THE SENATE
THIRTY-THIRD LEGISLATURE, 2026
STATE OF HAWAII

S.B. NO. 2933

JAN 23 2026

A BILL FOR AN ACT

RELATING TO HEALTH CARE COSTS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The legislature finds that the rising costs of prescription drugs continue to place essential medications out of reach for many residents of the State, especially those managing chronic conditions such as diabetes, asthma, and severe allergies. High and unpredictable drug prices directly contribute to medication nonadherence, avoidable hospitalizations, and long-term health complications that drive up both public and private health care expenditures.

The legislature further finds that as part of efforts to address health care costs in the insurance and prescription drug markets, several states, including Colorado, Maryland, Minnesota, and Oregon, have established prescription drug affordability boards to evaluate high-cost prescription drugs and set upper payment limits when appropriate to protect consumers and purchasers. Other state legislatures are currently working to pass legislation through the National Council of Insurance Legislators. Illinois' proposed regulatory

framework in particular, as outlined in H.B. No. 1443 (2025), provides a robust, multifactor affordability model that evaluates medicare price benchmarks, patient access barriers, state budget impact, manufacturer conduct, and availability of therapeutic alternatives.

The legislature additionally finds that direct-to-consumer affordability policies--such as out-of-pocket limits for essential medications and the prohibition of copayment adjustment programs--provide immediate, tangible relief to patients while longer-term, systemic affordability tools, such as a prescription drug affordability board, take effect.

The legislature recognizes that opposition may arise from those who argue that an affordability board may disrupt market dynamics, discourage drug innovation, or reduce availability of specialty medications. However, the legislature finds that numerous adaptive measures exist to combat these risks. For example, access protections and waiver processes can prevent unintended restrictions on medications for rare or complex conditions. Drug research and development decisions are also driven primarily by global market forces, not reimbursement decisions made by a single state. Additionally, medicare

negotiations now establish national price benchmarks that states may fairly consider. Furthermore, a phased implementation framework, combined with shared rulemaking across state agencies, can prevent administrative overload and ensure effective adoption of new legislation establishing a prescription drug affordability board.

Accordingly, the purpose of this Act is to safeguard patient access, strengthen pricing transparency, and promote long-term sustainability in the delivery of prescription drugs throughout the State by creating a comprehensive, balanced, and patient-centered approach to prescription drug affordability that includes:

(1) Establishing a prescription drug affordability board to identify and evaluate high-cost prescription drugs and, when appropriate, set upper payment limits tied to medicare price benchmarks;

(2) Implementing statutory limits on out-of-pocket costs for certain medications to provide immediate financial relief to patients;

(3) Prohibiting copayment adjustment programs that prevent financial assistance provided by manufacturers or

nonprofit organizations from counting towards a patient's deductibles and maximum out-of-pocket amounts;

(4) Ensuring that affordability tools do not impede access to medication for patients with chronic or life-threatening conditions; and

(5) Aligning the State with national drug pricing trends while protecting the health and financial well-being of its residents.

SECTION 2. The Hawaii Revised Statutes is amended by adding a new chapter to title 19 be appropriately designated and to read as follows:

"CHAPTER

PRESCRIPTION DRUG AFFORDABILITY BOARD

§ -1 Definitions. As used in this chapter:

"Board" means the prescription drug affordability board established pursuant to section -2.

"Department" means the department of health.

"Director" means the director of health.

"Generic drug" has the same meaning as the term "authorized generic drug" is defined in title 21 United States Code section 355.

"Health insurance carrier" means any accident and health or sickness insurer governed under article 10A, chapter 431; mutual benefit society governed under article 1, chapter 432; or health maintenance organization governed under chapter 432D.

"Manufacturer" means any entity engaged in the manufacture of prescription drugs sold or distributed in the State.

"Pharmacy benefit manager" has the same meaning as defined in section 431R-1.

"Prescription drug" or "drug" means a drug regulated under title 21 United States Code section 353(b), including biologics and biosimilars.

"Upper payment limit" means the maximum amount that may be reimbursed or paid for a prescription drug subject to an affordability determination under this chapter.

