
SENATE COMMITTEE ON HEALTH

Senator Akilah Weber Pierson, Chair

BILL NO: AB 2575
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SUBJECT: Health care services: artificial intelligence

SUMMARY: Requires a health facility and other health providers that use or deploy a clinical decision support system for patient care to provide a list of required information, including details on how the system was developed and how it works, to any licensed health care professional or other person that views outputs from a clinical decision support system, 90 days before deploying the system and when onboarding new employees. Prohibits an employer from retaliating or discriminating against a worker based solely on the worker’s override of, or reliance on, the output of a clinical decision support system. Prohibits the failure of a health care worker to override an output of a clinical decision support system from being asserted as a superseding cause severing the defendant’s liability for the alleged harm in a civil action against a defendant who developed or deployed a clinical decision support system that is alleged to have caused harm.

Existing law:

- 1) Establishes the California Department of Public Health (CDPH) which licenses and regulates health facilities and clinics. [HSC §1200 et seq. and §1250, et seq.]
- 2) Defines “clinic” as an organized outpatient health facility that provides direct medical, surgical, dental, optometric, or podiatric advice, services, or treatment to patients who remain less than 24 hours, and that may also provide diagnostic or therapeutic services to patients in the home as an incident to care provided at the clinic facility. [HSC §1200]
- 3) Defines “health facility” to mean a facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness, physical or mental, including convalescence and rehabilitation and including care during and after pregnancy, or for any one or more of these purposes, for one or more persons, to which the persons are admitted for a 24-hour stay or longer, including, but not limited to, hospitals, nursing facilities, and hospice facilities. [HSC §1250]
- 4) Requires a health facility, clinic, physician’s office, or office of a group practice that uses generative artificial intelligence (AI) to generate written or verbal patient communications pertaining to patient clinical information to ensure that those communications include a disclaimer, as specified, that indicates to the patient that the communication was generated by generative AI, and clear instructions describing how a patient may contact a human health care provider, employee, or other appropriate person. Exempts communications generated by generative AI from this requirement if it is read and reviewed by a human licensed or certified health care provider. [HSC §1339.75]
- 5) Defines the following terms for purposes of 4) above:

- a) “Artificial intelligence” means an engineered or machine-based system that varies in its level of autonomy and that can, for explicit or implicit objectives, infer from the input it receives how to generate outputs that can influence physical or virtual environments; and,
 - b) “Generative artificial intelligence” means AI that can generate derived synthetic content, including images, videos, audio, text, and other digital content.
- 6) Establishes the California Privacy Protection Agency (CPPA) to implement and enforce the California Privacy Rights Act of 2020, and provides the CPPA with the full administrative power, authority and jurisdiction to implement and enforce the California Consumer Privacy Act of 2018, including responsibilities to update existing regulations and adopt new regulations. [CIV §1798.100, et seq.]
 - 7) Requires the Department of Technology to conduct, in coordination with other interagency bodies as it deems appropriate, a comprehensive inventory of all high-risk automated decision systems that have been proposed for use, development, or procurement by, or are being used, developed, or procured by, and state agency. Defines “high-risk automated decision system” as an automated decision system that is used to assist or replace human discretionary decisions that have a legal or similarly significant effect, including decisions that materially impact access to, or approval for, housing or accommodations, education, employment, credit, health care, and criminal justice. [GOV §11546.45.5]
 - 8) Establishes misdemeanor penalties for health facilities and clinics for violations of their respective laws, with penalties of a fine of up to \$1,000 or imprisonment in the county jail for up to 180 days, or both. [HSC §1235 and §1290]
 - 9) Establishes the Unfair Competition Law, and defines “unfair competition” as any unlawful, unfair, or fraudulent business act or practice; any unfair, deceptive, untrue, or misleading advertising; and any act prohibited by the False Advertising Act, as specified. [BPC §17200, et seq.]
 - 10) Specifies that any person who engages, has engaged, or proposes to engage in unfair competition shall be liable for a civil penalty not to exceed \$2,500 for each violation, and provides that the civil penalty, with some exceptions, can only be assessed and recovered in a civil action brought by the Attorney General, any district attorney, and any city attorney of a city with a population in excess of 750,000. [BPC §17206(a)]

