
SENATE COMMITTEE ON HEALTH

Senator Akilah Weber Pierson, Chair

BILL NO: AB 2311
AUTHOR: Schiavo
VERSION: May 19, 2026
HEARING DATE: July 1, 2026
CONSULTANT: Vincent D. Marchand

SUBJECT: Health care districts: employment

SUMMARY: Exempts health care districts from the ban on the corporate practice of medicine, until January 1, 2037, in order to permit the health care district to employ physicians and charge for professional services rendered by those physicians, under certain specified conditions.

Existing law:

- 1) Prohibits, within the Medical Practice Act, corporations and other artificial legal entities from having any professional rights, privileges, or powers. However, permits the Medical Board of California (MBC), in its discretion, to grant approval of the employment of physicians on a salary basis by licensed charitable institutions, foundation, or clinics, if no charge for professional services rendered to patients is made by any such institution, foundation, or clinic. This is known as the ban on the corporate practice of medicine (CPM). [BPC §2400]
- 2) Establishes certain exemptions from the ban on the CPM, including the following:
 - a) Clinics operated primarily for the purpose of medical education by a public or private nonprofit university medical school, are permitted 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; [BPC §2401(a)]
 - 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, are permitted to employ physicians and charge for professional services, but are prohibited from interfering with or directing a physician's professional judgment; [BPC §2401(b)]
 - c) A narcotic treatment program regulated by the Department of Alcohol and Drug Programs is permitted to employ physicians and charge for professional services rendered by those physicians, but is prohibited from interfering with or directing a physician's professional judgment; [BPC §2401(c)]
 - d) A hospital that is owned and operated by a licensed charitable organization that offers only pediatric subspecialty care, and that employed physicians prior to January 1, 2013, is permitted to charge for professional services, under certain specified conditions; and, [BPC §2401(d)]
 - e) Although not in statute, existing case law establishes an exemption from the ban on the CPM for county hospitals to employ physicians.
- 3) Exempts from the ban on the CPM, a federally certified critical access hospital (CAH), to enable CAHs to employ physicians, provided the medical staff concur by an affirmative vote that the licensee's employment is in the best interest of the communities served by the hospital, and the hospital does not interfere with, control, or otherwise direct a physician's judgment. [BPC §2401(e)]

- 4) Establishes “The Local Health Care District Law,” under which a local hospital district may be organized, incorporated and managed. Permits a district to include incorporated or unincorporated territory, or both, in any one or more counties. Requires health care districts to be governed by an elected board of five members, who are required to live within the healthcare district. [HSC §32000 et seq., §32001, and §32100]
- 5) Provides local health care districts with certain powers, including establishing and operating health facilities or other health care programs, and to establish and operate, or provide assistance in the operation of, free clinics, diagnostic and testing centers, health education programs, wellness and prevention programs, rehabilitation, aftercare, and any other health care services providers, groups, and organizations that are necessary for the maintenance of good physical and mental health in the communities served by the district. [HSC §32121]

This bill:

- 1) Exempts from the ban on the CPM, until January 1, 2037, 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, in order to permit the health care district to employ physicians and charge for professional services rendered by those physicians.
- 2) Requires the medical staff to concur by an affirmative vote, pursuant to medical staff bylaws, that the licensee’s employment is in the best interest of the communities served by the hospital.
- 3) Prohibits a health care district or nonprofit corporation, and any hospital under its ownership or control, from interfering with, controlling, or otherwise directing the professional judgment of a physician.
- 4) Requires the licensee positions employed by the health care district or nonprofit to be in addition to, and are not supplanting, any licensee positions 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. Specifies that this provision does not prohibit a health care district or nonprofit corporation from negotiating or amending existing contracts for professional services upon mutual agreement of the parties to the contract.
- 5) Requires the health care district or nonprofit corporation to affirmatively offer a licensee who is a prospective employee the option to contract with the facility in lieu of employment.
- 6) Sunsets the provisions of this bill on July 1, 2037.

