A REPORT TO THE 2025–2026 CALIFORNIA LEGISLATURE

Bill Analysis Report: California Senate Bill 1094 Prescription Drugs

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

chbrp.org

KEY FINDINGS

Analysis of California Senate Bill 1094 Prescription Drugs

Summary to the 2025-2026 California State Legislature, April 4, 2026

CHBRP

Summary

The version of California Senate Bill (SB) 1094 analyzed by California Health Benefits Review Program (CHBRP) would expand the practice of nonmedical switching — the substitution of prescription drugs by nonprescribers to increase cost savings — for patients who have been approved for coverage of a prescription drug. Specifically, for patients with ***existing approved*** coverage, the bill would allow (1) pharmacists to switch patients from reference biologics to biosimilars, and (2) health plans, insurers, and utilization review organizations to switch patients from brand-name drugs to AB-rated generic drugs, and from reference biologics to biosimilars or interchangeable biological products, unless the prescriber prohibits substitution in the order. The bill allows for patients to remain on their current medication by requesting an exception to any nonmedical switches.

In 2027, all of the 22.8 million Californians enrolled in state-regulated health insurance would have insurance subject to SB 1094. The bill would not change benefit coverage for prescription drugs or exceed essential health benefits.

Background

Most pharmaceutical products can be broadly categorized as either small-molecule drugs, which are made from chemicals, or biological (large-molecule) drugs, which are complex products derived from living organisms. Biosimilars are biologics that are highly similar to a biologic that has been approved by the U.S. Food and Drug Administration (FDA). Interchangeable biological products are biosimilars that meet additional FDA criteria.

California permits pharmacists to substitute lower-cost generic small-molecule drugs provided they are "AB-rated" — deemed therapeutically equivalent by the FDA. They may also substitute interchangeable biological products for brand-name biologics (reference products). For patients on established treatments, the decision whether and when to make a substitution of a less expensive biosimilar has been one that requires coordination between the patient and/or caregiver, the physician, and the dispensing pharmacist.

Medical Effectiveness

The FDA has determined that there are no clinically significant safety concerns for switching between reference products and biosimilars. In addition, CHBRP found *very strong evidence*[1] that approved biosimilars do not introduce new or greater harms than their reference product. Biosimilars match the reference product's safety profile in clinical trials and real-world use, including post switching.

Cost Impacts

Postmandate, CHBRP estimates SB 1094 would result in approximately 27,400 enrollees being switched from a brand-name reference product to a lower-cost biosimilar, and a $87.7 million **reduction** in total annual premiums paid by employers and enrollees. Enrollee cost sharing and premiums for enrollees switched from a reference product would **decrease** between $92 and $310 per year depending on market segment.

Public Health Impacts

SB 1094 would have no short-term public health impact because the evidence suggests that the switching of patients to biosimilar prescription drugs does not negatively impact health outcomes. For this reason, CHBRP concludes that SB 1094 would also have no impact on disparities in health outcomes by gender, race/ethnicity, age, or other determinants. Despite no change in health status, there could be decreased financial burden on enrollees due to a decrease in out-of-pocket costs of prescription drugs.

Long-Term Impacts

Increased competition among biosimilar manufacturers may lead to a reduction in net prices for prescription drugs and substitution of lower-cost drugs may become the norm. This could lead to a decrease in prescription drug spending over the long-term and may help alleviate the financial burden on enrollees, especially those with chronic conditions treated with high-cost biologics.

[1] *Very strong evidence* indicates that there are multiple studies of a treatment, and the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective. Conclusions are unlikely to be altered by additional evidence.

Table of Contents

Lists of Tables and Figures

Acronyms and Terminology

Acronyms

AB – Assembly Bill

ACA – Affordable Care Act

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

EHB – essential health benefits

FDA – U.S. Food and Drug Administration

PBM – pharmacy benefit manager

SB – Senate Bill

URO – utilization review organization

Terminology

CHBRP uses the following terminology for this analysis:

Small-molecule drugs: Chemicals with relatively simple, well-defined structures that can be copied, small-molecule drugs are typically first introduced as **brand-name products** protected by patents and regulatory exclusivity.

AB-rated generic drug: As defined in SB 1094 and federal law,[2] refers to a group of small-molecule drugs that have met specific U.S. Food and Drug Administration (FDA) requirements as both a pharmaceutical and therapeutic equivalent to the brand-name drug product (also called a **reference drug**).

Biological product: As defined in SB 1094 and federal law,[3] refers to a group of pharmaceutical products derived or developed from living organisms like yeast, bacteria, or animal cells.

Reference product: Refers to a brand-name biologic.

Biosimilar: Refers to a biological product that is highly similar to a reference product, with minor differences in inactive components, and no clinically meaningful differences in safety, purity, and potency of the product.

Interchangeable biological product: A biosimilar that has met additional standards set by the FDA so that it may be substituted for a reference product without the intervention of the health care provider who prescribed the reference product.

Prescription: As defined in SB 1094, this term, with respect to a biological product, means a prescription for a product that is subject to Section 503(b) of the Federal Food, Drug, and Cosmetic Act,[4] and may only be dispensed via a licensed practitioner's written order, a recorded oral order, or an authorized refill.

[2] 42 U.S. Code 262(i)(1).
[3] 42 U.S. Code 262(i)(1).
[4] 21 U.S. Code 353(b).

Overview: SB 1094 and Prescription Drugs

On February 13, 2026, the California Senate Committee on Health requested that the California Health Benefits Review Program (CHBRP)[5] conduct an evidence-based assessment of the medical, financial, and public health impacts of Senate Bill (SB) 1094, Prescription drugs, as introduced on February 13, 2026. The bill was then amended on April 8, 2026. CHBRP has adjusted its analysis to accommodate the amendments as much as possible, given the time constraints.

Bill Language of SB 1094

SB 1094 would expand the practice of nonmedical switching — the substitution of patients' prescription drugs by nonprescribers to increase cost savings — for patients who have already been approved for coverage of a prescription drug. New or additional nonmedical switching would be allowed by the following entities:

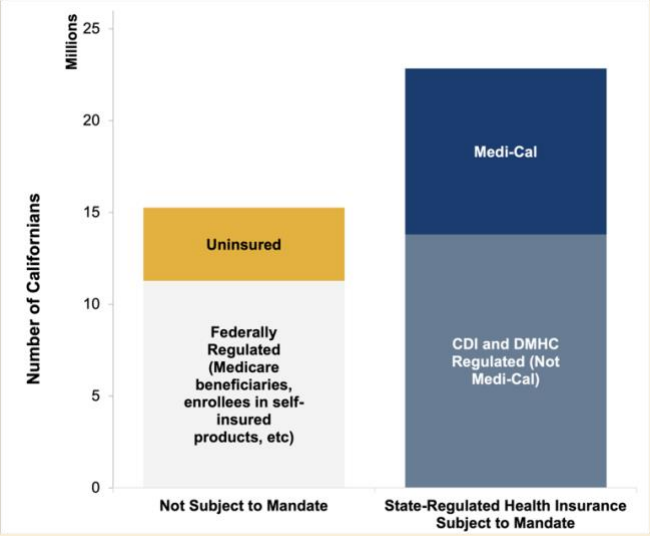
- **Pharmacists:** The bill would authorize pharmacists to substitute a biological product with a biosimilar when filling a prescription, provided the prescriber has not explicitly prohibited substitution.
- **Health plans, insurers, and utilization review organizations:** For patients who have *already been approved* for coverage of a reference biologic or brand-name drug, SB 1094 would authorize health plans regulated by the Department of Managed Health Care (DMHC), health insurers regulated by the California Department of Insurance (CDI), and utilization review organizations (UROs) to require an enrollee/insured to switch to an AB-rated generic equivalent, biosimilar, or interchangeable biological product, under certain conditions. Specifically, (1) the prescriber must not have explicitly prohibited substitution; (2) the net cost to the plan of the substitute must be lower than the brand-name or reference product; and (3) the enrollee cost sharing must be based on the net cost of the drug or product and must be the same or less than the cost sharing for the brand-name drug or reference product.

