Date of Hearing: June 30, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 950 (Weber Pierson) – As Amended April 20, 2026

SENATE VOTE: 38-0

SUBJECT: Health care coverage: dementia.

SUMMARY: Requires a health plan and insurer to cover 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 related dementia. Specifically, **this bill**:

1) Requires a health plan and health insurer to cover all medically necessary treatments or medications, as determined by a health care provider, approved by the FDA for the treatment of Alzheimer's disease or other related dementia. Defines medically necessary treatments or medications to include, but not be limited to, those that reduce clinical decline.

2) Includes medications administered through a medical benefit, an outpatient prescription drug benefit to the extent the health care service plan contract covers outpatient prescription drugs, or both in the definition of medically necessary treatments in 1) above.

3) States that coverage for all medically necessary treatment or medications pursuant to paragraph 1) above does not require a health care service plan contract to cover drugs or treatments that are pharmaceutically equivalent drug products if the FDA approves more than one medication or treatment that are pharmaceutically equivalent drug products, unless otherwise required by law.

4) Prohibits a health plan and 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. Defines "step therapy protocol" as a process that specifies the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are prescribed. Specifies that step therapy is prohibited for both self-administered drugs and physician-administered drugs.

5) Exempts plans and insurers from covering all types of treatment for Alzheimer's disease or other medical conditions affecting memory without step therapy if at least one antiamyloid therapy is covered without step therapy, as specified.

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

7) Requires coverage criteria for FDA-approved treatments under this bill to not be more restrictive than FDA-approved indications for those treatments.

8) Requires authorization for a medically necessary treatment approved by the FDA for the treatment of Alzheimer's disease or other medical conditions affecting memory to be considered an exigent circumstance (requiring a 24-hour review timeline), consistent with requirements under existing law.

9) Exempts Medicare supplements, Medi-Cal managed care plans, specialized health care service plans that cover only dental or vision benefits, vision-only, dental-only, accident-only, specified disease, and hospital indemnity insurers from this bill.

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 and California Department of Insurance (CDI) to regulate health insurers. [Health and Safety Code (HSC) § 1340, *et seq*., and Insurance Code (INS) § 106, *et seq*.]

2) Establishes California's essential health benefits (EHBs) benchmark under the Patient Protection and Affordable Care Act (ACA) as the Kaiser Small Group Health Maintenance Organization, establishes existing California health insurance mandates, and the 10 ACA mandated benefits, including prescription drug coverage. [HSC § 1367.005 and INS § 10112.27]

3) Defines "basic health care services" as all of the following:

   a) Physician services, including consultation and referral;

   b) Hospital inpatient services and ambulatory care services;

   c) Diagnostic laboratory and therapeutic radiologic services;

   d) Home health services;

   e) Preventive health services;

   f) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. Basic health care services includes ambulance and ambulance transport services provided through the 911 emergency response system; and,

   g) Hospice care, as specified. [HSC § 1345 and INS § 10112.281]

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 (UR) or UM functions. [HSC § 1342.71 and § 1367.206, Title 28 California Code of Regulations (CCR) § 1300.67.205, and INS § 10123.193 and § 10123.201]

5) Requires health plans and disability insurers and any contracted entity that performs UR or UM functions, prospectively, retrospectively, or concurrently, based on medical necessity requests to comply with specified requirements. [HSC § 1367.01 and INS § 10123.135]

6) Requires decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to be made in a timely fashion that does not to exceed five business days from the health plan or health insurer's receipt of the information reasonably necessary and requested by the plan to make the determination. Requires, in cases where the review is retrospective, the decision to be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and be communicated to the provider in a manner that is consistent with current law. [HSC § 1367.01 and INS § 10123.135]

7) Authorizes a health care provider or prescribing provider, enrollee, insured, or their designee or guardian to appeal a denial of an exception request for coverage of a nonformulary drug, prior authorization request, or step therapy exception request consistent with the plan's or insurer's current UM process. [HSC § 1367.206 and INS § 10123.201]

8) Prohibits a health plan or insurer from subjecting antiretroviral drugs that are medically necessary for the prevention of AIDS/HIV, including PrEP or PEP, to PA or step therapy. Permits a health plan or insurer not to cover all of the therapeutically equivalent versions without PA or step therapy, if at least one therapeutically equivalent version is covered without PA or step therapy, if the FDA has approved one or more therapeutic equivalents of a drug, device, or product for the prevention of AIDS/HIV. Limits coverage to a 60-day supply to a single patient once every two years, unless the pharmacist has been directed otherwise by a prescriber. [HSC § 1342.74 and INS § 10123.1933]

FISCAL EFFECT: According to the Senate Appropriations Committee, DMHC anticipates minor and absorbable costs for state administration (Managed Care Fund). CDI estimates costs of $11,000 in 2026-27 and $23,000 in 2027-28 for state administration (Insurance Fund).

