GOVERNOR'S VETO
AB 2575 (Ortega)
As Enrolled September 4, 2026
2/3 vote

SUMMARY

Prohibits an employer from retaliating or discriminating against a worker providing patient care based solely on the worker's override of, or reliance on, the output of a clinical decision support system (CDSS), as defined, and specifies certain duties not affected by these prohibitions. Authorizes a worker who is subject to retaliation or discrimination in violation of this bill to file a complaint with the Labor Commissioner against an employer. Prohibits a defendant who developed, modified, selected, or deployed a CDSS that is alleged to have harmed a plaintiff from asserting a defense that the failure of a licensed health care professional or other health care worker to override an output of the CDSS is a superseding cause severing the defendant's liability for the alleged harm.

Senate Amendments

1) Strike the provisions requiring a health facility to create an inventory of CDSSs and to disclose certain information to licensed health care professionals or others viewing outputs of the CDSS, upon request.

2) Define "CDSS" to mean an artificial intelligence system that produces a prediction, classification, recommendation, evaluation, or analysis that aids clinical decisionmaking related to timing of care, diagnosis, or treatment. It does not include booking, canceling and rescheduling appointments, appointment reminders, patient education and previsit materials and preparation, and payment processing, to the extent the independent performance of these activities by the system does not require a professional license.

3) Expand on a worker's duties that are not affected by the retaliation and discrimination protections to also include: following standard operating procedures or other policies established by the employer or by a California governmental department or agency; complying with regulations regarding planning and implementation of patient care; complying with antidiscrimination requirements; and complying with the bylaws, rules, and regulations relative to an organized medical staff. State that a policy, procedure, or protocol that requires a worker to accept, defer to, or refrain from overriding the output of a CDSS is not a duty described in this bill.

4) Specify the considerations and determinations to be made by the Labor Commissioner in enforcing the labor provisions of this bill.

5) Add to the list of defenses not limited or precluded by this bill: evidence that the defendant took reasonable precautions to prevent harm, including providing clear and conspicuous disclosures and disclaimers regarding the intended use, scope, known risks, and limitations of a system to the health facility, clinic, physician's office, or office of a group practice. Clarifies that this bill does not apply in medical malpractice lawsuits.

Governor's Veto Message
While I commend the author's commitment to ensure that artificial intelligence (Al) technologies deployed in clinical settings support safe patient care and preserve professional standards, including the ability of healthcare workers to exercise their professional judgment, it is essential that new laws in this area be practical and enforceable in their implementation to achieve their intended goals.

This bill's anti-retaliation provisions do not protect workers as intended. By prohibiting adverse actions based solely on the employee's override of, or reliance on, a clinical decision support system, this bill ties the Labor Commissioner's hands in establishing a violation – a higher bar than other retaliation protections, which simply prohibit action because of a protected activity.

More importantly, linking anti-retaliation protections to a scope-of-practice determination puts the Labor Commissioner in the position of adjudicating the standard of care for patients – something the Labor Commissioner does not have the medical expertise or skill to do. Without that requisite specialized knowledge, the Labor Commissioner cannot effectively and fairly enforce the bill's anti-retaliation provisions as the author intends.

COMMENTS

Artificial Intelligence (AI). AI is the mimicking of human intelligence by artificial systems. AI uses algorithms, or sets of rules, to transform inputs into outputs. Inputs and outputs can be anything a computer can process: numbers, text, audio, video, or movement. AI is not fundamentally different from other computer functions; unlike other computer functions, however, AI is able to accomplish tasks that are normally performed by humans. Most modern AI tools are created through a process known as "machine learning." Machine learning involves techniques that enable AI tools to learn the relationship between inputs and outputs without being explicitly programmed. The next step is "training," the process of exposing a naïve AI to data. The algorithm that an AI develops during training is known as its "model." Models trained on small, specific datasets in order to make recommendations and predictions are referred to as "predictive AI." This differentiates them from "generative AI" (GenAI), which are trained on massive datasets in order to produce detailed text, images, audio, and video. Because it can process a range of data sources and create novel outputs, and because it can convincingly mimic human capabilities and convincingly generate perfectly worded nonsense, GenAI poses unique opportunities and challenges.

Administrative and clinical-adjacent uses of AI applications in health care. Hospitals, clinics, physician groups, and health plans are leveraging GenAI to automate a wide range of routine back-office tasks as well as those tasks that provide administrative support for clinical work.