FISCAL EFFECT: According to the Assembly Appropriations Committee, the Osteopathic Medical Board of California anticipates no costs. The 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).

PRIOR VOTES:

Senate Business, Professions and Economic Development Committee:	10 - 0
Assembly Floor:	75 - 1
Assembly Appropriations Committee:	15 - 0
Assembly Business and Professions Committee:	15 - 2
Assembly Health Committee:	14 - 0

COMMENTS:

- 1) *Author’s statement.* 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. 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 Center, and academic medical center.
- 2) *Background on the CPM and California Research Bureau (CRB) reports.* The ban on the CPM has historically prevented corporations from practicing medicine, which includes the employment of physicians. From the late 1920s, California courts have staunchly protected the right of physicians to practice without being subject to potential interference by corporate employers. Since that time, California has created a number of exemptions to the ban on the CPM. Where exemptions do not exist, physicians and hospitals work together without creating employment relationships.

In 2007, the CRB published a report examining the status of the ban on the CPM, and it argued that exemptions had created a doctrine whose “power and meaning are now inconsistent.” The CRB also raised the idea that the many exemptions to the ban may “signal a change in public opinion.” The CRB report noted that although the CPM doctrine is generally not believed to be extremely detrimental, its present utility seems limited, as the evolution and erosion of the CPM prohibition over many decades has resulted in a doctrine that is far removed from its origin and lacks coherence and relevance in today’s health care landscape. On April 12, 2016, the CRB released a new report, "The Corporate Practice of Medicine in a Changing Healthcare Environment," which reviewed the current status of the ban in California and key policy issues associated with it. In the 2016 report, the CRB pointed out that there are a variety of issues within the health care environment that cause conflicts of interest, though not necessarily wrongdoing, within the health care field, including self-referrals for office services and physician-owned centers, reimbursement models and bonuses, and pharmaceutical promotions and drug samples, among others. With respect to physician autonomy, the CRB states that recent survey research indicates that physicians’ status as salaried employees in large organizations is not associated with decreased reports by physicians of freedom in making clinical decisions. The CRB notes that as discussions about the ban on the CPM continue, it is important that public policy discussions consider it within the context of conflicts of interest and autonomy in the modern healthcare environment.

- 3) *Overview of health care districts.* The Local Hospital District Law was established in 1945 to authorize special districts to build and operate hospitals and other health care facilities in underserved areas. Legislation in 1994 renamed it the Local Health Care District Law to

reflect the fact health care was increasingly being provided outside of the hospital setting. Health care districts are a form of special district. Special districts are local governments that are legally separate from counties and cities, and they have the authority to build public works projects and run programs, and the power to impose taxes to raise funds to pay for these services. Special districts have the ability to enter into contracts, purchase property, exercise eminent domain, issue debt, and hire staff. Each health care district is governed by a locally elected five-member board of directors, and are subject to state policies and regulations as applied by each county's Local Agency Formation Commission.

There are currently 77 health care districts, and most of these were established in the first two decades following enactment of the Local Hospital District Law. Of these, 33 own and operate hospitals, while a handful of others own either the hospital or the land and lease the hospital to another entity to operate the hospital. The remainder operate ambulance services, clinics, skilled nursing facilities, or do not provide any direct health services. Most health care districts receive a share of local property taxes, which varies among districts. Some health care districts have received two-thirds approval to levy special "parcel taxes," such as Alameda Health Care District, which was formed in 2002 when voters approved a \$298 annual parcel tax to assume operation of Alameda Hospital. Health care districts can also generate revenues from other resources, including property lease income and interest earnings from investments, or by creating debt to borrow money for capital projects.

