



BLANNING & BAKER

Associates, Inc.

CSR Legislative Report

9/10/2026

3) Support

[AB 280](#) ([Aguiar-Curry, D](#)) Health care coverage: provider directories.

Current Text: 09/04/2026 - Enrolled [HTML](#) [PDF](#)

Introduced: 01/21/2025

Last Amended: 08/21/2026

Status: 09/04/2026 - Enrolled and presented to the Governor at 4 p.m.

Location: 09/04/2026 - Assembly ENROLLED

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan and a health insurer that contracts with providers for alternative rates of payment to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services enrollees or insureds, and requires a health care service plan and health insurer to regularly update its printed and online provider directory or directories, as specified. Existing law authorizes the departments to require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on materially inaccurate, incomplete, or misleading information contained in a plan's or insurer's provider directory or directories. This bill would require the Department of Managed Health Care to select a central utility and develop uniform provider directory standards requiring a health care service plan to use the designated central utility to collect, manage, and verify the consistency and completeness of their provider directories. The bill would also require health insurers to use the designated central utility and follow the uniform provider directory standards. The bill would require plans and health insurers to submit their provider directories to the central utility for analysis, and would require the central utility to create a consistency report for each directory. This bill contains other related provisions and other existing laws. (Based on 09/01/2026 text)

Memo: Support letter sent to Author

Support letter sent to Asm. APPR

Support letter sent to Sen. Health

Support letter sent to Sen. APPR

Signature request letter sent to Governor -- 08/31/26

[AB 1609](#) ([Zbur, D](#)) Customer service chatbots.

Current Text: 09/04/2026 - Enrolled [HTML](#) [PDF](#)

Introduced: 01/20/2026 (Spot bill)

Last Amended: 08/20/2026

Status: 08/31/2026 - Senate amendments concurred in. To Engrossing and Enrolling. (Ayes 58. Noes 18.).

Location: 09/01/2026 - Assembly ENROLLMENT

Summary: Existing law prohibits a person from using a bot, as defined, to mislead another person about the bot's artificial identity to incentivize the purchase or sale of goods or services, among other things. Existing law requires an operator of a companion chatbot, as defined, to provide a disclosure regarding the companion chatbot's artificial identity if a reasonable person interacting with the companion chatbot would be misled to believe that the

person is interacting with a human. This bill would prohibit a large private business, as defined, from representing that a customer service chatbot is a human. The bill would also require the large private business to provide certain disclosures if a reasonable person interacting with the chatbot would be misled to believe they are interacting with a human. This bill would require a large private business to provide a customer service feature allowing customers to contact a customer service agent during its regular business hours, as defined. This bill would require, except as specified, large private businesses to make a good faith effort to connect a customer to an agent within 15 minutes after a request for human customer service is made, or schedule an appointment with the customer, as specified. For online chatbot customer service platforms and telephonic customer service platforms, the bill would require a large private business to make a good faith effort to limit initial and cumulative telephonic hold times, and would require certain large private businesses to post prescribed contact information on their internet website. This bill contains other related provisions. (Based on 09/04/2026 text)

Memo:

Support letter sent to Author -- 8/10/26
Support letter sent to Sen. APPR -- 8/10/26
Support letter sent to Sen. PDTCP -- 8/12/26
Signature request letter sent to Governor -- 9/4/26

[AB 1629](#) ([Haney, D](#)) Dental coverage.

Current Text: 09/03/2026 - Enrolled [HTML](#) [PDF](#)

Introduced: 01/26/2026

Last Amended: 08/20/2026

Status: 09/03/2026 - Enrolled and presented to the Governor at 4 p.m.

Location: 09/03/2026 - Assembly ENROLLED

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits a contract between a plan or insurer and a dentist from requiring a dentist to accept an amount set by the plan or insurer as payment for dental care services provided to an enrollee or insured that are not covered services under the enrollee's contract or the insured's policy. Existing law requires a plan or insurer to make specified disclosures to an enrollee or insured regarding noncovered dental services. Existing law requires a health care service plan or health insurer to comply with specified timely access requirements. Under existing law, a health care service plan is required to annually report to the Department of Managed Health Care on this compliance. Existing law authorizes the Department of Insurance to issue guidance to insurers regarding annual timely access and network reporting methodologies. This bill would require a plan or insurer, including a specialized plan or insurer, covering dental services, to pay a noncontracting dental provider, which includes a registered dental hygienist in alternative practice, directly for covered services rendered to the enrollee or insured in accordance with the benefit provided in the contract or policy when the noncontracting dental provider submits to the plan or insurer an assignment of benefits. The bill would require a noncontracting dental provider to obtain a signed and dated consent to collect an assignment of benefits from an enrollee or insured. The bill would prohibit a noncontracting dental provider collecting an enrollee's or insured's assignment of benefits from charging an enrollee or insured, prior to the plan or insurer payment, more than an estimate of the enrollee's or the insured's cost sharing for the treatment or a deposit that approximates that cost share. Because a willful violation of these provisions relative to health care service plans would be a crime, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws. (Based on 08/30/2026 text)

