A REPORT TO THE 2025–2026 CALIFORNIA LEGISLATURE

Bill Analysis Report: California Senate Bill 950 Dementia

APRIL 5, 2026

California Health Benefits Review Program (CHBRP)
University of California, Berkeley

chbrp.org

KEY FINDINGS

Analysis of California Senate Bill 950 Dementia

Summary to the 2025–2026 California State Legislature, April 5, 2026

CHBRP

The version of California Senate Bill (SB) 950 analyzed by the California Health Benefits Review Program (CHBRP) would require coverage of all U.S. Food and Drug Administration (FDA)-approved treatments for Alzheimer's disease and would prohibit step therapy for specified medications. Medications covered under the medical benefit would also need to be covered under the pharmacy benefit.

In 2027, of the 22.8 million Californians enrolled in state-regulated health insurance, 13.8 million of them would have insurance subject to SB 950.

Background

Alzheimer's disease is a progressive, irreversible neurologic condition; memory, language, and cognitive processing challenges are often the first symptoms to emerge. 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. In the United States, 31.8 people out of 100,000 persons aged 35 to 64 years (an estimated 4,800 persons aged 35 to 64 years in California) have Alzheimer's disease.

Medication treatments for Alzheimer's disease include medications that treat symptoms of the disease and disease-modifying medications that aim to slow the rate of disease progression. 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. Eligibility to receive disease-modifying medications is narrow, requires special testing, and may only be available in specialized facilities.

Benefit Coverage

No enrollees have fully compliant coverage at baseline. Baseline coverage of medication varies between less than 10% to 93% for medications to treat symptoms, and 88% for disease-modifying medications covered under the medical benefit. No enrollees are in plans or policies with step therapy requirements for disease-modifying medications; similarly, no enrollees are in plans or policies that cover disease-modifying medications under both the medical and pharmacy benefit. SB 950 would not exceed essential health benefits (EHBs).

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.

Cost Impacts

CHBRP estimates SB 950 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. Enrollee cost sharing for new users of medications would increase between $1,310 and $1,990 annually.

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 SB 950 and eligible for the medications. However, SB 950 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.

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Acronyms and Terminology

Acronyms

ACA – Affordable Care Act

ARIA – amyloid-related imaging abnormalities

CA – California

CalPERS – California Public Employees' Retirement System

CDC – Centers for Disease Control and Prevention

CDI – California Department of Insurance

CHBRP – California Health Benefits Review Program

COHS – County Organized Health System

DHCS – Department of Health Care Services

DMHC – Department of Managed Health Care

DMT – disease-modifying treatment

EHBs – essential health benefits

FDA – U.S. Food and Drug Administration

MCI – mild cognitive impairment

MHPAEA – Mental Health Parity and Addiction Equity Act

MRI – magnetic resonance imaging

PET – positron emission tomography

RCT – randomized controlled trial

SB – Senate Bill

Terminology

CHBRP uses the following terminology for this analysis:

Bill-Specific Terminology

Dementia is a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems. Symptoms may also include personality changes and emotional problems. Dementia usually gets worse over time.

Alzheimer's disease: a progressive, irreversible neurologic condition that damages and destroys neurons in the brain.

Early-onset Alzheimer's disease: a form of Alzheimer's dementia that develops before the age of 65 and is associated with a faster cognitive decline

Cognitive impairment describes problems with a person's ability to think, learn, remember, use judgement, and make decisions. Signs of cognitive impairment include memory loss and trouble concentrating, completing tasks, understanding, remembering, following instructions, and solving problems. Other common signs may include changes in mood or behavior, loss of motivation, and being unaware of surroundings.

ARIA-E: edema or effusion brain abnormalities seen on an MRI.

ARIA-H: hemorrhage (including microhemorrhages and superficial siderosis) seen on an MRI.

Utilization Management–Related Terminology

Utilization management: Utilization management techniques are used by health plans and insurers to control costs, ensure medication compatibility, and manage safety (Busch and Muller, 2023). Examples include benefit coverage requirements related to prior authorization, step therapy, quantity limits, and limits related to the age or sex of the enrollee (such as prescription-only infant formula or prostate cancer screening for men).

Prior authorization:[1] Also known as precertification, prior approval, or prospective review, prior authorization is a utilization management technique commonly used by health insurance carriers to ensure that a given medical intervention meets the insurance plan or policy's criteria for coverage (Newcomer et al., 2017). Prior authorization was developed as a tool for insurers to assess the appropriateness of treatment that would result in a hospital admission or a high-cost procedure (Resneck, 2020). The primary uses of prior authorization include:

- **Coverage evaluation:** Allows evaluation of whether a test, treatment, or service is medically necessary and otherwise covered.
- **Safety:** Acts as a safeguard to confirm that a patient's medications are compatible and provides an opportunity to check that proper diagnostic testing has been completed to ensure patient safety prior to use of a requested treatment. Prior authorization also reduces inappropriate patient care by stopping unsafe or low-value care that is inconsistent with the most recent clinical evidence.
- **Cost control:** Imposition of prior authorization for nonpreferred medications can encourage the use of preferred medications that can be procured at lower price.

Step therapy: Defined by Senate Bill (SB) 950 and current law[2] 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". Also known as "fail-first" protocols, step therapy may be applied to prescription medications by health plans and insurers to control costs, ensure medication compatibility, and manage safety. Health plans/insurers may use step therapy protocols to apply clinical guidelines established by professional societies and other recognized organizations to treatment plans. They require an enrollee to try and fail one or more medications prior to receiving coverage for the initially prescribed medication. Step therapy protocols usually recommend starting with a medication that is less expensive (generics) and/or has more "post-marketing safety experience" (PBMI, 2015).

[1] More information about prior authorization is available in CHBRP's 2023 analysis *Prior Authorization in California*.
[2] INS 10123.201.

Overview: SB 950 and Dementia

On February 4, 2026, the California Senate Committee on Health requested that the California Health Benefits Review Program (CHBRP)[3] conduct an evidence-based assessment of the medical, financial, and public health impacts of Senate Bill (SB) 950 Dementia, as introduced on February 2, 2026.

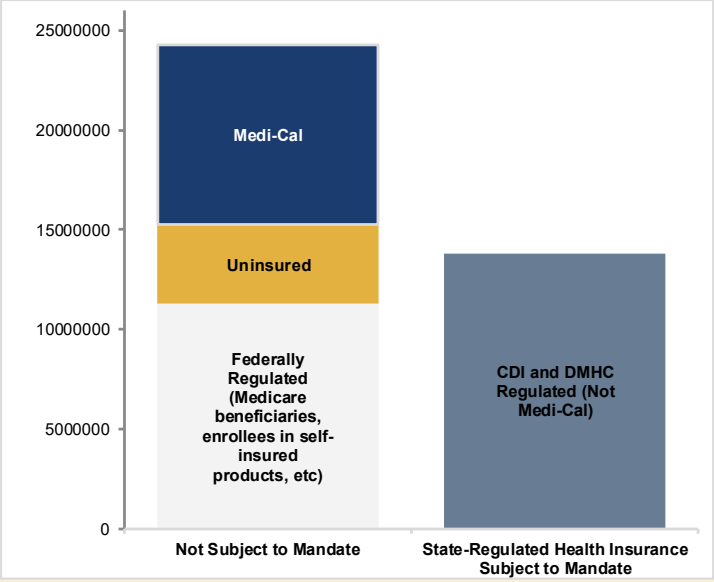
Bill Language of SB 950

SB 950 would require coverage for *all* medically necessary treatments or medications, as determined by a health care provider, approved by the U.S. Food and Drug Administration (FDA) for the treatment of Alzheimer's disease or other related dementia. Medically necessary treatments and medications include, but are not limited to, those that reduce clinical decline.

