STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
DEPARTMENT OF HEALTH - *KA ʻOIHANA OLAKINO*

JOSH GREEN, MD
GOVERNOR OF HAWAIʻI
KE KIAʻĀINA O KA MOKUʻĀINA ʻO HAWAIʻI

KENNETH S. FINK, MD, MGA, MPH
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JOHN C. (JACK) LEWIN, MD
ADMINISTRATOR

February 13, 2026

TO: SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES
Senator Joy A. San Buenaventura, Chair;
Senator Angus L.K. McKelvey, Vice Chair; and

SENATE COMMITTEE ON COMMERCE AND CONSUMER PROTECTION
Senator Jarrett Keohokalole, Chair;
Senator Carol Fukunaga, Vice Chair; and
Honorable Members

FROM: John C. (Jack) Lewin, MD, Administrator, SHPDA, and Sr. Advisor to Governor Josh Green, MD on Healthcare Innovation

RE: **SB 2933 -- RELATING TO HEALTH CARE COSTS**

HEARING: Tuesday, February 17, 2026 @ 09:45 am; Conference Room 229

POSITION: SUPPORT INTENT with COMMENTS

Testimony:

SHPDA strongly supports the intent of SB 2933, with comments.

This bill is intended to make essential prescription drugs more affordable for Hawaiʻi residents. Of course, SHPDA enthusiastically supports that, including the intent to cap price increases and/or excessive costs for life-saving drugs including insulin, epinephrine, and asthma inhalers. These changes would represent responsible public policy positions.

However, it also establishes a Prescription Drug Affordability Board by the DOH with Insurance Commissioner participation. Both agencies already have enormous responsibilities and ongoing staff shortages and other workload challenges. We therefore defer to DOH and DCCA on their ability to fulfill this broad new responsibility.

If not, one novel possibility with this bill would be to start small by amending it to simply cap prices on the three life-saving drugs mentioned, namely insulin, epinephrine, and asthma inhalers, noting there is large price variation on these medications, and particularly for inhalers that may need to be considered in terms of including generic versions or a limited formulary for inhalers. This alone would be a big step first forward

in these regards. Perhaps advice from the Hawai`i Pharmacists Association or the Legislative Reference Bureau could establish fair prices if this amended route is favored.

Of course, if DOH and DCCA can accommodate the bill's additional responsibilities at this time with an appropriation, we would enthusiastically support the full intent of SB 2933.

Thank you for hearing SB 2933; and for the opportunity to testify.

■ -- Jack Lewin, MD, Administrator, SHPDA

JOSH GREEN, M.D.
GOVERNOR | KE KIA'ĀINA

SYLVIA LUKE
LIEUTENANT GOVERNOR | KA HOPE KIA'ĀINA

STATE OF HAWAII | KA MOKU'ĀINA 'O HAWAI'I
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Testimony of the Department of Commerce and Consumer Affairs

Before the
Senate Committees on Health and Human Services
and
Commerce and Consumer Protection
Tuesday, February 17, 2026
9:45 a.m.
State Capitol, Room 229 and via Videoconference

On the following measure:
S.B. 2933, RELATING TO HEALTH CARE COSTS

Chair San Buenaventura, Chair Keohokalole, and Members of the Committees:

My name is Scott K. Saiki, and I am the Insurance Commissioner of the Department of Commerce and Consumer Affairs' (Department) Insurance Division. The Department offers comments on this bill.

The purpose of this bill is to: (1) establish 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; (2) establish out-of-pocket maximums for prescribed insulin, asthma inhalers, and epinephrine auto-injectors; (3) prohibits copayment adjustment programs; (4) require health insurers, mutual benefit societies, and health maintenance organizations to comply with certain affordability measures; (5) require annual reports to the Legislature; (6) require adoption of rules by the Affordability Board and Insurance Commissioner; and (7) appropriate funds.

The Department offers the following comments on sections 3, 4, and 5 of this bill, which establish insurance mandates for specific prescription drugs.

The Department notes that it is unclear whether the amendments in sections 3 through 5 of this bill would trigger the defrayal requirements of 45 Code of Federal Regulations (CFR) § 155.170. Under the Affordable Care Act, if a state mandates benefits that are "in addition to" the essential health benefits defined in the state's benchmark plan, the State is required to defray the cost of those additional benefits. This means the State would be responsible for paying the additional premium costs for those benefits for all individuals enrolled in qualified health plans on the exchange.

Additionally, the Department notes the requirements set forth in Hawaii Revised Statutes (HRS) section 23-51. This statute mandates that "[b]efore any legislative measure that mandates health insurance coverage for specific health services... can be considered, there shall be concurrent resolutions passed requesting the auditor to prepare and submit to the legislature a report that assesses both the social and financial effects of the proposed mandated coverage."

The purpose of the auditor's report is twofold. First, the report determines the actual public demand for the service and whether its lack of coverage results in financial hardship or restricted access to care. Second, the report evaluates the potential financial impact of the new mandated benefit, including potential impacts to premiums, total cost of health care, and state defrayal. The completion of the report before the bill is enacted provides the Legislature with the objective data necessary to balance the benefits of the proposed coverage against its potential economic impact. Additionally, the auditor's report could be used in the Department's actuarial analysis in determining whether an issuer's proposed rates are justified.

As this measure establishes mandatory cost-sharing limits for specific medications, an auditor's report would help to evaluate the potential financial impact, including potential impacts to premiums and the total cost of health care.

Thank you for the opportunity to testify on this bill.

