



PHYSICIAN ASSISTANT BOARD

2005 Evergreen Street, Suite 1100, Sacramento, CA 95815
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MEETING NOTICE

November 2, 2015

PHYSICIAN ASSISTANT BOARD

**2005 Evergreen Street – Hearing Room #1150
Sacramento, CA 95815
8:00 A.M. – 5:00 P.M.**

AGENDA

(Please see below for Webcast information)

EXCEPT "TIME CERTAIN"* ITEMS, ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

1. Call to Order by President (Sachs)
2. Roll Call (Winslow)
3. Approval of August 3, 2015 Meeting Minutes (Sachs)
4. Public Comment on items not on the Agenda (Sachs) (Note: The Board may not discuss or take action on any matter raised during this public comment section that is not included on this agenda, except to decide whether to place the matter on the agenda for a future meeting. [Government Code Sections 11125, 11125.7(a).])
5. Reports
 - a. President's Report (Sachs)
 1. California Academy of Physician Assistants (CAPA) Annual Conference: Update
 - b. Executive Officer's Report (Mitchell)
 1. BreEZe Implementation: Update
 2. Controlled Substance Utilization Review and Evaluation System (CURES): Update
 - c. Licensing Program Activity Report (Winslow)
 - d. Diversion Program Activity Report (Mitchell)
 - e. Enforcement Program Activity Report (Forsyth)
6. Department of Consumer Affairs
 - a. Director's Update (Christine Lally)
7. Nomination and Election of Physician Assistant Board Officers (Mitchell)
8. Approval of Passing Score for 2016 PA Initial Licensing Examination and 2016 Dates and Locations for PA Initial Licensing Examination (Sachs/Winslow)
9. Schedule of 2016 Board Meeting Dates and Locations (Sachs)
10. Regulations
 - a. Proposed Amendments to Title 16, California Code of Regulations, Section 1399.523 – Disciplinary Guidelines: Update (Mitchell)
 - b. Proposed Amendments to Title 16, California Code of Regulations, Section 1399.546 – Reporting of Physician Assistant Supervision: Related to the implementation of SB 337 (Schieldge)
11. **CLOSED SESSION:**
 - a. Pursuant to Section 11126(c)(3) of the Government Code, the Board will move into closed session to deliberate on disciplinary matters

- b. Pursuant to Section 11126(a)(1) of the Government Code, the Board will move into closed session to conduct the annual evaluation of performance of the Executive Officer

RETURN TO OPEN SESSION

12. Lunch break will be taken at some point during the day's meeting.
13. The Education/Workforce Development Advisory Committee: Update (Grant/Alexander)
 - a. ARC-PA Accreditation
 - b. Responses from Commission on Accreditation of Allied Health Education Programs (CAAHEP) and Council for Higher Educational Accreditation (CHEA)
14. 2015/16 Physician Assistant Board's Sunset Review Process and Report to the Legislature (Sachs/Mitchell)
15. Presentation and Discussion Regarding February 2015 United States Supreme Court decision: North Carolina State Board of Dental Examiners v. Federal Trade Commission (FTC) (Grant/Schildge)
 - a. California Attorney General's Opinion
 - b. FTC Staff Guidance
16. Medical Board of California Activities (Bishop)
17. Budget Update
 - a. Budget Update (Forsyth)
 - b. Discussion Regarding Pro-rata Costs to DCA Boards and Survey by DCA (Martinez)
18. The Legislative Committee (Hazelton/Earley)
 - a. Legislation of Interest to the Physician Assistant Board: AB 85, AB 611, AB 637, AB 728, AB 1351, AB 1352, SB 323, SB 337, SB 464, SB 800 and other bills impacting the Board identified by staff after publication of the agenda.
 - b. AB 12: Update, staff impact if passed.
19. Agenda Items for Next Meeting (Sachs)
20. Adjournment (Sachs)

Note: Agenda discussion and report items are subject to action being taken on them during the meeting by the Board at its discretion. Action may be taken on any item on the agenda. All times when stated are approximate and subject to change without prior notice at the discretion of the Board unless listed as "time certain". The meeting may be canceled without notice. For meeting verification, call (916) 561-8780 or access the Board's website at <http://www.pac.ca.gov>. Public comments will be taken on agenda items at the time the item is heard and prior to the Board taking any action on said items. Agenda items may be taken out of order and total time allocated for public comment on particular issues may be limited at the discretion of the Chair.

While the Board intends to webcast this meeting, it may not be possible to webcast the meeting due to limitations on resources. The webcast can be located at www.dca.ca.gov. If you would like to ensure participation, please plan to attend at the physical location.

Notice: The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Anita Winslow at (916) 561-8782 or email Anita.Winslow@mbc.ca.gov send a written request to the Physician Assistant Board, 2005 Evergreen Street, Suite 1100, Sacramento, California 95815. Providing your request at least five (5) business days before the meeting will help to ensure availability of the request.

Agenda

Item

3

MEETING MINUTES

August 3, 2015

PHYSICIAN ASSISTANT BOARD
2005 Evergreen Street – Hearing Room #1150
Sacramento, CA 95815
9:00 A.M. – 5:00 P.M.

1. Call to Order by President

President Sachs called the meeting to order at 9:05 a.m.

2. Roll Call

Staff called the roll. A quorum was present.

Board Members Present:

Robert Sachs, PA-C
Charles Alexander, Ph.D.
Michael Bishop, M.D.
Jed Grant, PA-C
Sonya Earley, PA-C
Xavier Martinez
Catherine Hazelton
Cristina Gomez-Vidal Diaz

Staff Present:

Glenn L. Mitchell, Jr., Executive Officer
Kristy Schieldge, Senior Staff Counsel,
Department of Consumer Affairs (DCA)
Lynn Forsyth, Enforcement Analyst
Anita Winslow, Administration Analyst

3. Approval of May 4, 2015 Meeting Minutes

Jed Grant requested amendments to agenda item 12 – The Education/Workforce Development Advisory Committee, to specify that ARC-PA is an independent organization. However, the Council for Higher Education Accreditation (CHEA) has oversight responsibility for ARC-PA. He also noted that the motion should have stated that the Board staff was to write to CHEA not CAAHEP.

M/ Jed Grant S/ Sonya Earley C/ to:

Approve the May 4, 2015 meeting minutes as amended.

Member	Yes	No	Abstain	Absent	Recusal
Charles Alexander	X				
Michael Bishop	X				
Cristina Gomez-Vidal Diaz	X				
Sonya Earley	X				
Jed Grant	X				
Catherine Hazelton	X				
Xavier Martinez	X				
Robert Sachs	X				

Motion approved.

4. Approval of July 13, 2015 Teleconference Meeting Minutes

Kristy Schieldge requested an amendment to page 3 to correct a spelling error, specifically to correct the word "counsel's."

M/ Jed Grant S/ Sonya Earley C/ to:

Approve the July 13, 2015 teleconference meeting minutes as amended.

Member	Yes	No	Abstain	Absent	Recusal
Charles Alexander	X				
Michael Bishop	X				
Cristina Gomez-Vidal Diaz	X				
Sonya Earley	X				
Jed Grant	X				
Catherine Hazelton	X				
Xavier Martinez	X				
Robert Sachs	X				

Motion approved.

5. Public Comment on items not on the Agenda

There was no public comment at this time.

6. Reports

a. President's Report

- 1) Mr. Sachs notified the Board that member Rosalee Shorter, who was appointed to the Board in 2013, was relocating out-of-state and was resigning her position. He thanked her for her service and dedication to consumer protection.

Mr. Sachs also thanked Board members and staff for their efforts to curtail spending to assist in ensuring that last fiscal year's budget was not overspent.

- 2) Mr. Sachs reported that Board staff has recently been informed that the Senate Committee on Business, Professions and Economic Development and Assembly Committee on Business and Professions will begin their Sunset Oversight Review in the Fall of 2015. The Physician Assistant Board

is scheduled to be reviewed. The Board was last reviewed in 2012. It is anticipated that the hearing will take place in early 2016.

Staff will begin preparation of the report, which is due to the Legislature December 1, 2015. They will present a draft report for Board review and approval at the next Board meeting. Mr. Sachs informed the Board that this is their opportunity to create a "wish list" of what they would like for the Board. He noted that effective January 1, 2016 the Medical Board physician member will become a non-voting member. Mr. Sachs spoke of the positive relationship we have with the Medical Board and how the Board appreciates the input and guidance from the Medical Board of California Board member.

- 3) Mr. Sachs noted that the annual California Academy of Physician Assistant Conference will take place October 8-11, 2015. Mr. Sachs indicated that the Board will have exhibit space there so that physician assistant applicants and licensees will have an opportunity to meet and interact with the Board. Mr. Sachs stated that he and Mr. Grant will be attending the meeting.

Mr. Sachs briefly discussed the requirements for an approved controlled substance education course, specifically the responsibility of the course providers. Mr. Sachs stressed that the course may only be taken by licensees and not students. He also stressed that the course participants must take a proctored examination upon completing the course.

b. Executive Officer's Report

1) Update on BreEZe Implementation

Mr. Mitchell reported that the Board continues to work with the BreEZe team on implementation of BreEZe. The issues with the enforcement reports are being resolved. The reports are becoming more reflective of our actual statistics and anticipate their usefulness soon.

The BreEZe licensing program continues to function with no issues.

The Board went "live" with BreEZe online renewals on May 22, 2015. The Board's website was updated to reflect the availability of this new service. The system seems to be performing well. Staff has reported that fewer paper renewals are received in the office and last minute renewal issues are quickly resolved by directing licensees to renew online. Staff and licensees continue to receive support from the Medical Board of California's Information System Branch. Their expertise and guidance is appreciated and beneficial in helping us to understand and implement the system.

2) CURES update

Mr. Mitchell reported that the Department of Consumer Affairs and the Department of Justice agreed to a "soft launch and phased rollout" in early July 2015 and over the next few months of CURES 2.0. This will ensure a smooth transition from the current system. Initially, current users who meet the new security standards, including minimum browser specifications will transition to the CURES 2.0.

The Board's website has been updated to provide licensees with information regarding the CURES 2.0 rollout and registration requirements.

3) Implementation of Business and Professions Code Section 3518.1 – Mandated Personal Data Collection from Physician Assistants

SB 2101 (Ting) (Effective January 1, 2015) requires the:

Physician Assistant Board, Board of Registered Nursing, Board of Vocational Nursing and Psychiatric Technicians, and Respiratory Board to collect demographic data for the Office of Statewide Health Planning and Development (OSHPD).

The Board is required to collect the data biennially at the time of initial licensure and renewal obtaining the following data:

- Location of practice (including city, county, and Zip code)
- Race or ethnicity (licensees may, but are not required to report race and ethnicity)
- Gender
- Languages spoken
- Education background
- Classification of primary practice site (such as a clinic, hospital, managed care organization, or private practice)

The Board is working with legal counsel, DCA, and other boards to implement the provisions of SB 2102.

PAB staff is currently working with other DCA Boards and DCA staff on the development of the survey questions. Initially, the plan is to include a link to the electronic online survey. Our initial license letter inserted with the wall certificate and pocket ID card will be updated with a link to the survey. The renewal notice will also be updated. Staff will also update the Board's website with information and links for SB 2102. Roll out of the survey was scheduled for July 2015.

Mr. Mitchell encouraged licensees to complete the survey as the data will provide helpful and useful information to assist the state in determining health care shortages, such as the need for additional PA training programs. This data will also provide useful information to improve access to patient care. The data will also be useful to the Board with regard to its public and policy goals of consumer protection.

Mr. Mitchell also would like to encourage professional associations, such as the California Academy of Physician Assistants (CAPA), to encourage their members to complete the survey.

c. Licensing Program Activity Report

Between May 1, 2015 and July 31, 2015, 200 physician assistant licenses were issued. As of July 31, 2015, 10,293 physician assistant licenses are renewed and current.

d. Diversion Program Activity Report

As of July 1, 2015, the Board's Diversion Program has 12 participants, which includes 3 self-referral participants and 9 board-referral participants.

A total of 133 participants have participated in the program since implementation in 1990.

e. Enforcement Program Activity Report

Between May 1, 2015 and July 31, 2015, there were no accusations filed; there were no Statement of Issues filed; there were no probationary licenses issued, we issued 1 citation and there are currently 56 probationers.

7. Department of Consumer Affairs

Christine Lally, Deputy Director, Board and Bureau Relations, reported on three issues that impact the Board.

Ms. Lally reported that the Department has been working on finalizing the BreEZe enforcement reports. Reports showing details on intake and investigations are on track for an August – September release. She added that licensing data extracts can be provided to the Board by the Department either weekly or bi-weekly. In the future these extracts will be made into reports capable of being run on demand. Final maintenance, which includes fixes and enhancements for Release 1 Boards including the Physician Assistant Board, is scheduled for September. Ms. Lally indicated that BreEZe Release 2 is scheduled to launch in late December 2015.

Ms. Lally stated that the Department's legal office is working with the Business, Consumer Services and Housing Agency, the Governor's office and the Attorney General's office to determine the impact of the North Carolina Board of Dental Examiners v. Federal Trade Commission Supreme Court decision. The Department's legal office is developing training for Executive Officers, Directors, and Board Presidents to address the potential impact this decision may have on Department Boards and Bureaus. The Department's legal office is also tracking developments in similar cases filed in other states which may also have an impact in California.

Ms. Lally presented an update on the department's recent pro-rata study. SB 1243 was enacted into law in January 2015 and required the Department to conduct a one-time study of the pro rata system and how expenses are distributed to the Boards and Bureaus within the Department. The study consisted of a survey and an analysis of the pro-rata distribution. The survey discovered two areas of necessary improvement, customer service and timeliness. The survey is being used as a starting point to initiate improvements within the Department. Ms. Lally added that the complete survey and pro-rata study are available on the Department's website.

8. Regulations

a. Discussion and possible action regarding proposed amendments to Guidelines for Imposing Discipline/Uniform Standards Regarding Substance Abusing Health

Arts Licensees. Section 1399.523 of Division 13.8 of Title 16 of the California Code of Regulations.

A regulatory hearing on the Proposed Language for Guidelines for Imposing Discipline/Uniform Standards Regarding Substance-Abusing Healing Arts Licensees, Section 1399.52 of Division 13.8 of Title 16 of the California Code of Regulations was held on February 9, 2015.

The Board voted to approve additional amendments and a 15-day public comment period took place. No public comments were received.

The rulemaking file was finalized and has been submitted to the Department of Consumer Affairs for their review. Upon their approval, the file will be forwarded to the Office of Administrative Law (OAL). OAL has thirty working days to review the file.

9. Closed Session:

- a. Pursuant to Section 11126(c)(3) of the Government Code, the Board moved into closed session to deliberate on disciplinary matters.

Return to open session

10. A lunch break was taken.

11. The Legislative Committee Report

Ms. Hazelton discussed specific bills that were of interest to the Board, including:

AB 12 (Cooley) This bill would require every state agency, department, board, bureau or other entity to review and revise regulations to eliminate inconsistent, overlapping, duplicative, and outdated provisions and adopt the revisions as emergency regulations by January 1, 2018. Additionally, this bill would require the Business, Consumer Services, and Housing Agency to submit a report to the Governor and Legislature affirming compliance with these provisions. These provisions would be repealed by January 1, 2019.

AB 85 (Wilk) This urgency bill would require two-member advisory committees or panels of a "state body" (as defined in the Bagley-Keene Open Meeting Act) to hold open, public meetings if at least one member of the advisory committee is a member of the larger state body and the advisory committee is supported, in whole or in part, by state funds.

This bill would impact how the Board's committees' work, all committee meetings would have to be public if this bill passes. The Board previously took an opposed position on this bill.

Ms. Hazelton stated that the Board took an oppose position on both AB 12 and AB 85. She added that both bills appear to be on track for enactment and that Board staff should be thinking about the process of implementing the provisions of these bills.

There was general discussion about the fiscal impact to the Board and whether additional funds should be requested to implement the provisions of those bills.

AB 637 (Campos) This bill would allow nurse practitioners and physician assistants to sign the Physician Orders for Life Sustaining Treatment form. This Treatment Form allows terminally-ill patients to inform their loved ones and health care professionals of their end-of-life wishes. By expanding the number of people who are allowed to sign the Treatment Form, the intent of this bill is to assist terminally-ill patients in making their end-of-life wishes known to their families and health care providers. This bill would impact licensees of the Physician Assistant Board and the Board of Registered Nursing.

Ms. Hazelton stated that the Board supported this bill and will likely be signed by the Governor.

AB 1060 (Bonilla) This bill was amended. The bill now requires the California Health and Human Services Agency to establish a nonprofit Cancer Clinical Trials Foundation to solicit and receive funds from business, industry, foundations, and other private and public sources for the purpose of administering the Cancer Clinical Trials Grant Program to increase patient access to cancer clinical trials.

The Board took no position on the previous version of AB 1060 and will no longer track amended version of AB 1060.

AB 1351 (Eggman) This bill would:

1. Convert the existing system of deferred entry of judgement (DEJ) for qualified drug possession offender – generally those with no prior convictions or non-drug current charges – to a true diversion system, under which eligible defendants are admitted to an education and treatment program prior to conviction and granted a dismissal of the charges upon successful completion of the program;
2. Allow persons previously convicted of a drug possession offense, or who have previously participated in a diversion of DEJ program, or those for whom parole or probation has been revoked may participate in a diversion program; and
3. Set the length of the program from six months to one year, except that the court can extend that time for good cause.

AB 1352 (Eggman) The purpose of this bill is to allow any person who has successfully completed a deferred entry of judgement (DEJ) treatment program to obtain dismissal of the plea upon which DEJ was granted, on the basis that the guilty or no-contest plea underlying DEJ may result in a denial of employment benefit, license or certificate, or have adverse immigration consequences, in conflict with the statement in the governing statute that the plea shall not result in “denial of any employment, benefit, license, or certificate.”

Ms. Schieldge provided the Board members a detailed description and analysis of AB 1351 and how it would change the existing deferred entry of judgement program. She indicated that the Board should be concerned about several aspects of these bills, including:

1. A shorter diversion program, perhaps, only 6-12 months
2. Eliminates the discretion of the courts to remove a person from the program.

3. If the defendant fails the court-ordered diversion program, the defendant has the option to go back to the program multiple times, making it harder to prosecute later if they don't complete the program due to length of time from the initial arrest.
4. No penalties can be imposed after the completion of the diversion program.
5. There is less evidence for the Board to determine if an applicant is fit for licensure, because no guilty plea is entered.

Ms. Schiedge added that the overall effect of AB 1351 is to substantially change the program from a deferred entry of judgement program to a pretrial diversion program where the Board could not impose any kind of penalty after the arrest, because the Board would no longer be able to rely on the guilty plea.

Ms. Schiedge discussed how AB 1352 would change the law to completely eradicate the records back to 1997, thus removing the ability of the public to have knowledge of the violation as it would be deleted from the person's criminal record. The concern is that this bill would potentially remove a public protection component as there would be no history of any admission of possible drug or alcohol addictions.

These bills affect all of the Healing Arts Boards, as of now these Boards have the right to deny licensure on a guilty plea without a conviction. These bills would affect that right of denial.

M/ Jed Grant S/ Charles Alexander C/ to:

Take an oppose position on AB 1351 and AB 1352 because they impair the Board's ability to protect the public.

Member	Yes	No	Abstain	Absent	Recusal
Charles Alexander	X				
Michael Bishop	X				
Cristina Gomez-Vidal Diaz	X				
Sonya Earley	X				
Jed Grant	X				
Catherine Hazelton		X			
Xavier Martinez	X				
Robert Sachs	X				

Motion approved.

SB 337 (Pavley) This bill would require medical records to reflect the supervising physician for each episode of care; require a physician assistant who transmits an oral order to identify the supervising physician; recast medical record review provisions to require the supervising physician to utilize one or more mechanisms; and recast prescribing provisions to allow a physician assistant to prescribe Schedule II controlled substances.

Teresa Anderson, Public Policy Director, California Academy of Physician Assistants (CAPA) introduced Katheryn Scott, from CAPA. Ms. Scott noted that the amendments requested during the July teleconference meeting have been incorporated into the bill and it was sent to Appropriations and then the Senate.

All changes conformed to Exhibit A, as presented at the teleconference meeting. Therefore, no new motion was necessary.

SB 464 (Hernandez) This bill clarifies that health care practitioners, including physician assistants, may use patient self-screening tools that will identify patient risk factors for the use of self-administered hormonal contraceptives, for purposes of furnishing self-administered hormonal contraceptives to the patient.

Ms. Hazelton reported that the only health measurement typically reviewed when assessing the safety of birth control pills is whether a patient has hypertension or not and this is measured through blood pressure. This bill would allow patients to self-report their blood pressure.

Ms. Schiedge presented the background to this legislation. Last year a bill was enacted that allowed pharmacists to prescribe hormonal birth control pills (the pill). Since the pill can cause hypertension, which is monitored through blood pressure, the concern is, can self-screening be an acceptable tool or is it necessary for the patient to have their blood pressure taken by a medical professional before prescribing? Planned Parenthood, who is sponsoring the bill, feels that the risk of pregnancy is greater than the risk of hypertension and therefore, they believe that the self-screening tool, used appropriately, is an adequate control to provide the pill.

The Medical Board of California took a neutral position on this bill and Dr. Bishop stated that there was not any discussion on this bill at their last meeting.

The Board took no position on SB 464.

12. The Education/Workforce Development Advisory Committee: Update

Mr. Grant asked about the status of letters that staff were requested to send to CHEA and PAEA. Assembly Member Medina had suggested to the Board that they seek clarification of the issue. Mr. Mitchell informed the Board that the letter to CHEA requesting them to review the process by which ARC-PA withdrew the accreditation of two California based Associate Degree training programs was completed and currently being reviewed by legal counsel. A letter was also sent to PAEA requesting information on how the Board could be involved with their workforce committee. The Board is still awaiting a response from them.

Mr. Grant reported that there are twelve new programs that have an interest in obtaining accreditation and seven of those programs have started the accreditation process with ARC-PA. The pathway to accreditation by ARC-PA is approximately two years. Mr. Grant added that with seven California programs seeking accreditation will help address workforce shortages. Each program should have 25 to 30 students with an initial start dates in 2016 and 2017.

13. Medical Board of California activities summary and update

The Medical Board held its meeting on July 30 and 31, 2015 in San Francisco. It was a very busy meeting and included several educational presentations.

The Board received an update from the interested parties meeting that was held on June 30. Dr. Bishop informed the Board that the Medical Board is looking at

requiring three years of postgraduate training for both US/Canadian and International medical school graduates, versus one and two years respectively. Unfortunately the meeting on June 30th was not well attended, but the Board will be holding another meeting in October in Southern California. The Board hopes to identify any unintended consequences of such a change to the number of years of postgraduate training. In addition, the interested parties meeting also began discussions regarding physician reentry. The Board is concerned that individuals may be able to not practice for several years, for one reason or another, unbeknownst to the Board, and then just begin practicing again without any indication of the physician's competency. This is an issue that several other state boards are looking at as well. The Board is trying to identify a way to ensure consumer protection after an individual is out of practice for a certain amount of time. This issue will also be discussed at the September Board meeting.

During the Board's Education and Wellness Committee, the Board heard from Dr. Wolfe, from the Center for Medicare and Medicaid Services, who provided an update on the Affordable Care Act and Physician Compliance Programs. In addition, the Committee also had a presentation on Trauma Informed Care and its impact on lifelong health by Dr. Sciolla from the University of California, Davis.

The Full Board heard two presentations regarding Physician Health Programs, one from the Medical Director of the Monitored Aftercare Program who provides the Physician Health Program in Arizona, and one from the Medical Director from the Colorado Physician Health Program. In addition, Board staff provided an analysis on licensee health programs within the Department of Consumer Affairs as well as an analysis on physician health programs in other states. As you may be aware, the Medical Board has not had a Physician Health Program for substance abusing or mentally ill licensees since the elimination of the Board's Diversion Program in 2008. The Board had requested data on other physician health programs and this presentation provided a lot of information. The Board requested staff meet with interested parties to further discuss this issue.

The Medical Board also discussed numerous bills related to the practice of medicine impacting physicians. Of interest to the Physician Assistant Board, the Board took a support position on SB 337 regarding changes to the supervision requirements for Physician Assistants. The Board also discussed federal legislation that was just introduced that would allow physicians in any state to treat California patients that are receiving Medicare. The Board opposed this legislation and requested that staff send a letter to the congressman who introduced these bills.

The Board held three regulatory hearings on regulations pertaining to the minimum passing score for the physician's and surgeon's licensing examination, outpatient surgery settings, and information posted on the Board's website. The Board also approved staff moving forward with several changes to the Board's disciplinary guidelines that will clarify and enhance the guidelines for disciplinary actions against physicians who violate the law.

The Medical Board had a presentation from two representatives from the Federation of State Medical Boards. These individuals discussed the roles and functions of the Federation and provided the Members an update on the important projects at the Federation, including a work group on marijuana and medical regulation and a workgroup on team-based regulation.

Dr. Bishop reported the Board had a presentation from Dr. Coffman from the University of California in San Francisco on their findings from their survey on electronic health records and Medi-Cal participation. They partner with the Medical Board every two years to include a special survey in the June and July physician renewals. This survey requests information from physicians on these two topics. Of note, was a significant increase, from 54% to 81%, in the use of Electronic Health records in community/public clinics from 2011 to 2013. This was attributed to the incentives that were provided by Medicare for the use of electronic health records. Also of note was a slide on the percentage of physicians accepting new Medi-Cal Patients in 2013 by specialty. Of those sampled receiving new patients the top specialty was facility-based and Obstetrics and Gynecology, and the lowest was psychiatry at only 36%.

The Board also received an update on the CURES 2.0 roll out from the Department of Justice and an update from the Department of Consumer Affairs and the Attorney General's Office on the Vertical Enforcement process. It was reported that a new Vertical Enforcement and Prosecution Joint Protocol was just released to all investigators and Deputies.

The Medical Board will be meeting next on October 29 and 30 in the San Diego Area.

The Board is appreciative of the great relationship it has with the Physician Assistant Board, specifically with Mr. Mitchell and his staff. The Board continues to offer any assistance it can provide to the Physician Assistant Board with any future issues.

14. Budget Update

Wilbert Rumbaoa, Budget Analyst, Department of Consumer Affairs reported that the Board would be reverting \$20,000 at the end of the fiscal year and the budget remains sound. Mr. Rumbaoa added that the Board is currently pursuing acquiring a budget augmentation for fiscal year 2015/2016. He added that the request is moving forward.

15. Discussion of compliance with Title 16 of the California Code of Regulations Section 1399.546: Reporting of Physician Assistant Supervision – Electronic Records and Signatures

The Board discussed the impact on Title 16, California Code of Regulations Section 1399.546, if SB 337 becomes law. Amendments may have an impact to this regulation. Specifically, the Board may need to amend the regulation to reflect technological changes on how supervision is noted using electronic medical records (EMR). EMRs have replaced paper records in most practices. The Board requested that this be placed on the next agenda for review and further discussion.

16. Re-scheduling of November Board meeting.

M/ Jed Grant S/ Charles Alexander C/ to:

Change the November Board meeting to November 2, 2015.

Member	Yes	No	Abstain	Absent	Recusal
Charles Alexander			X		
Michael Bishop	X				
Cristina Gomez-Vidal Diaz			X		
Sonya Earley			X		
Jed Grant	X				
Catherine Hazelton	X				
Xavier Martinez	X				
Robert Sachs	X				

Motion approved.

17. Agenda items for the next meeting

- a. Sunset Report
- b. Report from the Physician Assistant Education/Workforce Committee: Update – letters to CHEA and PAEA.
- c. Legislation Committee – Legislation update and potential changes for staffing needs to comply with AB 12 and AB 85.
- d. Possible amendments to Title 16 California Code of Regulations Section 1399.546 to update to accommodate SB 337.
- e. Exam score and location approval.
- f. Meeting dates and locations for 2016.
- g. Discussion of U.S. Supreme Court Decision North Carolina Board of Dental Examiners v. Federal Trade Commission.
- h. Pro-rata Study – Budget
- i. Status on process for new positions – update.

18. Adjournment

With no further business the meeting was adjourned at 12:04 P.M.

Agenda

Item

5

PHYSICIAN ASSISTANT BOARD
LICENSING PROGRAM ACTIVITY REPORT

INITIAL LICENSES ISSUED

	August 1, 2015- October 23, 2015	August 1, 2014- October 31, 2014
Initial Licenses	241	189

SUMMARY OF RENEWED/CURRENT LICENSES

	As of October 23, 2015	As of October 31, 2014
Physician Assistant	10,534	9729

**PHYSICIAN ASSISTANT BOARD
DIVERSION PROGRAM**

ACTIVITY REPORT

California licensed physician assistants participating in the Physician Assistant Board drug and alcohol diversion program:

	As of 1 October 2015	As of 1 October 2014	As of 1 October 2013
Voluntary referrals	03	03	02
Board referrals	09	13	12
Total number of participants	12	16	14

HISTORICAL STATISTICS

(Since program inception: 1990)

Total intakes into program as of 1 October 2015:	133
Closed Cases as of 1 October 2015	
• Participant expired:	01
• Successful completion:	45
• Dismissed for failure to receive benefit:	04
• Dismissed for non-compliance:	24
• Voluntary withdrawal:	22
• Not eligible:	22
Total closed cases:	118

OTHER DCA BOARD DIVERSION PROGRAM PARTICIPANTS

(As of 30 September 2015)

Dental Board of California:	27
Osteopathic Medical Board of California:	16
Board of Pharmacy:	66
Physical Therapy Board of California:	15
Board of Registered Nursing:	444
Veterinary Board of California:	8

PHYSICIAN ASSISTANT BOARD
ENFORCEMENT ACTIVITY REPORT

August 1, 2015 to October 31, 2015

Disciplinary Decisions

License Denied	0
Probation	1
Public Reprimand/Reproval	0
Revocation	0
Surrender	1
Probationary Licenses Issued.....	0
Petition for Reinstatement Denied	0
Petition for Reinstatement Granted	0
Petition for Termination of Prob Denied	0
Petition for Termination of Prob Granted... ..	0
Other	0

Accusation/Statement of Issues

Accusation Filed.....	5
Accusation Withdrawn	0
Statement of Issues Filed	0
Statement of Issues Withdrawn.....	0
Petition to Revoke Probation Filed	1
Petition to Compel Psychiatric Exam.....	0
Interim Suspension Orders (ISO)/PC23	0

Citation and Fines

Pending from previous FY	5
Issued	0
Closed	0
Withdrawn	0
Sent to AG/noncompliance	0
Pending	0
Initial Fines Issued	\$0.00
Modified Fines Due	\$0.00
Fines Received	\$250

Current Probationers

Active.....	55
Tolled.....	5

Agenda

Item

8

LICENSING INITIAL LICENSING EXAMINATION

PASSING SCORE

Business and Professions Code section 3517 provides in pertinent part:

“The board shall, however, establish a passing score for each examination.”

Motion to approve the passing score for the physician assistant initial licensing examination for year 2016 as established by the National Commission on Certification of Physician Assistants.

DATES AND LOCATIONS

Business and Professions Code section 3517 provides in pertinent part:

“The time and place of examination shall be fixed by the board.”

Motion to approve the dates and locations for the physician assistant initial licensing examination for year 2016.

Dates: The examination is given on a year-round basis. There will be no testing December 19 – 30, 2016.

Locations: Pearson VUE Professional Centers.

**

NCCPA Exam Development and Scoring

NCCPA's exam questions are developed by committees comprising PAs and physicians selected based on both their item writing skills, experience and demographic characteristics (i.e., practice specialty, geographic region, practice setting, etc.). The test committee members each independently write a certain number of test questions or items, and then, each item then goes through an intense review by content experts and medical editors from which only some items emerge for pre-testing. Every NCCPA exam includes both scored and pre-test items, and examinees have no way of distinguishing between the two. This allows NCCPA to collect important statistics about how the pre-test items perform on the exam, which informs the final decision about whether a particular question meets the standards for inclusion as a scored item on future PANCE or PANRE exams.

When NCCPA exams are scored, candidates are initially awarded 1 point for every correct answer and 0 points for incorrect answers to produce a raw score. After examinees' raw scores have been computed by two independent computer systems to ensure accuracy, the scored response records for PANCE and PANRE examinees are entered into a maximum likelihood estimation procedure, a sophisticated, mathematically-based procedure that uses the difficulties of all the scored items in the form taken by an individual examinee as well as the number of correct responses to calculate that examinee's proficiency measure. This calculation is based on the *Rasch model* and equates the scores, compensating for minor differences in difficulty across different versions of the exam. Thus, in the end, all proficiency measures are calculated as if everyone took the same exam.

Finally, the proficiency measure is converted to a scaled score so that results can be compared over time and among different groups of examinees. The scale is based on the performance of a reference group (some particular group of examinees who took the exam in the past) whose scores were scaled so that the average proficiency measure was assigned a scaled score of 500 and the standard deviation was established at 100. The minimum reported score is 200, and the maximum reported score is 80.

We do not publish the percent correct level necessary to pass our examinations any more. Given that we have multiple test forms this information would not be accurate since some test forms, while built to be exactly the same, are slightly different in their difficulty. Therefore, we convert the percent correct to a scaled score and report scores and the passing standard on that scale.

Agenda

Item

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2016

January						
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31						

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Proposed Meeting Dates within the 100 day limit

Meeting #1

Medical Board Meeting Dates:

Thursday – January 21 & Friday – January 22

Physician Assistant Board Proposed Dates:

Monday – January 4 or Monday – January 11

Meeting #2

Medical Board Meeting Dates:

Thursday – May 5 & Friday – May 6

Physician Assistant Board Proposed Dates:

Monday – April 4, or Monday – April 11 or Monday – April 18

Meeting #3

Medical Board Meeting Dates:

Thursday – July 28 & Friday – July 29

Physician Assistant Board Proposed Dates:

Monday – July 11 or Monday – July 18

Meeting #4

Medical Board Meeting Dates:

Thursday – October 27 & Friday October 28

Physician Assistant Board Proposed Dates:

Monday – October 17 or Monday – October 24

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2016 Board and Committee Meetings

Dates and Locations May Change

[Public Participation at Board Meetings](#)

[2016](#) | [2015](#) | [2014](#) | [2013](#) | [2012](#) | [2011](#) | [2010](#) | [2009](#) | [2008](#) | [2007](#)

Upcoming Events

JAN
21-22 **Quarterly Board and Committee Meetings**
Sacramento Area

MAY
5-6 **Quarterly Board and Committee Meetings**
Los Angeles Area

JUL
28-29 **Quarterly Board and Committee Meetings**
San Francisco Bay Area

OCT
27-28 **Quarterly Board and Committee Meetings**
San Diego Area

[2016](#) | [2015](#) | [2014](#) | [2013](#) | [2012](#) | [2011](#) | [2010](#) | [2009](#) | [2008](#) | [2007](#)

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Agenda

Item

10

Section 3502 of the Business and Professions Code:

3502.

(a) Notwithstanding any other law, a physician assistant may perform those medical services as set forth by the regulations adopted under this chapter when the services are rendered under the supervision of a licensed physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that supervision or prohibiting the employment of a physician assistant. The medical record, for each episode of care for a patient, shall identify the physician and surgeon who is responsible for the supervision of the physician assistant.

(b) (1) Notwithstanding any other law, a physician assistant performing medical services under the supervision of a physician and surgeon may assist a doctor of podiatric medicine who is a partner, shareholder, or employee in the same medical group as the supervising physician and surgeon. A physician assistant who assists a doctor of podiatric medicine pursuant to this subdivision shall do so only according to patient-specific orders from the supervising physician and surgeon.

(2) The supervising physician and surgeon shall be physically available to the physician assistant for consultation when that assistance is rendered. A physician assistant assisting a doctor of podiatric medicine shall be limited to performing those duties included within the scope of practice of a doctor of podiatric medicine.

(c) (1) A physician assistant and his or her supervising physician and surgeon shall establish written guidelines for the adequate supervision of the physician assistant. This requirement may be satisfied by the supervising physician and surgeon adopting protocols for some or all of the tasks performed by the physician assistant. The protocols adopted pursuant to this subdivision shall comply with the following requirements:

(A) A protocol governing diagnosis and management shall, at a minimum, include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be provided to the patient.

(B) A protocol governing procedures shall set forth the information to be provided to the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the followup care.

(C) Protocols shall be developed by the supervising physician and surgeon or adopted from, or referenced to, texts or other sources.

(D) Protocols shall be signed and dated by the supervising physician and surgeon and the physician assistant.

(2) (A) The supervising physician and surgeon shall use one or more of the following mechanisms to ensure adequate supervision of the physician assistant functioning under the protocols:

(i) The supervising physician and surgeon shall review, countersign, and date a sample consisting of, at a minimum, 5 percent of the medical records of patients treated by the physician assistant functioning under the protocols within 30 days of the date of treatment by the physician assistant.

(ii) The supervising physician and surgeon and physician assistant shall conduct a medical records review meeting at least once a month during at least 10 months of the year. During any month in which a medical records review meeting occurs, the supervising physician and surgeon and physician assistant shall review an aggregate of at least 10 medical records of patients treated by the physician assistant functioning under protocols. Documentation of medical records reviewed during the month shall be jointly signed and dated by the supervising physician and surgeon and the physician assistant.

(iii) The supervising physician and surgeon shall review a sample of at least 10 medical records per month, at least 10 months during the year, using a combination of the countersignature mechanism described in clause (i) and the medical records review meeting mechanism described in clause (ii). During each month for which a sample is reviewed, at least one of the medical records in the sample shall be reviewed using the mechanism described in clause (i) and at least one of the medical records in the sample shall be reviewed using the mechanism described in clause (ii).

(B) In complying with subparagraph (A), the supervising physician and surgeon shall select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

(3) Notwithstanding any other law, the Medical Board of California or the board may establish other alternative mechanisms for the adequate supervision of the physician assistant.

(d) No medical services may be performed under this chapter in any of the following areas:

(1) The determination of the refractive states of the human eye, or the fitting or adaptation of lenses or frames for the aid thereof.

(2) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, or orthoptics.

(3) The prescribing of contact lenses for, or the fitting or adaptation of contact lenses to, the human eye.

(4) The practice of dentistry or dental hygiene or the work of a dental auxiliary as defined in Chapter 4 (commencing with Section 1600).

(e) This section shall not be construed in a manner that shall preclude the performance of routine visual screening as defined in Section 3501.

(f) Compliance by a physician assistant and supervising physician and surgeon with this section shall be deemed compliance with Section 1399.546 of Title 16 of the California Code of Regulations.

Title 16 California Code of Regulations Section 1399.546

Reporting of Physician Assistant Supervision.

Each time a physician assistant provides care for a patient and enters his or her name, signature, initials, or computer code on a patient's record, chart or written order, the physician assistant shall also enter the name of his or her supervising physician who is responsible for the patient. When a physician assistant transmits an oral order, he or she shall also state the name of the supervising physician responsible for the patient.

Agenda

Item

13

**Council for
Higher Education
Accreditation**

One Dupont Circle NW • Suite 510
Washington DC 20036-1135

tel: 202-955-6126
fax: 202-955-6129

e-mail: chea@chea.org
web: www.chea.org

September 23, 2015

RECEIVED

SEP 28 2015

PHYSICIAN ASSISTANT
BOARD

Mr. Jed Grant
Chairman
Education/Workforce Development Committee
Physician Assistant Board
2005 Evergreen Street, Suite 1100
Sacramento, CA 95815

Dear Mr. Grant:

On September 21, 2015, the Council for Higher Education Accreditation (CHEA) received the September 14, 2015, Physician Assistant Board (PAB) correspondence. The recent communication expressed concerns regarding the Accreditation Review Commission on Education for the Physician Assistant, Inc. (ARC-PA) located in Johns Creek, Georgia.

We urge that you work with the accreditor to resolve the concerns. CHEA does not have processes that address issues to be resolved between an accreditor and an individual program. Please be advised that ARC-PA has been apprised of your recent communication and contents therein.

Should you have any questions, please contact CHEA at 202-955-6126.

Thank you.

Sincerely,



Thomas J. Cornacchia
Vice President for Recognition Services

c: Mr. John E. McCarty, ARC-PA



PHYSICIAN ASSISTANT BOARD

2005 Evergreen Street, Suite 1100, Sacramento, CA 95815
P (916) 561-8783 F (916) 263-2671 | www.pac.ca.gov



September 14, 2015

Judith S. Eaton, President
Council for Higher Education Accreditation
One Dupont Circle NW, Suite 510
Washington DC 20036

Dear Dr. Eaton,

The Legislative intent of establishing the Physician Assistant Practice Act ("Act" -- Business and Professions Code sections 3500 et seq.) is to encourage the utilization of physician assistants by physicians and to provide that existing legal constraints should not be an unnecessary hindrance to the more effective provision of health care services to California consumers. Additionally, the purpose of the Act is to allow for the innovative development of programs for the education, training, and utilization of physician assistants.

The Physician Assistant Board (Board) is concerned that, due to the implementation of the Patient Protection and Affordable Care Act in California, the current health care delivery system will be required to accommodate additional consumers who are now eligible to receive health care services. A more efficient use of health care providers, including physician assistants, will be required to address the increase of consumers utilizing the health care delivery system.

Because of concerns with the need to ensure that California consumers have access to medical services, the Board recently created a Physician Assistant Education/Workforce Development Committee to evaluate and offer reasonable solutions to address this important issue.

As you may be aware, the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) recently withdrew the accreditation of two California-based community college physician assistant training programs, including the Moreno Valley College Physician Assistant Program. The Board is concerned with ARC-PA's decision to withdraw the accreditation of these programs due to the need for additional physician assistants in California to address the health care needs of consumers.

The closure of the Moreno Valley College Physician Assistant Program prompted California Assemblymember Jose Medina to recently write to the Board to express his concern with the closure of this program. He pointed out that the closure of the Moreno Valley College program will only serve to exacerbate the health care worker shortage in California and in his district. He also pointed out that the program was affordable to students and a high-quality option for non-traditional students in the region.

September 14, 2015
Judith S. Eaton, President
Council for Higher Education Accreditation
Page two

Assemblymember Medina recommended that the Board look into the withdrawal of accreditation for the Moreno Valley College physician assistant training program. Likewise, the Board acknowledges and shares Assemblymember Medina's concerns with regard to the closure of this program.

Based on Assemblymember Medina and the Board's concerns, we are requesting that the Council for Higher Education Accreditation (CHEA) do the following:

- Request from ARC-PA documented reasons behind their decision to withdraw accreditation from the Moreno Valley College program, which was fully accredited for 10 years, and any potential underlying motives surrounding the loss of ARC-PA accredited community college programs in California. It is understood that the program was placed on probation in 2012, but responded proactively and reduced citations from 32 to 10, and observations from 27 to 8 within a two-year period.
- Determine whether the ARC-PA action is in compliance with its own organizational policies and review process and respond in writing to the Board. Was this closure proper? Did the decision appropriately take into account the improvement in the program's student outcomes, including an increase in the PANCE pass rate from 70% in 2012 to 90% in 2014? This is important in light of ARC-PA's own Policy 9.2, which states that an established program's accreditation can only be withdrawn when it is determined to no longer be in compliance with the standards *and* is no longer capable of providing an acceptable education experience for its members.

The information provided by CHEA to the Board regarding this matter will assist the Board in determining what actions may need to be taken to ensure that an adequate number of physician assistant training programs are located in California, which will help to address the health care needs of California consumers.

If you have any questions regarding our request please contact the Board's Executive Officer, Glenn L. Mitchell, Jr. at (916) 561-8783 or glenn.mitchell@mbc.ca.gov.

Thank you.

Sincerely,



Jed Grant, PA-C, Chairman
Education/Workforce Development Committee
Physician Assistant Board

cc: Members, Physician Assistant Board
Assembly member Jose Medina

Mitchell, Glenn@MBC

From: Mitchell, Glenn@MBC
Sent: Tuesday, July 28, 2015 11:17 AM
To: 'info@paeaonline.org'
Subject: California Physician Assistant Board: Participation Request

Good Morning,

I am the Executive Officer of the State of California Physician Assistant Board. The Board is responsible for licensing and enforcement of physician assistants in California.

Our Board is looking into workforce issues for California physician assistants as well as the physician assistant education accreditation process. The Board is concerned that potential workforce shortages could negatively impact California consumers accessing health care.

The Board has requested that I contact PAEA as ask if it is possible for the Physician Assistant Board to participate in PAEA's task force on accreditation.

On behalf of the Physician Assistant Board, thank you for consideration of my request.

Glenn L. Mitchell, Jr.
Executive Officer
Physician Assistant Board
(916) 561-8783
(916) 263-2671 (Fax)
email: Glenn.Mitchell@mbc.ca.gov

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Mitchell, Glenn@MBC

From: Timi Agar Barwick [tbarwick@paeaonline.org]
Sent: Wednesday, August 12, 2015 12:23 PM
To: Mitchell, Glenn@MBC; Lisa Belding
Subject: PAEA accred task force

Mitchell, thank you for your recent correspondence about PAEA's interest in forming a task force related to accreditation. I appreciate your interest in PA education and accreditation. While task force members have not been identified, please know that the PAEA board places a high value on assuring an unbiased and neutral process in its investigation of the issues. This will be a primary consideration when appointments are made. I will see that your perspective gets due consideration at that time. Thank you, Timi Agar Barwick

--

Timi Agar Barwick, MPM
CEO
Physician Assistant Education Association
703-667-4337
PAEAonline.org



[Register now for the national conference for PA educators](#)

Agenda

Item

14

**TO BE
FORWARDED
ON
WEDNESDAY
10/28/15**

Agenda

Item

15

NORTH CAROLINA BOARD OF DENTAL EXAMINERS

v.

FEDERAL TRADE COMMISSION

113 S.Ct. 1101 (2015)

Decided by the United States Supreme Court

February 25, 2015

Syllabus

NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States v. Detroit Timber & Lumber Co.*, 200 U. S. 321, 337.

SUPREME COURT OF THE UNITED STATES

Syllabus

**NORTH CAROLINA STATE BOARD OF DENTAL
EXAMINERS v. FEDERAL TRADE COMMISSION****CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR
THE FOURTH CIRCUIT**

No. 13–534. Argued October 14, 2014—Decided February 25, 2015

North Carolina’s Dental Practice Act (Act) provides that the North Carolina State Board of Dental Examiners (Board) is “the agency of the State for the regulation of the practice of dentistry.” The Board’s principal duty is to create, administer, and enforce a licensing system for dentists; and six of its eight members must be licensed, practicing dentists.

The Act does not specify that teeth whitening is “the practice of dentistry.” Nonetheless, after dentists complained to the Board that nondentists were charging lower prices for such services than dentists did, the Board issued at least 47 official cease-and-desist letters to nondentist teeth whitening service providers and product manufacturers, often warning that the unlicensed practice of dentistry is a crime. This and other related Board actions led nondentists to cease offering teeth whitening services in North Carolina.

The Federal Trade Commission (FTC) filed an administrative complaint, alleging that the Board’s concerted action to exclude nondentists from the market for teeth whitening services in North Carolina constituted an anticompetitive and unfair method of competition under the Federal Trade Commission Act. An Administrative Law Judge (ALJ) denied the Board’s motion to dismiss on the ground of state-action immunity. The FTC sustained that ruling, reasoning that even if the Board had acted pursuant to a clearly articulated state policy to displace competition, the Board must be actively supervised by the State to claim immunity, which it was not. After a hearing on the merits, the ALJ determined that the Board had unreasonably restrained trade in violation of antitrust law. The FTC again sustained the ALJ, and the Fourth Circuit affirmed the FTC in

Syllabus

all respects.

Held: Because a controlling number of the Board's decisionmakers are active market participants in the occupation the Board regulates, the Board can invoke state-action antitrust immunity only if it was subject to active supervision by the State, and here that requirement is not met. Pp. 5–18.

(a) Federal antitrust law is a central safeguard for the Nation's free market structures. However, requiring States to conform to the mandates of the Sherman Act at the expense of other values a State may deem fundamental would impose an impermissible burden on the States' power to regulate. Therefore, beginning with *Parker v. Brown*, 317 U. S. 341, this Court interpreted the antitrust laws to confer immunity on the anticompetitive conduct of States acting in their sovereign capacity. Pp. 5–6.