SB 950 would prohibit step therapy protocols as a prerequisite to authorizing coverage for both self-administered medications and clinician-administered medications. If the FDA has approved one or more types of treatment for Alzheimer's disease, SB 950 does not require coverage of all types of these medications without step therapy, if at least one anti-amyloid therapy is covered without step therapy.

SB 950 would not prohibit other utilization management, including prior authorization, to determine medical necessity if the medical necessity determinations are made in the same manner as those determinations are made for other illnesses covered by the plan or policy. SB 950 states that a plan or policy shall "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 related dementia.

Figure 1. Health Insurance in CA and SB 950



Source: California Health Benefits Review Program, 2026.
Note: CHBRP generally assumes alignment of Medi-Cal managed care plan benefits, with limited exceptions.
Key: CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

SB 950 states that coverage shall not be more restrictive than the FDA-approved indications for these treatments.

Lastly, SB 950 would require a health care service plan or health insurer that covers non-self-administered treatments approved by the FDA for the treatment of Alzheimer's disease or other related dementia, as a medical benefit, to also include those non–self-administered treatments as an outpatient prescription drug benefit.

See the full text of SB 950 in the Technical Brief: SB 950 Dementia, available at www.chbrp.org.

[3] See CHBRP's authorizing statute.

If enacted, SB 950 would apply to the health insurance of approximately 13,799,000 enrollees (36.2% of all Californians) (see Figure 1). Within this population, less than 2% are over the age of 65 years; most people with Alzheimer's disease are over age 65 years.

- **Includes**: enrollees in commercial or CalPERS health insurance regulated by the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI).
- **Excludes**: Medi-Cal beneficiaries enrolled in DMHC-regulated plans and county organized health system (COHS) plans.

It should be noted that DMHC regulates the plans and policies of approximately 74% of enrollees associated with CalPERS, in addition to commercial enrollees.[4]

CHBRP provides an overview of common utilization management practices, including step therapy, in its explainer *Utilization Management: An Overview*.

What Is Alzheimer's Disease?

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 (Alzheimer's Association, 2025). 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 for instrumental and then basic activities of daily living (such as cooking, dressing, bathing, toileting, eating) (Alzheimer's Association, 2025). 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 Association, 2025).

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 (Alzheimer's Association, 2025). Brain inflammation, atrophy, and reduced glucose metabolism and uptake by the brain cells are also pathological features of the disease (Alzheimer's Association, 2025).

For those over 65 years, Alzheimer's disease affects over 7 million people nationally (Alzheimer's Association, 2025; Murphy et al., 2024). Prevalence is higher amongst older age groups, affecting 5.1% of people aged 65 to 74 years, 13.2% of people aged 75 to 84 years, and 33.4% of people aged 85 years or older (Alzheimer's Association, 2025). In the United States, 74% of people with Alzheimer's disease above age 65 years are aged 75 or older (Alzheimer's Association, 2025). In 2020, California had an estimated 719,700 adults aged 65+ living with Alzheimer's disease (Dhana et al., 2023). Of these people, 547,629 are 75 years old or older (Ross et al., 2021).

Early-onset Alzheimer's disease is a rare version that develops before the age of 65 years and is often associated with a faster cognitive decline (Seath et al., 2024). The estimated prevalence for early-onset Alzheimer's disease is 31.8 people out of 100,000 persons aged 35 to 64 years in the United States, or 40,326 persons total (Alzheimer's Association, 2025; Hendriks et al., 2021; KFF, 2026).

Disparities and differences exist for Alzheimer's disease. Risk for developing the disease increases with age, with highest risk being for patients aged 85+ years. Women, and people who are African American and/or Latino/Hispanic are at higher risk for developing the disease. People who are African American and/Latino/Hispanic are more likely to experience delays in receiving a diagnosis of dementia than non-Hispanic white people.

[4] For more detail, see CHBRP's resource, *Sources of Health Insurance in California*.

Medication treatments for Alzheimer's disease

FDA-approved treatments include:

- **Medications to treat symptoms** – intended to treat symptoms of dementia without altering beta-amyloid accumulation and can be used at any stage of the disease
    - **Cholinesterase Inhibitors (pill or patch)**
        - Donepezil (Aricept)
        - Galantamine (Razadyne)
        - Benzgalantamine (Zunveyl)
        - Rivastigmine (Exelon)
    - **NMDA-receptor antagonists (pill)**
        - Memantine (Namenda)
    - **Combination cholinesterase inhibitor + NMDA-receptor antagonists (pill)**
        - Donepezil + memantine (Namzaric)
- **Disease-modifying medications** – intended to slow and reverse beta-amyloid accumulation in the brain, and only approved for use in mild stages of Alzheimer's disease (mild cognitive impairment or mild dementia)
    - **Amyloid beta–directed monoclonal antibodies** (infusions or infusions then injections), also referred to as anti-amyloid medications
        - Lecanemab (Leqembi)
        - Donanemab (Kisunla)

At this time, disease-modifying medications are only available for patients who meet certain clinical criteria (see more in the *Background* section in the Technical Brief for SB 950). 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[5]) (U.S. Food and Drug Administration, 2023, 2024). Additionally, patients who are unable to safely undergo MRI, or those with certain pre-existing medical conditions may be considered ineligible for these treatments.[5]

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.

Barriers

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.[5] 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.[6]

[5] Personal communication with CHBRP's content expert, February 27th, 2026.
[6] Personal communication with CHBRP's content expert, February 27th, 2026.

For additional information about Alzheimer's disease, prevalence, treatment options, and barriers to care, please see *Background on Alzheimer's Disease* in CHBRP's Technical Brief on SB 950.

How Effective Are FDA-Approved Treatments for Alzheimer's Disease?

CHBRP's medical effectiveness literature review focused on determining the effectiveness of FDA-approved treatments for Alzheimer's disease. Measurable health outcomes relevant to SB 950 include cognitive function, functional ability, cognitive function and functional ability (combined measure), neuropsychiatric/behavioral symptoms, global assessment (combined measures), biomarkers (amyloid burden), and potential harms.

Although several biomarkers are thought to be involved in the pathogenesis of Alzheimer's disease (e.g., amyloid, tau, p-tau), CHBRP focused on amyloid burden and clearance as the main biomarker outcomes, as the mechanism of action of current disease-modifying therapies is based on decreasing amyloid burden in the brain.

CHBRP relied on three meta-analyses to identify individual studies that evaluated the safety and efficacy of FDA-approved medications that treat symptoms of Alzheimer's disease. CHBRP relied on seven individual trials that evaluated the safety and efficacy of FDA-approved disease-modifying treatments for Alzheimer's disease.

Additional information, including more detail on studies included in this review, is available in the *Medical Effectiveness* section in the Technical Brief on SB 950 Dementia.

Medications That Treat Symptoms of Alzheimer's Disease

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*[7] that cholinesterase inhibitors are associated with small improvements in cognitive function and global assessment relative to placebo but do not improve functional ability. Evidence for neuropsychiatric/behavioral symptoms is conflicting. 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.

Table 1. Summary of Findings From Meta-Analyses of Medications That Treat Symptoms of Alzheimer's Disease

Outcome	Cholinesterase Inhibitor vs. Placebo	NMDA-Receptor Antagonist vs. Placebo	Combination Therapy (Cholinesterase Inhibitor and NMDA-Receptor Antagonist) Compared to Cholinesterase Inhibitor Alone
Cognitive function	*Strong evidence* – small improvement	*Some evidence*[8] – no difference	*Some evidence* – small improvement for moderate to severe Alzheimer's disease; no difference for mild to moderate Alzheimer's disease
Functional ability	*Strong evidence* – no difference	*Some evidence* – no difference	*Some evidence* – no difference

[7] *Strong evidence* indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective. Conclusions could be altered with additional strong evidence.
[8] *Some evidence* indicates that a small number of studies have limited generalizability to the population of interest and/or the studies have a serious methodological concern in research design or implementation. Conclusions could be altered with additional evidence.

