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**HOUSE BILL 1508**

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**State of Washington**

**68th Legislature**

**2023 Regular Session**

**By** Representatives Macri and Riccelli

1 AN ACT Relating to improving consumer affordability through the  
2 health care cost transparency board; amending RCW 70.390.020,  
3 70.390.040, 70.390.050, 70.390.070, 43.71C.030, and 70.405.030;  
4 adding new sections to chapter 70.390 RCW; creating a new section;  
5 and providing an expiration date.

6 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

7 NEW SECTION. **Sec. 1.** (1) The legislature finds that:

8 (a) Although the legislature established the health care cost  
9 transparency board in 2020 and the board has established a health  
10 care cost growth benchmark to monitor cost growth, health care costs  
11 and spending continue to rise. According to the health care cost  
12 transparency board, research demonstrates that Washington's health  
13 care cost trends, particularly hospital and pharmacy costs, outpace  
14 other states and the national average;

15 (b) According to the commonwealth fund, Washington workers and  
16 businesses have seen double-digit increases for employer-based health  
17 insurance over the last decade, with the total average premium for a  
18 single worker rising by 49 percent and the deductible rising by 51  
19 percent from 2010 through 2020;

20 (c) According to an analysis by the office of the insurance  
21 commissioner, health care spending in Washington's commercial market

1 grew by 13 percent from 2016 to 2019, even though inflation grew by  
2 only seven percent of this period;

3 (d) According to the office of financial management, health care  
4 spending now accounts for 20 percent of Washington's state general  
5 fund budget; and

6 (e) In a recent survey by Altarum, more than 60 percent of  
7 Washingtonians surveyed in 2022 reported experiencing a health care  
8 affordability burden in the last year. More than half of respondents  
9 reported delaying or skipping care due to cost. More than 80 percent  
10 of respondents said the government should set limits on health care  
11 spending growth and penalize payers or providers that fail to curb  
12 excessive spending growth.

13 (2) The legislature intends to empower the health care cost  
14 transparency board to accelerate its work to analyze the underlying  
15 drivers of health care cost growth, and further to take action to  
16 address outlier spending that exceeds the health care cost growth  
17 benchmark.

18 **Sec. 2.** RCW 70.390.020 and 2020 c 340 s 2 are each amended to  
19 read as follows:

20 (1) The authority shall establish a board to be known as the  
21 health care cost transparency board. The board is responsible for the  
22 analysis of total health care expenditures in Washington, identifying  
23 trends in health care cost growth, and establishing a health care  
24 cost growth benchmark. The board shall provide analysis of the  
25 factors impacting these trends in health care cost growth and, after  
26 review and consultation with identified entities, shall identify  
27 those health care providers and payers that are exceeding the health  
28 care cost growth benchmark.

29 (2) The authority is authorized to conduct activities necessary  
30 to support the activities and decisions of the board, including  
31 activities related to data collection and analysis and the  
32 enforcement of performance improvement plan submissions and the  
33 payment of fees and fines issued by the board pursuant to this  
34 chapter.

35 **Sec. 3.** RCW 70.390.040 and 2020 c 340 s 4 are each amended to  
36 read as follows:

37 (1) The board shall establish an advisory committee on data  
38 issues and an advisory committee of health care providers and

1 carriers. The board may establish other advisory committees as it  
2 finds necessary. Any other standing advisory committee established by  
3 the board shall include members representing the interests of  
4 consumer, labor, and employer purchasers.

5 (2) Appointments to the advisory committee on data issues shall  
6 be made by the board. Members of the committee must have expertise in  
7 health data collection and reporting, health care claims data  
8 analysis, health care economic analysis, and actuarial analysis.