(b) The Board's actions are not cloaked with *Parker* immunity. A nonsovereign actor controlled by active market participants—such as the Board—enjoys *Parker* immunity only if “the challenged restraint . . . [is] clearly articulated and affirmatively expressed as state policy, and . . . ‘the policy . . . [is] actively supervised by the State.’” *FTC v. Phoebe Putney Health System, Inc.*, 568 U. S. ____ (quoting *California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc.*, 445 U. S. 97, 105). Here, the Board did not receive active supervision of its anticompetitive conduct. Pp. 6–17.

(1) An entity may not invoke *Parker* immunity unless its actions are an exercise of the State's sovereign power. See *Columbia v. Omni Outdoor Advertising, Inc.*, 499 U. S. 365, 374. Thus, where a State delegates control over a market to a nonsovereign actor the Sherman Act confers immunity only if the State accepts political accountability for the anticompetitive conduct it permits and controls. Limits on state-action immunity are most essential when a State seeks to delegate its regulatory power to active market participants, for dual allegiances are not always apparent to an actor and prohibitions against anticompetitive self-regulation by active market participants are an axiom of federal antitrust policy. Accordingly, *Parker* immunity requires that the anticompetitive conduct of nonsovereign actors, especially those authorized by the State to regulate their own profession, result from procedures that suffice to make it the State's own. *Midcal*'s two-part test provides a proper analytical framework to resolve the ultimate question whether an anticompetitive policy is indeed the policy of a State. The first requirement—clear articulation—rarely will achieve that goal by itself, for entities purporting to act under state authority might diverge from the State's considered definition of the public good and engage in private self-dealing. The second *Midcal* requirement—active supervision—seeks to avoid this

Syllabus

harm by requiring the State to review and approve interstitial policies made by the entity claiming immunity. Pp. 6–10.

(2) There are instances in which an actor can be excused from *Midcal's* active supervision requirement. Municipalities, which are electorally accountable, have general regulatory powers, and have no private price-fixing agenda, are subject exclusively to the clear articulation requirement. See *Hallie v. Eau Claire*, 471 U. S. 34, 35. That *Hallie* excused municipalities from *Midcal's* supervision rule for these reasons, however, all but confirms the rule's applicability to actors controlled by active market participants. Further, in light of *Omni's* holding that an otherwise immune entity will not lose immunity based on ad hoc and *ex post* questioning of its motives for making particular decisions, 499 U. S., at 374, it is all the more necessary to ensure the conditions for granting immunity are met in the first place, see *FTC v. Ticor Title Ins. Co.*, 504 U. S. 621, 633, and *Phoebe Putney, supra*, at _____. The clear lesson of precedent is that *Midcal's* active supervision test is an essential prerequisite of *Parker* immunity for any nonsovereign entity—public or private—controlled by active market participants. Pp. 10–12.

(3) The Board's argument that entities designated by the States as agencies are exempt from *Midcal's* second requirement cannot be reconciled with the Court's repeated conclusion that the need for supervision turns not on the formal designation given by States to regulators but on the risk that active market participants will pursue private interests in restraining trade. State agencies controlled by active market participants pose the very risk of self-dealing *Midcal's* supervision requirement was created to address. See *Goldfarb v. Virginia State Bar*, 421 U. S. 773, 791. This conclusion does not question the good faith of state officers but rather is an assessment of the structural risk of market participants' confusing their own interests with the State's policy goals. While *Hallie* stated "it is likely that active state supervision would also not be required" for agencies, 471 U. S., at 46, n. 10, the entity there was more like prototypical state agencies, not specialized boards dominated by active market participants. The latter are similar to private trade associations vested by States with regulatory authority, which must satisfy *Midcal's* active supervision standard. 445 U. S., at 105–106. The similarities between agencies controlled by active market participants and such associations are not eliminated simply because the former are given a formal designation by the State, vested with a measure of government power, and required to follow some procedural rules. See *Hallie, supra*, at 39. When a State empowers a group of active market participants to decide who can participate in its market, and on what terms, the need for supervision is manifest. Thus,

Syllabus

the Court holds today that a state board on which a controlling number of decisionmakers are active market participants in the occupation the board regulates must satisfy *Midcal's* active supervision requirement in order to invoke state-action antitrust immunity. Pp. 12–14.

(4) The State argues that allowing this FTC order to stand will discourage dedicated citizens from serving on state agencies that regulate their own occupation. But this holding is not inconsistent with the idea that those who pursue a calling must embrace ethical standards that derive from a duty separate from the dictates of the State. Further, this case does not offer occasion to address the question whether agency officials, including board members, may, under some circumstances, enjoy immunity from damages liability. Of course, States may provide for the defense and indemnification of agency members in the event of litigation, and they can also ensure *Parker* immunity is available by adopting clear policies to displace competition and providing active supervision. Arguments against the wisdom of applying the antitrust laws to professional regulation absent compliance with the prerequisites for invoking *Parker* immunity must be rejected, see *Patrick v. Burget*, 486 U. S. 94, 105–106, particularly in light of the risks licensing boards dominated by market participants may pose to the free market. Pp. 14–16.

(5) The Board does not contend in this Court that its anticompetitive conduct was actively supervised by the State or that it should receive *Parker* immunity on that basis. The Act delegates control over the practice of dentistry to the Board, but says nothing about teeth whitening. In acting to expel the dentists' competitors from the market, the Board relied on cease-and-desist letters threatening criminal liability, instead of other powers at its disposal that would have invoked oversight by a politically accountable official. Whether or not the Board exceeded its powers under North Carolina law, there is no evidence of any decision by the State to initiate or concur with the Board's actions against the nondentists. P. 17.

(c) Here, where there are no specific supervisory systems to be reviewed, it suffices to note that the inquiry regarding active supervision is flexible and context-dependent. The question is whether the State's review mechanisms provide "realistic assurance" that a non-sovereign actor's anticompetitive conduct "promotes state policy, rather than merely the party's individual interests." *Patrick*, 486 U. S., 100–101. The Court has identified only a few constant requirements of active supervision: The supervisor must review the substance of the anticompetitive decision, see *id.*, at 102–103; the supervisor must have the power to veto or modify particular decisions to ensure they accord with state policy, see *ibid.*; and the "mere potential for state

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supervision is not an adequate substitute for a decision by the State,” *Ticor, supra*, at 638. Further, the state supervisor may not itself be an active market participant. In general, however, the adequacy of supervision otherwise will depend on all the circumstances of a case. Pp. 17–18.

717 F. 3d 359, affirmed.

KENNEDY, J., delivered the opinion of the Court, in which ROBERTS, C. J., and GINSBURG, BREYER, SOTOMAYOR, and KAGAN, JJ., joined. ALITO, J., filed a dissenting opinion, in which SCALIA and THOMAS, JJ., joined.

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SUPREME COURT OF THE UNITED STATES

No. 13–534

NORTH CAROLINA STATE BOARD OF DENTAL
EXAMINERS, PETITIONER *v.* FEDERAL
TRADE COMMISSION

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF
APPEALS FOR THE FOURTH CIRCUIT

[February 25, 2015]

JUSTICE KENNEDY delivered the opinion of the Court.

This case arises from an antitrust challenge to the actions of a state regulatory board. A majority of the board’s members are engaged in the active practice of the profession it regulates. The question is whether the board’s actions are protected from Sherman Act regulation under the doctrine of state-action antitrust immunity, as defined and applied in this Court’s decisions beginning with *Parker v. Brown*, 317 U. S. 341 (1943).

I

A

In its Dental Practice Act (Act), North Carolina has declared the practice of dentistry to be a matter of public concern requiring regulation. N. C. Gen. Stat. Ann. §90–22(a) (2013). Under the Act, the North Carolina State Board of Dental Examiners (Board) is “the agency of the State for the regulation of the practice of dentistry.” §90–22(b).

The Board’s principal duty is to create, administer, and enforce a licensing system for dentists. See §§90–29 to

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90-41. To perform that function it has broad authority over licensees. See §90-41. The Board's authority with respect to unlicensed persons, however, is more restricted: like "any resident citizen," the Board may file suit to "perpetually enjoin any person from . . . unlawfully practicing dentistry." §90-40.1.

The Act provides that six of the Board's eight members must be licensed dentists engaged in the active practice of dentistry. §90-22. They are elected by other licensed dentists in North Carolina, who cast their ballots in elections conducted by the Board. *Ibid.* The seventh member must be a licensed and practicing dental hygienist, and he or she is elected by other licensed hygienists. *Ibid.* The final member is referred to by the Act as a "consumer" and is appointed by the Governor. *Ibid.* All members serve 3-year terms, and no person may serve more than two consecutive terms. *Ibid.* The Act does not create any mechanism for the removal of an elected member of the Board by a public official. See *ibid.*

Board members swear an oath of office, §138A-22(a), and the Board must comply with the State's Administrative Procedure Act, §150B-1 *et seq.*, Public Records Act, §132-1 *et seq.*, and open-meetings law, §143-318.9 *et seq.* The Board may promulgate rules and regulations governing the practice of dentistry within the State, provided those mandates are not inconsistent with the Act and are approved by the North Carolina Rules Review Commission, whose members are appointed by the state legislature. See §§90-48, 143B-30.1, 150B-21.9(a).

B

In the 1990's, dentists in North Carolina started whitening teeth. Many of those who did so, including 8 of the Board's 10 members during the period at issue in this case, earned substantial fees for that service. By 2003, nondentists arrived on the scene. They charged lower

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prices for their services than the dentists did. Dentists soon began to complain to the Board about their new competitors. Few complaints warned of possible harm to consumers. Most expressed a principal concern with the low prices charged by nondentists.

Responding to these filings, the Board opened an investigation into nondentist teeth whitening. A dentist member was placed in charge of the inquiry. Neither the Board's hygienist member nor its consumer member participated in this undertaking. The Board's chief operations officer remarked that the Board was "going forth to do battle" with nondentists. App. to Pet. for Cert. 103a. The Board's concern did not result in a formal rule or regulation reviewable by the independent Rules Review Commission, even though the Act does not, by its terms, specify that teeth whitening is "the practice of dentistry."

Starting in 2006, the Board issued at least 47 cease-and-desist letters on its official letterhead to nondentist teeth whitening service providers and product manufacturers. Many of those letters directed the recipient to cease "all activity constituting the practice of dentistry"; warned that the unlicensed practice of dentistry is a crime; and strongly implied (or expressly stated) that teeth whitening constitutes "the practice of dentistry." App. 13, 15. In early 2007, the Board persuaded the North Carolina Board of Cosmetic Art Examiners to warn cosmetologists against providing teeth whitening services. Later that year, the Board sent letters to mall operators, stating that kiosk teeth whiteners were violating the Dental Practice Act and advising that the malls consider expelling violators from their premises.

These actions had the intended result. Nondentists ceased offering teeth whitening services in North Carolina.

C

In 2010, the Federal Trade Commission (FTC) filed an

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administrative complaint charging the Board with violating §5 of the Federal Trade Commission Act, 38 Stat. 719, as amended, 15 U. S. C. §45. The FTC alleged that the Board's concerted action to exclude nondentists from the market for teeth whitening services in North Carolina constituted an anticompetitive and unfair method of competition. The Board moved to dismiss, alleging state-action immunity. An Administrative Law Judge (ALJ) denied the motion. On appeal, the FTC sustained the ALJ's ruling. It reasoned that, even assuming the Board had acted pursuant to a clearly articulated state policy to displace competition, the Board is a "public/private hybrid" that must be actively supervised by the State to claim immunity. App. to Pet. for Cert. 49a. The FTC further concluded the Board could not make that showing.

Following other proceedings not relevant here, the ALJ conducted a hearing on the merits and determined the Board had unreasonably restrained trade in violation of antitrust law. On appeal, the FTC again sustained the ALJ. The FTC rejected the Board's public safety justification, noting, *inter alia*, "a wealth of evidence . . . suggesting that non-dentist provided teeth whitening is a safe cosmetic procedure." *Id.*, at 123a.

The FTC ordered the Board to stop sending the cease-and-desist letters or other communications that stated nondentists may not offer teeth whitening services and products. It further ordered the Board to issue notices to all earlier recipients of the Board's cease-and-desist orders advising them of the Board's proper sphere of authority and saying, among other options, that the notice recipients had a right to seek declaratory rulings in state court.

On petition for review, the Court of Appeals for the Fourth Circuit affirmed the FTC in all respects. 717 F. 3d 359, 370 (2013). This Court granted certiorari. 571 U. S. ____ (2014).

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II

Federal antitrust law is a central safeguard for the Nation's free market structures. In this regard it is "as important to the preservation of economic freedom and our free-enterprise system as the Bill of Rights is to the protection of our fundamental personal freedoms." *United States v. Topco Associates, Inc.*, 405 U. S. 596, 610 (1972). The antitrust laws declare a considered and decisive prohibition by the Federal Government of cartels, price fixing, and other combinations or practices that undermine the free market.

The Sherman Act, 26 Stat. 209, as amended, 15 U. S. C. §1 *et seq.*, serves to promote robust competition, which in turn empowers the States and provides their citizens with opportunities to pursue their own and the public's welfare. See *FTC v. Ticor Title Ins. Co.*, 504 U. S. 621, 632 (1992). The States, however, when acting in their respective realm, need not adhere in all contexts to a model of unfettered competition. While "the States regulate their economies in many ways not inconsistent with the antitrust laws," *id.*, at 635–636, in some spheres they impose restrictions on occupations, confer exclusive or shared rights to dominate a market, or otherwise limit competition to achieve public objectives. If every duly enacted state law or policy were required to conform to the mandates of the Sherman Act, thus promoting competition at the expense of other values a State may deem fundamental, federal antitrust law would impose an impermissible burden on the States' power to regulate. See *Exxon Corp. v. Governor of Maryland*, 437 U. S. 117, 133 (1978); see also Easterbrook, *Antitrust and the Economics of Federalism*, 26 J. Law & Econ. 23, 24 (1983).

For these reasons, the Court in *Parker v. Brown* interpreted the antitrust laws to confer immunity on anticompetitive conduct by the States when acting in their sovereign capacity. See 317 U. S., at 350–351. That ruling

recognized Congress' purpose to respect the federal balance and to "embody in the Sherman Act the federalism principle that the States possess a significant measure of sovereignty under our Constitution." *Community Communications Co. v. Boulder*, 455 U. S. 40, 53 (1982). Since 1943, the Court has reaffirmed the importance of *Parker's* central holding. See, e.g., *Ticor, supra*, at 632–637; *Hoover v. Ronwin*, 466 U. S. 558, 568 (1984); *Lafayette v. Louisiana Power & Light Co.*, 435 U. S. 389, 394–400 (1978).

III

In this case the Board argues its members were invested by North Carolina with the power of the State and that, as a result, the Board's actions are cloaked with *Parker* immunity. This argument fails, however. A nonsovereign actor controlled by active market participants—such as the Board—enjoys *Parker* immunity only if it satisfies two requirements: "first that 'the challenged restraint . . . be one clearly articulated and affirmatively expressed as state policy,' and second that 'the policy . . . be actively supervised by the State.'" *FTC v. Phoebe Putney Health System, Inc.*, 568 U. S. ___, ___ (2013) (slip op., at 7) (quoting *California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc.*, 445 U. S. 97, 105 (1980)). The parties have assumed that the clear articulation requirement is satisfied, and we do the same. While North Carolina prohibits the unauthorized practice of dentistry, however, its Act is silent on whether that broad prohibition covers teeth whitening. Here, the Board did not receive active supervision by the State when it interpreted the Act as addressing teeth whitening and when it enforced that policy by issuing cease-and-desist letters to nondentist teeth whiteners.

A

Although state-action immunity exists to avoid conflicts

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between state sovereignty and the Nation's commitment to a policy of robust competition, *Parker* immunity is not unbounded. “[G]iven the fundamental national values of free enterprise and economic competition that are embodied in the federal antitrust laws, ‘state action immunity is disfavored, much as are repeals by implication.’” *Phoebe Putney, supra*, at ____ (slip op., at 7) (quoting *Ticor, supra*, at 636).

An entity may not invoke *Parker* immunity unless the actions in question are an exercise of the State's sovereign power. See *Columbia v. Omni Outdoor Advertising, Inc.*, 499 U. S. 365, 374 (1991). State legislation and “decision[s] of a state supreme court, acting legislatively rather than judicially,” will satisfy this standard, and “*ipso facto* are exempt from the operation of the antitrust laws” because they are an undoubted exercise of state sovereign authority. *Hoover, supra*, at 567–568.

But while the Sherman Act confers immunity on the States' own anticompetitive policies out of respect for federalism, it does not always confer immunity where, as here, a State delegates control over a market to a non-sovereign actor. See *Parker, supra*, at 351 (“[A] state does not give immunity to those who violate the Sherman Act by authorizing them to violate it, or by declaring that their action is lawful”). For purposes of *Parker*, a nonsovereign actor is one whose conduct does not automatically qualify as that of the sovereign State itself. See *Hoover, supra*, at 567–568. State agencies are not simply by their governmental character sovereign actors for purposes of state-action immunity. See *Goldfarb v. Virginia State Bar*, 421 U. S. 773, 791 (1975) (“The fact that the State Bar is a state agency for some limited purposes does not create an antitrust shield that allows it to foster anticompetitive practices for the benefit of its members”). Immunity for state agencies, therefore, requires more than a mere facade of state involvement, for it is necessary in light of

Parker's rationale to ensure the States accept political accountability for anticompetitive conduct they permit and control. See *Ticor*, 504 U. S., at 636.

Limits on state-action immunity are most essential when the State seeks to delegate its regulatory power to active market participants, for established ethical standards may blend with private anticompetitive motives in a way difficult even for market participants to discern. Dual allegiances are not always apparent to an actor. In consequence, active market participants cannot be allowed to regulate their own markets free from antitrust accountability. See *Midcal*, *supra*, at 106 (“The national policy in favor of competition cannot be thwarted by casting [a] gauzy cloak of state involvement over what is essentially a private price-fixing arrangement”). Indeed, prohibitions against anticompetitive self-regulation by active market participants are an axiom of federal antitrust policy. See, e.g., *Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U. S. 492, 501 (1988); *Hoover*, *supra*, at 584 (Stevens, J., dissenting) (“The risk that private regulation of market entry, prices, or output may be designed to confer monopoly profits on members of an industry at the expense of the consuming public has been the central concern of . . . our antitrust jurisprudence”); see also Elhauge, *The Scope of Antitrust Process*, 104 Harv. L. Rev. 667, 672 (1991). So it follows that, under *Parker* and the Supremacy Clause, the States’ greater power to attain an end does not include the lesser power to negate the congressional judgment embodied in the Sherman Act through unsupervised delegations to active market participants. See Garland, *Antitrust and State Action: Economic Efficiency and the Political Process*, 96 Yale L. J. 486, 500 (1986).

Parker immunity requires that the anticompetitive conduct of nonsovereign actors, especially those authorized by the State to regulate their own profession, result from procedures that suffice to make it the State’s own.

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See *Goldfarb, supra*, at 790; see also 1A P. Areeda & H. Hovencamp, *Antitrust Law* ¶226, p. 180 (4th ed. 2013) (Areeda & Hovencamp). The question is not whether the challenged conduct is efficient, well-functioning, or wise. See *Ticor, supra*, at 634–635. Rather, it is “whether anti-competitive conduct engaged in by [nonsovereign actors] should be deemed state action and thus shielded from the antitrust laws.” *Patrick v. Burget*, 486 U. S. 94, 100 (1988).

To answer this question, the Court applies the two-part test set forth in *California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc.*, 445 U. S. 97, a case arising from California’s delegation of price-fixing authority to wine merchants. Under *Midcal*, “[a] state law or regulatory scheme cannot be the basis for antitrust immunity unless, first, the State has articulated a clear policy to allow the anticompetitive conduct, and second, the State provides active supervision of [the] anticompetitive conduct.” *Ticor, supra*, at 631 (citing *Midcal, supra*, at 105).

Midcal’s clear articulation requirement is satisfied “where the displacement of competition [is] the inherent, logical, or ordinary result of the exercise of authority delegated by the state legislature. In that scenario, the State must have foreseen and implicitly endorsed the anticompetitive effects as consistent with its policy goals.” *Phoebe Putney*, 568 U. S., at ____ (slip op., at 11). The active supervision requirement demands, *inter alia*, “that state officials have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy.” *Patrick, supra*, U. S., at 101.

The two requirements set forth in *Midcal* provide a proper analytical framework to resolve the ultimate question whether an anticompetitive policy is indeed the policy of a State. The first requirement—clear articulation—rarely will achieve that goal by itself, for a policy may

satisfy this test yet still be defined at so high a level of generality as to leave open critical questions about how and to what extent the market should be regulated. See *Ticor, supra*, at 636–637. Entities purporting to act under state authority might diverge from the State’s considered definition of the public good. The resulting asymmetry between a state policy and its implementation can invite private self-dealing. The second *Midcal* requirement—active supervision—seeks to avoid this harm by requiring the State to review and approve interstitial policies made by the entity claiming immunity.

Midcal’s supervision rule “stems from the recognition that ‘[w]here a private party is engaging in anticompetitive activity, there is a real danger that he is acting to further his own interests, rather than the governmental interests of the State.’” *Patrick, supra*, at 100. Concern about the private incentives of active market participants animates *Midcal*’s supervision mandate, which demands “realistic assurance that a private party’s anticompetitive conduct promotes state policy, rather than merely the party’s individual interests.” *Patrick, supra*, at 101.

B

In determining whether anticompetitive policies and conduct are indeed the action of a State in its sovereign capacity, there are instances in which an actor can be excused from *Midcal*’s active supervision requirement. In *Hallie v. Eau Claire*, 471 U. S. 34, 45 (1985), the Court held municipalities are subject exclusively to *Midcal*’s “clear articulation” requirement. That rule, the Court observed, is consistent with the objective of ensuring that the policy at issue be one enacted by the State itself. *Hallie* explained that “[w]here the actor is a municipality, there is little or no danger that it is involved in a private price-fixing arrangement. The only real danger is that it will seek to further purely parochial public interests at the

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expense of more overriding state goals.” 471 U. S., at 47. *Hallie* further observed that municipalities are electorally accountable and lack the kind of private incentives characteristic of active participants in the market. See *id.*, at 45, n. 9. Critically, the municipality in *Hallie* exercised a wide range of governmental powers across different economic spheres, substantially reducing the risk that it would pursue private interests while regulating any single field. See *ibid.* That *Hallie* excused municipalities from *Midcal*’s supervision rule for these reasons all but confirms the rule’s applicability to actors controlled by active market participants, who ordinarily have none of the features justifying the narrow exception *Hallie* identified. See 471 U. S., at 45.

Following *Goldfarb*, *Midcal*, and *Hallie*, which clarified the conditions under which *Parker* immunity attaches to the conduct of a nonsovereign actor, the Court in *Columbia v. Omni Outdoor Advertising, Inc.*, 499 U. S. 365, addressed whether an otherwise immune entity could lose immunity for conspiring with private parties. In *Omni*, an aspiring billboard merchant argued that the city of Columbia, South Carolina, had violated the Sherman Act—and forfeited its *Parker* immunity—by anticompetitively conspiring with an established local company in passing an ordinance restricting new billboard construction. 499 U. S., at 367–368. The Court disagreed, holding there is no “conspiracy exception” to *Parker*. *Omni, supra*, at 374.

Omni, like the cases before it, recognized the importance of drawing a line “relevant to the purposes of the Sherman Act and of *Parker*: prohibiting the restriction of competition for private gain but permitting the restriction of competition in the public interest.” 499 U. S., at 378. In the context of a municipal actor which, as in *Hallie*, exercised substantial governmental powers, *Omni* rejected a conspiracy exception for “corruption” as vague and unworkable, since “virtually all regulation benefits some

segments of the society and harms others” and may in that sense be seen as “‘corrupt.’” 499 U. S., at 377. *Omni* also rejected subjective tests for corruption that would force a “deconstruction of the governmental process and probing of the official ‘intent’ that we have consistently sought to avoid.” *Ibid.* Thus, whereas the cases preceding it addressed the preconditions of *Parker* immunity and engaged in an objective, *ex ante* inquiry into nonsovereign actors’ structure and incentives, *Omni* made clear that recipients of immunity will not lose it on the basis of ad hoc and *ex post* questioning of their motives for making particular decisions.

Omni’s holding makes it all the more necessary to ensure the conditions for granting immunity are met in the first place. The Court’s two state-action immunity cases decided after *Omni* reinforce this point. In *Ticor* the Court affirmed that *Midcal*’s limits on delegation must ensure that “[a]ctual state involvement, not deference to private price-fixing arrangements under the general auspices of state law, is the precondition for immunity from federal law.” 504 U. S., at 633. And in *Phoebe Putney* the Court observed that *Midcal*’s active supervision requirement, in particular, is an essential condition of state-action immunity when a nonsovereign actor has “an incentive to pursue [its] own self-interest under the guise of implementing state policies.” 568 U. S., at ___ (slip op., at 8) (quoting *Hallie*, *supra*, at 46–47). The lesson is clear: *Midcal*’s active supervision test is an essential prerequisite of *Parker* immunity for any nonsovereign entity—public or private—controlled by active market participants.

C

The Board argues entities designated by the States as agencies are exempt from *Midcal*’s second requirement. That premise, however, cannot be reconciled with the Court’s repeated conclusion that the need for supervision

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turns not on the formal designation given by States to regulators but on the risk that active market participants will pursue private interests in restraining trade.

State agencies controlled by active market participants, who possess singularly strong private interests, pose the very risk of self-dealing *Midcal's* supervision requirement was created to address. See *Areeda & Hovencamp* ¶227, at 226. This conclusion does not question the good faith of state officers but rather is an assessment of the structural risk of market participants' confusing their own interests with the State's policy goals. See *Patrick*, 486 U. S., at 100–101.

The Court applied this reasoning to a state agency in *Goldfarb*. There the Court denied immunity to a state agency (the Virginia State Bar) controlled by market participants (lawyers) because the agency had “joined in what is essentially a private anticompetitive activity” for “the benefit of its members.” 421 U. S., at 791, 792. This emphasis on the Bar's private interests explains why *Goldfarb*, though it predates *Midcal*, considered the lack of supervision by the Virginia Supreme Court to be a principal reason for denying immunity. See 421 U. S., at 791; see also *Hoover*, 466 U. S., at 569 (emphasizing lack of active supervision in *Goldfarb*); *Bates v. State Bar of Ariz.*, 433 U. S. 350, 361–362 (1977) (granting the Arizona Bar state-action immunity partly because its “rules are subject to pointed re-examination by the policymaker”).

While *Hallie* stated “it is likely that active state supervision would also not be required” for agencies, 471 U. S., at 46, n. 10, the entity there, as was later the case in *Omni*, was an electorally accountable municipality with general regulatory powers and no private price-fixing agenda. In that and other respects the municipality was more like prototypical state agencies, not specialized boards dominated by active market participants. In important regards, agencies controlled by market partici-

pants are more similar to private trade associations vested by States with regulatory authority than to the agencies *Hallie* considered. And as the Court observed three years after *Hallie*, “[t]here is no doubt that the members of such associations often have economic incentives to restrain competition and that the product standards set by such associations have a serious potential for anticompetitive harm.” *Allied Tube*, 486 U. S., at 500. For that reason, those associations must satisfy *Midcal*’s active supervision standard. See *Midcal*, 445 U. S., at 105–106.

The similarities between agencies controlled by active market participants and private trade associations are not eliminated simply because the former are given a formal designation by the State, vested with a measure of government power, and required to follow some procedural rules. See *Hallie*, *supra*, at 39 (rejecting “purely formalistic” analysis). *Parker* immunity does not derive from nomenclature alone. When a State empowers a group of active market participants to decide who can participate in its market, and on what terms, the need for supervision is manifest. See *Areeda & Hovencamp* ¶227, at 226. The Court holds today that a state board on which a controlling number of decisionmakers are active market participants in the occupation the board regulates must satisfy *Midcal*’s active supervision requirement in order to invoke state-action antitrust immunity.

D

The State argues that allowing this FTC order to stand will discourage dedicated citizens from serving on state agencies that regulate their own occupation. If this were so—and, for reasons to be noted, it need not be so—there would be some cause for concern. The States have a sovereign interest in structuring their governments, see *Gregory v. Ashcroft*, 501 U. S. 452, 460 (1991), and may conclude there are substantial benefits to staffing their

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agencies with experts in complex and technical subjects, see *Southern Motor Carriers Rate Conference, Inc. v. United States*, 471 U. S. 48, 64 (1985). There is, moreover, a long tradition of citizens esteemed by their professional colleagues devoting time, energy, and talent to enhancing the dignity of their calling.

Adherence to the idea that those who pursue a calling must embrace ethical standards that derive from a duty separate from the dictates of the State reaches back at least to the Hippocratic Oath. See generally S. Miles, *The Hippocratic Oath and the Ethics of Medicine* (2004). In the United States, there is a strong tradition of professional self-regulation, particularly with respect to the development of ethical rules. See generally R. Rotunda & J. Dzienkowski, *Legal Ethics: The Lawyer's Deskbook on Professional Responsibility* (2014); R. Baker, *Before Bioethics: A History of American Medical Ethics From the Colonial Period to the Bioethics Revolution* (2013). Dentists are no exception. The American Dental Association, for example, in an exercise of “the privilege and obligation of self-government,” has “call[ed] upon dentists to follow high ethical standards,” including “honesty, compassion, kindness, integrity, fairness and charity.” American Dental Association, *Principles of Ethics and Code of Professional Conduct* 3–4 (2012). State laws and institutions are sustained by this tradition when they draw upon the expertise and commitment of professionals.

Today's holding is not inconsistent with that idea. The Board argues, however, that the potential for money damages will discourage members of regulated occupations from participating in state government. Cf. *Filarisky v. Delia*, 566 U. S. ____, ____ (2012) (slip op., at 12) (warning in the context of civil rights suits that the “the most talented candidates will decline public engagements if they do not receive the same immunity enjoyed by their public employee counterparts”). But this case, which does not

present a claim for money damages, does not offer occasion to address the question whether agency officials, including board members, may, under some circumstances, enjoy immunity from damages liability. See *Goldfarb*, 421 U. S., at 792, n. 22; see also Brief for Respondent 56. And, of course, the States may provide for the defense and indemnification of agency members in the event of litigation.

States, furthermore, can ensure *Parker* immunity is available to agencies by adopting clear policies to displace competition; and, if agencies controlled by active market participants interpret or enforce those policies, the States may provide active supervision. Precedent confirms this principle. The Court has rejected the argument that it would be unwise to apply the antitrust laws to professional regulation absent compliance with the prerequisites for invoking *Parker* immunity:

“[Respondents] contend that effective peer review is essential to the provision of quality medical care and that any threat of antitrust liability will prevent physicians from participating openly and actively in peer-review proceedings. This argument, however, essentially challenges the wisdom of applying the antitrust laws to the sphere of medical care, and as such is properly directed to the legislative branch. To the extent that Congress has declined to exempt medical peer review from the reach of the antitrust laws, peer review is immune from antitrust scrutiny only if the State effectively has made this conduct its own.” *Patrick*, 486 U. S. at 105–106 (footnote omitted).

The reasoning of *Patrick v. Burget* applies to this case with full force, particularly in light of the risks licensing boards dominated by market participants may pose to the free market. See generally Edlin & Haw, *Cartels by Another Name: Should Licensed Occupations Face Antitrust Scrutiny?* 162 U. Pa. L. Rev. 1093 (2014).

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E

The Board does not contend in this Court that its anti-competitive conduct was actively supervised by the State or that it should receive *Parker* immunity on that basis.

By statute, North Carolina delegates control over the practice of dentistry to the Board. The Act, however, says nothing about teeth whitening, a practice that did not exist when it was passed. After receiving complaints from other dentists about the nondentists' cheaper services, the Board's dentist members—some of whom offered whitening services—acted to expel the dentists' competitors from the market. In so doing the Board relied upon cease-and-desist letters threatening criminal liability, rather than any of the powers at its disposal that would invoke oversight by a politically accountable official. With no active supervision by the State, North Carolina officials may well have been unaware that the Board had decided teeth whitening constitutes “the practice of dentistry” and sought to prohibit those who competed against dentists from participating in the teeth whitening market. Whether or not the Board exceeded its powers under North Carolina law, cf. *Omni*, 499 U. S., at 371–372, there is no evidence here of any decision by the State to initiate or concur with the Board's actions against the nondentists.

IV

The Board does not claim that the State exercised active, or indeed any, supervision over its conduct regarding nondentist teeth whiteners; and, as a result, no specific supervisory systems can be reviewed here. It suffices to note that the inquiry regarding active supervision is flexible and context-dependent. Active supervision need not entail day-to-day involvement in an agency's operations or micromanagement of its every decision. Rather, the question is whether the State's review mechanisms provide “realistic assurance” that a nonsovereign actor's anticom-

petitive conduct "promotes state policy, rather than merely the party's individual interests." *Patrick, supra*, at 100-101; see also *Ticor*, 504 U. S., at 639-640.

The Court has identified only a few constant requirements of active supervision: The supervisor must review the substance of the anticompetitive decision, not merely the procedures followed to produce it, see *Patrick*, 486 U. S., at 102-103; the supervisor must have the power to veto or modify particular decisions to ensure they accord with state policy, see *ibid.*; and the "mere potential for state supervision is not an adequate substitute for a decision by the State," *Ticor, supra*, at 638. Further, the state supervisor may not itself be an active market participant. In general, however, the adequacy of supervision otherwise will depend on all the circumstances of a case.

* * *

The Sherman Act protects competition while also respecting federalism. It does not authorize the States to abandon markets to the unsupervised control of active market participants, whether trade associations or hybrid agencies. If a State wants to rely on active market participants as regulators, it must provide active supervision if state-action immunity under *Parker* is to be invoked.

The judgment of the Court of Appeals for the Fourth Circuit is affirmed.

It is so ordered.

ALITO, J., dissenting

SUPREME COURT OF THE UNITED STATES

No. 13-534

NORTH CAROLINA STATE BOARD OF DENTAL
EXAMINERS, PETITIONER *v.* FEDERAL
TRADE COMMISSION

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF
APPEALS FOR THE FOURTH CIRCUIT

[February 25, 2015]

JUSTICE ALITO, with whom JUSTICE SCALIA and JUSTICE THOMAS join, dissenting.

The Court's decision in this case is based on a serious misunderstanding of the doctrine of state-action antitrust immunity that this Court recognized more than 60 years ago in *Parker v. Brown*, 317 U. S. 341 (1943). In *Parker*, the Court held that the Sherman Act does not prevent the States from continuing their age-old practice of enacting measures, such as licensing requirements, that are designed to protect the public health and welfare. *Id.*, at 352. The case now before us involves precisely this type of state regulation—North Carolina's laws governing the practice of dentistry, which are administered by the North Carolina Board of Dental Examiners (Board).

Today, however, the Court takes the unprecedented step of holding that *Parker* does not apply to the North Carolina Board because the Board is not structured in a way that merits a good-government seal of approval; that is, it is made up of practicing dentists who have a financial incentive to use the licensing laws to further the financial interests of the State's dentists. There is nothing new about the structure of the North Carolina Board. When the States first created medical and dental boards, well before the Sherman Act was enacted, they began to staff

them in this way.¹ Nor is there anything new about the suspicion that the North Carolina Board—in attempting to prevent persons other than dentists from performing teeth-whitening procedures—was serving the interests of dentists and not the public. Professional and occupational licensing requirements have often been used in such a way.² But that is not what *Parker* immunity is about. Indeed, the very state program involved in that case was unquestionably designed to benefit the regulated entities, California raisin growers.

The question before us is not whether such programs serve the public interest. The question, instead, is whether this case is controlled by *Parker*, and the answer to that question is clear. Under *Parker*, the Sherman Act (and the Federal Trade Commission Act, see *FTC v. Ticor Title Ins. Co.*, 504 U. S. 621, 635 (1992)) do not apply to state agencies; the North Carolina Board of Dental Examiners is a state agency; and that is the end of the matter. By straying from this simple path, the Court has not only distorted *Parker*; it has headed into a morass. Determining whether a state agency is structured in a way that militates against regulatory capture is no easy task, and there is reason to fear that today's decision will spawn confusion. The Court has veered off course, and therefore I cannot go along.

¹S. White, *History of Oral and Dental Science in America* 197–214 (1876) (detailing earliest American regulations of the practice of dentistry).

²See, e.g., R. Shrylock, *Medical Licensing in America* 29 (1967) (Shrylock) (detailing the deterioration of licensing regimes in the mid-19th century, in part out of concerns about restraints on trade); Gellhorn, *The Abuse of Occupational Licensing*, 44 *U. Chi. L. Rev.* 6 (1976); Shepard, *Licensing Restrictions and the Cost of Dental Care*, 21 *J. Law & Econ.* 187 (1978).

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I

In order to understand the nature of *Parker* state-action immunity, it is helpful to recall the constitutional landscape in 1890 when the Sherman Act was enacted. At that time, this Court and Congress had an understanding of the scope of federal and state power that is very different from our understanding today. The States were understood to possess the exclusive authority to regulate “their purely internal affairs.” *Leisy v. Hardin*, 135 U. S. 100, 122 (1890). In exercising their police power in this area, the States had long enacted measures, such as price controls and licensing requirements, that had the effect of restraining trade.³

The Sherman Act was enacted pursuant to Congress’ power to regulate interstate commerce, and in passing the Act, Congress wanted to exercise that power “to the utmost extent.” *United States v. South-Eastern Underwriters Assn.*, 322 U. S. 533, 558 (1944). But in 1890, the understanding of the commerce power was far more limited than it is today. See, e.g., *Kidd v. Pearson*, 128 U. S. 1, 17–18 (1888). As a result, the Act did not pose a threat to traditional state regulatory activity.

By 1943, when *Parker* was decided, however, the situation had changed dramatically. This Court had held that the commerce power permitted Congress to regulate even local activity if it “exerts a substantial economic effect on interstate commerce.” *Wickard v. Filburn*, 317 U. S. 111, 125 (1942). This meant that Congress could regulate many of the matters that had once been thought to fall exclusively within the jurisdiction of the States. The new interpretation of the commerce power brought about an expansion of the reach of the Sherman Act. See *Hospital*

³See Handler, *The Current Attack on the Parker v. Brown State Action Doctrine*, 76 Colum. L. Rev. 1, 4–6 (1976) (collecting cases).

Building Co. v. Trustees of Rex Hospital, 425 U. S. 738, 743, n. 2 (1976) (“[D]ecisions by this Court have permitted the reach of the Sherman Act to expand along with expanding notions of congressional power”). And the expanded reach of the Sherman Act raised an important question. The Sherman Act does not expressly exempt States from its scope. Does that mean that the Act applies to the States and that it potentially outlaws many traditional state regulatory measures? The Court confronted that question in *Parker*.

In *Parker*, a raisin producer challenged the California Agricultural Prorate Act, an agricultural price support program. The California Act authorized the creation of an Agricultural Prorate Advisory Commission (Commission) to establish marketing plans for certain agricultural commodities within the State. 317 U. S., at 346–347. Raisins were among the regulated commodities, and so the Commission established a marketing program that governed many aspects of raisin sales, including the quality and quantity of raisins sold, the timing of sales, and the price at which raisins were sold. *Id.*, at 347–348. The *Parker* Court assumed that this program would have violated “the Sherman Act if it were organized and made effective solely by virtue of a contract, combination or conspiracy of private persons,” and the Court also assumed that Congress could have prohibited a State from creating a program like California’s if it had chosen to do so. *Id.*, at 350. Nevertheless, the Court concluded that the California program did not violate the Sherman Act because the Act did not circumscribe state regulatory power. *Id.*, at 351.

The Court’s holding in *Parker* was not based on either the language of the Sherman Act or anything in the legislative history affirmatively showing that the Act was not meant to apply to the States. Instead, the Court reasoned that “[i]n a dual system of government in which, under the Constitution, the states are sovereign, save only as Con-

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gress may constitutionally subtract from their authority, an unexpressed purpose to nullify a state's control over its officers and agents is not lightly to be attributed to Congress." 317 U. S., at 351. For the Congress that enacted the Sherman Act in 1890, it would have been a truly radical and almost certainly futile step to attempt to prevent the States from exercising their traditional regulatory authority, and the *Parker* Court refused to assume that the Act was meant to have such an effect.

When the basis for the *Parker* state-action doctrine is understood, the Court's error in this case is plain. In 1890, the regulation of the practice of medicine and dentistry was regarded as falling squarely within the States' sovereign police power. By that time, many States had established medical and dental boards, often staffed by doctors or dentists,⁴ and had given those boards the authority to confer and revoke licenses.⁵ This was quintessential police power legislation, and although state laws were often challenged during that era under the doctrine of substantive due process, the licensing of medical professionals easily survived such assaults. Just one year before the enactment of the Sherman Act, in *Dent v. West Virginia*, 129 U. S. 114, 128 (1889), this Court rejected such a challenge to a state law requiring all physicians to obtain a certificate from the state board of health attesting to their qualifications. And in *Hawker v. New York*, 170 U. S. 189, 192 (1898), the Court reiterated that a law

⁴Shrylock 54–55; D. Johnson and H. Chaudry, *Medical Licensing and Discipline in America* 23–24 (2012).

⁵In *Hawker v. New York*, 170 U. S. 189 (1898), the Court cited state laws authorizing such boards to refuse or revoke medical licenses. *Id.*, at 191–193, n. 1. See also *Douglas v. Noble*, 261 U. S. 165, 166 (1923) (“In 1893 the legislature of Washington provided that only licensed persons should practice dentistry” and “vested the authority to license in a board of examiners, consisting of five practicing dentists”).

specifying the qualifications to practice medicine was clearly a proper exercise of the police power. Thus, the North Carolina statutes establishing and specifying the powers of the State Board of Dental Examiners represent precisely the kind of state regulation that the *Parker* exemption was meant to immunize.

II

As noted above, the only question in this case is whether the North Carolina Board of Dental Examiners is really a state agency, and the answer to that question is clearly yes.

- The North Carolina Legislature determined that the practice of dentistry “affect[s] the public health, safety and welfare” of North Carolina’s citizens and that therefore the profession should be “subject to regulation and control in the public interest” in order to ensure “that only qualified persons be permitted to practice dentistry in the State.” N. C. Gen. Stat. Ann. §90–22(a) (2013).
- To further that end, the legislature created the North Carolina State Board of Dental Examiners “as the agency of the State for the regulation of the practice of dentistry in th[e] State.” §90–22(b).
- The legislature specified the membership of the Board. §90–22(c). It defined the “practice of dentistry,” §90–29(b), and it set out standards for licensing practitioners, §90–30. The legislature also set out standards under which the Board can initiate disciplinary proceedings against licensees who engage in certain improper acts. §90–41(a).
- The legislature empowered the Board to “maintain an action in the name of the State of North Carolina to perpetually enjoin any person from . . . unlawfully practicing dentistry.” §90–40.1(a). It authorized the Board to conduct investigations and to hire legal

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counsel, and the legislature made any “notice or statement of charges against any licensee” a public record under state law. §§ 90–41(d)–(g).

- The legislature empowered the Board “to enact rules and regulations governing the practice of dentistry within the State,” consistent with relevant statutes. §90–48. It has required that any such rules be included in the Board’s annual report, which the Board must file with the North Carolina secretary of state, the state attorney general, and the legislature’s Joint Regulatory Reform Committee. §93B–2. And if the Board fails to file the required report, state law demands that it be automatically suspended until it does so. *Ibid.*

As this regulatory regime demonstrates, North Carolina’s Board of Dental Examiners is unmistakably a state agency created by the state legislature to serve a prescribed regulatory purpose and to do so using the State’s power in cooperation with other arms of state government.

The Board is not a private or “nonsovereign” entity that the State of North Carolina has attempted to immunize from federal antitrust scrutiny. *Parker* made it clear that a State may not “give immunity to those who violate the Sherman Act by authorizing them to violate it, or by declaring that their action is lawful.” *Ante*, at 7 (quoting *Parker*, 317 U. S., at 351). When the *Parker* Court disapproved of any such attempt, it cited *Northern Securities Co. v. United States*, 193 U. S. 197 (1904), to show what it had in mind. In that case, the Court held that a State’s act of chartering a corporation did not shield the corporation’s monopolizing activities from federal antitrust law. *Id.*, at 344–345. Nothing similar is involved here. North Carolina did not authorize a private entity to enter into an anticompetitive arrangement; rather, North Carolina created a state agency and gave that agency the power to regulate a particular subject affecting public health and

safety.

Nothing in *Parker* supports the type of inquiry that the Court now prescribes. The Court crafts a test under which state agencies that are “controlled by active market participants,” *ante*, at 12, must demonstrate active state supervision in order to be immune from federal antitrust law. The Court thus treats these state agencies like private entities. But in *Parker*, the Court did not examine the structure of the California program to determine if it had been captured by private interests. If the Court had done so, the case would certainly have come out differently, because California conditioned its regulatory measures on the participation and approval of market actors in the relevant industry.

Establishing a prorate marketing plan under California’s law first required the petition of at least 10 producers of the particular commodity. *Parker*, 317 U. S., at 346. If the Commission then agreed that a marketing plan was warranted, the Commission would “select a program committee from among nominees chosen by the qualified producers.” *Ibid.* (emphasis added). That committee would then formulate the proration marketing program, which the Commission could modify or approve. But even after Commission approval, the program became law (and then, automatically) only if it gained the approval of 65 percent of the relevant producers, representing at least 51 percent of the acreage of the regulated crop. *Id.*, at 347. This scheme gave decisive power to market participants. But despite these aspects of the California program, *Parker* held that California was acting as a “sovereign” when it “adopt[ed] and enforc[ed] the prorate program.” *Id.*, at 352. This reasoning is irreconcilable with the Court’s today.

III

The Court goes astray because it forgets the origin of the

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Parker doctrine and is misdirected by subsequent cases that extended that doctrine (in certain circumstances) to private entities. The Court requires the North Carolina Board to satisfy the two-part test set out in *California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc.*, 445 U. S. 97 (1980), but the party claiming *Parker* immunity in that case was not a state agency but a private trade association. Such an entity is entitled to *Parker* immunity, *Midcal* held, only if the anticompetitive conduct at issue was both “‘clearly articulated’” and “‘actively supervised by the State itself.’” 445 U. S., at 105. Those requirements are needed where a State authorizes private parties to engage in anticompetitive conduct. They serve to identify those situations in which conduct by *private parties* can be regarded as the conduct of a State. But when the conduct in question is the conduct of a state agency, no such inquiry is required.

This case falls into the latter category, and therefore *Midcal* is inapposite. The North Carolina Board is not a private trade association. It is a state agency, created and empowered by the State to regulate an industry affecting public health. It would not exist if the State had not created it. And for purposes of *Parker*, its membership is irrelevant; what matters is that it is part of the government of the sovereign State of North Carolina.

Our decision in *Hallie v. Eau Claire*, 471 U. S. 34 (1985), which involved Sherman Act claims against a municipality, not a State agency, is similarly inapplicable. In *Hallie*, the plaintiff argued that the two-pronged *Midcal* test should be applied, but the Court disagreed. The Court acknowledged that municipalities “are not themselves sovereign.” 471 U. S., at 38. But recognizing that a municipality is “an arm of the State,” *id.*, at 45, the Court held that a municipality should be required to satisfy only the first prong of the *Midcal* test (requiring a clearly articulated state policy), 471 U. S., at 46. That municipalities

are not sovereign was critical to our analysis in *Hallie*, and thus that decision has no application in a case, like this one, involving a state agency.

Here, however, the Court not only disregards the North Carolina Board's status as a full-fledged state agency; it treats the Board less favorably than a municipality. This is puzzling. States are sovereign, *Northern Ins. Co. of N. Y. v. Chatham County*, 547 U. S. 189, 193 (2006), and California's sovereignty provided the foundation for the decision in *Parker, supra*, at 352. Municipalities are not sovereign. *Jinks v. Richland County*, 538 U. S. 456, 466 (2003). And for this reason, federal law often treats municipalities differently from States. Compare *Will v. Michigan Dept. of State Police*, 491 U. S. 58, 71 (1989) (“[N]either a State nor its officials acting in their official capacities are ‘persons’ under [42 U. S. C.] §1983”), with *Monell v. City Dept. of Social Servs., New York*, 436 U. S. 658, 694 (1978) (municipalities liable under §1983 where “execution of a government’s policy or custom . . . inflicts the injury”).

