SENATE COMMITTEE ON HEALTH
Senator Dr. Akilah Weber Pierson, Chair

BILL NO: SB 950
AUTHOR: Weber Pierson
VERSION: February 2, 2026
HEARING DATE: April 15, 2026
CONSULTANT: Teri Boughton

SUBJECT: Health care coverage: dementia

SUMMARY: Requires health plans and insurers to cover all medically necessary treatments or medications, as determined by a health care provider, that are approved by the federal Food and Drug Administration (FDA) for the treatment of Alzheimer's disease or other related dementia. Prohibits health plans and insurers from imposing step therapy protocols when one or more medications are approved by the FDA, unless a plan or insurer has covered at least one anti-amyloid therapy without step therapy. Requires a plan or insurer to cover non-self-administered treatments approved by the FDA as an outpatient prescription drug benefit if covered as a medical benefit.

Existing law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and the California Department of Insurance (CDI) to regulate health insurers under the Insurance Code. [HSC §1340, et seq. and INS §106, et seq.]

2) Requires health plans and insurers, and any contracted entity that performs utilization review or utilization management functions, prospectively, retrospectively, or concurrently, based on medical necessity requests to comply with specified requirements, including a decision within five business days of receiving reasonable information to make a decision, conducting retrospective review within 30 days and decisions associated with imminent and serious threat within 72 hours or sooner. [HSC §1367.01 and INS §10123.135]

3) Establishes a requirement, under federal regulations, that health plans and insurers have a process for review, upon request, of a decision that a drug is not covered by a plan. Requires notification of the determination within 72 hours of the request, or 24 hours based on exigent circumstances. Requires health plans and insurers to have a process for external review of denials of a standard exception, or for an expedited exception. [45 CFR §156.122]

4) Permits health plans and insurers to require step therapy and prior authorization and defines step therapy as a type of protocol that specifies the sequence in which different prescription drugs for a given medical condition that are medically appropriate for a particular patient are to be prescribed. Includes utilization review organizations that perform utilization review or utilization management functions. [HSC §1342.71 and §1367.206, Title 28 CCR §1300.67.205, and INS §10123.193 and §10123.201]

5) Requires a health plan contract that provides coverage for outpatient prescription drugs to cover medically necessary prescription drugs, including nonformulary drugs determined to be medically necessary consistent with the Knox-Keene Act. Excludes specified drugs such as drugs for cosmetic purposes and indicates drugs for mental performance are not excluded when they are used to treat diagnosed mental illness or medical conditions affecting memory,

including, but not limited to treatment of the conditions or symptoms of dementia or Alzheimer's disease. [HSC §1342.71, Title 28, CCR §1300.67.24 and INS §10123.193]

6) Requires an external exception request review process for a denial of a prior authorization or step therapy exception request. Requires an independent review organization's reversal of a health plan or insurer denial of a request for an exception, prior authorization, or step therapy exception to be binding and apply for the duration of the prescription, and refills. [HSC §1367.241 and INS §10123.191]

7) Requires every health plan contract and insurance policy that provides hospital, medical, or surgical coverage to provide coverage for medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions, as specified. [HSC §1374.72 and INS §10144.5]

8) Requires plans and insurers that offer contracts and policies described above to base any medical necessity determination or utilization review criteria used to determine medical necessity on current generally accepted standards of mental health and substance use disorder care. [HSC §1374.721 and INS §10144.52]

9) Prohibits a health plan or insurer from subjecting antiretroviral drugs that are medically necessary for the prevention of AIDS/HIV, including preexposure prophylaxis or postexposure prophylaxis, to prior authorization or step therapy, except if the FDA has approved one or more therapeutic equivalents of a drug, device, or product for the prevention of AIDS/HIV, in which case the plan or insurer is required to only cover one therapeutically equivalent version without prior authorization or step therapy. [HSC §1342.74 and INS §10123.1933]

This bill:

1) Requires a health plan contract or health insurance policy 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, that are approved by the FDA for the treatment of Alzheimer's disease or other related dementia. Indicates medically necessary treatments or medications include, but are not limited to, those that reduce clinical decline.

2) Prohibits a health plan or health insurer from imposing step therapy protocols as a prerequisite to authorizing coverage of medically necessary treatments or medications approved by the FDA for the treatment of Alzheimer's disease, except as provided in 3) below. Prohibits step therapy for both self-administered drugs and physician-administered drugs, except as provided in 3) below.

3) Permits a health plan or health insurer to cover only one anti-amyloid therapy (disease modifying medication) without step therapy if the FDA has approved one or more types of treatment for Alzheimer's disease or other medical conditions affecting memory.