SB 1094 also requires health plans and insurers to provide at least a 30-day advanced notice to a patient and their prescriber of any nonmedical switches, prior to implementing the switch. The bill allows for patients to remain on their current medication if they request an exception to a nonmedical switch.

See the full text of SB 1094 in the section entitled *Legislative Text Analyzed* in CHBRP's Technical Brief on SB 1094. If enacted, SB 1094 would apply to the health insurance of approximately 22.8 million enrollees (60% of all Californians) (see Figure 1).

SB 1094 applies to: Enrollees in commercial or CalPERS health insurance regulated by DMHC and CDI, and Medi-Cal beneficiaries enrolled in DMHC-regulated plans and County Organized Health System plans (COHS). However, as noted later in the *Policy Context* section, it is possible that the corporate bar on medicine would prevent CDI-regulated policies from complying with the bill.

Figure 1. Health Insurance in CA and SB 1094



Source: California Health Benefits Review Program, 2026.
Note: CHBRP generally assumes alignment of Medi-Cal managed care plan benefits, with limited exceptions.[1]
Key: CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

[5] See CHBRP's authorizing statute.

It should be noted that DMHC regulates the plans and policies of approximately 74% of enrollees associated with CalPERS, and 80% of Medi-Cal beneficiaries, in addition to commercial enrollees.[6]

What Are Different Types of Pharmaceutical Products?

Most pharmaceutical products can be broadly categorized as either **small-molecule drugs**, which are made from chemicals and are relatively easy to copy, or **biological (large-molecule) drugs**, which are complex products derived from living organisms like yeast, bacteria, or animal cells. Some examples include insulin glargine (brand name Lantus) and adalimumab (brand name Humira). California and other states have enacted laws that permit pharmacists to substitute lower-cost **generic small-molecule drugs** provided they are "AB-rated" — deemed therapeutically equivalent by the U.S. Food and Drug Administration (FDA) (FDA CDER, 2026a). **Biosimilars**[7] are large-molecule biologics that are highly similar to an already approved biological reference product (FDA, n.d.-a). **Interchangeable biological products** are biosimilars that meet additional FDA criteria such as lack of substantial immunologic adverse reactions or no changes in therapeutic effect from repeated switching (FDA, 2024b). There are currently over 90 biosimilar products approved by the FDA, of which less than half (41) have been approved as interchangeable biological products (FDA CDER, 2026b).

See Table 1 below for a comparison.

Table 1. Comparison of Different Types of Pharmaceutical Products

	Small-Molecule Drugs	Biologics (Reference Product)
Molecule size	Small	Large
Structure	Simple, well defined	Complex, heterogenous
Manufacturing	Chemical synthesis	Produced in living cells or organisms
Substitutes	Generics	Biosimilars or interchangeable biological products
Rules for substitution	Generics may be substituted by pharmacists for brand-name drugs	Interchangeable biological products may be substituted by pharmacists for biologics
SB 1094 Impact	Yes	Yes

Source: California Health Benefits Review Program, 2026. Adapted from FDA CDER, 2026a.

Disparities in Access to and Use of Reference Biologics and Biosimilars

Disparities by age and race exist in patient access to, and subsequent use of, reference biologics and biosimilars. These disparities are dependent on the reference biologic or biosimilar in question. Black patients and persons who are older may have delayed access and initiation of disease-modifying antirheumatic drugs and biosimilars (Jin et al., 2017; Kim et al., 2015). There may also be lower rates of use of biosimilar trastuzumab for treatment of patients aged over 65 years with HER-2 positive breast cancer (Reeder-Hayes et al., 2016).

[6] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.
[7] Biosimilars include products called "follow-on biologics." Follow-ons were biological products approved by the FDA under the Food, Drug & Cosmetics Act section 505 (b)(2) as similar to a biological reference product. This regulatory pathway was switched over to the follow the same process as biologic license application provisions in the Public Health Service Act, section 351(k) in 2020, so that follow-ons are now deemed biosimilars under current federal regulations. However, follow-ons have not been considered interchangeable for the reference product under state laws controlling pharmacy practices.

Barriers to Accessing Biosimilars and AB-rated Generics

Multiple interconnected barriers limit patient access to biosimilars and AB-rated generics. Limited knowledge and acceptance among patients and providers,[8] combined with financial incentives favoring reference biologics — such as rebates for health plans/insurers and pharmacy benefit managers (PBMs) — discourage biosimilar uptake (Mulcahy et al., 2018). A considerable barrier to the acceptance of biosimilars by patients and prescribers is the misleading narrative that biosimilars are inferior to reference products or that reference products have met higher standards than biosimilars, which may be part of marketing messaging used to differentiate reference products from competitors (Lang et al., 2023). The FDA and the Federal Trade Commission have begun to address false or misleading promotional information about biosimilars to counter anti-competitive business practices (FDA, 2020). The "nocebo effect" — in which negative expectations cause patients to report worsening symptoms despite no measurable clinical difference — presents an additional psychological barrier (Canter et al., 2021; Gonczi and Lakatos, 2019; Odinet et al., 2018; Pineles et al., 2018; Pouillon et al., 2018; Rossmann and Cross, 2020; Smeeding et al., 2019; Stebbing et al., 2020; Whalen, 2020). Patients may also face substantial out-of-pocket costs for long-term specialty treatments even for AB-generic drugs, with no clear financial advantage to switching when formulary options remain unaffordable (CHBRP, 2022). In addition, provider reimbursement structures may also mean that financial differences between lower-priced biosimilars may not be significant enough to encourage physicians to support switching, particularly if there is uncertainty about newly approved biosimilars (Nabhan et al., 2018).

Societal Impact

Patient access to and use of biosimilars and generic prescription drug products in California has direct and indirect economic and societal costs. In dollar terms, the societal impact can be indirect (lost wages, etc.), as well as direct (medical care, etc.). CHBRP is unable to find data that displays the larger societal impact of the ability for patients to access biologics and biosimilars specifically. However, the high costs of prescription drug products, including biologics, may cause financial toxicity to health care systems, leading to restricted access to effective treatments for cancer and inflammatory diseases (Rodriguez et al., 2023). Biosimilars may lead to substantial reductions in the cost to patients and health care systems for prescription treatments (Canter et al., 2021).

For an in-depth look at clinical guidance, existing disparities, and barriers to access to biosimilars and AB-rated generics, please see the *Background on Substitution of Prescription Products* and *Safety* and *Harms Considerations* sections in CHBRP's Technical Brief on SB 1094.

When Is Substitution of Different Types of Pharmaceutical Products Possible?

Biosimilar products may be provided through the pharmacy benefit or administered by health care providers in hospitals or ambulatory clinic[9] settings under the medical benefit. Some biological products are part of a cancer treatment regimen, like Rituxan (rituximab) for non-Hodgkin's lymphoma or chronic lymphocytic leukemia and Herceptin (trastuzumab) for early-stage breast cancer. Patients can be treated on an outpatient basis, where the reference product is provided from the hospital or clinic pharmacy for administration by a health care provider, and then the patient may be discharged home after treatment. These products may require infusion (intravenous injection) or special monitoring to minimize risk to patients and so cannot be self-administered (FDA CDER, 2026b).

