Date of Hearing: August 30, 2026

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 1811 (Rogers) – As Amended August 20, 2026

NOTE: This bill is being heard pursuant to Assembly Rule 77.2 for concurrence in Senate amendments only.

SUBJECT: Health professionals.

SUMMARY: Expands existing requirements for healing arts boards to collect workforce data from their licensees and registrants, requires that workforce data to be provided more regularly to the Department of Health Care Access and Information (HCAI), and establishes a statutory definition of health professional shortage area (HPSA) for purposes of state law and regulation.

EXISTING LAW:

1) Establishes the Department of Consumer Affairs (DCA) within the Business and Consumer Services Agency. (Business and Professions Code (BPC) §§ 100 *et seq.*)

2) Enumerates various regulatory boards, bureaus, and other entities within the jurisdiction of the DCA. (BPC § 101)

3) Requires information retained by each board under the DCA relating to license applicants with criminal records to include the final disposition and demographic information, consisting of voluntarily provided information on race or gender. (BPC § 480(g))

4) Establishes "healing arts" boards within the jurisdiction of DCA, which includes the following entities:

    a) Acupuncture Board;

    b) Board of Behavioral Sciences;

    c) State Board of Chiropractic Examiners;

    d) Dental Board of California;

    e) Dental Hygiene Board of California;

    f) Medical Board of California;

    g) California Board of Naturopathic Medicine;

    h) California Board of Occupational Therapy;

    i) California Board of Optometry;

    j) Osteopathic Medical Board of California;

k) California State Board of Pharmacy;

l) Physical Therapy Board of California;

m) Physician Assistant Board;

n) Podiatric Medical Board of California;

o) Board of Psychology;

p) Board of Registered Nursing;

q) Respiratory Care Board of California;

r) Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board;

s) Veterinary Medical Board;

t) Board of Vocational Nursing and Psychiatric Technicians.

(BPC §§ 500 *et seq.*)

5) Requires the Board of Registered Nursing, the Board of Vocational Nursing and Psychiatric Technicians, the Physician Assistant Board, and the Respiratory Care Board of California to collect specified workforce data from their respective licensees and registrants for future workforce planning at least biennially, with data collected at the time of electronic license or registration renewal as applicable. (BPC § 502(a)(1))

6) Provides that all other healing arts boards shall request the specified workforce data for future workforce planning at least biennially, with data collected at the time of electronic license or registration renewal, as applicable. (BPC § 502(a)(2))

7) Specifies the following information as included within the workforce data collected or requested by healing arts boards:

a) Anticipated year of retirement.

b) Area of practice or specialty.

c) City, county, and ZIP Code of practice.

d) Date of birth.

e) Educational background and the highest level attained at time of licensure or registration.

f) Gender or gender identity.

g) Hours spent in direct patient care, including telehealth hours as a subcategory, training, research, and administration.

h) Languages spoken.

i) National Provider Identifier.

j) Race or ethnicity.

k) Type of employer or classification of primary practice site among the types of practice sites specified by the board, including, but not limited to, clinic, hospital, managed care organization, or private practice.

l) Work hours.

m) Sexual orientation.

n) Disability status.

(BPC § 502(b))

8) Requires each board to maintain the confidentiality of the information it receives from licensees and registrants and to only release information in an aggregate form that cannot be used to identify an individual. (BPC § 502(c))

9) Requires the DCA, in consultation with HCAI, to specify for each board the specific information and data that will be collected or requested. (BPC § 502(d))

10) Requires each board, or the DCA on its behalf, to provide the workforce data it collects to HCAI on a quarterly basis in a manner directed by HCAI, including license or registration number and associated license or registration information. (BPC § 502(e))

11) Prohibits boards from requiring a licensee or registrant to provide the workforce data as a condition for license or registration renewal, or from disciplining licensees or registrants for not providing the information. (BPC § 502(f))

12) Requires each healing arts board within the DCA to require its licensees or registrants who electronically renew their license or registration to provide to that board the licensee's or registrant's individual National Provider Identifier, if they have one. (BPC § 850.2)

