Date of Hearing: August 20, 2025

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
SB 40 (Wiener) – As Amended July 17, 2025

Policy Committee: Health Vote: 16 - 0

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

SUMMARY:

This bill generally prohibits a health plan contract or insurance policy (collectively, "health plan") from imposing a copayment, coinsurance, deductible, or other cost sharing of more than $35 for a 30-day supply of an insulin prescription drug.

Specifically, this bill:

1) Prohibits a large group health care service plan contract or policy issued, amended, or renewed on or after January 1, 2026, from imposing a copayment, coinsurance, deductible, or any other cost sharing exceeding $35 for a 30-day supply of an insulin prescription drug. Requires the prescription drug formulary include at least one insulin for a given drug type in all forms and concentrations.

2) Prohibits an individual or small group health plan contract or policy issued, amended, or renewed on or after January 1, 2027, from imposing any cost sharing that exceeds $35 for a 30-day supply of an insulin prescription drug. Specifies the cost-sharing cap applies only to insulin prescription drugs in Tier 1 and Tier 2 if the individual or small group health plan maintains a drug formulary grouped into tiers, and requires at least one insulin for a given drug type in all forms and concentrations be on Tier 1 or Tier 2. Requires the health plan limit the cost sharing for a higher tier drug to no more than $35 for a 30-day supply for an individual enrollee if no Tier 1 or Tier 2 insulin prescription drug is clinically appropriate for that enrollee.

3) Prohibits a high deductible health plan, as defined, from imposing a deductible, coinsurance, or any other cost sharing on an insulin prescription drug, unless not applying the cost sharing would conflict with federal requirements for high deductible health plans.

4) Applies the deductible and copayment limitations in item 1, above, to an insulin prescription drug, or any therapeutic equivalent insulin prescription drug, that is labeled or produced by the state, when the state labels or produces an insulin prescription drug.

5) Provides that "drug type" includes rapid acting, regular or short acting, intermediate acting, long acting, ultra-long acting, and premixed.

6) Defines "insulin prescription drug" to mean a prescription drug that contains insulin and is used to control blood glucose levels to treat diabetes.

7) Defines, for purposes of this bill, "step therapy protocol" to mean a process that specifies the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are prescribed.

8) Prohibits, on and after January 1, 2026, a health plan from imposing step therapy as a prerequisite to authorizing coverage of an insulin prescription drug, with the following exceptions:

   a) Self-administered drugs and physician-administered drugs.

   b) If at least one insulin in each drug type is covered without step therapy.

9) Makes findings and declarations concerning diabetes and the need to reduce insulin costs.

10) Provides that the provisions of this bill are severable.

FISCAL EFFECT:

The Department of Insurance estimates costs of $6,000 in fiscal year 2025-26 for state administration (Insurance Fund).

The Department of Managed Health Care anticipates minor and absorbable costs.

The California Public Employees Retirement System (CalPERS) anticipates no fiscal impact.

The California Health Benefits Review Program (CHBRP) estimates this bill will increase total health insurance premiums paid by employers and enrollees by $10.38 million and decrease enrollee expenses by $8.23 million, for a total net increase in annual expenditures of $2.15 million (0.001%).

COMMENTS:

1) **Purpose**. This bill is sponsored by the American Diabetes Association. According to the author:

> Senate Bill 40 caps the out-of-pocket cost patients pay for insulin, as 25 states have already done, at thirty-five dollars ($35) for a 30-day supply. Beyond that co-pay amount, [this bill will prohibit plans from requiring] cost-sharing for prescription insulin drugs, and from pursuing step therapy for insulin. It makes no sense that people with diabetes in states like West Virginia can access affordable insulin while Californians are stuck with higher prices. When basic life necessities like medication become unaffordable…, working people pay the price as they are forced to choose between risking bankruptcy or risking their lives by rationing essential medication. California should lead the nation in making people's lives better and more affordable, and we shouldn't ask people to wait any longer for affordable medications.

2) **Background.** ***CHBRP Analysis.*** According to CHBRP, there is clinical consensus that insulin is essential for effective treatment of diabetes and that delayed introduction of insulin or ineffective insulin therapy contributes to poor glycemic control and places patients at risk of complications.

   CHBRP estimates that of 92,636 enrollees in commercial and CalPERS health plans and insurance who use insulin, 39,178 (42%) have cost sharing that exceeds the $35 cap proposed by this bill. This bill limits cost sharing for these enrollees to $35 per month – a 44% reduction, and the average share of cost would drop to $29 – which CHBRP estimates would increase insulin utilization by 4%. CHBRP states there is strong evidence that higher cost sharing reduces adherence, and lower cost sharing increases adherence. CHBRP further states there is some evidence that reducing cost sharing is associated with decreased diabetes-related complications, emergency department visits, and hospitalizations. CHBRP assumes a 10% reduction in diabetes-related emergency department visits associated with reduced cost sharing and increased insulin utilization.

   CHBRP found strong evidence that step therapy is associated with lower likelihood of initiating or continuing medications and with poorer adherence to medication, and expert consensus that step therapy protocols for insulin would be associated with lowered use and adherence. CHBRP also states that removal of step therapy could result in a portion of enrollees using more expensive insulins within the same therapeutic class, which would result in an increase in the average unit cost of insulin.

   Federal Inflation Reduction Act (IRA). H.R. 5376 of 2022, also known as the IRA, amended federal Medicare to prohibit, effective January 1, 2023, Medicare beneficiaries with Medicare Part D coverage (for prescription drugs) or a Medicare Advantage plan that covers prescription drugs, from paying more than $35 for a one-month supply of a covered insulin product. This cap applies regardless of whether the beneficiary has met their deductible. For people who use an insulin pump and get insulin through Medicare Part B, a similar $35 monthly copayment limit began on July 1, 2023. During plan year 2026 and each subsequent plan year, the out-of-pocket cost is the lowest of the following three amounts: (a) $35, (b) 25% of the "maximum fair price" (determined through federal government negotiations with drug manufacturers), or (c) 25% of the negotiated price that the insurance plan and manufacturer agree to, which may be less than the list price due to rebates or discounts.

3) **Prior Legislation.** SB 90 (Wiener), of the 2023-24 Legislative Session, would have prohibited health plans from imposing a copayment of more than $35 for a 30-day supply of an insulin prescription drug. Governor Newsom vetoed SB 90, stating:

   > In March, I announced the state's partnership with Civica to create our own line of CalRx biosimilar insulins that will cost no more than $30 per 10 mL vial or $55 for five 3 mL cartridges. This is a fraction of the current price for most insulins, and CalRx biosimilar insulins will be available to insured and uninsured patients nationwide. With CalRx, we are getting at the underlying cost, which is the true sustainable solution to high-cost pharmaceuticals. With copay caps however, the long-term costs are still passed down to consumers through higher premiums from health plans. As a state, we have led the nation in our

efforts and investments to address the true underlying costs of insulin prescription affordability.

Recently, several other bills have proposed limits on cost sharing for insulin, including: SB 473 (Bates), of the 2021-22 Legislative Session ($35 for a monthly supply; held in this committee); AB 97 (Nazarian), of the 2021-22 Legislative Session (prohibited imposing a deductible on insulin; held in the Senate Appropriations Committee), and AB 2203 (Nazarian), of the 2019-20 Legislative Session ($50 per 30-day supply of insulin, and $100 total per month; due to the shortened Legislative calendar brought on by the COVID-19 pandemic, AB 2203 was not heard in the Senate Health Committee).

Analysis Prepared by: Allegra Kim / APPR. / (916) 319-2081