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**SUBSTITUTE HOUSE BILL 1508**

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**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.

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 new sections; and  
5 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, identifying drivers of health care  
24 cost growth, and establishing a health care cost growth benchmark.  
25 The board shall provide analysis of the factors impacting these  
26 trends in health care cost growth and, after review and consultation  
27 with identified entities, shall identify those health care providers  
28 and payers that are exceeding the health care cost growth benchmark.  
29 The board's analysis must be performed by individuals with relevant  
30 expertise.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

32 (1) The board has the authority to establish and appoint advisory  
33 committees, in accordance with the requirements of RCW 70.390.040,  
34 and shall seek input and recommendations from ~~((the))~~ relevant  
35 advisory committees ~~((on topics relevant to the work of the board))~~  
36 in advance of major votes or decisions, unless exigent conditions  
37 require otherwise.

38 (2) The board shall:

1 (a) Determine and require collection from payers and health care  
2 providers of the types and sources of data necessary to annually  
3 calculate total health care expenditures and health care cost growth,  
4 (~~and to~~) establish the health care cost growth benchmark, and  
5 analyze the impact of cost drivers on health care spending, including  
6 execution of any necessary access and data security agreements with  
7 the custodians of the data. The board shall first identify existing  
8 data sources, such as the statewide health care claims database  
9 established in chapter 43.371 RCW and prescription drug data  
10 collected under chapter 43.71C RCW, and primarily rely on these  
11 sources when possible in order to minimize the creation of new  
12 reporting requirements. The board may use data received from existing  
13 data sources, including, but not limited to, data collected under  
14 chapters 43.71, 43.71C, and 70.405 RCW, in its analyses and  
15 discussions to the same extent that the custodians of the data are  
16 permitted to use the data. The board also may use other available  
17 data sources, such as medicare cost reports. As appropriate to  
18 promote administrative efficiencies, the board may share its data  
19 with the prescription drug affordability board under chapter 70.405  
20 RCW and other health care cost analysis efforts conducted by the  
21 state;

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

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

38 (i) Statewide and by geographic rating area;

39 (ii) For each health care provider or provider system and each  
40 payer, (~~taking into account~~) both adjusted and unadjusted for the

1 health status of the patients of the health care provider or the  
2 enrollees of the payer, utilization by the patients of the health  
3 care provider or the enrollees of the payer, intensity of services  
4 provided to the patients of the health care provider or the enrollees  
5 of the payer, and regional differences in input prices to the extent  
6 data permits. The board may establish, in consultation with the  
7 advisory committee on data issues and the health care stakeholder  
8 advisory committee, a common risk adjustment methodology for use in  
9 relevant analysis. The board must develop an implementation plan for  
10 reporting information about health care providers, provider systems,  
11 and payers;

12 (iii) By market segment;

13 (iv) Per capita; and

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

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

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

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

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

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

32 (iv) Uncompensated care;

33 (v) Administrative and compliance costs;

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

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

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

38 ~~(f)~~) (ix) Financial earnings of health care providers and  
39 payers, including information regarding profits, assets, accumulated  
40 surpluses, reserves, and investment income, and similar information;

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

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

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

9 (f) Levy civil fines on payers or health care providers that  
10 violate the board's data submission requirements, including the  
11 failure to submit data, the late submission of data, and the  
12 submission of inaccurate data. The board, in consultation with the  
13 advisory committee on data issues, shall develop a schedule of civil  
14 fines for the violation of data submission requirements that  
15 considers the nature of the violation and the characteristics of the  
16 violating entity. The board may not levy civil fines under this  
17 subsection on health care providers composed of 25 or fewer health  
18 care professionals licensed by a disciplining authority under RCW  
19 18.130.040. The authority shall develop rules to implement this  
20 subsection, including a data process to verify provider counts; and

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

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

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

35 ~~(2))~~ Beginning August 1, 2022, the board shall submit annual  
36 reports to the governor and each chamber of the legislature. The  
37 first annual report shall determine the total health care  
38 expenditures for the most recent year for which data is available and  
39 shall establish the health care cost growth benchmark for the

1 following year. The annual reports may include policy recommendations  
2 applicable to the board's activities and analysis of its work,  
3 including any recommendations related to lowering health care costs,  
4 focusing on private sector purchasers, and the establishment of a  
5 rating system of health care providers and payers. Each report must  
6 include information about any testimony or public comments received  
7 in conjunction with the hearing mandated under section 8 of this act.  
8 Beginning with the August 1, 2024, annual report, the annual reports  
9 shall include an analysis of the underinsurance survey results  
10 obtained pursuant to section 6 of this act.