For patients on established treatments, the decision whether and when to make a substitution of a less expensive biosimilar product has been one that requires coordination between the patient and/or caregiver, the physician, and the dispensing pharmacist. Clinical practice guidelines for biosimilar substitutions have been published by major medical specialty organizations representing professionals who manage patients with cancer, diabetes, inflammatory diseases of the gastrointestinal system, skin, and/or joints since 2015. These guidelines support the dialog between health care

[8] These and other factors may contribute to prescribers specifying "Do Not Substitute" when prescribing treatments for patients, which also limits access, though this barrier is not specifically addressed by SB 1094.
[9] Treatments may be administered in an infusion clinic by a health care professional, and the patient does not require admission to the hospital for this procedure. Patients may return home after the treatment is given.

professionals and patients on the decision to switch to biosimilars (Dolinar et al., 2018; Fonseca et al., 2017; Kay et al., 2018; Rodriguez et al., 2023). See the *Safety and Harms Considerations* section of CHBRP's Technical Brief on SB 1094 for more information on the clinical guidelines.

How Safe Is it to Switch to a Biosimilar?

CHBRP's medical literature review focused on the safety of switching from a reference biologic to a biosimilar. Small-molecule drugs were not included in the review because the FDA has determined them to have the same clinical benefit and risks as their brand-name counterparts. AB-rated generics contain identical active ingredients to brand-name drugs and are required to be the same as a brand-name drug in dosage, safety, effectiveness, strength, stability, and quality, as well as in the way it is administered (FDA, 2026a). CHBRP relied on the FDA's approval of biosimilars and interchangeable biological products to establish that these products have met the current evidence standards for safety and effectiveness.

CHBRP found *very strong evidence*[10] that FDA-approved biosimilars do not introduce new or greater harms than their reference product. Biosimilars match the reference product's safety profile in clinical trials and real-world use, including post switching. While the accumulated 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, prescribers and patients are still hesitant because of misinformation about the differences between biosimilars and interchangeable biological product and reference products and concerns about disrupting stable treatment regimens (Lang et al., 2023).

Policy Context

Existing California Law and Regulations

Pharmacists

California law currently allows pharmacists to substitute an interchangeable biological product[11] for a prescribed biologic, as long as the patient's cost sharing is the same or lower than it would be for the prescribed biologic and the prescribing provider has not indicated substitution is not allowed.[12] SB 1094 would allow pharmacists to be able to also substitute biosimilars. Currently the FDA does not consider all biosimilars to be interchangeable; the FDA differentiates the two products by requiring switching studies from manufacturers for marketing applications for the latter category (FDA, n.d.-b). However, the FDA is in the process of updating its guidance to industry to move towards recognizing that all approved biosimilars are effectively interchangeable and streamlining biosimilar development by removing the requirement for switching studies (FDA, 2024b; FDA, 2026).

Health plans and insurers

For *new* coverage requests for prescriptions, California law allows health plans and insurers to implement step therapy protocols if more than one drug is clinically appropriate to treat a medical condition.[13] Step therapy protocols require patients to attempt treatment with an alternative clinically appropriate medication before coverage for the originally requested drug is approved. Existing law also mandates that health plans and insurers have a formal process for patients to obtain medications that are typically not on the formulary when medically necessary; this is sometimes known as an

[10] *Very strong evidence* indicates that there are multiple studies of a treatment, and the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective. Conclusions are unlikely to be altered by additional evidence.
[11] An interchangeable biological product, also called interchangeable biosimilar or interchangeable products, is a biosimilar that meets additional requirements and may be substituted for the reference product at the pharmacy, depending on state pharmacy laws (FDA, n.d.-b).
[12] Business and Professions Code (BPC) 4073.5.
[13] Health and Safety Code (HSC) 1367.22 and Insurance Code (INS) 10112.27.

exception request. Plans and insurers are required to respond within 72 hours for standard requests and 24 hours for emergencies to ensure timely access to care.[14]

SB 1094 applies to prescription drugs that have *already been approved* for coverage. For example, if a patient was approved for a new biologic and then two years later a biosimilar was newly available on the market, SB 1094 states the enrollee or insured's health plan or insurer would be allowed to substitute the biosimilar for the original biologic, as long as the prescriber did not prohibit substitutions and the net cost and cost sharing was lower for the biosimilar.

Corporate practice of medicine

The corporate practice of medicine (CPOM), often referred to as the "corporate bar," is a legal doctrine in California that bans general corporations from practicing medicine or employing physicians to deliver medical services.[15] Per the Medical Board of California, the CPOM is intended to prevent unlicensed persons from making health care decisions that should be made by a state-licensed physician, such as taking responsibility for the ultimate overall care of a patient, including treatment options available to the patient (MBC, 2026). Health maintenance organizations (HMOs), which are regulated by the DMHC, are exempt from the CPOM.[16] However, there is no current exemption for health insurers. Thus, the CPOM may prevent CDI-regulated health insurers from substituting prescription drugs on their own, even if SB 1094 were enacted.[17]

Essential Health Benefits and the Affordable Care Act

In California, nongrandfathered[18] individual and small-group health insurance are generally required to cover essential health benefits (EHBs).[19] States may require state-regulated health insurance to offer benefits that exceed EHBs.[20,21,22,23] Should California do so, the state could be required to defray the cost of additionally mandated benefits for enrollees in health plans or policies purchased through Covered California, the state's health insurance marketplace. Because SB 1094 does not require coverage for any additional prescription drugs, the proposed mandate would not exceed the current definition of EHBs in California.

Similar Legislation and Laws in Other States

All 50 states, and Washington, D.C., and Puerto Rico have laws that address biosimilar substitution (NCSL, 2022). Like California, most state laws allow pharmacist substitutions of interchangeable biological products for reference products (NCSL, 2022). In 2025, Tennessee enacted legislation similar to SB 1094; the state now authorizes health carriers, benefit plans, or utilization review organizations to require a patient to try a biosimilar product prior to providing coverage for the equivalent branded prescription drug.[24]

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[14] HSC 1367.24 and INS 10123.191.
[15] BPC 2400 and 2052.
[16] 42 United States Code, Section 300e; HSC 1340, et seq.
[17] Communication with CDI, March 9, 2026.
[18] A grandfathered health plan is "a group health plan that was created — or an individual health insurance policy that was purchased — on or before March 23, 2010. Plans or policies may lose their 'grandfathered' status if they make certain significant changes that reduce benefits or increase costs to consumers."
[19] For more detail, see CHBRP's issue brief, *Essential Health Benefits: An Overview of Benefits, Benchmark Plan Options, and EHBs in California*.
[20] ACA Section 1311(d)(3).
[21] State benefit mandates enacted on or before December 31, 2011, may be included in a state's EHBs, according to the U.S. Department of Health and Human Services (HHS). Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. Final Rule. Federal Register, Vol. 78, No. 37. February 25, 2013.
[22] However, as laid out in the Final Rule on EHBs U.S. Department of Health and Human Services (HHS) released in February 2013, state benefit mandates enacted on or before December 31, 2011, would be included in the state's EHBs, and there would be no requirement that the state defray the costs of those state-mandated benefits. For state benefit mandates enacted after December 31, 2011, that are identified as exceeding EHBs, the state would be required to defray the cost.
[23] In February 2026, HHS released a proposed rule that would alter what benefits would be determined to exceed EHBs. The conclusions in this analysis of SB 1094 are subject to change based on the final language of the regulations. U.S. Department of Health and Human Services (HHS). Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program. Proposed Rule. Federal Register, Vol. 91, No. 28. February 11, 2026.
[24] Tennessee House Bill 1198, 2025.