This bill:

- 1) Defines “artificial intelligence” and “generative artificial intelligence” as having the same meaning as definitions described in Existing Law 5) above.
- 2) Defines “automated decision system” as a computational process derived from machine learning, statistical modeling, data analytics, or AI that issues simplified output, including a score, classification, or recommendation, that is used to assist or replace human discretionary decision-making and materially impacts natural persons. Excludes from this definition a spam email filter, firewall, antivirus software, identify and access management tools, calculator, database, dataset, or other compilation of data.
- 3) Defines “clinical decision support system” as an automated decision system or generative AI system whose outputs are used to inform clinical decision-making with respect to the provision, timing, or course of patient care.

- 4) Requires a health facility, clinic, physician's office, or office of a group practice that uses or deploys a clinical decision support system for patient care to provide written notice of required information, as specified in this bill, to any licensed health care professional or other person using a clinical decision support system or viewing outputs from a clinical decision support system.
- 5) Requires the information in the written notice to include all of the following:
 - a) Details on the clinical decision support system, including developer and description of output;
 - b) Intended use of the clinical decision support system, including intended patient population, intended users, and intended decision-making role;
 - c) Cautioned out-of-scope use of the clinical decision support system, including known risks and limitations;
 - d) List of the inputs into the clinical decision support system;
 - e) Description of how the clinical decision support system generates outputs;
 - f) Development details of the clinical decision support system including, but not limited to, all of the following:
 - i) Description of the training set or clinical research underlying recommendations, including demographic representativeness and known biases based on protected characteristics;
 - ii) Description of the relevance of training data to deployed setting; and,
 - iii) Process used to ensure fairness in development of the intervention;
 - g) Description of the validation process;
 - h) Qualitative measures of performance;
 - i) Description of ongoing maintenance of intervention implementation and use;
 - j) Description of updates and continued validation or fairness assessment process; and,
 - k) Notice that a worker providing direct patient care may override the output of a clinical decision support system if, in the independent professional judgment of the worker acting within their scope of practice, the override is necessary to meet the applicable standard of care or comply with applicable law.
- 6) Requires the written notice to be provided consistent with all of the following:
 - a) To a new licensed health care professional or other person upon hire, onboarding, or credentialing, if that individual will likely use the clinical decision support system or view outputs from the clinical decision support system;
 - b) At least 90 days before a new clinical decision support system is first deployed for patient care; and,
 - c) On or before February 1, 2028, and annually thereafter, by providing an updated inventory of all clinical decision support systems currently in use or deployed for patient care.
- 7) Exempts from the written notice requirements the use of a clinical decision support system for documentation, communication, or other administrative tasks that do not involve the application of professional judgment by a licensed health care professional, including, but not limited to, automated messages to inform patients of their health records.
- 8) Specifies that a violation of the written notice requirement by a licensed health facility or a licensed clinic is subject to existing provisions of law establishing misdemeanor penalties for

violations of laws governing health facilities and clinics, with a fine of up to \$1,000 or imprisonment in the county jail for up to 180 days, or both.

- 9) Specifies that a violation of the written notice requirement by a physician is subject to the jurisdiction of the Medical Board of California or the Osteopathic Medical Board of California, as appropriate.
- 10) Specifies that a violation of the written notice requirement constitutes “unfair competition,” as defined in existing law, and is subject to civil penalties of up to \$2,500 per violation as provided for in the Unfair Competition Law.
- 11) Provides that it is the public policy of the State of California that a worker providing direct patient care be free to use their professional judgment to make assessments and decisions within their scope of practice as appropriate for their patients.
- 12) Prohibits an employer from retaliating or discriminating against a worker providing direct patient care using their professional judgment to make an assessment or decision within their appropriate scope of practice based solely on the worker’s override of, or reliance on, the output of a clinical decision support system. Specifies that this provision does not affect a worker’s duty to meet the applicable standard of care, act within their scope of practice, or exercise independent judgment in providing direct patient care.
- 13) Requires a worker who is subject to retaliation or discrimination in violation of this bill to have the right to file a complaint with the Labor Commissioner against an employer who retaliates or discriminates against the worker.
- 14) Prohibits using as a defense, in an action against a defendant who developed, modified, selected, or deployed a clinical decision support system that is alleged to have caused harm to the plaintiff, and prohibits a defendant from asserting, that the failure of a licensed health care professional or other health care worker to override an output of a clinical decision support system is a superseding cause severing the defendant’s liability for the alleged harm. Specifies that this provision does not limit or preclude a defendant from presenting any other affirmative defense, including evidence relevant to causation or foreseeability, or presenting other evidence relevant to the comparative fault of any other person or entity.

