Wednesday, February 4, 2026

9:30 am, 60 East Wing

Hearing Topic: House Bill 305, Printer Number 258 (McNeill): Establishes a $35 cap on patient cost-sharing for insulin.

Call to order

Opening Comments

Testimony on House Bill 305:

- Colleen Nguyen, *Patient and Advocate*
- Dr. Ajay D. Rao, *Chief, Section Endocrinology, Diabetes and Metabolism; Associate Professor of Medicine at Lewis Katz School of Medicine, Temple University*
- Monica Billger, *Director, State Government Affairs Mid-Atlantic, American Diabetes Association*
- Michelle Crimmins, *Government Affairs, Prime Therapeutics*
- Megan Barbour, *Insurance Federation of Pennsylvania*

Any other business

Closing Comments

Adjournment

Attachments:

- 02.04.26 Hearing Notice
- 02.04.26 Hearing Agenda
- Colleen Ngyuen HB 305 Testimony
- Rao House Bill 305 Testimony
- ADA Testimony to House Insurance re HB305 PN 258_2.4.26
- IFP HB 305 testimony
- HB 305_Prime Therapeutics_Testimony 1.28.26
- IBX Testimony House Bill 305 2.4.26
- Highmark HB 305 Testimony

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House of Representatives
Commonwealth of Pennsylvania
Harrisburg

MEMORANDUM

DATE: 01.28.26

TO: House Insurance Committee Members

FROM: Perry Warren, Majority Chair
House Insurance Committee

RE: House Insurance Committee Public Hearing—02.04.26

The House Insurance Committee will meet at 9:30 am on February 4th in 60 East Wing. The purpose of this to hold a public hearing on the following legislation and any other business that may come before the committee:

House Bill 305, Printer Number 258 (McNeill)—Establishes a $35 cap on patient cost-sharing for insulin.

Please contact Insurance Committee staff at DemInsuranceCommittee@pahouse.net or (717) 787-4437 if you have any questions. If you are unable to attend this meeting, please submit a designation or leave form to your respective Chair's office prior to the start of the meeting.

SEAL OF THE HOUSE OF REPRESENTATIVES OF PENNSYLVANIA

House Insurance Committee

Meeting Agenda

Wednesday, February 4, 2026
9:30 am
60 East Wing

Call to order

Opening Comments

Testimony on House Bill 305:

- Colleen Nguyen*, Patient and advocate*
- Dr. Ajay D. Rao, *Chief, Section Endocrinology, Diabetes and Metabolism; Associate Professor of Medicine at Lewis Katz School of Medicine, Temple University*
- Monica Billger, *Director, State Government Affairs Mid-Atlantic*, *American Diabetes Association*
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- Megan Barbour, *Insurance Federation of Pennsylvania*

Any other business

Closing Comments

Adjournment

Good morning, Chairwoman and members of the Committee. My name is Colleen Gray Nguyen. I was diagnosed with Type 1 Diabetes in 1989 at the age of three.

To put that in perspective: I have lived with this disease for 37 years. I have navigated childhood, adolescence, marriage, and motherhood while tethered to a medical requirement that never takes a holiday. For nearly four decades, a function of my body that most people don't even think about... has been controlled by a pharmaceutical product.

I have seen incredible technological shifts, from primitive and painful finger sticks to continuous glucose monitors and closed loop insulin pump systems. But as the technology has moved forward, the accessibility has moved backward. We are living in a terrifying paradox where the treatment is more advanced than ever, but the access to treatment is at its most fragile.

There is often a fundamental misunderstanding about what managing type 1 diabetes looks like. Many people think of it like a daily pill or monthly treatment, one bottle, once a month. That is not our reality.

Most adults with Type 1 Diabetes require a complex regimen. We either use an insulin pump, which requires a constant stream of rapid-acting insulin, or we use "Multiple Daily Injections." This involves two distinct types of medication:

1. Basal (Long-acting): The background insulin that keeps us alive while we sleep.
2. Bolus (Rapid-acting): The insulin we must take every single time we eat a morsel of food.