§ -2 Prescription drug affordability board; established. (a) There is established within the department for administrative purposes only the prescription drug affordability

board for the proper administration and enforcement of this chapter.

(b) The board shall consist of five voting members appointed by the governor pursuant to section 26-34 and three ex officio, nonvoting members.

(c) Voting members shall possess expertise in one or more of the following areas:

(1) Health care economics;

(2) Clinical medicine or pharmacy practice;

(3) Health insurance coverage or actuarial analysis;

(4) Public health policy; or

(5) Consumer health advocacy relating to prescription drug access.

(d) No voting member shall be an employee, board member, or lobbyist of a manufacturer, pharmacy benefit manager, wholesale drug distributor, or health insurance carrier.

(e) The following shall serve as ex officio, nonvoting members:

(1) The director of health or the director's designee;

(2) The director of human services or the director's designee; and

(3) The insurance commissioner or the commissioner's designee.

(f) The board shall select a chairperson from among its voting members.

§ -3 **Meetings; quorum; voting.** (a) The board shall meet at least quarterly and may hold additional meetings as the board deems necessary.

(b) A majority of the voting members of the board shall constitute a quorum to do business and the concurrence of at least three voting members shall be necessary to make any action of the board valid.

(c) Meetings of the board shall be conducted subject to chapter 92; provided that the board may enter an executive meeting pursuant to section 92-4 or 92-5(8) to receive proprietary or confidential pricing data submitted by a manufacturer, health insurance carrier, or pharmacy benefit manager.

§ -4 **Powers and duties of the board.** The board shall:

(1) Identify prescription drugs that may create affordability challenges for patients, purchasers, or the State;

(2) Conduct affordability reviews of identified prescription drugs;

(3) Make affordability determinations;

(4) Recommend and, where authorized under this chapter, establish upper payment limits tied to medicare price benchmarks;

(5) Analyze the impact of prescription drug prices on state and county expenditures, including medicaid and public employee health benefits; and

(6) Consult affected stakeholders, including patients, health care providers, health insurance carriers, pharmacies, and manufacturers.

§ -5 **Staffing; administrative support.** (a) The board may employ staff, including analysts, economists, pharmacists, or other subject matter experts, as necessary to assist the board in performing its duties.

(b) The board may contract for professional services, including actuarial analysis and clinical review, to support its affordability review process.

(c) The department shall provide administrative support to the board.

§ -6 **Data submission; confidentiality; data-sharing agreements.** (a) Upon request of the board, a manufacturer, health insurance carrier, or pharmacy benefit manager shall submit to the board pricing, rebate, utilization, or other cost data necessary for the board to conduct an affordability review.

(b) The board shall maintain the confidentiality of proprietary information received pursuant to this section to the extent permitted under state law; provided that the board may publish aggregated findings that do not disclose individual contract terms or pricing.

(c) The board may enter into data-sharing agreements with other states' prescription drug affordability boards or pricing authorities to support multistate analysis and price benchmarking.

§ -7 **Affordability review of prescription drugs; identification; determination; criteria.** (a) The board shall conduct a review of prescription drugs to identify drugs that may require an affordability review to determine whether the prescription drug presents an affordability challenge for patients or purchasers in the State. A prescription drug may be

subject to an affordability review pursuant to this section if it meets one or more of the following criteria:

(1) The drug has a wholesale acquisition cost of $30,000 or more per year or per course of treatment;

(2) The drug has experienced a wholesale acquisition cost increase of more than fifteen per cent in a single year or more than forty per cent over any three-year period;

(3) The drug is a generic or off-patent drug that has experienced a wholesale acquisition cost increase of more than two hundred per cent in a twelve-month period;

(4) The drug is a new-to-market drug with a launch price substantially higher than therapeutic alternatives or medicare price benchmarks; or

(5) The department of human services or the Hawaii employer-union health benefits trust fund has reported a significant increase in state expenditure for the drug.

(b) In conducting an affordability review of a prescription drug, the board may consider:

(1) Medical necessity and the severity of the disease or condition treated by the drug;

(2) The availability, effectiveness, and cost of therapeutic alternatives;

(3) The extent to which the drug addresses an unmet medical need;

(4) The impact of the drug's cost on patient adherence and access; and

(5) Any additional factors the board deems relevant to the public interest.

