil costs directly attributable to home care activities.

(S) Modification of medical equipment for home use.

(T) Training and orientation for use of life-support systems, including, but not limited to, support of respiratory functions.

(U) Respiratory care practitioner services as defined in Sections 3702 and 3703 of the Business and Professions Code, subject to prescription by a physician and surgeon.

(4) A beneficiary receiving in-home medical care services is entitled to the full range of services within the Medi-Cal scope of benefits as defined by this section, subject to medical necessity and applicable utilization control. Services provided pursuant to this subdivision, which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with a home- and community-based services waiver.

(t) Home- and community-based services approved by the United States Department of Health and Human Services are covered to the extent that federal financial participation is available for those services under the state plan or waivers granted in accordance with Section 1315 or 1396n of Title 42 of the United States Code. The director may seek waivers for any or all home- and community-based services approvable under Section 1315 or 1396n of Title 42 of the United States Code. Coverage for those services shall be limited by the terms, conditions, and duration of the federal waivers.

(u) Comprehensive perinatal services, as provided through an agreement with a health care provider designated in Section 14134.5 and meeting the standards developed by the department pursuant to Section 14134.5, subject to utilization controls.

The department shall seek any federal waivers necessary to implement the provisions of this subdivision. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented. Provisions for which waivers are obtained or for which waivers are not required shall be implemented

notwithstanding any inability to obtain federal waivers for the other provisions. No provision of this subdivision shall be implemented unless matching funds from Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are available.

(v) Early and periodic screening, diagnosis, and treatment for any individual under 21 years of age is covered, consistent with the requirements of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(w) Hospice service that is Medicare-certified hospice service is covered, subject to utilization controls. Coverage shall be available only to the extent that no additional net program costs are incurred.

(x) When a claim for treatment provided to a beneficiary includes both services that are authorized and reimbursable under this chapter and services that are not reimbursable under this chapter, that portion of the claim for the treatment and services authorized and reimbursable under this chapter shall be payable.

(y) Home- and community-based services approved by the United States Department of Health and Human Services for a beneficiary with a diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex, who requires intermediate care or a higher level of care.

Services provided pursuant to a waiver obtained from the Secretary of the United States Department of Health and Human Services pursuant to this subdivision, and that are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with the waiver, and subject to the terms, conditions, and duration of the waiver. These services shall be provided to a beneficiary in accordance with the client's needs as identified in the plan of care, and subject to medical necessity and applicable utilization control.

The director may, under this section, contract with organizations qualified to provide, directly or by subcontract, services provided for in this subdivision to an eligible beneficiary. Contracts or agreements entered into pursuant to this division shall not be subject to the Public Contract Code.

(z) Respiratory care when provided in organized health care systems as defined in Section 3701 of the Business and Professions

Code, and as an in-home medical service as outlined in subdivision (s).

(aa) (1) There is hereby established in the department a program to provide comprehensive clinical family planning services to any person who has a family income at or below 200 percent of the federal poverty level, as revised annually, and who is eligible to receive these services pursuant to the waiver identified in paragraph (2). This program shall be known as the Family Planning, Access, Care, and Treatment (Family PACT) Program.

(2) The department shall seek a waiver in accordance with Section 1315 of Title 42 of the United States Code, or a state plan amendment adopted in accordance with Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States Code, which was added to Section 1396a of Title 42 of the United States Code by Section 2303(a)(2) of the federal Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148), for a program to provide comprehensive clinical family planning services as described in paragraph (8). Under the waiver, the program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject to the terms, conditions, and duration of the waiver. Under the state plan amendment, which shall replace the waiver and shall be known as the Family PACT successor state plan amendment, the program shall be operated only in accordance with this subdivision and the statutes and regulations in paragraph (4). The state shall use the standards and processes imposed by the state on January 1, 2007, including the application of an eligibility discount factor to the extent required by the federal Centers for Medicare and Medicaid Services, for purposes of determining eligibility as permitted under Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States Code. To the extent that federal financial participation is available, the program shall continue to conduct education, outreach, enrollment, service delivery, and evaluation services as specified under the waiver. The services shall be provided under the program only if the waiver and, when applicable, the successor state plan amendment are approved by the federal Centers for Medicare and Medicaid Services and only to the extent that federal financial participation is available for the services. This section does not prohibit the department from seeking the Family PACT successor state plan amendment during the operation of the waiver.

(3) Solely for the purposes of the waiver or Family PACT successor state plan amendment and notwithstanding any other law, the collection and use of an individual's social security number shall be necessary only to the extent required by federal law.

(4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005, and 24013, and any regulations adopted under these statutes shall apply to the program provided for under this subdivision. No other law under the Medi-Cal program or the State-Only Family Planning Program shall apply to the program provided for under this subdivision.

(5) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, without taking regulatory action, the provisions of the waiver after its approval by the federal Centers for Medicare and Medicaid Services and the provisions of this section by means of an all-county letter or similar instruction to providers. Thereafter, the department shall adopt regulations to implement this section and the approved waiver in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of the act adding this subdivision, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(6) If the Department of Finance determines that the program operated under the authority of the waiver described in paragraph (2) or the Family PACT successor state plan amendment is no longer cost effective, this subdivision shall become inoperative on the first day of the first month following the issuance of a 30-day notification of that determination in writing by the Department of Finance to the chairperson in each house that considers appropriations, the chairpersons of the committees, and the appropriate subcommittees in each house that considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(7) If this subdivision ceases to be operative, all persons who have received or are eligible to receive comprehensive clinical family planning services pursuant to the waiver described in paragraph (2) shall receive family planning services under the Medi-Cal program pursuant to subdivision (n) if they are otherwise

eligible for Medi-Cal with no spend down of excess income, or shall receive comprehensive clinical family planning services under the program established in Division 24 (commencing with Section 24000) either if they are eligible for Medi-Cal with a spend down of excess income or if they are otherwise eligible under Section 24003.

(8) For purposes of this subdivision, "comprehensive clinical family planning services" means the process of establishing objectives for the number and spacing of children, and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, federal Food and Drug Administration-approved contraceptive drugs, devices, and supplies, natural family planning, abstinence methods, and basic, limited fertility management. Comprehensive clinical family planning services include, but are not limited to, preconception counseling, maternal and fetal health counseling, general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability, medical family planning treatment and procedures, including supplies and followup, and informational, counseling, and educational services. Comprehensive clinical family planning services shall not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, or pregnancy care that is not incident to the diagnosis of pregnancy. Comprehensive clinical family planning services shall be subject to utilization control and include all of the following:

(A) Family planning related services and male and female sterilization. Family planning services for men and women shall include emergency services and services for complications directly related to the contraceptive method, federal Food and Drug Administration-approved contraceptive drugs, devices, and supplies, and followup, consultation, and referral services, as indicated, which may require treatment authorization requests.

(B) All United States Department of Agriculture, federal Food and Drug Administration-approved contraceptive drugs, devices, and supplies that are in keeping with current standards of practice and from which the individual may choose.

(C) Culturally and linguistically appropriate health education and counseling services, including informed consent, that include all of the following:

(i) Psychosocial and medical aspects of contraception.

(ii) Sexuality.

(iii) Fertility.

(iv) Pregnancy.

(v) Parenthood.

(vi) Infertility.

(vii) Reproductive health care.

(viii) Preconception and nutrition counseling.

(ix) Prevention and treatment of sexually transmitted infection.

(x) Use of contraceptive methods, federal Food and Drug Administration-approved contraceptive drugs, devices, and supplies.

(xi) Possible contraceptive consequences and followup.

(xii) Interpersonal communication and negotiation of relationships to assist individuals and couples in effective contraceptive method use and planning families.

(D) A comprehensive health history, updated at the next periodic visit (between 11 and 24 months after initial examination) that includes a complete obstetrical history, gynecological history, contraceptive history, personal medical history, health risk factors, and family health history, including genetic or hereditary conditions.

(E) A complete physical examination on initial and subsequent periodic visits.

(F) Services, drugs, devices, and supplies deemed by the federal Centers for Medicare and Medicaid Services to be appropriate for inclusion in the program.

(G) (i) Home test kits for sexually transmitted diseases, including any laboratory costs of processing the kit, that are deemed medically necessary or appropriate and ordered directly by an enrolled Medi-Cal or Family PACT clinician or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs.

(ii) For purposes of this subparagraph, “home test kit” means a product used for a test recommended by the federal Centers for Disease Control and Prevention guidelines or the United States Preventive Services Task Force that has been CLIA-waived,

FDA-cleared or -approved, or developed by a laboratory in accordance with established regulations and quality standards, to allow individuals to self-collect specimens for STDs, including HIV, remotely at a location outside of a clinical setting.

(iii) Reimbursement under this subparagraph shall be contingent upon the addition of codes specific to home test kits in the Current Procedural Terminology or Healthcare Common Procedure Coding System to comply with Health Insurance Portability and Accountability Act requirements. The home test kit shall be sent by the enrolled Family PACT provider to a Medi-Cal-enrolled laboratory with fee based on Medicare Clinical Diagnostic Laboratory Tests Payment System Final Rule.

(9) In order to maximize the availability of federal financial participation under this subdivision, the director shall have the discretion to implement the Family PACT successor state plan amendment retroactively to July 1, 2010.

(ab) (1) Purchase of prescribed enteral nutrition products is covered, subject to the Medi-Cal list of enteral nutrition products and utilization controls.

(2) Purchase of enteral nutrition products is limited to those products to be administered through a feeding tube, including, but not limited to, a gastric, nasogastric, or jejunostomy tube. A beneficiary under the Early and Periodic Screening, Diagnostic, and Treatment Program shall be exempt from this paragraph.

(3) Notwithstanding paragraph (2), the department may deem an enteral nutrition product, not administered through a feeding tube, including, but not limited to, a gastric, nasogastric, or jejunostomy tube, a benefit for patients with diagnoses, including, but not limited to, malabsorption and inborn errors of metabolism, if the product has been shown to be neither investigational nor experimental when used as part of a therapeutic regimen to prevent serious disability or death.

(4) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement the amendments to this subdivision made by the act that added this paragraph by means of all-county letters, provider bulletins, or similar instructions, without taking regulatory action.

(5) The amendments made to this subdivision by the act that added this paragraph shall be implemented June 1, 2011, or on the

first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later.

(ac) Diabetic testing supplies are covered when provided by a pharmacy, subject to utilization controls.

(ad) (1) Nonmedical transportation is covered, subject to utilization controls and permissible time and distance standards, for a beneficiary to obtain covered Medi-Cal services.

(2) (A) (i) Nonmedical transportation includes, at a minimum, round trip transportation for a beneficiary to obtain covered Medi-Cal services by passenger car, taxicab, or any other form of public or private conveyance, and mileage reimbursement when conveyance is in a private vehicle arranged by the beneficiary and not through a transportation broker, bus passes, taxi vouchers, or train tickets.

(ii) Nonmedical transportation does not include the transportation of a sick, injured, invalid, convalescent, infirm, or otherwise incapacitated beneficiary by ambulance, litter van, or wheelchair van licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations.

(B) Nonmedical transportation shall be provided for a beneficiary who can attest in a manner to be specified by the department that other currently available resources have been reasonably exhausted. For a beneficiary enrolled in a managed care plan, nonmedical transportation shall be provided by the beneficiary's managed care plan. For a Medi-Cal fee-for-service beneficiary, the department shall provide nonmedical transportation when those services are not available to the beneficiary under Sections 14132.44 and 14132.47.

(3) Nonmedical transportation shall be provided in a form and manner that is accessible, in terms of physical and geographic accessibility, for the beneficiary and consistent with applicable state and federal disability rights laws.

(4) It is the intent of the Legislature in enacting this subdivision to affirm the requirement under Section 431.53 of Title 42 of the Code of Federal Regulations, in which the department is required to provide necessary transportation, including nonmedical transportation, for recipients to and from covered services. This subdivision shall not be interpreted to add a new benefit to the Medi-Cal program.

(5) The department shall seek any federal approvals that may be required to implement this subdivision, including, but not limited to, approval of revisions to the existing state plan that the department determines are necessary to implement this subdivision.

(6) This subdivision shall be implemented only to the extent that federal financial participation is available and not otherwise jeopardized and any necessary federal approvals have been obtained.

(7) Prior to the effective date of any necessary federal approvals, nonmedical transportation was not a Medi-Cal managed care benefit with the exception of when provided as an Early and Periodic Screening, Diagnostic, and Treatment service.

(8) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. By July 1, 2018, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Commencing January 1, 2018, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(9) This subdivision shall not be implemented until July 1, 2017.

(ae) (1) No sooner than January 1, 2022, Rapid Whole Genome Sequencing, including individual sequencing, trio sequencing for a parent or parents and their baby, and ultra-rapid sequencing, is a covered benefit for any Medi-Cal beneficiary who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit.

(2) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted.

(3) This subdivision shall be implemented only to the extent that any necessary federal approvals are obtained, and federal financial participation is available and not otherwise jeopardized.

(af) (1) Home test kits for sexually transmitted diseases that are deemed medically necessary or appropriate and ordered directly by an enrolled Medi-Cal clinician or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs.

(2) For purposes of this subdivision, "home test kit" means a product used for a test recommended by the federal Centers for Disease Control and Prevention guidelines or the United States Preventive Services Task Force that has been CLIA-waived, FDA-cleared or -approved, or developed by a laboratory in accordance with established regulations and quality standards, to allow individuals to self-collect specimens for STDs, including HIV, remotely at a location outside of a clinical setting.

(3) Reimbursement under this subparagraph shall be contingent upon the addition of codes specific to home test kits in the Current Procedural Terminology or Healthcare Common Procedure Coding System to comply with Health Insurance Portability and Accountability Act requirements. The home test kit shall be sent by the enrolled Medi-Cal provider to a Medi-Cal-enrolled laboratory with fee based on Medicare Clinical Diagnostic Laboratory Tests Payment System Final Rule.

(4) This subdivision shall be implemented only to the extent that federal financial participation is available and not otherwise jeopardized, and any necessary federal approvals have been obtained.

(5) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement this subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking any further regulatory action.

(ag) (1) Violence prevention services are covered, subject to medical necessity and utilization controls.

(2) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, may implement, interpret, or make specific this subdivision by means

of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted.

(3) This subdivision shall be implemented only to the extent that any necessary federal approvals are obtained, and federal financial participation is available and not otherwise jeopardized.

(4) The department shall post on its internet website the date upon which violence prevention services may be provided and billed pursuant to this subdivision.

(5) "Violence prevention services" means evidence-based, trauma-informed, and culturally responsive preventive services provided to reduce the incidence of violent injury or reinjury, trauma, and related harms and promote trauma recovery, stabilization, and improved health outcomes.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O

Date of Hearing: May 7, 2025

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
AB 350 (Bonta) – As Amended April 24, 2025

Policy Committee: Health Vote: 14 - 0

Urgency: No State Mandated Local Program: Yes Reimbursable: No

SUMMARY:

This bill requires a health plan or health insurer to cover the application of fluoride varnish in the primary care setting for children under 21 years of age, to be billed as a medical benefit, without a deductible, copayment, or other cost-sharing requirement. The bill also clarifies that Medi-Cal provides the same fluoride coverage, and requires Medi-Cal policy to allow reimbursement when the varnish is applied by nonclinical personnel.

Specific to Medi-Cal, this bill:

Requires the Department of Health Care Services (DHCS) to establish and promulgate a billing policy that allows a Medi-Cal enrolled provider who is authorized to apply and bill for the application of fluoride varnish to be reimbursed for application of fluoride varnish if the fluoride varnish is physically applied by a person who is both of the following:

1) Employed by, or working in a contractual relationship with, the Medi-Cal enrolled provider.

2) Otherwise authorized to apply fluoride varnish.

FISCAL EFFECT:

The California Health Benefits Review Program (CHBRP) estimates costs of $2.25 million annually to DHCS for enrollees in Medi-Cal (General Fund, federal funds).

Costs of approximately $30,000 per year for increases in premiums for enrollees in state-sponsored health plans (Public Employees Retirement Fund). This estimate is based on CHBRP's estimate that CalPERS premium costs would increase by $56,000, and 54% of CalPERS enrollees are associated with state employment.

The Department of Managed Health Care estimates minor and absorbable costs.

Likely minor and absorbable costs to the Department of Insurance.

The average unit cost of fluoride varnish application is $33.77 in commercial/CalPERS plans and policies and $18.55 in Medi-Cal. This average unit cost would not be expected to change as a result of AB 350.

COMMENTS:

1) **Purpose.** This bill is sponsored by Children Now and the California Dental Association. According to the author:

> Fluoride varnish is a safe, inexpensive, and effective dental intervention that can help prevent tooth decay. However, Medi-Cal policy stated in the Medi-Cal provider manual requires a qualified health professional to "hold the brush" when applying fluoride varnish, making it more difficult and costly to incorporate into primary care and public health settings. While schools and public health settings may offer additional opportunities for the application of fluoride varnish, and even though many types of non-clinical staff can be authorized to apply the varnish, Medi-Cal will only cover this service if a qualified health professional applies the varnish. Medi-Cal policy guidance is also unclear that medically necessary fluoride varnish in the primary care setting is currently covered by Medi-Cal for all children under 21 under the federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) rules. In addition, commercial insurance covers fluoride varnish in the primary care setting only for children under the age of five, which leaves out other children who could benefit from this preventive intervention.

2) **Background.**
Recommendations for Fluoride Varnish. According to CHBRP, there is strong evidence that repeated fluoride varnish is effective based on 16 studies that examined fluoride varnish applied in a medical setting. For young children, studies suggest that fluoride varnish applied in medical settings is effective in improving oral health outcomes such as the prevention of dental caries and loss of tooth enamel.

Application of fluoride varnish in primary care and community-based settings is a key preventive strategy in the California Department of Public Health's California Oral Health Plan 2018–2028 (Plan). Specifically, the Plan seeks to increase the number of Medi-Cal beneficiaries under six years of age receiving a dental disease prevention protocol by primary care medical providers that includes the application of fluoride varnish. The Plan also seeks to improve the performance of school-based and school-linked fluoride programs.

Nonclinical Providers. Existing law permits any person working in a public health setting or a public health program that is created or administered by a federal, state, or local governmental entity to apply fluoride varnish or other topical fluoride to a person being served in that setting or program, in accordance with a prescription and protocol established by a dentist or physician. Thus, nonclinical individuals such as teachers, parents, *promotoras*, and community health workers may apply fluoride varnish.

3) **Potential Reductions in Cavities and Costs**. CHBRP reports that if enrollees continue to receive fluoride varnish annually, this bill could potentially result in a reduction of 24,200 cavities among the 112,800 new users age six to 20 years with Medi-Cal, and a reduction in expenditures for the Medi-Cal dental program of $1.5 million over a four-year period.

Analysis Prepared by: Allegra Kim / APPR. / (916) 319-2081

AMENDED IN ASSEMBLY APRIL 24, 2025

AMENDED IN ASSEMBLY MARCH 13, 2025

CALIFORNIA LEGISLATURE—2025–26 REGULAR SESSION

ASSEMBLY BILL No. 371

Introduced by Assembly Member Haney
(Coauthors: Assembly Members Addis and Rogers)

February 3, 2025

An act to amend Section 1367.03 of, and to add Section 1374.191 to, the Health and Safety Code, and to amend Section 10133.54 of, and to add Section 10120.6 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 371, as amended, Haney. Dental coverage.

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's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits a contract between a plan or insurer and a dentist from requiring a dentist to accept an amount set by the plan or insurer as payment for dental care services provided to an enrollee or insured that are not covered services under the enrollee's contract or the insured's policy. Existing law requires a plan or insurer to make specified disclosures to an enrollee or insured regarding noncovered dental services.

Existing law requires a health care service plan or health insurer to comply with specified timely access requirements. For a specified plan

or insurer offering coverage for dental services, existing law requires urgent dental appointments to be offered within 72 hours of a request, nonurgent dental appointments to be offered within 36 business days of a request, and preventive dental care appointments to be offered within 40 business days of a request, as specified. Existing law requires a contract between a health care service plan and health care provider to ensure compliance with network adequacy standards and to require reporting by providers to plans to ensure compliance. Under existing law, a health care service plan is required to annually report to the Department of Managed Health Care on this compliance. Existing law authorizes the Department of Insurance to issue guidance to insurers regarding annual timely access and network reporting methodologies.

If a health care service plan or health insurer pays a contracting dental provider directly for covered services, this bill would require the plan or insurer to pay a noncontracting dental provider directly for covered services if the noncontracting provider submits to the plan or insurer a written assignment of benefits form signed by the enrollee or insured. The bill would require the plan or insurer to provide a predetermination or prior authorization to the dental provider and to reimburse the provider for not less than that amount, except as specified. The bill would require the plan or insurer to notify the enrollee or insured that the provider was paid and that the out-of-network cost may count towards their annual or lifetime maximum. The bill would require a noncontracting dental provider to make specified disclosures to an enrollee or insured before accepting an assignment of benefits.

This bill would require specified plans and insurers that cover dental services to offer urgent dental appointments within 48 hours of a request, nonurgent dental appointments within 18 business days of a request, and preventive dental care appointments within 20 business days of a request, as specified. The bill would ~~require dentists to be available within 15 miles or 30 minutes from an enrollee's or insured's residence or workplace.~~ *subject dentists to the relevant department's regulatory geographic accessibility standards.* The bill would require plans and insurers to report comprehensive information regarding the networks that each dental provider ~~serves, including the plan's or insurer's self-insured network.~~ *serves.* The bill would require the Department of Managed Health Care or the Department of Insurance to review the adequacy of an entire dental provider network, including the portions of the network serving plans and insurers not regulated by the respective department.

Because a willful violation of the above-described provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1367.03 of the Health and Safety Code is amended to read:

1367.03. (a) A health care service plan that provides or arranges for the provision of hospital or physician services, including a specialized mental health plan that provides physician or hospital services, or that provides mental health services pursuant to a contract with a full service plan, shall comply with the following timely access requirements:

(1) A health care service plan shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. A plan shall establish and maintain networks, policies, procedures, and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard. A health care service plan that uses a tiered network shall demonstrate compliance with the standards established by this section based on providers available at the lowest cost-sharing tier.

(2) A health care service plan shall ensure that all plan and provider processes necessary to obtain covered health care services, including, but not limited to, prior authorization processes, are completed in a manner that assures the provision of covered health care services to an enrollee in a timely manner appropriate for the enrollee's condition and in compliance with this section.

(3) If it is necessary for a provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs,

and ensures continuity of care consistent with good professional practice, and consistent with this section and the regulations adopted thereunder.

(4) Interpreter services required by Section 1367.04 of this code and Section 1300.67.04 of Title 28 of the California Code of Regulations shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment without imposing delay on the scheduling of the appointment. This subdivision does not modify the requirements established in Section 1300.67.04 of Title 28 of the California Code of Regulations, or approved by the department pursuant to Section 1300.67.04 of Title 28 of the California Code of Regulations for a plan's language assistance program.

(5) In addition to ensuring compliance with the clinical appropriateness standard set forth in paragraph (1), a health care service plan shall ensure that its network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the following timeframes:

(A) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in subparagraph (H).

(B) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in subparagraph (H).

(C) Nonurgent appointments for primary care: within 10 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(D) Nonurgent appointments with specialist physicians: within 15 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(E) Nonurgent appointments with a nonphysician mental health care or substance use disorder provider: within 10 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(F) Commencing July 1, 2022, nonurgent followup appointments with a nonphysician mental health care or substance use disorder provider: within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition, except as provided in

subparagraph (H). This subparagraph does not limit coverage for nonurgent followup appointments with a nonphysician mental health care or substance use disorder provider to once every 10 business days.

(G) Nonurgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within 15 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(H) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.

(I) Preventive care services, as defined in subdivision (e), and periodic followup care, including standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac, mental health, or substance use disorder conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of their practice.

(J) A referral to a specialist by a primary care provider or another specialist shall be subject to the relevant time-elapsed standard in subparagraph (A), (B), or (D), unless the requirements in subparagraph (H) or (I) are met, and shall be subject to the other provisions of this section.

(K) A plan may demonstrate compliance with the primary care time-elapsed standards established by this subdivision through implementation of standards, processes, and systems providing advanced access to primary care appointments, as defined in subdivision (e).

(6) In addition to ensuring compliance with the clinical appropriateness standard set forth in paragraph (1), each dental plan, and each full service plan offering coverage for dental services, shall ensure that dental networks have adequate capacity and availability of licensed health care providers to offer enrollees

appointments for covered dental services in accordance with the following requirements:

(A) Urgent appointments within the dental plan network shall be offered within 48 hours of the time of request for appointment, if consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice.

(B) Nonurgent appointments shall be offered within 18 business days of the request for appointment, except as provided in subparagraph (C).

(C) Preventive dental care appointments shall be offered within 20 business days of the request for appointment.

(D) Dentists shall be available ~~within 15 miles or 30 minutes from an enrollee's residence or workplace~~. *pursuant to the geographic accessibility standards in Section 1300.67.2 of Title 28 of the California Code of Regulations.*

(7) A plan shall ensure it has sufficient numbers of network providers to maintain compliance with the standards established by this section.

(A) This section does not modify the requirements regarding provider-to-enrollee ratio or geographic accessibility established by Section 1300.51, 1300.67.2, or 1300.67.2.1 of Title 28 of the California Code of Regulations.

(B) A plan operating in a network service area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by referring an enrollee to, or, in the case of a preferred provider network, by assisting an enrollee to locate available and accessible network providers in neighboring network service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs.

(C) A plan shall arrange for the provision of covered services from providers outside the plan's network if unavailable within the network if medically necessary for the enrollee's condition. A plan shall ensure that enrollee costs for medically necessary referrals to nonnetwork providers shall not exceed applicable in-network copayments, coinsurance, and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific network provider. If medically

necessary treatment of a mental health or substance use disorder is not available in network within the geographic and timely access standards set by law or regulation, a health care service plan shall arrange coverage outside the plan's network in accordance with subdivision (d) of Section 1374.72.

(8) A plan shall provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone, as defined in subdivision (e).

(A) A plan shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the enrollee's condition, and that the triage or screening waiting time does not exceed 30 minutes.

(B) A plan may provide or arrange for the provision of telephone triage or screening services through one or more of the following means: plan-operated telephone triage or screening services, telephone medical advice services pursuant to Section 1348.8, the plan's primary care and mental health care or substance use disorder network, or another method that provides triage or screening services consistent with this section.

(i) A plan that arranges for the provision of telephone triage or screening services through network primary care, mental health care, and substance use disorder providers shall require those providers to maintain a procedure for triaging or screening enrollee telephone calls, which, at a minimum, shall include the employment, during and after business hours, of a telephone answering machine, an answering service, or office staff, that shall inform the caller of both of the following:

(I) Regarding the length of wait for a return call from the provider.

(II) How the caller may obtain urgent or emergency care, including, if applicable, how to contact another provider who has agreed to be on call to triage or screen by phone, or if needed, deliver urgent or emergency care.

(ii) A plan that arranges for the provision of triage or screening services through network primary care, mental health care, and substance use disorder providers who are unable to meet the time-elapsed standards established in subparagraph (A) shall also provide or arrange for the provision of plan-contracted or operated triage or screening services, which shall, at a minimum, be made available to enrollees affected by that portion of the plan's network.

(iii) An unlicensed staff person handling enrollee calls may ask questions on behalf of a licensed staff person to help ascertain the condition of an insured so that the enrollee may be referred to licensed staff. However, an unlicensed staff person shall not, under any circumstances, use the answers to those questions in an attempt to assess, evaluate, advise, or make a decision regarding the condition of an enrollee or determine when an enrollee needs to be seen by a licensed medical professional.

(9) Dental, vision, chiropractic, and acupuncture plans shall ensure that network providers employ an answering service or a telephone answering machine during nonbusiness hours, which provide instructions regarding how an enrollee may obtain urgent or emergency care, including, if applicable, how to contact another provider who has agreed to be on call to triage or screen by phone, or if needed, deliver urgent or emergency care.

(10) A plan shall ensure that, during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed 10 minutes.

(b) With regard to subdivision (a), dental, vision, chiropractic, and acupuncture plans shall comply with paragraphs (1), (3), (4), (7), (9), and (10).

(c) The obligation of a plan to comply with this section shall not be waived if the plan delegates to its provider groups or other contracting entities any services or activities that the plan is required to perform. A plan's implementation of this section shall be consistent with the Health Care Providers' Bill of Rights, and a material change in the obligations of a plan's network providers shall be considered a material change to the provider contract, within the meaning of subdivision (b) and paragraph (2) of subdivision (h) of Section 1375.7.

(d) A health care service plan shall incorporate the standards set forth in subdivision (a) into the health plan's quality assurance systems and the processes set forth in Sections 1367 and 1370 of this code and Title 28 of the California Code of Regulations, including Sections 1300.67.2, 1300.67.2.2, 1300.68, and 1300.70. A plan shall not prevent, discourage, or discipline a network provider or employee for informing an enrollee or subscriber about the timely access standards.

(e) For purposes of this section:

(1) "Advanced access" means the provision, by a network provider, or by the provider group to which an enrollee is assigned, of appointments with a primary care physician, or other qualified primary care provider such as a nurse practitioner or physician's assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the enrollee prefers not to accept the appointment offered within the same or the next business day.

(2) "Appointment waiting time" means the time from the initial request for health care services by an enrollee or the enrollee's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its network providers.

(3) "Preventive care" means health care provided for prevention and early detection of disease, illness, injury, or another health condition and, in the case of a full service plan includes all of the basic health care services required by Sections 1345, 1367.002, 1367.3, and 1367.35 of this code and subdivision (f) of Section 1300.67 of Title 28 of the California Code of Regulations.

(4) "Provider group" has the meaning set forth in subdivision (g) of Section 1373.65.

(5) "Triage" or "screening" means the assessment of an enrollee's health concerns and symptoms via communication with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage an enrollee who may need care for the purpose of determining the urgency of the enrollee's need for care.

(6) "Triage or screening waiting time" means the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage an enrollee who may need care.

(7) "Urgent care" means health care for a condition that requires prompt attention, consistent with paragraph (2) of subdivision (h) of Section 1367.01.

(f) (1) Contracts between health care service plans and health care providers shall ensure compliance with the standards developed under this chapter. These contracts shall require

reporting by health care providers to health care service plans and by health care service plans to the department to ensure compliance with the standards.

(2) Health care service plans shall report annually to the department on compliance with the standards in a manner specified by the department. The reported information shall allow consumers to compare the performance of plans and their network providers in complying with the standards, as well as changes in the compliance of plans with these standards.

(3) The department shall develop standardized methodologies for reporting that shall be used by health care service plans to demonstrate compliance with this section and any regulations adopted pursuant to it, including demonstration of the average waiting time for each class of appointment regulated under this section, except the department may develop methodologies to demonstrate compliance with, and the average appointment wait time for, each class of appointments regulated under paragraph (6) of subdivision (a). The methodologies shall be sufficient to determine compliance with the standards developed under this section for different networks of providers if a health care service plan uses a different network for Medi-Cal managed care products than for other products or if a health care service plan uses a different network for individual market products than for small group market products. The development and adoption of these methodologies shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) until December 31, 2025. The department shall consult with stakeholders in developing standardized methodologies under this paragraph.

(4) Notwithstanding paragraph (3), the department may take compliance or disciplinary action, including assessment of administrative penalties, on the basis of noncompliance with any of the provisions of this section, including, but not limited to, timeframes for appointments and followup appointments.

(5) Information reported by a plan to the department pursuant to paragraph (2) shall include comprehensive information regarding the dental provider networks that each dental provider ~~serves, including the plan's self-insured network.~~ *serves*. Comprehensive information shall include the number of covered lives per line of business, including ~~self-insured, third party,~~ *third party* or

administrative service organizations, as applicable. For the purpose of determining network adequacy and compliance with time and distance requirements, the department shall review the adequacy of an entire dental provider network, as reported by the health care service plans, including the portions of the network serving plans and insurers not regulated by the department.

(6) The department may review and adopt standards, in addition to those specified in this article, concerning the availability of primary care physicians, specialty physicians, hospital care, and other health care, so that consumers have timely access to care. In so doing, the department shall consider the nature of physician practices, including individual and group practices, as well as the nature of the plan network. The department shall also consider various circumstances affecting the delivery of care, including urgent care, care provided on the same day, and requests for specific providers. If the department finds that health care service plans and health care providers have difficulty meeting these standards, the department may make recommendations to the Assembly Committee on Health and the Senate Committee on Health pursuant to subdivision (i). The development and adoption of standards under this paragraph shall not be subject to the Administrative Procedure Act until December 31, 2028. The department shall consult with stakeholders in developing the standards and methodologies described in this section.

(g) (1) The director may investigate and, by order, take enforcement action against plans, including, but not limited to, assessing administrative penalties subject to appropriate notice of, and the opportunity for, a hearing in accordance with Section 1397, regarding noncompliance with the requirements of this section. The director shall consider, as an aggravating factor when assessing administrative penalties, if harm to an enrollee, including financial or health impacts to an enrollee or substantial harm as defined in Section 3428 of the Civil Code, has occurred as a result of plan noncompliance. The director has the discretion to determine what harm constitutes harm to an enrollee. The plan may provide to the director, and the director may consider, information regarding the plan's overall compliance with the requirements of this section. When taking enforcement action against a plan, the director may consider patterns of noncompliance. The administrative penalties shall not be deemed an exclusive remedy available to the director.

These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45. The director shall periodically evaluate grievances to determine if any audit, investigative, or enforcement actions should be undertaken by the department.

(2) The director may, after appropriate notice and opportunity for hearing in accordance with Section 1397, by order, assess administrative penalties if the director determines that a health care service plan has knowingly committed, or has performed with a frequency that indicates a general business practice, either of the following:

(A) Repeated failure to act promptly and reasonably to assure timely access to care consistent with this chapter.

(B) Repeated failure to act promptly and reasonably to require network providers to assure timely access that the plan is required to perform under this chapter and that have been delegated by the plan to the network provider when the obligation of the plan to the enrollee or subscriber is reasonably clear.

(3) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed warranted by the director to enforce this chapter.

(4) The administrative penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(h) The department shall work with the patient advocate to assure that the quality of care report card incorporates information provided pursuant to subdivision (f) regarding the degree to which health care service plans and health care providers comply with the requirements for timely access to care.

(i) The department shall annually review information regarding compliance with the standards developed under this section and shall make recommendations for changes that further protect enrollees. Commencing no later than December 1, 2015, and annually thereafter, the department shall post its final findings from the review on its internet website.

(j) The department shall post on its internet website any waivers or alternative standards that the department approves under this section on or after January 1, 2015.

(k) This section applies to a licensed health care service plan that provides services to Medi-Cal beneficiaries. Except for appointment wait time standards set forth in paragraph (5) of subdivision (a) of this section and in Section 1300.67.2.2 of Title 28 of the California Code of Regulations, this section does not alter the requirements or standards of the State Department of Health Care Services specified in Section 14197 of the Welfare and Institutions Code.

(*l*) This section does not prevent the department from developing additional standards to improve timely access to care and network adequacy.

SEC. 2. Section 1374.191 is added to the Health and Safety Code, to read:

1374.191. (a) If a health care service plan pays a contracting dental provider directly for covered services rendered to an enrollee, the plan shall pay a noncontracting dental provider directly for covered services rendered to an enrollee if the noncontracting provider submits to the plan a written assignment of benefits form signed by the enrollee.

(b) Before accepting an assignment of benefits, a noncontracting dental provider shall disclose all of the following information to an enrollee:

(1) That the provider is a noncontracting dental provider.

(2) That the enrollee may experience lower out-of-pocket costs if services are rendered by a contracting network dentist.

(3) An estimate of what the planned treatment would cost and the enrollee's portion of the cost.

(c) A plan shall provide notice to the enrollee that the out-of-network cost may count towards their annual or lifetime maximum, as applicable, and shall inform the enrollee that payment was sent to the provider.

(d) A plan shall provide a predetermination or prior authorization to the dental provider and shall not reimburse the provider less than the amount set forth in the predetermination or prior authorization for the services, except in cases of fraud, billing error, or loss of coverage.

(e) For purposes of this section, "assignment of benefits" means the transfer of reimbursement or other rights provided for under a health care service plan contract to a treating provider for services or items rendered to an enrollee.

(f) This section applies only to a health care service plan contract covering dental services or a specialized health care service plan contract covering dental services pursuant to this chapter.

(g) This section does not apply to Medi-Cal managed care plan contracts, including dental managed care contracts, authorized under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

SEC. 3. Section 10120.6 is added to the Insurance Code, to read:

10120.6. (a) If a health insurer pays a contracting dental provider directly for covered services rendered to an insured, the insurer shall pay a noncontracting dental provider directly for covered services rendered to an insured if the noncontracting provider submits to the insurer a written assignment of benefits form signed by the insured.

(b) Before accepting an assignment of benefits, a noncontracting dental provider shall disclose all of the following information to an insured:

(1) That the provider is a noncontracting dental provider.

(2) That the insured may experience lower out-of-pocket costs if services are rendered by a contracting network dentist.

(3) An estimate of what the planned treatment would cost and the insured's portion of the cost.

(c) An insurer shall provide notice to the insured that the out-of-network cost may count towards their annual or lifetime maximum, as applicable, and shall inform the insured that payment was sent to the provider.

(d) An insurer shall provide a predetermination or prior authorization to the dental provider and shall not reimburse the provider less than the amount set forth in the predetermination or prior authorization for the services, except in cases of fraud, billing error, or loss of coverage.

(e) For purposes of this section, "assignment of benefits" means the transfer of reimbursement or other rights provided for under a health insurance policy to a treating provider for services or items rendered to an insured.

(f) This section applies only to a health insurance policy covering dental services or a specialized health insurance policy covering dental services pursuant to this part.

SEC. 4. Section 10133.54 of the Insurance Code is amended to read:

10133.54. (a) This section applies to policies of health insurance, as defined by subdivision (b) of Section 106. The requirements of this section apply to all health care services covered by a health insurance policy.

(b) Notwithstanding Section 10133.5, a health insurer shall comply with the timely access requirements in this section, but a specialized health insurance policy as defined in subdivision (c) of Section 106, other than a specialized mental health insurance policy, is exempt from the provisions of this section, except as specified in paragraph (6) and subdivision (c).

(1) A health insurer shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the insured's condition, consistent with good professional practice. An insurer shall establish and maintain provider networks, policies, procedures, and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard. An insurer that uses a tiered network shall demonstrate compliance with the standards established by this section based on providers available at the lowest cost-sharing tier.

(2) A health insurer shall ensure that all insurer and provider processes necessary to obtain covered health care services, including, but not limited to, prior authorization processes, are completed in a manner that assures the provision of covered health care services to an insured in a timely manner appropriate for the insured's condition and in compliance with this section.

(3) If it is necessary for a provider or an insured to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the insured's health care needs, and ensures continuity of care consistent with good professional practice, and consistent with the objectives of Section 10133.5, the regulations adopted pursuant to Section 10133.5, and this section.

(4) Interpreter services required by Section 10133.8 of this code and Article 12.1 (commencing with Section 2538.1) of Title 10 of the California Code of Regulations shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the

appointment, consistent with Section 2538.6 of Title 10 of the California Code of Regulations, without imposing delay on the scheduling of the appointment. This subdivision does not modify the requirements established in Sections 10133.8 and 10133.9 of this code and Section 2538.6 of Title 10 of the California Code of Regulations, or approved by the department pursuant to Section 2538.6 of Title 10 of the California Code of Regulations for an insurer's language assistance program.

(5) In addition to ensuring compliance with the clinical appropriateness standard set forth in paragraph (1), a health insurer shall ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer insureds appointments that meet the following timeframes:

(A) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in subparagraph (H).

(B) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in subparagraph (H).

(C) Nonurgent appointments for primary care: within 10 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(D) Nonurgent appointments with specialist physicians: within 15 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(E) Nonurgent appointments with a nonphysician mental health care or substance use disorder provider: within 10 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(F) Commencing July 1, 2022, nonurgent followup appointments with a nonphysician mental health care or substance use disorder provider: within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition, except as provided in subparagraph (H). This subparagraph does not limit coverage for nonurgent followup appointments with a nonphysician mental health care or substance use disorder provider to once every 10 business days.

(G) Nonurgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition:

within 15 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(H) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the insured.

(I) Preventive care services, as defined in subdivision (e), and periodic follow up care, including standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac, mental health, or substance use disorder conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of their practice.

(J) A referral to a specialist by a primary care provider or another specialist shall be subject to the relevant time-elapsed standard in subparagraph (A), (B), or (D), unless the requirements in subparagraph (H) or (I) are met, and shall be subject to the other provisions of this section.

(6) (A) The following types of health insurance policies shall be subject to the applicable requirements in subparagraphs (B) and (C):

(i) A health insurance policy covering the pediatric oral or vision essential health benefit.

(ii) A specialized health insurance policy that provides coverage for the pediatric oral essential health benefit, as defined in paragraph (5) of subdivision (a) of Section 10112.27.

(iii) A specialized health insurance policy that covers dental benefits only, as defined in subdivision (c) of Section 106.

(B) In addition to ensuring compliance with the clinical appropriateness standard set forth in paragraph (1), each applicable health insurance policy specified in subparagraph (A) shall ensure that contracted vision provider networks have adequate capacity and availability of licensed health care providers, including ophthalmologists, optometrists, and opticians, to offer insureds

appointments for covered vision services in accordance with the following requirements:

(i) Urgent appointments within the plan network shall be offered within 72 hours of the time of request for appointment.

(ii) Nonurgent appointments shall be offered within 36 business days of the request for appointment, except as provided in clause (iii).

(iii) Preventive care appointments shall be offered within 40 business days of the request for appointment.

(iv) The applicable waiting time for a particular appointment in this paragraph may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of the provider's practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the insured.

(C) Each applicable health insurance policy specified in subparagraph (A) shall ensure that contracted oral provider networks have adequate capacity and availability of licensed health care providers, including generalist and specialist dentists, to offer insureds appointments for covered oral services in accordance with the following requirements:

(i) Urgent appointments within the insurer network shall be offered within 48 hours of the time of request for appointment, if consistent with the insured's individual needs and as required by professionally recognized standards of dental practice.

(ii) Nonurgent appointments shall be offered within 18 business days of the request for appointment, except as provided in clause (iii).

(iii) Preventive care appointments shall be offered within 20 business days of the request for appointment.

(iv) Dentists shall be available ~~within 15 miles or 30 minutes from an insured's residence or workplace.~~ *pursuant to the geographic accessibility standards in Section 2240.1 of Title 10 of the California Code of Regulations.*

(7) An insurer shall ensure it has sufficient numbers of contracted providers to maintain compliance with the standards established by this section.

(A) This section does not modify the requirements regarding accessibility established by Article 6 (commencing with Section 2240) of Title 10 of the California Code of Regulations.

(B) An insurer shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by assisting an insured to locate available and accessible contracted providers in a timely manner appropriate for the insured's health needs. An insurer shall arrange for the provision of services outside the insurer's contracted network if unavailable within the network if medically necessary for the insured's condition. Insured costs for medically necessary referrals to nonnetwork providers shall not exceed applicable in-network copayments, coinsurance, and deductibles.

(8) An insurer shall provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone, as defined in subdivision (f).

(A) An insurer shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the insured's condition, and that the triage or screening waiting time does not exceed 30 minutes.

(B) An insurer may provide or arrange for the provision of telephone triage or screening services through one or more of the following means: insurer-operated telephone triage or screening services, telephone medical advice services pursuant to Section 10279, the insurer's contracted primary care and mental health care or substance use disorder provider network, or other method that provides triage or screening services consistent with this section.

(i) An insurer that arranges for the provision of telephone triage or screening services through contracted primary care and mental health care and substance use disorder providers shall require those providers to maintain a procedure for triaging or screening insured telephone calls, which, at a minimum, shall include the employment, during and after business hours, of a telephone answering machine, an answering service, or office staff, that shall inform the caller of both of the following:

(I) Regarding the length of wait for a return call from the provider.

(II) How the caller may obtain urgent or emergency care, including, if applicable, how to contact another provider who has

agreed to be on call to triage or screen by phone, or if needed, deliver urgent or emergency care.

(ii) An insurer that arranges for the provision of triage or screening services through contracted primary care and mental health care and substance use disorder providers who are unable to meet the time-elapsed standards established in subparagraph (A) shall also provide or arrange for the provision of insurer-contracted or operated triage or screening services, which shall, at a minimum, be made available to insureds affected by that portion of the insurer's network.

(iii) An unlicensed staff person handling insured calls may ask questions on behalf of a licensed staff person to help ascertain the condition of an insured so that the insured may be referred to licensed staff. However, an unlicensed staff person shall not, under any circumstances, use the answers to those questions in an attempt to assess, evaluate, advise, or make a decision regarding the condition of an insured or determine when an insured needs to be seen by a licensed medical professional.

(9) A health insurance policy providing coverage for the pediatric oral and vision essential health benefit, and a specialized health insurance policy that provides coverage for dental care expenses only, shall require that contracted providers employ an answering service or a telephone answering machine during nonbusiness hours, which provides instructions regarding how an insured may obtain urgent or emergency care, including, if applicable, how to contact another provider who has agreed to be on call to triage or screen by phone, or if needed, deliver urgent or emergency care.

(10) An insurer shall ensure that, during normal business hours, the waiting time for an insured to speak by telephone with an insurer customer service representative knowledgeable and competent regarding the insured's questions and concerns shall not exceed 10 minutes, or that the covered person will receive a scheduled call-back within 30 minutes.

(c) Notwithstanding subdivision (b), a specialized health insurance policy, as defined in subdivision (c) of Section 106, other than a specialized mental health insurance policy, is exempt from this section, except as specified in this subdivision. A specialized health insurance policy that provides coverage for

dental care expenses only shall comply with paragraphs (1), (3), (4), (6), (7), (9), and (10) of subdivision (b).

(d) An insurer shall incorporate the standards set forth in the insurer's quality assurance systems and processes, as set forth in subdivision (b), and the processes as set forth in Title 10 of the California Code of Regulations, including Sections 2240.1, 2240.15, and 2240.16. An insurer shall not prevent, discourage, or discipline a contracting provider or employee for informing an insured or policyholder about the timely access standards.

(e) For purposes of this section:

(1) "Appointment waiting time" means the time from the initial request for health care services by an insured or the insured's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the insurer or completing any other condition or requirement of the insurer or its contracting providers.

(2) "Preventive care" means health care provided for prevention and early detection of disease, illness, injury, or other health conditions and includes, but is not limited to, all of the services required by all of the following laws:

(A) Section 146.130 of Title 45 of the Code of Federal Regulations.

(B) Section 10112.2 (incorporating the requirements of Section 2713 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-13)).

(C) Clause (ii) of subparagraph (A) of paragraph (2) of subdivision (a) of Section 10112.27.

(3) "Provider group" has the meaning set forth in subdivision (v) of Section 10133.15.

(4) "Triage" or "screening" means the assessment of an insured's health concerns and symptoms via communication with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage an insured who may need care for the purpose of determining the urgency of the insured's need for care.

(5) "Triage or screening waiting time" means the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage an insured who may need care.

(6) "Urgent care" means health care for a condition that requires prompt attention, consistent with paragraph (2) of subdivision (h) of Section 10123.135.

(f) (1) The department may issue guidance to insurers regarding annual timely access and network reporting methodologies. The development and adoption of these methodologies shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) until December 31, 2025.

(2) Notwithstanding paragraph (1), the department may take compliance or disciplinary action, including imposition of administrative penalties, on the basis of noncompliance with any of the provisions of this section, including, but not limited to, timeframes for appointments and followup appointments.

(3) Information reported by an insurer to the department pursuant to this article shall include comprehensive information regarding the dental provider networks that each dental provider ~~serves, including the insurer's self-insured network.~~ *serves*. Comprehensive information shall include the number of covered lives per line of business, including ~~self-insured, third party,~~ *third party* or administrative service organizations, as applicable. For the purpose of determining network adequacy and compliance with time and distance requirements, the department shall review the adequacy of an entire dental provider network, as reported by the health insurers, including the portions of the network serving plans and insurers not regulated by the department.

(4) The department may review and adopt standards, in addition to those specified in this article, concerning the availability of primary care physicians, specialty physicians, hospital care, and other health care, so that consumers have timely access to care. In so doing, the department shall consider the nature of physician practices, including individual and group practices, as well as the nature of the network. The department shall also consider various circumstances affecting the delivery of care, including urgent care, care provided on the same day, and requests for specific providers. If the department finds that insurers and health care providers have difficulty meeting these standards, the department may make recommendations to the Assembly Committee on Health and the Senate Committee on Health. The development and adoption of standards under this paragraph shall not be subject to the

Administrative Procedure Act until December 31, 2028. The department shall consult with stakeholders in developing the standards and methodologies described in this section.

(g) Nothing in this section shall be construed to prevent the department from developing additional standards to improve timely access to care and network adequacy.

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O

Date of Hearing: April 22, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 371 (Haney) – As Amended March 13, 2025

SUBJECT: Dental coverage.

SUMMARY: Requires a health care service plan (health plan) or health insurer, if they pay a contracting dental provider directly for covered services, to pay a non-contracting dental provider directly for covered services if the non-contracting provider submits a written assignment of benefits (AOB) form signed by the enrollee. Requires a health plan or health insurer offering dental services to meet specified timely and geographic access requirements. Specifically, **this bill**:

1) Requires a health plan or health insurer, if they pay a contracting dental provider directly for covered services, to pay a non-contracting dental provider directly for covered services if the non-contracting provider submits a written AOB form signed by the enrollee.

2) Requires a non-contracting dental provider, before accepting an AOB, to disclose the following information to an enrollee:

    a) That the provider is a non-contracting dental provider;

    b) That the enrollee may experience lower out-of-pocket costs if services are rendered by a contracting network dentist; and,

    c) An estimate of what the planned treatment would cost and the enrollee's portion of the cost.

3) Requires a health plan or health insurer to provide notice to an enrollee that the out-of-network cost may count towards their annual or lifetime maximum, as applicable and that payment was sent to the provider.

4) Requires a dental plan or insurer to provide a predetermination or prior authorization to the dental provider. Prohibits the dental plan or insurer from reimbursing the provider less than the amount set forth in the predetermination or prior authorization for the services, except in cases of fraud, billing error, or loss of coverage.

5) Shortens existing timely access requirements, requiring a health plan or health insurer offering dental services to offer:

    a) Urgent appointments within 48 hours of the time of request for appointment, if consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice;

    b) Non-urgent appointments within 18 business days of the request for appointment; and,

    c) Preventive dental care appointments within 20 business days of the request for appointment.

6) Requires dentists to be available within 15 miles or 30 minutes from an enrollee's residence or workplace.

7) Requires information reported by a dental plan or insurer to the Department of Managed Health Care (DMHC) or California Department of Insurance (CDI) to include comprehensive information regarding the dental provider networks that each dental provider serves, including the plan's self-insured network. Specifies comprehensive information includes the number of covered lives per line of business, including self-insured, third party, or administrative service organizations, as applicable. For the purpose of determining network adequacy and compliance with time and distance requirements, requires the departments to review the adequacy of an entire dental provider network, as reported by the health care service plans, including the portions of the network serving plans and insurers not regulated by the department.

8) Specifies that the provisions of this bill do not apply to Medi-Cal managed care plans.

9) Defines AOB as the transfer of reimbursement or other rights provided for under a plan or insurance contract to a treating provider for services or items rendered to an enrollee.

EXISTING LAW:

1) Establishes DMHC to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 and CDI to regulate health insurance. [Health and Safety Code (HSC) § 1340, *et seq*. and Insurance Code (INS) § 106, *et seq*.]

2) Requires DMHC to develop and adopt regulations to ensure that enrollees have access to health care services in a timely manner, regarding:

   a) Waiting times for appointments, including primary and specialty care physicians;

   b) Care in an episode of illness, including timeliness of referrals and obtaining other services, as needed; and,

   c) Waiting time to speak to a physician, registered nurse, or other qualified health professional trained to screen or triage. [HSC § 1367.03]

3) Requires, in developing these standards, DMHC to consider the clinical appropriateness, the nature of the specialty, the urgency or care, and the requirements of law governing utilization review. [HSC § 1367.03]

4) Requires CDI to promulgate regulations applicable to health insurers to ensure access to health care in a timely manner, and designed to ensure adequacy of the number of locations of institutional facilities and professional providers, adequacy of number of professional providers, and license classifications, consistent with standards of good health care and clinically appropriate care, and that contracts are fair and reasonable. [INS § 10133.5]

5) Requires, in designing the regulations, CDI to consider regulations promulgated by DMHC and all other relevant guidelines in an effort to accomplish maximum accessibility within a cost efficient system of indemnification. [INS § 10133.5]

6) Requires, for a plan or insurer offering coverage for dental services, urgent dental appointments to be offered within 72 hours of a request, non-urgent dental appointments to be offered within 36 business days of a request, and preventive dental care appointments to be offered within 40 business days of a request. [HSC § 1367.03 and INS § 10133.54]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, too many Californians are struggling to find a dentist near their home or work, and even when they do, insurance companies are forcing them to pay out of pocket for care that should be covered. The author states that we can put a stop to these unfair practices by ensuring that everyone gets the dental care they need without any unnecessary obstacles or hidden costs. The author argues that this bill will require dental insurance companies to ensure patients can access in-network care within a reasonable distance from their home or workplace. The author continues that this bill will also ban insurers from making patients pay upfront for covered services and will require them to report network adequacy data.

