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CALIFORNIA HEALTH LAW NEWS

THE LATEST DEVELOPMENTS IN CALIFORNIA HEALTH LAW

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CALIFORNIA HEALTH LAW NEWS

California Health Law News (CHLN) is a quarterly publication of the California Society for Healthcare Attorneys (CSHA). The mission of CHLN and the CSHA Publications Committee is to publish articles that are interesting and useful to health lawyers practicing California law. While the Publications Committee strives to ensure that CHLN articles provide accurate and authoritative information regarding the subject matters covered, the information is provided with the understanding that neither CSHA nor CHLN contributors are engaged in rendering legal services. Contributors to CHLN are not agents of CSHA and the opinions and positions stated in CHLN articles are those of the authors and not of CSHA, its staff, the CHLN editors or Publications Committee members.

CALIFORNIA HEALTH LAW NEWS

2025-2026 BOARD OF DIRECTORS

Letter from the Editor

Welcome to the Summer Issue of CHLN!

Dear Members,

Welcome to the Fall 2025 edition of California Health Law News!

This issue is packed with thoughtful and timely analysis. We begin with an article from Carla Hartley of Dillingham & Murphy—also a CSHA Board member and former Co-Editor of the Publications Committee—provides an excellent update on AB 692 and its implications for employers, including new limits on the use of "exit fees" or "stay or pay" provisions for departing employees. Next, Sunaya Padmanabhan of Hooper, Lundy & Bookman breaks down the new CCPA regulations, which introduce several compliance obligations for many of our clients—especially around cybersecurity, risk assessments, and automated decision-making. Felicia Sze and Kyle Brierly then tackle the murkiness of Proposition 35's Managed Care Organization tax and the future of Medi-Cal funding. Jonah Retzinger of Nixon Peabody follows with a fascinating look at California's NIH grant landscape, featuring a survey of recipients, ongoing litigation over grant terminations, and representative False Claims Act cases that highlight compliance risks for research institutions. And last, but not least, Dan Cody, a partner at Mintz, reviews recent guidance issued by the California Attorney General on the use of AI, including in healthcare settings, closing out with an overview of emerging industry best practices. We're also delighted to spotlight one of our own in this issue's "Getting to Know" section: Anna Molander, a Deputy Attorney General at the California Department of Justice. Fun fact: before joining the AG's Office, Anna was an aviation attorney—so it's no surprise she's been helping the Publications Committee really take off.

As always, we'd love to hear from you. If you have an idea for an article or a topic you'd like to see covered in CHLN or the Weekly, please feel free to reach out at afrey@hooperlundy.com or Katherine.broderick@providence.org.

Thank you for your continued readership. Wishing you a wonderful holiday season!

ANNOUNCEMENTS

MEMBERSHIP RENEWAL CAMPAIGN

The CSHA membership renewal campaign is underway, and it's time to renew your membership. You should have received an email with a link to complete your renewal. If you didn't receive it, please contact info@csha.info. You can also renew by logging in to your CSHA profile on the website.

For added convenience, consider enabling auto-renewal to keep your membership active each year without extra steps. Renew by January 14, 2026, and you'll be entered to win one of four $100 Amazon gift cards.

Thank you for being part of CSHA. We look forward to the year ahead.

ANNOUNCEMENTS

SAVE THE DATE: ANNUAL MEETING & SPRING SEMINAR – 2026 IN NAPA & 2027 IN DANA POINT

Join us for two standout weekends at CSHA's premier annual event—designed to keep you informed, inspired, and connected. With top-tier education, valuable networking, and the latest in healthcare law, these seminars are not to be missed. Mark your calendars!

Watch your inbox for upcoming details on registration, hotel booking, the call for speakers, and sponsorships.

2026 Annual Meeting & Spring Seminar

- Dates: May 1–3, 2026
- Location: Meritage Resort & Spa, Napa, CA

2027 Annual Meeting & Spring Seminar

- Dates: April 16–18, 2027
- Location: Waldorf Astoria Monarch Beach Resort & Club, Dana Point, CA

Getting to Know... Anna F. Molander

Deputy Attorney General, Department of Justice, Sacramento

Why are you a member of CSHA?

I joined CSHA to learn more about the landscape of healthcare law in California. I had no idea it would be fun and rewarding, too. I've met some of the brightest, wittiest, and most dedicated lawyers in healthcare through the CSHA publications committee.

When and why did you become a health lawyer?

Although I was in private practice for many years, I joined the ranks of healthcare lawyers when I went to the Department of Healthcare Services in 2012, just as the Department was implementing the ACA. I was forever hooked after that.

As with many things, it starts with a personal story. As a child, my mother had a number of surgeries and required a great deal of medical care. The safety net then wasn't as good as it is now. My family was nearly bankrupted and my mother chose to forego lifesaving care rather than financially ruin us. I don't want other families to face that choice.

Did you practice in any other area of law before you became a health lawyer, and if so, what area?

I've been lucky enough to do some fascinating work in my career. Probably the most interesting area is Aviation law. In aviation law, you get the facts on the ground as it happens. The day of an accident or crash, the attorneys are called in to join the investigation. Although we often dealt with tragic events, the collegiality and empathy of aviation lawyers made it rewarding.

What do you think is the biggest challenge the health care system faces today?

California needs to hire and retain far more providers at all levels and in all specialties. We face an increasing need for health and dental care and a shocking loss of providers, exacerbated by the Covid-19 pandemic. At the other end of the spectrum, we need to ensure Californians receive accurate and reliable vaccination information.

What has been the biggest change you have seen in the health care system during your career?

I was fortunate to watch California lead the nation in expanding Medicaid and providing a true healthcare safety net for Californians. Seeing so many children and adults able to access healthcare and dental care is extraordinary. I've also seen a greater focus on the care provided for seniors and reducing barriers that seniors and their families face in accessing care.

What is your motto?

Go Mad. Go out and make a difference.

CASE SUMMARIES
H. Thomas Watson, Lacey L. Estudillo and Peder K. Batalden
Horvitz & Levy, LLP

Resident's arbitration agreement with skilled nursing facility applies to his heirs' wrongful death claim if it primarily sounds in medical malpractice.

Holland v. Silverscreen Healthcare, Inc. (Aug. 14, 2025, S285429) _ Cal.5th _ [2025 WL 2349863]

Following the death of their son at a skilled nursing facility operated by Silverscreen Healthcare, plaintiffs sued Silverscreen, alleging survivor claims on their son's behalf as well as a wrongful death claim as heirs. Silverscreen moved to compel arbitration pursuant to its agreement with the son. The agreement stated it was binding on the son's representatives, executors, family, and heirs and it required arbitration of all medical malpractice disputes and other claims involving the provision of care to a resident. The trial court agreed that plaintiffs' survivor claims were subject to arbitration, but—relying on Avila v. Southern California Specialty Care, Inc. (2018) 20 Cal.App.4th 835, 843—ruled that the wrongful death claim was not subject to arbitration because it was based on Elder Abuse Act neglect, rather than medical malpractice. Silverscreen appealed, and the Court of Appeal reversed. The Supreme Court granted plaintiffs' petition for review.

The Supreme Court announced a new test and remanded for further proceedings. The Court acknowledged that, as a general rule, plaintiffs cannot be compelled to arbitrate their disputes if they have not previously agreed to arbitration.

The Court explained that Ruiz v. Podolsky (2010) 50 Cal.4th 838 identified a narrow exception for certain wrongful death claims based on medical malpractice: if a patient agreed to arbitrate medical malpractice disputes in compliance with MICRA's arbitration provision (Code Civ. Proc., § 1295), the agreement may bind the patient's heirs in a wrongful death action, even if they never agreed to arbitration. The key question is whether a wrongful death claim sounds in professional negligence against a medical provider. The Court acknowledged that deciding that question is difficult when the defendant is a skilled nursing facility, which "wears multiple hats, rendering services in its capacity as a medical provider as well

as in its capacity as custodian of residents' general well-being, which includes responsibilities such as providing nutrition and hydration." The test, the Court stated, is "whether 'the primary basis for the wrongful death claim sounds in' medical malpractice or in custodial neglect." Here, the Court could not apply the test at this stage because "there remains substantial uncertainty about whether plaintiffs seek to challenge the defendants' provision of medical care, its provision of custodial care, or both." Accordingly, the Court remanded to give plaintiffs a chance to amend their complaint.

No Elder Abuse Act violation against nursing facility physician who had intermittent and limited interaction with patient, not a caregiver or custodian relationship.

Frankland v. Etehad (Aug. 8, 2025, B338370) __ Cal.App.5th __ [2025 WL 2267750]

James Frankland was admitted to Casitas Care Center, where Dr. Siamak Etehad provided in-facility resident care. After several months, Frankland's health deteriorated and he was transferred to a hospital where he later died. Plaintiff, Frankland's brother, sued Casitas and Dr. Etehad, alleging neglect and financial abuse under the Elder Abuse and Dependent Adult Civil Protection Act. Dr. Etehad filed a demurrer, arguing plaintiff's neglect claim failed because Dr. Etehad lacked a caretaking or custodial relationship with Frankland, and plaintiff's financial abuse claim failed because Medicare payments are not a property right belonging to Frankland. The trial court agreed and sustained the demurrer without leave to amend. Plaintiff appealed.

The Court of Appeal affirmed. The court concluded that plaintiff failed to state a claim for "neglect" under the Act because plaintiff had not sufficiently alleged that Dr. Etehad had the requisite "robust caretaking or custodial relationship" with Frankland. The court explained that intermittent, episodic, limited, or casual engagement or interaction with an elder does not create the necessary relationship. The court reasoned that physicians working in care facilities do not enter into a caretaking or custodial relationship with the facility's patients simply by providing services to the facility's patients. The court held the financial abuse claim failed because Welfare and Institutions Code section 15657.2 is inapplicable to claims based solely on professional negligence.

Employee's unauthorized disclosure of confidential records to patient's relative triggers treble damages.

Doe v. County of Orange (Sept. 2, 2025, G064562) _ Cal.App.4th _ [2025 WL 2505955]

After John Doe was placed on an involuntary 72-hour psychiatric hold pursuant to Welfare and Institutions Code section 5150, the Orange County Sheriff's Department generated a confidential mental health record of the incident. Sheriff's Department employee Robert Reyna later gave this record to Doe's sister, who claimed she was concerned about him. She and her attorney then used the information to coerce Doe to dismiss his lawsuit against her. Doe sued the County under section 5330, which authorizes an action against anyone who unlawfully discloses section 5150 records. A jury found that Reyna unlawfully disclosed records, awarded Doe damages, and apportioned 25 percent fault to Doe's sister and her attorney.

The trial court granted the County's motion for partial JNOV, ruling there was no substantial evidence of willfulness, and refused to award treble damages as required for willful violations. Doe appealed.

The Court of Appeal reversed. The court explained that under section 5330, persons who "willfully and knowingly" disclose confidential medical records to unauthorized recipients are liable for the greater of $10,000 or treble damages, plus costs and attorney's fees. The court held that a person "willfully and knowingly" releases confidential records when they intentionally release them to a person they know is not entitled to them and the disclosure violates the Lanterman-Petris-Short Act. The court held the plaintiff did not need to establish bad faith, ill intent, or knowledge that further harm would flow from the wrongful disclosure. Applying that standard, the trial court erred by granting JNOV: there was substantial evidence that Reyna willfully and knowingly released Doe's confidential section 5150 record to his sister knowing she was not entitled to it.

Healthcare facilities are not strictly liable for breaches of patient confidentiality but may be liable if they fail to employ reasonable measures to safeguard confidential medical information.

Regents of University of California v. State Department of Public Health (Sept. 23, 2025) _ Cal.App.5th _ [2025 WL 2701640]

California Department of Public Health (DPH) imposed a $75,000 penalty on University of California hospital affiliate Resnick Neuropsychiatric Hospital (Resnick) after a Resnick employee photographed confidential patient information and posted the picture on social media. DPH found that Resnick violated Health and Safety Code section 1280.15, which provides that healthcare facilities "shall prevent unlawful or unauthorized" disclosure of patient medical information "consistent with" the facility's statutory duty under section 1280.18 to use "reasonable" and "appropriate safeguards" to protect the privacy of that information. Although DPH did not that find that Resnick violated section 1280.18, DPH maintained that Resnick was strictly liable for any confidentiality breach regardless whether it complied with section 1280.18. The administrative law judge (ALJ) upheld DPH's penalty. The trial court granted Resnick's petition for administrative mandamus, ruling that section 1280.15 incorporates section 1280.18's reasonableness standards and therefore cannot be violated absent a concurrent violation of section 1280.18. DPH appealed.

The Court of Appeal affirmed. The court held that "the plain and unambiguous language of section 1280.15 effectively incorporates the reasonableness standard set forth in section 1280.18." The court reasoned that a "finding of violation of section 1280.15 . . . where the facility had implemented appropriate safeguards in compliance with section 1280.18 would not be 'consistent with' section 1280.18." Thus, the " 'only reasonable interpretation' of the statutory framework 'is that a violation of section 1280.15 cannot occur without a concurrent violation of section 1280.18.' "

Battery claim against obstetrician viable if delivery substantially deviated from the scope of consent, but statutory gender violence claim is not viable absent bias or animus against a woman in childbirth.