(c) After completing an affordability review, the board shall determine whether the prescription drug is unaffordable in the State by applying a multi-factor rubric, which shall include:

(1) Price benchmarking, which shall consider whether the drug's price exceeds the medicare part D negotiated prices for plans issued for medicare recipients in the State or the medicare maximum fair price for the drug negotiated pursuant to title 42 United States Code section 1320f or other nationally recognized benchmarks by thirty per cent or more;

(2) State spending impact, which shall consider whether expenditures for the drug contribute significantly to medicaid, public employee health benefits, or other state health program cost trends;

(3) Patient access data, which shall consider documented cases of high out-of-pocket costs, nonadherence, financial hardship, or utilization drop-off attributable to drug cost;

(4) Manufacturer conduct, which shall consider whether the manufacturer has engaged in patterns of unjustified price increases, anti-competitive behavior, or failure to justify cost increases upon request of the board; and

(5) Availability of alternatives, which shall consider whether generic, biosimilar, or therapeutic equivalents are available and clinically appropriate;

provided that, in addition to the price benchmarks in paragraph (1), the board may consider national and international pricing data in an affordability determination, including prices in jurisdictions with drug price negotiation or regulation.

§ -8 **Upper payment limits; authority; medicare reference pricing.** (a) If the board determines that a prescription drug is unaffordable in the State pursuant to section -7, the board may establish an upper payment limit for that drug.

(b) The upper payment limit shall be based on, to the extent practicable:

(1) The medicare part D negotiated price for the drug for plans issued for medicare recipients in the State;

(2) The medicare maximum fair price for the drug negotiated pursuant to title 42 United States Code section 1320f; or

(3) A percentage of the medicare price benchmark reflecting market conditions of the State.

(c) The board shall adopt rules establishing the methodology for calculating upper payment limits, including:

(1) Adjustments for dispensing fees, supply chain costs, and other reasonable administrative expenses; and

(2) A requirement that upper payment limits apply uniformly across all payers regulated by the State, including health insurance carriers.

(d) In adopting an upper payment limit, the board shall:

(1) Consult with patient advocacy organizations, clinicians, and other stakeholders as to whether an upper payment limit will affect patient access to treatment;

(2) Issue public notice of the proposed limit;

(3) Conduct at least one public hearing;

(4) Solicit written input from affected stakeholders including patients, health care providers, pharmacies, health insurance carriers, and manufacturers; and

(5) Publish its final determination regarding the upper payment limit for the prescription drug, which shall include a summary of the evidence and analysis supporting its determination and responses to stakeholder comments.

(e) An upper payment limit established pursuant to this section shall not apply to any drug:

(1) Used to treat a rare disease for which no therapeutic alternative exists, unless the board determines that applying the limit will not restrict patient access;

(2) For which the manufacturer demonstrates that application of the limit would result in withdrawal from the state market; or

(3) Administered exclusively in inpatient hospital settings.

§ -9 **Administrative priorities; patient access.** (a) In administering this chapter, the board shall ensure that affordability measures, including upper payment limits, do not impede patient access to medically necessary prescription drugs.

(b) The board shall prioritize:

(1) Preserving access to chronic care medications needed for diabetes, asthma, severe allergies, cardiovascular disease, mental health conditions, and other long-term illnesses;

(2) Not disrupting treatment regimens for patients who rely on complex or specialty medication;

(3) Ensuring continuity of care for vulnerable populations, including kupuna, individuals with disabilities, and low-income residents; and

(4) Preventing discriminatory impacts on patients with rare, pediatric, or life-threatening conditions.

§ **-10 Waivers and variances.** (a) A manufacturer, health insurance carrier, pharmacy, or pharmacy benefit manager may apply to the board for a waiver or variance from an upper payment limit.

(b) Upon proper filing of an application, the board shall conduct a hearing in accordance with sections 91-9, 91-9.5, 91-10, 91-11, 91-12, and 91-13, as applicable.