We aren't buying one vial; many of us are using three, four, or five vials a month. When a single vial retails for hundreds of dollars, the "sticker price" you see in headlines is actually tripled or quadrupled for the average patient. This is why rationing isn't just for poor people and is far more common than is ever reported. It is for the teacher, the office manager, and the nurse who hits their deductible limit or finds their prescribed brand of insulin has been dropped by a formulary. It is an "outrageous" financial burden that can hits hard working people like a sledgehammer.

We often talk about insulin rationing in terms of "emergency." We think of the person who runs out, goes into Diabetic Ketoacidosis, and ends up in the ICU. That is a horror in itself. But there is a quieter, slower horror: Micro-rationing.

This is when someone takes 8 units instead of the 10 they actually need because they are trying to make the vial last until Friday. This isn't an immediate trip to the ER, but it is a death sentence by a thousand cuts. High blood sugar is corrosive. It is like pouring acid through your veins.

I have seen the results of this "slow rationing" in my own community. I have lost friends to heart disease and kidney failure—people who didn't die because they ran out of insulin today, but because they couldn't afford *enough* insulin years ago.

- Many of my peers—people in their late 30s and early 40s—are already losing their vision to Retinopathy.
- They are losing the ability to walk without pain due to Neuropathy.
- They are facing Gastroparesis, where their stomach effectively ceases to function.

These aren't side effects of diabetes; they are side effects of a pricing model that prevents consistent, tight control of the disease.

Because the system is so volatile, I have become a hoarder. I consider myself "lucky" because I have a stockpile of insulin in my fridge. Think about how dark that is, that I feel "lucky" to have a surplus of a hormone my body requires to breathe.

But my fridge doesn't just serve me. It has also saved my friends and neighbors.

On more than one occasion, I have had to meet people in parking lots, complete strangers, to hand over life-saving medication. The most heart-wrenching among them are domestic violence victims. When a woman leaves an abusive situation, she often leaves with nothing but the clothes on her back. Her insurance is often tied to her abuser’s employer. Her prescriptions are at a pharmacy she can no longer safely visit.

I have stood in those parking lots, handing over vials, knowing that if I weren't there, that person could end up in the ICU in a matter of days. I am not a medical distributor. The fact that I *have* to do this is a searing indictment of the current insurance landscape in Pennsylvania.

On top of insulin, there is so much more financial burden to diabetes:

- CGM Sensors and testing supplies: Which can cost hundreds of dollars a month and are necessary to know how much insulin to safely take
- Insulin pumps and the supplies needed to make them work: Plastic sites and tubing that must be replaced every three days.
- Glucagon: The $200+ "fire extinguisher" we carry in case our blood sugar crashes.

We are paying thousands of dollars a year just to stay at the "baseline" of a healthy person. When insulin prices are allowed to skyrocket, it collapses the entire house of cards.

I have lived with this since 1989. I am tired of seeing my friends die or go blind because of a corporate bottom line. I am tired of wondering if the person I meet in a parking lot tomorrow will be the last one I'm able to help.

I urge this committee to pass meaningful insulin cost-capping legislation. Do not let luck be the determining factor in whether a Pennsylvanian survives the night.

Thank you.

TEMPLE UNIVERSITY
Lewis Katz School of Medicine

TEMPLE HEALTH
Temple Faculty Physicians

Ajaykumar (Ajay) D Rao, MD, MMSc, FACP
Associate Professor of Medicine
Chief, Section of Endocrinology, Diabetes and Metabolism
Center for Metabolic Disease Research
Lewis Katz School of Medicine
email: ajay.rao@temple.edu

To:

House Insurance Committee

Good morning Chair, members of the House Insurance Committee, and staff.

Thank you for the opportunity to speak with you today.

My name is Ajay Rao, and I am an adult endocrinologist practicing in North Philadelphia, where I care for a large population of persons living with type 1 and type 2 diabetes.

I am currently the Section Chief of Endocrinology, Diabetes and Metabolism at the Katz School of Medicine at Temple University.

Access to insulin is one of the most critical issues my patients face, and I appreciate the chance to offer clinical perspective on House Bill 305 and the proposed thirty-five-dollar cap on insulin cost sharing.

