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NEW YORK SENATE BILL S1618 MEMORANDUM AND ANALYSIS

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MAY 7, 2026

a. Executive Summary

At the request of T1 International and the NYU Science, Health & Information Clinic, Public Interest Experts (PIE) has reviewed the economic justifications for New York State Senate Bill S1618, the "New York affordable drug manufacturing act."[1] The proposed bill would "direct the commissioner of health to enter into partnerships to increase competition, lower prices, and address shortages in the market for generic prescription drugs, to reduce the cost of prescription drugs for public and private purchasers, taxpayers, and consumers, and to increase patient access to affordable drugs."[2]

According to preliminary unpublished calculations, if New York State were able to procure insulin at approximately $0.03 per unit (roughly $45 per five-pack of pens or $30 per vial), total acquisition costs for the 6.3 billion non-Medicaid units sold in the State would equal approximately $190.5 million annually.[3] Depending on available rebates, this would result in annual savings to payers of between $74 million and $162 million, assuming that all payers obtain insulin at $0.03/unit, either because they choose to purchase through the state program or because the state program drives down the market price.[4] The precise fiscal impact would depend on prevailing rebate levels, coverage arrangements, and implementation details across commercial insurance, assistance programs, and out-of-pocket purchasers.

The most direct source of savings to the State will arise from the New York State Health Insurance Program (NYSHIP). This program covers 1.2 million people.[5] Assuming that 11

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1 The New York State Senate, Senate Bill S1618, available at: https://www.nysenate.gov/legislation/bills/2025/S1618.

2 The New York State Senate, Senate Bill S1618, available at: https://www.nysenate.gov/legislation/bills/2025/S1618.

3 William B. Feldman, "Draft calculations for the public manufacturing of insulin in New York," unpublished, February 8, 2026, ("Feldman Memo"), Table 3. The assumption that New York State would be able to procure insulin at $0.03/unit assumption is derived from the pricing that CalRx is offering for glargine insulin manufactured by Civica Rx.

4 Feldman Memo, Table 3. Since only list prices are known, but not rebates, the range that Feldman provides reflects a range of rebate levels from 20% to 40%. Feldman estimates that the wholesale acquisition cost in 2025 for all non-Medicaid insulin prescribed in New York State, prior to rebates, was $440.5 million for 6.3 billion units of insulin ($0.07/unit). Assuming payers received a 20 percent rebate off list prices results in a total WAC of $352.4 million for 6.3 billion units of insulin ($0.056/unit). Total WAC based on $0.03/unit would equal $190.5 million (6,348,600,000 * 0.03). Thus, savings under the 20 percent rebate scenario equal $161.9 million ($352.4 million - $190.5 million). Assuming payers received a 40 percent rebate off list prices results in a total WAC of $264.3 million for 6.3 billion units of insulin ($0.042/unit), which translates to savings of $73.8 million ($264.3 million - $190.5 million).

5 New York State Department of Civil Service, "New York State Health Insurance Program – Frequently Asked Questions," available at: https://www.cs.ny.gov/employee-benefits/pa-market/faq.cfm#3.

percent of this population has diagnosed diabetes,[6] and that 27 percent of the diabetic population takes insulin,[7] this means that New York State is buying insulin for approximately 35,640 people.[8] Further assuming that the average insulin user uses 50 units/day (i.e., one five-pack of 3 mL pens per month)[9] means that, based on these assumptions, New York State is purchasing approximately 650 million units of insulin per year.[10] This translates to annual savings between $7.8 million (40 percent rebate scenario)[11] and $16.9 million (20 percent rebate scenario).[12] We note that these are estimated annual savings for NYSHIP alone (not other programs), and we have not independently verified the quantity and price that NYSHIP currently pays for insulin.