2) **BACKGROUND.**

   a) **Dental insurance.** According to the California Health Benefits Review Program (CHBRP), the majority of dental benefit plans are "fully insured" and regulated at the state level by DMHC or CDI. The Affordable Care Act helped California expand Medi-Cal eligibility and offer dental benefits to newly eligible adult enrollees (the "expansion population"). Additionally, all Covered California health insurance plans offer embedded pediatric dental coverage at no extra cost. For adults, a dental plan can be added to health plan purchases. Dental insurance commonly divides oral health services into the following categories: preventive and diagnostic, basic restorative services, major restorative services, and orthodontics. Preventive and diagnostic services are typically the most generous in terms of coverage. Basic restorative services include the treatments for common dental problems and are generally straightforward and nonsurgical in nature, such as simple extractions and basic root canals. Major restorative services, however, are often complex or lengthy, typically requiring more time and expense than basic services. Coverage for major restorative services can be limited in many dental plan designs and products.

      Dental plans, like health plans, come in various models including Preferred Provider Organization (PPO) plans. In a PPO arrangement, the health insurer contracts with a network of providers who agree to accept lower fees and/or to control utilization. Enrollees in a PPO plan receive a higher level of benefits if they go to a preferred provider than if they go to a non-preferred or non-contracted provider.

   b) **AOB.** A core function of dental insurance is the development of a network of dental providers who agree to treat patients covered by the plan. Dentists who contract with a dental plan will agree to terms about reimbursement rates, cost-sharing, benefits covered, and other details. Contracting dentists are then listed as participating provider by the insurance plan and have access to the patient network covered by the plan. Contracting dentists are also able to bill the dental plan directly for services while patients are responsible for paying any cost-sharing amounts detailed under their coverage.

Patients under a PPO plan may seek services from non-contracted providers. The patients may seek an AOB, which is an arrangement where a patient requests that their plan payments be made directly to a designated person or facility, such as a dentist, physician, or hospital. In the context of this bill, an AOB would apply to non-contracting dentists. Under AOB, a patient may permit a non-contracting dentist to bill the dental plan directly and collect authorized reimbursement from the plan. The patient is on the hook to pay the dentist the remaining balance of their bill. Under AOB non-contracting dentists aren't required to limit their rates to contractual levels, meaning the patient may pay higher cost-sharing amounts. For example, a plan may cover a filling for $100 with the patient paying 20%. A contracted dentist would then be able to collect $80 from the plan and $20 from the patient. However, if that patient had an AOB with a non-contracting dentist who charges $150 for a filling, the dentist would collect $80 from the dental plan and $70 from the patient. If an AOB was not in place the dentist would not be able to directly bill the insurer, meaning the patient would be balance billed for the full $150 and have to seek reimbursement for $80 from their dental plan.

c) **Network Adequacy Requirements**. Network adequacy standards are utilized to ensure that plans contain and maintain a network of providers adequate for enrollees to access medically necessary in a timely manner. In California, state law sets forth various network adequacy requirements on plans and insurers, including the following:

i) **Timely Access to Care.** State law requires that plans meet a set of standards which include specific time frames under which enrollees must be able to access care. These requirements generally provide dental plan members the right to appointments within the following time frames:

(1) Urgent care **within 72 hours**;

(2) Non-urgent care **within 36 business days**; and

(3) Preventive dental care **within 40 business days.**

For comparison, health plan members have the right to appointments within the following time frames:

(1) Urgent care without prior authorization: **within 48 hours**;

(2) Urgent care with prior authorization: **within 96 hours**;

(3) Non-urgent primary care appointments: **within 10 business days;**

(4) Non-urgent specialist appointments: **within 15 business days;**

(5) Non-Urgent mental health (MH) appointments: **within 15 business days** for psychiatrist, **within 10 business days** for non-physician MH provider; and,

(6) Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness or other health condition: **within 15 business days**.

ii) **Geographic Access.** Health plans are also generally required to ensure geographic access, meaning there are a sufficient number of providers located within a

reasonable distance from where each enrollee lives or works. For example, primary care physicians (PCPs) and hospitals should be **located within 15 miles or 30 minutes** from work or home.

Health plans must also ensure provider capacity such that health plan networks have enough of each of the right types of providers to deliver the volume of services needed. For example, plan networks should include **one PCP for every 2,000 beneficiaries**.

3) **SUPPORT.** The California Dental Association (CDA), sponsor of this bill, states that Californians are increasingly finding it difficult to locate in-network dentists. CDA continues that this challenge is not due to a shortage of dentists but rather a result of dental plans failing to offer adequate networks for consumers. CDA states that current California law mandates that DMHC and CDI assess the network adequacy of commercial dental plans to ensure they have enough providers to meet the needs of their enrollees. CDA argues that undermining this oversight is the fact that roughly half of Californians with commercial dental plans have a plan that is self-insured by their employer, known as ERISA plans, which fall outside of state regulatory oversight, and are not included in the network adequacy assessments, despite serving a significant number of patients. CDA continues that in addition to this loophole in the state's oversight, while medical insurance plans are held to stringent time and distance standards, dental plans are not subject to the same requirements. CDA further argues that due to limited in-network options, many patients are forced to seek care from out-of-network providers but some dental plans refuse to honor a patient's AOB. CDA states that patients should not be penalized for choosing to see an out-of-network dentist, especially when their plan fails to provide an adequate network. CDA concludes that this bill will ensure that patients receive better value from their dental coverage, both in terms of benefits and accessibility.

4) **OPPOSITION.** Delta Dental of California (Delta Dental) opposes this bill, stating that it threatens to increase consumer costs and reduce dental networks thereby reducing access to affordable dental care. Delta Dental continues that this bill proposes to reduce the current appointment wait time standards by half and they have concerns that more restrictive appointment wait times do not take into account the dental workforce shortage that is affecting California – particularly in rural areas. Delta Dental states that the DMHC applies existing regulatory time and distance standards to dental plans and the regulations allows for plans to request a waiver to these requirements in exchange for an alternate standard approved by the regulator, which is especially crucial in areas of California where there is a shortage of dental health professionals. Delta Dental argues that the reporting requirements including a dental plan's self-insured population are an overreach as state law does not cover self-insured business regulated under ERISA. Lastly, Delta Dental states that the ability to receive direct payment for covered services is one of the primary reasons dentists join a carrier's network and agree to lower their usual fees from what they would otherwise normally charge. Delta Dental argues that AOB erodes the value of direct reimbursement for those dentists who do contract and agree to discount their fees in return for higher patient volume, another reason providers join networks.

5) PREVIOUS LEGISLATION.

a) AB 1048 (Wicks), Chapter 557, Statutes of 2023 prohibits, after January 1, 2025, a plan or health insurer from issuing, amending, renewing, or offering a plan contract or policy that imposes a dental waiting period provision in large group contracts and policies, or a preexisting condition provision in any contracts or policies. Requires health plan contracts and insurance policies covering dental services to be subject to premium rate reviews.

b) SB 221 (Wiener), Chapter 724, Statutes of 2021, codifies existing timely access to care standards for health plans and insurers, applies these requirements to Medi-Cal Managed Care plans, and adds a standard for non-urgent follow-up appointments for nonphysician MH care or substance use disorder (SUD) providers that is within 10 business days of the prior appointment.

c) SB 855 (Wiener), Chapter 151, Statutes of 2020, revises and recasts California's Mental Health Parity provisions, and requires a health plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of MH and SUD, as defined, under the same terms and conditions applied to other medical conditions and prohibits a health plan or disability insurer from limiting benefits or coverage for MH and SUD to short-term or acute treatment. Specifies that if services for the medically necessary treatment of a MH and SUD are not available in network within the geographic and timely access standards in existing law, the health plan or insurer is required to arrange coverage to ensure the delivery of medically necessary out of network services and any medically necessary follow up services, as specified.

d) SB 964 (Hernandez), Chapter 573, Statutes of 2014, requires a health plan to annually report specified network adequacy data to DMHC as a part of its annual timely access compliance report, and requires DMHC to review the network adequacy data for compliance.

e) AB 1579 (Campos) of 2012, would have required a health plan or health insurer that pays a contracting dental provider directly for covered services rendered to an enrollee or insured to also pay a non-contracting dental provider directly for covered services rendered to an enrollee or insured where the provider submits a written assignment of benefits signed by the enrollee or insured, or their legal representative. AB 1579 was held in the Senate Health Committee.

f) AB 2179 (Cohn), Chapter 797, Statutes of 2002, requires DMHC and CDI to develop and adopt regulations to ensure that enrollees have access to needed health care services.

6) POLICY COMMENTS. Some opposing groups argue that that the ability to receive direct payment for covered services is the primary reason dentists choose to participate in carrier networks, agreeing to lower their fees in exchange for streamlined reimbursement. Delta Dental estimates that the AOB provisions of this bill could lead to a five to 15% reduction in network participation, which would mean enrollees would face an additional $235 million to $700 million in out-of-pocket costs annually. However, the true impact of an AOB mandate is unclear. The California Association of Dental Plans (CADP) states that many of their

members offer AOB as a business decision, although they argue that it should not be mandated for all plans. The author and sponsors shared a report with the committee from the George Washington University (GWU) titled "*Analysis of the Impact of Dental AOB Laws*," which was published after multiple states passed their own AOB laws. The GWU report examined the impact of AOB laws on the number of total dentists participating in PPO networks in four states, Tennessee, New Jersey, Mississippi, and South Dakota. The report found that the number of total participating dentists in PPO networks did not decline, but actually rose following the adoption of AOB laws.

This committee asked Delta Dental for data on the impact of AOB laws on their networks in other states that have passed similar laws, but have not received such data at the time of publishing this analysis.

It's important to note that if an AOB mandate were to be enacted, patients would no longer be burdened with passing payment between their dental plan and provider. Removing patients from the middle of such transactions would align with recent state and federal efforts to limit patient exposure to balance billing from their health plan. When a consumer enrolls in a PPO they are generally making a conscious choice to pick a plan with more flexibility to see out-of-network providers, even if it costs more. While some opposition groups have noted that this bill erodes consumer protections, this bill does not give PPO consumers any more ability to see an out-of-network provider than they already do. In fact, this bill would provide consumers with more disclosure and notification about the cost impact of going out-of-network than they would without an AOB. Making these trade-offs more clear to patients should be considered a step forward.

While the impact of AOB on the dental plan market is an important consideration that the Legislature should continue to question, it is important to also center the patient experience when considering the context of this bill.

7) PROPOSED AMENDMENTS.

a) To address concerns with the ability to meet time and distance requirements in rural areas, the committee may wish to amend the bill to clarify that existing geographic access standards, including waivers and flexibilities that DMHC and CDI provide, would also apply to dental networks.

b) The committee may also wish to remove references to self-insured plans in the reporting requirements to ensure that these provisions do not conflict with ERISA.

REGISTERED SUPPORT / OPPOSITION:

Support

California Dental Association (sponsor)
American Federation of State, County and Municipal Employees, AFL-CIO
California Association of Orthodontists
California Dental Hygienists' Association
California Hospital Association
California Medical Association (CMA)
California Pan - Ethnic Health Network

California Society of Pediatric Dentistry
California State Council of Service Employees International Union (SEIU California)
Union of American Physicians and Dentists

Oppose

Association of California Life & Health Insurance Companies
Bay Area Council
California Association of Dental Plans (CADP)
California Association of Health Plans
California Chamber of Commerce
Delta Dental of California
Los Angeles County Business Federation (BIZFED)

Analysis Prepared by: Riana King / HEALTH / (916) 319-2097

AMENDED IN ASSEMBLY APRIL 10, 2025

CALIFORNIA LEGISLATURE—2025–26 REGULAR SESSION

ASSEMBLY BILL No. 489

Introduced by Assembly Member Bonta
(Coauthors: Assembly Members Bains, Berman, Lowenthal, Pellerin, and Wilson)

February 10, 2025

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.

LEGISLATIVE COUNSEL'S DIGEST

AB 489, as amended, Bonta. Health care professions: deceptive terms or letters: artificial intelligence.

Existing law establishes various healing arts boards within the Department of Consumer Affairs that license and regulate various healing arts licensees. Existing laws, including, among others, the Medical Practice Act and the Dental Practice Act, make it a crime for a person who is not licensed as a specified health care professional to use certain words, letters, and phrases or any other terms that imply that they are authorized to practice that profession.

Existing law requires, with certain exemptions, a health facility, clinic, physician's office, or office of a group practice that uses generative artificial intelligence, as defined, to generate written or verbal patient communications pertaining to patient clinical information, as defined, to ensure that those communications include both (1) a disclaimer that indicates to the patient that a communication was generated by generative artificial intelligence, as specified, and (2) clear instructions describing how a patient may contact a human health care provider,

employee, or other appropriate person. Existing law provides that a violation of these provisions by a physician shall be subject to the jurisdiction of the Medical Board of California or the Osteopathic Medical Board of California, as appropriate.

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 *(AI) or generative artificial intelligence (GenAI)* 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 *or GenAI* technology of certain terms, letters, or phrases that indicate or imply that the ~~advice or care~~ *advice, care, reports, or assessments* being provided through AI *or GenAI* 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.

By expanding the scope of existing crimes, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Chapter 15.5 (commencing with Section 4999.8) is added to Division 2 of the Business and Professions Code, to read:

Chapter 15.5. Health Advice From Artificial Intelligence

~~4999.8. (a) For purposes of this chapter, "artificial~~

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 "GenAI" 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 GenAI* 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 GenAI* 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.

SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O

Date of Hearing: May 7, 2025

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
AB 489 (Bonta) – As Amended April 10, 2025

Policy Committee:	Business and Professions	Vote:	17 - 0
	Privacy and Consumer Protection		14 - 0

Urgency: No State Mandated Local Program: Yes Reimbursable: No

SUMMARY:

This bill extends the enforceability of existing title protections for various licensed health care professions to expressly apply against a person or entity who develops or deploys artificial intelligence (AI) or generative AI (GenAI) systems that misrepresent themselves as titled health care professionals. The bill also authorizes state boards to pursue legal recourse against developers and deployers of AI and GenAI systems that impersonate healthcare workers.

FISCAL EFFECT:

The Department of Consumer Affairs (DCA) reports the healing arts boards within DCA have received few complaints concerning AI or GenAI and do not anticipate a significant increase in complaints as a result of this bill. However, the individual healing arts boards estimate a range of potential costs.

The Board of Psychology, the Medical Board of California, the Physical Therapy Board, the Board of Registered Nursing, and the Board of Naturopathic Medicine all anticipate an increase in workload due to a higher volume of complaints resulting from this bill. However, they are unable to estimate the increase in complaint volume or related enforcement costs due to the lack of data on the frequency of AI or GenAI violations and the resulting enforcement costs.

The Dental Board estimates an ongoing fiscal impact of $76,000 per year (State Dentistry Fund), assuming additional workload of 20 enforcement cases per year, which will take approximately 14 hours per case. The Dental Board estimates two cases per year would need injunctions, at a cost of $6,000 each. In addition to the increase in enforcement workload, the Dental Board anticipates the need to provide annual training to its enforcement staff.

The Board of Pharmacy estimates ongoing costs of approximately $56,000 per year. The Board of Pharmacy estimates this bill would create an additional workload of 480 hours per year for an inspector to investigate, write reports, and issue cease-and-desist orders for 40 enforcement cases that each take approximately 12 hours (Pharmacy Board Contingent Fund).

The DCA Office of Information Services has determined that up to 40 new enforcement codes are needed as a result of this bill, at an absorbable cost of $8,000.

COMMENTS:

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

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

2) **Background.**

Title Protection. Title protection is one of the forms of regulation of professional services that the Legislature may impose to protect patients and consumers by reserving the use of words, terms, initials, and titles for individuals who have met certain requirements to demonstrate competence.

Potential Harm from AI in Health Care. AI role-playing as a medical professional raises serious privacy and ethical concerns. Entities such as Character.ai do not have to comply with federal and state confidentiality laws, which protect sensitive patient information. Even if an AI bot includes a disclaimer noting it is not a real medical professional, users may still be misled, especially younger, older, or emotionally vulnerable individuals. Believing they are confiding in a legitimate healthcare provider, users may share deeply personal information about their mental or physical health, or life circumstances. While some may argue that such data can be deidentified, companies can often reidentify individuals by combining this information with other data points.

Two lawsuits are pending that address Character.ai's potential liability for harmful chatbot interactions with minors. In one case, a teenager died by suicide after a chatbot allegedly did not recognize signs of suicidal ideation and did not dissuade him from self-harm. In another, a bot reportedly encouraged a teen to harm his family because the family was trying to limit his time with the bot. Although these cases do not involve bots impersonating medical professionals, they underscore the serious risks such interactions can pose.

Analysis Prepared by: Allegra Kim / APPR. / (916) 319-2081

AMENDED IN ASSEMBLY MARCH 13, 2025

CALIFORNIA LEGISLATURE—2025–26 REGULAR SESSION

ASSEMBLY BILL No. 742

Introduced by Assembly Member Elhawary
(Principal coauthors: Assembly Members Bonta, Bryan, Gipson, Jackson, McKinnor, Sharp-Collins, and Wilson)
(Principal coauthors: Senators Richardson, Smallwood-Cuevas, and Weber Pierson)
(Coauthor: Assembly Member Lowenthal)

February 18, 2025

An act to add and repeal Section 115.7 of the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

AB 742, as amended, Elhawary. Department of Consumer Affairs: licensing: applicants who are descendants of slaves.

Existing law establishes the Department of Consumer Affairs, which is composed of specified boards that license and regulate various professions.

This bill would require those boards to prioritize applicants *seeking licensure* who are descendants of ~~slaves seeking licenses, especially applicants who are descended from a person enslaved within the United States.~~ *American slaves once a process to certify descendants of American slaves is established, as specified. 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.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 115.7 is added to the Business and Professions Code, to read:

115.7. *(a)* Notwithstanding any other law, ~~a~~ *once the process to certify descendants of American slaves is established by the Bureau for Descendants of American Slavery pursuant to Part 15 (commencing with Section 16000) of Division 3 of Title 2 of the Government Code that confirms an individual's status as a descendant of an American slave, each* board shall prioritize applicants *seeking licensure* who are descendants of ~~slaves seeking licenses, especially applicants who are descended from a person enslaved within the United States.~~ *American slaves.*

(b) This section shall become operative on the date that the certification process for the descendants of American Slaves is established by the Bureau for Descendants of American Slavery pursuant to Part 15 (commencing with Section 16000) of Division 3 of Title 2 of the Government Code.

(c) This section shall remain in effect only for four years from the date on which this section became operative, or until January 1, 2032, whichever is earlier, and as of that date is repealed.

(d) This section shall become operative only if Senate Bill 518 of the 2025–26 Regular Session is enacted establishing the Bureau for Descendants of American Slavery.

REVISIONS:
Heading—Line 6.

O

Date of Hearing: May 7, 2025

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
AB 742 (Elhawary) – As Amended March 13, 2025

Policy Committee:	Business and Professions	Vote:	12 - 2
	Judiciary		8 - 2

Urgency: No State Mandated Local Program: No Reimbursable: No

SUMMARY:

This bill requires a state licensing board within the Department of Consumer Affairs (DCA) to prioritize applicants seeking licensure who are descendants of American slaves.

Specifically, this bill:

1) Upon establishment of the process to certify descendants of American slaves by the Bureau for Descendants of American Slavery, requires each state licensing board within the DCA to prioritize applicants seeking licensure who are descendants of American slaves.

2) Specifies the bill's provisions become operative on the date that the certification process for the descendants of American slaves is established by the Bureau for Descendants of American Slavery.

3) Sunsets the bill's provisions four years from the date the bill becomes operative, or on January 1, 2032, whichever is earlier, and as of that date is repealed.

4) Specifies the bill's provisions become operative only if Senate Bill 518 of the 2025–26 Regular Session is enacted establishing the Bureau for Descendants of American Slavery.

FISCAL EFFECT:

The Department of Consumer Affairs (DCA), after surveying all DCA boards and bureaus (programs), indicates the following special fund costs (various funds):

1) The majority of programs determined that additional workload, such as updates to applications, websites, materials, annual reports, procedures, regulations, as well as required training and outreach, would be minor and absorbable within existing resources. Most of the programs indicated they already have a process in place to expedite applications. A portion of the programs also identified the need to promulgate regulations.

2) One program, the Board of Barbering and Cosmetology (BBC), identified a non-absorbable cost as follows:

> The BBC would require $275,000 in the first year, and $128,000 ongoing to support a one-year limited-term position, as well as one permanent position to support the implementation of this bill. The limited-term position will develop new procedures for applicants, update policies, system modifications, and reporting, and coordinate with

licensing staff. The permanent position will be responsible for processing all prioritized applications, and the associated workload to maintain records and support system modifications. The BBC will also need to promulgate regulations and update translations for all eight applications with a cost of approximately $25,000, which is absorbable within the board's current resources.

3) The Office of Information Services (OIS), within DCA, estimates a one-time IT General Fund cost of $305,000. OIS indicates this bill will require updates to online applications and posting of paper applications on websites, and assumes all 302 application types would be affected. OIS indicates it can absorb $30,000 of this cost within existing resources. However, OIS will require one-time funding for the remaining $278,000 to contract with a vendor to update all online forms.

COMMENTS:

1) **Purpose.** This bill is part of a package of bills introduced by members of the California Legislative Black Caucus that seek to implement recommendations of the California's Task Force to Study and Develop Reparations Proposals for African Americans (Task Force). According to the author:

> Descendant of slaves have faced historical barriers to accessing licenses due to longstanding impact of racial bias. By prioritizing descendants of slaves when applying for licenses, we hope to increase the number of applicants and recipients of licensure in various businesses and professions where descendants of slaves have often been overlooked and underrepresented. This is one small step in righting the wrongs of the past.

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

   AB 3121 (Weber), Chapter 319, Statutes of 2020, established the Task Force and required it to study and develop reparation proposals for African Americans as a result of slavery and numerous subsequent forms of discrimination based on race. The Task Force was required to recommend appropriate remedies in consideration of its findings, which were submitted as a report to the Legislature on June 29, 2023.

   Chapter 10 of the Task Force's report, titled "Stolen Labor and Hindered Opportunity," addresses how African Americans have historically been excluded from occupational licenses. In its discussion of professional licensure, the Task Force includes a recommendation in favor of "prioritizing African American applicants seeking occupational licenses, especially those who are descendants [of slavery]."

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

This year, the California Legislative Black Caucus announced its "Road to Repair 2025 Priority Bill Package." This bill, included as part of that package, is similar to AB 2862. However, this bill replaces references to "African American applicants" with a requirement that boards prioritize "descendants of American slaves." Because there is no established way to prove this status, this bill's requirements are contingent on the Legislature also enacting Senate Bill 518 (Weber Pierson), which establishes a Bureau for Descendants of American Slavery.

Once this Bureau has implemented a process for certifying descendants of American slaves, certified applicants would qualify for prioritization under this bill. This requirement would be similar to existing expedited licensure processes for military families, refugee applicants, and abortion providers. The author believes this bill would meaningfully address the specific impact specific transgressions have had on African Americans seeking licensure in California.

3) **Arguments in Support.** The Greater Sacramento Urban League asserts:

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

4) **Arguments in Opposition.** The Pacific Legal Foundation (PLF) and Californians for Equal Rights Foundation each oppose this bill for substantially the same reasons, contending that the operative classification of "descendants of American slavery" is a proxy for race, and, as such, it is a racial classification that violates the 14th Amendment of the U.S. Constitution. PLF contends that this classification would be held to a strict scrutiny test, and that under this test the state could not satisfy either the "compelling interest" prong or the "narrow tailoring" prong of that test.

Analysis Prepared by: Jennifer Swenson / APPR. / (916) 319-2081

AMENDED IN ASSEMBLY APRIL 9, 2025

CALIFORNIA LEGISLATURE—2025–26 REGULAR SESSION

ASSEMBLY BILL No. 873

Introduced by Assembly Member Alanis

February 19, 2025

An act to amend ~~Section 1750 of, and to repeal Section 1755 of,~~ *Sections 1725, 1750, and 1755 of* the Business and Professions Code, relating to healing arts, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 873, as amended, Alanis. Dentistry: dental assistants: infection control course.

Existing law, the Dental Practice Act, establishes the Dental Board of California to license and regulate the practice of dentistry, including the licensure and regulation of dental auxiliaries, including, among others, dental assistants, as defined, and sets forth duties and functions that those dental auxiliaries are authorized to perform. *Existing law authorizes the board to review and evaluate all applications for licensure in all dental assisting categories to ascertain whether a candidate meets the appropriate licensing requirements specified by statute and board regulation. Existing law establishes the Dental Assisting Council within the Dental Board of California and requires the council to consider all matters relating to dental assistants in the state, as specified, and to make appropriate recommendations to the board and the standing committees of the board in specified areas, including standards and criteria for approval of dental assisting educational programs, courses, and continuing education. Existing law requires the board to approve, modify, or reject recommendations by*

the council within 120 days of submission to the board during full board business.

Existing law requires that fees relating to the licensing and permitting of dental assistants be established by regulation, subject to certain limitations prescribed by statute.

This bill would require that the fee for review of each approval application or reevaluation for a course for instruction in interim therapeutic restoration and radiographic decisionmaking, radiation safety, or infection control that is not accredited by a board-approved agency or the Chancellor's office of the California Community Colleges not exceed $300, and would make conforming changes.

Existing law ~~establishes various requirements for courses in infection control for certain unlicensed dental assistants and requires an unregistered dental assistant not enrolled in a board-approved program for registered dental assisting or an alternative dental assisting program, as specified, to complete a certification course, as specified.~~ *provides that the employer of a dental assistant is responsible for ensuring that the dental assistant has successfully completed a board-approved 8-hour course in infection control prior to performing any basic supportive dental procedures involving potential exposure to blood, saliva, or other potentially infectious material.*

~~This bill would repeal those requirements for courses in infection control for certain unlicensed dental assistants.~~

~~Existing law provides the employer of a dental assistant is responsible for ensuring that the dental assistant has successfully completed the above course prior to performing any basic supportive dental procedures involving potential exposure to blood, saliva, or other potentially infectious material.~~

~~This bill would, instead, provide that the employer of a dental assistant is responsible for ensuring that a dental assistant who has been in continuous employment for 90 days or more has already completed, or successfully completes, the above course within a year of the date of employment.~~

This bill would, instead, provide that the employer is responsible for ensuring that the dental assistant has successfully completed the course within 90 days from the date of first employment with the employer. The bill would also expand the courses that a dental assistant may take to comply with this requirement to include a course provided by a board-approved registered dental assisting education program, and a course with 6 hours of didactic instruction and at least 2 hours of

laboratory instruction using video or a series of video training tools, as specified.

Existing law requires an unregistered dental assistant not enrolled in a board-approved program for registered dental assisting or an alternative dental assisting program, as specified, to complete a certification course in infection control, as specified. Existing law requires a certification course in infection control to meet minimum requirements related to duration, including having at least 6 hours of didactic instruction and 2 hours of laboratory instruction, as prescribed. Existing law requires that, upon successful completion of the course, students receive a certificate of completion, as defined.

This bill would delete the above-described requirement for unregistered dental assistants not enrolled in a board-approved program for registered dental assisting or an alternative dental assisting program. The bill would also provide that for certain infection control courses, a provider shall submit an application on a form furnished by the board for board approval to offer the course, the above-described fee, and certain documentation related to course identification and course structure, including written laboratory protocols that comply with certain regulations, as specified. The bill would require the course director to, among other things, actively participate in, and be responsible for, the administration of the course, as specified. The bill would require the course provider to, among other things, notify prospective students of the computer or communications technology necessary to participate in didactic and laboratory instruction.

This bill would authorize the board or its designees to approve, provisionally approve, or deny approval of a course in infection control after evaluating all of its components. The bill would limit provisional approval to a course that substantially complies with all existing standards for full approval and would make that provisional approval expire one year after provisional approval or upon subsequent approval or denial, whichever occurs first. The bill would require a board-approved course to be reevaluated every 7 years, as specified, and would authorize the board to withdraw approval at any time if it determines the course does not meet specified requirements. The bill would impose various requirements on certain courses in infection control, including that the course provide technological assistance to students, as needed, to participate in didactic and laboratory instruction.

This bill would require the certificate of completion to state the statutory authority used to approve the course, as specified. The bill

would prohibit certain courses from satisfying the infection control course requirement for licensure as a registered dental assistant or obtaining an orthodontic assistant permit or a dental sedation assistant permit. The bill would require course records to be available for inspection by the board at any time.

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

Vote: ⅔. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 1725 of the Business and Professions Code is amended to read:

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

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

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

(c) The fee for application and for the issuance of an orthodontic assistant permit or a dental sedation assistant permit shall not exceed two hundred dollars ($200).

(d) The fee for the written examination for an orthodontic assistant permit or a dental sedation assistant permit shall not exceed the actual cost of the examination.

(e) The fee for the Registered Dental Assistant Combined Written and Law and Ethics Examination for a registered dental assistant shall not exceed the actual cost of the examination.

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

(g) The biennial renewal fee for a registered dental assistant license, registered dental assistant in extended functions license, dental sedation assistant permit, or orthodontic assistant permit shall not exceed two hundred dollars ($200).

(h) The delinquency fee shall be 50 percent of the renewal fee for the license or permit in effect on the date of the renewal of the license or permit.

(i) The fee for issuance of a duplicate registration, license, permit, or certificate to replace one that is lost or destroyed, or in the event of a name change, shall not exceed one hundred dollars ($100).

(j) The fee for each curriculum review and site evaluation for educational programs for registered dental assistants that are not accredited by a board-approved agency, or the Chancellor's office of the California Community Colleges shall not exceed seven thousand five hundred dollars ($7,500).

(k) The fee for review of each approval application or reevaluation for a course that is not accredited by a board-approved agency or the Chancellor's office of the California Community Colleges shall not exceed two thousand dollars ($2,000).

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

~~(l)~~

(m) Fees collected pursuant to this section shall be deposited in the State Dentistry Fund.

~~SECTION 1.~~

SEC. 2. Section 1750 of the Business and Professions Code is amended to read:

1750. (a) A dental assistant is an individual who, without a license, may perform basic supportive dental procedures, as authorized by Section 1750.1 and by regulations adopted by the board, under the supervision of a licensed dentist. "Basic supportive dental procedures" are those procedures that have technically elementary characteristics, are completely reversible, and are unlikely to precipitate potentially hazardous conditions for the patient being treated.

(b) The supervising licensed dentist shall be directly responsible for determining the competency of the dental assistant to perform the basic supportive dental procedures, as authorized by Section 1750.1.

(c) The employer of a dental assistant shall be responsible for ensuring that ~~a dental assistant who has been in continuous employment for 90 days or more, has already completed, or successfully completes, a board-approved eight-hour course in~~

~~infection control within a year of the date of employment.~~ *the dental assistant has successfully completed a board-approved eight-hour course in infection control within 90 days from the date of first employment at the dental office.*

(d) The employer shall maintain evidence for the length of the employment for the dental assistant at the supervising dentist's treatment facility to verify the dental assistant has met and maintained all certification requirements as dictated by statute and regulation.

(e) The employer shall inform the dental assistant of the educational requirements described in subdivision (f) to maintain employment as an unlicensed dental assistant.

(f) The employer of a dental assistant shall be responsible for ensuring that the dental assistant who has been employed continuously or on an intermittent basis by that employer for one year from the date of first employment provides evidence to the employer that the dental assistant has already successfully completed, or successfully completes, all of the following within one year of the first date of employment:

(1) A board-approved two-hour course in the Dental Practice Act.

(2) Current certification in basic life support issued by the American Red Cross, the American Heart Association, the American Safety and Health Institute, the American Dental Association's Continuing Education Recognition Program, or the Academy of General Dentistry's Program Approval for Continuing Education, in accordance with both of the following:

(A) The dental assistant shall be responsible for maintaining current certification in basic life support to perform duties involving patients.

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

(3) To perform radiographic procedures, a dental assistant shall complete a board-approved course in radiation safety. The original or a copy of the current, valid certificate issued by a board-approved radiation safety course provider shall be publicly displayed at the treatment facility where the dental assistant performs dental services.

(4) To perform coronal polishing prior to licensure as a registered dental assistant, an unlicensed dental assistant shall complete a board-approved coronal polishing course and obtain a certificate of completion. Prior to taking the coronal polishing course, the dental assistant shall provide evidence to the course provider of having completed a board-approved eight-hour course in infection control and a current, valid certification in basic life support.

(A) Coronal polishing performed pursuant to this paragraph shall be performed under the direct supervision and pursuant to the order, control, and full professional responsibility of a licensed dentist, who shall, at minimum, evaluate each patient after coronal polishing procedures are performed by the dental assistant.

(B) The original or a copy of the current, valid certificate issued by a board-approved coronal polishing course provider shall be publicly displayed at the treatment facility where the dental assistant performs dental services.

~~SEC. 2. Section 1755 of the Business and Professions Code is repealed.~~

SEC. 3. Section 1755 of the Business and Professions Code is amended to read:

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

~~(b) An unlicensed dental assistant not enrolled in a board-approved program for registered dental assisting or an alternative dental assisting program as defined in subdivision (a) of Section 1741, shall complete one of the following infection control certification courses:~~

(b) An eight-hour infection control course taken for compliance with the requirements of subdivision (c) of Section 1750 shall be one of the following:

(1) A board-approved eight-hour ~~course, with six hours being didactic instruction and two hours being laboratory instruction.~~ *infection control course provided by a board-approved registered dental assisting education program.*

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

~~(2)~~

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

~~(c) A course shall establish specific instructional objectives. Instruction shall provide the content necessary for students to make safe and ethical judgments regarding infection control and asepsis.~~

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

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

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

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

~~(d)~~

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

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

~~(e) Didactic~~

(6) Documentation of didactic instruction ~~shall include,~~ *that includes,* at a minimum, all of the following as they relate to Cal/OSHA regulations, as set forth in Sections 300 to 344.85,

inclusive, of Title 8 of the California Code of Regulations, and the board's Minimum Standards for Infection Control, as set forth in Section 1005 of Title 16 of the California Code of Regulations:

~~(1)~~

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

~~(2)~~

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

~~(3)~~

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

~~(4)~~

(D) Principles of modes of disease transmission and prevention.

~~(5)~~

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

~~(6) Principles and protocols~~

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

~~(7) Principles and protocols~~

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

~~(8) Principles and protocols~~

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

~~(9) Principles and protocols~~

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

~~(10) Principles and protocols of regulated and nonregulated waste management.~~

(J) Principles, protocols, and procedures of contaminated medical waste management occurring in the dental health care setting.

~~(11) Principles and protocols~~

(K) Principles, protocols, and procedures related to injury and illness prevention, hazard communication, general office safety,

exposure control, postexposure requirements, and monitoring systems for radiation safety and sterilization systems.

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

(A) Applying hand cleansing products and performing hand cleansing techniques, protocols, and procedures.

(B) Applying, removing, and disposing of patient treatment gloves, utility gloves, overgloves, protective eyewear, masks, and clinical attire.

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

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

(E) Precleaning and disinfecting contaminated operatory surfaces and devices, and properly using, placing, and removing surface barriers.

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

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

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

(I) Performing waterline maintenance, including using water tests and purging waterlines.

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

(8) Written laboratory protocols that comply with the board's Minimum Standards for Infection Control as set forth in Section

1005 of Title 16 of the California Code of Regulations, and other federal, state, and local requirements governing infection control. The course shall provide these protocols to all students and course instructors to ensure compliance.

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

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

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

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

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

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

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

(B) Informing the board of the closure of, or any major change to, the course, including changes to the course provider name,

course director, business contact information, or course content, within 10 days of the closure or change.

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

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

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

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

~~(f)~~

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

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

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

~~(g)~~

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

~~SEC. 3.~~

SEC. 4. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the California Constitution and shall go into immediate effect. The facts constituting the necessity are:

Unlicensed dental assistants are currently required to take an eight-hour course prior to performing any basic supportive dental procedures that would have potential exposure to infectious materials. There have been issues preventing the establishment of the eight-hour course virtually and the eight-hour course is not readily available in many parts of the state, especially remote and rural areas already experiencing access and workforce shortage

issues. To mitigate these outcomes, it is necessary that this act take effect immediately.

O

Date of Hearing: April 23, 2025

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
AB 873 (Alanis) – As Amended April 9, 2025

Policy Committee: Business and Professions Vote: 17 - 0

Urgency: Yes State Mandated Local Program: No Reimbursable: No

SUMMARY:

The bill revises requirements for infection control training for dental assistants (DAs). This bill also requires the fee the Dental Board of California (Board) charges for reviewing approval or reevaluation for certain non-accredited courses for DAs not exceed $300, and would take effect immediately as an urgency statute.

Specifically, this bill:

1) Provides that the employer of a DA (a licensed dentist) is responsible for ensuring the DA has successfully completed an approved infection control course within 90 days of first employment with the employer.

2) Authorizes the Board or its designees to approve, provisionally approve, or deny approval of, a course in infection control, as specified. Requires the Board or its designees reevaluate a Board-approved course every seven years, and authorizes the Board to withdraw approval if it determines the course does not meet specified requirements.

3) Prohibits the Board from requiring a fee of over $300 for review of an approval application or reevaluation for an infection control course.

4) Imposes requirements on infection control courses, including content areas, and that the provider of the course obtain approval from the Board to offer the course, as specified.

5) Expands the courses that may meet the requirements for Board approval, and prohibits certain courses from satisfying the infection control course requirement for licensure as a registered DA or obtaining an orthodontic assistant permit or a dental sedation assistant permit.

6) Requires the certificate of completion of an infection control course to state the statutory authority used to approve the course.

7) Declares this act an urgency statute necessary because unlicensed DAs are currently required to take an eight-hour course prior to performing procedures with potential exposure to infectious materials, and access to such courses is not readily available in many parts of the state, especially remote and rural areas already experiencing access problems and workforce shortages.

FISCAL EFFECT:

The Board estimates it would receive 173 new applications for approval of infection control courses annually. The Board will need to review each course for compliance with the state's Dental Practice Act and related regulations, minimum standards for infection control such as those set forth by the federal Centers for Disease Control and Prevention, Occupational Safety and Health Administration (OSHA), and California OSHA. The Board estimates it will need one program analyst and an increase in subject matter expert workload of four hours per application, at a rate of $100 per hour in 2026-27 and ongoing. If the Board charged the maximum fee of $300 to review an application, the Board would experience a revenue increase of $52,000 per year, which will not cover the total yearly cost associated with the workload. Assuming the maximum fee, the Board estimates costs of $184,000 in 2026-27 and $176,000 in 2027-28 and ongoing (State Dentistry Fund).

The Department of Consumer Affairs Office of Information Services anticipates absorbable costs to post the new course approval form in compliance with existing standards.

COMMENTS:

1) **Purpose.** This bill is sponsored by the California Dental Association. According to the author:

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

2) **Background.** DAs are one of three types of dental practitioners that assist licensed dentists, the other two being registered dental assistants (RDAs) and registered dental assistants in extended functions (RDAEFs). RDAs and RDAEFs are licensed by the DBC and can perform relatively complex services. DAs are unlicensed and may perform "basic supportive dental procedures," which are procedures that are elementary from a technical standpoint, are completely reversible, and are unlikely to result in hazardous conditions for the patient. DAs are indirectly regulated by the Board through requirements on their dentist employers. Dentist employers are responsible for the services provided by their DA employees, so they must provide proper training and oversight. They must also document compliance with all relevant requirements. When there is an adverse event, the employing or supervising dentist's license may be subject to discipline by the Board.

***DA Training*.** In addition to any training needed to successfully incorporate a DA into a dental practice, statutes and regulations require employers of DAs to meet training requirements. The Dental Practice Act (Act) specifies that DA employers are responsible for DAs completing a Board-approved two-hour course on the Act and maintaining certification in basic life support. The Act also requires DA employers to ensure DA employees complete a Board-approved eight-hour course in infection control that meets various statutory requirements prior to performing any service that involves potential

exposure to blood, saliva, or other potentially infectious materials. This bill instead allows DAs to begin providing services prior to completing the infection course.

3) **Prior Legislation.**

AB 2242 (Carrillo) and AB 481 (Carrillo), of the 2023-24 Legislative Session, would have made numerous changes to the education, scope of practice, and regulation of dental auxiliaries, including DAs, orthodontic assistants, and RDAs. AB 2242 died pending a hearing in the Assembly Business and Professions Committee. AB 481 was held on the Senate Appropriations Committee suspense file.

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

Analysis Prepared by: Allegra Kim / APPR. / (916) 319-2081

AMENDED IN ASSEMBLY APRIL 7, 2025

CALIFORNIA LEGISLATURE—2025–26 REGULAR SESSION

ASSEMBLY BILL No. 966

Introduced by Assembly Member Carrillo

February 20, 2025

An act to amend Sections 1628 and 1634.1 of, to repeal and add Section 1636.5 of, and to repeal, add, and repeal Section 1636.6 of, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 966, as amended, Carrillo. Dental Practice Act: foreign dental schools.

Existing law, the Dental Practice Act, provides for the licensure and regulation of dentists by the Dental Board of California within the Department of Consumer Affairs. Existing law requires an applicant for licensure to meet specified requirements, including, among others, furnishing satisfactory evidence of having graduated from a dental college approved by the board or by the Commission on Dental Accreditation of the American Dental Association (CODA). Prior law provided for the approval of foreign dental schools by the board. Beginning January 1, 2024, existing law requires foreign dental schools seeking approval by the board to complete the international consultative and accreditation process with CODA. Notwithstanding that requirement, existing law maintained the approval of any foreign dental schools whose program was renewed by the board prior to January 1, 2020, through any date between January 1, 2024, and June 30, 2026, through that renewal date.

This bill would instead maintain the approval of any foreign dental school whose program was approved by the board prior to January 1,

2024, until the school has been issued a denial of accreditation by CODA and the school does not appeal, the school has been issued a denial by CODA following the completion of the appeals process, or the school withdraws its application for accreditation by CODA, provided the school applies for accreditation on or before January 1, 2026, and updates the board on the accreditation process, as specified. The bill would specify that a graduate of a foreign dental school with this extended approval is eligible for licensure to practice dentistry pursuant to the requirements of the Dental Practice Act, including graduates who were enrolled in the school at the time the extended approval expires, provided they were enrolled on or after July 1, 2025. The bill would require an applicant who is a graduate of a foreign dental school with this extended approval to agree to practice dentistry full time in one of 5 specified practice settings for at least 2 years within the first 3 years of licensure. The bill would require the board, as part of the board's first sunset review report following January 1, 2032, to report specified information regarding workforce data of licensees and graduates of foreign dental schools with extended approval, as specified. *The bill would state findings and declarations of the Legislature relating to the shortage or maldistribution of dentists in California.*

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following relating to the shortage or maldistribution of dentists throughout California, including a lack of Latino and Black dental students and licensed dentists in proportion to their population in the state:

(a) The State Department of Public Health's California Oral Health Plan 2018-2028 and a study by the Healthforce Center at the University of California at San Francisco (UCSF) identified the following major oral health issues in California:

(1) There are marked oral health disparities in California with respect to race and ethnicity, income, and education. The uneven distribution of the oral care workforce and inadequate infrastructure and capacity in the public health system have presented difficulties in delivering preventive and early treatment for oral care services to millions of Californians.

(2) Approximately 2.2 million Californians live in dental health professional shortage areas, which are largely concentrated in the northern Sierra counties, the central valley, and the Inland Empire.

(b) According to the United States Department of Health and Human Services, rural populations have a higher prevalence of cavities and tooth loss, a lower degree of private dental insurance, and limited access to public dental services. Rural areas often have inadequate public transportation systems, making it very difficult to access dentists outside the proximal area.

(c) Most dentists practiced in the greater bay area (25 percent), Los Angeles (26 percent), and other southern California counties (29 percent).

(d) A disproportionate number of people living in poverty and the working poor reside in geographically isolated areas with a maldistribution of dentists and a limited number of Medicaid providers. As a result, those who need dental care the most are often the least likely to receive it.

(e) According to the UCSF study, estimates of the total supply of dentists in California do not reflect the supply available to care for medically underserved communities and individuals covered by Medi-Cal, which covers 26 percent of the state's population and nearly one-half (43 percent) of the state's children.

(f) In 2016, only 15.7 percent of California dentists participated in Medi-Cal or the Healthy Families Program, the second lowest in the nation.

(g) In 2024, the Little Hoover Commission, after conducting additional reviews of the program, stated that California still ranks among the worst in the nation when it comes to care and treatment of pediatric dental disease.

(h) The racial and ethnic diversity of the workforce is not congruent with California's population, affecting access to services and culturally appropriate delivery of dental care.

(i) Despite the Latino population comprising approximately 38 percent of the people in California, only 6 percent of practicing dentists are Latino, according to data from the California Health and Human Services Open Data Portal.

(j) Similarly, Black dentists make up 2 percent of the California dentist workforce despite the Black population making up 6 percent of California's population.

(k) The deficient number of Latino and Black dentists contributes to and accentuates the access to dental care problem as it is well documented that cultural competency in the delivery of oral health effectively addresses societal barriers in accessing and receiving preventative and treatment services.

(l) In 1998, to alleviate the shortage or maldistribution of dentists, the Legislature created a program requiring the Dental Board of California (the board) to evaluate, and if qualified, approve foreign dental schools.

(m) Under this program, the board established an evaluation process conducted by experts in the dental arena to assess curriculum, faculty qualifications, facilities, and other relevant factors to ensure that the schools would provide an education that is equivalent to that of similar accredited institutions in the United States and that would adequately prepare students for the practice of dentistry.

(n) The board approved two foreign dental schools: the University of De La Salle-Bajío School of Dentistry (La Salle University) in Guanajuato, Mexico, in 2004, and the State University of Medicine and Pharmacy "Nicolae Testemitanu" in Moldova in 2016.

(o) Moldova University has been a center of undergraduate and postgraduate education of doctors and pharmacists since 1945, and of dentistry since 1959.

(p) Moldova University has over 5,600 students from Moldova and 30 other countries currently studying at the university.

(q) La Salle University, founded in 1975, is ranked as one of the best dental schools in Mexico.

(r) The University of De La Salle-Bajío is composed of five campuses, with 13,500 students.

(s) In order to become approved foreign dental schools, La Salle University and Moldova University underwent extensive approval and evaluation processes conducted by the board that took years to complete.

(t) Graduates from these approved schools were required to pass the same licensure standards as graduates from schools within the United States.

(u) Since the inception of this program, approximately 900 graduates from La Salle University and Moldova University have passed the required California exams and are practicing in

California. Many are practicing in low-income, underserved communities, like Yuba City, Madera, Bakersfield, Fresno, and Los Angeles.

(v) At the board's sunset review hearing in 2019, the board stated that it did not have the resources to continue approving foreign dental schools and requested that foreign dental schools be accredited by the Commission on Dental Accreditation of the American Dental Association (CODA) instead, as CODA is better equipped to carry on the task.

(w) Assembly Bill 1519 (Chapter 865 of the Statutes of 2019), the board's sunset review bill, eliminated the board's authority to approve additional foreign dental schools, and required that, to maintain their status as board-approved schools, La Salle University and Moldova University must successfully complete the international consultative and accreditation process with CODA by January 1, 2024.

(x) Moldova University began the CODA accreditation process on March 15, 2021. CODA responded that they would not be conducting reviews of international dental schools in the foreseeable future because of travel restrictions resulting from the COVID-19 pandemic.

(y) La Salle University began the CODA accreditation process in 2007, was denied accreditation in March 2019, and is currently in the process of appealing the decision.

(z) CODA began its process of creating an international school accreditation process in 2005, completed this process in 2006, and began accepting applications in 2007. Documentation from CODA shows that in 2007, 10 international dental programs submitted applications.

(aa) In 2019, CODA approved its first foreign dental school, King Abdulaziz University in Jeddah, Saudi Arabia. The process took approximately 12 years to complete.

(ab) In 2024, CODA approved its second foreign school, Yeditepe University in Istanbul, Turkey. The process took approximately 17 years to complete.

~~SECTION 1.~~

SEC. 2. Section 1628 of the Business and Professions Code is amended to read:

1628. Any person over 18 years of age is eligible to take an examination before the board upon making application therefor and meeting all of the following requirements:

(a) Paying the fee for applicants for examination provided by this chapter.

(b) Furnishing satisfactory evidence of having graduated from a dental college approved by the board or by the Commission on Dental Accreditation of the American Dental Association, including a foreign dental school previously approved by the board pursuant to Section 1636.5, and presenting satisfactory evidence of having completed at dental school or schools the full number of academic years of undergraduate courses required for graduation. For purposes of this article, "dental college approved by the board" or "approved dental school" include a foreign dental school accredited by a body that has a reciprocal accreditation agreement with any commission or accreditation organization whose findings are accepted by the board.

(c) Furnishing the satisfactory evidence of financial responsibility or liability insurance for injuries sustained or claimed to be sustained by a dental patient in the course of the examination as a result of the applicant's actions.

(d) If the applicant has been issued a degree of doctor of dental medicine or doctor of dental surgery by a foreign dental school, the applicant shall furnish all of the following documentary evidence to the board:

(1) That the applicant has completed, in a dental school or schools approved by the board pursuant to Section 1636.4, a resident course of professional instruction in dentistry for the full number of academic years of undergraduate courses required for graduation.

(2) Subsequent thereto, the applicant has been issued by the dental school a dental diploma or a dental degree, as evidence of the successful completion of the course of dental instruction required for graduation.

(e) Any applicant who has been issued a dental diploma from a foreign dental school that has not, at the time of the applicant's graduation from the school, been approved by the board pursuant to Section 1636.4 shall not be eligible for examination until the applicant has successfully completed a minimum of two academic years of education at a dental college approved by the board

pursuant to Article 1 (commencing with Section 1024) of Chapter 2 of Division 10 of Title 16 of the California Code of Regulations and has been issued a degree of doctor of dental medicine or doctor of dental surgery or its equivalent. This subdivision shall not apply to applicants who have successfully completed the requirements of Section 1636 as it read before it was repealed on January 1, 2004, on or before December 31, 2003, or who have successfully completed the requirements of Section 1628.2 on or before December 31, 2008. An applicant who has successfully completed the requirements of Section 1636 as it read before it was repealed on January 1, 2004, on or before December 31, 2003, or who has successfully completed the requirements of Section 1628.2 on or before December 31, 2008, shall be eligible to take the examination required by Section 1632, subject to the limitations set forth in subdivisions (b) and (c) of Section 1633.

(f) Subdivisions (d) and (e) do not apply to a person who has been issued a degree of doctor of dental medicine or doctor of dental surgery by a foreign dental school accredited by a body that has a reciprocal accreditation agreement with any commission or accreditation organization whose findings are accepted by the board.

(g) (1) If the applicant is a graduate of a foreign dental school with extended approval pursuant to subdivision (a) of Section 1636.5, the applicant agrees to practice dentistry full time for two years in one or more of the following practice settings:

(A) A primary care clinic licensed under Section 1204 of the Health and Safety Code.

(B) A primary care clinic exempt from licensure pursuant to subdivision (c) of Section 1206 of the Health and Safety Code.

(C) A clinic owned or operated by a public hospital or health system.

(D) A clinic owned and operated by a hospital that maintains the primary contract with a county government to fill the county's role under Section 17000 of the Welfare and Institutions Code.

(E) A federally qualified health center, as defined in Section 1396d of Title 42 of the United States Code.

(2) The applicant shall complete the two years of practice described in paragraph (1) within the first three years of receiving a license to practice dentistry.

(3) The board may periodically request verification of compliance with this subdivision, and may revoke the license upon a finding that the applicant has not complied with this subdivision.

(4) The board shall provide information about the areas of the state that are experiencing a shortage of dentists in the application packet for licensure to practice dentistry pursuant to this section.