The Court recognizes that municipalities, although not sovereign, nevertheless benefit from a more lenient standard for state-action immunity than private entities. Yet under the Court’s approach, the North Carolina Board of Dental Examiners, a full-fledged state agency, is treated like a private actor and must demonstrate that the State actively supervises its actions.

The Court’s analysis seems to be predicated on an assessment of the varying degrees to which a municipality and a state agency like the North Carolina Board are likely to be captured by private interests. But until today, *Parker* immunity was never conditioned on the proper use of state regulatory authority. On the contrary, in *Columbia v. Omni Outdoor Advertising, Inc.*, 499 U. S. 365 (1991), we refused to recognize an exception to *Parker* for cases in which it was shown that the defendants had

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engaged in a conspiracy or corruption or had acted in a way that was not in the public interest. *Id.*, at 374. The Sherman Act, we said, is not an anticorruption or good-government statute. 499 U. S., at 398. We were unwilling in *Omni* to rewrite *Parker* in order to reach the allegedly abusive behavior of city officials. 499 U. S., at 374–379. But that is essentially what the Court has done here.

III

Not only is the Court's decision inconsistent with the underlying theory of *Parker*; it will create practical problems and is likely to have far-reaching effects on the States' regulation of professions. As previously noted, state medical and dental boards have been staffed by practitioners since they were first created, and there are obvious advantages to this approach. It is reasonable for States to decide that the individuals best able to regulate technical professions are practitioners with expertise in those very professions. Staffing the State Board of Dental Examiners with certified public accountants would certainly lessen the risk of actions that place the well-being of dentists over those of the public, but this would also compromise the State's interest in sensibly regulating a technical profession in which lay people have little expertise.

As a result of today's decision, States may find it necessary to change the composition of medical, dental, and other boards, but it is not clear what sort of changes are needed to satisfy the test that the Court now adopts. The Court faults the structure of the North Carolina Board because "active market participants" constitute "a controlling number of [the] decisionmakers," *ante*, at 14, but this test raises many questions.

What is a "controlling number"? Is it a majority? And if so, why does the Court eschew that term? Or does the Court mean to leave open the possibility that something less than a majority might suffice in particular circum-

stances? Suppose that active market participants constitute a voting bloc that is generally able to get its way? How about an obstructionist minority or an agency chair empowered to set the agenda or veto regulations?

Who is an "active market participant"? If Board members withdraw from practice during a short term of service but typically return to practice when their terms end, does that mean that they are not active market participants during their period of service?

What is the scope of the market in which a member may not participate while serving on the board? Must the market be relevant to the particular regulation being challenged or merely to the jurisdiction of the entire agency? Would the result in the present case be different if a majority of the Board members, though practicing dentists, did not provide teeth whitening services? What if they were orthodontists, periodontists, and the like? And how much participation makes a person "active" in the market?

The answers to these questions are not obvious, but the States must predict the answers in order to make informed choices about how to constitute their agencies.

I suppose that all this will be worked out by the lower courts and the Federal Trade Commission (FTC), but the Court's approach raises a more fundamental question, and that is why the Court's inquiry should stop with an examination of the structure of a state licensing board. When the Court asks whether market participants control the North Carolina Board, the Court in essence is asking whether this regulatory body has been captured by the entities that it is supposed to regulate. Regulatory capture can occur in many ways.⁶ So why ask only whether

⁶See, e.g., R. Noll, *Reforming Regulation* 40-43, 46 (1971); J. Wilson, *The Politics of Regulation* 357-394 (1980). Indeed, it has even been

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the members of a board are active market participants? The answer may be that determining when regulatory capture has occurred is no simple task. That answer provides a reason for relieving courts from the obligation to make such determinations at all. It does not explain why it is appropriate for the Court to adopt the rather crude test for capture that constitutes the holding of today's decision.

IV

The Court has created a new standard for distinguishing between private and state actors for purposes of federal antitrust immunity. This new standard is not true to the *Parker* doctrine; it diminishes our traditional respect for federalism and state sovereignty; and it will be difficult to apply. I therefore respectfully dissent.

charged that the FTC, which brought this case, has been captured by entities over which it has jurisdiction. See E. Cox, "The Nader Report" on the Federal Trade Commission vii-xiv (1969); Posner, Federal Trade Commission, *Chi. L. Rev.* 47, 82-84 (1969).

CALIFORNIA ATTORNEY GENERAL

OPINION 15-402

September 10, 2015

TO BE PUBLISHED IN THE OFFICIAL REPORTS

OFFICE OF THE ATTORNEY GENERAL
State of California

KAMALA D. HARRIS
Attorney General

OPINION	:	No. 15-402
	:	
of	:	September 10, 2015
	:	
KAMALA D. HARRIS	:	
Attorney General	:	
	:	
SUSAN DUNCAN LEE	:	
Deputy Attorney General	:	
	:	

THE HONORABLE JERRY HILL, MEMBER OF THE STATE SENATE, has requested an opinion on the following question:

What constitutes “active state supervision” of a state licensing board for purposes of the state action immunity doctrine in antitrust actions, and what measures might be taken to guard against antitrust liability for board members?

CONCLUSIONS

“Active state supervision” requires a state official to review the substance of a regulatory decision made by a state licensing board, in order to determine whether the decision actually furthers a clearly articulated state policy to displace competition with regulation in a particular market. The official reviewing the decision must not be an active member of the market being regulated, and must have and exercise the power to approve, modify, or disapprove the decision.

Measures that might be taken to guard against antitrust liability for board members include changing the composition of boards, adding lines of supervision by state officials, and providing board members with legal indemnification and antitrust training.

ANALYSIS

In *North Carolina State Board of Dental Examiners v. Federal Trade Commission*,¹ the Supreme Court of the United States established a new standard for determining whether a state licensing board is entitled to immunity from antitrust actions.

Immunity is important to state actors not only because it shields them from adverse judgments, but because it shields them from having to go through litigation. When immunity is well established, most people are deterred from filing a suit at all. If a suit is filed, the state can move for summary disposition of the case, often before the discovery process begins. This saves the state a great deal of time and money, and it relieves employees (such as board members) of the stresses and burdens that inevitably go along with being sued. This freedom from suit clears a safe space for government officials and employees to perform their duties and to exercise their discretion without constant fear of litigation. Indeed, allowing government actors freedom to exercise discretion is one of the fundamental justifications underlying immunity doctrines.²

Before *North Carolina Dental* was decided, most state licensing boards operated under the assumption that they were protected from antitrust suits under the state action immunity doctrine. In light of the decision, many states—including California—are reassessing the structures and operations of their state licensing boards with a view to determining whether changes should be made to reduce the risk of antitrust claims. This opinion examines the legal requirements for state supervision under the *North Carolina Dental* decision, and identifies a variety of measures that the state Legislature might consider taking in response to the decision.

¹ *North Carolina State Bd. of Dental Examiners v. F. T. C.* (2015) ___ U.S. ___, 135 S. Ct. 1101 (*North Carolina Dental*).

² See *Mitchell v. Forsyth* (1985) 472 U.S. 511, 526; *Harlow v. Fitzgerald* (1982) 457 U.S. 800, 819.

I. *North Carolina Dental* Established a New Immunity Standard for State Licensing Boards

A. *The North Carolina Dental* Decision

The North Carolina Board of Dental Examiners was established under North Carolina law and charged with administering a licensing system for dentists. A majority of the members of the board are themselves practicing dentists. North Carolina statutes delegated authority to the dental board to regulate the practice of dentistry, but did not expressly provide that teeth-whitening was within the scope of the practice of dentistry.

Following complaints by dentists that non-dentists were performing teeth-whitening services for low prices, the dental board conducted an investigation. The board subsequently issued cease-and-desist letters to dozens of teeth-whitening outfits, as well as to some owners of shopping malls where teeth-whiteners operated. The effect on the teeth-whitening market in North Carolina was dramatic, and the Federal Trade Commission took action.

In defense to antitrust charges, the dental board argued that, as a state agency, it was immune from liability under the federal antitrust laws. The Supreme Court rejected that argument, holding that a state board on which a controlling number of decision makers are active market participants must show that it is subject to “active supervision” in order to claim immunity.³

B. State Action Immunity Doctrine Before *North Carolina Dental*

The Sherman Antitrust Act of 1890⁴ was enacted to prevent anticompetitive economic practices such as the creation of monopolies or restraints of trade. The terms of the Sherman Act are broad, and do not expressly exempt government entities, but the Supreme Court has long since ruled that federal principles of dual sovereignty imply that federal antitrust laws do not apply to the actions of states, even if those actions are anticompetitive.⁵

This immunity of states from federal antitrust lawsuits is known as the “state action doctrine.”⁶ The state action doctrine, which was developed by the Supreme Court

³ *North Carolina Dental*, *supra*, 135 S.Ct. at p. 1114.

⁴ 15 U.S.C. §§ 1, 2.

⁵ *Parker v. Brown* (1943) 317 U.S. 341, 350-351.

⁶ It is important to note that the phrase “state action” in this context means something

in *Parker v. Brown*,⁷ establishes three tiers of decision makers, with different thresholds for immunity in each tier.

In the top tier, with the greatest immunity, is the state itself: the sovereign acts of state governments are absolutely immune from antitrust challenge.⁸ Absolute immunity extends, at a minimum, to the state Legislature, the Governor, and the state's Supreme Court.

In the second tier are subordinate state agencies,⁹ such as executive departments and administrative agencies with statewide jurisdiction. State agencies are immune from antitrust challenge if their conduct is undertaken pursuant to a "clearly articulated" and "affirmatively expressed" state policy to displace competition.¹⁰ A state policy is sufficiently clear when displacement of competition is the "inherent, logical, or ordinary result" of the authority delegated by the state legislature.¹¹

The third tier includes private parties acting on behalf of a state, such as the members of a state-created professional licensing board. Private parties may enjoy state action immunity when two conditions are met: (1) their conduct is undertaken pursuant to a "clearly articulated" and "affirmatively expressed" state policy to displace competition, and (2) their conduct is "actively supervised" by the state.¹² The

very different from "state action" for purposes of analysis of a civil rights violation under section 1983 of title 42 of the United States Code. Under section 1983, *liability* attaches to "state action," which may cover even the inadvertent or unilateral act of a state official not acting pursuant to state policy. In the antitrust context, a conclusion that a policy or action amounts to "state action" results in *immunity* from suit.

⁷ *Parker v. Brown, supra*, 317 U.S. 341.

⁸ *Hoover v. Ronwin* (1984) 466 U.S. 558, 574, 579-580.

⁹ Distinguishing the state itself from subordinate state agencies has sometimes proven difficult. Compare the majority opinion in *Hoover v. Ronwin, supra*, 466 U.S. at p. 581 with dissenting opinion of Stevens, J., at pp. 588-589. (See *Costco v. Maleng* (9th Cir. 2008) 522 F.3d 874, 887, subseq. hrg. 538 F.3d 1128; *Charley's Taxi Radio Dispatch Corp. v. SIDA of Haw., Inc.* (9th Cir. 1987) 810 F.2d 869, 875.)

¹⁰ See *Town of Hallie v. City of Eau Claire* (1985) 471 U.S. 34, 39.

¹¹ *F.T.C. v. Phoebe Putney Health Systems, Inc.* (2013) ___ U.S. ___, 133 S.Ct. 1003, 1013; see also *Southern Motor Carriers Rate Conference, Inc. v. U.S.* (1985) 471 U.S. 48, 57 (state policy need not compel specific anticompetitive effect).

¹² *Cal. Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc.* (1980) 445 U.S. 97, 105 (*Midcal*).

fundamental purpose of the supervision requirement is to shelter only those private anticompetitive acts that the state approves as actually furthering its regulatory policies.¹³ To that end, the mere possibility of supervision—such as the existence of a regulatory structure that is not operative, or not resorted to—is not enough. “The active supervision prong . . . requires that state officials have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy.”¹⁴

C. State Action Immunity Doctrine After *North Carolina Dental*

Until the Supreme Court decided *North Carolina Dental*, it was widely believed that most professional licensing boards would fall within the second tier of state action immunity, requiring a clear and affirmative policy, but not active state supervision of every anticompetitive decision. In California in particular, there were good arguments that professional licensing boards¹⁵ were subordinate agencies of the state: they are formal, ongoing bodies created pursuant to state law; they are housed within the Department of Consumer Affairs and operate under the Consumer Affairs Director’s broad powers of investigation and control; they are subject to periodic sunset review by the Legislature, to rule-making review under the Administrative Procedure Act, and to administrative and judicial review of disciplinary decisions; their members are appointed by state officials, and include increasingly large numbers of public (non-professional) members; their meetings and records are subject to open-government laws and to strong prohibitions on conflicts of interest; and their enabling statutes generally provide well-guided discretion to make decisions affecting the professional markets that the boards regulate.¹⁶

Those arguments are now foreclosed, however, by *North Carolina Dental*. There, the Court squarely held, for the first time, that “a state board on which a controlling

¹³ *Patrick v. Burget* (1988) 486 U.S. 94, 100-101.

¹⁴ *Ibid.*

¹⁵ California’s Department of Consumer Affairs includes some 25 professional regulatory boards that establish minimum qualifications and levels of competency for licensure in various professions, including accountancy, acupuncture, architecture, medicine, nursing, structural pest control, and veterinary medicine—to name just a few. (See http://www.dca.gov/about_ca/entities.shtml.)

¹⁶ Cf. 1A Areeda & Hovenkamp, *supra*, ¶ 227, p. 208 (what matters is not what the body is called, but its structure, membership, authority, openness to the public, exposure to ongoing review, etc.).

number of decisionmakers are active market participants in the occupation the board regulates must satisfy *Midcal*'s active supervision requirement in order to invoke state-action antitrust immunity."¹⁷ The effect of *North Carolina Dental* is to put professional licensing boards "on which a controlling number of decision makers are active market participants" in the third tier of state-action immunity. That is, they are immune from antitrust actions as long as they act pursuant to clearly articulated state policy to replace competition with regulation of the profession, *and* their decisions are actively supervised by the state.

Thus arises the question presented here: What constitutes "active state supervision"?¹⁸

D. Legal Standards for Active State Supervision

The active supervision requirement arises from the concern that, when active market participants are involved in regulating their own field, "there is a real danger" that they will act to further their own interests, rather than those of consumers or of the state.¹⁹ The purpose of the requirement is to ensure that state action immunity is afforded to private parties only when their actions actually further the state's policies.²⁰

There is no bright-line test for determining what constitutes active supervision of a professional licensing board: the standard is "flexible and context-dependent."²¹ Sufficient supervision "need not entail day-to-day involvement" in the board's operations or "micromanagement of its every decision."²² Instead, the question is whether the review mechanisms that are in place "provide 'realistic assurance'" that the anticompetitive effects of a board's actions promote state policy, rather than the board members' private interests.²³

¹⁷ *North Carolina Dental*, *supra*, 135 S.Ct. at p. 1114; *Midcal*, *supra*, 445 U.S. at p. 105.

¹⁸ Questions about whether the State's anticompetitive policies are adequately articulated are beyond the scope of this Opinion.

¹⁹ *Patrick v. Burget*, *supra*, 486 U.S. at p. 100, citing *Town of Hallie v. City of Eau Claire*, *supra*, 471 U.S. at p. 47; see *id.* at p. 45 ("A private party . . . may be presumed to be acting primarily on his or its own behalf").

²⁰ *Patrick v. Burget*, *supra*, 486 U.S. at pp. 100-101.

²¹ *North Carolina Dental*, *supra*, 135 S.Ct. at p. 1116.

²² *Ibid.*

²³ *Ibid.*

The *North Carolina Dental* opinion and pre-existing authorities allow us to identify “a few constant requirements of active supervision”:²⁴

- The state supervisor who reviews a decision must have the power to reverse or modify the decision.²⁵
- The “mere potential” for supervision is not an adequate substitute for supervision.²⁶
- When a state supervisor reviews a decision, he or she must review the substance of the decision, not just the procedures followed to reach it.²⁷
- The state supervisor must not be an active market participant.²⁸

Keeping these requirements in mind may help readers evaluate whether California law already provides adequate supervision for professional licensing boards, or whether new or stronger measures are desirable.

II. Threshold Considerations for Assessing Potential Responses to *North Carolina Dental*

There are a number of different measures that the Legislature might consider in response to the *North Carolina Dental* decision. We will describe a variety of these, along with some of their potential advantages or disadvantages. Before moving on to those options, however, we should put the question of immunity into proper perspective.

²⁴ *Id.* at pp. 1116-1117.

²⁵ *Ibid.*

²⁶ *Id.* at p. 1116, citing *F.T.C. v. Ticor Title Ins. Co.* (1992) 504 U.S. 621, 638. For example, a passive or negative-option review process, in which an action is considered approved as long as the state supervisor raises no objection to it, may be considered inadequate in some circumstances. (*Ibid.*)

²⁷ *Ibid.*, citing *Patrick v. Burget, supra*, 486 U.S. at pp. 102-103. In most cases, there should be some evidence that the state supervisor considered the particular circumstances of the action before making a decision. Ideally, there should be a factual record and a written decision showing that there has been an assessment of the action’s potential impact on the market, and whether the action furthers state policy. (See *In the Matter of Indiana Household Moves and Warehousemen, Inc.* (2008) 135 F.T.C. 535, 555-557; see also Federal Trade Commission, Report of the State Action Task Force (2003) at p. 54.)

²⁸ *North Carolina Dental, supra*, 135 S.Ct. at pp. 1116-1117.

There are two important things keep in mind: (1) the loss of immunity, if it is lost, does not mean that an antitrust violation has been committed, and (2) even when board members participate in regulating the markets they compete in, many—if not most—of their actions do not implicate the federal antitrust laws.

In the context of regulating professions, “market-sensitive” decisions (that is, the kinds of decisions that are most likely to be open to antitrust scrutiny) are those that create barriers to market participation, such as rules or enforcement actions regulating the scope of unlicensed practice; licensing requirements imposing heavy burdens on applicants; marketing programs; restrictions on advertising; restrictions on competitive bidding; restrictions on commercial dealings with suppliers and other third parties; and price regulation, including restrictions on discounts.

On the other hand, we believe that there are broad areas of operation where board members can act with reasonable confidence—especially once they and their state-official contacts have been taught to recognize actual antitrust issues, and to treat those issues specially. Broadly speaking, promulgation of regulations is a fairly safe area for board members, because of the public notice, written justification, Director review, and review by the Office of Administrative Law as required by the Administrative Procedure Act. Also, broadly speaking, disciplinary decisions are another fairly safe area because of due process procedures; participation of state actors such as board executive officers, investigators, prosecutors, and administrative law judges; and availability of administrative mandamus review.

We are not saying that the procedures that attend these quasi-legislative and quasi-judicial functions make the licensing boards altogether immune from antitrust claims. Nor are we saying that rule-making and disciplinary actions are *per se* immune from antitrust laws. What we are saying is that, assuming a board identifies its market-sensitive decisions and gets active state supervision for those, then ordinary rule-making and discipline (faithfully carried out under the applicable rules) may be regarded as relatively safe harbors for board members to operate in. It may require some education and experience for board members to understand the difference between market-sensitive and “ordinary” actions, but a few examples may bring in some light.

North Carolina Dental presents a perfect example of a market-sensitive action. There, the dental board decided to, and actually succeeded in, driving non-dentist teeth-whitening service providers out of the market, even though nothing in North Carolina’s laws specified that teeth-whitening constituted the illegal practice of dentistry. Counter-examples—instances where no antitrust violation occurs—are far more plentiful. For example, a regulatory board may legitimately make rules or impose discipline to prohibit license-holders from engaging in fraudulent business practices (such as untruthful or

deceptive advertising) without violating antitrust laws.²⁹ As well, suspending the license of an individual license-holder for violating the standards of the profession is a reasonable restraint and has virtually no effect on a large market, and therefore would not violate antitrust laws.³⁰

Another area where board members can feel safe is in carrying out the actions required by a detailed anticompetitive statutory scheme.³¹ For example, a state law prohibiting certain kinds of advertising or requiring certain fees may be enforced without need for substantial judgment or deliberation by the board. Such detailed legislation leaves nothing for the state to supervise, and thus it may be said that the legislation itself satisfies the supervision requirement.³²

Finally, some actions will not be antitrust violations because their effects are, in fact, pro-competitive rather than anti-competitive. For instance, the adoption of safety standards that are based on objective expert judgments have been found to be pro-competitive.³³ Efficiency measures taken for the benefit of consumers, such as making information available to the purchasers of competing products, or spreading development costs to reduce per-unit prices, have been held to be pro-competitive because they are pro-consumer.³⁴

III. Potential Measures for Preserving State Action Immunity

A. Changes to the Composition of Boards

The *North Carolina Dental* decision turns on the principle that a state board is a group of private actors, not a subordinate state agency, when “a controlling number of decisionmakers are active market participants in the occupation the board regulates.”³⁵

²⁹ See generally *California Dental Assn. v. F.T.C.* (1999) 526 U.S. 756.

³⁰ See *Oksanen v. Page Memorial Hospital* (4th Cir. 1999) 945 F.2d 696 (*en banc*).

³¹ See *324 Liquor Corp. v. Duffy* (1987) 479 U.S. 335, 344, fn. 6.

³² 1A Areeda & Hovenkamp, *Antitrust Law*, *supra*, ¶ 221, at p. 66; ¶ 222, at pp. 67, 76.

³³ See *Allied Tube & Conduit Corp. v. Indian Head, Inc.* (1988) 486 U.S. 492, 500-501.

³⁴ *Broadcom Corp. v. Qualcomm Inc.* (3rd Cir. 2007) 501 F.3d 297, 308-309; see generally *Bus. & Prof. Code*, § 301.

³⁵ 135 S.Ct. at p. 1114.

This ruling brings the composition of boards into the spotlight. While many boards in California currently require a majority of public members, it is still the norm for professional members to outnumber public members on boards that regulate healing-arts professions. In addition, delays in identifying suitable public-member candidates and in filling public seats can result in de facto market-participant majorities.

In the wake of *North Carolina Dental*, many observers' first impulse was to assume that reforming the composition of professional boards would be the best resolution, both for state actors and for consumer interests. Upon reflection, however, it is not obvious that sweeping changes to board composition would be the most effective solution.³⁶

Even if the Legislature were inclined to decrease the number of market-participant board members, the current state of the law does not allow us to project accurately how many market-participant members is too many. This is a question that was not resolved by the *North Carolina Dental* decision, as the dissenting opinion points out:

What is a “controlling number”? Is it a majority? And if so, why does the Court eschew that term? Or does the Court mean to leave open the possibility that something less than a majority might suffice in particular circumstances? Suppose that active market participants constitute a voting bloc that is generally able to get its way? How about an obstructionist minority or an agency chair empowered to set the agenda or veto regulations?³⁷

Some observers believe it is safe to assume that the *North Carolina Dental* standard would be satisfied if public members constituted a majority of a board. The

³⁶ Most observers believe that there are real advantages in staffing boards with professionals in the field. The combination of technical expertise, practiced judgment, and orientation to prevailing ethical norms is probably impossible to replicate on a board composed entirely of public members. Public confidence must also be considered. Many consumers would no doubt share the sentiments expressed by Justice Breyer during oral argument in the *North Carolina Dental* case: “[W]hat the State says is: We would like this group of brain surgeons to decide who can practice brain surgery in this State. I don’t want a group of bureaucrats deciding that. I would like brain surgeons to decide that.” (*North Carolina Dental*, *supra*, transcript of oral argument p. 31, available at http://www.supremecourt.gov/oral_arguments/argument_transcripts/13-534_16h1.pdf (hereafter, Transcript).)

³⁷ *North Carolina Dental*, *supra*, 135 S.Ct. at p. 1123 (dis. opn. of Alito, J).

obvious rejoinder to that argument is that the Court pointedly did not use the term “majority;” it used “controlling number.” More cautious observers have suggested that “controlling number” should be taken to mean the majority of a quorum, at least until the courts give more guidance on the matter.

North Carolina Dental leaves open other questions about board composition as well. One of these is: Who is an “active market participant”?³⁸ Would a retired member of the profession no longer be a participant of the market? Would withdrawal from practice during a board member’s term of service suffice? These questions were discussed at oral argument,³⁹ but were not resolved. Also left open is the scope of the market in which a member may not participate while serving on the board.⁴⁰

Over the past four decades, California has moved decisively to expand public membership on licensing boards.⁴¹ The change is generally agreed to be a salutary one for consumers, and for underserved communities in particular.⁴² There are many good reasons to consider continuing the trend to increase public membership on licensing boards—but we believe a desire to ensure immunity for board members should not be the decisive factor. As long as the legal questions raised by *North Carolina Dental* remain unresolved, radical changes to board composition are likely to create a whole new set of policy and practical challenges, with no guarantee of resolving the immunity problem.

B. Some Mechanisms for Increasing State Supervision

Observers have proposed a variety of mechanisms for building more state oversight into licensing boards’ decision-making processes. In considering these alternatives, it may be helpful to bear in mind that licensing boards perform a variety of

³⁸ *Ibid.*

³⁹ Transcript, *supra*, at p. 31.

⁴⁰ *North Carolina Dental*, *supra*, 135 S.Ct. at p. 1123 (dis. opn. of Alito, J). Some observers have suggested that professionals from one practice area might be appointed to serve on the board regulating another practice area, in order to bring their professional expertise to bear in markets where they are not actively competing.

⁴¹ See Center for Public Interest Law, *A Guide to California’s Health Care Licensing Boards* (July 2009) at pp. 1-2; Shimberg, *Occupational Licensing: A Public Perspective* (1982) at pp. 163-165.

⁴² See Center for Public Interest Law, *supra*, at pp. 15-17; Shimberg, *supra*, at pp. 175-179.

distinct functions, and that different supervisory structures may be appropriate for different functions.

For example, boards may develop and enforce standards for licensure; receive, track, and assess trends in consumer complaints; perform investigations and support administrative and criminal prosecutions; adjudicate complaints and enforce disciplinary measures; propose regulations and shepherd them through the regulatory process; perform consumer education; and more. Some of these functions are administrative in nature, some are quasi-judicial, and some are quasi-legislative. Boards' quasi-judicial and quasi-legislative functions, in particular, are already well supported by due process safeguards and other forms of state supervision (such as vertical prosecutions, administrative mandamus procedures, and public notice and scrutiny through the Administrative Procedure Act). Further, some functions are less likely to have antitrust implications than others: decisions affecting only a single license or licensee in a large market will rarely have an anticompetitive effect within the meaning of the Sherman Act. For these reasons, it is worth considering whether it is less urgent, or not necessary at all, to impose additional levels of supervision with respect to certain functions.

Ideas for providing state oversight include the concept of a superagency, such as a stand-alone office, or a committee within a larger agency, which has full responsibility for reviewing board actions *de novo*. Under such a system, the boards could be permitted to carry on with their business as usual, except that they would be required to refer each of their decisions (or some subset of decisions) to the superagency for its review. The superagency could review each action file submitted by the board, review the record and decision in light of the state's articulated regulatory policies, and then issue its own decision approving, modifying, or vetoing the board's action.

Another concept is to modify the powers of the boards themselves, so that all of their functions (or some subset of functions) would be advisory only. Under such a system, the boards would not take formal actions, but would produce a record and a recommendation for action, perhaps with proposed findings and conclusions. The recommendation file would then be submitted to a supervising state agency for its further consideration and formal action, if any.

Depending on the particular powers and procedures of each system, either could be tailored to encourage the development of written records to demonstrate executive discretion; access to administrative mandamus procedures for appeal of decisions; and the development of expertise and collaboration among reviewers, as well as between the reviewers and the boards that they review. Under any system, care should be taken to structure review functions so as to avoid unnecessary duplication or conflicts with other agencies and departments, and to minimize the development of super-policies not

adequately tailored to individual professions and markets. To prevent the development of “rubber-stamp” decisions, any acceptable system must be designed and sufficiently staffed to enable plenary review of board actions or recommendations at the individual transactional level.

As it stands, California is in a relatively advantageous position to create these kinds of mechanisms for active supervision of licensing boards. With the boards centrally housed within the Department of Consumer Affairs (an “umbrella agency”), there already exists an organization with good knowledge and experience of board operations, and with working lines of communication and accountability. It is worth exploring whether existing resources and minimal adjustments to procedures and outlooks might be converted to lines of active supervision, at least for the boards’ most market-sensitive actions.

Moreover, the Business and Professions Code already demonstrates an intention that the Department of Consumer Affairs will protect consumer interests as a means of promoting “the fair and efficient functioning of the free enterprise market economy” by educating consumers, suppressing deceptive and fraudulent practices, fostering competition, and representing consumer interests at all levels of government.⁴³ The free-market and consumer-oriented principles underlying *North Carolina Dental* are nothing new to California, and no bureaucratic paradigms need to be radically shifted as a result.

The Business and Professions Code also gives broad powers to the Director of Consumer Affairs (and his or her designees)⁴⁴ to protect the interests of consumers at every level.⁴⁵ The Director has power to investigate the work of the boards and to obtain their data and records;⁴⁶ to investigate alleged misconduct in licensing examinations and qualifications reviews;⁴⁷ to require reports;⁴⁸ to receive consumer complaints⁴⁹ and to initiate audits and reviews of disciplinary cases and complaints about licensees.⁵⁰

⁴³ Bus. & Prof. Code, § 301.

⁴⁴ Bus. & Prof. Code, §§ 10, 305.

⁴⁵ See Bus. & Prof. Code, § 310.

⁴⁶ Bus. & Prof. Code, § 153.

⁴⁷ Bus. & Prof. Code, § 109.

⁴⁸ Bus. & Prof. Code, § 127.

⁴⁹ Bus. & Prof. Code, § 325.

⁵⁰ Bus. & Prof. Code, § 116.

In addition, the Director must be provided a full opportunity to review all proposed rules and regulations (except those relating to examinations and licensure qualifications) before they are filed with the Office of Administrative Law, and the Director may disapprove any proposed regulation on the ground that it is injurious to the public.⁵¹ Whenever the Director (or his or her designee) actually exercises one of these powers to reach a substantive conclusion as to whether a board's action furthers an affirmative state policy, then it is safe to say that the active supervision requirement has been met.⁵²

It is worth considering whether the Director's powers should be amended to make review of certain board decisions mandatory as a matter of course, or to make the Director's review available upon the request of a board. It is also worth considering whether certain existing limitations on the Director's powers should be removed or modified. For example, the Director may investigate allegations of misconduct in examinations or qualification reviews, but the Director currently does not appear to have power to review board decisions in those areas, or to review proposed rules in those areas.⁵³ In addition, the Director's power to initiate audits and reviews appears to be limited to disciplinary cases and complaints about licensees.⁵⁴ If the Director's initiative is in fact so limited, it is worth considering whether that limitation continues to make sense. Finally, while the Director must be given a full opportunity to review most proposed regulations, the Director's disapproval may be overridden by a unanimous vote of the board.⁵⁵ It is worth considering whether the provision for an override maintains its utility, given that such an override would nullify any "active supervision" and concomitant immunity that would have been gained by the Director's review.⁵⁶

⁵¹ Bus. & Prof. Code, § 313.1.

⁵² Although a written statement of decision is not specifically required by existing legal standards, developing a practice of creating an evidentiary record and statement of decision would be valuable for many reasons, not the least of which would be the ability to proffer the documents to a court in support of a motion asserting state action immunity.

⁵³ Bus. & Prof. Code, §§ 109, 313.1.

⁵⁴ Bus. & Prof. Code, § 116.

⁵⁵ Bus. & Prof. Code, § 313.1.

⁵⁶ Even with an override, proposed regulations are still subject to review by the Office of Administrative Law.

C. Legislation Granting Immunity

From time to time, states have enacted laws expressly granting immunity from antitrust laws to political subdivisions, usually with respect to a specific market.⁵⁷ However, a statute purporting to grant immunity to private persons, such as licensing board members, would be of doubtful validity. Such a statute might be regarded as providing adequate authorization for anticompetitive activity, but active state supervision would probably still be required to give effect to the intended immunity. What is quite clear is that a state cannot grant blanket immunity by fiat. “[A] state does not give immunity to those who violate the Sherman Act by authorizing them to violate it, or by declaring that their action is lawful”⁵⁸

IV. Indemnification of Board Members

So far we have focused entirely on the concept of immunity, and how to preserve it. But immunity is not the only way to protect state employees from the costs of suit, or to provide the reassurance necessary to secure their willingness and ability to perform their duties. Indemnification can also go a long way toward providing board members the protection they need to do their jobs. It is important for policy makers to keep this in mind in weighing the costs of creating supervision structures adequate to ensure blanket state action immunity for board members. If the costs of implementing a given supervisory structure are especially high, it makes sense to consider whether immunity is an absolute necessity, or whether indemnification (with or without additional risk-management measures such as training or reporting) is an adequate alternative.

As the law currently stands, the state has a duty to defend and indemnify members of licensing boards against antitrust litigation to the same extent, and subject to the same exceptions, that it defends and indemnifies state officers and employees in general civil litigation. The duty to defend and indemnify is governed by the Government Claims Act.⁵⁹ For purposes of the Act, the term “employee” includes officers and uncompensated servants.⁶⁰ We have repeatedly determined that members of a board,

⁵⁷ See 1A Areeda & Hovenkamp, *Antitrust Law*, *supra*, 225, at pp. 135-137; e.g. *A1 Ambulance Service, Inc. v. County of Monterey* (9th Cir. 1996) 90 F.3d 333, 335 (discussing Health & Saf. Code, § 1797.6).

⁵⁸ *Parker v. Brown*, *supra*, 317 U.S. at 351.

⁵⁹ Gov. Code, §§ 810-996.6.

⁶⁰ See Gov. Code § 810.2.

commission, or similar body established by statute are employees entitled to defense and indemnification.⁶¹

A. Duty to Defend

Public employees are generally entitled to have their employer provide for the defense of any civil action “on account of an act or omission in the scope” of employment.⁶² A public entity may refuse to provide a defense in specified circumstances, including where the employee acted due to “actual fraud, corruption, or actual malice.”⁶³ The duty to defend contains no exception for antitrust violations.⁶⁴ Further, violations of antitrust laws do not inherently entail the sort of egregious behavior that would amount to fraud, corruption, or actual malice under state law. There would therefore be no basis to refuse to defend an employee on the bare allegation that he or she violated antitrust laws.

B. Duty to Indemnify

The Government Claims Act provides that when a public employee properly requests the employer to defend a claim, and reasonably cooperates in the defense, “the public entity shall pay any judgment based thereon or any compromise or settlement of the claim or action to which the public entity has agreed.”⁶⁵ In general, the government is liable for an injury proximately caused by an act within the scope of employment,⁶⁶ but is not liable for punitive damages.⁶⁷

One of the possible remedies for an antitrust violation is an award of treble damages to a person whose business or property has been injured by the violation.⁶⁸ This raises a question whether a treble damages award equates to an award of punitive damages within the meaning of the Government Claims Act. Although the answer is not

⁶¹ E.g., 81 Ops.Cal.Atty.Gen. 199, 200 (1998); 57 Ops.Cal.Atty.Gen. 358, 361 (1974).

⁶² Gov. Code, § 995.

⁶³ Gov. Code, § 995.2, subd. (a).

⁶⁴ Cf. *Mt. Hawley Insurance Co. v. Lopez* (2013) 215 Cal.App.4th 1385 (discussing Ins. Code, § 533.5).

⁶⁵ Gov. Code, § 825, subd. (a).

⁶⁶ Gov. Code, § 815.2.

⁶⁷ Gov. Code, § 818.

⁶⁸ 15 U.S.C. § 15(a).

entirely certain, we believe that antitrust treble damages do *not* equate to punitive damages.

The purposes of treble damage awards are to deter anticompetitive behavior and to encourage private enforcement of antitrust laws.⁶⁹ And, an award of treble damages is automatic once an antitrust violation is proved.⁷⁰ In contrast, punitive damages are “uniquely justified by and proportioned to the actor’s particular reprehensible conduct as well as that person or entity’s net worth . . . in order to adequately make the award ‘sting’”⁷¹ Also, punitive damages in California must be premised on a specific finding of malice, fraud, or oppression.⁷² In our view, the lack of a malice or fraud element in an antitrust claim, and the immateriality of a defendant’s particular conduct or net worth to the treble damage calculation, puts antitrust treble damages outside the Government Claims Act’s definition of punitive damages.⁷³

C. Possible Improvements to Indemnification Scheme

As set out above, state law provides for the defense and indemnification of board members to the same extent as other state employees. This should go a long way toward reassuring board members and potential board members that they will not be exposed to undue risk if they act reasonably and in good faith. This reassurance cannot be complete, however, as long as board members face significant uncertainty about how much litigation they may have to face, or about the status of treble damage awards.

Uncertainty about the legal status of treble damage awards could be reduced significantly by amending state law to specify that treble damage antitrust awards are not punitive damages within the meaning of the Government Claims Act. This would put them on the same footing as general damages awards, and thereby remove any uncertainty as to whether the state would provide indemnification for them.⁷⁴

⁶⁹ *Clayworth v. Pfizer, Inc.* (2010) 49 Cal.4th 758, 783-784 (individual right to treble damages is “incidental and subordinate” to purposes of deterrence and vigorous enforcement).

⁷⁰ 15 U.S.C. § 15(a).

⁷¹ *Piscitelli v. Friedenber*g (2001) 87 Cal.App.4th 953, 981-982.

⁷² Civ. Code, §§ 818, 3294.

⁷³ If treble damages awards were construed as constituting punitive damages, the state would still have the option of paying them under Government Code section 825.

⁷⁴ Ideally, treble damages should not be available at all against public entities and public officials. Since properly articulated and supervised anticompetitive behavior is

As a complement to indemnification, the potential for board member liability may be greatly reduced by introducing antitrust concepts to the required training and orientation programs that the Department of Consumer Affairs provides to new board members.⁷⁵ When board members share an awareness of the sensitivity of certain kinds of actions, they will be in a much better position to seek advice and review (that is, active supervision) from appropriate officials. They will also be far better prepared to assemble evidence and to articulate reasons for the decisions they make in market-sensitive areas. With training and practice, boards can be expected to become as proficient in making and demonstrating sound market decisions, and ensuring proper review of those decisions, as they are now in making and defending sound regulatory and disciplinary decisions.

V. Conclusions

North Carolina Dental has brought both the composition of licensing boards and the concept of active state supervision into the public spotlight, but the standard it imposes is flexible and context-specific. This leaves the state with many variables to consider in deciding how to respond.

Whatever the chosen response may be, the state can be assured that *North Carolina Dental*'s "active state supervision" requirement is satisfied when a non-market-

permitted to the state and its agents, the deterrent purpose of treble damages does not hold in the public arena. Further, when a state indemnifies board members, treble damages go not against the board members but against public coffers. "It is a grave act to make governmental units potentially liable for massive treble damages when, however 'proprietary' some of their activities may seem, they have fundamental responsibilities to their citizens for the provision of life-sustaining services such as police and fire protection." (*City of Lafayette, La. v. Louisiana Power & Light Co.* (1978) 435 U.S. 389, 442 (dis. opn. of Blackmun, J.))

In response to concerns about the possibility of treble damage awards against municipalities, Congress passed the Local Government Antitrust Act (15 U.S.C. §§ 34-36), which provides that local governments and their officers and employees cannot be held liable for treble damages, compensatory damages, or attorney's fees. (See H.R. Rep. No. 965, 2nd Sess., p. 11 (1984).) For an argument that punitive sanctions should never be levied against public bodies and officers under the Sherman Act, see 1A Areeda & Hovenkamp, *supra*, ¶ 228, at pp. 214-226. Unfortunately, because treble damages are a product of federal statute, this problem is not susceptible of a solution by state legislation.

⁷⁵ Bus. & Prof. Code, § 453.

participant state official has and exercises the power to substantively review a board's action and determines whether the action effectuates the state's regulatory policies.

FTC Staff Guidance on Active Supervision of State Regulatory Boards Controlled by Market Participants*

I. Introduction

States craft regulatory policy through a variety of actors, including state legislatures, courts, agencies, and regulatory boards. While most regulatory actions taken by state actors will not implicate antitrust concerns, some will. Notably, states have created a large number of regulatory boards with the authority to determine who may engage in an occupation (*e.g.*, by issuing or withholding a license), and also to set the rules and regulations governing that occupation. Licensing, once limited to a few learned professions such as doctors and lawyers, is now required for over 800 occupations including (in some states) locksmiths, beekeepers, auctioneers, interior designers, fortune tellers, tour guides, and shampooers.¹

In general, a state may avoid all conflict with the federal antitrust laws by creating regulatory boards that serve only in an advisory capacity, or by staffing a regulatory board exclusively with persons who have no financial interest in the occupation that is being regulated. However, across the United States, “licensing boards are largely dominated by active members of their respective industries . . .”² That is, doctors commonly regulate doctors, beekeepers commonly regulate beekeepers, and tour guides commonly regulate tour guides.

Earlier this year, the U.S. Supreme Court upheld the Federal Trade Commission’s determination that the North Carolina State Board of Dental Examiners (“NC Board”) violated the federal antitrust laws by preventing non-dentists from providing teeth whitening services in competition with the state’s licensed dentists. *N.C. State Bd. of Dental Exam’rs v. FTC*, 135 S. Ct. 1101 (2015). NC Board is a state agency established under North Carolina law and charged with administering and enforcing a licensing system for dentists. A majority of the members of this state agency are themselves practicing dentists, and thus they have a private incentive to limit

* This document sets out the views of the Staff of the Bureau of Competition. The Federal Trade Commission is not bound by this Staff guidance and reserves the right to rescind it at a later date. In addition, FTC Staff reserves the right to reconsider the views expressed herein, and to modify, rescind, or revoke this Staff guidance if such action would be in the public interest.

¹ Aaron Edlin & Rebecca Haw, *Cartels By Another Name: Should Licensed Occupations Face Antitrust Scrutiny*, 162 U. PA. L. REV. 1093, 1096 (2014).

² *Id.* at 1095.

competition from non-dentist providers of teeth whitening services. NC Board argued that, because it is a state agency, it is exempt from liability under the federal antitrust laws. That is, the NC Board sought to invoke what is commonly referred to as the “state action exemption” or the “state action defense.” The Supreme Court rejected this contention and affirmed the FTC’s finding of antitrust liability.

In this decision, the Supreme Court clarified the applicability of the antitrust state action defense to state regulatory boards controlled by market participants:

“The Court holds today that a state board on which a controlling number of decisionmakers are active market participants in the occupation the board regulates must satisfy *Midcal’s* [*Cal. Retail Liquor Dealers Ass’n v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980)] active supervision requirement in order to invoke state-action antitrust immunity.” *N.C. Dental*, 135 S. Ct. at 1114.

In the wake of this Supreme Court decision, state officials have requested advice from the Federal Trade Commission regarding antitrust compliance for state boards responsible for regulating occupations. This outline provides FTC Staff guidance on two questions. *First*, when does a state regulatory board require active supervision in order to invoke the state action defense? *Second*, what factors are relevant to determining whether the active supervision requirement is satisfied?

Our answers to these questions come with the following caveats.

- Vigorous competition among sellers in an open marketplace generally provides consumers with important benefits, including lower prices, higher quality services, greater access to services, and increased innovation. For this reason, a state legislature should empower a regulatory board to restrict competition only when necessary to protect against a credible risk of harm, such as health and safety risks to consumers. The Federal Trade Commission and its staff have frequently advocated that states avoid unneeded and burdensome regulation of service providers.³
- Federal antitrust law does not require that a state legislature provide for active supervision of any state regulatory board. A state legislature may, and generally should, prefer that a regulatory board be subject to the requirements of the federal antitrust

³ See, e.g., Fed. Trade Comm’n Staff Policy Paper, *Policy Perspectives: Competition and the Regulation of Advanced Practice Registered Nurses* (Mar. 2014), <https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf>; Fed. Trade Comm’n & U.S. Dept. of Justice, Comment before the South Carolina Supreme Court Concerning Proposed Guidelines for Residential and Commercial Real Estate Closings (Apr. 2008), <https://www.ftc.gov/news-events/press-releases/2008/04/ftcdoj-submit-letter-supreme-court-south-carolina-proposed>.

laws. If the state legislature determines that a regulatory board should be subject to antitrust oversight, then the state legislature need not provide for active supervision.

- Antitrust analysis – including the applicability of the state action defense – is fact-specific and context-dependent. The purpose of this document is to identify certain overarching legal principles governing when and how a state may provide active supervision for a regulatory board. We are not suggesting a mandatory or one-size-fits-all approach to active supervision. Instead, we urge each state regulatory board to consult with the Office of the Attorney General for its state for customized advice on how best to comply with the antitrust laws.
- This FTC Staff guidance addresses only the active supervision prong of the state action defense. In order successfully to invoke the state action defense, a state regulatory board controlled by market participants must also satisfy the clear articulation prong, as described briefly in Section II. below.
- This document contains guidance developed by the staff of the Federal Trade Commission. Deviation from this guidance does not necessarily mean that the state action defense is inapplicable, or that a violation of the antitrust laws has occurred.

II. Overview of the Antitrust State Action Defense

“Federal antitrust law is a central safeguard for the Nation’s free market structures The antitrust laws declare a considered and decisive prohibition by the Federal Government of cartels, price fixing, and other combinations or practices that undermine the free market.” *N.C. Dental*, 135 S. Ct. at 1109.

Under principles of federalism, “the States possess a significant measure of sovereignty.” *N.C. Dental*, 135 S. Ct. at 1110 (quoting *Community Communications Co. v. Boulder*, 455 U.S. 40, 53 (1982)). In enacting the antitrust laws, Congress did not intend to prevent the States from limiting competition in order to promote other goals that are valued by their citizens. Thus, the Supreme Court has concluded that the federal antitrust laws do not reach anticompetitive conduct engaged in by a State that is acting in its sovereign capacity. *Parker v. Brown*, 317 U.S. 341, 351-52 (1943). For example, a state legislature may “impose restrictions on occupations, confer exclusive or shared rights to dominate a market, or otherwise limit competition to achieve public objectives.” *N.C. Dental*, 135 S. Ct. at 1109.

Are the actions of a state regulatory board, like the actions of a state legislature, exempt from the application of the federal antitrust laws? In *North Carolina State Board of Dental Examiners*, the Supreme Court reaffirmed that a state regulatory board is not the sovereign. Accordingly, a state regulatory board is not necessarily exempt from federal antitrust liability.

More specifically, the Court determined that “a state board on which a controlling number of decisionmakers are active market participants in the occupation the board regulates” may invoke the state action defense only when two requirements are satisfied: first, the challenged restraint must be clearly articulated and affirmatively expressed as state policy; and second, the policy must be actively supervised by a state official (or state agency) that is not a participant in the market that is being regulated. *N.C. Dental*, 135 S. Ct. at 1114.

- The Supreme Court addressed the clear articulation requirement most recently in *FTC v. Phoebe Putney Health Sys., Inc.*, 133 S. Ct. 1003 (2013). The clear articulation requirement is satisfied “where the displacement of competition [is] the inherent, logical, or ordinary result of the exercise of authority delegated by the state legislature. In that scenario, the State must have foreseen and implicitly endorsed the anticompetitive effects as consistent with its policy goals.” *Id.* at 1013.
- The State’s clear articulation of the intent to displace competition is not alone sufficient to trigger the state action exemption. The state legislature’s clearly-articulated delegation of authority to a state regulatory board to displace competition may be “defined at so high a level of generality as to leave open critical questions about how

and to what extent the market should be regulated.” There is then a danger that this delegated discretion will be used by active market participants to pursue private interests in restraining trade, in lieu of implementing the State’s policy goals. *N.C. Dental*, 135 S. Ct. at 1112.

➤ The active supervision requirement “seeks to avoid this harm by requiring the State to review and approve interstitial policies made by the entity claiming [antitrust] immunity.” *Id.*

Where the state action defense does not apply, the actions of a state regulatory board controlled by active market participants may be subject to antitrust scrutiny. Antitrust issues may arise where an unsupervised board takes actions that restrict market entry or restrain rivalry. The following are some scenarios that have raised antitrust concerns:

➤ A regulatory board controlled by dentists excludes non-dentists from competing with dentists in the provision of teeth whitening services. *Cf. N.C. Dental*, 135 S. Ct. 1101.

➤ A regulatory board controlled by accountants determines that only a small and fixed number of new licenses to practice the profession shall be issued by the state each year. *Cf. Hoover v. Ronwin*, 466 U.S. 558 (1984).