(c) Notwithstanding any law to the contrary, notice of the hearing, together with a copy of the application, shall be served on the director and insurance commissioner. In addition, notice of the hearing shall be mailed to all persons who have made a timely written request for advance notice of waivers or variances from upper payment limits, and public notice shall be given at least once statewide at least thirty days in advance of the hearing.

(d) Notwithstanding any law to the contrary, state agencies and persons may intervene in the proceedings in accordance with rules adopted by the board; provided that the applicant, the department, and the insurance commissioner shall appear as parties in every case and make recommendations relative to the waiver or variance.

(e) The board may grant a waiver or variance from an upper payment limit if the applicant demonstrates, with supporting evidence, that:

(1) Application of the upper payment limit would jeopardize patient access to the prescription drug;

(2) Compliance with the upper payment limit is not feasible due to supply chain or market conditions unique to the State;

(3) The applicant is unable to procure the prescription drug at a cost consistent with the upper payment limit despite good-faith negotiation efforts;

(4) The prescription drug is used to treat a rare disease or other condition for which no therapeutic alternative exists; or

(5) The waiver or variance is otherwise necessary to protect the health and safety of state residents.

(f) The board, by publication of its findings of fact and conclusions of law, together with its decision and order, shall act to approve the application, deny the application, or modify the application by imposing conditions necessary to uphold the purpose and intent of this chapter.

(g) A waiver or variance granted pursuant to this section shall remain in effect for a period specified by the board in its decision and order, and may be renewed with good cause.

(h) The board shall adopt rules pursuant to chapter 91 establishing:

(1) Application procedures for a waiver or variance;

(2) Required supporting documentation;

(3) Timeframes for board action;

(4) Intervention procedures for state agencies and persons; and

(5) Conditions for renewal, modification, or revocation of waivers and variances.

§ **-11 Appeals.** (a) Any person aggrieved by a final decision of the board under this chapter may appeal the decision to the circuit court of the first circuit pursuant to section 91-14.

(b) The filing of an appeal shall not stay the effectiveness of an upper payment limit or other board action unless ordered by the court for good cause shown.

§ **-12 Enforcement; penalty; attorney general.** (a) The board shall monitor compliance with upper payment limits or

waivers or variances therefrom, established or granted pursuant to this chapter.

(b) Any health insurance carrier, pharmacy benefit manager, or pharmacy that violates an upper payment limit or waivers or variances granted by the board shall be subject to administrative penalties established by the board by rule; provided that penalties under this subsection shall not exceed $1,000 per violation per day.

(c) A manufacturer that withdraws a prescription drug from the state market in retaliation for the establishment of an upper payment limit shall be subject to:

(1) A civil penalty of not more than $25,000 per day; and

(2) A public notice identifying the manufacturer and prescription drug.

(d) The board may refer repeated or intentional violations to the attorney general for enforcement of this section.

§ -13 Interagency coordination. (a) The board shall collaborate with the department of human services, the Hawaii employer-union health benefits trust fund, the insurance division of the department of commerce and consumer affairs, and

other state agencies as appropriate to carry out its duties under this chapter.

(b) All state agencies shall provide the board, upon request and to the extent permitted by law, data and technical assistance necessary for conducting affordability reviews.

(c) The board may recommend statutory or regulatory changes to improve data collection, transparency, and oversight of prescription drug pricing.

§ **-14 Annual reports.** The board shall submit a report of its administration of this chapter to the legislature no later than twenty days prior to the convening of each regular session, including:

(1) A list of the prescription drugs reviewed and affordability determinations issued by the board in the preceding year;

(2) Any upper payment limits established by the board in the preceding year and the rationale for each upper payment limit;

(3) Any waivers or variances from upper payment limits granted by the board in the preceding year;

(4) Data on changes in drug spending and patient access through the preceding year;

(5) A summary of stakeholder concerns and recommendations received by the board in the preceding year; and

(6) Other findings and recommendations, including proposed legislation or regulations.

§ **-15 Rules.** The board shall adopt rules pursuant to chapter 91 necessary to carry out the purposed of this chapter."