(5) The board shall define "full-time employment status" as described in this subdivision, and the board may establish exemptions to this requirement on a case-by-case basis.

~~SEC. 2.~~

SEC. 3. Section 1634.1 of the Business and Professions Code is amended to read:

1634.1. Notwithstanding Section 1634, the board may grant a license to practice dentistry to an applicant who submits all of the following to the board:

(a) A completed application form and all fees required by the board.

(b) Satisfactory evidence of having graduated from a dental school approved by a national accrediting body approved by the board or by the Commission on Dental Accreditation of the American Dental Association or from a foreign dental school previously approved by the board pursuant to Section 1636.5.

(c) Satisfactory evidence of having completed a clinically based advanced education program in general dentistry or an advanced education program in general practice residency that is, at minimum, one year in duration and is accredited by either the Commission on Dental Accreditation of the American Dental Association or a national accrediting body approved by the board. The advanced education program shall include a certification of clinical residency program completion approved by the board, to be completed upon the resident's successful completion of the program in order to evaluate the resident's competence to practice dentistry in the state. The certification shall be within two years prior to the date of the resident's application for a license under this section. Completion of the program shall be within two years prior to the date of their application for a license under this section.

(d) Satisfactory evidence of having successfully completed the written examination of the National Board Dental Examination of the Joint Commission on National Dental Examinations.

(e) Satisfactory evidence of having successfully completed an examination in California law and ethics.

(f) Proof that the applicant has not failed a state, regional, or national examination for licensure to practice dentistry under this chapter within five years prior to the date of the application for a license under this chapter. If the applicant subsequently passed the examination for licensure, the prior failure shall not make the applicant ineligible under this subdivision.

(g) (1) If the applicant is a graduate of a foreign dental school with extended approval pursuant to subdivision (a) of Section 1636.5, the applicant agrees to practice dentistry full time for two years in one or more of the following practice settings:

(A) A primary care clinic licensed under Section 1204 of the Health and Safety Code.

(B) A primary care clinic exempt from licensure pursuant to subdivision (c) of Section 1206 of the Health and Safety Code.

(C) A clinic owned or operated by a public hospital or health system.

(D) A clinic owned and operated by a hospital that maintains the primary contract with a county government to fill the county's role under Section 17000 of the Welfare and Institutions Code.

(E) A federally qualified health center, as defined in Section 1396d of Title 42 of the United States Code.

(2) The applicant shall complete the two years of practice described in paragraph (1) within the first three years of receiving a license to practice dentistry.

(3) The board may periodically request verification of compliance with this subdivision, and may revoke the license upon a finding that the applicant has not complied with this subdivision.

(4) The board shall provide information about the areas of the state that are experiencing a shortage of dentists in the application packet for licensure to practice dentistry pursuant to this section.

(5) The board shall define "full-time employment status" as described in this subdivision, and the board may establish exemptions to this requirement on a case-by-case basis.

~~SEC. 3.~~

SEC. 4. Section 1636.5 of the Business and Professions Code is repealed.

~~SEC. 4.~~

SEC. 5. Section 1636.5 is added to the Business and Professions Code, to read:

1636.5. (a) Notwithstanding Section 1636.4, any foreign dental school whose program was approved prior to January 1, 2024, shall maintain approval until the school has been issued a denial of accreditation by the Commission on Dental Accreditation of the American Dental Association (CODA) and the school does not appeal, the school has been issued a denial by CODA following the completion of the appeals process, or the school withdraws its application for accreditation by CODA, provided it complies with both of the following:

(1) The foreign dental school seeks accreditation by CODA on or before January 1, 2026.

(2) Commencing July 1, 2026, and every six months thereafter, the foreign dental school provides updates to the board on the CODA application process.

(b) Upon expiration of the extended approval described in subdivision (a), the foreign dental school shall be required to comply with the provisions of Section 1636.4.

(c) (1) A graduate of a foreign dental school with extended approval pursuant to subdivision (a) who enrolled in the school on or after July 1, 2025, shall be eligible for licensure to practice dentistry pursuant to this chapter.

(2) A graduate of the foreign dental school shall be eligible for licensure to practice dentistry upon expiration of the extended approval described in subdivision (a) if they were enrolled on or after July 1, 2025, and before the expiration of the school's extended approval.

~~SEC. 5.~~

SEC. 6. Section 1636.6 of the Business and Professions Code is repealed.

~~SEC. 6.~~

SEC. 7. Section 1636.6 is added to the Business and Professions Code, to read:

1636.6. (a) As part of its first sunset review report following January 1, 2032, as required by subdivision (d) of Section 1601.1, the board shall ~~report all of the following information:~~ *provide metrics summarizing all of the following:*

~~(1) The quality of care provided by dentists who graduated from a foreign dental school approved pursuant to Section 1636.5.~~

~~(2) Response to and approval of dentists who graduated from a foreign dental school approved pursuant to Section 1636.5.~~

~~(3) Impact of dentists who graduated from a foreign dental school approved pursuant to Section 1636.5.~~

~~(4) Increases in dental encounters provided by dentists who graduated from a foreign dental school approved pursuant to Section 1636.5 to limited-English-speaking patient populations and increases in the number of limited-English-speaking patients seeking health care services from nonprofit community health centers.~~

~~(5) Metrics summarizing all of the following:~~

~~(A)~~

(1) The total number of active licenses to practice dentistry in California.

~~(B)~~

(2) The number of active licenses to practice dentistry in California that were issued to graduates from a foreign dental school approved pursuant to Section 1636.5.

~~(C)~~

(3) Rate of passage of licensing examinations by graduates from a foreign dental school approved pursuant to Section 1636.5.

~~(D)~~

(4) The number of complaints and disciplinary actions of dentists from a foreign dental school approved pursuant to Section 1636.5.

~~(E)~~

(5) Aggregate workforce data, to the extent available to the board pursuant to Section 502 and through additional license renewal surveys, in consultation with the Department of Health Care Access and Information, relating to the following categories:

~~(i)~~

(A) Area of practice or specialty.

~~(ii)~~

(B) City, county, and ZIP Code of practice.

~~(iii)~~

(C) Languages spoken.

~~(iv)~~

(D) Race or ethnicity.

~~(v)~~

(E) Type of employer or classification of primary practice site.

(b) This section shall remain in effect only until January 1, 2034, and as of that date is repealed.

O

AMENDED IN ASSEMBLY APRIL 21, 2025

CALIFORNIA LEGISLATURE—2025–26 REGULAR SESSION

ASSEMBLY BILL No. 980

Introduced by Assembly Member Arambula

February 20, 2025

An act to amend Section 3428 of the Civil Code, *to add Section 1367.52 to the Health and Safety Code, and to add Section 10123.52 to the Insurance Code,* relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

AB 980, as amended, Arambula. Health ~~care service plan: managed care entity: duty of care~~. *care: medically necessary treatment.*

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 health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy to provide coverage for medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions, as specified. Existing law generally authorizes a health care service plan or health insurer to use utilization review to approve, modify, delay, or deny requests for health care services based on medical necessity.

This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to provide coverage for medically necessary treatment of physical conditions and diseases under the same terms and conditions applied to other medical conditions, as specified. The bill would require the

delivery of medically necessary services out of network if those services are not available within geographic and timely access standards. The bill would require a plan or insurer to apply specified clinical criteria and guidelines in conducting utilization review of the covered health care services and benefits for physical conditions and diseases. The bill would authorize the Director of the Department of Managed Health Care or the Insurance Commissioner, as applicable, to assess administrative or civil penalties, as specified, for violation of the requirements relating to utilization review. Because a willful violation of these requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

Under existing law, a health care service plan or managed care entity has a duty of ordinary care to arrange for the provision of medically necessary health care services to its subscribers or enrollees and is liable for all harm legally caused by its failure to exercise that ordinary care when the failure resulted in the denial, delay, or modification of the health care service recommended for, or furnished to, a subscriber or enrollee and the subscriber or enrollee suffers substantial harm, as defined.

This bill would define "medically necessary health care service" for purposes of the above-described provision to mean legally prescribed medical care that is reasonable and comports with the medical community standard.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: ~~no~~ *yes*.

The people of the State of California do enact as follows:

SECTION 1. Section 3428 of the Civil Code is amended to read:

3428. (a) For services rendered on or after January 1, 2001, a health care service plan or managed care entity, as described in subdivision (f) of Section 1345 of the Health and Safety Code, shall have a duty of ordinary care to arrange for the provision of

medically necessary health care service to its subscribers and enrollees, if the health care service is a benefit provided under the plan or through the entity, and shall be liable for all harm legally caused by its failure to exercise that ordinary care when both of the following apply:

(1) The failure to exercise ordinary care resulted in the denial, delay, or modification of the health care service recommended for, or furnished to, a subscriber or enrollee.

(2) The subscriber or enrollee suffered substantial harm.

(b) (1) For purposes of this section: (A) "substantial harm" means loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss; (B) health care services need not be recommended or furnished by an in-plan provider, but may be recommended or furnished by a health care provider practicing within the scope of the provider's practice; and (C) health care services shall be recommended or furnished at any time prior to the inception of the action, and the recommendation need not be made prior to the occurrence of substantial harm.

(2) For purposes of this section, "medically necessary health care service" means legally prescribed medical care that is reasonable and comports with the medical community standard.

(c) Health care service plans and managed care entities are not health care providers under any law, including, but not limited to, Section 6146 of the Business and Professions Code, Sections 3333.1 or 3333.2 of this code, or Sections 340.5, 364, 425.13, 667.7, or 1295 of the Code of Civil Procedure.

(d) A health care service plan or managed care entity shall not seek indemnity, whether contractual or equitable, from a provider for liability imposed under subdivision (a). Any provision to the contrary in a contract with providers is void and unenforceable.

(e) This section shall not create a liability on the part of an employer or an employer group purchasing organization that purchases coverage or assumes risk on behalf of its employees or on behalf of self-funded employee benefit plans.

(f) Waiver by a subscriber or enrollee of the provisions of this section is contrary to public policy and shall be unenforceable and void.

(g) This section does not create any new or additional liability on the part of a health care service plan or managed care entity for

harm caused that is attributable to the medical negligence of a treating physician or other treating health care provider.

(h) This section does not abrogate or limit any other theory of liability otherwise available at law.

(i) This section does not apply in instances where subscribers or enrollees receive treatment by prayer, consistent with the provisions of subdivision (a) of Section 1270 of the Health and Safety Code, in lieu of medical treatment.

(j) Damages recoverable for a violation of this section include, but are not limited to, those set forth in Section 3333.

(k) (1) A person may not maintain a cause of action pursuant to this section against an entity required to comply with an independent medical review system or independent review system required by law unless the person or the person's representative has exhausted the procedures provided by the applicable independent review system.

(2) Compliance with paragraph (1) is not required in a case where either of the following applies:

(A) Substantial harm, as defined in subdivision (b), has occurred prior to the completion of the applicable review.

(B) Substantial harm, as defined, in subdivision (b), will imminently occur prior to the completion of the applicable review.

(*l*) If any provision of this section or the application thereof to a person or circumstance is held to be unconstitutional or otherwise invalid or unenforceable, the remainder of the section and the application of those provisions to other persons or circumstances shall not be affected by that holding.

SEC. 2. Section 1367.52 is added to the Health and Safety Code, to read:

1367.52. (a) (1) A health care service plan contract issued, amended, or renewed on or after January 1, 2026, shall provide coverage for medically necessary treatment of physical conditions and diseases under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

(2) A health care service plan contract shall not limit benefits or coverage for physical conditions and diseases to short-term or acute treatment.

(b) The benefits covered pursuant to this section shall include all of the following:

(1) Basic health care services, as defined in Section 1345.

(2) Intermediate services, including the full range of levels of care, including residential treatment, partial hospitalization, and intensive outpatient treatment.

(3) Prescription drugs, if the plan contract includes coverage for prescription drugs.

(c) The terms and conditions applied to the benefits covered pursuant to this section that shall be applied equally to all benefits under the plan contract shall include all of the following enrollee financial responsibilities:

(1) Maximum annual and lifetime benefits, if not prohibited by applicable law.

(2) Copayments and coinsurance.

(3) Individual and family deductibles.

(4) Out-of-pocket maximums.

(d) If services for the medically necessary treatment of physical conditions and diseases are not available in network within the geographic and timely access standards set by law or regulation, the health care service plan shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services that, to the maximum extent possible, meet those geographic and timely access standards. As used in this subdivision, to "arrange coverage to ensure the delivery of medically necessary out-of-network services" includes providing services to secure medically necessary out-of-network options that are available to the enrollee within geographic and timely access standards. The enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from an in-network provider.

(e) (1) A health care service plan shall base a medical necessity determination or the utilization review criteria that the plan, and an entity acting on the plan's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of physical conditions and diseases on current generally accepted standards of health care.

(2) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of physical conditions and diseases in children, adolescents, and adults, a health care service plan or an entity acting on the plan's behalf shall apply the criteria and guidelines set forth in the most

recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

(3) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subdivision (b), a health care service plan or an entity acting on the plan's behalf shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. This subdivision does not prohibit a health care service plan or an entity acting on the plan's behalf from applying utilization review criteria to health care services and benefits for physical conditions and diseases that meet either of the following criteria:

(A) Are outside the scope of the criteria and guidelines set forth in the sources specified in paragraph (2), provided the utilization review criteria were developed in accordance with paragraph (1).

(B) Relate to advancements in technology or types of care that are not covered in the most recent versions of the sources specified in paragraph (2), provided that the utilization review criteria were developed in accordance with paragraph (1).

(4) If a health care service plan or an entity acting on the plan's behalf purchases or licenses utilization review criteria pursuant to subparagraph (A) or (B) of paragraph (3), the plan or entity shall verify and document before use that the criteria were developed in accordance with paragraph (1).

(5) To ensure the proper use of the criteria described in paragraph (2), a health care service plan or an entity acting on the plan's behalf shall do all of the following:

(A) Sponsor a formal education program by nonprofit clinical specialty associations to educate the health care service plan's staff, including any third parties contracted with the health care service plan to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria.

(B) Make the education program available to other stakeholders, including the health care service plan's participating providers and covered lives. Participating providers shall not be required to participate in the education program.

(C) Provide, at no cost, the clinical review criteria and any training material or resources to providers and enrollees.

(D) Track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process.

(E) Conduct interrater reliability testing to ensure consistency in utilization review decisionmaking covering how medical necessity decisions are made. This assessment shall cover all aspects of utilization review.

(F) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities.

(G) Achieve interrater reliability pass rates of at least 90 percent and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

(6) A health care service plan that authorizes a specific type of treatment by a provider pursuant to this section shall not rescind or modify the authorization after the provider renders the health care service in good faith and pursuant to this authorization for any reason, including the plan's subsequent rescission, cancellation, or modification of the enrollee's or subscriber's contract, or the plan's subsequent determination that it did not make an accurate determination of the enrollee's or subscriber's eligibility. This section does not expand or alter the benefits available to the enrollee.

(7) All medical necessity determinations by the health care service plan concerning service intensity, level of care placement, continued stay, and transfer or discharge of enrollees diagnosed with physical conditions and diseases shall be conducted in accordance with this subdivision. This subdivision does not deprive an enrollee of the other protections of this chapter, including grievances, appeals, independent medical review, discharge, transfer, and continuity of care.

(8) Notwithstanding any other law, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing in the provision of benefits required by this section, if these practices are consistent with Section 1367.01 of this code, and Section 2052 of the Business and Professions Code.

(9) This section does not limit the independent medical review rights of an enrollee under this chapter.

(10) The director may assess administrative penalties for violations of this subdivision as provided for in Section 1368.04, in addition to any other remedies permitted by law.

(f) (1) To comply with this section, a health care service plan may provide coverage for all or part of the health care services required by this section through a separate specialized health care service plan or health plan, and shall not be required to obtain an additional or specialized license for this purpose.

(2) A health care service plan shall provide the physical conditions and diseases treatment coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements may require enrollees who reside or work in geographic areas served by specialized health care service plans or health plans to secure all or part of their health services within those geographic areas served by specialized health care service plans or health plans, if all physical conditions and diseases treatment services are actually available within those geographic service areas within timeliness standards.

(g) A health care service plan shall not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program, including special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program.

(h) A health care service plan shall not adopt, impose, or enforce terms in its plan contracts or provider agreements, in writing or in operation, that undermine, alter, or conflict with this section.

(i) For purposes of this section:

(1) "Generally accepted standards of care for physical conditions and diseases" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence-based

sources establishing generally accepted standards of health care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(2) "Medically necessary treatment of physical conditions and diseases" means a service or product addressing the specific needs of that enrollee, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

(A) In accordance with the generally accepted standards of care for physical conditions and diseases.

(B) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(C) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the enrollee, treating physician, or other health care provider.

(3) "Utilization review" means either of the following:

(A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, enrollees, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to enrollees.

(B) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in a health care service plan contract is covered as medically necessary for an enrollee.

(4) "Utilization review criteria" means any criteria, standards, protocols, or reviewed community guidelines used by a health care service plan to conduct utilization review.

(j) This section does not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, between the State Department of

Health Care Services and a health care service plan for enrolled Medi-Cal beneficiaries.

(k) This section does not deny or restrict the department's authority to ensure plan compliance with this chapter.

SEC. 3. Section 10123.52 is added to the Insurance Code, to read:

10123.52. (a) (1) A health insurance policy issued, amended, or renewed on or after January 1, 2026, shall provide coverage for medically necessary treatment of physical conditions and diseases under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

(2) A health insurance policy shall not limit benefits or coverage for physical conditions and diseases to short-term or acute treatment.

(b) The benefits covered pursuant to this section shall include all of the following:

(1) Basic health care services, as defined in Section 10112.281.

(2) Intermediate services, including the full range of levels of care, including residential treatment, partial hospitalization, and intensive outpatient treatment.

(3) Prescription drugs, if the policy includes coverage for prescription drugs.

(c) The terms and conditions applied to the benefits covered pursuant to this section that shall be applied equally to all benefits under the policy shall include all of the following insured financial responsibilities:

(1) Maximum annual and lifetime benefits, if not prohibited by applicable law.

(2) Copayments and coinsurance.

(3) Individual and family deductibles.

(4) Out-of-pocket maximums.

(d) If services for the medically necessary treatment of physical conditions and diseases are not available in network within the geographic and timely access standards set by law or regulation, the health insurer shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services that, to the maximum extent possible, meet those geographic and timely access standards. As used in this subdivision, to "arrange coverage to ensure the delivery of medically necessary out-of-network services" includes providing

services to secure medically necessary out-of-network options that are available to the insured within geographic and timely access standards. The insured shall pay no more than the same cost sharing that the insured would pay for the same covered services received from an in-network provider.

(e) (1) A health insurer shall base a medical necessity determination or the utilization review criteria that the insurer, and an entity acting on the insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of physical conditions and diseases on current generally accepted standards of health care.

(2) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of physical conditions and diseases in children, adolescents, and adults, a health insurer or an entity acting on the insurer's behalf shall apply the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

(3) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subdivision (b), a health insurer or an entity acting on the insurer's behalf shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. This subdivision does not prohibit a health insurer or an entity acting on the insurer's behalf from applying utilization review criteria to health care services and benefits for physical conditions and diseases that meet either of the following criteria:

(A) Are outside the scope of the criteria and guidelines set forth in the sources specified in paragraph (2), provided the utilization review criteria were developed in accordance with paragraph (1).

(B) Relate to advancements in technology or types of care that are not covered in the most recent versions of the sources specified in paragraph (2), provided that the utilization review criteria were developed in accordance with paragraph (1).

(4) If a health insurer or an entity acting on the insurer's behalf purchases or licenses utilization review criteria pursuant to subparagraph (A) or (B) of paragraph (3), the insurer or entity shall verify and document before use that the criteria were developed in accordance with paragraph (1).

(5) To ensure the proper use of the criteria described in paragraph (2), a health insurer or an entity acting on the insurer's behalf shall do all of the following:

(A) Sponsor a formal education program by nonprofit clinical specialty associations to educate the health insurer's staff, including any third parties contracted with the health insurer to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria.

(B) Make the education program available to other stakeholders, including the health insurer's participating providers and covered lives. Participating providers shall not be required to participate in the education program.

(C) Provide, at no cost, the clinical review criteria and any training material or resources to providers and insureds.

(D) Track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process.

(E) Conduct interrater reliability testing to ensure consistency in utilization review decisionmaking covering how medical necessity decisions are made. This assessment shall cover all aspects of utilization review.

(F) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities.

(G) Achieve interrater reliability pass rates of at least 90 percent and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

(6) A health insurer that authorizes a specific type of treatment by a provider pursuant to this section shall not rescind or modify the authorization after the provider renders the health care service in good faith and pursuant to this authorization for any reason, including the insurer's subsequent rescission, cancellation, or modification of the insured's or policyholder's contract, or the insurer's subsequent determination that it did not make an accurate determination of the insured's or policyholder's eligibility. This section does not expand or alter the benefits available to the insured.

(7) All medical necessity determinations by the health insurer concerning service intensity, level of care placement, continued stay, and transfer or discharge of insureds diagnosed with physical conditions and diseases shall be conducted in accordance with this subdivision. This subdivision does not deprive an insured of the other protections of this chapter, including grievances, appeals, independent medical review, discharge, transfer, and continuity of care.

(8) Notwithstanding any other law, a health insurer may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing in the provision of benefits required by this section, if these practices are consistent with Section 10123.135 of this code, and Section 2052 of the Business and Professions Code.

(9) This section does not limit the independent medical review rights of an insured under this chapter.

(10) If the commissioner determines that an insurer has violated this subdivision, the commissioner may, after appropriate notice and opportunity for hearing in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), by order, assess a civil penalty not to exceed five thousand dollars ($5,000) for each violation, or, if a violation was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each violation.

(f) (1) To comply with this section, a health insurer may provide coverage for all or part of the health care services required by this section through a separate specialized health insurer or health insurer, and shall not be required to obtain an additional or specialized license for this purpose.

(2) A health insurer shall provide the physical conditions and diseases treatment coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health insurance policies that provide benefits to insureds through preferred provider contracting arrangements may require insureds who reside or work in geographic areas served by specialized health insurers or health insurers to secure all or part of their health services within those geographic areas served by specialized health insurers or health insurers, if all physical conditions and

diseases treatment services are actually available within those geographic service areas within timeliness standards.

(g) A health insurer shall not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program, including special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program.

(h) A health insurer shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with this section.

(i) For purposes of this section:

(1) "Generally accepted standards of care for physical conditions and diseases" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence-based sources establishing generally accepted standards of health care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(2) "Medically necessary treatment of physical conditions and diseases" means a service or product addressing the specific needs of that insured, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

(A) In accordance with the generally accepted standards of care for physical conditions and diseases.

(B) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(C) Not primarily for the economic benefit of the health insurer and policyholders or for the convenience of the insured, treating physician, or other health care provider.

(3) "Utilization review" means either of the following:

(A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to insureds.

(B) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in a health insurance policy is covered as medically necessary for an insured.

(4) "Utilization review criteria" means any criteria, standards, protocols, or reviewed community guidelines used by a health insurer to conduct utilization review.

(j) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, dental-only, or vision-only insurance policies.

(k) This section does not deny or restrict the department's authority to ensure insurer compliance with this chapter.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O

AMENDED IN ASSEMBLY APRIL 2, 2025

CALIFORNIA LEGISLATURE—2025–26 REGULAR SESSION

ASSEMBLY BILL No. 1307

Introduced by Assembly Member Ávila Farías
(Coauthors: Assembly Members Bains and Jackson)

February 21, 2025

An act to repeal and add Article 2.7 (commencing with Section 1645.4) of Chapter 4 of Division 2 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1307, as amended, Ávila Farías. Licensed Dentists from Mexico Pilot Program.

Existing law, the Licensed Dentists from Mexico Pilot Program, requires the Dental Board of California to issue 3-year nonrenewable permits to practice dentistry to dentists from Mexico who meet specified criteria.

This bill would repeal those provisions and replace them with a new Licensed Dentists from Mexico Pilot Program. Under that new program, the bill would require the board to issue a 3-year nonrenewable license to practice dentistry to an applicant that meets specified criteria, and require participants in the program to comply with specified requirements. The bill would authorize participants to be employed only by federally qualified health centers that meet specified conditions, and would impose requirements on those centers. The bill would require an evaluation of the program to be commenced beginning one year after the program has commenced, as specified, and would prescribe the information to be included in that evaluation. The bill would require

the costs for the program to be fully paid for by funds provided by philanthropic foundations.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Article 2.7 (commencing with Section 1645.4) of Chapter 4 of Division 2 of the Business and Professions Code is repealed.

SEC. 2. Article 2.7 (commencing with Section 1645.4) is added to Chapter 4 of Division 2 of the Business and Professions Code, to read:

Article 2.7. Licensed Dentists from Mexico Pilot Program

1645.4. (a) For purposes of this article, the following definitions apply:

(1) "Board" means the Dental Board of California.

(2) "License" means a license issued pursuant to subdivision (c).

(3) "Participant" means a person who has been issued a license pursuant to subdivision (c).

(4) "Program" means the Licensed Dentists from Mexico Pilot Program.

(b) *(1)* The program is hereby created.

(2) (A) The board shall accept 30 participating dentists pursuant to the procedures in this section.

(B) The board shall maintain an alternate list of program applicants.

(C) If a participant leaves the program for any reason, the board shall choose an applicant from the alternate list described in subparagraph (B) to fill the vacancy.

(c) The board shall issue a three-year nonrenewable license to practice dentistry to an applicant that meets all of the following criteria:

(1) The applicant graduated from a dental program accredited by either of the following:

(A) Consejo Nacional de Educación Odontológica, A.C.

(B) Comités Interinstitucionales para la Evaluación de la Educación Superior.

(2) The applicant is certified by the Asociación Dental Mexicana through a written examination that confirms competency of all of the following clinical experiences:

(A) Oral diagnosis and treatment planning.

(B) Periodontics.

(C) Direct restorations.

(D) Indirect restorations.

(E) Endodontics.

(F) Removal prosthodontics.

(3) The applicant has a license to practice from the Secretaría de Educación Pública Dirección General de Profesiones.

(4) The applicant has satisfactorily completed the Test of English as a Foreign Language by scoring a minimum of 85 percent or the Occupational English Test with a minimum score of 350.

(5) The applicant has satisfactorily completed an orientation program approved by the board in connection with the Licensed Physicians and Dentists from Mexico Pilot Program, as established in former Section 853, that includes all of the following components:

(A) Dental protocols.

(B) Community clinic history and operations.

(C) Dental administration.

(D) Medical ethics.

(E) Managed care standards, practices, and procedures.

(F) Medication documentation and script protocols and procedures.

(G) The California medical delivery system.

(H) Health maintenance organizations.

(6) Except as provided by subdivision (d), provide the board with an individual taxpayer identification number or social security number.

(d) (1) The board shall issue a license to an applicant who has not provided an individual taxpayer identification number or social security number if both of the following conditions are satisfied:

(A) The board determines the applicant is otherwise eligible for a license.

(B) The applicant provides evidence to the board that the applicant has sought an appropriate three-year visa and accompanying social security number.

(2) (A) A participant who has been issued a license pursuant to paragraph (1) shall provide the board with the social security number within 10 days of receipt of a social security card and related visa.

(B) The board may terminate a license if a participant fails to comply with subparagraph (A).

(3) If the board determines that a participant has met the requirements of paragraphs (1) and (2), the board shall notify the applicant that the applicant may engage in the practice of dentistry under the license issued pursuant to paragraph (1).

(e) (1) An applicant shall submit copies of documents establishing that the applicant meets the criteria described in subdivision (c) to the board.

(2) A document submitted pursuant to this subdivision shall be a primary source document.

(3) The board shall confirm the authenticity of a document submitted pursuant to this subdivision.

(f) The fee for a license and associated Controlled Substance Utilization Review and Evaluation System fee shall be one thousand two dollars ($1002).

(g) The three-year period for a license shall commence on the first day the participant engages in the practice of dentistry.

(h) (1) Before engaging in the practice of dentistry, a participant shall complete an eight-hour infection control program approved by the board.

(2) For each year that a participant has a license, the participant shall comply with Article 2.6 (commencing with Section 1645).

(3) Within three months of receiving a license, a participant shall complete eight hours of infection disease continuing medical education courses, and thereafter complete at least two hours of those courses per year.

(i) A license shall be deemed to be in good standing pursuant to the provisions of this chapter for the purpose of participation and reimbursement in all federal, state, and local health programs, including, but not limited to, all of the following:

(1) The Medicare Program.

(2) The fee-for-service system of the Medi-Cal program.

(3) The managed care delivery system of the Medi-Cal program.
(4) Private insurance.
(j) (1) Except as provided in paragraph (2), suspension or revocation of a license shall be governed by Article 4 (commencing with Section 1670).
(2) In addition to the requirements of Article 4 (commencing with Section 1670), the board shall notify a participant of a suspension or revocation of a license by certified mail, return receipt requested, at the participant's address of record.
(k) Representatives from California and the National Autonomous University of Mexico that executed and implemented the provisions of the former Physicians and Dentists from Mexico Pilot Program shall be the points of contact for all of the following:
(1) Securing required documents.
(2) Recruiting and vetting candidates.
(3) Assisting candidates for this program in Mexico in meeting all program requirements.
(4) Selecting appropriate federally qualified health centers throughout California.
(5) Ensuring compliance with program provisions.
(6) Developing policy and clinical workshops.
(7) Monitoring productivity and increased access to medical care.
(8) Assessing the necessity of policy and programmatic improvements.
(9) Working with the governments of Mexico and the United States to obtain the visas required for program participation.
(*l*) A participant may only be employed by a federally qualified health center that meets all of the following conditions:
(1) The center has at least one health professional shortage area or dental professional shortage area within its service area, as determined by the Department of Health Care Access and Information:
(2) The center has medical quality assurance protocols.
(3) The center is either of the following:
(A) Accredited by any of the following:
(i) The Joint Commission.
(ii) The Accreditation Association for Ambulatory Health Care.
(iii) The National Committee for Quality Assurance.

(B) Affiliated with a federally qualified health center that satisfies subparagraph (A).

(m) A federally qualified health center that employs a participant shall do all of the following:

(1) Continue the peer review protocols and procedures required by the federal government.

(2) Work with a dental school in California approved by the board to conduct 10 secondary peer reviews of randomly selected patient encounters with each participant per six-month period and transmit complete records of those encounters to the dental school.

(3) Provide all applicable employment benefits, salary, and policies to the participant as it provides to other current employees, including, but not limited to, malpractice insurance.

(n) (1) Beginning one year after the program has commenced, an evaluation of the program shall be conducted by either of the following:

(A) A dental school in California and either the National Autonomous University of Mexico or a foreign dental school approved by the board.

(B) An independent consultant selected by the Director of Consumer Affairs.

(2) The evaluation required by paragraph (1) shall include, but is not limited to, an evaluation of all of the following:

(A) Quality of care provided by participants.

(B) Adaptability of participants to California dental standards.

(C) Impact on working and administrative environments in the federally qualified health centers employing participants.

(D) Impact on interpersonal relations with medical licensed counterparts in the federally qualified health centers employing participants.

(E) Responses by patients of participants.

(F) Impact on cultural and linguistic services.

(G) Increases in dental encounters provided by participants with various patient populations.

(H) Increases in the number of various patient populations seeking dental services from federally qualified health centers.

(3) The evaluation required by paragraph (1) shall be fully paid for by funds provided by philanthropic foundations.

(o) The costs for administering the program shall be fully paid for by funds provided by philanthropic foundations.

O

Date of Hearing: April 23, 2025

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
AB 1307 (Ávila Farías) – As Amended April 2, 2025

Policy Committee: Business and Professions Vote: 17 - 0

Urgency: No State Mandated Local Program: No Reimbursable: No

SUMMARY:

This bill reestablishes and modifies the Licensed Dentists from Mexico Pilot Program (program). The bill requires the Dental Board of California (Board) to issue three-year nonrenewable licenses to up to 30 dentists from Mexico, to be employed only by federally qualified health centers (FQHCs), and requires the program's costs be fully paid for by funds from philanthropic foundations.

Specifically, this bill:

1) Replaces the Licensed Dentists from Mexico Pilot Program with new provisions, requiring the Board to accept 30 participating dentists into the new program, keep a list of alternate applicants, and fill any vacancy created if a participant leaves the program.

2) Requires the Board issue a three-year nonrenewable license to practice dentistry to an applicant that meets specified criteria, including licensure from the Secretaría de Educación Pública Dirección General de Profesiones, graduation from a dental program accredited by one of two specific organizations, certification of competency in specified clinical practice areas, completion of one of two specified English language tests with specific scores, and completion of a Board-approved program orientation, as specified.

3) Limits employment to an FQHC that meets accreditation and quality assurance requirements and that includes at least one health professional shortage area or dental professional shortage area within its service area, and is accredited, as specified.

4) Requires an FQHC that employs a participating dentist to provide all applicable employment benefits, salary, and policies it provides to other employees, work with a dental school to conduct 10 secondary peer reviews of patient encounters with each participant per six-month period.

5) Sets the fee for a three-year nonrenewable license at $1,002, which includes a Controlled Substance Utilization Review and Evaluation System (CURES) fee.

6) Requires evidence of a visa application, but allows practice while waiting for a social security number, with a 10-day deadline upon receipt.

7) Deems a license to be in good standing for the purpose of participation and reimbursement in all federal, state, and local health programs, including, but not limited to Medicare, Medi-

Cal, and private insurance.

8) Requires either of the following conduct an evaluation of the program, as specified, one year after the program has commenced: (a) a dental school in California and either the National Autonomous University of Mexico or a foreign dental school, or (b) an independent consultant selected by the Director of Consumer Affairs.

9) Requires the program's costs be fully paid for by funds provided by philanthropic foundations.

FISCAL EFFECT:

Although the bill requires the program's costs be fully paid for by philanthropic foundations, the Board anticipates it will still require time and resources to implement. The Board estimates costs of $334,000 in fiscal year (FY) 2026-27, $318,000 in FY 2027-28, and $159,000 annually, ongoing, to fund one permanent Associate Governmental Program Analyst (AGPA) and one limited term AGPA to research, review, and respond to written correspondence, provide analytical guidance, and prepare written correspondence to the applicant identifying specific deficiencies, among other things (State Dentistry Fund).

In addition, the Department of Consumer Affairs, Office of Information Services estimates absorbable costs of $72,000 to create a new license type in its online licensing and enforcement system (special fund).

COMMENTS:

1) **Purpose.** According to the author:

> [O]ver 2.7 million Californians live in areas that have limited access to dental health professionals. AB 1307 expands access to dental health professional by establishing the Licensed Dentists from Mexico Pilot Program, allowing 30 qualified dentists from Mexico to obtain a time-limited license and visa to practice in federally qualified health centers…This bill is modeled after a successful physician pilot program and reflects our state's commitment to health equity. AB 1307 offers a targeted, cost-neutral solution to reduce disparities and improve oral health outcomes for some of California's most vulnerable populations.

2) **Background.** AB 2860 (Garcia), Chapter 246, Statutes of 2024, reestablished the dental component of a prior pilot program as the Licensed Dentists from Mexico Pilot Program. To date, no dentists from Mexico have been able to participate in the pilot program, as supporters of the program prioritized physicians in the early stages of implementation. Evaluation of the Licensed Physicians from Mexico Pilot Program concluded that the pilot program "has strong positive feedback from all. Physicians integrated seamlessly, making healthcare more accessible, and increasing patient trust. Staff reported excellent patient care processes and a supportive environment."

Analysis Prepared by: Allegra Kim / APPR. / (916) 319-2081

ASSEMBLY BILL No. 1418

Introduced by Assembly Member Schiavo

February 21, 2025

An act to amend Section 128052 of the Health and Safety Code, relating to public health.

LEGISLATIVE COUNSEL'S DIGEST

AB 1418, as introduced, Schiavo. Department of Health Care Access and Information.

Existing law requires the Department of Health Care Access and Information to establish a health care workforce research and data center to serve as the central source of health care workforce and educational data in the state. Existing law requires the department to prepare an annual report to the Legislature that, among other things, identifies education and employment trends in the health care profession and describes the health care workforce program outcomes and effectiveness.

This bill would additionally require the department's report to include health care coverage trends for employees subject to waiting periods before receiving employer-sponsored health care coverage, and provide recommendations for state policy necessary to address gaps in health care coverage for those same employees. The bill would also specify the format for the above-described report.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 128052 of the Health and Safety Code is amended to read:

128052. *(a)* The Department of Health Care Access and Information shall prepare an annual report to the Legislature that does all of the following:

~~(a)~~

(1) Identifies education and employment trends in the health care profession.

~~(b)~~

(2) Reports on the current supply and demand for health care workers in California and gaps in the educational pipeline producing workers in specific occupations and geographic areas.

~~(c)~~

(3) Recommends state policy needed to address issues of workforce shortage and distribution.

~~(d)~~

(4) Describes the health care workforce program outcomes and effectiveness.

(5) Reports on trends in health care coverage for employees in California in all sectors, including whether employees otherwise eligible for employer-sponsored health care are subject to waiting periods before receiving coverage.

(6) Recommends state policy needed to address gaps in health care coverage for employees subject to waiting periods before receiving employer-sponsored health care.

(b) A report submitted pursuant to this section shall be submitted in compliance with Section 9795 of the Government Code.

O

Date of Hearing: April 23, 2025

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
AB 1418 (Schiavo) – As Introduced February 21, 2025

Policy Committee: Health Vote: 14 - 0

Urgency: No State Mandated Local Program: No Reimbursable: No

SUMMARY:

This bill requires the Department of Health Care Access and Information (HCAI) to include in an existing annual health workforce report the following additional information: (1) trends in health care coverage for employees in all sectors, including whether employees are subject to waiting periods before receiving coverage and (2) recommendations on state policies to address gaps in health care coverage for employees subject to waiting periods.

FISCAL EFFECT:

HCAI estimates annual costs of approximately $750,000 in fiscal year 2026-27 and ongoing for data collection, analysis, and reporting (General Fund). HCAI does not collect this data currently and is unaware of any state entity that does, so it would need to perform all aspects of data collection and analysis, potentially including surveying employers.

COMMENTS:

Purpose. This bill is sponsored by Service Employees International Union (SEIU) California. According to the author:

> AB 1418 is a study bill committed to ensuring that every newly hired employee eligible for health benefits begins their journey with the security of comprehensive healthcare coverage—starting on day one—because anyone providing healthcare deserves peace of mind and remain healthy as they care for our family, ourselves and our community.

Background. The federal Affordable Care Act (ACA) included multiple provisions to expand health insurance coverage, including adding employer shared responsibility provisions to the federal Internal Revenue Code. In addition to the employer shared responsibility provisions, the ACA prohibits a group health plan or health insurance issuer offering group health insurance coverage from applying any waiting period for an employee to receive coverage that exceeds 90 days. This provision applies to group health plans sold to employers of all sizes. This provision of the ACA does not require the employer to offer coverage to any particular employee or class of employees, but prevents an otherwise eligible employee (or dependent) from waiting more than 90 days before coverage becomes effective.

The Kaiser Family Foundation's "Employer Health Benefits 2023 Annual Survey" found 65% of

covered workers face a waiting period before coverage is available. The average waiting period among covered workers who face a waiting period is two months. A small percentage (7%) of covered workers with a waiting period have a waiting period of more than 3 months (survey respondents with waiting periods greater than four months generally were due to training, orientation, or measurement periods in which they were employees but were not eligible for health benefits). Some employers have measurement periods to determine whether variable hour employees will meet the requirements for the emploer's health benefits. In an effort to reduce respondent burden, the 2024 annual survey removed questions in several areas, including questions about waiting periods.

Analysis Prepared by: Allegra Kim / APPR. / (916) 319-2081

AMENDED IN SENATE APRIL 23, 2025

SENATE BILL No. 62

Introduced by Senator Menjivar

January 9, 2025

An act to amend Section 1367.005 of the Health and Safety Code, and to amend Section 10112.27 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 62, as amended, Menjivar. Health care coverage: essential health benefits.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service ~~plans.~~ *plans and makes a willful violation of the act a crime.* Existing law requires the Department of Insurance to regulate health insurers. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Existing law requires a health care service plan contract or health insurance policy to cover the same health benefits that the benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan, offered during the first quarter of 2014, as specified.

This bill would express the intent of the Legislature to review California's essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year. ~~The bill would limit the applicability of the current benchmark plan benefits to plan years on or before the 2027 plan year.~~ *The bill would require, commencing January*

1, 2027, if the United States Department of Health and Human Services approves a new essential health benefits benchmark plan for the state, as specified, the benchmark plan to include certain additional benefits, including coverage for specified fertility services and specified durable medical equipment. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: ~~no~~ *yes*.

The people of the State of California do enact as follows:

SECTION 1. It is the intent of the Legislature to review California's essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year.

SEC. 2. Section 1367.005 of the Health and Safety Code is amended to read:

1367.005. (a) An individual or small group health care service plan contract issued, amended, or renewed on or after January 1, 2017, shall include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act (PPACA) and as outlined in this section. For purposes of this section, "essential health benefits" means all of the following:

(1) Health benefits within the categories identified in Section 1302(b) of PPACA: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

(2) (A) ~~For plan years on or before the 2027 plan year,~~ *The* health benefits covered by the Kaiser Foundation Health Plan

Small Group HMO 30 plan (federal health product identification number 40513CA035) as this plan was offered during the first quarter of 2014, as follows, regardless of whether the benefits are specifically referenced in the evidence of coverage or plan contract for that plan:

(i) Medically necessary basic health care services, as defined in subdivision (b) of Section 1345 and Section 1300.67 of Title 28 of the California Code of Regulations.

(ii) The health benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in the following sections: Sections 1367.002, 1367.06, and 1367.35 (preventive services for children); Section 1367.25 (prescription drug coverage for contraceptives); Section 1367.45 (AIDS vaccine); Section 1367.46 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha-fetoprotein testing); Section 1367.6 (breast cancer screening); Section 1367.61 (prosthetics for laryngectomy); Section 1367.62 (maternity hospital stay); Section 1367.63 (reconstructive surgery); Section 1367.635 (mastectomies); Section 1367.64 (prostate cancer); Section 1367.65 (mammography); Section 1367.66 (cervical cancer); Section 1367.665 (cancer screening tests); Section 1367.67 (osteoporosis); Section 1367.68 (surgical procedures for jaw bones); Section 1367.71 (anesthesia for dental); Section 1367.9 (conditions attributable to diethylstilbestrol); Section 1368.2 (hospice care); Section 1370.6 (cancer clinical trials); Section 1371.5 (emergency response ambulance or ambulance transport services); subdivision (b) of Section 1373 (sterilization operations or procedures); Section 1373.4 (inpatient hospital and ambulatory maternity); Section 1374.56 (phenylketonuria); Section 1374.17 (organ transplants for HIV); Section 1374.72 (mental health parity); and Section 1374.73 (autism/behavioral health treatment).

(iii) Any other benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in those statutes.

(iv) The health benefits covered by the plan that are not otherwise required to be covered under this chapter, to the extent required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22, 1367.24, and 1367.25, and Section 1300.67.24 of Title 28 of the California Code of Regulations.

(v) Any other health benefits covered by the plan that are not otherwise required to be covered under this chapter.

(B) If there are any conflicts or omissions in the plan identified in subparagraph (A) as compared with the requirements for health benefits under this chapter that were enacted prior to December 31, 2011, the requirements of this chapter shall be controlling, except as otherwise specified in this section.

(C) Notwithstanding subparagraph (B) or any other provision of this section, the home health services benefits covered under the plan identified in subparagraph (A) shall be deemed to not be in conflict with this chapter.

(D) For purposes of this section, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) shall apply to a contract subject to this section. Coverage of mental health and substance use disorder services pursuant to this paragraph, along with any scope and duration limits imposed on the benefits, shall be in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), and all rules, regulations, or guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

(E) Commencing January 1, 2027, if the United States Department of Health and Human Services approves a new essential health benefits benchmark plan for the State of California pursuant to submissions to the department made on behalf of the state in 2025 for this purpose, the benchmark plan described in subparagraph (A) shall additionally include all of the following benefits:

(i) Services to evaluate, diagnose, and treat infertility that include all of the following:

(I) Artificial insemination.

(II) Three attempts to retrieve gametes.

(III) Three attempts to create embryos.

(IV) Three rounds of pretransfer testing.

(V) Cryopreservation of gametes and embryos.

(VI) Two years of storage for cryopreserved embryos.

(VII) Unlimited storage for cryopreserved gametes.

(VIII) Unlimited embryo transfers.

(IX) Two vials of donor sperm.

(X) Ten donor eggs.

(XI) Surrogacy coverage for the services described above.

(XII) Health testing of the surrogate for each attempted round of covered services.

(ii) All of the following durable medical equipment:

(I) Mobility devices, including, but not limited to, walkers and manual and power wheelchairs and scooters.

(II) Augmented communications devices, including, but not limited to, speech generating devices, communications boards, and computer applications.

(III) Continuous positive airway pressure machines.

(IV) Portable oxygen.

(V) Hospital beds.

(iii) (I) An annual hearing exam.

(II) One hearing aid per ear every three years.

(3) With respect to habilitative services, in addition to any habilitative services and devices identified in paragraph (2), coverage shall also be provided as required by federal rules, regulations, and guidance issued pursuant to Section 1302(b) of PPACA. Habilitative services and devices shall be covered under the same terms and conditions applied to rehabilitative services and devices under the plan contract. Limits on habilitative and rehabilitative services and devices shall not be combined.

(4) With respect to pediatric vision care, the same health benefits for pediatric vision care covered under the Federal Employees Dental and Vision Insurance Program vision plan with the largest national enrollment as of the first quarter of 2014. The pediatric vision care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any vision services covered under the plan identified in paragraph (2).

(5) With respect to pediatric oral care, the same health benefits for pediatric oral care covered under the dental benefit received by children under the Medi-Cal program as of 2014, including the provision of medically necessary orthodontic care provided pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009. The pediatric oral care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any dental or orthodontic services covered under the plan identified in paragraph (2).

(b) Treatment limitations imposed on health benefits described in this section shall be no greater than the treatment limitations

imposed by the corresponding plans identified in subdivision (a), subject to the requirements set forth in paragraph (2) of subdivision (a).

(c) Except as provided in subdivision (d), this section does not permit a health care service plan to make substitutions for the benefits required to be covered under this section, regardless of whether those substitutions are actuarially equivalent.

(d) To the extent permitted under Section 1302 of PPACA and any rules, regulations, or guidance issued pursuant to that section, and to the extent that substitution would not create an obligation for the state to defray costs for any individual, a plan may substitute its prescription drug formulary for the formulary provided under the plan identified in subdivision (a) if the coverage for prescription drugs complies with the sections referenced in clauses (ii) and (iv) of subparagraph (A) of paragraph (2) of subdivision (a) that apply to prescription drugs.

(e) A health care service plan, or its agent, solicitor, or representative, shall not issue, deliver, renew, offer, market, represent, or sell any product, contract, or discount arrangement as compliant with the essential health benefits requirement in federal law, unless it meets all of the requirements of this section.

(f) This section applies regardless of whether the plan contract is offered inside or outside the California Health Benefit Exchange created by Section 100500 of the Government Code.

(g) This section does not exempt a plan or a plan contract from meeting other applicable requirements of law.

(h) This section does not prohibit a plan contract from covering additional benefits, including, but not limited to, spiritual care services that are tax deductible under Section 213 of the Internal Revenue Code.

(i) Subdivision (a) does not apply to any of the following:

(1) A specialized health care service plan contract.

(2) A Medicare supplement plan.

(3) A plan contract that qualifies as a grandfathered health plan under Section 1251 of PPACA or any rules, regulations, or guidance issued pursuant to that section.

(j) This section shall not be implemented in a manner that conflicts with a requirement of PPACA.

(k) An essential health benefit is required to be provided under this section only to the extent that federal law does not require the state to defray the costs of the benefit.

(*l*) This section does not obligate the state to incur costs for the coverage of benefits that are not essential health benefits as defined in this section.

(m) A plan is not required to cover, under this section, changes to health benefits that are the result of statutes enacted on or after December 31, 2011.

(n) (1) The department may adopt emergency regulations implementing this section. The department may, on a one-time basis, readopt any emergency regulation authorized by this section that is the same as, or substantially equivalent to, an emergency regulation previously adopted under this section.

(2) The initial adoption of emergency regulations implementing this section and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(3) The initial adoption of emergency regulations implementing this section made during the 2015–16 Regular Session of the Legislature and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(4) The director shall consult with the Insurance Commissioner to ensure consistency and uniformity in the development of regulations under this subdivision.

(5) This subdivision shall become inoperative on July 1, 2018.

(o) For purposes of this section, the following definitions apply:

(1) "Habilitative services" means health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings, or both. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the plan contract.

(2) (A) "Health benefits," unless otherwise required to be defined pursuant to federal rules, regulations, or guidance issued pursuant to Section 1302(b) of PPACA, means health care items or services for the diagnosis, cure, mitigation, treatment, or prevention of illness, injury, disease, or a health condition, including a behavioral health condition.

(B) "Health benefits" does not mean any cost-sharing requirements such as copayments, coinsurance, or deductibles.

(3) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(4) "Small group health care service plan contract" means a group health care service plan contract issued to a small employer, as defined in Section 1357.500.

SEC. 3. Section 10112.27 of the Insurance Code is amended to read:

10112.27. (a) An individual or small group health insurance policy issued, amended, or renewed on or after January 1, 2017, shall include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act (PPACA) and as outlined in this section. This section shall exclusively govern the benefits a health insurer must cover as essential health benefits. For purposes of this section, "essential health benefits" means all of the following:

(1) Health benefits within the categories identified in Section 1302(b) of PPACA: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services

and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

(2) (A) ~~For plan years on or before the 2027 plan year,~~ *The* health benefits covered by the Kaiser Foundation Health Plan Small Group HMO 30 plan (federal health product identification number 40513CA035) as this plan was offered during the first quarter of 2014, as follows, regardless of whether the benefits are specifically referenced in the plan contract or evidence of coverage for that plan:

(i) Medically necessary basic health care services, as defined in subdivision (b) of Section 1345 of the Health and Safety Code and Section 1300.67 of Title 28 of the California Code of Regulations.

(ii) The health benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in the following sections of the Health and Safety Code: Sections 1367.002, 1367.06, and 1367.35 (preventive services for children); Section 1367.25 (prescription drug coverage for contraceptives); Section 1367.45 (AIDS vaccine); Section 1367.46 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha-fetoprotein testing); Section 1367.6 (breast cancer screening); Section 1367.61 (prosthetics for laryngectomy); Section 1367.62 (maternity hospital stay); Section 1367.63 (reconstructive surgery); Section 1367.635 (mastectomies); Section 1367.64 (prostate cancer); Section 1367.65 (mammography); Section 1367.66 (cervical cancer); Section 1367.665 (cancer screening tests); Section 1367.67 (osteoporosis); Section 1367.68 (surgical procedures for jaw bones); Section 1367.71 (anesthesia for dental); Section 1367.9 (conditions attributable to diethylstilbestrol); Section 1368.2 (hospice care); Section 1370.6 (cancer clinical trials); Section 1371.5 (emergency response ambulance or ambulance transport services); subdivision (b) of Section 1373 (sterilization operations or procedures); Section 1373.4 (inpatient hospital and ambulatory maternity); Section 1374.56 (phenylketonuria); Section 1374.17 (organ transplants for HIV); Section 1374.72 (mental health parity); and Section 1374.73 (autism/behavioral health treatment).

(iii) Any other benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in those statutes.

(iv) The health benefits covered by the plan that are not otherwise required to be covered under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, to the extent otherwise required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22, 1367.24, and 1367.25 of the Health and Safety Code, and Section 1300.67.24 of Title 28 of the California Code of Regulations.

(v) Any other health benefits covered by the plan that are not otherwise required to be covered under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(B) If there are any conflicts or omissions in the plan identified in subparagraph (A) as compared with the requirements for health benefits under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code that were enacted before December 31, 2011, the requirements of Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code shall control, except as otherwise specified in this section.

(C) Notwithstanding subparagraph (B) or any other provision of this section, the home health services benefits covered under the plan identified in subparagraph (A) shall not be in conflict with Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(D) For purposes of this section, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) shall apply to a policy subject to this section. Coverage of mental health and substance use disorder services pursuant to this paragraph, along with any scope and duration limits imposed on the benefits, shall be in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

(E) Commencing January 1, 2027, if the United States Department of Health and Human Services approves a new essential health benefits benchmark plan for the State of California pursuant to submissions to the department made on behalf of the state in 2025 for this purpose, the benchmark plan described in

subparagraph (A) shall additionally include all of the following benefits:

(i) Services to evaluate, diagnose, and treat infertility that include all of the following:

(I) Artificial insemination.

