

ESHB 1508 - H AMD 799

By Representative Macri

ADOPTED 02/06/2024

1 Strike everything after the enacting clause and insert the
2 following:

3 **"Sec. 1.** RCW 70.390.040 and 2020 c 340 s 4 are each amended to
4 read as follows:

5 (1) The board shall establish an advisory committee on data
6 issues and ~~((and)) a health care stakeholder~~ advisory committee ~~((of~~
7 ~~health care providers and carriers))~~. The board may establish other
8 advisory committees as it finds necessary. Any other standing
9 advisory committee established by the board shall include members
10 representing the interests of consumer, labor, and employer
11 purchasers, at a minimum, and may include other stakeholders with
12 expertise in the subject of the advisory committee, such as health
13 care providers, payers, and health care cost researchers.

14 (2) Appointments to the advisory committee on data issues shall
15 be made by the board. Members of the committee must have expertise in
16 health data collection and reporting, health care claims data
17 analysis, health care economic analysis, ~~((and))~~ actuarial analysis,
18 or other relevant expertise related to health data.

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

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

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

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

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

- 1 (e) One member representing behavioral health providers, selected
2 from a list of three nominees submitted by the Washington council for
3 behavioral health;
- 4 (f) One member representing pharmacists and pharmacies, selected
5 from a list of three nominees submitted by the Washington state
6 pharmacy association;
- 7 (g) One member representing advanced registered nurse
8 practitioners, selected from a list of three nominees submitted by
9 ARNPs united of Washington state;
- 10 (h) One member representing tribal health providers, selected
11 from a list of three nominees submitted by the American Indian health
12 commission;
- 13 (i) One member representing a health maintenance organization,
14 selected from a list of three nominees submitted by the association
15 of Washington health care plans;
- 16 (j) One member representing a managed care organization that
17 contracts with the authority to serve medical assistance enrollees,
18 selected from a list of three nominees submitted by the association
19 of Washington health care plans;
- 20 (k) One member representing a health care service contractor,
21 selected from a list of three nominees submitted by the association
22 of Washington health care plans;
- 23 (l) One member representing an ambulatory surgery center selected
24 from a list of three nominees submitted by the ambulatory surgery
25 center association; ((and))
- 26 (m) Three members, at least one of whom represents a disability
27 insurer, selected from a list of six nominees submitted by America's
28 health insurance plans;
- 29 (n) At least two members representing the interests of consumers,
30 selected from a list of nominees submitted by consumer organizations;
- 31 (o) At least two members representing the interests of labor
32 purchasers, selected from a list of nominees submitted by the
33 Washington state labor council; and
- 34 (p) At least two members representing the interests of employer
35 purchasers, including at least one small business representative,
36 selected from a list of nominees submitted by business organizations.
37 The members appointed under this subsection (3)(p) may not be
38 directly or indirectly affiliated with an employer which has income
39 from health care services, health care products, health insurance, or

1 other health care sector-related activities as its primary source of
2 revenue.

3 **Sec. 2.** RCW 70.390.050 and 2020 c 340 s 5 are each amended to
4 read as follows:

5 (1) The board has the authority to establish and appoint advisory
6 committees, in accordance with the requirements of RCW 70.390.040,
7 and shall seek input and recommendations from ~~((the))~~ relevant
8 advisory committees ~~((on topics relevant to the work of the board))~~.

9 (2) The board shall:

10 (a) Determine the types and sources of data necessary to annually
11 calculate total health care expenditures and health care cost growth,
12 ~~((and to))~~ establish the health care cost growth benchmark, and
13 analyze the impact of cost drivers on health care spending, including
14 execution of any necessary access and data security agreements with
15 the custodians of the data. The board shall first identify existing
16 data sources, such as the statewide health care claims database
17 established in chapter 43.371 RCW and prescription drug data
18 collected under chapter 43.71C RCW, and primarily rely on these
19 sources when possible in order to minimize the creation of new
20 reporting requirements. The board may use data received from existing
21 data sources including, but not limited to, publicly available
22 information filed by carriers under Title 48 RCW and data collected
23 under chapters 43.70, 43.71, 43.71C, 43.371, and 70.405 RCW, in its
24 analyses and discussions to the same extent that the custodians of
25 the data are permitted to use the data. As appropriate to promote
26 administrative efficiencies, the board may share its data with the
27 prescription drug affordability board under chapter 70.405 RCW and
28 other health care cost analysis efforts conducted by the state;

29 (b) Determine the means and methods for gathering data to
30 annually calculate total health care expenditures and health care
31 cost growth, and to establish the health care cost growth benchmark.
32 The board must select an appropriate economic indicator to use when
33 establishing the health care cost growth benchmark. The activities
34 may include selecting methodologies and determining sources of data.
35 The board shall ~~((accept))~~ solicit and consider recommendations from
36 the advisory committee on data issues and the health care stakeholder
37 advisory committee ~~((of health care providers and carriers))~~
38 regarding the value and feasibility of reporting various categories
39 of information under (c) of this subsection, such as urban and rural,