FISCAL EFFECT: According to the Assembly Appropriations Committee: Costs of an unknown but potentially significant amount to the California Department of Public Health to adopt regulations and add enforcement of this bill's requirements into its facility surveys, among other activities (Licensing and Certification Fund).

The Department of Industrial Relations expects costs to the Labor Commissioner to exceed \$300,000 annually for staff workload, including enforcement deputies, support, and supervisory staff, to enforce the retaliation prohibition (Labor Enforcement and Compliance Fund).

The University of California (UC) estimates costs of approximately \$30 million per year, ongoing (General Fund). UC states compliance would require a cross-departmental effort from enterprise information technology, legal, human resources, and clinical operations at each UC Health location and across the system. Costs would principally arise from the annual requirements to audit, track, and extract highly specific proprietary data from third-party vendors for every clinical decision system.

Costs of an unknown but potentially significant amount to the Department of Justice (DOJ) to bring enforcement actions as authorized by this bill. Actual costs will depend on the number of enforcement actions pursued by DOJ and the amount of additional work created by each action, but costs may be in the hundreds of thousands of dollars annually (Unfair Competition Law Fund).

Cost pressures of an unknown but potentially significant amount to the courts to adjudicate any additional filings (Trial Court Trust Fund, General Fund). It generally costs approximately \$1,000 to operate a courtroom for one hour. Although courts are not funded based on workload, increased pressure on the Trial Court Trust Fund may create a demand for increased funding for courts from the General Fund. The state budget provides annual General Fund backfills to the Trial Court Trust Fund to offset revenue reductions, totaling approximately \$117.3 million in 2025-26.

PRIOR VOTES:

Assembly Floor:	48 - 15
Assembly Appropriations Committee:	10 - 4
Assembly Privacy and Consumer Protection Committee:	9 - 4
Assembly Labor and Employment Committee:	5 - 2
Assembly Health Committee:	11 - 1

COMMENTS:

- 1) *Author’s statement.* According to the author, healthcare workers are facing new challenges as AI is integrated into their workplaces. They are pressured by employers to defer to AI systems that may be opaque, erroneous, or systemically biased. They face an added risk of professional and legal blame when they follow algorithmic recommendations that fail. This bill preserves healthcare workers’ ability to follow their professional judgment by prohibiting employer retaliation when a worker overrides or follows a recommendation. This bill requires transparency for AI tools so that providers understand how they work and what the risks are. Overall, this bill requires that AI tools are used to support clinical judgement—not replace it, ensuring that human expertise and patient safety remain the focus of California’s healthcare system.
- 2) *What is generative AI?* In a draft regulation, the CPPA defines AI as follows: AI means a machine-based system that infers, from the input it receives, how to generate outputs that can influence physical or virtual environments. The AI may do this to achieve explicit or implicit objectives. Outputs can include predictions, content, recommendations, or decisions. Different AI varies in its levels of autonomy and adaptiveness after deployment. For example, AI includes generative AI models, such as large language models (LLMs), that can learn from inputs and create new outputs, such as text, images, audio, or video; and facial- or speech-recognition or -detection technology.

According to an article in *MIT News*, from the Massachusetts Institute of Technology, before the generative AI boom of the past few years, when people talked about AI, typically they were talking about machine-learning models that can learn to make a prediction based on data. For instance, such models are trained, using millions of examples, to predict whether a certain X-ray shows signs of a tumor or if a particular borrower is likely to default on a loan.