OFFICE OF INFORMATION PRACTICES

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To: Senate Committees on Health and Human Services and
on Commerce and Consumer Protection

From: Carlotta Amerino, Director

Date: February 17, 2026, 9:45 a.m.
State Capitol, Conference Room 229

Re: Testimony on S.B. No. 2933
Relating to Health Care Costs

Thank you for the opportunity to submit testimony on this bill, which would create a Prescription Drug Affordability Board (Board) and set out-of-pocket maximums for specified prescriptions. The Office of Information Practices (OIP) takes no position on the substance of this bill, but offers a comment and a recommended amendment to a proposed special executive session purpose for the Board.

Proposed subsection __-3(c), Hawaii Revised Statutes (HRS), on page 7 beginning at line 12, would allow "the board [to] enter an executive meeting pursuant to section 92-4 or 92-5(8) to receive proprietary or confidential pricing data[.]" OIP does not object to allowing the board to receive confidential pricing data in executive session, but has a technical concern with this provision. Section 92-4, HRS, sets out the procedures for a board to hold an executive session closed to the public, and section 92-5(a), HRS, sets out the purposes for which a board can do so. Discussion of confidential pricing data does not clearly fall within section 92-5(a)(8) or the other executive session purposes set out in section 92-5(a). Even

though such information could likely be withheld from the public in response to a record request under the Uniform Information Practices Act (UIPA), chapter 92F, HRS, the UIPA's exceptions to disclosure are not confidentiality statutes that would authorize holding an executive session under section 92-5(a)(8). Thus, to ensure that this provision clearly authorizes the Board to go into executive session for the purpose of receiving confidential pricing data, OIP respectfully recommends replacing the language at page 7, lines 12-17, with the following:

> "provided that the board may enter an executive meeting pursuant to section 92-4 to receive proprietary or confidential pricing data submitted by a manufacturer, health insurance carrier, or pharmacy benefit manager, and this shall be an authorized purpose for the board to hold an executive meeting in addition to those listed in section 92-5(a)."

Thank you for considering OIP's testimony.

February 13, 2026

TO: Chair Joy A. San Buenaventura
Vice Chair Angus L.K. McKelvey
Members of the Senate Committee on Health and Human Services

TO: Chair Jarrett Keohokalole
Vice Chair Carol Fukunaga
Members of the Senate Committee on Commerce and Consumer Protection

FROM: Pharmaceutical Research and Manufacturers of America (PhRMA)
(William Goo)

RE: **SB2933** - Relating to Health Care Costs
Hearing Date: February 17, 2026
Time: 9:45 am

PhRMA strongly opposes **SB2933** which establishes a Prescription Drug Affordability Board the creation of which risks reducing treatment options, increasing costs in other areas of the health care system, limiting innovation and creating constitutional challenges. Attached is PhRMA's full testimony in opposition.

Thank you for considering this testimony.

STATEMENT

PhRMA
RESEARCH • PROGRESS • HOPE

In Opposition to Hawaii SB2933
February 12, 2026

Position: PhRMA respectfully opposes SB2933. PhRMA believes that discussions about the affordability of medicines are important, but the intention of this bill is for the government to decide drug prices, which could limit the prescription options available to Hawaii residents. SB2933 shortsightedly targets drug spending in ways that likely will have long-term, harmful effects on innovation and the development of new, life-saving therapies.

Specifically, SB2933 implements a government-appointed Board to review prescription drug costs and value with the goal of setting price limits by way of an upper payment limit (UPL) for the entire drug supply system. Regulating drug prices in-state could lead to a shortage of or limit access to medicines for patients. Specifically, if a pharmacy or provider cannot obtain a medicine at the government price, the medicine may not be available to Hawaii residents. By disincentivizing the development of innovative treatments, this legislation could threaten the positive effect that the biopharmaceutical industry has on Hawaii's economy. In the nearly seven years since the first PDAB law passed in 2019, no savings have been achieved for patients or states. PDABs are unlikely to help patients, because irrespective of the amount at which the UPL is set or the evidence and criteria for determining "unaffordability," patients may find themselves worse off than before. This is largely due to how health insurers have stated they expect to react: by modifying benefit design, formularies, and provider reimbursement.[1]

PDABs are not a good use of state funds

State PDAB implementation efforts to date have languished severely. State officials have encountered firsthand the complexity of the U.S. pharmaceutical supply chain and the lack of consensus across a broad range of stakeholders that would be impacted by potential UPLs. As some states have endeavored to select drugs for affordability reviews and then to conduct such reviews—a precursor to UPLs—the experience has been wrought with bureaucratic process, public and private stakeholder expense, and unclear timelines.[2] While well-intentioned, PDABs are not accomplishing their objectives and are wasting public and private money, time, and energy. PDAB funding to date ranges from more than $1 million (Minnesota) to more than $7.2 million (Washington), exceeding $23 million across the

[1] P'ship to Fight Chronic Disease, Health Plans Predict: Implementing Upper Payment Limits May Alter Formularies and Benefit Design but Won't Reduce Patient Costs 3 (Mar. 2024).

[2] For example, the Maine PDAB missed its March 1, 2020, deadline to convene its inaugural meeting, and then missed its October 1, 2020, deadline to report its first recommendations to the legislature—its first report is dated March 2, 2022, nearly a year and a half after the deadline. *See* Me. PDAB Report (Mar. 22, 2022); Me. Rev. Stat. § 2041.4. As another example, the Colorado PDAB repeatedly delayed rulemaking. *See* Colo. PDAB Meeting Agenda (Apr. 26, 2024) (delaying April rulemaking hearing to September). Additionally, the Oregon PDAB paused affordability reviews in June 2024 and did not complete its statutory mandate on affordability reviews that year. *See* Or. PDAB Meeting Minutes (June 26, 2024); Or. Rev. Stat. § 646A.694(1).

six states that have published funding data in fiscal notes or supplemental budget requests.[3] In 2025, New Hampshire disbanded their PDAB entirely.[4]

PDABs are often structured in a way that does not adequately take provider and patient feedback into consideration.