To date, at least five other states are considering legislation similar to SB 1094. New Jersey, New York, and Washington are considering legislation that would allow health insurers to require a patient to try a biosimilar prior to providing coverage for the reference product; New Jersey's legislation specifies that the biosimilar must have a lower wholesale acquisition cost than the reference product.[25] Legislative proposals from Kentucky, Louisiana, and Minnesota focus on formulary management to ensure health plans include lower-cost biosimilars in their drug list.[26]

Back to Table of Contents

[25] New Jersey AB 1510 New York SB 3485/AB 3973; Washington SB 5594/House Bill 1725.
[26] Kentucky SB 211; Louisiana House Bill 870; Minnesota SF1876.

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 1094, unless otherwise specifically mentioned.

CHBRP previously analyzed similar bill language, AB 621 in 2023 (CHBRP, 2023). Where applicable, this analysis builds off that previous analysis. For this analysis, CHBRP made the assumptions outlined below to estimate the projected impacts of SB 1094, if it were to be enacted. For further details on the underlying data sources, methods, and assumptions used in this analysis please see CHBRP's Technical Brief on SB 1094, available at www.chbrp.org.

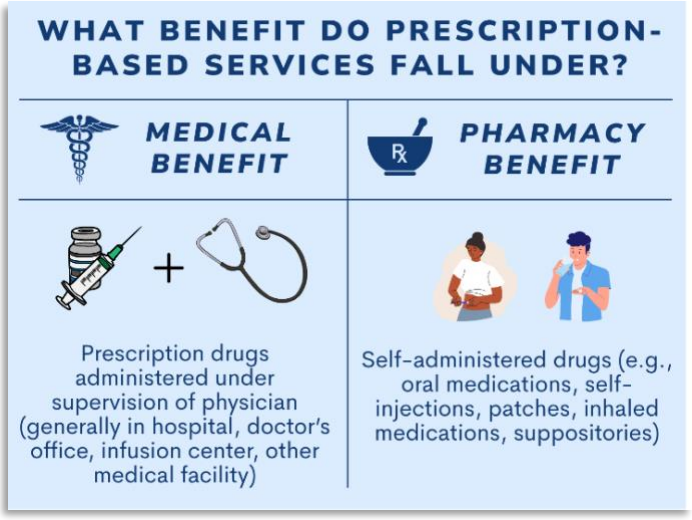
Language Interpretation

- **On-label usage:** Medications are FDA-approved for a specific purpose but can also be used "off-label" for other purposes. Off-label use refers to the practice of prescribing or using a medication for a purpose, dosage, route of administration, or patient population that is not explicitly approved by the FDA. As amended on April 8, 2026, CHBRP assumes SB 1094 would only apply to on-label use of prescription drugs.
- **Applicable markets:** CHBRP assumes SB 1094 would apply to nongrandfathered DMHC-regulated health plans and CDI-regulated health policies in the individual, small-group, and large-group markets.

It is unclear whether CDI-regulated policies would be prohibited from implementing the bill due to the prohibition on the corporate practice of medicine, also known as the "**corporate bar**."[27] For this analysis, CHBRP included estimates of the impacts of SB 1094 on CDI-regulated markets. If, however, CDI-regulated markets would not legally be able to implement SB 1094, the projected impacts (i.e., reductions in premiums and cost sharing) of this analysis would be smaller. See more information in the Policy Context subsection in the *Overview* section.

Pharmacy vs. Medical Benefit Coverage

- **Applicable benefits:** For this analysis, CHBRP considered self-administered biological drugs, which are relevant to pharmacy benefit coverage, and biological drugs administered under the supervision of a physician (generally in a hospital, a provider's office, infusion center, or similar medical facility), which are generally covered through a medical benefit. Pharmacy benefits cover outpatient prescription drugs by covering scripts that are generally filled at a retail pharmacy, a mail-order pharmacy, or a specialty pharmacy.
- **Impact on Medi-Cal:** For Medi-Cal beneficiaries, the pharmacy benefit is separate and administered by the Department of Health Care Services (DHCS) under the Medi-Cal Rx program and is not subject to DMHC regulation. Because SB 1094 would not require creation of a pharmacy benefit, baseline benefit coverage for enrollees is compliant if they are either without a pharmacy benefit or the pharmacy benefit is not regulated by DMHC or CDI. Being compliant with SB 1094 at baseline does not necessarily mean that these Medi-Cal plans have a pharmacy benefit that includes coverage for all reference biological drugs, as



[27] Correspondence with CDI, March 9, 2026.

CHBRP did not survey the administrator of the Medi-Cal pharmacy benefit. Claims that are submitted on the medical benefit on behalf of Medi-Cal beneficiaries are not carved out and therefore those impacts are included in this analysis.

Cost-Related Analytical Approach and Assumptions

This analysis reports the estimated incremental impact of full-scale implementation of SB 1094 on benefit coverage, utilization, and cost for a single year.[28] 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 1094. 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 1094, 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.[29] For a discussion of long-term impacts of SB 1094, see the *Long-Term Impacts* section.

Table 2 shows the impacts of SB 1094 on nonmedical switching for different types of prescription products and the entities authorized to conduct nonmedical switches under the legislation.

Table 2. Nonmedical Switching Authority and SB 1094

Original Prescription	Switched Prescription	Entity Making Switch: Pharmacist	Entity Making Switch: Health Plan/Insurer/URO
Small-molecule brand-name drugs	Small-molecule AB-rated generic	No impact due to existing law	Impacted by SB 1094, yet relatively small compared to biologics contributions
Biologic (reference product)	Biosimilar	Impacted by SB 1094	Impacted by SB 1094
Biologic (reference product)	Interchangeable biological product	No impact due to existing law	Impacted by SB 1094

Source: California Health Benefits Review Program, 2026.
Key: URO = utilization review organization.

In its analytic approach, CHBRP assumed the fiscal impacts of SB 1094 depend on two primary factors:

- **Extent to which nonmedical switching occurs:** Per SB 1094, new nonmedical switching occurring postmandate would be driven by several actions, including (1) pharmacists switching patients from reference products to biosimilars; (2) health plans/insurers/UROs switching patients from reference products to biosimilars or interchangeable biological products; (3) health plans/insurers and UROs switching patients from brand-name drugs to generics; (4) the frequency with which prescribers include "do not substitute" statements on prescriptions; and, (5) the extent to which patients request an exemption from the nonmedical switch.
- **Difference in cost between the original and switched pharmaceutical product:** Nonmedical switching is generally implemented to save on pharmaceutical costs. The difference in cost is dependent on several factors, including but not limited to the list price of the biologic or brand-name drug, the price of the biosimilar or generic, and any rebate amount provided by the drug manufacturer for either drug.

[28] 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.
[29] 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.