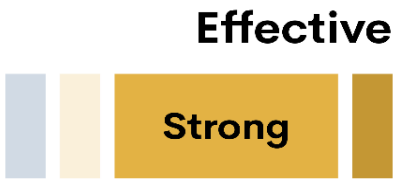
Outcome	Cholinesterase Inhibitor vs. Placebo	NMDA-Receptor Antagonist vs. Placebo	Combination Therapy (Cholinesterase Inhibitor and NMDA-Receptor Antagonist) Compared to Cholinesterase Inhibitor Alone
Neuropsychiatric/ behavioral symptoms	*Conflicting evidence*[9] – galantamine associated with small improvement in NPI score for mild-to-moderate Alzheimer's disease and donepezil for moderate-to-severe Alzheimer's disease; other differences not statistically significant	*Some evidence* – small improvement for moderate to severe Alzheimer's disease; no difference for mild to moderate Alzheimer's disease	*Strong evidence* – small reduction in symptoms
Global assessment	*Some evidence* – more likely to have small improvement but low likelihood of moderate improvement	*Some evidence* – small improvement	*Some evidence* – small improvement for persons with moderate to severe Alzheimer's disease; no difference for mild to moderate Alzheimer's disease

Source: California Health Benefits Review Program, 2026.
Key: NPI = Neuropsychiatric Inventory.

Disease-Modifying Medications

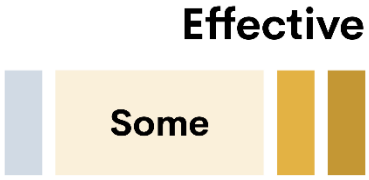
Effect on amyloid burden: There is *strong evidence* that disease-modifying medications are effective at reducing or clearing amyloid plaque based on six studies (Figure 2). All studies consistently demonstrated substantial reductions in amyloid burden among treated participants. Additionally, results showed that most treated participants achieved amyloid clearance. Most randomized controlled trial findings on amyloid burden were statistically significant, whereas outcomes of clearance and extension studies were generally reported descriptively without formal statistical testing. Overall, disease-modifying medications demonstrate robust and consistent effects on amyloid biomarkers.

Figure 2. Level of Evidence of Effectiveness on Amyloid Burden



Effectiveness of slowing cognitive decline, functional decline, and combined measures of cognitive and functional decline: 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, with statistically significant findings reported in most RCTs (Figure 3). However, effect sizes were generally modest, and most findings did not meet thresholds for clinical meaningfulness. Evidence from extension studies suggests that these effects may be maintained for up to three years, although statistical significance was often not reported.

Figure 3. Level of Evidence of Effectiveness on Slowing Decline



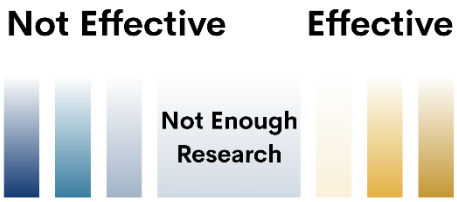
Risk of harms: There is *some* evidence that disease-modifying medications are associated with increased risk of harms based on six studies. Most findings were reported descriptively, with limited statistical testing across studies. All studies consistently demonstrated higher rates of amyloid-related imaging abnormalities (ARIA, including ARIA-E [edema or effusion abnormalities] and ARIA-H [hemorrhage, including microhemorrhages and superficial siderosis]) among treated participants, particularly during the initial treatment period. Most ARIA events were asymptomatic and detected through imaging, although symptomatic cases occurred in a smaller proportion of participants. Mortality rates were low and similar between treatment and placebo groups, with no clear evidence of increased mortality risk. Other adverse events, including infusion-related reactions and mild systemic symptoms, were common but generally manageable. However, adverse events led to treatment discontinuation in a subset of participants and were more frequent than in placebo

[9] *Conflicting evidence* indicates that a similar number of studies of equal quality suggest the treatment is effective as suggest the treatment is not effective.

groups. Additionally, some events, such as intracerebral hemorrhage, have the potential to result in severe disability or death. Overall, disease-modifying medications are associated with increased risk of imaging abnormalities; while serious adverse events were infrequent, some may result in severe outcomes. The clinical significance of these harms remains uncertain.

Whether amyloid plaque reduction leads to improved health outcomes: There is *not enough research*[10] to determine whether amyloid plaque reduction improves health outcomes based on one study that provided subgroup results for all disease-modifying medications (i.e., did not limit findings to donanemab and/or lecanemab) (Figure 4). Findings suggest that amyloid reduction is associated with a statistically significant but small improvement in cognitive and combined measure outcomes; however, the small effect sizes did not meet the threshold for minimum clinically important differences.

Figure 4. Level of Evidence of Effectiveness on Improved Outcomes



Policy Context

Existing California Law and Regulations

Current California law requires coverage of medically necessary prescription medications by plans and policies that cover outpatient prescription medications.[11] Additionally, DMHC-regulated plans and large-group CDI-regulated policies are required to of medically necessary Basic Health Care Services, including hospital inpatient services and ambulatory care services.[12] Broadly speaking, treatments for Alzheimer's disease and related dementia fall under these requirements.[13]

Medi-Cal

Medi-Cal RX provides coverage for some medications to treat Alzheimer's and related dementia (donepezil, galantamine, rivastigmine) (DHCS, 2026). Medi-Cal Managed Care plans also provide coverage for the two currently available anti-amyloid medications, lecanemab and donanemab.

Mental health parity

California law[14] requires plans and policies to cover all mental health and substance use disorders listed in the most recent edition of either the *International Classification of Disease* or the *Diagnostic and Statistical Manual of Mental Disorders* at parity with other medical services. This requirement is similar to those specified by the federal Mental Health Parity and Addiction Equity Act (MHPAEA) (see more information in the Technical Brief: SB 950 Dementia), but applies to all health insurance plans and policies subject to either the Health and Safety Code or the Insurance Code. Alzheimer's disease is recognized in the *Diagnostic and Statistical Manual of Mental Disorders* under "Dementia of the Alzheimer's Type." Therefore, treatment for Alzheimer's disease is required to be covered at parity with other medical services, although not all medications would need to be included "on formulary," and there is no requirement for plans and policies to cover all therapeutically equivalent medications.

Additionally, California law requires medical necessity determinations and utilization management review criteria to be consistent with generally accepted standards of mental health and substance use disorder care.[15] "Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved

[10] *Not enough research* indicates that there are no studies of the treatment, or the available studies are not of high quality, meaning there is not enough evidence available to know whether or not a treatment is effective. It does not indicate that a treatment is not effective.
[11] INS 10123.201.
[12] INS 10112.281.
[13] Personal communication with the California Department of Insurance, February 26, 2026.
[14] Health and Safety Code (HSC) Section 1374.72; Insurance Code (INS) Section 10144.5 and 10123.15.
[15] HSC 1374.721 and INS 10144.52.

by the [FDA]." The Alzheimer's Association and the American Academy of Neurology publish clinical practice guidelines and resources for clinical decision-making.

Prior authorization

California law requires plans and policies to notify a prescribing provider of its coverage determinations within 72 hours of nonurgent requests or within 24 hours if exigent circumstances exist.[16] For services covered under the medical benefit, insurers must make determinations within five business days, or within 72 hours if an enrollee faces imminent and serious threat to their health.[17]

Medicare

Medicare covers both anti-amyloid medications under the Medicare Part B benefit (CMS, 2024). Patients must also be registered with a free Centers for Medicare and Medicaid Services National Patient Registry. For Medicare beneficiaries enrolled in traditional Medicare, the standard 20% coinsurance for these medications apply after a beneficiary meets their deductible. For beneficiaries enrolled in Medicare Advantage plans or other supplemental policies, cost sharing would reflect those plans and policies. Medicare Part D plans must cover at least two drugs used to treat Alzheimer's symptoms, including cholinesterase inhibitors and memantine (National Council on Aging, 2025).

