
SENATE BILL 5519

State of Washington

68th Legislature

2023 Regular Session

By Senator Robinson

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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