Other public programs include New York State's Essential Plan, which is largely federally funded,[13] and state-owned hospitals that receive highly discounted drugs through the federal 340B Drug Pricing Program.[14]

S1618 is aimed not just at short-term savings, however, but at reshaping how insulin is purchased in New York to promote long-term affordability and stability. By leveraging the State's large purchasing power through a coordinated procurement strategy, the policy could strengthen competition in a market that is currently highly concentrated among a few manufacturers—conditions that tend to put upward pressure on prices without sustained oversight.

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6 Jane A. Gwira, Cheryl D. Fryar, and Qiuping Gu, November 2024, "Prevalence of Total, Diagnosed, and Undiagnosed Diabetes in Adults: United States, August 2021–August 2023," U.S. Centers for Disease Control and Prevention, *NCHS Data Brief*, No. 516, available at: https://www.cdc.gov/nchs/products/databriefs/db516.htm.

7 Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, December 16, 2022, "Report to Congress on the Affordability of Insulin," available at: https://aspe.hhs.gov/reports/insulin-affordability-rtc.

8 35,640 = 1,200,000 * 0.11 * 0.27

9 This assumption is consistent with the assumptions used in peer-reviewed research. *See*, e.g., Chien-Wen Tseng, Camlyn Masuda, Randi Chen, and Daniel M. Hartung, April 2020, "Impact of Higher Insulin Prices on Out-of-Pocket Costs in Medicare Part D," *Diabetes Care*, Volume 43, Issue 4 ("Cost projections were based on insulin use (50 units/day) and no other medications."). There are 100 units of insulin in each mL of standard U-100 insulin. *See* U.S. Food and Drug Administration, Lantus (insulin glargine injection) prescribing information, available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/021081s076lbl.pdf.

10 650 million units per year = 50 units/day * 365 days/year * 35,640 users

11 $7.8 million = ($0.042/unit - $0.03/unit) * 650 million units

12 $16.9 million = ($0.056/unit - $0.03/unit) * 650 million units

13 Office of the New York State Comptroller, "Federal Funding and New York," available at: https://www.osc.ny.gov/reports/budget/fed-funding-ny/essential-plan.

14 Health Resources and Services Administration, U.S. Department of Health and Human Services, "340B Drug Pricing Program," available at: https://www.hrsa.gov/opa.

Beyond direct pricing effects, the legislation may generate broader benefits. Improved insulin access could reduce costly emergency care, while policies that encourage new market entrants—similar to California's CalRx initiative—could spur in-state manufacturing, providing jobs and generating tax revenue. This memo outlines the economic rationale for using state-supported procurement to enhance competition, stabilize pricing, and expand access over time.

b. Background on Insulin Expenditures in New York State

Approximately 2.6 million prescriptions for the four most commonly prescribed insulins (Glargine, Lispro, Aspart, and Degludec) were dispensed in New York in 2025, corresponding to approximately 7.7 billion units of insulin and approximately $531.7 million in wholesale acquisition cost (WAC) spending.[15] Medicare accounted for roughly 43 percent of total insulin volume, commercial insurers 37 percent, Medicaid 18 percent, and the remaining 2 percent reflected cash payments or assistance programs.[16]

Because Medicaid receives statutory rebates under federal law, the proposed program focuses primarily on non-Medicaid prescriptions. Recent national and state-level pricing initiatives have altered the short-run pricing environment, making near-term fiscal projections more complex. However, the scale of the New York insulin market and the concentrated structure of insulin manufacturing underscore the importance of policies aimed at promoting durable competition and supply stability.

Procurement costs differ by delivery format, and any state acquisition program would need to align with existing utilization patterns to ensure continuity of care and clinical appropriateness. Given the large volume of insulin dispensed annually, even incremental shifts in market structure or acquisition terms may have meaningful implications for pricing dynamics and budget predictability.

c. Recent Market Developments

Recent developments indicate that insulin prices have declined significantly in the retail market:

- TrumpRx is offering insulin lispro at $25 per 10 mL vial for uninsured and underinsured individuals.[17]

[15] Feldman Memo, p. 2.