Generative AI can be thought of as a machine-learning model that is trained to create new data, rather than making a prediction about a specific dataset. A generative AI system is one that learns to generate more objects that look like the data it was trained on. Generative AI systems such as ChatGPT are powerful because they are trained on extremely large datasets, which could potentially take advantage of nearly all the information on the internet. According to an article published by *CalTech Science Exchange*, today's generative AI models produce content that often is indistinguishable from that created by humans. Generative AI has successfully written news articles, created realistic artwork, and composed aesthetically pleasing music. While these applications sometimes make glaring mistakes (sometimes referred to as hallucinations), they are being used for many purposes, including in health care.

- 3) *Generative AI in health care.* According to a July 25, 2023 viewpoint article in the *Journal of the American Medical Association*, "Generative AI in Health Care and Liability Risks for Physicians and Safety Concerns for Patients," generative AI is being heralded in the medical field for its potential to ease the long-lamented burden of medical documentation by generating visit notes, treatment codes, and medical summaries. This article stated that to date, no court in the U.S. has considered the question of liability for medical injuries caused by relying on AI-generated information. The article warned that to minimize risks, even medical professionals must exercise caution when relying on AI-generated information, due to the "black-box" nature of how these systems generate output, because it may be impossible for the physician to independently evaluate the accuracy of the AI's output. An article in *Implement Science*, published in March 2024, stated that the utility and impact of generative AI in healthcare remain poorly understood, with concerns about ethical and legal implications, integration into healthcare service delivery, and workforce utilization. The American Medical Association (AMA) published "Principles for Augmented Intelligence Development, Deployment, and Use," which was approved by the AMA Board of Trustees on November 14, 2023. According to this AMA document, as the number of AI-enabled health care tools and systems continue to grow, these technologies must be designed, developed, and deployed in a manner that is ethical, equitable, responsible, and transparent. The AMA notes that while the U.S. Food and Drug Administration (FDA) regulates AI-enabled medical devices, many types of AI-enabled technologies fall outside the scope of FDA oversight, including AI that may have clinical applications, such as some clinical decision support functions. The AMA report specifically looked at transparency in use of AI-enabled systems, and stated that it is essential that use of AI in health care be transparent to both physicians and patients, and disclosure should contribute to physician and patient knowledge and not create unnecessary administrative burden. The AMA report states that when AI is utilized in health care decision-making, that use should be disclosed and documented in order to limit risks to, and mitigate inequities for, both physicians and patients. The AMA noted that while transparency does not necessarily ensure AI-enabled tools are accurate, secure, or fair, it is difficult to establish trust if certain characteristics are hidden. According to the AMA, when AI is used in a manner which directly impacts patient care, access to care, or medical decision-making, that use of AI should be disclosed and documented to both physicians and patients. The opportunity for a patient to request additional review from a licensed clinician should be made available upon request. The AMA policy also states that AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review.