4) Permits a health plan or insurer to apply utilization management, including prior authorization, to determine medical necessity for the treatment of Alzheimer's or other medical conditions affecting memory, if appropriateness and medical necessity determinations are made in the same manner as treatment of any other illness, condition, or

disorder covered by the plan contract or insurance policy.

5) Prohibits coverage criteria for FDA-approved treatments from being more restrictive than the FDA-approved indications for those treatments.

6) Requires plans and insurers to cover non-self-administered FDA-approved treatments as an outpatient prescription drug benefit if plans and insurers cover those FDA-approved treatments as a medical benefit.

7) Requires health plans and insurers to maintain an expeditious process by which prescribing providers may obtain authorization for a medically necessary treatment approved by the FDA for the treatment of Alzheimer's disease or other medical conditions affecting memory, consistent with existing law.

8) Exempts a specialized health plan or insurer that covers only dental, vision, or Medicare supplement contracts or policies, Medi-Cal managed care plan contracts with Department of Health Care Services, as specified, accident-only, specified disease, or hospital indemnity policies.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) *Author's statement.* According to the author, Alzheimer's disease, while often thought of as a condition of aging, reflects broader disparities in our public health system. Californian women, lower-income Californians, and Californians of color face disproportionately elevated risks, higher diagnosis rates, and poorer outcomes once living with the disease. This devastating diagnosis is life- and community-changing. As Alzheimer's progresses, individuals lose independence and the memories that connect them to their loved ones. Families often sacrifice their livelihoods to become caregivers while navigating a complex health system. During one of the most difficult times in their lives, California cannot allow barriers to delay or prevent access to appropriate treatment. Today, FDA-approved therapies offer new hope by slowing the progression of Alzheimer's disease in its early stages. Removing the plaque responsible for progression can preserve precious time, memories, and quality of life. But, because they are only effective early in the disease, any delays can take away the opportunity to receive this treatment altogether. As a state, we must ensure timely access to these treatments and alleviate pressure from our families and healthcare system. Families deserve more time and support when navigating Alzheimer's.

2) *California Health Benefits Review Program (CHBRP) report.* AB 1996 (Thomson, Chapter 795, Statutes of 2002) requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written report with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996 and reviewed this bill.

   Key findings include:

   a) *Background on Alzheimer's disease.* Alzheimer's disease is a progressive, irreversible neurologic condition that damages and destroys neurons in the brain, and as the disease progresses, memory, language, and cognitive processing challenges are often the first symptoms to emerge. Patients may live up to ten years or longer after diagnosis. There is no cure or treatment to reverse the disease. In 2020, for California there were an

estimated 719,700 adults aged 65+ living with Alzheimer's, 547,629 of them were over 75 years old. In 2022, 17,363 people in California died from Alzheimer's disease. For people with early-onset Alzheimer's disease (occurring in people ages 34 to 64) the estimated prevalence in the U.S. is 31.8 people out of 100,000, or 40,326 people. Risk increases with age, with the highest risk for patients ages 85+. Women and people who are African American, Latino and Hispanic are at higher risk. People who are African American, Latino, and Hispanic are more likely to experience delays in receiving a diagnosis of dementia than white people. Barriers to receiving a diagnosis for Alzheimer's disease and accessing disease-modifying medications are substantial and may be attributed in part to the limited supply of treating clinicians who have experience prescribing the disease-modifying medications. Additionally, eligibility to receive disease-modifying medications is narrow, requires special testing that may be challenging to access, and may only be available in specialized facilities that treat a limited number of patients each year.

b) *Coverage impacts and enrollees covered*. According to CHBRP, of the 22.8 million enrolled in state-regulated health insurance, this bill would impact 13.8 million, as Medi-Cal managed care plans are exempt from this bill. Another 15 million Californians would not be covered because they are either uninsured, or have coverage that is not state regulated, such as Medicare or other federally regulated employer coverage. No enrollees have fully compliant coverage, however 88% of enrollees have coverage for disease-modifying medication under their medical benefit and 93% of enrollees have coverage of three out nine medications for treatment of symptoms.

c) *Medi-Cal and Medicare*. Medi-Cal Rx provides coverage for some medications to treat Alzheimer's and related dementia, and Medi-Cal managed care plans also provide coverage for the two currently available anti-amyloid medications. Medicare also covers both anti-amyloid medications under the Medicare Part B benefit. Cost sharing applies depending upon type of Medicare coverage (traditional Medicare or Medicare Advantage). Medicare Part D plans must cover at least two drugs used to treat Alzheimer's symptoms.