Pharmacists in California are currently authorized to switch patients from brand-name drugs to generics, and prescribers have high confidence in their effectiveness. In the United States, over 90% of all prescriptions filled are generics (DrugPatentWatch, 2026). Therefore, CHBRP assumed that volume of drug switches for small-molecule drugs would be insignificant compared to that of large-molecule drugs. Relatedly, CHBRP assumed the difference in total cost savings from switching from a brand-name small-molecule drug to a generic postmandate would not be measurable in comparison to that due to switching from a reference product to a biosimilar or interchangeable biological product. Therefore, CHBRP assumed zero fiscal impact from switching from a small-molecule brand-name drug to an AB-rated generic; all fiscal impacts of SB 1094 postmandate would be driven by nonmedical switching of biologics to biosimilars and interchangeable biological products.

CHBRP assumed that the provision allowing patients to request an exemption from a nonmedical switch would not have a measurable fiscal impact. Although exception requests may be made by patients under SB 1094, CHBRP assumed that some patients would choose to not go through the administrative burden to take such action, and that other patients would often prefer to discuss medication changes with a prescriber; in the latter circumstance, a “do not substitute” request could be made if the prescriber agreed to no nonmedical switching on behalf of the patient. CHBRP assumed the 30-day notification of nonmedical switching by health plans and insurers would have a similar effect.

Approach and Assumptions on Baseline Coverage and Utilization

- CHBRP assumed that this bill would only impact biological prescription drugs and physician-administered drugs that (1) the patient has already received approval for coverage of, and (2) have an interchangeable biological product and/or biosimilar alternative.
- Because SB 1094 would only apply to prescription drugs that have already been approved for coverage, CHBRP assumed that 100% of enrollees would have coverage for the biologic and associated interchangeable biological product and biosimilar products in physician-administered settings.
- As SB 1094 allows for nonmedical switching by pharmacists, CHBRP assumed that 100% of enrollees with an outpatient prescription drug benefit would have coverage for the biological reference products and associated interchangeable biological products and biosimilar products.

Approach and Assumptions on Postmandate Coverage and Utilization

The volume of nonmedical switches postmandate would depend on several factors, including the unique health conditions of each patent; prescribers’ propensity to specify “do not substitute” on prescriptions; the willingness of health plans/insurers, UROs, and pharmacists to make nonmedical switches; the number of biosimilars and/or interchangeable biological product available on the market; and the list prices and available rebates for biologics, biosimilars, and interchangeable biological product. To represent the impact of these factors, CHBRP made the following assumptions:

- Of the patients using reference products at baseline, 50% would be switched to a biosimilar or interchangeable biological product postmandate. This rate is inclusive of switches conducted by pharmacists, health plans/insurers, and UROs. A sensitivity analysis measuring the impacts with an upper and lower bound of 90% and 10% was also conducted; the fiscal impacts were comparable. For more details, see the *Cost Impact Analysis: Data Sources, Caveats, and Assumptions* section of CHBRP’s Technical Brief on SB 1094.
- For reference products that have multiple biosimilars or interchangeable biological product on the market, CHBRP assumed the shift from the reference product to each biosimilar or interchangeable biological product would be proportional to the relative utilization of such products in the 2024 data from Milliman’s Consolidated Health Cost Guidelines database. If no data were available, CHBRP assumed that utilization would be split uniformly between all the biosimilars and interchangeable biological product available for that reference product.
- 100% of any cost savings would be passed along in the form of lower premiums.

- There would be no increase in utilization as a result of SB 1094. This assessment considers two primary sources of potential growth:
  - New patients: Under existing law, health plans and insurers can already require patients to start with lower-cost biosimilars for new prescriptions. Because this "biosimilar-first" pathway is already established, SB 1094 is not expected to change utilization for this group.
  - Existing patients: Some patients currently prescribed high-cost reference products may be underutilizing their medication due to cost. CHBRP assumes that if cost-driven underutilization were occurring, prescribers would have already moved these patients to available lower-cost alternatives at baseline.

Approach and Assumptions on Baseline and Postmandate Cost

- CHBRP assumed that drug manufacturers would offer rebates on reference products that would lower the effective cost below the publicly available list price for health plan/insurer cost. Rebate amounts for prescription drugs are confidential. CHBRP accounted for this by assuming different rebate levels for biologics based on drug-specific considerations, including public announcements and list price information for the reference products, and their corresponding biosimilar and interchangeable biological product alternatives. For more details, please see the *Cost Impact Analysis: Data, Caveats, and Assumptions* section of CHBRP's Technical Brief on SB 1094.
- CHBRP developed costs for biosimilar and interchangeable biological product products based on their list price relative to the reference biologic. Certain biosimilar and interchangeable biological product products have multiple versions with different list prices, depending on a plan sponsor's or URO's preference for rebates versus list price discounts. For such drugs, CHBRP used the high discount, low list price alternative when developing average costs for biosimilar and interchangeable biological product drugs and assumed that there would not be rebates that would offset plan cost amounts.
- Postmandate, CHBRP assumed the average cost per prescription drug would not change.

Back to Table of Contents

SB 1094 Impacts: Benefit Coverage and Cost

Benefit Coverage

CHBRP estimates that at baseline, 22.8 million Californians (60% of the 38 million residents) with state-regulated insurance subject to the mandate are enrolled in plans or policies that would be impacted by SB 1094. CHBRP assumes 100% have coverage for physician-administered drugs through the **medical benefit**, including those that are biosimilars, interchangeable biological products, and reference products. CHBRP also assumes 57.6% have outpatient drug benefits, or coverage for drugs covered by a **pharmacy benefit**, including biosimilars, interchangeable biological products, and reference products. This difference is due to the carve out of all prescription drugs for Medi-Cal through the Medi-CalRx program, and the approximate 5% of enrollees who have commercial insurance or DMHC-regulated insurance through CalPERS who do not have pharmacy benefit coverage in their plan or policy. CHBRP assumes that the proportion of enrollees with coverage for drugs through their medical and pharmacy benefits would remain unchanged postmandate (Table 3).

Table 3. Impacts of SB 1094 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 SB 1094 (b)	22,842,000	22,842,000	0	0.00%
Enrollees with coverage for biological prescription drug treatment on the **medical** benefit (c)	100%	100%	0	0.00%
Enrollees with coverage for biological prescription drug treatment on the **pharmacy** benefit(d)	57.6%	57.6%	0	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.[30]
(b) Includes pharmaceutical products (i.e., brand-name drugs, generics, biologics, biosimilars, and interchangeable biological product).
(c) The medical benefit includes prescription drugs administered under the supervision of a physician (generally in a hospital, a provider's office, infusion center, or similar medical facility).
(d) The pharmacy benefit includes outpatient prescription drugs that are self-administered and generally filled at a retail pharmacy, a mail-order pharmacy, or a specialty pharmacy.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

Utilization and Unit Cost

Table 4 provides estimates of the impacts of SB 1094 on utilization from a 50% shift in the market from the reference biological product to the biosimilars and/or interchangeable biological products.[31] The average unit cost of the reference drugs is assumed to remain the same, but the unit cost of the interchangeable biological products and the biosimilars is assumed to change due to a shift in the mix of medications used by patients postmandate. Some reference products have more than one biosimilar and/or interchangeable biological product, which vary in price. The average per unit cost shown in Table 4 represents an average over the net expenditures (volume x price) for each of the biosimilars and

[30] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.
[31] "A 50% shift was used based on data from available literature and a sensitivity analysis conducted by CHBRP. Previous studies reported switches ranging from 3.4% to 99% (Chang et al., 2023; Roberts et al., 2025; Saxby et al., 2019; Waterhouse et al., 2021). CHBRP's sensitivity analyses explored the impacts of a 10% and 90% shift. See the *Cost Impact Analysis: Data Sources, Caveats, and Assumptions* section *of CHBRP's Technical Brief on SB 1094* for more information.

interchangeable biological products. If, as a result of SB 1094, enrollees are switched from reference products to some of the more expensive biosimilars or interchangeable biological products (relative to the other biosimilars or interchangeable biological products), then the average per unit cost would increase. This does not imply that the total expenditure for that class of biological products would increase (since there is movement away from the more expensive reference products) but that the average unit cost for the biosimilars and/or interchangeable biological product would increase. Note also that the unit cost for the interchangeable biological products and biosimilars are higher than the reference unit cost for biological infusions. This occurs because biosimilars are already commonly used for biological infusions, and providers have already switched out most of the expensive reference products for less expensive biosimilars and interchangeable biological products. Thus, the higher unit cost for biological infusion biosimilars and interchangeable biological product compared with the prescription drugs merely represents the fact that more expensive reference groups have already been substituted. In each case, regardless of the source of delivery (pharmacy or infusion), the unit price of the reference drug is above the biosimilar and/or interchangeable biological product, even if the average across all products differs.