Doe v. Kachru (Oct. 13, 2025, A168669) __ Cal.App.5th __, 2025 WL 2902027

Jane and John Doe sued an obstetrician, Dr. Amita Kachru, and the hospital and other medical personnel involved in the birth of their child. They alleged nine causes of action against Dr. Kachru, including medical battery, gender violence, and dependent adult abuse. The Does' claims against Dr. Kachru were premised on allegations (a) that they consented only to low-intervention care, (b) that Dr. Kachru performed a vacuum-assisted delivery without their consent, and (c) that she forcibly removed Jane's placenta, inserted and removed a catheter in Jane's

urethra, and sutured Jane. Jane was diagnosed with postpartum PTSD, among other conditions. The trial court sustained Dr. Kachru's demurrer to all causes of action against her except John's consortium claim, which the Does dismissed. The Does then appealed the judgment of dismissal.

The Court of Appeal affirmed dismissal of all claims except Jane's medical battery cause of action based on the allegedly unconsented vacuum-assisted delivery. The court explained that this was not a "no-consent" case because Jane necessarily consented to obstetric care and most of the "touching" allegations in support of her medical battery claim by presenting to the hospital for delivery. The court concluded that Jane alleged a potentially viable claim that Dr. Kachru exceeded the scope of Jane's consent by performing a procedure that substantially differed from what she authorized. But the court noted that Dr. Kachru might prevail eventually by proving (a) the vacuum-assisted delivery was not "substantially" different from the care Jane authorized or (b) she reasonably determined that an emergency situation had developed requiring immediate delivery. The court also affirmed dismissal of Jane's gender violence claim under Civil Code section 52.4, holding that "some discriminatory motive" is required and Jane failed to allege that "Dr. Kachru performed a vacuum-assisted delivery because she was motivated, in some part, by bias or animus against Jane because of Jane's status as a woman in childbirth." Finally, Jane's dependent adult abuse claim failed because she failed to allege that Dr. Kachru "acted with " 'recklessness, oppression, fraud or malice' " as required to state such a claim.

California Supreme Court upholds statute prohibiting long-term care facility employees from intentionally misgendering residents.

Taking Offense v. State of California (Nov. 6, 2025, S270535) __ Cal.5th __ [2025 WL 3097904]

Taking Offense, an association opposed to laws requiring recognition of transgender identities, filed a writ petition challenging Health and Safety Code section 1439.51, subdivision (a)(5)'s pronouns provision as facially unconstitutional under the First Amendment. This pronouns provision prohibited staff at long-term care facilities from "[w]illfully and repeatedly fail[ing] to use a resident's preferred name or pronouns after being clearly informed of the preferred name or pronouns," when they do so "wholly or partially on the basis of a person's actual or perceived sexual orientation, gender identity, gender expression, or human immunodeficiency virus (HIV) status." After the trial court denied Taking Offense's petition, the Court of Appeal reversed in part, holding that, under a strict scrutiny analysis, the challenged provision violates the First Amendment because it is

insufficiently tailored to address the state's interest in eliminating discrimination, and thus is facially unconstitutional.

The Supreme Court reversed the Court of Appeal and upheld the pronouns provision. The Court concluded the provision must be analyzed as a regulation of discriminatory conduct that incidentally affects speech, analogous to Title VII's bar against hostile work environments, not as an abridgment of speech subject to First Amendment strict scrutiny. The Court emphasized the narrow context in which the statute operates. It regulates the professional conduct of long-term care staff, seeks to promote a caring environment, and protects long-term care residents (a "captive audience") from discrimination in what is "in effect" their homes. The Court reasoned that the provision is "carefully calibrated" to achieve those ends and does not restrict staff from "expressing their views about gender to anyone (including a resident) in any otherwise lawful manner other than by misgendering a resident—and even then, the prohibition is limited to willful, repeated, knowing acts done because of a legally protected characteristic." The Court concluded that, even assuming the provision were subject to intermediate scrutiny, it "easily satisfies that test." Finally, the Court concluded that the possibility of enforcement through pre-existing criminal penalties for particularly egregious violations of the statute does not render the pronouns provision facially unconstitutional.

The Affordable Care Act's bar against sex-based discrimination applies to healthcare insurers receiving federal funding, but it may not prohibit the exclusion of gender-dysphoria treatment coverage.

Pritchard v. Blue Cross Blue Shield of Ill., _ F.4th _, 2025 WL 3202338 (9th Cir. Nov. 17, 2025)

Class action plaintiffs sued Blue Cross alleging it violated section 1557 of the Affordable Care Act, which prohibits sex-based discrimination, by denying coverage for gender dysphoria treatment pursuant to exclusions in certain employer sponsored health plans. A federal district court granted summary judgment for Plaintiffs, ruling that section 1557 applied to Blue Cross, that Blue Cross was not shielded from liability by the Religious Freedom Restoration Act (RFRA), and that gender dysphoria exclusions discriminated based on sex under Bostock v. Clayton County, 590 U.S. 644 (2020). Blue Cross appealed.

The Ninth Circuit vacated the district court's judgment and remanded for further proceedings. The court first held that section 1557 applies to entities (not merely to plans) if any part of the entity receives federal funds, even if the plans at issue are not federally funded. Accordingly, Blue Cross was governed by section 1557.

Next, the Ninth Circuit affirmed the district court's conclusion that third-party administrators can be liable for violating section 1557 when implementing plan terms drafted by a plan sponsor, because ERISA does not permit administrators to violate federal law. In addition, Blue Cross could not invoke RFRA as a defense because (1) a RFRA defense applies only to government action, not disputes between private parties; and (2) Blue Cross is a secular entity.

Finally, the Ninth Circuit held that the district court's Bostock-based decision addressing the gender dysphoria exclusion "ran afoul of" United States v. Skrmetti, 145 S. Ct. 1816 (2025), but Plaintiffs could still potentially prevail on remand. The court explained that mere reference to "sex" in the policy exclusions, without more, is insufficient to establish that sex was a "but for" cause of the coverage denial since dysphoria treatment coverage was denied for all patients regardless of their sex. But some of the class plaintiffs alleged diagnoses other than gender dysphoria that would entitle them to treatment Blue Cross had refused to cover. Also, plaintiffs may claim that Blue Cross's categorical gender dysphoria coverage exclusion was a pretext for proxy-discrimination against transgender individuals, since Blue Cross admitted that such treatments are sometimes medically necessary. The Ninth Circuit remanded for the district court to assess these arguments.

Noneconomic damages should be reduced to the MICRA cap before being reduced further by the relevant fault allocation when MICRA applies to all the defendants.

Snover v. Gupta (Nov. 18, 2025, No. A172568) _ Cal.App.5th _ [2025 WL 3215132]

The guardian of Adria Snover sued Dr. Aruna Gupta, Dr. Neel Pandya, and Riverside Community Hospital after medical complications during a cesarean section left her in a permanent coma. Before trial, Snover settled separately with Dr. Pandya and with the hospital. The hospital's settlement allocated $250,000 to Snover's son in exchange for a waiver of his right to bring a future wrongful death claim. At trial against Dr. Gupta, the jury awarded Snover almost $7.5 million in economic damages and $10 million in noneconomic damages; the jury allocated 15 percent fault to Dr. Gupta. To prepare a judgment, the trial court reduced the verdict to account for the pretrial settlements and Dr. Gupta's percentage of fault. The court calculated Dr. Gupta's noneconomic liability by first reducing the noneconomic damages award to $250,000 (the then-existing MICRA cap) and then reducing that sum to $37,500 (Dr. Gupta's 15 share of fault). In calculating economic damages, the trial court followed Mayes v. Bryan (2006) 139 Cal.App.4th 1075 by calculating the ratio of economic damages to total damages (here, economic damages plus $37,500), and then applying that percentage to the pretrial settlement amounts to determine the amount of setoffs to apply to the total damages. The court included the $250,000 allocated to Snover's son in its setoff calculation. Snover appealed.

The Court of Appeal affirmed the trial court's sequencing and result. It held that, consistent with Gilman v. Beverly California Corp. (1991) 231 Cal.App.3d 121 and Rashidi v. Moser (2014) 60 Cal.4th 718, the trial court correctly applied the MICRA cap before apportioning liability for noneconomic damages because all defendants were healthcare providers covered by MICRA. The court explained that reversing the order of operations—i.e., first multiplying noneconomic damages by a defendant's percentage of fault and then capping noneconomic damages at $250,000 under MICRA—would improperly inflate the noneconomic damages award. The court next explained that, under Mayes, the trial court must apply the MICRA cap before determining the portion of pretrial settlements setoff against economic damages because all defendants were protected by MICRA. This prevents skewed allocation of settlement dollars to noneconomic damages (thereby reducing the amount of settlements offsetting the economic damage award) and ensures that settlement allocations are consistent with defendant's MICRA-capped exposure. Finally, the court rejected Snover's argument that, when valuing her settlement with the hospital, the trial court should have excluded the $250,000 allocated to her son's future wrongful death claim, reasoning that plaintiff's son was not a party to the settlement and Snover failed to prove the amount disbursed to her son was "arrived at in a sufficiently adversarial proceeding that it should be deducted from the hospital's settlement with her."

AB 692 "ANTI-TRAP" LEGISLATION AND IMPLICATIONS FOR HEALTHCARE EMPLOYMENT RECRUITMENT AND RETENTION PRACTICES

Carla Hartley
Dillingham & Murphy

Employers who require employees to reimburse them at termination for such things as training programs and signing bonuses need to be aware of AB 692, which will apply to such agreements entered into on or after January 1, 2026. Because these types of agreements are common in healthcare, the new laws may significantly impact recruiting and retention for employers such as healthcare systems and medical groups.

AB 692, dubbed the "anti-TRAP" bill ("TRAP" is the acronym for "Training Repayment Agreement Provisions"), was intended to address employee training programs that require employees to repay employers large sums of money if they end employment within a specified period. The legislation, which adds section 16608 to the Business and Professions Code, is intended, like California's ban on noncompete agreements, to further the goal of employee mobility. TRAPs or "stay-or-pay" provisions are sometimes referred to as de facto non-compete provisions because they create a large financial burden if an employee changes jobs.

AB 692 was sponsored by, among others, the California Nurses Association (and opposed by healthcare organizations, such as the California Hospital Association). According to the authors, a 2022 report by the Student Borrower Protection Center found that three industries – healthcare, trucking and retail – were heavily reliant on TRAPs. [1] A 2022 survey of registered nurses, determined that almost 40% who had started working in the past decade were impacted by TRAPs for the new graduate residency programs. [2] Proponents of the bill also cited a 2023 report by the Consumer Financial Protection Bureau finding that debts ranged from $4,000 to $30,000.

The bill, however, is not limited to training reimbursement provisions. It will impact a large variety of common employee reimbursement obligations, including relocation bonuses, signing bonuses and agreements to reimburse immigration or visa related expenses. In addition, given the overly broad language, the bill has the potential for being applied in other contexts.

Beginning January 1, 2026, subject to limited exceptions, section 16608 will make it unlawful to include in any employment agreement or as a condition of employment a provision that:

(A) Requires the worker to pay an employer (or others, such as training provider or debt collector) for a debt if the worker's relationship with a specific employer terminates.

(B) Permits an employer (or certain others) to resume or initiate collection of a debt, or end forbearance of collection if the worker's employment terminates.

(C) Imposes any penalty, fee, or cost on a worker if the worker's employment terminates.

The law has four exceptions. The first is for contracts entered into under a loan repayment assistance or forgiveness program provided by a government agency.

Second, contracts for the reimbursement of tuition are still permissible if they are for a transferable credential and meet the following requirements:

(1) The contract is separate from any employment contract.

(2) The contract does not require the credential as a condition of employment.

(3)The contract specifies the amount of repayment before the worker signs it and the amount does not exceed the employer's cost.

(4)The contract has a prorated repayment amount covering any required period of employment, the repayment is proportional to that period and is not subject to an accelerated payment schedule if the worker separates from employment.

(5)Finally, the contract does not require repayment if the worker is terminated, unless the worker is terminated for misconduct.

This exception is potentially inconsistent with existing Labor Code section 2802.1 which addresses employer-provided or required training programs for employees providing direct patient care for general acute care hospitals. Section 2802.1 clarifies that such programs must be paid by the employer pursuant to Labor Code section 2802 unless they satisfy requirements for licensure necessary to legally provide direct patient care or the employee voluntarily participates in the program. Thus, section 2802.1 permits employers to require reimbursement when the training is for a credential that is a legal condition of the job whereas the AB 692 exception does not permit reimbursement when the credential is a condition of employment. However, certain types of training programs (for example, for graduate nursing degrees that are not a condition of current employment) could require reimbursement and comply with both AB 692 and section 2802.1.

The third exception is for contracts for enrollment in an apprenticeship program approved by the Division of Apprenticeship Standards.

Finally, and of significance to many healthcare (and other) employers, contracts for the "receipt of a discretionary or unearned monetary payment, including a financial bonus, at the outset of employment that is not tied to specific job performance" will only be permitted if the following requirements are met:

(1)The repayment terms are in an agreement separate from the primary employment agreement.

(2)The employee must be notified that they have the right to consult an attorney and given at least five days to consult.

(3)Any repayment provision triggered by early separation from employment is not subject to interest accrual, is prorated based on the remaining term of any retention period, and the retention period cannot exceed two years from the date payment was received.

(4)The worker has the option to defer payment until the end of the retention period and thus avoid any repayment obligation.

(5)Separation from employment before the end of the retention period was either at the sole election of the employee, or by the employer for misconduct.

This fourth exception will continue to permit relocation cost and sign-on bonuses to be subject to reimbursement, provided they comply with the above five requirements. Thus, for example, employers who currently specify a three year or longer repayment obligation will need to switch to two years.