13) Requires licensed dentists to report to the Dental Board of California, upon initial licensure and any subsequent application for renewal, the licensee's practice status and any completed advanced educational program, as well as information regarding the licensee's cultural background and foreign language proficiency if voluntarily reported by the applicant or licensee. (BPC § 1715.5)

14) Requires licensed dental hygienists to the Dental Hygiene Board, upon initial licensure and any subsequent application for renewal, the licensee's practice or employment status, as well as information regarding the licensee's cultural background and foreign language proficiency if reported by the licensee. (BPC § 1902.2)

15) Requires licensed physicians and surgeons to report to the Medical Board of California (MBC), immediately upon issuance of an initial license and at the time of license renewal, their practice status and any specialty board certification they hold, along with information relating to their cultural background and foreign language proficiency unless the licensee declines to provide that information. (BPC § 2425.3)

16) Requires licensed osteopathic physicians and surgeons to report to the Osteopathic Medical Board of California (OMBC), either immediately upon issuance of an initial license or at the time of renewal, as provided, any specialty board certification they hold and their practice status, along with information relating to their cultural background and foreign language proficiency if reported by the licensee. (BPC § 2455.2)

17) Requires the Board of Registered Nursing to incorporate regional forecasts into its biennial analyses of the nursing workforce and to develop a plan to address shortages. (BPC § 2717)

18) Establishes HCAI, previously established as the Office of Statewide Health Planning and Development, within the state Health and Human Services Agency, and provides HCAI with responsibilities related to health planning and research development. (Health and Safety Code (HSC) §§ 127000 *et seq.*)

19) Requires HCAI to establish a health care workforce research and data center to serve as the central source of health care workforce and educational data in the state. (HSC § 128050)

20) Requires HCAI to work with the Employment Development Department's Labor Market Information Division, state licensing boards, and state higher education entities to collect, to the extent available, all of the following data:

    a) The current supply of health care workers, by specialty.

    b) The geographical distribution of health care workers, by specialty.

    c) The diversity of the health care workforce, by specialty, including, but not necessarily limited to, data on race, ethnicity, and languages spoken.

    d) The current and forecasted demand for health care workers, by specialty.

    e) The educational capacity to produce trained, certified, and licensed health care workers, by specialty and by geographical distribution, including, but not necessarily limited to, the number of educational slots, the number of enrollments, the attrition rate, and wait time to enter the program of study.

    (HSC § 128051)

21) Requires HCAI to prepare an annual report to the Legislature that does all of the following:

    a) Identifies education and employment trends in the health care profession.

    b) Reports on the current supply and demand for health care workers in California and gaps in the educational pipeline producing workers in specific occupations and geographic areas.

    c) Recommends state policy needed to address issues of workforce shortage and distribution.

    d) Describes the health care workforce program outcomes and effectiveness.

    (HSC § 128052)

22) Defines "medically underserved area" as an area defined under federal regulation as a HPSA or an area of the state where unmet priority needs for physicians exist as determined by HCAI. (HSC § 128552)

THIS BILL:

1) Specifies that licensees and registrants must report required workforce information at the time the license or registration is issued and then at least biennially thereafter.

2) Requires workforce data collected by healing arts boards to be reported to HCAI monthly, rather than quarterly.

3) Adds the following information to the workforce data collected or requested from licensees and registrants by their respective healing arts boards:

   a) Primary and secondary area of practice or specialty.

   b) Hours worked in inpatient care.

   c) Hours worked in outpatient care.

   d) Hours worked providing direct outpatient primary care services.

   e) Whether the licensee or registrant accepts Medicaid.

   f) Whether the licensee or registrant offers a formal sliding fee scale.

4) Defines "health professional shortage area" for the purpose of state law and regulation as meaning all of the following:

   a) A HPSA designated or recognized by the United States Department of Health and Human Services.

   b) An area designated or recognized as a HPSA by the United States Department of Health and Human Services on January 1, 2025, regardless of whether that area remains designated or recognized by the United States Department of Health and Human Services as a HPSA.

   c) An area determined by HCAI to have a shortage of health professionals.