My comments today will focus on four areas:

1. How insulin affordability currently plays out in endocrinology practice

2. Tiering and co-pay systems as they affect specialized diabetes care

3. The barriers my patients encounter in obtaining insulin

4. How other states' experiences can inform policy decisions

1. Insulin Coverage and Affordability in Endocrinology Practice

Endocrinologists care for some of the most insulin-dependent patients—adults with type 1 diabetes, individuals with longstanding type 2 diabetes requiring complex regimens, and patients with conditions such as pancreatitis or cystic-fibrosis–related diabetes. For many of these patients, insulin is not optional. It is a daily, life-sustaining medication.

In practice, we see wide fluctuations in out-of-pocket costs. Some plans cover commonly used basal and rapid-acting insulins at a reasonable tier, while others impose high co-pays or deductibles that patients struggle to anticipate. Even clinically stable patients may suddenly learn in January of each calendar year that the insulin they've used safely for years has been moved to a higher tier or replaced with a non-preferred option.

The medical consequences of these shifts are significant: insulin is not a medication we can easily switch without risk. Dose-to-dose variability, pharmacologic differences, and patient familiarity all matter. Sudden non-medical switching can destabilize glucose control, create safety concerns, and increase the burden on both patients and clinicians.

2. Tiering, Co-Pay Cards, and Coupons in Real-World Diabetes Care

Insulin tiering has become increasingly complex. A patient may “have coverage,” but that coverage often comes with a co-pay that is functionally prohibitive. Some long-acting or ultra-rapid insulins, which we rely on to achieve safe and individualized glucose control, are routinely placed on higher tiers even when clinically indicated.

Manufacturer co-pay cards can provide temporary relief for commercially insured patients, but as an endocrinologist I see the limitations daily:

- They cannot be used by Medicare or Medicaid patients, who make up a large portion of those with diabetes.

- They require patients to navigate enrollment processes that are burdensome for individuals already managing a complex chronic condition.

Although these tools can help short-term, they do not offer the consistent affordability that chronic insulin therapy requires.

3. Barriers Patients Face in Accessing Insulin

Despite the essential nature of insulin, many of my patients encounter barriers that place them at risk for serious harm.

The most common barriers I see include:

- High and unpredictable monthly out-of-pocket costs

- Yearly formulary changes that force medication switches

- Delays in prior authorization processes

- Costs associated with technology that must be paired with insulin, such as pumps and continuous glucose monitors

- Transportation challenges for patients relying on specific pharmacies or mail-order systems

Insulin rationing—taking smaller doses or skipping doses to save money—is unfortunately not rare. When this happens, patients are at risk of severe hyperglycemia and diabetic ketoacidosis, both of which are medical emergencies.

Predictable, capped cost-sharing helps prevent the dangerous cycle of rationing, emergency department visits, and most importantly, long-term complications such as kidney disease, retinopathy, neuropathy, and cardiovascular events. These complications not only affect patient well-being but also place a substantial burden on healthcare systems and state programs.

4. Approaches in Other States

Many states have already implemented insulin cost caps, with limits generally ranging between twenty-five and one hundred dollars per month. Some include diabetes supplies as well. Although structures vary, early evaluations show:

- Reduced patient out-of-pocket spending
- Better medication adherence
- Fewer reports of insulin rationing
- Improved continuity of diabetes management

Importantly, cost-sharing caps are not a full solution to all insulin affordability issues—they do not affect list prices, however, they do address a major barrier that endocrinologists see every day: the immediate out-of-pocket cost that determines whether a patient walks out of the pharmacy with the insulin they need to live.

Closing

In endocrinology, we see firsthand how essential consistent, affordable access to insulin is for our patients' health and safety. The out-of-pocket cost remains one of the most significant determinants of adherence. A predictable, manageable monthly cost cap such as the one proposed in House Bill 305 can prevent dangerous rationing, reduce medical emergencies, and support better long-term health outcomes.

Thank you for the opportunity to share my clinical experience and perspective. I would be glad to answer any questions.

Sincerely.

Ajaykumar (Ajay) D. Rao, MD, MMSc, FACP
Chief, Section of Endocrinology, Diabetes and Metabolism
Associate Professor of Medicine
Lewis Katz School of Medicine at Temple University

House Insurance Committee Testimony in **Support of HB 305 PN 258**
Monica Billger, State Government Affairs Director
January 20, 2026

Thank you, Chair Warren, Chair Pickett, and Honorable Members of the House Insurance Committee,:

My name is Monica Billger, and I am the Director of Government Affairs and Advocacy for the American Diabetes Association (ADA). We are in strong support of House Bill 305, to make insulin more affordable for Pennsylvanians who need it.

