
**SENATE COMMITTEE ON
BUSINESS, PROFESSIONS AND ECONOMIC DEVELOPMENT**
Senator Aisha Wahab, Chair
2025 - 2026 Regular

Bill No:	AB 2311	Hearing Date:	June 15, 2026
Author:	Schiavo		
Version:	May 19, 2026		
Urgency:	No	Fiscal:	Yes
Consultant:	Sarah Mason		

Subject: Health care districts: employment.

SUMMARY: Authorizes specified health care districts or nonprofit corporations with a health care district as sole corporate member to employ physicians and charge for professional services, with protections against interfering with physician judgment.

NOTE: *This bill is double-referred to the Senate Committee on Health, second.*

Existing law:

- 1) Enacts the Medical Practice Act, which provides for the licensure and regulation of physicians and surgeons. (BPC §§ 2000 *et seq.*)
- 2) Establishes the Medical Board of California (MBC) responsible for administering and enforcing the Medical Practice Act. (BPC § 2001)
- 3) Establishes the Osteopathic Medical Board of California (OMBC), which administers and enforces the Osteopathic Act governing the licensure and regulation of osteopathic physicians and surgeons. Osteopathic physicians and surgeons are licensed to practice medicine and surgery with substantially the same scope of practice and prescribing authority as physicians and surgeons licensed under the Medical Practice Act, while receiving training that includes osteopathic principles and a whole-person approach to patient care. (BPC §§ 2450 *et seq.*)
- 4) States that corporations and other artificial legal entities shall have no professional rights, privileges, or powers except as expressly authorized by law. Authorizes the Medical Board of California, under specified circumstances, to approve the employment of physicians and surgeons by certain charitable institutions, foundations, or clinics. (BPC § 2400)
- 5) Establishes exceptions to the ban on the corporate practice of medicine (CPM), thereby allowing certain types of facilities to employ physicians, including:
 - a) Clinics operated primarily for the purpose of medical education by a public or private nonprofit university medical school, to charge for professional services rendered to teaching patients by licensed physicians who hold academic appointments on the faculty of the university, if the charges are approved by the physician in whose name the charges are made;

- b) Certain nonprofit clinics organized and operated exclusively for scientific and charitable purposes, that have been conducting research since before 1982, and that meet other specified requirements, to employ physicians and charge for professional services. Prohibits, however, these clinics from interfering with, controlling, or otherwise directing a physician's professional judgment in a manner prohibited by the CPM prohibition or any other provision of law;
 - c) A narcotic treatment program regulated by the Department of Alcohol and Drug Programs to employ physicians and charge for professional services rendered by those physicians. Prohibits, however, the narcotic clinic from interfering with, controlling, or otherwise directing a physician's professional judgment in a manner that is prohibited by the CPM prohibition or any other provision of law; and,
 - d) A hospital that is owned and operated by a licensed charitable organization that offers only pediatric subspecialty care, as specified.
 - e) A federally certified critical access care hospital, as specified. (BPC § 2401)
- 6) Establishes the following protections against retaliation for health care practitioners who advocate for appropriate health care for their patients pursuant to *Wickline v. State of California* (192 Cal. App. 3d 1630):
- a) It is the public policy of the State of California that a health care practitioner be encouraged to advocate for appropriate health care for his or her patients. For purposes of this section, "to advocate for appropriate health care" means to appeal a payer's decision to deny payment for a service pursuant to the reasonable grievance or appeal procedure established by a medical group, independent practice association, preferred provider organization, foundation, hospital medical staff and governing body, or payer, or to protest a decision, policy, or practice that the health care practitioner, consistent with that degree of learning and skill ordinarily possessed by reputable health care practitioners with the same license or certification and practicing according to the applicable legal standard of care, reasonably believes impairs the health care practitioner's ability to provide appropriate health care to his or her patients.
 - b) The application and rendering by any individual, partnership, corporation, or other organization of a decision to terminate an employment or other contractual relationship with or otherwise penalize a health care practitioner principally for advocating for appropriate health care consistent with that degree of learning and skill ordinarily possessed by reputable health care practitioners with the same license or certification and practicing according to the applicable legal standard of care violates the public policy of this state.
 - c) This law shall not be construed to prohibit a payer from making a determination not to pay for a particular medical treatment or service, or the services of a type of health care practitioner, or to prohibit a medical group, independent practice association, preferred provider organization, foundation, hospital medical staff, hospital governing body, or payer from enforcing reasonable peer review or utilization review protocols or determining whether a health care practitioner has complied with those protocols. (BPC § 510)

