Office of Senate Floor Analyses
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THIRD READING

Bill No: AB 2575
Author: Ortega (D)
Amended: 6/18/26 in Senate
Vote: 21

SENATE HEALTH COMMITTEE: 8-2, 6/17/26
AYES: Weber Pierson, Caballero, Durazo, Gonzalez, Menjivar, Padilla, Pérez, Smallwood-Cuevas
NOES: Valladares, Grove
NO VOTE RECORDED: Rubio

SENATE LABOR, PUB. EMP. & RET. COMMITTEE: 4-1, 6/24/26
AYES: Smallwood-Cuevas, Cortese, Durazo, Laird
NOES: Strickland

SENATE PRIV., DIGITAL TECH. & CONS. PROT. COMMITTEE: 6-2, 6/29/26
AYES: Gonzalez, McNerney, Padilla, Reyes, Umberg, Wiener
NOES: Seyarto, Ochoa Bogh
NO VOTE RECORDED: Cabaldon

ASSEMBLY FLOOR: 48-15, 5/27/26 - See last page for vote

SUBJECT: Health care services: artificial intelligence

SOURCE: California Nurses Association
California Federation of Labor Unions

DIGEST: This bill requires a health facility and other health providers that use or deploy a clinical decision support system for patient care to make information about these systems available to any licensed health care professional or other person that views outputs from a clinical decision support system. 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.

ANALYSIS:

Existing law:

1) Establishes the California Department of Public Health (CDPH) which licenses and regulates health facilities and clinics. [HSC §1200 et seq., §1250 et seq.]

2) 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]

3) 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.

4) 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]

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 that produces a prediction, classification, recommendation, evaluation, or analysis used to inform clinical decision-making with respect to the provision, timing, or course of patient care.

4) Requires, on or before July 1, 2027, 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 make available, upon request from a person using a clinical decision support system, an inventory of all clinical decision support systems currently in use, and requires this list to be updated annually.

5) Requires a health facility, clinic, physician’s office, or office of a group practice to make available, upon request from a person using a clinical decision support system, information about the system, including all of the following:
   a) A summary of the clinical decision support system, including developer and description of the output produced by the system;
   b) Intended use of the clinical decision support system, including intended patient population, intended users, and intended role in supporting clinical decisionmaking;
   c) Cautioned out-of-scope use of the clinical decision support system, including known risks and limitations;
   d) Summary of how the clinical decision support system generates outputs;
   e) Summary of the training set or clinical research underlying recommendations, including demographic representativeness and known biases based on protected characteristics;
   f) Summary of the validation process;
   g) Summary of qualitative measures of performance; and,

h) A link to the Certified Health IT Product List produced by the Office of the National Coordinator for Health Information Technology at the United States Department of Health and Human Services.

6) Requires a health facility, clinic, physician's office, or office of a group practice to notify a person whose duties including using a clinical decision support system, upon hire and annually, of their right to request the inventory of all clinical decision support systems currently in use.

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 an administrative enforcement process.

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) 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.

11) 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.

12) Specifies that the protection in 11) above against employer retaliation or discrimination does not affect a worker's duty do any of the following:
   a) Meet the applicable standard of care;
   b) Act within their scope of practice;
   c) Exercise independent judgment in providing direct patient care;
   d) Follow standard operating procedures or other policies established by the employer or by a California governmental department; or,

e) Comply with regulations governing the planning and implementation of 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) Requires the Labor Commission to enforce the anti-retaliation and discrimination provisions of this bill, including investigating an alleged violation, ordering appropriate temporary relief to mitigate a violation or maintain the status quo pending the completion of a full investigation or hearing, issuing a citation to an employer, and filing a civil action.

15) Requires the Labor Commissioner to determine whether an employer retaliated or discriminated against a worker, and to consider evidence relevant to the reasons the employer took the action alleged to be retaliation or discrimination, including evidence supporting the alternate reasons for the action, such as an alleged failure by the worker to satisfy a duty described in 12) above.