[16] Feldman Memo, Table 2.

[17] TrumpRx, "Insulin Lispro," available at: https://trumprx.gov/p/insulin-lispro.

- Medicare beneficiaries face a $35 monthly cap on insulin costs under federal policy.[18]
- Beginning January 1, 2026, CalRx began offering insulin Glargine pens at approximately $11 per 3 mL pen in California.[19]
- Civica Rx, the CalRx manufacturer, announced similar Glargine pricing to the broader market (not just California) beginning in January 2026.[20]

These changes follow several significant policy and market shifts—including the Inflation Reduction Act, voluntary manufacturer price reductions, and biosimilar approvals—that have reduced retail insulin prices relative to historical levels.[21] However, retail prices do not necessarily reflect net payer spending, and costs vary substantially across insurance arrangements and assistance programs.

Using conservative WAC assumptions for currently available lower-cost products, total non-Medicaid insulin spending in New York is approximately $440.5 million per year.[22] The evolving pricing landscape and historic behavior of the incumbent pharmaceutical companies reinforces the importance of focusing on long-run market structure rather than solely on short-term price comparisons.

d. Market Structure and Long-Run Risks

In addition to potential savings, there are several structural features of the insulin market that warrant continued policy attention.

[18] Juliette Cubanski and Tricia Neuman, June 12, 2024, *KFF*, "The Facts About the $35 Insulin Copay Cap in Medicare," available at: https://www.kff.org/medicare/the-facts-about-the-35-insulin-copay-cap-in-medicare.

[19] CalRx, "Biosimilar Insulin Initiative," available at: https://calrx.ca.gov/biosimilar-insulin-initiative/.

[20] Civica, October 15, 2025, "Civica To Launch Long-Acting Insulin Glargine in the US in January 2026," available at: https://civicarx.org/civica-to-launch-long-acting-insulin-glargine-in-the-us-in-january-2026/.

[21] GoodRx, "Insulin Costs Plummet: A Decade-Long High Comes to an End," January 15, 2025, available at: https://www.goodrx.com/healthcare-access/research/how-much-does-insulin-cost-compare-brands.

[22] Feldman Memo, p. 3.

Historically, the market for insulin production has been highly concentrated.[23] High prices for insulin have been attributed to this concentration of a small number of manufacturers.[24] Limited competition enabled sustained supercompetitive pricing over many years.[25]

Although prices have recently fallen, the market remains concentrated, and there is no guarantee that current pricing levels will persist. There have been positive developments in the biosimilar insulin market because biosimilar insulin can be produced at lower cost relative to originator biologic insulin. Yet, entry has been slow due to:[26]

- High capital investment requirements
- Regulatory barriers
- Strategic behavior by incumbent manufacturers
- Supply chain and contracting dynamics

To date, Civica Rx has emerged as a new entrant partly because of its partnership with California's CalRx program to manufacture biosimilar insulin Glargine, with plans to expand into rapid-acting insulin. Notably, Civica Rx has entered into agreements with BioCon, a large India-based manufacturer, reflecting the scale and manufacturing complexity required to compete.[27]

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[23] Ryan Knox, January-June 2020, "Insulin insulated: barriers to competition and affordability in the United States insulin market," *Journal of Law and the Biosciences,* Volume 7, Issue 1, pp. 1-25; Bianca Silva Gordon, Aditi Sen, John Hargraves, April 4, 2023, "Insulin Prices in ESI Nearly Doubled from 2012-2021, with Effects of Emerging Biosimilars Evident in Recent Years," *Health Care Cost Institute*, available at: https://healthcostinstitute.org/all-hcci-reports/https-healthcostinstitute-org-hcci-research-insulin-prices-in-esi-nearly-doubled-from-2012-2021-with-effects-of-emerging-biosimilars-evident-in-recent-years/.