5) Authorizes HCAI to revoke a HPSA designation it previously designated.

6) Provides that for purposes of state law or regulation, any reference to a HPSA, including, but not limited to, references qualified as referring to health professional shortage areas designated or recognized by a federal agency, shall be deemed to refer to the definition established in the bill.

7) Subjects the statute establishing a definition of HPSA to repeal on January 1, 2035.

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

COMMENTS:

Purpose. This bill is co-sponsored by the *Association of California Healthcare Districts* and *Rural County Representatives of California*. According to the author:

> HPSA designations are a critical tool for identifying where resources and workforce programs are most needed to serve underserved populations. In the author's district, there are many rural clinics and hospitals at risk of having their designation withdrawn. By safeguarding and expanding HPSA eligibility, this bill helps reduce health disparities, protect rural and tribal health infrastructure, and ensure that vulnerable communities continue to receive essential health and mental health services. This bill ensures that these areas remain eligible for state programs that place physicians and other health professionals where they are needed most.

Background.

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

Compounding these issues of access is a significant lack of diversity among health care practitioners, with several minority groups remaining persistently underrepresented within the healing arts fields. A recent study of data from the American Community Survey and the Integrated Postsecondary Education Data System found that Black, Hispanic, and Native American people are nationally represented across 10 different health care professions.[2] As a result, minorities seeking to enter these professions face significant systemic obstacles, and patients who are representative of minority groups or immigrant communities often do not have access to practitioners who possess the cultural or linguistic competence to provide them with appropriate care.

Research cited by the California Health Care Foundation (CHCF) in its 2021 report "Health Workforce Strategies for California: A Review of the Evidence" found that while 39 percent of Californians identified as Latino/x in 2019, only 14 percent of medical school matriculants and 6 percent of active patient care physicians in California were Latino/x.[3] A 2018 study published by the Latino Policy & Politics Initiative at the University of California, Los Angeles found that while nearly 44 percent of the California population speaks a language other than English at home, many of the most commonly spoken languages are underrepresented by the physician workforce.[4] While the physician community has worked with the MBC to improve linguistic competency among providers, these efforts have yet to resolve systemic challenges with addressing language barriers in California.

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[1] Liu M, Wadhera RK. *Primary Care Physician Supply by County-Level Characteristics*, 2010-2019.
[2] Salsberg, Edward *et al*. "Estimation and Comparison of Current and Future Racial/Ethnic Representation in the US Health Care Workforce." *JAMA network open* vol. 4,3 e213789. 1 March 2021.
[3] https://www.chcf.org/publication/health-workforce-strategies-california
[4] https://latino.ucla.edu/wp-content/uploads/2019/08/The_Patient_Perspective-UCLA-LPPI-Final.pdf

Another issue resulting from underrepresentation in the health professions relates to implicit bias. According to the Stanford Encyclopedia of Philosophy, "implicit bias" can be described as "a term of art referring to relatively unconscious and relatively automatic features of prejudiced judgment and social behavior." In her 2019 book *Biased: Uncovering the Hidden Prejudice That Shapes What We See, Think, and Do*, Dr. Jennifer L. Eberhardt explains that "implicit bias is not a new way of calling someone a racist. In fact, you don't have to be a racist at all to be influenced by it. Implicit bias is a kind of distorting lens that's a product of both the architecture of our brain and the disparities in our society." Dr. Eberhardt goes on to describe how "bias is not limited to one domain of life. It is not limited to one profession, one race, or one country. It is also not limited to one stereotypic association."[5]

In December 2015, the American Journal of Public Health published a systematic review titled *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes*. The review concluded that "most health care providers appear to have implicit bias in terms of positive attitudes toward whites and negative attitudes toward people of color." Additional published studies suggest that implicit bias in regards to gender, sexual orientation and identity, and other characteristics has resulted in inconsistent diagnoses and courses of treatment being provided to patients based on their respective demographic. These trends take into account not only the characteristics of the person being treated, but those of the licensed professional in correlation to that patient.