Pennsylvania, like the rest of the country, is experiencing a diabetes epidemic. The ADA estimates more than 1.1 million people in Pennsylvania have been diagnosed with diabetes – a staggering 1 in 10 adults. And every year - another 91,000 people in our state are diagnosed with diabetes. The cost of managing it can be unsustainable. People with diabetes have medical expenses approximately 2.3 times higher than those who do not. In addition to a diabetes epidemic, we are facing an insulin affordability crisis.

Developed over 100 years ago, the patent for insulin was sold for $1 because the developers believed everyone who needed this life-saving drug should have it. Insulin is an essential chronic disease management medicine. People with type 1 diabetes produce little to no insulin, requiring that they administer insulin simply to continue to live each day. Others with diabetes may no longer be sufficiently producing insulin, or their bodies may be resistant to its effect, requiring that they also administer insulin to control glucose levels and avoid complications. Simply put, without it, people with diabetes die, and very quickly.

Many people with diabetes need to take two different types of insulin and require a lot of it, averaging 2-4 vials per month. When people cannot afford the medication necessary to manage their diabetes, they scale back or forego the care they need to manage their health, exposing themselves to complications. Or they are forced to choose between paying for their medication or rent, utilities, and other necessities just to live. You likely know someone who may be rationing their medication due to economic struggles as **1 in 6 people have reported needing to ration their insulin.**

Addressing insulin affordability by lowering cost sharing burdens will allow people with diabetes to better manage their glucose levels to stay healthy and productive. When people with diabetes are unable to manage the disease and access the insulin they need, it increases the risk of developing costly and burdensome complications including diabetic ketoacidosis, increased risk for infections, increased hospital visits, cerebral edema and premature death, and over a long period of time, insulin rationing can lead to heart disease, kidney failure, amputations, and even blindness. But evidence suggests that copay reductions do improve medication adherence.

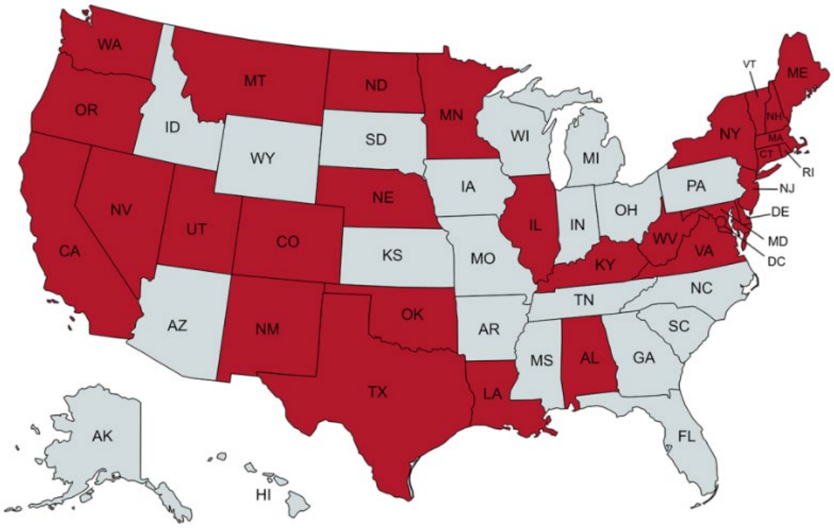
In the spring of 2017, the ADA Board of Directors convened an Insulin Access and Affordability Working Group to examine the full scope of the insulin affordability issue. The Working Group's findings were published in a White Paper that included a recommendation to lower or remove patient cost-sharing for insulin, specifically noting that cost-sharing for insured people with diabetes should be based on the lowest price available.