➤ A regulatory board controlled by attorneys adopts a regulation (or a code of ethics) that prohibits attorney advertising, or that deters attorneys from engaging in price competition. *Cf. Bates v. State Bar of Ariz.*, 433 U.S. 350 (1977); *Goldfarb v. Va. State Bar*, 421 U.S. 773 (1975).

III. Scope of FTC Staff Guidance

A. This Staff guidance addresses the applicability of the state action defense under the federal antitrust laws. Concluding that the state action defense is inapplicable does not mean that the conduct of the regulatory board necessarily violates the federal antitrust laws. A regulatory board may assert defenses ordinarily available to an antitrust defendant.

1. Reasonable restraints on competition do not violate the antitrust laws, even where the economic interests of a competitor have been injured.

Example 1: A regulatory board may prohibit members of the occupation from engaging in fraudulent business practices without raising antitrust concerns. A regulatory board also may prohibit members of the occupation from engaging in untruthful or deceptive advertising. *Cf. Cal. Dental Ass'n v. FTC*, 526 U.S. 756 (1999).

Example 2: Suppose a market with several hundred licensed electricians. If a regulatory board suspends the license of one electrician for substandard work, such action likely does not unreasonably harm competition. *Cf. Oksanen v. Page Mem'l Hosp.*, 945 F.2d 696 (4th Cir. 1991) (en banc).

2. The ministerial (non-discretionary) acts of a regulatory board engaged in good faith implementation of an anticompetitive statutory regime do not give rise to antitrust liability. See *324 Liquor Corp. v. Duffy*, 479 U.S. 335, 344 n. 6 (1987).

Example 3: A state statute requires that an applicant for a chauffeur's license submit to the regulatory board, among other things, a copy of the applicant's diploma and a certified check for \$500. An applicant fails to submit the required materials. If for this reason the regulatory board declines to issue a chauffeur's license to the applicant, such action would not be considered an unreasonable restraint. In the circumstances described, the denial of a license is a ministerial or non-discretionary act of the regulatory board.

3. In general, the initiation and prosecution of a lawsuit by a regulatory board does not give rise to antitrust liability unless it falls within the "sham exception." *Professional Real Estate Investors v. Columbia Pictures Industries*, 508 U.S. 49 (1993); *California Motor Transport Co. v. Trucking Unlimited*, 404 U.S. 508 (1972).

Example 4: A state statute authorizes the state's dental board to maintain an action in state court to enjoin an unlicensed person from practicing dentistry. The members of the dental board have a basis to believe that a particular individual is practicing dentistry but does not hold a valid license. If the dental board files a lawsuit against that individual, such action would not constitute a violation of the federal antitrust laws.

B. Below, FTC Staff describes when active supervision of a state regulatory board is required in order successfully to invoke the state action defense, and what factors are relevant to determining whether the active supervision requirement has been satisfied.

1. When is active state supervision of a state regulatory board required in order to invoke the state action defense?

General Standard: “[A] state board on which a controlling number of decisionmakers are active market participants in the occupation the board regulates must satisfy *Midcal*’s active supervision requirement in order to invoke state-action antitrust immunity.” *N.C. Dental*, 135 S. Ct. at 1114.

Active Market Participants: A member of a state regulatory board will be considered to be an active market participant in the occupation the board regulates if such person (i) is licensed by the board or (ii) provides any service that is subject to the regulatory authority of the board.

- If a board member participates in any professional or occupational sub-specialty that is regulated by the board, then that board member is an active market participant for purposes of evaluating the active supervision requirement.
- It is no defense to antitrust scrutiny, therefore, that the board members themselves are not directly or personally affected by the challenged restraint. For example, even if the members of the NC Dental Board were orthodontists who do not perform teeth whitening services (as a matter of law or fact or tradition), their control of the dental board would nevertheless trigger the requirement for active state supervision. This is because these orthodontists are licensed by, and their services regulated by, the NC Dental Board.
- A person who temporarily suspends her active participation in an occupation for the purpose of serving on a state board that regulates her former (and intended future) occupation will be considered to be an active market participant.

Method of Selection: The method by which a person is selected to serve on a state regulatory board is not determinative of whether that person is an active market participant in the occupation that the board regulates. For example, a licensed dentist is deemed to be an active market participant regardless of whether the dentist (i) is appointed to the state dental board by the governor or (ii) is elected to the state dental board by the state’s licensed dentists.

A Controlling Number, Not Necessarily a Majority, of Actual Decisionmakers:

- Active market participants need not constitute a numerical majority of the members of a state regulatory board in order to trigger the requirement of active supervision. A decision that is controlled, either as a matter of law, procedure, or fact, by active participants in the regulated market (*e.g.*, through veto power, tradition, or practice) must be actively supervised to be eligible for the state action defense.
- Whether a particular restraint has been imposed by a “controlling number of decisionmakers [who] are active market participants” is a fact-bound inquiry that must be made on a case-by-case basis. FTC Staff will evaluate a number of factors, including:
 - ✓ The structure of the regulatory board (including the number of board members who are/are not active market participants) and the rules governing the exercise of the board’s authority.
 - ✓ Whether the board members who are active market participants have veto power over the board’s regulatory decisions.

Example 5: The state board of electricians consists of four non-electrician members and three practicing electricians. Under state law, new regulations require the approval of five board members. Thus, no regulation may become effective without the assent of at least one electrician member of the board. In this scenario, the active market participants effectively have veto power over the board’s regulatory authority. The active supervision requirement is therefore applicable.

- ✓ The level of participation, engagement, and authority of the non-market participant members in the business of the board – generally and with regard to the particular restraint at issue.
- ✓ Whether the participation, engagement, and authority of the non-market participant board members in the business of the board differs from that of board members who are active market participants – generally and with regard to the particular restraint at issue.
- ✓ Whether the active market participants have in fact exercised, controlled, or usurped the decisionmaking power of the board.

Example 6: The state board of electricians consists of four non-electrician members and three practicing electricians. Under state law, new regulations require the approval of a majority of board members. When voting on proposed regulations, the non-electrician members routinely defer to the preferences of the electrician members. Minutes of

board meetings show that the non-electrician members generally are not informed or knowledgeable concerning board business – and that they were not well informed concerning the particular restraint at issue. In this scenario, FTC Staff may determine that the active market participants have exercised the decisionmaking power of the board, and that the active supervision requirement is applicable.

Example 7: The state board of electricians consists of four non-electrician members and three practicing electricians. Documents show that the electrician members frequently meet and discuss board business separately from the non-electrician members. On one such occasion, the electrician members arranged for the issuance by the board of written orders to six construction contractors, directing such individuals to cease and desist from providing certain services. The non-electrician members of the board were not aware of the issuance of these orders and did not approve the issuance of these orders. In this scenario, FTC Staff may determine that the active market participants have exercised the decisionmaking power of the board, and that the active supervision requirement is applicable.

2. What constitutes active supervision?

FTC Staff will be guided by the following principles:

- “[T]he purpose of the active supervision inquiry . . . is to determine whether the State has exercised sufficient independent judgment and control” such that the details of the regulatory scheme “have been established as a product of deliberate state intervention” and not simply by agreement among the members of the state board. “Much as in causation inquiries, the analysis asks whether the State has played a substantial role in determining the specifics of the economic policy.” The State is not obliged to “[meet] some normative standard, such as efficiency, in its regulatory practices.” *Ticor*, 504 U.S. at 634-35. “The question is not how well state regulation works but whether the anticompetitive scheme is the State’s own.” *Id.* at 635.
- It is necessary “to ensure the States accept political accountability for anticompetitive conduct they permit and control.” *N.C. Dental*, 135 S. Ct. at 1111. See also *Ticor*, 504 U.S. at 636.
- “The Court has identified only a few constant requirements of active supervision: The supervisor must review the substance of the anticompetitive decision, not merely the procedures followed to produce it; the supervisor must have the power to veto or modify particular decisions to ensure they accord with state policy; and the ‘mere potential for state supervision is not an adequate substitute for a decision by the State.’ Further, the state supervisor may not itself be an active market participant.” *N.C. Dental*, 135 S. Ct. at 1116–17 (citations omitted).

- The active supervision must precede implementation of the allegedly anticompetitive restraint.
- “[T]he inquiry regarding active supervision is flexible and context-dependent.” “[T]he adequacy of supervision . . . will depend on all the circumstances of a case.” *N.C. Dental*, 135 S. Ct. at 1116–17. Accordingly, FTC Staff will evaluate each case in light of its own facts, and will apply the applicable case law and the principles embodied in this guidance reasonably and flexibly.

3. What factors are relevant to determining whether the active supervision requirement has been satisfied?

FTC Staff will consider the presence or absence of the following factors in determining whether the active supervision prong of the state action defense is satisfied.

- The supervisor has obtained the information necessary for a proper evaluation of the action recommended by the regulatory board. As applicable, the supervisor has ascertained relevant facts, collected data, conducted public hearings, invited and received public comments, investigated market conditions, conducted studies, and reviewed documentary evidence.
 - ✓ The information-gathering obligations of the supervisor depend in part upon the scope of inquiry previously conducted by the regulatory board. For example, if the regulatory board has conducted a suitable public hearing and collected the relevant information and data, then it may be unnecessary for the supervisor to repeat these tasks. Instead, the supervisor may utilize the materials assembled by the regulatory board.
- The supervisor has evaluated the substantive merits of the recommended action and assessed whether the recommended action comports with the standards established by the state legislature.
- The supervisor has issued a written decision approving, modifying, or disapproving the recommended action, and explaining the reasons and rationale for such decision.
 - ✓ A written decision serves an evidentiary function, demonstrating that the supervisor has undertaken the required meaningful review of the merits of the state board’s action.
 - ✓ A written decision is also a means by which the State accepts political accountability for the restraint being authorized.

Scenario 1: Example of satisfactory active supervision of a state board regulation designating teeth whitening as a service that may be provided only by a licensed dentist, where state policy is to protect the health and welfare of citizens and to promote competition.

- The state legislature designated an executive agency to review regulations recommended by the state regulatory board. Recommended regulations become effective only following the approval of the agency.
- The agency provided notice of (i) the recommended regulation and (ii) an opportunity to be heard, to dentists, to non-dentist providers of teeth whitening, to the public (in a newspaper of general circulation in the affected areas), and to other interested and affected persons, including persons that have previously identified themselves to the agency as interested in, or affected by, dentist scope of practice issues.
- The agency took the steps necessary for a proper evaluation of the recommended regulation. The agency:
 - ✓ Obtained the recommendation of the state regulatory board and supporting materials, including the identity of any interested parties and the full evidentiary record compiled by the regulatory board.
 - ✓ Solicited and accepted written submissions from sources other than the regulatory board.
 - ✓ Obtained published studies addressing (i) the health and safety risks relating to teeth whitening and (ii) the training, skill, knowledge, and equipment reasonably required in order to safely and responsibly provide teeth whitening services (if not contained in submission from the regulatory board).
 - ✓ Obtained information concerning the historic and current cost, price, and availability of teeth whitening services from dentists and non-dentists (if not contained in submission from the regulatory board). Such information was verified (or audited) by the Agency as appropriate.
 - ✓ Held public hearing(s) that included testimony from interested persons (including dentists and non-dentists). The public hearing provided the agency with an opportunity (i) to hear from and to question providers, affected customers, and experts and (ii) to supplement the evidentiary record compiled by the state board. (As noted above, if the state regulatory board has previously conducted a suitable public hearing, then it may be unnecessary for the supervising agency to repeat this procedure.)
- The agency assessed all of the information to determine whether the recommended regulation comports with the State's goal to protect the health and

welfare of citizens and to promote competition.

- The agency issued a written decision accepting, rejecting, or modifying the scope of practice regulation recommended by the state regulatory board, and explaining the rationale for the agency's action.

Scenario 2: Example of satisfactory active supervision of a state regulatory board administering a disciplinary process.

A common function of state regulatory boards is to administer a disciplinary process for members of a regulated occupation. For example, the state regulatory board may adjudicate whether a licensee has violated standards of ethics, competency, conduct, or performance established by the state legislature.

Suppose that, acting in its adjudicatory capacity, a regulatory board controlled by active market participants determines that a licensee has violated a lawful and valid standard of ethics, competency, conduct, or performance, and for this reason, the regulatory board proposes that the licensee's license to practice in the state be revoked or suspended. In order to invoke the state action defense, the regulatory board would need to show both clear articulation and active supervision.

- In this context, active supervision may be provided by the administrator who oversees the regulatory board (*e.g.*, the secretary of health), the state attorney general, or another state official who is not an active market participant. The active supervision requirement of the state action defense will be satisfied if the supervisor: (i) reviews the evidentiary record created by the regulatory board; (ii) supplements this evidentiary record if and as appropriate; (iii) undertakes a *de novo* review of the substantive merits of the proposed disciplinary action, assessing whether the proposed disciplinary action comports with the policies and standards established by the state legislature; and (iv) issues a written decision that approves, modifies, or disapproves the disciplinary action proposed by the regulatory board.

Note that a disciplinary action taken by a regulatory board affecting a single licensee will typically have only a *de minimis* effect on competition. A pattern or program of disciplinary actions by a regulatory board affecting multiple licensees may have a substantial effect on competition.

The following do not constitute active supervision of a state regulatory board that is controlled by active market participants:

- The entity responsible for supervising the regulatory board is itself controlled by active market participants in the occupation that the board regulates. *See N.C. Dental*, 135 S. Ct. at 1113-14.
- A state official monitors the actions of the regulatory board and participates in deliberations, but lacks the authority to disapprove anticompetitive acts that fail to accord with state policy. *See Patrick v. Burget*, 486 U.S. 94, 101 (1988).
- A state official (*e.g.*, the secretary of health) serves *ex officio* as a member of the regulatory board with full voting rights. However, this state official is one of several members of the regulatory board and lacks the authority to disapprove anticompetitive acts that fail to accord with state policy.
- The state attorney general or another state official provides advice to the regulatory board on an ongoing basis.
- An independent state agency is staffed, funded, and empowered by law to evaluate, and then to veto or modify, particular recommendations of the regulatory board. However, in practice such recommendations are subject to only cursory review by the independent state agency. The independent state agency perfunctorily approves the recommendations of the regulatory board. *See Ticor*, 504 U.S. at 638.
- An independent state agency reviews the actions of the regulatory board and approves all actions that comply with the procedural requirements of the state administrative procedure act, without undertaking a substantive review of the actions of the regulatory board. *See Patrick*, 486 U.S. at 104-05.

Agenda

Item

17

**CURRENT FY 2014/2015
FINAL MONTH 13
ACTUAL EXPENIDTURES
FUND CONDITION**

DEPARTMENT OF CONSUMER AFFAIRS

BUDGET REPORT AS OF 6/30/2015

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PHYSICIAN ASSISTANT COMMITTEE

PHYSICIAN ASSISTANT BOARD

DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
PERSONAL SERVICES							
SALARIES AND WAGES							
003 00 CIVIL SERVICE-PERM	193,094	0	179,755	0	179,755	13,339	
033 04 TEMP HELP (907)	30,000	0	32,099	0	32,099	(2,099)	
063 00 STATUTORY-EXEMPT	79,344	0	85,908	0	85,908	(6,564)	
063 03 COMM MEMBER (904.9	1,530	200	7,500	0	7,500	(5,970)	
083 00 OVERTIME	0	0	1,702	0	1,702	(1,702)	
TOTAL SALARIES AND WAGES	303,968	200	306,963	0	306,963	(2,995)	-0.99%
STAFF BENEFITS							
103 00 OASDI	16,290	0	16,205	0	16,205	85	
104 00 DENTAL INSURANCE	1,659	0	2,050	0	2,050	(391)	
105 00 HEALTH/WELFARE INS	39,901	0	25,135	0	25,135	14,766	
106 01 RETIREMENT	67,014	0	57,808	0	57,808	9,206	
125 00 WORKERS' COMPENSAT	4,266	0	0	0	0	4,266	
125 15 SCIF ALLOCATION CO	0	0	1,845	0	1,845	(1,845)	
134 00 OTHER-STAFF BENEFI	0	0	9,043	0	9,043	(9,043)	
135 00 LIFE INSURANCE	0	0	83	0	83	(83)	
136 00 VISION CARE	445	0	354	0	354	91	
137 00 MEDICARE TAXATION	391	0	4,361	0	4,361	(3,970)	
TOTAL STAFF BENEFITS	129,966	0	116,885	0	116,885	13,081	10.07%
TOTAL PERSONAL SERVICES	433,934	200	423,848	0	423,848	10,086	2.32%
OPERATING EXPENSES & EQUIPMENT							
FINGERPRINTS							
213 04 FINGERPRINT REPORT	14,890	1,225	15,582	0	15,582	(692)	
TOTAL FINGERPRINTS	14,890	1,225	15,582	0	15,582	(692)	-4.65%
GENERAL EXPENSE							
201 00 GENERAL EXPENSE	14,556	0	0	0	0	14,556	
206 00 MISC OFFICE SUPPLI	0	0	3,521	0	3,521	(3,521)	
207 00 FREIGHT & DRAYAGE	0	100	977	0	977	(977)	
213 02 ADMIN OVERHEAD-OTH	0	4	2,152	0	2,152	(2,152)	
217 00 MTG/CONF/EXHIBIT/S	0	0	7,309	2,190	9,499	(9,499)	
TOTAL GENERAL EXPENSE	14,556	104	13,959	2,190	16,150	(1,594)	-10.95%

DEPARTMENT OF CONSUMER AFFAIRS

BUDGET REPORT

AS OF 6/30/2015

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PHYSICIAN ASSISTANT COMMITTEE

PHYSICIAN ASSISTANT BOARD

DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
PRINTING							
241 00 PRINTING	6,890	0	0	0	0	6,890	
242 03 COPY COSTS ALLO	0	0	430	0	430	(430)	
242 05 METRO PRINT/MAIL	0	0	4,334	0	4,334	(4,334)	
244 00 OFFICE COPIER EXP	0	0	927	393	1,320	(1,320)	
TOTAL PRINTING	6,890	0	5,690	393	6,084	806	11.70%
COMMUNICATIONS							
251 00 COMMUNICATIONS	5,669	0	0	0	0	5,669	
252 00 CELL PHONES,PDA,PA	0	0	528	0	528	(528)	
257 01 TELEPHONE EXCHANGE	0	0	1,274	0	1,274	(1,274)	
TOTAL COMMUNICATIONS	5,669	0	1,802	0	1,802	3,867	68.21%
POSTAGE							
261 00 POSTAGE	8,187	0	0	0	0	8,187	
262 00 STAMPS, STAMP ENVE	0	0	1,641	0	1,641	(1,641)	
263 05 DCA POSTAGE ALLO	0	0	2,207	0	2,207	(2,207)	
TOTAL POSTAGE	8,187	0	3,848	0	3,848	4,339	53.00%
TRAVEL: IN-STATE							
291 00 TRAVEL: IN-STATE	20,957	0	0	0	0	20,957	
292 00 PER DIEM-I/S	0	2,633	6,756	0	6,756	(6,756)	
294 00 COMMERCIAL AIR-I/S	0	0	4,312	0	4,312	(4,312)	
296 00 PRIVATE CAR-I/S	0	0	2,509	0	2,509	(2,509)	
297 00 RENTAL CAR-I/S	0	0	1,811	0	1,811	(1,811)	
301 00 TAXI & SHUTTLE SER	0	0	39	0	39	(39)	
305 00 MGMT/TRANS FEE-I/S	0	0	167	0	167	(167)	
305 01 CALATERS SERVICE F	0	0	224	0	224	(224)	
TOTAL TRAVEL: IN-STATE	20,957	2,633	15,817	0	15,817	5,140	24.53%
TRAINING							
331 00 TRAINING	1,034	0	0	0	0	1,034	
TOTAL TRAINING	1,034	0	0	0	0	1,034	100.00%
FACILITIES OPERATIONS							
341 00 FACILITIES OPERATI	55,958	0	0	0	0	55,958	
343 00 RENT-BLDG/GRND(NON	0	0	44,230	0	44,230	(44,230)	
346 00 RECURRING MAINT SV	0	0	120	0	120	(120)	
347 00 FACILITY PLNG-DGS	0	0	916	0	916	(916)	
TOTAL FACILITIES OPERATIONS	55,958	0	45,266	0	45,266	10,692	19.11%

DEPARTMENT OF CONSUMER AFFAIRS

PHYSICIAN ASSISTANT COMMITTEE

**BUDGET REPORT
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PHYSICIAN ASSISTANT BOARD

DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
C/P SVS - INTERDEPARTMENTAL							
382 00 CONSULT/PROF-INTER	1,900	0	0	0	0	1,900	
TOTAL C/P SVS - INTERDEPARTMENTAL	1,900	0	0	0	0	1,900	100.00%
C/P SVS - EXTERNAL							
402 00 CONSULT/PROF SERV-	33,561	0	0	0	0	33,561	
404 05 C&P EXT ADMIN CR C	16,568	0	789	6,823	7,612	8,956	
409 00 INFO TECHNOLOGY-EX	0	(1,514)	0	0	0	0	
418 02 CONS/PROF SVS-EXTR	0	(715)	17,936	33,265	51,201	(51,201)	
TOTAL C/P SVS - EXTERNAL	50,129	(2,229)	18,725	40,088	58,813	(8,684)	-17.32%
DEPARTMENTAL SERVICES							
424 03 OIS PRO RATA	80,839	(2,980)	77,436	0	77,436	3,403	
427 00 INDIRECT DISTRB CO	51,311	0	51,821	0	51,821	(510)	
427 01 INTERAGENCY SERVS	7,717	0	0	0	0	7,717	
427 02 SHARED SVS-MBC ONL	93,326	0	90,112	0	90,112	3,214	
427 30 DOI - ISU PRO RATA	1,604	(145)	910	0	910	694	
427 34 PUBLIC AFFAIRS PRO	1,569	0	2,057	0	2,057	(488)	
427 35 PCSD PRO RATA	1,704	(63)	1,988	0	1,988	(284)	
TOTAL DEPARTMENTAL SERVICES	238,070	(3,188)	224,324	0	224,324	13,746	5.77%
CONSOLIDATED DATA CENTERS							
428 00 CONSOLIDATED DATA	4,810	0	0	0	0	4,810	
TOTAL CONSOLIDATED DATA CENTERS	4,810	0	0	0	0	4,810	99.99%
DATA PROCESSING							
431 00 INFORMATION TECHNO	3,019	0	0	0	0	3,019	
436 00 SUPPLIES-IT (PAPER	0	0	160	0	160	(160)	
TOTAL DATA PROCESSING	3,019	0	160	0	160	2,859	94.70%
CENTRAL ADMINISTRATIVE SERVICES							
438 00 PRO RATA	69,681	0	69,681	0	69,681	0	
TOTAL CENTRAL ADMINISTRATIVE SERVICES	69,681	0	69,681	0	69,681	0	0.00%
ENFORCEMENT							
396 00 ATTORNEY GENL-INTE	382,418	26,489	363,002	0	363,002	19,416	
397 00 OFC ADMIN HEARNG-I	81,251	3,678	57,102	0	57,102	24,149	
414 31 EVIDENCE/WITNESS F	492	2,000	44,713	0	44,713	(44,221)	
418 97 COURT REPORTER SER	0	500	3,817	0	3,817	(3,817)	
427 32 INVEST SVS-MBC ONL	218,870	0	155,327	0	155,327	63,543	

DEPARTMENT OF CONSUMER AFFAIRS

BUDGET REPORT
AS OF 6/30/2015

RUN DATE 8/7/2015

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PHYSICIAN ASSISTANT COMMITTEE

PHYSICIAN ASSISTANT BOARD

DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
<u>TOTAL</u> ENFORCEMENT	683,031	32,667	623,961	0	623,961	59,070	8.65%
MINOR EQUIPMENT							
226 00 MINOR EQUIPMENT	2,500	0	0	0	0	2,500	
226 55 MIN EQPMT-PHONE-RE	0	0	323	0	323	(323)	
<u>TOTAL</u> MINOR EQUIPMENT	2,500	0	323	0	323	2,177	87.07%
<u>TOTAL</u> OPERATING EXPENSES & EQUIPMEN	1,181,281	31,212	1,039,139	42,671	1,081,811	99,470	8.42%
PHYSICIAN ASSISTANT BOARD	1,615,215	31,412	1,462,987	42,671	1,505,659	109,556	6.78%
	1,615,215	31,412	1,462,987	42,671	1,505,659	109,556	6.78%

**PHYSICIAN ASSISTANT BOARD - FUND 0280
BUDGET REPORT
FY 2014-15 EXPENDITURE PROJECTION**

FM 13

OBJECT DESCRIPTION	FY 2013-14		FY 2014-15			
	ACTUAL EXPENDITURES (MONTH 13)	BUDGET STONE 2014-15	CURRENT YEAR EXPENDITURES FM 13 (2015)	PERCENT SPENT	ACTUALS YEAR END	UNENCUMBERED BALANCE
PERSONNEL SERVICES						
Civil Service-Perm	142,342	193,094	179,755	93%	179,755	13,339
Statutory Exempt (EO)	77,454	79,344	85,908	108%	85,908	(6,564)
Temp Help - Expert Examiner (903)		0				0
Temp Help Reg (907)	34,475	30,000	32,099	107%	32,099	(2,099)
Bd / Commsn (901, 920)		0			0	0
Comm Member (911)	6,100	1,530	7,500	490%	7,500	(5,970)
Overtime	0	0	1,702		1,702	(1,702)
Staff Benefits	88,051	129,966	116,885	90%	116,885	13,081
TOTALS, PERSONNEL SVC	348,422	433,934	423,849	98%	423,849	10,085
OPERATING EXPENSE AND EQUIPMENT						
General Expense	15,280	14,556	16,150	111%	16,150	(1,594)
Fingerprint Reports	9,867	14,890	15,582	105%	15,582	(692)
Minor Equipment	2,361	2,500	323		323	2,177
Printing	6,559	6,890	6,084	88%	6,084	806
Communication	2,564	5,669	1,802	32%	1,802	3,867
Postage	4,882	8,187	3,848	47%	3,848	4,339
Insurance		0			0	0
Travel In State	12,768	20,957	15,817	75%	15,817	5,140
Travel, Out-of-State		0			0	0
Training	1,200	1,034	0	0%	0	1,034
Facilities Operations	42,473	55,958	45,266	81%	45,266	10,692
Utilities		0			0	0
C & P Services - Interdept.	63,000	1,899	0	0%	0	1,899
C & P Services - External	75,110	50,129	58,813	117%	58,813	(8,684)
DEPARTMENTAL SERVICES:						
OIS Pro Rata	79,865	80,839	77,436	96%	77,436	3,403
Administration Pro Rata	46,017	51,311	51,821	101%	51,821	(510)
Interagency Services	0	7,717	0	0%	0	7,717
Shared Svcs - MBC Only	93,326	93,326	90,112	97%	90,112	3,214
DOI - Pro Rata	1,466	1,604	910	57%	910	694
Public Affairs Pro Rata	1,693	1,569	2,057	131%	2,057	(488)
PCSD Pro Rata	1,673	1,704	1,988	117%	1,988	(284)
INTERAGENCY SERVICES:						
Consolidated Data Center	639	4,810	0	0%	0	4,810
DP Maintenance & Supply	9	3,019	160	5%	160	2,859
Statewide - Pro Rata	61,708	69,681	69,681	100%	69,681	0
EXAMS EXPENSES:						
Exam Supplies		0			0	0
OTHER ITEMS OF EXPENSE:						
ENFORCEMENT:						
Attorney General	313,066	382,418	363,002	95%	363,002	19,416
Office Admin. Hearings	43,906	81,251	57,102	70%	57,102	24,149
Court Reporters	1,843		3,817		3,817	(3,817)
Evidence/Witness Fees	47,198	492	44,713	9088%	44,713	(44,221)
Investigative Svcs - MBC Only	133,542	218,870	155,327	71%	155,327	63,543
Vehicle Operations					0	0
Major Equipment					0	0
TOTALS, OE&E	1,062,015	1,181,280	1,081,811	92%	1,081,811	99,469
TOTAL EXPENSE	1,410,437	1,615,214	1,505,660	189%	1,505,660	109,554
Sched. Reimb. - Fingerprints	(4,889)	(25,000)	(11,493)	46%	(25,000)	0
Sched. Reimb. - Other	(2,680)	(25,000)	(940)	4%	(25,000)	0
Unsched. Reimb. - ICR	(46,525)		(50,421)			0
Unsched. Reimb. - ICR - Prob Monitor	(22,723)		(6,750)			0
NET APPROPRIATION	1,333,620	1,565,214	1,436,056	92%	1,455,660	109,554
SURPLUS/(DEFICIT):						7.0%

0280 - Physician Assistant Board

Analysis of Fund Condition

10/8/2015

(Dollars in Thousands)

NOTE: \$1.5 Million General Fund Repayment Outstanding

2015 Budget Act

	ACTUAL 2014-15	CY 2015-16	BY 2016-17	BY + 1 2017-18
BEGINNING BALANCE	\$ 1,531	\$ 1,763	\$ 1,899	\$ 2,031
Prior Year Adjustment	\$ 24	\$ -	\$ -	\$ -
Adjusted Beginning Balance	\$ 1,555	\$ 1,763	\$ 1,899	\$ 2,031
REVENUES AND TRANSFERS				
Revenues:				
125600 Other regulatory fees	\$ 12	\$ 5	\$ 5	\$ 5
125700 Other regulatory licenses and permits	\$ 246	\$ 250	\$ 253	\$ 253
125800 Renewal fees	\$ 1,378	\$ 1,395	\$ 1,410	\$ 1,410
125900 Delinquent fees	\$ 4	\$ 4	\$ 4	\$ 4
141200 Sales of documents	\$ -	\$ -	\$ -	\$ -
142500 Miscellaneous services to the public	\$ -	\$ -	\$ -	\$ -
150300 Income from surplus money investments	\$ 5	\$ 6	\$ 6	\$ 6
160400 Sale of fixed assets	\$ -	\$ -	\$ -	\$ -
161000 Escheat of unclaimed checks and warrants	\$ 1	\$ -	\$ -	\$ -
161400 Miscellaneous revenues	\$ -	\$ -	\$ -	\$ -
164300 Penalty Assessments	\$ -	\$ -	\$ -	\$ -
Totals, Revenues	\$ 1,646	\$ 1,660	\$ 1,678	\$ 1,678
Totals, Revenues and Transfers	\$ 1,646	\$ 1,660	\$ 1,678	\$ 1,678
Totals, Resources	\$ 3,201	\$ 3,423	\$ 3,577	\$ 3,709
EXPENDITURES				
Disbursements:				
0840 State Controllers	\$ -	\$ -	\$ -	\$ -
1110 Program Expenditures (State Operations)	\$ 1,436	\$ 1,521	\$ 1,546	\$ 1,577
8880 FISCAL (State Operations)	\$ 1	\$ 3	\$ -	\$ -
Total Disbursements	\$ 1,437	\$ 1,524	\$ 1,546	\$ 1,577
FUND BALANCE				
Reserve for economic uncertainties	\$ 1,763	\$ 1,899	\$ 2,031	\$ 2,132
Months in Reserve	13.9	14.7	15.5	15.9

NOTES:

- A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED IN BY+1 AND ON-GOING.
- B. ASSUMES APPROPRIATION GROWTH OF 2% PER YEAR BEGINNING IN BY+1.
- C. ASSUMES INTEREST RATE AT 0.3%.

**CURRENT FY 2015/2016
MONTH 3**

DEPARTMENT OF CONSUMER AFFAIRS

PHYSICIAN ASSISTANT COMMITTEE

**BUDGET REPORT
AS OF 9/30/2015**

RUN DATE 10/13/2015

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FM 03

PHYSICIAN ASSISTANT BOARD

DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
PERSONAL SERVICES							
SALARIES AND WAGES							
003 00 CIVIL SERVICE-PERM	0	10,911	32,732	0	32,732	(32,732)	
033 04 TEMP HELP (907)	0	2,799	7,355	0	7,355	(7,355)	
063 00 STATUTORY-EXEMPT	0	7,554	22,662	0	22,662	(22,662)	
063 03 COMM MEMBER (904,9	0	1,600	2,400	0	2,400	(2,400)	
TOTAL SALARIES AND WAGES	0	22,863	65,149	0	65,149	(65,149)	0.00%
STAFF BENEFITS							
103 00 OASDI	0	1,120	3,359	0	3,359	(3,359)	
104 00 DENTAL INSURANCE	0	164	491	0	491	(491)	
105 00 HEALTH/WELFARE INS	0	1,901	5,704	0	5,704	(5,704)	
106 01 RETIREMENT	0	4,644	13,931	0	13,931	(13,931)	
125 15 SCIF ALLOCATION CO	0	115	236	0	236	(236)	
134 00 OTHER-STAFF BENEFI	0	756	2,251	0	2,251	(2,251)	
135 00 LIFE INSURANCE	0	7	21	0	21	(21)	
136 00 VISION CARE	0	26	78	0	78	(78)	
137 00 MEDICARE TAXATION	0	327	929	0	929	(929)	
TOTAL STAFF BENEFITS	0	9,059	26,999	0	26,999	(26,999)	0.00%
TOTAL PERSONAL SERVICES	0	31,922	92,148	0	92,148	(92,148)	0.00%
OPERATING EXPENSES & EQUIPMENT							
FINGERPRINTS							
213 04 FINGERPRINT REPORT	0	2,058	4,214	0	4,214	(4,214)	
TOTAL FINGERPRINTS	0	2,058	4,214	0	4,214	(4,214)	0.00%
GENERAL EXPENSE							
206 00 MISC OFFICE SUPPLI	0	126	126	0	126	(126)	
207 00 FREIGHT & DRAYAGE	0	42	175	0	175	(175)	
213 02 ADMIN OVERHEAD-OTH	0	591	591	0	591	(591)	
217 00 MTG/CONF/EXHIBIT/S	0	703	1,010	9,458	10,468	(10,468)	
TOTAL GENERAL EXPENSE	0	1,462	1,902	9,458	11,360	(11,360)	0.00%
PRINTING							
242 03 COPY COSTS ALLO	0	45	45	0	45	(45)	
242 05 METRO PRINT/MAIL	0	2,019	2,019	0	2,019	(2,019)	
244 00 OFFICE COPIER EXP	0	0	0	330	330	(330)	

DEPARTMENT OF CONSUMER AFFAIRS

BUDGET REPORT

AS OF 9/30/2015

RUN DATE 10/13/2015

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PHYSICIAN ASSISTANT COMMITTEE

PHYSICIAN ASSISTANT BOARD

DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
DATA PROCESSING							
436 00 SUPPLIES-IT (PAPER	0	158	158	0	158	(158)	
TOTAL DATA PROCESSING	0	158	158	0	158	(158)	0.00%
CENTRAL ADMINISTRATIVE SERVICES							
438 00 PRO RATA	0	0	18,502	0	18,502	(18,502)	
TOTAL CENTRAL ADMINISTRATIVE SERVICES	0	0	18,502	0	18,502	(18,502)	0.00%
ENFORCEMENT							
396 00 ATTORNEY GENL-INTE	0	27,803	54,119	0	54,119	(54,119)	
414 31 EVIDENCE/WITNESS F	0	3,600	6,600	0	6,600	(6,600)	
418 97 COURT REPORTER SER	0	83	83	0	83	(83)	
TOTAL ENFORCEMENT	0	31,485	60,802	0	60,802	(60,802)	0.00%
TOTAL OPERATING EXPENSES & EQUIPMEN	0	45,327	156,072	153,851	309,922	(309,922)	0.00%
PHYSICIAN ASSISTANT BOARD							
	0	77,249	248,219	153,851	402,070	(402,070)	0.00%
	0	77,249	248,219	153,851	402,070	(402,070)	0.00%

DEPARTMENT OF CONSUMER AFFAIRS
ENCUMBRANCE REPORT

AS OF: 9/30/2015

FM 03

RUN DATE: 10/13/2015

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63500 PHYSICIAN ASSISTANT BOARD

DOCUMENT	VENDOR	ORIG. AMOUNT	ADJUSTMENTS	LIQUIDATIONS	BALANCE
GENERAL EXPENSE					
217	REQ00101-15 0000064514-00 NEW DIRECTION SER	\$10,468.40	\$0.00	(\$1,010.11)	\$9,458.29
TOTAL GENERAL EXPENSE					\$9,458.29
PRINTING					
244	REQ00131-45 0000065284-00 SHARP ELECTRONICS	\$330.00	\$0.00	\$0.00	\$330.00
TOTAL PRINTING					\$330.00
FACILITIES OPERATIONS					
343	2367-007-14 0000076245-00 WESTCORE WEST SAC	\$36,936.80	\$0.00	\$0.00	\$36,936.80
TOTAL FACILITIES OPERATIONS					\$36,936.80
C/P SVS - EXTERNAL					
404 05	REQ01500-3B 0000074019-01 ELAVON INC	\$21,000.00	\$0.00	(\$1,204.62)	\$19,795.38
404 05	REQ01500-6B 0000073449-00 AMERICAN EXPRESS	\$5,000.00	\$0.00	(\$358.82)	\$4,641.18
418 02	REQ00136-01 0000073128-00 FIRSTLAB	\$1,500.00	\$0.00	\$0.00	\$1,500.00
418 02	REQ13862-PA 0000069741-01 MAXIMUS HEALTH SE	\$82,372.80	\$0.00	(\$1,183.54)	\$81,189.26
TOTAL C/P SVS - EXTERNAL					\$107,125.82

63500 PHYSICIAN ASSISTANT BOARD

\$153,850.91



BUSINESS CONSUMER SERVICES AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN, JR.
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July 1, 2015

Assembly Member Susan Bonilla, Chair
Assembly Business and Professions Committee
1020 N St., Room 383
Sacramento, CA 95814

Senator Jerry Hill, Chair
Senate Business, Professions and Economic Development Committee
State Capitol, Room 2053
Sacramento, CA 95814

Re: Pro Rata Study

Dear Assembly Member Bonilla and Senator Hill,

Senate Bill 1243 (Hill, Chapter 395, Statutes of 2014) required the Department of Consumer Affairs (Department) to provide a one-time study of its process for distributing administrative costs (pro rata) among its 39 boards, bureaus, committees, commission and program (boards). The purpose of the study is to:

- Determine if the current methodology is the most productive and cost efficient manner for the Department and the boards;
- Consider whether some services provided by the Department should be outsourced or charged based on usage; and,
- Consider whether boards should be allowed to opt out of paying and receiving certain administrative services.

In December 2014, the Department contracted with CPS HR Consulting (CPS) to conduct a study in accordance with SB 1243. Attached is the completed study, including a survey of the Department's boards in regards to the pro rata process.

The following is a brief summary of what CPS recommends the Department explore as possible alternative approaches to its current process:

- Changing the cost distribution of non-jurisdictional calls and correspondence to all boards evenly.
- Mitigating the effects of high costs in a particular fiscal year, by changing the distribution of Office of Information Services costs to a two-year roll forward methodology as used by the Division of Investigation.
- Use an approach for authorized positions that considers weighted authorized positions and workload or an approach that utilizes historical trends and distributes costs based on an average amount of authorized positions and workload over time.
- Utilizing an activity-based costing (ABC) methodology. ABC is a form of cost accounting that is designed to accurately reflect the cause-and-effect relationships between products or services, activities and costs.

Each of these recommendations will be taken under consideration by the Department as it looks to improve the process for distributing its costs. While basing costs on client usage is often a preferred method for ensuring a fair and equitable distribution, it is not always the most appropriate as it may discourage use of necessary services that are imperative to protecting consumers and ensuring each board complies with its mandate.

In the course of undergoing this review, the Department has also identified the following improvements to promote a more equitable and transparent pro rata process:

- Currently, a portion of the costs for the Office of Professional Examination Services (OPES) are distributed to all boards based on authorized position count, even for programs with no examination requirements. With the upcoming budget cycle, the Department will be removing OPES costs for these programs.
- The Department will be reviewing the Complaint Resolution Program (CRP) to determine the future use of this program. The CRP is currently in the process of closing its Riverside office in order to consolidate its resources to provide services in the most cost effective manner.
- The Department will be moving its annual pro rata review with the boards from January to October. This will provide the boards sufficient time to provide additional input into the Department's process for distributing costs. Part of this change will also include greater outreach to the boards to ensure that each board is aware of the services provided by each division and office, who to contact for assistance, and how those services are distributed.

With regard to the Department's services being outsourced or allowing boards to opt out, in many cases, statutory provisions govern the services provided by the Department. Additionally, a number of the services, especially administrative, are provided by the Department in a delegated role from a control agency in order to ensure that statutes, regulations, policies and procedures governing state agencies are met. As part of the study, CPS also conducted a survey of the Department's boards regarding the ability to opt out and it largely reflected that most programs do not want to opt out of the core Department services. While this is encouraging for the Department, the survey did reveal quality issues with some of the services provided by the Department. As mentioned above, the Department will be focusing on improving its outreach and being more responsive to the concerns and needs of the boards.

SB 1243, specifically Business & Professions Code Section 201, also requires DCA to submit a report of the accounting of the pro rata calculation of administrative expenses to the Legislature by July 1, 2015 and annually thereafter. Attached to this letter is DCA's first submission of this report.

Should you have any questions regarding this study or the Department's pro rata process, please contact Melinda McClain, the Department's Deputy Director for Legislation at (916) 574-7800 or melinda.mcclain@dca.ca.gov.



Awet Kidane
Director
Department of Consumer Affairs

Cc: Graciela Castillo-Krings, Deputy Legislative Secretary, Governor's Office
Anna Caballero, Secretary, Business, Consumer Services, and Housing Agency

DEPARTMENT OF CONSUMER AFFAIRS

DISTRIBUTED COSTS METHODOLOGY FOR FY 2015-16

CONSUMER AND CLIENT SERVICES DIVISION (CCSD)

1. ADMINISTRATIVE & INFORMATION SERVICES DIVISION (AISD):

- A. *AISD LESS OFFICE OF INFORMATION SERVICES* (which consists of the Executive Office, Equal Employment Opportunity Office, Internal Audits, Legal Affairs, Legislative & Regulatory Review, Office of Professional Examination Services, SOLID Training Services, Information Security, and the Office of Administrative Services [which consists of Fiscal Operations (Budgets, Accounting, Cashiering), Business Services Office, Office of Human Resources]): Distributed costs to all Boards/Bureaus/Programs based on authorized position count.
- B. *OFFICE OF INFORMATION SERVICES (OIS)*: Distributed costs based on service center usage. The cost centers have been refined to more accurately distribute each client's costs and include ATS/CAS, BreZze, telecom, PC support, LAN/WAN, and Web services among others.

2. COMMUNICATIONS DIVISION:

- A. *PUBLIC AFFAIRS*: Distributed costs based on authorized position count.
- B. *CONSUMER INFORMATION CENTER (CIC)*: Distributed costs based on client's past year workload to determine the client's distributed costs in budget year.
- C. *CORRESPONDENCE UNIT*: Distributed costs based on client's past year workload to determine the client's distributed costs in budget year. Mainly Bureaus/Programs incur Correspondence costs.
- D. *PUBLICATIONS, DESIGN AND EDITING*: Distributed costs based on authorized position count. All Boards/Bureaus/Programs incur costs.

3. PROGRAM AND POLICY REVIEW DIVISION:

- A. *COMPLAINT RESOLUTION (CRP)*: Distributed costs based on client's past year workload to determine the client's distributed costs in budget year. Only Bureaus/Programs incur resolution costs.

DIVISION OF INVESTIGATION (DOI)

- A. *INVESTIGATION*: Fee for service: Based on two-year roll-forward methodology. This methodology uses a client's actual workload/costs in past year to determine the client's budget in budget year (BY), which will cover the BY estimated workload, plus any credit or debit for services already provided.
- B. *INVESTIGATIONS AND SERVICES TEAM*: Distributed costs based on authorized position count.
- C. *HEALTH QUALITY INVESTIGATION UNIT (HQIU)*: Costs distributed fully to the Medical Board of California. Costs incurred by Allied Health Programs are based on an hourly rate and invoiced directly with reimbursement going to the Medical Board.