- 4) *Disclosure requirements at least partially based on federal standards for health information technology developers.* The author and sponsors have pointed to standards adopted by the Office of the National Coordinator for Health Information Technology (ONC), which is part of the federal Department of Health and Human Services. As part of the final rule implementing the Electronic Health Record Reporting Program provision of the 21st Century Cures Act, on January 9, 2024, the ONC adopted certification requirements for a “decision support intervention (DSI),” which revised the “clinical decision support” criterion. According to the ONC, this final rule directly responds to the emergence of AI and machine learning-based predictive algorithms used to aid decision-making in health care. The ONC requirements apply to Predictive DSIs that are supplied by Certified Health IT developers. Predictive DSIs that are developed by a health system, or a third-party technology company are not subject to the requirements unless or until a Certified Health IT developer supplies a Predictive DSI as part of a Certified Health IT module. While the certification program is technically a voluntary program, health providers are required to use certified electronic health record technology to participate in incentive programs such as the Medicare Promoting Interoperability Program. Among the certification requirements for a Predictive DSI, are a list of source attributes that include many of the disclosure requirements in this bill, including funding source, description of output, intended use and population target, cautioned out-of-scope use, process used to ensure fairness, and description of the validation process, among other overlaps. Other requirements in this bill are not included in the ONC certification requirements, such as the requirements in this bill of a list of the inputs into the system, and a description of how the covered tool generates output.
- 5) *Model card proposed by the Coalition for Health AI.* The Coalition for Health AI (CHAI), is a coalition of nearly 3,000 organizations and hundreds of individual experts, including 218 health systems, and describes itself as a public-private partnership committed to harnessing the transformative potential of AI to improve clinical practice and accelerate healthcare innovation. CHAI states that they are a trusted convener and consensus-builder, and unites a diverse network of interdisciplinary stakeholders to shape the development, evaluation, and implementation of responsible AI in healthcare. One of CHAI’s projects is the “applied model card,” which describes an AI system focused on the application in a health use case. The author and sponsors have pointed to CHAI’s model card as an example of how a health care entity might comply with the disclosure requirements in this bill. According to information on CHAI’s website, the model card supports meeting the criteria developed by the ONC (described in 4) above), and additionally, provides transparency for all five of CHAI’s Principles of Responsible AI: transparency, safety, security & privacy, fairness & bias, and usefulness. According to CHAI, individuals or teams completing the model card can include vendor or health organization developers of applied AI solutions. The primary intended use of this model card is for transparency purposes, and may be used as part of transparency processes during procurement, or as internal transparency documentation for tracking or governance of AI solutions within a health organization. CHAI developed a model template with a number of data fields, including the following: warnings, such as known limitations, biases, or ethical considerations; system facts, such as outputs, foundation models used in application, input data source, development data characterization, and bias mitigation approaches; transparency information, such as funding source of the technical implementation, third party information if applicable, and stakeholders consulted during the design; key metrics across the categories of useability and efficacy, fairness and equity, and safety and reliability; and, resources, such as clinical trials or peer reviewed publications, reimbursement status, patient consent or disclosure required or suggested, etc. CHAI’s

website includes a populated model card based on an AI model related to triage for intracranial hemorrhage, which ran several pages of detailed and dense information.

- 6) *Racial bias in algorithms and AI.* Several studies have identified risks of racial bias in algorithms and AI. An October 2019 article in the journal *Science*, “Dissecting racial bias in an algorithm used to manage the health of populations,” found that Black patients assigned the same level of risk by the algorithm are sicker than White patients. The study estimated that this racial bias reduces the number of Black patients identified for extra care by more than half. According to the study, bias occurs because the algorithm uses health costs as a proxy for health needs, and because less money is spent on Black patients who have the same level of need, the algorithm falsely concludes that Black patients are healthier than equally sick White patients. The journal *NPJ Digital Medicine* published a study in 2023, “LLMs propagate race-based medicine,” that assessed four LLMs used in healthcare systems. The study found that all models had examples of perpetuating race-based medicine in their response to questions. Models were not always consistent in their response when asked the same question repeatedly, and that based on their findings, these LLMs could potentially cause harm by perpetuating debunked, racist ideas.
- 7) *Trustworthy AI.* The federal Health and Human Services Agency (HHS) has developed a “playbook” for AI development with the goal of maintaining public trust by using AI solutions that are “ethical, effective, and secure,” according to the HHS Chief AI Officer. With regard to HHS agencies, principles have been established for trustworthy AI that “fosters public trust and confidence while protecting privacy, civil rights, civil liberties, and American values, consistent with applicable laws.” The playbook describes AI as whether the solution or system:
 - a) Performs tasks under varying and unpredictable circumstances without significant human oversight, or can learn from experience and improvement performance when exposed to data sets;
 - b) Uses computer software, physical hardware, or other technology to solve tasks that require human-like perception, thinking, planning, learning, communication, or physical action;
 - c) Thinks or acts like a human, including the use of cognitive architecture or neural networks (e.g., developed to mimic the underlying mechanisms of the human mind);
 - d) Relies on a set of techniques, including machine learning, to approximate a cognitive task; and,
 - e) Is designed to act rationally by utilizing intelligent software or an embodied robot to achieve goals using perception, planning, reasoning, learning, communicating, decision-making, and action.