The findings remain as relevant today as they were nine years ago. Since that time, 29 states and the District of Columbia have passed laws to limit monthly out-of-pocket spending for insulin, alongside Medicare beneficiaries who also have out-of-pocket monthly spending for insulin capped at $35. A recent study of the 2019 Colorado law found that average out-of-pocket costs for insulin dropped by about 40 percent in the two years after the law's passage. Annual savings were the highest for children and adults aged 18 to 34, and rural patients saw greater savings than those in non-rural areas.

But don't just take our word for it. Last year the Joint State Government Commission released its seventh biennial Diabetes in Pennsylvania report. The report included expanding caps on out-of-pocket payment for insulin, coming in at the top of their twelve policy recommendations.

The ADA believes that no individual in need of life-saving medications should ever go without due to prohibitive costs or accessibility issues. The ADA urges your support for capping insulin cost sharing for people with diabetes to address the financial barriers to managing this common and serious chronic disease.

I am happy to answer any questions you may have. Thank you for your time.



As indicated above in red, more than half of the states (29 states plus the District of Columbia) have capped insulin copayments in state-regulated commercial health insurance plans. Some states have also capped insulin copayments for state employee health plans or capped copayments for other diabetes medications or supplies.
https://diabetes.org/tools-resources/affordable-insulin/state-insulin-copay-caps

INSURANCE FEDERATION OF PENNSYLVANIA
IFP 1926

Thank you for the opportunity to speak with you today on House Bill 305, which proposes a $35 monthly cap on out-of-pocket costs for insulin. My name is Megan Barbour, and I am Executive Director of Government Affairs for the Insurance Federation of Pennsylvania, a multi-line state trade association representing commercial health insurers across the Commonwealth.

We fully share your commitment to making insulin more affordable. Action on prescription drug prices is not only warranted—it is essential. However, as written, HB 305 poses significant risks to insurance affordability, market stability, and long-term prescription drug costs in Pennsylvania.

Lack of Any Regulation of Insulin List Prices

First and foremost, this bill does nothing to regulate insulin list prices. Manufacturers remain entirely free to raise prices, and because cost-sharing is capped at $35, they can do so without facing the usual market pushback. Insurers, however, would be prohibited from adjusting cost-sharing to reflect those increases. As a result, the full financial impact of rising list prices would fall squarely on insurers.

This will inevitably find its way back to consumers through higher premiums, higher deductibles, and higher cost-sharing in other benefit areas. This outcome is not speculative—it is the predictable economic result of forcing insurers to absorb unlimited manufacturer price increases while preventing corresponding patient cost adjustments.

The Loss of Tiered Cost-Sharing and Its Consequences

Tiered cost-sharing is one of the most effective tools insurers have to negotiate lower drug prices. It encourages patients to choose lower-cost medications and pressures manufacturers to keep their products competitively priced. HB 305 eliminates this tool by requiring the same capped cost-sharing for all insulin products.

Without any ability to differentiate between products, consumers lose the price signals that help steer them toward more affordable options. Insurers lose the leverage needed to push manufacturers toward lower prices. Manufacturers, in turn, gain more freedom to increase list prices because they know those price hikes will not affect what patients pay at the pharmacy counter.

Although the bill mandates an Attorney General investigation, it does not provide enforcement mechanisms or give the AG expanded authority to regulate prices. Without meaningful tools to rein in pricing behavior, an investigation alone will not curb list-price inflation.

Premium and Market Impacts

Upward Pressure on Premiums

By requiring insurers to cover the entire difference between actual insulin prices and the $35 cap, the bill guarantees escalating costs as insulin prices continue to rise. Over time, insurers will be paying far more for insulin than they can ever recover in premiums without raising rates. This dynamic puts upward pressure on premiums across the board.

Employer plans will experience higher costs. The individual market will face higher premiums as well. Small businesses that offer health insurance will experience greater financial strain. Some plans may be forced to scale back benefit richness or reduce the number of products they offer. Ultimately, all Pennsylvanians, even those who never use insulin, could end up paying more.

Existing Affordability Challenges

These consequences come at a time when health-care affordability is already worsening. As we have previously testified, the Pennsylvania Insurance Department approved average rate increases of 19 percent in the individual market and 13 percent in the small-group market this year. Rising healthcare costs, increased utilization, and the expiration of enhanced premium tax credits have led some consumers to face premium increases of more than 100 percent. A number of Pennsylvanians have experienced increases approaching 500 percent, pushing many out of the market entirely.