SECTION 3. Chapter 431, Hawaii Revised Statutes, is amended by adding three new sections to article 10A to be appropriately designated and to read as follows:

"**§431:10A-A Prescription drugs; out-of-pocket maximum.** (a) Each individual and group accident and health or sickness insurance policy, contract, plan, or agreement issued or renewed after December 31, 2026, that includes coverage or benefits for prescription drugs shall comply with the following requirements:

(1) Cost-share for prescription insulin drugs shall not exceed $35 for a thirty-day supply, inclusive of all forms and delivery devices;

(2) Cost-share for a portable prescription drug delivered by inhalation and approved by the United States Food

and Drug Administration for treatment or management of asthma shall not exceed $50 per inhaler, regardless of the quantity or dosage; provided that this paragraph shall not prohibit a covered person from choosing a higher-priced inhaler; and

(3) Cost-share for a package of two single-use prescription automatic injector devices that contain epinephrine and are approved by the United States Food and Drug Administration for the emergency treatment of life-threatening allergic reactions, including anaphylaxis, shall not exceed $60.

(b) Every insurer shall provide notice to its policyholders regarding the maximum cost-share amount required by this section. The notice shall be in writing and prominently positioned in any literature or correspondence sent to policyholders and shall be transmitted to policyholders within calendar year 2027 when annual information is made available to policyholders or in any other mailing to policyholders, but in no case later than December 31, 2027.

(c) Nothing in this section shall prevent an insurer from offering lower cost-sharing amounts or waiving cost-sharing entirely for covered prescription drugs.

(d) As used in this section, "cost-share" or "cost-sharing" includes copayment, coinsurance, and deductible provisions applicable to coverage for medications or treatments.

§431:10A-B Copayment adjustment programs; prohibited. (a) Every insurer shall apply all third-party payments, including manufacturer copayment assistance or assistance from nonprofit patient assistance programs, toward a covered person's maximum cost-share amount, unless prohibited by federal law.

(b) No insurer shall implement a copayment adjustment program or any similar policy that disregards third-party payments for the purpose of calculating a covered person's cost-sharing obligations.

(c) The commissioner shall adopt rules pursuant to chapter 91 to implement this section.

(d) As used in this section, "cost-share" or "cost-sharing" includes copayment, coinsurance, and deductible provisions applicable for coverage for medications or treatments.

§431:10A-C Prescription drug upper payment limits; compliance. (a) Every insurer shall comply with any upper payment limit established or a waiver or variance therefrom granted by the prescription drug affordability board pursuant to chapter .

(b) No insurer shall reimburse a pharmacy, prescriber, or patient for a prescription drug subject to an upper payment limit established pursuant to chapter in an amount greater than the upper payment limit.

(c) Nothing in this section shall prohibit an insurer from negotiating a lower reimbursement rate."

SECTION 4. Chapter 432, Hawaii Revised Statutes, is amended by adding three new sections to article 1 to be appropriately designated and to read as follows:

"**§432:1- Prescription drugs; out-of-pocket maximum.** (a) Notwithstanding any law to the contrary, each individual and group hospital or medical service plan contract issued or renewed in this State after December 31, 2026, that includes coverage or benefits for prescription drugs shall comply with the following requirements:

(1) Cost-share for prescription insulin drugs shall not exceed $35 for a thirty-day supply, inclusive of all forms and delivery devices;

(2) Cost-share for a portable prescription drug delivered by inhalation and approved by the United States Food and Drug Administration for treatment or management of asthma shall not exceed $50 per inhaler, regardless of the quantity or dosage; provided that this paragraph shall not prohibit a member from choosing a higher-priced inhaler; and

(3) Cost-share for a package of two single-use prescription automatic injector devices that contain epinephrine and are approved by the United States Food and Drug Administration for the emergency treatment of life-threatening allergic reactions, including anaphylaxis, shall not exceed $60.

(b) Every mutual benefit society shall provide notice to its members regarding the maximum cost-share amount required by this section. The notice shall be in writing and prominently positioned in any literature or correspondence sent to members and shall be transmitted to members within calendar year 2027

when annual information is made available to members or in any other mailing to members, but in no case later than December 31, 2027.

