ASSEMBLY THIRD READING
AB 2311 (Schiavo)
As Introduced February 19, 2026
Majority vote

SUMMARY

Authorizes a health care district, as defined, or a nonprofit corporation with a health care district as its sole corporate member, that owns or controls a general acute care hospital to employ licensees and charge for professional services rendered by those licensees. Prohibits the health care district from interfering with, controlling, or directing the professional judgement of a physician and surgeon.

COMMENTS

Overview of corporate practice of medicine (CPM) laws. CPM laws vary significantly across the United States. While some states, such as California, New York, North Carolina, and Texas strictly regulate corporate involvement in medical practice, others have more permissive or ambiguous rules. These laws aim to protect the independence of medical professionals and prioritize patient care over corporate interests. As of 2024, 33 states and the District of Columbia have implemented some form of CPM doctrine. These laws typically limit the ability of corporations or non-licensed entities to employ physicians or control medical practices.

Seventeen states do not have formal CPM restrictions. However, even in these jurisdictions, other healthcare regulations and professional licensing laws may impose limitations on corporate involvement in medical practice. The states without CPM laws are: Alabama, Alaska, Delaware, Florida (requires Health Clinic License for non-physician owners), Hawaii, Idaho, Maine, Mississippi, Missouri, Nebraska, New Hampshire, New Mexico, Ohio, Oklahoma, Utah, Vermont, Virginia, and Wyoming.

California's CPM law. California enforces one of the most stringent CPM doctrines in the United States, primarily through statutory provisions and reinforced by case law. The Medical Practice Act, specifically California Business and Professions Code Section 2400, states that "[c]orporations and other artificial entities shall have no professional rights, privileges, or powers." This provision effectively prohibits unlicensed entities from practicing medicine or employing physicians. The California Supreme Court, in People v. Pacific Health Corp. (1938), upheld this principle, emphasizing that corporations cannot possess the personal qualifications necessary for medical licensure.

Despite the general prohibition, California allows certain exceptions where specific entities can employ physicians without violating CPM laws. These exceptions include:

1) *Professional Medical Corporations*: Under the Moscone-Knox Professional Corporation Act, licensed physicians may form professional corporations to render medical services;

2) *Health Maintenance Organizations (HMOs)*: Entities licensed under the Knox-Keene Health Care Service Plan Act are permitted to employ physicians to provide care within their networks;

3) *Certain Nonprofit Organizations:* Charitable institutions and teaching hospitals may employ physicians under specific conditions, provided they do not interfere with clinical judgment.

California's Physician Shortage. According to the California Health Care Foundations' 2025 *California Physician Almanac*, California is facing a significant physician shortage, particularly in primary care, with many regions lacking adequate healthcare providers to meet the needs of the population. The physician shortage in California is a complex issue influenced by demographic trends, economic factors, and geographic disparities. While efforts are underway to address the shortage, significant challenges remain, particularly in ensuring that all Californians have access to adequate healthcare services. Continued focus on training, recruitment, and retention strategies will be essential to mitigate this ongoing crisis.

2023 Survey of Medical Residents. A 2023 Survey of Final-Year Medical Residents: "*Many Job Choices, Many Reservations*" by AMN Healthcare's Physician Solutions division (formerly known as Merritt Hawkins), found that medical residents are inundated with job opportunities. The majority of medical residents surveyed (56%) received 100 or more job solicitations during their training, the highest number since the survey was first conducted in 1991. Despite the robust job market, 30% of residents indicated they would not choose medicine if they had their careers to do over, the highest number since the survey was first conducted. Residents prefer "hospital employment" as a practice setting. 68% said "hospital employment" was their first or second preference in a practice setting, while only 6% selected "solo practice." Close to one half of residents (48%) said they are unprepared for the business side of medicine.

Pilot project for some district hospitals from 2004-2010. SB 376 (Chesbro), Chapter 411, Statutes of 2003 created a limited exemption from the CPM for some district hospitals. Under this pilot program, a district hospital that was located in a county with less than 750,000 people, that had net losses in a previous year, and that served a high proportion of Medi-Cal and Medicare patients, could directly employ up to two physicians for a maximum of four years, with the maximum number of employed physicians statewide capped at 20. The pilot program required a report from the Medical Board of California (MBC) to be provided to the Legislature by October 1, 2008, and sunset the pilot project on January 1, 2011. According to the MBC's report, unexpectedly, only six physicians were hired by five eligible hospitals during the years the pilot was operational. The MBC stated that such a low number would not offer a significant, quantifiable improvement in access to healthcare nor would such a low number offer much information to MBC in preparing a valid and useful analysis of the pilot. Only four of the six participating physicians, and three of the five participating hospitals, responded for requests for input. The MBC stated that there may be justification to extend the pilot so that a better evaluation of the direct employment of physicians could be made. While several bills sought to either extend or expand the pilot project, these bills did not pass and the pilot project expired.

Pilot project for Critical Access Hospitals (CAHs). AB 2024 (Wood), Chapter 496, Statutes of 2016 created a new pilot project that allowed federally certified CAHs to employ physicians until January 1, 2024. CAHs are licensed general acute care hospitals that are certified to receive cost-based reimbursement from Medicare in order to reduce hospital closures in rural areas. To be certified as a CAH, a hospital can have no more than 25 beds, must be located in a rural area, and cannot be close to another hospital. There are 36 federally certified CAHs in California. Unlike the pilot program for district hospitals created by SB 376 in 2003, the CAH exemption did not limit the number of physicians that a CAH could employ, and there is no statewide cap. According to the California Department of Health Care Access and Information (HCAI), of the

36 CAHs, 18 have hired at least one physician, for a total of 123 physicians employed by CAHs at some point during the pilot program. One hospital (Tahoe Forest Hospital District in Truckee) employed the most at 54 physicians. Mark Twain Medical Center in San Andreas hired 16 physicians, Healdsburg Hospital hired 10 physicians, and Ridgecrest Regional Hospital hired 6 physicians, with most of the remaining hospitals hiring one to two physicians. AB 242 (Wood) Chapter 641, Statutes of 2023 deleted the sunset on the pilot project, permanently allowing CAHs to hire physicians.