Essential Health Benefits and the Affordable Care Act

Because treatments for Alzheimer's disease and related dementia are required to be covered under existing state law and are included in California's benchmark plan, SB 950 would not exceed the current definition of essential health benefits (EHBs) in California.

Similar Legislation in Other States

Illinois passed a similar bill in 2025, which requires coverage for all medically necessary diagnostic testing and FDA-approved treatments or medications prescribed to slow the progression of Alzheimer's disease or other related dementia.[18] Illinois' law also prohibits step therapy for FDA-approved treatments of Alzheimer's disease or other related dementia. This law goes into effect January 1, 2027. Illinois had previously required, as of July 1, 2025, the State Employees Group Insurance Program to cover necessary diagnostic testing and all medically necessary FDA-approved treatments or medications to slow the progression of Alzheimer's disease or other related dementia without step therapy.

Although SB 950 does not include coverage requirements for diagnostic testing, medically necessary laboratory tests and imaging services are required to be covered under EHBs and Basic Health Care Services.

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[16] HSC 1367.241 and INS 10123.191.
[17] HSC 1367.01 and INS 10123.135.
[18] Illinois Senate Bill 126 (2025).

Analytic Approach and Assumptions

CHBRP analyzes bills in the current environment given current law and regulations at both the state and federal levels. All estimates are based on current data and do not take into consideration any future or potential changes to factors that may influence the impacts of SB 950, unless otherwise specifically mentioned.

Language Interpretation

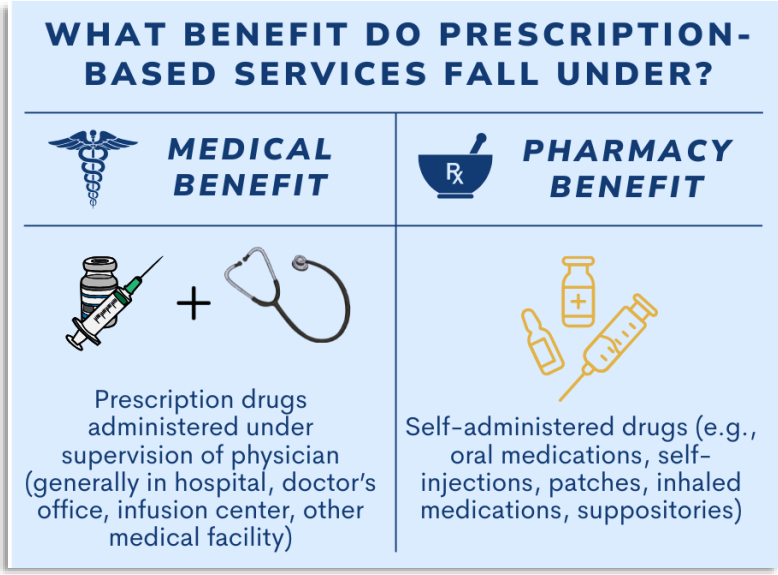
CHBRP made the following assumptions based on the language of SB 950:

- This bill is specific to FDA-approved treatments for Alzheimer's disease and related dementia. There are other types of dementia that are not related to Alzheimer's disease, which CHBRP does not include in this analysis. Clinical materials, such as the DSM, describe Alzheimer's disease as "Alzheimer's disease and related dementia," and this category does not include dementia as a result of non-Alzheimer's disease causes.

- This bill is specific to treatments that are FDA-approved and therefore is limited to medications with on-label indications for use by patients with Alzheimer's disease and related dementia.

It is unclear whether SB 950 would require prior authorization determinations for treatments for Alzheimer's disease to be made within the more limited time periods, as required for "exigent" circumstances for prescription medications or "imminent and serious threats to health" for other medical services.

Pharmacy Benefit Coverage



Drugs that are physician-ordered and administered under the supervision of a physician (generally in a hospital, a provider's office, infusion center, or similar medical facility), along with the hospital stay or office visit, are generally covered through a medical benefit. Pharmacy benefits cover outpatient prescription drugs by covering prescriptions that are generally filled at a retail pharmacy, a mail-order pharmacy, or a specialty pharmacy.

SB 950 would require plans and policies that cover FDA-approved treatments for Alzheimer's disease under the medical benefit to also cover those medications under the pharmacy benefit. SB 950 does not specify whether plans and policies without a pharmacy benefit or without a state-regulated pharmacy benefit would need to create a pharmacy benefit through which to cover these medications in order to be in compliance. CHBRP has assumed that these plans and policies **would not** need to create a pharmacy benefit in order to comply with SB 950. However, should compliance require the creation of a pharmacy benefit, there would be associated administrative costs for insurers and additional expenses due to the shift of some medications from the medical benefit to the pharmacy benefit. See the *Benefit Coverage and Cost* section and the Technical Brief on SB 950 for more information.

Cost-Related Assumptions

This analysis reports the estimated incremental impact of full-scale implementation of SB 950 on benefit coverage, utilization, and cost for a single year.[19] Full-scale implementation typically requires a "ramp up" period which may include educating enrollees, providers and insurance carriers on the new benefits or coverage, updating procedures and policies, and increasing provider capacity for marginal utilization resulting from SB 950. Furthermore, some policies may have staggered implementation or longer-term changes in utilization. The incremental impact estimates below assume there is no "ramp up" period and represent ongoing annual costs at full-scale implementation of SB 950 including potential short-term offsets. CHBRP further assumes that state and industry policies and provider and patient behaviors would remain constant throughout the time it takes for the full impact of the bill to be realized.[20] For a discussion of long-term impacts of SB 950, see the *Long-Term Impacts* section.

For further details on the underlying data sources, methods, and assumptions used in this analysis please see the Technical Brief on SB 950 Dementia.

Approach and Assumptions on Baseline Coverage and Utilization

- The prevalence rate of mild cognitive impairment or mild dementia related to Alzheimer's disease among non-elderly adults aged 35 to 64 years is 31.8/100,000. There are no cases of mild cognitive impairment or mild dementia related to Alzheimer's disease among persons aged 0 to 34 years. For the purposes of this analysis, which focuses on enrollees in the commercial insurance market, 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 enrollees with commercial health insurance subject to SB 950. Because most enrollees with health insurance subject to SB 950 are under aged 65 years (all but 2% of enrollees), this bill impacts only a small portion of the overall population with Alzheimer's disease.

Approach and Assumptions on Postmandate Coverage and Utilization

- Based on Content Expert guidance, which is in line with recent studies (Dobson et al., 2024; Padovani et al., 2022; Pittock et al., 2023), CHBRP assumes 10% of the medically eligible population enrolled in commercial plans subject to SB 950 (based on diagnoses, imaging, and age) will use newly covered disease-modifying medications and the related imaging (MRI and PET scans). These imaging services are ancillary to the actual infusion treatments and are used to ascertain eligibility and monitor the effect of the treatment on amyloid plaques and potential side effects.
    - Although there would be new use of imaging and infusion services due to new postmandate benefit coverage, CHBRP assumes that the rate of use will be the same as current users who already have coverage. Based on the carrier surveys, a high proportion of enrollees subject to SB 950 have existing coverage for disease modifying medications without any step therapy requirements.
    - As discussed in the *Medical Effectiveness* section of the Technical Brief, discontinuation rates vary from 6.9% to 30.5% in published clinical trials of the disease modifying medications (Mintun et al., 2021; van Dyck et al., 2023). CHBRP applied a 20% discontinuation rate to the new users of the treatment postmandate. This discontinuation rate also alters the use of PET and MRI scans postmandate.