Under the first and fourth exceptions, employers can only require reimbursement when an involuntary termination is for "misconduct."AB 692 defines "misconduct" consistent with section 1256 of the Unemployment Insurance Code. Thus, an employer will need to show "substantial evidence of deliberate, willful and intentional disobedience"[3] on the part of the employee and "mere inefficiency, unsatisfactory conduct, inadvertencies or ordinary negligence or good faith errors in judgment or discretion"[4] will not be sufficient. Employers who have opposed applications for unemployment benefits know this is a high burden.

This also means that employers cannot contractually control the circumstances under which repayment is required. While many employers currently require repayment if there is a termination "for cause" as defined in the agreement, these definitions will not override the need to show misconduct as defined for section 1256.

It is unclear if AB 692 permits agreements for the reimbursement of immigration or visa related expenses. Such agreements are clearly covered in the definition of "penalty, fee or cost" and the prohibition against such items. However, it is unclear if such expenses would fall under the exception for "the receipt of discretionary or unearned monetary payment at the outset of employment that is not tied to specific job performance" since the employee does not receive, for example, fees paid for an H-1B visa. To the extent that healthcare employers are still contemplating hiring foreign workers, they should consult with immigration counsel on provisions to potentially recoup immigration-related costs in the event of early separation.

The overly broad language of AB 692 also creates opportunities for unforeseen applications, particularly in light of the private right of action provision (discussed below). For example, it is not uncommon for clinicians to be paid based on production, including with a recoverable advance that

the employee is required to repay upon separation. Such provisions would appear to be covered by AB 692 and are not clearly excepted. The only potentially applicable exception, for "discretionary or unearned payment," only applies to those payments that are not tied to a specific job performance, which would appear to exclude production pay.

Similarly, since the bill defines "debt" to include "personal property," there is a question as to whether it can be interpreted to cover the laptop or other equipment given to employees that is supposed to be returned upon separation. While it does not appear that the bill was intended to apply to employer property, the potential for creative expansion of the language is a concern in light of the private right of action provision.

Business and Professions Code section 16608 provides that prohibited contracts are void against public policy. However, the real enforcement teeth are in newly enacted Labor Code section 926 which creates a private right of action that employees may bring individually and on behalf of others similarly situated. Employers or other persons found to be in violation of section 16608 will be liable for actual damages or $5,000 per worker, whichever is greater, injunctive relief, and of course, attorney's fees and costs.

While AB 692 does not specifically address PAGA (Private Attorneys General Act)[5], it appears that agreements violating the new laws would also be subject to PAGA actions and civil penalties, in addition to statutory penalties under the private right of action provision.

Labor Code section 432.5, which makes it unlawful for an employer to require an employee to agree in writing to a term or condition which the employer knows is prohibited by law, would provide the basis for a PAGA claim.

AB 692 is limited to agreements entered into on or after January 1, 2026. Thus, employers will not be required to change pre-existing agreements. However, employers who currently utilize training repayment agreements or relocation or sign-on bonuses with repayment provisions may need to revise their recruiting and retention practices and agreements before the end of 2025.

Endnotes

[1] Student Borrower Protection Center (July 2022), "Trapped at Work." https://protectborrowers.org/wp-content/uploads/2023/12/stay-or-pay-compendium_12-2023_FINAL.pdf
[2] National Nurses United (Dec. 2022), "Caught in a TRAP," National Nurse Magazine. https://nnumagazine.uberflip.com/i/1489186-national-nurse-magazine-october-november-december-2022/19?
[3] Robles v. Employment Development Dept. (2012) 207 Cal.App.4th 1029, 1035.
[4] American Federation of Labor v. Unemployment Insurance Appeals Board (1994) 23 Cal.App.4th 51, 59.
[5] Labor Code section 2699 et seq.

Carla Hartley is a partner with Dillingham & Murphy in San Francisco specializing in employment advice and litigation. Carla represents medical groups and other healthcare entities in employment-related matters as well as peer review issues, Medical Board reporting, governmental investigations, and False Claims Act litigation.

California Finalizes CCPA Regulation Amendments – New Compliance Obligations for Cybersecurity, Risk Assessments, and Automated Decision-Making

Sunaya M. Padmanabhan
Hooper, Lundy & Bookman, PC

On September 22, 2025, the California Office of Administrative Law approved the California Privacy Protection Agency (the "Agency") Board's long-anticipated amendments to the regulations promulgated under the California Consumer Privacy Act (as amended by the California Privacy Rights Act (the "CPRA" and collectively the "CCPA")). [1] The newly approved regulations impose substantial compliance requirements on businesses subject to the CCPA, particularly concerning cybersecurity audits, data risk assessments, and the use of automated decision-making technologies ("ADMT"). The updated regulations take effect on January 1, 2026, with phased compliance deadlines extending into 2030. [2]

I. Application of CCPA to Health Care Organizations

As a reminder, the CCPA generally applies to for-profit businesses, and only to the extent they meet any of the following thresholds: annual gross revenues over $25 million; buying, selling, or sharing personal information of 100,000 or more California residents; or deriving 50 percent or more of annual revenue from selling personal data. [3] The law also extends to entities under common ownership or control that share consumer personal information and branding, as well as joint ventures or partnerships in which each participant holds at least forty percent interest. [4]

Personal information means any data that identifies, relates to, describes, or can reasonably be linked- directly or indirectly- to a particular consumer or household. [5] This includes common identifiers (such as name, address, email, IP address, government-issued numbers, etc.), protected classification characteristics (such as race, gender, sex, disability, etc.), commercial and biometric data, online activity, geolocation, audio/visual information, employment and education details, inferences drawn from such data, and sensitive personal information. [6] Sensitive personal information is a category of personal data that poses a higher risk of harm if misused, typically including government identifiers (such as social security numbers, passport numbers, driver's license numbers, etc.), financial account details when combined with access credentials, precise geolocation, racial or ethnic origin, citizenship or immigration status, religious or philosophical beliefs, union membership, genetic, neural and biometric data, health information, sexual orientation, and the contents of a consumer's mail, email, or text messages (unless the business is the intended recipient). [7] The new regulations also modified the definition of "sensitive personal information" to include "[p]ersonal information of consumers that the business has actual knowledge are less than 16 years of age. A business that willfully disregards the consumer's age shall be deemed to have had actual knowledge of the consumer's age."[8]

Importantly, for health care organizations that are subject to the CCPA, the law carves out from the definition of protected "personal information" (i) medical information covered by California's Confidentiality of Medical Information Act ("CMIA"), and (ii) protected health information ("PHI") subject to the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) and its implementing regulations ("HIPAA"). [9] Additionally, if a health care organization extends the same protections to other personal information that it has in place for medical information and/or PHI, that data is also exempt. [10] Personal information collected during clinical trials or biomedical research is likewise exempt from the law if the study complies with recognized federal guidelines for protecting research participants and the data is not sold or shared in any way that exceeds the scope of participant consent. [11]

As such, many health care organizations fall outside of the law's jurisdiction because they operate as not-for-profit entities. Even for the those that are for-profit, much of the personal information maintained by the entity would be exempted under these provisions. However, other types of personal information collected outside of clinical contexts, such as applicant/employee/contractor data, marketing data, or consumer behavior analytics may constitute "personal information" subject to the CCPA and the revised regulatory requirements.

II. Summary of Key Regulatory Revisions

The finalized regulations represent a significant expansion of California's privacy framework, building on years of rulemaking and public engagement.[12] They reflect the California Privacy Protection Agency's evolving enforcement priorities and clarify existing obligations. A central focus is a covered business's use of ADMT, defined as any technology that processes personal information and uses computation to replace or substantially replace human decision making. [13] The rules aim to ensure transparency, accountability, and consumer control over technologies that influence significant life decisions.

1. Automated Decision-Making Technology

Beginning January 1, 2027, businesses that use ADMT to make "significant decisions" relating to consumers, including the provision or denial of services around health care, employment or contracting, education, housing, and financial or lending services, must comply with new consumer rights and disclosure obligations. [14] These new requirements include:

- Pre-Use Notice: Businesses must provide consumers with a clear notice at or before the point when the business collects the consumer's personal information that the business plans to process using ADMT. This notice must explain the purpose of the technology, how it will be used, and the consumer's rights. [15]

- Opt-Out Rights: Consumers must be given the opportunity to opt out of ADMT-based decision-making unless a limited exception applies.[16]
- Access Rights: Upon request, businesses must provide consumers with meaningful information about how the business used ADMT in the decision-making process, including logic, outputs, and ADMT's role in the final decision. [17]

While initial drafts of the regulations contemplated broad limitations on artificial intelligence use, the Agency significantly scaled back those provisions in the final rulemaking. [18]

2. Cybersecurity Audits

Also beginning in 2027, certain businesses that meet risk-based revenue and data processing thresholds must conduct annual, independent cybersecurity audits to assess the effectiveness of their data protection programs. [19] The audits will assess the business's cybersecurity policies, procedures, vulnerabilities and incident response plans and will describe the business' remediation activities. [20]

Under the new regulations, cybersecurity audits must be conducted by an independent auditor with relevant cybersecurity expertise, following standardized audit procedures. [21] The auditor may be internal or external; however, if internal, they must report to an executive who does not have cybersecurity management responsibilities. [22]

A covered business must also submit an annual certificate of completion to the Agency for each calendar year in which the business is required to conduct an audit, signed by a senior executive or authorized member of the company. [23]

The Agency adopted a phased implementation timeline for these cybersecurity audits based on business size. Please refer to the chart below to see the compliance deadlines.

3. Risk Assessments

Finally, and starting January 1, 2026, covered businesses must conduct and document risk assessments to evaluate the impact of data processing activities that present a "significant risk" to consumer privacy. [24] A business subject to the CCPA must complete a risk assessment before starting any high-risk activity, review and update its assessment every three years, and revise it within forty-five (45) calendar days of any material change in processing.[25] A "material change" includes changes to the purpose of the processing, minimum personal information necessary to achieve the purpose, the risks to the consumer privacy. [26]

High-risk data processing activities include:

- Selling or sharing personal information
- Processing sensitive personal information
- Using ADMT for significant decisions, like those detailed above
- Profiling or inferring personal attributes using automated technologies, under certain conditions

- Processing personal information that the business intends to use for the purpose of training an ADMT for significant decisions about consumers, or training facial-recognition, emotion-recognition, or other identity verification or profiling technologies. “Intends to use” includes current use, planned use, permitting others to use, or marketing such use. [27]

For the risk assessments, covered businesses must:

- Evaluate the benefits of the processing activity against the potential risks to consumers.
- Consider the nature, scope, context, and purpose of the processing.
- Identify safeguards and mitigation strategies to reduce privacy risks. [28]

Businesses must submit an attestation of completion and a summary of the risk assessment to the Agency by April 1, 2028. [29] For any high-risk processing activity that began before January 1, 2026, the business must complete a risk assessment by December 31, 2027, but those assessments are still due to the Agency by April 1, 2028 [30]. The California Attorney General may request a copy of the full risk assessment at any time, and businesses must respond within 30 days of such a request. [31]

III. Key Regulatory Deadlines Regarding ADMT, Cyber Audits and Risk Assessments

Requirement	Compliance Deadline
ADMT Compliance	Jan 1, 2027
Risk Assessments	Apr 1, 2028
Cybersecurity Audit (Revenue > $100M)	Apr 1, 2028
Cybersecurity Audit ($50M–$100M)	Apr 1, 2029
Cybersecurity Audit (< $50M)	Apr 1, 2030

The new regulations also provide for additional updates to existing provisions of the CCPA, which shall be effective as of January 1, 2026. Some of the key provisions are summarized as follows:

- Right to Correct. Consumers have the right to request corrections to inaccurate personal information held by a business. In certain cases, a business may deny this request. However, under the new regulations, if a business denies a consumer's request to correct personal health information that was collected and analyzed about the consumer's health, the business must inform the consumer of the denial. The consumer may then submit a written statement to be included in their record and can request that this statement be shared with any third parties to whom the business discloses, shares, or sells the information. Additionally, businesses previously had discretion in whether to provide the consumer with the name of the source of the inaccurate information. Under the new rules, businesses must either provide the source's name or notify the source that the information is incorrect and must be corrected. [32]
- Right to Know. Consumers have a right to know what personal information a business collects about them and how it is used and shared. If a business maintains the consumers' personal information for more than twelve (12) months, then the business must include a means for the consumer to request access to information collected prior to the twelve (12) month period, going backwards until January 1, 2022. [33]
- Right to Opt-Out of Selling or Sharing Personal Information. Businesses that sell or share personal information must provide consumers with a way to opt out of those practices. Under the new regulations, businesses must also give consumers a means to confirm that their opt-out request was honored, by displaying an 'Opt-Out Request Honored' toggle or radio button on the business's website. [34] Businesses subject to the CCPA should prioritize updating their opt-out mechanisms, as the Agency and the California Attorney General have announced plans to investigate whether businesses are honoring consumers' right to opt out. [35]

V. Takeaways for Covered Healthcare Organizations

With the new regulations now finalized and compliance deadlines approaching, health care organizations subject to the CCPA should begin preparing for implementation to comply with the revised regulations. The expanded rules introduce complex obligations around cybersecurity, risk management, and the use of automated technologies, requiring thoughtful planning and cross-functional coordination. Entities that have determined they are subject to the CCPA should take proactive steps to assess their data practices, update internal policies, and build the necessary infrastructure to meet the new requirements.

Recommended actions include reviewing data processing activities to identify high-risk operations, inventorying ADMT systems to determine whether they trigger compliance obligations, updating privacy policies to reflect new notice and opt-out rights, engaging qualified professionals to support cybersecurity audits, and establishing internal governance processes for risk assessments and ADMT disclosures.