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

13 (1) Beginning January 1, 2024, the board shall conduct an annual  
14 survey of underinsurance among Washington residents. The survey shall  
15 be conducted among a representative sample of Washington residents.  
16 Analysis of the survey results shall be disaggregated by demographic  
17 factors such as race, ethnicity, gender and gender identity, age,  
18 disability status, household income level, type of insurance  
19 coverage, geography, and preferred language. In addition, the survey  
20 shall be designed to allow for the analyses of the aggregate impact  
21 of out-of-pocket costs and premiums according to the standards in  
22 subsection (2) of this section as well as the share of Washington  
23 residents who delay or forego care due to cost.

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

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

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

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

34 (b) By January 1, 2026, the board shall recommend any  
35 improvements to the measure of underinsurance defined in (a) of this  
36 subsection, such as a broader health care affordability index that  
37 considers health care expenses in the context of other household  
38 expenses.



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

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

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

8 (1) The board shall conduct a study of costs to the state,  
9 whether actual spending or foregone revenue collections, as related  
10 to nonprofit health care providers and nonprofit payers, that are not  
11 included in the calculation of total health care expenditures. The  
12 study shall evaluate how the consideration of state tax preferences,  
13 tax deductions, tax-exempt capital financing, and other public  
14 reimbursement and funding streams available to nonprofit health care  
15 providers and nonprofit payers would affect the calculation of total  
16 health care expenditures if they were included in the calculation.

17 (2) The study, as well as recommendations related to whether or  
18 not the costs to the state identified in subsection (1) of this  
19 section should be included in the calculation of total health care  
20 expenditures and incorporated into the health care cost growth  
21 benchmark, must be submitted by the board as a part of the August 1,  
22 2025, annual report required under RCW 70.390.070.

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

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

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

29 (1)(a) Concurrent with the issuance of the annual report required  
30 under RCW 70.390.070, the board shall hold at least one public  
31 hearing related to discussing the growth in total health care  
32 expenditures in relation to the health care cost growth benchmark in  
33 the previous calendar year, as established in the annual report, in  
34 accordance with the open public meetings act, chapter 42.30 RCW. The  
35 agenda and any materials for this hearing must be made available to  
36 the public at least seven days prior to the hearing.

37 (b) The hearing shall include the public identification of any  
38 payers or health care providers for which health care cost growth in

1 the previous calendar year exceeded the health care cost growth  
2 benchmark.

3 (c) At the hearing, the board:

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

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

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

14 (2)(a) Except as provided in subsection (7) of this section,  
15 beginning July 1, 2024, the board may require that any payer or  
16 health care provider submit a performance improvement plan to the  
17 board if it has substantially exceeded the health care cost growth  
18 benchmark without reasonable justification or meaningful improvement  
19 for two of the previous three calendar years. The board must consider  
20 the factors identified in subsection (3)(b) of this section in  
21 determining whether a performance improvement plan is warranted. The  
22 performance improvement plan shall: Identify key cost drivers and  
23 include distinct steps that the payer or health care provider shall  
24 take to address costs exceeding the health care cost growth  
25 benchmark; identify an appropriate time frame by which a payer or  
26 health care provider will reduce costs to levels below the health  
27 care cost growth benchmark, subject to evaluation by the board; and  
28 have clear measurements of success, including progress reports. The  
29 first year that the board may consider in calculating the number of  
30 years of substantially exceeding the health care cost growth  
31 benchmark is calendar year 2021.