[19] For some analyses, impacts as a result of changes to health insurance benefits may occur over multiple years (e.g., impacts in pregnancy and childbirth rates resulting from changes to utilization of fertility services, staggered implementation, or long-term changes in utilization). CHBRP's estimates represent the full impact of the mandate in one year even if changes in coverage, utilization offsets, and costs may be realized in more than one year.
[20] CHBRP's Cost and Coverage Model also assumes enrollees maintain one form of health insurance for the entire calendar year. Examples of state and industry policies and behavior include medications that may be developed or approved in the future, health insurance market changes beyond what is known at the time of publication of this analysis, and statutory changes resulting from other health benefit mandates.

- Infusion treatment is complex and can be subject to error and risk. There are existing limitations in supply of trained clinicians who administer disease-modifying medications through infusions. CHBRP assumes clinicians not currently providing these infusions in infusion centers are unlikely to expand their offering to include lecanemab and donanemab infusions in the short term (see more information in the *Long-Term Impacts* section about potential impacts beyond the first 12 months of implementation).
- Pharmacy benefit coverage would allow "white bagging[21]" to be used as an option, but infusion centers with limited experience administering the treatments would still be reluctant to do so.
- For medications to treat symptoms of Alzheimer's disease, utilization of these medications would increase due to increases in benefit coverage for some medications.

Offsets

CHBRP uses the term "offset" to describe the amount of medical care costs that may not occur as a result of the use of another covered benefit. For this analysis, CHBRP synthesized the evidence and calculated that there would be no cost offsets due to avoided service use due to increased utilization of Alzheimer's treatment medications postmandate. However, there would be new services provided linked to the increased use of the prescription drugs and infusion services as a result of benefit coverage changes from SB 950. These additional services include diagnostic imaging and ongoing monitoring and medical treatment for complications and side effects.

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[21] The practice of obtaining a medication from a contracted specialty pharmacy rather than a hospital's internal pharmacy.

SB 950 Impacts: Benefit Coverage and Cost

Benefit Coverage

CHBRP estimates that at baseline, 13,799,000 Californians (100%) with state-regulated insurance subject to the mandate are enrolled in plans or policies out of compliance with SB 950 (Table 2). This is due to baseline coverage rates for medications to treat symptoms and disease-modifying medications for Alzheimer's disease, and the lack of coverage for disease-modifying medications on the pharmacy benefit on any plan or policy. Of note, 88% of enrollees with state-regulated insurance subject to the mandate are enrolled in plans or policies that cover the two disease-modifying infusion medications via the medical benefit, lecanemab and donanemab. There is full compliance with the step therapy requirement among enrollees with baseline coverage for disease-modifying medications because no enrollees are in plans or policies that require step therapy prior to use of lecanemab or donanemab. Approximately half of enrollees with baseline coverage of disease-modifying medications are in plans and policies with prior authorization requirements. However, prior authorization requirements appear to be highly aligned with eligibility criteria used by clinicians to prescribe treatment (e.g., presence of amyloid plaque as measured by PET scan or other tests, no use of anticoagulants). Postmandate, CHBRP estimates 13,799,000 Californians would have coverage compliant with SB 950. Please note that CHBRP's approach is to assume full compliance postmandate on the part of all health insurance subject to the proposed mandate.

Table 2. Impacts of SB 950 on Benefit Coverage, 2027

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Total enrollees with health insurance subject to state benefit mandates (a)	22,842,000	22,842,000	0	0.00%
Total enrollees with health insurance subject to SB950	13,799,000	13,799,000	0	0.00%
Percentage of enrollees with fully compliant coverage for mandated benefit via *medical benefit*				
Lecanemab (infusion)	88%	100%	12%	14.25%
Donanemab (infusion)	88%	100%	12%	14.25%
Percentage of enrollees with fully compliant coverage for mandated benefit *via pharmacy benefit*				
Donepezil	93%	100%	7%	7.41%
Galantamine	93%	100%	7%	7.41%
Benzgalantamine	7%	100%	93%	1,397.85%
Rivastigmine	33%	100%	67%	200.46%
Memantine + Donepezil Combination	12%	100%	88%	718.49%
Memantine	93%	100%	7%	7.41%

Lecanemab (subcutaneous)	25%	100%	75%	293.53%
Lecanemab (infusion)	0%	100%	100%	0.00%
Donanemab (infusion)	0%	100%	100%	0.00%

Source: California Health Benefits Review Program, 2026.
Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[22]
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

Utilization and Unit Cost

Utilization

At baseline, utilization of prescription drugs and services covered by SB 950 is relatively low (Table 3); however, these estimates reflect the limited population with Alzheimer's disease and health insurance subject to SB 950.

CHBRP estimates 89 enrollees are using disease-modifying treatments via infusion through the medical benefit at baseline and1,086 enrollees use medications to treat symptoms for mild cognitive impairment or mild dementia. The medications to treat symptoms are typically covered through the pharmacy benefit, rather than the medical benefit like the infusion treatments. There is a subcutaneous version of lecanemab that is typically covered on the pharmacy benefit because it is self-administered, but it is only available as a weekly maintenance dose for people who have already undergone 18 months of infusion treatment. See more information in the *Long Term Impa*cts section about the impact of the expansion of subcutaneous medications.

Those using disease-modifying medications require imaging to monitor amyloid (see more information in the *What Is Alzheimer's Disease* section), resulting in 92 PET scans and 354 MRIs each year at baseline. A PET scan (or lumbar puncture or blood test) is required to initiate infusion treatment. However, a PET scan could also be used for checking amyloid plaque during or at the conclusion of treatment. Therefore, CHBRP estimates at least one PET scan per year due to initial treatment requirements for new patients and monitoring needs for existing patients. In addition, some enrollees would receive additional health care services related to side effects and complications from anti-amyloid treatments (see information in the *Harms* section of the *Medical Effectiveness* section).

The medications to treat symptoms do not require extensive screening and monitoring. They can also be taken at the same time as disease-modifying medications, so the number of enrollees using each treatment is not unique and could represent enrollees receiving two or three methods of treatment.

Due to new coverage for enrollees who did not have coverage for disease-modifying medications or medications to treat symptoms at baseline:

- For **disease-modifying medications**, the number of enrollees receiving treatments through their medical benefits would increase by 14.61% (an increase of 13 enrollees). Under the pharmacy benefit, utilization of disease-modifying medications would increase from 4 enrollees to 14 enrollees (representing a 250% increase) obtaining disease-modifying medications through the pharmacy benefit, postmandate.
    - Any additional medical services needed for screening, monitoring, or managing side effects will also increase by 25.42% to 26.09% due to the new group of eligible enrollees obtaining disease-modifying medications.

[22] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.

- Use of **medications to treat symptoms** would increase by 6.08%. Due to the low level of baseline coverage for benzgalantamine (7%) there is likely to be an increase in use due to new benefit coverage because the treatment has fewer side effects than galantamine.

Unit Cost

For disease-modifying medications, there is a small increase in the average unit cost due to the new coverage of disease-modifying medications via the pharmacy benefit. Per unit costs for pharmacy benefit dispensed infusion medications have been assumed to be slightly higher cost compared to those dispensed on the medical benefit based on analysis of claims data (see more information in the Technical Brief on SB 950). Additionally, the average unit cost for medications to treat symptoms would increase because of the shift in utilization to a more expensive medication (shift in use from galantamine to benzgalantamine).

Table 3 provides estimates of the impacts of SB 950 on utilization and unit cost of medication, imaging, and other services.