Memo:

Support letter sent to Author -- 8/10/26
Support letter sent to Sen. APPR -- 8/10/26
Floor Alert sent to Sen -- 8/20/26
Signature request letter sent to Governor -- 08/31/26

[AB 1906](#) ([Aguilar-Curry, D](#)) Health care coverage: home test kits.

Current Text: 09/08/2026 - Enrolled [HTML](#) [PDF](#)

Introduced: 02/12/2026

Last Amended: 08/21/2026

Status: 09/08/2026 - Enrolled and presented to the Governor at 3:30 p.m.

Location: 09/08/2026 - Assembly ENROLLED

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2002, to provide coverage for an annual cervical cancer screening test upon the referral of the patient's health care provider. This bill would require a health care service plan contract or health insurance policy, except for a vision-only, dental-only, or Medicare supplement contract or policy, issued, amended, or renewed on or after January 1, 2027, to provide coverage without cost sharing for cervical cancer screening, including the United States Food and Drug Administration (FDA)-authorized or cleared self-collected cervical screening kits, when ordered or provided by an in-network provider and consistent with specified recommendations published by the State Department of Public Health. For health savings account-eligible plans or policies, the bill would require the above-described coverage only to the extent the plan is a high deductible health plan under specified federal law. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws. (Based on 09/02/2026 text)

Memo:

Support letter sent to Author -- 8/11/26

Support letter sent to Sen. APPR -- 8/11/26

Signature request letter sent to Governor -- 9/4/26

SB 296 (**Archuleta, D**) **Property taxation: exemption: disabled veteran homeowners.**

Current Text: 08/27/2026 - Enrolled [HTML](#) [PDF](#)

Introduced: 02/10/2025

Last Amended: 08/13/2026

Status: 08/27/2026 - Enrolled and presented to the Governor at 4:30 p.m.

Location: 08/27/2026 - Senate ENROLLED

Summary: The California Constitution provides that all property is taxable and requires that it be assessed at the same percentage of fair market value, unless otherwise provided by the California Constitution or federal law. The California Constitution and existing property tax law provide various exemptions from taxation, including, among others, a disabled veterans' exemption and a veterans' organization exemption. This bill would exempt from taxation, as provided, 50% of that part of the full value of the property that does not exceed \$1,000,000 that is owned by, and that constitutes the principal place of residence of, a veteran, the veteran's spouse, or the veteran and the veteran's spouse jointly, if the veteran is 100% disabled. The bill would provide an unmarried surviving spouse a property exemption in the same amount that they would have been entitled to if the veteran were alive and if certain conditions are met. In the case of a disabled veteran or unmarried surviving spouse whose household income does not exceed a specified amount for the relevant assessment year, as prescribed, the bill would exempt 100% of that part of the full value of the property that does not exceed \$1,000,000 from taxation. The bill would require certain documentation to be provided to the county assessor to receive the exemption and would prohibit any other real property tax exemption from being granted to the claimant if receiving the exemption provided by the provisions of this bill. The bill would make these exemptions applicable for property tax lien dates occurring on or after January 1, 2027, but occurring before January 1, 2032. By imposing additional duties on local tax officials, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws. (Based on 08/25/2026 text)

Memo:

Support letter sent to Author -- 8/10/26

Support letter sent to Asm. APPR -- 8/10/26

Signature request letter sent to Governor -- 08/31/26

SB 1244 (**Allen, D**) **Public Agency Benefits Intermediary Compensation Disclosure Act.**

Current Text: 08/31/2026 - Enrolled [HTML](#) [PDF](#)

Introduced: 02/19/2026

Last Amended: 08/19/2026

Status: 08/31/2026 - Enrolled and presented to the Governor at 6 p.m.