- 7) Under the Knox-Keene Health Care Service Plan Act of 1975, authorizes licensed health care service plans to employ or contract with health care professionals, including physicians, to deliver professional services, and requires health plans to demonstrate that medical decisions are rendered by qualified medical providers unhindered by fiscal and administrative management. Provides in regulation that the organization of a health plan must include separation of medical services from fiscal and administrative management. (Health and Safety Code §§ 1340 *et seq.*)

This bill:

- 1) Until January 1, 2037, authorizes a health care district, 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 physicians and charge for professional services rendered by those physicians if the following conditions are met:
- a) The medical staff concur by that the physician's employment is in the best interest of the communities served by the hospital.
 - b) The health care district or nonprofit corporation must not interfere with, control, or otherwise direct the professional judgment of a physician.
 - c) The physicians employed by the health care district or nonprofit corporation must be in addition to, and must not supplant, any physicians providing professional services as a member of the medical staff at any hospitals owned or controlled by the health care district or nonprofit corporation, as of January 1, 2026.
 - d) The health care district or nonprofit corporation must affirmatively offer a physician who is a prospective employee the option to contract with the facility in lieu of employment.
- 2) Specifies that, beginning January 1, 2028, a health care district or nonprofit corporation, that is employing physicians and charging for professional services rendered by those physicians must publish a report on or before July 1 of each year that includes data about the ability of general acute care hospitals under the health care district's or nonprofit corporation's ownership and control to recruit and retain physicians during the prior year, as well as the total number of physicians and surgeons recruited and retained to date since January 1, 2027, reported separately by employment and contracted positions.

FISCAL EFFECT: This bill is keyed fiscal by Legislative Counsel. According to the Assembly Committee on Appropriations, the Osteopathic Medical Board of California anticipates no costs and 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.

COMMENTS:

1. **Purpose.** The Association of California Healthcare Districts is the Sponsor of this bill. 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. 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. AB 2311 will allow wholly owned and operated public hospitals to directly hire physicians, a tool currently available to every other public hospital, FQHCs and academic medical center."

The Author notes that "California is one of five remaining states with the strictest version of the ban on the corporate practice of medicine, which has been interpreted to mean that certain types of entities may not directly employ physicians. Even though the American Medical Association has said that physicians should be able to enter into contractual agreements including employment with hospitals. California currently allows for several exceptions to the ban on the CPOM, including allowing designated public hospitals (UC & County Hospitals), Critical Access Hospitals, certain academic medical centers, and FQHC's to directly employ physicians. Of the Critical Access Hospitals 17 are district hospitals. This means the state has 15 public district hospitals that remain unable to utilize this critical tool.

District hospitals have an incredibly difficult time recruiting and retaining health care professionals, even in urban/suburban areas. Most district hospitals serve well above the statewide Medicaid average. Many have in and outpatient government payers in the 60-85% range.

Physician contracting means that physicians are compensated through the reimbursement of the patient they see. For district hospitals with high government payer mixes, they are unable to secure the necessary types and numbers of physicians to deliver care to both commercial and government beneficiaries, as they are less attractive to contract with."

2. **Background.** Prior to 1968, the common practice in California was that professional services could be provided only pursuant to a license and generally could not be rendered through a professional business organized as a corporation. Discussions began in the early 1960s regarding whether certain licensed professionals should be permitted to organize as corporations in order to obtain some of the same benefits available to general business corporations, including tax and employee benefit advantages and limitations on personal liability. Opponents of expanding corporate practice authority expressed concern that lay shareholders and directors would not be subject to the same professional and ethical obligations as licensed practitioners and could place financial interests above professional judgment and consumer protection.

In 1968, the Legislature enacted the Moscone-Knox Professional Corporation Act, establishing a framework under which specified licensed professions could provide professional services through professional corporations. Over time, the Act was

expanded to authorize additional professions to utilize the professional corporation model while retaining safeguards intended to preserve professional independence and accountability.

