KEY FINDINGS

Analysis of California Senate Bill 40: Insulin

Summary to the 2025–2026 California State Legislature, March 15, 2025

CHBRP

Summary

The version of California Senate Bill (SB) 40 analyzed by California Health Benefits Review Program (CHBRP) would limit cost sharing for insulin to $35 for a 30-day supply and prohibit step therapy.

In 2026, of the 22.2 million Californians enrolled in state-regulated health insurance, 13.57 million of them would have insurance subject to SB 40.

Benefit Coverage

At baseline there are 92,636 enrollees who use insulin in commercial and California Public Employees' Retirement System (CalPERS) Department of Managed Health Care (DMHC)-regulated plans and California Department of Insurance (CDI)-regulated policies. CHBRP estimates 39,178 enrollees (42%) using insulin have cost sharing that exceeds the SB 40 cap. Postmandate, 100% of enrollees with cost sharing that exceeds the cap at baseline would have cost sharing below the cap. SB 40 would not exceed the definition of essential health benefits (EHBs) in California.

Medical Effectiveness

There is *strong evidence* that cost sharing affects insulin use and adherence in patients with diabetes; higher cost sharing reduces adherence, and lower cost sharing increases adherence. There is *some evidence* that reducing cost sharing is associated with decreased diabetes-related complications, emergency department visits, and hospitalizations.

There is *strong evidence* that step therapy is associated with a 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.

Cost and Health Impacts

The 42% of enrollees with cost sharing that exceeds the cap at baseline would experience a 44% reduction in cost sharing, which would result in in a 4% increase in utilization of insulin postmandate for those enrollees. Average cost sharing for these enrollees would decrease from $52 per month to $29 per month.

In 2026, SB 40 would increase total net annual expenditures by $2,147,000 (0.001%) for enrollees with plans regulated by the DMHC and policies regulated by the CDI. This is due to an increase of $10,377,000 in total health insurance premiums paid by employers and enrollees, and a $8,230,000 decrease in enrollee expenses.

Step therapy is generally designed to require an enrollee to try a lower cost option before trying a higher cost option. 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.

At the population level, SB 40 is unlikely to have a public health impact due to limited overall impacts. However, for the share of enrollees who would experience significant reductions in cost sharing, and therefore a clinically meaningful increase in utilization of insulin, SB 40 may result in a reduction in health care utilization, and potentially in reduced complications from diabetes over time.

Context

Diabetes mellitus (diabetes) is a chronic disease that prevents the proper production of and/or response to insulin, a hormone that facilitates the transfer of glucose

into cells to provide energy.[1] Three common types of diabetes are type 1 diabetes, type 2 diabetes, and gestational diabetes. Insulin is frequently used to treat all three types of diabetes. As of 2023, about 11.5% of the adult population in California has been diagnosed with diabetes. The incidence of diabetes is highest among adults aged 65 years and older.

The American Diabetes Association recommends different insulin regimens based on the patient's level of insulin deficiency, pattern of glucose levels, and individual patient characteristics. Insulin is necessary for the treatment of type 1 diabetes and is often needed for the treatment of type 2 diabetes and diabetes in pregnancy. Sometimes insulin is needed first line for type 2 diabetes for patients who have symptoms of acute insulin deficiency. However, most patients begin treatment with non-insulin medications for type 2 diabetes. Relatively new medications such as SGLT2 inhibitors and GLP-1 agonists are playing an increasingly important role in the management of type 2 diabetes because of their proven efficacy at improving long-term cardiovascular and renal outcomes compared to other medications (including insulin). As a result, the number of enrollees in California using insulin has decreased over time.

In general, insulin is expensive for individuals living with diabetes; therefore, cost may be a barrier to insulin use for some individuals.