Location: 08/31/2026 - Senate ENROLLED

Summary: Existing law requires various disclosures to be made regarding health care service plan and health insurance benefits and coverages. Existing law generally regulates the conduct of business between health care service plans and solicitors and health insurers and broker-agents, including requirements regarding contracts in which the solicitor represents the health care service plan or the broker-agent represents the insurer. This bill, the Public Agency Benefits Intermediary Compensation Disclosure Act, would require a covered service provider, defined to mean a broker, agent, consultant, or advisor that meets specified criteria, to disclose to a public agency, as defined, or its group health plan the direct and indirect compensation it expects to receive for providing brokerage or consulting services, among other information, before it enters into, extends, renews, or materially amends a contract or arrangement for brokerage services or consulting services with the public agency or its plan. The bill would also require a covered service provider to disclose compensation and material financial interests related to a covered health care benefits arrangement that the covered service provider recommends, places, renews, services, or materially influences for the public agency or its group health plan. Disclosure would be required under these provisions if the covered service provider reasonably expects it would receive \$1,000 or more in compensation during the term of the contract or arrangement. The bill would require these disclosures at specified times. This bill would prohibit a covered service provider from requesting, accepting, or receiving direct or indirect compensation in connection with brokerage services or consulting services provided to a public agency or its plan unless the compensation is disclosed, and would prohibit evasion of disclosure requirements. (Based on 08/28/2026 text)

Memo: Signature request letter sent to Governor -- 08/31/26

5) Watch

[AB 539](#) ([Schiavo, D](#)) **Health care coverage: prior authorizations.**

Current Text: 09/03/2026 - Enrolled [HTML](#) [PDF](#)

Introduced: 02/11/2025

Last Amended: 08/21/2026

Status: 09/03/2026 - Enrolled and presented to the Governor at 4 p.m.

Location: 09/03/2026 - Assembly ENROLLED

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law provides that a health care service plan or a health insurer that authorizes a specific type of treatment by a health care provider shall not rescind or modify this authorization after the provider renders the health care service in good faith and pursuant to the authorization. This bill would require an approved prior authorization for a health care service requested by an in-network provider to remain valid for at least one year from the date of approval, or the period requested by the treating provider if less than one year. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws. (Based on 08/30/2026 text)

[AB 871](#) ([Stefani, D](#)) **Mandated reporters of suspected financial abuse of an elder or dependent adult.**

Current Text: 08/27/2026 - Enrolled [HTML](#) [PDF](#)

Introduced: 02/19/2025

Last Amended: 06/22/2026

Status: 08/27/2026 - Enrolled and presented to the Governor at 4 p.m.

Location: 08/27/2026 - Assembly ENROLLED

Summary: Existing law, the Elder Abuse and Dependent Adult Civil Protection Act, establishes procedures for the reporting, investigation, and prosecution of elder and dependent adult abuse. Existing law requires a mandated reporter of suspected financial abuse of an elder or dependent adult, as defined, to report financial abuse in a

specified manner, including by telephone or through a confidential internet reporting tool, as specified, immediately, or as soon as practicably possible. If reported by telephone, existing law requires a written report to be sent, or an internet report to be made through the internet reporting tool, to the local adult protective services agency or the local law enforcement agency within 2 working days. Existing law deems all officers and employees of a financial institution to be mandated reporters of suspected financial abuse of an elder or dependent adult. A mandated reporter who fails to report financial abuse of an elder or dependent adult is liable for civil penalties, as specified. If a report of financial abuse is made by a mandated reporter, as described above, this bill would also require a report to be made to the Federal Bureau of Investigation Internet Crime Complaint Center within 2 working days. Within 48 hours of filing a report, the bill would require a financial institution to notify the elder or dependent adult identified in the report, as specified, and provide additional required information. The bill would require a financial institution to provide annual training to its mandated reporters on how to escalate internally and report suspected financial abuse of an elder or a dependent adult to both local and federal authorities, as specified. The bill would specify that violations of these provisions would not incur the above-described liability for civil penalties. The bill would make its provisions operative on January 1, 2028. (Based on 08/24/2026 text)

AB 1054 (Gipson, D) Public employees' retirement: deferred retirement option program: public employee health benefits.

Current Text: 09/03/2026 - Enrolled [HTML](#) [PDF](#)

Introduced: 02/20/2025

Last Amended: 08/13/2026

Status: 09/03/2026 - Enrolled and presented to the Governor at 4 p.m.

