SB-40 Health care coverage: insulin. (2025-2026)

Date Published: 10/14/2025 02:00 PM

Senate Bill No. 40

CHAPTER 737

An act to amend Section 1367.51 of the Health and Safety Code, and to amend Section 10176.61 of the Insurance Code, relating to health care coverage.

[Approved by Governor October 13, 2025. Filed with Secretary of State October 13, 2025.]

LEGISLATIVE COUNSEL'S DIGEST

SB 40, Wiener. Health care coverage: insulin.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or disability insurance policy issued, amended, delivered, or renewed on or after January 1, 2000, that covers prescription benefits to include coverage for insulin if it is determined to be medically necessary.

This bill would prohibit a large group health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after January 1, 2026, or an individual or small group health care service plan contract or health insurance policy on or after January 1, 2027, from imposing a copayment, coinsurance, deductible, or other cost sharing of more than $35 for a 30-day supply of an insulin prescription drug, except as specified. On and after January 1, 2026, the bill would prohibit a health care service plan or health insurer from imposing step therapy as a prerequisite to authorizing coverage of insulin, and, for a large group health care service plan contract or health insurance policy, would require at least one insulin for a given drug type in all forms and concentrations to be on the prescription drug formulary. The bill would limit the $35 cap for an individual or small group health care service plan contract or health insurance policy to only Tier 1 and Tier 2 insulin if the drug formulary is grouped into tiers, except as provided. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. (a) The Legislature finds and declares all of the following:

(1) Approximately 263,000 Californians are diagnosed with type 1 diabetes each year. Approximately 4,037,000 Californian adults have diabetes.

(2) Every Californian with type 1 diabetes, and many with type 2 diabetes, rely on daily doses of insulin to survive.

(3) Insulin prices have nearly tripled, creating financial hardships for people who rely on it to survive.

(4) One in four people using insulin have reported insulin underuse due to the high cost of insulin.

(5) Imposing a deductible on insulin, and requiring individuals to meet that deductible, creates a financial burden that presents a barrier to accessing insulin.

(6) Diabetes is the seventh leading cause of death, and it is a leading cause of disabling and life-threatening complications, including heart disease, stroke, kidney failure, amputation of the lower extremities, and new cases of blindness among adults.

(7) Studies have shown that managing diabetes can prevent complications and medical emergencies associated with diabetes that result in emergency room visits, hospitalizations, and costly treatments.

(b) Therefore, it is the intent of the Legislature to enact legislation on important policies to reduce the costs for Californians with diabetes to obtain lifesaving and life-sustaining insulin.

SEC. 2. Section 1367.51 of the Health and Safety Code is amended to read:

1367.51. (a) A health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after January 1, 2000, and that covers hospital, medical, or surgical expenses shall include coverage for the following equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without a prescription:

(1) Blood glucose monitors and blood glucose testing strips.

(2) Blood glucose monitors designed to assist the visually impaired.

(3) Insulin pumps and all related necessary supplies.

(4) Ketone urine testing strips.

(5) Lancets and lancet puncture devices.

(6) Pen delivery systems for the administration of insulin.

(7) Podiatric devices to prevent or treat diabetes-related complications.

(8) Insulin syringes.

(9) Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

(b) A health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after January 1, 2000, that covers prescription benefits shall include coverage for the following prescription items if the items are determined to be medically necessary:

(1) Insulin.

(2) Prescriptive medications for the treatment of diabetes.

(3) Glucagon.

(c) The copayments and deductibles for the benefits specified in subdivisions (a) and (b) shall not exceed those established for similar benefits within the given plan.

(d) (1) Notwithstanding subdivision (c), a large group health care service plan contract that is issued, amended, or renewed on or after January 1, 2026, shall not impose a copayment, coinsurance, deductible, or any other cost sharing on an insulin prescription drug that exceeds thirty-five dollars ($35) for a 30-day supply. At least one insulin for a given drug type in all forms and concentrations shall be on the prescription drug formulary.

(2) Notwithstanding subdivision (c), an individual or small group health care service plan contract that is issued, amended, or renewed on or after January 1, 2027, shall not impose a copayment, coinsurance, deductible, or any other cost sharing on an insulin prescription drug that exceeds thirty-five dollars ($35) for a 30-day supply. If an individual or small group health care service plan contract maintains a drug formulary grouped into tiers, the cost-sharing cap pursuant to paragraph (1) shall apply

only to insulin prescription drugs that are in Tier 1 and Tier 2. At least one insulin for a given drug type in all forms and concentrations shall be on Tier 1 or Tier 2. If there is no Tier 1 or Tier 2 insulin prescription drug that is clinically appropriate for an enrollee, the health care service plan shall limit the cost sharing for a higher tier drug to no more than thirty-five dollars ($35) for a 30-day supply for an individual enrollee.