The HHS principles for use of trustworthy AI in government cover six areas: fair and impartial application; transparent and explainable data use; responsible and accountable governance and policies; robust and reliable outputs; safe and secure from risks; and, that privacy should be respected, data not used beyond its intended and stated use, and that its use is approved by the data owner or steward.

- 8) *Triple referral.* This bill is triple referred. Should it pass out of this Committee, it will be referred to the Senate Committee on Labor, Public Employment and Retirement, followed by the Senate Committee on Privacy, Digital Technologies, and Consumer Protection.

- 9) *Related legislation.* SB 503 (Weber Pierson) would impose requirements on developers and deployers of AI systems used to support clinical decision-making or health care resource allocation, including that they make reasonable efforts to mitigate the risk of biased impacts in the system's outputs resulting from the use of the systems in health programs or activities. *SB 503 is pending on the Assembly Floor.*

SB 813 (McNerney) would require the Government Operations Agency to establish the California Artificial Intelligence Standards and Safety Commission to designate "independent verification organizations," which would ensure compliance with best practices for the prevention of personal injury and property damage and certify qualified AI models or AI applications. *SB 813 is pending in the Assembly Privacy and Consumer Protection Committee.*

SB 903 (Padilla) would prohibit individuals or corporations from using, advertising, or offering psychotherapy services, including through AI, unless conducted by a licensed health care professional, as defined. Would authorize licensed health care professionals to use AI for limited administrative or supplementary support, as indicated. SB 903 would provide state licensing boards and enforcement agencies the authority to pursue legal recourse for any violations. *SB 903 is pending in the Assembly Business and Professions Committee.*

AB 1018 (Bauer-Kahan) would regulate the use of automated decision systems (ADS) used to make consequential decisions, as defined, and would require a developer of a covered ADS to take certain actions, including conducting impact assessments. *AB 1018 is pending on the Senate Floor.*

AB 1898 (Schultz) would require employers to give workers at least 90 days' advance written notice before deploying any "workplace AI tool," defined to include both automated decision systems and AI-based surveillance technologies; require employers to provide workers a notice that, among other disclosures, lists the tools used by the employers, each tool's purpose, the data it collects, the employment decisions it may affect, and any quotas the tool sets or enforces; and, allow enforcement by the Labor Commissioner, public prosecutors, and workers themselves, with civil penalties of up to \$500 per violation. *AB 1898 was held on the Assembly Appropriations Committee suspense file.*

AB 1979 (Bonta) subjects businesses offering "healthcare chatbots" to the California Medical Information Act, and imposes guardrails around the use of automated decision systems and other generative AI models in clinical decisionmaking. *AB 1979 is pending in the Senate Privacy, Digital Technologies, and Consumer Protection Committee.*

- 10) *Prior legislation.* SB 7 (McNerney of 2025) would have required an employer, or a vendor engaged by the employer, to provide a written notice that an ADS, for the purpose of making employment-related decisions, is in use at the workplace to a worker who will be directly or indirectly affected by the ADS, as specified. Defined ADS as any computational process derived from machine learning, statistical modeling, data analytics, or AI that issues simplified output, including a score, classification, or recommendation, that is used to assist or replace human discretionary decision-making and materially impacts natural persons. *SB 7 was vetoed by the Governor, who stated, in part, that he "shared the author's concern that in certain cases unregulated use of ADS by employers can be harmful to workers. However, rather than address the specific ways employers misuse this technology, this bill imposes unfocused notification requirements on any business using even the most innocuous tools.*

This proposed solution fails to directly address incidents of misuse.”

SB 243 (Padilla and Becker, Chapter 677, Statutes of 2025) establishes specified requirements on persons who make a companion chatbot that uses an AI system with a natural language interface, as specified, to protect users.

AB 489 (Bonta, Chapter 615, Statutes of 2025) prohibits AI and generative AI systems from misrepresenting themselves as licensed or certified healthcare professionals and provides state licensing boards or enforcement agencies the authority to pursue legal recourse against developers or deployers of these systems.