16) Specifies that the Labor Commissioner is not required to adjudicate or make a final determination of whether a worker met or failed to meet a duty described in 12) above. Specifies that a determination under these provisions is not determinative of any legal action for professional negligence or malpractice or disciplinary action against a professional license, and these provisions do not limit the authority of an appropriate licensing authority or a court.

17) 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.

18) Specifies that the provision in 17) above 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, including evidence that the defendant took reasonable precautions to prevent harm, as specified.

19) Specifies that the provision in 17) above does not apply to an action for injury or death against a licensed health care provider based upon professional negligence, as specified.

Comments

According to the author of this bill:

> 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.

Background

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.

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.

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.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Senate Appropriations Committee,

- Unknown ongoing costs, ranging in the low millions, for CDPH for state administration (Licensing and Certification Fund). Costs would cover staffing resources needed to verify health facilities and clinics are disclosing all the required technical information related to the written disclosure about the clinical decision support system.
- Unknown ongoing costs, ranging in the low millions, for the Labor Commissioner's Office for state administration (Labor Enforcement and Compliance Fund). The actual costs would depend on a number of factors, including, but not limited to, the volume and nature of the complaints filed.
- Minor and absorbable costs for the Osteopathic Medical Board of California to oversee complaints.
- Minor costs for the Medical Board of California resulting from an increase in complaints (Medical Board Contingent Fund).
- Unknown ongoing costs for the University of California (UC) health centers, potentially low tens of millions (costs would be covered by UC health center revenues), for compliance.
- No significant fiscal impact to the California Department of Justice.
- Unknown, potential workload costs to the courts related to enforcement of civil penalties (Trial Court Trust Fund, General Fund). While the courts are not

funded on a workload basis, an increase in workload could result in delayed court services and would put pressure on the General Fund to increase the amount appropriated for trial court operations.

SUPPORT: (Verified 8/14/26)

California Nurses Association (cosource)
California Federation of Labor Unions (cosource)
Alameda County Democratic Party
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
County of Ventura
Engineers and Scientists of California, IFPTE Local 20
Health Access California
National Union of Healthcare Workers
Oakland Privacy
Osteopathic Medical Board of California
Peace and Freedom Party of California
TechEquity Action
Western Center on Law & Poverty, Inc.

OPPOSITION: (Verified 8/14/26)

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 Children's Hospital Association
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
Los Angeles County Business Federation
MemorialCare Health System
Oceanside Chamber of Commerce
Ochin, Inc.
Orange County Business Council
Planned Parenthood Affiliates of California
Private Essential Access Community Hospital
San Diego Regional Chamber of Commerce
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
Valley Industry and Commerce Association
University of California

ARGUMENTS IN 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.

ARGUMENTS IN 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 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. 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.

ASSEMBLY FLOOR: 48-15, 5/27/26
AYES: Addis, Aguiar-Curry, Ahrens, Arambula, Bains, Bauer-Kahan, Bennett, Berman, Boerner, Bonta, Bryan, Calderon, Caloza, Connolly, Davies, Elhawary, Fong, Gabriel, Garcia, Mark González, Haney, Harabedian, Hart, Jackson, Kalra, Krell, Lee, Lowenthal, McKinnor, Muratsuchi, Ortega, Pacheco, Papan, Patel, Pellerin, Ransom, Michelle Rodriguez, Rogers, Schiavo, Schultz, Sharp-Collins, Solache, Stefani, Ward, Wicks, Wilson, Zbur, Rivas
NOES: Ávila Farías, DeMaio, Dixon, Ellis, Flora, Jeff Gonzalez, Hadwick, Hoover, Johnson, Lackey, Macedo, Sanchez, Ta, Tangipa, Wallis
NO VOTE RECORDED: Alanis, Alvarez, Carrillo, Castillo, Chen, Gallagher, Gipson, Irwin, Nguyen, Patterson, Petrie-Norris, Quirk-Silva, Ramos, Celeste Rodriguez, Blanca Rubio, Soria, Valencia

Prepared by: Vincent D. Marchand / HEALTH / (916) 651-4111
8/17/26 9:53:52

****** END ******