(3) If a health care service plan contract is a high deductible health plan, as defined in Section 223(c)(2) of Title 26 of the United States Code, the contract shall not impose a deductible, coinsurance, or any other cost sharing on an insulin prescription drug that exceeds thirty-five dollars ($35) for a 30-day supply, unless applying the thirty-five-dollar ($35) limitation for a 30-day supply of an insulin prescription drug would conflict with federal requirements for high deductible health plans.

(4) When the state has the capacity to label or produce an insulin prescription drug, the deductible and copayment limitations in paragraph (1) shall also apply to an insulin prescription drug, or any therapeutic equivalent insulin prescription drug, that is labeled or produced by the state.

(5) For purposes of this subdivision and subdivision (e):

(A) “Drug type” includes, but is not limited to, rapid acting, regular or short acting, intermediate acting, long acting, ultra-long acting, and premixed.

(B) “Insulin prescription drug” means a prescription drug that contains insulin and is used to control blood glucose levels to treat diabetes.

(e) (1) Consistent with this section, on and after January 1, 2026, a health care service plan shall not impose step therapy protocols as a prerequisite to authorizing coverage of an insulin prescription drug described in subdivision (d), except as provided in paragraph (2). For purposes of this section, “step therapy protocol” means 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. For purposes of this section, step therapy is prohibited for both self-administered drugs and physician-administered drugs, except as provided in paragraph (2).

(2) Because the United States Food and Drug Administration has approved one or more types of insulin, this section does not require a health care service plan to cover all of the types of insulin without step therapy, if at least one insulin in each drug type is covered without step therapy.

(3) This subdivision does not apply to Medi-Cal managed care plans contracting with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

(f) A health care service plan shall provide coverage for diabetes outpatient self-management training, education, and medical nutrition therapy necessary to enable an enrollee to properly use the equipment, supplies, and medications set forth in subdivisions (a) and (b), and additional diabetes outpatient self-management training, education, and medical nutrition therapy upon the direction or prescription of those services by the enrollee’s participating physician. If a plan delegates outpatient self-management training to contracting providers, the plan shall require contracting providers to ensure that diabetes outpatient self-management training, education, and medical nutrition therapy are provided by appropriately licensed or registered health care professionals.

(g) The diabetes outpatient self-management training, education, and medical nutrition therapy services identified in subdivision (f) shall be provided by appropriately licensed or registered health care professionals as prescribed by a participating health care professional legally authorized to prescribe the service. These benefits shall include, but not be limited to, instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to thereby avoid frequent hospitalizations and complications.

(h) The copayments for the benefits specified in subdivision (f) shall not exceed those established for physician office visits by the plan.

(i) A health care service plan governed by this section shall disclose the benefits covered pursuant to this section in the plan’s evidence of coverage and disclosure forms.

(j) A health care service plan shall not reduce or eliminate coverage as a result of this section.

(k) This section does not deny or restrict in any way the department’s authority to ensure plan compliance with this chapter if a plan provides coverage for prescription drugs.

(l) This section does not apply to Medi-Cal managed care plans contracting with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75

(commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code to the extent that the services described in this section are excluded from coverage under the contract between the Medi-Cal managed care plans and the State Department of Health Care Services.

SEC. 3. Section 10176.61 of the Insurance Code is amended to read:

10176.61. (a) An insurer issuing, amending, delivering, or renewing a disability insurance policy on or after January 1, 2000, that covers hospital, medical, or surgical expenses shall include coverage for the following equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without a prescription:

(1) Blood glucose monitors and blood glucose testing strips.

(2) Blood glucose monitors designed to assist the visually impaired.

(3) Insulin pumps and all related necessary supplies.

(4) Ketone urine testing strips.

(5) Lancets and lancet puncture devices.

(6) Pen delivery systems for the administration of insulin.

(7) Podiatric devices to prevent or treat diabetes-related complications.

(8) Insulin syringes.

(9) Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

(b) An insurer issuing, amending, delivering, or renewing a disability insurance policy on or after January 1, 2000, that covers prescription benefits shall include coverage for the following prescription items if the items are determined to be medically necessary:

(1) Insulin.

(2) Prescriptive medications for the treatment of diabetes.