9 (3) Appointments to the health care stakeholder advisory  
10 committee (~~(of health care providers and carriers)~~) shall be made by  
11 the board and must include the following membership:

12 (a) One member representing hospitals and hospital systems,  
13 selected from a list of three nominees submitted by the Washington  
14 state hospital association;

15 (b) One member representing federally qualified health centers,  
16 selected from a list of three nominees submitted by the Washington  
17 association for community health;

18 (c) One physician, selected from a list of three nominees  
19 submitted by the Washington state medical association;

20 (d) One primary care physician, selected from a list of three  
21 nominees submitted by the Washington academy of family physicians;

22 (e) One member representing behavioral health providers, selected  
23 from a list of three nominees submitted by the Washington council for  
24 behavioral health;

25 (f) One member representing pharmacists and pharmacies, selected  
26 from a list of three nominees submitted by the Washington state  
27 pharmacy association;

28 (g) One member representing advanced registered nurse  
29 practitioners, selected from a list of three nominees submitted by  
30 ARNPs united of Washington state;

31 (h) One member representing tribal health providers, selected  
32 from a list of three nominees submitted by the American Indian health  
33 commission;

34 (i) One member representing a health maintenance organization,  
35 selected from a list of three nominees submitted by the association  
36 of Washington health care plans;

37 (j) One member representing a managed care organization that  
38 contracts with the authority to serve medical assistance enrollees,  
39 selected from a list of three nominees submitted by the association  
40 of Washington health care plans;

1 (k) One member representing a health care service contractor,  
2 selected from a list of three nominees submitted by the association  
3 of Washington health care plans;

4 (l) One member representing an ambulatory surgery center selected  
5 from a list of three nominees submitted by the ambulatory surgery  
6 center association; ~~((and))~~

7 (m) Three members, at least one of whom represents a disability  
8 insurer, selected from a list of six nominees submitted by America's  
9 health insurance plans;

10 (n) At least two members representing the interests of consumers,  
11 selected from a list of nominees submitted by consumer organizations;

12 (o) At least two members representing the interests of labor  
13 purchasers, selected from a list of nominees submitted by the  
14 Washington state labor council; and

15 (p) At least two members representing the interests of employer  
16 purchasers, including at least one small business representative,  
17 selected from a list of nominees submitted by business organizations.  
18 The members appointed under this subsection (3)(p) may not be  
19 directly or indirectly affiliated with an employer which has income  
20 from health care services, health care products, health insurance, or  
21 other health care sector-related activities as its primary source of  
22 revenue.

23 **Sec. 4.** RCW 70.390.050 and 2020 c 340 s 5 are each amended to  
24 read as follows:

25 (1) The board has the authority to establish and appoint advisory  
26 committees, in accordance with the requirements of RCW 70.390.040,  
27 and seek input and recommendations from the advisory committees on  
28 topics relevant to the work of the board.

29 (2) The board shall:

30 (a) Determine and require collection from payers and health care  
31 providers of the types and sources of data necessary to annually  
32 calculate total health care expenditures and health care cost growth,  
33 ~~((and to))~~ establish the health care cost growth benchmark, and  
34 analyze the impact of cost drivers on health care spending, including  
35 execution of any necessary access and data security agreements with  
36 the custodians of the data. The board shall first identify existing  
37 data sources, such as the statewide health care claims database  
38 established in chapter 43.371 RCW and prescription drug data  
39 collected under chapter 43.71C RCW, and primarily rely on these

1 sources when possible in order to minimize the creation of new  
2 reporting requirements. The board may use data received from existing  
3 data sources, including, but not limited to, data collected under  
4 chapters 43.71, 43.71C, and 70.405 RCW, in its analyses and  
5 discussions to the same extent that the custodians of the data are  
6 permitted to use the data. As appropriate to promote administrative  
7 efficiencies, the board may share its data with the prescription drug  
8 affordability board under chapter 70.405 RCW and other health care  
9 cost analysis efforts conducted by the state;

10 (b) Determine the means and methods for gathering data to  
11 annually calculate total health care expenditures and health care  
12 cost growth, and to establish the health care cost growth benchmark.  
13 The board must select an appropriate economic indicator to use when  
14 establishing the health care cost growth benchmark. The activities  
15 may include selecting methodologies and determining sources of data.  
16 The board shall accept recommendations from the advisory committee on  
17 data issues and the advisory committee of health care providers and  
18 carriers regarding the value and feasibility of reporting various  
19 categories of information under (c) of this subsection, such as urban  
20 and rural, public sector and private sector, and major categories of  
21 health services, including prescription drugs, inpatient treatment,  
22 and outpatient treatment;

