Office of Senate Floor Analyses
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UNFINISHED BUSINESS

Bill No: SB 40
Author: Wiener (D) and Wahab (D), et al.
Amended: 8/29/25 in Assembly
Vote: 21

SENATE HEALTH COMMITTEE: 11-0, 4/2/25
AYES: Menjivar, Valladares, Durazo, Gonzalez, Grove, Limón, Padilla, Richardson, Rubio, Weber Pierson, Wiener

SENATE APPROPRIATIONS COMMITTEE: 6-0, 5/23/25
AYES: Caballero, Seyarto, Cabaldon, Grayson, Richardson, Wahab
NO VOTE RECORDED: Dahle

SENATE FLOOR: 37-0, 5/28/25
AYES: Allen, Alvarado-Gil, Archuleta, Arreguín, Ashby, Becker, Blakespear, Cabaldon, Caballero, Choi, Cortese, Dahle, Durazo, Gonzalez, Grayson, Grove, Hurtado, Jones, Laird, McGuire, McNerney, Menjivar, Niello, Ochoa Bogh, Padilla, Pérez, Richardson, Rubio, Seyarto, Smallwood-Cuevas, Stern, Strickland, Umberg, Valladares, Wahab, Weber Pierson, Wiener
NO VOTE RECORDED: Cervantes, Limón, Reyes

ASSEMBLY FLOOR: 79-0, 9/3/25 - See last page for vote

SUBJECT: Health care coverage: insulin

SOURCE: American Diabetes Association

DIGEST: This bill prohibits a health plan contract and health insurance policy from imposing a copayment, coinsurance, deductible, or any other cost-sharing on an insulin prescription drug that exceeds $35 for a 30-day supply. Requires at least one insulin for a given drug type in all forms and concentrations to be on the prescription drug formulary. Prohibits a health plan from imposing step therapy as a prerequisite to authorizing coverage of at least one insulin drug type, as specified.

Assembly Amendments of 8/29/25 clarify on or after January 1, 2026, large group plans and policies are required to cover at least one insulin for a given drug type in all forms and concentrations to be on the prescription drug formulary; and on or after January 1, 2027, for individual and small group plans and policies at least one insulin for a given drug type in all forms and concentrations to be on Tier 1 or Tier 2 of a formulary, and if an insulin in Tier 1 or 2 is not clinically appropriate for an enrollee or insured, a higher tier insulin's copayment, coinsurance, deductible or cost-sharing must be limited to $35. Exclude rapid acting inhaled insulin from the definition of drug type. Exempt Medi-Cal managed care plans from this bill.

ANALYSIS:

Existing law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and the California Department of Insurance (CDI) to regulate health insurers under the Insurance Code. [Health and Safety Code (HSC) §1340, et seq. and Insurance Code (INS) §106, et seq.]

2) Requires coverage for medically necessary insulin, prescriptive medications for the treatment of diabetes, and glucagon. [HSC §1367.51 and INS §10176.61]

3) Requires every plan and policy to provide coverage for diabetes outpatient self-management training, education, and medical nutrition therapy that meets specified requirements including that it is provided by an appropriately licensed or registered heath care professional. [HSC §1367.51 and INS §10176.61]

4) Permits health plans and insurers to require step therapy and prior authorization. Requires a health plan or physician group that contracts with a pharmacy benefit manager to include a contract provision to comply with specified law regarding prior authorizations. [HSC §1342.71, §1367.206, Title 28 California Code of Regulations (CCR) §1300.67.205 and INS §10123.193 and §10123.201]

This bill:

1) Prohibits a large group health plan contract and health insurance policy that is issued, amended, or renewed on or after January 1, 2026, or a contract or policy offered in the individual or small group market on or after January 1, 2027, from imposing a copayment, coinsurance, deductible, or any other cost-sharing on an insulin prescription drug that exceeds $35 for a 30-day supply. Requires

for the large group market at least one insulin for a given drug type in all forms and concentrations to be on the prescription drug formulary.