32 (b) By July 1, 2024, the authority, in consultation with the  
33 board, shall adopt rules related to the submission, content, and  
34 enforcement of performance improvement plans. The rules shall include  
35 a process to notify the payer or health care provider in advance of  
36 public notice that a performance improvement plan must be submitted  
37 and the areas of health care costs that are the source of the growth.  
38 The rules shall provide a reasonable opportunity to correct any  
39 practices causing excessive health care cost growth. The rules shall  
40 address appeals procedures to allow payers and health care providers

1 to seek review of a decision by the board to impose a performance  
2 improvement plan upon the payer or health care provider.

3 (3) (a) Except as provided in subsection (7) of this section,  
4 beginning July 1, 2025, the board may impose a civil fine on a payer  
5 or health care provider that either: (i) Substantially exceeded the  
6 health care cost growth benchmark without reasonable justification or  
7 meaningful improvement for three of the previous five calendar years;  
8 or (ii) fails to participate in a performance improvement plan. The  
9 first year that the board may consider in calculating the number of  
10 years of substantially exceeding the health care cost growth  
11 benchmark is calendar year 2021.

12 (b) By July 1, 2024, the authority, in consultation with the  
13 board, shall adopt rules related to the criteria for imposing a civil  
14 fine on a payer or health care provider, notifying the payer or  
15 health care provider in advance of public notice, providing a  
16 reasonable opportunity to correct any practices causing excessive  
17 health care cost growth, and establishing a civil fine schedule. The  
18 rules shall address appeals procedures to allow payers and health  
19 care providers to seek review of a decision by the board to impose a  
20 civil fine upon the payer or health care provider. In establishing  
21 the civil fine schedule, the authority shall account for:

22 (i) The amount and duration by which the payer or health care  
23 provider exceeded the health care cost growth benchmark, with initial  
24 civil fine amounts commensurate with the failure to meet the health  
25 care cost growth benchmark and escalating civil fine amounts beyond  
26 this initial civil fine amount for repeated or continuing failure to  
27 meet the benchmark;

28 (ii) The relative size and financial condition of the payer or  
29 health care provider, including revenues, reserves, profits, and  
30 assets of the entity, as well as any affiliates, subsidiaries, or  
31 other entities that control, govern, or are financially responsible  
32 for the entity or are subject to the control, governance, or  
33 financial control of the entity;

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

36 (iv) The good faith efforts of the payer or health care provider  
37 to address health care costs and cooperate with the board; and

38 (v) The relative starting price position of the payer or health  
39 care provider prior to the health care cost growth benchmark,

1 including but not limited to consideration of the primary care  
2 expenditure goal set forth in RCW 70.390.080.

3 (4) Except as provided in subsection (7) of this section, the  
4 authority may levy a reasonable fee on any payer or health care  
5 provider that is subject to a performance improvement plan or civil  
6 fine pursuant to this section to account for the authority's costs in  
7 developing and monitoring the plan or levying the civil fine. Any  
8 fees levied under this subsection must be used by the authority to  
9 offset administrative costs related to this chapter.

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

14 (6) Any fines levied under subsection (4) of this section or  
15 civil fines imposed under subsection (3) of this section must be  
16 deposited in the state health care affordability account established  
17 under RCW 43.71.130.

18 (7) The board may not impose performance improvement plans,  
19 fines, or fees under this section on health care providers composed  
20 of 25 or fewer health care professionals licensed by a disciplining  
21 authority under RCW 18.130.040. The authority shall develop rules to  
22 implement this subsection, including a data process to verify  
23 provider counts.

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

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

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

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

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

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

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

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

9 (g) The results of any appeal filed pursuant to RCW  
10 (~~(19.340.100(3))~~) 48.200.280(3).

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

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

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

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

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

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

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

37 (b) Have a price increase of 15 percent or more in any 12-month  
38 period or for a course of treatment lasting less than 12 months, or a  
39 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.

11 NEW SECTION. **Sec. 12.** If specific funding for the purposes of  
12 this act, referencing this act by bill or chapter number, is not  
13 provided by June 30, 2023, in the omnibus appropriations act, this  
14 act is null and void.

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