[24] Jentora White, Afton Wagner, and Hima Patel, January 2022, "The impact of biosimilar insulins on the diabetes landscape," *Journal of Managed Care and Specialty Pharmacy*, Volume 28, Number 1, pp. 91-98.

[25] Bianca Silva Gordon, Aditi Sen, John Hargraves, April 4, 2023, "Insulin Prices in ESI Nearly Doubled from 2012-2021, with Effects of Emerging Biosimilars Evident in Recent Years," *Health Care Cost Institute*, available at: https://healthcostinstitute.org/all-hcci-reports/https-healthcostinstitute-org-hcci-research-insulin-prices-in-esi-nearly-doubled-from-2012-2021-with-effects-of-emerging-biosimilars-evident-in-recent-years/; Sean Dickson, Nico Gabriel, and Walid F. Gellad, and Inmaculada Hernandez, June 2023, "Estimated Changes in Insulin Prices and Discounts After Entry of New Insulin Products, 2012-2019," *JAMA Health Forum*, Vol. 4, No. 6.

[26] Jentora White, Afton Wagner, and Hima Patel, January 2022, "The impact of biosimilar insulins on the diabetes landscape," *Journal of Managed Care and Specialty Pharmacy*, Volume 28, Number 1, pp. 91-98.

[27] CalRx, "Biosimilar Insulin Initiative," available at: https://calrx.ca.gov/biosimilar-insulin-initiative/; Civica, October 15, 2025, "Civica To Launch Long-Acting Insulin Glargine in the US in January 2026," available at: https://civicarx.org/civica-to-launch-long-acting-insulin-glargine-in-the-us-in-january-2026/.

At the same time, incumbent manufacturers have introduced—or plan to introduce—their own biosimilars.[28] While this may initially support price competition, it could also represent a strategy to preserve market share and stabilize prices at higher levels over time.[29]

Absent sustained competitive pressure, there is a meaningful risk that prices could rise again once political and public scrutiny recede. Given that non-Medicaid insulin spending in New York approximates $440 million annually at WAC levels,[30] even modest upward price movements could produce substantial fiscal consequences. For example, a 10 percent price increase applied to this base would represent roughly $44 million in additional annual spending. This risk could result in much higher costs to the State and consumers as diabetes among young people is forecast to rise over the next decade.[31]

e. Policy Rationale Beyond Immediate Fiscal Effects

Considering recent price reductions, the strongest justification for New York's proposed acquisition program may extend beyond immediate fiscal savings and instead focus on strengthening the long-run competitive dynamics of the insulin market.

First, the proposal may support durable competition. State-backed purchasing commitments can help reinforce biosimilar entry by providing predictable demand and revenue certainty to new or smaller manufacturers. In a market characterized by high fixed costs, regulatory complexity, and entrenched incumbent firms, such commitments may counteract structural advantages enjoyed by existing manufacturers and lower effective barriers to sustained competition.

Second, the policy may help prevent price reversal. Although insulin prices have declined recently, those reductions may reflect temporary political scrutiny, regulatory changes, or voluntary manufacturer actions rather than permanent structural shifts in market competition.

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[28] Jentora White, Afton Wagner, and Hima Patel, January 2022, "The impact of biosimilar insulins on the diabetes landscape," *Journal of Managed Care and Specialty Pharmacy*, Volume 28, Number 1, pp. 91-98; Frank Vinluan, January 28, 2024, "Biosimilar Insulins Promise Patients New Choices, But Competition Is Still Lacking," *MedCity News*, available at: https://medcitynews.com/2024/01/biosimilar-insulin-diabetes-biologic-drugs/.

[29] Ryan Knox, January-June 2020, "Insulin insulated: barriers to competition and affordability in the United States insulin market," *Journal of Law and the Biosciences,* Volume 7, Issue 1, pp. 1-25.

[30] Feldman Memo, Table 3.