Implicit bias can have serious consequences in the provision of health care. For example, one frequently cited statistic is that Black women have average maternal mortality rates that are three-to-four times higher than white women. While much of the research and action relating to implicit bias has been focused on the area of law enforcement and police procedure, there has been a growing call to also address the presence of implicit bias in the healing arts professions through additional awareness and training. In 2019, the Legislature enacted Assembly Bill 241 (Kamlager-Dove) to require continuing education courses for physicians and surgeons, nurses, and physician assistants to include the understanding of implicit bias and the promotion of bias-reducing strategies. While implementation of these requirements has undoubtedly had at least some impact on improving health care outcomes for minority patients, education and training is not a substitute for increasing diversity and representation among providers.

In February 2024, the Assembly Committee on Health held an informational hearing focused on Diversity in California's Health Care Workforce. This hearing included perspectives from various stakeholders and public health researchers, along with policymakers who provided updates on the state's efforts to increase diversity. The background paper for the hearing cited research published in December 2022 by the Fitzhugh Mullan Institute for Health Workforce Equity at George Washington University in a report titled "The Race and Ethnicity of the California Health Care Workforce," which demonstrated that "a health workforce that reflects the racial and ethnic diversity of the population can improve access to, quality of, and outcomes of care."[6] As explained in the background paper, underrepresentation in the health care workforce both "contributes to health disparities" and "limits access to high-paying, meaningful professions for underrepresented minorities."

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[5] Eberhardt, Jennifer L. *Biased: Uncovering the Hidden Prejudice That Shapes What We See, Think, and Do.* New York: Viking, 2019.

[6] Bogucki C, Brantley E, Salsberg E. "The Race and Ethnicity of the California Health Workforce." Fitzhugh Mullan Institute for Health Workforce Equity. Washington, DC: George Washington University, 2022.

Health Care Workforce Data Collection. California has historically attempted to resolve longstanding issues of health care professional representation and access through a number of different approaches. For example, the Legislature has previously enacted and funded loan repayment programs, such as the Dental Corps Loan Repayment Program of 2002, which provided grants to qualifying dentists who agreed to work for at least three years in a clinic or dental practice located in a dentally unserved area, or in which at least 50 percent of patients are from a dentally underserved population. The Health Professions Career Opportunity Program within HCAI similarly supports initiatives designed to enhance diversity and representation in the health professions by awarding grant funding through competitive programs.

As discussed in the Health Committee's background paper, it is often challenging to evaluate the long-term impacts of these programs, as "HCAI does not currently collect longitudinal data that could demonstrate which of these programs are more effective." During joint sunset review oversight hearings on healing arts boards in 2024, committee members expressed frustration that there was not sufficient data to confirm whether any particular strategy to improve access has been successful. This is in large part due to a lack of consistent data from healing arts licensees to inform policymakers about how many practitioners of particular specialties are providing services in any given area of the state, or about the demographic makeup of those practitioners.

The California Health Workforce Research and Data Center, previously established in 2007 as the Healthcare Workforce Clearinghouse under the prior Office of Statewide Health Planning and Development, serves as California's central source for collection, analysis, and reporting of information on the healthcare workforce employment and educational data trends for the state. As part of its statutory duties, HCAI is mandated to prepare an annual report to the Legislature that accomplishes the following three goals: (1) identifying education and employment trends in the health care professions (2) reporting on the current supply and demand for health care workers in California and gaps in the educational pipeline producing workers in specific occupations and geographic areas; and (3) recommending state policy needed to address issues of workforce shortage and distribution.