2) Requires the cost-sharing cap described in 1) above to apply only to insulin prescription drugs in Tier 1 and Tier 2 for individual or small group plan contracts and insurance policies that maintain a drug formulary grouped into tiers. Requires at least one insulin for a given drug type in all forms and concentrations to be on Tier 1 or Tier 2. Requires if there is no Tier 1 or Tier 2 insulin prescription drug that is clinically appropriate for an enrollee or insured, the plan or insurer to limit the cost-sharing for a higher tier drug as described in 1) above.

3) Defines drug type to include, but not be limited to, rapid acting, regular or short acting, intermediate acting, long acting, ultra-long acting and premixed.

4) Prohibits application on a high deductible health plan (HDHP), as defined under federal law, if not applying a deductible, coinsurance, or other cost-sharing to an insulin prescription would conflict with federal HDHP requirements.

5) Applies the deductible and copayment limitations in 1) and 2) above to an insulin prescription drug, or any therapeutic insulin prescription drug, that is labeled or produced by the state.

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) Prohibits a health plan or health insurer from imposing step therapy protocols as a prerequisite to authorizing coverage of an insulin prescription drug. For health plans, defines step therapy protocol as a process that specifies the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are prescribed. Prohibits step therapy for both self-administered drugs and physician-administered drugs, except as described in 2) above. For health insurers, defines step therapy as having the same meaning as defined in existing law. Additionally, for health insurers step therapy is prohibited for self-administered drugs and physician-administered drugs. Requires plans and insurers to cover at least one insulin in each drug type without step therapy.

8) Exempts Medi-Cal managed care plans.

9) Makes the provisions of this bill severable, if any are held invalid.

Comments

According to the author of this bill:

> The bill prohibits cost-sharing for an insulin prescription drug from exceeding $35 for a 30 day-supply, and from requiring step therapy treatment. 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 in blue states, working people pay the price. It is past time California put basic protections in place to contain the astronomical cost of basic medications and bring economic relief to Californians forced to stretch beyond their means every month to pay for their insulin.

Related/Prior legislation

SB 90 (Wiener) of 2023–24 would have prohibited a health plan contract or disability insurance policy that is issued, amended, or renewed on or after January 1, 2024, or plan or policy offered in in the individual or small group market on or after January 1, 2025, from imposing a copayment, deductible, coinsurance, or any other out-of-pocket expense on an insulin prescription drug that exceeds $35 for a 30-day supply, as specified. SB 90 was vetoed by Governor Newsom. In his veto message, the Governor stated:

> This bill would prohibit health plans from imposing a copayment of more than $35 for a 30-day supply of an insulin prescription drug. Bringing down the costs of prescription drugs, and particularly insulin, has long been a priority of mine. People should not be forced to go into debt to get lifesaving medicines. 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 10mL vial or $55 for five 3mL 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.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Assembly Appropriations Committee:

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

2) DMHC anticipates minor and absorbable costs.

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

4) 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%).

SUPPORT: (Verified 9/3/25)

American Diabetes Association (Source)
AIDS Healthcare Foundation
American College of Obstetricians & Gynecologists – District IX
American Academy of Pediatrics, California Beta Cell Action
California Academy of Family Physicians
California Academy of Preventative Medicine
California Association for Health Services at Home
California Chronic Care Coalition
California Life Sciences Association
California Medical Association
California Nurses Association
California Pharmacists Association
California Podiatric Medical Association
California Society of Health-System Pharmacists
California State Board of Pharmacy
California State Council of Service Employees International Union
California State PTA
Cystic Fibrosis Foundation
Davis College Democrats
Diabetes Patient Advocacy Coalition
Health Access California
Insurance Commissioner Ricardo Lara
San Francisco Marin Medical Society

OPPOSITION: (Verified 9/3/25)