Table 3. Impacts of SB 950 on Utilization and Unit Cost, 2027

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Number of enrollees using treatment				
Disease-modifying treatments for Alzheimer's dementia				
Via medical benefit	89	102	13	14.61%
Via pharmacy benefit	4	14	10	250.00%
Medication to treat symptoms				
Via pharmacy benefit	1,086	1,152	66	6.08%
Count of units/events				
Disease-modifying treatments for Alzheimer's dementia				
Via medical benefit	793	908	115	14.50%
Via pharmacy benefit	34	124	90	264.71%
Services related to disease-modifying treatments				
MRI of brain	354	444	90	25.42%
PET scan of brain	92	116	24	26.09%
Complication events	21	26	5	23.81%
Medication to treat symptoms				
Via pharmacy benefit	5,672	6,011	339	5.98%

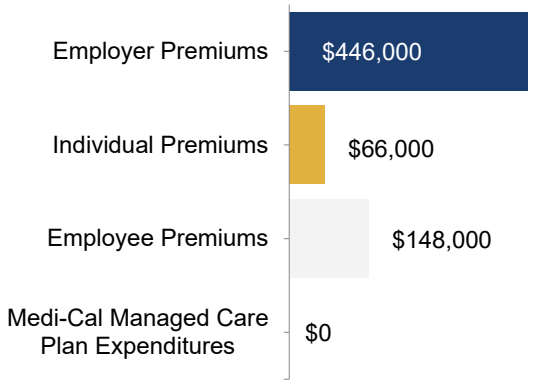
	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Average cost per unit				
Disease-modifying treatments for Alzheimer's dementia	$1,338	$1,370	$31.19	2.33%
MRI of brain	$2,434	$2,434	$0.00	0.00%
PET scan of brain	$5,866	$5,866	$0.00	0.00%
Complication events	$2,434	$2,434	$0.00	0.00%
Medication to treat symptoms	$25	$30	$4.59	18.10%
Average cost sharing per unit				
Disease-modifying treatments for Alzheimer's dementia	$149	$147	−$2.62	−1.76%
MRI of brain	$568	$568	$0.00	0.00%
PET Scan of brain	$1,597	$1,597	$0.00	0.00%
Complication events	$568	$568	$0.00	0.00%
Medication to treat symptoms	$8	$9	$0.42	5.02%

Source: California Health Benefits Review Program, 2026.
Key: MRI = magnetic resonance imaging; PET = positron emission tomography.

Expenditures and Premium Impacts

Policies affecting health insurance benefits, such as benefit coverage mandates, impact stakeholders in distinct ways. In terms of direct costs, these stakeholders can generally be grouped into two categories: (1) enrollees who utilize the benefit,[23] and (2) those who pay for the benefit but do not utilize it. Enrollees who use a benefit may be responsible for paying premiums and any out-of-pocket expenses related to the benefit. All enrollees within a risk pool share in these costs through the benefit's impact on plan premiums.

Figure 5. Expenditure Impacts of SB 950 on Employers and Enrollees



Premium Impacts on Employers and All Enrollees

As shown in Figure 2, for DMHC-regulated plans and CDI-regulated policies, SB 950 would increase total premiums paid by employers and enrollees for newly covered benefits by approximately $660,000 (0.0004%). For more details, see Table 9 in the Appendix. Premiums calculated include premiums for those enrollees using the benefit in addition to those not using the benefit. No measurable offsets are projected, although side effects and additional services needed to maintain disease-modifying medications will add to the overall cost of SB 950. Changes in premiums as a result of SB 950 would vary by market segment (Table 4; see also Table 8 and Table 9 in the Appendix).

[23]Depending on their health insurance and the benefit in question, enrollees may or may not also pay for the benefit. For example, most Medi-Cal beneficiaries do not have cost sharing and do not pay health insurance premiums, whereas enrollees with health insurance a plan in the individual market may pay both insurance premiums and cost sharing or other out-of-pocket expenses.

Table 4. Premium Impact Ranges of SB 950 by Market Segment

Market Segment	Premium Impact Range (PMPM)
Commercial plans/policies	$0.0000–$0.0031
Covered California – individually purchased	$0.0000–$0.0001
CalPERS	$0.0000
Medi-Cal	N/A

Source: California Health Benefits Review Program, 2026.
Key: CalPERS = California Public Employees' Retirement System; PMPM = per member per month.

Below, Table 5 provides estimates of the aggregate impacts of SB 950 on premiums.

Table 5. Impacts of SB 950 on Premiums, 2027

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Non-enrollee premiums				
Employer-sponsored (a)	$75,730,916,000	$75,731,359,000	$443,000	0.0006%
CalPERS employer (b)	$8,611,855,000	$8,611,858,000	$3,000	0.0000%
Medi-Cal (c)	$42,982,384,000	$42,982,384,000	$0	0.0000%
Enrollee premiums				
Enrollees, individually purchased insurance	$25,775,325,000	$25,775,391,000	$66,000	0.0003%
Outside Covered California	$9,551,761,000	$9,551,805,000	$44,000	0.0005%
Through Covered California	$16,223,564,000	$16,223,586,000	$22,000	0.0001%
Enrollees, group insurance (d)	$21,828,135,000	$21,828,283,000	$148,000	0.0007%
Total premiums	$174,928,615,000	$174,929,275,000	$660,000	0.0004%

Source: California Health Benefits Review Program, 2026.
Notes: (a) In some cases, a union or other organization. Excludes CalPERS.
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.7% are state retirees, state employees, or their dependents. About one in five of these enrollees has a pharmacy benefit not subject to DMHC.[24] CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).
(c) Includes Medi-Cal beneficiaries enrolled in DMHC-regulated plans and COHS managed care. CHBRP assumes the premiums for Medi-Cal beneficiaries in COHS managed care are comparable to those for Medi-Cal beneficiaries in DMHC-regulated plans.
(d) Enrollee premium expenditures include contributions by enrollees to employer (or union or other organization)-sponsored health insurance, health insurance purchased through Covered California, and any contributions to enrollment through Medi-Cal to a DMHC-regulated plan.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

[24] For more detail, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance*.

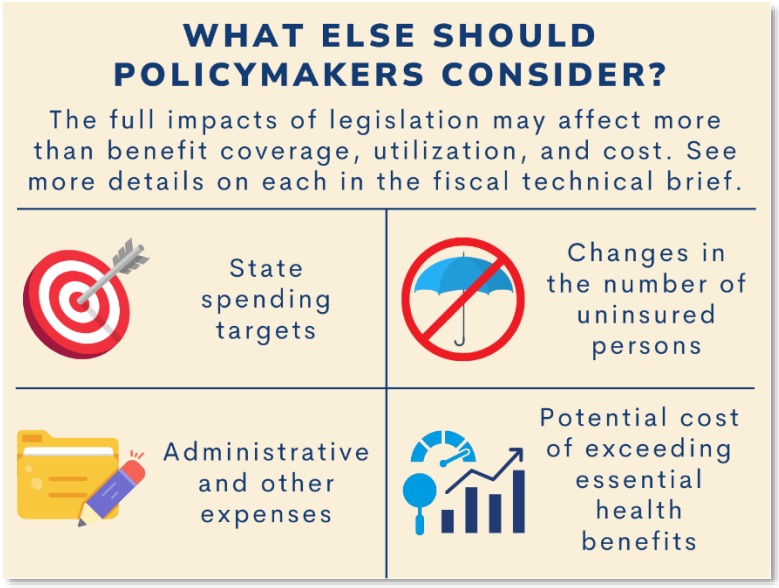
Enrollee Expenses for Benefit Users

SB 950 would impact expenses for those using the benefit by increasing cost sharing by a total of $124,000 across all users (Table 9). The average cost sharing increase for enrollees newly utilizing treatments for Alzheimer's disease and related services would increase by between $1,310 and $1,990 annually (Table 6). These changes would vary by market segment. There would be no impact of SB 950 on average enrollee out-of-pocket expenses for those enrollees not utilizing the benefit (Table 7).