If health insurance is becoming unaffordable, the cause is not the design of coverage—it is the underlying cost of care. HB 305 does nothing to address that cost. In fact, it risks making the situation worse.

What Insurers Are Already Doing

Insurers are not standing still on insulin affordability. Many of our member companies already provide insulin at no cost to patients under certain preferred drug programs. Others already offer most insulin products below the $35 threshold for a thirty-day supply. These efforts demonstrate a commitment to affordability.

However, HB 305 would prevent insurers from distinguishing between preferred and non-preferred products. It removes the ability to use tiered pricing strategies that encourage the use of lower-cost options and help keep premiums down. The bill focuses narrowly on cost-sharing rather than addressing the actual cost of insulin.

Better Alternatives to Address High Insulin Prices

If the goal is truly to make insulin affordable—not just for patients at the counter, but for everyone who pays premiums—then we must target the root cause: the price of insulin itself.

There are several more effective alternatives. These include adopting stronger manufacturer transparency laws, imposing caps on insulin list prices rather than on patient cost-sharing, restricting excessive annual price increases, creating bulk-purchasing programs, and encouraging greater use of biosimilar insulin products. These approaches go directly to the cause of high prices instead of shifting the financial burden onto insurers and, ultimately, all policyholders.

Conclusion

We fully understand and respect the intent behind HB 305. The desire to ease financial strain on patients is both commendable and shared by all of us. However, as written, the bill would unintentionally give manufacturers greater pricing power, raise premiums for Pennsylvanians at a time when affordability is already strained, undermine insurers' ability to manage drug costs responsibly, and do nothing to address the actual price of insulin.

For these reasons, we respectfully urge the committee to oppose HB 305 in its current form and instead pursue comprehensive reforms that tackle insulin costs at their source.

Thank you for your time and consideration. I would be happy to answer any questions.

January 28, 2026

The Honorable Representative Perry Warren
Majority Chair, House Insurance Committee
115 Irvis Office Building
Harrisburg, PA 17120

The Honorable Representative Tina Pickett
Minority Chair, House Insurance Committee
315A Main Capitol Building
Harrisburg, PA 17120

RE: HB 305: Insulin $35 Copay Cap

Dear Chair Warren, Chair Pickett, and House Insurance Committee Members:

Thank you for the opportunity to comment on SB 305. I represent Prime Therapeutics (Prime), a pharmacy benefit manager (PBM) owned by 19 not-for-profit Blue Cross and Blue Shield Insurers, subsidiaries, or affiliates of those Insurers, including Capitol Blue Cross. Most Commercially insured individuals currently have access to insulin for a co-pay of $35 or less. The free market has addressed the problem of insulin affordability for covered individuals, but the uninsured may still face an affordability crisis. SB 305 does not address insulin affordability for Pennsylvanians without health insurance. For this reason, Prime opposes HB 305.

Prime helps people get the medicine they need to feel better and live well by managing pharmacy benefits for health plans, employers, and government programs including Medicare and Medicaid. Our company manages pharmacy claims for more than 30 million people nationally and offers clinical services for people with complex medical conditions. Our business model relies on transparency and advocating for simpler, lowest-net-cost prices for drugs. Importantly, Prime is focused on purpose beyond profits. We are not publicly traded or owned by a private equity firm. As such, it is not our primary motivation to maximize profits; our primary motivation is to do the right thing.

High List Prices and Low Availability of Affordable Insulin Products Created an Affordability Crisis
Before 2020, consumers faced high out-of-pocket costs for insulin medications due to high list prices and a limited number of affordable insulin medications on the market. This meant that the cost of insulin was out of reach to many patients, leading to widespread reports of insulin rationing, delaying refills, or completely skipping doses.

Since 2020, the market has taken action to limit the impact of high insulin costs to insured consumers. The impact on patients was addressed in the following ways:

- **Medicare co-pay's capped at 35 a month** for covered insulin in Part D
- **Commercial insurers voluntarily capped co-pays for insulin at $35** for the majority of commercially insured.
- **Lilly, Novo Nordisk, and Sanofi** cut list prices 65–78% across many insulin products. Retail cash prices per insulin unit dropped >40% by mid-2024.