(II) Three attempts to retrieve gametes.

(III) Three attempts to create embryos.

(IV) Three rounds of pretransfer testing.

(V) Cryopreservation of gametes and embryos.

(VI) Two years of storage for cryopreserved embryos.

(VII) Unlimited storage for cryopreserved gametes.

(VIII) Unlimited embryo transfers.

(IX) Two vials of donor sperm.

(X) Ten donor eggs.

(XI) Surrogacy coverage for the services described above.

(XII) Health testing of the surrogate for each attempted round of covered services.

(ii) All of the following durable medical equipment:

(I) Mobility devices, including, but not limited to, walkers and manual and power wheelchairs and scooters.

(II) Augmented communications devices, including, but not limited to, speech generating devices, communications boards, and computer applications.

(III) Continuous positive airway pressure machines.

(IV) Portable oxygen.

(V) Hospital beds.

(iii) (I) An annual hearing exam.

(II) One hearing aid per ear every three years.

(3) With respect to habilitative services, in addition to any habilitative services and devices identified in paragraph (2), coverage shall also be provided as required by federal rules, regulations, or guidance issued pursuant to Section 1302(b) of PPACA. Habilitative services and devices shall be covered under the same terms and conditions applied to rehabilitative services and devices under the policy. Limits on habilitative and rehabilitative services and devices shall not be combined.

(4) With respect to pediatric vision care, the same health benefits for pediatric vision care covered under the Federal Employees Dental and Vision Insurance Program vision plan with the largest national enrollment as of the first quarter of 2014. The pediatric

vision care services covered pursuant to this paragraph shall be in addition to, and shall not replace, any vision services covered under the plan identified in paragraph (2).

(5) With respect to pediatric oral care, the same health benefits for pediatric oral care covered under the dental benefit received by children under the Medi-Cal program as of 2014, including the provision of medically necessary orthodontic care provided pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009. The pediatric oral care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any dental or orthodontic services covered under the plan identified in paragraph (2).

(b) Treatment limitations imposed on health benefits described in this section shall be no greater than the treatment limitations imposed by the corresponding plans identified in subdivision (a), subject to the requirements set forth in paragraph (2) of subdivision (a).

(c) Except as provided in subdivision (d), this section does not permit a health insurer to make substitutions for the benefits required to be covered under this section, regardless of whether those substitutions are actuarially equivalent.

(d) To the extent permitted under Section 1302 of PPACA and any rules, regulations, or guidance issued pursuant to that section, and to the extent that substitution would not create an obligation for the state to defray costs for any individual, an insurer may substitute its prescription drug formulary for the formulary provided under the plan identified in subdivision (a) if the coverage for prescription drugs complies with the sections referenced in clauses (ii) and (iv) of subparagraph (A) of paragraph (2) of subdivision (a) that apply to prescription drugs.

(e) A health insurer, or its agent, producer, or representative, shall not issue, deliver, renew, offer, market, represent, or sell any product, policy, or discount arrangement as compliant with the essential health benefits requirement in federal law, unless it meets all of the requirements of this section. This subdivision shall be enforced in the same manner as Section 790.03, including through the means specified in Sections 790.035 and 790.05.

(f) This section applies regardless of whether the policy is offered inside or outside the California Health Benefit Exchange created by Section 100500 of the Government Code.

(g) This section does not exempt a health insurer or a health insurance policy from meeting other applicable requirements of law.

(h) This section does not prohibit a policy from covering additional benefits, including, but not limited to, spiritual care services that are tax deductible under Section 213 of the Internal Revenue Code.

(i) Subdivision (a) does not apply to any of the following:

(1) A policy that provides excepted benefits as described in Sections 2722 and 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91).

(2) A policy that qualifies as a grandfathered health plan under Section 1251 of PPACA or any binding rules, regulations, or guidance issued pursuant to that section.

(j) This section shall not be implemented in a manner that conflicts with a requirement of PPACA.

(k) An essential health benefit is required to be provided under this section only to the extent that federal law does not require the state to defray the costs of the benefit.

(*l*) This section does not obligate the state to incur costs for the coverage of benefits that are not essential health benefits as defined in this section.

(m) An insurer is not required to cover, under this section, changes to health benefits that are the result of statutes enacted on or after December 31, 2011.

(n) (1) The commissioner may adopt emergency regulations implementing this section. The commissioner, on a one-time basis, may readopt any emergency regulation authorized by this section that is the same as, or substantially equivalent to, an emergency regulation previously adopted under this section.

(2) The initial adoption of emergency regulations implementing this section and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(3) The initial adoption of emergency regulations implementing this section made during the 2015–16 Regular Session of the Legislature and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(4) The commissioner shall consult with the Director of the Department of Managed Health Care to ensure consistency and uniformity in the development of regulations under this subdivision.

(5) This subdivision shall become inoperative on July 1, 2018.

(o) This section does not impose on health insurance policies the cost sharing or network limitations of the plans identified in subdivision (a) except to the extent otherwise required to comply with this code, including this section, and as otherwise applicable to all health insurance policies offered to individuals and small groups.

(p) For purposes of this section, the following definitions apply:

(1) "Habilitative services" means health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings, or both. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the policy.

(2) (A) "Health benefits," unless otherwise required to be defined pursuant to federal rules, regulations, or guidance issued pursuant to Section 1302(b) of PPACA, means health care items or services for the diagnosis, cure, mitigation, treatment, or prevention of illness, injury, disease, or a health condition, including a behavioral health condition.

(B) "Health benefits" does not mean any cost-sharing requirements such as copayments, coinsurance, or deductibles.

(3) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(4) "Small group health insurance policy" means a group health insurance policy issued to a small employer, as defined in subdivision (q) of Section 10753.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O

SENATE COMMITTEE ON HEALTH
Senator Caroline Menjivar, Chair

BILL NO: SB 62
AUTHOR: Menjivar
VERSION: April 23, 2025
HEARING DATE: April 30, 2025
CONSULTANT: Teri Boughton

SUBJECT: Health care coverage: essential health benefits

SUMMARY: Adds services to evaluate, diagnose, and treat infertility; durable medical equipment such as mobility devices; and, hearing aids to California's Essential Health Benefits benchmark, which is mandated coverage for nongrandfathered individual and small group health insurance in California pursuant to the federal Affordable Care Act.

Existing federal law: Establishes, pursuant to the Patient Protection and Affordable Care Act (ACA), federal Essential Health Benefits (EHBs) requirements, including that the Secretary of the United States Department of Health and Human Services (HHS) not make coverage decisions, determine reimbursement rates, establish incentive program, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life. [42 U.S.C. §18022]

Existing state law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act); California Department of Insurance (CDI) to regulate health and other insurance; and, the Department of Health Care Services (DHCS) to administer the Medi-Cal program. [HSC §1340, et seq., INS §106, et seq., and WIC §14000, et seq.]

2) Requires an individual or small group health plan contract or insurance policy to include at a minimum, coverage for EHBs pursuant to the ACA, and as outlined below:

    a) Health benefits within the categories identified in the ACA;
    b) Ambulatory patient services;
    c) Emergency services;
    d) Hospitalization;
    e) Maternity and newborn care;
    f) Mental health and substance use disorder services;
    g) Prescription drugs;
    h) Rehabilitative and habilitative services and devices;
    i) Laboratory services;
    j) Preventive and wellness services and chronic disease management; and,
    k) Pediatric services, including oral and vision care;
    l) Health benefits covered by the Kaiser Foundation Health Plan Small Group HMO 30 (Kaiser Small Group HMO), as this plan was offered during the first quarter of 2014, regardless of whether the benefits are specifically referenced in the evidence of coverage or plan contract for that plan;
    m) Medically necessary basic health care services, as specified;
    n) Health benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described; and,

o) Health benefits covered by the plan that are not otherwise required to be covered, as specified. [HSC §1367.005 and INS §10112.27]

3) Requires pediatric vision care to be the same health benefits for pediatric vision care covered under the Federal Employees Dental and Vision Insurance Program vision plan with the largest national enrollment as of the first quarter of 2014. [HSC §1367.005 and INS §10112.27]

4) Requires pediatric oral care to be the same health benefits for pediatric oral care covered under the dental benefit received by children under the Medi-Cal program as of 2014, including the provision of medically necessary orthodontic care provided pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009. [HSC §1367.005 and INS §10112.27]

5) Defines "habilitative services" to mean health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings, or both. Requires habilitative services to be covered under the same terms and conditions applied to rehabilitative services under the plan contract. [HSC §1367.005 and INS §10112.27]

This bill: Adds to California's EHB benchmark the following services beginning January 1, 2027, if approved by HHS:

a) Services to evaluate, diagnose, and treat infertility. Requires the services to include:
   i) Artificial insemination;
   ii) Three attempts to retrieve gametes;
   iii) Three attempts to create embryos;
   iv) Three rounds of pre-transfer testing;
   v) Cryopreservation of gametes and embryos;
   vi) Two years of storage for cryopreserved embryos;
   vii) Unlimited storage for cryopreserved gametes;
   viii) Unlimited embryo transfers;
   ix) Two vials of donor sperm;
   x) Ten donor eggs; and,
   xi) Surrogacy coverage for the aforementioned services, as well as health testing of the surrogate for each attempted round of covered services.
b) The following additional durable medical equipment (DME):
   i) Mobility devices, including walkers and manual and power wheelchairs and scooters;
   ii) Augmented communications devices, such as speech generating devices, communications boards, and apps;
   iii) Continuous positive airway pressure (CPAP) machines;
   iv) Portable oxygen; and,
   v) Hospital beds.
c) An annual hearing exam and one hearing aid per ear every three years.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) *Author's statement.* According to the author, gaps have been identified in coverage in California's EHB benchmark plan for health insurance under the ACA. For example, the existing benchmark excludes coverage for hearing aids, some medically necessary durable medical equipment and infertility treatment. California's benchmark plan can be updated to expand benefits to cover these needed services and treatment. After a stakeholder process held by DMHC which included an actuarial report comparing California's EHB to the most generous typical employer health plan, California decided to keep the current benchmark plan but add coverage for hearing aids, additional durable medical equipment, and infertility diagnosis and treatment. This bill is needed to update California's EHB law to incorporate these changes.

2) *California's benchmark plan.* California's current benchmark plan is the Kaiser Small Group HMO plan. The benchmark plan and other state mandates existing prior to December 31, 2011 are used to determine EHBs. Any state mandate exceeding EHBs requires the state to defray the costs associated with the mandate. California last reviewed its benchmark plan in 2015. At that time, the California Health Benefits Review Program (CHBRP) asked Milliman to analyze and compare the health services covered by the ten plans available to California as options for California's EHB benchmark effective January 1, 2017, similar to an analysis completed for Covered California in 2012. Milliman found relatively small differences in average healthcare costs among the ten benchmark options. Among the plan options, Milliman found differing coverage of acupuncture, infertility treatment, chiropractic care, and hearing aids. The three California small group plans were essentially the same average cost as the California EHB plan and the California large group and CalPERS plans were approximately 0.2% to 1% higher in cost. The estimated average costs for the three federal employee plan options was approximately 0.8% to 1.2% higher than the California EHB plan. On April 17, 2015, the Secretary of California's Health and Human Services Agency sent a letter to the federal Center for Consumer Information and Insurance Oversight (CCIIO) selecting the same Kaiser Small Group Plan to remain as California's benchmark plan.

3) *Updating EHBs.* According to a 2022 CHBRP brief on EHBs, the federal HHS issued final rules in 2018 and 2019, which provided new flexibility for states by allowing three new options for the EHB benchmark plan, in addition to the option of retaining the current EHB benchmark plan. Beginning with the 2020 plan year, states could: a) select an EHB benchmark plan used by another state for the 2017 plan year; b) replace one or more of the ten EHB categories in the state's EHB benchmark plan with the same category or categories of EHBs from another state's 2017 EHB benchmark plan; or, c) otherwise select a set of benefits that would become the state's EHB benchmark plan. At a minimum, the EHB benchmark plan must provide a scope of benefits equal to or greater than a typical employer plan. Furthermore, a new "generosity test" requires that EHBs cannot exceed the generosity of the most generous among the set of ten previous 2017 benchmark comparison plan options. A mandate that is added through the benchmark plan process is not subject to the requirement that the state defray those mandate costs if it is not a state mandated benefit enacted after December 31, 2011. According to the Centers for Medicaid and Medicare Services (CMS) website, for plan years between 2020 and 2025, nine states have updated their EHB benchmark plans.

4) *Updated process rules.* CMS finalized new rules for EHB benchmark updates through the HHS Notice of Benefit and Payment Parameters for 2025. As part of this update, CMS removed a regulatory prohibition on plans and insurers from including routine non-

pediatric dental services as an EHB. This allows states to add routine adult dental services as an EHB by updating their EHB benchmark plans. For plan years beginning on or after January 1, 2026, CMS approved three revisions to the standards for state selection of EHB-benchmark plans to address long-standing requests from states to improve, and reduce the burden of, the EHB-benchmark plan update process. First, CMS allows states to consolidate the options for states to change EHB-benchmark plans such that a state may change its EHB-benchmark plan by selecting a set of benefits that would become the state's EHB-benchmark plan. Any changes to state EHB-benchmark plan options is also applicable to states when choosing a benchmark plan used to define EHBs in a state Basic Health Programs (BHPs) established under section 1331 of the ACA and Medicaid Alternative Benefit Plans (ABPs) implemented pursuant to section 1937 of the ACA. Second, CMS removed the generosity standard and revised the typicality standard so that, in demonstrating that a state's new EHB-benchmark plan provides a scope of benefits that is equal to the scope of benefits of a typical employer plan in the state, the scope of benefits of a typical employer plan in the state would be defined as any scope of benefits that is as or more generous than the scope of benefits in the state's least generous typical employer plan, and as or less generous than the scope of benefits in the state's most generous typical employer plan. Third, CMS removed the requirement for states to submit a formulary drug list as part of their documentation to change EHB-benchmark plans unless the state changes its prescription drug EHBs.

5) *California stakeholder process.* On June 27, 2024, DMHC held a public meeting to discuss California's EHBs and the process for updating the benchmark plan. At that meeting, DMHC shared the timeline and introduced the consultant, who explained the federal rules and recently approved and proposed EHB benchmark changes from other states. Oral public comment was received, and DMHC requested written public comment by July 11, 2024. Public comments included requests for hearing aids for children, infertility treatment, DME, (such as wheelchairs, oxygen equipment, and CPAP machines, intermittent catheters, trach tubes, canes, walkers, neuromodulators, transcutaneous electrical nerve stimulation [TENs], and other medically necessary equipment), oral dietary enteral nutritional formulas, dental benefits at parity with other ACA reforms, massage therapy, and chiropractic. Some requested that benefits not fall below the existing EHB floor. Health plans and insurers urged striking a balance between benefits, cost, and access. Dental plans raised concerns about market impacts of embedding dental services into health plan structures and the impact it could have on the stand alone dental plans that exist in the market today. There were also several letters submitted urging wig coverage for individuals with Alopecia areata. A second stakeholder meeting was held on January 28, 2025 with another public comment period established by February 4th.

6) *Benefit analysis.* At the January 28th meeting, the Wakely Consulting Group (Wakely) presented an actuarial analysis that identified the benefit allowance and potential options and prices for the proposed benchmark plan. Through a typicality test following current CMS standards, Wakely determined that California's proposed benchmark plan can impact benefit costs (which is what the plan pays for the service plus member cost share) ranging between 1.06% to 2.23%. This means that the value of the benefit additions cannot exceed 2.23%. Wakely further estimated the pricing of a suite of proposed benefits that potentially could be added, including hearing aids, DME, wigs, chiropractic, infertility, and adult dental. Altogether, the cost of these benefits, with the exception of adult dental would add 1.63% to 3.48% cost. These benefits exceed the allowed cost impact range by 0.57% to 1.25%. This means choices must be made to narrow the set of proposed benefits to be

covered. The allowed cost range of adult dental preventive services is 1.26% to 1.83% and for comprehensive dental services, the cost range is 2.6% to 4.6%. In addition to the high cost of adding preventive dental services, there are other challenges with adding adult dental benefits to the EHB, such as that as an EHB there cannot be annual or lifetime dollar limits on benefits. This is not typically how dental benefits are offered today.

7) *Informational hearing.* On February 11, 2025, the Senate and Assembly Committees on Health held an informational hearing on California's EHB benchmark options. Testimony was provided by DMHC, Covered California, CHBRP, and the public. CHBRP included the following fiscal estimates:

Proposed EHB Benefit Expansion	Estimated Plan Paid PMPM (per member per month) Increase for Silver Plans	Estimated Premium Increase for Silver Plans
Hearing Aids	$1.52	.21%
Wigs	$.31	.04%
Chiropractic care	$.78	.11%
DME – General	$1.64	.23%
DME – Augmented Communication Devices	$.03	.00%
DME – Neuromodulators	$.01	.00%
Infertility	$5.36	.76%

CHBRP February 11, 2025

8) *DMHC Announcement.* On March 28, 2025, DMHC announced that California intends to apply to CMS to update the state's benchmark plan to take effect January 1, 2027. A public comment period was held on the draft document submissions to CMS. The documents include a benchmark plan summary, confirmations, certifications, benefits and limits summary and a valuation report. The additional benefits are described in the table below. DMHC received comments from a variety of organizations expressing support for the chosen benefits. Some organizations express disappointment that adult dental benefits were not included, as well as chiropractic, and neuromodulators. Some requested clarifications regarding the artificial insemination benefit, and description of behavioral health provider in the benchmark plan summary. Lastly, two organizations requested a delay in the submission to take additional time for review and consultation of the premium impact of these added benefits, impacts of federal decisions related to terminating enhanced Advanced Premium Tax Credits (APTCs), and guidance on infertility treatment requirements in the large group market.

Hearing Aid Coverage	Annual exam and one hearing aid per ear every three years	Cost estimate .21% of total allowed claims.
Expanded DME	Removing DME limitation to home use; and, wheelchairs, portable oxygen, CPAP machines, walkers, scooters, hospital beds, and augmented communication devices.	Allowed cost impact 1.03%
Infertility diagnosis, AI, and IVF.	See description of this bill 1a) above.	Allowed cost impact .93%
Total		Allowed cost impact 2.18%
Value of benefit limit based on typicality test		2.23%

9) *Related legislation.* AB 224 (Bonta) is substantially similar to this bill. *AB 224 is set for hearing on April 29, 2025 in the Assembly Health Committee.*

10) *Prior legislation.* SB 1290 (Roth) and AB 2914 (Bonta) of 2024 would have placed a sunset on California's EHB benchmark after the 2026 plan year. *SB 1290 and AB 2914 were held on the Assembly and Senate Floor at request of authors.*

SB 635 (Menjivar and Portantino of 2023) would have required a health plan contract or health insurance policy to include coverage for hearing aids for all enrollees and insureds under 21 years of age, if medically necessary. SB 635 would have limited the maximum required coverage amount to $3,000 per individual hearing aid, and prohibited hearing aids covered from being subject to a coinsurance, deductible or copayment requirement, or, subject to financial or treatment limitations, including a dollar limit set below $3,000 per individual hearing aid. *SB 635 was vetoed by Governor Newsom, who stated:*

This bill would require health plans to cover medically necessary hearing aids for individuals under 21 years of age, up to $3,000 per individual hearing aid without any cost sharing, beginning January 1, 2025. I am committed to ensuring that hearing impaired children have access to the services and supports they need, including hearing aids. Today, children can receive hearing aids and related services through the California Children's Services (CCS) program or through Medi-Cal. In July 2021 we launched the Hearing Aid Coverage for Children Program (HACCP) within the Department of Health Care Services (DHCS) for those who do not qualify for hearing aids through CCS or Medi-Cal. HACCP was created to improve access and coverage for children's hearing aids, a shared goal of this proposed bill. Unlike HACCP, however, SB 635 would exceed the state's set of essential health benefits, which are established by the state's benchmark plan under the provisions of the federal Affordable Care Act (ACA). As such, this bill's mandate would require the state to defray the costs of coverage in Covered California. This would not only increase ongoing state General Fund costs, but it would set a new precedent by adding requirements that exceed the benchmark plan. A pattern of new coverage mandate bills like this could open the state to millions to billions of dollars in new costs to cover services relating to other health conditions. This creates uncertainty for our healthcare system's

affordability, particularly when we have developed an alternative program that can serve the target population. That said, improving access to hearing aids for children is a priority for my Administration. We can, and we must, do better for these children and their families as we implement HACCP. To this end, I am directing my Administration to explore increases to Medi-Cal provider payments with the goal of incentivizing additional provider participation in HACCP, increasing access for youth in need of hearing aids.

In addition, DHCS has developed a comprehensive plan to increase provider participation and program enrollment. These improvements will enable HACCP to reach and serve more children, which is our shared goal. Specifically, in the next six months, DHCS will take a variety of steps to help patients maximize benefits, including: (1) partnering with other state entities to promote participation and awareness of HACCP, (2) completing translations for HACCP related materials into 18 languages, (3) implementing a streamlined annual eligibility renewal process to simplify provider enrollment, (4) conducting outreach to Medi-Cal providers not yet participating in HACCP to support their participation, (5) hosting quarterly webinars with providers and stakeholders, and (6) continuing to identify potential service improvements and strategies to increase program success. Given the structural concerns this bill presents to our healthcare system and the opportunity to improve the existing HACCP to accomplish the same objectives, I cannot sign this bill.

AB 598 (Bloom of 2019) would have required a health plan contract or a health insurance to include coverage for hearing aids for an enrollee or insured under 18 years of age, and would have limited the maximum coverage amount to $3,000 per hearing aid. *AB 598 was placed on the Assembly inactive file at the request of the author.*

AB 1601 (Bloom of 2017) and AB 2004 (Bloom of 2016) were substantially similar to AB 598. *AB 1601 was held in Assembly Appropriations Committee. AB 2004 was held in Senate Appropriations Committee.*

SB 43 (Hernandez, Chapter 648, Statutes of 2015) updates California's EHB law to make it consistent with new federal requirements promulgated under the ACA, which includes adoption of the federally required definition of habilitative services and devices.

SB 951 (Hernandez, Chapter 866, Statutes of 2012) and AB 1453 (Monning, Chapter 854, Statutes of 2012) select the Kaiser Small Group HMO as California's benchmark plan to serve as the EHB standard.

AB 368 (Carter of 2007) would have required health care service plans and health insurers to offer, at minimal cost, coverage up to $1,000 for hearing aids, as defined, to all enrollees, subscribers, and insureds under 18 years of age. *AB 368 was vetoed by Governor Schwarzenegger who stated, in part: "The addition of a new mandate, no matter how small, will only serve to increase the overall cost of health care and increasing the cost of coverage by mandating benefits, may ultimately leave more children without any coverage."*

SB 1223 (Scott of 2006) would have required health plans and health insurers to offer or provide, as specified, coverage up to $1,000 for hearing aids, as defined, to all enrollees, subscribers, and insureds under 18 years of age. *SB 1223 was vetoed by Governor Schwarzenegger, who indicated that the bill may contribute to rising premiums and make*

health care less affordable and accessible for uninsured Californians.

SB 174 (Scott of 2004) would have required health plans and health insurers to provide coverage, up to $1,000, for hearing aids, as defined, to all enrollees and subscribers under 18 years of age. *SB 174 was held in Senate Rules Committee.*

SB 1158 (Scott of 2004) would have required health plans and health insurers to provide coverage up to $1,000 for hearing aids, as defined, to all enrollees, subscribers, and insureds under 18 years of age. *SB 1158 was vetoed by Governor Schwarzenegger, who indicated that increasing the cost of health coverage by mandating benefits, if even by a small amount, would have the far more serious consequence of leaving some children without health insurance.*

8) *Support.* Health Access California supports the additional items to be add to California's EHBs because hearing loss can result in delayed language development in children and social isolation among people of all ages. Many Californians do not have access to wheelchairs, augmentation communication devices, hearing aids, oxygen equipment and other DME that they need. California as a state is committed to reproductive rights: infertility treatment is as much a part of that as abortion. Much has changed in the dozen years since the EHB standard was initially adopted in California law: it is time and past time to update that standard. Western Center on Law and Poverty writes the current benchmark creates a significant gap in services due to its lack of coverage for DME. Without adequate coverage, people go without medically necessary devices, obtain inferior ones that put their safety at risk, or turn to publicly-funded health care programs for help. The Santa Clara County Office of Education writes this bill would establish a new benchmark plan for the 2027 plan year, which would include, among other things, a requirement that private health plans cover hearing aids for children. This bill would support our deaf and hard of hearing students by ensuring that all families have access to the choices that meet their needs. RESOLVE: The National Infertility Association writes as the American Society for Reproductive Medicine has declared in prior support letters, the proposed benchmark plan meets the standard of care for in vitro fertilization by covering three egg retrievals and an unlimited number of transfers, among other enumerated services. This standard is based on extensive U.S. and international literature, as well as professional consensus, which supports this approach as the most cost-effective way to maximize an individual's chances for a healthy pregnancy and neonatal outcome. This standard is maintained by most states with similar mandates and closely aligns with what commercial insurance companies provide for their covered lives. Without adequate insurance coverage for fertility care, the out-of-pocket costs for these treatments are simply insurmountable for most Californians. Hormone therapy alone can cost as much as $2,000 and intrauterine insemination can cost more than $5,000. IVF can run anywhere between $24,000 and $38,015 depending on the clinic and whether a patient needs donor eggs or sperm. For Californians struggling with infertility, the very existence of the family they hope to build can depend on income alone. Children Now writes this legislation presents a welcome opportunity to update the EHB benchmark package to include hearing aid coverage for children and adults in 2027, pending federal approval. In closing the hearing aid coverage gap, these bills will ensure that all children in California have the opportunity to reach their full potential.

9) *Support if amended.* The California Dental Association (CDA) writes that CDA understands the challenges with including adult dental coverage as highlighted in the

benefit review analysis and is aware that adult dental is not included in the draft plan under current consideration. However, CDA urges the Legislature to consider adding adult dental at the earliest opportunity as oral healthcare is not a luxury; it is a core component of overall health.

10) *Concerns.* The California Association of Health Plans (CAHP) and the Association of California Life and Health Insurance Companies (ACLHIC) express significant concerns with legislation seeking to expand California's EHB benchmark plan. They believe that proceeding with this legislation now is premature and warrants a delay to allow for a more thorough review and consultation on premium impact and affordability. The Wakely studies have already indicated a potential 2% premium increase to cover these benefits, a cost that will further strain the affordability of healthcare for many Californians. As Wakely themselves noted in their Benchmark Plan Benefit Valuation Report, the actual cost and premium impacts could be even higher depending on various factors. It is imperative that the State undertake a more comprehensive evaluation of these potential premium increases. CAHP and ACLHIC urge the State to consult with CHBRP to conduct a detailed analysis of the cost implications for these proposed services. Also, the looming expiration of the APTC subsidies at the end of 2025 presents a significant risk. The expiration of these subsidies could lead to higher insurance premiums for all 2.37 million Californians in the individual market, potentially increasing the number of uninsured individuals. Covered California has publicly testified that the loss of these subsidies would increase the ranks of the state's uninsured by an estimated 400,000 Californians.

SUPPORT AND OPPOSITION:

Support: Alliance for Fertility Preservation
California State Council of Service Employees International Union
Children Now
County of Santa Clara Office of Education
Health Access California
Indivisible CA: StateStrong
Resolve: The National Infertility Association
Western Center on Law & Poverty, Inc.

Oppose: None received

-- END --

Introduced by Senator Cabaldon

February 12, 2025

An act to add Division 1.7 (commencing with Section 1190) to the Health and Safety Code, relating to health practices.

LEGISLATIVE COUNSEL'S DIGEST

SB 351, as introduced, Cabaldon. Health facilities.

Existing law generally regulates the licensing and operation of health facilities and other facilities providing health care in this state. Existing law, the Medical Practice Act, creates the Medical Board of California to license and regulate physicians and surgeons. Under existing law, the Dental Practice Act, the Dental Board of California licenses and regulates dentists.

Existing law, the Nonprofit Public Benefit Corporation Law, generally requires a nonprofit public benefit corporation to give written notice to the Attorney General before it sells, leases, conveys, exchanges, transfers, or disposes of its assets, except as specified. Existing law provides specific procedures for health facilities and additionally requires these facilities to obtain the consent of the Attorney General prior to entering into a specified agreement or transaction.

This bill would prohibit a private equity group or hedge fund, as defined, involved in any manner with a physician or dental practice doing business in this state from interfering with the professional judgment of physicians or dentists in making health care decisions and exercising power over specified actions, including, among other things, making decisions regarding coding and billing procedures for patient care services. The bill would prohibit a private equity group or hedge fund from entering into an agreement or arrangement with a physician or dental practice if the agreement or arrangement would enable the

person or entity to engage in the prohibited actions described above. The bill would render void and unenforceable specified types of contracts between a physician or dental practice and a private equity group or hedge fund that explicitly or implicitly include any clause barring any provider in that practice from competing with that practice in the event of a termination or resignation, or from disparaging, opining, or commenting on that practice in any manner as to any issues involving quality of care, utilization of care, ethical or professional challenges in the practice of medicine or dentistry, or revenue-increasing strategies employed by the private equity group or hedge fund, as specified. This bill would entitle the Attorney General to injunctive relief and attorney's fees and costs for the enforcement of these provisions, as specified.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Division 1.7 (commencing with Section 1190) is added to the Health and Safety Code, to read:

DIVISION 1.7. PRIVATE EQUITY OR HEDGE FUND OWNERSHIP OF HEALTH CARE PRACTICES

1190. For purposes of this division, the following definitions shall apply:

(a) (1) "Hedge fund" means a pool of funds managed by investors for the purpose of earning a return on those funds, regardless of the strategies used to manage the funds. Hedge funds include, but are not limited to, a pool of funds managed or controlled by private limited partnerships.

(2) "Hedge fund" does not include:

(A) Natural persons or other entities that contribute, or promise to contribute, funds to the hedge fund, but otherwise do not participate in the management of the hedge fund or the fund's assets, or in any change in control of the hedge fund or the fund's assets.

(B) Entities that solely provide or manage debt financing secured in whole or in part by the assets of a health care facility, including, but not limited to, banks and credit unions, commercial real estate lenders, bond underwriters, and trustees.

(b) (1) "Private equity group" means an investor or group of investors who primarily engage in the raising or returning of capital and who invests, develops, or disposes of specified assets.

(2) "Private equity group" does not include natural persons or other entities that contribute, or promise to contribute, funds to the private equity group, but otherwise do not participate in the management of the private equity group or the group's assets, or in any change in control of the private equity group or the group's assets.

1191. (a) A private equity group or hedge fund involved in any manner with a physician or dental practice doing business in this state, including as an investor in that physician or dental practice or as an investor or owner of the assets of that practice, shall not do either of the following with respect to that practice:

(1) Interfere with the professional judgment of physicians or dentists in making health care decisions, including any of the following:

(A) Determining what diagnostic tests are appropriate for a particular condition.

(B) Determining the need for referrals to, or consultation with, another physician, dentist, or licensed health professional.

(C) Being responsible for the ultimate overall care of the patient, including treatment options available to the patient.

(D) Determining how many patients a physician or dentist shall see in a given period of time or how many hours a physician or dentist shall work.

(2) Exercise control over, or be delegated the power to do, any of the following:

(A) Owning or otherwise determining the content of patient medical records.

(B) Selecting, hiring, or firing physicians, dentists, allied health staff, and medical assistants based, in whole or in part, on clinical competency or proficiency.

(C) Setting the parameters under which a physician, dentist, or physician or dental practice shall enter into contractual relationships with third-party payers.

(D) Setting the parameters under which a physician or dentist shall enter into contractual relationships with other physicians or dentists for the delivery of care.

(E) Making decisions regarding coding and billing procedures for patient care services.

(F) Approving the selection of medical equipment and medical supplies for the physician or dental practice.

(b) The corporate form of that physician or dental practice as a sole proprietorship, a partnership, a foundation, or a corporate entity of any kind shall not affect the applicability of this section.

(c) A private equity group or hedge fund, or an entity controlled directly, in whole or in part, by a private equity group or hedge fund, shall not enter into an agreement or arrangement with a physician or dental practice doing business in this state if the agreement or arrangement would enable the person or entity to interfere with the professional judgment of physicians or dentists in making health care decisions, as set forth in paragraph (1) of subdivision (a), or exercise control over or be delegated the powers set forth in paragraph (2) of subdivision (a).

(d) Any contract involving the management of a physician or dental practice doing business in this state by, or the sale of real estate or other assets owned by a physician or dental practice doing business in this state to, a private equity group or hedge fund, or any entity controlled directly or indirectly, in whole or in part, by a private equity group or hedge fund, shall not explicitly or implicitly include any clause barring any provider in that practice from competing with that practice in the event of a termination or resignation of that provider from that practice, or from disparaging, opining, or commenting on that practice in any manner as to any issues involving quality of care, utilization of care, ethical or professional challenges in the practice of medicine or dentistry, or revenue-increasing strategies employed by the private equity group or hedge fund. Any such explicit or implicit contractual clauses are void, unenforceable, and against public policy. This subdivision shall not impact the validity of an otherwise enforceable sale of business noncompete agreement, but a contract described in this subdivision shall not operate as an employee noncompete agreement.

(e) The Attorney General shall be entitled to injunctive relief and other equitable remedies a court deems appropriate for enforcement of this section and shall be entitled to recover attorney’s fees and costs incurred in remedying any violation of this section.

(f) This section is intended to ensure that clinical decisionmaking and treatment decisions are exclusively in the hands of licensed health care providers and to safeguard against nonlicensed individuals or entities, such as private equity groups and hedge funds, exerting influence or control over care delivery.

(g) This section does not narrow, abrogate, or otherwise lower the bar on the corporate practice of medicine or dentistry as set forth in the Business and Professions Code or the Corporations Code, or any other applicable state or federal law.

O

SENATE JUDICIARY COMMITTEE
Senator Thomas Umberg, Chair
2025-2026 Regular Session

SB 351 (Cabaldon)
Version: February 12, 2025
Hearing Date: April 29, 2025
Fiscal: Yes
Urgency: No
AM

SUBJECT

Health facilities

DIGEST

This bill prohibits a private equity group or hedge fund, as defined, involved in any manner with a physician or dental practice doing business in this state from interfering with the professional judgment of physicians or dentists in making health care decisions and exercising power over specified actions, including, among other things, determining what diagnostic tests are appropriate for a particular condition. The bill authorizes the Attorney General (AG) to seek injunctive relief and other equitable remedies a court deems appropriate for enforcement of the bill, and provides that AG is entitled to recover attorney's fees and costs incurred in remedying any such violation.

EXECUTIVE SUMMARY

The author and sponsors of the bill state this bill is needed to address the growing number of private equity acquisitions of medical practices in the state, which they argue leads to increased prices and worsening medical care for patients. The bill accomplishes this by strengthening the existing ban on the corporate practice of medicine and dentistry as it applies to private equity groups or hedge funds, and authorizing enforcement by the AG. The bill is sponsored by the California Medical Association and the California Dental Association. The bill is supported by Attorney General, Rob Bonta, numerous associations representing health care providers and patients, and SEIU California. The bill is opposed by the American Investment Council, Association of Dental Support Organizations, and Children's Choice Dental. The bill passed the Senate Business and Professions Committee on a vote of 9 to 1.

PROPOSED CHANGES TO THE LAW

Existing law:

1) Regulates the practice of dentistry under the Dental Practice Act and establishes the Dental Board of California (Dental Board) to license dentists. (Bus. & Prof. Code §§ 1600 et seq.)

2) Specifies that a person practices dentistry if the person does any one or more of the following:
    a) advertises themselves or represents themselves to be a dentist;
    b) performs, or offers to perform, an operation or diagnosis of any kind, or treats diseases or lesions of the human teeth, alveolar process, gums, jaws, or associated structures, or corrects malposed positions thereof;
    c) in any way indicates that the person will perform by themselves or their agents or servants any operation upon the human teeth, alveolar process, gums, jaws, or associated structures, or in any way indicates that the person will construct, alter, repair, or sell any bridge, crown, denture, or other prosthetic appliance or orthodontic appliance;
    d) makes, or offers to make, an examination of, with the intent to perform or cause to be performed any operation on the human teeth, alveolar process, gums, jaws, or associated structures; and
    e) manages or conducts as manager, proprietor, conductor, lessor, or otherwise, a place where dental operations are performed, other than a facility owned or managed by a tax-exempt nonprofit corporation supported and maintained in whole or in substantial part by donations, bequests, gifts, grants, government funds, or contributions. (Bus. & Prof. Code §§ 1625 & 1625.2.)

3) Authorizes specified clinics to employ dentists and dental assistants and charge for the professional services they render, and specifies that these clinics are not deemed to be practicing dentistry within the meaning of 2), above.
    a) Prohibits specified clinics from interfering with, controlling, or otherwise directing the professional judgment of a dentist or dental assistant lawfully acting within the their scope of practice, but does not require dentists to constitute all or a percentage of the governing body of the clinic. (Bus. & Prof. Code § 1625.1.)

4) Defines a dental corporation as a corporation that is authorized to render professional services, as defined in the Moscone-Knox Professional Corporation Act, if the corporation, its shareholders, officers, directors, and employees rendering professional services who are dentists are in compliance with the Moscone-Knox Act, the Dental Practice Act, and other laws applicable to a dental corporation and

the conduct of its affairs. Provides that a dental corporation is entitled to practice dentistry. (Bus. & Prof. Code § 1800.)

5) Regulates the practice of medicine under the Medical Practice Act and establishes the Medical Board of California (Medical Board) and Osteopathic Medical Board of California for the licensure, regulation, and discipline of physicians and surgeons. (Bus. & Prof. Code §§ 2000 et seq.)

6) Makes any person who practices or attempts to practice, or who advertises or holds themselves out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of so doing a valid, unrevoked, or unsuspended license guilty of a public offense, punishable by a fine not exceeding $10,000, by imprisonment, by imprisonment in a county jail not exceeding one year, or by both the fine and either imprisonment.
    a) Makes any person who conspires with or aids or abets another to commit any of the above acts guilty of a public offense, subject to the punishment described above. (Bus. & Prof. Code § 2052.)

7) States that corporations and other artificial legal entities have no professional rights, privileges, or powers, which is generally referred to as the ban on the corporate practice of medicine.
    a) Provides that the Medical Board may, in its discretion and under regulations adopted by it, grant approval for physicians to be employed on a salary basis by licensed charitable institutions, foundations, or clinics, if no charge for professional services rendered is made to patients by any such institution, foundation, or clinic. (Bus. & Prof. Code § 2400.)

8) Establishes certain exceptions to the ban on the corporate practice of medicine, thereby allowing certain types of facilities to employ physicians, including, among others, clinics operated primarily for the purpose of medical education by a public or private nonprofit university medical school, to charge for professional services rendered to teaching patients by licensed physicians who hold academic appointments on the faculty of the university, if the charges are approved by the physician in whose name the charges are made. (Bus. & Prof. Code § 2401.)

9) Establishes protections against retaliation for health care practitioners who advocate for appropriate health care for their patients pursuant to *Wickline v. State of California*:[1]
    a) It is the public policy of the State of California that a health care practitioner be encouraged to advocate for appropriate health care for their patients.

[1] *Wickline v. State of California* (1986) 192 Cal. App. 3d 1630.

Provides that "to advocate for appropriate health care" means to appeal a payer's decision to deny payment for a service pursuant to the reasonable grievance or appeal procedure established by a medical group, independent practice association, preferred provider organization, foundation, hospital medical staff and governing body, or payer, or to protest a decision, policy, or practice that the health care practitioner, consistent with that degree of learning and skill ordinarily possessed by reputable health care practitioners with the same license or certification and practicing according to the applicable legal standard of care, reasonably believes impairs the health care practitioner's ability to provide appropriate health care to their patients.

b) The application or rendering by any individual, partnership, corporation, or other organization of a decision to terminate an employment or other contractual relationship with or otherwise penalize a health care practitioner principally for advocating for appropriate health care consistent with that degree of learning and skill ordinarily possessed by reputable health care practitioners with the same license or certification and practicing according to the applicable legal standard of care violates the public policy of this state.

c) This law is not to be construed to prohibit a payer from making a determination not to pay for a particular medical treatment or service, or the services of a type of health care practitioner, or to prohibit a medical group, independent practice association, preferred provider organization, foundation, hospital medical staff, hospital governing body, or payer from enforcing reasonable peer review or utilization review protocols or determining whether a health care practitioner has complied with those protocols. (Bus. & Prof. Code § 510.)

10) Authorizes, under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), licensed health care service plans to employ or contract with health care professionals, including physicians, to deliver professional services, and requires health plans to demonstrate that medical decisions are rendered by qualified medical providers unhindered by fiscal and administrative management. Provides in regulation that the organization of a health plan must include separation of medical services from fiscal and administrative management. (Health & Saf. Code §§ 1340 et seq.)

This bill:

1) Prohibits a private equity group or hedge fund involved in any manner with a physician or dental practice doing business in this state, including as an investor in or as an investor or owner of the assets of that practice, from interfering with the professional judgment of physicians or dentists in making health care decisions, including any of the following:
    a) determining what diagnostic tests are appropriate for a particular condition;

b) determining the need for referrals to, or consultation with, another physician, dentist, or licensed health professional;
c) being responsible for the ultimate overall care of the patient, including treatment options available to the patient; and
d) determining how many patients a physician or dentist shall see in a given period of time or how many hours a physician or dentist shall work.

2) Prohibits a private equity group or hedge fund from exercising control over, or be delegated the power to do, any of the following:
   a) owning or otherwise determining the content of patient medical records;
   b) selecting, hiring, or firing physicians, dentists, allied health staff, and medical assistants based, in whole or in part, on clinical competency or proficiency;
   c) setting the parameters under which a physician, dentist, or physician or dental practice must enter into contractual relationships with third-party payers;
   d) setting the parameters under which a physician or dentist must enter into contractual relationships with other physicians or dentists for the delivery of care;
   e) making decisions regarding coding and billing procedures for patient care services; and
   f) approving the selection of medical equipment and medical supplies for the physician or dental practice.

3) Specifies that the corporate form of that physician or dental practice as a sole proprietorship, a partnership, a foundation, or a corporate entity of any kind does not affect the applicability of this bill.

4) Prohibits a private equity group or hedge fund, or an entity controlled directly, in whole or in part, by a private equity group or hedge fund from entering into an agreement or arrangement with a physician or dental practice doing business in this state if the agreement or arrangement would enable the person or entity to interfere with the professional judgment of physicians or dentists in making health care decisions as described in 1), above, or exercise control over or be delegated the powers set forth in 2), above.

5) Prohibits any contract involving the management of a physician or dental practice doing business in this state by, or the sale of real estate or other assets owned by a physician or dental practice doing business in this state to, a private equity group or hedge fund, or any entity controlled directly or indirectly, in whole or in part, by a private equity group or hedge fund, from explicitly or implicitly including any clause barring any provider in that practice from competing with that practice in the event of a termination or resignation of that provider from that practice, or from disparaging, opining, or commenting on that practice in any manner as to any issues involving quality of care, utilization of care, ethical or professional challenges in the

practice of medicine or dentistry, or revenue-increasing strategies employed by the private equity group or hedge fund.

a) Any such explicit or implicit contractual clauses are void, unenforceable, and against public policy.
b) This provision does not impact the validity of an otherwise enforceable sale of business noncompete agreement.
c) A contract described in this 5), above, does not operate as an employee noncompete agreement.

6) Authorizes the Attorney General (AG) to seek injunctive relief and other equitable remedies a court deems appropriate for enforcement of these provisions, and provides the AG is entitled to recover attorney's fees and costs incurred in remedying any violation of these provisions.

7) Provides that the bill is intended to ensure that clinical decisionmaking and treatment decisions are exclusively in the hands of licensed health care providers and to safeguard against nonlicensed individuals or entities, such as private equity groups and hedge funds, exerting influence or control over care delivery.

8) This bill does not narrow, abrogate, or otherwise lower the bar on the corporate practice of medicine or dentistry as set forth in the Business and Professions Code or the Corporations Code, or any other applicable state or federal law.

9) Defines various terms, including:
   a) "Hedge fund" means a pool of funds managed by investors for the purpose of earning a return on those funds, regardless of the strategies used to manage the funds. Hedge funds include, but are not limited to, a pool of funds managed or controlled by private limited partnerships.
      i. "Hedge fund" does not include:
         1. Natural persons or other entities that contribute, or promise to contribute, funds to the hedge fund, but otherwise do not participate in the management of the hedge fund or the fund's assets, or in any change in control of the hedge fund or the fund's assets.
         2. Entities that solely provide or manage debt financing secured in whole or in part by the assets of a health care facility, including, but not limited to, banks and credit unions, commercial real estate lenders, bond underwriters, and trustees.
   b) "Private equity group" means an investor or group of investors who primarily engage in the raising or returning of capital and who invests, develops, or disposes of specified assets.
      i. Private equity group" does not include natural persons or other entities that contribute, or promise to contribute, funds to the private equity group, but otherwise do not participate in the management of

the private equity group or the group's assets, or in any change in control of the private equity group or the group's assets.

COMMENTS

1. Stated need for the bill

The author writes:

> Private equity firms are gaining influence in our health care system, leading to rising costs and undermining the quality of care. As these firms acquire more medical practices, there is a growing need for stronger enforcement to protect patient care and ensure that decisions are made based on medical needs and patient care, not profit. If left unchecked, these acquisitions could erode existing protections, violate the Corporate Bar, and put financial interests above the well-being of Californians.
>
> In response, SB 351 empowers the Attorney General (AG) to hold private equity groups accountable for interfering with the practice of medicine. The bill strengthens California's ban on the corporate practice of medicine by allowing the AG to investigate and take action against private equity firms that unlawfully interfere in the patient-physician relationship. The goal is to restore trust in the health care system, ensuring that medical decisions are made in the best interest of patients, not financial shareholders.

2. Background

a. Ban on the corporate practice of medicine and dentistry

Historically, the corporate practice of medicine ban sought to prevent a corporation from practicing medicine, including employing physicians, with the goal of ensuring that any medical decisions made by a physician are made with the health of the patient in mind and not the financial needs of the corporation or physician's employer.[2] The Medical Board provides guidance on its website and gives specific examples of some types of behaviors and controls that the corporate practice of medicine is designed to prevent and that, in the opinion of the Medical Board, are to be made solely by licensed physicians in their professional judgment.[3] These behaviors and controls are identical to the ones the bill prohibits a private equity group or hedge fund from doing, exercising control over, or being delegated the power to do because they would interfere with the professional judgment of a physician or dentist. The only prohibited act not specifically included on the Medical Board's guidance on its website is the prohibition on exercising

[2] Cal. Res. Bur., *The Corporate Practice of Medicine in a Changing Healthcare Environment* (Apr. 2016) p. 2, available at https://www.library.ca.gov/wp-content/uploads/crb-reports/CRB_CPM_Final.pdf.
[3] Medical Bd. Of Cal., *Corporate Practice of Medicine* (2025), available at https://www.mbc.ca.gov/Licensing/Physicians-and-Surgeons/Practice-Information/.

control over setting, or being delegated the power to set, the parameters under which a physician or dentist shall enter into contractual relationships with other physicians or dentists for the delivery of care. (*see* 1) and 2) under the This bill section, above.) Section 1625.1 of the Business Code is the statutory ban on the corporate practice of dentistry and is substantially similar to the ban on the corporate practice of medicine.

b. AB 3129 (Wood, 2024)

AB 3129 attempted to address the issue of private equity and hedge fund investment in the health care system by requiring written notice to, and consent of, the AG prior to a transaction between a private equity group or hedge fund and certain health care facilities, provider groups, or providers. The bill also prohibited a private equity group or hedge fund involved in any manner with a physician, psychiatric, or dental practice doing business in this state, including as an investor, or as an investor or owner of the assets, from interfering with the professional judgment of physicians, psychiatrists, or dentists in making health care decisions. The bill specified certain actions that would interfere with the professional judgment of those medical professionals and prohibited them exercising control over, or being delegated the power to do, certain activities. This provision in AB 3129 is almost identical to the provisions in this bill. The main difference is this bill does not apply to psychiatrists. Additionally, the definitions in this bill for hedge fund and private equity group are identical to the definitions for those terms in AB 3129.

AB 3129 was vetoed by Governor Newsom writing: "I appreciate the author's continued efforts and partnership to increase oversight of California's health care system in an effort to ensure consumers receive affordable and quality health care. However, [the Office of Health Care Affordability] OHCA was created as the responsible state entity to review proposed health care transactions, and it would be more appropriate for the OHCA to oversee these consolidation issues as it is already doing much of this work."

3. <u>The issues this bill seeks to address</u>

A California Health Care Foundation report from 2024 noted that private equity investment into health care totaled about $83 billion nationally and $20 billion in California in 2021.[4] The majority of this investment was in pharmaceutical companies, but also included investments in health care service providers, health care technology, and biotech industries.[5] In California, "acquisitions of providers totaled $4.31 billion dollars between 2019 and 2023."[6] The report concluded after reviewing several peer-reviewed studies that private equity acquisition of health care service providers has

[4] Christopher Cai, MD & Zirui Song, MD, PHD, Cal. Health Care Foundation, *Private Equity in Health Care: Prevalence, Impact, and Policy Options For California and the US*, (May 2024) p. 3, available at https://www.chcf.org/wp-content/uploads/2024/05/PrivateEquityPrevalenceImpactPolicy.pdf.
[5] *Id*. at 3 & 9.
[6] *Ibid*.

resulted in: higher prices, lower patient satisfaction, mixed changes in operating costs, mixed to worse clinical quality, and worse financial outcomes. A report by Private Equity Stakeholder Project titled *Private Equity Descends on Rural Healthcare* notes that private equity firms seek high returns on their investments, generally trying to double or triple the investment in a condensed time period, generally less than 10 years.[7] Typical ways this return on investment is achieved is through cutting operating costs or taking on new debt for the health facility, paying itself with the borrowed money, and then saddling the health facility with the debt and repayment of the loan.[8]

The bill seeks to address the growing number of private equity acquisitions of medical practices in the state. The author points to an article in the L.A. Times as evidence for why this bill is need. A doctor of one of Orange County's largest pediatric practices partnered with a hedge fund during COVID-19, but ended up suing them for wrongful termination and defamation.[9] The article states that Doctor "Abelowitz said Pediatric Associates [the hedge fund investor] began making decisions that should have been left to medical staff and was responsible for a drop in both the number of support employees and the quality of their training. He and his attorneys allege patients' vitals weren't being properly recorded, and there were multiple cases when children were given the wrong vaccines."[10]

The bill seeks to bolster the existing ban on the corporate practice of medicine by placing the Medical Board's guidelines regarding behaviors and controls the ban is designed to prevent into statute. The bill expands enforcement of the corporate practice of medicine ban by authorizing the AG to seek injunctive relief and other equitable remedies a court deems appropriate for enforcement of the statutory prohibitions this bill would enact. The AG is entitled to recover attorney's fees and costs incurred in remedying any violation under the bill. The bill also prohibits any contract involving the management of a physician or dental practice doing business in this state that explicit or implicitly includes a clause barring any provider in that practice from competing with that practice in the event of a termination or resignation of that provider from that practice. It also prohibits in such a contract a clause barring any provide in that practice from disparaging, opining, or commenting on that practice in any manner as to any issues involving quality of care, utilization of care, ethical or professional challenges in the practice of medicine or dentistry, or revenue-increasing strategies employed by the private equity group or hedge fund.

---

[7] Eileen O'Grady, et. al., *Private Equity Descends on Rural Healthcare*, Private Equity Stakeholder Project, (Jan. 2023), available at https://pestakeholder.org/wp-content/uploads/2023/02/PE_Rural_Health_Jan2023.pdf at 4.
[8] *Ibid*.
[9] Eric Licas, L.A. Times, *Newport Beach pediatrician sues hedge fund he partnered with, alleges managers put profits before patients*, (Aug. 2, 2024), available at https://www.latimes.com/socal/daily-pilot/news/story/2024-08-02/newport-beach-pediatrician-sues-hedge-fund-he-partnered-with-alleges-managers-put-profits-before-patients.
[10] *Id*.