[31] Thaddaus Tonnies, Ralph Brinks, Scott Isom, Dana Dabelea, Jasmin Divers, Elizabeth J. Mayer-Davis, Jean M. Lawrence, Catherine Pihoker, Lawrence Dolan, Angela D. Liese, Sharon H. Saydah, Ralph B. D'Agostino, Annika Hoyer, and Giuseppina Imperatore, February 2023, "Projections of Type 1 and Type 2 Diabetes Burden in the U.S. Population Aged <20 Years Through 2060: The SEARCH for Diabetes in Youth Study," *Diabetes Care*, Volume 46, Issue 2.

If underlying concentration and entry barriers remain unchanged, there is a risk that prices could rise again once external pressure diminishes. Reinforcing competitive entry may therefore serve as a safeguard against reversion to higher pricing levels.

Third, the presence of credible public alternatives may maintain downward pressure on market pricing. A publicly supported purchasing pathway can anchor pricing expectations among payers and manufacturers and reduce the likelihood of coordinated or parallel price increases in a concentrated market.

Fourth, the State could require that a new entrant like Civica Rx build its new plant in New York, which would result in a notable investment in the State and support several hundred jobs during construction and operations.[32]

Fifth, the proposed approach may offer a lower-risk mechanism for promoting competition relative to direct state manufacturing. Unlike California's partnership model, which involves manufacturing collaboration and associated operational risks, New York's proposed structure would not require the State to assume production risk. This distinction may provide a more measured pathway to supporting competitive dynamics while limiting fiscal and operational exposure.

Sixth, the addition of a state-sponsored supply chain may help to mitigate future drug shortages and potential price spikes in shortage environments.

Seventh, the legislation provides the basis to extend the program to other drugs beyond insulin, which could provide further savings and benefits for New Yorkers.

Finally, the State may see savings from reduced visits to emergency departments stemming from diabetics who cannot at present afford their medications.[33]

f. Caveats

Several caveats apply. First, fiscal estimates reflect aggregate non-Medicaid effects and do not isolate direct State budget impacts.[34] Second, dispensing fees and certain program-specific

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[32] Katherine Schulte, October 17, 2025, "Civica to start selling long-acting insulin in January 2026," *Virginia Business*, available at: https://virginiabusiness.com/civica-sell-insulin-january-2026-petersburg/.

[33] Ryan Lyerla, Brianna Johnson-Rabbett, Almoutaz Shakally, Rekha Magar, Hind Alameddine, and Lisa Fish, August 2021, "Recurrent DKA results in high societal costs – a retrospective study identifying social predictors of recurrence for potential future intervention," *Clinical Diabetes and Endocrinology*, Volume 7, Number 13, pp. 1-6.

[34] Feldman Memo, p. 4.

dynamics are simplified in the modeling assumptions.[35] Third, rebate arrangements and 340B interactions are confidential and complex, limiting precision.[36] Fourth, the analysis assumes substantial substitution to a state-supported product; real-world uptake may differ.[37] Accordingly, fiscal projections should be interpreted as illustrative ranges rather than precise forecasts.

g. Conclusion

Recent market developments have materially altered the insulin pricing landscape, introducing new sources of competition and lowering retail prices. At the same time, insulin manufacturing remains structurally concentrated, and long-run pricing stability is not guaranteed.

New York's non-Medicaid insulin market remains substantial—approximately $440.5 million annually under conservative WAC assumptions. While modeled fiscal effects vary depending on rebate assumptions and implementation details, the more enduring justification for the legislation lies in its potential to reinforce competition, promote market stability, and mitigate the risk of future price escalation.

Accordingly, the proposal is best understood not primarily as a short-term savings initiative, but as a structural intervention designed to strengthen long-run competitive dynamics and preserve access in a critical therapeutic market.

[35] Feldman Memo, p. 4.

[36] Feldman Memo, p. 4.

[37] Feldman Memo, p. 4.