In 2014, the Legislature enacted Assembly Bill 2102, authored by Assemblymember Phil Ting and co-sponsored by the California Pan-Ethnic Health Network and the Latino Coalition for a Healthy California. The bill required four specified healing arts boards—the Board of Registered Nursing, the Physician Assistant Board, the Respiratory Care Board of California, and the Board of Vocational Nursing and Psychiatric Technicians—to collect and report specific demographic data related to its licensees. Specifically, AB 2102 mandated that the four boards collect the following data from licensees: (1) location of practice, including city, county, and zip Code; (2) race or ethnicity; (3) gender; (4) languages spoken; (5) educational background and (6) classification of primary practice site, such as clinic, hospital, managed care organization, or private practice. In order to implement AB 2102, the DCA and HCAI established an interagency agreement to facilitate the specified data collection and exchange.

Assemblymember Ting subsequently introduced Assembly Bill 2704 in 2020, which sought to replace the distinct data collection requirements for the four healing arts boards with a single statute requiring data collection for all healing arts boards. The bill ultimately was not set for a hearing in this committee. The next year, Assemblymember Ting reintroduced the bill as Assembly Bill 1236, adding sexual orientation and disability status to the list of required data points. This bill was ultimately not presented by the author on the Assembly floor.

Instead, language was included in the omnibus health trailer bill as part of the Budget Act of 2021 consolidating the existing workforce data collection requirements for the four healing arts boards into one section with an expanded list of data points. However, the trailer bill did not require this data to be collected by any additional boards under the DCA; instead, it provided that all other healing arts boards *request* the information. The trailer bill also expressly provided that licensees could not be required to provide the information as a condition for license renewal, and that they could not be disciplined for failing to provide the information.

In 2024, AB 1991 (Bonta) was introduced to amend the consolidated workforce data collection law enacted through the trailer bill to require all healing arts boards to collect the workforce data and report it to HCAI. The author cited recommendations in a 2019 report by the California Future Health Workforce Commission, which included among its goals an objective to "expand and scale pipeline programs to recruit and prepare students from underrepresented and low-income backgrounds for health careers." However, following opposition from certain physician specialty associations, the bill was subsequently amended to simply require healing arts licensees or registrants to provide their National Provider Identifier, if they have one.

This bill would expand the existing workforce data collection laws in several ways. First, it would require data to be submitted to boards at the time of issuance, in addition to renewal, and would require boards to report that data to HCAI monthly rather than quarterly. The bill would then add several new data points to the survey, including hours worked in inpatient care, outpatient care, and direct outpatient primary care services, and whether the licensee or registrant accepts Medicaid or offers a formal sliding fee scale. The bill would not place new requirements on any licensees or registrants whose reporting is currently voluntary, but the data that is collected would now include information that could be valuable to researchers and policymakers aiming to increase access to care in the state.

Health Professional Shortage Areas. A HPSA is a federally recognized geographic area, population group, or health care facility that has been determined to have an insufficient supply of health professionals. HPSAs are designated by the federal Health Resources and Services Administration (HRSA) under criteria established in federal law and regulation. Specific HPSA designations exist for primary care, dental health, or mental health care.

While HPSA is a federal designation, it is frequently used in the context of state policies intended to increase access to care. Current law defines "medically underserved area" (MUA) as an area defined as a HPSA, or an area of the state that HCAI determines to have unmet priority needs for physicians. This MUA definition is then used in connection with a number of state laws; for example, the MBC and the OMBC are both required to give priority review status to applicants who can demonstrate that they intend to practice in an MUA. Other laws reference HPSA directly; for example, registered dental hygienists in alternative practice are authorized to independently practice only in specified settings, including a certified dental HPSA.

In September 2025, HRSA's National Shortage Designation Update raised concerns regarding the accuracy of provider and demographic data and the methodology used to evaluate HPSA designations in California. As a result, HRSA placed numerous California HPSAs in "Proposed for Withdrawal" status, including 306 of approximately 400 existing designations. HCAI has worked to review and correct the underlying data and submit updates to HRSA to ensure that communities that continue to meet federal criteria retain their HPSA designations.