A 2025 survey[5] by the Value of Care Coalition found broad concerns among physicians about PDABs. 93% of respondents believe there is not sufficient knowledge-sharing between boards and doctors. 96% of specialty doctors surveyed were concerned that setting UPLs could lead to non-medical switching. Additionally, 100% of physicians surveyed were concerned that decisions made by PDABs will lead to additional administrative burdens for staff that cut into patient care time.

A recent survey of health plans reveals significant concerns about access to medicines and patient out-of-pocket costs with the implementation of upper payment limits.

The Partnership to Fight Chronic Disease (PFCD) released a white paper in 2025 that analyzed a survey of regional and national health plan payers with PDAB-related experience. These payers cover the majority of Americans. A key point included that, **"77% of health plan payers** believe UPLs would **disrupt patient access** to prescription drugs due to coverage changes, tiering adjustments, increased cost-sharing, or supply chain complications, including pharmacies potentially refusing to stock medicines with UPLs."[6] The paper also reported that, **"67% of payers** anticipate that **patient cost-sharing for UPL-designated drugs will either increase (50%)** or remain the same (17%), while **70%** expect **out-of-pocket (OOP) costs for drugs in the same class to either rise (53%)** or stay unchanged (17%)."[7]

The use of the federal Maximum Fair Price (MFP) as a reference price in UPL decisions may reduce patient access and pose challenges in state healthcare markets.

For prescription drugs identified by the Board as "creating an affordability challenge" and subject to the Medicare MFP, SB2933 requires the Board to set the UPL at the MFP. Medicare MFP is a price-setting mechanism recently enacted as part of the federal Inflation Reduction Act ("IRA"). Implementation of the IRA statute and the complex framework of its MFP provisions is at an early stage, and many operational and legal issues remain to be sorted out.

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[3] Colo. Legis. Council Staff, SB 21-175 Final Fiscal Note (Oct. 6, 2021); Joint Budget Committee Staff FY2023-24 Budget Briefing Summary (Dec. 6, 2022); Md. Dep't of Legis. Servs., HB 768 Fiscal and Policy Note (May 7, 2019); Md. Operating Budget FY25: Volume 1 at 244; Md. Operating Budget FY26: Volume 1 at 248; Minn. S.2744 (2023); N.J. Off. of Legis. Servs., S1615 Legislative Fiscal Estimate (May 23, 2023); Or. Legis. Fiscal Off., Fiscal Impact of Proposed Legislation SB 844 – A9 (June 15, 2021); Wash. Fiscal Note Package 65329 (2022).

[4] https://www.dhhs.nh.gov/programs-services/medicaid/new-hampshire-prescription-drug-affordability-board#:~:text=Pursuant%20to%20the%202026%20biennium%20state%20budget%2C,statute%20that%20established%20the%20board%20in%202020.

[5] Magnolia Market Access. "State Prescription Drug Affordability Boards (PDAB) and Analysis of Patient Impact: A US Physician Survey Study." February 2026. Available at: https://www.magnoliamarketaccess.com/wp-content/uploads/CPPH_Magnolia_Final-white-paper_for-release.pdf

[6] The Partnership to Fight Chronic Disease. "Health Plans Predict: Implementing Upper Payment Limits May Alter Formularies And Benefit Design But Won't Reduce Patient Costs." March 2025. Available at: http://www.fightchronicdisease.org/_files/ugd/b11210_20c7d158bf93452395d6b4e2b0056bb0.pdf

[7] The Partnership to Fight Chronic Disease. "Health Plans Predict: Implementing Upper Payment Limits May Alter Formularies And Benefit Design But Won't Reduce Patient Costs." March 2025. Available at: http://www.fightchronicdisease.org/_files/ugd/b11210_20c7d158bf93452395d6b4e2b0056bb0.pdf

In addition, the Medicare Drug Negotiation Program is beginning to disrupt and reduce Medicare Part D beneficiaries' access to medicines.[8] Specifically, a recent survey found that 78 percent of Part D plans expect to decrease the number of therapeutic options in drug classes containing one or more IRA-selected drugs.[9] Moreover, approximately 60% of payers plan to add utilization management requirements.[10] In addition, the National Community Pharmacists Association (NCPA) surveyed 8,000 independent pharmacy owners and managers in January 2025. NCPA reports that "93.2% of independent pharmacists are considering not stocking, or have already decided to not stock, one or more of the first 10 drugs listed in the Medicare Drug Price Negotiation Program."[11] In addition to concerns that federal price controls could cause plans and pharmacies to limit patient access to medicines, experts predict that price controls in Medicare will shift incentives for research and development away from many diseases and illnesses, including those that disproportionately affect underserved communities, such as diabetes, heart disease, and some cancers.[12]

Price controls like MFP myopically target prescription drugs without addressing other components of our highly interconnected health care system, such as hospitalizations, preventive care, administration, taxes, and benefit mandates.[13] This is extremely concerning given that state PDAB programs are attempting to import aspects of the MDPNP into states as they undertake the risky prospect of implementing price controls. States likely will have trouble broadening MFP to state markets given the MFP was designed specifically for the Medicare program, which differs greatly from the state-regulated plans for which PDAB UPLs would apply.