SB 1120 (Becker, Chapter 879, Statutes of 2024) establishes requirements on health plans and insurers applicable to their use of AI for utilization review and utilization management decisions, including, that the use of AI, algorithm, or other software must be based upon a patient’s medical or other clinical history and individual clinical circumstances as presented by the requesting provider and not supplant health care provider decision making.

AB 2930 (Bauer-Kahan of 2024) would have regulated the use of ADSs in order to prevent “algorithmic discrimination.” This includes requirements on developers and deployers that make and use these tools to make “consequential decisions” to perform impact assessments on ADSs. AB 2930 would have also established the right of individuals to know when an ADS is being used, the right to opt out of its use, and an explanation of how it is used. *AB 2930 died on the Assembly Floor.*

AB 3030 (Calderon, Chapter 848, Statutes of 2024) requires a health facility, clinic, physician’s office, or office of a group practice that uses generative AI to generate written or verbal patient communications pertaining to patient clinical information to ensure that those communications include a disclaimer that indicates to the patient that the communication was generated by generative AI and clear instructions on how the patient may contact a human person.

AB 858 (Jones-Sawyer of 2022) would have provided that a direct patient care worker at a general acute care hospital and their collective bargaining representative shall be notified of the implementation of new health information technology, may provide input in such implementation, and is permitted to override it, as specified, without fear of discrimination or retaliation. *AB 858 was vetoed by the Governor, with his veto message stating it was “Per the request of the author and sponsor.”*

- 11) *Support.* This bill is co-sponsored by the California Nurses Association/National Nurses United (CNA) and the California Federation of Labor Unions. According to CNA, as hospitals rapidly adopt AI-driven technologies that influence clinical decisions and working conditions, California must ensure that these tools support safe patient care rather than undermine professional standards or patient protections. CNA states that hospitals and clinics now use AI tools in electronic health records, clinical decision-support systems, remote monitoring platforms, staffing management software, and administrative workflows. California currently lacks clear guardrails governing the use of AI in health care settings, and evidence increasingly shows that many AI tools used in health care algorithms raise serious safety and accuracy concerns. CNA also argues that lack of transparency prevents clinicians and patients from understanding how AI systems influence care decisions, and that health care entities often provide little or no information about when AI tools are used, how they

generate outputs, what data they rely on, or what limitations they carry. Without this information, nurses cannot fully evaluate the reliability of automated recommendations that appear in clinical workflows. CNA asserts that existing federal guidance has already demonstrated that developers can disclose key information about algorithm design, training data, and system limitations through standardized document such as “model cards.” According to CNA, the disclosure requirements in this bill align with previously established federal standards by the ONC, which required developers of clinical decision support tools to provide information about a tool’s design, purpose, and limitations. Hospitals require nurses and other health care workers to rely on technologies chosen by their employers, yet when those systems make mistakes, clinicians often bear the consequences. CNA states that nurses increasingly spend hours reviewing, correcting, and verifying AI-generated documentation that may contain errors or missing information. CNA nurses support tested and regulated technology that strengthens our ability to provide safe, high-quality care. However, we cannot allow technology to override professional judgment, justify unsafe staffing, or shift responsibility for corporate technology failures onto frontline caregivers. The California Federation of Labor Unions makes similar arguments, and points to a recent Virginia Tech study that found that AI systems designed to predict patient risk of death are failing to recognize critical inductions much of the time, demonstrating the risk that reliance on AI tools could mislead providers. However, the California Labor Federation states health care workers have few protections if they choose to disregard automated recommendations.