23 (c) Annually calculate total health care expenditures and health  
24 care cost growth:

25 (i) Statewide and by geographic rating area;

26 (ii) For each health care provider or provider system and each  
27 payer, taking into account the health status of the patients of the  
28 health care provider or the enrollees of the payer, utilization by  
29 the patients of the health care provider or the enrollees of the  
30 payer, intensity of services provided to the patients of the health  
31 care provider or the enrollees of the payer, and regional differences  
32 in input prices. The board must develop an implementation plan for  
33 reporting information about health care providers, provider systems,  
34 and payers;

35 (iii) By market segment;

36 (iv) Per capita; and

37 (v) For other categories, as recommended by the advisory  
38 committees in (b) of this subsection, and approved by the board;

39 (d) Annually establish the health care cost growth benchmark for  
40 increases in total health expenditures. The board, in determining the

1 health care cost growth benchmark, shall begin with an initial  
2 implementation that applies to the highest cost drivers in the health  
3 care system and develop a phased plan to include other components of  
4 the health system for subsequent years;

5 (e) Beginning in 2023, analyze the impacts of cost drivers to  
6 health care and incorporate this analysis into determining the annual  
7 total health care expenditures and establishing the annual health  
8 care cost growth benchmark. The cost drivers may include, to the  
9 extent such data is available:

10 (i) Labor, including but not limited to, wages, benefits, and  
11 salaries;

12 (ii) Capital costs, including but not limited to new technology;

13 (iii) Supply costs, including but not limited to prescription  
14 drug costs;

15 (iv) Uncompensated care;

16 (v) Administrative and compliance costs;

17 (vi) Federal, state, and local taxes;

18 (vii) Capacity, funding, and access to postacute care, long-term  
19 services and supports, and housing; (~~and~~)

20 (viii) Regional differences in input prices; (~~and~~

21 ~~(f)~~) (ix) Financial earnings of health care providers and  
22 payers, including information regarding profits, assets, accumulated  
23 surpluses, reserves, and investment income, and similar information;  
24 and

25 (x) Other cost drivers determined by the board to be informative  
26 to determining annual total health care expenditures and establishing  
27 the annual health care cost growth benchmark;

28 (f) Levy civil fines on payers or health care providers that  
29 violate the board's data submission requirements, including the  
30 failure to submit data, the late submission of data, and the  
31 submission of inaccurate data. The board, in consultation with the  
32 advisory committee on data issues, shall develop a schedule of civil  
33 fines for the violation of data submission requirements that  
34 considers the nature of the violation and the characteristics of the  
35 violating entity; and

36 (g) Release reports in accordance with RCW 70.390.070.

37 **Sec. 5.** RCW 70.390.070 and 2020 c 340 s 7 are each amended to  
38 read as follows:

1 (1) By August 1, 2021, the board shall submit a preliminary  
2 report to the governor and each chamber of the legislature. The  
3 preliminary report shall address the progress toward establishment of  
4 the board and advisory committees and the establishment of total  
5 health care expenditures, health care cost growth, and the health  
6 care cost growth benchmark for the state, including proposed  
7 methodologies for determining each of these calculations. The  
8 preliminary report shall include a discussion of any obstacles  
9 related to conducting the board's work including any deficiencies in  
10 data necessary to perform its responsibilities under RCW 70.390.050  
11 and any supplemental data needs.

12 (2) Beginning August 1, 2022, the board shall submit annual  
13 reports to the governor and each chamber of the legislature. The  
14 first annual report shall determine the total health care  
15 expenditures for the most recent year for which data is available and  
16 shall establish the health care cost growth benchmark for the  
17 following year. The annual reports may include policy recommendations  
18 applicable to the board's activities and analysis of its work,  
19 including any recommendations related to lowering health care costs,  
20 focusing on private sector purchasers, and the establishment of a  
21 rating system of health care providers and payers. Beginning with the  
22 August 1, 2024, annual report, the annual reports shall include an  
23 analysis of the underinsurance survey results obtained pursuant to  
24 section 6 of this act.