This legislation ignores that there are meaningful policies for addressing affordability without importing government price setting that could reduce treatment options.

PhRMA is increasingly concerned that the substantial rebates and discounts paid by pharmaceutical manufacturers, approximately $356 billion in 2024,[14] do not make their way to offsetting patient costs at the pharmacy counter. Patients need concrete reforms that will help lower the price they pay for medicines at the pharmacy, such as sharing negotiated savings on medicines with patients, making cost-sharing assistance count toward a plan's out-of-pocket spending requirements, and making monthly costs more predictable. These policies can be done without importing government price setting, which can reduce the options available to treat patients.

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8 Magnolia Market Access, Inflation Reduction Act Payer Insights Report, Chartbook: Summary of Key Findings 5 (2024).

9 Ibid.

10 Ibid.

11 NCPA, Report for January 2025 Survey of Independent Pharmacy Owners/Managers (2025).

12 Kenneth E. Thorpe, *Penny Wise and Pound Foolish: IRA Impact on Chronic Disease Costs in Medicare*, Health Affairs (June 27, 2024) ("[C]hronic disease . . . is the largest driver of health care costs and a significant source of disparate health outcomes in underserved and marginalized communities[.]").

13 *Drug Price Controls Are 'Ill-Conceived, Counterproductive'*, Conn. Bioscis. Growth Council (Apr. 9, 2021) (explaining that "prescription drug prices represent just 10% to 14% of overall healthcare costs and reflect the significant time and costs of developing lifesaving medicines").

14 Fein, A. "The 2025 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers," Drug Channels Institute. March 2025.

Further, this legislation myopically targets prescription drugs without addressing other components of our highly interconnected health care system, such as hospitalizations, preventive care, administration, taxes, and benefit mandates.[15]

This legislation does not account for insurance benefit design issues that prevent discounts from flowing to patients, and SB2933 assumes incorrectly that the price a patient pays is determined solely by drug manufacturers.

This legislation singles out the biopharmaceutical industry and ignores the variety of stakeholders involved in determining what consumers ultimately pay for a medicine, including insurers, pharmacy benefit managers (PBMs), wholesalers, and the government. The important role that these entities play in determining drug coverage and patient out-of-pocket costs is overlooked by the requirements of this legislation. For example, PBMs and payers—which dictate the terms of coverage for medicines and the amount a patient ultimately pays—negotiate substantial rebates and discounts.

According to research from the Berkeley Research Group (BRG), rebates, discounts, and fees account for an increasing share of spending for brand medicines each year, while the share received by manufacturers has decreased over time. Manufacturers retain only 49.9% of brand medicine spending—the rest goes to others in the supply chain insurers/plan sponsors, the government, and PBMs.[16] Increased rebates and discounts have largely offset the modest increases in list prices and reflect the competitive market for brand medicines.

The growth of net prices, which reflects rebates and discounts, has been in line with or below inflation for the past five years. Specifically, average net prices for protected brand medicines grew 3.0% in 2023, below the rate of inflation for the fifth year in a row. Looking ahead, average net price growth is projected to be -1 to -4% per year through 2028.[17]

This, of course, does not necessarily reconcile with what patients are feeling at the pharmacy counter, which is why looking at the whole system is so important. For example, despite manufacturers' rebates and discounts negotiated by health plans, nearly half of commercially insured patients' out-of-pocket spending for brand medicines is based on the medicine's list price rather than the negotiated price that health plans receive.[18]

Price controls on brand medicines raise constitutional concerns.

Application of this price control to patented medicines raises constitutional concerns under the Supremacy Clause because it would restrict the goal of federal patent law, which is to provide pharmaceutical patent holders with the economic value of exclusivity during the life of a patent. Congress determined that this economic reward provides appropriate incentive for invention,

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15 *Drug Price Controls Are 'Ill-Conceived, Counterproductive'*, Conn. Bioscis. Growth Council (Apr. 9, 2021) (explaining that "prescription drug prices represent just 10% to 14% of overall healthcare costs and reflect the significant time and costs of developing lifesaving medicines").

16 BRG: The Pharmaceutical Supply Chain, 2013–2023. January 2025.

17 IQVIA Institute for Human Data Science. "The Use of Medicines in the U.S. 2024: Usage and Spending Trends and Outlook to 2028." Accessed February 2026. https://www.iqvia.com/insights/the-iqvia-institute/reports-and-publications/reports/the-use-of-medicines-in-the-us-2024

18 IQVIA Institute for Human Data Science. Medicine spending and affordability in the United States. Accessed August 2020. https://www.iqvia.com/insights/theiqvia-institute/reports/medicine-spending-and-affordabilityin-the-us

and Hawaii is not free to diminish the value of that economic reward. Specifically, in the case of BIO v. District of Columbia, 496 F.3d 1362 (2007), the U.S. Court of Appeals for the Federal Circuit overturned a District of Columbia law imposing price controls on branded drugs, reasoning that the law at issue conflicted with the underlying objectives of the federal patent framework by undercutting a company's ability to set prices for its patented products. The bill raises due process concerns as it provides broad authority to the PDAB, with very few standards or safeguards to ensure that authority is exercised in a consistent manner. The bill gives the PDAB the authority to determine which products will be subject to a cost review, and which products will ultimately have a UPL imposed on them but provides no clear and consistent standard for how the PDAB will conduct price reviews or set UPLs. The bill also raises constitutional concerns about Hawaii's ability to regulate commercial activity beyond its own borders. See Nat'l Pork Producers Council v. Ross, 143 S. Ct. 1142, 1157 n.1 (2023); Association for Affordable Medicines v. Frosh, 887 F.3d 664 (4th Cir. 2018). A law similar to SB2933 that Colorado enacted is currently the subject of litigation.