Location: 09/03/2026 - Assembly ENROLLED

Summary: Existing law, the County Employees Retirement Law of 1937, prescribes retirement benefits for members of specified county and district retirement systems. Existing law establishes the Deferred Retirement Option Program as an optional benefit program for specified safety members of those systems that, by ordinance or resolution by the county board of supervisors or the governing body, elect to adopt it. The program provides eligible members access, upon service retirement, to a lump sum or, in some cases, monthly payments in addition to a monthly retirement allowance, as specified. Existing law, the Public Employees' Retirement Law (PERL), creates the Public Employees' Retirement System (PERS) for the purpose of providing pension benefits to state employees and employees of contracting agencies and prescribes the rights and duties of members of the system and their beneficiaries. This bill would establish the Deferred Retirement Option Program as a voluntary program within PERS for employees of State Bargaining Units 5 (Highway Patrol) and 8 (Firefighters), and certain supervisory or managerial employees of the Department of the California Highway Patrol or the Department of Forestry and Fire Protection. The bill would require certain actions to occur, including completion of an actuarial analysis to determine the proposed program will be cost neutral, before the program becomes effective and applicable. The bill would require members who elect to participate in the program to meet certain requirements, including waiving any claims with respect to age and other discrimination in employment laws relative to the program. The bill would establish a program account for each participant and would require the Board of Administration of the Public Employees' Retirement System to, among other things and at least once annually, provide a statement to the participant that displays the value or balance of the participant's program account. The bill would require PERS to commence paying the member their monthly retirement allowance as of the first day of the month following the deferred retirement date. The bill would authorize the participant to designate a person or persons as beneficiaries of the participant's program account at any time during the program period from their election date to the deferred retirement calculation date. Beginning on July 1 of the fiscal year the program is implemented, and every 5 years thereafter, the bill would require the Board of Administration of the Public Employees' Retirement System to submit a report of an actuarial analysis to specified entities. The bill would entitle participants who entered the program prior to the effective date of any modifications by the Legislature to elect whether to become subject to those modified provisions or to remain subject to the program as it existed on the participant's election date. This bill contains other existing laws. (Based on 08/30/2026 text)

AB 1383 (McKinnor, D) Public employees' retirement benefits.

Current Text: 09/09/2026 - Enrolled [HTML](#) [PDF](#)

Introduced: 02/21/2025

Last Amended: 08/27/2026

Status: 09/09/2026 - Enrolled and presented to the Governor at 1 p.m.

Location: 09/09/2026 - Assembly ENROLLED

Summary: The Public Employees' Retirement Law (PERL) establishes the Public Employees' Retirement System (PERS) to provide a defined benefit to members of the system based on final compensation, credited service, and age at retirement, subject to certain variations. Existing law creates the Public Employees' Retirement Fund, which is continuously appropriated for purposes of PERS, including depositing employer and employee contributions. Under the California Constitution, assets of a public pension or retirement system are trust funds. The California Public Employees' Pension Reform Act of 2013 (PEPRA) establishes a variety of requirements and restrictions on public employers offering defined benefit pension plans. In this regard, PEPRA restricts the amount of compensation that may be applied for purposes of calculating a defined pension benefit for a new member, as defined, by restricting it to specified percentages of the contribution and benefit base under a specified federal law with respect to old age, survivors, and disability insurance benefits. Existing law, the Teachers' Retirement Law, establishes the State Teachers' Retirement System (STRS) and creates the Defined Benefit Program of the State Teachers' Retirement Plan, which provides a defined benefit to members of the program, based on final compensation, creditable service, and age at retirement, subject to certain variations. This bill, for service performed on and after January 1, 2027, would prohibit the pensionable compensation for calendar year 2027 used to calculate the defined benefit paid to a new member of a retirement system subject to PEPRA who retires from the system from exceeding specified percentages of the contribution and benefit base under the specified federal law with respect to old age, survivors, and disability insurance benefits. The bill would make related, conforming changes to these provisions on pensionable compensation. The bill also would require a new member of STRS to be subject to specified limits of the Teachers' Retirement Law. This bill contains other related provisions and other existing laws. (Based on 09/03/2026 text)

[AB 1439](#) (Garcia, D) Public retirement systems: development projects: labor standards.

Current Text: 09/04/2026 - Enrolled [HTML](#) [PDF](#)

Introduced: 02/21/2025

Last Amended: 08/13/2026

Status: 09/04/2026 - Enrolled and presented to the Governor at 4 p.m.

Location: 09/04/2026 - Assembly ENROLLED

Summary: The California Constitution grants the retirement board of a public employee retirement system plenary authority and fiduciary responsibility for investment of moneys and administration of the retirement fund and system. These provisions qualify this grant of powers by reserving to the Legislature the authority to prohibit investments if it is in the public interest and the prohibition satisfies standards of fiduciary care and loyalty required of a retirement board. Existing law prohibits the boards of the Public Employees' Retirement System (PERS) and the State Teachers' Retirement System (STRS) from making certain new investments or renewing existing investments of public employee retirement funds, including in a thermal coal company, as defined. Existing law provides that a board is not required to take any action regarding those investments unless the board determines in good faith that the action is consistent with the board's fiduciary responsibilities established in the California Constitution. This bill would request the University of California, Berkeley, Labor Center to conduct an independent study to analyze the extent of labor standards protections in California real estate and infrastructure development projects funded through the real asset portfolios of PERS and STRS. The bill would request that the study and a report of its findings be completed and provided to the Legislature and the Department of Finance by January 1, 2028, as specified. (Based on 09/01/2026 text)

[AB 1770](#) (Garcia, D) Arbitration: health care service plans: Lindalee's Law.