d) *Medical effectiveness.*
   i) Evidence for medications to treat symptoms. Medications used to treat symptoms of Alzheimer's disease demonstrate generally small and inconsistent effects across medications, severity of disease, and outcomes. There is strong evidence that cholinesterase inhibitors are associated with small improvements in cognitive function and global assessment (clinical assessment evaluating cognition, behavior and function) relative to placebo but do not improve functional ability. Evidence for neuropsychiatric/behavioral symptoms is conflicting. N-methyl-D-aspartate (NMDA)-receptor antagonists show no meaningful effects on cognition or functional ability but are associated with small improvements in global assessment and neuropsychiatric symptoms in patients with moderate-to-severe disease relative to placebo. Compared with cholinesterase inhibitors alone, combination therapy was associated with small improvements in cognitive function, neuropsychiatric/behavioral symptoms, and global assessment, but not in functional ability. Rates of serious adverse events did not differ between cholinesterase inhibitors and placebo and between NMDA-receptor antagonists and placebo.
   ii) Treatment to modify disease. Disease-modifying medications are only available for patients who meet certain clinical criteria. Those criteria include having mild

cognitive impairment or mild dementia due to Alzheimer's disease, and a confirmed presence of amyloid pathology (such as through positron emission tomography [PET] brain scan, lumbar puncture, or blood test). Additionally, patients who are unable to safely undergo MRI, or those with certain pre-existing medical conditions may be considered ineligible for these treatments. Enrollees can use medications to treat symptoms and disease-modifying medications concurrently. There is no duration limit for how long enrollees can take the medications to treat symptoms. The disease-modifying medications (anti-amyloids) are intravenous infusions that are usually administered for around 18 months, with the option to extend using a subcutaneous version for one of the medications. Periodic MRIs are required prior to, during, and after the conclusion of treatment for safety monitoring.

iii) Evidence for disease-modifying medications. There is strong evidence that disease-modifying medications are effective at reducing or clearing amyloid plaque and demonstrate robust and consistent effects on amyloid biomarkers. There is some evidence that disease modifying medications are effective at slowing cognitive decline, functional decline, and combined measures of cognitive and functional decline by a small amount. However, effect sizes were generally modest, and most findings did not meet thresholds for clinical meaningfulness. There is some evidence that disease-modifying medications are associated with increased risk of harm. All studies consistently demonstrated higher rates of amyloid-related imaging abnormalities and hemorrhage, including microhemorrhages and superficial siderosis, among treated participants, in initial treatment period. Most events were asymptomatic and detected through imaging, although symptomatic cases occurred in a smaller proportion of participants. Mortality rates were low and similar to placebo groups, with no clear evidence of increased mortality risk. Other adverse events, such as infusion-related reactions, were common and manageable but led to discontinuation in a subset of participants. Some reactions, such as intracerebral hemorrhage, have the potential to result in sever disability or death.

iv) Health improvement. There is not enough research to determine whether amyloid plaque reduction improves heath outcomes. Findings suggest that amyloid reduction is associated with a statistically significant but small improvement in cognitive and combined measure outcomes, but the small effect sizes did not meet the threshold for minimum clinically important differences.

e) *Utilization*. CHBRP relied on commercial claims data to estimate the likely prevalence of mild cognitive decline or mild dementia related to Alzheimer's disease. It is likely to be lower than the population-level prevalence of 31.8/100,000 due to the increased likelihood that people experiencing mild cognitive impairment or mild dementia would qualify for Medi-Cal or Medicare due to short-term or long-term disability, or be unable to work and maintain health insurance benefits through an employer. Using Milliman claims data, the prevalence rate was 5.76/100,000 among the commercial enrollers with commercial health insurance subject to this bill. CHBRP estimates 66 additional enrollees will receive medications to treat symptoms (currently 1,086 enrollees are estimated to be using these treatments typically through the pharmacy benefit) and 23 additional enrollees will receive disease-modifying medications (currently 89 enrollees are using disease-modifying treatments via infusion through the medical benefit). There is a subcutaneous treatment that is typically covered on the pharmacy benefit because it is self-administered but is a weekly maintenance dose available after 18 months of infusion treatment. Those using disease-modifying medications require imaging to monitor amyloid resulting in 92 PET scans and 354 MRIs each year. CHBRP estimates at least

one PET scan per year due to initial treatment requirements for new patients and monitoring needs for existing patients.

f) *Impact on expenditures*. Total annual premiums (paid by employers and enrollees) would increase by $660,000 or up to $.03 per member per month. Enrollee cost-sharing for new users of medications who previously did not have coverage is $1,310 (small group market), $1,390 (large group market) and $1,990 (individual market), annually.

g) *Public health.* No measurable public health impact at the population level due to the small estimated increase in utilization in the population that would be covered by this bill and eligible for the medications. However, this bill would likely yield some health and quality of life improvements, such as slowing decline of cognitive function, functional ability, and global assessment after 18 months of treatment among the 23 additional enrollees who would newly have access to and use disease-modifying medications.