The challenging timelines for reviewing proposed withdrawals and submitting corrective information to HRSA has placed significant demands on HCAI. Meanwhile, state laws and programs aimed at promoting health care workforce expansion efforts and supporting health care providers in low-access areas are at serious risk of being undermined if HPSA designations are withdrawn. This bill would ensure that existing HPSA designations are preserved notwithstanding federal actions by defining "health professional shortage area" for purposes of California law as including an area was previously federally designated or recognized as a HPSA on January 1, 2025, regardless of whether that area remains designated or recognized by HRSA. HCAI would also be able to designate additional HPSAs for areas determined to have a shortage of health professionals, and could revoke any designation not currently recognized federally. The bill would sunset on January 1, 2035; in the meantime, the author believes that allowing HPSAs in California to maintain their status regardless of what occurs on the federal level will provide for stability and safeguard successful programs to increase and preserve access to care.

Current Related Legislation. SB 1271 (Reyes) would require the MBC to work with HCAI to collect information regarding the eligibility and availability of licensed midwives to serve as clinical preceptors for midwifery students. *This bill is pending on the Senate Floor.*

Prior Related Legislation. AB 1991 (Bonta), Chapter 369, Statutes of 2024 required all healing arts boards under the DCA to require their licensees or registrants who electronically renews their license or registration to provide to that board the licensee's or registrant's individual National Provider Identifier, if they have one.

AB 133 (Committee on Budget), Chapter 143, Statutes of 2021 consolidated workforce data collection requirements and requires all healing arts boards to request, if not require, that data.

AB 1236 (Ting) of 2021 would have consolidated workforce data collection requirements and required all healing arts boards to collect that data. *This bill died on the inactive file of the Assembly Floor.*

AB 2704 (Ting) of 2020 would have consolidated workforce data collection requirements and required all healing arts boards to collect that data. *This bill was not set for a hearing in this committee.*

AB 2102 (Ting), Chapter 420, Statutes of 2014 required four specified healing arts boards to collect and report specific demographic data related to its licensees.

AB 1288 (Pérez), Chapter 307, Statutes of 2013 required the MBC and the OMBC to give priority review status to applicants who can demonstrate that they intend to practice in a medically underserved area or serve a medically underserved population.

ARGUMENTS IN SUPPORT:

This bill's co-sponsors, the *Rural County Representatives of California* (RCRC) and the *Association of California Healthcare Districts* (ACHD), write jointly with numerous other organizations in support of this bill: "In 2026, 285 of approximately 5,000 California HPSA designations are proposed for withdrawal, despite continued workforce shortages in those areas. Assembly Bill 1811 would preserve HPSA designations held as of January 1, 2025, through January 1, 2035, for purposes of state benefits, incentives, and resource prioritization, and would authorize the Department of Health Care Access and Information to authorize new HPSAs.

Without state action, the loss of these designations will jeopardize access to critical programs for healthcare providers in underserved areas. In addition, the bill requires the collection of additional workforce data in the re-licensing surveys for health care professionals, to help ensure that HCAI has all the information required to verify HPSA designations for the federal government."

ARGUMENTS IN OPPOSITION:

There is no opposition on file.

REGISTERED SUPPORT:

Association of California Healthcare Districts *(Co-Sponsor)*
Rural County Representatives of California *(Co-Sponsor)*
Adventist Health
AltaMed Health Services
Antelope Valley Medical Center
California Academy of Family Physicians
California Association of Health Facilities
California Democratic Party
California Democratic Party Rural Caucus
California Dental Hygienists' Association
California Hospital Association
California Special Districts Association
California State Association of Counties
Del Puerto Health Care District
Desert Healthcare District and Foundation
District Hospital Leadership Forum
Eden Health District
Fallbrook Regional Health District
Healthy Petaluma District and Foundation
Inland Empire Health Plan Foundation
LeadingAge California
Mayers Memorial Healthcare District
Medical Board of California
Plumas District Hospital
Private Essential Access Community Hospitals
Providence
Salinas Valley Health
San Bernardino Mountains Community Hospital District
Sequoia Healthcare District
Sierra View Health Care District
Soledad Community Health Care District

REGISTERED OPPOSITION:

None on file

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