CERTIFICATION OF ENROLLMENT

SECOND ENGROSSED SUBSTITUTE HOUSE BILL 1508

Chapter 80, Laws of 2024

68th Legislature
2024 Regular Session

HEALTH CARE COST TRANSPARENCY BOARD—VARIOUS PROVISIONS

EFFECTIVE DATE: June 6, 2024

Passed by the House February 6, 2024
Yeas 94 Nays 3

LAURIE JINKINS

Speaker of the House of Representatives

Passed by the Senate February 28, 2024
Yeas 45 Nays 2

DENNY HECK

President of the Senate

Approved March 14, 2024 11:11 AM

JAY INSLEE

Governor of the State of Washington

CERTIFICATE

I, Bernard Dean, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **SECOND ENGROSSED SUBSTITUTE HOUSE BILL 1508** as passed by the House of Representatives and the Senate on the dates hereon set forth.

BERNARD DEAN

Chief Clerk

FILED

March 14, 2024

Secretary of State
State of Washington

SECOND ENGROSSED SUBSTITUTE HOUSE BILL 1508

Passed Legislature - 2024 Regular Session

State of Washington 68th Legislature 2023 Regular Session

By House Appropriations (originally sponsored by Representatives Macri, Riccelli, Simmons, Fitzgibbon, Berry, Alvarado, Bateman, Ormsby, Doglio, Reed, Callan, Stonier, Tharinger, and Bergquist)

READ FIRST TIME 02/24/23.

AN ACT Relating to improving consumer affordability through the health care cost transparency board; amending RCW 70.390.040, 70.390.050, 70.390.070, and 70.405.030; adding new sections to chapter 70.390 RCW; and adding a new section to chapter 43.71C RCW.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) The board shall:

(a) Determine the types and sources of data necessary to annually calculate total health care expenditures and health care cost growth, ((~~and to~~)) establish the health care cost growth benchmark, and analyze the impact of cost drivers on health care spending, including execution of any necessary access and data security agreements with the custodians of the data. The board shall first identify existing data sources, such as the statewide health care claims database established in chapter 43.371 RCW and prescription drug data collected under chapter 43.71C RCW, and primarily rely on these sources when possible in order to minimize the creation of new reporting requirements. The board may use data received from existing data sources including, but not limited to, publicly available information filed by carriers under Title 48 RCW and data collected under chapters 43.70, 43.71, 43.71C, 43.371, and 70.405 RCW, in its analyses and discussions to the same extent that the custodians of the data are permitted to use the data. As appropriate to promote

administrative efficiencies, the board may share its data with the prescription drug affordability board under chapter 70.405 RCW and other health care cost analysis efforts conducted by the state;

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

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

(i) Statewide and by geographic rating area;

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

(iii) By market segment;

(iv) Per capita; and

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

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

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

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

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

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

(iv) Uncompensated care;

(v) Administrative and compliance costs;

(vi) Federal, state, and local taxes;

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

(viii) Regional differences in input prices; ((~~and~~ ~~(f)~~)) (ix) Financial earnings of health care providers and payers, including information regarding profits, assets, accumulated surpluses, reserves, and investment income, and similar information;

(x) Utilization trends and adjustments for demographic changes and severity of illness;

(xi) New state health insurance benefit mandates enacted by the legislature that require carriers to reimburse the cost of specified procedures or prescriptions; and

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

(f) Release reports in accordance with RCW 70.390.070.

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

((~~(1) By August 1, 2021, the board shall submit a preliminary report to the governor and each chamber of the legislature. The preliminary report shall address the progress toward establishment of the board and advisory committees and the establishment of total health care expenditures, health care cost growth, and the health care cost growth benchmark for the state, including proposed methodologies for determining each of these calculations. The preliminary report shall include a discussion of any obstacles related to conducting the board's work including any deficiencies in~~

~~data necessary to perform its responsibilities under RCW 70.390.050 and any supplemental data needs.~~

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

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

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

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

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

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

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

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

(c) Beginning in 2026, the board may implement improvements to the measure of underinsurance defined in (b) of this subsection, such

as a broader health care affordability index that considers health care expenses in the context of other household expenses.

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

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

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

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

(1) No later than December 1, 2024, and annually thereafter, the board shall hold a public hearing related to discussing the growth in total health care expenditures in relation to the health care cost growth benchmark in the previous performance period, in accordance with the open public meetings act, chapter 42.30 RCW. The agenda and any materials for this hearing must be made available to the public at least 14 days prior to the hearing.

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

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

(3) At the hearing, the board:

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

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

(c) Shall provide an opportunity for public comment.

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

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

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

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

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

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

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

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

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

Passed by the House February 6, 2024.
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