4. Statements in support

The Attorney General, Rob Bonta, writes in support of the bill, stating:

> Private equity firms are gaining influence in our health care system, leading to rising costs and undermining the quality of care. As these firms acquire more medical and dental practices, there is a growing need for stronger enforcement to protect patient care and ensure that decisions are made based on medical needs and patient care, not profit. If left unchecked, these acquisitions could erode existing protections, violate the Corporate Bar, and put financial interests above the well-being of Californians.
>
> In response, SB 351 empowers the AG to hold private equity groups accountable for interfering with the Corporate Bar. The bill strengthens California's ban on the corporate practice of medicine by allowing the AG to investigate and take action against private equity firms that unlawfully interfere in the patient-physician relationship. The goal is to restore trust in the health care system, ensuring that medical decisions are made in the best interest of patients, not financial shareholders.

The California Medical Association, one of the sponsors of the bill, writes:

> This bill strengthens California's Ban on the Corporate Practice of Medicine (Corporate Bar) by empowering the Attorney General to investigate and take action against private equity firms that unlawfully interfere in the patient-physician relationship. This bill will help ensure that medical decisions are made in the best interest of patients, not financial shareholders.
>
> The Corporate Bar was established to protect patients from excessive healthcare costs and prevent the commercial exploitation that arises when clinical decisions are influenced by private equity investors seeking to maximize short-term profits. Under the Corporate Bar, non-physician entities, such as hospitals and other corporations, are prohibited from controlling healthcare decisions made by physicians when providing care to their patients. Existing law allows for enforcement of the Corporate Bar by the Medical Board of California, based on complaints related to unlawful interference in the patient-physician relationship.
>
> Given the increasing number of private equity acquisitions of medical practices, additional enforcement tools—such as those proposed in SB 351—are crucial for upholding the integrity of the Corporate Bar, deterring violations and protecting patients. Without adequate enforcement, private equity investments in healthcare could drive up costs for patients and erode consumer protections, as investors prioritize profits over patient well-being and quality care.

5. Statements in opposition

The American Investment Council writes in opposition, stating that the bill picks "winners and losers" by singling out private equity investment over any other type of investment and subjecting them to different enforcement then others who violate the ban on the corporate practice of medicine or dentistry. They note:

> If passed, SB 351 will result in less capital being available to fund medical and dental services in California, and diminished access to care for patients throughout the state. More broadly, the enactment of SB 351 would send the wrong message to private equity investors. California has long been the top destination for private equity investment and innovation. The state ranks first in the country for attracting private equity investment dollars, averaging around $100 billion per year over the past 5 years. In 2024 alone, private equity invested $88.3 billion in California's economy, many supporting medical technologies, life sciences and access to health care. Private equity is responsible for 1,621,000 direct jobs and another 4 million indirect jobs in the state. California is home to over 805 private equity firms that are responsible for some of the state's most innovative and successful companies.
>
> SB 351 implies that one of the state's most important economic contributors is the "culprit" for many of the challenges faced by California's physicians and dentists – an assertion that sends the wrong message to an industry that has played a critical role in expanding services and access. The likely result is a reduction in capital to fund innovation and access to health care, particularly for underserved communities.

Additionally they argue that the prohibitions in the bill, including those based on the guidelines from the Medical Board, are vague, imprecise, and unworkable. They also take issue with AG enforcement stating it creates a double standard, since only private equity would be subject to AG enforcement, and increases litigation risk and financial exposure potentially deterring beneficial investments.

SUPPORT

California Medical Association (sponsor)
California Dental Association (sponsor)
Attorney General Rob Bonta
American Academy of Emergency Medicine
American College of Obstetricians & Gynecologists - District IX
California Association of Orthodontists
California Chapter of the American College of Emergency Physicians
California Independent Physician Practice Association
California Orthopedic Association
California Podiatric Medical Association

California Retired Teachers Association
California State Council of Service Employees International Union (SEIU California)
California State Retirees
Coalition for Patient-Centered Care
Private Equity Stakeholder Project
1 Individual

OPPOSITION

American Investment Council
Association of Dental Support Organizations
Children's Choice Dental

RELATED LEGISLATION

Pending Legislation: None known.

Prior Legislation:

AB 3129 (Wood, 2024), *see* Comment 2)b), above.

PRIOR VOTES:

Senate Business, Professions and Economic Development Committee (Ayes 9, Noes 1)
****

AMENDED IN SENATE APRIL 7, 2025

AMENDED IN SENATE MARCH 18, 2025

SENATE BILL No. 386

Introduced by Senator Limón

February 14, 2025

An act to add Section 1371.11 to the Health and Safety Code, and to add Section 10123.146 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 386, as amended, Limón. Dental providers: fee-based payments.

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's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law imposes specified coverage and disclosure requirements on health care service plans and health insurers, including specialized plans and insurers, that cover dental services.

This bill would require a health care service plan contract or health insurance policy, as defined, issued, amended, or renewed on and after ~~January~~ *April* 1, 2026, that provides payment directly or through a contracted vendor to a dental provider to have a non-fee-based default method of payment, as specified. The ~~bill~~ *bill, beginning April 1, 2026,* would require a health care service plan, health insurer, or contracted vendor to obtain ~~written authorization~~ *affirmative consent* from a dental provider ~~opting~~ *who opts* in to a fee-based payment method before the plan or vendor provides a fee-based payment method to the ~~provider and~~ *provider. The bill* would authorize ~~the~~ *a* dental provider to opt out

of ~~the~~ *a* fee-based payment method at any time by providing ~~written authorization~~ *affirmative consent* to the health care service plan, health insurer, or contracted vendor. The bill would require a health care service plan, health insurer, or contracted vendor that obtains ~~written authorization~~ *affirmative consent* to opt in or opt out of fee-based payment to apply the decision to include both the dental provider's entire practice and all products or services covered pursuant to a contract with the dental provider, as specified. The bill would specify that its provisions do not apply if a health care service plan or health insurer has a direct contract with a provider that allows the provider to choose payment methods, including a non-fee-based payment method for services rendered.

Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1371.11 is added to the Health and Safety Code, to read:

1371.11. (a) The following definitions *shall* apply for purposes of this section:

(1) (A) "Affirmative consent" means a dental provider's express consent to opt in or opt out of receiving fee-based payment. Affirmative consent requires a dental provider's signature. The terms of the affirmative consent shall be clear and readily understandable.

(B) Affirmative consent may be given through email.

(C) A provider accessing funds does not constitute affirmative consent to receive a fee-based payment.

~~(1)~~

(2) "Contracted vendor" means a third party facilitating payment processing on behalf of the health care service plan.

~~(2)~~

(3) "Dental provider" means an individual or group of individuals licensed under Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code.

~~(3)~~

(4) "Fee-based payment" refers to any payment type that requires the dental provider to incur a fee *from the health care service plan or its contracted vendor* to access payment from a plan or its contracted vendor.

~~(4)~~

(5) "Health care service plan" or "plan" means a health care service plan defined in paragraph (2) of subdivision (a) of Section 1374.194.

~~(5) "Written authorization" means a dental provider's express consent to opt in or opt out of receiving fee-based payment indicated by a provider's written, signed, or similar authentication, including electronic signature or checking a box to indicate authorization. A written authorization shall be identified as an authorization to the provider. The terms of the written authorization shall be clear and readily understandable. A provider accessing funds does not constitute consent to receive fee-based payment.~~

(6) "Signature" includes an electronic or digital signature if the form of the signature is recognized as a valid signature under applicable federal or state law, including, but not limited to, checking a box indicating affirmative consent.

(b) (1) A health care service plan contract issued, amended, or renewed on and after ~~January~~ *April* 1, 2026, that provides payment directly, or through a contracted vendor, to a dental ~~provider,~~ *provider* shall have a non-fee-based default method of payment.

(2) The health care service plan shall remit or associate with each payment the claims and claim details associated with payment.

(c) (1) ~~A~~ *Beginning April 1, 2026, a* health care service plan or its contracted vendor shall obtain ~~written authorization~~ *affirmative consent* from a dental provider ~~opting~~ *who opts* in to a fee-based payment method before the plan or vendor provides a fee-based payment method to the provider.

(2) At the time a dental provider opts in to a fee-based payment method, the health care service plan or its contracted vendor shall provide information on the payment method, including a notice of the fees charged by the plan or contracted vendor, alternative

methods of payment, instructions on how to opt out of the fee-based payment method, and a notice of the dental provider's ability to opt out of the fee-based payment method at any time.

(3) Upon receipt of the dental provider's ~~written authorization,~~ *affirmative consent,* the health care service plan or its contracted vendor subsequently may issue payments to the dental provider using a fee-based payment method.

(4) The health care service plan also shall notify the dental provider if its contracted vendor is sharing ~~any~~ *a* part of the profit, fee arrangement, or board composition with the plan.

(d) (1) A dental provider may opt out of a fee-based payment method and opt in to a non-fee-based payment method at any time by providing ~~written authorization~~ *affirmative consent* to the health care service plan or its contracted vendor.

(2) If a dental provider opts *in or opts* out of a fee-based method of payment pursuant to paragraph (1), the provider's payment method decision shall remain in effect until the provider informs the plan or contracted vendor of another preferred method of payment, including fee-based or non-fee-based methods.

(e) A health care service plan or its contracted vendor that obtains a dental provider's ~~written authorization~~ *affirmative consent* to opt in or opt out of a fee-based payment method shall apply the decision to include both of the following:

(1) The dental provider's entire practice.

(2) To all products or services covered by the health care service plan pursuant to a contract with the dental provider, including network provider contracts, as described in Section 1374.193.

(f) This section does not apply if a health care service plan has a direct contract with a provider that allows the provider to choose payment methods, including a non-fee-based payment method for services rendered.

(g) This section does not change, alter, or extend the scope of Section 1367.

SEC. 2. Section 10123.146 is added to the Insurance Code, to read:

10123.146. (a) The following definitions shall apply for purposes of this section:

(1) (A) "Affirmative consent" means a dental provider's express consent to opt in or opt out of receiving fee-based payment. Affirmative consent requires a dental provider's signature. The

terms of the affirmative consent shall be clear and readily understandable.

(B) Affirmative consent may be given through email.

(C) A provider accessing funds does not constitute affirmative consent to receive a fee-based payment.

~~(1)~~

(2) "Contracted vendor" means a third party facilitating payment processing on behalf of the health insurer.

~~(2)~~

(3) "Dental provider" means an individual or group of individuals licensed under Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code.

~~(3)~~

(4) "Fee-based payment" refers to any payment type that requires the dental provider to incur a fee *from the health insurer or its contracted vendor* to access payment from a plan or its contracted vendor.

~~(4)~~

(5) "Health insurer" has the same meaning as defined in paragraph (2) of subdivision (a) of Section 10120.41.

~~(5) "Written authorization" means a dental provider's express consent to opt in or opt out of receiving fee-based payment indicated by a provider's written, signed, or similar authentication, including electronic signature or checking a box to indicate authorization. A written authorization shall be identified as an authorization to the provider. The terms of the written authorization shall be clear and readily understandable. A provider accessing funds does not constitute consent to receive fee-based payment.~~

(6) "Signature" includes an electronic or digital signature if the form of the signature is recognized as a valid signature under applicable federal or state law, including, but not limited to, checking a box indicating affirmative consent.

(b) (1) A health insurance policy issued, amended, or renewed on and after ~~January~~ *April* 1, 2026, that provides payment directly, or through a contracted ~~vendor~~ *vendor,* to a dental ~~provider,~~ *provider* shall have a non-fee-based default method of payment.

(2) ~~A~~ *The* health insurer shall remit or associate with each payment the claims and claim details associated with payment.

(c) (1) ~~A~~ *Beginning April 1, 2026, a* health insurer or its contracted vendor shall obtain ~~written authorization~~ *affirmative*

consent from a dental provider ~~opting~~ *who opts* in to a fee-based payment method before the insurer or vendor provides a fee-based payment method to the provider.

(2) At the time a dental provider opts in to a fee-based payment method, the health insurer or its contracted vendor shall provide information on the payment method, including a notice of the fees charged by the health insurer or contracted vendor, alternative methods of payment, instructions on how to ~~opt-out~~ *opt out* of the fee-based payment method, and a notice of the dental provider's ability to opt out of ~~a~~ *the* fee-based payment method at any time.

(3) Upon receipt of the ~~written authorization,~~ *dental provider's affirmative consent*, the health insurer or its contracted vendor subsequently may issue payments *to the dental provider* using a fee-based payment method.

(4) ~~A~~ *The* health insurer also shall notify the dental provider if its contracted vendor is sharing a part of the profit, fee arrangement, or board composition with the ~~plan.~~ *health insurer.*

(d) (1) A dental provider may opt out of a fee-based payment method and opt in to a non-fee-based payment method at any time by providing ~~written authorization~~ *affirmative consent* to the health insurer or its contracted vendor.

(2) If a dental provider opts *in or opts* out of a method of payment pursuant to paragraph (1), the provider's payment method decision shall remain in effect until the provider informs the health insurer or contracted vendor of another preferred method of payment, including fee-based or non-fee-based methods.

(e) A health insurer or its contracted vendor that obtains a dental provider's ~~written authorization~~ *affirmative consent* to opt in or opt out of a fee-based payment method shall apply the decision to include both of the following:

(1) The dental provider's entire practice.

(2) To all products or services covered by the health insurer pursuant to a contract with the dental provider, including network provider contracts, as described in Section 10120.4.

(f) This section does not apply if a health insurer has a direct contract with a provider that allows the provider to choose payment methods, including a non-fee-based payment method for services rendered.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because

the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O

Office of Senate Floor Analyses
(916) 651-1520 Fax: (916) 327-4478

THIRD READING

Bill No: SB 386
Author: Limón (D)
Amended: 4/7/25
Vote: 21

SENATE HEALTH COMMITTEE: 11-0, 4/2/25
AYES: Menjivar, Valladares, Durazo, Gonzalez, Grove, Limón, Padilla, Richardson, Rubio, Weber Pierson, Wiener

SENATE APPROPRIATIONS COMMITTEE: Senate Rule 28.8

SUBJECT: Dental providers: fee-based payments

SOURCE: California Dental Association

DIGEST: This bill requires a health plan or health insurance policy that provides direct payment to a dental provider, or payment through a contracted vendor, to have a non-fee-based default method of payment, and, obtain affirmative consent from a dental provider who opts in, prior to providing a fee-based payment.

ANALYSIS:

Existing law:

1) Establishes the Department of Managed Health Care to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 and the California Department of Insurance to regulate health and other insurers. [Health and Safety Code (HSC) §1340, et seq. and Insurance Code (INS) §106, et seq.]

2) Requires health plans and insurers to reimburse provider claims within specified time frames, including contested claims, or pay interest and penalties, as specified. [HSC §1371.35 and INS §10123.13]

3) Requires every plan to have a procedure for prompt payment or denial of provider and subscriber or enrollee claims covered by the plan. [HSC §1375.1]

4) Permits a plan or insurer covering dental services, including a specialized health plan contract or health insurance policy covering dental services, or a contracting entity, to grant a third party access to a provider network contract, or a provider's dental services or contractual discounts if certain conditions exist and the provider chooses to participate. [HSC §1374.193 and INS §10120.4]

This bill:

1) Requires health plans and insurers, for contracts and policies that provide payment directly to a dental provider, or through a contracted vendor, to have a non-fee-based default method of payment. Requires the plan or insurer to remit or associate with each payment the claims and claim details associated with the payment. This bill applies to contracts and policies issued, amended, or renewed on and after April 1, 2026.

2) Requires the plan or insurer to obtain affirmative consent from a dental provider who opts in to a fee-based payment method before the plan or vendor provides a fee-based payment method to the dental provider.

3) Requires, at the time a dental provider opts in to a fee-based payment method, information to be provided on the payment method, including a notice of the fees charged by the plan, insurer or contracted vendor, alternative methods of payment, instructions on opting out, and that the dental provider can opt out at any time.

4) Requires disclosure, if the plan's or insurer's contracted vendor is sharing any part of the profit, fee arrangement, or board composition with the plan or insurer.

5) Requires any decision to opt in or opt out of a fee-based payment method to apply to the dental provider's entire practice, and to all products or services covered under the contract or policy, including third party access, as specified.

6) Exempts from this bill a direct contract with a provider that allows the provider to choose payment methods, including a non-fee-based payment method for services rendered.

7) Defines the following:

   a) "Contracted vendor" is a third party facilitating payment processing on behalf of a plan or insurer;

b) "Dental provider" is an individual or group of individuals licensed, as specified;
c) "Fee-based payment" is any payment type that requires the dental provider to incur a fee to access payment from a plan, insurer, or its contracted vendor; and,
d) "Affirmative consent" is a dental provider's express consent to opt in or opt out of receiving a fee-based payment. It requires a dental provider's signature, and to be clear and readily understandable. It may be given through email. A provider accessing funds does not constitute affirmative consent to receive a fee-based payment.
e) "Signature" includes an electronic or digital signature if the form of the signature is recognized as a valid signature under applicable federal law, including, but not limited to, checking a box indicating affirmative consent.

Comments

Author's statement. According to the author, dental plans will often contract with third-party companies to issue provider payments to dental practices with virtual credit cards (VCCs). However, accepting this form of payment charges the dental office processing fees of up to 10% of the total payment amount – in addition to – the standard merchant fee of 2% to 5% for processing the payment through their credit card terminal. These unjustly high fees simply to access contracted payments owed by the dental plans often force dentists to accept payment via VCC even when they have requested another method of payment**.** This bill requires that any provider payment that includes a processing fee must be disclosed to dentists and cannot be the default payment method. This bill also mandates that dental plans and VCC companies clearly outline opt in and opt out procedures for VCC payments. The process must also outline alternative payment methods; ensuring dentists receive full payment for their services. This does not apply if the health insurer directly contracts and allows providers to choose payment methods.

VCCs. According to J.P. Morgan, VCCs are digital credit cards that function like physical credit cards. Companies can limit their exposure to potential fraud by generating unique card numbers and expiration dates for each transaction. These cards can be used for accounts payable transactions, claims payments, travel management, and reimbursements to independent contractors. Some VCCs operate through networks such as Visa or MasterCard.

National Council of Insurance Legislators (NCOIL). A model law related to VCC was approved by NCOIL, which is an organization of legislators "represented principally by legislators serving in their states' insurance and financial institutions

committees." NCOIL writes model laws in insurance and financial services, works to preserve state jurisdiction over insurance, and serves as an educational forum for public policymakers and interested parties. The model law would prohibit dental benefit plans from restricting methods of payments to only VCCs, and would require when initiating or changing payments to a dentist using electronic funds transfer payments, including VCC, the plan or contractor to notify the dentist of any fees associated with the payment model, advise the dentist of the available method of payments and provide clear instructions on how to select an alternative payment method. Additionally, the model law would prohibit a fee from being charged unless the dentist has consented to the fee. The model law would allow a dentist's agent to charge reasonable fees when transmitting an Automated Clearing House Network payment related to transaction management, data management, portal services and other value-added services in addition to the bank transmittal.

Related/Prior Legislation

SB 1369 (Limón of 2024) was substantially similar to this bill. SB 1369 was vetoed by Governor Newsom who said in his veto message:

"This bill would require dental plans to default to a non-fee-based method of payment to providers, and to remit with each payment the associated claims and claim details, beginning April 1, 2025. Currently, a dental provider and a plan determine the method of reimbursement during contract negotiations. A provider may opt into direct payments or payments through a contracted vendor. While I appreciate the author's intent to increase dental providers' reimbursements through changing the default payment method, this should be addressed during contract negotiations. For this reason, I cannot sign this bill."

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

SUPPORT: (Verified 4/17/25)

California Dental Association (source)
California Association of Orthodontists
California Dental Hygienists' Association
California Society of Pediatric Dentistry

OPPOSITION: (Verified 4/17/25)

None Received

ARGUMENTS IN SUPPORT: This bill is sponsored by the California Dental Association (CDA), which writes that there is a growing trend in dentistry with the

use of VCC companies as a mechanism for plans to pay providers. Dental plans contract with third-party vendors to issue provider payment via VCCs, which includes a 16-digit credit card number that is commonly faxed or emailed to the provider. To withdraw or access the funds, dental offices must run VCCs through their credit card terminals. Vendor processing fees can range from 2% to 5% of the total amount, on top of which the dentist pays the usual merchant transaction fee when processing the payment. Dental offices can sometimes pay up to 10% in fees before accessing payments they are owed. These fees are compounded by coercive behavior that forces dental offices to accept payment via VCCs. Attempts to opt-out are disregarded shortly after opting out. This bill restricts these predatory practices. CDA writes, dentists deserve to be able to fully understand and choose whether to accept payment processing fees, rather than being trapped into accepting payment methods that charge fees. The California Dental Hygienists Association writes that it supports restricting these predatory payment practices, which syphon away resources from dental offices that are already operating on a thin margin. This activity harms the entire dental team and as a result, these practices reduce a dental office's ability to provide optimum access to oral health care for patients. This bill is a critical step in correcting these predatory payment practices.

Prepared by: Teri Boughton / HEALTH / (916) 651-4111
4/23/25 16:26:28

****** END ******

AMENDED IN SENATE APRIL 10, 2025

SENATE BILL **No. 470**

Introduced by Senator Laird

February 19, 2025

An act to amend ~~Section 11123.2 of, and to amend and repeal Section~~ *Sections 11123.2 and* 11123.5 of, the Government Code, relating to state government.

LEGISLATIVE COUNSEL'S DIGEST

SB 470, as amended, Laird. Bagley-Keene Open Meeting Act: teleconferencing.

Existing law, the Bagley-Keene Open Meeting Act, requires, with specified exceptions, that all meetings of a state body be open and public and all persons be permitted to attend any meeting of a state body. The act authorizes meetings through teleconference subject to specified requirements, including, among others, that the state body post agendas at all teleconference locations, that each teleconference location be identified in the notice and agenda of the meeting or proceeding, that each teleconference location be accessible to the public, that the agenda provide an opportunity for members of the public to address the state body directly at each teleconference location, and that at least one member of the state body be physically present at the location specified in the notice of the meeting.

The act authorizes an additional, alternative set of provisions under which a state body may hold a meeting by teleconference subject to specified requirements, including, among others, that at least one member of the state body is physically present at each teleconference location, as defined, that a majority of the members of the state body are physically present at the same teleconference location, except as

specified, and that members of the state body visibly appear on camera during the open portion of a meeting that is publicly accessible via the internet or other online platform, except as specified. The act authorizes, under specified circumstances, a member of the state body to participate pursuant to these provisions from a remote location, which would not be required to be accessible to the public and which the act prohibits the notice and agenda from disclosing. The act repeals these provisions on January 1, 2026.

This bill would ~~delete the January 1, 2026 repeal date, thereby authorizing the above-described additional, alternative set of teleconferencing provisions indefinitely.~~ *instead repeal these provisions on January 1, 2030.*

The act authorizes a multimember state advisory body to hold an open meeting by teleconference pursuant to an alternative set of provisions that are in addition to the above-described provisions generally applicable to state bodies. These alternative provisions specify requirements, including, among others, that the multimember state advisory body designates the primary physical meeting location in the notice of the meeting where members of the public may physically attend the meeting, observe and hear the meeting, and participate, that at least one staff member of the state body to be present at the primary physical meeting location during the meeting, and that the members of the state body visibly appear on camera during the open portion of a meeting that is publicly accessible via the internet or other online platform, except as specified. ~~Existing law~~ *The act* repeals these provisions on January 1, 2026.

This bill would ~~delete the January 1, 2026 repeal date, thereby authorizing the above-described alternative set of teleconferencing provisions for multimember state advisory bodies indefinitely.~~ *instead repeal these provisions on January 1, 2030.*

The act, beginning January 1, 2026, removes the above-described requirements for the alternative set of teleconferencing provisions for multimember state advisory bodies, and, instead, requires, among other things, that the multimember state advisory body designates the primary physical meeting location in the notice of the meeting where members of the public may physically attend the meeting and participate.

This bill would ~~repeal those provisions.~~ *instead make these provisions operative on January 1, 2030.*

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public

officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 11123.2 of the Government Code is amended to read:

11123.2. (a) For purposes of this section, the following definitions apply:

(1) "Teleconference" means a meeting of a state body, the members of which are at different locations, connected by electronic means, through either audio or both audio and video.

(2) "Teleconference location" means a physical location that is accessible to the public and from which members of the public may participate in the meeting.

(3) "Remote location" means a location from which a member of a state body participates in a meeting other than a teleconference location.

(4) "Participate remotely" means participation by a member of the body in a meeting at a remote location other than a teleconference location designated in the notice of the meeting.

(b) (1) In addition to the authorization to hold a meeting by teleconference pursuant to subdivision (b) of Section 11123 and Section 11123.5, a state body may hold an open or closed meeting by teleconference as described in this section, provided the meeting complies with all of this section's requirements and, except as set forth in this section, it also complies with all other applicable requirements of this article relating to the specific type of meeting.

(2) This section does not limit or affect the ability of a state body to hold a teleconference meeting under another provision of this article, including Sections 11123 and 11123.5.

(c) The portion of the teleconferenced meeting that is required to be open to the public shall be visible and audible to the public at each teleconference location.

(d) (1) The state body shall provide a means by which the public may remotely hear audio of the meeting, remotely observe the

meeting, remotely address the body, or attend the meeting by providing on the posted agenda a teleconference telephone number, an internet website or other online platform, and a physical address for each teleconference location. The telephonic or online means provided to the public to access the meeting shall be equivalent to the telephonic or online means provided to a member of the state body participating remotely.

(2) The applicable teleconference telephone number, internet website or other online platform, and physical address of each teleconference location, as well as any other information indicating how the public can access the meeting remotely and in person, shall be specified in any notice required by this article.

(3) If the state body allows members of the public to observe and address the meeting telephonically or otherwise electronically, the state body shall do both of the following:

(A) Implement a procedure for receiving and swiftly resolving requests for reasonable modification or accommodation from individuals with disabilities, consistent with the federal Americans with Disabilities Act of 1990 (42 U.S.C. Sec. 12101 et seq.), and resolving any doubt whatsoever in favor of accessibility.

(B) Advertise that procedure each time notice is given of the means by which members of the public may observe the meeting and offer public comment.

(e) This section does not prohibit a state body from providing members of the public with additional locations from which the public may observe or address the state body by electronic means, through either audio or both audio and video.

(f) (1) The agenda shall provide an opportunity for members of the public to address the state body directly pursuant to Section 11125.7.

(2) Members of the public shall be entitled to exercise their right to directly address the state body during the teleconferenced meeting without being required to submit public comments before the meeting or in writing.

(g) The state body shall post the agenda on its internet website and, on the day of the meeting, at each teleconference location.

(h) This section does not affect the requirement prescribed by this article that the state body post an agenda of a meeting in accordance with the applicable notice requirements of this article, including Section 11125, requiring the state body to post an agenda

of a meeting at least 10 days in advance of the meeting, Section 11125.4, applicable to special meetings, and Sections 11125.5 and 11125.6, applicable to emergency meetings.

(i) At least one member of the state body shall be physically present at each teleconference location.

(j) (1) Except as provided in paragraph (2), a majority of the members of the state body shall be physically present at the same teleconference location. Additional members of the state body in excess of a majority of the members may attend and participate in the meeting from a remote location. A remote location is not required to be accessible to the public. The notice and agenda shall not disclose information regarding a remote location.

(2) A member attending and participating from a remote location may count toward the majority required to hold a teleconference if both of the following conditions are met:

(A) The member has a need related to a physical or mental disability, as those terms are defined in Sections 12926 and 12926.1, that is not otherwise reasonably accommodated pursuant to the federal Americans with Disability Act of 1990 (42 U.S.C. Sec. 12101 et seq.).

(B) The member notifies the state body at the earliest opportunity possible, including at the start of a meeting, of their need to participate remotely, including providing a general description of the circumstances relating to their need to participate remotely at the given meeting.

(3) If a member notifies the body of the member's need to attend and participate remotely pursuant to paragraph (2), the body shall take action to approve the exception and shall request a general description of the circumstances relating to the member's need to participate remotely at the meeting, for each meeting in which the member seeks to participate remotely. The body shall not require the member to provide a general description that exceeds 20 words or to disclose any medical diagnosis or disability, or any personal medical information that is already exempt under existing law, such as the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code).

(4) If a member of the state body attends the meeting by teleconference from a remote location, the member shall disclose whether any other individuals 18 years of age or older are present

in the room at the remote location with the member, and the general nature of the member's relationship with any such individuals.

(k) (1) Except as provided in paragraph (2), the members of the state body shall visibly appear on camera during the open portion of a meeting that is publicly accessible via the internet or other online platform.

(2) The visual appearance of a member of the state body on camera may cease only when the appearance would be technologically impracticable, including, but not limited to, when the member experiences a lack of reliable broadband or internet connectivity that would be remedied by joining without video, or when the visual display of meeting materials, information, or speakers on the internet or other online platform requires the visual appearance of a member of a state body on camera to cease.

(3) If a member of the state body does not appear on camera due to challenges with internet connectivity, the member shall announce the reason for their nonappearance when they turn off their camera.

(*l*) All votes taken during the teleconferenced meeting shall be by rollcall.

(m) The state body shall publicly report any action taken and the vote or abstention on that action of each member present for the action.

(n) The portion of the teleconferenced meeting that is closed to the public shall not include the consideration of any agenda item being heard pursuant to Section 11125.5.

(o) Upon discovering that a means of remote public access and participation required by subdivision (d) has failed during a meeting and cannot be restored, the state body shall end or adjourn the meeting in accordance with Section 11128.5. In addition to any other requirements that may apply, the state body shall provide notice of the meeting's end or adjournment on the state body's internet website and by email to any person who has requested notice of meetings of the state body by email under this article. If the meeting will be adjourned and reconvened on the same day, further notice shall be provided by an automated message on a telephone line posted on the state body's agenda, internet website, or by a similar means, that will communicate when the state body intends to reconvene the meeting and how a member of the public may hear audio of the meeting or observe the meeting.

(p) This section shall remain in effect only until January 1, 2030, and as of that date is repealed.

SEC. 2. Section 11123.5 of the Government Code, as amended by Section 2 of Chapter 216 of the Statutes of 2023, is amended to read:

11123.5. (a) For purposes of this section, the following definitions apply:

(1) "Participate remotely" means participation in a meeting at a location other than the physical location designated in the agenda of the meeting.

(2) "Remote location" means a location other than the primary physical location designated in the agenda of a meeting.

(3) "Teleconference" has the same meaning as in Section 11123.

(b) In addition to the authorization to hold a meeting by teleconference pursuant to subdivision (b) of Section 11123 or Section 11123.2, any state body that is an advisory board, advisory commission, advisory committee, advisory subcommittee, or similar multimember advisory body may hold an open meeting by teleconference as described in this section, provided the meeting complies with all of the section's requirements and, except as set forth in this section, it also complies with all other applicable requirements of this article.

(c) A member of a state body as described in subdivision (b) who participates in a teleconference meeting from a remote location subject to this section's requirements shall be listed in the minutes of the meeting.

(d) The state body shall provide notice to the public at least 24 hours before the meeting that identifies any member who will participate remotely by posting the notice on its internet website and by emailing notice to any person who has requested notice of meetings of the state body under this article. The location of a member of a state body who will participate remotely is not required to be disclosed in the public notice or email and need not be accessible to the public. The notice of the meeting shall also identify the primary physical meeting location designated pursuant to subdivision (f).

(e) This section does not affect the requirement prescribed by this article that the state body post an agenda of a meeting at least 10 days in advance of the meeting. The agenda shall include information regarding the physical meeting location designated

pursuant to subdivision (f), but is not required to disclose information regarding any remote location.

(f) A state body described in subdivision (b) shall designate the primary physical meeting location in the notice of the meeting where members of the public may physically attend the meeting, observe and hear the meeting, and participate. At least one staff member of the state body shall be present at the primary physical meeting location during the meeting. The state body shall post the agenda at the primary physical meeting location, but need not post the agenda at a remote location.

(g) When a member of a state body described in subdivision (b) participates remotely in a meeting subject to this section's requirements, the state body shall provide a means by which the public may remotely hear audio of the meeting or remotely observe the meeting, including, if available, equal access equivalent to members of the state body participating remotely. The applicable teleconference phone number or internet website, or other information indicating how the public can access the meeting remotely, shall be in the 24-hour notice described in subdivision (b) that is available to the public.

(h) (1) Except as provided in paragraph (2), the members of the state body shall visibly appear on camera during the open portion of a meeting that is publicly accessible via the internet or other online platform.

(2) The visual appearance of a member of a state body on camera may cease only when the appearance would be technologically impracticable, including, but not limited to, when the member experiences a lack of reliable broadband or internet connectivity that would be remedied by joining without video, or when the visual display of meeting materials, information, or speakers on the internet or other online platform requires the visual appearance of a member of a state body on camera to cease.

(3) If a member of the body does not appear on camera due to challenges with internet connectivity, the member shall announce the reason for their nonappearance when they turn off their camera.

(i) Upon discovering that a means of remote access required by subdivision (g) has failed during a meeting, the state body described in subdivision (b) shall end or adjourn the meeting in accordance with Section 11128.5. In addition to any other requirements that may apply, the state body shall provide notice

of the meeting's end or adjournment on its internet website and by email to any person who has requested notice of meetings of the state body under this article. If the meeting will be adjourned and reconvened on the same day, further notice shall be provided by an automated message on a telephone line posted on the state body's agenda, or by a similar means, that will communicate when the state body intends to reconvene the meeting and how a member of the public may hear audio of the meeting or observe the meeting.

(j) This section does not limit or affect the ability of a state body to hold a teleconference meeting under another provision of this article.

(k) This section shall remain in effect only until January 1, 2030, and as of that date is repealed.

~~SEC. 3. Section 11123.5 of the Government Code, as added by Section 3 of Chapter 216 of the Statutes of 2023, is repealed.~~

SEC. 3. Section 11123.5 of the Government Code, as added by Section 3 of Chapter 216 of the Statutes of 2023, is amended to read:

11123.5. (a) In addition to the authorization to hold a meeting by teleconference pursuant to subdivision (b) of Section 11123, any state body that is an advisory board, advisory commission, advisory committee, advisory subcommittee, or similar multimember advisory body may hold an open meeting by teleconference as described in this section, provided the meeting complies with all of the section's requirements and, except as set forth in this section, it also complies with all other applicable requirements of this article.

(b) A member of a state body as described in subdivision (a) who participates in a teleconference meeting from a remote location subject to this section's requirements shall be listed in the minutes of the meeting.

(c) The state body shall provide notice to the public at least 24 hours before the meeting that identifies any member who will participate remotely by posting the notice on its internet website and by emailing notice to any person who has requested notice of meetings of the state body under this article. The location of a member of a state body who will participate remotely is not required to be disclosed in the public notice or email and need not be accessible to the public. The notice of the meeting shall also

identify the primary physical meeting location designated pursuant to subdivision (e).

(d) This section does not affect the requirement prescribed by this article that the state body post an agenda of a meeting at least 10 days in advance of the meeting. The agenda shall include information regarding the physical meeting location designated pursuant to subdivision (e), but is not required to disclose information regarding any remote location.

(e) A state body described in subdivision (a) shall designate the primary physical meeting location in the notice of the meeting where members of the public may physically attend the meeting and participate. A quorum of the members of the state body shall be in attendance at the primary physical meeting location, and members of the state body participating remotely shall not count towards establishing a quorum. All decisions taken during a meeting by teleconference shall be by rollcall vote. The state body shall post the agenda at the primary physical meeting location, but need not post the agenda at a remote location.

(f) When a member of a state body described in subdivision (a) participates remotely in a meeting subject to this section's requirements, the state body shall provide a means by which the public may remotely hear audio of the meeting or remotely observe the meeting, including, if available, equal access equivalent to members of the state body participating remotely. The applicable teleconference phone number or internet website, or other information indicating how the public can access the meeting remotely, shall be in the 24-hour notice described in subdivision (a) that is available to the public.

(g) Upon discovering that a means of remote access required by subdivision (f) has failed during a meeting, the state body described in subdivision (a) shall end or adjourn the meeting in accordance with Section 11128.5. In addition to any other requirements that may apply, the state body shall provide notice of the meeting's end or adjournment on its internet website and by email to any person who has requested notice of meetings of the state body under this article. If the meeting will be adjourned and reconvened on the same day, further notice shall be provided by an automated message on a telephone line posted on the state body's agenda, or by a similar means, that will communicate when

the state body intends to reconvene the meeting and how a member of the public may hear audio of the meeting or observe the meeting.

(h) For purposes of this section:

(1) "Participate remotely" means participation in a meeting at a location other than the physical location designated in the agenda of the meeting.

(2) "Remote location" means a location other than the primary physical location designated in the agenda of a meeting.

(3) "Teleconference" has the same meaning as in Section 11123.

(i) This section does not limit or affect the ability of a state body to hold a teleconference meeting under another provision of this article.

(j) This section shall become operative on January 1, ~~2026.~~ *2030*.

SEC. 4. The Legislature finds and declares that Section 1 of this act, which amends Section 11123.2 of the Government Code, and Sections 2 and 3 of this act, which amend and repeal Section 11123.5 of the Government Code, modify the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

(a) By continuing to ensure that agendas are not required to be posted at, and that agendas and notices do not disclose information regarding, the location of each public official participating in a public meeting remotely, including from the member's private home or hotel room, this act protects the personal, private information of public officials and their families while preserving the public's right to access information concerning the conduct of the people's business.

(b) During the COVID-19 public health emergency, audio and video teleconference were widely used to conduct public meetings in lieu of physical location meetings, and those public meetings have been productive, increased public participation by all members of the public regardless of their location and ability to travel to physical meeting locations, increased the pool of people who are able to serve on these bodies, protected the health and safety of civil servants and the public, and have reduced travel

costs incurred by members of state bodies and reduced work hours spent traveling to and from meetings.

(c) Conducting audio and video teleconference meetings enhances public participation and the public's right of access to meetings of the public bodies by improving access for individuals who often face barriers to physical attendance.

O

Office of Senate Floor Analyses
(916) 651-1520 Fax: (916) 327-4478

THIRD READING

Bill No: SB 470
Author: Laird (D)
Amended: 4/10/25
Vote: 21

SENATE GOVERNMENTAL ORG. COMMITTEE: 9-1, 3/25/25
AYES: Padilla, Archuleta, Ashby, Blakespear, Cervantes, Hurtado, Richardson, Wahab, Weber Pierson
NOES: Jones
NO VOTE RECORDED: Valladares, Dahle, Ochoa Bogh, Rubio, Smallwood-Cuevas

SENATE JUDICIARY COMMITTEE: 10-1, 4/8/25
AYES: Umberg, Allen, Arreguín, Ashby, Durazo, Laird, Stern, Wahab, Weber Pierson, Wiener
NOES: Niello
NO VOTE RECORDED: Caballero, Valladares

SENATE APPROPRIATIONS COMMITTEE: Senate Rule 28.8

SUBJECT: Bagley-Keene Open Meeting Act: teleconferencing

SOURCE: Author

DIGEST: This bill extends the January 1, 2026, repeal date for certain provisions in the Bagley-Keene Open Meeting Act (Bagley-Keene) until January 1, 2030, authorizing and specifying conditions under which a state body may hold a meeting by teleconference, as specified.

ANALYSIS:

Existing law:

1) Requires, pursuant to Bagley-Keene, and with specified exceptions, that all meetings of a state body be open and public and all persons be permitted to attend any meeting of a state body.

2) Authorizes meetings through teleconference subject to specified requirements, including, among other things, that the state body post agendas at all teleconference locations, that each teleconference location be identified in the notice and agenda of the meeting or proceeding, that each teleconference location be accessible to the public, that the agenda provide an opportunity for members of the public to address the state body directly at each teleconference location, and that at least one member of the state body be physically present at the location specified in the notice of the meeting.

3) Authorizes an additional, alternative set of provisions under which a state body may hold a meeting by teleconference subject to specified requirements, including, among others, that at least one member of the state body is physically present at each teleconference location, and that members of the state body visibly appear on camera during the open portion of a meeting that is publicly accessible, as specified. Existing law repeals these provisions on January 1, 2026.

4) Authorizes a multimember state advisory body to hold an open meeting by teleconference pursuant to an alternative set of provisions that specify requirements, including, among others, that the advisory body designates the primary physical meeting location in the notice of the meeting where members of the public may physically attend the meeting, observe and hear the meeting, and participate, that at least one staff member of the advisory body be present at the primary physical meeting location during the meeting, and that the members of the advisory body appear on camera during the open portion of a meeting, as specified. Existing law repeals these provisions on January 1, 2026.

5) Repeals, on January 1, 2026, the above-described requirements for the alternative set of teleconferencing provisions for multimember state advisory bodies, and, instead, requires, among other things, that the advisory body designates the primary physical meeting location in the notice of the meeting where members of the public may physically attend the meeting and participate.

This bill:

1) Extends the January 1, 2026, repeal date on the authorization of an alternative set of provisions under which a state body may hold a meeting by teleconference until January 1, 2030.

2) Extends the January 1, 2026, repeal date on the authorization for a multimember state advisory body to hold an open meeting by teleconference pursuant to an alternative set of provisions until January 1, 2030.

3) Includes related legislative findings and declarations.

Background

Author Statement. According to the author's office, "when the Bagley-Keene Act was adopted in 1967, no one envisioned the computer age. The Americans with Disabilities Act had not been adopted. The idea that citizens could participate in public meetings remotely was not common. The COVID pandemic demonstrated the need to address those changes. The state conducted meetings remotely to continue the public process, and learned of the benefits and drawbacks of virtual participation."

Further, "Senate Bill 470 builds upon the successful implementation of [last year's] SB 544 by [extending] the January 1, 2026 sunset to enshrine public and disability access in state board and commission meetings, while preserving transparency in the decision-making process. The provisions provide that boards and commissions must have a quorum present in public at one location, require that remote public officials have their camera on, and require remote testimony options for public hearings."

The Bagley-Keene Open Meeting Act of 1967. Bagley-Keene originated as a response to growing concerns about transparency and public involvement in the decision-making process of state agencies. Bagley-Keene aims to ensure that state boards, commissions, and agencies conduct their business openly and transparently, allowing the public to be informed and participate in the decision-making process.

Bagley-Keene generally requires state bodies to conduct their meetings openly and make them accessible to the public. The law also requires state bodies to provide advance notice of their meetings and agendas and to allow public comments on

matters under consideration. The act includes certain exceptions, such as closed sessions for discussing personnel issues or pending litigation, to protect the privacy and legal interests of individuals and the state.

The act applies to state bodies, including: every state board, or commission created by statute or required by law to conduct official meetings and every commission created by executive order; any board, commission, or committee exercising the authority of a state body delegated to it; an advisory board, advisory commission, advisory committee or subcommittee created by formal action of the state body; and any board, commission, or committee on which a member of a body that is a state body serves in his or her official capacity as a representative of the state body, as specified. The law does not apply to individual officials or the California State Legislature.

The Americans with Disabilities Act of 1990 (ADA). The ADA is a federal civil rights law that prohibits discrimination against individuals with disabilities in everyday activities. The ADA prohibits discrimination on the basis of disability just as other civil rights laws prohibit discrimination on the basis of race, color, sex, national origin, age, and religion. The ADA guarantees that those with disabilities have equal opportunities to pursue employment, purchase goods and services, and participate in state and local government programs. The ADA contains specific requirements for state and local governments to ensure equal access for people with disabilities.

COVID-19 and Executive Order N-29-20. On March 4, 2020, Governor Newsom proclaimed a State of Emergency in California as a result of what at the time was a novel and rapidly growing COVID-19 pandemic. Despite early efforts, the virus continued to spread. On March 17, 2020, Governor Newsom issued Executive Order (EO) N-29-20 citing the fact that strict compliance with various statutes and regulations on open meetings of state bodies would have prevented, hindered, or delayed appropriate actions to prevent and mitigate the effects of the COVID-19 pandemic. The executive order, among other things, required public meetings be accessible telephonically or otherwise electronically to all members of the public seeking to observe and to address the local legislative body or state body.

Temporary Teleconferencing Extensions in 2022 and 2023. SB 189 (Committee on Budget and Fiscal Review, Chapter 48, Statutes of 2022), among other things, provided a temporary statutory extension for state bodies in California to hold public meetings through teleconferencing, such as phone or video calls, instead of in-person gatherings. The law suspended certain requirements that would typically

apply to in-person meetings, such as having a physical location for the public to attend and providing access to all remote teleconference locations until July 1, 2023.

State bodies are encouraged to use their best judgment when holding teleconferenced meetings, and to make an effort to follow the other provisions of Bagley-Keene as closely as possible. This helps ensure that these remote meetings remain transparent and accessible to the public. This section of the law was temporary, set to expire on July 1, 2023.

SB 544 (Laird, Chapter 216, Statutes of 2023) authorized, until January 1, 2026, granted state bodies an additional option to conduct meetings via teleconference provided that at each teleconference location—defined as a physical site accessible to the public—at least one member of the state body is physically present. In specified circumstances, individual members may participate remotely without being in a public location, such as when a majority of members at a given teleconference site are physically present or if the member has a disability-related need.

Public participation must be ensured: meetings must be visible and audible at each teleconference location, and the public must be able to attend remotely through equivalent audio or video access provided to members. The agenda must list all teleconference locations, internet or telephone access information, and physical addresses, and members of the public must be allowed to provide public comment live (not just in writing beforehand). State bodies must also provide accommodations for individuals with disabilities and prominently advertise those procedures.

SB 544 sets specific rules for member participation: a majority of members must generally be physically present at a single teleconference location, though exceptions are allowed for members with qualifying disabilities. Members participating remotely must disclose if other adults are present at their location and appear on camera during open meetings unless there are technological barriers. Voting must be conducted by roll call, and all actions taken must be publicly reported. If remote public access fails during a meeting and cannot be restored, the meeting must be adjourned, and notice must be promptly provided online and via email to interested parties.

SB 544 authorizes advisory state bodies (like advisory boards, advisory commissions, advisory committees, or advisory subcommittees) to hold meetings

by teleconference, allowing members to participate remotely under specific conditions. Members participating remotely must be identified in the meeting minutes, and public notice must be given at least 24 hours in advance, though the remote location of participating members does not have to be disclosed. The notice and agenda must include a designated primary physical meeting location where the public can attend, observe, and participate, with at least one staff member present at that site. Public remote access must also be provided by phone or internet, with the access information included in the 24-hour notice.

During meetings, advisory body members must appear on camera unless doing so is technologically impracticable, in which case the reason must be announced. If remote public access fails and cannot be restored, the meeting must be adjourned with appropriate public notice online and by email. This section complements, but does not replace, other teleconference provisions in existing law and retains the 10-day public posting requirement for agendas under broader open meeting rules. Importantly, the remote participation framework here is designed specifically for advisory bodies, offering more flexibility than general state body teleconferencing rules.

The teleconference exemptions in Bagley-Keene limit the public's access to public meetings of state bodies by allowing a state body to hold a teleconference meeting without allowing the public to access the locations of where members are participating from, providing notice of where they are participating from, and also not requiring any member of the state body to be present at the one physical location required to be provided to the public for any state body that is an advisory board, advisory commission, advisory committee, advisory subcommittee, or similar multimember advisory body. For other state bodies, only one member of the state body is required to be present at the one physical location required to be provided to the public. This bill includes legislative findings and declarations regarding the need to limit access of public meetings.

This bill extends the January 1, 2026, repeal date on the above discussed teleconferencing authorizations in Bagley-Keene until January 1, 2030.

Related/Prior Legislation

SB 544 (Laird, Chapter 216, Statutes of 2023) revised and repealed, until January 1, 2026, certain teleconference requirements under Bagley-Keene, which requires all meetings of a state body be open and public, as specified.

SB 189 (Committee on Budget and Fiscal Review, Chapter 48, Statutes of 2022) among other things, provided a temporary statutory extension (July 1, 2023) for state bodies in California to hold public meetings through teleconferencing, such as phone or video calls, instead of in-person gatherings, as specified.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: No

SUPPORT: (Verified 4/28/25)

AARP
Alzheimer's Association
Alzheimer's Greater Los Angeles
Alzheimer's Orange County
Alzheimer's San Diego
Association of California State Employees With Disabilities
Association of Regional Center Agencies
California Association of Licensed Investigators
California Coalition on Family Caregiving
California Commission on Aging
California Foundation for Independent Living Centers
California Long Term Care Ombudsman Association
Disability Rights California
DMS Registered Service Agency Advisory Committee
Easterseals Northern California
Family Caregiver Alliance
LeadingAge California
Little Hoover Commission
State Council on Developmental Disabilities

OPPOSITION: (Verified 4/28/25)

ACLU California Action
California Broadcasters Association
California Chamber of Commerce
California Common CAUSE
California News Publishers Association
CCNMA: Latino Journalists of California
First Amendment Coalition
Freedom of the Press Foundation
Howard Jarvis Taxpayers Association
League of Women Voters of California
Media Guild of the West

National Press Photographers Association
Orange County Press Club
Pacific Media Workers Guild
Radio Television Digital News Association
Society of Professional Journalists, Northern California Chapter

ARGUMENTS IN SUPPORT: In support of this bill, AARP California writes that, "[l]imiting participation to those who can attend to in-person only (or to an approved physical location) poses a barrier to equitable participation in public debate and discussion for many older Californians, persons with disabilities, and Californians living in remote areas. AARP views this as an issue of both equity and access, and our policy supports removing unnecessary barriers to participation on boards and commissions for individuals representing under-served communities."

ARGUMENTS IN OPPOSITION: A coalition of opponents jointly write, "[t]he stated goal of being able to attract more people to serve in public office is no reason to remove accountability protections. These multi-member bodies, including those that are advisory, wield immense power, influencing policy and priorities in our state.

"For example, the Peace Officer Standards Accountability Advisory Board created by SB 2, signed into law in 2021 to bring more accountability to policing in California, is tasked with reviewing and recommending when law enforcement officers should be stripped of their badges. This is a process that all stakeholders – impacted families, officers, and the leadership of the agencies that employ them – should be able to observe and engage in. But by virtue of being 'advisory' in nature, this important board could arguably avail itself to these relaxed rules and hold these decertification investigations entirely virtually. That which deprives the public a chance to attend, engage, and interact face-to-face with members of that body and those who testify. That is just one example of the types of weighty subject matters handled by state legislative bodies governed by Bagely-Keene."

Further, "[w]e urge you to consider a more narrowly tailored approach, such as the framework introduced by Assemblymember Blanca Rubio in AB 2449 of 2022,

Brown Act legislation that allows members of local government bodies to participate virtually from private locations when the need for that flexibility is tied to specific hardships, such as health issues or caregiving needs, subject to reasonable caps and other modest provisions that serve the public interest."

Prepared by: Brian Duke / G.O. / (916) 651-1530
4/30/25 16:52:55

****** END ******

AMENDED IN SENATE MAY 14, 2025

SENATE BILL No. 861

Introduced by Committee on Business, Professions and Economic Development (Senators Ashby (Chair), Archuleta, Arreguín, Choi, Grayson, Menjivar, Niello, Smallwood-Cuevas, *Strickland*, Umberg, ~~Valladares,~~ and Weber Pierson)

March 13, 2025

An act to amend Sections 27, 144, 1602, 1603, 1901, 1903, *1905, 1926.3, 1944,* 2125, 2532.2, 2532.3, 2532.4, 2532.6, 2532.7, 2536, *6501,* 6584, 7076.5, 7137, 7152, 7524, 8027, 9889.1, 9889.2, 9889.9, 12107, 12211, 12500.8, 12609, 13404.5, 13711, ~~and 19094~~ *19094, 26051.5, and 26067* of, and to add and repeal Section 1616.5 of, the Business and Professions Code, to amend Sections 44831, 94834, 94866, 94897, 94900, 94902, 94909, and 94910 of, and to repeal Sections 94880.1, 94929.9, and 94949 of, the Education Code, and to amend Section 14132.55 of the Welfare and Institutions Code, relating to consumer affairs.

LEGISLATIVE COUNSEL'S DIGEST

SB 861, as amended, Committee on Business, Professions and Economic Development. Consumer affairs.

(1) Existing law establishes in the Business, Consumer Services, and Housing Agency the Department of Consumer Affairs, which is composed of various agencies that license and regulate various businesses and professions. Existing law requires certain agencies to disclose information on the status of its licensees on the internet, as specified. In this regard, existing law specifies the licensees on which the Cemetery and Funeral Bureau is required to disclose information, including, among others, cemetery brokers, salespersons, and managers.

This bill would also specify that the bureau is required to disclose information on licensed hydrolysis facilities and reduction facilities.

(2) Existing law requires designated agencies in the Department of Consumer Affairs to require applicants to furnish a full set of fingerprints to the agency for purposes of conducting criminal history record checks.

This bill would include the State Board of Chiropractic Examiners as one of those designated agencies.