Association of California Life and Health Insurance Companies

California Association of Health Plans

ARGUMENTS IN SUPPORT: This bill is sponsored by the American Diabetes Association (ADA), which believes this bill is a solution to help Californians with diabetes as they await CalRx biosimilar insulins. According to ADA, Californians would be protected from predatory practices that are the subject of a Federal Trade Commission complaint filed against the three largest pharmacy benefit managers for inflating the list price of insulin. ADA writes, according to the complaint, "In some cases, the patient may pay more at the pharmacy counter than the actual cost to their commercial insurer. In other words, the insurer functionally makes a profit from the prescription, instead of paying its share of the cost. This turns the normal insurance model on its head with the sick subsidizing the healthy, rather than the other way around. As one PBM manager bluntly put it: 'I don't see how it's justifiable to charge someone 100% of the cost of the drug (during the deductible phase) while you receive a rebate on the backend … I can't think of any other insurance industry that works like that." ADA also writes that a recent study on the impact of the first copay cap legislation passed in the country (Colorado) found significant savings for enrollees, with out-of-pocket payments falling in half, and only a minor 1% increase in the amount paid by plans per prescription. ADA indicates researchers also found that the number of prescriptions and days supplied increased after the law passed, indicating that some patients may have been rationing insulin prior to the cap. ADA writes, to date, more than half the country, twenty-six states (plus Washington, D.C.) have passed legislation to limit out-of-pocket costs for insulin. The Diabetes Patient Advocacy Coalition (DPAC) writes that this bill would be a strong step in ensuring access to affordable care for Californians with diabetes. DPAC says one in four diabetes patients rations insulin due to its high cost, which can have life-threatening health conditions including heart disease, stroke, kidney failure, amputation of the lower extremities and blindness.

ARGUMENTS IN OPPOSITION: The California Association of Health Plans (CAHP) and the Association of California Life and Health Insurance Companies (ACLHIC) write in opposition to 17 health insurance mandate bills including this one. The opposition writes these bills will increase costs, reduce choice and competition and further incent some employers and individuals to avoid state regulation by seeking other coverage options. According to the opposition, benefit mandates impose a one-size-fits all approach to medical care and benefit design without consideration for consumer choice. The opposition strongly urges the Legislature to pause any new mandate bills at this time given the uncertainty regarding what benefits may or may not be covered in the essential health benefits

(EHB) benchmark plan. The opposition also indicates that adding new mandates at a time when the Office of Health Care Affordability (OHCA) is working to curb healthcare costs could disrupt those efforts and make it difficult for health care entities to meet the OCHA spending target. The opposition urges the Legislature to consider the cumulative impacts of these mandates on premiums and access to coverage, and they believe that benefit mandates stifle the use of innovative, evidence-based medicine.

ASSEMBLY FLOOR: 79-0, 9/3/25
AYES: Addis, Aguiar-Curry, Ahrens, Alanis, Alvarez, Arambula, Ávila Farías, Bains, Bauer-Kahan, Bennett, Berman, Boerner, Bonta, Bryan, Calderon, Caloza, Carrillo, Castillo, Chen, Connolly, Davies, DeMaio, Dixon, Elhawary, Ellis, Flora, Fong, Gabriel, Gallagher, Garcia, Gipson, Jeff Gonzalez, Mark González, Hadwick, Haney, Harabedian, Hart, Hoover, Irwin, Jackson, Kalra, Krell, Lackey, Lee, Lowenthal, Macedo, McKinnor, Muratsuchi, Nguyen, Ortega, Pacheco, Papan, Patel, Patterson, Pellerin, Petrie-Norris, Quirk-Silva, Ramos, Ransom, Celeste Rodriguez, Michelle Rodriguez, Rogers, Blanca Rubio, Sanchez, Schiavo, Schultz, Sharp-Collins, Solache, Soria, Stefani, Ta, Tangipa, Valencia, Wallis, Ward, Wicks, Wilson, Zbur, Rivas

Prepared by: Teri Boughton / HEALTH / (916) 651-4111
9/3/25 18:38:05

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