Overlap of district hospitals and CAHs. A number of CAHs are also district hospitals, therefore some district hospitals are already permitted to hire physicians under AB 242. According to the Association of California Healthcare Districts, 17 of the 33 district hospitals are CAHs, so this bill would only affect the remaining 16 district hospitals that are not certified as a CAH.

According to the Author
According to the author, the passage of H.R. 1 will result in deep cuts to Medi-Cal patients across California. As a result, physicians contracting with high Medi-Cal volume employers face substantial revenue losses, rendering district hospitals even less competitive as employment options. This bill will allow a district hospital to offer a physician a set salary to practice, without it mattering how many Medi-Cal or uninsured patients they see. Right now, the contract model dictates a physicians' reimbursement based on the type of patient they see. Some of the hospitals looking to utilize this benefit, Antelope Valley Hospital and Watsonville Community Hospital for example have inpatient and outpatient Medi-Cal numbers ranging from 60 to 90%.

Despite being the sole or closest source of health and medical services for many families and seniors, district hospitals are the only public hospitals not allowed to directly employ physicians. The author concludes that this bill will allow wholly owned and operated public hospitals to directly hire physicians, a tool currently available to every other public hospital, Federally Qualified Health Centers, and academic medical centers.

Arguments in Support
The Association of California Healthcare Districts (ACHD) is the sponsor of this bill and states that currently, district hospitals are the only public hospitals in the state that cannot directly employ physicians. Of the 33 wholly owned and operated districts hospitals, 17 already have access to this tool through their CAH designation. The remaining district hospitals, however, must rely on contracting with physician groups, or individual doctors to provide care. As a result, district hospitals are forced to compete in competitive labor markets without the tools necessary to do so. ACHD notes that this bill would allow district hospitals to employ physicians directly with clear guardrails preventing any interference with clinical judgement. California currently allows for several exceptions to the ban on the CPM, including all designated public hospitals (UC and county facilities), CAHs, certain academic medical centers, and federally qualified health centers (FQHCs) to directly employ physicians. In fact, over half of the State's CAH's are district hospitals, who have successfully utilized the tool with success and no adverse patient care outcomes.

Data from 2023 shows that California has 159,012 active physicians (MDs) in the state. Kaiser Permanente alone shows data to suggest they employ 25,605 of those physicians. Sutter Health has 8 medical groups and self-reports employing 12,000 physicians. The UC Health System approximates 11,000 employed doctors, and 19,300 medical students, many of which are residents. In total across just those three, nearly a third of California's doctors are already

accounted for in largely closed system models. Allowing district hospitals the opportunity to offer set salaries, offer generous benefits, and set schedules, will make serving in public settings more attractive. It additionally, would allow the districts the ability to grow their own workforce, making it more attractive to stand up residency programs or increase slots, where the investment previously may not have penciled out.

Arguments in Opposition
The California Chapter of the American College of Emergency Physicians (California ACEP) is opposed to this bill and states that this exemption to California's bar on the CPM is a threat to physician autonomy and to patient safety. California ACEP contends that it is of the utmost importance that physicians have the ability to treat patients according to their specific medical needs without the influence or pressure of an administrator. Hospital CEOs and administrative staff have different motivations and mandates and are bound by different ethical and professional licensure standards than physicians. California ACEP concludes that patients deserve to be treated by clinicians exclusively motivated by their medical care needs. The California Society of Pathologists (CSP) is opposed to this bill and states that, for pathologists, independent medical judgment is essential to ensuring accurate diagnoses, appropriate utilization of laboratory testing, and overall patient safety.

FISCAL COMMENTS

According to the Assembly Appropriations Committee, the Osteopathic Medical Board of California anticipates no costs. The Medical Board of California (MBC) anticipates new workload, including updating outreach materials, website content, and staff training, along with supervisory, legal, and IT review. MBC also expects increased enforcement workload, assuming 100 complaints annually, with approximately five Health Quality Investigation Unit and Attorney General cases per year, resulting in estimated costs of $178,000 in the first year of implementation, $179,000 in the second year, and $205,000 in the third year and ongoing. MBC considers these costs minor and absorbable individually, but notes that cumulative impacts from multiple bills may reduce its ability to absorb them (Contingent Fund of the Medical Board of California).

VOTES

ASM HEALTH: 14-0-2
YES: Bonta, Addis, Aguiar-Curry, Pacheco, Caloza, Carrillo, Mark González, Johnson, Patel, Rogers, Sanchez, Schiavo, Sharp-Collins, Stefani
ABS, ABST OR NV: Chen, Patterson

ASM BUSINESS AND PROFESSIONS: 15-2-2
YES: Berman, Johnson, Addis, Ahrens, Alanis, Bauer-Kahan, Elhawary, Hadwick, Haney, Hart, Jackson, Lowenthal, Macedo, Nguyen, Pellerin
NO: Bains, Irwin
ABS, ABST OR NV: Caloza, Chen

ASM APPROPRIATIONS: 15-0-0
YES: Wicks, Hoover, Aguiar-Curry, Calderon, Caloza, Dixon, Fong, Mark González, Krell, Pacheco, Pellerin, Sharp-Collins, Solache, Ta, Tangipa

UPDATED

VERSION: February 19, 2026

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