PhRMA recognizes the access challenges faced by patients in Hawaii with serious diseases. We stand ready to work with the Hawaii legislature to develop market-based solutions that help patients better afford their medicines at the pharmacy counter. We believe this bill could risk patient access to current and future medicines and respectfully oppose the passage of SB2993.

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DIRECTOR OF HEALTH
KA LUNA HO'OKELE

Testimony in SUPPORT of SB2933
RELATING TO HEALTH CARE COSTS**.**

SEN. JOY A. SAN BUENAVENTURA, CHAIR
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

SEN. JARRETT KEOHOKALOLE, CHAIR
SENATE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

Hearing Date: February 17, 2026 Room Number: 229

Department Testimony: The Department of Health (DOH) appreciates the intent of SB2933 and supports efforts to increase the affordability of prescription drugs. With healthcare affordability being its statutory purview, DOH suggests this proposed board may be more appropriate for the State Health Planning and Development Agency.

For the past 20 years, drug price inflation has outpaced general inflation and the Consumer Price Index by more than 30%, placing essential medications out of reach for many families. For patients managing chronic conditions such as diabetes, asthma, and severe allergies, these costs are not optional, they are life-sustaining. According to a May 2025 report from the National Association of Insurance Commissioners, poor adherence to medication therapies due to out-of-pockets costs is linked to up to 25% of U.S. hospitalizations, and it drives 50–69% of medication-related admissions, the overall impact of which disproportionately impacts Asian, Hispanice, and Black Americans.

Several states have enacted some form of prescription drug affordability boards with encouraging results. Reports and resources available on the National Academy for State Health Policy describe Colorado's Prescription Drug Affordability Board capped the price of a popular

biologic drug, which is a product made from living cells requiring complex manufacturing and that has an average annual treatment costs that often exceed $50,000 per patient, saving an estimated $32 million across the state.

In Hawai‘i, where the cost of living is already among the highest in the nation, this burden is even more acute. Medication nonadherence due to cost is a leading driver of preventable emergency room visits and hospital admissions, which ultimately increase public health expenditures.

DOH defers to the Department of Commerce and Consumer Affairs for proposed amendments to chapter 431, Hawaii Revised Statutes.

Thank you for the opportunity to testify.

Offered Amendments: N/A.

To: Senator Joy A. San Buenaventura, Chair
Senator Angus L.K. McKelvey, Vice Chair
Committee on Health and Human Services

Senator Jarrett Keohokalole, Chair
Senator Carol Fukunaga, Vice Chair
Committee on Commerce and Consumer Protection

From: Veronica Moore, Individual Citizen

Date: February 16, 2026

RE: Senate Bill 2933
Measure Title: RELATING TO HEALTH CARE COSTS.
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 ($)

To All Concerned,

My name is Veronica Moore and I support Senate Bill 2933. Thank you for introducing this bill.

Sincerely,

Veronica M. Moore

LATE

SB-2933
Submitted on: 2/16/2026 10:09:09 AM
Testimony for HHS on 2/17/2026 9:45:00 AM

Submitted By	Organization	Testifier Position	Testify
Sam Miller	Testifying for National Infusion Center Association	Oppose	Written Testimony Only

Comments:

Dear Committee Members,

On behalf of the infusion providers we represent across the state, thank you for your service and commitment to improving health care access and affordability for Hawaiians. As a nonprofit trade association that provides a national voice for non-hospital, community-based infusion providers, we write to express our strong concerns with SB 2933, legislation that would establish a Prescription Drug Affordability Board (PDAB) in Hawaii with the authority to set upper payment limits (UPLs) on certain prescription drugs.

The National Infusion Center Association (NICA) is a nonprofit organization formed to support non-hospital, community-based infusion centers caring for patients in need of infused and injectable medications. To improve access to medical benefit drugs that treat complex, rare, and chronic diseases, we work to ensure that patients can access these drugs in high-quality, non-hospital care settings. NICA supports policies that improve drug affordability for beneficiaries, increase price transparency, reduce disparities in quality of care and safety across care settings, and enable care delivery in the highest-quality, lowest-cost setting.

While we appreciate the intent of SB 2933 to address rising prescription drug costs, we are deeply concerned that the establishment of a PDAB with authority to impose UPLs would have serious unintended consequences for patients and providers, particularly those serving vulnerable populations. UPLs applied to provider-administered drugs will likely not address the underlying cost of drug acquisition and, instead, destabilize the fragile economics of community-based infusion care.

Infusion providers operate under a buy-and-bill model, in which they must purchase high-cost medications upfront, store and manage inventory, administer treatment, and then seek reimbursement. Professional service payments alone do not begin to cover the substantial overhead associated with this care, including staffing, clinical infrastructure, drug storage, and compliance requirements. Drug reimbursement is the financial linchpin that allows these centers to remain viable and continue serving patients in lower-cost, non-hospital settings.

By capping what insurers may pay for certain infusion drugs without reducing the actual acquisition or administration costs faced by providers, UPLs would place many community-based infusion centers in an untenable financial position. The likely result would be the closure

of smaller, independent providers that offer the most cost-effective site of care. Patients would be forced into hospital outpatient departments, significantly increasing overall health care spending, or face delays and disruptions in medically necessary treatment.