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The Majority of Commercially Insured Individuals Pay $35.00 or Less Per Month for Insulin
SB 205 has a noble goal of helping diabetics afford lifesaving medication. Unfortunately, this bill does not help uninsured Pennsylvanian's that still face high list prices of insulin. Today, most commercially insured individuals pay $35.00 or less for a one-month supply of insulin; a review of our claim data showed this number to be more than 90% of commercially insured members.

I urge the committee to consider whether passing another mandate on an already highly regulated industry achieves the goal of improving affordability and access. I welcome the opportunity to further discuss these concerns and work towards evidence-based solutions to help people receive the medicine they need to feel better and live well. Thank you for your time and consideration.

Respectfully,

Michelle K Crimmins

Michelle Crimmins
Government Affairs, Prime Therapeutics

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Independence

Written Testimony

House Bill 305

Establishing Cost Sharing Caps for Insulin Products

House Insurance Committee

February 4, 2026

Introduction

Independence Blue Cross (IBX) thanks Chairman Warren, Chairwoman Pickett and members and staff of the House Insurance Committee for the opportunity to offer written comment on House Bill 305. This legislation would prohibit health insurers from requiring a copayment, coinsurance or deductible of more than $35 for a 30-day supply of insulin, regardless of the amount or type of insulin needed to fill a covered individual's prescription. Additionally, the bill would require the Pennsylvania Attorney General to investigate the role of drug manufacturers in the pricing of insulin.

Unfortunately, the limitations on cost-sharing in House Bill 305 do not address the issue at hand - the cost of the insulin product itself. To that end, the second part of the legislation requiring the Attorney General to investigate the pricing of prescription insulin is a step in the right direction. Understanding what actually drives the cost of a drug that has been in existence, in some form, for over 100 years, is where this conversation should begin if we are serious about effectuating real change and lowering costs for consumers.

By the Numbers and IBX Affordability Solutions

In the U.S., between 2020-2023, insurer and patient out-of-pocket costs increased by over $100 billion as drug manufacturer revenue increased at the same rate. In recent years, the median launch price of FDA-approved drugs has increased by 35%, and more than 1,000 brand name drugs have seen price increases year over year.

At IBX, more than a quarter of our commercial members have three or more chronic conditions, requiring consistent use of prescription medication to manage symptoms and prevent disease progression. Recent integration of various programs and collaborative efforts, a few of which are outlined below, have led to savings of $40 per-member per-month, for those with chronic conditions.

As a result of ever-rising prescription drug prices, IBX has and will continue to pursue solutions to help our members better afford their medications. Solutions include our partnership with CivicaScript, our Most Cost-Effective Setting program and entering into agreements with select drug manufacturers to offer biosimilar prescription drugs.

CivicaScript, a partnership by Civica and over 20 Blue Cross Blue Shield companies, including IBX, focuses on the development and production of certain generic and biosimilar medicines in order to make low-cost, high-quality alternatives available for members. CivicaScript's first offering, a treatment for prostate cancer, saved members nearly $1,000 per year.

On January 1, 2026, CivicaScript released generic (biosimilar) insulin pens. This long-acting treatment is priced at $55 per box, compared to the brand name boxes that cost $150 or more per box that patients would pay without insurance or major manufacturer co-pay coupons, establishing the lowest list price in the current long-acting insulin market.

CivicaScript continues to develop alternative biosimilar forms of insulin and other generic treatments that seek to lower the cost of prescription drugs. Other generic drugs that CivicaScript has made available include lower-cost treatments for multiple sclerosis and hypotension.

Another affordability solution is our Most Cost-Effective Setting (MCES) program. The MCES program allows specialty drugs which need to be administered by a health care professional to be given to members in the most cost-effective setting appropriate, such as a doctor's office, infusion clinic, or even at home, providing a much-needed convenience to the member. The MCES program has saved over $260 million since 2012 by significantly reducing added cost associated with the administration of over 114 high-cost medical specialty drugs.