- 4) *Limited 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 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 health care 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.
- 5) *Pilot project for Critical Access Hospitals, which is now permanent.* AB 2024 (Wood, Chapter 496, Statutes of 2016) created a new pilot project that allowed federal certified Critical Access Hospitals (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, the CAH exemption did not limit the number of physicians that a CAH could employ, and there is no statewide cap. According to HCAI, of the 36 CAHs, between 2017 and 2023, 18 had 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 ten physicians, and Ridgecrest Regional Hospital hired six physicians, with most of the remaining hospitals hiring one to two physicians. AB 242 (Wood, Chapter 641, Statutes of 2023) made this pilot program permanent.

- 6) *Overlap of district hospitals and CAHs.* A number of CAHs are also district hospitals, and so some district hospitals are already permitted to hire physicians under the AB 2024 pilot project above, which was made permanent in 2023. 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.
- 7) *Double referral.* This bill was heard in the Senate Business, Professions and Economic Development Committee on June 15, 2026, and passed on a 10-0 vote.
- 8) *Prior legislation.* SB 784 (Becker of 2023) would have exempted health care district hospitals from the ban on the CPM. *SB 784 was held on the Senate Appropriations Committee suspense file.*

AB 242 (Wood, Chapter 641, Statutes of 2023) deleted the sunset date on a provision of law exempting CAHs from the ban on the CPM, thereby making this exemption permanent, and deletes reporting requirements related to this exemption.

AB 2024 (Wood, Chapter 496, Statutes of 2016) established an exemption, until January 1, 2024, from the prohibition on the CPM in order to allow federally certified CAHs to employ physicians and charge for those services.

SB 1274 (Wolk, Chapter 793, Statutes of 2012) permits a hospital that is owned and operated by a charitable organization and offers only pediatric subspecialty care to begin billing health carriers for physician services rendered, notwithstanding the prohibition in the CPM if specified conditions are met.

SB 726 (Ashburn of 2009) would have revised and extended the MBC pilot project that allows qualified district hospitals, as defined, to employ a physician, if the hospital does not interfere with, control, or otherwise direct the professional judgment of the physician. *SB 726 failed passage in the Senate Business, Professions and Economic Development Committee.*

AB 648 (Chesbro of 2009) would have established a demonstration project to permit rural hospitals, as defined, whose service area includes a medically underserved or federally designated shortage area and which meet certain specified requirements, to directly employ physicians and surgeons. *AB 648 failed passage in the Senate Business, Professions and Economic Development Committee.*

AB 646 (Swanson of 2009) would have permitted health care districts and certain public hospitals, independent community nonprofit hospitals, and clinics, as specified, to directly employ physicians and surgeons. *AB 646 failed passage in the Senate Business, Professions and Economic Development Committee.*

SB 1294 (Ducheny of 2008) would have expanded the pilot project enabling health care districts to directly employ physicians. *SB 1294 failed passage in the Assembly*

Appropriations Committee.

AB 1944 (Swanson of 2008) would have allowed health care districts to employ a physician. *AB 1944 failed passage in the Senate Committee on Health.*

SB 376 (Chesbro, Chapter 411, Statutes of 2003) authorized, until January 1, 2011, a hospital owned and operated by a health care district meeting specified criteria to employ a physician, and to charge for professional services rendered by the physician if the physician approves the charges.

- 9) *Support.* This bill is sponsored by the Association of California Healthcare Districts (ACHD) to allow the small number of remaining public district hospitals to directly employ physicians without interfering with the professional judgment of the physicians they hire. ACHD states that district hospitals are the only public hospitals in the state that cannot directly employ physicians. Of the 33 wholly owned and operated district hospitals, 17 already have access to this tool through their CAH designation. The remaining district hospitals must rely on contracting with physician groups or individual doctors to provide care, which forces district hospitals to compete in competitive markets without the tools necessary to do so. ACHD states that California is one of five remaining states with the strictest version of the ban on the corporate practice of medicine. Data from 2023 shows that California has 159,012 active physicians in the state. According to ACHD, Kaiser Permanent's data suggests they employ 25,605 of those physicians, Sutter Health's eight medical groups report employing 12,000 physicians, and the UC Health system has 11,000 employed doctors, plus additional residents. Nearly one third of California's doctors are accounted for across those three largely closed system models. ACHD states that allowing district hospitals the opportunity to offer set salaries, generous benefits, and set schedules will make serving in public settings more attractive, and would also give districts the ability to grow their own workforce through residency programs and other workforce pipeline programs.