In short, SB 2933 would not lower the true cost of drugs for providers or patients. Instead, it risks reducing access to care, increasing system-wide costs, and undermining the community-based infrastructure that Hawaii patients rely on.

For these reasons, NICA respectfully urges you to oppose SB 2933 or, at a minimum, consider alternative approaches that would protect access to provider-administered therapies, including explicit exemptions for community-based infusion providers. Thoughtful drug affordability policy must address costs without jeopardizing patient access or driving care into more expensive settings.

Thank you for your consideration of our concerns. We would welcome the opportunity to provide additional information or serve as a resource as you evaluate this legislation.

Sincerely,

Brian Nyquist, MPH
President and CEO
National Infusion Center Association

LATE

SB-2933
Submitted on: 2/16/2026 11:02:16 PM
Testimony for HHS on 2/17/2026 9:45:00 AM

Submitted By	Organization	Testifier Position	Testify
Primo Castro, BIO	Testifying for Biotechnology Innovation Organization (BIO)	Oppose	Remotely Via Zoom

Comments:

Chair and Members of the Committee, thank you for the opportunity to testify. My name is Primo Castro, and I am here on behalf of the Biotechnology Innovation Organization.

Prescription Drug Affordability Boards, or PDABs, are an unproven experiment with zero record of success where states have collectively spent over $17 million with zero documented patient savings to date.

Importantly, PDABs do not lower what patients actually pay. They focus on list prices, even though patient costs are driven by insurance design and pharmacy benefit managers—not by the manufacturer. That's why three patients can walk into the same pharmacy and pay three entirely different prices for the same medicine.

Price caps also threaten patient access. Providers may be forced to buy medicines at higher prices than they can sell them for, leading to reduced availability. Insurers may respond by restricting coverage or switching patients to non-equivalent therapies.

Finally, PDABs risk undermining the innovation ecosystem that patients depend on. Developing a new therapy takes over a decade and billions of dollars; blunt price controls jeopardize that investment.

If our goal is true affordability, we should focus on solutions that actually help patients—like capping out-of-pocket costs, reforming PBM practices, and ensuring rebates reach the patient.

Thank you for your time.

LATE

Hawaii Senate Bill 2933 – Prescription Drug Affordability Board

Technical Implementation Recommendations

Chairs, Vice Chairs, and Members of the HHS/CPN committee:

Thank you for the opportunity to provide written testimony on Senate Bill 2933. I appreciate the Legislature's efforts to address rising prescription drug costs and to establish a structured review process through a Prescription Drug Affordability Board (PDAB). These comments are informed by my professional experience working on implementation and analytical review processes within a state PDAB program, and offered to support clarity, administrative feasibility, and long-term sustainability of the proposed framework.

The recommendations below are intended to provide analytical clarity while preserving the Board's discretion to consider additional relevant factors through rulemaking and case-by-case review. They are not intended to alter the policy intent of the bill, but rather to strengthen statutory clarity and ensure that the Board's determinations are grounded in measurable and transparent criteria.

Throughout this testimony, the term "affordability" is used consistent with the bill's intent and is operationalized as measurable cost impacts to the health care system, including impacts to state purchasers and payers, and patient out-of-pocket costs. Clarifying this operational basis may help ensure that Board decisions are analytically grounded, reproducible, and defensible.

Guiding implementation considerations

In developing these recommendations, several core implementation principles were considered:

- Clear statutory authority and sequencing of Board actions
- Transparent and reproducible analytical methodology
- Evaluation of measurable cost impacts to the health care system, including impacts to purchasers, payers, and patient out-of-pocket costs
- Protection of patient access and market stability
- Administrative feasibility, including realistic timelines and data infrastructure needs

These considerations are intended to support consistent, evidence-based implementation of SB2933 while preserving the Legislature's policy objectives.

Recommendation 1: Clarify the operational basis for affordability determinations

Issue

The bill uses the concept of affordability as a central criterion for Board review and action but may benefit from additional clarity regarding the measurable indicators used to assess affordability impacts.

Implementation consideration

Clarifying that affordability determinations are informed by measurable cost impacts to the health care system, including impacts to state purchasers, payers, and patient out-of-pocket costs, would help ensure that Board decisions are based on quantifiable and reproducible analyses rather than subjective judgments.

Suggested clarification

Consider specifying that affordability review determinations are informed by measurable indicators such as system-level spending, impacts to public and private purchasers and payers, and patient out-of-pocket exposure, consistent with the bill's focus on prescription drug costs and consumer protections.

Recommendation 2: Clarify scope of board review authority

Issue

The bill establishes cost and price thresholds that make certain drugs eligible for review. However, additional clarity may be helpful regarding whether drugs meeting those thresholds *must* be reviewed or *may* be reviewed at the Board's discretion.

Implementation consideration

Distinguishing between eligibility for review and discretionary selection for further action would promote predictability, consistent workload planning, and stakeholder understanding of how qualifying drugs will be evaluated.

Suggested clarification

Consider clarifying that drugs meeting statutory cost or price increase thresholds are eligible for review, while the Board retains discretion to determine, based on measurable cost impacts, whether further action is warranted.

Recommendation 3: Clarify available Board actions following affordability review determinations

Issue

The bill provides authority for the Board to establish upper payment limits following an affordability review but does not specify what actions the Board may take when a drug demonstrates measurable cost impacts yet does not meet the statutory standard for a UPL.

Implementation consideration

In practice, many drugs that meet review thresholds will show meaningful system-level spending or patient cost pressures but may not satisfy all criteria required for a UPL. Clarifying the range of post-review actions would support consistent decision-making, transparent communication of findings, and ongoing affordability oversight without requiring a UPL in every case.