Current Text: 09/04/2026 - Enrolled [HTML](#) [PDF](#)

Introduced: 02/09/2026

Last Amended: 08/18/2026

Status: 09/04/2026 - Enrolled and presented to the Governor at 4 p.m.

Location: 09/04/2026 - Assembly ENROLLED

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law requires a health care service plan contract that includes terms requiring binding arbitration for dispute settlement to provide a

specified disclosure to subscribers or enrollees. Existing law, the California Arbitration Act, provides a statutory framework for the enforcement of contractual arbitration under California law. Existing law establishes standards for arbitration, and requires a court to vacate an arbitration award if it makes certain findings. This bill would require the Attorney General to oversee compliance by health care service plans with specified provisions regulating the use of binding arbitration to settle disputes. The bill would authorize the Attorney General to require reports from health care service plans for this purpose. The bill would also require the Attorney General to notify the director of the department of any corrective action taken pursuant to these provisions. (Based on 09/01/2026 text)

[AB 1887](#) ([Zbur, D](#)) Prescription drug coverage for rare diseases.

Current Text: 09/03/2026 - Enrolled [HTML](#) [PDF](#)

Introduced: 02/12/2026

Last Amended: 08/21/2026

Status: 08/30/2026 - Read third time. Passed. Ordered to the Assembly. (Ayes 40. Noes 0.). In Assembly. Concurrence in Senate amendments pending. Senate amendments concurred in. To Engrossing and Enrolling.

Location: 08/30/2026 - Assembly ENROLLMENT

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law sets forth specified prior authorization and step therapy limitations for health care service plans and health insurers. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, to require a health care service plan or health insurer to complete prior authorization within 30 days upon initial request, as specified, for a drug approved by the United States Food and Drug Administration (FDA) for the treatment of a rare disease if the drug is prescribed by a specialist with expertise in the condition or disease being treated, the specialist has determined the drug is medically necessary, and the drug is the only FDA-approved treatment for the rare disease. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws. (Based on 09/03/2026 text)

[AB 1979](#) ([Bonta, D](#)) Health care services: artificial intelligence.

Current Text: 09/04/2026 - Enrolled [HTML](#) [PDF](#)

Introduced: 02/13/2026

Last Amended: 08/20/2026

Status: 09/04/2026 - Enrolled and presented to the Governor at 4 p.m.

Location: 09/04/2026 - Assembly ENROLLED

Summary: The Confidentiality of Medical Information Act (CMIA) prohibits a provider of health care, a health care service plan, a contractor, or a corporation and its subsidiaries and affiliates from intentionally sharing, selling, using for marketing, or otherwise using any medical information, as defined, for any purpose not necessary to provide health care services to a patient, except as provided. Existing law makes a violation of these provisions that results in economic loss or personal injury punishable as a misdemeanor. Existing law deems a business that offers a mental health digital service or reproductive or sexual health digital service to a consumer for the purpose of allowing the individual to manage the individual's information, or for the diagnosis, treatment, or management of a medical condition of the individual, to be a provider of health care subject to the requirements of the CMIA. The bill would additionally deem a business that offers a health care chatbot, as defined, to a consumer for the above-described purposes to be a provider of health care subject to the requirements of the CMIA. Because the bill would expand the scope of a crime, it would impose a state-mandated local program. This bill contains other related provisions and other existing laws. (Based on 09/01/2026 text)

[AB 2575](#) ([Ortega, D](#)) Health care services: artificial intelligence.

Current Text: 09/04/2026 - Enrolled [HTML](#) [PDF](#)

Introduced: 02/20/2026

Last Amended: 08/28/2026

Status: 08/31/2026 - Read third time. Passed. Ordered to the Assembly. (Ayes 21. Noes 10.). In Assembly. Concurrence in Senate amendments pending. Assembly Rule 63 suspended. Senate amendments concurred in. To Engrossing and Enrolling.

Location: 08/31/2026 - Assembly ENROLLMENT

Summary: Existing law charges the Labor Commissioner with enforcement of various labor laws, including investigation of employee complaints. This bill would declare it is the policy of the state that a worker providing direct patient care be free to use their professional judgment to make assessments and decisions within their scope of practice as appropriate for their patients. The bill would prohibit an employer from retaliating or discriminating against a worker providing patient care, as specified. The bill would authorize a worker who is subject to retaliation or discrimination in violation of these provisions to file a complaint with the Labor Commissioner against an employer. The bill would require the Labor Commissioner to enforce these provisions, as specified. This bill contains other related provisions and other existing laws. (Based on 09/04/2026 text)

[AB 2613](#) ([Sharp-Collins, D](#)) Health care service plans: provider contract termination: notice.

