Date of Hearing: May 13, 2026

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
AB 2000 (Aguiar-Curry) – As Amended April 16, 2026

Policy Committee: Health Vote: 16 - 0

Urgency: No State Mandated Local Program: Yes Reimbursable: No

SUMMARY:

This bill prohibits a health plan or health insurer (collectively, health plan) that provides prescription drug benefits and maintains a drug formulary from making changes to a formulary during a plan or policy year, except as specified.

Specifically, this bill:

1) Prohibits a health plan from making changes to a formulary during a plan year, including removing a drug from a formulary, moving a drug to a higher cost tier, or imposing new utilization management requirements on a drug.

2) Provides exemptions to item (1), above, for any of the following reasons:

    a) To replace a covered drug on the formulary with another drug in the same drug class. Requires the enrollee's cost sharing for the newly covered drug during the plan year to be the same as or lower than the cost-sharing amount for the previously covered drug.

    b) To replace a covered brand name drug on the formulary with a generic of the same drug or drug class; in which case the enrollee's cost sharing for the newly covered drug during the plan year must be lower than the cost-sharing amount for the previously covered drug.

    c) To add a biosimilar or interchangeable biologic product that is the same or similar to a previously covered drug or reference product if the net cost to the plan and the amount of the enrollee's cost sharing is the same as or lower than the net cost to the plan and the cost-sharing amount for the previously covered drug or reference product.

    d) To add an additional drug.

    e) To remove a drug due to safety concerns from the U.S. Food and Drug Administration.

    f) To move a specified drug to a lower formulary tier or otherwise modify its formulary placement in a manner that reduces enrollee cost sharing.

    g) To remove utilization management or prior authorization requirements for a covered drug.

3) Requires a health plan to allow an enrollee to remain on a drug for the rest of the plan year if the health plan implements a formulary change requiring an enrollee to change to a different drug in the same drug class, if specified conditions are met.

4) Requires a health plan, insurer, or their pharmacy benefit manager (PBM) to report any changes made to a formulary during a plan year to the Department of Managed Health Care (DMHC) or California Department of Insurance (CDI) within 30 days of making the change.

5) Requires a health plan or insurer to authorize appeals for coverage denials based on formulary changes through its existing internal and external appeals processes.

6) Allows DMHC and CDI to impose an administrative penalty for a violation of $500 to $5,000 per 1,000 enrollees.

7) Requires, beginning January 1, 2030, and every five years thereafter, the penalty amounts to be adjusted according to specified parameters.

8) Requires penalties levied under this bill to be paid by the plan and not by the provider, subscriber, or enrollee.

9) Allows DMHC and CDI to conduct audits that relate to this bill and are not based on an enrollee's complaint.

10) Requires DMHC and CDI to each use existing data and to collect data from health plans to prepare a report on authorizations for providers to prescribe medically necessary non-formulary prescription drugs, as specified, and annually publish the report on its website and submit that report to the Legislature.

FISCAL EFFECT:

1) DMHC anticipates ongoing costs of up to $6.5 million, based on an increase in consumer complaints to DMHC's Help Center, and protracted litigation due to the penalty structure of this bill (Managed Care Fund).

2) CDI estimates costs of $10,000 in fiscal year (FY) 2026-27, $22,000 in FY 2027-28, and $19,000 in FY 2028-29 and ongoing (Insurance Fund).

3) The California Public Employees Retirement System (CalPERS) estimates costs in the range of $0 to $7.7 million a year (General Fund). CalPERS explains that the range of cost from year to year depends on when cost-effective biosimilars or generics enter the market, particularly if there are alternatives to reference products with high costs and utilization amongst CalPERS members. This bill allows the addition of biosimilar or generic drugs but does not allow replacement of a reference product if the reference product is more costly, which means CalPERS would need to cover the reference product for the remainder of the year.

The Legislative Analyst's Office recently warned of General Fund structural deficits of around $35 billion per year in the 2027-28 fiscal year and ongoing.

COMMENTS:

1) **Purpose.** This bill is sponsored by California Academy of Family Physicians and the Crohn's and Colitis Foundation. According to the author:

    > [This bill] prohibits health plans and PBMs from changing prescription drug coverage midyear, protecting patients from unexpected costs and treatment disruptions. It ensures Californians may continue needed medications, especially for chronic or serious conditions, without interruption. The bill also brings greater clarity and predictability to coverage, helping patients plan and budget for care. By safeguarding access to essential medications, [this bill] supports continuity of treatment, reduces administrative burdens on providers, and strengthens patient protections.

2) **Background.** A formulary is a list of drugs a health plan or PBM has approved for coverage. Formularies are a tool used by plans to adapt to the evolving landscape of pharmacy products. With the rise of high-cost and specialty drugs, formulary management can be leveraged as a strategy to manage costs for the plan and enrollee while optimizing enrollee access to a range of prescription drugs.

    Prescription drug costs have increased more rapidly than overall medical expenses and health plan premiums. In California, total prescription drug costs increased by 9.5% in 2024, whereas total medical expenses increased by 6.9% and health plan premiums increased by 8% from 2023 to 2024. Specialty drugs and brand name drugs are primary drivers of the increase in total prescription drug-cost spending. Brand name drugs account for only 9.4% of all prescriptions dispensed but accounted for 25.2% of total annual spending on prescription drugs. In contrast, generic drugs accounted for 88.8% of all prescriptions but only 11.8% of the total annual spending on prescription drugs. According to DMHC, health plans paid almost $1.3 billion more on prescription drugs in 2024 than in 2023. Since 2017, total prescription drug costs paid by health plans increased by $6.2 billion or 72%.

    While enrollees choose a plan for the plan year, changes in what is covered, new prescription drugs and approved uses, and more can happen at any time of the year. Health plans and PBMs negotiate their drug contracts and formularies throughout the year, not only at the beginning of the plan year. Although some formulary changes may be disruptive for patients and providers, many of these result from a more affordable drug becoming available, a different use for a drug, or a new generic or biosimilar coming to market. To allow plans to maintain formulary flexibility while ensuring patient continuity of care, existing law prohibits health plans from limiting or excluding coverage for a drug for an enrollee if the drug previously had been approved for coverage by the plan for their medical condition. Existing law also requires health plans to maintain a process for providers to request authorization to prescribe a medically necessary prescription drug that isn't on their formulary.

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