It is possible that some enrollees incurred expenses related to treatments for Alzheimer's disease for which coverage was denied, but CHBRP cannot estimate the frequency with which such situations occur and so cannot offer a calculation of impact.

The presence of a deductible not yet met for the year[25] could result in the enrollee paying the full unit cost; but hitting the annual out-of-pocket maximum[26] would result in the enrollee having no further cost sharing.

See more information in the Technical Brief on SB 950, including what else policymakers should consider such as state spending targets, impacts to the number of uninsured in California, how lack of benefit coverage shifts costs to other payers, changes in public program enrollment, and administrative and other expenses.



[25] For estimates of enrollees in plans and policies with deductibles, see CHBRP's resource *Deductibles in State-Regulated Health Insurance*.
[26] For most enrollees in most plans and policies regulated by DMHC or CDI, applicable copays and coinsurance for prescription medications is limited to $250, or $500 for enrollees in the "bronze plans" available from Covered California, the state's ACA marketplace (HSC 1342.73; INS 10123.1932). Cost sharing could be higher for an enrollee in a plan or policy that includes a deductible.

Table 6. Impact of SB 950 on Average Annual User Expenses, 2027

	Large Group	Small Group	Individual	CalPERS	Medi-Cal
Users with baseline benefit coverage					
% of Population with enrollee expenses impact due to SB950	0.0088%	0.0074%	0.0072%	0.0124%	N/A
Avg. annual enrollee expenses impact for users*	$0.00	$0.00	$0.00	$0.00	N/A
Users with new coverage					
% of Population with enrollee expenses impact due to SB950	0.0005%	0.0020%	0.0003%	Not measurable	N/A
Avg. annual enrollee expenses and premium impact for users*	$1,390	$1,310	$1,990	Not measurable	N/A

Source: California Health Benefits Review Program, 2026.
Notes: * Average enrollee expenses includes cost sharing (e.g., deductibles, copays, etc.) for covered benefits and premiums. Average annual enrollee premium impact includes the employee portion of the premium only.

Table 7. Impact of SB 950 on Average Annual Non-User Enrollee Expenses, 2027

	Large Group	Small Group	Individual	CalPERS	Medi-Cal
% of Population without enrollee expenses impact due to SB950	99.99%	99.99%	99.99%	99.99%	N/A
Avg. annual enrollee premium impact for non-users	$0.04	$0.13	$0.03	$0.00	N/A

Source: California Health Benefits Review Program, 2026.
Notes: Average annual enrollee premium impact includes the employee portion of the premium only.

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SB 950 Impacts: Public Health

The public health impact analysis includes estimated impacts in the short term (within 12 months of full implementation) and in the long term (beyond the first 12 months following full implementation). This section estimates the short-term impact[27] of SB 950 on health outcomes, potential treatment harms, and potential disparities. See the *Long-Term Impacts* section for discussion of premature death, economic loss, and social determinants of health.

Estimated Public Health Outcomes

As presented in the *Overview* section, there are two pharmacologic classes of medications to treat symptoms of Alzheimer's disease: cholinesterase inhibitors and NMDA receptor antagonists. Combination therapy with the two classes is also available. **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 relative to placebo but do not improve functional ability. Evidence for neuropsychiatric/behavioral symptoms is conflicting. 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.

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, with statistically significant findings reported in most RCTs. However, effect sizes were generally modest, and most findings did not meet thresholds for clinical meaningfulness. Evidence from extension studies suggests that these effects may be maintained for up to three years, although statistical significance was often not reported. Disease-modifying medications were also associated with an increased risk of harms, particularly ARIA-E and ARIA-H, which are typically asymptomatic but can be serious in rare cases. Mortality rates were not increased compared to placebo. Although amyloid reduction was robust, evidence linking amyloid reduction to improved clinical outcomes was limited. Analyses across monoclonal antibody trials suggest small, statistically significant associations that do not meet thresholds for clinical meaningfulness, and post-hoc analyses of individual donanemab trials report correlations but do not establish causality.

As presented in the *Benefit Coverage and Cost Impacts* section, an estimated 23 additional patients with Alzheimer's disease will receive disease-modifying medications, and an additional 66 patients would receive medications to treat symptoms postmandate. Patients who pursue disease-modifying medications may incur out-of-pocket costs, including cost-sharing for the treatment itself ($147 per treatment), repeated MRIs ($568 each), and travel to a treating provider. It is also possible that patients may require a PET scan of the brain, which could cost the patient $1,597 in cost sharing for each scan. While disease-modifying medications do not substantially alter the course of disease over the long term, it may slow the rate of progression to severe disease, which could provide a higher quality of life and valuable time for the patient and reduced caregiver burden for a slightly longer period than if the patient did not receive the disease-modifying medication (Tysinger et al., 2025).

Despite evidence that medications to treat symptoms and disease-modifying medications for Alzheimer's disease are medically effective, CHBRP projects no measurable public health impact at the population level due to the small estimated increase in utilization and the small population of patients with mild symptoms of early-onset Alzheimer's disease who would be both in the population covered by the bill and eligible for the disease-modifying medications. However, at the

[27] CHBRP defines short-term impacts as changes occurring within 12 months of full implementation of an enacted law.

person-level, enrollees who meet criteria for disease-modifying medications, are able to access these medications from a treating provider, and who can afford cost-sharing payments for medications and related services, may experience a reduced rate of decline for cognitive and functional symptoms. SB 950 would likely yield some health and quality-of-life improvements, such as slightly slowed worsening of cognitive function, functional ability, global assessment, and reduced neuropsychiatric and behavioral symptoms among the additional 23 enrollees who would newly use disease-modifying medications and 66 enrollees who would newly use the medications to treat symptoms.

Potential Harms From SB 950

When data are available, CHBRP estimates the marginal change in relevant harms associated with interventions affected by the proposed mandate. In the case of SB 950, there is some evidence to suggest that an increase in the use of disease-modifying medications could result in harm. Potential harms associated with the use of these medications include ARIA-E, ARIA-H, and infusion-related reactions. Patients with two copies of the APOE4 gene and who use disease-modifying medications have a higher risk of developing ARIA (U.S. Food and Drug Administration, 2023, 2024). See more information in the *Medical Effectiveness* section of the Technical Brief on SB 950 Dementia.

Impact on Disparities[28]

Disparities and differences in Alzheimer's disease exist by race, ethnicity, age, sex, geography, and education. More information on disparities in Alzheimer's disease can be found in the *Background* section in the Technical Brief on SB 950. Within the first 12 months postmandate, CHBRP estimates SB 950 would not change these disparities.

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[28] For details about CHBRP's methodological approach to analyzing disparities, see the *Benefit Mandate Structure and Unequal Racial/Ethnic Health Impacts* document.

SB 950 Impacts: Long-Term

In this section, CHBRP estimates the long-term impact of SB 950, which CHBRP defines as impacts occurring beyond the first 12 months after legislation is fully implemented.[29] These estimates are qualitative and based on the existing evidence available in the literature. CHBRP does not provide quantitative estimates of long-term impacts because of unknown improvements in clinical care, changes in prices, implementation of other complementary or conflicting policies, and other unexpected factors.

Long-Term Utilization and Cost Impacts

Utilization Impacts

Over time, provider and population awareness of disease-modifying medications and medications to treatment symptoms are likely to improve and utilization of the services is expected to increase as a greater proportion of the eligible population access the newly covered services postmandate. New use of disease-modifying medications will result in increased use of initial screening, monitoring, and ongoing measurement of amyloid plaque, resulting in at least one PET scan per year for new and existing patients. In addition, new, subcutaneous versions of the disease-modifying treatments will likely become available for initial and subsequent doses, reducing reliance on infusion centers for disease-modifying treatments. However, if the subcutaneous medications have similar side effects (e.g., ARIA-H, ARIA-E, etc.) to current infusion-based treatments, the same barriers in terms of risk, availability of prescribing specialists, and follow-up care (such as additional MRI) could slow increases in demand.