- 12) *Opposition.* This bill is opposed by a large coalition of health care provider organizations, and business organizations, including the California Hospital Association, the California Medical Association, the California Chamber of Commerce, Advanced Medical Technology Association, and others. Opponents state that AI utilized in clinical decision support systems has the potential to improve nearly every aspect of health care, and that these systems are the latest in a series of innovative resources that trained and experienced health care providers use to help their patients. Opponents point to a number of examples, including AI-assisted imaging tools that help radiologists identify suspicious findings in mammograms, chest scans, and pathology slides; tools that provide sepsis alerts, flag concerning imaging results, and offer clinical decision support to enable clinicians to better assess a patient’s condition; and, AI-generated clinical summaries that are used to help with handoffs between nurses, physicians, and other licensed professionals. Opponents state that before any AI tool is deployed, it undergoes an extensive review process, including via multidisciplinary committees from the health care workers who will use it, standardized privacy and security assessments, and review of AI registries. No AI platform is continued for use in patient care without a thorough assessment and ongoing monitoring for effectiveness and safety. At every stage of clinical care, opponents state that health care professionals retain full oversight and responsibility. Health care providers do not deploy AI or related technologies to make care decisions; instead, they are used to assist and free up resources for patient care, reduce clinician burnout, and expand early warning systems. Opponents state that this bill would undermine patient-centric policies and conflict with medical staff rules and regulations by protecting any worker who provides direct patient care from reprimand or discipline. This bill would essentially create a new protected class of workers, allowing them to make independent, subjective decisions about patient care without accountability, so long as those decisions fall within their scope of practice. Opponents argue that this would effectively give any worker who provides care unfettered authority, even when the subjective judgment causes patient harm. If a patient were to suffer harm, or even if harm is averted after a clinician “overrides” a tool’s output, the health facility would be unable to take corrective action, as doing so would be considered retaliation under this bill. Opponents state that this

bill would force health providers to pull back AI tools that patients and clinicians currently rely on, and point to a 2025 review of 92 published studies that found AI tools are delivering meaningful improvements across the health care system, in real clinical settings. Opponents state that this bill's disclosure requirements would force health care entities to disable AI tools currently embedded within electronic health record platforms, which are the same platforms California law requires providers to use to meet the health data exchange obligations. The disclosure requirements include details that may not be available for all tools or even to the deployer of the technology. Further, the content list applies to everything meeting the definition of a clinical decision support system, so a decades-old interaction checker or assessment score carries the same burden as a new diagnostic tool. Failing to include all of the information, even when it may not be available or applicable to a specific tool, would potentially bring criminal penalties and a private right of action. Opponents state that AI is not an aspiration in health care, but is a reality that is currently saving lives. We have a shared obligation to ensure that these tools continue to be developed and deployed responsibly, equitable, and transparently. This bill would not achieve those goals, but would bury health care providers in unworkable disclosure requirements, create perverse liability incentives, undermine patient safety systems, impair clinical quality oversight, increase costs, and ultimately reduce patient access to beneficial technology.

SUPPORT AND OPPOSITION:

Support: California Nurses Association (co-sponsor)
 California Federation of Labor Unions (co-sponsor)
 American Federation of State, County and Municipal Employees
 California Alliance for Retired Americans
 California Democratic Party Rural Caucus
 California Faculty Association
 California Federation of Teachers
 California Pan - Ethnic Health Network
 California School Employees Association
 Consumer Watchdog
 Engineers and Scientists of California, IFPTE Local 20
 Health Access California
 National Union of Healthcare Workers
 Oakland Privacy
 Osteopathic Medical Board of California
 TechEquity Action
 Western Center on Law & Poverty, Inc.

Oppose: Advanced Medical Technology Association
 Adventist Health
 America's Physician Groups
 Association of California Life & Health Insurance Companies
 Association of Dental Support Organizations
 American Telemedicine Association Action
 Biocom California
 California Association of Health Facilities
 California Association of Health Plans
 California Chamber of Commerce
 California Dental Association
 California Hospital Association

California Life Sciences
California Medical Association
California Podiatric Medical Association
California Primary Care Association Advocates
California Radiological Society
California Society of Pathologists
Central City Association of Los Angeles
Civil Justice Association of California
Connected Health Initiative
Glendale Chamber of Commerce
Greater Conejo Valley Chamber of Commerce
Kaiser Permanente
LAX Coastal Chamber of Commerce
Los Angeles Area Chamber of Commerce
Oceanside Chamber of Commerce
Ochin, Inc.
Orange County Business Council
Planned Parenthood Affiliates of California
San Gabriel Valley Economic Partnership
Santa Monica Chamber of Commerce
Scripps Health
Southwest California Legislative Council
Stanford Health Care
Sutter Health
TechNet
The Greater Coachella Valley Chamber of Commerce
Tri County Chamber Alliance
University of California

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