Current Text: 09/04/2026 - Enrolled [HTML](#) [PDF](#)

Introduced: 02/20/2026 (Spot bill)

Last Amended: 08/21/2026

Status: 09/04/2026 - Enrolled and presented to the Governor at 4 p.m.

Location: 09/04/2026 - Assembly ENROLLED

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law requires a health care service plan to notify an enrollee by United States mail at least 60 days before the termination date of a contract between a health care service plan and a provider group or a general acute care hospital to which the enrollee is assigned. If the plan reaches an agreement with a terminated provider after sending that notice, existing law requires the plan to offer each affected enrollee the option to return to that provider and to reassign the enrollee to another provider if the enrollee does not exercise that option. This bill would additionally require a health care service plan to notify an enrollee by email or text message, as specified and only if the enrollee has opted in and provided their contact information, at least 60 days before the termination date of a contract between a health care service plan and a provider group or a general acute care hospital to which the enrollee is assigned. If the plan reaches an agreement with a terminating or terminated provider after sending the notice of termination, the bill would require the health care service plan to send written notice by United States mail and by email or text message, as specified and only if the enrollee has opted in and provided their contact information, to affected enrollees no later than 10 business days after department approval of the notice. If the agreement is to renew, enter into a new contract, or to not terminate their contract before the termination date in the notice of termination, the bill would require the health care service plan to notify enrollees that they will remain assigned to the provider. If the agreement is to renew, enter into a new contract, or to not terminate their contract after the termination date in the notice of termination, the bill would require the health care service plan to notify and offer each affected enrollee the option to return to that provider. The bill would require a health care service plan to submit these notices to the department for approval within 5 business days of reaching an agreement. Because a willful violation of these provisions would be a crime, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws. (Based on 09/01/2026 text)

[SB 503](#) ([Weber Pierson, D](#)) Health care services: artificial intelligence.

Current Text: 08/30/2026 - Enrolled [HTML](#) [PDF](#)

Introduced: 02/19/2025 (Spot bill)

Last Amended: 08/19/2026

Status: 08/30/2026 - Enrolled and presented to the Governor at 6 p.m.

Location: 08/30/2026 - Senate ENROLLED

Summary: Existing law requires a health facility, clinic, physician's office, or office of a group practice that uses generative artificial intelligence to generate written or verbal patient communications pertaining to patient clinical information, as defined, to ensure that those communications include both (1) a disclaimer that indicates to the patient that a communication was generated by generative artificial intelligence, as specified, and (2) clear instructions describing how a patient may contact a human health care provider, employee, or other appropriate person. Existing law exempts from this requirement a communication read and reviewed by a human licensed or certified health care provider. This bill would require developers and deployers, as defined, of an artificial intelligence system that produces a prediction, classification, recommendation, evaluation, or analysis that aids decisionmaking related to diagnosis or treatment, known as a clinical decision support system, to make reasonable efforts to identify clinical decision support systems developed for use by deployers that are known or have a reasonably foreseeable risk for biased impacts resulting from deployment of the system in health programs or activities. The bill would require developers to make a statement describing the intended uses and known or reasonably foreseeable risks associated with the use of the clinical decision support system and certain documentation available to deployers, as specified. The bill would require developers to make reasonable efforts to mitigate known or reasonably foreseeable risk for biased impacts resulting from use of the clinical decision support system in health programs or activities. The bill would require deployers to regularly monitor clinical decision support systems and take reasonable and proportionate steps to mitigate known or reasonably foreseeable risk of biased impacts. The bill would specify that a person, partnership, state or local governmental agency, or corporation may be both a developer and a deployer. (Based on 08/27/2026 text)

[SB 895](#) ([Wiener, D](#)) California Science and Health Research Bond Act.

Current Text: 09/08/2026 - Enrolled [HTML](#) [PDF](#)

Introduced: 01/15/2026

Last Amended: 08/27/2026

Status: 08/31/2026 - Read third time. Urgency clause adopted. Passed. Ordered to the Senate. In Senate. Concurrence in Assembly amendments pending. Urgency clause adopted. Assembly amendments concurred in. (Ayes 28. Noes 9.) Ordered to engrossing and enrolling.