(3) Glucagon.

(c) The coinsurances and deductibles for the benefits specified in subdivisions (a) and (b) shall not exceed those established for similar benefits within the given policy.

(d) (1) Notwithstanding subdivision (c), a large group health insurance policy that is issued, amended, or renewed on or after January 1, 2026, shall not impose a copayment, coinsurance, deductible, or any other cost sharing on an insulin prescription drug that exceeds thirty-five dollars ($35) for a 30-day supply. At least one insulin for a given drug type in all forms and concentrations shall be on the prescription drug formulary.

(2) Notwithstanding subdivision (c), an individual or small group health insurance policy that is issued, amended, or renewed on or after January 1, 2027, shall not impose a copayment, coinsurance, deductible, or any other cost sharing on an insulin prescription drug that exceeds thirty-five dollars ($35) for a 30-day supply. If an individual or small group health insurance policy maintains a drug formulary grouped into tiers, the cost-sharing cap pursuant to paragraph (1) shall apply only to insulin prescription drugs that are in Tier 1 and Tier 2. At least one insulin for a given drug type in all forms and concentrations shall be on Tier 1 or Tier 2. If there is no Tier 1 or Tier 2 insulin prescription drug that is clinically appropriate for an insured, the health insurer shall limit the cost sharing for a higher tier drug to no more than thirty-five dollars ($35) for a 30-day supply for an individual insured.

(3) If a health insurance policy is a high deductible health plan, as defined in Section 223(c)(2) of Title 26 of the United States Code, the policy shall not impose a deductible, coinsurance, or any other cost sharing on an insulin prescription drug that exceeds thirty-five dollars ($35) for a 30-day supply, unless applying the thirty-five-dollar ($35) limitation for a 30-day supply of an insulin prescription drug would conflict with federal requirements for high deductible health plans.

(4) When the state has the capacity to label or produce an insulin prescription drug, the deductible and copayment limitations in paragraph (1) shall also apply to an insulin prescription drug, or any therapeutic equivalent insulin prescription drug, that is labeled or produced by the state.

(5) For purposes of this subdivision and subdivision (e):

(A) “Drug type” includes, but is not limited to, rapid acting, regular or short acting, intermediate acting, long acting, ultra-long acting, and premixed.

(B) “Insulin prescription drug” means a prescription drug that contains insulin and is used to control blood glucose levels to treat diabetes.

(e) (1) Consistent with this section, on and after January 1, 2026, a health insurer shall not impose step therapy as a prerequisite to authorizing coverage of an insulin prescription drug described in subdivision (d), except as provided in paragraph (2). For purposes of this section, “step therapy” has the same meaning as defined in paragraph (2) of subdivision (i) of Section 10123.201. For purposes of this section, step therapy is prohibited for both self-administered drugs and physician-administered drugs, except as provided in paragraph (2).

(2) Because the United States Food and Drug Administration has approved one or more types of insulin, this section does not require a health care service plan to cover all of the types of insulin without step therapy, if at least one insulin in each drug type is covered without step therapy.

(f) An insurer shall provide coverage for diabetes outpatient self-management training, education, and medical nutrition therapy necessary to enable an insured to properly use the equipment, supplies, and medications set forth in subdivisions (a) and (b) and additional diabetes outpatient self-management training, education, and medical nutrition therapy upon the direction or prescription of those services by the insured’s participating physician. If an insurer delegates outpatient self-management training to contracting providers, the insurer shall require contracting providers to ensure that diabetes outpatient self-management training, education, and medical nutrition therapy are provided by appropriately licensed or registered health care professionals.

(g) The diabetes outpatient self-management training, education, and medical nutrition therapy services identified in subdivision (f) shall be provided by appropriately licensed or registered health care professionals as prescribed by a health care professional legally authorized to prescribe the services.

(h) The coinsurances and deductibles for the benefits specified in subdivision (f) shall not exceed those established for physician office visits by the insurer.

(i) Every disability insurer governed by this section shall disclose the benefits covered pursuant to this section in the insurer’s evidence of coverage and disclosure forms.

(j) An insurer shall not reduce or eliminate coverage as a result of this section.

(k) This section does not apply to vision-only, dental-only, accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, or disability income insurance, except that for accident-only, specified disease, and hospital indemnity insurance coverage, benefits under this section only apply to the extent that the benefits are covered under the general terms and conditions that apply to all other benefits under the policy. This section does not impose a new benefit mandate on accident-only, specified disease, or hospital indemnity insurance.

SEC. 4. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.