**Fiscal Year 2015/16 Governor's Budget
Department of Consumer Affairs Distributed Costs**

Board / Bureau Name	2015-16 Authorized Positions	427.00	424.03	427.34	427.35			427.30	427.32	427.31	TOTAL	% of Budget		
		ASIS LESS OIS	OIS (less BreEZe)	OIS (BreEZe)	Public Affairs	Consumer Information Center	Correspondence	Publications Design & Editing	Complaint Resolution	DOI (IST)			DOI (HQ/U)	DOI (INVEST)
Arbitration Certification Program	8.0	96,000	29,000	-	3,000	1,000	-	-	4,000	-	3,000	-	136,000	12%
Private Security Services	48.4	572,000	1,830,000	3,030,000	16,000	688,000	91,000	20,000	418,000	16,000	-	-	6,681,000	47%
Private Investigators	3.0	35,000	70,000	122,000	1,000	-	-	1,000	-	1,000	-	38,000	288,000	32%
Private Postsecondary	91.0	1,073,000	485,000	2,000	32,000	1,000	162,000	38,000	178,000	31,000	-	322,000	2,304,000	15%
Electronic/ Appliance Repair	15.5	183,000	188,000	71,000	5,000	6,000	19,000	5,000	572,000	4,000	-	-	1,053,000	37%
Home Furnishings	27.9	331,000	235,000	107,000	9,000	-	-	10,000	284,000	8,000	-	-	984,000	20%
Automotive Repair (VIRF)	521.8	6,155,000	3,386,000	383,000	185,000	1,121,000	115,000	232,000	816,000	177,000	-	-	12,570,000	12%
Automotive Repair (HPRRA)	59.6	704,000	366,000	-	21,000	-	-	25,000	-	20,000	-	-	1,136,000	10%
Automotive Repair (EFM)	9.0	108,000	34,000	-	3,000	-	-	4,000	-	4,000	-	-	153,000	18%
Telephone Medical Advice	1.0	11,000	1,000	-	-	-	2,000	-	-	-	-	-	14,000	8%
Cemetary	13.9	166,000	71,000	29,000	4,000	3,000	6,000	6,000	107,000	5,000	-	-	397,000	16%
Funeral Directors & Embalmers	7.6	89,000	59,000	38,000	2,000	-	-	4,000	132,000	2,000	-	-	326,000	18%
Bureau of Real Estate Appraisers	33.8	401,000	20,000	-	12,000	-	3,000	14,000	-	10,000	-	-	460,000	8%
Bureau of Real Estate	329.7	3,906,000	201,000	-	115,000	4,000	324,000	142,000	-	110,000	-	74,000	4,876,000	10%
Fiduciaries	2.7	31,000	21,000	1,000	1,000	10,000	15,000	1,000	111,000	1,000	-	-	192,000	31%
TOTAL, 1111	1,172.9	13,861,000	6,876,000	3,783,000	409,000	1,834,000	737,000	506,000	2,618,000	392,000	434,000	31,550,000	14%	
Accountancy	98.8	1,166,000	214,000	288,000	36,000	-	-	44,000	-	32,000	-	-	1,780,000	13%
Board of Architectural Examiners	24.9	296,000	198,000	99,000	9,000	-	-	11,000	-	8,000	-	32,000	653,000	18%
Landscape Arch Committee	5.5	66,000	23,000	13,000	2,000	-	-	2,000	-	2,000	-	22,000	130,000	13%
Athletic Commission	10.2	121,000	55,000	3,000	3,000	-	-	5,000	-	3,000	-	-	190,000	13%
Boxer's Neurological	-	-	3,000	-	-	-	-	-	-	-	-	-	3,000	5%
Boxer's Pension	0.5	6,000	2,000	-	-	-	-	-	-	-	-	-	8,000	7%
Barbering & Cosmetology	92.2	1,087,000	2,924,000	5,032,000	31,000	1,213,000	99,000	40,000	-	30,000	-	85,000	10,541,000	43%
Board of Behavioral Sciences	53.0	628,000	589,000	983,000	18,000	-	-	23,000	-	16,000	-	81,000	2,338,000	23%
Chiropractic Examiners	19.4	229,000	135,000	135,000	8,000	-	-	8,000	-	5,000	-	7,000	525,000	13%
Contractors State License Bd	405.6	4,797,000	543,000	982,000	144,000	5,000	-	174,000	-	136,000	-	267,000	7,048,000	11%
Dental Board of CA	65.5	775,000	519,000	559,000	23,000	1,000	-	26,000	-	22,000	-	-	1,925,000	15%
Dental Assistants Program	11.1	131,000	157,000	422,000	4,000	-	-	5,000	-	4,000	-	-	723,000	28%
Dental Hygiene Committee	9.2	109,000	95,000	195,000	3,000	-	-	4,000	-	3,000	-	-	409,000	22%
Guide Dogs for the Blind	1.5	18,000	8,000	1,000	-	-	-	1,000	-	-	-	-	26,000	13%
Medical Board of California	287.4	3,368,000	1,105,000	1,623,000	101,000	-	-	123,000	-	95,000	16,341,000	-	22,756,000	37%
Registered Dispensing Opticians	0.9	11,000	12,000	48,000	-	-	-	-	-	-	-	-	71,000	20%
Acupuncture Board	11.0	130,000	98,000	36,000	4,000	148,000	-	5,000	-	4,000	-	494,000	919,000	27%
Physical Therapy Board	19.4	232,000	230,000	314,000	8,000	-	-	8,000	-	5,000	-	596,000	1,391,000	34%
Physician Assistant Board	4.5	54,000	53,000	90,000	1,000	-	-	2,000	-	1,000	-	-	201,000	13%
Board of Podiatric Medicine	5.2	62,000	40,000	27,000	2,000	-	-	2,000	-	2,000	-	-	135,000	9%
Board of Psychology	20.3	241,000	270,000	239,000	6,000	-	-	8,000	-	7,000	-	-	771,000	16%
Respiratory Care Board	17.4	204,000	179,000	212,000	6,000	-	-	7,000	-	6,000	-	77,000	691,000	19%
Speech-Language P.A./ Hearing Aid	8.6	104,000	102,000	67,000	3,000	-	-	4,000	-	3,000	-	331,000	614,000	30%
Occupational Therapy	7.7	92,000	83,000	130,000	2,000	-	-	4,000	-	3,000	-	41,000	355,000	25%
Board of Optometry	10.4	124,000	110,000	132,000	3,000	-	-	5,000	-	3,000	-	-	377,000	21%
Osteopathic Medical Board	11.4	135,000	78,000	79,000	4,000	-	-	5,000	-	4,000	-	-	305,000	16%
Naturopathic Medicine	2.0	24,000	11,000	3,000	1,000	-	-	1,000	-	1,000	-	75,000	116,000	31%
Board of Pharmacy	101.1	1,195,000	718,000	448,000	35,000	-	-	42,000	-	33,000	-	-	2,471,000	12%
Board for Professional Engineers	58.7	690,000	361,000	381,000	20,000	-	-	25,000	-	20,000	-	206,000	1,703,000	17%
Geologists and Geophysicists	6.0	73,000	27,000	30,000	2,000	-	-	2,000	-	2,000	-	13,000	149,000	10%
Board of Registered Nursing	158.8	1,874,000	2,787,000	4,840,000	56,000	-	-	68,000	-	52,000	-	5,443,000	15,120,000	36%
Court Reporters Board	4.5	53,000	47,000	59,000	1,000	-	-	2,000	-	1,000	-	-	163,000	15%
Structural Pest- Support	29.9	353,000	210,000	34,000	11,000	-	-	12,000	-	9,000	-	145,000	774,000	16%
Veterinary Medical Board	23.8	280,000	191,000	281,000	9,000	-	-	10,000	-	7,000	-	610,000	1,368,000	29%
Vocational Nursing Program	57.5	679,000	505,000	936,000	19,000	1,000	-	24,000	-	20,000	-	-	2,184,000	22%
Psychiatric Technician Program	10.4	125,000	59,000	112,000	3,000	-	-	5,000	-	3,000	-	-	307,000	14%
TOTAL, 1110	1,654.3	19,532,000	12,739,000	18,813,000	574,000	1,368,000	99,000	707,000	2,618,000	542,000	16,341,000	8,525,000	79,240,000	24%
Distributed Cost TOTAL	2,827.2	33,393,000	19,715,000	22,596,000	983,000	3,202,000	836,000	1,213,000	2,618,000	934,000	16,341,000	8,959,000	110,790,000	20%

Agenda

Item

18

AB 85



California
LEGISLATIVE INFORMATION

AB-85 Open meetings. (2015-2016)

Senate: 1st Cmt 2nd 3rd Pass
 Assembly: 1st Cmt 2nd Cmt 2nd 3rd Pass Pass Veto

Bill Status	
Measure:	AB-85
Lead Authors:	Wilk (A)
Principal Coauthors:	-
Coauthors:	-
Topic:	Open meetings.
31st Day in Print:	02/06/15
Title:	An act to amend Section 11121 of the Government Code, relating to state government, and declaring the urgency thereof, to take effect immediately.
House Location:	Assembly
Enrolled Date:	09/02/15
Last Amended Date:	04/15/15

Type of Measure
Inactive Bill - Vetoed
Two Thirds Vote Required
Non-Appropriation
Fiscal Committee
Non-State-Mandated Local Program
Urgency
Non-Tax levy

Last 5 History Actions	
Date	Action
09/28/15	Vetoed by Governor.
09/09/15	Enrolled and presented to the Governor at 4 p.m.
08/31/15	In Assembly. Ordered to Engrossing and Enrolling.
08/31/15	Read third time. Urgency clause adopted. Passed. Ordered to the Assembly. (Ayes 40. Noes 0. Page 2288.)
08/19/15	Read second time. Ordered to third reading.

Governor's Veto Message

To the Members of the California State Assembly:

I am returning Assembly Bill 85 without my signature.

This bill expands the Bagley-Keene Open Meeting Act to include state advisory bodies, regardless of their size.

My thinking on this matter has not changed from last year when I vetoed a similar measure, AB 2058. I believe strongly in transparency and openness but the more informal deliberation of advisory bodies is best left to current law.

Sincerely,

Edmund G. Brown Jr.

GOVERNOR'S VETO
AB 85 (Wilk)
As Enrolled September 2, 2015
2/3 vote

Committee	Votes	Ayes	Noes
Governmental Organization	21-0	Gray, Linder, Achadjian, Alejo, Bigelow, Campos, Cooley, Cooper, Daly, Cristina Garcia, Eduardo Garcia, Gipson, Roger Hernández, Jones-Sawyer, Levine, Mayes, Perea, Salas, Steinorth, Waldron, Wilk	
Appropriations	17-0	Gomez, Bigelow, Bonta, Calderon, Chang, Daly, Eggman, Gallagher, Eduardo Garcia, Gordon, Holden, Jones, Quirk, Rendon, Wagner, Weber, Wood	

ASSEMBLY: 80-0 (June 1, 2015) SENATE: 40-0 (August 31, 2015)

SUMMARY: Modifies the Bagley-Keene Open Meeting Act to require two-member advisory committees of a "state body" (as defined in the Act) to hold open, public meetings if at least one member of the advisory committee is a member of the larger state body and the advisory committee is supported, in whole or in part, by state funds. Specifically, **this bill:**

- 1) Clarifies that, under the Bagley-Keene Act, a two-member advisory committee of a state body is a state body if a member of that state body sits on the advisory committee and the committee receives funds from the state body.
- 2) Contains an urgency clause to take effect immediately.

EXISTING LAW:

- 1) Requires that all meetings of a state body, as defined, be open and public and that all persons be permitted to attend and participate in a meeting of a state body, subject to certain conditions and exceptions. (The Bagley-Keene Open Meeting Act, set forth in Government Code Sections 11120 to 11132)
- 2) Defines a state body, for purposes of the Bagley-Keene Open Meeting Act, to mean each of the following:

- a) Every state board, or commission, or similar multimember body of the state that is created by statute or required by law to conduct official meetings and every commission created by executive order.
- b) A board, commission, committee, or similar multimember body that exercises any authority of a state body delegated to it by that state body.
- c) An advisory board, advisory commission, advisory committee, advisory subcommittee, or similar multimember advisory body of a state body, if created by formal action of the state body or of any member of the state body, and if the advisory body so created consists of three or more persons.
- d) A board, commission, committee, or similar multimember body on which a member of a body that is a state body pursuant to this section serves in his or her official capacity as a representative of that state body and that is supported, in whole or in part, by funds provided by the state body, whether the multimember body is organized and operated by the state body or by a private corporation.

FISCAL EFFECT: According to the Senate Appropriations Committee, this bill imposes minor to moderate costs on affected state entities. Some state entities may simply decide to eliminate certain advisory bodies and specified standing committees rather than spend limited resources for compliance with open meeting requirements.

COMMENTS: The Bagley-Keene Open Meeting Act, set forth in Government Code Sections 11120 to 11132, covers all state boards and commissions and generally requires these bodies to publicly notice their meetings, prepare agendas, accept public testimony and conduct their meetings in public unless specifically authorized by the Act to meet in closed session. The Ralph M. Brown Act, set forth in Government Code Section 54950 et seq., governs meetings of legislative bodies of local agencies. In general, both Acts are virtually identical. While both Acts contain specific exceptions from the open meeting requirements where government has demonstrated a need for confidentiality, such exceptions have been narrowly construed by the courts.

When the Legislature enacted the Bagley-Keene Act, it essentially said that when a state body sits down to develop its consensus, there needs to be a seat at the table reserved for the public. By reserving this place for the public, the Legislature has provided the public with the ability to monitor and participate in the decision-making process. If the body were permitted to meet in secret, the public's role in the decision-making process would be negated. Therefore, absent a specific reason to keep the public out of the meeting, the public should be allowed to monitor and participate in the decision-making process.

Purpose of the bill: According to the author's office, the current definition of "state body" in the Bagley-Keene Act contains an ambiguity with respect to whether standing committees composed of fewer than three members need to comply with the public notice and open meeting requirements of the Act. The author's office contends this ambiguity has been interpreted by certain state agencies to allow standing committees to hold closed-door meetings so long as those committees contain fewer than three members and do not vote on action items. The author's office states that this bill is simply intended to clarify that all standing committees, including advisory committees, are subject to the transparency of open meeting regulations regardless of committee size or membership.

The author's office notes that prior to 1993, the Brown Act contained language very similar to the current language in the Bagley-Keene Act relative to standing committees. However, in the 1990s when a local government entity attempted to claim a loophole existed for two-member standing committees, the Legislature promptly removed any ambiguity on the matter from the Brown Act through enactment of SB 1140 (Calderon), Chapter 1138, Statutes of 1993. A conforming change was not made, however, to the Bagley-Keene Act, as no change was thought necessary.

The author's office believes that the ambiguity left in the Bagley-Keene Act is allowing state bodies to deliberate and direct staff behind closed doors. These state agencies are allowing standing committees to interpret the language of the Bagley-Keene Act in a manner that is contrary to the intent of the Legislature and the public.

Last year, the Governor vetoed a similar measure, AB 2058 (Wilk). In his veto message of AB 2058, the Governor wrote, "an advisory committee does not have authority to act on its own and must present any findings and recommendations to a larger body in a public setting for formal action," which he argued should be sufficient for transparency purposes.

In support: Writing in support, the California Association of Licensed Investigators states that this bill provides for enhanced transparency in the proceedings of government.

In opposition: Certain state professional boards contend this bill essentially prevents them and their various committees from asking fewer than three members to review a document, draft a letter, provide expert analysis, or work on legal language without giving public notice. Opening such advisory activities to the public could greatly increase costs for staff to attend meetings and record minutes as well as contract for public meeting space. Under current law, the advisory activities of two-member bodies are already vetted and voted upon in publically noticed meetings of the whole committee or board.

GOVERNOR'S VETO MESSAGE:

This bill expands the Bagley-Keene Open Meeting Act to include state advisory bodies, regardless of their size.

My thinking on this matter has not changed from last year when I vetoed a similar measure, AB 2058. I believe strongly in transparency and openness but the more informal deliberation of advisory bodies is best left to current law.

Analysis Prepared by: Eric Johnson / G.O. / (916) 319-2531

FN: 0002466

CHAPTER _____

An act to amend Section 11121 of the Government Code, relating to state government, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 85, Wilk. Open meetings.

The Bagley-Keene Open Meeting Act requires that all meetings of a state body, as defined, be open and public and that all persons be permitted to attend and participate in a meeting of a state body, subject to certain conditions and exceptions.

This bill would specify that the definition of "state body" includes an advisory board, advisory commission, advisory committee, advisory subcommittee, or similar multimember advisory body of a state body that consists of 3 or more individuals, as prescribed, except a board, commission, committee, or similar multimember body on which a member of a body serves in his or her official capacity as a representative of that state body and that is supported, in whole or in part, by funds provided by the state body, whether the multimember body is organized and operated by the state body or by a private corporation.

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

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

SECTION 1. Section 11121 of the Government Code is amended to read:

11121. As used in this article, "state body" means each of the following:

(a) Every state board, or commission, or similar multimember body of the state that is created by statute or required by law to conduct official meetings and every commission created by executive order.

(b) A board, commission, committee, or similar multimember body that exercises any authority of a state body delegated to it by that state body.

(c) An advisory board, advisory commission, advisory committee, advisory subcommittee, or similar multimember advisory body of a state body, if created by formal action of the state body or of any member of the state body, and if the advisory body so created consists of three or more persons, except as in subdivision (d).

(d) A board, commission, committee, or similar multimember body on which a member of a body that is a state body pursuant to this section serves in his or her official capacity as a representative of that state body and that is supported, in whole or in part, by funds provided by the state body, whether the multimember body is organized and operated by the state body or by a private corporation.

SEC. 2. 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 Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to avoid unnecessary litigation and ensure the people's right to access the meetings of public bodies pursuant to Section 3 of Article 1 of the California Constitution, it is necessary that this act take effect immediately.

AB 611



California
LEGISLATIVE INFORMATION

AB-611 Controlled substances: prescriptions: reporting. (2015-2016)

Senate:
Assembly: 1st Cmt

Bill Status	
Measure:	AB-611
Lead Authors:	Dahle (A)
Principal Coauthors:	-
Coauthors:	-
Topic:	Controlled substances: prescriptions: reporting.
31st Day in Print:	03/27/15
Title:	An act to amend Section 11165.1 of the Health and Safety Code, relating to controlled substances.
House Location:	Assembly
Last Amended Date:	04/15/15
Committee Location:	Asm Business and Professions

Type of Measure
Active Bill - In Committee Process
Majority Vote Required
Non-Appropriation
Fiscal Committee
Non-State-Mandated Local Program
Non-Urgency
Non-Tax levy

Last 5 History Actions	
Date	Action
04/21/15	In committee: Set, first hearing. Hearing canceled at the request of author.
04/16/15	Re-referred to Com. on B. & P.
04/15/15	From committee chair, with author's amendments: Amend, and re-refer to Com. on B. & P. Read second time and amended.
04/14/15	Re-referred to Com. on B. & P.
04/13/15	From committee chair, with author's amendments: Amend, and re-refer to Com. on B. & P. Read second time and amended.

AMENDED IN ASSEMBLY APRIL 15, 2015

AMENDED IN ASSEMBLY APRIL 13, 2015

AMENDED IN ASSEMBLY MARCH 24, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 611

Introduced by Assembly Member Dahle

February 24, 2015

An act to amend Section 11165.1 of the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

AB 611, as amended, Dahle. Controlled substances: prescriptions: reporting.

Existing law requires certain health care practitioners and pharmacists to apply to the Department of Justice to obtain approval to access information contained in the Controlled Substance Utilization Review and Evaluation System (CURES) Prescription Drug Monitoring Program (PDMP) regarding the controlled substance history of a patient under his or her care. Existing law requires the Department of Justice, upon approval of an application, to provide the approved health care practitioner or pharmacist the history of controlled substances dispensed to an individual under his or her care. Existing law authorizes an application to be denied, or a subscriber to be suspended, for specified reasons, including, among others, a subscriber accessing information for any reason other than caring for his or her patients.

This bill would also authorize an individual designated to investigate a holder of a professional license to apply to the Department of Justice to obtain approval to access information contained in the CURES PDMP

regarding the controlled substance history of an applicant or a licensee for the purpose of investigating the alleged substance abuse of a licensee. The bill would, upon approval of an application, require the department to provide to the approved individual the history of controlled substances dispensed to the licensee. The bill would clarify that only a subscriber who is a health care practitioner or a pharmacist may have an application denied or be suspended for accessing subscriber information for any reason other than caring for his or her patients. The bill would also specify that an application may be denied, or a subscriber may be suspended, if a subscriber who has been designated to investigate the holder of a professional license accesses information for any reason other than investigating the holder of a professional license.

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

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

1 SECTION 1. Section 11165.1 of the Health and Safety Code
 2 is amended to read:
 3 11165.1. (a) (1) (A) (i) A health care practitioner authorized
 4 to prescribe, order, administer, furnish, or dispense Schedule II,
 5 Schedule III, or Schedule IV controlled substances pursuant to
 6 Section 11150 shall, before January 1, 2016, or upon receipt of a
 7 federal Drug Enforcement Administration (DEA) registration,
 8 whichever occurs later, submit an application developed by the
 9 Department of Justice to obtain approval to access information
 10 online regarding the controlled substance history of a patient that
 11 is stored on the Internet and maintained within the Department of
 12 Justice, and, upon approval, the department shall release to that
 13 practitioner the electronic history of controlled substances
 14 dispensed to an individual under his or her care based on data
 15 contained in the CURES Prescription Drug Monitoring Program
 16 (PDMP).
 17 (ii) A pharmacist shall, before January 1, 2016, or upon
 18 licensure, whichever occurs later, submit an application developed
 19 by the Department of Justice to obtain approval to access
 20 information online regarding the controlled substance history of
 21 a patient that is stored on the Internet and maintained within the
 22 Department of Justice, and, upon approval, the department shall
 23 release to that pharmacist the electronic history of controlled

1 substances dispensed to an individual under his or her care based
2 on data contained in the CURES PDMP.

3 (iii) (I) An individual designated by a board, bureau, or
4 program within the Department of Consumer Affairs to investigate
5 a holder of a professional license may, for the purpose of
6 investigating the alleged substance abuse of a licensee, submit an
7 application developed by the Department of Justice to obtain
8 approval to access information online regarding the controlled
9 substance history of a licensee that is stored on the Internet and
10 maintained within the Department of Justice, and, upon approval,
11 the department shall release to that individual the electronic history
12 of controlled substances dispensed to the licensee based on data
13 contained in the CURES PDMP. ~~An application for an individual~~
14 ~~designated by a board, bureau, or program that does not regulate~~
15 ~~health care practitioners authorized to prescribe, order, administer,~~
16 ~~furnish, or dispense Schedule II, Schedule III, or Schedule IV~~
17 ~~controlled substances pursuant to Section 11150. The application~~
18 shall contain facts demonstrating the probable cause to believe the
19 licensee has violated a law governing controlled substances.

20 (II) *This clause does not require an individual designated by a*
21 *board, bureau, or program within the Department of Consumer*
22 *Affairs that regulates health care practitioners to submit an*
23 *application to access the information stored within the CURES*
24 *PDMP.*

25 (B) An application may be denied, or a subscriber may be
26 suspended, for reasons which include, but are not limited to, the
27 following:

28 (i) Materially falsifying an application for a subscriber.

29 (ii) Failure to maintain effective controls for access to the patient
30 activity report.

31 (iii) Suspended or revoked federal DEA registration.

32 (iv) Any subscriber who is arrested for a violation of law
33 governing controlled substances or any other law for which the
34 possession or use of a controlled substance is an element of the
35 crime.

36 (v) Any subscriber described in clause (i) or (ii) of subparagraph

37 (A) accessing information for any other reason than caring for his
38 or her patients.

1 (vi) Any subscriber described in clause (iii) of subparagraph
2 (A) accessing information for any other reason than investigating
3 the holder of a professional license.

4 (C) Any authorized subscriber shall notify the Department of
5 Justice within 30 days of any changes to the subscriber account.

6 (2) A health care practitioner authorized to prescribe, order,
7 administer, furnish, or dispense Schedule II, Schedule III, or
8 Schedule IV controlled substances pursuant to Section 11150 or
9 a pharmacist shall be deemed to have complied with paragraph
10 (1) if the licensed health care practitioner or pharmacist has been
11 approved to access the CURES database through the process
12 developed pursuant to subdivision (a) of Section 209 of the
13 Business and Professions Code.

14 (b) Any request for, or release of, a controlled substance history
15 pursuant to this section shall be made in accordance with guidelines
16 developed by the Department of Justice.

17 (c) In order to prevent the inappropriate, improper, or illegal
18 use of Schedule II, Schedule III, or Schedule IV controlled
19 substances, the Department of Justice may initiate the referral of
20 the history of controlled substances dispensed to an individual
21 based on data contained in CURES to licensed health care
22 practitioners, pharmacists, or both, providing care or services to
23 the individual.

24 (d) The history of controlled substances dispensed to an
25 individual based on data contained in CURES that is received by
26 an authorized subscriber from the Department of Justice pursuant
27 to this section shall be considered medical information subject to
28 the provisions of the Confidentiality of Medical Information Act
29 contained in Part 2.6 (commencing with Section 56) of Division
30 1 of the Civil Code.

31 (e) Information concerning a patient's controlled substance
32 history provided to an authorized subscriber pursuant to this section
33 shall include prescriptions for controlled substances listed in
34 Sections 1308.12, 1308.13, and 1308.14 of Title 21 of the Code
35 of Federal Regulations.

O

AB 637



California
LEGISLATIVE INFORMATION

AB-637 Physician Orders for Life Sustaining Treatment forms. (2015-2016)

Senate:	1st	Cmt	2nd	3rd	Pass	Chp
Assembly:	1st	Cmt	2nd	3rd	Pass	Pass

Bill Status	
Measure:	AB-637
Lead Authors:	Campos (A)
Principal Coauthors:	-
Coauthors:	-
Topic:	Physician Orders for Life Sustaining Treatment forms.
31st Day in Print:	03/27/15
Title:	An act to amend Section 4780 of the Probate Code, relating to resuscitative measures.
House Location:	Secretary of State
Chaptered Date:	08/17/15

Type of Measure	
Inactive Bill - Chaptered	
Majority Vote Required	
Non-Appropriation	
Non-Fiscal Committee	
Non-State-Mandated Local Program	
Non-Urgency	
Non-Tax levy	

Last 5 History Actions	
Date	Action
08/17/15	Chaptered by Secretary of State - Chapter 217, Statutes of 2015.
08/17/15	Approved by the Governor.
08/03/15	Enrolled and presented to the Governor at 3 p.m.
07/06/15	In Assembly. Ordered to Engrossing and Enrolling.
07/06/15	Read third time. Passed. Ordered to the Assembly. (Ayes 37. Noes 2. Page 1784.).

THIRD READING

Bill No: AB 637
Author: Campos (D)
Introduced: 2/24/15
Vote: 21

SENATE HEALTH COMMITTEE: 8-0, 6/10/15
AYES: Hernandez, Nguyen, Hall, Mitchell, Monning, Pan, Roth, Wolk
NO VOTE RECORDED: Nielsen

ASSEMBLY FLOOR: 75-0, 4/16/15 - See last page for vote

SUBJECT: Physician Orders for Life Sustaining Treatment forms

SOURCE: California Medical Association
Coalition for Compassionate Care of California

DIGEST: This bill allows a nurse practitioner or a physician assistant acting under the supervision of a physician to sign a completed Physician Orders for Life Sustaining Treatment form.

ANALYSIS:

Existing law:

- 1) Establishes the Physicians Orders for Life Sustaining Treatment (POLST) form and medical intervention and procedures, and requires that POLST be explained by a health care provider, defined as an individual licensed, certified, or otherwise authorized or permitted by the law of this state to provide health care in the ordinary course of business or practice of a profession.
- 2) Requires the form to be completed by a health care provider based on patient preferences and medical indications, and signed by a physician and the patient or his or her legally recognized health care decision maker. Requires the health care provider, during the process of completing form, to inform the patient

about the difference between an advance health care directive and the POLST form.

This bill adds a nurse practitioner (NP), or a physician assistant (PA) acting under the supervision of the physician and within the scope of practice authorized by law, to the POLST law to sign a completed POLST form.

Comments

- 1) *Author's statement.* According to the author, POLST is viewed by health care professionals as useful, helpful, reliable and most importantly, very effective at ensuring preferences for end-of-life care are honored. Physicians recognize and appreciate the value of the multiple member health care team and support efforts to increase productivity while ensuring quality of care. NPs and PAs are currently having conversations with patients about their end-of-life care options and preferences, and in some instances are able to sign off on other immediately actionable documents under supervision, such as drug orders and medical certificates. By allowing NPs and PAs under physician supervision to sign POLST forms, this bill will improve end-of-life care by increasing the availability of actionable medical orders for medically indicated care consistent with patient preferences.
- 2) *What is POLST?* POLST includes a clinical process designed to facilitate communication between health care professionals and patients with serious illness or frailty (or their authorized surrogate) where the health care professional would not be surprised if the patient died within the next year. The process encourages shared, informed medical decision-making leading to a set of portable medical orders that respects the patient's goals for care in regard to the use of cardiopulmonary resuscitation and other medical interventions, is applicable across health care settings, and can be reviewed and revised as needed. The POLST form is a highly visible, portable medical form that transfers from one setting to another with the patient. It functions as a Do Not Resuscitate order and provides treatment direction for multiple situations. The POLST form itself is outcome neutral, meaning treatment options range from full treatment to comfort care only.
- 3) *POLST and advance directive.* POLST is neither an advance directive nor a replacement for an advance directive. Both documents are helpful for communicating patient wishes when appropriately used. An advance directive is a form in which an individual appoints a person or persons to make health

care decisions for the individual if and when the individual loses capacity to make health care decisions (health care power of attorney) and/or provides guidance or instructions for making health care decisions (living will). An advance directive is from the patient, not a medical order. POLST consists of a set of medical orders that applies to a limited population of patients and addresses a limited number of critical medical decisions. POLST is a complement to advance directives in that it serves as a translation tool and a continuity of care assurance.

- 4) *POLST in California.* According to information presented at a December 3, 2014, briefing on POLST in California, based on an evaluation by UCLA, POLST is widely used in California but there are challenges with completing the form and making sure it travels with the patient. Additional problems include incomplete or inaccurate information and for emergency medical responders the documents are not always available.
- 5) *NPs and PAs.* A PA may perform those medical services as set forth in regulations when the services are rendered under the supervision of a licensed physician and surgeon. A PA may only provide those medical services which he or she is competent to perform and which are consistent with his or her education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that PA. According to the California Association of Nurse Practitioners, NPs are advanced practice registered nurses who are licensed by the Board of Registered Nursing and have pursued higher education, either a master's or doctoral degree, and certification as a NP. NPs provide care in a variety of settings, including hospitals, community clinics, and private practice settings under physician supervision.

Related Legislation

SB 19 (Wolk) establishes a POLST Registry operated by the California Health and Human Services Agency (CHHS) for the purpose of collecting a POLST form received from a physician, or his or her designee, and disseminating the information in the form to persons authorized by CHHS. SB 19 is pending in the Assembly.

SB 128 (Wolk) permits a qualified adult with capacity to make medical decisions, who has been diagnosed with a terminal disease to receive a prescription for an aid in dying drug if certain conditions are met, such as two oral requests, a minimum

of 15 days apart and a signed written request witnessed by two individuals is provided to his or her attending physician, the attending physician refers the patient to an independent, consulting physician to confirm diagnosis and capacity of the patient to make medical decisions, and the attending physician refers the patient for a mental health specialist assessment if there are indications of a mental disorder. SB 128 is set for hearing in the Assembly Health Committee on June 23, 2015.

SB 323 (Hernandez) authorizes a NP who holds a national certification to practice without physician supervision in specified settings. SB 323 is set for hearing in the Assembly Business and Professions Committee on June 30, 2015.

Prior Legislation

SB 1357 (Wolk, 2014) would have established a POLST registry at CHHS and is substantially similar to SB 19. *The bill was held on the Senate Appropriations Committee suspense file.*

AB 3000 (Wolk, Chapter 266, Statutes of 2008) created POLST in California, which is a standardized form to reflect a broader vision of resuscitative or life sustaining requests and to encourage the use of POLST orders to better handle resuscitative or life sustaining treatment consistent with a patient's wishes.

FISCAL EFFECT: Appropriation: No Fiscal Com.: No Local: No

SUPPORT: (Verified 6/15/15)

California Medical Association (co-source)
Coalition for Compassionate Care of California (co-source)
AARP
Association of Northern California Oncologists
Blue Shield of California
California Assisted Living Association
California Association for Health Services at Home
California Association for Nurse Practitioners
California Chapter of the American College of Emergency Physicians
California Long-Term Care Ombudsman Association
Contra Costa County Advisory Council on Aging
Contra Costa County Board of Supervisors
LeadingAge California
Medical Board of California
Medical Oncology Association of Southern California, Inc.

Physician Assistant Board

OPPOSITION: (Verified 6/15/15)

California Right to Life Committee, Inc.

ARGUMENTS IN SUPPORT: The California Medical Association, this bill's co-sponsor, writes that a POLST becomes actionable when signed by a physician and the patient. NPs and PAs are having conversations with patients about their end-of-life care options and preferences and, in some instances, are able to sign off on other immediately actionable documents under supervision, such as drug orders, and medical certificates. The Coalition for Compassionate Care of California, the other co-sponsor of this bill, writes that the two signature requirement can create a roadblock to timely completion, particularly in rural areas and skilled nursing facilities where timely access to a physician can be difficult to obtain. The situation can create an unnecessarily stressful delay. NPs and PAs receive advanced training that enables them to talk with patients about the medical treatment choices in POLST and they are often able to spend more one-on-one time with patients than physicians. Sixteen states, including Oregon, already allow NPs and PAs to sign POLST forms, and no problems have occurred. The California Chapter of the American College of Emergency Physicians writes that end-of-life decisions a patient sets out in their POLST are often put into practice in the emergency department, and unfortunately, many patients arrive with an invalid POLST not signed by a physician. Allowing a NP or, PA under physician supervision, to sign and validate a POLST form will increase the number of valid POLST forms that emergency physicians can act on, and ensure patient's end-of-life wishes are honored. AARP writes POLST is an effective but underutilized advance-care planning tool and utilization may be improved by authorizing other health care team members such as NPs and PAs who are already discussing health care decisions with patients and/or their decision makers regarding the levels of medical intervention identified on the POLST form.

ARGUMENTS IN OPPOSITION: The California Right to Life Committee, Inc. writes that this bill raises the status of NPs and PAs to a level of medical competence that is not warranted by their level of education and knowledge of illness or treatments.

ASSEMBLY FLOOR: 75-0, 4/16/15

AYES: Achadjian, Alejo, Travis Allen, Baker, Bigelow, Bloom, Bonilla, Bonta, Brough, Brown, Burke, Calderon, Campos, Chang, Chau, Chávez, Chiu, Chu, Cooley, Cooper, Dababneh, Dahle, Daly, Frazier, Beth Gaines, Gallagher,

Cristina Garcia, Eduardo Garcia, Gatto, Gomez, Gonzalez, Gordon, Gray, Grove, Hadley, Roger Hernández, Holden, Irwin, Jones, Jones-Sawyer, Kim, Lackey, Levine, Linder, Lopez, Low, Maienschein, Mathis, Mayes, McCarty, Medina, Melendez, Mullin, Nazarian, Obernolte, O'Donnell, Olsen, Patterson, Perea, Rendon, Ridley-Thomas, Rodriguez, Salas, Santiago, Steinorth, Mark Stone, Thurmond, Ting, Wagner, Waldron, Weber, Wilk, Williams, Wood, Atkins

NO VOTE RECORDED: Dodd, Eggman, Gipson, Harper, Quirk

Prepared by: Teri Boughton / HEALTH /
6/16/15 13:51:05

**** END ****



Assembly Bill No. 637

CHAPTER 217

An act to amend Section 4780 of the Probate Code, relating to resuscitative measures.

[Approved by Governor August 17, 2015. Filed with
Secretary of State August 17, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

AB 637, Campos. Physician Orders for Life Sustaining Treatment forms.

Existing law defines a request regarding resuscitative measures to mean a written document, signed by an individual, as specified, and the physician, that directs a health care provider regarding resuscitative measures, and includes a Physician Orders for Life Sustaining Treatment form (POLST form). Existing law requires a physician to treat a patient in accordance with the POLST form and specifies the criteria for creation of a POLST form, including that the form be completed by a health care provider based on patient preferences and medical indications, and signed by a physician and the patient or his or her legally recognized health care decisionmaker.

This bill would authorize the signature of a nurse practitioner or a physician assistant acting under the supervision of the physician and within the scope of practice authorized by law to create a valid POLST form.

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

SECTION 1. Section 4780 of the Probate Code is amended to read:

4780. (a) As used in this part:

(1) "Request regarding resuscitative measures" means a written document, signed by (A) an individual with capacity, or a legally recognized health care decisionmaker, and (B) the individual's physician, that directs a health care provider regarding resuscitative measures. A request regarding resuscitative measures is not an advance health care directive.

(2) "Request regarding resuscitative measures" includes one, or both of, the following:

(A) A prehospital "do not resuscitate" form as developed by the Emergency Medical Services Authority or other substantially similar form.

(B) A Physician Orders for Life Sustaining Treatment form, as approved by the Emergency Medical Services Authority.

(3) "Physician Orders for Life Sustaining Treatment form" means a request regarding resuscitative measures that directs a health care provider regarding resuscitative and life-sustaining measures.

(b) A legally recognized health care decisionmaker may execute the Physician Orders for Life Sustaining Treatment form only if the individual lacks capacity, or the individual has designated that the decisionmaker's authority is effective pursuant to Section 4682.

(c) The Physician Orders for Life Sustaining Treatment form and medical intervention and procedures offered by the form shall be explained by a health care provider, as defined in Section 4621. The form shall be completed by a health care provider based on patient preferences and medical indications, and signed by a physician, or a nurse practitioner or a physician assistant acting under the supervision of the physician and within the scope of practice authorized by law, and the patient or his or her legally recognized health care decisionmaker. The health care provider, during the process of completing the Physician Orders for Life Sustaining Treatment form, should inform the patient about the difference between an advance health care directive and the Physician Orders for Life Sustaining Treatment form.

(d) An individual having capacity may revoke a Physician Orders for Life Sustaining Treatment form at any time and in any manner that communicates an intent to revoke, consistent with Section 4695.

(e) A request regarding resuscitative measures may also be evidenced by a medallion engraved with the words "do not resuscitate" or the letters "DNR," a patient identification number, and a 24-hour toll-free telephone number, issued by a person pursuant to an agreement with the Emergency Medical Services Authority.

AB 728



California
LEGISLATIVE INFORMATION

AB-728 State government: financial reporting. (2015-2016)

Senate: 1st Cmt 2nd Pass 3rd 2nd 3rd Pass Chp
Assembly: 1st Cmt 2nd Pass Pass Pass

Bill Status	
Measure:	AB-728
Lead Authors:	Hadley (A)
Principal Coauthors:	-
Coauthors:	-
Topic:	State government: financial reporting.
31st Day in Print:	03/28/15
Title:	An act to amend Section 13405 of the Government Code, relating to state government.
House Location:	Secretary of State
Chaptered Date:	09/30/15
Last Amended Date:	08/24/15

Type of Measure
Inactive Bill - Chaptered
Majority Vote Required
Non-Appropriation
Fiscal Committee
Non-State-Mandated Local Program
Non-Urgency
Non-Tax levy

Last 5 History Actions	
Date	Action
09/30/15	Chaptered by Secretary of State - Chapter 371, Statutes of 2015.
09/30/15	Approved by the Governor.
09/15/15	Enrolled and presented to the Governor at 4 p.m.
09/02/15	Senate amendments concurred in. To Engrossing and Enrolling. (Ayes 80. Noes 0. Page 2810.)
09/02/15	Assembly Rule 77 suspended. (Page 2795.)

CONCURRENCE IN SENATE AMENDMENTS

AB 728 (Hadley)

As Amended August 24, 2015

Majority vote

ASSEMBLY: 77-0 (May 7, 2015)

SENATE: 40-0 (September 1, 2015)

Original Committee Reference: **A. & A.R.**

SUMMARY: Requires state agencies to post their State Leadership Accountability Act (SLAA) reports on their Web sites after acceptance by the Department of Finance (DOF).

The Senate amendments:

- 1) Specify the reports must be posted within five business days after acceptance by DOF.
- 2) Make technical non-substantive changes to incorporate the chaptering of a budget trailer bill that affected the same code section in this bill.

EXISTING LAW:

- 1) Requires agency heads covered by SLAA to conduct reviews and issue SLAA reports about internal controls and monitoring processes.
- 2) Requires agencies to submit SLAA reports to various state entities, including the State Library, where reports are required to be available for public inspection.

FISCAL EFFECT: According to the Senate Appropriations Committee, pursuant to Senate Rule 28.8, negligible state costs.

COMMENTS: This bill requires state agencies to post SLAA reports on their website. Senate amendments clarify that they must be posted within five business days after acceptance by DOF. The prior version of this bill required posting "within five days of finalization" and did not specify if the days were calendar or business days, or how finalization would be determined.

SLAA reports, which are due by the end of each odd-number calendar year, assess an agency's systems of internal controls and monitoring practices.

State agencies are currently required to submit SLAA reports to the Legislature, State Auditor, Controller, DOF, the Secretary of Government Operations, and to the State Library where they must be available for public inspection.

Senate amendments incorporate language in SB 84 (Budget and Fiscal Review Committee), Chapter 25, Statutes of 2015, a budget trailer bill, which change the name of the Financial Integrity and State Manager's Accountability Act of 1983 (FISMA) to SLAA.

Analysis Prepared by: Scott Herbstman / A. & A.R. / (916) 319-3600

FN: 0001701



Assembly Bill No. 728

CHAPTER 371

An act to amend Section 13405 of the Government Code, relating to state government.

[Approved by Governor September 30, 2015. Filed with
Secretary of State September 30, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

AB 728, Hadley. State government: financial reporting.

Existing law, the State Leadership Accountability Act, provides that state agency heads are responsible for the establishment and maintenance of a system or systems of internal accounting and administrative control within their agencies, as specified. Existing law requires state agency heads to, biennially, conduct an internal review and prepare a report on the adequacy of the agency's systems of internal accounting, administrative control, and monitoring practices. Copies of the reports are required to be submitted to the Legislature, the California State Auditor, the Controller, the Department of Finance, the Secretary of Government Operations, and to the State Library where the copy is required to be available for public inspection.

This bill would also require the report to be posted on the agency's Internet Web site within 5 business days after acceptance by the department.

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

SECTION 1. Section 13405 of the Government Code, as amended by Section 18 of Chapter 25 of the Statutes of 2015, is amended to read:

13405. (a) To ensure that the requirements of this chapter are fully complied with, each agency head that the Department of Finance determines is covered by this section shall, on a biennial basis but no later than December 31 of each odd-numbered year, conduct an internal review and prepare a report on the adequacy of the state agency's systems of internal control, and monitoring practices in accordance with the guide prepared by the Department of Finance pursuant to subdivision (d).

(b) The report, including the state agency's response to review recommendations, shall be signed by the agency head and addressed to the agency secretary, or the Director of Finance for a state agency without a secretary. An agency head shall submit a copy of the report and related response, pursuant to a method determined by the Department of Finance, to the Legislature, the California State Auditor, the Controller, the Department of Finance, the Secretary of Government Operations, and to the State Library where the copy shall be available for public inspection. A

copy of the report shall be posted on the agency's Internet Web site within five business days after acceptance by the Department of Finance.

(c) The report shall identify any material inadequacy or material weakness in a state agency's systems of internal control that prevents the agency head from stating that the state agency's systems comply with this chapter. Concurrently with the submission of the report pursuant to subdivision (b), the state agency shall provide to the Department of Finance a plan and schedule for correcting the identified inadequacies and weaknesses, that shall be updated every six months until all corrections are implemented.

(d) The Department of Finance in consultation with the California State Auditor and the Controller, shall establish, and may modify from time to time as necessary, a system of reporting and a general framework to guide state agencies in conducting internal reviews of their systems of internal control.

(e) The Department of Finance in consultation with the California State Auditor and the Controller, shall establish, and may modify from time to time as necessary, a general framework of recommended practices to guide state agencies in conducting active, ongoing monitoring of processes for internal control.

AB 1351



California
LEGISLATIVE INFORMATION

AB-1351 Deferred entry of judgment: pretrial diversion. (2015-2016)

Senate: 1st Cmt 2nd 3rd 2nd 3rd Pass
 Assembly: Int 1st Cmt 2nd 3rd Pass Pass Veto

Bill Status	
Measure:	AB-1351
Lead Authors:	Eggman (A)
Principal Coauthors:	-
Coauthors:	Hall (S)
Topic:	Deferred entry of judgment: pretrial diversion.
31st Day in Print:	03/31/15
Title:	An act to amend Sections 1000, 1000.1, 1000.2, 1000.3, 1000.4, 1000.5, and 1000.6 of, and to add Section 1000.7 to, the Penal Code, relating to deferred entry of judgment.
House Location:	Assembly
Enrolled Date:	09/14/15
Last Amended Date:	09/03/15

Type of Measure
Inactive Bill - Vetoed
Majority Vote Required
Non-Appropriation
Fiscal Committee
Non-State-Mandated Local Program
Non-Urgency
Non-Tax levy

Last 5 History Actions	
Date	Action
10/08/15	Vetoed by Governor.
09/18/15	Enrolled and presented to the Governor at 4 p.m.
09/10/15	Senate amendments concurred in. To Engrossing and Enrolling. (Ayes 48. Noes 30. Page 3082.).
09/09/15	In Assembly. Concurrence in Senate amendments pending.
09/09/15	Read third time. Passed. Ordered to the Assembly. (Ayes 22. Noes 15. Page 2617.).

Governor's Veto Message

To the Members of the California State Assembly:

I am returning Assembly Bill 1351 without my signature.

AB 1351 would transform the existing deferred entry of judgment program available to low level drug offenders to one that does not require a guilty plea. Instead, the offender would plead not guilty and when the program is completed, the charges would be dropped. If the offender fails to complete the program, the prosecutor would proceed with the charges at that time.

While I support the goal of giving low-level offenders a second chance, I am concerned that the bill eliminates the most powerful incentive to stay in treatment - the knowledge that judgment will be entered for failure to do so. The bill goes too far.

Sincerely,

Edmund G. Brown Jr.

GOVERNOR'S VETO
AB 1351 (Eggman)
As Enrolled September 14, 2015
2/3 vote

ASSEMBLY: 47-30 (June 3, 2015) SENATE: 22-15 (September 9, 2015)

ASSEMBLY: 48-30 (September 10, 2015)

Original Committee Reference: **PUB. S.**

SUMMARY: Makes the existing deferred entry of judgment (DEJ) program for specified offenses involving personal use or possession of controlled substances a pretrial drug diversion program.

The Senate amendments:

- 1) Provide that in order to qualify for pretrial drug diversion, the defendant must not have a conviction within five years prior to the alleged commission of the charged offense for any offense involving controlled substances other than the offenses that qualify for diversion.
- 2) State that the pretrial drug diversion program created by this bill does not affect the existing pretrial misdemeanor diversion program.

EXISTING LAW:

- 1) Provides that a defendant may qualify for DEJ of specified non-violent drug possession offenses if the following apply to the defendant:
 - a) The defendant has no prior conviction for any offense involving controlled substances;
 - b) The offense charged did not involve a crime of violence or threatened violence;
 - c) There is no evidence of a violation relating to narcotics or restricted dangerous drugs other than a violation of the specified deferrable drug offenses;
 - d) The defendant's record does not indicate that probation or parole has ever been revoked without thereafter being completed;
 - e) The defendant's record does not indicate that he or she has successfully completed or been terminated from diversion or DEJ pursuant to this chapter within five years prior to the alleged commission of the charged offense;
 - f) The defendant has no prior felony conviction within five years prior to the alleged commission of the charged offense.
- 2) Specifies the offenses that are eligible for DEJ, which include possession for personal use of specified controlled substances, possession of certain drug paraphernalia, being under the influence of a controlled substance, cultivation of marijuana for personal use, and being present in a place where controlled substances are being used.

- 3) States a prosecutor has a duty to review files to decide whether the defendant is eligible for DEJ. The prosecuting attorney shall file with the court a declaration in writing or state for the record the grounds upon which the determination is based, and shall make this information available to the defendant and his or her attorney. This procedure is intended to allow the court to set the hearing for DEJ at the arraignment.
- 4) Requires all referrals for DEJ granted by the court pursuant to this chapter to be made only to programs that have been certified by the county drug program administrator, or to programs that provide services at no cost to the participant and have been deemed by the court and the county drug program administrator to be credible and effective. The defendant may request to be referred to a program in any county, as long as that program meets the criteria specified.
- 5) Provides that the court shall hold a hearing and, after consideration of any information relevant to its decision, shall determine if the defendant consents to further proceedings and if the defendant should be granted DEJ. If the court does not deem the defendant a person who would be benefited by DEJ, or if the defendant does not consent to participate, the proceedings shall continue as in any other case. The period during which DEJ is granted shall be for no less than 18 months nor longer than three years. Progress reports shall be filed by the probation department with the court as directed by the court.
- 6) Requires, if the defendant has performed satisfactorily during the period in which DEJ was granted, at the end of that period, the criminal charge or charges to be dismissed. If the defendant does not perform satisfactorily, DEJ may be terminated and the defendant may be sentenced as he or she would for a conviction.
- 7) States that upon successful completion of a DEJ program, the arrest upon which the judgment was deferred shall be deemed to have never occurred. The defendant may indicate in response to any question concerning his or her prior criminal record that he or she was not arrested or granted DEJ for the offense, except as specified for employment as a peace officer. A record pertaining to an arrest resulting in successful completion of a DEJ program shall not, without the defendant's consent, be used in any way that could result in the denial of any employment, benefit, license, or certificate.

AS PASSED BY THE ASSEMBLY, this bill:

- 1) Required, to be eligible for diversion, the defendant must not have a prior conviction for any offense involving a controlled substance other than the offenses that may be diverted as specified; the offense charged must not have involved a crime of violence or threatened violence; there must be no evidence of a violation relating to narcotics or restricted dangerous drugs other than a violation of an offense that may be diverted; and the defendant must not have any prior convictions within five years prior to the alleged commission of the charged offense for a serious or violent felony, as defined.
- 2) Provided that a defendant's participation in pretrial diversion shall not constitute a conviction or an admission of guilt in any action or proceeding.
- 3) Stated if the court determines that it is appropriate, the court shall grant pretrial diversion if the defendant pleads not guilty to the charge or charges and waives the right to a speedy trial and to a speedy preliminary hearing, if applicable.

- 4) Changed the minimum time allowed prior to dismissal of the case from 18 months to six months, and the maximum time the proceedings in the case can be suspended from three years to one year.
- 5) Stated that a defendant may request, and the court shall grant, for good cause shown, an extension of time to complete the program.
- 6) Provided that if it appears to the prosecuting attorney, the court, or the probation department that the defendant is performing unsatisfactorily in the assigned program, or that the defendant is convicted of an offense that reflects the defendant's propensity for violence, or the defendant is convicted of a felony, the prosecuting attorney, the court on its own, or the probation department may make a motion for termination of pre-trial diversion.
- 7) Provided that if the court finds that the defendant is not performing satisfactorily in the assigned program, or the court finds that the defendant has been convicted of a specified type of crime, the court shall reinstate the criminal charge or charges and schedule the matter for further proceedings.
- 8) Stated if the defendant has completed pretrial diversion, at the end of that period, the criminal charge or charges shall be dismissed. Upon successful completion of a pretrial diversion program, the arrest upon which the defendant was diverted shall be deemed to have never occurred.
- 9) Stated that a person participating in a pretrial diversion program or a preguilty plea program shall be allowed, under the direction of a licensed health care practitioner, to use medications to treat substance use disorders if the participant allows release of his or her medical records to the court for the limited purpose of determining whether or not the participant is using such medications under the direction of a licensed health care practitioner and is in compliance with the pretrial diversion or preguilty plea program rules.

FISCAL EFFECT: According to the Senate Appropriations Committee:

- 1) Potential increase in state trial court costs (General Fund) to the extent additional and/or more lengthy trials result than otherwise would have occurred under the existing system of DEJ. The removal of the requirement to plead guilty in order to qualify for a treatment program could potentially result in additional defendants who enter a not guilty plea but are unsuccessful in a diversion program, who subsequently require a more lengthy trial than otherwise would have been required under the DEJ process after a guilty plea was entered.
- 2) The Department of Justice (DOJ) has indicated an unknown, but potentially significant impact (General Fund) should its Criminal Law Division experience an increase in workload due to an increase in litigation for defendants able to have qualifying drug offenses be diverted, repeatedly, which would require status appearances for each new case.