CHBRP estimates that on the pharmacy benefit, the average unit cost of the interchangeable biological product prescription treatments would increase by 3.96% and the unit cost for the biosimilar prescription treatments would decrease by 3.1%. Similarly, on the medical benefit, CHBRP estimates that the average unit cost of the interchangeable biological product infusions would increase by 2.1% and for the biosimilar infusions the unit cost would decrease by 8.93%

For the treatments administered in a medical facility postmandate, prescription utilization is expected to shift from reference products to interchangeable biological products or biosimilars by approximately 83,000 infusions (or 46%); approximately 95,600 prescriptions for reference products would shift to prescriptions for biosimilars or interchangeable biological products on the pharmacy side, postmandate. At baseline, biosimilars have a larger share of the market for biologic infusions (medical benefit) than interchangeable biological products; the opposite is true for outpatient biological prescription drug treatments (pharmacy benefit).

Table 4. Impacts of SB 1094 on Utilization and Cost, 2027

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Annual number of biological prescription drug treatments (a)				
Reference	217,809	122,237	(95,572)	-43.88%
Interchangeable biological product	294,223	368,041	73,818	25.09%
Biosimilar	61,221	82,975	21,754	35.53%
Average per unit net cost for a 30-day supply (a, b)				
Reference	$1,662	$1,662	$0	0.00%
Interchangeable biological product	$1,011	$1,051	$40	3.96%
Biosimilar	$829	$803	($26)	-3.10%
Annual number of biologic infusions (c)				
Reference	181,153	97,884	(83,269)	-45.97%
Interchangeable biological product	41,004	57,659	16,655	40.62%

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Biosimilar	261,729	328,343	66,614	25.45%
Average cost per infusion (b, c)				
Reference	$1,798	$1,832	$34	1.90%
Interchangeable biological product	$1,583	$1,616	$33	2.10%
Biosimilar	$2,446	$2,228	($218)	-8.93%

Source: California Health Benefits Review Program, 2026.
Notes: (a) Includes prescription drugs on the pharmacy benefit. The pharmacy benefit includes outpatient prescription drugs that are self-administered and generally filled at a retail pharmacy, a mail-order pharmacy, or a specialty pharmacy. Only includes utilization for biological drugs for which a biosimilar or interchangeable biological product drug is approved by the FDA and available on the market.
(b) The listed cost for biological reference products in this table reflects a reduction for assumed rebate payments received from pharmaceutical manufacturers, if applicable. Actual rebate payments are confidential. Therefore, these estimates may not reflect the true cost of the medication.
(c) Includes prescription drugs on the medical benefit. The medical benefit includes prescription drugs administered under the supervision of a physician (generally in a hospital, a provider's office, infusion center, or similar medical facility). Only includes utilization for biological drugs for which a biosimilar or interchangeable biological product drug is approved by the FDA and available on the market.

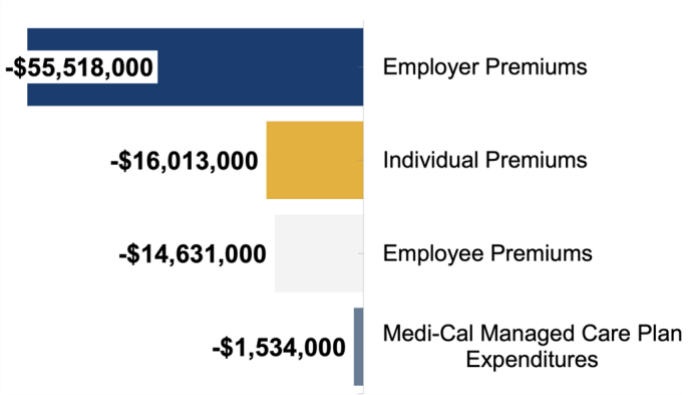
Expenditures and Premium Impacts

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,[32] and (2) those who do not utilize benefit but pay for it through premiums. 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 benefits impact on plan premiums.

Expenditure Impacts on Employers and All Enrollees

As shown in Figure 2, for DMHC-regulated plans and CDI-regulated policies, SB 1094 would decrease total premiums paid by employers and enrollees for newly covered benefits by approximately $87.7 million (Table 5).

Figure 5. Expenditure Impacts of SB 1094 on Employers and Enrollees



Source: California Health Benefits Review Program, 2026.

[32]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 5. Impacts of SB 1094 on Premiums, 2027

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Non-enrollee premiums				
Employer-sponsored (a)	$75,730,916,000	$75,679,514,000	-$51,402,000	-0.07%
CalPERS employer (b)	$8,611,855,000	$8,607,739,000	-$4,116,000	-0.05%
Medi-Cal (c)	$42,982,384,000	$42,980,850,000	-$1,534,000	0.00%
Enrollee premiums				
Enrollees, individually purchased insurance	$25,775,325,000	$25,759,312,000	-$16,013,000	-0.06%
Outside Covered California	$9,551,761,000	$9,545,653,000	-$6,108,000	-0.06%
Through Covered California	$16,223,564,000	$16,213,659,000	-$9,905,000	-0.06%
Enrollees, group insurance (d)	$21,828,135,000	$21,813,504,000	-$14,631,000	-0.07%
Total premiums	$174,928,615,000	$174,840,919,000	-$87,696,000	-0.05%

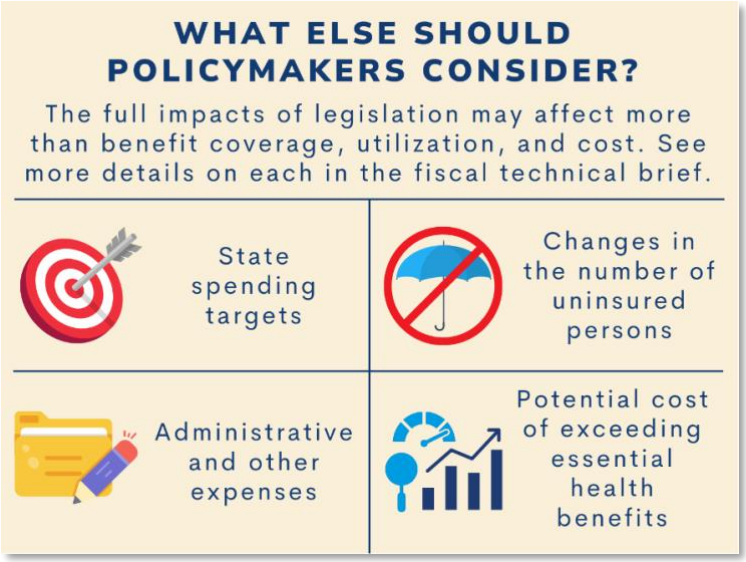
Source: California Health Benefits Review Program, 2026.
Notes: (a) In some cases, a union or other organization. Excludes CalPERS.
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 49.0% are state retirees, state employees, or their dependents. About one in five (20.4%) of these enrollees has a pharmacy benefit not subject to DMHC. 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.
(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; DMHC = Department of Managed Health Care.