1 public sector and private sector, and major categories of health
2 services, including prescription drugs, inpatient treatment, and
3 outpatient treatment;

4 (c) Annually calculate total health care expenditures and health
5 care cost growth:

6 (i) Statewide and by geographic rating area;

7 (ii) For each health care provider or provider system and each
8 payer, taking into account the health status of the patients of the
9 health care provider or the enrollees of the payer, utilization by
10 the patients of the health care provider or the enrollees of the
11 payer, intensity of services provided to the patients of the health
12 care provider or the enrollees of the payer, and regional differences
13 in input prices. The board must develop an implementation plan for
14 reporting information about health care providers, provider systems,
15 and payers;

16 (iii) By market segment;

17 (iv) Per capita; and

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

20 (d) Annually establish the health care cost growth benchmark for
21 increases in total health expenditures. The board, in determining the
22 health care cost growth benchmark, shall begin with an initial
23 implementation that applies to the highest cost drivers in the health
24 care system and develop a phased plan to include other components of
25 the health system for subsequent years;

26 (e) Beginning in 2023, analyze the impacts of cost drivers to
27 health care and incorporate this analysis into determining the annual
28 total health care expenditures and establishing the annual health
29 care cost growth benchmark. The cost drivers may include, to the
30 extent such data is available:

31 (i) Labor, including but not limited to, wages, benefits, and
32 salaries;

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

34 (iii) Supply costs, including but not limited to prescription
35 drug costs;

36 (iv) Uncompensated care;

37 (v) Administrative and compliance costs;

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

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

1 (viii) Regional differences in input prices; ((and
2 ~~(f)~~)) (ix) Financial earnings of health care providers and
3 payers, including information regarding profits, assets, accumulated
4 surpluses, reserves, and investment income, and similar information;
5 (x) Utilization trends and adjustments for demographic changes
6 and severity of illness;
7 (xi) New state health insurance benefit mandates enacted by the
8 legislature that require carriers to reimburse the cost of specified
9 procedures or prescriptions; and
10 (xii) Other cost drivers determined by the board to be
11 informative to determining annual total health care expenditures and
12 establishing the annual health care cost growth benchmark; and
13 (f) Release reports in accordance with RCW 70.390.070.

14 **Sec. 3.** RCW 70.390.070 and 2020 c 340 s 7 are each amended to
15 read as follows:

16 ~~((1) By August 1, 2021, the board shall submit a preliminary~~
17 ~~report to the governor and each chamber of the legislature. The~~
18 ~~preliminary report shall address the progress toward establishment of~~
19 ~~the board and advisory committees and the establishment of total~~
20 ~~health care expenditures, health care cost growth, and the health~~
21 ~~care cost growth benchmark for the state, including proposed~~
22 ~~methodologies for determining each of these calculations. The~~
23 ~~preliminary report shall include a discussion of any obstacles~~
24 ~~related to conducting the board's work including any deficiencies in~~
25 ~~data necessary to perform its responsibilities under RCW 70.390.050~~
26 ~~and any supplemental data needs.~~

27 ~~(2) Beginning August 1, 2022))~~ By December 1st of each year, the
28 board shall submit annual reports to the governor and each chamber of
29 the legislature. ~~((The first annual report shall determine the total~~
30 ~~health care expenditures for the most recent year for which data is~~
31 ~~available and shall establish the health care cost growth benchmark~~
32 ~~for the following year.))~~ The annual reports may include policy
33 recommendations applicable to the board's activities and analysis of
34 its work, including any recommendations related to lowering health
35 care costs, focusing on private sector purchasers, and the
36 establishment of a rating system of health care providers and payers.

37 NEW SECTION. **Sec. 4.** A new section is added to chapter 70.390
38 RCW to read as follows:

1 (1) At least biennially, the board shall conduct a survey of
2 underinsurance among Washington residents.

3 (a) The survey shall be conducted among a representative sample
4 of Washington residents. Analysis of the survey results shall be
5 disaggregated to the greatest extent feasible by demographic factors
6 such as race, ethnicity, gender and gender identity, age, disability
7 status, household income level, type of insurance coverage,
8 geography, and preferred language. In addition, the survey shall be
9 designed to allow for the analyses of the aggregate impact of out-of-
10 pocket costs and premiums according to the standards in (b) of this
11 subsection as well as the share of Washington residents who delay or
12 forego care due to cost.

13 (b) The board shall measure underinsurance as the share of
14 Washington residents whose out-of-pocket costs over the prior 12
15 months, excluding premiums, are equal to:

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

18 (ii) For persons whose household income is less than 200 percent
19 of the federal poverty level, five percent or more of household
20 income; or

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

23 (c) Beginning in 2026, the board may implement improvements to
24 the measure of underinsurance defined in (b) of this subsection, such
25 as a broader health care affordability index that considers health
26 care expenses in the context of other household expenses.

