April 11, 2025

The Honorable Steve Padilla
Chair, Senate Governmental Organization Committee
1020 N Street, Room 584
Sacramento, CA 95814

SUBJECT: SB 420 (Padilla) — Concern

Dear Senator Padilla:

The California Hospital Association (CHA), on behalf of more than 400 hospitals and health systems, recognizes the intent behind Senate Bill (SB) 420 to promote fairness and accountability in the development and use of automated decision systems (ADS). However, we have serious concerns about the current language in the bill, particularly as it applies to health care settings. Some of our main concerns are described below.

Overbroad Definition of "High-Risk" ADS

SB 420 defines high-risk ADS as systems used in decisions with "significant legal or similar effects," but this threshold remains vague. As written, it could unintentionally encompass a wide array of common tools used in health care — such as risk calculators or population health analytics — that assist, but do not determine, decisions. ADS that merely provide information to a human decision maker such as a physician should not be subject to the same requirements as ADS that actually make decisions.

Strict Liability for Algorithmic Discrimination

SB 420 imposes civil penalties of up to $25,000 per violation for algorithmic discrimination, without requiring a showing of intent. Although the bill references "reasonable safeguards," it does not provide a clear safe harbor for developers or deployers who make documented, good-faith efforts to reduce bias. This is especially concerning in health care, where characteristics that are typically protected by anti-discrimination law — such as age, sex, medical condition, and disability status — may be legitimate factors to consider in making health care decisions.

Onerous Deployer Obligations

Despite being framed as developer-focused, the bill imposes significant responsibilities on deployers, including conducting impact assessments, providing individualized notice, and allowing for human review upon request. The bill assumes that all "high-risk" ADS are the same, rather than allowing developers to

tailor the impact analysis to the nature of the risk involved. The bill requires overly detailed notices to be given to patients when ADS is used, containing information that a patient is unlikely to want or benefit from. For example, a physician may consider a patient's T-score — which compares a patient's bone density to that of a healthy 30-year-old — when deciding whether to prescribe an osteoporosis medication. The detailed notice required by the bill would not be of any interest to the patient, and allowing the patient to appeal the decision for review by a natural person (the physician or someone else?) makes no sense.

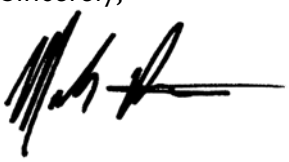
Emergency and Clinical Exceptions Missing

SB 420 does not exempt ADS used in emergency or time-sensitive clinical decision-making, such as stroke alerts, sepsis detection, or triage tools. In these cases, taking time to obtain patient consent or allowing a patient to opt out would result in harm to patients.

CHA believes that SB 420 needs significant revisions to become targeted, workable, and aligned with the realities of ADS use in clinical care. CHA would welcome the opportunity to work with you to refine the bill's language in a way that preserves its core objectives while avoiding unintended consequences in the health care space.

For these reasons, **CHA is concerned about SB 420.**

Sincerely,



Mark Farouk
Vice President, State Advocacy

cc: Honorable Members of the Senate Governmental Organization Committee
Brian Duke, Consultant, Senate Governmental Organization Committee
Ted Morley, Consultant, Senate Republican Caucus