Location: 08/31/2026 - Senate ENROLLMENT

Summary: (1)Existing law establishes various grant and loan programs for research, including, among others, the California Institute for Regenerative Medicine, California Firefighter Cancer Prevention and Research Program, and the Public Interest Research, Development, and Demonstration Program. This bill would establish the California Foundation for Science and Health Research within the Government Operations Agency. The bill would require the Secretary of Government Operations to oversee the process of appointing the director of the foundation, and would authorize the Secretary of Government Operations to delegate the task of hiring and determining the salaries, bonuses, and benefits of additional personnel to the director, as specified. The bill would require the director and personnel of the foundation to be responsible for implementing the strategic objectives of the California Foundation for Science and Health Research Council, as described below, administering grants, loans, and contracts awarded by the council, and all other duties as deemed necessary for the operation of the foundation. This bill contains other related provisions and other existing laws. (Based on 09/08/2026 text)

[SB 950](#) ([Weber Pierson, D](#)) Health care coverage: dementia.

Current Text: 08/30/2026 - Enrolled [HTML](#) [PDF](#)

Introduced: 02/02/2026

Last Amended: 08/19/2026

Status: 08/30/2026 - Enrolled and presented to the Governor at 6 p.m.

Location: 08/30/2026 - Senate ENROLLED

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits specified health care service plan contracts and disability insurance policies from excluding persons covered by the plan from receiving benefits if they are diagnosed as having any significant destruction of brain tissue with resultant loss of brain function, including Alzheimer's disease. This bill would require a health care service plan contract or health insurance policy that is issued, amended, or renewed on or

after January 1, 2027, to include coverage for all medically necessary treatments or medications, as determined by a health care provider, approved by the United States Food and Drug Administration (FDA) for the treatment of Alzheimer's disease or other medical conditions affecting memory. On and after January 1, 2027, the bill would prohibit a health care service plan or health insurer from imposing step therapy protocols as a prerequisite to authorizing that coverage, except as provided. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws. (Based on 08/27/2026 text)

SB 964 **(Smallwood-Cuevas, D) Prescription drug coverage: dose adjustments.**

Current Text: 08/30/2026 - Enrolled [HTML](#) [PDF](#)

Introduced: 02/03/2026

Last Amended: 08/17/2026

Status: 08/30/2026 - Enrolled and presented to the Governor at 6 p.m.

Location: 08/30/2026 - Senate ENROLLED

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use utilization review, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law also prohibits a health care service plan that covers prescription drug benefits from limiting or excluding coverage for a drug that was previously approved for coverage if an enrollee continues to be prescribed that drug, as specified. This bill would authorize an enrollee's or insured's treating contracting provider to submit a written request to a health care service plan or health insurer requesting the authority to adjust the dose or frequency of a drug to meet the specific medical needs of the enrollee or insured without prior authorization or subsequent utilization management. The bill would require the plan or insurer to issue a written response within 72 hours and to authorize the request if specified conditions are established in the request. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws. (Based on 08/27/2026 text)

SB 971 **(Choi, R) Healthy Aging Community Partnership Program.**

Current Text: 09/02/2026 - Enrolled [HTML](#) [PDF](#)

Introduced: 02/04/2026

Last Amended: 08/05/2026

Status: 09/02/2026 - Enrolled and presented to the Governor at 3 p.m.

Location: 09/02/2026 - Senate ENROLLED

Summary: Existing law establishes various programs and services for older adults, as defined, including, among other things, the Adult Education Program under the administration of the Chancellor of the California Community Colleges and the Superintendent of Public Instruction, and health promotion and preventative health services for older adults under the administration of the State Department of Public Health. This bill would authorize a local health department, area agency on aging, community college, public or private college, public or private university, or other appropriate county department, as determined by a county, to establish a Healthy Aging Community Partnership Program for older individuals designed to promote healthy aging, social engagement, and independent living in collaboration with relevant local entities, including school districts, libraries, faith institutions, and community organizations. The bill would authorize program activities to include, among other things, technology assistance, physical activity, and other community-based enrichment activities that support healthy aging and social connection. The bill would make implementation of these provisions subject to the availability of local resources and partnerships. The bill would specify that these provisions do not duplicate or supplant specified current adult education courses, classes, and services provided by the California Community Colleges, including through the Adult Education Program, as provided. (Based on 08/30/2026 text)

SB 1037 **(Weber Pierson, D) Health care coverage: rate review.**

Current Text: 08/30/2026 - Enrolled [HTML](#) [PDF](#)

Introduced: 02/11/2026

Last Amended: 08/18/2026

Status: 08/30/2026 - Enrolled and presented to the Governor at 6 p.m.