27 (2) At least biennially, the board shall conduct a survey of
28 insurance trends among employers and employees. The survey must be
29 conducted among a representative sample of Washington employers and
30 employees.

31 (3) The board may conduct the surveys through the authority, by
32 contract with a private entity, or by arrangement with another state
33 agency conducting a related survey.

34 (4) Beginning in 2025, analysis of the survey results shall be
35 included in the annual report required by RCW 70.390.070.

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

38 (1) No later than December 1, 2024, and annually thereafter, the
39 board shall hold a public hearing related to discussing the growth in

1 total health care expenditures in relation to the health care cost
2 growth benchmark in the previous performance period, in accordance
3 with the open public meetings act, chapter 42.30 RCW. The agenda and
4 any materials for this hearing must be made available to the public
5 at least 14 days prior to the hearing.

6 (2) (a) Except as provided in (b) of this subsection, to the
7 extent data permits, the hearing must include the public
8 identification of any payers or health care providers for which
9 health care cost growth in the previous performance period exceeded
10 the health care cost growth benchmark.

11 (b) Provider groups with fewer than 10,000 unique attributed
12 lives shall be exempt from identification under (a) of this
13 subsection.

14 (3) At the hearing, the board:

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

21 (b) Shall invite testimony from health care stakeholders, other
22 than payers and health care providers, including health care
23 consumers, business interests, and labor representatives; and

24 (c) Shall provide an opportunity for public comment.

25 NEW SECTION. **Sec. 6.** A new section is added to chapter 43.71C
26 RCW to read as follows:

27 Information collected pursuant to this chapter may be shared with
28 the health care cost transparency board established under chapter
29 70.390 RCW, subject to the same disclosure restrictions applicable
30 under this chapter.

31 **Sec. 7.** RCW 70.405.030 and 2022 c 153 s 3 are each amended to
32 read as follows:

33 By June 30, 2023, and annually thereafter, utilizing data
34 collected pursuant to (~~chapter~~) chapters 43.71C, 43.371, and 70.390
35 RCW, (~~the all-payer health care claims database,~~) or other data
36 deemed relevant by the board, the board must identify prescription
37 drugs that have been on the market for at least seven years, are
38 dispensed at a retail, specialty, or mail-order pharmacy, are not

1 designated by the United States food and drug administration under 21
2 U.S.C. Sec. 360bb as a drug solely for the treatment of a rare
3 disease or condition, and meet the following thresholds:

- 4 (1) Brand name prescription drugs and biologic products that:
5 (a) Have a wholesale acquisition cost of \$60,000 or more per year
6 or course of treatment lasting less than one year; or
7 (b) Have a price increase of 15 percent or more in any 12-month
8 period or for a course of treatment lasting less than 12 months, or a
9 50 percent cumulative increase over three years;
10 (2) A biosimilar product with an initial wholesale acquisition
11 cost that is not at least 15 percent lower than the reference
12 biological product; and
13 (3) Generic drugs with a wholesale acquisition cost of \$100 or
14 more for a 30-day supply or less that has increased in price by 200
15 percent or more in the preceding 12 months."

16 Correct the title.

EFFECT: Removes the requirement that the Health Care Cost Transparency Board (Board) seek input from advisory committees prior to major votes or decisions. Removes the Board's authority to require reporting and collection of data from payers and health care providers and to levy civil fines on payers and health care providers that violate data submission requirements. Removes the Board's authority to use data from nonspecified sources. Allows the Board to use publicly available information filed by insurance carriers. Removes requirements of the Board to adopt risk adjustment methodologies for use in analyzing total health care expenditures and health care cost growth.

Changes the due date of the Board's annual report to December 1st each year, rather than August 1st. Removes the requirement that the annual report include information about testimony and public comments received during the annual public hearing on growth in total health care expenditures.

Eliminates the study of costs to the state related to nonprofit health care providers and nonprofit payers that are not included in the calculation of total health care expenditures.

Changes the annual survey of underinsurance to a biennial survey. Directs the Board to conduct a biennial survey of insurance trends among employers and employees.

Removes the Health Care Authority's authority to support activities and decisions of the Board, such as data collection and analysis, technical assistance, and the enforcement of performance improvement plan submissions and the payment of fines. Eliminates the requirements that the Board's analyses be performed by individuals with relevant expertise.

Requires the Board's public hearing on growth in total health care expenditures to occur once a year, rather than at least once a year, and does not require that it be held concurrent with the issuance of the annual report. Requires the Board to make materials for the public hearing available at least 14 days prior to the public

hearing, rather than seven days prior. Requires the Board to provide at least 21 days' notice to payers or health care providers that are required to testify. Exempts provider groups with fewer than 10,000 unique attributed lives from public identification as having exceeded the health care cost growth benchmark.

Eliminates the Board's authority to require payers and health care providers to establish performance improvement plans or pay civil fines.

Removes legislative findings and intent. Removes the null and void clause.

--- END ---