Endnotes

[1] Cal. Privacy Protection Agency, Office of Administrative Law File No. Z-2024-1112-05, CCPA Updates: Cybersecurity, Risk Assessments, ADMT & Insurance (approved Sept. 22, 2025; eff. Jan. 1, 2026), available at https://cppa.ca.gov/regulations/pdf/ccpa_updates_cyber_risk_admt_appr_text.pdf; California Consumer Privacy Act of 2018, Cal. Civ. Code Sections 1798.100 - 1798.199.100, available at: https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?division=3.&part=4.&lawCode=CIV&title=1.81.5.
[2] Id. at Sections 7121, 7155, 7157 & 7200, Office of Administrative Law File No. Z-2024-1112-05, (eff. Jan. 1, 2026).
[3] Cal. Civ. Code Section 1798.140(d).
[4] Id.
[5] Id. at Section 1798.140(v)(1).
[6] Id.
[7] Id. at Section 1798.140(ae).
[8] Id. at Section 7001(bbb).
[9] Id. at Section 1798.145(c)(1)(A).
[10] Id at Section 1798.145(c)(1)(B).
[11] Id at Section 1798.145(c)(1)(C).
[12] See "Documents" and "Public Comments," California Privacy Protection Agency, CCPA Updates – Insurance, Cybersecurity Audits, Risk Assessments, and Automated Decisionmaking Technology (ADMT) Regulations (Sept. 2025), https://cppa.ca.gov/regulations/ccpa_updates.html.
[13] Section 7001(e), Office of Administrative Law File No. Z-2024-1112-05 (eff. Jan. 1, 2026).
[14] Id. at Sections 7200, 7001(ddd).
[15] Id. at Section 7220.
[16] Id. at Section 7221.
[17] Id. at Section 7222.
[18] Cal. Privacy Protection Agency, Proposed Text, CCPA Updates: Cyber, Risk, ADMT, and Insurance Regs., Title 11, Div. 6, Ch. 1 (Nov. 22, 2024), available at: https://cppa.ca.gov/regulations/pdf/ccpa_updates_cyber_risk_admt_ins_text.pdf.
[19] Sections 7120, 7121, Office of Administrative Law File No. Z-2024-1112-05 (eff. Jan. 1, 2026).
[20] Id. at Section 7123.
[21] Id. at Section 7122.
[22] Id.
[23] Id. at Section 7124.
[24] Id. at Section 7150.
[25] Id. at Sections 7155.
[25] Id. at Sections 7155.
[26] Id.
[27] Id. at Section 7150(b).
[28] Id. at Sections 7152, 7153.
[29] Id. at Section 7157(a).
[30] Id. at Sections 7155, 7157(a).
[31] Id. at Section 7157(e).
[32] Id. at Section 7023.
[33] Id. at Section 7020.
[34] Id. at Section 7026.
[35] Cal. Privacy Protection Agency, California Privacy Protection Agency Announces Joint Investigative Privacy Sweep: CA, CO, and CT Investigate Businesses Refusing to Honor Consumers' Right to Opt-Out of the Sale of Their Personal Information (Sept. 2025), available at: https://cppa.ca.gov/announcements/2025/20250909.html.

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Proposition 35 and the Managed Care Organization Tax: Future of Important Medi-Cal Funding Mechanism Murky

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I. Introduction

In November 2024, California voters approved Proposition 35, a constitutional amendment that made permanent the state's managed care organization tax ("MCO Tax") and dedicated the tax revenues exclusively to specified healthcare purposes. The measure restructured how California allocates approximately $4 billion of annual proceeds from the MCO Tax to ensure that the funds are used for specific provider rate increases and health workforce initiatives primarily under the Medi-Cal program.

Since its enactment, however, the State's implementation has not been consistent with Proposition 35 as written. The State's financial picture has changed significantly into a deficit position, prompting the State to creatively reallocate portions of the MCO Tax revenues. At the same time, federal reforms to Medicaid provider-tax waiver rules threaten the continued federal approval of the MCO Tax's framework, raising the prospect that the program could be rendered inoperative.

II. Background

A. Medi-Cal Program Background

The Medicaid Act, 42 U.S.C. § 1396, et seq., authorizes federal financial support to states for medical assistance provided to certain low-income persons.[2] The program is jointly financed by the federal and state governments and administered by the states.[3] In order to receive matching federal financial participation ("FFP"), states must agree to comply with the applicable federal Medicaid law and regulations.[4]

Medi-Cal, California's Medicaid program, is the state's largest "safety net" program, distributing over $115 billion dollars to health care providers per year for the treatment of Medi-Cal beneficiaries. It is administered by the Department of Health Care Services ("DHCS").[5]

B. History of Healthcare-Related Tax Rules and Waivers

Financing state Medicaid programs has long been challenging, given rising healthcare costs and relatively limited state budgets. To generate the non-federal share of Medicaid funding, states have historically relied on healthcare-related taxes [6] imposed on providers, managed care plans, and other entities. Prior to 1991, states could, in effect, "hold harmless" the taxpayers by returning to them, either directly or indirectly, the full amount of the tax through increased Medicaid payments financed by the resulting federal match. This allowed states to draw down additional FFP without increasing their own net expenditures.

In response to concerns that states were using hold harmless arrangements and other creative financing mechanisms to increase federal Medicaid matching funds, Congress amended the Social Security Act in 1991 to authorize the Centers for Medicare & Medicaid Services ("CMS") to reduce FFP when a state funds its share of Medicaid expenditures from certain impermissible provider taxes or donations. [7]

The 1991 amendments and their implementing at 42 C.F.R. § 433.68, set forth three requirements for a permissible healthcare-related tax:

1. Broad-based: The tax must be imposed on all healthcare entities, items or services within a class and throughout the state.

2. Uniform: The tax must be applied consistently in amount and scope. For an MCO tax, the tax rate should not be higher for an MCO's Medicaid line of service compared to non-Medicaid lines of service.

3. Hold Harmless: The taxpayer cannot be held harmless. The statute and regulations include three scenarios in which an arrangement is considered a "hold harmless" arrangement. [8]

A. The state provides for a payment to taxpayers positively correlated to the amount of the tax;

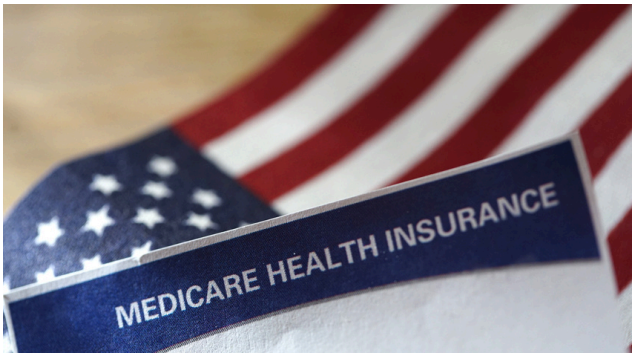
B. All or any portion of the payment made to the taxpayer varies based only upon the amount of the total tax paid, including where Medicaid payment is conditional on receipt of the tax amount; or

C. The state tax provides for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount. CMS has explained that "a direct guarantee will be found when a state payment is made available to a taxpayer . . . with the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax."[9]

CMS utilizes a two-part test to determine whether a provider tax rises to the level of a hold harmless "guarantee": 1) if the tax is at or below 6% of a provider's revenue, the tax is assumed permissible, and 2) if the tax is above 6%, a hold harmless guarantee exists where Medicaid payments are used to repay at least 75% of providers for at least 75% of their total cost.[10]

While CMS is prohibited from waiving the hold harmless requirement, it is permitted to waive the broad-based and uniformity requirements. To do so, the state must demonstrate, "to the satisfaction of the Secretary," that the tax is "generally redistributive."[11]

If the state seeks to waive both the broad-based and uniformity requirements, as California has done for the MCO Tax, it must apply the "B1/B2" test. The B1/B2 test compares the total tax paid under two scenarios: 1) a hypothetical tax that is uniformly applied to all taxpayers regardless of the amount of Medicaid revenue; and 2) the actual tax that is proposed in which Medicaid revenue is taxed at a higher rate than non-Medicaid revenue. If the resulting B1/B2 ratio exceeds 1.0, the tax is deemed sufficiently redistributive, and CMS must approve the waiver. [12]



C. California's MCO Tax

1. California's Historical Reliance on Healthcare-Related Taxes

California has long relied on healthcare-related taxes to fund its Medi-Cal program. For example, California has historically imposed fees on skilled nursing facilities, hospitals and ambulance providers to fund additional Medi-Cal payments to those providers. For more than a decade, California has also imposed the MCO Tax on health plans. The MCO Tax has changed over time, but this article outlines an overview of the program immediately preceding Proposition 35.

2. Assembly Bill 119 (2023)

Assembly Bill 119, signed into law in 2023, restructured the MCO Tax for purposes of the tax periods of April 1, 2023, through December 31, 2023, and the 2024, 2025, and 2026 calendar years, sunsetting December 31, 2026. The bill established the Managed Care Enrollment Fund, the monies of which, upon appropriation, will be available to DHCS for the purpose of funding the following subcomponents to support the Medi-Cal program: (1) the nonfederal share of increased capitation payments to Medi-Cal managed care plans "accounting for their projected tax obligation" for the applicable fiscal year(s); (2) the nonfederal share of Medi-Cal managed care rates for health care services; and (3) transfers to the Medi-Cal Provider Payment Reserve Fund.

The legislation applies different rates for Medi-Cal and non-Medi-Cal enrollees in these MCOs. For MCOs with between 1,250,001 and 4,000,000 enrollees, for April 1, 2023, through 2026, the tax rate is between $182.50 and $192.50 for Medi-Cal enrollees and between $1.75 to $2.25 for non-Medi-Cal enrollees. Plans with fewer than 1,250,000 are not subject to the tax, and the tax is capped for those with more than 4,000,000 enrollees.

On December 20, 2024, CMS approved the use of the current MCO Tax by waiving the requirement that the tax be broad-based and uniform, effective April 1, 2023. The approval waived those requirements for a tax rate on 1,250,000 to 4,000,000 member months of $192.50 for Medi-Cal member months and $2.25 for other Knox-Keene Act member months for CY 2026, which was the last year of the approval. CMS granted the approval based on the results of the B1/B2 test, which exceeded 1.0 for each of the years. [13]

D. Proposition 35

In November 2024, California voters approved Proposition 35, a ballot initiative that permanently authorized the MCO Tax by statutorily continuing the tax beyond its prior December 31, 2026, sunset date.[14] As drafted, beginning January 1, 2027, Proposition 35 extends the MCO tax indefinitely unless amended or repealed by the Legislature.

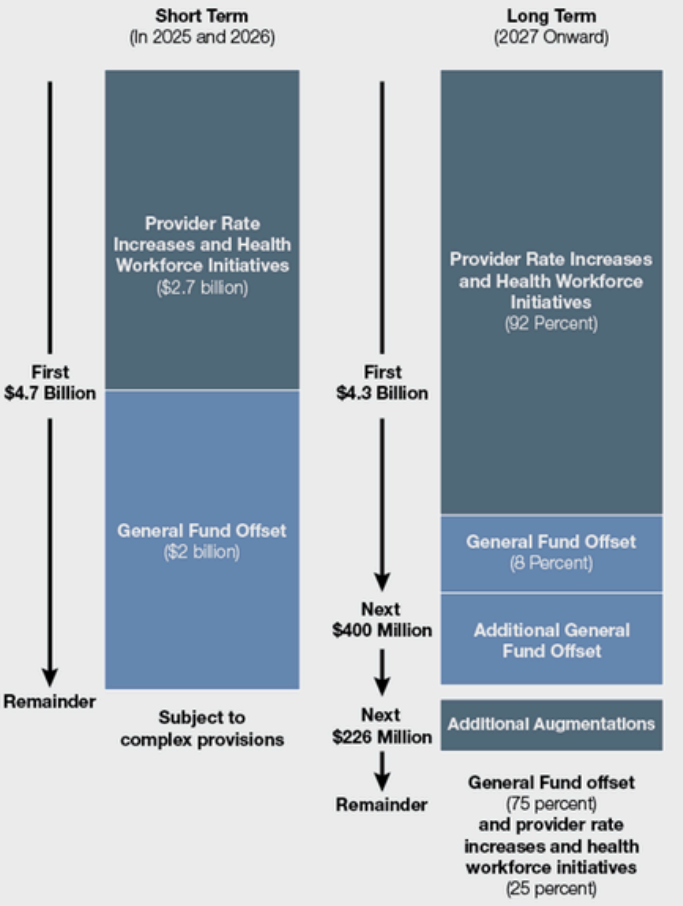
In addition to making the MCO Tax permanent, Proposition 35 mandates that nearly all revenue from the MCO Tax be used to increase reimbursement to targeted providers.

Under Proposition 35, the defined service categories that would receive increased reimbursement include: Medi-Cal Program Support, Primary Care, Specialty Care, Emergency Department Facilities and Physicians, Community and Outpatient Procedures, Reproductive Health, Designated Public Hospitals, Services and Supports for Primary Care, Ground Emergency Medical Transportation, Behavioral Health Facility Throughputs, Graduate Medical Education, and Medi-Cal Workforce. It also provides for a 2 year "transition" period during which more of the MCO Tax proceeds could be used to backfill Medi-Cal expenditures.

Figure 3

Proposition 35 Rules Differ in Short Term and Long Term

Rules for Spending Net MCO Tax Revenue



Note: Excludes funds for administrative costs and periodic audits.
MCO = managed care organization.