(3) The Dental Practice Act establishes the Dental Board of California to license and regulate the practice of dentistry, and repeals the provision establishing the board on January 1, 2029. Chapter 483 of the Statutes of 2024 revised the membership of the board by, among other things, removing a requirement that the board include a registered dental hygienist, and, instead, requiring the inclusion of a 2nd member who is a registered dental assistant.

This bill would make conforming changes, including deleting obsolete references to a dental hygienist member of the board. The bill would also authorize the board to appoint a person exempt from civil service as an executive officer, and would repeal this provision on January 1, 2029.

(4) Existing law establishes the Dental Hygiene Board of California to license and regulate dental hygienists. Chapter 858 of the Statutes of 2018 created the board out of the former Dental Hygiene Committee of California, as specified. *Existing law requires the dental hygiene board to make recommendations to the Dental Board of California regarding dental hygiene scope of practice issues. Existing law also requires the Dental Hygiene Board of California to establish the amount of fees relating to the licensing of dental hygienists and imposes limitations on those fees, including prohibiting the application fee for an original license and the fee for issuance of an original license from exceeding $250.*

This bill *would remove the requirement for the dental hygiene board to make recommendations to the Dental Board of California, as described above. The bill would instead prohibit an application fee from exceeding $100 and an initial licensure fee from exceeding $150. The bill* would make technical changes to the provisions regulating dental hygienists ~~by~~ *by, among other things,* correcting references to the dental hygiene board and deleting an obsolete provision affecting *the* expiration of terms for members of the former Dental Hygiene Committee of California.

(5) Existing law establishes the Licensed Physicians from Mexico Program under which the Medical Board of California is required to issue a 3-year physician and surgeon's license to each licensed physician from Mexico who, among other requirements, passes a board review course with a score equivalent to that registered by United States applicants when passing a board review course for the United States certification examination in each of the physician's specialty areas.

This bill would delete that requirement.

(6) The Speech-Language Pathologist and Audiologist and Hearing Aid Dispensers Licensure Act establishes the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board to license and regulate speech-language pathologists, audiologists, and hearing aid dispensers. Existing law establishes the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Fund to deposit revenue received pursuant to the act and makes moneys in the fund available upon appropriation by the Legislature to carry out the purposes of the act.

This bill would make technical changes to various provisions of the act and other related provisions, including updating references to the names of the board and the fund.

(7) The Professional Fiduciaries Act establishes the Professional Fiduciaries Bureau to license and regulate professional ~~fiduciaries.~~ *fiduciaries, as defined.* Existing law requires a licensee to file a statement with the bureau annually that contains specified information, including whether the licensee has been convicted of a crime. Existing law authorizes the suspension, revocation, denial or other disciplinary action for a failure to notify the bureau of a conviction pursuant to that requirement.

This bill would update the cross-reference to that requirement. *The bill would make a nonsubstantive change to the definition of professional fiduciary.*

(8) The Contractors State License Law establishes the Contractors State License Board to license and regulate contractors. Existing law exempts an inactive contractor's license from certain requirements during the period that a license is inactive, including specified bonding and qualifier requirements.

This bill would also exempt an inactive license from workers' compensation requirements.

The Contractors State License Law requires a licensee that is subject to a public complaint requiring a professional or expert investigation

or inspection and report to pay fees to cover the costs of the investigation or inspection and report if it resulted in the issuance of a letter of admonishment or a citation. Existing law requires the full amount of the assessed fee to be added to the fee for the active or inactive renewal of a licensee.

Under this bill, the licensee would be required to pay those fees only if the letter of admonishment or citation has become a final order of the registrar. The bill would delete the provision requiring the assessed fee to be added to the fee for renewal of a license.

The Contractors State License Law requires a home improvement salesperson to register with the board in order to engage in the business of, or act in the capacity of, a home improvement salesperson. Existing law creates exemptions for certain individuals who, at the time of the sales transaction, are listed as personnel of record for a licensee responsible for soliciting, negotiating, or contracting for a service or improvement that is subject to registration, as specified.

This bill would update a cross-reference to the provisions specifying those exempt individuals.

(9) The Private Investigator Act provides for the licensure and regulation of private investigators by the Director of Consumer Affairs, and requires a licensee to make signed agreements and investigative findings available for inspection by the Bureau of Security and Investigative Services.

This bill would specify that making these records available for inspection by the bureau does not violate rules or laws related to attorney work product and attorney-client privilege, as specified.

(10) Existing law establishes the Court Reporters Board of California to license and regulate shorthand reporters and requires the board to develop standardization of policies on the use and administration of qualifier examinations by schools. Existing law requires the qualifier examination to consist of 4-voice testimony of 10-minute duration at 200 words per minute graded at 97.5 percent accuracy.

This bill would instead require the qualifier examination to be graded at 95 percent accuracy.

(11) The Automotive Repair Act establishes the Bureau of Automotive Repair to license and regulate automotive repair dealers, authorizes the Director of Consumer Affairs to adopt and enforce rules and regulations that are necessary to carry out the purposes of the act. Chapter 372 of the Statutes of 2021 replaced provisions that governed the licensure of lamp and brake adjusting stations and adjusters with

provisions that govern the licensure of vehicle safety systems inspection, as specified.

This bill would update cross-references to those provisions of the act.

(12) Existing law provides that the Department of Food and Agriculture has general supervision of the weights and measures and weighing and measuring devices sold or used in the state. Existing law requires the Secretary of Food and Agriculture to adopt by reference certain tolerances, specifications, procedures, requirements, and standards for methods of sale that are recommended or published by the National Conference on Weights and Measures.

This bill would replace references to "National Conference on Weights and Measures" with "National Council on Weights and Measures."

(13) Existing law, the Control, Regulate and Tax Adult Use of Marijuana Act (AUMA), an initiative measure approved as Proposition 64 at the November 8, 2016, statewide general election, authorizes a person who obtains a state license under AUMA to engage in commercial adult-use cannabis activity pursuant to that license and applicable local ordinances. Existing law, the Medicinal and Adult-Use Cannabis Regulation and Safety Act (MAUCRSA), among other things, consolidates the licensure and regulation of commercial medicinal and adult-use cannabis activities and requires the Department of Cannabis Control to administer its provisions.

Existing law requires an applicant for a state license to conduct commercial cannabis activity to provide, among other things, specified information to the Department of Cannabis Control and the Department of Justice.

This bill would make nonsubstantive changes to those provisions by updating cross-references.

Existing law requires the department to establish a track and trace program for reporting the movement of cannabis and cannabis products throughout the distribution chain, as specified. Existing law requires the department, in consultation with the California Department of Tax and Fee Administration, to create an electronic database containing the electronic shipping manifests to facilitate the administration of the track and trace program, as specified.

This bill would instead refer to the electronic database as an electronic system.

~~(13)~~

(14) Existing law, the California Private Postsecondary Education Act of 2009, provides for the regulation of private postsecondary

institutions by the Bureau for Private Postsecondary Education. Existing law defines "distance education" for purposes of the act to mean transmission of instruction to students at a location separate from the institution, and defines "teach-out" to mean the arrangements an institution makes for its students to complete their educational programs when the institution ceases to operate. Existing law requires an institution to maintain permanent records, for each student granted a degree or certificate.

This bill would instead define "distance education" to mean transmission of instruction to students at a location separate from the faculty. The bill would revise the definition of "teach-out" to mean the arrangements an institution makes for its students to complete their educational programs when the institution or an educational program ceases to operate. The bill would repeal a provision requiring the bureau to establish a task force no later than March 1, 2015, to review standards for educational and training programs specializing in innovative subjects and instructing students in high-demand technology fields for which there is a shortage of skilled employees. The bill would require the permanent records required to be maintained by the institution to be complete and accurate.

~~(14)~~

(15) Existing law requires a student to enroll in a private postsecondary institution by executing an enrollment agreement and makes the agreement unenforceable unless the student has received the institution's catalog and School Performance Fact Sheet before signing the agreement. Existing law requires an institution to provide a prospective student with a School Performance Fact Sheet prior to enrollment.

This bill would require the student to receive the institution's current catalog and would require the institution to provide a prospective student with a current School Performance Fact Sheet. The bill would repeal a requirement that the bureau consider specified factors, including graduate salary and other outcome data and reporting requirements used by the United States Department of Education and specified other entities, and the reporting requirements of public postsecondary institutions to evaluate the feasibility of adopting these reporting requirements for private postsecondary institutions. The bill would repeal an obsolete reporting requirement relating to the bureau's staffing resources.

~~(15)~~

(16) This bill would make other technical changes, including eliminating gendered pronouns.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 27 of the Business and Professions Code is amended to read:

27. (a) Each entity specified in subdivisions (c), (d), and (e) shall provide on the internet information regarding the status of every license issued by that entity in accordance with the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code) and the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code). The public information to be provided on the internet shall include information on suspensions and revocations of licenses issued by the entity and other related enforcement action, including accusations filed pursuant to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) taken by the entity relative to persons, businesses, or facilities subject to licensure or regulation by the entity. The information may not include personal information, including home telephone number, date of birth, or social security number. Each entity shall disclose a licensee's address of record. However, each entity shall allow a licensee to provide a post office box number or other alternate address, instead of the licensee's home address, as the address of record. This section shall not preclude an entity from also requiring a licensee, who has provided a post office box number or other alternative mailing address as the licensee's address of record, to provide a physical business address or residence address only for the entity's internal administrative use and not for disclosure as the licensee's address of record or disclosure on the internet.

(b) In providing information on the internet, each entity specified in subdivisions (c) and (d) shall comply with the Department of Consumer Affairs' guidelines for access to public records.

(c) Each of the following entities within the Department of Consumer Affairs shall comply with the requirements of this section:

(1) The Board for Professional Engineers, Land Surveyors, and Geologists shall disclose information on its registrants and licensees.

(2) The Bureau of Automotive Repair shall disclose information on its licensees, including automotive repair dealers, smog check stations, smog check inspectors and repair technicians, and vehicle safety systems inspection stations and technicians.

(3) The Bureau of Household Goods and Services shall disclose information on its licensees, registrants, and permitholders.

(4) The Cemetery and Funeral Bureau shall disclose information on its licensees, including cemetery brokers, cemetery salespersons, cemetery managers, crematory managers, cemetery authorities, crematories, cremated remains disposers, embalmers, funeral establishments, hydrolysis facilities, reduction facilities, and funeral directors.

(5) The Professional Fiduciaries Bureau shall disclose information on its licensees.

(6) The Contractors State License Board shall disclose information on its licensees and registrants in accordance with Chapter 9 (commencing with Section 7000) of Division 3. In addition to information related to licenses as specified in subdivision (a), the board shall also disclose information provided to the board by the Labor Commissioner pursuant to Section 98.9 of the Labor Code.

(7) The Bureau for Private Postsecondary Education shall disclose information on private postsecondary institutions under its jurisdiction, including disclosure of notices to comply issued pursuant to Section 94935 of the Education Code.

(8) The California Board of Accountancy shall disclose information on its licensees and registrants.

(9) The California Architects Board shall disclose information on its licensees, including architects and landscape architects.

(10) The State Athletic Commission shall disclose information on its licensees and registrants.

(11) The State Board of Barbering and Cosmetology shall disclose information on its licensees.

(12) The Acupuncture Board shall disclose information on its licensees.

(13) The Board of Behavioral Sciences shall disclose information on its licensees and registrants.

(14) The Dental Board of California shall disclose information on its licensees.

(15) The California State Board of Optometry shall disclose information on its licensees and registrants.

(16) The Board of Psychology shall disclose information on its licensees, including psychologists and registered psychological associates.

(17) The Veterinary Medical Board shall disclose information on its licensees, registrants, and permitholders.

(d) The State Board of Chiropractic Examiners shall disclose information on its licensees.

(e) The Structural Pest Control Board shall disclose information on its licensees, including applicators, field representatives, and operators in the areas of fumigation, general pest and wood destroying pests and organisms, and wood roof cleaning and treatment.

(f) "Internet" for the purposes of this section has the meaning set forth in paragraph (6) of subdivision (f) of Section 17538.

SEC. 2. Section 144 of the Business and Professions Code is amended to read:

144. (a) Notwithstanding any other law, an agency designated in subdivision (b) shall require an applicant to furnish to the agency a full set of fingerprints for purposes of conducting criminal history record checks. Any agency designated in subdivision (b) may obtain and receive, at its discretion, criminal history information from the Department of Justice and the United States Federal Bureau of Investigation.

(b) Subdivision (a) applies to the following:

(1) California Board of Accountancy.

(2) State Athletic Commission.

(3) Board of Behavioral Sciences.

(4) Court Reporters Board of California.

(5) Dental Board of California.

(6) California State Board of Pharmacy.

(7) Board of Registered Nursing.

(8) California Veterinary Medical Board.

(9) Board of Vocational Nursing and Psychiatric Technicians of the State of California.
(10) Respiratory Care Board of California.
(11) Physical Therapy Board of California.
(12) Physician Assistant Board.
(13) Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board.
(14) Medical Board of California.
(15) California State Board of Optometry.
(16) Acupuncture Board.
(17) Cemetery and Funeral Bureau.
(18) Bureau of Security and Investigative Services.
(19) Division of Investigation.
(20) Board of Psychology.
(21) California Board of Occupational Therapy.
(22) Structural Pest Control Board.
(23) Contractors State License Board.
(24) California Board of Naturopathic Medicine.
(25) Professional Fiduciaries Bureau.
(26) Board for Professional Engineers, Land Surveyors, and Geologists.
(27) Podiatric Medical Board of California.
(28) Osteopathic Medical Board of California.
(29) California Architects Board, beginning January 1, 2021.
(30) Landscape Architects Technical Committee, beginning January 1, 2022.
(31) Bureau of Household Goods and Services with respect to household movers as described in Chapter 3.1 (commencing with Section 19225) of Division 8.
(32) State Board of Chiropractic Examiners.
(c) For purposes of paragraph (26) of subdivision (b), the term "applicant" shall be limited to an initial applicant who has never been registered or licensed by the board or to an applicant for a new licensure or registration category.
SEC. 3. Section 1602 of the Business and Professions Code is amended to read:
1602. All of the members of the board, except the public members, shall have been actively and lawfully engaged in the practice of dentistry in the State of California, for at least five years next preceding the date of their appointment. The registered dental

assistant members shall have been a registered dental assistant, in the State of California for at least five years next preceding the date of their appointment. The public members shall not be licensees of the board or of any other board under this division or of any board referred to in Sections 1000 and 3600. No more than one member of the board shall be a member of the faculty of any dental college or dental department of any medical college in the State of California. None of the members, including the public members, shall have any financial interest in any such college.

SEC. 4. Section 1603 of the Business and Professions Code is amended to read:

1603. (a) Except for the initial appointments, members of the board shall be appointed for a term of four years, and each member shall hold office until the appointment and qualification of the member's successor or until one year shall have elapsed since the expiration of the term for which the member was appointed, whichever first occurs.

(b) A vacancy occurring during a term shall be filled by appointment for the unexpired term, within 30 days after it occurs.

(c) No person shall serve as a member of the board for more than two terms.

(d) The Governor shall appoint three of the public members, the two registered dental assistant members, and the eight licensed dentist members of the board. The Senate Committee on Rules and the Speaker of the Assembly shall each appoint a public member.

(e) Of the initial appointments, one of the dentist members and one of the public members appointed by the Governor shall serve for a term of one year. Two of the dentist members appointed by the Governor shall each serve for a term of two years. One of the public members and two of the dentist members appointed by the Governor shall each serve a term of three years. The registered dental assistant members and the remaining three dentist members appointed by the Governor shall each serve for a term of four years. The public members appointed by the Senate Committee on Rules and the Speaker of the Assembly shall each serve for a term of four years.

SEC. 5. Section 1616.5 is added to the Business and Professions Code, to read:

1616.5. (a) The board, by and with the approval of the director, may appoint a person exempt from civil service who shall be designated as an executive officer and who shall exercise the powers and perform the duties delegated by the board and vested in the executive officer by this chapter.

(b) This section shall remain in effect only until January 1, 2029, and as of that date is repealed.

SEC. 6. Section 1901 of the Business and Professions Code is amended to read:

1901. (a) There is hereby created in the Department of Consumer Affairs a Dental Hygiene Board of California in which the administration of this article is vested.

(b) Whenever the terms "Dental Hygiene Committee of California" or "committee" are used in this article, they mean the Dental Hygiene Board of California.

(c) Whenever the term "Dental Hygiene Committee of California" is used in any other law, it means the Dental Hygiene Board of California.

(d) This section shall remain in effect only until January 1, 2028, and as of that date is repealed. Notwithstanding any other law, the repeal of this section renders the dental hygiene board subject to review by the appropriate policy committees of the Legislature.

SEC. 7. Section 1903 of the Business and Professions Code is amended to read:

1903. (a) (1) The dental hygiene board shall consist of nine members as follows:

(A) Seven members appointed by the Governor as follows:

(i) Two members shall be public members.

(ii) One member shall be a practicing general or public health dentist who holds a current license in California.

(iii) Four members shall be registered dental hygienists who hold current licenses in California. Of the registered dental hygienist members, one shall be licensed either in alternative practice or in extended functions, one shall be a dental hygiene educator, and two shall be registered dental hygienists. No public member shall have been licensed under this chapter within five years of the date of their appointment or have any current financial interest in a dental-related business.

(B) One public member appointed by the Senate Committee on Rules.

(C) One public member appointed by the Speaker of the Assembly.

(2) The first appointment by the Senate Committee on Rules or the Speaker of the Assembly pursuant to this subdivision shall be made upon the expiration of the term of a public member that is scheduled to occur, or otherwise occurs, on or after January 1, 2019.

(3) For purposes of this subdivision, a public health dentist is a dentist whose primary employer or place of employment is in any of the following:

(A) A primary care clinic licensed under subdivision (a) of Section 1204 of the Health and Safety Code.

(B) A primary care clinic exempt from licensure pursuant to subdivision (c) of Section 1206 of the Health and Safety Code.

(C) A clinic owned or operated by a public hospital or health system.

(D) A clinic owned and operated by a hospital that maintains the primary contract with a county government to fill the county's role under Section 17000 of the Welfare and Institutions Code.

(b) (1) Except as specified in paragraph (2), members of the dental hygiene board shall be appointed for a term of four years. Each member shall hold office until the appointment and qualification of the member's successor or until one year shall have lapsed since the expiration of the term for which the member was appointed, whichever comes first.

(2) For the term commencing on January 1, 2012, two of the public members, the general or public health dentist member, and two of the registered dental hygienist members, other than the dental hygiene educator member or the registered dental hygienist member licensed in alternative practice or in extended functions, shall each serve a term of two years, expiring January 1, 2014.

(c) Notwithstanding any other provision of law and subject to subdivision (e), the Governor may appoint to the dental hygiene board a person who previously served as a member of the former committee or dental hygiene board even if the person's previous term expired.

(d) The dental hygiene board shall elect a president, a vice president, and a secretary from its membership.

(e) No person shall serve as a member of the dental hygiene board for more than two consecutive terms.

(f) A vacancy in the dental hygiene board shall be filled by appointment to the unexpired term.

(g) Each member of the dental hygiene board shall receive a per diem and expenses as provided in Section 103.

(h) Each appointing authority shall have the power to remove from office at any time any member of the dental hygiene board appointed by that authority pursuant to Section 106.

(i) The dental hygiene board, with the approval of the director, may appoint a person exempt from civil service who shall be designated as an executive officer and who shall exercise the powers and perform the duties delegated by the dental hygiene board and vested in the executive officer by this article.

(j) This section shall remain in effect only until January 1, 2028, and as of that date is repealed.

SEC. 8. Section 1905 of the Business and Professions Code is amended to read:

1905. (a) The dental hygiene board shall perform the following functions:

(1) Evaluate all registered dental hygienist, registered dental hygienist in alternative practice, and registered dental hygienist in extended functions educational programs that apply for approval and grant or deny approval of those applications in accordance with regulations adopted by the dental hygiene board. Any such educational programs approved by the dental board on or before June 30, 2009, shall be deemed approved by the dental hygiene board. Any dental hygiene program accredited by the Commission on Dental Accreditation may be approved.

(2) Withdraw or revoke its prior approval of a registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions educational program in accordance with regulations adopted by the dental hygiene board. The dental hygiene board may withdraw or revoke a dental hygiene program approval if the Commission on Dental Accreditation has indicated an intent to withdraw approval or has withdrawn approval.

(3) Review and evaluate all registered dental hygienist, registered dental hygienist in alternative practice, and registered dental hygienist in extended functions applications for licensure to ascertain whether the applicant meets the appropriate licensing requirements specified by statute and regulations, maintain

application records, cashier application fees, issue and renew licenses, and perform any other tasks that are incidental to the application and licensure processes.

(4) Determine the appropriate type of license examination consistent with the provisions of this article, and develop or cause to be developed and administer examinations in accordance with regulations adopted by the dental hygiene board.

(5) Determine the amount of fees assessed under this article, not to exceed the actual cost.

(6) Determine and enforce the continuing education requirements specified in Section 1936.1.

(7) Deny, suspend, or revoke a license under this article, or otherwise enforce the provisions of this article. Any such proceedings shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the dental hygiene board shall have all of the powers granted therein.

~~(8) Make recommendations to the dental board regarding dental hygiene scope of practice issues.~~

~~(9)~~

(8) Adopt, amend, and revoke rules and regulations to implement the provisions of this article, including the amount of required supervision by a registered dental hygienist, a registered dental hygienist in alternative practice, or a registered dental hygienist in extended functions of a registered dental assistant.

(b) The dental hygiene board may employ employees and examiners that it deems necessary to carry out its functions and responsibilities under this article.

SEC. 9. Section 1926.3 of the Business and Professions Code is amended to read:

1926.3. (a) Every person who is now or hereafter licensed as a registered dental hygienist in alternative practice in this state shall register with the executive officer, on forms prescribed by the dental hygiene ~~board,~~ *board within 30 calendar days,* the physical facility of *the* registered dental hygienist in alternative practice or, if the registered dental hygienist in alternative practice has more than one physical facility pursuant to Section 1926.4, all of the physical facilities. If the registered dental hygienist in alternative practice does not have a physical facility, the registered dental hygienist in alternative practice shall notify the executive

officer. ~~A person licensed by the dental hygiene board shall register with the executive officer within 30 days after the date of the issuance of the person's license as a registered dental hygienist in alternative practice.~~

(b) (1) A registered dental hygienist in alternative practice who utilizes portable equipment to practice dental hygiene shall register with the executive officer, on forms prescribed by the dental hygiene board, the registered dental hygienist in alternative practice's physical facility where the portable equipment is maintained.

(2) The dental hygiene board may conduct announced and unannounced reviews and inspections of a registered dental hygienist in alternative practice's physical facilities and equipment described in paragraph (1) to ensure continued compliance with the requirements for continued approval under this article.

(c) It shall constitute unprofessional conduct if the registered dental hygienist in alternative practice's physical facility or equipment is found to be noncompliant with any requirements necessary for licensure and a registered dental hygienist in alternative practice may be placed on probation with terms, issued a citation and fine, or have the owned physical facility registration withdrawn if compliance is not demonstrated within reasonable timelines, as established by the dental hygiene board.

(d) The dental hygiene board, by itself or through an authorized representative, may issue a citation containing fines and orders of abatement to the registered dental hygienist in alternative practice for any violation of this section, Section 1925, Section 1926.4, or any regulations adopted thereunder. Any fine collected pursuant to this section shall be deposited into the State Dental Hygiene Fund established pursuant to Section 1944.

SEC. 10. Section 1944 of the Business and Professions Code is amended to read:

1944. (a) The dental hygiene board shall establish by resolution the amount of the fees that relate to the licensing of a registered dental hygienist, a registered dental hygienist in alternative practice, and a registered dental hygienist in extended functions. The fees established by dental hygiene board resolution in effect on June 30, 2009, as they relate to the licensure of registered dental hygienists, registered dental hygienists in alternative practice, and registered dental hygienists in extended functions, shall remain in

effect until modified by the dental hygiene board. The fees are subject to the following limitations:

(1) The application fee ~~for an original license and the fee for issuance of an original license shall not exceed two hundred fifty dollars ($250).~~ *shall not exceed one hundred dollars ($100).*

(2) The initial licensure fee shall not exceed one hundred fifty dollars ($150).

~~(2)~~

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

~~(3)~~

(4) The fee for examination for licensure as a registered dental hygienist in extended functions shall not exceed the actual cost of the examination.

~~(4)~~

(5) The fee for examination for licensure as a registered dental hygienist in alternative practice shall not exceed the actual cost of administering the examination.

~~(5)~~

(6) The biennial renewal fee shall not exceed five hundred dollars ($500).

~~(6)~~

(7) The delinquency fee shall not exceed one-half of the renewal fee. Any delinquent license may be restored only upon payment of all fees, including the delinquency fee, and compliance with all other applicable requirements of this article.

~~(7)~~

(8) The fee for issuance of a duplicate license to replace one that is lost or destroyed, or in the event of a name change, shall not exceed twenty-five dollars ($25) or one-half of the renewal fee, whichever is greater.

~~(8)~~

(9) The fee for certification of licensure shall not exceed one-half of the renewal fee.

~~(9)~~

(10) The fee for each curriculum review and feasibility study review for educational programs for dental hygienists who are not accredited by a dental hygiene board-approved agency shall not exceed two thousand one hundred dollars ($2,100).

~~(10)~~

(11) The fee for each review or approval of course requirements for licensure or procedures that require additional training shall not exceed seven hundred fifty dollars ($750).

~~(11)~~

(12) The initial application and biennial fee for a provider of continuing education shall not exceed five hundred dollars ($500).

~~(12)~~

(13) The amount of fees payable in connection with permits issued under Section 1962 is as follows:

(A) The initial permit fee is an amount equal to the renewal fee for the applicant's license to practice dental hygiene in effect on the last regular renewal date before the date on which the permit is issued.

(B) If the permit will expire less than one year after its issuance, then the initial permit fee is an amount equal to 50 percent of the renewal fee in effect on the last regular renewal date before the date on which the permit is issued.

~~(13)~~

(14) The fee for the dental hygiene board to conduct a site visit to educational programs for a registered dental hygienist, a registered dental hygienist in alternative practice, or a registered dental hygienist in extended functions to ensure compliance of educational program requirements shall not exceed the actual cost incurred by the dental hygiene board for cost recovery of site visit expenditures.

~~(14)~~

(15) The fee for a retired license shall not exceed one-half of the current license renewal fee.

(b) The renewal and delinquency fees shall be fixed by the dental hygiene board by resolution at not more than the current amount of the renewal fee for a license to practice under this article nor less than five dollars ($5).

(c) Fees fixed by the dental hygiene board by resolution pursuant to this section shall not be subject to the approval of the Office of Administrative Law.

(d) Fees collected pursuant to this section shall be collected by the dental hygiene board and deposited into the State Dental Hygiene Fund, which is hereby created. All money in this fund, upon appropriation by the Legislature in the annual Budget Act, shall be used to implement this article.

(e) No fees or charges other than those listed in this section shall be levied by the dental hygiene board in connection with the licensure of registered dental hygienists, registered dental hygienists in alternative practice, or registered dental hygienists in extended functions.

(f) The fee for registration of an extramural dental facility shall not exceed two hundred fifty dollars ($250).

(g) The fee for registration of a mobile dental hygiene unit shall not exceed one hundred fifty dollars ($150).

(h) The biennial renewal fee for a mobile dental hygiene unit shall not exceed two hundred fifty dollars ($250).

(i) The fee for an additional office permit shall not exceed two hundred fifty dollars ($250).

(j) The biennial renewal fee for an additional office as described in Section 1926.4 shall not exceed two hundred fifty dollars ($250).

(k) The initial application and biennial special permit fee is an amount equal to the biennial renewal fee specified in paragraph ~~(6)~~ *(7)* of subdivision (a).

(*l*) The fees in this section shall not exceed an amount sufficient to cover the reasonable regulatory cost of carrying out this article.

~~SEC. 8.~~

SEC. 11. Section 2125 of the Business and Professions Code is amended to read:

2125. (a) For purposes of this article, the following definitions apply:

(1) "Board" means the Medical Board of California.

(2) "Program" means the Licensed Physicians from Mexico Program.

(b) (1) The Licensed Physicians from Mexico Program is hereby created.

(2) The board shall approve physician candidates from Mexico for program participation.

(c) (1) This program extends the physician component of the Licensed Physicians and Dentists from Mexico Pilot Program, as established in former Section 853, which authorized up to 30 licensed physicians specializing in family practice, internal medicine, pediatrics, and obstetrics and gynecology from Mexico to practice medicine in California for a period not to exceed three years.

(2) The program shall also maintain an alternate list of program participants.

(d) The board shall issue a nonrenewable three-year physician's and surgeon's license to each licensed physician from Mexico who meets the criteria set forth in this section.

(e) Each physician from Mexico, to be eligible to participate in this program, shall comply with all of the following:

(1) Be licensed, certified or recertified, and in good standing in their medical specialty in Mexico. This certification or recertification shall be performed, as appropriate, by the Consejo Mexicano de Ginecología y Obstetricia, A.C., the Consejo Mexicano de Certificación en Medicina Familiar, A.C., the Consejo Mexicano de Medicina Interna, A.C., the Consejo Mexicano de Certificación en Pediatría, A.C., or the Consejo Mexicano de Psiquiatría, A.C.

(2) Before leaving Mexico, have completed all of the following requirements:

(A) Passed an interview examination developed by the National Autonomous University of Mexico (UNAM) for each specialty area. Each family practitioner who includes obstetrics and gynecology in their practice and shall not perform deliveries in California unless they have performed 50 live birth deliveries, as required by United States standards, confirmed by written documentation by the supervising department chair, hospital administrator, or hospital chief medical officer. Each obstetrician and gynecologist from Mexico shall be a fellow in good standing of the American College of Obstetricians and Gynecologists.

(B) (i) Satisfactorily completed an orientation program approved by the board in connection with the Licensed Physicians and Dentists from Mexico Pilot Program, as established in former Section 853, and that includes medical protocol, community clinic history and operations, medical administration, hospital operations and protocol, medical ethics, the California medical delivery system, health maintenance organizations and managed care practices, medication documentation and reconciliation, the electronic medical records system utilized by federally qualified health centers, and standards for medical record documentation to support medical decisionmaking and quality care. This orientation program may be changed by a committee of at least five chief medical officers at federally qualified health centers employing

program licensees to ensure that the orientation program contains the requisite subject matter and meets appropriate California law and medical standards where applicable.

(ii) Satisfactorily completed the Test of English as a Foreign Language by scoring a minimum of 85 percent or the Occupational English Test with a minimum score of 350, and provided written documentation of their completion to the board.

(C) Representatives from California and the UNAM in Mexico that executed and implemented the provisions of the former Physicians and Dentists from Mexico Pilot Program shall be the points of contact involved in securing required documents, recruiting and vetting candidates, assisting candidates for this program in Mexico to meet all program requirements, selecting appropriate federally qualified health centers throughout California, ensuring compliance with program provisions, developing policy and clinical workshops, monitoring productivity and increased access to medical care, and assessing the necessity of policy and programmatic improvements.

(3) Upon satisfactory completion of the requirements in paragraphs (1) and (2), and after having received their nonrenewable three-year physician's and surgeon's license, each licensee shall be required to obtain continuing education pursuant to Section 2190. Each physician shall obtain 25 continuing education units per year for three years of program participation, which shall be subject to random audits by the board to ensure compliance. The board may issue a citation and administrative fine against a licensee who fails to comply with the requirements of this paragraph.

(4) The federally qualified health centers employing physicians from Mexico shall continue the peer review protocols and procedures as required by the federal government. The federally qualified health centers shall work with a California medical school approved by the board pursuant to Section 2084 or a residency program approved by the Accreditation Council for Graduate Medical Education to conduct 10 secondary reviews of randomly selected patient encounters with each licensee per six-month period, and the reviews shall be transmitted to the approved medical school or medical institution with an approved residency program in PDF format. The secondary reviews shall be undertaken every six months of each year for the three years that the physicians from

Mexico are employed by federally qualified health centers. The faculty reviewers in family medicine, pediatrics, internal medicine, psychiatry, and obstetrics and gynecology from the California medical school approved by the board pursuant to Section 2084 or the residency program approved by the Accreditation Council for Graduate Medical Education shall provide feedback to the federally qualified health centers of the findings of their secondary reviews. The faculty and federally qualified health center chief medical officers shall jointly develop no less than two quality assurance (QA) seminars for all physicians from Mexico to attend during the six months of secondary reviews conducted. The purpose of the approved medical school or medical institution with an approved residency program secondary peer reviews shall be to provide feedback on compliance with medical standards, protocols, and procedures required by the federal government and assessed by the monthly or quarterly peer reviews conducted by federally qualified health centers. The associated costs for the secondary reviews and QA seminars shall be the responsibility of the federally qualified health centers on a pro rata basis.

(5) The federally qualified health centers employing physicians in the program shall be required to have medical quality assurance protocols and be accredited by The Joint Commission, National Committee for Quality Assurance, or Accreditation Association for Ambulatory Health Care.

(6) Participating hospitals shall have the authority to establish criteria necessary to allow individuals participating in this program to be granted hospital privileges in their facilities, taking into consideration the need and concerns for access to patient populations served by federally qualified health centers and attending doctors from Mexico, especially in rural areas that do not have hospitals staffed to provide deliveries of newborns.

(7) A licensee shall practice only in the nonprofit community health center that offered the licensee employment and the corresponding hospital. This three-year physician's and surgeon's license shall be deemed to be a license in good standing pursuant to the provisions of this chapter for the purpose of participation and reimbursement in all federal, state, and local health programs. These programs shall include the Medicare Program, the fee-for-service and managed care delivery systems of the Medi-Cal program, and private insurance. A physician from Mexico shall

not be denied credentials by a health plan because the physician is a participant in this state program and did not receive their medical education and training in the United States. The nonrenewable three-year physician's and surgeon's license issued pursuant to this program shall be referred to as a Physician's and Surgeon's from Mexico License and shall not include any additional notations beyond the current numerical identifiers that the board applies.

(f) (1) Notwithstanding subdivisions (a) to (d), inclusive, of Section 30, the board shall issue a nonrenewable three-year physician's and surgeon's license pursuant to this section to an applicant who has not provided an individual taxpayer identification number or social security number if the board staff determines the applicant is otherwise eligible for a license only under the program pursuant to this section, subject to the following conditions:

(A) The applicant shall immediately seek both an appropriate three-year visa and the accompanying social security number from the United States government within 14 days of being issued a medical license under this section.

(B) The applicant shall immediately provide to the board a social security number obtained in accordance with subparagraph (A) within 10 days of the federal government issuing the social security card related to the issued visa.

(C) The applicant shall not engage in the practice of medicine pursuant to this section until the board determines that the conditions in subparagraphs (A) and (B) have been met.

(2) The board, if it determines that an applicant has met the conditions in paragraph (1), shall notify the applicant that the applicant may engage in the practice of medicine under the license in accordance with this section.

(g) (1) (A) Between January 1, 2025, and January 1, 2029, the board shall coordinate with the representatives described in subparagraph (C) of paragraph (2) of subdivision (e) to ensure that no more than 155 program participants have a current and active license at the same time.

(B) During the time period described in subparagraph (A), no more than 30 of the 155 licenses may be issued to physicians whose primary area of practice is psychiatry.

(C) During the time period described in subparagraph (A), an applicant shall submit an application to the board between October 1, 2025, and December 31, 2025, except that the board may accept up to 15 applications after December 31, 2025, and before January 1, 2028.

(2) (A) Between January 1, 2029, and January 1, 2033, the board shall coordinate with the representatives described in subparagraph (C) of paragraph (2) of subdivision (e) to ensure that no more than 195 program participants have a current and active license at the same time.

(B) During the time period described in subparagraph (A), no more than 40 of the 195 licenses may be issued to physicians whose primary area of practice is psychiatry.

(C) During the time period described in subparagraph (A), an applicant shall submit an application to the board between October 1, 2029, and December 31, 2029, except that the board may accept up to 19 applications after December 31, 2029, and before January 1, 2032.

(3) (A) Between January 1, 2033, and January 1, 2037, the board shall coordinate with the representatives described in subparagraph (C) of paragraph (2) of subdivision (e) to ensure that no more than 225 program participants have a current and active license at the same time.

(B) During the time period described in subparagraph (A), no more than 40 of the 225 licenses may be issued to physicians whose primary area of practice is psychiatry.

(C) During the time period described in subparagraph (A), an applicant shall submit an application to the board between October 1, 2033, and December 31, 2033, except that the board may accept up to 22 applications after December 31, 2033, and before January 1, 2036.

(4) (A) Between January 1, 2037, and January 1, 2041, the board shall coordinate with the representatives described in subparagraph (C) of paragraph (2) of subdivision (e) to ensure that no more than 255 program participants have a current and active license at the same time.

(B) During the time period described in subparagraph (A), no more than 40 of the 255 licenses may be issued to physicians whose primary area of practice is psychiatry.

(C) During the time period described in subparagraph (A), an applicant shall submit an application to the board between October 1, 2037, and December 31, 2037, except that the board may accept up to 25 applications after December 31, 2037, and before January 1, 2040.

(5) (A) Between January 1, 2041, and January 1, 2045, the board shall coordinate with the representatives described in subparagraph (C) of paragraph (2) of subdivision (e) to ensure that no more than 275 program participants have a current and active license at the same time.

(B) During the time period described in subparagraph (A), no more than 40 of the 275 licenses may be issued to physicians whose primary area of practice is psychiatry.

(C) During the time period described in subparagraph (A), an applicant shall submit an application to the board between October 1, 2041, and December 31, 2041, except that the board may accept up to 27 applications after December 31, 2041, and before January 1, 2044.

(6) A physician's eligibility pursuant to this subdivision is subject to the physician complying with all of the requirements set forth in this section.

(h) All applicable employment benefits, salary, and policies provided by nonprofit community health centers to their current employees shall be provided to medical practitioners from Mexico participating in this program. This shall include nonprofit community health centers providing malpractice insurance coverage.

(i) Each program applicant shall be responsible for working with the governments of Mexico and the United States in order to obtain the necessary three-year visa required for program participation.

~~SEC. 9.~~

SEC. 12. Section 2532.2 of the Business and Professions Code is amended to read:

2532.2. Except as required by Section 2532.25, to be eligible for licensure by the board as a speech-language pathologist or audiologist, the applicant shall possess all of the following qualifications:

(a) Possess at least a master's degree in speech-language pathology or audiology from an educational institution approved by the board or qualifications deemed equivalent by the board.

(b) (1) Submit evidence of the satisfactory completion of supervised clinical practice with individuals representative of a wide spectrum of ages and communication disorders. The board shall establish by regulation the required number of clock hours, not to exceed 375 clock hours, of supervised clinical practice necessary for the applicant.

(2) The clinical practice shall be under the direction of an educational institution approved by the board.

(c) Submit evidence of no less than 36 weeks of satisfactorily completed supervised professional full-time experience or 72 weeks of professional part-time experience obtained under the supervision of a licensed speech-language pathologist or audiologist or a speech-language pathologist or audiologist having qualifications deemed equivalent by the board. This experience shall be evaluated and approved by the board. The required professional experience shall follow completion of the requirements listed in subdivisions (a) and (b). Full time is defined as at least 36 weeks in a calendar year and a minimum of 30 hours per week. Part time is defined as a minimum of 72 weeks and a minimum of 15 hours per week.

(d) (1) Pass an examination or examinations approved by the board. The board shall determine the subject matter and scope of the examinations and may waive the examination upon evidence that the applicant has successfully completed an examination approved by the board. Written examinations may be supplemented by oral examinations as the board shall determine. An applicant who fails their examination may be reexamined at a subsequent examination upon payment of the reexamination fee required by this chapter.

(2) A speech-language pathologist or audiologist who holds a license from another state or territory of the United States or who holds equivalent qualifications as determined by the board and who has completed no less than one year of full-time continuous employment as a speech-language pathologist or audiologist within the past three years is exempt from the supervised professional experience in subdivision (c).

(e) As applied to licensure as an audiologist, this section shall apply to applicants who graduated from an approved educational institution on or before December 31, 2007.

~~SEC. 10.~~

SEC. 13. Section 2532.3 of the Business and Professions Code is amended to read:

2532.3. (a) Upon approval of an application filed pursuant to Section 2532.1, and upon the payment of the fee prescribed by subdivision (i) of Section 2534.2, the board may issue a temporary license for a period of six months from the date of issuance to a speech-language pathologist or audiologist who holds an unrestricted license from another state or territory of the United States or who holds equivalent qualifications as determined by the board and has made application to the board for a license in this state.

(b) A temporary license shall terminate upon notice thereof by certified mail, return receipt requested, if it is issued by mistake or if the application for permanent licensure is denied.

(c) Upon written application, the board may reissue a temporary license to any person who has applied for a regular renewable license pursuant to Section 2532.1, and who, in the judgment of the board, has been excusably delayed in completing their application or the minimum requirements for a regular license. The board may not reissue a temporary license more than twice to any one person.

~~SEC. 11.~~

SEC. 14. Section 2532.4 of the Business and Professions Code is amended to read:

2532.4. (a) The board may direct applicants to be examined for knowledge in whatever theoretical or applied fields in speech-language pathology or audiology it deems appropriate. It may examine the applicant with regard to their professional skills and their judgment in the utilization of speech-language pathology or audiology techniques and methods.

(b) The examination may be written or oral or both. The examination shall be given at least once a year at the time and place and under such supervision as the board may determine. The board shall determine what shall constitute a passing grade.

(c) The board shall keep an accurate recording of any oral examination and keep the recordings as well as any written

examination as part of its records for at least two years following the date of examination.

~~SEC. 12.~~

SEC. 15. Section 2532.6 of the Business and Professions Code is amended to read:

2532.6. (a) The Legislature recognizes that the education and experience requirements of this chapter constitute only minimal requirements to assure the public of professional competence. The Legislature encourages all professionals licensed and registered by the board under this chapter to regularly engage in continuing professional development and learning that is related and relevant to the professions of speech-language pathology and audiology.

(b) The board shall not renew any license or registration pursuant to this chapter unless the applicant certifies to the board that they have completed in the preceding two years not less than the minimum number of continuing professional development hours established by the board pursuant to subdivision (c) for the professional practice authorized by their license or registration.

(c) (1) The board shall prescribe the forms utilized for and the number of hours of required continuing professional development for persons licensed or registered under this chapter.

(2) The board shall have the right to audit the records of any applicant to verify the completion of the continuing professional development requirements.

(3) Applicants shall maintain records of completion of required continuing professional development coursework for a minimum of two years and shall make these records available to the board for auditing purposes upon request.

(d) The board shall establish exceptions from the continuing professional development requirements of this section for good cause as defined by the board.

(e) (1) The continuing professional development services shall be obtained from accredited institutions of higher learning, organizations approved as continuing education providers by either the American Speech-Language Hearing Association or the American Academy of Audiology, the California Medical Association's Institute for Medical Quality Continuing Medical Education Program, or other entities or organizations approved as continuing professional development providers by the board, in its discretion.

(2) No hours shall be credited for any course enrolled in by a licensee that has not first been approved and certified by the board, if the board has sufficient funding and staff resources to implement the approval and certification process.

(3) The continuing professional development services offered by these entities may, but are not required to, utilize pretesting and posttesting or other evaluation techniques to measure and demonstrate improved professional learning and competency.

(4) An accredited institution of higher learning, an organization approved as continuing education providers by either the American Speech-Language Hearing Association or the American Academy of Audiology, and the California Medical Association's Institute for Medical Quality Continuing Education Program shall be exempt from any application or registration fees that the board may charge for continuing education providers.

(5) Unless a course offered by entities listed in paragraph (4) meets the requirements established by the board, the course may not be credited towards the continuing professional development requirements for license renewal.

(6) The licensee shall be responsible for obtaining the required course completion documents for courses offered by entities specified in paragraph (1).

(f) The board, by regulation, shall fund the administration of this section through professional development services provider and licensing fees to be deposited in the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Fund. The fees related to the administration of this section shall be sufficient to meet, but shall not exceed, the costs of administering the corresponding provisions of this section.

(g) The continuing professional development requirements adopted by the board shall comply with any guidelines for mandatory continuing education established by the Department of Consumer Affairs.

~~SEC. 13.~~

SEC. 16. Section 2532.7 of the Business and Professions Code is amended to read:

2532.7. (a) Upon approval of an application filed pursuant to Section 2532.1, and upon payment of the fee prescribed by Section 2534.2, the board may issue a required professional experience (RPE) temporary license for a period to be determined by the board

to an applicant who is obtaining the required professional experience specified in subdivision (c) of Section 2532.2 or paragraph (2) of subdivision (b) of Section 2532.25.

(b) Effective July 1, 2003, no person shall obtain the required professional experience for licensure in either an exempt or nonexempt setting, as defined in Section 2530.5, unless they are licensed in accordance with this section or is completing the final clinical externship of a board-approved audiology doctoral training program in accordance with paragraph (2) of subdivision (b) of Section 2532.25 in another state.

(c) A person who obtains an RPE temporary license outside the State of California shall not be required to hold a temporary license issued pursuant to subdivision (a) if the person is completing the final clinical externship of an audiology doctoral training program in accordance with paragraph (2) of subdivision (b) of Section 2532.25.

(d) Any experience obtained in violation of this act shall not be approved by the board.

(e) An RPE temporary license shall terminate upon notice thereof by certified mail, return receipt requested, if it is issued by mistake or if the application for permanent licensure is denied.

(f) Upon written application, the board may reissue an RPE temporary license for a period to be determined by the board to an applicant who is obtaining the required professional experience specified in subdivision (c) of Section 2532.2 or paragraph (2) of subdivision (b) of Section 2532.25.

~~SEC. 14.~~

SEC. 17. Section 2536 of the Business and Professions Code is amended to read:

2536. A speech-language pathology corporation or an audiology corporation is a corporation which is authorized to render professional services, as defined in Section 13401 of the Corporations Code, so long as that corporation and its shareholders, officers, directors, and employees rendering professional services who are speech-language pathologists or audiologists are in compliance with the Moscone-Knox Professional Corporation Act, this article, and all other statutes and regulations now or hereafter enacted or adopted pertaining to the corporation and the conduct of its affairs.

With respect to a speech-language pathology corporation or an audiology corporation, the governmental agency referred to in the Moscone-Knox Professional Corporation Act is the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board.

SEC. 18. Section 6501 of the Business and Professions Code is amended to read:

6501. As used in this chapter, the following terms have the following meanings:

(a) "Act" means this chapter.

(b) "Bureau" means the Professional Fiduciaries Bureau within the Department of Consumer Affairs, established pursuant to Section 6510.

(c) "Client" means an individual who is served by a professional fiduciary.

(d) "Department" means the Department of Consumer Affairs.

(e) "Licensee" means a person who is licensed under this chapter as a professional fiduciary.

(f) (1) "Professional fiduciary" means either of the following:

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

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

(2) "Professional fiduciary" also means a person who acts as a trustee, agent under a durable power of attorney for health care, or agent under a durable power of attorney for finances, for ~~more than three~~ *four or more* individuals, at the same time.

In counting individuals under this paragraph to determine whether a person is a professional fiduciary:

(A) Individuals who are related to the fiduciary shall not be counted.

(B) All individuals who are related to each other shall be counted as one individual.

(C) All trustors who are related to each other shall be counted as one individual, and neither the number of trusts nor the number of beneficiaries of those trusts shall be counted.

(D) "Professional fiduciary" also includes a person acting as a professional fiduciary practice administrator, appointed pursuant to Section 2469 or 9765 of the Probate Code.

(3) For purposes of this subdivision, "related" means related by blood, adoption, marriage, or registered domestic partnership.

(4) "Professional fiduciary" does not include any of the following:

(A) A trust company, as defined in Section 83 of the Probate Code.

(B) An FDIC-insured institution, or its holding companies, subsidiaries, or affiliates. For the purposes of this subparagraph, "affiliate" means an entity that shares an ownership interest with, or that is under the common control of, the FDIC-insured institution.

(C) A public agency, including the public guardian, public conservator, or other agency of the State of California or of a county of California or a regional center for persons with developmental disabilities, as defined in Section 4620 of the Welfare and Institutions Code.

(D) A nonprofit corporation or charitable trust that is described in Section 501(c)(3) of the Internal Revenue Code and that satisfies all of the following requirements:

(i) Is an organization described in Section 509(a)(1), Section 509(a)(2), or Section 509(a)(3) of the Internal Revenue Code.

(ii) Has been in existence for at least five years.

(iii) Has total institutional funds as described in subdivision (e) of Section 18502 of the Probate Code according to its most recent audited financial statement with a value of at least two million dollars ($2,000,000) net of encumbrances.

(iv) Is acting as a trustee, incidental to the purposes for which it was organized, of a trust that meets at least one of the following conditions:

(I) It is a trust from which annual distributions are limited to income, a sum certain, or a fixed percentage of the net fair market value of the trust assets as described in Section 664(d) of the Internal Revenue Code governing charitable remainder trusts.

(II) It is a trust from which annual distributions are limited to a guaranteed annuity or a fixed percentage of the fair market value of the property as described in Section 2055(e)(2)(B) or Section 2522(c)(2)(B) of the Internal Revenue Code.

(III) It is a trust from which annual distributions are limited to income, including a pooled income fund from which annual distributions are limited to income as described in Section 642(c)(5) of the Internal Revenue Code governing pooled income funds.

(IV) It is a trust as to which the value of the charitable interest was presently ascertainable upon creation of the trust and deductible for federal gift, estate, or income tax purposes under the Internal Revenue Code as in effect prior to enactment of the federal Tax Reform Act of 1969 (Public Law 91-172).

(E) A person employed by, or acting as an agent on behalf of, an entity or agency described in subparagraph (A), (B), (C), or (D) who is acting within the course and scope of that employment or agency, and a public officer of an agency described in subparagraph (C) acting in the course and scope of official duties.

(F) A person whose sole activity as a professional fiduciary is as a broker-dealer, broker-dealer agent, investment adviser, or investment adviser representative registered and regulated under the Corporate Securities Law of 1968 (Division 1 (commencing with Section 25000) of Title 4 of the Corporations Code), the Investment Advisers Act of 1940 (15 U.S.C. Sec. 80b-1 et seq.), or the Securities Exchange Act of 1934 (15 U.S.C. Sec. 78a et seq.), or involves serving as a trustee to a company regulated by the Securities and Exchange Commission under the Investment Company Act of 1940 (15 U.S.C. Sec. 80a-1 et seq.).

(g) "Committee" means the Professional Fiduciaries Advisory Committee, as established pursuant to Section 6511.

~~SEC. 15.~~

SEC. 19. Section 6584 of the Business and Professions Code is amended to read:

6584. A license issued under this chapter may be suspended, revoked, denied, or other disciplinary action may be imposed for one or more of the following causes:

(a) Conviction of any felony or any misdemeanor, if the misdemeanor is substantially related to the functions and duties of a professional fiduciary. The record of conviction, or a certified copy thereof, is conclusive evidence of the conviction.

(b) Failure to notify the bureau of a conviction as required by paragraph (11) of subdivision (a) of Section 6561.

(c) Fraud or misrepresentation in obtaining a license.

(d) Fraud, dishonesty, corruption, willful violation of duty, gross negligence or incompetence in practice, or unprofessional conduct in, or related to, the practice of a professional fiduciary. For purposes of this section, unprofessional conduct includes, but is not limited to, acts contrary to professional standards concerning any provision of law substantially related to the duties of a professional fiduciary.

(e) Failure to comply with, or to pay a monetary sanction imposed by, a court for failure to provide timely reports. The record of the court order, or a certified copy thereof, is conclusive evidence that the sanction was imposed.

(f) Failure to pay a civil penalty relating to the licensee's professional fiduciary duties.

(g) The revocation of, suspension of, or other disciplinary action against, any other professional license by the State of California or by another state. A certified copy of the revocation, suspension, or disciplinary action is conclusive evidence of that action.

(h) Violation of this chapter or of the applicable provisions of Division 4 (commencing with Section 1400), Division 4.5 (commencing with Section 4000), Division 4.7 (commencing with Section 4600), or Division 5 (commencing with Section 5000) of the Probate Code or of any of the statutes, rules, or regulations pertaining to duties or functions of a professional fiduciary.

~~SEC. 16.~~

SEC. 20. Section 7076.5 of the Business and Professions Code is amended to read:

7076.5. (a) A contractor may inactivate their license by submitting a form prescribed by the registrar accompanied by the current active license certificate. When the current license certificate has been lost, the licensee shall pay the fee prescribed by law to replace the license certificate. Upon receipt of an acceptable application to inactivate, the registrar shall issue an inactive license certificate to the contractor. The holder of an inactive license shall not be entitled to practice as a contractor until their license is reactivated.