Location: 08/30/2026 - Senate ENROLLED

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a violation of the act by a health care service plan a misdemeanor. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law defines “unreasonable rate increase,” for these purposes, to have the same meaning as in the federal Patient Protection and Affordable Care Act, which is that an unreasonable rate increase exists when the federal Centers for Medicare and Medicaid Services makes a determination that a rate increase is excessive, unjustified, or unfairly discriminatory, among other things. This bill would instead define “unreasonable rate increase,” for the above-described purposes, to mean a rate increase that the Director of the Department of Managed Health Care or the Insurance Commissioner, as applicable, determines is excessive, unjustified, unfairly discriminatory, or otherwise unreasonable. This bill contains other related provisions and other existing laws. (Based on 08/27/2026 text)

SB 1049 **(Weber Pierson, D) Health care claims reimbursement.**

Current Text: 08/28/2026 - Enrolled [HTML](#) [PDF](#)

Introduced: 02/12/2026

Last Amended: 08/13/2026

Status: 08/28/2026 - Enrolled and presented to the Governor at 11 a.m.

Location: 08/28/2026 - Senate ENROLLED

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer to reimburse a complete claim or a portion thereof within 30 calendar days after receipt of the claim, or, if a claim or portion thereof does not meet the criteria for completeness, to notify the claimant no later than 30 calendar days after receipt that the claim or portion thereof is contested or denied. This bill would grant a claimant no less than 90 calendar days to submit a corrected claim after a health care service plan or health insurer denies a claim or portion thereof or sends a notice of overpayment for a claim based on a defect that may be remedied by submitting a corrected claim. The bill would prohibit a plan or insurer from denying a corrected claim on the grounds that the claim was not submitted within another applicable claim filing deadline. Under the bill, a dispute related to a corrected claim would be required to be eligible for submission to the plan's or insurer's fast, fair, and cost-effective dispute resolution mechanism. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws. (Based on 08/25/2026 text)

SB 1088 **(Blakespear, D) Health care decisions: life-sustaining treatment.**

Current Text: 09/03/2026 - Enrolled [HTML](#) [PDF](#)

Introduced: 02/13/2026

Last Amended: 06/18/2026

Status: 09/03/2026 - Enrolled and presented to the Governor at 3 p.m.

Location: 09/03/2026 - Senate ENROLLED

Summary: Existing law defines a request regarding resuscitative measures to mean a written document, signed by an individual with capacity or legally recognized health care decisionmaker and the individual's physician that directs a health care provider regarding resuscitative measures, as prescribed. Existing law includes a prehospital “do not resuscitate” form, as developed by the Emergency Medical Services Authority or other substantially similar form, and Physician Orders for Life Sustaining Treatment form (POLST form), as approved by the Emergency Medical Services Authority as requests regarding resuscitative measures. This bill would replace the term

“Physician Orders for Life Sustaining Treatment” with “POLST,” or “Portable Orders Listing Scope of Treatment.” The bill would authorize a request regarding resuscitative measures to be entered into by an individual with capacity or a health care agent, conservator with health care decisionmaking authority, or surrogate, as defined, and a physician, nurse practitioner, or physician assistant, as specified. The bill would specify that a request regarding resuscitative measures is entirely voluntary and the provision of care or admission to a facility cannot be conditioned on completion of or refusal to complete a POLST or prehospital “do not resuscitate” order. This bill contains other related provisions and other existing laws. (Based on 08/30/2026 text)

SB 1089 **(Richardson, D) Preventive Treatment Health Care Act.**

Current Text: 09/03/2026 - Enrolled [HTML](#) [PDF](#)

Introduced: 02/13/2026

Last Amended: 08/20/2026

Status: 09/03/2026 - Enrolled and presented to the Governor at 3 p.m.

Location: 09/03/2026 - Senate ENROLLED

Summary: Existing law requires the California Health and Human Services Agency (CHHSA) to enter into partnerships resulting in the production of generic prescription drugs, including at least one form of insulin made available at production and dispensing costs, if one does not already exist in the market. Existing law additionally authorizes CHHSA to enter into partnerships to increase competition, lower prices, and address supply shortages for generic or brand name drugs to address emerging health concerns. This bill, the Preventive Treatment Health Care Act, would authorize CHHSA to enter into partnerships, if needed and subject to an appropriation, to increase competition, lower prices, and address supply shortages for at least one glucagon-like peptide-1 (GLP-1) antiobesity medication approved by the United States Food and Drug Administration (FDA). The bill would require CHHSA to establish distribution partners, if needed, and make its best effort to negotiate pricing at or lower than the cost to Medi-Cal beneficiaries in 2025. (Based on 08/30/2026 text)

Total Measures: 25

Total Tracking Forms: 25