Suggested clarification

Consider specifying that, after completing an affordability review, the Board may take one or more actions, as appropriate, including:

- Concluding that no UPL is warranted at that time;
- Placing the drug under continued monitoring for future reassessment;
- Issuing findings summarizing measurable cost impacts to the health care system; or
- Providing policy recommendations to address identified affordability concerns.

Recommendation 4: Implementation timeline and administrative capacity

Issue

Establishing a new PDAB program involves significant start-up activities, including rulemaking, staffing, data infrastructure development, and stakeholder engagement.

Implementation consideration

Providing flexibility for phased implementation would allow the Board to build the analytical and administrative infrastructure necessary to conduct complex cost impact reviews.

Suggested clarification

Consider allowing for a phased implementation timeline that includes initial rulemaking, staffing, data infrastructure development, and stakeholder engagement prior to full review operations.

Recommendation 5: Clarify annual reporting scope align with review cycle activities

Issue

The bill requires an annual report to the Legislature, but affordability reviews may span multiple years due to data development, stakeholder input, and analytical evaluation. Without clarification, annual reporting could be interpreted as implying that full review cycles must occur each year.

Implementation consideration

A newly established PDAB program will conduct ongoing activities—such as identification of high-impact drugs, preliminary analyses, and initiation of review cycles—that may not conclude within a single reporting year. Focusing annual reporting primarily on completed reviews or UPL actions may not fully reflect the Board's affordability oversight work or phased implementation timeline.

Suggested clarification

Consider specifying that the annual report summarizes affordability oversight activities conducted during the reporting period, as applicable, including: (1) statewide prescription drug cost trends for high-impact drugs, (2) drugs identified for review and the status of any ongoing reviews, (3) summary findings regarding measurable cost impacts to the health care system, (4) monitoring or follow-up actions for drugs reviewed but not subject to further intervention, (5) policy recommendations to support affordability oversight, and (6) any UPL actions taken, if applicable. The statute may also allow more detailed reports to be submitted upon completion of individual affordability reviews.

Conclusion

SB2933 represents an important step toward addressing prescription drug cost challenges in Hawaii. The recommendations provided above are intended to strengthen implementation by clarifying how affordability determinations are informed by measurable cost impacts to the health care system, including impacts to state purchasers and payers, and patient out-of-pocket costs.

These technical considerations are offered to support a clear, consistent, and sustainable framework that enables the Board to conduct evidence-based reviews while protecting patient access and market stability.

Thank you for your consideration of these implementation-focused recommendations and for your leadership in addressing prescription drug affordability.

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The views expressed are my own and do not represent the official position of my employer or the State of Oregon.

Appendix A

Technical Amendment Concepts for SB2933

1. Operational basis for affordability determinations

Relevant section: Provisions describing affordability review criteria and Board determination standards

Concept: Clarify that affordability determinations are informed by measurable cost impacts to the health care system, including impacts to state purchasers and payers, and patient out-of-pocket costs.

2. Eligibility for review vs. discretionary board action

Relevant section: Drug review eligibility thresholds and selection authority.

Concept: Clarify that drugs meeting statutory cost or price thresholds are eligible for review, while the Board retains discretion to determine, based on measurable cost impacts, whether further action is warranted.

3. Post-review actions following affordability review determinations

Relevant section: Provisions describing affordability review determinations and authority to establish upper payment limits

Concept: Clarify that, after completing an affordability review, the Board may determine that no upper payment limit is warranted and may instead take alternative actions, such as monitoring the drug for future reassessment, issuing summary findings regarding measurable cost impacts, or providing policy recommendations to address identified affordability concerns.

4. Phased implementation timeline

Relevant section: Implementation timelines and Board operational requirements

Concept: Allow phased implementation including initial staffing, data infrastructure development, rulemaking, and stakeholder engagement prior to full review operations.

5. Annual reporting scope aligned with review cycle activities

Relevant section: Provisions describing annual reporting requirements to the Legislature

Concept: Clarify that the annual report summarizes affordability oversight activities conducted during the reporting period, as applicable, including cost trend analyses, drugs identified for review and review status, summary findings on measurable cost impacts, monitoring or follow-up actions, policy recommendations, and any upper payment limit actions.

Allow more detailed reports to be submitted upon completion of individual affordability reviews.

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LATE

February 17, 2026

Dear Chair San Buenaventura and Committee Members:

The **Biotechnology Innovation Organization (BIO) respectfully opposes SB 2933**, which would create a Prescription Drug Affordability Board tasked with reviewing prescription drug costs and setting upper payment limits for specified prescription drugs. Government price controls like those proposed by this bill are an especially drastic action with unpredictable consequences. While the intent of this bill is to lower drug prices, we fear SB 2933 will fail to bring down costs for consumers or institutions and instead disincentivize development of new therapeutic breakthroughs.

This bill will not lower prescription drug costs for patients because it does not address out-of-pocket costs. Patients pay a given price when they visit a pharmacy based on what their health insurer determines—it is for this reason why two patients will pay a different price for the same drug. Out-of-pocket costs have been rising for patients as a result of decisions made by health insurers. SB 2933 does not address the price patients pay out-of-pocket and will therefore not directly impact patient affordability for prescription medications.