Enrollee premiums calculated include premiums for those enrollees using the benefit in addition to those not using the benefit. No offsets are projected. Changes in premiums as a result of SB 1094 would vary by market segment (see Table 5 and Table 6; see also Table 9 and Table 10 in Appendix).

Table 6. Premium Impact Ranges of SB 1094 by Market Segment

Market Segment	Premium Impact Range (PMPM)
Commercial plans/policies	($0.51-$0.58)
Covered California – individually purchased	($0.54-$0.62)
CalPERS	($0.44)
Medi-Cal	($0.01)

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



Enrollee Expenses for Benefit Users

SB 1094 would impact expenses for those using pharmaceutical products relevant to SB 1094 by decreasing cost sharing by a total of $3.74 million across all users (Table 10). Table 7 summarizes the differential impacts of SB 1094 on enrollee expenses for each average user of biologics at baseline who would have their drug switched due to SB 1094. The average per user impact on out-of-pocket expenses, including cost sharing, noncovered expenses, and premiums, would be a decrease of between $92 and $310 per year. The impacts of SB 1094 are dampened for the small-group and individual market segments due to California's cost sharing cap on outpatient prescription drugs for these markets; at baseline, enrollees in plans and policies in the nongrandfathered small-group and individual markets pay no more than $250 per month under existing law. Cost sharing for physician-administered biologics do not have a similar cap; cost sharing (coinsurance) can range between 20% and 35% of the cost of the biologic, and as shown in Table 4, the unit cost for physician-administered biologics are between $1,583 and $2,446 depending on the pharmaceutical product. Therefore, the impact of SB 1094 would be greater for the large-group market, including CalPERS. CHBRP estimates SB 1094 would decrease annual premiums between $1 and $6 in commercial/CalPERS health plans and policies for those enrollees not using prescription drugs subject to SB 1094 (Table 8). There would be no impact on Medi-Cal because benefit coverage for Medi-Cal beneficiaries does not generally include any cost sharing.

Note that for some enrollees, the presence of a deductible not yet met for the year[33] could result in the enrollee paying the full unit cost, but hitting the annual out-of-pocket maximum[34] would result in the enrollee having no further cost sharing. The impacts on nonusers of pharmaceutical products subject to SB 1094 is the reduction in premiums estimated if the bill were to be enacted.

See more information in CHBRP's Technical Brief on SB 1094, including what else policymakers should consider such as state spending targets, impacts to the number of uninsured in California, changes in public program enrollment, and administrative and other expenses.

Back to Table of Contents

[33] For estimates of enrollees in plans and policies with deductibles, see CHBRP's resource *Deductibles in State-Regulated Health Insurance*.
[34] 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 7. Impact of SB 1094 on Average User Enrollee Expenses

	Large Group	Small Group	Individual	CalPERS	Medi-Cal
% of population with enrollee expenses impact due to SB 1094	0.15%	0.15%	0.15%	0.15%	0.08%
Average annual enrollee premium impact for users (a)	($217)	($107)	($92)	($310)	$0

Source: California Health Benefits Review Program, 2026.
Notes: Average enrollee expenses include cost sharing (deductibles, copays, etc.) for covered benefits and out-of-pocket expenses for noncovered benefits. Average annual enrollee premium impact includes the employee portion of the premium only.
(a) Benefit coverage for Medi-Cal beneficiaries does not generally include any cost sharing.

Table 8. Impact of SB 1094 on Average Nonuser Enrollee Expenses

	Large Group	Small Group	Individual	CalPERS	Medi-Cal
% of population without enrollee expenses impact due to SB 1094	99.85%	99.85%	99.85%	99.85%	99.92%
Average annual enrollee expenses and premium impact for nonusers (a)	($1)	($2)	($6)	($1)	$0

Source: California Health Benefits Review Program, 2026.
Notes: Average enrollee expenses includes cost sharing (deductibles, copays, etc.) for covered benefits and out-of-pocket expenses for noncovered benefits. Average annual enrollee premium impact includes the employee portion of the premium only.
(a) Benefit coverage for Medi-Cal beneficiaries does not generally include any cost sharing.

SB 1094 Impacts: Public Health

The public health impact analysis includes estimated impacts in the short term (within 12 months of implementation) and in the long term (beyond the first 12 months postmandate). This section estimates the short-term impact[35] of SB 1094 on potential patient outcomes and financial burden. See *Long-Term Impacts* for discussion of premature death, economic loss and other long-term considerations.

Estimated Public Health Outcomes

As presented in the *Benefit Coverage, Utilization, and Cost Impacts* section, it is estimated that an additional 27,419 people would have their biological reference drug switched out for a biosimilar as a result of SB 1094. As presented in the How Safe Is it to Switch to a Biosimilar? section, there is *very strong evidence* that there is similar medical effectiveness and no difference in safety (side effects) when switching between a reference biologic and an approved biosimilar drug.

CHBRP concludes that passage of SB 1094 would have no short-term public health impact because the evidence suggests that the switching of patients to biosimilar prescription drugs does not negatively impact health outcomes; the medical effectiveness and safety biosimilars are equivalent to reference products by definition. For this reason, CHBRP also concludes that SB 1094 also would have no impact on disparities in health outcomes by gender, race/ethnicity, age, or other determinants. The bill does not address structural barriers to prescribing biological products.

There is *very strong evidence* that reference biologics and biosimilars have similar medical effectiveness and safety profiles. Despite no change in health status, there could be decreased financial burden on enrollees due to a decrease in out-of-pocket costs of prescription drugs as discussed below.

Estimated Impact on Financial Burden

When possible, CHBRP estimates the marginal impact of mandates on financial burden, defined as noncovered medical expenses paid by the enrollee as well as out-of-pocket expenses (i.e., deductibles, copayments, and coinsurance). Despite no change in health outcomes, SB 1094 could potentially impact enrollees in high deductible health plans who would still have substantial out-of-pocket spending on pharmaceuticals, even if the cost savings from substitution of biosimilars are passed on to them. Persons with lower incomes may experience a financial burden for treating chronic conditions like diabetes or inflammatory bowel disease, until their deductible or out-of-pocket maximum amounts are met.

SB 1094 could decrease the financial burden for those enrollees who are switched from a higher cost biologic to a lower cost biosimilar. CHBRP estimates that 27,419 enrollees would have an average reduction in annual out-of-pocket expenses by $217 for enrollees in large-group plans and policies and $310 for CalPERS enrollees. Because of the variety of products impacted, and uncertainty on savings for each substitution, the change in out-of-pocket spending could be broad based on the actual products used. See further discussion of financial impacts in the *Long-Term Impacts* of SB 1094 section.