(b) Any licensed contractor who is not engaged in work or activities which require a contractor's license may apply for an inactive license.

(c) Inactive licenses shall be valid for a period of four years from their due date.

(d) During the period that an existing license is inactive, no bonding requirement pursuant to Section 7071.6, 7071.8, or 7071.9, qualifier requirement pursuant to Section 7068, or workers' compensation requirements pursuant to Section 7125 shall apply. An applicant for license having met the qualifications for issuance may request that the license be issued inactive unless the applicant is subject to the provisions of Section 7071.8.

(e) The board shall not refund any of the renewal fee which a licensee may have paid prior to the inactivation of their license.

(f) An inactive license shall be renewed on each established renewal date by submitting the renewal application and paying the inactive renewal fee.

(g) An inactive license may be reactivated by submitting an application acceptable to the registrar, by paying the full renewal fee for an active license and by fulfilling all other requirements of this chapter. No examination shall be required to reactivate an inactive license.

(h) The inactive status of a license shall not bar any disciplinary action by the board against a licensee for any of the causes stated in this chapter.

~~SEC. 17.~~

SEC. 21. Section 7137 of the Business and Professions Code is amended to read:

7137. (a) The board may set fees by regulation. These fees shall be set according to the following schedule:

(1) Application fees shall be set as follows:

(A) The application fee for an original license in a single classification shall be four hundred fifty dollars ($450) and may be increased to not more than five hundred sixty-three dollars ($563).

(B) The application fee for each additional classification applied for in connection with an original license shall be one hundred fifty dollars ($150) and may be increased to not more than one hundred eighty-eight dollars ($188).

(C) The application fee for each additional classification pursuant to Section 7059 shall be two hundred thirty dollars ($230) and may be increased to not more than two hundred eighty-eight dollars ($288).

(D) The application fee to replace a responsible managing officer, responsible managing manager, responsible managing

member, or responsible managing employee pursuant to Section 7068.2 shall be two hundred thirty dollars ($230) and may be increased to not more than two hundred eighty-eight dollars ($288).

(E) The application fee to add personnel, other than a qualifying individual, to an existing license shall be one hundred twenty-five dollars ($125) and may be increased to not more than one hundred fifty-seven dollars ($157).

(F) The application fee for an asbestos certification shall be one hundred twenty-five dollars ($125) and may be increased to not more than one hundred fifty-seven dollars ($157).

(G) The application fee for a hazardous substance removal or remedial action certification shall be one hundred twenty-five dollars ($125) and may be increased to not more than one hundred fifty-seven dollars ($157).

(2) The fee to take an examination conducted or administered by a public or private organization pursuant to Section 7065 shall be no greater than the actual cost of the administration of the examination and shall be paid directly to the organization by the applicant.

(3) Initial license and registration fees shall be set as follows:

(A) The initial license fee for an active or inactive license for an individual owner shall be two hundred dollars ($200) and may be increased to not more than two hundred fifty dollars ($250).

(B) The initial license fee for an active or inactive license for a partnership, corporation, limited liability company, or joint venture shall be three hundred fifty dollars ($350) and may be increased to not more than four hundred thirty-eight dollars ($438).

(C) The registration fee for a home improvement salesperson shall be two hundred dollars ($200) and may be increased to not more than two hundred fifty dollars ($250).

(D) (i) The board shall grant a 50-percent reduction in the fees prescribed by this paragraph to an applicant who is a veteran of the United States Armed Forces, including the National Guard or Reserve components, and was not dishonorably discharged.

(ii) To demonstrate discharge grade at the time of the board's request for the initial license or registration fee, the applicant shall provide the board a copy of a current and valid driver's license or identification card issued by this state or another state with the word "Veteran" printed on its face or a copy of their DD214 long form.

(4) License and registration renewal fees shall be set as follows:

(A) The renewal fee for an active license for an individual owner shall be four hundred fifty dollars ($450) and may be increased to not more than five hundred sixty-three dollars ($563).

(B) The renewal fee for an inactive license for an individual owner shall be three hundred dollars ($300) and may be increased to not more than three hundred seventy-five dollars ($375).

(C) The renewal fee for an active license for a partnership, corporation, limited liability company, or joint venture shall be seven hundred dollars ($700) and may be increased to not more than eight hundred seventy-five dollars ($875).

(D) The renewal fee for an inactive license for a partnership, corporation, limited liability company, or joint venture shall be five hundred dollars ($500) and may be increased to not more than six hundred twenty-five dollars ($625).

(E) The renewal fee for a home improvement salesperson registration shall be two hundred dollars ($200) and may be increased to not more than two hundred fifty dollars ($250).

(5) The delinquency fee is an amount equal to 50 percent of the renewal fee, if the license is renewed after its expiration.

(6) Miscellaneous fees shall be set as follows:

(A) In addition to any other fees charged to C-10 contractors, the board shall charge a fee of twenty dollars ($20), to be assessed with the renewal fee for an active license, which shall be used by the board to enforce provisions of the Labor Code related to electrician certification.

(B) The board shall require a licensee that is subject to a public complaint requiring a professional or expert investigation or inspection and report pursuant to Section 7019 to pay those reasonable fees that are necessary to cover the costs of that investigation or inspection and report, in accordance with the following provisions:

(i) Fees shall be fixed in an amount not more than the board's cost of contracting for the investigation or inspection and report, except that the minimum fee shall be one hundred dollars ($100) for each investigation or inspection and report and may be increased to not more than one thousand dollars ($1,000) for each investigation or inspection and report.

(ii) The fee shall only be assessed for an investigation or inspection and report that resulted in issuance of a letter of

admonishment or a citation pursuant to Sections 7099 and 7099.9 that has become a final order of the registrar.

(iii) A license shall not be renewed without payment of the renewal fee and all fees for the investigation or inspection and report pursuant to this subparagraph.

(C) The service fee to deposit with the registrar lawful money or cashier's check pursuant to paragraph (1) of subdivision (a) of Section 995.710 of the Code of Civil Procedure for purposes of compliance with any provision of Article 5 (commencing with Section 7065) shall be one hundred dollars ($100), which shall be used by the board only to process each deposit filed with the registrar, to cover the reasonable costs to the registrar for holding money or cashier's checks in trust in interest bearing deposit or share accounts, and to offset the costs of processing payment of lawful claims against a deposit in a civil action.

(D) The fee for the processing and issuance of a duplicate copy of any certificate of licensure or other form evidencing licensure or renewal of licensure pursuant to Section 122 shall be twenty-five dollars ($25).

(E) The fee to change the business name of a license as it is recorded under this chapter shall be one hundred dollars ($100) and may be increased to not more than one hundred twenty-five dollars ($125).

(F) The service charge for a dishonored check authorized by Section 6157 of the Government Code shall be twenty-five dollars ($25) for each check.

(b) The board shall, by regulation, establish criteria for the approval of expedited processing of applications. Approved expedited processing of applications for licensure or registration, as required by other provisions of law, shall not be subject to this subdivision.

~~SEC. 18.~~

SEC. 22. Section 7152 of the Business and Professions Code is amended to read:

7152. (a) "Home improvement salesperson" is a person who is registered under this chapter and engaged in the business of soliciting, selling, negotiating, or executing contracts for home improvements, for the sale, installation or furnishing of home improvement goods or services, or of swimming pools, spas, or

hot tubs on behalf of a home improvement contractor licensed under this chapter.

(b) A home improvement salesperson shall register with the board in order to engage in the business of, or act in the capacity of, a home improvement salesperson.

(c) Subject to the provisions of Section 7154, a home improvement salesperson may be employed by one, or more than one, home improvement contractor. However, prior to engaging in any activity described in subdivision (a) of this section, a home improvement salesperson shall identify to the owner or tenant the business name and license number of the contractor they are representing for the purposes of that transaction. Failure to do so is a cause of disciplinary action within the meaning of Section 7155.

(d) The following shall not be required to be registered as home improvement salespersons:

(1) An officer of record of a corporation licensed pursuant to this chapter, or a manager, member, or officer of record of a limited liability company licensed pursuant to this chapter.

(2) A general partner listed on the license record of a partnership licensed pursuant to this chapter.

(3) A qualifying person, as defined in Section 7025.

(4) A salesperson whose sales are all made pursuant to negotiations between the parties if the negotiations are initiated by the prospective buyer at or with a general merchandise retail establishment that operates from a fixed location where goods or services are offered for sale.

(5) A person who contacts the prospective buyer for the exclusive purpose of scheduling appointments for a registered home improvement salesperson.

(6) A bona fide service repairperson who is in the employ of a licensed contractor and whose repair or service call is limited to the service, repair, or emergency repair initially requested by the buyer of the service.

(e) The exemption to registration provided under paragraphs (1), (2), and (3) of subdivision (d) shall apply only to those individuals who, at the time of the sales transaction, are listed as personnel of record for the licensee responsible for soliciting, negotiating, or contracting for a service or improvement that is subject to regulation under this article.

~~SEC. 19.~~

SEC. 23. Section 7524 of the Business and Professions Code is amended to read:

7524. (a) Every agreement to provide a service regulated by this chapter, including, but not limited to, contract agreements and investigative agreements, shall be in writing. An initial client service agreement shall contain, but not be limited to, the following:

(1) The licensed private investigator's name, business address, business telephone number, and license number.

(2) A disclosure that private investigators are licensed and regulated by the Bureau of Security and Investigative Services within the Department of Consumer Affairs.

(3) Approximate start and completion dates of the work to be provided.

(4) A description of the scope of the investigation or services to be provided. An agreement shall indicate whether or not a written report is to be provided to the client and the agreed upon method of delivery of that written report, as applicable.

(5) All labor, services, and materials to be provided for the scope of work conducted by the private investigator.

(6) An explanation of the fees agreed upon by the parties, including a breakdown of how the fees are assessed by the licensee.

(7) Any other matters agreed upon by the parties.

(b) Any amendment, addendum, or other modification to an initial client service agreement shall be in writing and is subject to the requirements of this section. An amendment, addendum, or other modification shall include a description of the changes to the scope of work, start and completion dates, method of delivery, fees to be charged, and other matters agreed upon in the initial client service agreement, as applicable.

(c) (1) The initial client service agreement and any amendment, addendum, or other modification to the agreement shall be legible and clearly indicate any other document incorporated into it.

(2) Before any work commences, the client shall receive a signed copy of the written initial client service agreement and any amendment, addendum, or other modification to the agreement that was agreed to before commencement of the work.

(3) Services detailed under the scope of work shall not be performed and charges shall not accrue before written authorization to proceed is obtained from the client.

(d) Upon completion of the investigation, any written report, as agreed upon by all parties and indicated in the agreement, shall be provided to the client within 30 days from the completion date and in accordance with the agreed upon delivery method.

(e) The licensee shall maintain a legible copy of the signed agreement and investigative findings, including any written report, for a minimum of two years. These records shall be made available for inspection by the bureau upon demand. Making these records available for inspection by the bureau shall not violate, waive, or extinguish the lawyer-client privilege under Article 3 (commencing with Section 950) of Chapter 4 of Division 8 of the Evidence Code, the attorney work product doctrine as restated in Chapter 4 (commencing with Section 2018.010) of Title 4 of Part 4 of the Code of Civil Procedure, the duty to maintain the confidence and preserve the secrets of an attorney's client under subdivision (e) of Section 6068, or the protections of any other rule or law related to attorney work product or the attorney-client privilege.

(f) This section shall become operative on July 1, 2025.

~~SEC. 20.~~

SEC. 24. Section 8027 of the Business and Professions Code is amended to read:

8027. (a) As used in this section, "school" means a court reporter training program or an institution that provides a course of instruction approved by the board and the Bureau for Private Postsecondary Education, is a public school in this state, or is accredited by the Western Association of Schools and Colleges.

(b) A court reporting school shall be primarily organized to train students for the practice of shorthand reporting, as defined in Sections 8016 and 8017. Its educational program shall be on the postsecondary or collegiate level. It shall be legally organized and authorized to conduct its program under all applicable laws of the state, and shall conform to and offer all components of the minimum prescribed course of study established by the board. Its records shall be kept and shall be maintained in a manner to render them safe from theft, fire, or other loss. The records shall indicate positive daily and clock-hour attendance of each student for all classes, apprenticeship and graduation reports, high school

transcripts or the equivalent or self-certification of high school graduation or the equivalent, transcripts of other education, and student progress to date, including all progress and counseling reports.

(c) Any school intending to offer a program in court reporting shall notify the board within 30 days of the date on which it provides notice to, or seeks approval from, the State Department of Education, the Bureau for Private Postsecondary Education, the Office of the Chancellor of the California Community Colleges, or the Western Association of Schools and Colleges, whichever is applicable. The board shall review the proposed curriculum and provide the school tentative approval, or notice of denial, within 60 days of receipt of the notice. The school shall apply for provisional recognition pursuant to subdivision (d) within no more than one year from the date it begins offering court reporting classes.

(d) The board may grant provisional recognition to a new court reporting school upon satisfactory evidence that it has met all of the provisions of subdivision (b) and this subdivision. Recognition may be granted by the board to a provisionally recognized school after it has been in continuous operation for a period of no less than three consecutive years from the date provisional recognition was granted, during which period the school shall provide satisfactory evidence that at least one person has successfully completed the entire course of study established by the board and complied with the provisions of Section 8020, and has been issued a certificate to practice shorthand reporting as defined in Sections 8016 and 8017. The board may, for good cause shown, extend the three-year provisional recognition period for not more than one year. Failure to meet the provisions and terms of this section shall require the board to deny recognition. Once granted, recognition may be withdrawn by the board for failure to comply with all applicable laws and regulations.

(e) Application for recognition of a court reporting school shall be made upon a form prescribed by the board and shall be accompanied by all evidence, statements, or documents requested. Each branch, extension center, or off-campus facility requires separate application.

(f) All recognized and provisionally recognized court reporting schools shall notify the board of any change in school name,

address, telephone number, responsible court reporting program manager, owner of private schools, and the effective date thereof, within 30 days of the change. All of these notifications shall be made in writing.

(g) A school shall notify the board in writing immediately of the discontinuance or pending discontinuance of its court reporting program or any of the program's components. Within two years of the date this notice is sent to the board, the school shall discontinue its court reporting program in its entirety. The board may, for good cause shown, grant not more than two one-year extensions of this period to a school. If a student is to be enrolled after this notice is sent to the board, a school shall disclose to the student the fact of the discontinuance or pending discontinuance of its court reporting program or any of its program components.

(h) The board shall maintain a roster of currently recognized and provisionally recognized court reporting schools, including, but not limited to, the name, address, telephone number, and the name of the responsible court reporting program manager of each school.

(i) The board shall maintain statistics that display the number and passing percentage of all first-time examinees, including, but not limited to, those qualified by each recognized or provisionally recognized school and those first-time examinees qualified by other methods as defined in Section 8020.

(j) Inspections and investigations shall be conducted by the board as necessary to carry out this section, including, but not limited to, unannounced site visits.

(k) All recognized and provisionally recognized schools shall print in their school or course catalog the name, address, and telephone number of the board. At a minimum, the information shall be in 8-point bold type and include the following statement:

"IN ORDER FOR A PERSON TO QUALIFY FROM A SCHOOL TO TAKE THE STATE LICENSING EXAMINATION, THE PERSON SHALL COMPLETE A PROGRAM AT A RECOGNIZED SCHOOL. FOR INFORMATION CONCERNING THE MINIMUM REQUIREMENTS THAT A COURT REPORTING PROGRAM MUST MEET IN ORDER TO BE RECOGNIZED, CONTACT: THE COURT REPORTERS

BOARD OF CALIFORNIA; (ADDRESS); (TELEPHONE NUMBER).”

(*l*) Each court reporting school shall file with the board, not later than June 30 of each year, a current school catalog that shows all course offerings and staff, and for private schools, the owner, except that where there have been no changes to the catalog within the previous year, no catalog need be sent. In addition, each school shall also file with the board a statement certifying whether the school is in compliance with all statutes and the rules and regulations of the board, signed by the responsible court reporting program manager.

(m) A school offering court reporting shall not make any written or verbal claims of employment opportunities or potential earnings unless those claims are based on verified data and reflect current employment conditions.

(n) If a school offers a course of instruction that exceeds the board’s minimum requirements, the school shall disclose orally and in writing the board’s minimum requirements and how the course of instruction differs from those criteria. The school shall make this disclosure before a prospective student executes an agreement obligating that person to pay any money to the school for the course of instruction. The school shall also make this disclosure to all students enrolled on January 1, 2002.

(o) Private and public schools shall provide each prospective student with all of the following and have the prospective student sign a document that shall become part of that individual’s permanent record, acknowledging receipt of each item:

(1) A student consumer information brochure published by the board.

(2) A list of the school’s graduation requirements, including the number of tests, the pass point of each test, the speed of each test, and the type of test, such as jury charge or literary.

(3) A list of requirements to qualify for the state-certified shorthand reporter licensing examination, including the number of tests, the pass point of each test, the speed of each test, and the type of test, such as jury charge or literary, if different than those requirements listed in paragraph (2).

(4) A copy of the school’s board-approved benchmarks for satisfactory progress as identified in subdivision (u).

(5) A report showing the number of students from the school who qualified for each of the certified shorthand reporter licensing examinations within the preceding two years, the number of those students that passed each examination, the time, as of the date of qualification, that each student was enrolled in court reporting school, and the placement rate for all students that passed each examination.

(6) On and after January 1, 2005, the school shall also provide to prospective students the number of hours each currently enrolled student who has qualified to take the next licensing test, exclusive of transfer students, has attended court reporting classes.

(p) All enrolled students shall have the information in subdivisions (n) and (o) on file no later than June 30, 2005.

(q) Public schools shall provide the information in subdivisions (n) and (o) to each new student the first day they attend theory or machine speed class, if it was not provided previously.

(r) Each enrolled student shall be provided written notification of any change in qualification or graduation requirements that is being implemented due to the requirements of any one of the school's oversight agencies. This notice shall be provided to each affected student at least 30 days before the effective date of the change and shall state the new requirement and the name, address, and telephone number of the agency that is requiring it of the school. Each student shall initial and date a document acknowledging receipt of that information and that document, or a copy thereof, shall be made part of the student's permanent file.

(s) Schools shall make available a comprehensive final examination in each academic subject to any student desiring to challenge an academic class in order to obtain credit towards certification for the state licensing examination. The points required to pass a challenge examination shall not be higher than the minimum points required of other students completing the academic class.

(t) An individual serving as a teacher, instructor, or reader shall meet the qualifications specified by regulation for their position.

(u) Each school shall provide a substitute teacher or instructor for any class for which the teacher or instructor is absent for two consecutive days or more.

(v) The board has the authority to approve or disapprove benchmarks for satisfactory progress which each school shall

develop for its court reporting program. Schools shall use only board-approved benchmarks to comply with the provisions of paragraph (4) of subdivision (o) and subdivision (u).

(w) Each school shall counsel each student a minimum of one time within each 12-month period to identify the level of attendance and progress, and the prognosis for completing the requirements to become eligible to sit for the state licensing examination. If the student has not progressed in accordance with the board-approved benchmarks for that school, the student shall be counseled a minimum of one additional time within that same 12-month period.

(x) The school shall provide to the board, for each student qualifying through the school as eligible to sit for the state licensing examination, the number of hours the student attended court reporting classes, both academic and machine speed classes, including theory.

(y) The pass rate of first-time examination takers for each school offering court reporting shall meet or exceed the average pass rate of all first-time test takers for a majority of examinations given for the preceding three years. Failure to do so shall require the board to conduct a review of the program. In addition, the board may place the school on probation and may withdraw recognition if the school continues to place below the above-described standard on the two examinations that follow the three-year period.

(z) A school shall not require more than one 10-minute qualifying examination, as defined in the regulations of the board, for a student to be eligible to sit for the state certification examination.

(aa) A school shall provide the board the actual number of hours of attendance for each applicant the school qualifies for the state licensing examination.

(ab) The board shall, by December 1, 2001, do the following by regulation as necessary:

(1) Establish the format that shall be used by schools to report tracking of all attendance hours and actual timeframes for completed coursework.

(2) Require schools to provide a minimum of 10 hours of live dictation class each school week for every full-time student.

(3) Require schools to provide students with the opportunity to read back from their stenographic notes a minimum of one time each day to their instructor.

(4) Require schools to provide students with the opportunity to practice with a school-approved speed-building audio recording, or other assigned material, a minimum of one hour per day after school hours as a homework assignment and provide the notes from this audio recording to their instructor the following day for review.

(5) Develop standardization of policies on the use and administration of qualifier examinations by schools.

(6) Define qualifier examination as follows: the qualifier examination shall consist of 4-voice testimony of 10-minute duration at 200 words per minute, graded at 95 percent accuracy, and in accordance with the guidelines followed by the board. Schools shall be required to date and number each qualifier and announce the date and number to the students at the time of administering the qualifier. All qualifiers shall indicate the actual dictation time of the test and the school shall catalog and maintain the qualifier for a period of not less than three years for the purpose of inspection by the board.

(7) Require schools to develop a program to provide students with the opportunity to interact with professional court reporters to provide skill support, mentoring, or counseling that they can document at least quarterly.

(8) Define qualifications and educational requirements required of instructors and readers that read test material and qualifiers.

(ac) The board shall adopt regulations to implement the requirements of this section not later than September 1, 2002.

(ad) The board may recover costs for any additional expenses incurred under the enactment amending this section in the 2001–02 Regular Session of the Legislature pursuant to its fee authority in Section 8031.

~~SEC. 21.~~

SEC. 25. Section 9889.1 of the Business and Professions Code is amended to read:

9889.1. Any license issued pursuant to Article 6.5 (commencing with Section 9888.5) may be suspended or revoked by the director. The director may refuse to issue a license to any applicant for the reasons set forth in Section 9889.2. The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title

2 of the Government Code, and the director shall have all the powers granted therein.

~~SEC. 22.~~

SEC. 26. Section 9889.2 of the Business and Professions Code is amended to read:

9889.2. The director may deny a license if the applicant or any partner, officer, or director thereof:

(a) Fails to meet the qualifications established by the bureau pursuant to Article 6.5 (commencing with Section 9888.5) for the issuance of the license applied for.

(b) Was previously the holder of a license issued under this chapter which license has been revoked and never reissued or which license was suspended and the terms of the suspension have not been fulfilled.

(c) Has committed any act which, if committed by any licensee, would be grounds for the suspension or revocation of a license issued pursuant to this chapter.

(d) Has committed any act involving dishonesty, fraud, or deceit whereby another is injured or whereby the applicant has benefited.

(e) Has acted in the capacity of a licensed person or firm under this chapter without having a license therefor.

(f) Has entered a plea of guilty or nolo contendere to, or been found guilty of, or been convicted of a crime substantially related to the qualifications, functions and duties of the license holder in question, and the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal, irrespective of an order granting probation following such conviction, suspending the imposition of sentence, or of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing such person to withdraw their plea of guilty and to enter a plea of not guilty, or setting aside the plea or verdict of guilty, or dismissing the accusation or information.

~~SEC. 23.~~

SEC. 27. Section 9889.9 of the Business and Professions Code is amended to read:

9889.9. When any license has been revoked or suspended following a hearing under the provisions of this article, any additional license issued under Article 6.5 (commencing with Section 9888.5) in the name of the licensee may be likewise revoked or suspended by the director.

~~SEC. 24.~~

SEC. 28. Section 12107 of the Business and Professions Code is amended to read:

12107. The secretary shall establish tolerances and specifications and other technical requirements for commercial weighing and measuring. In doing so, the secretary shall adopt, by reference, the latest standards as recommended by the National Council on Weights and Measures and published in the National Institute of Standards and Technology Handbook 44 "Specifications, Tolerances, and other Technical Requirements for Weighing and Measuring Devices," except as specifically modified, amended, or rejected by regulation adopted by the secretary.

The secretary may, by regulation, establish tolerances and specifications for commercial weighing and measuring devices not included in Handbook 44.

Any regulation shall be adopted, amended, or repealed in conformity with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

It shall be unlawful for any person to violate any of the rules, regulations, tolerances, specifications, or standards established under this section.

~~SEC. 25.~~

SEC. 29. Section 12211 of the Business and Professions Code is amended to read:

12211. Each sealer shall, from time to time, weigh or measure packages, containers, or amounts of commodities sold, or in the process of delivery, in order to determine whether they contain the quantity or amount represented and whether they are being sold in accordance with law.

The secretary shall adopt necessary regulations governing the procedures to be followed by sealers in connection with the weighing or measuring of amounts of commodities in individual packages, containers, or lots of packages or containers, including the procedures for sampling a lot, and for determining whether any package, container, or a lot of packages or containers complies with this section.

In adopting those regulations, the secretary shall adopt by reference the package checking procedures recommended by the National Council on Weights and Measures and published in the

current edition of the National Institute of Standards and Technology Handbook 133, "Checking the Net Contents of Packaged Goods," and any subsequent amendments thereto, except insofar as those requirements are specifically modified, amended, or rejected by a regulation adopted by the secretary.

Any lot, package, or container of any commodity that conforms to this section shall be deemed to be in conformity with this division relating to stated net weights or measures.

Whenever a lot, package, or container of any commodity is found to contain, through the procedures authorized in this section, a less amount than that represented, the sealer shall order, in writing, that lot, package, or container of commodity off sale and require that an accurate statement of quantity be placed on each package or container before it may be released for sale by the sealer in writing. The sealer may seize as evidence any package or container that is found to contain a less amount than that represented.

~~SEC. 26.~~

SEC. 30. Section 12500.8 of the Business and Professions Code is amended to read:

12500.8. The secretary may enter into an agreement with the National Type Evaluation Program, a certification program of the National Council on Weights and Measures, and other weights and measures jurisdictions, to accept the certifications of each other for prototype examination purposes.

~~SEC. 27.~~

SEC. 31. Section 12609 of the Business and Professions Code is amended to read:

12609. The secretary shall adopt necessary regulations to carry out the purpose of this division and for the testing of packages to verify the net quantity statements. In adopting these regulations, the secretary shall adopt by reference the packaging and labeling requirements recommended by the National Council on Weights and Measures and published in the current edition of the National Institute of Standards and Technology Handbook 130, Uniform Packaging and Labeling Regulations, except insofar as those requirements are specifically modified, amended, or rejected by regulation by the secretary. The regulations shall include exemptions from full compliance with this chapter for good and sufficient reasons. Any exemptions affecting consumer commodities shall be in conformance with exemptions permitted

by federal regulations. Any regulation, or amendment thereof, shall be adopted by the secretary in conformity with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

~~SEC. 28.~~

SEC. 32. Section 13404.5 of the Business and Professions Code is amended to read:

13404.5. The secretary shall establish the method of sale of motor vehicle fuels and lubricants sold at retail to the public. In doing so, the secretary shall adopt, by reference, the latest method of sale for motor vehicle fuels and lubricants adopted by the National Council on Weights and Measures and published in the National Institute of Standards and Technology Handbook 130 "Uniform Laws and Regulations in the Areas of Legal Metrology and Engine Fuel Quality," except as specifically provided by the Legislature or modified, amended, or rejected by regulations adopted by the secretary. In the absence of national standards, the secretary may adopt interim standards of method of sale until the time when the standards are adopted by the National Council on Weights and Measures and published by the National Institute of Standards and Technology.

~~SEC. 29.~~

SEC. 33. Section 13711 of the Business and Professions Code is amended to read:

13711. (a) An engine coolant or antifreeze is mislabeled if any of the following occurs:

(1) The container does not bear a label on which is printed the brand name, principal ingredient, intended application of the coolant or antifreeze, name and place of business of the manufacturer, packer, seller, or distributor, and an accurate statement of the quantity of the contents in terms of liquid measure.

(2) The container does not bear a chart on the label showing appropriate amounts of engine coolant or antifreeze and water in terms of liquid measure to be used to provide protection from freezing at temperatures to at least 30 degrees below zero Fahrenheit.

(3) The container does not bear a statement on the label showing the boiling point of a 50 percent by volume mixture of engine coolant or antifreeze and water in degrees Fahrenheit.

(4) The container is one quart or less and does not bear a label on which is printed the words “engine coolant” or “antifreeze” in letters at least ⅛ inch high on the principal display panel. The container is greater than one quart and does not bear a label on which is printed the words “engine coolant” or “antifreeze” in letters at least ¼ inch high on the principal display panel.

(5) The principal ingredient is propylene glycol or glycerin and the container does not bear a statement on the label not to use an ethylene glycol hydrometer concentration tester for propylene glycol or glycerin coolants.

(6) The container and carton do not bear a lot or batch number on the label identifying the container lot and date of packaging.

(b) A prediluted engine coolant or prediluted antifreeze is mislabeled if any of the following occurs:

(1) The container does not bear a label on which is printed the brand name, principal ingredient, intended application of the coolant or antifreeze, name and place of business of the manufacturer, packer, seller, or distributor, and an accurate statement of the quantity of the contents in terms of liquid measure.

(2) The container does not bear a statement on the label showing the protection from freezing in degrees Fahrenheit.

(3) The container does not bear a statement on the label showing the boiling point in degrees Fahrenheit.

(4) The container is one quart or less and does not bear a label on which is printed the words “prediluted engine coolant” or “prediluted antifreeze” in letters at least ⅛ inch high on the principal display panel. The container is greater than one quart and does not bear a label on which is printed the words “prediluted engine coolant” or “prediluted antifreeze” in letters at least ¼ inch high on the principal display panel.

(5) The container is one quart or less and does not bear a label on which is printed the words “DO NOT ADD WATER” in letters at least ⅛ inch high. The container is greater than one quart and does not bear a label on which is printed the words “DO NOT ADD WATER” in letters at least ¼ inch high.

(6) The principal ingredient is propylene glycol or glycerin and the container does not bear a statement on the label not to use an ethylene glycol hydrometer concentration tester for propylene glycol or glycerin coolants.

(7) The container and carton do not bear a lot or batch number on the label identifying the container lot and date of packaging.

(c) "Transmission fluid" is mislabeled if any of the following occurs:

(1) The container does not bear a label on which is printed the brand name, the name and place of business of the manufacturer, packer, seller, or distributor, the words "Transmission Fluid," and the duty type classification.

(2) The container does not bear a label on which is printed an accurate statement of the quantity of the contents in terms of liquid measure.

(3) The labeling on the container is false or misleading.

(4) The container and carton do not bear information that identifies the container lot or batch.

(d) Brake fluid is mislabeled if any of the following occurs:

(1) The container does not bear a label that conforms to the requirements of the National Highway Traffic Safety Administration, United States Department of Transportation, and upon which is printed the brand name.

(2) The container does not bear an accurate statement on the label of the quantity of the contents in terms of liquid measure.

(3) The labeling on the container is false or misleading.

(e) The secretary shall establish the method of sale of diesel exhaust fluid sold at retail to the public. In doing so, the secretary shall adopt, by reference, the latest method of sale for diesel exhaust fluid adopted by the National Council on Weights and Measures and published in the National Institute of Standards and Technology Handbook 130 "Uniform Laws and Regulations in the Areas of Legal Metrology and Engine Fuel Quality," except as specifically modified, amended, or rejected by regulation adopted by the secretary.

(f) If a container or lot of containers of any commodity subject to this chapter is found to contain a commodity not in conformity with this chapter, the sealer may take one or more samples reasonably necessary for enforcement purposes and may, in writing, order the containers off sale. Any lot or container ordered off sale pursuant to this section shall be subject to a disposal order by the enforcing officer and shall not be sold, offered for sale, or transported, except in accordance with that disposal order. Any

action pursuant to this section shall not affect any rights of a retailer under a warranty of merchantability or warranty of fitness.

~~SEC. 30.~~

SEC. 34. Section 19094 of the Business and Professions Code is amended to read:

19094. (a) For the purposes of this section, the following definitions shall apply:

(1) "Component" means the separate constituent parts of upholstered furniture sold in California, as identified in Technical Bulletin 117-2013, specifically cover fabrics, barrier materials, resilient filling materials, and decking materials.

(2) "Covered products" means any flexible polyurethane foam or upholstered or reupholstered furniture sold in California that is required to meet the test requirements set forth in Technical Bulletin 117-2013, entitled "Requirements, Test Procedure and Apparatus for Testing the Smolder Resistance of Materials Used in Upholstered Furniture."

(3) "Flame-retardant chemical" means any chemical or chemical compound for which a functional use is to resist or inhibit the spread of fire. Flame-retardant chemicals include, but are not limited to, halogenated, phosphorous-based, nitrogen-based, and nanoscale flame retardants, flame-retardant chemicals listed as "designated chemicals" pursuant to Section 105440 of the Health and Safety Code, and any chemical or chemical compound for which "flame retardant" appears on the substance Safety Data Sheet (SDS) pursuant to Section 1910.1200(g) of Title 29 of the Code of Federal Regulations.

(4) "Chemical" means either of the following:

(A) An organic or inorganic substance of a particular molecular identity, including any combination of those substances occurring, in whole or in part, as a result of a chemical reaction or occurring in nature, and any element, ion, or uncombined radical, and any degradate, metabolite, or reaction product of a substance with a particular molecular identity.

(B) A chemical ingredient, which means a substance comprising one or more substances described in subparagraph (A).

(5) "Molecular identity" means the substance's properties listed below:

(A) Agglomeration state.

(B) Bulk density.

(C) Chemical composition, including surface coating.
(D) Crystal structure.
(E) Dispersibility.
(F) Molecular structure.
(G) Particle density.
(H) Particle size, size distribution, and surface area.
(I) Physical form and shape, at room temperature and pressure.
(J) Physicochemical properties.
(K) Porosity.
(L) Solubility in water and biologically relevant fluids.
(M) Surface charge.
(N) Surface reactivity.

(6) "Added flame-retardant chemicals" means flame-retardant chemicals that are present in any covered product or component thereof at levels above 1,000 parts per million.

(7) "Department" means the Department of Toxic Substances Control.

(8) "Consumer Price Index" means the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics.

(b) (1) A manufacturer of covered products shall indicate whether or not the product contains added flame-retardant chemicals by including the following "flame-retardant chemical statement" on the label described in Section 1374.3 of Title 4 of the California Code of Regulations for covered products:

"The upholstery materials in this product:
_____contain added flame-retardant chemicals
_____contain NO added flame-retardant chemicals
The State of California has updated the flammability standard and determined that the fire safety requirements for this product can be met without adding flame-retardant chemicals. The state has identified many flame-retardant chemicals as being known to, or strongly suspected of, adversely impacting human health or development."

A manufacturer of covered products shall indicate the absence or presence of added flame-retardant chemicals by placing an "X" in one of the appropriate blanks.

(2) This statement shall be included in the label described in Section 1374.3 of Title 4 of the California Code of Regulations in accordance with the bureau's regulations for that label. The statement need not be in all capital letters, and shall follow the statement required by Section 1374.3 of Title 4 of the California Code of Regulations.

(c) (1) The bureau shall ensure compliance with the labeling requirements in this section.

(2) (A) The bureau shall provide the Department of Toxic Substances Control with a selection of samples from covered products marked "contain NO added flame-retardant chemicals" for testing for the presence of added flame-retardant chemicals. The samples shall be from the components identified in paragraph (1) of subdivision (a). The bureau shall select samples based on consultation with the department, taking into account a range of manufacturers and types of covered products. The bureau and the department shall consult on the tests to be conducted by the department. The department shall provide the results of any completed test to the bureau. The bureau shall reimburse the department for the cost of testing for the presence of added flame-retardant chemicals in covered products marked "contain NO added flame-retardant chemicals".

(B) No later than August 1 of each fiscal year, the bureau shall assess available resources and determine the number of tests to be conducted in the corresponding fiscal year, pursuant to this subparagraph.

(3) (A) If the department's testing shows that a covered product labeled as "contain NO added flame-retardant chemicals" is mislabeled because it contains added flame-retardant chemicals, the bureau may assess fines for violations against manufacturers of the covered product and component manufacturers to be held jointly and severally liable for the violation.

(B) A fine for a violation of this subparagraph relating to mislabeling shall be assessed in accordance with the factors described in subdivision (d) and the following schedule:

(i) The fine for the first violation shall be not less than one thousand dollars ($1,000) but not more than two thousand five hundred dollars ($2,500).

(ii) The fine for the second violation shall be not less than two thousand five hundred dollars ($2,500) but not more than five thousand dollars ($5,000).

(iii) The fine for the third violation shall be not less than five thousand dollars ($5,000) but not more than seven thousand five hundred dollars ($7,500).

(iv) The fine for any subsequent violation shall be not less than seven thousand five hundred dollars ($7,500) but not more than ten thousand dollars ($10,000).

(C) The fines in paragraph (B) shall replace any other fines in this article for a violation of the testing requirements of this section. This clause does not alter or amend any other penalty otherwise imposed by this article.

(D) If the department's testing shows that a covered product labeled as "contain NO added flame-retardant chemicals" is mislabeled because it contains added flame-retardant chemicals, in addition to a fine or any other request, the bureau may request that the label required by subdivision (b) for covered products that belong to the same stock keeping unit (SKU) currently produced by the manufacturer be corrected to reflect that flame-retardant chemicals are added to the covered product.

(E) If the department's testing shows that a covered product labeled as "contain NO added flame-retardant chemicals" is mislabeled because it contains added flame-retardant chemicals, in addition to a fine or any other request, the bureau may request additional testing of more products belonging to the same stock keeping unit (SKU) at the manufacturer's expense to verify the accuracy of the label required by subdivision (b) for covered products if the manufacturer wishes to retain the "contain NO added flame-retardant chemicals" designation on the label required by subdivision (b).

(d) (1) The bureau shall make information about any citation issued pursuant to this section available to the public on its internet website.

(2) In determining the amount of the fine for violations of this section, the bureau shall consider the following factors:

(A) The nature and severity of the violation.

(B) The good or bad faith of the cited person.

(C) The history of previous violations.

(D) Evidence that the violation was willful.

(E) The extent to which the cited person or entity has cooperated with the bureau.

(3) (A) The bureau shall adjust all minimum and maximum fines imposed by this section for inflation every five years.

(B) The adjustment shall be equivalent to the percentage, if any, that the Consumer Price Index at the time of adjustment exceeds the Consumer Price Index at the time this section goes into effect. Any increase determined under this paragraph shall be rounded as follows:

(i) In multiples of ten dollars ($10) in the case of penalties less than or equal to one hundred dollars ($100).

(ii) In multiples of one hundred dollars ($100) in the case of penalties greater than one hundred dollars ($100) but less than or equal to one thousand dollars ($1,000).

(iii) In multiples of one thousand dollars ($1,000) in the case of penalties greater than one thousand dollars ($1,000).

(4) It shall be the duty of the bureau to receive complaints from consumers concerning covered products sold in California.

(e) The bureau may adopt regulations pursuant to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) to carry out this section.

SEC. 35. Section 26051.5 of the Business and Professions Code is amended to read:

26051.5. (a) An applicant for a state license issued pursuant to this division to conduct commercial cannabis activity, as defined in Section 26001, shall do all of the following:

(1) Except as provided in subparagraph (G), require that each owner, as defined in paragraphs (1) to (3), inclusive, of subdivision ~~(ap)~~ *(aq)* of Section 26001, electronically submit to the Department of Justice fingerprint images and related information required by the Department of Justice for the purpose of obtaining information as to the existence and content of a record of state or federal convictions and state and federal arrests, and also information as to the existence and content of a record of state or federal convictions and arrests for which the Department of Justice establishes that the person is free on bail or on their own recognizance pending trial or appeal.

(A) Notwithstanding any other law, the department may obtain criminal history information from the Department of Justice and

the Federal Bureau of Investigation for an applicant or its owners, as defined in paragraphs (1) to (3), inclusive, of subdivision ~~(ap)~~ *(aq)* of Section 26001, for any state license, as described in Section 26050, under this division pursuant to subdivision (u) of Section 11105 of the Penal Code.

(B) When received, the Department of Justice shall transmit fingerprint images and related information received pursuant to this section to the Federal Bureau of Investigation for the purpose of obtaining a federal criminal history records check. The Department of Justice shall review the information returned from the Federal Bureau of Investigation and compile and disseminate a response to the licensing authority.

(C) The Department of Justice shall provide a response to the licensing authority pursuant to paragraph (1) of subdivision (p) of Section 11105 of the Penal Code.

(D) The department shall request from the Department of Justice subsequent notification service, as provided pursuant to Section 11105.2 of the Penal Code, for applicants.

(E) The Department of Justice shall charge the applicant a fee sufficient to cover the reasonable cost of processing the requests described in this paragraph.

(F) Notwithstanding any other law, a licensing authority may request and receive from a local or state agency certified records of all arrests and convictions, certified records regarding probation, and any and all other related documentation needed to complete an applicant or licensee investigation. A local or state agency may provide those records to a licensing authority upon request.

(G) If an owner has previously submitted fingerprint images and related information required by the Department of Justice pursuant to this paragraph in connection with a valid state license issued by a licensing authority, all of the following apply:

(i) The owner shall not be required to submit additional fingerprint images and related information pursuant to this paragraph in connection with a subsequent application for a state license.

(ii) The department shall not consider the owner’s criminal history information obtained from the fingerprint images and related information that were previously submitted pursuant to this paragraph when considering whether to issue a subsequent state license.

(iii) An owner shall not be required to resubmit owner-related information previously provided to the department.

(2) Provide evidence of the legal right to occupy and use the proposed location and provide a statement from the landowner of real property or that landowner's agent where the commercial cannabis activity will occur, as proof to demonstrate the landowner has acknowledged and consented to permit commercial cannabis activities to be conducted on the property by the tenant applicant.

(3) Provide evidence that the proposed location is in compliance with subdivision (b) of Section 26054.

(4) Provide a statement, signed by the applicant under penalty of perjury, that the information provided is complete, true, and accurate.

(5) (A) (i) For an applicant with 20 or more employees, or an applicant with 10 or more employees that submits an application on or after July 1, 2024, provide a notarized statement that the applicant will enter into, or demonstrate that it has already entered into, and will abide by the terms of a labor peace agreement. On and after July 1, 2024, the department shall not renew a license for a licensee with 10 or more employees unless the licensee provides a statement that the licensee has already entered into and will abide by the terms of a labor peace agreement.

(ii) For an applicant with 10 or more employees but less than 20 employees that has not yet entered into a labor peace agreement, provide a notarized statement as a part of its application indicating that the applicant will enter into and abide by the terms of a labor peace agreement within 60 days of employing its 20th employee, or on or before July 1, 2024, whichever is earlier.

(iii) For an applicant with less than 10 employees that has not yet entered into a labor peace agreement, provide a notarized statement as a part of its application indicating that the applicant will enter into and abide by the terms of a labor peace agreement within 60 days of employing its 10th employee, or on or before July 1, 2024, whichever is later.

(iv) Nothing in this paragraph shall be construed to limit the authority of the department to revoke or suspend a license for a violation of this paragraph.

(B) Compliance with the terms of an applicable labor peace agreement is a condition of licensure. A licensee seeking renewal

of any license shall attest to the department that it remains in compliance with the terms of any applicable labor peace agreement.

(C) Any labor organization, or any current or former employee of the relevant licensee, may report to the department that a licensee has failed to provide a truthful attestation of compliance with subparagraph (B).

(i) The reporting party shall provide documentation, in a form and manner required by the department, to substantiate their allegation before the department considers it. The department shall collaborate with such agencies as it deems relevant to evaluate the report.

(ii) If the department substantiates the validity of a report made pursuant to this subparagraph, the department may suspend, revoke, place on probation with terms and conditions, or otherwise discipline the license and fine the licensee.

(D) (i) Any labor organization, or any current or former employee of the relevant licensee, may file a complaint with the Agricultural Labor Relations Board that an organization with which a licensee has entered into a labor peace agreement is not a bona fide labor organization.

(ii) The Agricultural Labor Relations Board shall consider all relevant evidence provided or obtained in rendering a decision on whether the entity is a bona fide labor organization and issue a report with its findings no later than 90 days from receiving the complaint.

(iii) If the Agricultural Labor Relations Board determines that the entity is not a bona fide labor organization, the labor peace agreement shall be null and void. The department shall promptly notify all licensees that have signed labor peace agreements with the entity that the entity was found not to be a bona fide labor organization and offer those licensees a reasonable time period, not to exceed 180 days, to enter into a labor peace agreement with a bona fide labor organization. Failure to enter into a labor peace agreement with a bona fide labor organization after that reasonable time period shall be a violation of this section.

(E) For the purposes of this paragraph, all of the following shall apply:

(i) “Employee” does not include a supervisor.

(ii) “Labor organization” means any organization of any kind, or any agency or employee representation committee or plan, in

which employees participate and which exists, in whole or in part, for the purpose of dealing with employers concerning grievances, labor disputes, wages, rates of pay, hours of employment, or conditions of work for employees.

(iii) "Supervisor" means an individual having authority, in the interest of the applicant, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibility to direct them or to adjust their grievances, or effectively to recommend such action, if, in connection with the foregoing, the exercise of that authority is not of a merely routine or clerical nature, but requires the use of independent judgment.

(6) Provide the applicant's valid seller's permit number issued pursuant to Part 1 (commencing with Section 6001) of Division 2 of the Revenue and Taxation Code or indicate that the applicant is currently applying for a seller's permit.

(7) Provide any other information required by the department.

(8) For an applicant seeking a cultivation license, provide a statement declaring the applicant is an "agricultural employer," as defined in the Alatorre-Zenovich-Dunlap-Berman Agricultural Labor Relations Act of 1975 (Part 3.5 (commencing with Section 1140) of Division 2 of the Labor Code), to the extent not prohibited by law.

(9) Pay all applicable fees required for licensure by the department.

(10) Provide proof of a bond to cover the costs of destruction of cannabis or cannabis products if necessitated by a violation of licensing requirements.

(11) (A) Provide a statement, upon initial application and application for renewal, that the applicant employs, or will employ within one year of receiving or renewing a license, one supervisor and one employee who have successfully completed a Division of Occupational Safety and Health 30-hour general industry outreach course offered by a training provider that is authorized by an OSHA Training Institute Education Center to provide the course. This paragraph shall not be construed to alter or amend existing requirements for employers to provide occupational safety and health training to employees.

(B) An applicant with only one employee shall not be subject to subparagraph (A).

(C) For purposes of this paragraph "employee" has the same meaning as provided in ~~subparagraph (B)~~ *clause (i) of subparagraph (E)* of paragraph (5) and "supervisor" has the same meaning as provided in *clause (iii) of* subparagraph ~~(C)~~ *(E)* of paragraph (5).

(b) An applicant shall also include in the application a detailed description of the applicant's operating procedures for all of the following, as required by the department:

(1) Cultivation.

(2) Extraction and infusion methods.

(3) The transportation process.

(4) Inventory procedures.

(5) Quality control procedures.

(6) Security protocols.

(7) For applicants seeking licensure to cultivate, the source or sources of water the applicant will use for cultivation, as provided in subdivisions (a) to (c), inclusive, of Section 26060.1. For purposes of this paragraph, "cultivation" as used in Section 26060.1 shall have the same meaning as defined in Section 26001. The department shall consult with the State Water Resources Control Board and the Department of Fish and Wildlife in the implementation of this paragraph.

(c) The applicant shall also provide a complete detailed diagram of the proposed premises wherein the license privileges will be exercised, with sufficient particularity to enable ready determination of the bounds of the premises, showing all boundaries, dimensions, entrances and exits, interior partitions, walls, rooms, and common or shared entryways, and include a brief statement or description of the principal activity to be conducted therein, and, for licenses permitting cultivation, measurements of the planned canopy, including aggregate square footage and individual square footage of separate cultivation areas, if any, roads, water crossings, points of diversion, water storage, and all other facilities and infrastructure related to the cultivation.

(d) Provide a complete list of every person with a financial interest in the person applying for the license as required by the department. For purposes of this subdivision, "persons with a financial interest" does not include persons whose only interest in a licensee is an interest in a diversified mutual fund, blind trust, or similar instrument.

SEC. 36. Section 26067 of the Business and Professions Code is amended to read:

26067. (a) The department shall establish a track and trace program for reporting the movement of cannabis and cannabis products throughout the distribution chain that utilizes a unique identifier and is capable of providing information that captures, at a minimum, all of the following:

(1) The licensee from which the product originates and the licensee receiving the product.

(2) The transaction date.

(3) The unique identifier or identifiers for the cannabis or cannabis product.

(4) The date of retail sale to a customer and whether the sale is conducted on the retail premises or by delivery.

(5) Information relating to cannabis and cannabis products leaving the licensed premises in a delivery vehicle as determined by regulations adopted pursuant to subdivision (d) of Section 26068.

(b) (1) The department, in consultation with the California Department of Tax and Fee Administration, shall create an electronic ~~database~~ *system* containing the electronic shipping manifests to facilitate the administration of the track and trace program, which shall include, but not be limited to, the following information:

(A) The variety and quantity or weight of cannabis or cannabis products shipped.

(B) The estimated times of departure and arrival.

(C) The variety and quantity or weight of cannabis or cannabis products received.

(D) The actual time of departure and arrival.

(E) A categorization and the unique identifier of the cannabis or cannabis product.

(F) The license number issued by the department for all licensees involved in the shipping process, including, but not limited to, cultivators, manufacturers, distributors, and retailers.

(2) The ~~database~~ *electronic system* shall be designed to flag irregularities for the department to investigate.

(3) The department and state and local agencies may, at any time, inspect shipments and request documentation for current inventory.

(4) The California Department of Tax and Fee Administration shall have read access to the electronic ~~database~~ *system* for the purpose of taxation and regulation of cannabis and cannabis products.

(5) Information received and contained in records kept by the department for the purposes of administering this chapter are confidential and shall not be disclosed pursuant to the California Public Records Act (Division 10 (commencing with Section ~~7920.000~~ *7920.000)* of Title 1 of the Government Code), except as necessary for authorized employees of the State of California or any city, county, or city and county to perform official duties pursuant to this division or a local ordinance.

(6) Upon the request of a state or local law enforcement agency, the department shall allow access to or provide information contained within the ~~database~~ *electronic system* to assist law enforcement in their duties and responsibilities pursuant to this division.

~~SEC. 31.~~

SEC. 37. Section 44831 of the Education Code is amended to read:

44831. The governing board of a school district shall employ persons in public school service requiring certification qualifications as provided in this code, except that the governing board or a county office of education may contract with or employ an individual who holds a license issued by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board and has earned a master's degree in communication disorders to provide speech and language services if that individual meets the requirements of Section 44332.6 before employment or execution of the contract.

~~SEC. 32.~~

SEC. 38. Section 94834 of the Education Code is amended to read:

94834. "Distance education" means transmission of instruction to students at a location separate from the faculty.

~~SEC. 33.~~

SEC. 39. Section 94866 of the Education Code is amended to read:

94866. "Teach-out" means the arrangements an institution makes for its students to complete their educational programs when the institution or an educational program ceases to operate.

~~SEC. 34.~~

SEC. 40. Section 94880.1 of the Education Code is repealed.

~~SEC. 35.~~

SEC. 41. Section 94897 of the Education Code is amended to read:

94897. An institution shall not do any of the following:

(a) Use, or allow the use of, any reproduction or facsimile of the Great Seal of the State of California on a diploma.

(b) Promise or guarantee employment, or otherwise overstate the availability of jobs upon graduation.

(c) Advertise concerning job availability, degree of skill, or length of time required to learn a trade or skill unless the information is accurate and not misleading.

(d) Advertise, or indicate in promotional material, without including the fact that the educational programs are delivered by means of distance education if the educational programs are so delivered.

(e) Advertise, or indicate in promotional material, that the institution is accredited, unless the institution has been accredited by an accrediting agency.

(f) Solicit students for enrollment by causing an advertisement to be published in "help wanted" columns in a magazine, newspaper, or publication, or use "blind" advertising that fails to identify the institution.

(g) Offer to compensate a student to act as an agent of the institution with regard to the solicitation, referral, or recruitment of any person for enrollment in the institution, except that an institution may award a token gift to a student for referring an individual, provided that the gift is not in the form of money, no more than one gift is provided annually to a student, and the gift's cost is not more than one hundred dollars ($100).

(h) Pay any consideration to a person to induce that person to sign an enrollment agreement for an educational program.

(i) Use a name in any manner improperly implying any of the following:

(1) The institution is affiliated with any government agency, public or private corporation, agency, or association if it is not, in fact, thus affiliated.

(2) The institution is a public institution.

(3) The institution grants degrees, if the institution does not grant degrees.

(j) In any manner make an untrue or misleading change in, or untrue or misleading statement related to: a test score, grade or record of grades, attendance record, record indicating student completion, placement, employment, salaries, or financial information; a financial report filed with the bureau; information or records relating to the student's eligibility for student financial aid at the institution; or any other record or document required by this chapter or by the bureau.