Current law specifies which healing arts licensees may be shareholders, officers, directors or professional employees of professional corporations controlled, including by a differing profession so long as the sum of all shares owned by those licensed persons does not exceed 49 percent of the total number of shares of the professional corporation. Corporations Code Section 13401.5 authorizes the formation of various healing arts professional corporations and establishes which healing arts licensees who are not of the same license type as the corporation may be shareholders, officers, and directors of that corporation. Any person licensed under the BPC, the Chiropractic Act, or the Osteopathic Act may be employed by these professional corporations. Thus, the services of professional corporations are not limited to the named profession. For example, a nursing corporation may have a director who is a chiropractor, a shareholder who is an acupuncturist, and employ an accountant, podiatrist, and a marriage and family therapist, none of which would traditionally be seen as providing the professional services of nursing. Current law authorizes a medical corporation to have a number of health licensees as officers, directors, and shareholders.

License holders in a variety of other health professions can also serve as shareholders. Provisions of the Act requiring corporations to be owned by licensees are reflected in the various practice acts within the BPC that govern the licensure and regulation of a number of professions.

Corporate Practice of Medicine. California continues to maintain significant restrictions on the corporate practice of medicine (CPM), a doctrine intended to preserve physician independence and prevent non-physicians from exercising undue influence over medical decision-making. CPM is usually referred to in the context of a prohibition, banning hospitals from employing physicians. The ban on CPM evolved in the early 20th century when mining companies had to hire physicians directly to provide care for their employees in remote areas. However, problems arose when physicians' loyalty to the mining companies conflicted with patients' needs. Eventually, physicians, courts, and legislatures prohibited CPM, in an effort to preserve physicians' autonomy and improve patient care.

Over time, the Legislature and courts have recognized a number of exceptions to the CPM doctrine. As noted by the California Research Bureau (CRB) in a 2007 report, California's CPM doctrine has evolved through a combination of court decisions, Attorney General opinions, and statutory exceptions, resulting in a framework that permits physician employment in certain settings while maintaining restrictions in others. The report observed that professional medical corporations may employ physicians and operate on a for-profit basis, despite concerns about commercial influence having been one of the original rationales for the CPM doctrine.

A subsequent 2016 CRB report noted that California's health care delivery system had changed substantially since the doctrine was first developed. The report highlighted the significant expansion of health insurance coverage following

implementation of the federal Affordable Care Act and observed that increased demand for health care services had not been accompanied by a comparable increase in the supply of health care practitioners. The report suggested that policymakers evaluate whether existing safeguards adequately protect physician autonomy, assess the costs and benefits of current physician-hospital alignment models, and consider whether additional data would assist in evaluating the continued application of CPM restrictions.

Health Care District and Rural Hospital Physician Employment Efforts. In 2003, the Legislature enacted SB 376 (Chesbro, Chapter 411, Statutes of 2003), establishing a pilot project that authorized certain qualifying hospital districts to directly employ physicians. The measure was intended to assist rural and medically underserved communities in recruiting and retaining physicians while evaluating whether direct physician employment raised concerns regarding physician autonomy or patient protection.

MBC was required to evaluate the pilot project and report to the Legislature. Although participation was limited and the MBC concluded that insufficient data existed to conduct a comprehensive evaluation, the Board acknowledged ongoing concerns regarding physician shortages in rural and underserved areas and suggested that additional study could be warranted before broader policy changes were considered.

Between 2008 and 2011, the Legislature considered several measures that would have extended or expanded the district hospital physician-employment pilot or authorized additional categories of hospitals to employ physicians directly. These proposals generally sought to address physician recruitment and retention challenges in rural and medically underserved communities but were not enacted.

In 2016, the Legislature enacted AB 2024 (Wood, Chapter 496, Statutes of 2016), authorizing federally certified critical access hospitals (CAHs) to employ physicians and surgeons directly and bill for professional services rendered by those physicians. Subsequently, AB 242 (Wood, Chapter 551, Statutes of 2023) permanently extended that authority, reflecting the Legislature's continued recognition that targeted physician-employment models may assist hospitals serving rural and underserved communities while preserving safeguards for physician professional judgment.