25 NEW SECTION. **Sec. 6.** A new section is added to chapter 70.390  
26 RCW to read as follows:

27 (1) Beginning January 1, 2024, the board shall conduct an annual  
28 survey of underinsurance among Washington residents. The survey shall  
29 be conducted among a representative sample of Washington residents.  
30 Analysis of the survey results shall be disaggregated by demographic  
31 factors such as race, ethnicity, gender and gender identity, age,  
32 disability status, household income level, type of insurance  
33 coverage, geography, and preferred language. In addition, the survey  
34 shall be designed to allow for the analyses of the aggregate impact  
35 of out-of-pocket costs and premiums according to the standards in  
36 subsection (2) of this section as well as the share of Washington  
37 residents who delay or forego care due to cost.

1 (2) (a) The board shall measure underinsurance as the share of  
2 Washington residents whose out-of-pocket costs over the prior 12  
3 months, excluding premiums, are equal to:

4 (i) For persons whose household income is over 200 percent of the  
5 federal poverty level, 10 percent or more of household income;

6 (ii) For persons whose household income is less than 200 percent  
7 of the federal poverty level, five percent or more of household  
8 income; or

9 (iii) For any income level, deductibles constituting five percent  
10 or more of household income.

11 (b) By January 1, 2026, the board shall recommend any  
12 improvements to the measure of underinsurance defined in (a) of this  
13 subsection, such as a broader health care affordability index that  
14 considers health care expenses in the context of other household  
15 expenses.

16 (3) The board may conduct the survey through the authority, by  
17 contract with a private entity, or by arrangement with another state  
18 agency conducting a related survey.

19 (4) Beginning in 2024, analysis of the survey results shall be  
20 included in the annual report required by RCW 70.390.070.

21 NEW SECTION. **Sec. 7.** A new section is added to chapter 70.390  
22 RCW to read as follows:

23 (1) The board shall conduct a study of costs to the state,  
24 whether actual spending or foregone revenue collections, as related  
25 to nonprofit health care providers and nonprofit payers, that are not  
26 included in the calculation of total health care expenditures. The  
27 study shall evaluate how the consideration of state tax preferences,  
28 tax deductions, tax-exempt capital financing, and other public  
29 reimbursement and funding streams available to nonprofit health care  
30 providers and nonprofit payers would affect the calculation of total  
31 health care expenditures if they were included in the calculation.

32 (2) The study, as well as recommendations related to whether or  
33 not the costs to the state identified in subsection (1) of this  
34 section should be included in the calculation of total health care  
35 expenditures and incorporated into the health care cost growth  
36 benchmark, must be submitted by the board as a part of the August 1,  
37 2025, annual report required under RCW 70.390.070(2).



1 (3) The board may conduct the study through the authority, by  
2 contract with a private entity, or by arrangement with another state  
3 agency conducting related work.

4 (4) This section expires January 1, 2026.

5 NEW SECTION. **Sec. 8.** A new section is added to chapter 70.390  
6 RCW to read as follows:

7 (1)(a) Concurrent with the issuance of the annual report required  
8 under RCW 70.390.070(2), the board shall hold at least one public  
9 hearing related to discussing the growth in total health care  
10 expenditures in relation to the health care cost growth benchmark in  
11 the previous calendar year, as established in the annual report, in  
12 accordance with the open public meetings act, chapter 42.30 RCW.

13 (b) The hearing shall include the public identification of any  
14 payers or health care providers for which health care cost growth in  
15 the previous calendar year exceeded the health care cost growth  
16 benchmark.