COMMENTS:

1) **PURPOSE OF THIS BILL**. 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. The author states that this devastating diagnosis is life- and community-changing. The author continues that as Alzheimer's progresses; individuals lose independence and the memories that connect them to their loved ones. The author notes that families often sacrifice their livelihoods to become caregivers while navigating a complex health system. The author states that during one of the most difficult times in their lives, California cannot allow barriers to delay or prevent access to appropriate treatment. The author continues that FDA-approved therapies offer new hope by slowing the progression of Alzheimer's disease in its early stages. The author states that removing the plaque responsible for the progression can preserve precious time, memories, and quality of life. But, the author argues that because they are only effective early in the disease, any delays can take away the opportunity to receive this treatment altogether. The author concludes that 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) **BACKGROUND**. Alzheimer's disease is a progressive, irreversible neurologic condition that damages and destroys neurons in the brain. As the disease progresses, memory, language, and cognitive processing challenges are often the first symptoms to emerge. Patients with Alzheimer's disease may live up to 10 years or longer after receiving a diagnosis, spending roughly 40% of that time in the more severe stages of disease, during which they need help with activities of daily living. Early-onset Alzheimer's disease is a form of Alzheimer's dementia that develops before the age of 65 years and is often associated with a faster cognitive decline. As patients lose the ability to drive, work, and care for themselves, support from others becomes necessary. In 2024, an estimated 19.2 billion hours of assistance was provided for people with Alzheimer's disease by unpaid caregivers. There is no cure or treatment to reverse Alzheimer's disease, and it is eventually fatal. In 2022, an estimated 17,363 people died from Alzheimer's disease in California. Alzheimer's disease is distinguished from other forms of dementia and cognitive impairment by two biomarkers that accumulate in the brain: an abnormal form of tau protein and beta-amyloid protein fragments. Brain inflammation, atrophy, and reduced glucose metabolism and uptake by the brain cells are also pathological features of the disease.

   a) **Medications for Alzheimer's**. Medication treatments for Alzheimer's disease include medications that treat symptoms of the disease, which treat symptoms of dementia without altering beta-amyloid accumulation and can be used at any stage of the disease. There are also disease-modifying medications that aim to alter the rate of disease progression by slowing and reversing beta-amyloid accumulation in the brain. Barriers to receiving a diagnosis for Alzheimer's disease and accessing disease-modifying medications are substantial and may be attributed to the limited supply of treating clinicians. According to the California Health Benefits Review Program (CHBRP) currently, disease-modifying medications are only available for patients who meet certain clinical criteria. Eligibility to receive disease-modifying medications is narrow, requires special testing, and may only be available in specialized facilities.

   b) **CHBRP**. CHBRP was created in response to AB 1996 (Thomson), Chapter 795, Statutes of 2002, which requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. SB 125 (Hernandez), Chapter 9, Statutes of 2015, added an impact assessment on EHBs, and legislation that impacts health insurance benefit designs, cost-sharing, premiums, and other health insurance topics to CHBRP's purview. CHBRP reviewed this bill and included the following impact estimates in their analysis:

      i) **Increased premiums and consumer costs**. CHBRP estimates that the introduced version of this bill would result in 66 additional enrollees receiving medications to treat symptoms and 23 additional enrollees receiving disease-modifying medications. Total annual premiums would increase by $660,000, or up to $0.03 per member per month. Cost-sharing for enrollees who are new users of these medications would increase between $1,310 and $1,990 annually. CHBRP notes that amendments taken in the Senate would likely result in fewer enrollees newly using some medications. As a result, fiscal impacts would be slightly lower than projected in CHBRP's initial analysis.