(c) Nothing in this section shall prevent a mutual benefit society from offering lower cost-sharing amounts or waiving cost-sharing entirely for covered prescription drugs.

(d) For the purposes of this section, "cost-share" or "cost-sharing" includes copayment, coinsurance, and deductible provisions applicable to coverage for medications or treatments.

§432:1- Copayment adjustment programs; prohibited. (a) Every mutual benefit society shall apply all third-party payments, including manufacturer copayment assistance or assistance from nonprofit patient assistance programs, toward a covered person's maximum cost-share amount, unless prohibited by federal law.

(b) No mutual benefit society shall implement a copayment adjustment program or any similar policy that disregards third-party payments for the purpose of calculating a covered person's cost-sharing obligations.

(c) The commissioner shall adopt rules pursuant to chapter 91 to implement this section.

(d) For the purposes of this section, "cost-share" or "cost-sharing" includes copayment, coinsurance, and deductible provisions applicable to coverage for medications and treatments.

§432:1- Prescription drug upper payment limits; compliance. (a) Every mutual benefit society shall comply with any upper payment limit established or a waiver or variance therefrom granted by the prescription drug affordability board pursuant to chapter .

(b) No mutual benefit society shall reimburse a pharmacy, prescriber, or patient for a prescription drug subject to an upper payment limit established pursuant to chapter , in an amount greater than the upper payment limit.

(c) Nothing in this section shall prohibit a mutual benefit society from negotiating a lower reimbursement rate."

SECTION 5. Chapter 432D, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"**§432D- Prescription drugs; out-of-pocket maximum; copayment assistance; upper payment limits.** (a) Each policy, contract, plan, or agreement issued in the State after

December 31, 2026, by health maintenance organizations pursuant to this chapter, that includes coverage or benefits for prescription drugs shall comply with the maximum cost-share requirements for prescription drugs established in section 431:10A-A.

(b) Every health maintenance organization shall apply all third-party copayment assistance toward an enrollee's maximum cost-share amount in accordance with section 431:10A-B.

(c) Every health maintenance organization shall comply with any upper payment limits established or a waiver or variance therefrom granted by the prescription drug affordability board pursuant to chapter .

(d) The commissioner may enforce compliance with this section pursuant to chapter 431 and rules adopted pursuant to chapter 91."

SECTION 6. There is appropriated out of the general revenues of the State of Hawaii the sum of $500,000 or so much thereof as may be necessary for fiscal year 2026-2027 to establish and administer the prescription drug affordability board, including:

(1) The establishment and hiring of positions as deemed necessary by the department of health;

(2) Contracting of data systems, actuarial analysis, and clinical review services; and

(3) Conducting stakeholder engagement, rulemaking, and public hearings required under this Act.

The sum appropriated shall be expended by the department of health for the purposes of this Act.

SECTION 7. In codifying the new sections added by section 3 of this Act, the revisor of statutes shall substitute appropriate section numbers for the letters used in designating the new sections in this Act.

SECTION 8. This Act does not affect rights and duties that matured, penalties that were incurred, and proceedings that were begun before its effective date.

SECTION 9. New statutory material is underscored.

SECTION 10. This Act shall take effect on July 1, 2026.

INTRODUCED BY: 

S.B. NO. 2933

Report Title:
DOH; Insurance Commissioner; Health Care; Costs; Prescription Drug Affordability Board; Upper Payment Limits; Out-of-Pocket Maximums; Copayment Adjustment Programs; Reports; Rules; Appropriation

Description:
Establishes the Prescription Drug Affordability Board within the Department of Health to conduct affordability reviews on high-cost prescription drugs and establish upper payment limits under certain circumstances. Establishes out-of-pocket maximums for prescribed insulin, asthma inhalers, and epinephrine auto-injectors. Prohibits copayment adjustment programs. Requires health insurers, mutual benefit societies, and health maintenance organizations to comply with certain affordability measures. Requires annual reports to the Legislature. Requires adoption of rules by the Affordability Board and Insurance Commissioner. Appropriates funds.

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