The following table shows the allocation under Proposition 35 for calendar years 2025 and 2026. [15]

Table 1: CY 2025 & CY 2026 Allocation Overview

Domain	$ Millions
Medi-Cal Program Support	$2,000
Primary Care	$691
Specialty Care	$575
Emergency Department Facilities and Physicians	$355
Community and Outpatient Procedures	$245
Reproductive Health	$90
Designated Public Hospitals	$150
Services and Supports for Primary Care	$50
Ground Emergency Medical Transportation	$50
Behavioral Health Facility Throughputs	$300
Graduate Medical Education	$75
Medi-Cal Workforce	$75
TOTAL:	**$4,656**

Proposition 35 established a Stakeholder Advisory Committee, which DHCS is required to consult with for important decisions, including the development of changing an existing payment methodology, the establishment of the criteria or eligibility for increased payments or grants, or the issuance of provider bulletins, all-plan letters or other sub regulatory implementation documents.[16] The Stakeholder Advisory Committee was intended to be comprised of ten members, including representatives for primary and specialty physicians, hospitals, private ambulance, family planning and reproductive health providers, commercial Medi-Cal plans, clinics, public Medi-Cal Plans, dentists, and organized labor. These appointments were required to be made by January 30, 2025.

Proposition 35 also limits amendments to the MCO Tax. Any such amendment requires a three-fourths vote in each house of the Legislature and must be consistent with, and must further the purposes of, the MCO Tax framework enacted by Proposition 35.[17] Moreover, the tax becomes inoperative during any portion of a calendar year for which the DHCS does not obtain the necessary federal approvals.[18] If approval is denied or withdrawn, the measure requires DHCS to implement a wind-down and refund plan in consultation with the Department of Finance and stakeholder advisory committee.[19]

III. Implementation of Proposition 35

A. Stakeholder Advisory Committee

As discussed above, Proposition 35 required the appointment of the Stakeholder Advisory Committee by January 30, 2025. Nearly all appointments were made by that date. The Governor did not appoint a representative of private ambulance. However, the Senate President Pro Tempore did appoint a representative of air ambulance, as required by Proposition 35.

DHCS convened the Stakeholder Advisory Committee on April 14, 2025, May 19, 2025, and July 18, 2025. Because the first meeting did not occur before March 31, 2025, some interested stakeholders were concerned that DHCS failed to submit a Medicaid State Plan Amendment by March 31, 2025, which was the last day to submit a Medicaid State Plan Amendment to be effective January 1, 2025.[20] There have not been any recent meetings of the committee.

B. Governor's May Revised Budget

On May 14, 2025, Governor Newsom released his revised budget for State Fiscal Year 2025-26 (called the "May Revise"). Compared to the January proposed budget, the May Revise noted an anticipated $12 billion shortfall for the 2025-26 state fiscal year. The May Revise did not account for reductions that at the time were being contemplated by Congress and that are outlined below.

On May 14, 2025, Governor Newsom released his revised budget for State Fiscal Year 2025-26 (called the "May Revise"). Compared to the January proposed budget, the May Revise noted an anticipated $12 billion shortfall for the 2025-26 state fiscal year. The May Revise did not account for reductions that at the time were being contemplated by Congress and that are outlined below.

As a result, together with recommendations made by the Stakeholder Advisory Committee, Governor Newsom proposed changes to the expenditures from the MCO tax. The May Revise included a proposal for a loan from Proposition 35 for general Medi-Cal expenditures of $1.3 billion in SFY 2025-26 and $263.7 million in SFY 2026-27. Thereafter, DHCS proposed a new spending plan for the revenues of Proposition 35.[21] Most notably, in addition to the $2 billion that is already allocated by Proposition 35 for Medi-Cal program support, the new proposal would re-direct approximately $1.01 billion to fund the non-federal share of managed care base rate increases:

Category of Spending	2025 Amount Proposed to be Used for Capitation	2026 Amount Proposed to be Used for Capitation
Primary Care Services	$476 million	$117 million
Specialty Care Services	$533 million	$63 million
Community Outpatient Procedures	$245 million	$245 million
Ground Emergency Medical Transportation	$27 million	$27 million

The State further proposed using some funding to fund payment methodologies that arguably were already in existence prior to the passage of Proposition 35 and would redirect $100 million for each of calendar year 2025 and 2026 from behavioral health facility throughputs into housing subsidies.

IV. Federal Changes to Healthcare Related Tax Requirements

A. Federal Congressional Changes to Healthcare-Related Tax Waivers

Recent federal developments pose significant restrictions on states' ability to obtain waivers of the broad-based and uniform requirements for provider taxes. These changes may directly impact the continued operability of the MCO Tax. The changes specifically target the rate-tiered tax arrangements that define the MCO Tax structure.

B. H.R. 1 (the Big Beautiful Bill)

House Resolution 1 ("H.R. 1"), titled the "One Big Beautiful Bill Act," is a federal budget reconciliation bill recently passed into law that includes statutory amendments to 42 U.S.C. § 1396b(w) fundamentally altering CMS's waiver authority. The law imposes an additional requirement to the current B1/B2 or P1/P2 statistical tests by prohibiting CMS from approving, in most instances, any waiver where the tax imposes differential rates based on a provider's volume or percentage of Medicaid services. Specifically, a waiver is barred if the tax applies a higher rate to providers with a greater share of Medicaid taxable units, or a lower rate to those with a smaller Medicaid share, even if the statistical test result exceeds the 1.0 threshold.

H.R. 1 also prohibits waiver approval if the underlying tax employs terminology, classification, or groupings that serve as proxies for Medicaid status. For example, a tax that differentiates providers based on income levels, patient populations, geography, or receipt of payments from a joint federal-state health program would be considered impermissible if those distinctions effectively replicate a Medicaid-based classification. This restriction would thus extend beyond explicit references to Medicaid participation and could invalidate tiered-rate structures even when Medicaid is not expressly named as a basis for the tax. In addition, the law prohibits states from enacting any new provider taxes or increasing the rate or scope of existing taxes after the date of enactment. This provision functions as a permanent moratorium, effectively freezing state provider-tax authority at its current levels, subject to how CMS interprets what constitutes an "increase." For California, this severely constrains the State's ability to modify or recalibrate the MCO Tax. Even technical adjustments, such as altering tier definitions, adjusting base periods, or reconciling enrollment-based assessments, could be treated as impermissible "increases."

C. CMS Proposed Rule

Separately, on May 15, 2025, CMS published a proposed rule that closely mirrors the legislative proposal by amending the standards governing waivers of the broad-based and uniform requirements under 42 C.F.R. section 433.68.[22] The proposed rule builds on longstanding concerns that statistical tests alone do not ensure a provider tax structure is truly redistributive. CMS acknowledged that, while tests like B1/B2 may be satisfied numerically, some tax arrangements still impose a disproportionate burden on providers serving Medicaid populations, thus undermining the purpose of the redistribution standard. California's MCO Tax is cited prominently as an example of such a structure: it imposes a significantly higher per member per month ("PMPM") rate on Medicaid enrollees than on commercial members, despite achieving a favorable B1/B2 statistical result over 1.0.

Like H.R. 1, the proposed rule would disqualify any tax, regardless of statistical test performance, if it imposes a higher tax rate or amount on Medicaid providers or Medicaid business than non-Medicaid providers. In CMS's view, a permissible tax must generate an equal amount of revenue from entities that serve lower percentages of Medicaid beneficiaries and redistribute those funds to support payments to providers with higher Medicaid volume.

The CMS rule diverges from H.R. 1 in its implementation timeline. H.R. 1 authorizes CMS to create a three-year transition period. In contrast, the CMS rule includes much shorter compliance windows. States with provider tax waivers approved within two years of the final rule's effective date (like the MCO Tax) must comply immediately. States with older waivers will have a one-year grace period to bring their tax structures into compliance.
These proposed changes likely would effectively prohibit California from maintaining the MCO Tax's current tiered-rate structures. In its accompanying news release,[23]

CMS expressly identified California's MCO Tax as an example of a noncompliant arrangement, noting that the tax imposes a rate of $274 PMPM on Medicaid enrollment compared to just $1.75 PMPM for comparable commercial member months. The agency further linked the revenue generated from this funding "loophole" to the expansion of Medi-Cal coverage for undocumented immigrants. This framing signals that MCO Tax structure, and the broader policy choices it is perceived to fund, are under direct and deliberate scrutiny.

D. Impact of the Federal Changes on the MCO Tax

Under both H.R. 1 and the CMS proposed rule, the current MCO Tax structure as currently envisioned likely will become noncompliant with federal Medicaid financing rules. If the MCO Tax loses its federal approval, Proposition 35 would be rendered inoperative for the period during which the MCO Tax is not federally approved.[24] "[U]pon failure to obtain federal approval," DHCS is required to "implement a plan for conducting all appropriate wind-down and closeout activities, including issuance of any refunds[.]"

Proposition 35 requires legislation in order for DHCS to revise the MCO tax structure enough to preserve federal approval. Welfare and Institutions Code § 14199.126 caps the tax on non-Medi-Cal member months at $2.50 and limits annual revenue from the commercial tier to $36 million. Section 14199.126(c) permits DHCS limited flexibility to deviate from these limits by permitting a 10% upward adjustment for the purpose of satisfying federal statistical waiver requirements.[25] Applying this adjustment, however, would only raise the limits to a $2.75 PMPM and cap the aggregate tax revenue at $39.6 million, which likely would not ameliorate the risks from the new federal rules. Accordingly, any substantial revision to the tax rate structure such as increasing the non-Medi-Cal tax rate to the level of the Medi-Cal tier would require legislative action by a three-fourths vote as mandated by Welfare and Institutions Code section 14199.134.

However, the provisions that render Proposition 35 inoperative in the event of federal disapproval apply only to those statutes enacted by Proposition 35 itself. The law that existed prior to the enactment of Proposition 35 could give DHCS and the Legislature broader legal authority to revise the MCO Tax structure for calendar years 2025 and 2026 to bring it into compliance with the federal changes.[26] However, a compromise would have to be reached among various stakeholders, including Medi-Cal managed-care plans, for such a significant structural change.

V. Conclusion

A lot has happened on the state and federal level since California voters enacted Proposition 35 in November 2024. The State pivoted its planning due to the State's dire financial situation in May 2025. At present, the State has submitted some requests for approval to utilize Proposition 35 funding in ways consistent with the initiative, though in must instances not in the amounts listed in the initiative.

At the same time, there have been sweeping changes in Medicaid law from the enactment of H.R. 1 and more potentially to come when proposed regulations are finalized. The federal reforms to Medicaid provider-tax waiver rules directly threaten the variable-rate structure central to California's MCO Tax. While AB 119 remains operative, Proposition 35 would likely be rendered inoperative if CMS disapproved the tax, and DHCS lacks clear statutory authority to implement the structural adjustments that federal law may soon require. As a result, barring Congressional action, the MCO Tax program may be unlikely to continue as it has been after the implementation of the generally redistributive rules.

Endnotes

[1] The authors acknowledge Emily Glenn from University of California Berkeley law school for help on this article as part of the 2025 class of the California Medical Association/Athene Law, LLP Health Law and Policy Access Summer Internship Program.
[2] Orthopaedic Hospital v. Belshe 103 F.3d 1491, 1493 (9th Cir. 1997).
[3] Ibid.; 42 C.F.R. § 430.0.
[4] Alexander v. Choate 469 U.S. 287, 289 fn. 1 (1985).
[5] See Cal. Code Regs., tit. 22, § 50004.
[6] A healthcare related tax is a tax that "(i) is related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services, or ¶ (ii) is not limited to such items or services but provides for treatment of individuals or entities that are providing or paying for such items or services that is different from the treatment provided to other individuals or entities." (42 U.S.C. § 1396b(w)(3)(A).) The term "provider tax" is often used, but provider taxes are a subset of the broader category of healthcare related taxes.
[7] 42 U.S.C. § 1396b(w)(1)(A).
[8] 42 U.S.C. § 1396b(w)(4).
[9] 73 Fed. Reg. 9685, 9694 (Feb. 22, 2008).
[10] 42 C.F.R. § 433.68(f)(3).
[11] 42 C.F.R. § 433.68(e).
[12] 42 C.F.R . 433.68(e)(2)
[13] Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Hum. Servs., California Managed Care Organization Tax Waiver Approval & Companion Letter, https://www.dhcs.ca.gov/Documents/CA-MCO-Tax-Waiver.pdf.
[14] Welf. & Inst. Code § 14199.123(a), (b).
[15] Department of Health Care Services, Protecting Access to Health Care Act Stakeholder Advisory Committee Presentation, Apr. 14, 2025, https://www.dhcs.ca.gov/provgovpart/Documents/04-14-25-PAHCA-SAC-Meeting-Deck.pdf.
[16] Welf. & Inst. Code § 14199.129.
[17] Welf. & Inst. Code § 14199.134.
[18] Welf. & Inst. Code § 14199.127(a).
[19]Welf. & Inst. Code § 14199.127(c).
[20] Any changes to the fee-for-service rates must be effectuated through the submission of a Medicaid State Plan Amendment, which must be approved by the federal Centers for Medicare & Medicaid Services. (42 U.S.C. § 1396a(a)(30)(A).) A State Plan Amendment can be effective no earlier than the first day of the quarter in which it was submitted. (42 C.F.R. § 430.20.)
[21] Department of Health Care Services, Proposition 35 Spending Plan – 2025 & 2026, May 14, 2025, https://www.dhcs.ca.gov/Budget/Documetns/Prop-35-Spending-Plan-Overview.pdf.
[22] 90 Fed. Reg. 20,578 (May 15, 2025).
[23] The CMS news release may be accessed at https://www.cms.gov/newsroom/fact-sheets/preserving-medicaid-funding-vulnerable-populations-closing-health-care-related-tax-loophole-proposed.
[24] See Welf. & Inst. Code § 14199.127(a): "This article shall be inoperative during any portion of the calendar year for which during any portion of a calendar year for which the department does not obtain the necessary federal approvals for the tax imposed pursuant to Section 14199.123."
[25] Welf. & Inst. Code § 14199.126(c).
[26] Welf. & Inst. Code §§ 14199.80-14199.88. However, the authors note that Welfare and institutions Code section 14199.86 renders the MCO Tax inoperative on the first day of the calendar year if federal approval is not obtained or the tax is determined to not meet the intent of the statute, among other conditions. This could further limit DHCS' ability to propose amendments to the pre-existing MCO Tax. If any of these conditions are met, DHCS must post a formal determination and implement a wind-down and refund process.