17 (c) At the hearing, the board:

18 (i) May require testimony by payers or health care providers that  
19 have substantially exceeded the health care cost growth benchmark in  
20 the previous calendar year to better understand the reasons for the  
21 excess health care cost growth and measures that are being undertaken  
22 to restore health care cost growth within the limits of the  
23 benchmark;

24 (ii) Shall invite testimony from health care stakeholders, other  
25 than payers and health care providers, including health care  
26 consumers, business interests, and labor representatives; and

27 (iii) Shall provide an opportunity for public comment.

28 (2)(a) Beginning July 1, 2024, the board may require that any  
29 payer or health care provider submit a performance improvement plan  
30 to the board if it has substantially exceeded the health care cost  
31 growth benchmark without reasonable justification or meaningful  
32 improvement for two of the previous three calendar years. The  
33 performance improvement plan shall: Identify key cost drivers and  
34 include distinct steps that the payer or health care provider shall  
35 take to address costs exceeding the health care cost growth  
36 benchmark; identify an appropriate time frame by which a payer or  
37 health care provider will reduce costs to levels below the health  
38 care cost growth benchmark, subject to evaluation by the board; and  
39 have clear measurements of success, including progress reports. The

1 first year that the board may consider in calculating the number of  
2 years of substantially exceeding the health care cost growth  
3 benchmark is calendar year 2021.

4 (b) By July 1, 2024, the authority, in consultation with the  
5 board, shall adopt rules related to the submission, content, and  
6 enforcement of performance improvement plans. The rules shall include  
7 a process to notify the payer or health care provider that a  
8 performance improvement plan must be submitted and the areas of  
9 health care costs that are the source of the growth. The rules shall  
10 provide a reasonable opportunity to correct any practices causing  
11 excessive health care cost growth. The rules shall address appeals  
12 procedures to allow payers and health care providers to seek review  
13 of a decision by the board to impose a performance improvement plan  
14 upon the payer or health care provider.

15 (3)(a) Beginning July 1, 2025, the board may impose a civil fine  
16 on a payer or health care provider that either: (i) Substantially  
17 exceeded the health care cost growth benchmark without reasonable  
18 justification or meaningful improvement for three of the previous  
19 five calendar years; or (ii) fails to participate in a performance  
20 improvement plan. The first year that the board may consider in  
21 calculating the number of years of substantially exceeding the health  
22 care cost growth benchmark is calendar year 2021.

23 (b) By July 1, 2024, the authority, in consultation with the  
24 board, shall adopt rules related to the criteria for imposing a civil  
25 fine on a payer or health care provider, notifying the payer or  
26 health care provider, providing a reasonable opportunity to correct  
27 any practices causing excessive health care cost growth, and  
28 establishing a civil fine schedule. The rules shall address appeals  
29 procedures to allow payers and health care providers to seek review  
30 of a decision by the board to impose a civil fine upon the payer or  
31 health care provider. In establishing the civil fine schedule, the  
32 authority shall account for:

33 (i) The amount and duration by which the payer or health care  
34 provider exceeded the health care cost growth benchmark, with initial  
35 civil fine amounts commensurate with the failure to meet the health  
36 care cost growth benchmark and escalating civil fine amounts beyond  
37 this initial civil fine amount for repeated or continuing failure to  
38 meet the benchmark;

39 (ii) The relative size and financial condition of the payer or  
40 health care provider, including revenues, reserves, profits, and

1 assets of the entity, as well as any affiliates, subsidiaries, or  
2 other entities that control, govern, or are financially responsible  
3 for the entity or are subject to the control, governance, or  
4 financial control of the entity;

5 (iii) Quality performance data from reputable third-party sources  
6 regarding the payer or health care provider; and

7 (iv) The good faith efforts of the payer or health care provider  
8 to address health care costs and cooperate with the board.

9 (4) The authority may levy a reasonable fee on any payer or  
10 health care provider that is subject to a performance improvement  
11 plan or civil fine pursuant to this section to account for the  
12 authority's costs in developing and monitoring the plan or levying  
13 the civil fine. Any fees levied under this subsection must be used by  
14 the authority to offset administrative costs related to this chapter.