For instance, electronic health record (EHR) systems are being equipped with GenAI functionality that allows health care providers to automatically generate billing codes, improving accuracy and completeness by checking for errors, omissions, and compliance with current requirements. At the same time, health plans and insurers are using AI on the other end of the transaction to automate and streamline multiple functions, including processing claims and evaluating prior authorization requests. According to the *Wall Street Journal*, UnitedHealth Group said it now has a thousand AI applications in production, even as a class action lawsuit is advancing through the courts accusing the insurer of using AI algorithms instead of medical professionals to illegally deny Medicare Advantage claims. Other types of administrative tasks, such as appointment scheduling and other routine, non-clinical communication have significant

potential to be automated. Researchers also believe AI can assist in generation of quality metrics, which are important for measuring health system performance but often rely on data that must be manually extracted from EHRs. Similar to the Layer Health project mentioned above, a pilot study found that large language models (LLMs) could perform accurate extractions of specific data from these patient records for use in calculating complex quality measures.

Racial, ethnic, and gender bias. The performance of an AI is directly impacted by the quality, quantity, and relevance of the data used to train it. If the data used to train the AI is biased, the tool's outputs will be similarly biased and the results can be inaccurate when applied to populations not reflected in the training data. When automated decision systems are deployed in healthcare, biased historical data can lead to patients being recommended substandard care on the basis of their race or ethnicity. In 2007, an automated decision system was developed to help doctors estimate whether it was safe for people who had delivered previous children through cesarean section to deliver subsequent children vaginally. The system considered relevant factors as it made its decision, such as the woman's age, her reason for the previous cesarean, and how long ago the cesarean had been performed. However, a 2017 study found that the system was biased; it predicted Black and Latino people were less likely to have a successful vaginal birth after a cesarean than similar non-Hispanic white women. As a result, doctors performed more cesareans on Black and Latino people than on white people. Such discrepancies can potentially perpetuate historical biases and lead to worse health outcomes. The University of California (UC), San Francisco also reported bias in an algorithm used to identify potential appointment no-shows to facilitate double-booking for that appointment. The program was confirmed to result in low-resourced and marginalized populations being double-booked more often than others, reflecting underlying structural inequalities and highlighting how these tools, if not studied and corrected for bias, that can create feedback loops that worsen discrimination.

Cognitive biases and cognitive burden. Bias exhibited by an AI model based on underlying training data is not the only bias that may influence how an AI system works when deployed. Its effectiveness can also be impacted by predicable patterns of human error called cognitive biases. Reviewing an AI system's output for errors or omissions is a substantively different cognitive task than generating a clinical note or medical advice, and the use of AI systems raise questions about how cognitive bias evoked by AI assistance with clinical tasks might affect clinical judgement or practice in ways that are difficult to understand, predict, and measure.

Research shows automation bias, or placing undue confidence in and over-relying on automated outputs, is a problem in many fields. Automation-induced complacency, or insufficient monitoring of automation output, is also a concern. Over time, these biases can lead to people being less likely to catch errors or to disagree with what was written. There are many factors that can exacerbate the potential danger posed by automation bias in CDSS, including, for instance, if an AI model's process to arrive a given output lacks transparency or is not explainable, if the model is implemented with inadequate training of end users, or if a clinician is under significant time pressure or cognitive burden that limits their practical ability to systematically assess and effectively integrate the additional information provided by an AI system with their clinical knowledge and experience.

According to the Author
Health care 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. The author argues this bill preserves healthcare workers' ability to follow their professional judgment by prohibiting employer retaliation when a worker overrides or follows a recommendation, and requires transparency for AI tools so that patients and providers understand how they work and what the risks are. The author concludes that, 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 health care system.

Arguments in Support
The California Nurses Association (CNA) is a co-sponsor of this bill and states in support that this bill is necessary because California law currently lacks guardrails governing the use of AI in health care settings to ensure transparency, protect professional judgment, or establish accountability when these technologies contribute to harmful patient outcomes. Hospitals and clinics now use AI tools in electronic health records, clinical decision-support systems, remote monitoring platforms, staffing management software, and administrative workflows. CNA argues that these AI systems generate patient acuity scores, treatment recommendations, discharge planning prompts, insurance determinations, and nurse workload assignments. As hospitals and other health care entities expand their adoption of AI tools, these tools are increasingly shaping both clinical decision-making and working conditions. CNA concludes that hospitals are increasingly introducing algorithmic systems that induce unsafe staffing levels, inappropriate clinical recommendations, and workplace monitoring without adequate transparency or accountability, putting patients and nurses at risk, and this bill helps ensure that emerging technologies support nurses' work and protect the patients they serve.