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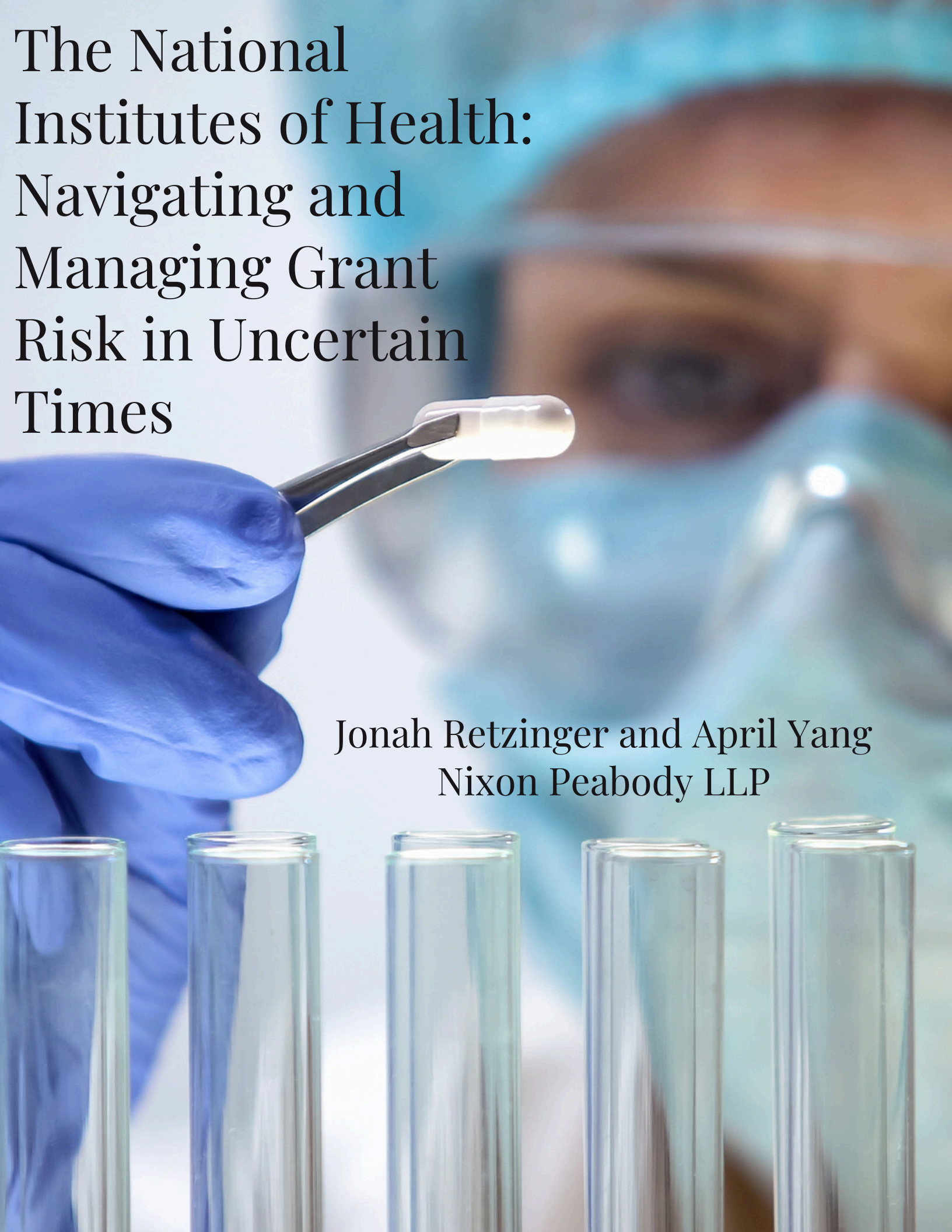
The National Institutes of Health: Navigating and Managing Grant Risk in Uncertain Times



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This has been a consequential year for the National Institutes of Health (NIH). Almost immediately after President Trump's inauguration, the administration began a sweeping reset of federal biomedical research policy with profound implications for both NIH and recipients of the agency's funding. These shifts included an attempt to impose a 15 percent cap on indirect costs paid to support operations at institutions receiving NIH money, as well as the broad termination of NIH grants purportedly tied to diversity, equity, and inclusion (DEI) and gender-related priorities.

In parallel, the U.S. Department of Health & Human Services (HHS) advanced structural and budgetary changes, including mass layoffs and a fiscal year 2026 budget blueprint to reduce NIH funding by roughly 40 percent. [1] These executive actions, along with interruptions to NIH grant review processes and the freezing of NIH grant disbursements, have triggered multiple, ongoing lawsuits around the country and significant operational disruption—especially at California universities and teaching hospitals.

Although several federal courts have enjoined or limited executive actions taken by the Trump Administration with respect to NIH activities (and Congress has signaled resistance to deep appropriation cuts), the cumulative effect of such actions has been acute uncertainty in NIH extramural funding and understandable anxiety from recipients of this money as to increased oversight of compliance with grant requirements. This anxiety has only been intensified after recent pronouncements from the U.S. Department of Justice (DOJ) that DOJ intends to use its full arsenal of enforcement authorities, including and especially the civil False Claims Act, 31 U.S.C. § 3729 et seq., to advance the administration's policy objectives. [2] Given the record number of qui tam lawsuits filed by whistleblowers in 2024, recipients of NIH funds are justifiably nervous about costs and exposures associated with increased oversight of NIH grant expenditures and the consequences of perceived noncompliance with grant terms and conditions. [3]

Accordingly, it is paramount that solicitors and recipients of NIH funding remain attentive to litigation developments, shifting NIH policies and processes, and related enforcement activity.

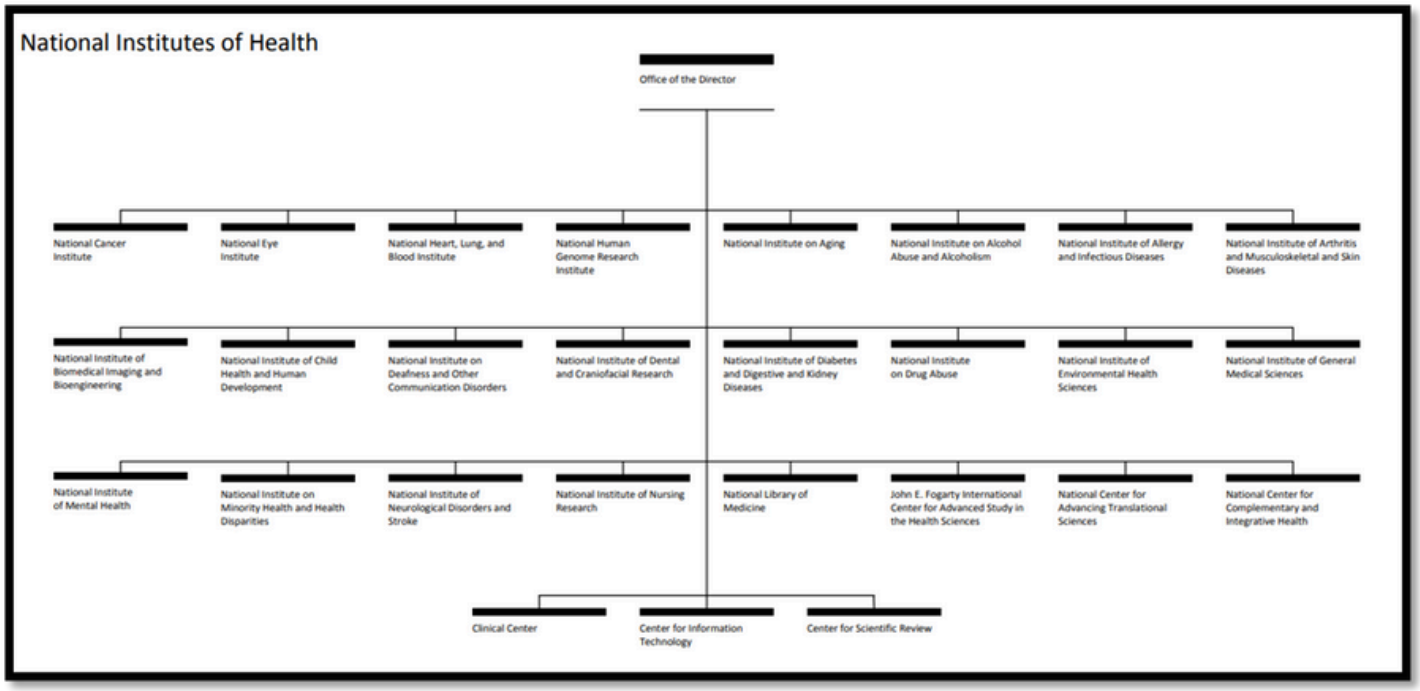
I. The National Institutes of Health

NIH is an HHS subagency and the world's largest public funder of biomedical research. Its mission is to seek fundamental knowledge about the nature and behavior of living systems and to apply that knowledge to enhance health, lengthen life, and reduce illness and disability. As provided in Image A, NIH presently comprises 27 distinct institutes and centers—each with its own research agenda—that collectively fund and conduct research across the full spectrum of human health. [4] However, the Trump Administration and the current NIH Director, Jay Bhattacharya, a former professor at Stanford University's School of Medicine and Department of Economics, recently announced their intention to consolidate the NIH's existing 27 institutes and centers into eight. [5] The proposed consolidation plan, which would eliminate four institutes entirely, is part of a larger plan to dramatically cut NIH's budget.

A. Complete Application Required for Review

NIH announces grant opportunities using a Notice of Funding Opportunity (NOFO). Each NOFO outlines the goals and objectives of the funding announcement and includes information to allow prospective applicants to assess eligibility. [7] NIH publishes all NOFOs online and is currently in the process of transitioning all NOFOs to a single official source, grants.gov, by the end of fiscal year 2025. [8] To achieve its research objectives, NIH engages in a detailed grant review process which is governed by federal law and regulation. [9] Grant applications must undergo two levels of peer review prior to a grant award. The first level of review is carried out by a scientific review group (SRG), also referred to as a "study section," typically organized by either the NIH Center for Scientific Review or a specific NIH institute or center. The SRG is composed primarily of non-federal scientists who have expertise in the relevant scientific discipline and research area.

Image A: Current Organizational Chart of the National Institutes of Health [6]



SRGs assess the overall impact that an applicant's proposal will have on the biomedical research field involved and evaluate significance, investigators, innovation, approach, and environment using a scoring system to produce criterion scores and an overall impact score.

National advisory councils or boards perform the second level of peer review for research grant applications and offer advice and recommendations on policy and program development, implementation, and evaluation, as well as other matters of significance to the mission and goals of the respective institute or center. The advisory council makes funding recommendations to the institute or center director, who may also consider budget, policy constraints, and strategic needs before ultimately making the final funding decision. Historically, NIH has posted notices of grant review meetings and grant review panels in the Federal Register in compliance with the Federal Advisory Committee Act. [10]

B. NIH Grant Awards and Oversight

Each successful applicant who submits an application in response to a NOFO receives a formal Notice of Award (NOA), which obligates NIH funds and sets the project period and budget. The NOA may include special terms, restrictions, or prior approval requirements. Additional general terms and conditions are included in the NIH Grants Policy Statement, as well as any potential cooperative agreements between NIH and relevant parties. [11]

NIH grants are also governed by the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, as adopted by HHS, as well as any applicable statutory and agency-wide policies. [12] Collectively, these authorities define allowability, allocability, reasonableness of costs, reporting obligations, property and procurement standards, and enforcement mechanisms.

NIH oversees grant expenditures and compliance with grant terms and conditions through a combination of proactive monitoring and post-award controls. Ongoing oversight can include audits, annual research performance progress reports, financial reports, and subrecipient monitoring, as well as prior approval for specified changes in scope, key personnel, or rebudgeting. NIH program and grants management staff may conduct site visits, and clinical research awards may require data and safety monitoring. Upon the completion of a project for which an NIH grant is awarded, award recipients may be required to submit final technical, financial, and invention reports within the mandated timeframe, and NIH may impose corrective actions, disallow costs, or adjust future funding depending on any identified deficiencies.

C. NIH Budget and California Awards

Congress appropriated roughly $47 billion to NIH for fiscal year 2024. [13] With respect to the 2025 fiscal year, NIH has been operating under a full-year

continuing resolution that generally holds funding at fiscal year 2024 levels. [14] However, for fiscal year 2026, the Trump Administration has proposed cutting NIH's discretionary budget by nearly 40 percent. [15]

NIH awards over 60,000 grants that directly support more than 300,000 researchers at more than 2,500 different institutions annually. [16] California consistently receives more NIH funding than any other state in the nation, by both total dollars and award count. Based on publicly available NIH award data, NIH awarded roughly $5 billion to over 8,000 California institutions in fiscal years 2024 and 2025, including funding provided to California research universities, medical centers, and nonprofit institutes for research and development and training, among other purposes.