(k) Willfully falsify, destroy, or conceal any document of record while that document of record is required to be maintained by this chapter.

(*l*) Use the terms "approval," "approved," "approval to operate," or "approved to operate" without stating clearly and conspicuously that approval to operate means compliance with state standards as set forth in this chapter. An institution may not state or imply either of the following:

(1) The institution or its educational programs are endorsed or recommended by the state or by the bureau.

(2) The approval to operate indicates that the institution exceeds minimum state standards as set forth in this chapter.

(m) Direct any individual to do any of the following:

(1) Perform an act that violates this chapter.

(2) Refrain from reporting unlawful conduct to the bureau or another government agency.

(3) Engage in any unfair act to persuade a student not to complain to the bureau or another government agency.

(n) Compensate an employee involved in recruitment, enrollment, admissions, student attendance, or sales of educational materials to students on the basis of a commission, commission draw, bonus, quota, or other similar method related to the recruitment, enrollment, admissions, student attendance, or sales of educational materials to students, except as provided in paragraph (1) or (2):

(1) If the educational program is scheduled to be completed in 90 days or less, the institution shall pay compensation related to a particular student only if that student completes the educational program.

(2) For institutions participating in the federal student financial aid programs, this subdivision shall not prevent the payment of compensation to those involved in recruitment, admissions, or the award of financial aid if those payments are in conformity with federal regulations governing an institution's participation in the federal student financial aid programs.

(o) Require a prospective student to provide personal contact information in order to obtain, from the institution's internet website, educational program information that is required to be contained in the school catalog or any information required pursuant to the consumer information requirements of Title IV of the federal Higher Education Act of 1965, and any amendments thereto.

(p) Offer an associate, baccalaureate, master's, or doctoral degree without disclosing to prospective students before enrollment whether the institution or the degree program is unaccredited and any known limitation of the degree, including, but not limited to, all of the following:

(1) Whether a graduate of the degree program will be eligible to sit for the applicable licensure exam in California and other states.

(2) A statement that reads: "A degree program that is unaccredited or a degree from an unaccredited institution is not recognized for some employment positions, including, but not limited to, positions with the State of California."

(3) That a student enrolled in an unaccredited institution is not eligible for federal financial aid programs.

(q) In any manner commit fraud against, or make a material untrue or misleading statement to, a student or prospective student under the institution's authority or the pretense or appearance of the institution's authority.

(r) Charge or collect any payment for institutional charges that are not authorized by an executed enrollment agreement.

(s) Violate Section 1788.93 of the Civil Code.

(t) Require a prospective, current, or former student or employee to sign a nondisclosure agreement pertaining to their relationship

to, or experience with, the institution, except that an institution may use a nondisclosure agreement to protect the institution's intellectual property and trade secrets. Any nondisclosure agreement in violation of this section is void and not enforceable at law or in equity.

(u) Fail to maintain policies related to compliance with this chapter or adhere to the institution's stated policies.

~~SEC. 36.~~

SEC. 42. Section 94900 of the Education Code is amended to read:

94900. (a) An institution shall maintain records of the name, address, e-mail address, and telephone number of each student who is enrolled in an educational program in that institution.

(b) An institution shall maintain, for each student granted a degree or certificate by that institution, complete and accurate permanent records of all of the following:

(1) The degree or certificate granted and the date on which that degree or certificate was granted.

(2) The courses and units on which the certificate or degree was based.

(3) The grades earned by the student in each of those courses.

~~SEC. 37.~~

SEC. 43. Section 94902 of the Education Code is amended to read:

94902. (a) A student shall enroll solely by means of executing an enrollment agreement. The enrollment agreement shall be signed by the student and by an authorized employee of the institution.

(b) An enrollment agreement is not enforceable unless all of the following requirements are met:

(1) The student has received the institution's current catalog and School Performance Fact Sheet prior to signing the enrollment agreement.

(2) At the time of the execution of the enrollment agreement, the institution held a valid approval to operate.

(3) Prior to the execution of the enrollment agreement, the student and the institution have signed and dated the information required to be disclosed in the School Performance Fact Sheet pursuant to subdivisions (a) to (d), inclusive, of Section 94910. Each of these items in the School Performance Fact Sheet shall

include a line for the student to initial and shall be initialed and dated by the student.

(c) A student shall receive a copy of the signed enrollment agreement, in writing or electronically, regardless of whether total charges are paid by the student.

~~SEC. 38.~~

SEC. 44. Section 94909 of the Education Code is amended to read:

94909. (a) Except as provided in subdivision (d), before enrollment, an institution shall provide a prospective student, either in writing or electronically, with a current school catalog containing, at a minimum, all of the following:

(1) The name, address, telephone number, and, if applicable, internet website address of the institution.

(2) Except as specified in Article 2 (commencing with Section 94802), a statement that the institution is a private institution and that it is approved to operate by the bureau.

(3) The following statements:

(A) "Any questions a student may have regarding this catalog that have not been satisfactorily answered by the institution may be directed to the Bureau for Private Postsecondary Education at (address), Sacramento, CA (ZIP Code), (internet website address), (telephone and fax numbers)."

(B) "As a prospective student, you are encouraged to review this catalog before signing an enrollment agreement. You are also encouraged to review the School Performance Fact Sheet, which must be provided to you before signing an enrollment agreement."

(C) "A student or any member of the public may file a complaint about this institution with the Bureau for Private Postsecondary Education by calling (toll-free telephone number) or by completing a complaint form, which can be obtained on the bureau's internet website (internet website address)."

(D) "The Office of Student Assistance and Relief is available to support prospective students, current students, or past students of private postsecondary educational institutions in making informed decisions, understanding their rights, and navigating available services and relief options. The office may be reached by calling (toll-free telephone number) or by visiting (internet website address)."

(4) The address or addresses where class sessions will be held.

(5) A description of the programs offered and a description of the instruction provided in each of the courses offered by the institution, the requirements for completion of each program, including required courses, any final tests or examinations, any required internships or externships, and the total number of credit hours, clock hours, or other increments required for completion.

(6) If the educational program is designed to lead to positions in a profession, occupation, trade, or career field requiring licensure in this state, a notice to that effect and a list of the requirements for eligibility for licensure.

(7) Information regarding the faculty and their qualifications.

(8) A detailed description of institutional policies in the following areas:

(A) Admissions policies, including the institution's policies regarding the acceptance of credits earned at other institutions or through challenge examinations and achievement tests, and a list describing any transfer or articulation agreements between the institution and any other college or university that provides for the transfer of credits earned in the program of instruction. If the institution has not entered into an articulation or transfer agreement with any other college or university, the institution shall disclose that fact.

(B) Cancellation, withdrawal, and refund policies, including an explanation that the student has the right to cancel the enrollment agreement and obtain a refund of charges paid through attendance at the first class session, or the seventh day after enrollment, whichever is later. The text shall also include a description of the procedures that a student is required to follow to cancel the enrollment agreement or withdraw from the institution and obtain a refund consistent with the requirements of Article 13 (commencing with Section 94919).

(C) Probation and dismissal policies.

(D) Attendance policies.

(E) Leave-of-absence policies.

(9) The schedule of total charges for a period of attendance and an estimated schedule of total charges for the entire educational program.

(10) A statement reporting whether the institution participates in federal and state financial aid programs, and if so, all consumer

information that is required to be disclosed to the student pursuant to the applicable federal and state financial aid programs.

(11) A statement specifying that, if a student obtains a loan to pay for an educational program, the student will have the responsibility to repay the full amount of the loan plus interest, less the amount of any refund, and that, if the student has received federal student financial aid funds, the student is entitled to a refund of the moneys not paid from federal student financial aid program funds.

(12) A statement specifying whether the institution has a pending petition in bankruptcy, is operating as a debtor in possession, has filed a petition within the preceding five years, or has had a petition in bankruptcy filed against it within the preceding five years that resulted in reorganization under Chapter 11 of the United States Bankruptcy Code (11 U.S.C. Sec. 1101 et seq.).

(13) If the institution provides placement services, a description of the nature and extent of the placement services.

(14) A description of the student's rights and responsibilities with respect to the Student Tuition Recovery Fund. This statement shall specify that it is a state requirement that a student who pays the student's tuition is required to pay a state-imposed assessment for the Student Tuition Recovery Fund. This statement shall also describe the purpose and operation of the Student Tuition Recovery Fund and the requirements for filing a claim against the Student Tuition Recovery Fund.

(15) The following statement:

"NOTICE CONCERNING TRANSFERABILITY OF CREDITS AND CREDENTIALS EARNED AT OUR INSTITUTION

The transferability of credits you earn at (name of institution) is at the complete discretion of an institution to which you may seek to transfer. Acceptance of the (degree, diploma, or certificate) you earn in (name of educational program) is also at the complete discretion of the institution to which you may seek to transfer. If the (credits or degree, diploma, or certificate) that you earn at this institution are not accepted at the institution to which you seek to transfer, you may be required to repeat some or all of your coursework at that institution. For this reason you should make certain that your

attendance at this institution will meet your educational goals. This may include contacting an institution to which you may seek to transfer after attending (name of institution) to determine if your (credits or degree, diploma, or certificate) will transfer."

(16) A statement specifying whether the institution, or any of its degree programs, are accredited by an accrediting agency recognized by the United States Department of Education. If the institution is unaccredited and offers an associate, baccalaureate, master's, or doctoral degree, or is accredited and offers an unaccredited program for an associate, baccalaureate, master's, or doctoral degree, the statement shall disclose the known limitations of the degree program, including, but not limited to, all of the following:

(A) Whether a graduate of the degree program will be eligible to sit for the applicable licensure exam in California and other states or become certified or registered as required for the applicable profession, occupation, trade, or career field in California.

(B) A degree program that is unaccredited or a degree from an unaccredited institution is not recognized for some employment positions, including, but not limited to, positions with the State of California.

(C) That a student enrolled in an unaccredited institution is not eligible for federal financial aid programs.

(b) If the institution has a general student brochure, the institution shall provide that brochure to the prospective student before enrollment. In addition, if the institution has a program-specific student brochure for the program in which the prospective student seeks to enroll, the institution shall provide the program-specific student brochure to the prospective student before enrollment.

(c) An institution shall provide the school catalog to any person upon request. In addition, if the institution has student brochures, the institution shall disclose the requested brochures to any interested person upon request.

(d) An accredited institution is not required to provide a School Performance Fact Sheet to a prospective student who is not a California resident, not residing in California at the time of the

student's enrollment, and enrolling in an accredited distance learning degree program offered by the institution, if the institution complies with all federal laws, the applicable laws of the state where the student is located, and other appropriate laws, including, but not limited to, consumer protection and student disclosure requirements.

~~SEC. 39.~~

SEC. 45. Section 94910 of the Education Code is amended to read:

94910. Except as provided in subdivision (d) of Section 94909 and Section 94910.5, prior to enrollment, an institution shall provide a prospective student with a current School Performance Fact Sheet containing, at a minimum, the following information, as it relates to the educational program:

(a) Completion rates, as calculated pursuant to Article 16 (commencing with Section 94928).

(b) Placement rates for each educational program, as calculated pursuant to Article 16 (commencing with Section 94928), if the educational program is designed to lead to, or the institution makes any express or implied claim related to preparing students for, a recognized career, occupation, vocation, job, or job title.

(c) License examination passage rates for programs leading to employment for which passage of a state licensing examination is required, as calculated pursuant to Article 16 (commencing with Section 94928).

(d) Salary or wage information, as calculated pursuant to Article 16 (commencing with Section 94928).

(e) If a program is too new to provide data for any of the categories listed in this subdivision, the institution shall state on its fact sheet: "This program is new. Therefore, the number of students who graduate, the number of students who are placed, or the starting salary you can earn after finishing the educational program are unknown at this time. Information regarding general salary and placement statistics may be available from government sources or from the institution, but is not equivalent to actual performance data."

(f) All of the following:

(1) A description of the manner in which the figures described in subdivisions (a) to (d), inclusive, are calculated or a statement informing the reader of where they may obtain a description of

the manner in which the figures described in subdivisions (a) to (d), inclusive, are calculated.

(2) A statement informing the reader of where they may obtain from the institution a list of the employment positions determined to be within the field for which a student received education and training for the calculation of job placement rates as required by subdivision (b).

(3) A statement informing the reader of where they may obtain from the institution a list of the objective sources of information used to substantiate the salary disclosure as required by subdivision (d).

(g) The following statements:

(1) "This fact sheet is filed with the Bureau for Private Postsecondary Education. Regardless of any information you may have relating to completion rates, placement rates, starting salaries, or license exam passage rates, this fact sheet contains the information as calculated pursuant to state law."

(2) "Any questions a student may have regarding this fact sheet that have not been satisfactorily answered by the institution may be directed to the Bureau for Private Postsecondary Education at (address), Sacramento, CA (ZIP Code), (internet website), (telephone and fax numbers)."

(h) If the institution participates in federal financial aid programs, the most recent three-year cohort default rate reported by the United States Department of Education for the institution and the percentage of enrolled students receiving federal student loans.

(i) Data and information disclosed pursuant to subdivisions (a) to (d), inclusive, is not required to include students who satisfy the qualifications specified in subdivision (d) of Section 94909, but an institution shall disclose whether the data, information, or both provided in its fact sheet excludes students pursuant to this subdivision. An institution shall not actively use data specific to the fact sheet in its recruitment materials or other recruitment efforts of students who are not California residents and do not reside in California at the time of their enrollment.

~~SEC. 40.~~

SEC. 46. Section 94929.9 of the Education Code is repealed.

~~SEC. 41.~~

SEC. 47. Section 94949 of the Education Code is repealed.

~~SEC. 42.~~

SEC. 48. Section 14132.55 of the Welfare and Institutions Code is amended to read:

14132.55. For the purposes of reimbursement under the Medi-Cal program, a speech pathologist or audiologist shall be licensed by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board or similarly licensed by a comparable agency in the state in which they practice. Licensed speech-language pathologists or licensed audiologists are authorized to utilize and shall be reimbursed for the services of those personnel in the process of completing requirements under the provisions of subdivision (c) of Section 2532.2 of the Business and Professions Code.

O

SENATE JUDICIARY COMMITTEE
Senator Thomas Umberg, Chair
2025-2026 Regular Session

SB 861 (Committee on Business, Professions and Economic Development)
Version: March 13, 2025
Hearing Date: April 29, 2025
Fiscal: Yes
Urgency: No
AM

SUBJECT

Consumer affairs

DIGEST

This bill makes various noncontroversial changes to existing law, and clarifies that if a licensed private investigator turns over a signed client agreement and investigative findings to the Bureau of Security and Investigative Services, protections under the lawyer-client privilege or attorney work product doctrine are not violated, waived, or extinguished.

EXECUTIVE SUMMARY

This bill is the annual Senate Business, Professions, and Economic Development Committee bill that makes various technical, clarifying, and noncontroversial changes to existing law. There is only one provision of this bill in this Committee's jurisdiction and this analysis will focus solely on that piece. This bill clarifies that if a licensed private investigator turns over a signed client agreement and investigative findings to the Bureau of Security and Investigative Services, protections under the lawyer-client privilege or attorney work product doctrine are not violated, waived, or extinguished. The provisions of the bill that are in this Committee's jurisdiction are supported by the California Lawyers Association. No timely opposition was received by the Committee. The bill passed the Senate Business, Professions, and Economic Development Committee on a vote of 11 to 0.

PROPOSED CHANGES TO THE LAW

Existing law:

1) Provides that no person has a privilege to refuse to be a witness; to refuse to disclose any matter or to refuse to produce any writing, object, or other thing, or

prevent another person from the same, unless otherwise provided by statute. (Evid. Code § 911.)

2) Governs the admissibility of evidence in court proceedings and generally provides a privilege to refuse to testify or otherwise disclose confidential communications made in the course of certain relationships. (Evid. Code §§ 954, 966, 980, 994, 1014, 1033, 1034, 1035.8, 1037.5, 1038.)

3) Establishes the lawyer-client privilege, where a client, whether or not a party, has a privilege to refuse to disclose, and to prevent another from disclosing, a confidential communication between the client and a lawyer if the privilege is claimed by the holder of the privilege; a person who is authorized to claim the privilege by the holder of the privilege; or the person who was the lawyer except where no holder exists or the holder instructs otherwise. (Evid. Code § 954.)
    a) The client is the holder of the privilege, as specified. (Evid. Code § 953.)

4) Defines a "confidential communication between client and lawyer" to mean information transmitted between a client and their lawyer in the course of that relationship and in confidence by a means which, so far as the client is aware, discloses the information to no third persons other than those who are present to further the interest of the client in the consultation or those to whom disclosure is reasonably necessary for the transmission of the information or the accomplishment of the purpose for which the lawyer is consulted, and includes a legal opinion formed and the advice given by the lawyer in the course of that relationship. (Evid. Code § 952.)

5) Provides that the right of a person to claim specified privileges is waived with respect to a protected communication if the holder of the privilege has disclosed a significant part of that communication or consented to disclosure, without coercion. Existing law provides that a disclosure does not constitute a waiver where it was reasonably necessary to accomplish the purposes for which the lawyer was consulted. (Evid. Code § 912(a), (d).)

6) Establishes the attorney work product doctrine by providing that a writing that reflects an attorney's impressions, conclusions, opinions, or legal research or theories is not discoverable under any circumstances.
    a) Work product of an attorney, other than a writing described in 2), above, is not discoverable unless the court determines that denial of discovery will unfairly prejudice the party seeking discovery in preparing that party's claim or defense or will result in an injustice. (Code of Civ. Proc. § 2018.030.)

7) Provides that it is the duty of an attorney to maintain inviolate the confidence, and at every peril to themselves to preserve the secrets, of their client. (Bus. & Prof. Code § 6068(e)(1).)

8) Establishes the Private Investigator Act (Act) to license and regulate private investigators in this state by the Bureau of Security and Investigative Services (Bureau). (Bus. & Prof. Code §§ 7212 et seq.)
   a) Requires every agreement to provide a service under the Act to be in writing. (Bus. & Prof. Code § 7524(a)
   b) Requires the licensee to maintain a legible copy of the signed agreement and investigative findings, including any written report, for a minimum of two years. (*Id*. at subd. (e).)
   c) Requires these records to be made available for inspection by the Bureau upon demand. (*Ibid*.)

This bill specifies that making a signed agreement and investigative findings available for inspection by the Bureau does not violate, waive, or extinguish the lawyer-client privilege, the attorney work product doctrine, the duty to maintain the confidence and preserve the secrets of an attorney's client, or the protections of any other rule or law related to attorney work product or the attorney-client privilege.

COMMENTS

1. Stated need for the bill

The author writes:

> This bill is the annual 'committee bill' authored by the Business, Professions, and Economic Development Committee, which is intended to consolidate a number of non-controversial provisions related to various regulatory programs and professions governed by the BPC. Consolidating the provisions in one bill aims to relieve the various licensing boards, bureaus, professions, and other regulatory agencies from the necessity and burden of having separate measures for a number of non-controversial revisions. Many of the provisions of this bill are minor, technical, and updating changes.

2. Lawyer-client relationship

Privileges are policy exclusions, unrelated to the reliability of the information involved, which are granted because it is considered more important to keep that information confidential than it is to require disclosure of all the information relevant to the issues in a pending proceeding. The lawyer-client privilege provides that a client has the privilege to refuse to disclose, and to prevent another from disclosing, a confidential communication between the client and a lawyer. (Evid. Code § 954.) This privilege is

necessary to protect the lawyer-client relationship by ensuring confidential communications made in the course of that relationship are kept confidential. (Comments to Evid. Code § 910.) Additionally, the attorney work product doctrine provides a privilege for material created or derived from an attorney's work on behalf of a client, which provides an attorney the ability to thoroughly prepare a case. (Code of Civ. Proc. § 2018.030.) These privileges stem from the duties an attorney has to their client, including to maintain inviolate the confidence of a client and preserve the secrets of a client at every peril to themselves. (Bus. Prof. Code § 6068(e)(1).) A disclosure of information could result in a waiver of these privileges. (Evid. Code § 912.)

SB 1454 (Ashby, Ch. 484, Stats. 2024) added Section 7524 to the Business and Professions Code and required a licensed private investigator to maintain a legible copy of the signed agreement and any investigative findings, including any written report, for a minimum of two years, and required these records to be made available for inspection by the Bureau upon demand. A concern has been raised that this could lead to a third party claiming one of the privileges above has been waived if the signed agreement and investigative findings were made available to the Bureau. As the California Lawyers Association notes:

> Attorneys often hire licensed private investigators in connection with anticipated or pending litigation. The private investigator's agreement with the attorney, investigative findings, and written report prepared for the attorney are likely to contain information protected by the attorney-client privilege, attorney work product, and attorney-client confidentiality. Disclosure to the [Bureau] of these records could result in an assertion by third parties, including adverse parties in anticipated or pending litigation, that protections that would otherwise be provided are waived by disclosure to the [Bureau], thereby entitling third parties to obtain these same records directly from the private investigator or the attorney.

The language being added by this bill is the same as in Section 6091.4 of the Business and Professions Codes applicable when attorneys are required to provide the State Bar of California with certain information, records, and communications as part of a compliance review or investigative audit relating to client trust accounts.

3. Statements in support

The California Lawyers Association writes in support to this provision of the bill, stating:

> The amendment contained in Section 19 of this bill would avoid any disputes about whether a licensed private investigator's disclosure of records to the [Bureau] results in a waiver that would entitle third parties to these same records. The proposed language follows the language of Business and Professions Code Section 6091.4,

recently added to the State Bar Act by AB 3279 (Committee on Judiciary, Ch. 227, Stats. 2024) applicable when attorneys are required to provide the State Bar with certain information, records, and communications pursuant to a request made by the State Bar as part of a compliance review or investigative audit relating to client trust accounting.

SUPPORT

California Lawyers Association

OPPOSITION

None received

RELATED LEGISLATION

Pending Legislation: None known.

Prior Legislation: SB 1454 (Ashby, Ch. 484, Stats. 2024), among other things, required a licensed private investigator to maintain a legible copy of a signed agreement and any investigative findings, including any written report, for a minimum of two years, and required these records to be made available for inspection by the Bureau upon demand.

PRIOR VOTES:

Senate Business, Professions and Economic Developemnt Committee (11 Ayes, 0 Noes)

****

DHBC
Dental Hygiene
Board of California

Tuesday, May 27, 2025

Dental Hygiene Board of California

Agenda Item 5.

Discussion and Possible Action on Amendments to 16 CCR Section 1116.5: Registered Dental Hygienist in Alternative Practice; Physical Facility Registration.

MEMORANDUM

DATE	May 27, 2025
TO	Dental Hygiene Board of California
FROM	Adina A. Pineschi-Petty DDS Education, Legislative, and Regulatory Specialist
SUBJECT	**LEG REG 5: Discussion and Possible Action on Amendments to California Code of Regulations (CCR), Title 16, Section 1116.5: Registered Dental Hygienist in Alternative Practice; Physical Facility Registration.**

BACKGROUND

On January 1, 2025, California Code of Regulations (CCR), Title 16, section 1116.5 went into effect for the registration of physical facilities by Registered Dental Hygienists in Alternative Practice (RDHAPs). Subsequently, the Dental Hygiene Board of California (Board) was informed about some confusion regarding the requirements for registration of physical facilities as a stand-alone practice versus registration of physical facilities to maintain portable equipment.

In an effort to address those concerns, Board staff prepared the proposed amendments to the previously approved language and associated form incorporated by reference for 16 CCR section 1116.5 for conciseness.

At the Board's March 21-22, 2025, the Board reviewed and approved the proposed amended language and associated form incorporated by reference and directed staff to continue the rulemaking to amend the previously approved language and associated form incorporated by reference for the registration of physical facilities by RDHAPs for conciseness.

However, during the process of preparing the regulatory package, Board staff identified additional minor, yet necessary, edits to the proposed amended language and associated form incorporated by reference. Although the Board has authorized the Executive Officer to make additional technical edits, to err on the side of caution, it was recommended that these edits be brought back to the Board for review and approval.

STAFF RECOMMENDATION

Staff recommends that the Board review the proposed amended language and associated form incorporated by reference and determine whether additional information or language is required. If the language is satisfactory, direct staff to continue the rulemaking to amend the previously approved language and associated

form incorporated by reference for the registration of physical facilities by RDHAPs for conciseness.

PROPOSED MOTION LANGUAGE

Motion for the Board to approve the proposed amended language and associated form incorporated by reference for 16 CCR section 1116.5, and direct staff to submit the text to the Director of the Department of Consumer Affairs and the Business, Consumer Services, and Housing Agency for review. If the Board does not receive any comments providing objections or adverse recommendations specifically directed at the proposed action or to the procedures followed by the Board in proposing or adopting the action, the Board authorizes the Executive Officer to take all steps necessary to initiate the rulemaking process, make any technical or non-substantive changes to the package, and set the matter for hearing, if requested. If after the 45-day public comment period, no adverse comments are received, and no public hearing is requested, the Board authorizes the Executive Officer to take all steps necessary to complete the rulemaking process, and adopt the proposed regulations as described in the text notice for 16 CCR section 1116.5.

Documents Included for Reference:

1. Proposed amended regulatory language for 16 CCR Section 1116.5.

2. Proposed amended form “DHBC HAPR-01 (Amended 5/2025).”

TITLE 16. DENTAL HYGIENE BOARD OF CALIFORNIA - DEPARTMENT OF CONSUMER AFFAIRS

PROPOSED TEXT

Legend:	
Underlined	Indicates proposed regulatory language.

Amend §1116.5 in Article 4 of Title 16 of the California Code of Regulations (CCR) toread as follows:

Article 4. Licensing

§ 1116.5. Registered Dental Hygienist in Alternative Practice; Physical Facility Registration.

(a) Definitions. For the purposes of this section, unless otherwise specified, the following definitions shall apply:

(1) “Active patient” refers to a patient of record whom the registered dental hygienist in alternative practice (RDHAP) owner or provider has examined, treated, or cared for within the two (2) year period prior to discontinuation of practice, or the RDHAP owner or provider moving from or leaving the city in which services were provided to the patient.

(2) “Dental hygiene services” means the professional practices of an RDHAP as set forth in Business and Professions Code (BPC) section 1925.

(3) “Equipment” means any tool, instrument, or device used by an RDHAP to provide dental hygiene services.

(4) “Necessary parties” means emergency responders, medical/dental/dental hygiene clinics, care facility or school staff, guardians, and designated family members.

(5) “Owner” means an individual licensed to practice dental hygiene in alternative practice pursuant to BPC section 1922 in the State of California who applies for registration or has registered a physical facility or portable equipment with the Board pursuant to the registration requirements of this section.

(6) "Patient of record" refers to a patient who has had a medical and dental history completed and evaluated, had oral conditions assessed and documented, and

had a written dental hygiene care plan, as defined in California Code of Regulations (CCR), Title 16, section 1100(g), developed by the RDHAP.

(7) "Patient treatment records" shall include the patient's dental history maintained by the facility related to medical history, dental hygiene evaluation(s), dental hygiene diagnosis(es), dental hygiene procedures and treatment, response to dental hygiene treatment, documented consultations with other dental care and healthcare providers, and referrals for dental care and healthcare follow-up treatment.

(8) "Physical facility" means a fixed structure in which dental hygiene services are rendered or where portable equipment is maintained.

(9) "Portable equipment" means any tool, instrument, or device used by an RDHAP to provide dental hygiene services designed for and capable of being carried or moved from one location to another.

(10) "Protected Health Information (PHI)" means the patient's "individually identifiable health information" as defined in section 1320d of Title 42 of the United States Code. PHI includes a patient's medical history, or dental history, which is a written record of the patient's personal health history that provides information about allergies, illnesses, surgeries, immunizations, and results of physical exams and tests.

(11) "Provider" means an individual licensed to practice dental hygiene in alternative practice or dentist who provides dental hygiene treatment and/or services in a dental hygiene physical facility but who is not the owner registering the physical facilities.

(b) Application for Registration.

(1) Within 30 days after the date of the issuance of their initial license, an RDHAP shall do the following:

(A) If the RDHAP owns a physical facility or utilizes portable equipment, the RDHAP shall register the physical facility where the dental hygiene services are rendered, or where the portable equipment is maintained according to the requirements of this section. The RDHAP shall register with the Executive Officer by submitting to the Board a completed "Registered Dental Hygienists in Alternative Practice: Registration of Physical Facilities" (form DHBC HAPR-01 ~~New~~ (~~11/2022~~Amended 5/2025)), which is hereby incorporated by reference, and meet all of the applicable requirements of this section; or,

(B) If the RDHAP does not own a physical facility, the RDHAP shall notify the Executive Officer by providing a written statement, signed and dated by the RDHAP, stating that they do not own a physical facility where dental hygiene

services are rendered.

(2) An RDHAP owner who desires to have more than one place of practice shall, before opening the additional physical facility or facilities, apply to and obtain permission from the Board to have the additional place of practice as provided in this section. The RDHAP owner shall submit a completed “Registered Dental Hygienists in Alternative Practice: Registration of Physical Facilities.” (form DHBC HAPR-01 (~~New 11/2022~~Amended 5/2025)), pay an additional office permit fee of $160, and meet all of the requirements of this section before the additional facility or facilities will be registered with the Board.

(3) The Board shall inform an RDHAP owner in writing whether the registration application (DHBC HAPR-01 (~~New 11/2022~~Amended 5/2025)) is complete and accepted for filingor is deficient and what further specific information is required. An applicant for alicense who fails to complete registration application requirements within one year after being notified by the Board of deficiencies in their application, shall bedeemed to have abandoned the application and shall be required to file a new application and meet all of the requirements in effect at the time of reapplication.

(4) The Board may deny or withdraw a registration or issue a citation as provided in BPC section 1926.3 for failure to meet the requirements of this section.

(5) Upon meeting the requirements of this section, the physical facility or facilities shall be registered with the Board and the RHDAP owner shall be issued an office permit for the initial facility, and, if applicable, an additional office permit if additional facilities are registered.

(c) Minimum Operating Requirements.

(1) An RDHAP applicant or owner shall meet all of the following requirements to obtain or maintain registration of their facility or facilities as required by BPC sections 1926.3 and 1926.4 and this section:

(A) There is a written procedure that specifies the means of obtaining emergency follow-up care for patients treated at the physical facility or after use of portable equipment. The procedure shall include arrangements an RDHAP must make for treatment in by a licensed dentist or physician whose place of practice is established within the city or county in which the RDHAP owner or provider provides dental hygiene services. A copy of these written procedures shall be given to each provider at the physical facility prior to any dental hygiene services being performed on a patient.

(B) An RDHAP shall maintain a relationship with at least one licensed dentist located in California for referral, consultation, and emergency services pursuant to 16 CCR section 1117.

(C) An RDHAP shall maintain a telephone number where patients are able to contact the RDHAP owner or provider with questions, concerns, or emergency needs, and have their calls returned within four (4) calendar days. If a live person is not available to answer calls, the telephone line shall include a recorded message with information about whom to contact in case of a dental emergency after receiving dental hygiene services.

(D) The applicant or RDHAP owner shall comply with all state and local laws and ordinances regarding business licensing and operations, and shall obtain and maintain all state and local licenses and permits necessary to provide the dental hygiene services being rendered by the applicant or provider at the physical facility, including, a local or county business license, a county building permit, a fictitious name permit as provided in BPC section 1962, and/or a seller's permit if a permit is required under the Sales and Use Tax Law, Part 1 (sections 6001 through 6024) of Division 2 of the Revenue and Taxation Code.

(E) If the RDHAP owner or any provider performs radiographs, a radiographic operatory must be used that complies with California Radiation Control Regulations. (Cal. Code Regs., tit. 17, Div. 1, Ch. 5, Subchapter 4, §§30100 through 30395.)

(2) Official Place of Business and Maintenance of Records.

(A) The RDHAP owner shall maintain a physical address of record for the physical facility or facilities registered with the Board and shall notify the Board in writing of any change in that address within thirty (30) days of the change.

(B) An RDHAP owner shall include the name of the facility (including any fictitious name authorized by BPC section 1962), physical address of record and office registration number of their physical facility for all forms of advertisement, solicitation, or other presentments made to the public in connection with the rendition of dental hygiene services, including any advertisement, card, letterhead, telephone listing, Internet Web site, written solicitation or communications to a prospective patient or patients, or contract proposal.

(C) All dental hygiene patient treatment records and communications following the discharge of a patient shall be maintained by the RDHAP owner for a minimum of seven (7) years.

(3) In addition to the other minimum operating requirements of this section, each physical facility shall:

(A) Use infection control equipment and follow infection control procedures

according to the requirements of 16 CCR section 1005.

(B) Comply with HIPAA's security standards in Subpart C of Part 164, 45 C.F.R. §§164.302 through 164.318, with respect to the patient's PHI. For the purposes of thissection "HIPAA" means the Health Insurance Portability and AccountabilityAct of 1996 (42 U.S.C. §§1320d - 1320d-8) as amended by subsequent legislation and the implementation of Privacy, Security, and Enforcement Rules under 45 C.F.R. Part 160 and Subparts A, C, D, and E of Part 164.

(C) Be readily accessible to and useable by individuals with disabilities pursuant to the federal Americans with Disabilities Act of 1990 (ADA)(42 U.S.C. §§12101 through 12212), in accordance with the ADA's implementing rules under 28 C.F.R Part 36 and Subparts A-D of Part 36. For the purposes of this section,"disability" has the meaning set forth in Section 51 of the Civil Code.

(D) Have access to a sufficient water supply to meet patients' health and safety needs at all times, including hot water. Water quality shall meet guidelines set forth in the "Guidelines for Infection Control in Dental Health-Care Settings – 2003" from the Centers for Disease Control and Prevention, in addition to the "Safe Drinking Water Act." (42 U.S.C. §§300f through 300j-27.)

(E) Have toilet facilities within the dental hygiene facility available to staff and the public.

(F) Have a covered galvanized, stainless steel, or other noncorrosive metal container for deposit of refuse and waste materials.

(G) Have a working Automated External Defibrillator (AED).

(H) Have a self-contained, portable emergency oxygen unit with administration equipment (wheeled cart with oxygen cylinder, variable regulator, demand valve system, supplemental adult and child oxygen masks, hoses, and nasal cannulas) to assist with administration of basic life support.

For RDHAPs who only utilize portable equipment and do not maintain a physical facility for patient treatment, (C), (E), and (G) of this subdivision do not apply. If an RDHAP utilizing portable equipment does not administer local anesthesia or perform soft tissue curettage pursuant to 16 CCR section 1118, (H) of this subdivision does not apply.

(4) Each RDHAP owner shall notify the Board in writing within thirty (30) days of any change in operational status or ownership of all registered physical facilities.

(d) An RDHAP operator shall provide access during business hours to the RDHAP's records and facility to the Board, or its authorized representative(s), to review the

physical facility for compliance with all laws, regulations, and standards applicableto physical facilities including, but not limited to, the BPC, CCR, CDC, and HIPAA.

(e) Transferability. A physical facility registration is not transferable.

(f) Renewal of Physical Facility Registration. The physical facility registration shall expire at the same time as the permit holder's RDHAP license.

(1) To renew the registration of a physical facility, an RDHAP shall submit:

(A) Form DHBC HAPR-01 (~~New 11/2022~~Amended 5/2025) for each physical facility;

(B) A biennial renewal fee in the amount of $250 for each additional physical facility if the RDHAP has more than one registered with the Board; and

(C) All supporting documentation required by form DHBC HARP-01 (~~New 11/2022~~Amended 5/2025).

(2) Renewal of each physical facility registration shall be accomplished by submission of form DHBC HARP-01 (~~New 11/2022~~Amended 5/2025), fees, and documentationrequired in subdivision (e)(1) by either:

(A) Electronic submission through a web link to the Department of Consumer Affairs' online licensing system entitled "BreEZe" that is located on the Board's website at: https://www.dhbc.ca.gov/ using the "BREEZE" tab or the "BreEZe Online System" portal at https://www.breeze.ca.gov/datamart/loginCADCA.do; or

(i) The owner and operator shall first register for a user account by creating a username and password.

(ii) The owner and operator shall provide all required documentation referenced in subdivision (e)(1) through the link referenced in subdivision (e)(2)(A) of this section. With respect to the application, the owner and operator may submit form DBHC HAPR-01 (~~New 11/2022~~Amended 5/2025) through BreEZe or electronically submit the same information that is requested by that form directly through BreEZe.

(iii) Electronic Signature: When a signature is required by the particular instructions of any filing to be made through the online portal, including any attestation under penalty of perjury, the owner shall affix their electronic signature to the filing by typing their name in the appropriate field and submitting the filing via the Board's online portal. Submission of a filing in this manner shall constitute evidence of legal signature by any individual whose name is typed on the filing.

(B) Submission of all required documentation referenced in (e)(1) by mail to the Board's physical address.

(g) Identification of Personnel, Notification of Changes in Written Procedures, and Display of Licenses.

(1) The RDHAP owner shall advise the Board in writing within thirty (30) days of any change to any of the information provided in application form DHBC HAPR-01 (~~New 11/2022~~Amended 5/2025), whether for initial or renewal.

(2) Each RDHAP, or any other provider licensed by the Board to provide dental hygiene services in the physical facility, shall prominently display evidence of their California RDHAP or other Board license in a conspicuous location accessible to public view on the premises where the RDHAP or other Board licensee provides the licensed services of patients pursuant to BPC section 680.

(3) A licensed RDHAP engaged in the practice of dental hygiene shall provide notice to each patient of the fact that the RDHAP is licensed and regulated by the Board.

(A) The notice shall include the following statement and information:

NOTICE:
Dental Hygienists in Alternative Practice are licensed and regulated
by the Dental Hygiene Board of California
(916) 263-1978
www.dhbc.ca.gov

(B) The notice required by this section shall be provided by prominently posting the notice in a conspicuous location accessible to public view on the premises where the RDHAP provides the licensed services, and the notice shall be in at least 48-point type font.

(h) Cessation of Operation.

(1) Upon cessation of operation of a physical facility, the owner shall notify the Board in writing within thirty (30) days after the last day of operation and inform the Board of the final disposition of patient treatment records, including the physical mailing address or location where the treatment records are maintained and the name, telephone number and address for the custodian of records or other person whom the owner designates as responsible for maintaining those records.

(2) If a physical facility is sold to another RDHAP, that RDHAP ("succeeding RDHAP provider") must register with the Board by filing a new form DHBC HAPR-01

(~~New 11/2022~~Amended 5/2025) and comply with this section.

(3) Upon cessation of operation of a physical facility, the previous RDHAP owner of the physical facility shall preserve all records for a minimum of seven (7) years.

(4) Within thirty (30) days before the last day of operation, the RDHAP owner shall provide written notice via first class mail to all active patients of record of the date of closure or cessation of the physical facility, including the last date the physical facility will remain open, and the name, telephone number and address of an individual the patient may contact to request transfer of copies of their patient treatment records to a succeeding provider or to the patient. The RDHAP owner shall maintain proof the notice was provided to all active patients in accordance with this section and upon request to the Board in accordance with BPC section 1955. Within fifteen (15) days of receipt of a written request by the patient, the RDHAP owner shall also provide for the transfer of copies of the patient's treatment records, including radiographs, to the succeeding provider or to the patient as specified by the patient. In addition, the RDHAP shall provide written acknowledgement of receipt of the patient's request to the patient within five (5) business days of receipt of the request, and also notify the patient of the method and date of expected delivery of the patient's treatment records.

(5) "Proof the notice was provided" shall mean proof of service of any notice required by this section to patients by mail by completion of a document showing the document's name and the person served, the person making service, and the date and manner of service (e.g., by first class mail, regular mail, or in person). Proof of service shall be in writing, but need not be signed, under oath, or in any particular format.

Note: Authority cited: Sections 1905, 1906, 1926.3, 1926.4 and 1944, Business and Professions Code. Reference: Sections 125.6, 137, 138, 142, 680, 1922, 1925, 1926.01, 1926.3,1926.4, 1955 and 1962 Business and Professions Code.

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS
DENTAL HYGIENE BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1350 Sacramento, CA 95815
P (916) 263-1978 | F (916) 623-4093 | www.dhbc.ca.gov

PHYSICAL FACILITY REGISTRATION/RENEWAL FOR REGISTERED DENTAL HYGIENISTS IN ALTERNATIVE PRACTICE (RDHAPs)

Business & Professions Code (BPC) sections 1905, 1906, 1926.3,1926.4, and 1944, and California Code of Regulations (CCR) Title 16, Division 11 section 1116.5.

NOTE: ALL questions on this registration/renewal application must be answered, and all information requested in this registration/renewal must be supplied by the applicant. If something does not apply to you, please check the "N/A" box. Failure to do so may cause a delay in processing your registration/renewal. Please type or print neatly; illegible registrations will be returned.

APPLICATION FEES

ALL FEES ARE NON-REFUNDABLE AND MUST ACCOMPANY APPLICATION

NO FEE FOR PRIMARY PHYSICAL FACILITY OR PORTABLE EQUIPMENT REGISTRATION

REGISTRATION FEE FOR EACH ADDITIONAL PHYSICAL FACILITY: $160
BIENNIAL RENEWAL FEE FOR EACH ADDITIONAL PHYSICAL FACILITY: $250

Payment must be made by personal check, cashier's check, business check, or money order and must be made payable to "DHBC".

RDHAP INFORMATION

*Note: The registration information provided in questions 1 and 2 will be used to establish the expiration date of the registration and will be the point-of-contact for this application.

1a. Last Name	1b. First Name	1c. Middle Name
2a. RDHAP License Number	2b. RDH License Number	2c. Social Security Number/Individual Taxpayer Number:
3a. Registered Fictitious Name: ☐ N/A		3b. Fictitious Name Permit Number: ☐ N/A

4. Type of Registration (check all that apply):

☐ New Registration ☐ Renewal - Facility #

☐ Portable Equipment ☐ Primary Office Facility ☐ Additional Office Facility

ADDRESS OF RECORD/MAILING ADDRESS FOR RDHAP* (REQUIRED)

*The address of record will be posted on the internet and be disclosed to the public upon request (see BPC 1902.2 and Government Code section 7922.530(a)).
The Board shall be notified within thirty (30) days of any change in the RDHAP owner's address of record.

5. Number and Street (including apartment number, if applicable):		
City	State	Zip Code
6. Email Address	7. RDHAP Contact Number	

ADDRESS OF PHYSICAL FACILITY* (REQUIRED)

*The RDHAP owner shall maintain a physical address of record for the physical facility or facilities registered with the Board and shall notify the Board in writing of any change in that address within thirty (30) days of the change. A physical facility is defined in 16 CCR section 1116.5 as a fixed structure in which dental hygiene services are rendered or where portable equipment is maintained.

8. Number and Street (including suite number, if applicable)		
City	State	Zip Code
9. Physical Facility's Email Address	10. Physical Facility's Contact Number	

~~PHYSICAL FACILITY~~RDHAP OWNER REQUIREMENTS

11. Does the ~~physical facility's~~RDHAP owner have a written procedure** that specifies the means of obtaining emergency follow-up care for patients treated at the physical facility or during use of portable equipment as required by 16 CCR section ~~1116~~1116.5? ***Provide a copy **(labeled as Exhibit 1)** if initial registration or written procedure has changed from initial registration. If no changes have been made check this box: ☐ N/A **The procedure shall include arrangements for treatment in a dental facility which is established within the city or county in which the RDHAP owner or provider provides dental hygiene services.	☐ YES*	☐ NO

~~PHYSICAL FACILITY~~RDHAP OWNER REQUIREMENTS		
12. Does the ~~physical facility's~~RDHAP owner have a relationship with at least one licensed dentist located in California for referral, consultation, and emergency services pursuant to 16 CCR section 1117? *If yes, provide a copy **(labeled as Exhibit 2)** of your completed "Documentation of Registered Dental Hygienist in Alternative Practice (RDHAP) Relationship with Dentist" (form RDHAP-01 (07-2021) with this application as set forth in 16 CCR section 1117. For renewals, attach a copy if this information has changed from initial registration. If no changes have been made check this box: ☐ N/A	☐ YES*	☐ NO
13. Is there a telephone number where patients are able to contact the ~~physical facility's~~RDHAP owner or provider with questions, concerns, or emergency needs, and have their calls returned within four (4) calendar days?	☐ YES	☐ NO
14. If a live person is not available to answer calls, does the telephone line include a recorded message with information about whom to contact in case of a dental emergency after receiving dental hygiene services?	☐ YES	☐ NO
15. Will the RDHAP owner comply with all state and local laws and ordinances regarding business licensing and operations?	☐ YES	☐ NO
16. Will the ~~physical facility~~RDHAP owner obtain and maintain all state and local licenses and permits necessary to provide the dental hygiene services being rendered by the applicant or provider at the physical facility including a local or county business license, a fictitious name permit as provided in BPC section 1962 if applicable, and/or a seller's permit if a permit is required under the Sales and Use Tax Law, Part 1 (sections 6001 through 6024) of Division 2 of the Revenue and Taxation Code? *A copy of each current license and permit shall be submitted with the application to include a local or county business license, a county building permit, a fictitious name permit as provided in Section 1962 of the BPC, and/or a seller's permit if a permit is required under the Sales and Use Tax Law, Part 1 (sections 6001 through 6024) of Division 2 of the Revenue and Taxation Code. **Provide copies and label as Exhibit 3.**	☐ YES*	☐ NO
17. Does the physical facility's radiographic operatory comply with California Radiation Control Regulations (Cal. Code Regs., tit. 17, Div. 1, Ch.5, Subchapter 4, §§30100 through 30395)? *Not applicable to Portable Equipment Registration. If registering portable equipment check this box: ☐ N/A	☐ YES	☐ NO

~~PHYSICAL FACILITY~~RDHAP OWNER REQUIREMENTS		
18. The RDHAP owner acknowledges receiving notice that the physical facility must maintain all dental hygiene patient treatment records and communications relating to the care and treatment of the patient following the discharge of a patient a minimum of seven years (see 16 CCR section 1116.5 for the minimum physical facility operating standards).	☐YES	☐NO
19. ~~Does~~Will the ~~physical facility's~~RDHAP owner use infection control equipment and follow infection control procedures according to the requirements of 16 CCR section 1005?	☐YES	☐NO
20. ~~Does~~Will the ~~physical facility~~RDHAP owner comply with HIPAA's security standards in Subpart C of Part 164, 45 C.F.R. §§164.302 through 164.31, with respect to the patient's "Protected Health Information (PHI)"? For the purposes of this question, PHI, as defined in section 1320d of Title 42 of the United States Code, includes a patient's medical history, or dental history, which is a written record of the patient's personal health history that provides information about allergies, illnesses, surgeries, immunizations, and results of physical exams and tests.	☐YES	☐NO
21. Is the physical facility readily accessible to and usable by individuals with disabilities pursuant to the federal Americans with Disabilities Act of 1990 (ADA)(42 U.S.C. §§12101 through 12212), in accordance with the ADA's implementing rules under 28 C.F.R Part 36 and Subparts A-D of Part 36? *Not applicable to Portable Equipment Registration. If registering portable equipment check this box: ☐ N/A	☐YES	☐NO
22. Does the physical facility have access to a sufficient water supply to meet patients' health and safety needs at all times, including hot water? *Water quality shall meet guidelines set forth in the "Guidelines for Infection Control in Dental Health-Care Settings – 2003" from the Centers for Disease Control and Prevention, in addition to the "Safe Drinking Water Act." (42 U.S.C. §§300f through 300j-27.)?	☐YES	☐NO
23. Does the physical facility have toilet facilities within the dental hygiene facility available to staff and the public? *Not applicable to Portable Equipment Registration. If registering portable equipment check this box: ☐ N/A	☐YES	☐NO
24. Does the physical facility have a covered galvanized, stainless steel, or other noncorrosive metal container for deposit of refuse and waste materials?	☐YES	☐NO
25. Does the physical facility have a working Automated External Defibrillator (AED)? *Not applicable to Portable Equipment Registration. If registering portable equipment check this box: ☐ N/A	☐YES	☐NO

~~PHYSICAL FACILITY~~RDHAP OWNER REQUIREMENTS		
26. Does the physical facility have a self-contained, portable emergency oxygen unit with administration equipment (wheeled cart with oxygen cylinder, variable regulator, demand valve system, supplemental adult and child oxygen masks, hoses, and nasal cannulas) to assist with administration of basic life support? If registering portable equipment and the RDHAP does not administer local anesthesia or perform soft tissue curettage, check this box: ☐ N/A *Not applicable to Portable Equipment Registration if the RDHAP does not administer local anesthesia or perform soft tissue curettage pursuant to 16 CCR section 1118.	☐ YES	☐ NO*

ACKNOWLEDGEMENT		
27. Have you reviewed BPC sections 1926.3, 1926.4, and 1944, and 16 CCR sections 1116.5~~, and~~ 1117, and 1118? Please be advised that failure to comply with these provisions is grounds for denial or revocation of the registration.	☐ YES	☐ NO

REGISTRATION CERTIFICATION

I hereby certify under penalty of perjury under the laws of the State of California that all licensed persons practicing at the location designated in the registration hold valid licenses and no charges of unprofessional conduct are pending against any person practicing at that location [BPC section 1962(b)(4)].

I hereby certify under penalty of perjury under the laws of the State of California that I have read the questions in the foregoing registration and that all information, statements, attachments, and representations provided by me in this registration are true and correct. By submitting the registration and signing below, I am granting permission to the Board or its assignees and agents to verify the information provided and to perform any investigation pertaining to the information I have provided as the Board deems necessary.

NOTICE: FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS REGISTRATION OR ANY ATTACHMENT HERETO IS GROUNDS FOR DENYING OR REVOKING THE REGISTRATION.

REGISTRANT SIGNATURE: _____ **DATE:** _____

PRINTED NAME: _____

NOTICES

The Dental Hygiene Board of California of the Department of Consumer Affairs collects the personal information requested on this form as authorized by Business and Professions Code Sections 1905, 1926.3, and 1926.4, and California Code of Regulations, Title 16, Section 1116.5. The Dental Hygiene Board of California uses this information principally to identify and evaluate applicants for registration and to

enforce licensing standards set by law and regulation.

MANDATORY SUBMISSION:
Submission of the requested information is mandatory. The Dental Hygiene Board of California cannot consider your registration unless you provide all the requested information.

ACCESS TO PERSONAL INFORMATION:
You may review the records maintained by the Dental Hygiene Board of California that contain your personal information, as permitted by the Information Practices Act. See below for contact information.

POSSIBLE DISCLOSURE OF PERSONAL INFORMATION:
We make every effort to protect the personal information you provide us. The information you provide, however, may be disclosed in the following circumstances:

- In response to a Public Records Act request (Government Code Sections 7920.000 through 7931.000), as allowed by the Information Practices Act (Civil Code Sections 1798 through 1798.78);
- To another government agency as required by state or federal law; or
- In response to a court or administrative order, a subpoena, or a search warrant.

MANDATORY DISCLOSURE OF SOCIAL SECURITY NUMBERS:
Disclosure of your Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN) is mandatory. Sections 30 and 31 of the Business and Professions Code authorize collection of your SSN or ITIN, which will be used exclusively for tax enforcement purposes, for investigation of tax evasion andviolations of cash-pay reporting laws as set forth in Section 329 of the Unemployment Insurance Code, for purposes of compliance with any judgement or order for family support in accordance with Section 17520 of the Family Code, for measurement of employment outcomes of students who participate in career technical education programs offered by the California Community Colleges, or for verification of license or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your SSN or ITIN, your application for initial licensure will not be processed AND you may be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

STATE TAX OBLIGATION NOTICE:
The California State Board of Equalization (BOE) and the California Franchise Tax Board (FTB) may share taxpayer information with the Board. You are required to pay your state tax obligation and your license may be suspended, or your renewal application denied if the state tax obligation is not paid, andyour name appears on either the BOE or FTB certified list of top 500 tax delinquencies (Sections 31 and494.5 of the California Business and Professions Code).

CONTACT INFORMATION:
For questions about this notice or access to your records, you may contact:Dental Hygiene Board of California
2005 Evergreen Street, Suite 1350Sacramento, CA 95815
(916) 263-1978

INTERNAL OFFICE USE ONLY			
Date Received:	**Receipt #:** ☐ **Initial** ☐ **Renewal**		**$ Amount:**
File #:	**Registration #:**		**RDHAP Lic. Exp. Date:**
Date Issued:	**Analyst:**		

DHBC
Dental Hygiene
Board of California

Tuesday, May 27, 2025

Dental Hygiene Board of California

Agenda Item 6.

Future Agenda Items.

DHBC
Dental Hygiene
Board of California

Tuesday, May 27, 2025

Dental Hygiene Board of California

Agenda Item 7.

Adjournment.