A coalition including Health Access California, the National Union of Health Care Workers, Teamsters, the California Federation of Labor Unions, and more supports this bill stating that an estimated 65% of U.S. hospitals are already using AI tools, including in direct patient care. They argue that this bill creates the conditions and guardrails to ensure that human health care workers are in command of AI tools used in direct patient care, and not commanded by them, protecting patients and workers. They contend that this bill protects health care workers' professional judgment by prohibiting employers from retaliating against workers who exercise their professional judgment to override or follow an AI tools' output. They also conclude that this bill ensures fair accountability when AI systems cause harm by prohibiting developers and deployers from using a superseding cause argument while allowing them to provide other defenses and evidence.

Arguments in Opposition
A coalition including ADVAMED, America's Physician Groups, ATA Action, Biocom, CalChamber, the California Hospital Association, California Association of Health Facilities, California Association of Health Plans, California Life Sciences, the California Medical Association, California Radiological Society, California Society of Pathologists, CPCA Advocates, Kaiser Permanente, Ochin, and more opposes this bill. The coalition states that AI utilized in CDSSs has the potential to improve nearly every aspect of health care, including quality, patient experience, and affordability. These systems are the latest in a series of innovative resources that trained and experienced health care providers use to help their patients. However, these providers do not deploy AI or related technologies to make care decisions; AI is simply used to assist with and maximize resources for patient care, reduce clinician burnout, and expand early warning systems. Clinician accountability and expertise are preserved at every stage of clinical care, and California's invaluable health care professionals retain full oversight and responsibility. The coalition argues that, despite these existing safeguards, this bill would

restrict the beneficial use of AI in health care while also creating significant liability and patient safety issues. The coalition contends that this bill gives a health care worker unrestrained authority to override a CDSS output without review or supervision, which could lead to patient harm, and allows health care workers to subjectively determine whether to incorporate potentially life-saving CDSS data into the care plan of patients.

TechNet, the Civil Justice Association of California, and Connected Health Initiative also opposed this bill stating it simultaneously expects clinicians to exercise independent professional judgment and retain decision-making authority yet forecloses developers from pointing to that very exercise of judgment—or failure to exercise it—as relevant to the causal chain. This creates a one-directional liability exposure that departs from established tort principles of shared responsibility. This framework may discourage developers from deploying beneficial tools in California, particularly for smaller companies and startups that cannot absorb the legal uncertainty. AI and CDSS have been used in clinical practice for over a decade under existing liability frameworks that already account for shared responsibility among developers, providers, and clinicians. They also argue that the retaliation protection provisions of this bill protect both overriding and relying on system outputs, which could create a de facto safe harbor for any clinical decision that references a CDSS tool, regardless of whether the decision meets the applicable standard of care. While this bill preserves the worker's duty to meet the standard of care, the interaction between these provisions will likely generate litigation and uncertainty.

FISCAL COMMENTS

According to the Senate Appropriations Committee:

1) Unknown ongoing costs, ranging in the low millions, for the Department of Public Health 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.

2) 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.

3) Minor and absorbable costs for the Osteopathic Medical Board of California to oversee complaints.

4) Minor costs for the Medical Board of California resulting from an increase in complaints (Medical Board Contingent Fund).

5) Unknown ongoing costs for UC health centers, potentially low tens of millions (costs would be covered by UC health center revenues), for compliance.

6) No significant fiscal impact to the California Department of Justice.

7) 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.