3) *Prior legislation.* SB 496 (Limón, Chapter 496, Statutes of 2023) requires Medi-Cal, and, health plans and insurers to cover medically necessary biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's or insured's disease or condition to guide treatment decisions only if the test is supported by medical and scientific evidence, as specified.

   SB 48 (Limón, Chapter 484, Statutes of 2021) requires an annual cognitive health assessment be a covered benefit for Medi-Cal beneficiaries who are 65 years of age or older and not otherwise eligible for a similar assessment as part of the Medicare program. This bill also requires the Department of Health Care Services to determine the training and validated tools for Medi-Cal providers to render and receive payment for the covered benefit.

4) *Support.* This bill's sponsor, the Alzheimer's Association, writes that "this legislation expedites access for monoclonal antibody therapies that target amyloid plaque buildup in the brain to reduce cognitive decline. These are among the first disease modifying treatments to become available for Alzheimer's disease. The advent of these treatments along with blood-based biomarker testing and new research on lifestyle interventions' efficacy staving off cognitive decline have encouraged early detection and diagnosis of Alzheimer's disease. Perspectives have changed because these developments provide proactive measures to manage cognitive decline for individuals contending with a diagnosis. Presently, these therapies are only available for those in the early stage of Alzheimer's disease, making access crucial. This legislation provides needed clarity in state law to ensure uninterrupted coverage for these new developments, so individuals do not unnecessarily exit their eligibility window and advance in the disease progression, which can involve higher costs and levels of care." The Association of California Healthcare Districts (ACHD) writes that these therapies have encouraged individuals to seek early detection and diagnosis and that they along with lifestyle interventions can measurably delay cognitive decline. ACHD believes this can result in individuals aging in place for longer periods of time, and less utilization of services as the disease progresses. The California Long-Term Care Ombudsman Association writes that this bill recognizes the importance of early intervention by improving access to treatments through coverage and reduced administrative barriers.

5) *Opposition.* The California Association of Health Plans (CAHP) and the Association of California Life and Health Insurance Companies (ACLHIC) write that this bill would categorize provider-administered drugs as outpatient prescription drug benefits despite that

they are not self-administered and are delivered in clinical settings, and, that reclassifying these drugs in this manner is inconsistent with longstanding industry standards and could create operational and administrative challenges. The opponents say this would set a concerning precedent. The opponents also write having all FDA approved drugs covered under both the medical and pharmacy benefit prevents plans and insurers from updating their formularies as new data emerges and limits plans and insurers from designing products that are both affordable and appropriate for a specific diagnosis. CAHP and ACLHIC also indicate that the demonstrated effectiveness of anti-amyloids has not been clearly substantiated, and they reference CHBRP statements that there is not enough research to determine whether amyloid plaque reduction improves health outcomes and that the small effect sizes did not meet the threshold for minimum clinically important differences. They are also concerned that this bill will accelerate utilization of these drugs before their value is proven and the infrastructure for treatment is available. Regarding the step therapy requirement, CAHP and ACLHIC are concerned that it further grants immediate access to a drug that has not been proven to improve health outcomes, which is a concern because an individual course of treatment is between $26,500 - $32,000.

6) *Policy comments regarding expeditious prior authorization process.* In existing law an expeditious prior authorization process is required for requests for coverage of nonformulary drug coverage. The process is not standardized and is subject to each plan's policy which must be filed with DMHC. If a more transparent and standardized process for prior authorization decisions is desired, the author may wish to utilize the existing prior authorization timeframes of 72 hours for nonurgent requests and 24 hours for exigent circumstances.

SUPPORT AND OPPOSITION:

Support: Alzheimer's Association (sponsor)
Alliance for Patient Access
Alzheimer's Greater Los Angeles
Alzheimer's Orange County
Alzheimer's San Diego
American Federation of State, County, and Municipal Employees
Association of California Healthcare Districts
Biocom California
California Alliance for Retired Americans
California Assisted Living Association
California Black Health Network
California Chronic Care Coalition
California Coalition on Family Caregiving
California Life Sciences
California Long Term Care Ombudsman Association
Family Caregiver Alliance
LeadingAge California
Multipurpose Senior Services Program Site Association
Western Center on Law & Poverty, Inc.
One individual

Oppose: Association of California Life & Health Insurance Companies
California Association of Health Plans

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