COMMENTS: According to the author, "This bill seeks to limit harsh consequences to immigrants by changing the current process for nonviolent, misdemeanor drug offenses from DEJ to pretrial diversion. While the current DEJ process eliminates a conviction if a defendant successfully completes DEJ, the defendant may still face federal consequences, including deportation if the defendant is undocumented, or the prohibition from becoming a United States (U.S.) citizen if the defendant is a legal permanent resident. This is systemic injustice to

immigrants in this country, but even U.S. citizens may face federal consequences, including loss of federal housing and educational benefits.

"Given that President Obama has publicly called for immigration officials to focus on violent, dangerous felons, this bill will have a profoundly positive impact on more than \$2 million undocumented immigrants and the more than 3 million legal permanent residents living in California by eliminating the draconian consequences faced by immigrants who participate in diversion programs in good faith. This bill will keep families together, help people retain eligibility for U.S. citizenship, and also preserve access to other benefits for those who qualify."

GOVERNOR'S VETO MESSAGE:

AB 1351 would transform the existing deferred entry of judgment program available to low level drug offenders to one that does not require a guilty plea. Instead, the offender would plead not guilty and when the program is completed, the charges would be dropped. If the offender fails to complete the program, the prosecutor would proceed with the charges at that time.

While I support the goal of giving low-level offenders a second chance, I am concerned that the bill eliminates the most powerful incentive to stay in treatment - the knowledge that judgment will be entered for failure to do so. The bill goes too far.

Analysis Prepared by: Stella Choe / PUB. S. / (916) 319-3744

FN: 0002478

CHAPTER _____

An act to amend Sections 1000, 1000.1, 1000.2, 1000.3, 1000.4, 1000.5, and 1000.6 of, and to add Section 1000.7 to, the Penal Code, relating to deferred entry of judgment.

LEGISLATIVE COUNSEL'S DIGEST

AB 1351, Eggman. Deferred entry of judgment: pretrial diversion.

Existing law allows individuals charged with specified crimes to qualify for deferred entry of judgment. A defendant qualifies if he or she has no conviction for any offense involving controlled substances, the charged offense did not involve violence, there is no evidence of a violation relating to narcotics or restricted dangerous drugs other than a violation that qualifies for the program, the defendant's record does not indicate that probation or parole has ever been revoked without being completed, and the defendant's record does not indicate that he or she has been granted diversion, deferred entry of judgment, or was convicted of a felony within 5 years prior to the alleged commission of the charged offense.

Under the existing deferred entry of judgment program, an eligible defendant may have entry of judgment deferred, upon pleading guilty to the offenses charged and entering a drug treatment program for 18 months to 3 years. If the defendant does not perform satisfactorily in the program, does not benefit from the program, is convicted of specified crimes, or engages in criminal activity rendering him or her unsuitable for deferred entry of judgment, the defendant's guilty plea is entered and the court enters judgment and proceeds to schedule a sentencing hearing. If the defendant completes the program, the criminal charges are dismissed. Existing law allows the presiding judge of the superior court, with the district attorney and public defender, to establish a pretrial diversion drug program.

This bill would make the deferred entry of judgment program a pretrial diversion program. The bill would provide that a defendant qualifies for the pretrial diversion program if he or she has no prior conviction within 5 years prior to the alleged commission of the

charged offense for any offense involving controlled substances other than the offense that qualifies him or her for diversion, the charged offense did not involve violence, there is no evidence of a violation relating to narcotics or restricted dangerous drugs other than a violation that qualifies for the program and the defendant has no prior conviction for a serious or violent felony within 5 years prior to the alleged commission of the charged offense.

Under the pretrial diversion program created by this bill, a qualifying defendant would enter a not guilty plea, and proceedings would be suspended in order for the defendant to enter a drug treatment program for 6 months to one year, or longer if requested by the defendant with good cause. The bill would require the court, if the defendant does not perform satisfactorily in the program or is convicted of specified crimes, to terminate the program and reinstate the criminal proceedings. The bill would require the criminal charges to be dismissed if the defendant completes the program.

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

SECTION 1. Section 1000 of the Penal Code is amended to read:

1000. (a) This chapter shall apply whenever a case is before any court upon an accusatory pleading for a violation of Section 11350, 11357, 11364, or 11365, paragraph (2) of subdivision (b) of Section 11375, Section 11377, or Section 11550 of the Health and Safety Code, or subdivision (b) of Section 23222 of the Vehicle Code, or Section 11358 of the Health and Safety Code if the marijuana planted, cultivated, harvested, dried, or processed is for personal use, or Section 11368 of the Health and Safety Code if the narcotic drug was secured by a fictitious prescription and is for the personal use of the defendant and was not sold or furnished to another, or subdivision (d) of Section 653f if the solicitation was for acts directed to personal use only, or Section 381 or subdivision (f) of Section 647 of the Penal Code, if for being under the influence of a controlled substance, or Section 4060 of the Business and Professions Code, and it appears to the prosecuting attorney that, except as provided in subdivision (b) of Section 11357 of the Health and Safety Code, all of the following apply to the defendant:

(1) The defendant has no prior conviction within five years prior to the alleged commission of the charged offense for any offense involving controlled substances other than the offenses listed in this subdivision.

(2) The offense charged did not involve a crime of violence or threatened violence.

(3) There is no evidence of a violation relating to narcotics or restricted dangerous drugs other than a violation of the sections listed in this subdivision.

(4) The defendant has no prior conviction within five years prior to the alleged commission of the charged offense for a serious felony, as defined in subdivision (c) of Section 1192.7, or a violent felony, as defined in subdivision (c) of Section 667.5.

(b) The prosecuting attorney shall review his or her file to determine whether or not paragraphs (1) to (4), inclusive, of subdivision (a) apply to the defendant. If the defendant is found eligible, the prosecuting attorney shall file with the court a declaration in writing or state for the record the grounds upon which the determination is based, and shall make this information available to the defendant and his or her attorney. This procedure is intended to allow the court to set the hearing for pretrial diversion at the arraignment. If the defendant is found ineligible for pretrial diversion, the prosecuting attorney shall file with the court a declaration in writing or state for the record the grounds upon which the determination is based, and shall make this information available to the defendant and his or her attorney. The sole remedy of a defendant who is found ineligible for pretrial diversion is a postconviction appeal.

(c) All referrals for pretrial diversion granted by the court pursuant to this chapter shall be made only to programs that have been certified by the county drug program administrator pursuant to Chapter 1.5 (commencing with Section 1211) of Title 8, or to programs that provide services at no cost to the participant and have been deemed by the court and the county drug program administrator to be credible and effective. The defendant may request to be referred to a program in any county, as long as that program meets the criteria set forth in this subdivision.

(d) Pretrial diversion for an alleged violation of Section 11368 of the Health and Safety Code shall not prohibit any administrative agency from taking disciplinary action against a licensee or from

denying a license. Nothing in this subdivision shall be construed to expand or restrict the provisions of Section 1000.4.

(e) Any defendant who is participating in a program referred to in this section may be required to undergo analysis of his or her urine for the purpose of testing for the presence of any drug as part of the program. However, urinalysis results shall not be admissible as a basis for any new criminal prosecution or proceeding.

SEC. 2. Section 1000.1 of the Penal Code is amended to read:

1000.1. (a) If the prosecuting attorney determines that this chapter may be applicable to the defendant, he or she shall advise the defendant and his or her attorney in writing of that determination. This notification shall include all of the following:

(1) A full description of the procedures for pretrial diversion.
(2) A general explanation of the roles and authorities of the probation department, the prosecuting attorney, the program, and the court in the process.

(3) A clear statement that the court may grant pretrial diversion with respect to any crime specified in subdivision (a) of Section 1000 that is charged, provided that the defendant pleads not guilty to the charge or charges, waives the right to a speedy trial and to a speedy preliminary hearing, if applicable, and that upon the defendant's successful completion of a program, as specified in subdivision (c) of Section 1000, the positive recommendation of the program authority and the motion of the defendant, prosecuting attorney, the court, or the probation department, but no sooner than six months and no later than one year from the date of the defendant's referral to the program, the court shall dismiss the charge or charges against the defendant.

(4) A clear statement that upon any failure of treatment or condition under the program, or any circumstance specified in Section 1000.3, the prosecuting attorney or the probation department or the court on its own may make a motion to the court to terminate pretrial diversion and schedule further proceedings as otherwise provided in this code.

(5) An explanation of criminal record retention and disposition resulting from participation in the pretrial diversion program and the defendant's rights relative to answering questions about his or her arrest and pretrial diversion following successful completion of the program.

(b) If the defendant consents and waives his or her right to a speedy trial and a speedy preliminary hearing, if applicable, the court may refer the case to the probation department or the court may summarily grant pretrial diversion. When directed by the court, the probation department shall make an investigation and take into consideration the defendant's age, employment and service records, educational background, community and family ties, prior controlled substance use, treatment history, if any, demonstrable motivation, and other mitigating factors in determining whether the defendant is a person who would be benefited by education, treatment, or rehabilitation. The probation department shall also determine which programs the defendant would benefit from and which programs would accept the defendant. The probation department shall report its findings and recommendations to the court. The court shall make the final determination regarding education, treatment, or rehabilitation for the defendant. If the court determines that it is appropriate, the court shall grant pretrial diversion if the defendant pleads not guilty to the charge or charges and waives the right to a speedy trial and to a speedy preliminary hearing, if applicable.

(c) (1) No statement, or any information procured therefrom, made by the defendant to any probation officer or drug treatment worker, that is made during the course of any investigation conducted by the probation department or treatment program pursuant to subdivision (b), and prior to the reporting of the probation department's findings and recommendations to the court, shall be admissible in any action or proceeding brought subsequent to the investigation.

(2) No statement, or any information procured therefrom, with respect to the specific offense with which the defendant is charged, that is made to any probation officer or drug program worker subsequent to the granting of pretrial diversion shall be admissible in any action or proceeding.

(d) A defendant's participation in pretrial diversion pursuant to this chapter shall not constitute a conviction or an admission of guilt for any purpose.

SEC. 3. Section 1000.2 of the Penal Code is amended to read:

1000.2. (a) The court shall hold a hearing and, after consideration of any information relevant to its decision, shall determine if the defendant consents to further proceedings under

this chapter and if the defendant should be granted pretrial diversion. If the defendant does not consent to participate in pretrial diversion the proceedings shall continue as in any other case.

(b) At the time that pretrial diversion is granted, any bail bond or undertaking, or deposit in lieu thereof, on file by or on behalf of the defendant shall be exonerated, and the court shall enter an order so directing.

(c) The period during which pretrial diversion is granted shall be for no less than six months nor longer than one year. However, the defendant may request, and the court shall grant, for good cause shown, an extension of time to complete a program specified in subdivision (c) of Section 1000. Progress reports shall be filed by the probation department with the court as directed by the court.

SEC. 4. Section 1000.3 of the Penal Code is amended to read:

1000.3. (a) If it appears to the prosecuting attorney, the court, or the probation department that the defendant is performing unsatisfactorily in the assigned program, or that the defendant is convicted of an offense that reflects the defendant's propensity for violence, or the defendant is convicted of a felony, the prosecuting attorney, the court on its own, or the probation department may make a motion for termination from pretrial diversion.

(b) After notice to the defendant, the court shall hold a hearing to determine whether pretrial diversion shall be terminated.

(c) If the court finds that the defendant is not performing satisfactorily in the assigned program, or the court finds that the defendant has been convicted of a crime as indicated in subdivision (a) the court shall schedule the matter for further proceedings as otherwise provided in this code.

(d) If the defendant has completed pretrial diversion, at the end of that period, the criminal charge or charges shall be dismissed.

(e) Prior to dismissing the charge or charges or terminating pretrial diversion, the court shall consider the defendant's ability to pay and whether the defendant has paid a diversion restitution fee pursuant to Section 1001.90, if ordered, and has met his or her financial obligation to the program, if any. As provided in Section 1203.1b, the defendant shall reimburse the probation department for the reasonable cost of any program investigation or progress report filed with the court as directed pursuant to Sections 1000.1 and 1000.2.

SEC. 5. Section 1000.4 of the Penal Code is amended to read:

1000.4. (a) Any record filed with the Department of Justice shall indicate the disposition in those cases referred to pretrial diversion pursuant to this chapter. Upon successful completion of a pretrial diversion program, the arrest upon which the defendant was diverted shall be deemed to have never occurred. The defendant may indicate in response to any question concerning his or her prior criminal record that he or she was not arrested or granted pretrial diversion for the offense, except as specified in subdivision (b). A record pertaining to an arrest resulting in successful completion of a pretrial diversion program shall not, without the defendant's consent, be used in any way that could result in the denial of any employment, benefit, license, or certificate.

(b) The defendant shall be advised that, regardless of his or her successful completion of the pretrial diversion program, the arrest upon which pretrial diversion was based may be disclosed by the Department of Justice in response to any peace officer application request and that, notwithstanding subdivision (a), this section does not relieve him or her of the obligation to disclose the arrest in response to any direct question contained in any questionnaire or application for a position as a peace officer, as defined in Section 830.

SEC. 6. Section 1000.5 of the Penal Code is amended to read:

1000.5. (a) The presiding judge of the superior court, or a judge designated by the presiding judge, together with the district attorney and the public defender, may agree in writing to establish and conduct a preguilty plea drug court program pursuant to the provisions of this chapter, wherein criminal proceedings are suspended without a plea of guilty for designated defendants. The drug court program shall include a regimen of graduated sanctions and rewards, individual and group therapy, urinalysis testing commensurate with treatment needs, close court monitoring and supervision of progress, educational or vocational counseling as appropriate, and other requirements as agreed to by the presiding judge or his or her designee, the district attorney, and the public defender. If there is no agreement in writing for a preguilty plea program by the presiding judge or his or her designee, the district attorney, and the public defender, the program shall be operated as a pretrial diversion program as provided in this chapter.

(b) The provisions of Section 1000.3 and Section 1000.4 regarding satisfactory and unsatisfactory performance in a program shall apply to preguilty plea programs. If the court finds that (1) the defendant is not performing satisfactorily in the assigned program, (2) the defendant is not benefiting from education, treatment, or rehabilitation, (3) the defendant has been convicted of a crime specified in Section 1000.3, or (4) the defendant has engaged in criminal conduct rendering him or her unsuitable for the preguilty plea program, the court shall reinstate the criminal charge or charges. If the defendant has performed satisfactorily during the period of the preguilty plea program, at the end of that period, the criminal charge or charges shall be dismissed and the provisions of Section 1000.4 shall apply.

SEC. 7. Section 1000.6 of the Penal Code is amended to read:

1000.6. (a) Where a person is participating in a pretrial diversion program or a preguilty plea program pursuant to this chapter, the person shall be allowed, under the direction of a licensed health care practitioner, to use medications including, but not limited to, methadone, buprenorphine, or levoalphacetylmethadol (LAAM) to treat substance use disorders if the participant allows release of his or her medical records to the court presiding over the participant's preguilty plea or pretrial diversion program for the limited purpose of determining whether or not the participant is using such medications under the direction of a licensed health care practitioner and is in compliance with the pretrial diversion or preguilty plea program rules.

(b) If the conditions specified in subdivision (a) are met, using medications to treat substance use disorders shall not be the sole reason for exclusion from a pretrial diversion or preguilty plea program. A patient who uses medications to treat substance use disorders and participates in a preguilty plea or pretrial diversion program shall comply with all court program rules.

(c) A person who is participating in a pretrial diversion program or preguilty plea program pursuant to this chapter who uses medications to treat substance use disorders shall present to the court a declaration from his or her health care practitioner, or his or her health care practitioner's authorized representative, that the person is currently under their care.

(d) Urinalysis results that only establish that a person described in this section has ingested medication duly prescribed to that

person by his or her physician or psychiatrist, or medications used to treat substance use disorders, shall not be considered a violation of the terms of the pretrial diversion or preguilty plea program under this chapter.

(e) Except as provided in subdivisions (a) to (d), inclusive, this section shall not be interpreted to amend any provisions governing diversion programs.

SEC. 8. Section 1000.7 is added to the Penal Code, immediately following Section 1000.6, to read:

1000.7. This chapter does not affect a pretrial diversion program provided pursuant to Chapter 2.7 (commencing with Section 1001).

AB 1352



California
LEGISLATIVE INFORMATION

AB-1352 Deferred entry of judgment: withdrawal of plea. (2015-2016)

Senate: 1st Cmt 2nd 3rd 2nd 3rd Cmt 3rd Pass Chp
 Assembly: Int 1st Cmt 2nd 3rd Pass Pass

Bill Status	
Measure:	AB-1352
Lead Authors:	Eggman (A)
Principal Coauthors:	-
Coauthors:	-
Topic:	Deferred entry of judgment: withdrawal of plea.
31st Day in Print:	03/31/15
Title:	An act to add Section 1203.43 to the Penal Code, relating to deferred entry of judgment.
House Location:	Secretary of State
Chaptered Date:	10/08/15
Last Amended Date:	09/09/15

Type of Measure
Inactive Bill - Chaptered
Majority Vote Required
Non-Appropriation
Fiscal Committee
State-Mandated Local Program
Non-Urgency
Non-Tax levy

Last 5 History Actions	
Date	Action
10/08/15	Chaptered by Secretary of State - Chapter 646, Statutes of 2015.
10/08/15	Approved by the Governor.
09/25/15	Enrolled and presented to the Governor at 2 p.m.
09/11/15	Senate amendments concurred in. To Engrossing and Enrolling. (Ayes 43. Noes 32. Page 3174.)
09/11/15	Assembly Rule 63 suspended. (Page 3169.)

(Without Reference to File)

CONCURRENCE IN SENATE AMENDMENTS

AB 1352 (Eggman)

As Amended September 9, 2015

Majority vote

ASSEMBLY: 42-33 (May 4, 2015)

SENATE: (September 11, 2015)

(vote not available)

Original Committee Reference: PUB. S.

SUMMARY: Requires the court to permit a defendant, who was granted deferred entry of judgment (DEJ) on or after January 1, 1997, and who has performed satisfactorily during the period in which DEJ was granted and for whom the criminal charge or charges were dismissed, to withdraw his or her plea and enter a plea of not guilty.

The Senate amendments:

- 1) Provide if court records showing the case resolution are no longer available, the defendant's declaration, under penalty of perjury, that the charges were dismissed after he or she completed the requirements for DEJ, shall be presumed to be true if the defendant has submitted a copy of his or her state summary criminal history information maintained by the Department of Justice that either shows that the defendant successfully completed the deferred entry of judgment program or that the record is incomplete in that it does not show a final disposition.
- 2) State that for purposes of this bill, a final disposition means that the state summary criminal history information shows either a dismissal after completion of the program or a sentence after termination of the program.
- 3) Delete the provision that required the defendant to submit documentation of the dismissal of charges or satisfactory participation in, or completion of diversion programming.
- 4) Delete the provision that required Judicial Council to develop the necessary form to be completed and submitted by the defendant.
- 5) Make technical, nonsubstantive changes.

EXISTING LAW:

- 1) Provides that a defendant may qualify for DEJ of specified non-violent drug possession offenses if the following apply to the defendant:
 - a) The defendant has no prior conviction for any offense involving controlled substances;
 - b) The offense charged did not involve a crime of violence or threatened violence;
 - c) There is no evidence of a violation relating to narcotics or restricted dangerous drugs other than a violation of the specified deferrable drug offenses;

- d) The defendant's record does not indicate that probation or parole has ever been revoked without thereafter being completed;
 - e) The defendant's record does not indicate that he or she has successfully completed or been terminated from diversion or deferred entry of judgment pursuant to this chapter within five years prior to the alleged commission of the charged offense;
 - f) The defendant has no prior felony conviction within five years prior to the alleged commission of the charged offense.
- 2) States that upon successful completion of a DEJ program, the arrest upon which the judgment was deferred shall be deemed to have never occurred. The defendant may indicate in response to any question concerning his or her prior criminal record that he or she was not arrested or granted deferred entry of judgment for the offense, except as specified for employment as a peace officer. A record pertaining to an arrest resulting in successful completion of a DEJ program shall not, without the defendant's consent, be used in any way that could result in the denial of any employment, benefit, license, or certificate.
- 3) States that in any case in which: a) a defendant has fulfilled the conditions of probation for the entire period of probation, or b) has been discharged prior to the termination of the period of probation, or c) in any other case in which a court, in its discretion and the interests of justice, determines that a defendant should be granted the relief available under this section, the defendant shall, at any time after the termination of the period of probation, if he or she is not then serving a sentence for any offense, on probation for any offense, or charged with the commission of any offense, be permitted by the court to withdraw his or her plea of guilty or plea of nolo contendere and enter a plea of not guilty; or, if he or she has been convicted after a plea of not guilty, the court shall set aside the verdict of guilty; and, in either case, the court shall thereupon dismiss the accusations or information against the defendant.
- 4) Provides circumstances that allow non-citizens to be deported, which include having been convicted of a violation of (or a conspiracy or attempt to violate) any law or regulation of a state, the United States, or a foreign country relating to a controlled substance as defined, other than a single offense involving possession for one's own use of 30 grams or less of marijuana.

AS PASSED BY THE ASSEMBLY, this bill required the court to allow a defendant to withdraw his or her guilty or nolo contendere plea in order to avoid specified adverse consequences if certain conditions are met:

- 1) Provided in any case in which a defendant was granted DEJ, on or after January 1, 1997, after pleading guilty or nolo contendere to the charged offense, the defendant shall be permitted by the court to withdraw the plea of guilty or nolo contendere and enter a plea of not guilty if the defendant shows both of the following:
- a) The charges were dismissed after the defendant performed satisfactorily during the DEJ period; and,
 - b) The plea may result in the denial or loss to the defendant of any employment, benefit, license, or certificate, including, but not limited to, causing a noncitizen defendant to

potentially be found inadmissible, deportable, or subject to any other kind of adverse immigration consequence.

- 2) Required the court to dismiss the complaint or information against the defendant.
- 3) Stated the Legislative finding that the statement in Penal Code Section 1000.4, that "successful completion of a DEJ program shall not, without the defendant's consent, be used in any way that could result in the denial of any employment, benefit, license, or certificate" constitutes misinformation about the actual consequences of making a plea in the case of some defendants, including all noncitizen defendants, because the disposition of the case may cause adverse consequences, including adverse immigration consequences.
- 4) Declared based upon this misinformation and the potential harm, the defendant's prior plea is invalid.

FISCAL EFFECT: According to the Senate Appropriations Committee, potentially significant increase in trial court costs (General Fund*) for new petitions to dismiss pleas of guilty and nolo contendere submitted for cases granted DEJ retroactive to January 1, 1997.

*Trial Court Trust Fund

COMMENTS: According to the author, "AB 1352 provides a minor expungement procedure to prevent the needless disruption of thousands of California families. The expungement proposed by this bill does not retroactively change the effect of the person's DEJ disposition under California law. Instead, it will eliminate the disposition as a conviction for federal immigration purposes. It also will make right the injustice inadvertently committed against the immigrant defendants who relied upon PC [Section] 1000.4 in deciding to enter a guilty plea.

"This bill will prevent terrible harm to California families and immigrant communities. The last several years have seen mass deportations from the U.S. [United States]. Of deportations based on criminal conviction, the largest number has been for minor, non-trafficking drug offenses. This especially affects California, the nation's most immigrant-rich state, where one out of two children lives in a household headed by at least one foreign born person (and the great majority of the children are U.S. citizens). Deportation of a parent devastates a family emotionally and economically and can drain state resources as U.S. citizen children go into foster care, homes go into foreclosure, and remaining citizen family seek public benefits."

Analysis Prepared by: Stella Choe / PUB. S. / (916) 319-3744

FN: 0002428



Assembly Bill No. 1352

CHAPTER 646

An act to add Section 1203.43 to the Penal Code, relating to deferred entry of judgment.

[Approved by Governor October 8, 2015. Filed with
Secretary of State October 8, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1352, Eggman. Deferred entry of judgment: withdrawal of plea.

Existing law allows judgment to be deferred with respect to a defendant who is charged with certain crimes involving possession of controlled substances and who meets certain criteria, including that he or she has no prior convictions for any offense involving controlled substances and has had no felony convictions within the 5 years prior, as specified. Existing law prohibits the record pertaining to an arrest resulting in successful completion of a deferred entry of judgment program from being used in any way that could result in the denial of any employment, benefit, license, or certificate.

This bill would require a court to allow a defendant who was granted deferred entry of judgment on or after January 1, 1997, who has performed satisfactorily during the period in which deferred entry of judgment was granted, and for whom the criminal charge or charges were dismissed, as specified, to withdraw his or her plea and enter a plea of not guilty, and would require the court to dismiss the complaint or information against the defendant. If court records showing the case resolution are no longer available, the bill would require that the defendant's declaration, under penalty of perjury, that the charges were dismissed after he or she completed the requirements, be presumed to be true if the defendant submits a copy of his or her state summary criminal history information that either shows that the defendant successfully completed the deferred entry of judgment program or that the record does not show a final disposition. By expanding the application of the crime of perjury, 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.

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

SECTION 1. Section 1203.43 is added to the Penal Code, to read:

1203.43. (a) (1) The Legislature finds and declares that the statement in Section 1000.4, that “successful completion of a deferred entry of judgment program shall not, without the defendant’s consent, be used in any way that could result in the denial of any employment, benefit, license, or certificate” constitutes misinformation about the actual consequences of making a plea in the case of some defendants, including all noncitizen defendants, because the disposition of the case may cause adverse consequences, including adverse immigration consequences.

(2) Accordingly, the Legislature finds and declares that based on this misinformation and the potential harm, the defendant’s prior plea is invalid.

(b) For the above-specified reason, in any case in which a defendant was granted deferred entry of judgment on or after January 1, 1997, has performed satisfactorily during the period in which deferred entry of judgment was granted, and for whom the criminal charge or charges were dismissed pursuant to Section 1000.3, the court shall, upon request of the defendant, permit the defendant to withdraw the plea of guilty or nolo contendere and enter a plea of not guilty, and the court shall dismiss the complaint or information against the defendant. If court records showing the case resolution are no longer available, the defendant’s declaration, under penalty of perjury, that the charges were dismissed after he or she completed the requirements for deferred entry of judgment, shall be presumed to be true if the defendant has submitted a copy of his or her state summary criminal history information maintained by the Department of Justice that either shows that the defendant successfully completed the deferred entry of judgment program or that the record is incomplete in that it does not show a final disposition. For purposes of this section, a final disposition means that the state summary criminal history information shows either a dismissal after completion of the program or a sentence after termination of the program.

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.

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SB 323



California
LEGISLATIVE INFORMATION

SB-323 Nurse practitioners: scope of practice. (2015-2016)

Senate: 1st Cmt 2nd Cmt 2nd 3rd Pass

Assembly: 1st Cmt

Bill Status	
Measure:	SB-323
Lead Authors:	Hernandez (S)
Principal Coauthors:	Eggman (A)
Coauthors:	Mark Stone (A)
Topic:	Nurse practitioners: scope of practice.
31st Day in Print:	03/26/15
Title:	An act to amend Sections 650.01 and 805 of, to amend and renumber Section 2837 of, and to add Section 2837 to, the Business and Professions Code, relating to healing arts.
House Location:	Assembly
Last Amended Date:	07/09/15
Committee Location:	Asm Business and Professions

Type of Measure
Active Bill - In Committee Process
Majority Vote Required
Non-Appropriation
Fiscal Committee
State-Mandated Local Program
Non-Urgency
Non-Tax levy

Last 5 History Actions	
Date	Action
07/14/15	July 14 hearing postponed by committee.
07/13/15	Joint Rule 62(a) suspended. (Page 2358.)
07/09/15	From committee with author's amendments. Read second time and amended. Re-referred to Com. on B. & P.
07/07/15	From committee with author's amendments. Read second time and amended. Re-referred to Com. on B. & P.
07/07/15	July 7 set for second hearing canceled at the request of author.

Date of Hearing: July 14, 2015

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS

Susan Bonilla, Chair

SB 323(Hernandez) – As Amended July 9, 2015

SENATE VOTE: 25-5

SUBJECT: Nurse practitioners: scope of practice

SUMMARY: Permits Nurse Practitioners (NPs) to practice, without being supervised by a physician and surgeon, if the NP has met specified requirements including possessing liability insurance and national certification.

EXISTING LAW:

- 1) Establishes the Board of Registered Nursing (BRN), within the Department of Consumer Affairs (DCA), and authorizes the BRN to license, certify and regulate nurses. (Business and Professions Code (BPC) §§ 2701; 2708.1)
- 2) Clarifies that there are various and conflicting definitions of “nurse practitioner” and “registered nurse” (RN) that are used within California and finds the public interest is served by determining the legitimate and consistent use of the title “nurse practitioner” established by the BRN. (BPC § 2834)
- 3) Requires applicants for licensure as a NP to meet specified educational requirements including: (BPC § 2835.5)
 - a) Holding a valid and active registered nursing license;
 - b) Possessing a Master’s degree in nursing, a Master’s degree in a clinical field related to nursing, or a graduate degree in nursing; and,
 - c) Completion of a NP program authorized by the BRN.
- 4) Recognizes the existence of overlapping functions between physicians and NPs and permits additional sharing of functions within organized health care systems that provide for collaboration between physicians and NPs. (BPC § 2725; Health and Safety Code (HSC) § 1250)
- 5) Defines "health facility" as any facility, place, or building that is organized, maintained and operated for the diagnosis, care, prevention and treatment of physical or mental human illness including convalescence, rehabilitation, care during and after pregnancy or for any one or more of these purposes, for which one or more persons are admitted for a 24-hour stay or longer. (HSC § 1250)
- 6) Authorizes a NP to do the following, pursuant to standardized procedures and protocols (SPPs) created by a physician or surgeon, or in consultation with a physician or surgeon: (BPC § 2835.7)
 - a) Order durable medical equipment;

- b) Certify disability claims; and,
 - c) Approve, sign, modify or add information to a plan of treatment for individuals receiving home health services.
- 7) Defines “furnishing” as the ordering of a drug or device in accordance with SPPs or transmitting an order of a supervising physician and surgeon. (BPC § 2836.1(h))
 - 8) Defines “drug order” or “order” as an order for medication which is dispensed to or for an ultimate user and issued by a NP. (BPC § 2836.1(i))
 - 9) Establishes that the furnishing and ordering of drugs or devices by NPs is done in accordance with the SPP developed by the supervising physician and surgeon, NP and the facility administrator or designee and shall be consistent with the NPs educational preparation and/or established and maintained clinical competency. (BPC § 2836.1)
 - 10) Indicates a physician and surgeon may determine the extent of supervision necessary in the furnishing or ordering of drugs and devices. (BPC § 2836.1(g)(2))
 - 11) Permits a NP to furnish or order Schedule II through Schedule V controlled substances and specifies that a copy of the SPP shall be provided upon request to any licensed pharmacist when there is uncertainty about the NP furnishing the order. (BPC § 2836.1(f)(1)(2); HSC §§ 11000; 11055; 11056).
 - 12) Indicates that for Schedule II controlled substances, the SPP must address the diagnosis of the illness, injury or condition for which the controlled substance is to be furnished. (BPC § 2836.1(2))
 - 13) Requires that a NP has completed a course in pharmacology covering the drugs or devices to be furnished or ordered. (BPC § 2836.1(g)(1))
 - 14) States that a NP must hold an active furnishing number, register with the United States Drug Enforcement Administration and take a continuing education course in Schedule II controlled substances. (BPC § 2836.1(3))
 - 15) Specifies that the SPP must list which NPs may furnish or order drugs or devices. (BPC § 2836.1(c)(1))
 - 16) Requires that the physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include collaboration to create the SPP, approval of the SPP and availability of the physician and surgeon to be contacted via telephone at the time of the patient examination by the NP. (BPC § 2836.1(d))
 - 17) Limits the physician and surgeon to supervise no more than four NPs at one time. (BPC § 2836.1(e))
 - 18) Authorizes the BRN to issue a number to NPs who dispense drugs or devices and revoke, suspend or deny issuance of the number for incompetence or gross negligence. (BPC § 2836.2)

THIS BILL:

- 1) Makes Legislative findings and declarations as to the importance of NPs providing safe and accessible primary care.
- 2) Specifies that, in the interest of providing patients with comprehensive care and consistent with the spirit of the federal Patient Protection and Affordable Care Act, the bill is supportive of the national health care movement towards integrated and team-based health care models.
- 3) Authorizes a NP who holds a national certification from a national certifying body recognized by the BRN ("certified NP") to practice without the supervision of a physician if the certified NP practices in one of the following settings:
 - a) A clinic;
 - b) Specified health facilities, including a general acute care hospital, acute psychiatric hospital, skilled nursing facility, intermediate care facility, correctional treatment center, and hospice facility, as specified;
 - c) A county medical facility;
 - d) An accountable care organization;
 - e) A group practice, including a professional medical corporation, another form of corporation controlled by physicians, a medical partnership, a medical foundation exempt from licensure, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services; and,
 - f) A medical group, independent practice association, or any similar association.
- 4) Provides that, in addition to any other practice authorized in statute or regulation, a "certified NP" practicing in specified settings may do all of the following without physician supervision, unless collaboration is specified:
 - a) Order durable medical equipment;
 - b) Certify disability for purposes of unemployment after performance of a physical examination by the certified NP and collaboration, if necessary, with a physician;
 - c) Approve, sign, modify, or add to a plan of treatment or plan of care for individuals receiving home health services or personal care services after consultation, if necessary, with the treating physician and surgeon;
 - d) Assess patients, synthesize and analyze data, and apply principles of health care;
 - e) Manage the physical and psychosocial health status of patients;
 - f) Analyze multiple sources of data, identify a differential diagnosis, and select, implement, and evaluate appropriate treatment;

- g) Establish a diagnosis by client history, physical examination, and other criteria, consistent with this section, for a plan of care;
 - h) Order, furnish, prescribe, or procure drugs or devices;
 - i) Delegate tasks to a medical assistant pursuant to SPPs developed by the NP and medical assistant that are within the medical assistant's scope of practice;
 - j) Order hospice care, as appropriate;
 - k) Order and interpret diagnostic procedures; and,
 - l) Perform additional acts that require education and training and that are recognized by the nursing profession as appropriate to be performed by a NP.
- 5) States that it is unlawful for a "certified NP" to refer a person for laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy or diagnostic imaging goods or services if the NP or his or her immediate family has a financial interest with the person or in the entity that receives the referral.
- 6) Further specifies that the BRN shall review the facts and circumstances of any conviction and take appropriate disciplinary action if the "certified NP" has committed unprofessional conduct and that the BRN may assess fines and appropriate disciplinary action including the revocation of a "certified NP's" license.
- 7) Specifies that a "certified NP" is subject to the peer review process where a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes or professional conduct of licentiates to make recommendations for quality improvement and education in order to do the following:
- a) Determine whether a licentiate may practice or continue to practice in a health care facility, as specified; and,
 - b) To assess and improve the quality of care rendered in a health care facility as specified.
- 8) Requires the BRN to disclose 805 reports, which are the written reports filed with the BRN, as a result of an action of a peer review body, within 15 days after any of the following occur:
- a) A "certified NP's" application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason;
 - b) A "certified NP's" membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason; or,
 - c) Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for accumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.

- 9) Indicates that if the BRN or licensing agency of another state revokes or suspends, without a stay, the license of a physician and surgeon, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.
- 10) Requires a “certified NP” to refer a patient to a physician or other licensed health care provider if a situation or condition of the patient is beyond the scope of the education and training of the NP.
- 11) Requires a “certified NP” to maintain professional liability insurance appropriate for the practice setting.
- 12) Specifies that settings where NPs practice shall not interfere with, control, or otherwise direct the professional judgment of a nurse practitioner.

FISCAL EFFECT: According to the Senate Appropriations Committee analysis, this bill will result in one-time costs, likely about \$75,000, to update existing regulations. The bill may also result in minor ongoing costs for enforcement.

COMMENTS:

Purpose. This bill is sponsored by the author. According to the author, “Numerous California editorial boards have endorsed full practice authority for NPs. A 2013 *New York Times* editorial stated ‘There is plenty of evidence that well-trained health workers can provide routine service that is every bit as good or even better than what patients would receive from a doctor. And because they are paid less than the doctors, they can save the patient and the healthcare system money.’”

Californians deserve access to high quality primary care offered by a range of safe, efficient, and regulated providers. NPs have advanced their educational, testing, and certification programs over the past decade. They've enhanced clinical training, moved to advanced degrees, and upgraded program accreditation processes. Other states have recognized advances with NP practice acts that align with professional competence and advanced education. But California has not kept pace.

In California, we have a robust network of providers that are well-trained, evenly distributed throughout the state, and well positioned to pay particular attention to underserved areas. Deploying these professionals in a team-based delivery model where they work collaboratively with physicians will allow us to meet the demands placed on our healthcare systems created by a rapidly aging physician population and expansion of health insurance coverage.”

Background. According to the Association of American Medical Colleges, by 2015, the nation will face a shortage of 62,100 physicians, 33,100 primary care practitioners and 29,000 other specialists. Estimates obtained from the Council on Graduate Medical Education indicate that the number of primary care physicians actively practicing in California is far below the state's need. The distribution of these primary care physicians is also poor. In 2008, there were 69,460 actively practicing primary care physicians in California, of which only 35 percent reported they actually practiced primary care. This equates to 63 active primary care physicians per 100,000 persons. However, according to the CGME, 60 to 80 primary care physicians are needed per 100,000 persons in order to adequately meet the needs of the population. When the same metric

is applied regionally, only 16 of California's 58 counties fall within the needed supply range for primary care physicians. In other words, less than one third of Californians live in a community where they have access to adequate health care services. In addition, a 2013 study in *Health Affairs* found that the proportion of U.S. medical students choosing careers in primary care dropped from 60 percent in 1998 to approximately 25 percent in 2013. Some purport that the way to address this shortage is by expanding the role of NPs and other allied healthcare professionals to provide primary care services.

NP Education and Training. There are approximately 19,000 NPs licensed by the BRN. The BRN sets the educational standards for NP certification. A NP is a registered nurse (RN) who has earned a bachelors and postgraduate nursing degree such as a Master's or Doctorate degree. NPs possess advanced skill in physical diagnosis, psycho-social assessment and management of health-illness needs in primary health care, which occurs when a consumer makes contact with a health care provider who assumes responsibility and accountability for the continuity of health care regardless of the presence or absence of disease (Title 16 California Code of Regulations (CCR) §§ 1480(b); 1484). Examples of primary health care include: physical and mental assessment, disease prevention and restorative measures, performance of skin tests and immunization techniques, withdrawal of blood and authority to initiate emergency procedures. Data from the Employment Developmental Department indicates that hospitals are the main employer of NPs.

NP Scope and SPPs. A NP does not have an additional scope of practice beyond the RNs scope and must rely on SPPs for authorization to perform medical functions which overlap with those conducted by a physician (16 CCR § 1485). According to the BRN, "SPPs are the legal mechanism for registered nurses, nurse practitioners to perform functions which would otherwise be considered the practice of medicine." Examples of these functions include: diagnosing mental and physical conditions, using drugs in or upon human beings, severing or penetrating the tissue of human beings and using other methods in the treatment of diseases, injuries, deformities or other physical or mental conditions.

SPPs must be developed collaboratively with NPs, physicians and administration of the organized health care system where they will be utilized. Because of this interdisciplinary collaboration, there is accountability on several levels for the activities to be performed by the NP. Importantly, a NP must provide the organized health system with satisfactory evidence that the NP meets the experience, training and/or education requirements to perform the functions. If a NP undertakes a procedure without the competence to do so, such an act may constitute gross negligence and be subject to discipline by the BRN.

The BRN and the Medical Board of California (MBC) jointly promulgated the following guidelines for SPPs: (BRN, 16 CCR § 1474; MBC, 16 CCR § 1379)

"SPPs shall include a written description of the method used in developing and approving them and any revision thereof. Each SPP shall:

- 1) Be in writing, dated and signed by the organized health care system personnel authorized to approve it.
- 2) Specify which SPP functions registered nurses may perform and under what circumstances.

- 3) State any specific requirements which are to be followed by NPs in performing particular SPP functions.
- 4) Specify any experience, training, and/or education requirements for performance of SPP functions.
- 5) Establish a method for initial and continuing evaluation of the competence of those NPs authorized to perform SPP functions.
- 6) Provide for a method of maintaining a written record of those persons authorized to perform SPP functions.
- 7) Specify the scope of supervision required for performance of SPP functions, for example, telephone contact with the physician.
- 8) Set forth any specialized circumstances under which the NP is to immediately communicate with a patient's physician concerning the patient's condition.
- 9) State the limitations on settings, if any, in which SPP functions may be performed.
- 10) Specify patient record-keeping requirements.
- 11) Provide for a method of periodic review of the SPP.”

Nurse-Managed Health Clinics. Nurse-managed health clinics, of which many are Federally Qualified Health Centers (FQHC) and independent non-profit clinics, are safety net clinics that provide primary care, health promotion and disease prevention services to patients who are least likely to receive ongoing health care. Unlike other FQHC and independent non-profits, these clinics are solely operated by NPs. The Patient Protections and Affordable Care Act (ACA) defines a nurse-managed health clinic as, “...a nurse practice arrangement, managed by advanced practice nurses, that provides primary care or wellness services to underserved or vulnerable populations and that is associated with a school, college, university or department of nursing, federally qualified health center, or independent non-profit health or social services agency.” (42 U.S.C. § 330A-1 (2010))

According to the National Nursing Centers Consortium, nurse-managed health clinics have doubled in their presence since 2013. To date, there are 500 nurse-managed health clinics most of which are located in the East Coast. A small percentage of these have been chosen for funding through a federal expansion initiative. One such clinic, GLIDE Health Services, is a FQHC located in San Francisco, California and provides primary and urgent care, preventative services and psychiatric treatment to an urban population.

Physician Supervision. In many of the nurse-managed health clinics, the physician to NP supervision relationship is quite flexible. A supervising physician may be present for a very limited amount of time to perform perfunctory tasks such as signing off on equipment orders, and reviewing and signing medical records. The physician may also elect to make himself/herself available for telephonic consult. For example, at GLIDE the supervising physician is physically on site 1-2 days a week to sign off on orders such as wheel chairs, walkers and commodes and to review medications that have been prescribed and furnished by NPs. According to Patricia Dennehy, a NP and director of GLIDE, “Though we value our MD

colleagues and consult with them for complex care issues, currently there are administrative barriers to care delivery and access that are not practical.”

Clinical Training Sites. In addition to providing care to patients, nurse-managed health clinics also play an important role in health professions education. More than 85 of the nation's leading nursing schools operate nurse-managed health clinics that serve as clinical education and practice sites for nursing students and faculty. Many, such as GLIDE, have partnerships with other academic programs and provide learning opportunities for medical, pharmacy, social work, public health and other students.

Full Practice Authority. The American Association of Nurse Practitioners defines full practice authority as, “The collection of state practice and licensure laws that allow for nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments, including prescribe medications, under the exclusive licensure authority of the state board of nursing.” Similar to the changes to statute proposed in this legislation, under full practice authority, “certified NPs” are still required to meet educational and practice requirements for licensure, maintain national certification and remain accountable to the public and the state board of nursing. Under this model, “certified NPs” would continue to consult with and refer patients to other health care providers according to the patient’s needs.

Over the past 50 years, several organizations and research institutions have examined the feasibility of full practice authority for NPs. The Institute of Medicine of the National Academies of Science released a 2010 report titled, “The Future of Nursing: Leading Change, Advancing Health,” in which the IOM wrote, “Remove scope of practice barriers. [NPs] should be able to practice to the full extent of their education and training...the current conflicts between what [NPs] can do based on their education and training and what they may do according to state federal regulations must be resolved so that they are better able to provide seamless, affordable and quality care.” In a 2011 report, the IOM noted that three to 14 NPs can be educated for the same cost as one physician. A report by the National Governor’s Association, “The Role of Nurse Practitioners in Meeting Increased Demand for Primary Care” noted, “In light of research evidence, states might consider changing scope of practice restrictions and assuring adequate reimbursement for their services as a way of encouraging and incentivizing greater NP involvement in the provision of primary health care.”

Despite these arguments, some physician groups, including the American Medical Association (AMA) assert that granting full practice authority for NPs may put patients’ health at risk. They cite the difference in educational attainment noting that physicians are required to complete four years of medical school plus three years of residency compared to the four years of nursing school and two years of graduate school required for NPs. The President of the AMA, Dr. Robert M. Wah, was quoted in a 2015 *New York Times* article, “[...nurses practicing independently] would further compartmentalize and fragment health care [which should be] collaborative with the physician at the head of the team.”

Financial Implications. Over the past 40 years, there have been a number of studies on the cost-effectiveness of NP practice. Results overwhelmingly show NPs provide equivalent or improved medical care at a lower cost than their physician counterparts. After insurance reform in Massachusetts, the state demonstrated that they could gain a cost savings of \$4.2 to \$8.4 billion, over a 10 year period, from the increased use of NPs (Eibner, E. et al 2009, *Controlling Health Care Spending in Massachusetts: An Analysis of Options*. RAND Health).

Though the ACA encourages the creation of nurse-managed practices, by requiring insurers to pay NPs the same rates paid to physicians for identical services rendered, Medicare will not provide equal reimbursement. Presently, Medicare pays NPs 85% of the physician rate for the same services. The Medicare Payment Advisory Commission, the federal agency that advises Congress on Medicare issues, found that there was no analytical foundation for this difference. Despite this fact, revising payment methodology would require Congress to change the Medicare law. A report by the IOM titled “The Future of Nursing, Leading Change, Advancing Health,” recommended that the Medicare program be expanded to include coverage of advanced practice registered nurse services just as physician services are covered. The report also recommended that Medicaid reimbursement rates for primary care physicians be extended to advanced practice registered nurses providing similar primary care services.

Additionally, health insurance plans have significant discretion to determine what services they cover and which providers they recognize. Not all plans cover NPs. Further, many managed care plans require enrollees to designate a primary care provider but do not always recognize NPs. In fact, a 2009 survey conducted by the National Nursing Centers Consortium found that nearly half of the major managed care organizations did not credential NPs as primary care providers (www.healthaffairs.org/healthpolicybriefs/brief.php). If NPs were granted full practice authority, efforts may need to be undertaken in order for NPs to be recognized as primary care providers by insurance companies.

Other States. Many other states have recognized the ability for NPs to play a more efficient role in the delivery of health care services and have updated their practice acts to align with NPs training and education. For example, 20 states have adopted full practice authority for NPs. The AMA contends that many of the NPs that practice independently in these states do not deliver care to underserved areas.

Prior Related Legislation. SB 491 (Hernandez) of 2013, would have permitted an NP to practice independently after a period of physician supervision if the NP has national certification and liability insurance, and authorizes the NP to perform various other specified tasks related to the practice of nursing without protocols. *NOTE: This bill was held in the Assembly Appropriations Committee.*

ARGUMENTS IN SUPPORT:

The American Nurses Association/California supports the bill and writes, “Nurse practitioners play an especially important role in the implementation of the federal Patient Protection and Affordable Care Act, which will bring an estimated five million more Californians into the health care delivery system. As primary care providers, nurse practitioners provide for greater access to primary care services in all areas of the state.”

The California Association of Physician Groups supports the bill and writes, “This bill increases the ability to provide access in meaningful ways to cope with the expansion of the patient base in California. It modernizes licensure law to reflect the current reality. It allows Nurse Practitioners to practice to the full extent of their education and training. Full practice authority has been proven safe and effective in nineteen other states.”

The California Hospital Association also supports the bill and writes, “California hospitals have been leaders in transforming the delivery of health care and preparing for the realities of ACA. NPs’ full practice authority as conceptualized in SB 323 will be a pivotal component of our

success in light of current and projected physician shortages, the much greater time and cost to train physicians, and expected increased in the demand for primary care. This is clearly a promising and rational strategy for increasing the supply of primary care providers for California.”

The United Nurses Associations of California/Union of Health Care Professionals (UNAC/UHCP) supports this bill and writes, “NPs full practice authority as conceptualized in SB 323 will be a pivotal component of our success in light of current and projected physician shortages, the much greater time and cost to train physicians, and expected increased in the demand for primary care. This is a promising strategy for increasing the supply of primary care providers for California.”