Cost Impacts

The long-term cost implications of SB 950 could be substantial as new drugs come to market. Because SB 950 requires coverage of all Alzheimer's-related drugs, new branded drugs that come to market would be covered. However, because health plans and insurance policies can still use prior authorization requirements that require imaging and could act as a barrier to use, cost increases might be mitigated by strict prior authorization requirements despite the ban on step therapy.

Long-Term Public Health Impacts

Some interventions in proposed mandates provide immediate measurable impacts (e.g., maternity service coverage or acute care treatments), whereas other interventions may take years to make a measurable impact (e.g., coverage for tobacco cessation or vaccinations). When possible, CHBRP estimates the long-term effects (beyond 12 months postmandate) to the public's health that would be attributable to the mandate, including impacts disparities, premature death, and economic loss.

As disease-modifying treatments slow the rate of symptom progression, the long-term public health impacts would likely be the same as the short-term health impacts, but for a larger population as public familiarity with the medication grows and if the medications become easier for patients to access.

Impacts on Disparities

In the case of SB 950, evidence shows that although disparities and differences in diagnosis and treatment use exist, CHBRP projects no changes in these disparities that would be attributable to SB 950 due to a combination of low disease prevalence and treatment access in the population subject to SB 950 and other barriers to treatment use. If disease-

[29] Full-scale implementation typically requires a "ramp up" period which may include educating enrollees, providers and insurance carriers on the new benefits or coverage, updating procedures and policies, and increasing provider capacity for marginal utilization resulting from SB 950. Furthermore, some policies may have staggered implementation or longer-term changes in utilization. The short-term, incremental impact estimated by CHBRP assumes there is no "ramp up" period and represent ongoing annual costs at full-scale implementation of SB 950, including potential short-term offsets. CHBRP further assumes that state and industry policies and provider and patient behaviors would remain constant throughout the time period it takes for the full impact of the bill to be realized.

modifying medications become available as subcutaneous, self-administered medications without requiring infusion-centered based infusions first, it is possible that geographic disparities could be reduced.

Impacts on Premature Death and Economic Loss

Premature death

Premature death, measured by years of potential life lost (YPLL), is often defined as death occurring before the age of 75 years (NCI, 2019).[30]

As stated in *Overview* section, disease-modifying medications can reduce the rate of decline for cognitive and functional ability symptoms, however they do not alter the long-term course of the disease. Thus, SB 950 is not expected to have an impact on premature death and economic loss.

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[30] For more information about CHBRP's public health methodology, see CHBRP's Public Health Impact Analysis and Research Approach.

Appendix. Impacts of SB 950 on Expenditures, 2027

Table 8. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2027

	DMHC-Regulated						CDI-Regulated			Total
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (Excludes COHS) (c)*		*Large Group*	*Small Group*	*Individual*	
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,929,000	2,097,000	2,444,000	931,000	8,078,000	965,000	315,000	42,000	41,000	22,842,000
Total enrollees in plans/policies subject to SB 950	7,929,000	2,097,000	2,444,000	931,000	0	0	315,000	42,000	41,000	13,799,000
Premiums										
Average portion of premium paid by employer (e)	$619.33	$539.05	$0.00	$770.84	$367.89	$632.17	$780.34	$573.31	$0.00	$127,325,155,000
Average portion of premium paid by enrollee	$134.02	$263.52	$864.90	$145.41	$0.00	$0.00	$184.88	$242.16	$832.16	$47,603,460,000
Total premium	**$753.35**	**$802.56**	**$864.90**	**$916.25**	**$367.89**	**$632.17**	**$965.22**	**$815.47**	**$832.16**	**$174,928,616,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	$56.38	$184.07	$271.63	$70.59	$0.00	$0.00	$126.72	$213.52	$192.93	$19,432,815,000
Expenses for noncovered benefits (f)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0
Total expenditures	**$809.72**	**$986.63**	**$1,136.53**	**$986.84**	**$367.89**	**$632.17**	**$1,091.94**	**$1,029.00**	**$1,025.09**	**$194,361,431,000**

Source: California Health Benefits Review Program, 2026.
Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.7% are state retirees, state employees, or their dependents. About one in five of these enrollees has a pharmacy benefit not subject to DMHC.[31] CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).
(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.
(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[32]
(e) In some cases, a union or other organization, or Medi-Cal for its beneficiaries.
(f) Includes only those expenses that are paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

[31] For more detail, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance.*
[32] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.

Table 9. Postmandate Change in Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2027

	DMHC-Regulated						CDI-Regulated			Total
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (c)*		*Large Group*	*Small Group*	*Individual*	
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,929,000	2,097,000	2,444,000	931,000	8,078,000	965,000	315,000	42,000	41,000	22,842,000
Total enrollees in plans/policies subject to SB 950	7,929,000	2,097,000	2,444,000	931,000	0	0	315,000	42,000	41,000	13,799,000
Premiums										
Average portion of premium paid by employer (e)	$0.0021	$0.0070	$0.0000	$0.0003	$0.0000	$0.0000	$0.0150	$0.0184	$0.0000	$447,000
Average portion of premium paid by enrollee	$0.0005	$0.0034	$0.0022	$0.0001	$0.0000	$0.0000	$0.0035	$0.0078	$0.0003	$214,000
Total premium	$0.0026	$0.0105	$0.0022	$0.0003	$0.0000	$0.0000	$0.0185	$0.0261	$0.0003	**$660,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	$0.0004	$0.0021	$0.0004	$0.0001	$0.0000	$0.0000	$0.0037	$0.0055	$0.0001	$124,000
Expenses for noncovered benefits (f)	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0
Total expenditures	$0.0030	$0.0125	$0.0027	$0.0004	$0.0000	$0.0000	$0.0222	$0.0316	$0.0004	**$785,000**
Percent change										
Premiums	0.0003%	0.0013%	0.0003%	0.0000%	0.0000%	0.0000%	0.0019%	0.0032%	0.0000%	0.0004%
Total expenditures	0.0004%	0.0013%	0.0002%	0.0000%	0.0000%	0.0000%	0.0020%	0.0031%	0.0000%	0.0004%

Source: California Health Benefits Review Program, 2026.
Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.6% are state retirees, state employees, or their dependents. About one in five of these enrollees has a pharmacy benefit not subject to DMHC.[33] CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).
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(e) In some cases, a union or other organization, or Medi-Cal for its beneficiaries.
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[33] For more detail, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance*.
[34] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.

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CHBRP is an independent program administered and housed by the University of California, Berkeley, under the Office of the Vice Chancellor for Research. A group of faculty, researchers, and staff complete the analysis that informs CHBRP reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** works with Task Force members in preparing parts of the analysis, and manages external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with an independent actuarial firm, **Milliman, Inc.**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. Information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at chbrp.org.

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CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at chbrp.org.

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About CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. CHBRP's mission is to inform and support policymaking in California through the creation of impartial, evidence-based resources. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. CHBRP is dedicated to providing academic rigor on a Legislature's timeline.

The state funds CHBRP through an annual assessment on health plans and insurers in California.

An analytic staff based at the University of California, Berkeley, supports a task force of faculty and research staff from multiple University of California campuses to complete each CHBRP analysis. A strict conflict-of-interest policy ensures that the analyses are undertaken without bias. An independent actuarial firm helps to estimate the financial impact. Content experts with comprehensive subject-matter expertise are consulted to provide essential background and input on the analytic approach for each report.

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This analysis is based on existing literature and public sources identified through systematic search methods. This evidence informs the California Legislature about potential impacts of proposed health benefit legislation and does not constitute a policy recommendation from CHBRP.

Public health impacts are estimated using literature review data and fiscal projections.

For more information about CHBRP's methods and approach, please visit our website.

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