More recently, California has continued to evaluate the relationship between physician autonomy and organizational structures in health care delivery. Recent legislation addressing physician practice management and private-equity involvement in health care reflects an ongoing interest in ensuring that business arrangements do not interfere with independent clinical decision-making while supporting access to care and health system sustainability.

AB 2311 proposes a targeted physician-employment authorization for specified health care districts and affiliated nonprofit entities operating hospitals while retaining statutory protections intended to preserve independent medical judgment and patient care.

3. **Arguments in Support.** Supporters write that AB 2311 is a modest approach to allow public district hospitals to effectively recruit and retain providers to their facilities, giving a small number of public hospitals a tool that has proven to be effective. Supporters note that California is one of only five states that still interprets the Ban on the Corporate Practice of Medicine Doctrine to include a prohibition on direct employment of physicians. According to supporters, the ability to employ physicians would allow public hospitals to attract specialty providers that otherwise may not reach our communities through physician groups. Employment or similar models are extremely attractive to graduates coming out of residency or doctors that practice in other states. Allowing district hospitals the opportunity to offer set salaries, generous benefits, set schedules, and align with the model of 45 states will make serving in public settings more attractive.
4. **Arguments in Opposition.** The California Chapter of the American College of Emergency Physicians writes that “Creating exemptions for CPM is often suggested as a policy solution for increasing the ability hospitals in rural areas to recruit physicians. However, when a pilot program created a limited exemption from the ban on the CPM for some health care district hospitals, only six physicians were hired by five eligible hospitals during the three years the pilot was operational. In the increasing corporatization of healthcare, it is critical that California continues to protect the ability of providers to practice medicine without undue non-clinical influence. AB 2311 will not increase physician access in rural areas, it will only reduce to physician autonomy and threaten patient safety.”

The California Medical Association writes that it “continues to strongly urge the author to limit eligibility for this CPOM exemption to hospitals serving a high governmental payor mix population. Our proposed amendment strikes an appropriate balance by limiting the exemption to those hospitals that may have greater workforce challenges, thereby minimizing unnecessary erosion of the longstanding protections in the CPOM doctrine.” CMA says that “While the bill includes language intended to prohibit interference with physicians’ professional judgment, these provisions do not meaningfully safeguard independent clinical decision-making. In practice, physicians employed by hospitals or hospital districts remain subject to a range of institutional pressures, including credentialing authority, employment terms, productivity expectations, referral patterns, and compensation structures. Even absent explicit directives regarding patient care, these factors can subtly—but significantly—influence medical decision-making.”

The California Orthopedic Association and California Radiological Society notes that although the organization “appreciates the amendments intended to narrow the bill, AB 2311 would still represent a significant expansion of hospital and district affiliated employment of physicians and would further erode the independent practice of medicine in California.”

The California Society of Pathologists states “California’s CPOM doctrine is a foundational safeguard that ensures medical decisions remain grounded in independent physician judgment, free from institutional or financial influence. AB 2311 would weaken these protections by allowing health care districts to directly employ physicians and bill for professional services, increasing the risk that clinical decision-making is shaped by administrative and operational priorities.”

SUPPORT AND OPPOSITION:

Support:

Association of California Healthcare Districts (sponsor)
Alzheimer's Association
Antelope Valley Healthcare District
California Hospital Association
California Special Districts Association
Community Services Agency
Del Puerto Health Care District
Desert Healthcare District and Foundation
District Hospital Leadership Forum
El Camino Health
Fallbrook Healthcare District
Health Petaluma District & Foundation
Imperial Valley Healthcare District
Kaweah Health
Lompoc Healthcare District
Northern Inyo Healthcare District
Palomar Health
Plumas District Hospital
Ravenswood Family Health Network
Salinas Valley Health
Santa Clara Family Health Plan
Sierra View Medical Center
Soledad Community Health Care District
Sonoma Valley Health Care District
Washington Healthcare District

Opposition:

California Chapter of the American College of Emergency Physicians
California Medical Association
California Orthopedic Association
California Radiological Society
California Society of Pathologists

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