VOTES

ASM HEALTH: 11-1-4
YES: Bonta, Addis, Aguiar-Curry, Ahrens, Caloza, Mark González, Patel, Rogers, Schiavo, Sharp-Collins, Stefani
NO: Johnson
ABS, ABST OR NV: Chen, Carrillo, Patterson, Sanchez

ASM LABOR AND EMPLOYMENT: 5-2-0
YES: Ortega, Elhawary, Kalra, Lee, Ward
NO: Lackey, Chen

ASM PRIVACY AND CONSUMER PROTECTION: 9-4-2
YES: Bauer-Kahan, Bryan, Lowenthal, McKinnor, Ortega, Pellerin, Ward, Wicks, Wilson
NO: Macedo, DeMaio, Hoover, Irwin
ABS, ABST OR NV: Patterson, Petrie-Norris

ASM APPROPRIATIONS: 10-4-1
YES: Wicks, Aguiar-Curry, Calderon, Caloza, Fong, Mark González, Krell, Pellerin, Sharp-Collins, Solache
NO: Hoover, Dixon, Ta, Tangipa
ABS, ABST OR NV: Pacheco

ASSEMBLY FLOOR: 48-15-17
YES: 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
NO: Ávila Farías, DeMaio, Dixon, Ellis, Flora, Jeff Gonzalez, Hadwick, Hoover, Johnson, Lackey, Macedo, Sanchez, Ta, Tangipa, Wallis
ABS, ABST OR NV: Alanis, Alvarez, Carrillo, Castillo, Chen, Gallagher, Gipson, Irwin, Nguyen, Patterson, Petrie-Norris, Quirk-Silva, Ramos, Celeste Rodriguez, Blanca Rubio, Soria, Valencia

SENATE FLOOR: 21-10-9
YES: Allen, Archuleta, Arreguín, Becker, Blakespear, Cervantes, Cortese, Durazo, Gonzalez, Hurtado, Laird, Limón, McGuire, McNerney, Menjivar, Padilla, Pérez, Reyes, Smallwood-Cuevas, Wahab, Wiener
NO: Alvarado-Gil, Choi, Dahle, Grove, Jones, Niello, Ochoa Bogh, Seyarto, Strickland, Valladares
ABS, ABST OR NV: Ashby, Cabaldon, Caballero, Grayson, Richardson, Rubio, Stern, Umberg, Weber Pierson

SENATE FLOOR: 18-10-12
YES: Archuleta, Arreguín, Becker, Cervantes, Cortese, Durazo, Gonzalez, Laird, Limón, McGuire, McNerney, Menjivar, Padilla, Pérez, Reyes, Smallwood-Cuevas, Wahab, Wiener

NO: Alvarado-Gil, Choi, Grove, Hurtado, Jones, Niello, Ochoa Bogh, Seyarto, Strickland, Valladares
ABS, ABST OR NV: Allen, Ashby, Blakespear, Cabaldon, Caballero, Dahle, Grayson, Richardson, Rubio, Stern, Umberg, Weber Pierson

SENATE FLOOR: 40-0-0
YES: Allen, Alvarado-Gil, Archuleta, Arreguín, Ashby, Becker, Blakespear, Cabaldon, Caballero, Cervantes, Choi, Cortese, Dahle, Durazo, Gonzalez, Grayson, Grove, Hurtado, Jones, Laird, Limón, McGuire, McNerney, Menjivar, Niello, Ochoa Bogh, Padilla, Pérez, Reyes, Richardson, Rubio, Seyarto, Smallwood-Cuevas, Stern, Strickland, Umberg, Valladares, Wahab, Weber Pierson, Wiener

ASSEMBLY FLOOR: 51-16-12
YES: Addis, Aguiar-Curry, Ahrens, Alvarez, Arambula, Bains, Bauer-Kahan, Bennett, Berman, Boerner, Bonta, Bryan, Calderon, Caloza, Carrillo, Connolly, Davies, Elhawary, Fong, Gabriel, Garcia, Mark González, Haney, Harabedian, Hart, Jackson, Kalra, Krell, Lee, Lowenthal, McKinnor, Muratsuchi, Ortega, Papan, Patel, Pellerin, Ramos, Ransom, Celeste Rodriguez, Michelle Rodriguez, Rogers, Schiavo, Schultz, Sharp-Collins, Solache, Stefani, Valencia, Ward, Wicks, Zbur, Rivas
NO: Alanis, Ávila Farías, DeMaio, Dixon, Ellis, Flora, Jeff Gonzalez, Hadwick, Hoover, Johnson, Lackey, Macedo, Sanchez, Ta, Tangipa, Wallis
ABS, ABST OR NV: Castillo, Chen, Gipson, Irwin, Nguyen, Pacheco, Patterson, Petrie-Norris, Quirk-Silva, Blanca Rubio, Soria, Wilson

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