A number of individual district hospitals and other organizations submitted letters of support. Kaweah Delta Health Care District, which operates a healthcare system in Visalia, including the region's only Level III Trauma Center. According to Kaweah Health, the inability to directly employ physicians compounds a number of challenges facing the health system, including a physician deficit in the region, a high Medi-Cal percentage, economic difficulties, and recent federal policy changes. Without an employment option, they are limited in their ability to compete for physicians in a market where employment is increasingly the standard, making recruitment into already underserved communities even more difficult. Other district hospitals make similar arguments in support.

- 10) *Oppose unless amended.* The California Medical Association (CMA) is opposed to this bill unless amended. According to CMA, California established the CPM doctrine to protect patients from corporate or institutional influence over clinical decision-making. These longstanding safeguards ensure that decisions about a patient's care remain between the patient and their treating physician, not hospital administrators, governing boards, or financial officers whose responsibilities may include balancing budgets or responding to political or operational pressures. CMA states that while this 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 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 significant, influence medical decision-making. CMA proposes an amendment to limit eligibility to hospitals serving a high governmental payor mix population. CMA states that this 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 CPM doctrine.

11) *Opposition.* This bill is opposed by a number of physician specialty groups, including the California Chapter of the American College of Emergency Physicians (California ACEP), the California Orthopedic Association, the California Radiological Society, and the California Society of Pathologists. California ACEP states that creating exemptions from the CPM is often suggested as a policy solution for increasing the ability of hospitals in rural areas to recruit physicians. However, when a pilot program created a limited exemption from the ban 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. Other specialty physician groups make similar arguments about the need to protect independent clinical judgment from corporate influence. The Medical Board of California also opposes this bill, stating that physicians should maintain their independence so they can be free to treat their patients according to the standard of care.

12) *Committee amendments.* The author has agreed to accept amendments requested by the Committee that limit eligibility to district hospitals that either have a public payer mix greater than 75%, or have received a loan under the distressed hospital loan program, by adding a new condition of eligibility as follows:

(A) The hospital is a licensed acute care hospital, as defined in subdivision (a) or (b) of Section 1250 of the Health and Safety Code, and satisfies either of the following conditions:

(i) Was awarded a loan under the Distressed Hospital Loan Program (Chapter(commencing with Section 129380) of Part 6 of Division 107 of the Health and Safety Code) before January 1, 2025.

(ii) (I) Has a combined Medicare and Medi-Cal payor mix greater than 75 percent, as determined using the adjusted patient days from the Department of Health Care Access and Information annual financial disclosure report, and as recorded and calculated as of January 1, 2025, pursuant to the Department of Health Care Access and Information guidance.

(II) For purposes of qualifying based on payor mix of Medicare and Medi-Cal pursuant to this clause, both the hospital and the health care system to which it belongs, if any, shall have a payor mix of greater than 75 percent.

SUPPORT AND OPPOSITION:

Support: Association of California Healthcare Districts (sponsor)
Alzheimer's Association
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
Imperial Valley Healthcare District
Kaweah Health Care District
Lompoc Healthcare District
Palomar Health
Plumas District Hospital
Ravenswood Family Health Network
Salinas Valley Health
Santa Clara Family Health Plan
Soledad Community Health Care District
Sonoma Valley Health Care District
Washington Healthcare District

Oppose: California Chapter of the American College of Emergency Physicians
California Medical Association (unless amended)
California Orthopedic Association
California Radiological Society
California Society of Pathologists
Medical Board of California

-- END --