II. Executive Orders Impacting NIH Grantmaking

In January, President Trump began issuing executive orders directing the termination of equity-related grants, contracts, and other assistance. On January 29, 2025, President Trump issued Executive Order No. 14151, which directed each federal agency to "terminate, to the maximum extent allowed by law, all... 'equity-related' grants or contracts" within 60 days. [17]

The next day, the President issued Executive Order No. 14168, which directed that "[f]ederal funds shall not be used to promote gender ideology," and instructed federal agencies to revise grant conditions accordingly. [18] Shortly thereafter, the president issued Executive Order No. 14173, which required the Office of Management and Budget (OMB), which oversees the implementation of the president's regulatory agenda, to "[t]erminate all 'diversity,' 'equity,' 'equitable decision-making,' 'equitable deployment of financial and technical assistance,' 'advancing equity,' and like mandates, requirements, programs, or activities, as appropriate." [19]

In August 2025, President Trump also issued Executive Order 14332, which increases political oversight and control over how federal discretionary grants are awarded and managed. The order requires all discretionary awards to "demonstrably advance the president's policy priorities" and what the administration unilaterally defines as the "national interest." In addition to the cessation of funding for initiatives related to DEI, the order prohibits funding for activities that promote illegal immigration or otherwise "compromise public safety or promote anti-American values." Furthermore, the order mandates that every federal agency with grantmaking authority must appoint a senior political appointee to oversee

the review and approval of all new discretionary grants and funding opportunities. This appointee is required to use their "independent judgment" rather than to defer to the expertise of grant reviewers or program officials. [20]

III. Indirect Cost Rates

Rather than reimbursing research institutions on a line-item basis for overhead like facility and administrative costs associated with NIH-funded research, NIH grant awards often apply a multiplier to the institution's "direct costs"—such as salaries and benefits for personnel working directly on the project, as well as direct supplies and equipment—to cover such overhead. In February, 2025, shortly after President Trump's inauguration, NIH issued supplemental guidance that unilaterally reduced and capped indirect cost rates at a standard 15 percent (supplanting prior grant-specific, negotiated indirect cost rates) for both existing and future NIH grants. [21] The new indirect costs policy implicated billions of dollars in funding.

In response, multiple plaintiffs—including, among others, the State of California, the Regents of the University of California, and the California Institute of Technology—filed lawsuits seeking to enjoin the supplemental guidance. In support of such claims, the plaintiffs argued that the supplemental guidance: (1) violated the plain language of existing regulations regarding the administration of indirect costs; (2) was otherwise contrary to law; and (3) was issued in violation of the Administrative Procedure Act (APA), in

part because it amounted to arbitrary, capricious, and impermissible retroactive agency action that did not undergo notice-and-comment rulemaking. The plaintiffs' claims framed the 15 percent cap as an impermissible legislative rule—not merely interpretive guidance—because it displaced previously-negotiated rate agreements and imposed a new binding ceiling on costs.

After three such cases were consolidated, on March 5, 2025, the U.S. District Court for the District of Massachusetts granted a nationwide preliminary injunction enjoining NIH from implementing the supplemental guidance. [22] The court found that the unilateral changes to indirect cost rates further posed an imminent threat to life-saving research and patient care, warranting immediate relief to maintain the status quo. The government has since appealed the decision and the U.S. Court of Appeals for the First Circuit heard oral arguments on November 5, 2025.

IV. Grant Terminations

On January 21, 2025, HHS issued a memorandum directing its agencies to cease the publication of grant review meeting notices in the Federal Register. [23, 24] Further, in accordance with President Trump's executive orders,

on January 27, 2025, OMB issued a memorandum directing all federal agencies, including NIH, to temporarily pause all agency activities that may be implicated, including, but not limited to, financial assistance for DEI-related initiatives and “woke gender ideology.” [25] Although OMB subsequently rescinded the memorandum, the agency was further directed to revise grant regulations to include "termination-for-convenience" clauses in all discretionary grant agreements, which allow agencies to terminate existing grants if they no longer align with administration priorities. [26] Beginning on February 12, 2025, NIH began issuing internal guidance implementing and revising its processes based on the president’s directives. This included initial guidance setting forth hard funding restrictions on projects perceived to promote or take part in DEI initiatives and instructions to NIH directors to cease awards of NIH grants to projects supporting DEI activities. [27] On March 25, 2025, NIH issued further internal guidance identifying a list of forbidden topics for NIH grants, including DEI and transgender issues. Following these directives, NIH terminated over 1,800 grants between February 2025 and June 2025. [28]

Because of the grant terminations, many states, including California, and several nonprofit organizations and labor unions, sued NIH in American Public Health Ass’n et al. v. NIH et al., alleging the NIH directives terminating and restricting DEI-related grants, and the resulting grant terminations, constituted impermissible rulemaking requiring notice-and-comment and were otherwise arbitrary and capricious. After deeming the plaintiffs’ arguments meritorious, on June 23, 2025, the U.S. District Court of Massachusetts vacated and set aside the NIH directives and the resulting grant terminations, deeming them void, illegal, and of no force and effect. [29] In August 2025, the U.S. Government Accountability Office issued a decision providing that the Administration violated the Impoundment Control Act of 1974 (ICA)—which allows the president to withhold funds from obligation only under strictly limited circumstances and only in a manner consistent with the ICA—when it withheld NIH funds from obligation and expenditure for fiscal year 2025. [30]

After the district court issued its decision, the government sought to stay the district court’s order pending appeal, which both the district court and the U.S. Court of Appeals for the First Circuit initially denied. However, after the government subsequently submitted an application to the U.S. Supreme Court to stay the district court’s judgment, on August 21, 2025, the Supreme Court vacated the government's termination of specific research-related grants but otherwise denied the government’s application for a stay as to the district court’s order vacating the challenged NIH directives. The government has since appealed the district court’s decision to the U.S. Court of Appeals for the First Circuit, and the matter is expected to be fully briefed and set for hearing on December 3, 2025.

V. American Association of University Professors Litigation in California

In September, the American Association of University Professors and a coalition of faculty, staff, student, and labor organizations representing tens of thousands of University of California (UC) stakeholders brought suit in the Northern District of California against the Trump Administration, NIH, and more than a dozen other federal funding agencies in American Association of University Professors et al. v. Trump et al. [31] The plaintiffs allege that, beginning in early 2025, the Trump Administration undertook actions intended to pressure the UC system to change its policies related to free speech, academic freedom, and diversity initiatives. The complaint asserts that these actions included cancelling or freezing approximately $584 million in federal research grants at UCLA, including NIH grants supporting medical research and clinical trials, threatening additional funding reductions system-wide, and requesting a $1 billion payment as a condition for restoring funding.

The complaint characterizes these actions as part of a broader approach the administration has taken in relation to other universities, including Columbia, Brown, UPenn, and Harvard. According to the plaintiffs, this approach involves terminating grant funding and conditioning its reinstatement on, among other things, curriculum changes, faculty hiring, and restrictions on certain protests and demonstrations. The plaintiffs further allege that the funding terminations, threats, and policy demands—including the suspension of NIH grants—amount to constitutional violations, as well as violations of Title VI, Title IX, and the APA.

The plaintiffs have asked that the court set aside all grant terminations, funding freezes—including those imposed by NIH—and future funding denials that they allege were undertaken in retaliation for protected speech or without compliance with statutory procedures. They also ask the court to enjoin the administration from conditioning UC funding on the surrender of constitutional or state-law rights, and to prohibit demands for monetary penalties not supported by statute. The suit, according to the plaintiffs, is intended to challenge what they describe as federal efforts to influence university policies through funding conditions and to reaffirm constitutional protections for academic freedom and speech. NIH responded to plaintiffs' motion for preliminary injunction on October 24, 2025, and the motion was heard on November 6, 2025. On November 14, 2025, the Court issued an order granting plaintiffs' motion for preliminary injunction, finding that "Defendants have engaged in coercive and retaliatory conduct in violation of the First Amendment and Tenth Amendment... [and] have flouted the requirements of Title VI and IX and cancelled funding in an arbitrary and capricious manner while ignoring required safeguards."

VI. Mitigating NIH Grant Risk

While recipients of NIH funding should stay alert to ongoing litigation developments, California stakeholders should appreciate risks associated with noncompliance with material grant terms.

The NIH Grants Policy Statement explicitly provides that fraud, waste and abuse of grant funds can give rise to administrative, civil, and criminal liability, including under the federal False Claims Act. This expressly includes, but is not limited to: embezzlement, misuse, or misappropriation of grant funds or property, false statements; theft of grant funds for personal use; using funds for non-grant-related purposes; theft of federally owned property or property acquired or leased under a grant; charging the federal government for the services of "ghost" individuals; charging inflated building rental fees for a building owned by the recipient; submitting false financial reports; and submitting false financial data material to grant payments. [32]

Further, in addition to exposure associated with noncompliance with material grant terms and conditions, arguable DEI preferences in recruitment, training, or participant selection under NIH grant awards also subject awardees to heightened risks. NIH's recent directives have emphasized the materiality of race-neutral approaches and strict adherence to Title VI and related requirements. While NIH rescinded proposed civil-rights-centered terms reinforcing nondiscrimination obligations as conditions of award on June 12, 2025, other civil rights requirements outlined in the NIH Grants Policy Statement remain in effect. [33]

Recent enforcement actions involving NIH awards have alleged material omissions of foreign affiliations, undisclosed appointments, and unreported in-kind support as the basis for implied false certifications. [34] Misrepresentations in grant applications and mandated reports, including image manipulation and data falsification, have also resulted in FCA exposure, in addition to research integrity sanctions. [35]

To mitigate risk, grant recipients should periodically review the operative terms incorporated into NOAs, maintain compliance documentation, and build evidence of compliance into day-to-day operations. Awardees should further align and update policies with current operative NIH supplemental guidance and make sure to conduct appropriate diligence to validate all disclosures, especially disclosures relating to foreign support and affiliations. Given DOJ's enforcement posture, anything less will likely leave an institution at risk.

Endnotes

[1] Office of Management and Budget, Executive Office of the President, Fiscal Year 2026 Discretionary Budget Request (May 2025), available at https://www.whitehouse.gov/wp-content/uploads/2025/05/Fiscal-Year-2026-Discretionary-Budget-Request.pdf.

[2] DOJ, Office of the Assistant Attorney General, Memorandum to All Civil Division Employees re: Civil Division Enforcement Priorities (June 11, 2025), available at https://www.justice.gov/civil/media/1404046/dl?inline.

[3] DOJ, Office of Public Affairs, Press Release, "False Claims Act Settlements and Judgments Exceed $2.9B in Fiscal Year 2024" (Jan. 15, 2025), available at https://www.justice.gov/archives/opa/pr/false-claims-act-settlements-and-judgments-exceed-29b-fiscal-year-2024.

[4] NIH Organization Chart (last reviewed Apr. 25, 2025), available at https://www.nih.gov/about-nih/organization.

[5] NIH, HHS, Fiscal Year 2026 Congressional Justification: Overview (2025), available at https://officeofbudget.od.nih.gov/pdfs/FY26/NIH%20FY%202026%20CJ%20Overview.pdf.

[6] Available at https://oma.od.nih.gov/IC_Organization_Chart/OD%20Organizational%20Chart.pdf.

[7] See NIH Grants & Funding, Grants Process (last updated July 24, 2024), available at https://grants.nih.gov/grants-process.

[8] See NIH Grants & Funding, Policy & Compliance, "Updates to Finding NIH Funding Opportunities and Information" (last updated Aug. 21, 2025), available at https://grants.nih.gov/policy-and-compliance/implementation-of-new-initiatives-and-policies/updates-to-finding-nih-funding-opportunities-and-information#recognizing-grants.gov-as-the-single-official-source-for-nih-grant-and-cooperative-agreement-funding-opportunities.

[9] See 42 C.F.R. § 52h (2025); 42 C.F.R. § 52.5 (2025).

[10] 5 U.S.C. § 10(a)(2).

[11] See NIH Grants & Funding, Policy & Compliance, NIH Grants Policy Statement (last updated Sept. 12, 2024), available at https://grants.nih.gov/policy-and-compliance/nihgps.

[12] 2 C.F.R. Part 200 (2025); 45 C.F.R. Part 75 (2025).

[13] Congressional Research Service, The National Institutes of Health (NIH): Background and Congressional Issues, R41705 (2025), available at https://www.congress.gov/crs-product/R41705#:~:text=The%20National%20Institutes%20of%20Health%20(NIH)%2C%20under%20the%20Department,training%20at%20its%20own%20facilities.

[14] NIH Notice, "NIH Operates Under a Continuing Resolution" (Apr. 3, 2025), available at https://grants.nih.gov/grants/guide/notice-files/NOT-OD-25-084.html; see also NIH Notice, "NIH Operates Under a Continuing Resolution" (Jan. 10, 2025), available at https://grants.nih.gov/grants/guide/notice-files/NOT-OD-25-054.html; see also NIH Notice, "NIH Operates Under a Continuing Resolution" (Oct. 10, 2024), available https://grants.nih.gov/grants/guide/notice-files/NOT-OD-25-010.html.

[15] Office of Management and Budget, Executive Office of the President, Fiscal Year 2026 Discretionary Budget Request (May 2025), available at https://www.whitehouse.gov/wp-content/uploads/2025/05/Fiscal-Year-2026-Discretionary-Budget-Request.pdf.

[16] Id., see also National Institutes of Health, Impact of NIH Research: Direct Economic Contributions (2025), available at https://www.nih.gov/about-nih/impact-nih-research/serving-society/direct-economic-contributions#:~:text=Research%20Investment,-Image&text=Every%20state%20and%20almost%20every,more%20than%202%2C500%20different%20institutions.