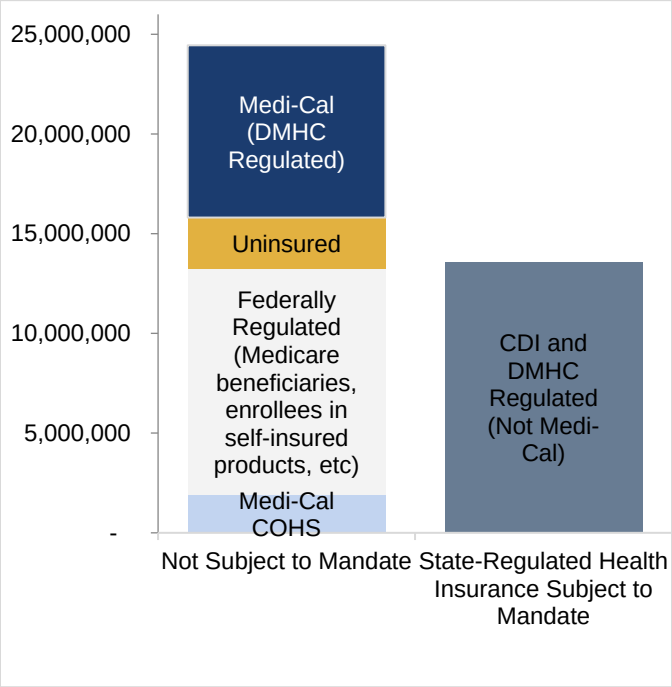
Bill Summary

Senate Bill (SB) 40 would limit cost sharing (copayments, coinsurance, and deductibles) for insulin to $35 for a 30-day supply and prohibit step therapy as a prerequisite to authorizing coverage of insulin. SB 40 states high deductible health plans (HDHPs) as defined under the definition set forth in Section 223(c)(2) of Title 26 of the United States Code would also be prohibited from imposing cost sharing exceeding $35, unless doing so would conflict with federal requirements for high deductible health plans.

For this analysis, CHBRP has assumed that mandates that reference plans and policies that cover prescription drugs are relevant to pharmacy benefit coverage.

Figure A notes how many Californians have health insurance that would be subject to SB 40.

Figure A. Health Insurance in CA and SB 40



Source: California Health Benefits Review Program, 2025.
Key: CDI = California Department of Insurance; COHS = County Organized Health System; DMHC = Department of Managed Health Care.

How does utilization impact premiums?

Health insurance, by design, distributes risk and expenditures across everyone enrolled in a plan or policy. It does so to help protect each enrollee from the full impact of health care costs that arise from that enrollee's use of prevention, diagnosis, and/or treatment of a covered medical condition, disease, or injury. Changes in utilization among any enrollees in a plan or policy can result in changes to premiums for all enrollees in that plan or policy.

[1] Refer to CHBRP's full report for full citations and references.

Impacts

Benefit Coverage

About 61% of enrollees with health insurance subject to state benefit mandates have pharmacy benefits subject to SB 40. Other enrollees with a pharmacy benefit not regulated by DMHC or CDI or without a pharmacy benefit are considered to have compliant coverage at baseline. SB 40 would establish a cost-sharing cap of $35 for a 30-day supply of insulin, which affects just those enrollees who have cost sharing greater than the cap/limit at baseline.

At baseline, no enrollees have health insurance that requires step therapy of a non-insulin treatment before receiving coverage for insulin, but most enrollees have health insurance that includes at least one form of step therapy that requires use of one insulin before granting approval of another insulin of the same therapeutic class.

CHBRP estimates at baseline there are 92,636 enrollees who use insulin in commercial and California Public Employees' Retirement System (CalPERS) DMHC-regulated plans and CDI-regulated policies, where 53,458 enrollees using insulin have cost sharing that does not exceed the SB 40 cost-sharing cap (58%). CHBRP estimates 39,178 enrollees (42%) using insulin have cost sharing that exceeds the SB 40 cap. Postmandate, 100% of enrollees with cost sharing that exceeds the cap at baseline would have cost sharing below the cap.

Utilization

CHBRP estimates that for those enrollees whose claims exceeded the cap at baseline their average monthly cost sharing is $52/month; postmandate, the average monthly cost sharing for this group would go down to $29/month, which reflects a reduction of 44%.

To estimate the change in utilization postmandate for these enrollees for whom cost sharing is reduced, CHBRP applied an assumption of an increase in utilization of insulin of 4% based on literature and content expert input. Additionally, CHBRP assumes a 10% reduction in diabetes-related emergency department visits for this population.

Step therapy is generally designed to require an enrollee to try a lower cost option before trying a higher cost option. 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.

Expenditures

In 2026, SB 40 would increase total net annual expenditures by $2,147,000 (0.001%) for enrollees with plans regulated by the California Department of Managed Health Care (DMHC) and policies regulated by the California Department of Insurance (CDI). This is due to an increase in $10,377,000 in total health insurance premiums paid by employers and enrollees, and a $8,230,000 decrease in enrollee expenses.

The changes in premiums as a result of SB 40 would be less than 0.03% for the different types of plans and policies by market segment and ranges from $0.04 per member per month (PMPM) for large-group DMHC-regulated plans and CDI-regulated policies to $0.19 PMPM for small group CDI-regulated policies.

The enrollees most likely to experience the greatest cost-sharing reductions postmandate are those who are enrolled in plans that require significant deductibles to be met before coinsurance is applied to the insulin purchase. Among the enrollees impacted by the cost-sharing cap, enrollees with out-of-pocket expenditures for insulin in the top 1% at baseline would have an annual savings of greater than $1,463. The annual savings for the top 5%, 10%, and 20% of enrollees based on cost-sharing expenditures for insulin would be greater than $446, $217, and $70, respectively.

Medi-Cal

The pharmacy benefit for beneficiaries in DMHC-regulated Medi-Cal managed care plans is administered by the Department of Health Care Services and therefore not impacted by SB 40.