Back to Table of Contents

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

SB 1094 Impacts: Long-Term

In this section, CHBRP estimates the long-term impact of SB 1094, which CHBRP defines as impacts occurring beyond the first 12 months after legislation is fully implemented.[36] 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

There are four distinct utilization dynamics that unfold over time and are not captured in the single-year model:

- **Ramp-up in substitution:** As discussed in the *Analytic Approach and Assumptions* section, CHBRP modeled the impacts using a fixed switch rate of 50% postmandate.[37] However, implementation of SB 1094 would likely have a gradual adoption curve. Pharmacist comfort with biosimilar substitution has been documented as low, and prescribers may exhibit "clinical inertia," or a tendency to remain unchanged in the therapeutic aspects of a patient's treatment if they are stable on a reference product (Roberts et al., 2026; Rupert et al., 2022; Stavem, 2021; Stevenson et al., 2023). Over time, as clinicians accumulate experience with switched patients and as professional education efforts occur, both pharmacist willingness to substitute and physician acceptance are likely to increase, as was the case with the adoption of AB-rated generic drugs for brand-name small-molecule drugs.
- **Cohort replacement effect:** SB 1094 applies only to patients who currently receive certain pharmaceutical treatments, not those starting new treatments. Over time, the pool of patients on original reference products will naturally shrink as people change plans or end therapy. Patients beginning new treatments will likely be started on biosimilars rather than reference products, per existing law and as pharmacist and prescriber comfort with biosimilars increases. This dynamic is not demonstrated in a short-term model. It should be noted that the group of patients and drugs relevant to SB 1094 is not likely to disappear despite this cohort replacement effect; it takes time for biosimilars to be introduced to the market after reference products become available and therefore SB 1094 would remain relevant for those patients and reference prodcuts.
- **Biosimilar availability:** The analysis was conducted based on the pharmaceutical products currently on the market. As new biosimilars enter the market, the pool of drugs subject to SB 1094 will expand, increasing the bill's long-term utilization impact beyond what the current model captures.
- **Underutilization due to cost:** To the extent that lower cost-sharing on biosimilars enables some patients to begin or continue therapy who would otherwise have reduced or discontinued use, there may be a long-term increase in utilization that partially offsets savings. The short-term analysis assumes minimal demand response; this assumption may be more appropriate for the near term than the long term, particularly for patients whose out-of-pocket costs were a meaningful barrier.

[36] 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 1094. 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 1094, 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.
[37] A sensitivity analysis was conducted using switch rates of 10% and 90%. The results can be found in CHBRP's Technical Brief on SB 1094.

Cost Impacts

On the cost side, three dynamics merit discussion.

- **Growing biosimilar market share:** In the short term, the primary tool manufacturers of reference products have for defending market share is increasing rebates rather than lowering list prices. In the long term, sustained market share loss to biosimilars may lead to list price reductions on reference products. If reference biologic manufacturers respond to SB 1094 by reducing list prices — rather than solely increasing rebates — the cost savings to health plans would be larger than the current model projects and would accrue whether or not patients are switched.
- **Nonmedical switching and cost offsets:** The primary clinical concern about biosimilar substitution is immunogenicity — the possibility that a patient stabilized on a reference biologic develops antibodies when switched to a different product, reducing effectiveness or causing adverse reactions. While the population-level probability of this event is low based on the accumulated European evidence on biosimilar switching (Canter et al., 2021; Mysler et al., 2021), it is not zero, and additional treatment costs for patients who experience adverse events would partially offset the savings from substitution. The magnitude of this offset is unknown and it was not included in CHBRP's analysis.
- **Federal Medicare drug price negotiations:** Three of the ten drugs selected in the first round of federal Inflation Reduction Act (IRA) price negotiation are biologics. If IRA-negotiated prices for biologics narrow the price gap between reference products and biosimilars in Medicare populations, the incentive for manufacturers to compete aggressively on biosimilar pricing could diminish for other markets, which may reduce the long-term cost savings achievable through substitution.

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.

At this time, CHBRP is unable to estimate the long-term public health impacts of SB 1094. This is due to several factors including the wide variety of conditions for which prescription drugs are used, variation in disease severity, appropriateness of high-cost biologic treatments, large variation in cost-sharing benefit design, and unknown market response to changes in brand-name drug pricing, including rebates and discounts managed by PBMs and health plans. However, if increased competition among manufacturers of biosimilars leads to reduction in net prices for prescription drugs and substitution of lower-cost prescription drugs becomes the norm, reduced spending on prescription products is possible over the long-term, similar to the experience in Europe (Canter et al., 2021; Mysler et al., 2021). This could lead to a larger decrease in financial burden for enrollees, especially those facing chronic conditions treated with high-cost biologics.

Impacts on Disparities and the Social Drivers of Health[38]

In the case of SB 1094, evidence shows that although racial and age-related disparities in the access to and use of biosimilars exist in California, CHBRP projects no changes in these disparities that would be attributable to SB 1094.

Back to Table of Contents

[38] For more information about SDOH, see CHBRP's Public Health Impact Analysis and Research Approach.

Appendix. Impacts of SB 1094 on Benefit Coverage and Expenditures, 2027

Table 9. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2026

	DMHC-Regulated						CDI-Regulated			
	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*	Total
					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 1094	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
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 51.6% are state retirees, state employees, or their dependents. About one in five of these enrollees has a pharmacy benefit not subject to DMHC.[39] 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 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.[40]
(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 would 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.

Back to Table of Contents

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

Table 10. 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 1094	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
Premiums										
Average portion of premium paid by employer (e)	-$0.4193	-$0.3878	$0.0000	-$0.3684	-$0.0141	-$0.0141	-$0.4115	-$0.3932	$0.0000	-$57,052,000
Average portion of premium paid by enrollee	-$0.0907	-$0.1896	-$0.5356	-$0.0695	$0.0000	$0.0000	-$0.0975	-$0.1661	-$0.6220	-$30,644,000
Total premium	-$0.5100	-$0.5773	-$0.5356	-$0.4379	-$0.0141	-$0.0141	-$0.5090	-$0.5592	-$0.6220	**-$87,696,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	-$0.0274	-$0.0131	-$0.0106	-$0.0384	$0.0000	$0.0000	-$0.0134	-$0.0119	-$0.0120	-$3,740,000
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	-$0.5374	-$0.5904	-$0.5462	-$0.4763	-$0.0141	-$0.0141	-$0.5224	-$0.5711	-$0.6340	**-$91,436,000**
Percent change										
Premiums	-0.0677%	-0.0719%	-0.0619%	-0.0478%	-0.0038%	-0.0022%	-0.0527%	-0.0686%	-0.0747%	-0.0501%
Total expenditures	-0.0664%	-0.0598%	-0.0481%	-0.0483%	-0.0038%	-0.0022%	-0.0478%	-0.0555%	-0.0618%	-0.0470%

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.[41] 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.[42]
(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 would 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; DMHC = Department of Managed Health Care.

Back to Table of Contents

[41] For more detail, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance*.
[42] 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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Please direct any questions concerning this document to: California Health Benefits Review Program, MC 3116, Berkeley, CA 94720-3116; info@chbrp.org; or chbrp.org.

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.

More detailed information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at chbrp.org.

Disclaimer

CHBRP analyzes bills in the current environment given current law and regulations at both the state and federal levels. Each analysis assumes that policy frameworks and stakeholder behaviors remain constant, unless otherwise noted. 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 the legislation, unless otherwise specifically mentioned. Differences between CHBRP's estimated impacts and actual impacts of legislation will depend on alignment with the assumptions used in this analysis, the timeline of implementation, and the final language of the legislation, should it be signed into law. Since actual experience is unlikely to match assumptions perfectly, final impacts will differ from those projected in this analysis.

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.

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

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