Date of Hearing: August 5, 2026

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
SB 1094 (Weber Pierson) – As Amended July 2, 2026

Policy Committee:	Business and Professions	Vote:	19 - 0
	Health		14 - 0

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

SUMMARY:

This bill allows a health care service plan or health insurer to require, under certain conditions, an enrollee to try a biosimilar or interchangeable biological product of a reference biologic product. The bill also allows a pharmacist to dispense a biosimilar product in place of a reference biologic product.

More specifically, this bill:

1) Allows a health plan, health insurer, or utilization review organization (collectively, health plan) to require an enrollee to try a biosimilar or interchangeable biological product of a reference product that the plan had previously approved if all the following conditions are met:

   a) The prescriber has not indicated "Do not substitute" or similar words.

   b) The plan has provided at least 60 days' advance notice to the enrollee and prescribing provider of a formulary change prior to requiring an enrollee to try an alternative, as specified, and the plan's advance notice to a prescribing provider identifies the prescriber's affected plan enrollees and provides other specified information, including how to request an exception.

   c) The net cost to the plan is lower than the brand name drug or reference product.

   d) The enrollee's cost sharing is based on the net cost of the drug or biologic product.

   e) The enrollee's cost sharing is the same as or less than the cost sharing of the brand name drug or reference product.

   f) The prescribing provider is not required to seek new prior authorization for the alternative biosimilar or interchangeable biological product if prior authorization was approved for the original product.

2) Provides that an enrollee subject to the above biosimilar or interchangeable substitution, or their prescribing provider, may request an exception.

3) Requires a health plan include in an existing report to the Department of Managed Health Care (DMHC) or the Department of Insurance (CDI) specified information related to the

effect of above biosimilar or interchangeable substitutions.

4) Requires a health plan notify prescribing providers of biosimilar and interchangeable biological products that are included on the plan formulary that a pharmacist may dispense a biosimilar or interchangeable biological product unless the prescriber indicates "Do not substitute" and identify the prescribing provider's enrollees whose prescriptions may be subject to such a substitution.

5) Prohibits a health plan, pharmacy benefit manager, or affiliated entity from requiring utilization of only a biosimilar product in which they have a financial interest if other biosimilar products may be available.

6) Allows a pharmacist to dispense a biosimilar product in place of a reference biological product if the prescribing provider has not indicated "Do not substitute" on the prescription.

7) Prohibits a health insurance policy that covers prescription drug benefits from limiting or excluding coverage for a drug that was previously approved for coverage if an insured continues to be prescribed that drug.

8) Provides that its provisions are severable.

FISCAL EFFECT:

The California Health Benefits Review Program (CHBRP) estimates savings of $1.5 million to the Medi-Cal program (General Fund, federal funds).

CHBRP estimates costs savings of $4.1 million in reduced premiums for DMHC-regulated health plans offered through the California Public Employees Retirement System (CalPERS). About one-half of CalPERS members are associated with state employment, and a portion of premiums are paid by members, so the state's share of the savings would be around $1.7 million (General Fund). In addition, there would be smaller cost reductions in CDI-regulated insurance policies offered through CalPERS.

Minor and absorbable costs to the Board of Pharmacy, CDI, and DMHC.

CHBRP estimates $87.7 million (0.05%) in reduced premiums paid by all payors, including employers, enrollees, and government.

COMMENTS:

1) **Purpose.** This bill is sponsored by the California Association of Health Plans. According to the author:

> [Although biological products make up] only 5% of prescriptions, they account for about half of all drug spending. Expanding the use of lower-cost alternatives, like generics and biosimilars, could help reduce pharmaceutical spending and lower insurance premiums. Despite no clinically meaningful differences in safety, purity, or potency, biosimilars are often significantly cheaper than their reference biologic. Furthermore, competition between biosimilars and

brand-name biologics helps drive prices down overall. Despite their potential savings, biosimilars remain underused. This bill encourages the use of lower cost biosimilars when available.

2) **Background.** DMHC reports that prescription drug costs paid by California health plans have increased by 72%, or $6.2 billion, since 2017. One of the primary drivers of these increases is the rising cost of specialty drugs, which in 2024 accounted for 63% of prescription drug spending but make up less than 2% of the total number of drugs dispensed in the state. Biological (large-molecule) drugs are a significant driver of prescription drug costs in the U.S., accounting for over half of U.S. drug spending in 2024 despite comprising 5% of prescriptions.

   Biological drugs are complex products derived from living organisms like yeast, bacteria, or animal cells. California allows pharmacists to substitute lower-cost generic small-molecule drugs that are deemed therapeutically equivalent by the U.S. Food and Drug Administration (FDA) and interchangeable biologics.

   A biosimilar is very similar to an already approved biological reference product. An interchangeable biological product is a biosimilar that meets additional FDA criteria such as lack of substantial immunologic adverse reactions or no changes in therapeutic effect from repeated switching. FDA has approved over 90 biosimilar products, of which 41 have been approved as interchangeable biological products. This bill expands a statute allowing pharmacists to substitute interchangeable biologics to include biosimilar products.

   CHBRP found that biosimilars match the reference product's safety profile in clinical trials and real-world use, including post switching, and experience with biosimilars over the last 15 years has confirmed that switching between reference products and biosimilars should not present significant changes in safety or effectiveness. However, CHBRP notes prescribers and patients are still hesitant to accept biosimilars because of misinformation about the differences between biosimilars and interchangeable biological products and reference products and concerns about disrupting stable treatment regimens, among other barriers.

3) **Opposition**. The California Chronic Care Coalition (CCCC) opposes this bill, stating that when a patient is moved off a stable therapy based on cost, formulary preference, or administrative convenience rather than clinical judgment, the consequences can be dangerous. CCCC contends that even when a replacement product is safe and effective for many patients, a forced switch can create delays in care, complications in monitoring, and uncertainty for patients whose conditions require consistency and close physician supervision. CCCC argues that patients enroll in coverage, pay premiums, satisfy deductibles, and rely on plan approval decisions with the understanding that a treatment that has been approved and is working will remain available absent a true clinical reason to change course. CCCC argues that when state law allows a plan to approve a drug on paper but later redirect the patient to a different product for non-clinical reasons, the practical value of that coverage promise is diminished. CCCC continues that prescribers are in the best position to evaluate whether a patient can safely transition from one product to another and that state policy that makes substitution easier outside that clinical relationship reduces transparency and weakens accountability when problems arise.

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