ARGUMENTS IN OPPOSITION:

The American Medical Association opposes the bill. In their letter they write, “The AMA believes that increased use of physician-led teams of multidisciplinary health care professionals will have a positive impact on the nation’s primary care needs. This team-based approach includes physicians and other clinicians working together, sharing decisions and information, to achieve improved care, improved patient health and reduced costs. However, independent practice and team-based care take health care delivery in two very different directions. One approach would further compartmentalize and fragment health care delivery; the other would foster integration and coordination.”

The California Medical Association also opposes the bill and writes, “The intent language in this bill claims that independent practice for nurse practitioners will provide for greater access to primary care services in all areas of the state. There is no evidence that states that have expanded scope of practice have experienced improved access to care or lower levels of underserved patient populations.”

The Medical Board of California states in their letter of opposition, “NPs are well qualified to provide medical care when practicing under standardized procedures and physician supervision. The standardized procedures and physician supervision, collaboration and consultation are in existing law to ensure that the patient care provided by a NP includes physician involvement and oversight, as physicians should be participating in the patient’s care in order to ensure consumer protection...The Board’s primary mission is consumer protection and by expanding the scope of practice for a certified NP and not requiring any type of physician collaboration, consultation, or oversight, patient care and consumer protection could be compromised.”

The Union of American Physicians and Dentists opposes the bill and writes, “Senate Bill 323 provides no assurances to the general public, and puts patients at risk. Moreover, Senate Bill 323 has grave consequences for public sector physicians, as it would enable state and counties to “supplant” physician services.”

POLICY ISSUES:

- 1) **Patient Protections.** If granted full practice authority, per the provisions of this bill, “certified NPs” would be required to adhere to a number of patient protection requirements – similar to the requirements for physicians who practice independently. Specifically, this bill would require that a “certified NP,” 1) carry malpractice insurance, 2) adhere to the anti-kickback and referral laws and 3) be subject to the same 805 reporting requirements that

physicians are subject to. However, unlike physicians who are subject to the corporate practice of medicine bar, the NPs would not be subject to this provision.

California law prohibits lay individuals, organizations and corporations from practicing medicine. This prohibition applies to lay entities and prohibits them from hiring or employing physicians or other health care practitioners from interfering with a physician or other health care practitioner's practice of medicine. It also prohibits most lay individuals, organizations and corporations from engaging in the business of providing health care services indirectly by contracting with health care professionals to render such services. This prohibition is designed to protect the public from possible abuses stemming from the commercial exploitation of the practice of medicine (California Physician's Legal Handbook, *Corporate Practice of Medicine Bar*, January, 2015).

According to a 2007 California Research Bureau report titled "The Corporate Practice of Medicine Doctrine," the employment status of physicians in California is applied inconsistently by the application of the doctrine as physicians are exempt from the doctrine if they work in specific settings including: professional medical corporations, local hospital districts, county hospitals, teaching hospitals, non-profit clinics and non-profit corporations.

Opponents of this bill argue that because the duties of "certified NPs" are similar to those of a physician and surgeon, "certified NPs" should be subject to the same corporate practice of medicine bar. Proponents of the measure indicate that nurse anesthetists practice independently and without being subject to the corporate practice of medicine bar. They also note that in the other four states that have a corporate practice of medicine bar and permit NPs to practice without supervision, the NPs are not subject to the corporate practice of medicine bar.

- 2) **Provision of Healthcare in Rural Settings.** The author indicates that passage of this legislation will result in increased access to care. As such, it is important to note that, according to the Office of Statewide Health Planning and Development, there are 62 rural hospitals in California that could benefit from additional healthcare providers. Additionally, according to the Robert Wood Johnson Foundation, NPs are the primary care providers most likely to be working in rural or remote areas. Thus, in context of the amendments which are outlined below, which may limit the ability of NPs to exercise full practice authority in rural hospital settings, the author and Committee may wish to consider if the bill should include provisions permitting NPs to practice without supervision in rural hospitals.
- 3) **Oversight.** Opponents of this bill share concerns about a need for a different oversight structure for the "certified NPs." They argue that this new class of providers needs an oversight mechanism that will include professionals who practice nursing as well as medicine. The author and Committee may wish to consider the necessity of having an oversight body, e.g. committee within the BRN, that contains physicians and NPs to help advise the BRN regarding oversight, e.g. licensing, enforcement etc., of "certified NPs."

AMENDMENTS:

- 1) Based on policy issue number 1, pertaining to the corporate practice of medicine bar, the author should amend this measure to include the following language to ensure that the same protections are in place for the practice of "certified NPs." This should include the same

exemptions from the corporate practice of medicine bar that apply to the practice of physicians and surgeons in certain settings:

On page 13, line 17, after “corporation,” insert the following:

(5) A group practice, including a professional medical corporation, as defined in Section 2406, another form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services.

On page 14, after line 27, insert the following:

(e) Corporations and other artificial legal entities shall have no professional rights, privileges, or powers under this section, except as provided in Sections 2400, 2401, 2402, and 2403.

REGISTERED SUPPORT:

AARP

Alliance of Catholic Health Care

AltaMed Health Services Corporation

Alzheimer’s Association

American Nurses Association\California

Anthem Blue Cross

Association of California Healthcare Districts

Association of California Nurse Leaders

Bay Area Council

Blue Shield of California

California Association for Health Services at Home

California Association for Nurse Practitioners

California Association of Nurse Anesthetists, Inc.

California Association of Physician Groups

California Association of Public Hospitals and Health Systems

California Commission on Aging

California Council of Community Mental Health Agencies

California El Camino Real Association of Occupational Health Nurses

California Family Health Council

California Health & Wellness (CH&W)

California Hospital Association

California Naturopathic Doctors Association

California Pharmacists Association

California Primary Care Association

California Senior Legislature

California Society of Health-System Pharmacists

California State Association of Occupational Health Nurses

Congress of California Seniors

Johns Hopkins University Division of Occupational and Environment Medicine

Maxim Healthcare Services, Inc.
MemorialCare Health System
Pacific Clinics
Private Essential Access Community Hospitals
Providence Health & Services
Sharp HealthCare
Small Business Majority
Stanford Health Care
St. Joseph Health
United Nurses Associations of California/Union of Health Care Professionals
University of California
Western University of Health Sciences

REGISTERED OPPOSITION:

American Medical Association
American Osteopathic Association
California Academy of Family Physicians (unless amended)
California Chapter of the American College of Cardiology
California Chapter of the American College of Emergency Physicians
California Medical Association
California Orthopaedic Association
California Psychiatric Association
California Society of Anesthesiologists
California Society of Plastic Surgeons
Medical Board of California
Union of American Physicians and Dentists
Over 600 physicians and individuals

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AMENDED IN ASSEMBLY JULY 9, 2015
AMENDED IN ASSEMBLY JULY 7, 2015
AMENDED IN ASSEMBLY JUNE 23, 2015
AMENDED IN SENATE APRIL 22, 2015
AMENDED IN SENATE MARCH 26, 2015

SENATE BILL

No. 323

Introduced by Senator Hernandez
(Principal coauthor: Assembly Member Eggman)
(Coauthor: Assembly Member Mark Stone)

February 23, 2015

An act to amend Sections 650.01 and 805 of, to amend and renumber Section 2837 of, and to add Section 2837 to, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 323, as amended, Hernandez. Nurse practitioners: scope of practice.

The Nursing Practice Act provides for the licensure and regulation of nurse practitioners by the Board of Registered Nursing. The act authorizes the implementation of standardized procedures that authorize a nurse practitioner to perform certain acts, including ordering durable medical equipment in accordance with standardized procedures, certifying disability for purposes of unemployment insurance after physical examination and collaboration with a physician and surgeon, and, for an individual receiving home health services or personal care services, approving, signing, modifying, or adding to a plan of treatment

or plan of care after consultation with a physician and surgeon. A violation of those provisions is a crime.

This bill would authorize a nurse practitioner who holds a national certification from a national certifying body recognized by the board to practice without the supervision of a physician and surgeon, if the nurse practitioner meets existing requirements for nurse practitioners and practices in one of certain specified settings. The bill would prohibit entities described in those specified settings from interfering with, controlling, or otherwise directing the professional judgment of such a nurse practitioner, as specified, and would authorize such a nurse practitioner, in addition to any other practice authorized in statute or regulation, to perform specified acts, including the acts described above, without reference to standardized procedures or the specific need for the supervision of a physician and surgeon. The bill, instead, would require a nurse practitioner to refer a patient to a physician and surgeon or other licensed health care provider if a situation or condition of the patient is beyond the scope of the nurse practitioner's education and training. The bill would require a nurse practitioner practicing under these provisions to maintain professional liability insurance appropriate for the practice setting. By imposing new requirements on nurse practitioners, the violation of which would be a crime, this bill would impose a state-mandated local program.

Existing law prohibits a licensee, as defined, from referring a person for laboratory, diagnostic, nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, or diagnostic imaging goods or services if the licensee or his or her immediate family has a financial interest with the person or entity that receives the referral, and makes a violation of that prohibition punishable as a misdemeanor. Under existing law, the Medical Board of California is required to review the facts and circumstances of any conviction for violating the prohibition, and to take appropriate disciplinary action if the licensee has committed unprofessional conduct.

This bill would include a nurse practitioner, as specified, under the definition of a licensee, which would expand the scope of an existing crime and therefore impose a state-mandated local program. The bill would also require the Board of Registered Nursing to review the facts and circumstances of any conviction of a nurse practitioner, as specified, for violating that prohibition, and would require the board to take appropriate disciplinary action if the nurse practitioner has committed unprofessional conduct.

Existing law provides for the professional review of specified healing arts licentiates through a peer review process. Existing law defines the term “licentiate” for those purposes to include, among others, a physician and surgeon.

This bill would include a nurse practitioner, as specified, under the definition of licentiate, and would require the Board of Registered Nursing to disclose reports, 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:

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

3 (a) Nurse practitioners are a longstanding, vital, safe, effective,
4 and important part of the state’s health care delivery system. They
5 are especially important given California’s shortage of physicians,
6 with just 16 of 58 counties having the federally recommended ratio
7 of physicians to residents.

8 (b) Nurse practitioners will play an especially important part in
9 the implementation of the federal Patient Protection and Affordable
10 Care Act (Public Law 111-148), which will bring an estimated
11 five million more Californians into the health care delivery system,
12 because they will provide for greater access to primary care
13 services in all areas of the state. This is particularly true for patients
14 in medically underserved urban and rural communities.

15 (c) *In the interest of providing patients with comprehensive care*
16 *and consistent with the spirit of the federal Patient Protection and*
17 *Affordable Care Act, this measure is supportive of the national*
18 *health care movement towards integrated and team-based health*
19 *care models.*

20 (e)
21 (d) Due to the excellent safety and efficacy record that nurse
22 practitioners have earned, the Institute of Medicine of the National
23 Academies has recommended full practice authority for nurse

1 practitioners. Currently, 20 states allow nurse practitioners to
2 practice to the full extent of their training and education.

3 ~~(d)~~

4 (e) Furthermore, nurse practitioners will assist in addressing the
5 primary care provider shortage by removing delays in the provision
6 of care that are created when dated regulations require a physician's
7 signature or protocol before a patient can initiate treatment or
8 obtain diagnostic tests that are ordered by a nurse practitioner.

9 SEC. 2. Section 650.01 of the Business and Professions Code
10 is amended to read:

11 650.01. (a) Notwithstanding Section 650, or any other
12 provision of law, it is unlawful for a licensee to refer a person for
13 laboratory, diagnostic nuclear medicine, radiation oncology,
14 physical therapy, physical rehabilitation, psychometric testing,
15 home infusion therapy, or diagnostic imaging goods or services if
16 the licensee or his or her immediate family has a financial interest
17 with the person or in the entity that receives the referral.

18 (b) For purposes of this section and Section 650.02, the
19 following shall apply:

20 (1) "Diagnostic imaging" includes, but is not limited to, all
21 X-ray, computed axial tomography, magnetic resonance imaging
22 nuclear medicine, positron emission tomography, mammography,
23 and ultrasound goods and services.

24 (2) A "financial interest" includes, but is not limited to, any
25 type of ownership interest, debt, loan, lease, compensation,
26 remuneration, discount, rebate, refund, dividend, distribution,
27 subsidy, or other form of direct or indirect payment, whether in
28 money or otherwise, between a licensee and a person or entity to
29 whom the licensee refers a person for a good or service specified
30 in subdivision (a). A financial interest also exists if there is an
31 indirect financial relationship between a licensee and the referral
32 recipient including, but not limited to, an arrangement whereby a
33 licensee has an ownership interest in an entity that leases property
34 to the referral recipient. Any financial interest transferred by a
35 licensee to any person or entity or otherwise established in any
36 person or entity for the purpose of avoiding the prohibition of this
37 section shall be deemed a financial interest of the licensee. For
38 purposes of this paragraph, "direct or indirect payment" shall not
39 include a royalty or consulting fee received by a physician and
40 surgeon who has completed a recognized residency training

1 program in orthopedics from a manufacturer or distributor as a
2 result of his or her research and development of medical devices
3 and techniques for that manufacturer or distributor. For purposes
4 of this paragraph, “consulting fees” means those fees paid by the
5 manufacturer or distributor to a physician and surgeon who has
6 completed a recognized residency training program in orthopedics
7 only for his or her ongoing services in making refinements to his
8 or her medical devices or techniques marketed or distributed by
9 the manufacturer or distributor, if the manufacturer or distributor
10 does not own or control the facility to which the physician is
11 referring the patient. A “financial interest” shall not include the
12 receipt of capitation payments or other fixed amounts that are
13 prepaid in exchange for a promise of a licensee to provide specified
14 health care services to specified beneficiaries. A “financial interest”
15 shall not include the receipt of remuneration by a medical director
16 of a hospice, as defined in Section 1746 of the Health and Safety
17 Code, for specified services if the arrangement is set out in writing,
18 and specifies all services to be provided by the medical director,
19 the term of the arrangement is for at least one year, and the
20 compensation to be paid over the term of the arrangement is set
21 in advance, does not exceed fair market value, and is not
22 determined in a manner that takes into account the volume or value
23 of any referrals or other business generated between parties.

24 (3) For the purposes of this section, “immediate family” includes
25 the spouse and children of the licensee, the parents of the licensee,
26 and the spouses of the children of the licensee.

27 (4) “Licensee” means a physician as defined in Section 3209.3
28 of the Labor Code, and a nurse practitioner practicing pursuant to
29 Section 2837.

30 (5) “Licensee’s office” means either of the following:

31 (A) An office of a licensee in solo practice.

32 (B) An office in which services or goods are personally provided
33 by the licensee or by employees in that office, or personally by
34 independent contractors in that office, in accordance with other
35 provisions of law. Employees and independent contractors shall
36 be licensed or certified when licensure or certification is required
37 by law.

38 (6) “Office of a group practice” means an office or offices in
39 which two or more licensees are legally organized as a partnership,
40 professional corporation, or not-for-profit corporation, licensed

1 pursuant to subdivision (a) of Section 1204 of the Health and Safety
2 Code, for which all of the following apply:

3 (A) Each licensee who is a member of the group provides
4 substantially the full range of services that the licensee routinely
5 provides, including medical care, consultation, diagnosis, or
6 treatment through the joint use of shared office space, facilities,
7 equipment, and personnel.

8 (B) Substantially all of the services of the licensees who are
9 members of the group are provided through the group and are
10 billed in the name of the group and amounts so received are treated
11 as receipts of the group, except in the case of a multispecialty
12 clinic, as defined in subdivision (I) of Section 1206 of the Health
13 and Safety Code, physician services are billed in the name of the
14 multispecialty clinic and amounts so received are treated as receipts
15 of the multispecialty clinic.

16 (C) The overhead expenses of, and the income from, the practice
17 are distributed in accordance with methods previously determined
18 by members of the group.

19 (c) It is unlawful for a licensee to enter into an arrangement or
20 scheme, such as a cross-referral arrangement, that the licensee
21 knows, or should know, has a principal purpose of ensuring
22 referrals by the licensee to a particular entity that, if the licensee
23 directly made referrals to that entity, would be in violation of this
24 section.

25 (d) No claim for payment shall be presented by an entity to any
26 individual, third party payer, or other entity for a good or service
27 furnished pursuant to a referral prohibited under this section.

28 (e) No insurer, self-insurer, or other payer shall pay a charge or
29 lien for any good or service resulting from a referral in violation
30 of this section.

31 (f) A licensee who refers a person to, or seeks consultation from,
32 an organization in which the licensee has a financial interest, other
33 than as prohibited by subdivision (a), shall disclose the financial
34 interest to the patient, or the parent or legal guardian of the patient,
35 in writing, at the time of the referral or request for consultation.

36 (1) If a referral, billing, or other solicitation is between one or
37 more licensees who contract with a multispecialty clinic pursuant
38 to subdivision (I) of Section 1206 of the Health and Safety Code
39 or who conduct their practice as members of the same professional
40 corporation or partnership, and the services are rendered on the

1 same physical premises, or under the same professional corporation
2 or partnership name, the requirements of this subdivision may be
3 met by posting a conspicuous disclosure statement at the
4 registration area or by providing a patient with a written disclosure
5 statement.

6 (2) If a licensee is under contract with the Department of
7 Corrections or the California Youth Authority, and the patient is
8 an inmate or parolee of either respective department, the
9 requirements of this subdivision shall be satisfied by disclosing
10 financial interests to either the Department of Corrections or the
11 California Youth Authority.

12 (g) A violation of subdivision (a) shall be a misdemeanor. In
13 the case of a licensee who is a physician, the Medical Board of
14 California shall review the facts and circumstances of any
15 conviction pursuant to subdivision (a) and take appropriate
16 disciplinary action if the licensee has committed unprofessional
17 conduct. In the case of a licensee who is a nurse practitioner
18 functioning pursuant to Section 2837, the Board of Registered
19 Nursing shall review the facts and circumstances of any conviction
20 pursuant to subdivision (a) and take appropriate disciplinary action
21 if the licensee has committed unprofessional conduct. Violations
22 of this section may also be subject to civil penalties of up to five
23 thousand dollars (\$5,000) for each offense, which may be enforced
24 by the Insurance Commissioner, Attorney General, or a district
25 attorney. A violation of subdivision (c), (d), or (e) is a public
26 offense and is punishable upon conviction by a fine not exceeding
27 fifteen thousand dollars (\$15,000) for each violation and
28 appropriate disciplinary action, including revocation of professional
29 licensure, by the Medical Board of California, the Board of
30 Registered Nursing, or other appropriate governmental agency.

31 (h) This section shall not apply to referrals for services that are
32 described in and covered by Sections 139.3 and 139.31 of the
33 Labor Code.

34 (i) This section shall become operative on January 1, 1995.

35 SEC. 3. Section 805 of the Business and Professions Code is
36 amended to read:

37 805. (a) As used in this section, the following terms have the
38 following definitions:

39 (1) (A) "Peer review" means both of the following:

- 1 (i) A process in which a peer review body reviews the basic
2 qualifications, staff privileges, employment, medical outcomes,
3 or professional conduct of licentiates to make recommendations
4 for quality improvement and education, if necessary, in order to
5 do either or both of the following:
- 6 (I) Determine whether a licentiate may practice or continue to
7 practice in a health care facility, clinic, or other setting providing
8 medical services, and, if so, to determine the parameters of that
9 practice.
- 10 (II) Assess and improve the quality of care rendered in a health
11 care facility, clinic, or other setting providing medical services.
- 12 (ii) Any other activities of a peer review body as specified in
13 subparagraph (B).
- 14 (B) “Peer review body” includes:
- 15 (i) A medical or professional staff of any health care facility or
16 clinic licensed under Division 2 (commencing with Section 1200)
17 of the Health and Safety Code or of a facility certified to participate
18 in the federal Medicare program as an ambulatory surgical center.
- 19 (ii) A health care service plan licensed under Chapter 2.2
20 (commencing with Section 1340) of Division 2 of the Health and
21 Safety Code or a disability insurer that contracts with licentiates
22 to provide services at alternative rates of payment pursuant to
23 Section 10133 of the Insurance Code.
- 24 (iii) Any medical, psychological, marriage and family therapy,
25 social work, professional clinical counselor, dental, or podiatric
26 professional society having as members at least 25 percent of the
27 eligible licentiates in the area in which it functions (which must
28 include at least one county), which is not organized for profit and
29 which has been determined to be exempt from taxes pursuant to
30 Section 23701 of the Revenue and Taxation Code.
- 31 (iv) A committee organized by any entity consisting of or
32 employing more than 25 licentiates of the same class that functions
33 for the purpose of reviewing the quality of professional care
34 provided by members or employees of that entity.
- 35 (2) “Licentiate” means a physician and surgeon, doctor of
36 podiatric medicine, clinical psychologist, marriage and family
37 therapist, clinical social worker, professional clinical counselor,
38 dentist, physician assistant, or nurse practitioner practicing pursuant
39 to Section 2837. “Licentiate” also includes a person authorized to
40 practice medicine pursuant to Section 2113 or 2168.

1 (3) “Agency” means the relevant state licensing agency having
2 regulatory jurisdiction over the licentiates listed in paragraph (2).

3 (4) “Staff privileges” means any arrangement under which a
4 licentiate is allowed to practice in or provide care for patients in
5 a health facility. Those arrangements shall include, but are not
6 limited to, full staff privileges, active staff privileges, limited staff
7 privileges, auxiliary staff privileges, provisional staff privileges,
8 temporary staff privileges, courtesy staff privileges, locum tenens
9 arrangements, and contractual arrangements to provide professional
10 services, including, but not limited to, arrangements to provide
11 outpatient services.

12 (5) “Denial or termination of staff privileges, membership, or
13 employment” includes failure or refusal to renew a contract or to
14 renew, extend, or reestablish any staff privileges, if the action is
15 based on medical disciplinary cause or reason.

16 (6) “Medical disciplinary cause or reason” means that aspect
17 of a licentiate’s competence or professional conduct that is
18 reasonably likely to be detrimental to patient safety or to the
19 delivery of patient care.

20 (7) “805 report” means the written report required under
21 subdivision (b).

22 (b) The chief of staff of a medical or professional staff or other
23 chief executive officer, medical director, or administrator of any
24 peer review body and the chief executive officer or administrator
25 of any licensed health care facility or clinic shall file an 805 report
26 with the relevant agency within 15 days after the effective date on
27 which any of the following occur as a result of an action of a peer
28 review body:

29 (1) A licentiate’s application for staff privileges or membership
30 is denied or rejected for a medical disciplinary cause or reason.

31 (2) A licentiate’s membership, staff privileges, or employment
32 is terminated or revoked for a medical disciplinary cause or reason.

33 (3) Restrictions are imposed, or voluntarily accepted, on staff
34 privileges, membership, or employment for a cumulative total of
35 30 days or more for any 12-month period, for a medical disciplinary
36 cause or reason.

37 (c) If a licentiate takes any action listed in paragraph (1), (2),
38 or (3) after receiving notice of a pending investigation initiated
39 for a medical disciplinary cause or reason or after receiving notice
40 that his or her application for membership or staff privileges is

1 denied or will be denied for a medical disciplinary cause or reason,
2 the chief of staff of a medical or professional staff or other chief
3 executive officer, medical director, or administrator of any peer
4 review body and the chief executive officer or administrator of
5 any licensed health care facility or clinic where the licentiate is
6 employed or has staff privileges or membership or where the
7 licentiate applied for staff privileges or membership, or sought the
8 renewal thereof, shall file an 805 report with the relevant agency
9 within 15 days after the licentiate takes the action.

10 (1) Resigns or takes a leave of absence from membership, staff
11 privileges, or employment.

12 (2) Withdraws or abandons his or her application for staff
13 privileges or membership.

14 (3) Withdraws or abandons his or her request for renewal of
15 staff privileges or membership.

16 (d) For purposes of filing an 805 report, the signature of at least
17 one of the individuals indicated in subdivision (b) or (c) on the
18 completed form shall constitute compliance with the requirement
19 to file the report.

20 (e) An 805 report shall also be filed within 15 days following
21 the imposition of summary suspension of staff privileges,
22 membership, or employment, if the summary suspension remains
23 in effect for a period in excess of 14 days.

24 (f) A copy of the 805 report, and a notice advising the licentiate
25 of his or her right to submit additional statements or other
26 information, electronically or otherwise, pursuant to Section 800,
27 shall be sent by the peer review body to the licentiate named in
28 the report. The notice shall also advise the licentiate that
29 information submitted electronically will be publicly disclosed to
30 those who request the information.

31 The information to be reported in an 805 report shall include the
32 name and license number of the licentiate involved, a description
33 of the facts and circumstances of the medical disciplinary cause
34 or reason, and any other relevant information deemed appropriate
35 by the reporter.

36 A supplemental report shall also be made within 30 days
37 following the date the licentiate is deemed to have satisfied any
38 terms, conditions, or sanctions imposed as disciplinary action by
39 the reporting peer review body. In performing its dissemination
40 functions required by Section 805.5, the agency shall include a

1 copy of a supplemental report, if any, whenever it furnishes a copy
2 of the original 805 report.

3 If another peer review body is required to file an 805 report, a
4 health care service plan is not required to file a separate report
5 with respect to action attributable to the same medical disciplinary
6 cause or reason. If the Medical Board of California, the Board of
7 Registered Nursing, or a licensing agency of another state revokes
8 or suspends, without a stay, the license of a physician and surgeon,
9 a peer review body is not required to file an 805 report when it
10 takes an action as a result of the revocation or suspension.

11 (g) The reporting required by this section shall not act as a
12 waiver of confidentiality of medical records and committee reports.
13 The information reported or disclosed shall be kept confidential
14 except as provided in subdivision (c) of Section 800 and Sections
15 803.1 and 2027, provided that a copy of the report containing the
16 information required by this section may be disclosed as required
17 by Section 805.5 with respect to reports received on or after
18 January 1, 1976.

19 (h) The Medical Board of California, the Osteopathic Medical
20 Board of California, the Board of Registered Nursing, and the
21 Dental Board of California shall disclose reports as required by
22 Section 805.5.

23 (i) An 805 report shall be maintained electronically by an agency
24 for dissemination purposes for a period of three years after receipt.

25 (j) No person shall incur any civil or criminal liability as the
26 result of making any report required by this section.

27 (k) A willful failure to file an 805 report by any person who is
28 designated or otherwise required by law to file an 805 report is
29 punishable by a fine not to exceed one hundred thousand dollars
30 (\$100,000) per violation. The fine may be imposed in any civil or
31 administrative action or proceeding brought by or on behalf of any
32 agency having regulatory jurisdiction over the person regarding
33 whom the report was or should have been filed. If the person who
34 is designated or otherwise required to file an 805 report is a
35 licensed physician and surgeon, the action or proceeding shall be
36 brought by the Medical Board of California. The fine shall be paid
37 to that agency but not expended until appropriated by the
38 Legislature. A violation of this subdivision may constitute
39 unprofessional conduct by the licentiate. A person who is alleged
40 to have violated this subdivision may assert any defense available

1 at law. As used in this subdivision, “willful” means a voluntary
2 and intentional violation of a known legal duty.

3 (l) Except as otherwise provided in subdivision (k), any failure
4 by the administrator of any peer review body, the chief executive
5 officer or administrator of any health care facility, or any person
6 who is designated or otherwise required by law to file an 805
7 report, shall be punishable by a fine that under no circumstances
8 shall exceed fifty thousand dollars (\$50,000) per violation. The
9 fine may be imposed in any civil or administrative action or
10 proceeding brought by or on behalf of any agency having
11 regulatory jurisdiction over the person regarding whom the report
12 was or should have been filed. If the person who is designated or
13 otherwise required to file an 805 report is a licensed physician and
14 surgeon, the action or proceeding shall be brought by the Medical
15 Board of California. The fine shall be paid to that agency but not
16 expended until appropriated by the Legislature. The amount of the
17 fine imposed, not exceeding fifty thousand dollars (\$50,000) per
18 violation, shall be proportional to the severity of the failure to
19 report and shall differ based upon written findings, including
20 whether the failure to file caused harm to a patient or created a
21 risk to patient safety; whether the administrator of any peer review
22 body, the chief executive officer or administrator of any health
23 care facility, or any person who is designated or otherwise required
24 by law to file an 805 report exercised due diligence despite the
25 failure to file or whether they knew or should have known that an
26 805 report would not be filed; and whether there has been a prior
27 failure to file an 805 report. The amount of the fine imposed may
28 also differ based on whether a health care facility is a small or
29 rural hospital as defined in Section 124840 of the Health and Safety
30 Code.

31 (m) A health care service plan licensed under Chapter 2.2
32 (commencing with Section 1340) of Division 2 of the Health and
33 Safety Code or a disability insurer that negotiates and enters into
34 a contract with licentiates to provide services at alternative rates
35 of payment pursuant to Section 10133 of the Insurance Code, when
36 determining participation with the plan or insurer, shall evaluate,
37 on a case-by-case basis, licentiates who are the subject of an 805
38 report, and not automatically exclude or deselect these licentiates.

39 SEC. 4. Section 2837 of the Business and Professions Code is
40 amended and renumbered to read:

1 2837.5. Nothing in this article shall be construed to limit the
2 current scope of practice of a registered nurse authorized pursuant
3 to this chapter.

4 SEC. 5. Section 2837 is added to the Business and Professions
5 Code, to read:

6 2837. (a) Notwithstanding any other law, a nurse practitioner
7 who holds a national certification from a national certifying body
8 recognized by the board may practice under this section without
9 supervision of a physician and surgeon, if the nurse practitioner
10 meets all the requirements of this article and practices in one of
11 the following:

12 (1) A clinic as described in Chapter 1 (commencing with Section
13 1200) of Division 2 of the Health and Safety Code.

14 (2) A facility as described in Chapter 2 (commencing with
15 Section 1250) of Division 2 of the Health and Safety Code.

16 (3) A facility as described in Chapter 2.5 (commencing with
17 Section 1440) of Division 2 of the Health and Safety Code.

18 (4) An accountable care organization, as defined in Section
19 3022 of the federal Patient Protection and Affordable Care Act
20 (Public Law 111-148).

21 (5) A group practice, including a professional medical
22 corporation, as defined in Section 2406, another form of
23 corporation controlled by physicians and surgeons, a medical
24 partnership, a medical foundation exempt from licensure, or another
25 lawfully organized group of physicians that delivers, furnishes, or
26 otherwise arranges for or provides health care services.

27 (6) A medical group, independent practice association, or any
28 similar association.

29 (b) An entity described in subdivision (a) shall not interfere
30 with, control, or otherwise direct the professional judgment of a
31 nurse practitioner functioning pursuant to this section in a manner
32 prohibited by Section 2400 or any other law.

33 (c) Notwithstanding any other law, in addition to any other
34 practice authorized in statute or regulation, a nurse practitioner
35 who meets the qualifications of subdivision (a) may do any of the
36 following without physician and surgeon supervision:

37 (1) Order durable medical equipment. Notwithstanding that
38 authority, this paragraph shall not operate to limit the ability of a
39 third-party payer to require prior approval.

1 (2) After performance of a physical examination by the nurse
2 practitioner and collaboration, if necessary, with a physician and
3 surgeon, certify disability pursuant to Section 2708 of the
4 Unemployment Insurance Code.

5 (3) For individuals receiving home health services or personal
6 care services, after consultation, if necessary, with the treating
7 physician and surgeon, approve, sign, modify, or add to a plan of
8 treatment or plan of care.

9 (4) Assess patients, synthesize and analyze data, and apply
10 principles of health care.

11 (5) Manage the physical and psychosocial health status of
12 patients.

13 (6) Analyze multiple sources of data, identify a differential
14 diagnosis, and select, implement, and evaluate appropriate
15 treatment.

16 (7) Establish a diagnosis by client history, physical examination,
17 and other criteria, consistent with this section, for a plan of care.

18 (8) Order, furnish, prescribe, or procure drugs or devices.

19 (9) Delegate tasks to a medical assistant pursuant to Sections
20 1206.5, 2069, 2070, and 2071, and Article 2 of Chapter 3 of
21 Division 13 of Title 16 of the California Code of Regulations.

22 (10) Order hospice care, as appropriate.

23 (11) Order diagnostic procedures and utilize the findings or
24 results in treating the patient.

25 (12) Perform additional acts that require education and training
26 and that are recognized by the nursing profession as appropriate
27 to be performed by a nurse practitioner.

28 (d) A nurse practitioner shall refer a patient to a physician and
29 surgeon or other licensed health care provider if a situation or
30 condition of the patient is beyond the scope of the education and
31 training of the nurse practitioner.

32 (e) A nurse practitioner practicing under this section shall
33 maintain professional liability insurance appropriate for the practice
34 setting.

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

- 1 the Government Code, or changes the definition of a crime within
- 2 the meaning of Section 6 of Article XIII B of the California
- 3 Constitution.

O

SB 337



California.
LEGISLATIVE INFORMATION

SB-337 Physician assistants. (2015-2016)

Senate: 1st Cmt 2nd 3rd Pass Pass Chp

Assembly: 1st Cmt 2nd Pass 3rd Pass

Bill Status	
Measure:	SB-337
Lead Authors:	Pavley (S)
Principal Coauthors:	-
Coauthors:	-
Topic:	Physician assistants.
31st Day in Print:	03/26/15
Title:	An act to amend Sections 3501, 3502, and 3502.1 of the Business and Professions Code, relating to healing arts.
House Location:	Secretary of State
Chaptered Date:	10/06/15
Last Amended Date:	09/01/15

Type of Measure
Inactive Bill - Chaptered
Majority Vote Required
Non-Appropriation
Fiscal Committee
State-Mandated Local Program
Non-Urgency
Non-Tax levy

Last 5 History Actions	
Date	Action
10/06/15	Chaptered by Secretary of State. Chapter 536, Statutes of 2015.
10/06/15	Approved by the Governor.
09/10/15	Enrolled and presented to the Governor at 3:30 p.m.
09/04/15	Assembly amendments concurred in. (Ayes 40. Noes 0. Page 2497.) Ordered to engrossing and enrolling.
09/03/15	In Senate. Concurrence in Assembly amendments pending.

UNFINISHED BUSINESS

Bill No: SB 337
Author: Pavley (D)
Amended: 9/1/15
Vote: 21

SENATE BUS, PROF. & ECON. DEV. COMMITTEE: 9-0, 4/20/15
AYES: Hill, Bates, Berryhill, Block, Galgiani, Hernandez, Jackson, Mendoza,
Wieckowski

SENATE APPROPRIATIONS COMMITTEE: Senate Rule 28.8

SENATE FLOOR: 38-0, 5/26/15
AYES: Allen, Anderson, Bates, Beall, Berryhill, Block, Cannella, De León,
Fuller, Gaines, Galgiani, Hancock, Hernandez, Hertzberg, Hill, Hueso, Huff,
Jackson, Lara, Leno, Leyva, Liu, McGuire, Mendoza, Mitchell, Monning,
Moorlach, Morrell, Nguyen, Nielsen, Pan, Pavley, Roth, Runner, Stone, Vidak,
Wieckowski, Wolk
NO VOTE RECORDED: Hall

ASSEMBLY FLOOR: 80-0, 9/3/15 - See last page for vote

SUBJECT: Physician assistants

SOURCE: California Academy of Physician Assistants

DIGEST: This bill provides two additional mechanisms for a supervising physician and surgeon to ensure adequate supervision of a physician assistant (PA) functioning under the protocols.

Assembly Amendments clarify that medical review meetings may occur in person or by electronic communication and specify how often a medical records review meeting must occur and in what manner.

ANALYSIS:

Existing law:

- 1) Establishes the Physician Assistant Board within the jurisdiction of the Medical Board of California (MBC) to administer and enforce the Medical Practice Act. (Business and Professions Code (BPC) § 3504)
- 2) Requires a PA and his or her supervising physician to establish written guidelines for the adequate supervision of the PA, and the requirement may be satisfied by the supervising physician adopting protocols for some or all of the tasks performed by the PA. (BPC § 3502 (c)(1))
- 3) Requires a supervising physician to review, countersign, and date a sample consisting of, at a minimum, five percent of the medical records of patients treated by the PA within 30 days of the date of treatment. Requires the supervising physician to select for review those cases that by diagnosis, problem, treatment, or procedure represent the most significant risk to the patient. (BPC § 3502 (c)(2))
- 4) Requires a supervising physician who delegates the authority to issue a drug order to a PA to prepare and adopt a formulary and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. Protocols for Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is being administered, provided, or issued. (BPC § 3502.1(a)(2))
- 5) Requires a supervising physician to review and countersign within seven days the record of any patient cared for by a PA for whom the PA's Schedule II drug order has been issued or carried out. (BPC § 3502.1 (e))

This bill:

- 1) Defines "medical records review meeting" as a meeting between the supervising physician and surgeon and the PA during which medical records are reviewed to ensure adequate supervision of the PA functioning under protocols. Medical records review meetings may occur in person or by electronic communication.
- 2) Requires that the medical record identify the physician and surgeon who is responsible for the supervision of the PA for each episode of patient care.

- 3) Authorizes a supervising physician and surgeon to conduct a medical records review meeting at least once a month during at least 10 months of the year. During any month in which a medical records review meeting occurs, the supervising physician and surgeon and PA shall review an aggregate of at least 10 medical records of patients treated by the PA functioning under protocols. Documentation of medical records reviewed during the month shall be jointly signed and dated by the supervising physician and surgeon and the PA.
- 4) Authorizes a supervising physician and surgeon to conduct a medical records review by reviewing a sample of at least 10 medical records per month, at least 10 months during the year, using a combination of the countersignature mechanism and the medical records review meeting mechanism, as specified.
- 5) Authorizes a supervising physician and surgeon to review, countersign, and date, within seven days, a sample consisting of the medical records of at least 20 percent of the patients cared for by the PA for whom the PA's Schedule II drug order has been issued or carried out, if the PA has documentation evidencing the successful completion of an education course that covers controlled substances, and that controlled substance education course meets specified standards.
- 6) Makes technical changes.

Background

According to the author, "This bill is also needed to address an issue related to co-signatures on Schedule II medications. In August of 2014 the DEA published a final rule, effective October 6, 2014, following recommendations from the U.S. Food and Drug Administration (FDA) to up-schedule or reclassify hydrocodone combination products (HCP) from a Schedule III controlled substance to a Schedule II. The rescheduling of HCPs has had a significant impact, and unintended consequence, on some practices throughout California as existing law requires a 100% physician co-signature requirement on these medications within 7 days. This can be particularly challenging for practices that employ PAs to practice medicine in areas such as pain management, orthopedics, general surgery and several other practice types. The new ruling restricts the ability of a practice to fully utilize the PAs they employ as there is no other profession with prescribing privileges that has that level of mandate for documentation. Further, a co-signature mandate of 100% is overly burdensome for physicians in various practice types.

“Existing law requires a supervising physician to be available in-person or through electronic communication at all times when a PA is providing care for a patient. Given the many models of team-based care supervising physicians and PA often practice at different locations and lead PA run clinics as well as assume significant administrative responsibilities. In this context, a 100% mandate on co-signatures creates a barrier to efficient team-based care and stands to jeopardize access to appropriate treatment of pain for those patients with legitimate need.”

A PA performs many of the same diagnostic, preventative and health maintenance services as a physician, but PAs are limited in practice to those duties delegated by a supervising physician. These services may include, but are not limited to, the following:

- Taking health histories.
- Performing physical examinations.
- Ordering X-rays and laboratory tests.
- Ordering respiratory, occupational, or physical therapy treatments.
- Performing routine diagnostic tests.
- Establishing diagnoses.
- Treating and managing patient health problems.
- Administering immunizations and injections.
- Instructing and counseling patients.
- Providing continuing care to patients in the home, hospital, or extended care facility.
- Providing referrals within the health care system.
- Performing minor surgery.
- Providing preventative health care services.
- Acting as first or second assistants during surgery.
- Responding to life-threatening emergencies.

A PA must attend a specialized medical training program associated with a medical school that includes classroom studies and clinical experience. An academic degree and/or certificate is awarded upon graduation. Many PAs already have two- or four-year academic degrees before entering a PA training program. Most PA training programs require prior health care experience. As of June 2013, there were 9,101 active California PA licensees.

Supervision. Existing law has very specific requirements for a supervising physician to delegate practice authority to a PA, and the supervising physician must be physically or electronically available to his or her PA at the time of

treatment. In addition to this, a supervising physician must review, countersign, and date a sample of at least five percent of a PA's cases within 30 days of treatment.

The author argues that the five percent review requirement is outdated and unnecessary, given the close working relationship between PAs and physicians and existing delegation of service agreements and protocols. This bill provides two additional mechanisms for a supervising physician to ensure adequate PA supervision, and establishes an additional method to supervise a PA's furnishing of Schedule II drugs.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Assembly Appropriations Committee, this bill will have minor and absorbable costs to the Physician Assistant Board within the MBC to conform to the new supervision options (Physician Assistant Fund).

SUPPORT: (Verified 9/3/15)

California Academy of Physician Assistants (source)
CAPG
Medical Board of California
Pacific Pain Medicine Consultants
Pacific Southwest Pain Center
Physician Assistant Board
Planned Parenthood Affiliates of California

OPPOSITION: (Verified 9/3/15)

None received

ARGUMENTS IN SUPPORT: The source of this bill, the California Academy of Physician Assistants, write, "With the implementation of the Patient Protection and Affordable Care Act, Covered California reported enrolling 3.4 million (1.4 through Covered CA plans and 1.9 in Medi-Cal) previously uninsured people in the first open enrollment year (2014). This bill recognizes the need to increase access to high quality, cost-effective and efficient team-based practice across all medical settings in order to meet the rising demand for health care services throughout the state.

"The physician/PA team is unique as PAs are licensed health professionals who practice medicine as members of a physician-led team, delivering a broad range of

medical and surgical services at the direction of and under the supervision of his or her supervising physician. The supervising physician delegates to a PA specified medical tasks and procedures, consistent with his or her scope of practice, based on education, training and experience.

“Established over 30 years ago, existing law stipulates supervision criteria between a supervising physician and surgeon and the Physician Assistant (PA). It narrowly defines documentation of this required supervision in the form of the supervising physician co-signature on the medical record. SB 377 increases the options for documenting supervision between a supervising physician and PA would allow for flexibility at the practice level to reflect current models of team-based care.”

ASSEMBLY FLOOR: 80-0, 9/3/15

AYES: Achadjian, Alejo, Travis Allen, Baker, Bigelow, Bloom, Bonilla, Bonta, Brough, Brown, Burke, Calderon, Campos, Chang, Chau, Chávez, Chiu, Chu, Cooley, Cooper, Dababneh, Dahle, Daly, Dodd, Eggman, Frazier, Beth Gaines, Gallagher, Cristina Garcia, Eduardo Garcia, Gatto, Gipson, Gomez, Gonzalez, Gordon, Gray, Grove, Hadley, Harper, Roger Hernández, Holden, Irwin, Jones, Jones-Sawyer, Kim, Lackey, Levine, Linder, Lopez, Low, Maienschein, Mathis, Mayes, McCarty, Medina, Melendez, Mullin, Nazarian, Obernolte, O'Donnell, Olsen, Patterson, Perea, Quirk, Rendon, Ridley-Thomas, Rodriguez, Salas, Santiago, Steinorth, Mark Stone, Thurmond, Ting, Wagner, Waldron, Weber, Wilk, Williams, Wood, Atkins

Prepared by: Sarah Huchel / B., P. & E.D. / (916) 651-4104
9/4/15 10:42:46

**** END ****



Senate Bill No. 337

CHAPTER 536

An act to amend Sections 3501, 3502, and 3502.1 of the Business and Professions Code, relating to healing arts.

[Approved by Governor October 6, 2015. Filed with
Secretary of State October 6, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SB 337, Pavley. Physician assistants.

Existing law, the Physician Assistant Practice Act, provides for regulation of physician assistants and authorizes a physician assistant to perform medical services as set forth by regulations when those services are rendered under the supervision of a licensed physician and surgeon, as specified. The act requires the supervising physician and surgeon to review, countersign, and date a sample consisting of, at a minimum, 5% of the medical records of patients treated by the physician assistant functioning under adopted protocols within 30 days of the date of treatment by the physician assistant. The act requires the supervising physician and surgeon to select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient. A violation of those supervision requirements is a misdemeanor.

This bill would require that the medical record for each episode of care for a patient identify the physician and surgeon who is responsible for the supervision of the physician assistant. The bill would delete those medical record review provisions, and, instead, require the supervising physician and surgeon to use one or more of described review mechanisms. By adding these new requirements, the violation of which would be a crime, this bill would impose a state-mandated local program by changing the definition of a crime.

The act authorizes a physician assistant, while under prescribed supervision of a physician and surgeon, to administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device. The act prohibits a physician assistant from administering, providing, or issuing a drug order to a patient for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for that particular patient unless the physician assistant has completed an education course that covers controlled substances and that meets approved standards. The act requires that the medical record of any patient cared for by a physician assistant for whom a physician assistant's Schedule II drug order has been issued or carried out to be

reviewed, countersigned, and dated by a supervising physician and surgeon within 7 days.

This bill would establish an alternative medical records review mechanism, and would authorize the supervising physician and surgeon to use the alternative mechanism, or a sample review mechanism using a combination of the 2 described mechanisms, as specified, to ensure adequate supervision of the administration, provision, or issuance by a physician assistant of a drug order to a patient for Schedule II controlled substances.

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.

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

SECTION 1. Section 3501 of the Business and Professions Code is amended to read:

3501. (a) As used in this chapter:

- (1) "Board" means the Physician Assistant Board.
- (2) "Approved program" means a program for the education of physician assistants that has been formally approved by the board.
- (3) "Trainee" means a person who is currently enrolled in an approved program.
- (4) "Physician assistant" means a person who meets the requirements of this chapter and is licensed by the board.
- (5) "Supervising physician" or "supervising physician and surgeon" means a physician and surgeon licensed by the Medical Board of California or by the Osteopathic Medical Board of California who supervises one or more physician assistants, who possesses a current valid license to practice medicine, and who is not currently on disciplinary probation for improper use of a physician assistant.
- (6) "Supervision" means that a licensed physician and surgeon oversees the activities of, and accepts responsibility for, the medical services rendered by a physician assistant.
- (7) "Regulations" means the rules and regulations as set forth in Chapter 13.8 (commencing with Section 1399.500) of Title 16 of the California Code of Regulations.
- (8) "Routine visual screening" means uninvasive nonpharmacological simple testing for visual acuity, visual field defects, color blindness, and depth perception.
- (9) "Program manager" means the staff manager of the diversion program, as designated by the executive officer of the board. The program manager shall have background experience in dealing with substance abuse issues.
- (10) "Delegation of services agreement" means the writing that delegates to a physician assistant from a supervising physician the medical services

the physician assistant is authorized to perform consistent with subdivision (a) of Section 1399.540 of Title 16 of the California Code of Regulations.

(11) “Other specified medical services” means tests or examinations performed or ordered by a physician assistant practicing in compliance with this chapter or regulations of the Medical Board of California promulgated under this chapter.

(12) “Medical records review meeting” means a meeting between the supervising physician and surgeon and the physician assistant during which medical records are reviewed to ensure adequate supervision of the physician assistant functioning under protocols. Medical records review meetings may occur in person or by electronic communication.

(b) A physician assistant acts as an agent of the supervising physician when performing any activity authorized by this chapter or regulations adopted under this chapter.

SEC. 2. Section 3502 of the Business and Professions Code is amended to read:

3502. (a) Notwithstanding any other law, a physician assistant may perform those medical services as set forth by the regulations adopted under this chapter when the services are rendered under the supervision of a licensed physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that supervision or prohibiting the employment of a physician assistant. The medical record, for each episode of care for a patient, shall identify the physician and surgeon who is responsible for the supervision of the physician assistant.

(b) (1) Notwithstanding any other law, a physician assistant performing medical services under the supervision of a physician and surgeon may assist a doctor of podiatric medicine who is a partner, shareholder, or employee in the same medical group as the supervising physician and surgeon. A physician assistant who assists a doctor of podiatric medicine pursuant to this subdivision shall do so only according to patient-specific orders from the supervising physician and surgeon.

(2) The supervising physician and surgeon shall be physically available to the physician assistant for consultation when that assistance is rendered. A physician assistant assisting a doctor of podiatric medicine shall be limited to performing those duties included within the scope of practice of a doctor of podiatric medicine.