15 (5) The authority may waive the imposition of a performance  
16 improvement plan or civil fine in the event of unforeseen market  
17 conditions or if doing so would promote consumer health care access  
18 and affordability.

19 (6) Any fines levied under subsection (4) of this section or  
20 civil fines imposed under subsection (3) of this section must be  
21 deposited in the state health care affordability account established  
22 under RCW 43.71.130.

23 **Sec. 9.** RCW 43.71C.030 and 2019 c 334 s 4 are each amended to  
24 read as follows:

25 (1) By March 1st of each year, a pharmacy benefit manager must  
26 submit to the authority the following data from the previous calendar  
27 year:

28 (a) All discounts, including the total dollar amount and  
29 percentage discount, and all rebates received from a manufacturer for  
30 each drug on the pharmacy benefit manager's formularies;

31 (b) The total dollar amount of all discounts and rebates that are  
32 retained by the pharmacy benefit manager for each drug on the  
33 pharmacy benefit manager's formularies;

34 (c) Actual total reimbursement amounts for each drug the pharmacy  
35 benefit manager pays retail pharmacies after all direct and indirect  
36 administrative and other fees that have been retrospectively charged  
37 to the pharmacies are applied;

38 (d) The negotiated price health plans pay the pharmacy benefit  
39 manager for each drug on the pharmacy benefit manager's formularies;

1 (e) The amount, terms, and conditions relating to copayments,  
2 reimbursement options, and other payments or fees associated with a  
3 prescription drug benefit plan;

4 (f) Disclosure of any ownership interest the pharmacy benefit  
5 manager has in a pharmacy or health plan with which it conducts  
6 business; and

7 (g) The results of any appeal filed pursuant to RCW  
8 (~~(19.340.100(3))~~) 48.200.280(3).

9 (2) The information collected pursuant to this section is not  
10 subject to public disclosure under chapter 42.56 RCW.

11 (3) The authority may examine or audit the financial records of a  
12 pharmacy benefit manager for purposes of ensuring the information  
13 submitted under this section is accurate. Information the authority  
14 acquires in an examination of financial records pursuant to this  
15 subsection is proprietary and confidential.

16 (4) Information collected pursuant to this section may be shared  
17 with the health care cost transparency board under chapter 70.390 RCW  
18 and other health care cost analysis efforts conducted by the state.  
19 Entities receiving information under this subsection are subject to  
20 the same disclosure restrictions as established under this chapter.

21 **Sec. 10.** RCW 70.405.030 and 2022 c 153 s 3 are each amended to  
22 read as follows:

23 By June 30, 2023, and annually thereafter, utilizing data  
24 collected pursuant to (~~chapter~~) chapters 43.71C, 43.371, and 70.390  
25 RCW, (~~the all-payer health care claims database,~~) or other data  
26 deemed relevant by the board, the board must identify prescription  
27 drugs that have been on the market for at least seven years, are  
28 dispensed at a retail, specialty, or mail-order pharmacy, are not  
29 designated by the United States food and drug administration under 21  
30 U.S.C. Sec. 360bb as a drug solely for the treatment of a rare  
31 disease or condition, and meet the following thresholds:

32 (1) Brand name prescription drugs and biologic products that:

33 (a) Have a wholesale acquisition cost of \$60,000 or more per year  
34 or course of treatment lasting less than one year; or

35 (b) Have a price increase of 15 percent or more in any 12-month  
36 period or for a course of treatment lasting less than 12 months, or a  
37 50 percent cumulative increase over three years;

1           (2) A biosimilar product with an initial wholesale acquisition  
2 cost that is not at least 15 percent lower than the reference  
3 biological product; and

4           (3) Generic drugs with a wholesale acquisition cost of \$100 or  
5 more for a 30-day supply or less that has increased in price by 200  
6 percent or more in the preceding 12 months.

7           NEW SECTION.   **Sec. 11.** A new section is added to chapter 70.390  
8 RCW to read as follows:

9           The authority may adopt rules independently or on behalf of the  
10 board, as necessary to implement this chapter.

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