Finally, direct purchase and value-based agreements with drug manufacturers through Evio allows IBX to offer certain low-cost biosimilar drugs to members. Depending on the biosimilar offered, savings range from 5% upwards to 85%. These offerings have amounted to nearly $130 million in savings in recent years. Evio is an organization dedicated to improving access, affordability and clinical outcomes for members utilizing innovative pharmacy solutions.
IBX will continue to explore opportunities to help our members save on prescription drugs.

Conclusion

There is no debating the well-intended objective of this bill. However well-intended, the legislation does nothing to address the core issue which is the cost of prescription drugs and the ability of drug manufacturers to set and raise prices at will. Mandating cost-sharing limitations will do nothing to change or reverse this dynamic.

IBX is proud to partner with Civica and to continue developing innovative solutions seeking to lower the cost of prescription drugs for our members. While IBX opposes the legislation as drafted, we remain committed to finding solutions to make prescription drugs more affordable for our members. We encourage the Committee to explore the driving force behind rising drug prices and welcome the opportunity to work further with the Committee and all stakeholders.

Comments on House Bill 305 Insulin Testimony
Submitted to:
Pennsylvania House Insurance Committee
February 4, 2026
Michael Yantis, Vice President, State Government Affairs

Good morning, Chairs Warren, Pickett, and members of the House Insurance Committee.

Thank you for the opportunity to allow Highmark to provide testimony on House Bill 305. Highmark understands and shares the concern for making access to quality health care, including medications, affordable and accessible to all Pennsylvanians. However, we have significant concerns that House Bill 305, while well-intentioned, may not achieve its desired outcome and could, in fact, have unintended negative consequences. A few key observations:

HB 305 is unintentionally inequitable

Establishing a mandated $35 copay for insulin, while not addressing the cost of other life-saving medications, creates an inequitable system. While diabetes management is critical, many other chronic conditions require expensive treatments. By singling out insulin, this legislation implicitly prioritizes one disease over others. This could lead to demands for similar mandates for other conditions, creating an unsustainable and fragmented healthcare system where certain diseases are favored over others based on legislative action rather than a holistic approach to patient care and affordability across the board.

State Mandates disproportionally harm individual and small group customers

It is crucial to understand that many of our Highmark members, particularly those covered under employer-sponsored health plans, are subject to the Employee Retirement Income Security Act (ERISA). It should be noted that self-funded ERISA plans are governed by federal law and are exempt from state insurance mandates. This means that while the bill aims to reduce insulin costs, it would only impact a small segment of the insured population, create a false sense of broad relief, and potentially lead to confusion and frustration for those whose plans are not subject to the mandate.

While the bill mandates a lower out-of-pocket cost for the patient at the pharmacy counter, it does not address the underlying cost of insulin itself. The cost of the medication does not disappear; it is simply shifted. This means premiums would absorb the difference between the actual cost of the insulin and the mandated $35 cost sharing. This places increased financial burden on customers, ability to afford health insurance premiums This is a critical point that often goes unaddressed in such legislation. Cost sharing is a benefit design chosen by customers to help them balance their health care between premium costs and out of pockets costs. Placing limits or restrictions on customers' ability to manage costs creates less choice for our customers.

Highmark is actively working to address the inflated cost of insulin through innovative partnerships. We were an early supporter of CivicaRx's and their insulin initiative, which aims to provide more affordable insulin to both insured and uninsured patients. CivicaScript, in partnership with the state of California's CalRx program, is already providing insulin. Additionally, CivicaScript is in the process of developing and bringing to market its own insulin products, including rapid-acting insulin and insulin glargine, which we anticipate being available by early 2027. We are currently evaluating the net cost of these CivicaScript products against our existing preferred insulin products to determine how to best incorporate them into our formularies to ensure affordability and access for our members. CivicaScript is also working to establish a national distribution network with pharmacies with a recommended retail price of $30 for a 30-day supply.

While we commend the intent behind House Bill 305 to reduce the financial burden on individuals managing diabetes, we urge the committee to consider the potential unintended consequences. We believe that a more comprehensive approach addressing the root causes of high drug costs, rather than mandating cost shifts , would be more effective in ensuring equitable and sustainable access to affordable medications for all Pennsylvanians.

We are committed to collaborating with the General Assembly to find solutions that genuinely lower healthcare costs and improve patient access.

Again, thank you for the opportunity to provide written remarks to you and the committee regarding this legislation.