ii) **Medical effectiveness**. Medications that treat symptoms of Alzheimer's disease demonstrate generally small and inconsistent effects across medications, severity of disease, and outcomes; strength of evidence varies. Disease-modifying medications demonstrate strong, consistent effects on amyloid biomarkers, with substantial reductions in amyloid burden and high rates of amyloid clearance across studies. There is some evidence that these therapies slow cognitive decline, functional decline, and combined measures of cognition and function; however, effect sizes were generally modest, and most findings did not meet thresholds for clinical meaningfulness. While there is some evidence disease-modifying medications are associated with an increased risk of harms, they are often asymptomatic but can occasionally result in serious harm.

iii) **Limited public health impacts.** CHBRP projects no measurable public health impact at the population level due to the small estimated increase in utilization in the small 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 the 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) **SUPPORT**. The Alzheimer's Association is sponsoring this bill, stating that it expedites access for monoclonal antibody therapies that target amyloid plaque buildup in the brain to reduce cognitive decline. The Alzheimer's Association continues that these are among the first disease modifying treatments to become available for Alzheimer's disease, and alongside blood-based biomarker testing and new research have encouraged early detection and diagnosis of Alzheimer's disease. The Alzheimer's Association argues that 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.

4) **OPPOSITION**. The California Association of Health Plans (CAHP) and the Association of California Life & Health Insurance Companies (ACLHIC) write in opposition stating that even though this bill permits plans/insurers to apply utilization management like prior authorization, the bill requires that all products to treat Alzheimer's be included on formularies, forcing plans to adjust their current coverage, impacting health care affordability. CAHP and ACLHIC continue that this bill prevents plans from updating their policies as new data emerges and from designing policies that are both affordable and appropriate for a specific diagnosis. CAHP and ACLHIC cite the CHBRP analysis, which noted there is "some evidence that disease-modifying medications are effective at slowing cognitive decline" but adds that "these effects generally fell below minimum clinically important difference thresholds." CAHP and ACLHIC are concerned that due to the intensive treatment requirements, potential of severe side effects, and limited amount of providers who have experience prescribing and providing this treatment, this bill will accelerate utilization of these drugs before their value is proven and the infrastructure for treatment is available. Finally, CAHP and ACLHIC are concerned with the recent amendment that requires anti-amyloids and other Alzheimer's drugs to be treated as an exigent circumstance. CAHP and ACLHIC conclude that 24-hour review is an incredibly short timeline for an entire class of drugs, specifically ones (like anti-amyloids) that are new to the market and required to be used under strict guidelines and supervision.

5) PREVIOUS LEGISLATION.

a) 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.

b) 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.

6) PROPOSED AMENDMENTS. While health plans do not have to maintain all drugs on their prescription drug formularies, they must *cover* all medically necessary drugs under existing law. Language in this bill could potentially undermine that protection by limiting the definition of coverage of medically necessary drugs for Alzheimer's. To ensure this bill isn't weakening existing law, the committee may wish to make the following amendment to the bill:

(a) (1) A health care service plan contract that is issued, amended, or renewed on or after January 1, 2027, shall 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 related dementia. Medically necessary treatments or medications include, but are not limited to, those that reduce clinical decline.

(2) Medically necessary treatments or medications covered pursuant to paragraph (1) include those administered through a medical benefit, an outpatient prescription drug benefit to the extent the health care service plan contract covers outpatient prescription drugs, or both.

~~(3) Coverage for all medically necessary treatment or medications pursuant to paragraph (1) does not require a health care service plan contract to cover drugs or treatments that are pharmaceutically equivalent drug products if the FDA approves more than one medication or treatment that are pharmaceutically equivalent drug products, unless otherwise required by law.~~

REGISTERED SUPPORT / OPPOSITION:

Support

Alzheimer's Association (sponsor)
AIDS Healthcare Foundation
Alzheimer's Greater Los Angeles
Alzheimer's Orange County
Alzheimer's San Diego
American Federation of State, County and Municipal Employees, AFL-CIO
Biocom

California Alliance for Retired Americans
California Assisted Living Association
California Chronic Care Coalition
California Coalition on Family Caregiving
California Life Sciences Association
Disability Rights California
LeadingAge California
Western Center on Law & Poverty

Opposition

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

Analysis Prepared by: Riana King / HEALTH / (916) 319-2097