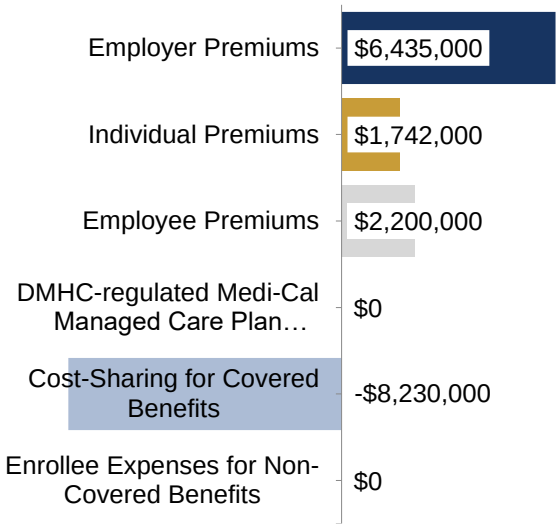
CalPERS

For enrollees associated with CalPERS in DMHC-regulated plans, there is no impact because there are no enrollees for whom cost sharing for insulin prescription is higher than the cap at baseline.

Number of Uninsured in California

Because the change in average premiums does not exceed 1% for any market segment, CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of SB 40.

Figure B. Expenditure Impacts of SB 40



Source: California Health Benefits Review Program, 2025.

Medical Effectiveness

There is *strong evidence*[2] from seven observational studies on cost-related insulin use/adherence that cost sharing affects insulin use and adherence in patients with diabetes; higher cost sharing reduces adherence and lower cost sharing increases adherence.

There is *some evidence*[3] from four studies on the effect of cost sharing for insulin on diabetes-related health outcomes and utilization. These studies suggest that reduced cost sharing is associated with decreased diabetes-related complications, emergency department visits, and hospitalizations. The effect of cost sharing on additional health outcomes, such as glycemic control, is unknown.

There is *strong evidence* based on CHBRP's previous analysis of Assembly Bill (AB) 2144 that step therapy is associated with a lower likelihood of initiating or continuing medications and with poorer adherence to medication.

There is *expert consensus*,[4] consistent with the finding for prescription medications, that step therapy protocols for insulin are associated with lowered use and adherence. Additionally, there is clinical consensus that insulin is considered essential for effective treatment of diabetes and that delayed introduction of, or ineffective insulin therapy contributes to poor glycemic control and places patients at risk of complications.

There are several limitations that contributed to the gradings provided in this review, most notably the barriers to conducting rigorous randomized controlled trials of differential cost-sharing or utilization management strategies on insulin use, inherent differences between the types of diabetes, and the multifaceted nature of diabetes treatment, resulting in a literature base that is not as rigorous as ideal and thereby limiting the certainty of conclusions drawn from the evidence.

Public Health

In the first year postmandate, 39,178 enrollees who exceed the insulin cost-sharing cap at baseline would have reduced cost sharing. CHBRP projects that as a result, there would be a 4% increase in utilization of insulin. At the population level, SB 40 is unlikely to have a public health impact due to the relatively limited overall number of enrollees affected. However, for the share of enrollees who would experience significant reductions in cost sharing and therefore a clinically meaningful increase in utilization of insulin, SB 40 may result in a reduction in health care utilization, and potentially in reduced complications from diabetes over time.

Long-Term Impacts

CHBRP estimates annual insulin utilization per user after the initial 12 months from the enactment of SB 40 would likely stay similar to utilization estimates during the first 12 months postmandate. Health care utilization due to

[2] *Strong evidence* indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective. Conclusions could be altered with additional strong evidence.
[3] *Some evidence* indicates that a small number of studies have limited generalizability to the population of interest and/or the studies have a serious methodological concern in research design or implementation. Conclusions could be altered with additional evidence.

[4] *Expert consensus* indicates that the CHBRP identified content expert has experience that agrees with at least one published clinical practice guideline from a professional society or government agency, editorial from those in the field, or opinion/consensus statement from a professional society, but no published empiric evidence is available.

improved diabetes management may change in the long term, particularly with the continued increased use of GLP-1 medications. Reductions in significant complications or comorbidities may take years to be realized, but the benefits are potentially very substantial. With regard to the prohibition of step therapy for insulin, it is possible insurers may change their utilization management protocols in response. It is possible that if step therapy is prohibited altogether on all insulin products, insurers may shift toward other utilization management strategies, such as prior authorization or formulary restrictions, to control costs. Prior authorization could require additional documentation or clinical justification before approving certain insulin prescriptions, potentially delaying access. Insurers might also implement tighter formulary controls, limiting the range of covered insulin options or imposing quantity limits.

Essential Health Benefits and the Affordable Care Act

SB 40 would not require coverage for a new state benefit mandate and instead modifies cost-sharing terms and conditions of an already covered medication. Therefore, SB 40 would not exceed the definition of EHBs in California.