[17] Donald J. Trump, Executive Order 14151, Ending Radical and Wasteful Government DEI Programs and Preferencing, 90 Fed. Reg. 8615-18 (Jan. 29, 2025).

[18] Donald J. Trump, Executive Order 14168, Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government, 90 Fed. Reg. 8339-41 (Jan. 30, 2025).

[19] Donald J. Trump, Executive Order 14173, Ending Illegal Discrimination and Restoring Merit-Based Opportunity, 90 Fed. Reg. 8633-36 (Jan. 31, 2025).

[20] Donald J. Trump, Executive Order 14332, Improving Oversight of Federal Grantmaking, 90 Fed. Reg. 38929-33 (Aug. 12, 2025).

[21] NIH, Office of the Director, Supplemental Guidance to the 2024 NIH Grants Policy Statement: Indirect Cost Rates (Feb. 7, 2025), available at https://grants.nih.gov/grants/guide/notice-files/NOT-OD-25-068.html.
[22] Commonwealth of Massachusetts et al. v. NIH et al., No. 1:25-cv-10338 (D. Mass. Feb 10, 2025); Ass'n of Am. Med. Colleges v. NIH, No. 1:25-cv-10340-AK (D. Mass. Feb 10, 2025); Ass'n of Am. Univs. v. HHS, No. 1:25-cv-10346 (D. Mass. Feb. 10, 2025).
[23] U.S. Government Accountability Office, Decision in the Matter of Department of Health and Human Services—National Institutes of Health—Application of Impoundment Control Act to Availability of Funds for Grants (Aug. 5, 2025), available at https://www.gao.gov/products/b-337203.
[24] As a result of the January 21 HHS memorandum, NIH did not publish any grant review meeting notices between January 22, 2025, and March 3, 2025.
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California Attorney General Issues Warning on Artificial Intelligence and Industry Best Practices

Daniel A. Cody, Mintz

I. Introduction

In January 2025, California Attorney General Rob Bonta (the "California AG") issued two Legal Advisories regarding the utilization of artificial intelligence ("AI"). The first, entitled "California Attorney General's Legal Advisory on the Application of Existing California Laws to Artificial Intelligence" provides guidance to consumers and entities developing, selling, and utilizing AI. (the "General Legal Advisory") [1] The General Legal Advisory describes consumers' and such entities' rights and obligations under California law. The second Legal Advisory, entitled "California Attorney General's Legal Advisory on the Application of Existing California Law to Artificial Intelligence in Healthcare," (the "Health Care Legal Advisory") is expressly directed at health care providers, insurers, vendors, investors, and other health care entities that develop, sell, or utilize AI and other automated decision-making tools. [2]

Both Legal Advisories outline existing California laws applicable to AI while also discussing new California AI-related laws that took effect on January 1, 2025. Neither Legal Advisory is intended to be exhaustive as various other California laws, including tort, public nuisance, environmental protection, business regulation, charitable trusts, and criminal laws, among others, apply to AI systems and entities utilizing AI. In the accompanying Legal Advisory press release, the California AG noted that: AI might be changing, innovating, and evolving quickly, but the fifth largest economy in the world is not the wild west; existing California laws apply to both the development and use of AI. Companies, including healthcare entities, are responsible for complying with new and existing California laws and must take full accountability for their actions, decisions, and products. [3]

II. Artificial Intelligence: Definition and Benefits/Risks

The Legal Advisories acknowledge that the definition of AI may vary depending upon the context, but for purposes of the Legal Advisories, AI includes a machine-based system that can, for a given set of human-defined objectives, make predictions, recommendations, or decisions influencing real or virtual environments. [4] Artificial intelligence systems utilize machine and human-based inputs to: (a) perceive real and virtual environments, (b) abstract such perceptions into models through automated analysis, and (c) use model inferences to formulate options for information or action. [5] California also recently enacted a law defining AI in certain instances as 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." [6] As discussed in the Legal Advisories, the California AG

encourages the responsible utilization of AI to explore potential solutions to urgent and persistent challenges, increase efficiencies, and provide universal access to information. [7] Such responsible utilization of AI requires adoption of AI in ways that are safe, ethical, and comply with California law, including laws regarding unfair and fraudulent business practices, anticompetitive activity, discrimination and bias, and abuse of data. Further, AI systems should be (a) tested and validated; (b) audited; (c) designed to reduce human error and biases; and (d) transparent to the greatest extent possible.

III. The California AG's Concerns with AI in Health Care

The California AG has previously expressed concerns regarding the increased utilization of AI and algorithmic tools in health care and the potential for violations of California law. In August 2022, the California AG sent letters to 30 California hospitals requesting information regarding how the hospitals identify and address racial and ethnic disparities that may exist in their commercial decision-making tools. [8] The California AG noted that such algorithmic tools, which often leverage AI, might have discriminatory impacts based on race and ethnicity.

The California AG's letters requested the hospitals to provide a list of all the algorithmic tools utilized for (a) clinical decision support, (b) population health management, patient care management, and utilization management, (c) operational optimization, and (d) payment management. Further, the letters requested the purposes for which these tools are utilized, how the tools inform decision-making, and any policies, procedures, or training adopted for utilization of the tools. [9]

The recent Legal Advisories highlight the California AG's ongoing concerns regarding AI and algorithmic tools. On the one hand, the Health Care Legal Advisory notes the potential benefits of AI-enabled tools including improving both patient and population health, reducing administrative burdens, increasing health equity, and facilitating appropriate information sharing. On the other hand, the risks of AI in health care include potential denials of necessary care, misallocation of health care resources, bias and discrimination, and interference with patient autonomy and privacy.

IV. The Health Care Legal Advisory and Compliance with California Laws

The Health Care Legal Advisory discusses compliance with existing California consumer protection, unfair competition, civil rights, and patient privacy laws. As with all the California laws referenced in both Legal Advisories, these laws apply equally in the AI context as compared to other contexts.

First, the Health Care Legal Advisory outlines the broad scope of California's Unfair Competition Law (the "UCL") which protects consumers against false advertising, marketing, and anticompetitive practices, among other legal protections. [10] The Health Care Legal Advisory notes that practices that deceive or harm consumers fall squarely within the UCL. Specific to the AI context, this includes creating, marketing, or distributing AI systems that fail to adhere to California's civil rights, privacy, and fraud and abuse laws.

From the practice of medicine perspective, only human practitioners are licensed to practice in California. [11] In other words, the practice of medicine may not be delegated to AI systems. In addition to violating the UCL, utilizing AI tools to make clinical decisions or override practitioner clinical determination may violate California's long-standing prohibition against the practice of medicine by corporations or other "artificial legal entities." [12]
In that regard, recent amendments to California's Knox-Keene Act and the California Insurance Code limit the ability of health care service plans to utilize AI systems to make final medical necessity determinations to delay, deny, or modify care. [13] Instead, health plans must ensure that AI and other algorithmic tools:

- Allow licensed health care practitioners competent to evaluate the specific, individual patient medical history and clinical issues involved to make medical necessity assessments;
- Do not discriminate and are applied fairly and equitably;
- Are open to inspection and audit by appropriate California agencies;
- Are periodically reviewed and revised to maximize accuracy and reliability;
- Do not utilize patient data beyond its intended use and stated purpose; and
- Do not directly or indirectly cause patient harm. [14]

Second, the Health Care Legal Advisory highlights California's anti-discrimination law applicable broadly to individuals and entities receiving "state support." [15] Such state support may be through the Medi-Cal program or any other California state funds or resources. [16] Here, the California AG warns that while AI and other automated decision-making tools may be facially neutral, health care entities may not ignore or avoid data indicating racial, gender, or other protected classification inequities.

The Health Care Legal Advisory provides an example where "an AI system that makes less accurate predictions about demographic groups of people who have historically faced barriers to healthcare (and whose information may be underrepresented in large datasets), though facially neutral, may have a disproportionate negative impact on members of protected groups." [17] This type of disparate impact is only allowable if utilization of the AI system is necessary for achieving a compelling, legitimate, and non-discriminatory purpose and is supported by factual evidence.

Third, the California AG notes that in some cases California medical privacy laws are more protective than federal laws such as the federal Health Insurance Portability and Accountability Act (HIPAA). [18] For example. pursuant to the California Confidentiality of Medical Information Act (CMIA), the Information Practices Act, and the Genetic Privacy Information Act, covered entities are subject to heightened requirements in connection with the confidentiality, access, disclosure, and use of patient medical information including mental, behavioral, reproductive, sexual, and genetic data. [19]

As such, California health care entities may have a heightened obligation to preserve the confidentiality of medical information, ensure patient access to their medical information, and obtain robust patient informed consents. Further, the Health Care Legal Advisory posits that California health care providers consider whether disclosure of the utilization of AI and other automated decision-making tools should be included in such informed consents. Moreover, recent California law requires that health care providers disclose to patients when AI is utilized to generate patient communications including clinical information. [20]

V. Potentially Unlawful Activities

Under these existing and newly enacted legal authorities, the California AG provides examples of activities that may be unlawful in California when AI or other automated decision-making tools are utilized including: [21]

- Denying health insurance claims in a manner that overrides a physician's determination regarding necessary treatment.
- Determining patient access to health care based upon predictions utilizing a patient's past health claims data and having a discriminatory disparate impact.
- Drafting patient notes, communications, or medical orders that include erroneous or misleading information.

VI. Recommendations and Best Practices

AI technologies are rapidly evolving in terms of their development and utilization. Moreover, AI tools are complex and the processes underlying AI systems often are opaque or poorly understood. As evidenced by the Legal Advisories, the California AG expects entities developing and utilizing AI and other algorithmic tools to focus on transparency and compliance with the myriad California laws applicable to AI.

As such, health care providers, insurers, vendors, and investors should continue to test, validate, and audit AI and other automated tools deployed in health care decision-making. Health care industry participants also should understand how the AI tools they utilize are trained, the quality and type of information that is considered, and how outputs and recommendations are generated. Health care entities should consider being transparent with patients regarding how AI is being utilized in making health care-related decisions.

Ultimately, the utilization of AI in health care must be accompanied by robust human oversight and judgment. Failure to do so subjects health care market participants to potential enforcement actions for non-compliance with the California laws highlighted in the Legal Advisories, along with potential California and federal false claims act and other liability.

To accomplish these goals and mitigate potential risk, health care companies should consider incorporating AI specific elements into their existing compliance programs or adopting stand-alone specialized AI compliance programs. In addition to the Department of Health and Human Services, Office of Inspector General's recently updated compliance program guidance, [22] key elements of an effective AI-specific compliance program might include:

- Establishment of an AI Governance Committee. Establish a multidisciplinary governance committee to oversee all AI-related matters at the organization including both internal AI activities and external, third-party vendor arrangements. Consistent with compliance programs generally, the structure and operation of the committee may be flexible consistent with the size, management style, and mission/ethos of the organization. The AI governance committee might include representatives from multiple departments including compliance, legal, information technology, risk management, and administrative and clinical operations.

- Written Policies, Procedures, and Protocols. Develop and implement comprehensive, written policies, procedures, and protocols addressing all aspects of AI including procurement, implementation, utilization, and routine auditing and monitoring. Given the rapid advancements with AI technologies, these policies, procedures, and protocols should be periodically reviewed and updated to comport with health care industry standards, best practices, and regulatory requirements.
- Training Programs. Develop and implement regular and consistent training programs for all organization stakeholders regarding the benefits and risks of AI and algorithmic tools, the legal landscape, organizational expectations and obligations, and best practices. Such training programs should be designed to be effective and adherence to training program requirements monitored.
- Monitoring, Auditing, and Risk Assessment. Develop and implement robust monitoring and auditing programs to assess AI technologies and their compliance with the organization's policies, procedures, and protocols along with California and other applicable federal and state law. Importantly, periodic risk assessments should be conducted to identify shortcomings and emerging risks with corresponding adjustments made as needed to the AI-specific compliance program. Organizations should strongly consider utilizing internal analytical tools mirroring those utilized by California and federal enforcement agencies to proactively identify anomalies and patterns that might trigger enforcement scrutiny. Failure to do so might be considered a significant shortcoming for an effective compliance program.

Endnotes

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[9] See id.
[10] See Cal. Bus. & Prof. Code § 17200
[11] See Cal. Bus. & Prof. Code, Division 2, § 500 et seq.
[12] See Cal. Bus. & Prof. Code § 2400.
[13] See Cal. Health & Safety Code § 1367.01(k)(1); Cal. Ins. Code § 10123.135(j)(2).
[14] See Cal. Health & Safety Code § 1367.01(k)(1)(A-K); Cal. Ins. Code § 10123.135(j)(2)(A-K).
[15] See Cal. Gov. Code § 11135.
[16] See id. § 14020.
[17] California Department of Justice, Office of the Attorney General (Jan. 13, 2025), p.4 (available at: https://oag.ca.gov/system/files/attachments/press-docs/Final%20Legal%20Advisory%20-%20Application%20of%20Existing%20CA%20Laws%20to%20Artificial%20Intelligence%20in%20Healthcare.pdf).
[18] See Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160 and 164.
[19] See Cal. Civ. Code § 56.10 et seq.
[20] See Health & Safety Code § 1339.75.
[21] See California Department of Justice, Office of the Attorney General (Jan. 13, 2025), p.2 (available at: https://oag.ca.gov/system/files/attachments/press-docs/Final%20Legal%20Advisory%20-%20Application%20of%20Existing%20CA%20Laws%20to%20Artificial%20Intelligence%20in%20Healthcare.pdf).
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