This bill also provides no clear path for lowering prescription drug costs for public or private payers or the healthcare system overall. The price control scheme in SB 2933 is designed around the premise that prescription drug costs have ballooned out of control or are increasing at an unsustainable rate. Yet according to the latest OECD Data for 2023, pharmaceutical spending in the U.S. accounted for 12.4% of national health expenditures-less than Canada (14.9%), Japan (17.6%), Germany (13.7%), France (12.9%), and over a dozen other OECD nations.[1] And net prices for branded medicines continue to grow slower than inflation; in 2024, net price growth was 0.1% while the annual average CPI growth was 2.9%.[2]

Unfortunately, artificial price controls only serve to disincentivize biopharmaceutical companies from developing new, more effective therapies. Economists have estimated that government price controls can have a significant, damaging effect on the development pipeline. For example, one study found that an artificial 50% decrease in prices could reduce the number of drugs in the development pipeline by as much as 24%,[3] while another study found investment in new Phase I research would fall by nearly 60%,[4] decreasing the hopes of patients who are seeking new cures and treatments.

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[1] Pharmaceutical Spending, % of Health Spending. OECD. Retrieved: https://www.oecd.org/en/data/indicators/pharmaceutical-spending.html?oecdcontrol-b84ba0ecd2-var3=2023

[2] "Understanding the Use of Medicines in the U.S. 2025." IQVIA. April 2025. Retrieved: https://www.iqvia.com/insights/the-iqvia-institute/reports-and-publications/reports/understanding-the-use-of-medicines-in-the-us-2025

[3] Maloney, Michael T. and Civan, Abdulkadir. *The Effect of Price on Pharmaceutical R&D* (June 1, 2007). Available at SSRN: https://ssrn.com/abstract=995175 or http://dx.doi.org/10.2139/ssrn.995175

[4] Vernon, John A., and Thomas A. Abbott, "The Cost of US Pharmaceutical Price Reductions: A financial simulation model of R&D Decisions," *NBER Working Paper*. NBER, February 2005. https://www.nber.org/papers/w11114.pdf Accessed: April 18, 2019.

Price controls will dampen investment and would not allow companies to adequately establish prices that will provide a return on investment. The average biopharmaceutical costs $2.6 billion to bring from research and development to market.[5] They sacrifice millions of dollars, often for decades before ever turning a profit, if at all. In fact, 92% of publicly traded therapeutic biotechnology companies, and 97% of private firms, operate with no profit.[6] Out of thousands of compounds only one will receive approval. For drugs that are advanced to phase I clinical trial, there is a 90% failure rate.[7] If counting drug candidates in the preclinical stage, the failure rate of drug development is even higher than 90%.[8]

Proposals such as these target the most innovative medicines, disproportionately impacting patients with diseases where there is high unmet need and where low-cost treatment options are not available (e.g. rare diseases), running counter to the aims of personalized medicine, and availability of new treatments. Further troubling, the arbitrary nature of upper payment limits ignores the value that an innovative therapy can have to an individual patient—especially one who may have no other recourse—or the societal impact innovative technologies can have, including increased productivity and decreased overall healthcare costs (e.g., due to fewer hospitalizations, surgical interventions, and physicians' office visits).

For these reasons, **we respectfully urge your no vote SB 2933**. If you have any questions, please do not hesitate to contact me at pcastro@bio.org to discuss this further.

Sincerely,

/s/

Primo J. Castro
Director, Western Region and Puerto Rico

[5] DiMasi, JA, et al., Innovation in the pharmaceutical industry: New estimates of R&D costs. Journal of Health Economics. February 12, 2016.
[6] DiMasi, Ibid.
[7] Sun D, Gao W, Hu H, Zhou S. Why 90% of clinical drug development fails and how to improve it? Acta Pharm Sin B. 2022 Jul;12(7):3049-3062. doi: 10.1016/j.apsb.2022.02.002. Epub 2022 Feb 11.
[8] Sun D et al., Ibid.

RARE READY
A GENETIC CONDITION COALITION

LATE

February 17, 2026

Testimony Opposing SB 2933
COMMITTEE ON HEALTH AND HUMAN SERVICES
COMMITTEE ON COMMERCE AND CONSUMER PROTECTION

The Rare & Ready Coalition would like to express our concern with SB 2933, a bill to establish a Prescription Drug Affordability Board (PDAB) in Hawaii. While we appreciate the inclusion of a rare disease exemption in the bill, we respectfully urge you to strengthen this language to ensure meaningful protections for rare disease patients, **two-thirds of which are children**.

The Rare & Ready Coalition represents 115 non-profit organizations working to ensure rare disease patients get timely access to the care they need. We are alarmed by the devastating impact PDABs will have on access to life-saving rare disease therapies.

One in ten people live with a rare disease. Those living with rare, genetic diseases have extremely limited treatment options, with 95 percent of such conditions with no FDA-approved therapies. State efforts to create PDABs, while intended to make drugs more affordable for health plans, will deter access to critical medical innovations.

PDABs threaten the development of future rare disease treatments by creating pricing uncertainty for medications that serve small patient populations. Products for these vulnerable patient populations, such as plasma-derived therapies, require significant investment and depend on complex manufacturing. PDABs strip away the patient protections afforded by orphan drug designation, leaving individuals with rare conditions at greater risk of losing access to the only therapies designed to treat them.

PDABs do not lower patient copayments, reduce premiums, or increase access to care for rare patients. We have found that PDABs can prevent insurers and pharmacies from purchasing medications exceeding government-set prices, taking away treatment options for patients.

We urge the committee to hear directly from rare disease patients before making any decisions. We welcome the opportunity to connect you to those who are directly impacted—please reach out to the coalition administrator at kari.lato@rx4good.com to schedule a meeting with **your rare disease constituents.**

Sincerely,

Rare & Ready Coalition Members