(c) (1) A physician assistant and his or her supervising physician and surgeon shall establish written guidelines for the adequate supervision of the physician assistant. This requirement may be satisfied by the supervising physician and surgeon adopting protocols for some or all of the tasks performed by the physician assistant. The protocols adopted pursuant to this subdivision shall comply with the following requirements:

(A) A protocol governing diagnosis and management shall, at a minimum, include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be provided to the patient.

(B) A protocol governing procedures shall set forth the information to be provided to the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the followup care.

(C) Protocols shall be developed by the supervising physician and surgeon or adopted from, or referenced to, texts or other sources.

(D) Protocols shall be signed and dated by the supervising physician and surgeon and the physician assistant.

(2) (A) The supervising physician and surgeon shall use one or more of the following mechanisms to ensure adequate supervision of the physician assistant functioning under the protocols:

(i) The supervising physician and surgeon shall review, countersign, and date a sample consisting of, at a minimum, 5 percent of the medical records of patients treated by the physician assistant functioning under the protocols within 30 days of the date of treatment by the physician assistant.

(ii) The supervising physician and surgeon and physician assistant shall conduct a medical records review meeting at least once a month during at least 10 months of the year. During any month in which a medical records review meeting occurs, the supervising physician and surgeon and physician assistant shall review an aggregate of at least 10 medical records of patients treated by the physician assistant functioning under protocols. Documentation of medical records reviewed during the month shall be jointly signed and dated by the supervising physician and surgeon and the physician assistant.

(iii) The supervising physician and surgeon shall review a sample of at least 10 medical records per month, at least 10 months during the year, using a combination of the countersignature mechanism described in clause (i) and the medical records review meeting mechanism described in clause (ii). During each month for which a sample is reviewed, at least one of the medical records in the sample shall be reviewed using the mechanism described in clause (i) and at least one of the medical records in the sample shall be reviewed using the mechanism described in clause (ii).

(B) In complying with subparagraph (A), the supervising physician and surgeon shall select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

(3) Notwithstanding any other law, the Medical Board of California or the board may establish other alternative mechanisms for the adequate supervision of the physician assistant.

(d) No medical services may be performed under this chapter in any of the following areas:

(1) The determination of the refractive states of the human eye, or the fitting or adaptation of lenses or frames for the aid thereof.

(2) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, or orthoptics.

(3) The prescribing of contact lenses for, or the fitting or adaptation of contact lenses to, the human eye.

(4) The practice of dentistry or dental hygiene or the work of a dental auxiliary as defined in Chapter 4 (commencing with Section 1600).

(e) This section shall not be construed in a manner that shall preclude the performance of routine visual screening as defined in Section 3501.

(f) Compliance by a physician assistant and supervising physician and surgeon with this section shall be deemed compliance with Section 1399.546 of Title 16 of the California Code of Regulations.

SEC. 3. Section 3502.1 of the Business and Professions Code is amended to read:

3502.1. (a) In addition to the services authorized in the regulations adopted by the Medical Board of California, and except as prohibited by Section 3502, while under the supervision of a licensed physician and surgeon or physicians and surgeons authorized by law to supervise a physician assistant, a physician assistant may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device pursuant to subdivisions (c) and (d).

(1) A supervising physician and surgeon who delegates authority to issue a drug order to a physician assistant may limit this authority by specifying the manner in which the physician assistant may issue delegated prescriptions.

(2) Each supervising physician and surgeon who delegates the authority to issue a drug order to a physician assistant shall first prepare and adopt, or adopt, a written, practice specific, formulary and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. Protocols for Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is being administered, provided, or issued. The drugs listed in the protocols shall constitute the formulary and shall include only drugs that are appropriate for use in the type of practice engaged in by the supervising physician and surgeon. When issuing a drug order, the physician assistant is acting on behalf of and as an agent for a supervising physician and surgeon.

(b) "Drug order," for purposes of this section, means an order for medication that is dispensed to or for a patient, issued and signed by a physician assistant acting as an individual practitioner within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription or order of the supervising physician, (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by physician assistants pursuant to authority granted by their supervising physicians and surgeons, and (3) the signature of a physician assistant on a drug order shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

(c) A drug order for any patient cared for by the physician assistant that is issued by the physician assistant shall either be based on the protocols

described in subdivision (a) or shall be approved by the supervising physician and surgeon before it is filled or carried out.

(1) A physician assistant shall not administer or provide a drug or issue a drug order for a drug other than for a drug listed in the formulary without advance approval from a supervising physician and surgeon for the particular patient. At the direction and under the supervision of a physician and surgeon, a physician assistant may hand to a patient of the supervising physician and surgeon a properly labeled prescription drug prepackaged by a physician and surgeon, manufacturer as defined in the Pharmacy Law, or a pharmacist.

(2) A physician assistant shall not administer, provide, or issue a drug order to a patient for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for that particular patient unless the physician assistant has completed an education course that covers controlled substances and that meets standards, including pharmacological content, approved by the board. The education course shall be provided either by an accredited continuing education provider or by an approved physician assistant training program. If the physician assistant will administer, provide, or issue a drug order for Schedule II controlled substances, the course shall contain a minimum of three hours exclusively on Schedule II controlled substances. Completion of the requirements set forth in this paragraph shall be verified and documented in the manner established by the board prior to the physician assistant's use of a registration number issued by the United States Drug Enforcement Administration to the physician assistant to administer, provide, or issue a drug order to a patient for a controlled substance without advance approval by a supervising physician and surgeon for that particular patient.

(3) Any drug order issued by a physician assistant shall be subject to a reasonable quantitative limitation consistent with customary medical practice in the supervising physician and surgeon's practice.

(d) A written drug order issued pursuant to subdivision (a), except a written drug order in a patient's medical record in a health facility or medical practice, shall contain the printed name, address, and telephone number of the supervising physician and surgeon, the printed or stamped name and license number of the physician assistant, and the signature of the physician assistant. Further, a written drug order for a controlled substance, except a written drug order in a patient's medical record in a health facility or a medical practice, shall include the federal controlled substances registration number of the physician assistant and shall otherwise comply with Section 11162.1 of the Health and Safety Code. Except as otherwise required for written drug orders for controlled substances under Section 11162.1 of the Health and Safety Code, the requirements of this subdivision may be met through stamping or otherwise imprinting on the supervising physician and surgeon's prescription blank to show the name, license number, and if applicable, the federal controlled substances registration number of the physician assistant, and shall be signed by the physician assistant. When

using a drug order, the physician assistant is acting on behalf of and as the agent of a supervising physician and surgeon.

(e) The supervising physician and surgeon shall use either of the following mechanisms to ensure adequate supervision of the administration, provision, or issuance by a physician assistant of a drug order to a patient for Schedule II controlled substances:

(1) The medical record of any patient cared for by a physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out shall be reviewed, countersigned, and dated by a supervising physician and surgeon within seven days.

(2) If the physician assistant has documentation evidencing the successful completion of an education course that covers controlled substances, and that controlled substance education course (A) meets the standards, including pharmacological content, established in Sections 1399.610 and 1399.612 of Title 16 of the California Code of Regulations, and (B) is provided either by an accredited continuing education provider or by an approved physician assistant training program, the supervising physician and surgeon shall review, countersign, and date, within seven days, a sample consisting of the medical records of at least 20 percent of the patients cared for by the physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out. Completion of the requirements set forth in this paragraph shall be verified and documented in the manner established in Section 1399.612 of Title 16 of the California Code of Regulations. Physician assistants who have a certificate of completion of the course described in paragraph (2) of subdivision (c) shall be deemed to have met the education course requirement of this subdivision.

(f) All physician assistants who are authorized by their supervising physicians to issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration (DEA).

(g) The board shall consult with the Medical Board of California and report during its sunset review required by Article 7.5 (commencing with Section 9147.7) of Chapter 1.5 of Part 1 of Division 2 of Title 2 of the Government Code the impacts of exempting Schedule III and Schedule IV drug orders from the requirement for a physician and surgeon to review and countersign the affected medical record of a patient.

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.

SB 464



California
LEGISLATIVE INFORMATION

SB-464 Healing arts: self-reporting tools. (2015-2016)

Senate: 1st Cmt 2nd 3rd Pass Cmt Pass Chp

Assembly: 1st Cmt 2nd 3rd Pass

Bill Status	
Measure:	SB-464
Lead Authors:	Hernandez (S)
Principal Coauthors:	-
Coauthors:	-
Topic:	Healing arts: self-reporting tools.
31st Day in Print:	03/28/15
Title:	An act to add Section 2242.2 to the Business and Professions Code, relating to healing arts.
House Location:	Secretary of State
Chaptered Date:	09/30/15
Last Amended Date:	05/22/15

Type of Measure
Inactive Bill - Chaptered
Majority Vote Required
Non-Appropriation
Fiscal Committee
Non-State-Mandated Local Program
Non-Urgency
Non-Tax levy

Last 5 History Actions	
Date	Action
09/30/15	Chaptered by Secretary of State. Chapter 387, Statutes of 2015.
09/30/15	Approved by the Governor.
09/01/15	Enrolled and presented to the Governor at 4:30 p.m.
08/31/15	Assembly amendments concurred in. (Ayes 29. Noes 5. Page 2270.) Ordered to engrossing and enrolling.
08/27/15	From committee: That the Assembly amendments be concurred in. (Ayes 8. Noes 0. Page 2235.)

UNFINISHED BUSINESS

Bill No: SB 464
Author: Hernandez (D)
Amended: 5/22/15
Vote: 21

PRIOR SENATE VOTES NOT RELEVANT

SENATE BUS, PROF. & ECON. DEV. COMMITTEE: 8-0, 8/27/15
(pursuant to Senate Rule 29.10)

AYES: Hill, Berryhill, Block, Galgiani, Hernandez, Jackson, Mendoza,
Wieckowski

NO VOTE RECORDED: Bates

ASSEMBLY FLOOR: 73-1, 8/20/15 - See last page for vote

SUBJECT: Healing arts: self-reporting tools

SOURCE: Planned Parenthood Affiliates of California

DIGEST: This bill permits a physician, registered nurse (RN), certified nurse-midwife (CNM), nurse practitioner (NP), physician assistant (PA), and pharmacist to use a self-screening tool to aid the prescription of self-administered hormonal contraceptives.

Assembly Amendments delete the contents of the bill and replace it with the current version.

ANALYSIS:

Existing law:

- 1) Prohibits a person or entity from prescribing, dispensing, or furnishing, or causing to be prescribed, dispensed, or furnished, dangerous drugs or dangerous devices on the Internet for delivery to any person in this state, without an

appropriate prior examination and medical indication, except as specified.
(BPC § 2242.1)

- 2) Authorizes a RN to dispense a self-administered hormonal contraceptive (SAHC) in accordance with standardized procedures, which shall include demonstration of competency in providing the appropriate prior examination comprised of checking blood pressure, weight, and patient and family health history, including medications taken by the patient. The appropriate prior examination shall be consistent with the evidence-based practice guidelines adopted by the federal Centers for Disease Control and Prevention (CDC) in conjunction with the United States Medical Eligibility Criteria for Contraceptive Use (USMEC). (BPC § 2725.2)
- 3) Authorizes a pharmacist to furnish SAHC in accordance with standardized procedures developed and approved by both the Board of Pharmacy (BOP) and the Medical Board of California (MBC) in consultation with other entities, as specified, and requires that the protocol mandate the use of a patient self-screening tool to identify risk factors for the use of SAHC, based on current USMEC developed by the federal CDC. (BPC § 4052.3)

This bill:

- 1) Authorizes a physician, RN, CNM, NP, PA, and pharmacist to use a self-screening tool that will identify patient risk factors for the use of SAHC by a patient, and, after an appropriate prior examination, prescribe, furnish, or dispense, as applicable, SAHC to the patient.
- 2) Permits blood pressure, weight, height, and patient health history to be self-reported using the self-screening tool.

Background

Telehealth and Self-Screening Tools. Current law defines telehealth as “the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site.” Telehealth is neither a distinct technology nor a type of care; it is the remote provision of healthcare services according to the same professional standards governing in-person care.

Telehealth may be facilitated by many mediums, including telephone, videoconferencing, store-and-forward technology, and increasingly, by mobile devices connected to the Internet.

A self-screening tool is not defined in law; it is any instrument by which an individual reports health information. BOP is developing a paper checklist as its self-screening tool, and there exist mobile apps that record consumers' answers in response to online prompts that are also considered self-screening tools.

Requirements for Prescribing SAHC. Current law authorizes a physician, RN, CNM, NP, PA, or a pharmacist to prescribe, furnish, or dispense SAHC. However, current laws and regulations are not specific as to the exact protocols required for each licensee to provide SAHC to patients.

Physician: An appropriate prior examination is mandated by law prior to a physician prescribing a SAHC. However, an in-person examination is not required and a physician is expected to use his or her professional judgment in determining the appropriate standard of care for each patient.

RN, CNM, NP, PA: These licensees are required to furnish or dispense SAHC pursuant to standardized procedures, which are the legal mechanism for non-physicians to perform functions which would otherwise be considered the practice of medicine, including prescribing drugs. Standardized procedures are policies and protocols developed by a health facility or organized health care system, with input from administrators and health professionals, which establish parameters for medical care. These licensees are also required to conduct an appropriate prior examination before dispensing or furnishing SAHC on the Internet for delivery to any person in this state, but what constitutes an appropriate prior examination is undefined.

As part of their standardized procedures for dispensing SAHC, RNs are required to demonstrate competency in providing an appropriate prior examination, which is comprised of checking blood pressure, weight, and collecting patient and family health history. Current law further states that the appropriate prior examination by a RN shall be consistent with the evidence-based practice guidelines adopted by the CDC.

The CDC recommended in their June 14, 2013 *Morbidity and Mortality Weekly Report* that, "among healthy women, few examinations or tests are needed before initiation of combined hormonal contraceptives." They recommend that blood

pressure be measured and that weight and body mass may be useful for monitoring SAHC use over time. However, nothing in the CDC recommendation states that a RN must measure blood pressure and weight for each patient prior to furnishing SAHC, and it is reasonable to infer that an accurate self-reporting of the same information would yield the necessary information.

Pharmacist: Pharmacists may furnish SAHC in accordance with standardized procedures developed and approved by the BOP and MBC. These standardized procedures have not yet been adopted, but the law states they must include a patient self-screening tool to identify risk factors based on the same CDC guidelines as required by RN protocols. The initial regulations formalizing the standardized procedures approved by the MBC and BOP required that the pharmacist also measure a patient's seated blood pressure, in addition to the information collected by the self-screening tool. However, at the July 29, 2015 BOP meeting, the BOP voted to modify the protocol so that a pharmacist may accept self-reported blood pressure at his or her discretion. This modification must now be approved by the MBC.

This bill acknowledges the need for patient health information, including blood pressure and weight, to appropriately recommend a SAHC, but permits practitioners to rely on information provided by the patient, rather than measured by the practitioner.

Self-Reported Health Metrics and Safety of SAHC. Accepting self-reported medical information for SAHC is supported by numerous medical reports and journals because of the nature of the drugs themselves, effective self-screening, and the greater risks of unintended pregnancies.

For example, the American College of Obstetricians and Gynecologists (ACOG) advocated for over-the-counter availability of SAHCs in 2014, noting that the primary risk associated with SAHC, venous thromboembolism (blood clots) is "extremely low," and that women can self-screen for contraindications. Further, the risk of blood clots due to SAHC is lower than the same risk of clotting in pregnancy. A 2014 article in the *American Journal of Obstetrics and Gynecology* reported on a study indicating that on average, there is a low prevalence of medical contraindications in women of reproductive age overall, so there is a very small portion of the population for whom information on a self-screening tool is truly vital.

This bill aims to clarify that existing and potential telehealth providers operate in accordance with current law by stating that practitioners who are currently authorized to provide SAHC may do so by relying on self-reported health information.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: No

According to the Assembly Appropriations analysis, this bill will have negligible costs to affected professional licensing boards within the Department of Consumer Affairs.

SUPPORT: (Verified 8/27/15)

Planned Parenthood Affiliates of California (source)
California Medical Association
California Primary Care Association
Community Action Fund of Planned Parenthood of Orange and San Bernardino Counties
Icebreaker Health
NARAL Pro-Choice California
Planned Parenthood Action Fund of Santa Barbara, Ventura and San Luis Obispo Counties
Planned Parenthood Action Fund of the Pacific Southwest
Planned Parenthood Advocacy Project Los Angeles County
Planned Parenthood Mar Monte
Planned Parenthood Northern California Action Fund
Planned Parenthood Pasadena and San Gabriel Valley
Numerous individuals.

OPPOSITION: (Verified 8/27/15)

California Catholic Conference
California Nurses Association
California Right to Life Committee, Inc.

ARGUMENTS IN SUPPORT: “Planned Parenthood supports efforts to better serve our patients through the development and expansion of telehealth services. Telehealth is a safe, effective delivery system that expands access to health care for people who otherwise would have to travel a long distance to see a provider.

“SB 464 seeks to help improve preventive health services by increasing access to services in rural communities through the utilization of telemedicine by allowing

patients to provide information to a health provider through a self-screening tool, including family history, blood pressure, or weight. As technology advances, telehealth will include models where patients communicate directly with a distant provider and are not physically present in a provider's office."

ARGUMENTS IN OPPOSITION: The California Catholic Conference writes in opposition, "Young girls, and other minors under the age of 18, would be able to receive contraceptives ... without an actual medical exam and without the consent of their parent(s) or guardian(s). Further, without any oversight, these dangerous drugs could easily get into the wrong hands of human traffickers or the hands of young people."

ASSEMBLY FLOOR: 73-1, 8/20/15

AYES: Achadjian, Alejo, Baker, Bigelow, Bloom, Bonilla, Bonta, Brown, Burke, Calderon, Campos, Chang, Chau, Chávez, Chiu, Cooley, Cooper, Dababneh, Dahle, Daly, Dodd, Eggman, Frazier, Beth Gaines, Cristina Garcia, Eduardo Garcia, Gatto, Gipson, Gomez, Gonzalez, Gordon, Gray, Grove, Hadley, Roger Hernández, Holden, Irwin, Jones, Jones-Sawyer, Kim, Lackey, Levine, Linder, Lopez, Low, Maienschein, Mathis, Mayes, McCarty, Medina, Melendez, Mullin, Nazarian, Obernolte, O'Donnell, Olsen, Perea, Quirk, Rendon, Ridley-Thomas, Rodriguez, Salas, Santiago, Steinorth, Mark Stone, Thurmond, Ting, Wagner, Weber, Wilk, Williams, Wood, Atkins

NOES: Gallagher

NO VOTE RECORDED: Travis Allen, Brough, Chu, Harper, Patterson, Waldron

Prepared by: Sarah Huchel / B., P. & E.D. / (916) 651-4104, Sarah Huchel / B., P. & E.D. / (916) 651-4104
8/28/15 15:24:23

**** END ****



Senate Bill No. 464

CHAPTER 387

An act to add Section 2242.2 to the Business and Professions Code, relating to healing arts.

[Approved by Governor September 30, 2015. Filed with
Secretary of State September 30, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SB 464, Hernandez. Healing arts: self-reporting tools.

The Medical Practice Act provides for licensure and regulation of physicians and surgeons by the Medical Board of California, and authorizes a physician and surgeon to, among other things, use drugs or devices in or upon human beings. The Medical Practice Act makes it unprofessional conduct for a physician and surgeon to prescribe, dispense, or furnish dangerous drugs without an appropriate prior examination and medical indication. The act prohibits, with specified exceptions, a person or entity from prescribing, dispensing, or furnishing, or causing to be prescribed, dispensed, or furnished, dangerous drugs or dangerous devices on the Internet for delivery to a person in California without an appropriate prior examination and medical indication.

The Nursing Practice Act provides for the licensure and regulation of registered nurses, including nurse practitioners and certified nurse-midwives, by the Board of Registered Nursing within the Department of Consumer Affairs. The Nursing Practice Act authorizes a registered nurse to dispense self-administered hormonal contraceptives, as specified, in accordance with standardized procedures, including demonstration of competency in providing the appropriate prior examination comprised of checking blood pressure, weight, and patient and family health history, including medications taken by the patient. The Nursing Practice Act also authorizes certified nurse-midwives and nurse practitioners to furnish or order drugs or devices, as specified.

The Physician Assistant Practice Act provides for the licensure and regulation of physician assistants by the Physician Assistant Board within the jurisdiction of the Medical Board of California, and authorizes a physician assistant to administer or provide medication to a patient or to transmit a drug order, as specified.

The Pharmacy Law provides for the licensing and regulation of pharmacists by the California State Board of Pharmacy within the Department of Consumer Affairs, and authorizes a pharmacist to furnish self-administered hormonal contraceptives in accordance with standardized procedures and protocols. The Pharmacy Law requires the standardized procedures and protocols to require a patient to use a self-screening tool

that will identify patient risk factors for the use of self-administered hormonal contraceptives, as specified.

This bill, notwithstanding any other law, would authorize a physician and surgeon, a registered nurse acting in accordance with the authority of the Nursing Practice Act, a certified nurse-midwife acting within the scope of specified existing law relating to nurse-midwives, a nurse practitioner acting within the scope of specified existing law relating to nurse practitioners, a physician assistant acting within the scope of specified existing law relating to physician assistants, or a pharmacist acting within the scope of a specified existing law relating to pharmacists to use a self-screening tool that will identify patient risk factors for the use of self-administered hormonal contraceptives by a patient, and, after an appropriate prior examination, to prescribe, furnish, or dispense, as applicable, self-administered hormonal contraceptives to the patient. The bill would authorize blood pressure, weight, height, and patient health history to be self-reported using the self-screening tool.

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

SECTION 1. Section 2242.2 is added to the Business and Professions Code, to read:

2242.2. Notwithstanding any other law, a physician and surgeon, a registered nurse acting in accordance with Section 2725.2, a certified nurse-midwife acting within the scope of Section 2746.51, a nurse practitioner acting within the scope of Section 2836.1, a physician assistant acting within the scope of Section 3502.1, and a pharmacist acting within the scope of Section 4052.3 may use a self-screening tool that will identify patient risk factors for the use of self-administered hormonal contraceptives by a patient, and, after an appropriate prior examination, prescribe, furnish, or dispense, as applicable, self-administered hormonal contraceptives to the patient. Blood pressure, weight, height, and patient health history may be self-reported using the self-screening tool that identifies patient risk factors.

SB 800



California.
LEGISLATIVE INFORMATION

SB-800 Healing arts. (2015-2016)

Senate: 1st Cmt 2nd Pass Pass Chp

Assembly: 1st Cmt 2nd Cmt 2nd 3rd Pass

Bill Status	
Measure:	SB-800
Lead Authors:	Committee on Business, Professions and Economic Development (S) - (Senators Hill (Chair), Bates, Berryhill, Block, Galgiani, Hernandez, Jackson, Mendoza, and Wiewkowski)
Principal Coauthors:	-
Coauthors:	-
Topic:	Healing arts.
31st Day in Print:	04/18/15
Title:	An act to amend Sections 28, 146, 500, 650.2, 800, 1603a, 1618.5, 1640.1, 1648.10, 1650, 1695, 1695.1, 1905.1, 1944, 2054, 2401, 2428, 2529, 2650, 2770, 2770.1, 2770.2, 2770.7, 2770.8, 2770.10, 2770.11, 2770.12, 2770.13, 2835.5, 3057, 3509.5, 4836.2, 4887, 4938, 4939, 4980.399, 4980.43, 4980.54, 4984.01, 4989.34, 4992.09, 4996.2, 4996.22, 4996.28, 4999.1, 4999.2, 4999.3, 4999.4, 4999.5, 4999.7, 4999.45, 4999.46, 4999.55, 4999.76, and 4999.100 of, to amend the heading of Article 3.1 (commencing with Section 2770) of Chapter 6 of Division 2 of, and to repeal Section 1917.2 of, the Business and Professions Code, relating to healing arts.
House Location:	Secretary of State
Chaptered Date:	10/01/15
Last Amended Date:	09/03/15

Type of Measure
Inactive Bill - Chaptered
Majority Vote Required
Non-Appropriation
Fiscal Committee
State-Mandated Local Program
Non-Urgency
Non-Tax levy

Last 5 History Actions	
Date	Action
10/01/15	Chaptered by Secretary of State. Chapter 426, Statutes of 2015.
10/01/15	Approved by the Governor.
09/15/15	Enrolled and presented to the Governor at 9:30 a.m.
09/10/15	Assembly amendments concurred in. (Ayes 39. Noes 0. Page 2671.) Ordered to engrossing and enrolling.
09/08/15	In Senate. Concurrence in Assembly amendments pending.

UNFINISHED BUSINESS

Bill No: SB 800
Author: Committee on Business, Professions and Economic Development
Amended: 9/3/15
Vote: 21

SENATE BUS, PROF. & ECON. DEV. COMMITTEE: 9-0, 4/27/15
AYES: Hill, Bates, Berryhill, Block, Galgiani, Hernandez, Jackson, Mendoza,
Wieckowski

SENATE APPROPRIATIONS COMMITTEE: Senate Rule 28.8

SENATE FLOOR: 36-0, 5/18/15 (Consent)
AYES: Allen, Anderson, Bates, Beall, Block, Cannella, De León, Fuller, Gaines,
Galgiani, Hancock, Hernandez, Hertzberg, Hill, Hueso, Huff, Jackson, Lara,
Leno, Leyva, Liu, McGuire, Mendoza, Mitchell, Monning, Moorlach, Morrell,
Nguyen, Nielsen, Pan, Roth, Runner, Stone, Vidak, Wieckowski, Wolk
NO VOTE RECORDED: Berryhill, Hall, Pavley

ASSEMBLY FLOOR: 79-0, 9/8/15 - See last page for vote

SUBJECT: Healing arts

SOURCE: Author

DIGEST: This bill makes several non-controversial minor, non-substantive, or technical changes to various provisions pertaining to the health-related regulatory boards under the Department of Consumer Affairs.

Assembly Amendments remove provisions relating to the Medical Board of California that were determined to be too substantive and address chaptering conflicts.

ANALYSIS: Existing law provides for the licensing and regulation of various professions and businesses by the boards, bureaus, committees, programs and

commission within the Department of Consumer Affairs under various licensing acts within the Business and Professions Code (BPC).

This bill:

- 1) Updates references to the “Board of Dental Examiners” with the “Dental Board of California” to ensure statutory consistency.
- 2) Makes the following changes relating to the California State Board of Optometry:
 - a) Removes the requirement for out of state applicants to submit proof of active practice.
 - b) Requires that the license of an out of state applicant has never been revoked or suspended in any state where the applicant holds a license.
 - c) Requires that an applicant has not been found mentally incompetent by a licensed psychologist or licensed psychiatrist.
- 3) Deletes the requirement for physical therapy assistants to complete the 18-week full-time clinical experience.
- 4) Makes the following changes relating to the Medical Board of California:
 - a) Clarifies that registration is required to practice as a polysomnographic technologist, technician, or trainee in California.
 - b) Requires that an individual who voluntarily cancels his or her license must apply again if it has been over five years since the cancellation.
 - c) Clarifies change that regulates when individuals can use the words “doctor”, “physician”, “Dr.”, or the initials “M.D.” when an individual has been issued a license to practice medicine in another jurisdiction and has had that license suspended or revoked.
 - d) Removes a code section referring to a repealed pilot program that no longer exists.

- 5) Makes the following changes relating to the Board of Behavioral Sciences (BBS):
 - a) Requires the responsible board (either the BBS or the California Board of Psychology) in regulation to specify a continued education (CE) provider and accept and approve a sponsored course to provide the training in child, elder, and dependent adult abuse assessment and reporting.
 - b) Includes licensed educational psychologists and licensed professional clinical counselors licensed professional clinical counselors (LPCCs) to the list of license types the BBS has authority to regulate.
 - c) Changes the reference to the current authority regarding acceptable CE providers.
 - d) Requires interns to register with the BBS in order to volunteer or work in a private practice.
 - e) States registrants may apply for and obtain a subsequent registration number to work in a private practice if the applicant meets all requirements for registration.
 - f) States the listed requirements are intended for applicants of a license as a licensed clinical social worker license.
- 6) Changes the name of the Board of Registered Nursing “Diversion Program” to “Intervention Program for Registered Nurses”.
- 7) Removes Canada as the domestic equivalent to the United States in regards to training and clinical experience for acupuncturists.
- 8) Makes the following changes relating to the Dental Hygiene Committee of California (DHCC):
 - a) States that the DHCC is a separate entity from the DBC and must separately create and maintain a central file of the names of persons who hold a license, certificate, or similar authority.
 - b) Removes a deadline date of January 1, 2010.

- c) Repeals fee for examination for licensure as a registered dental hygienist for third and fourth year dental students.
- 9) Makes the following changes relating to the Veterinary Medical Board (VMB):
- a) Allows VMB to deny a veterinary assistant controlled substance permit for specified reasons.
 - b) Removes ability of a person who is under sentence for any criminal offense to petition the Board for reinstatement or modification of penalty.
- 10) Makes the following changes relating to the Telephone Medical Advice Services Bureau:
- a) Removes references to in-state and out-of-state registrants.
 - b) Adds LPCC and naturopathic doctor licensure categories to the list of qualified medical advice licensed health care professionals.
 - c) Adds additional technical, clarifying amendments.

Background

This bill is a “committee bill” authored by the Senate Business, Professions and Economic Development Committee and 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 is designed 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, while other provisions are substantive changes intended to improve the ability of various licensing programs and other entities to efficiently and effectively administer their respective laws.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

SUPPORT: (Verified 9/8/15)

Medical Board of California

OPPOSITION: (Verified 9/8/15)

None received

ARGUMENTS IN SUPPORT: The Medical Board of California supports this bill, noting that these clarifying changes will help to ensure consumer protection and allow the Board to operate in a more efficient manner.

ASSEMBLY FLOOR: 79-0, 9/8/15

AYES: Achadjian, Alejo, Travis Allen, Baker, Bigelow, Bloom, Bonilla, Bonta, Brough, Brown, Burke, Calderon, Campos, Chang, Chau, Chiu, Chu, Cooley, Cooper, Dababneh, Dahle, Daly, Dodd, Eggman, Frazier, Beth Gaines, Gallagher, Cristina Garcia, Eduardo Garcia, Gatto, Gipson, Gomez, Gonzalez, Gordon, Gray, Grove, Hadley, Harper, Roger Hernández, Holden, Irwin, Jones, Jones-Sawyer, Kim, Lackey, Levine, Linder, Lopez, Low, Maienschein, Mathis, Mayes, McCarty, Medina, Melendez, Mullin, Nazarian, Obernolte, O'Donnell, Olsen, Patterson, Perea, Quirk, Rendon, Ridley-Thomas, Rodriguez, Salas, Santiago, Steinorth, Mark Stone, Thurmond, Ting, Wagner, Waldron, Weber, Wilk, Williams, Wood, Atkins

NO VOTE RECORDED: Chávez

Prepared by: Janelle Miyashiro / B., P. & E.D. / (916) 651-4104
9/8/15 21:51:48

**** **END** ****

Senate Bill No. 800

CHAPTER 426

An act to amend Sections 28, 146, 500, 650.2, 800, 1603a, 1618.5, 1640.1, 1648.10, 1650, 1695, 1695.1, 1905.1, 1944, 2054, 2401, 2428, 2529, 2650, 2770, 2770.1, 2770.2, 2770.7, 2770.8, 2770.10, 2770.11, 2770.12, 2770.13, 2835.5, 3057, 3509.5, 4836.2, 4887, 4938, 4939, 4980.399, 4980.43, 4980.54, 4984.01, 4989.34, 4992.09, 4996.2, 4996.22, 4996.28, 4999.1, 4999.2, 4999.3, 4999.4, 4999.5, 4999.7, 4999.45, 4999.46, 4999.55, 4999.76, and 4999.100 of, to amend the heading of Article 3.1 (commencing with Section 2770) of Chapter 6 of Division 2 of, and to repeal Section 1917.2 of, the Business and Professions Code, relating to healing arts.

[Approved by Governor October 1, 2015. Filed with
Secretary of State October 1, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SB 800, Committee on Business, Professions and Economic Development.
Healing arts.

Under existing law, the Department of Consumer Affairs is comprised of various boards that license and regulate the practice of various professions and vocations, including those relating to the healing arts:

(1) Existing law requires persons applying for initial licensure or renewal of a license as a psychologist, clinical social worker, professional clinical counselor, or marriage and family therapist to have completed prescribed coursework or training in child abuse assessment and reporting. Existing law requires the training to have been obtained from an accredited or approved educational institution, a continuing education provider approved by the responsible board, or a course sponsored or offered by a professional association or a local, county, or state department of health or mental health for continuing education and approved by the responsible board.

This bill would require the responsible board to specify a continuing education provider for child abuse assessment and reporting coursework by regulation, and would permit the responsible board to approve or accept a sponsored or offered course.

(2) Existing law relating to unlicensed activity enforcement lists specified provisions that require registration, licensure, certification, or other authorization in order to engage in certain businesses or professions and, notwithstanding any other law, makes a violation of a listed provision punishable as an infraction under specified circumstances.

This bill would include in those listed provisions an existing requirement for the registration of individuals as certified polysomnographic technologists, polysomnographic technicians, and polysomnographic trainees.

(1) Is not currently under investigation nor has been charged with an offense for any act substantially related to the practice of optometry by any public agency, nor entered into any consent agreement or subject to an administrative decision that contains conditions placed by an agency upon a person's professional conduct or practice, including any voluntary surrender of license, nor been the subject of an adverse judgment resulting from the practice of optometry that the board determines constitutes evidence of a pattern of incompetence or negligence.

(2) Has no physical or mental impairment related to drugs or alcohol, and has not been found mentally incompetent by a licensed psychologist or licensed psychiatrist so that the person is unable to undertake the practice of optometry in a manner consistent with the safety of a patient or the public.

SEC. 33. Section 3509.5 of the Business and Professions Code is amended to read:

3509.5. The board shall elect annually a president and a vice president from among its members.

SEC. 34. Section 4836.2 of the Business and Professions Code is amended to read:

4836.2. (a) Applications for a veterinary assistant controlled substance permit shall be upon a form furnished by the board.

(b) The fee for filing an application for a veterinary assistant controlled substance permit shall be set by the board in an amount the board determines is reasonably necessary to provide sufficient funds to carry out the purposes of this section, not to exceed one hundred dollars (\$100).

(c) The board may suspend or revoke the controlled substance permit of a veterinary assistant after notice and hearing for any cause provided in this subdivision. The proceedings under this section shall be conducted in accordance with the provisions for administrative adjudication in Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the board shall have all the powers granted therein. The board may deny, revoke, or suspend a veterinary assistant controlled substance permit for any of the following reasons:

(1) The employment of fraud, misrepresentation, or deception in obtaining a veterinary assistant controlled substance permit.

(2) Chronic inebriety or habitual use of controlled substances.

(3) The veterinary assistant to whom the permit is issued has been convicted of a state or federal felony controlled substance violation.

(4) Violating or attempts to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter, or of the regulations adopted under this chapter.

(d) The board shall not issue a veterinary assistant controlled substance permit to any applicant with a state or federal felony controlled substance conviction.

(e) (1) As part of the application for a veterinary assistant controlled substance permit, the applicant shall submit to the Department of Justice fingerprint images and related information, as required by the Department of Justice for all veterinary assistant applicants, for the purposes of obtaining

AB 12



California
LEGISLATIVE INFORMATION

AB-12 State government: administrative regulations: review. (2015-2016)

Senate: 1st Cmt

Assembly: 1st Cmt 2nd 3rd Pass

Bill Status	
Measure:	AB-12
Lead Authors:	Cooley (A)
Principal Coauthors:	-
Coauthors:	Chang (A) , Daly (A) , Huff (S) , Wilk (A)
Topic:	State government: administrative regulations: review.
31st Day in Print:	01/01/15
Title:	An act to add and repeal Chapter 3.6 (commencing with Section 11366) of Part 1 of Division 3 of Title 2 of the Government Code, relating to state agency regulations.
House Location:	Senate
Last Amended Date:	08/19/15
Committee Location:	Sen Appropriations

Type of Measure
Active Bill - In Committee Process
Majority Vote Required
Non-Appropriation
Fiscal Committee
Non-State-Mandated Local Program
Non-Urgency
Non-Tax levy

Last 5 History Actions	
Date	Action
08/27/15	In committee: Held under submission.
08/24/15	In committee: Referred to APPR. suspense file.
08/19/15	From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on APPR.
08/17/15	In committee: Hearing postponed by committee.
07/14/15	From committee: Do pass and re-refer to Com. on APPR. (Ayes 13. Noes 0.) (July 14). Re-referred to Com. on APPR.

SENATE COMMITTEE ON APPROPRIATIONS

Senator Ricardo Lara, Chair
2015 - 2016 Regular Session

AB 12 (Cooley) - State government: administrative regulations: review

Version: April 22, 2015

Policy Vote: G.O. 13 - 0

Urgency: No

Mandate: No

Hearing Date: August 24, 2015

Consultant: Mark McKenzie

This bill meets the criteria for referral to the Suspense File.

Bill Summary: AB 12 would require every state agency to review all provisions of the California Code of Regulations (CCR) it has adopted, and to adopt, amend, or repeal any regulations identified as duplicative, overlapping, or out of date by January 1, 2018.

Fiscal Impact:

- Office of Administrative Law (OAL) costs of approximately \$744,000 in the 2016 calendar year and approximately \$695,000 in 2017 for 7 PY of full-time, limited-term staff and associated costs to manage a significant increase in workload over two years. (General Fund)
- Unknown, major aggregate state costs, likely in the millions and potentially over ten million annually for two years, for over 200 state agencies to review all current regulations, make necessary revisions to identified regulations through the Administrative Procedure Act (APA) process, coordinate with other agencies and departments, and report to the Governor and Legislature. (General Fund and various special funds)

Background: The Administrative Procedures Act (APA) requires the Office of Administrative Law to ensure that state agency regulations are clear, necessary, legally valid, and available to the public. In seeking adoption of a proposed regulation, state agencies must comply with procedural requirements that include publishing the proposed regulation along with a supporting statement of reasons, mailing and publishing a notice of the proposed action 45 days before a hearing or before the close of the public comment period, and submitting a final statement to OAL that summarizes and responds to all objections, recommendations and proposed alternatives raised during the public comment period. The OAL is then required to approve or reject the proposed regulation within 30 days.

The OAL is responsible for reviewing administrative regulations proposed by over 200 state regulatory agencies for compliance with the standards set forth in the APA, for transmitting these regulations to the Secretary of State and for publishing regulations in the California Code of Regulations (CCR). On average, OAL reviews nearly 600 files that affect approximately 4,000 regulations packages per year. In 2014, 4,761 proposed regulations were submitted by state agencies for APA review. There are currently nearly 53,000 active regulations in the CCR.

Existing law requires OAL, at the request of any standing, select, or joint committee of the Legislature, to initiate a priority review of any regulation that committee believes does not meet the standards of necessity, authority, clarity, reference, and nonduplication. If OAL is made aware of an existing regulation for which statutory authority has been repealed or becomes ineffective, it must order the agency that adopted the regulation to show cause why it should not be repealed, and notify the Legislature of the order.

Proposed Law: AB 12 would require each state agency, as defined, to review all provisions of the California Code of Regulations (CCR) adopted by that agency and adopt, amend, or repeal regulations identified as duplicative, overlapping, inconsistent, or out of date. An agency acting on this requirement must hold at least one noticed public meeting to accept public comment, and notify the appropriate committees of the Legislature of the proposed revisions to regulations prior to initiating the APA process. Each state agency must also report to the Governor and Legislature on the number and content of regulations identified as duplicative, overlapping, inconsistent, or out of date, and the agency's actions to address those regulations. Each agency must complete all of these duties by January 1, 2018.

The bill also requires each cabinet-level agency, by January 1, 2018, to notify departments, boards, or other units within the agency of any regulations it has adopted that may be duplicative, overlapping, or inconsistent with a regulation adopted by another department, board, or unit within the agency. A department within an agency must notify that agency of any proposed revisions to regulations at least 90 days prior to the specified noticed public hearing noted above, and the agency must review the proposal and make recommendations to the department within 30 days. Cabinet-level agencies must also notify other agencies of existing regulations that may duplicate, overlap, or be inconsistent with that agency's regulations.

The bill's provisions would sunset on January 1, 2019.

Related Legislation: SB 981 (Huff), which was held in the Senate Governmental Organization Committee in 2014, would have required state agencies to review regulations adopted in the past and report specified information on each regulation to the Legislature, including whether a regulation is duplicative, still relevant, or needs to be updated to be less burdensome or more effective.

SB 366 (Calderon), which was referred to the Senate Governmental Organization Committee in 2011 but never heard, included provisions that were nearly identical to the introduced version of this bill.

Staff Comments: This bill is intended to implement a recommendation from an October, 2011 Little Hoover Commission Report entitled *Better Regulation: Improving California's Rulemaking Process*. Among the Commission's recommendations was a suggestion that the state establish a "look-back" mechanism to determine if regulations are effective and still necessary.

The last comprehensive review of state agency regulations occurred when OAL was established in 1980. At that time there were over 125 state agencies and over 40,000 regulations printed in the CCR, and today there are over 200 agencies and nearly

53,000 regulations. In addition, OAL had a staff of 50 employees, including 17 attorneys, while they currently have a staff of 20, half of which are attorneys. OAL anticipates it would need an additional five attorneys and two support staff on a full-time, limited-term basis to manage the significant increase in workload to ensure compliance with the APA for state agency proposals to adopt, amend, or repeal regulations over the next two years. Anticipated staff costs are noted above.

AB 12 would impose significant costs on every state office, department, board, bureau, and commission to review all regulations that each entity has in the CCR, and adopt, amend, or repeal any that are identified as duplicative, overlapping, inconsistent, or outdated. The bill would also require cabinet-level agencies to review the regulations of all of their constituent entities and notify them of any duplication, inconsistency, or overlap with the regulations of one of its other constituent entities. Costs are difficult to quantify in the aggregate since there are over 200 entities that must review regulations, and costs and staffing needs would vary for each of them. For individual agencies, costs could be relatively minor for smaller state entities that have few regulations in the CCR, but likely in the low hundreds of thousands annually for two years for many other agencies that have more, and/or more complex regulations on the books. Some state entities may have costs that exceed \$1 million for each of the next two years.

-- END --

AMENDED IN SENATE AUGUST 19, 2015
AMENDED IN ASSEMBLY APRIL 22, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 12

Introduced by Assembly Member Cooley
(Coauthors: Assembly Members Chang, Daly, and Wilk)
(Coauthor: Senator Huff)

December 1, 2014

An act to add and repeal Chapter 3.6 (commencing with Section 11366) of Part 1 of Division 3 of Title 2 of the Government Code, relating to state agency regulations.

LEGISLATIVE COUNSEL'S DIGEST

AB 12, as amended, Cooley. State government: administrative regulations: review.

Existing law authorizes various state entities to adopt, amend, or repeal regulations for various specified purposes. The Administrative Procedure Act requires the Office of Administrative Law and a state agency proposing to adopt, amend, or repeal a regulation to review the proposed changes for, among other things, consistency with existing state regulations.

This bill would, until January 1, 2019, require each state agency to, on or before January 1, 2018, review that agency's regulations, identify any regulations that are duplicative, overlapping, inconsistent, or out of date, to revise those identified regulations, as provided, and report to the Legislature and Governor, 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:

1 SECTION 1. Chapter 3.6 (commencing with Section 11366)
2 is added to Part 1 of Division 3 of Title 2 of the Government Code,
3 to read:

4
5 CHAPTER 3.6. REGULATORY REFORM

6
7 Article 1. Findings and Declarations

8
9 11366. The Legislature finds and declares all of the following:

10 (a) The Administrative Procedure Act (Chapter 3.5 (commencing
11 with Section 11340), Chapter 4 (commencing with Section 11370),
12 Chapter 4.5 (commencing with Section 11400), and Chapter 5
13 (commencing with Section 11500)) requires agencies and the
14 Office of Administrative Law to review regulations to ensure their
15 consistency with law and to consider impacts on the state’s
16 economy and businesses, including small businesses.

17 (b) However, the act does not require agencies to individually
18 review their regulations to identify overlapping, inconsistent,
19 duplicative, or out-of-date regulations that may exist.

20 (c) At a time when the state’s economy is slowly recovering,
21 unemployment and underemployment continue to affect all
22 Californians, especially older workers and younger workers who
23 received college degrees in the last seven years but are still awaiting
24 their first great job, and with state government improving but in
25 need of continued fiscal discipline, it is important that state
26 agencies systematically undertake to identify, publicly review, and
27 eliminate overlapping, inconsistent, duplicative, or out-of-date
28 regulations, both to ensure they more efficiently implement and
29 enforce laws and to reduce unnecessary and outdated rules and
30 regulations.

31
32 Article 2. Definitions

33
34 11366.1. For the purposes of this chapter, the following
35 definitions shall apply:

36 (a) “State agency” means a state agency, as defined in Section
37 11000, except those state agencies or activities described in Section
38 11340.9.

1 (b) "Regulation" has the same meaning as provided in Section
2 11342.600.

3
4 Article 3. State Agency Duties
5

6 11366.2. On or before January 1, 2018, each state agency shall
7 do all of the following:

8 (a) Review all provisions of the California Code of Regulations
9 ~~applicable to, or adopted by,~~ *adopted by* that state agency.

10 (b) Identify any regulations that are duplicative, overlapping,
11 inconsistent, or out of date.

12 (c) Adopt, amend, or repeal regulations to reconcile or eliminate
13 any duplication, overlap, inconsistencies, or out-of-date provisions,
14 and shall comply with the process specified in Article 5
15 (commencing with Section 11346) of Chapter 3.5, unless the
16 addition, revision, or deletion is without regulatory effect and may
17 be done pursuant to Section 100 of Title 1 of the California Code
18 of Regulations.

19 (d) Hold at least one noticed public hearing, ~~that~~ *which* shall be
20 noticed on the Internet Web site of the state agency, for the
21 purposes of accepting public comment on proposed revisions to
22 its regulations.

23 (e) Notify the appropriate policy and fiscal committees of each
24 house of the Legislature of the revisions to regulations that the
25 state agency proposes to make at least 30 days prior to initiating
26 the process under Article 5 (commencing with Section 11346) of
27 Chapter 3.5 or Section 100 of Title 1 of the California Code of
28 Regulations.

29 (g) (1) Report to the Governor and the Legislature on the state
30 agency's compliance with this chapter, including the number and
31 content of regulations the state agency identifies as duplicative,
32 overlapping, inconsistent, or out of date, and the state agency's
33 actions to address those regulations.

34 (2) The report shall be submitted in compliance with Section
35 9795 of the Government Code.

36 11366.3. (a) On or before January 1, 2018, each agency listed
37 in Section 12800 shall notify a department, board, or other unit
38 within that agency of any existing regulations adopted by that
39 department, board, or other unit that the agency has determined
40 may be duplicative, overlapping, or inconsistent with a regulation

1 adopted by another department, board, or other unit within that
2 agency.

3 (b) A department, board, or other unit within an agency shall
4 notify that agency of revisions to regulations that it proposes to
5 make at least 90 days prior to a noticed public hearing pursuant to
6 subdivision (d) of Section 11366.2 and at least 90 days prior to
7 adoption, amendment, or repeal of the regulations pursuant to
8 subdivision (c) of Section 11366.2. The agency shall review the
9 proposed regulations and make recommendations to the
10 department, board, or other unit within 30 days of receiving the
11 notification regarding any duplicative, overlapping, or inconsistent
12 regulation of another department, board, or other unit within the
13 agency.

14 11366.4. An agency listed in Section 12800 shall notify a state
15 agency of any existing regulations adopted by that agency that
16 may duplicate, overlap, or be inconsistent with the state agency's
17 regulations.

18 11366.45. This chapter shall not be construed to weaken or
19 undermine in any manner any human health, public or worker
20 rights, public welfare, environmental, or other protection
21 established under statute. This chapter shall not be construed to
22 affect the authority or requirement for an agency to adopt
23 regulations as provided by statute. Rather, it is the intent of the
24 Legislature to ensure that state agencies focus more efficiently and
25 directly on their duties as prescribed by law so as to use scarce
26 public dollars more efficiently to implement the law, while
27 achieving equal or improved economic and public benefits.

28

29

Article 4. Chapter Repeal

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31 11366.5. This chapter shall remain in effect only until January
32 1, 2019, and as of that date is repealed, unless a later enacted
33 statute, that is enacted before January 1, 2019, deletes or extends
34 that date.