Washington State Health Care Authority

Advisory Committee of Health Care Providers and Carriers

June 2, 2022

Washington State Health Care Authority

Health Care Cost Transparency Board
Board Book

June 2, 2022
3:00 p.m. – 5:00 p.m.

(Zoom Attendance Only)

Meeting Materials

Background and Topical Material

Washington State Health Care Authority

Agenda

TAB 1

Washington State Health Care Authority

Advisory Committee of the Health Care Providers and Carriers

June 2, 2022
3:00 p.m. – 5:00 p.m.
Zoom Meeting

AGENDA

Committee Members:					
☐	Mark Barnhart	☐	Stacy Kessel	☐	Megan McIntyre
☐	Bob Crittenden	☐	Ross Laursen	☐	Mika Sinanan
☐	Bill Ely	☐	Todd Lovshin	☐	Dorothy Teeter
☐	Paul Fishman	☐	Vicki Lowe	☐	Wes Waters
☐	Jodi Joyce	☐	Mike Marsh		
☐	Louise Kaplan	☐	Natalia Martinez-Kohler		

Committee Facilitator:
AnnaLisa Gellermann

Time	Agenda Items	Tab	Lead
3:00 – 3:05 (5 min)	Welcome and roll call		AnnaLisa Gellermann, Board Manager Health Care Authority
3:05 – 3:10 (5 min)	Approval of April meeting minutes	2	AnnaLisa Gellermann, Board Manager Health Care Authority
3:10 – 3:15 (5 min)	Topics we will discuss today	3	AnnaLisa Gellermann, Board Manager Health Care Authority
3:15 – 3:45 (30 min)	Hospital Cost Analysis: The Colorado story	4	John Bartholomew and Tom Nash, Consultants Bartholomew-Nash & Associates
3:45 – 3:55 (10 min)	The Washington hospital cost story - input for future Board presentations	5	AnnaLisa Gellermann, Board Manager Health Care Authority
3:55 – 4:10 (15 min)	Update on provider reporting list	6	Ross McCool, Operations Research Specialist Health Care Authority
4:10 – 4:20 (10 min)	Public comment		
4:20 – 4:55 (35 min)	Primary care project overview and discussion		Dr. Judy Zerzan, Chief Medical Officer Health Care Authority
4:55 – 5:00 (5 min)	Adjourn		AnnaLisa Gellermann, Board Manager Health Care Authority

In accordance with Governor Inslee's Proclamation 20-28 et seq amending requirements of the Open Public Meeting Act (Chapter 42.30 RCW) during the COVID-19 public health emergency, and out of an abundance of caution for the health and welfare of the Board and the public, this meeting of the Advisory Committee of Providers and Carriers will be conducted virtually.

Washington State Health Care Authority

April meeting minutes

TAB 2

Washington State Health Care Authority

Advisory Committee of Health Care Providers and Carriers meeting minutes

April 6, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2:00 p.m. – 4:00 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the board is available on the Health Care Cost Transparency Board webpage.

Members present

Bill Ely
Bob Crittenden
Jodi Joyce
Louise Kaplan
Mark Barnhart
Mika Sinanan
Mike Marsh
Natalia Martinez-Kohler
Ross Laursen
Stacy Kessel
Todd Lovshin
Vicki Lowe
Wes Waters

Members absent

Dorothy Teeter
Megan McIntyre
Paul Fishman

Agenda items

Welcome, call to order, approval of meeting minutes

AnnaLisa Gellermann, committee facilitator, called the meeting to order at 9:02 a.m. Minutes from February 1 were approved.

Topics we will discuss today

Ms. Gellermann shared the list of topics, including reviewing Board presentations and discussion on strategies for reducing cost growth, considering data on state health care costs, Impact of Covid on the benchmark, and update from Session 2022 on Primary Care, and a discussion and recommendation on reporting of benchmark results.

Strategies for reducing cost growth

AnnaLisa Gellermann, Committee facilitator
PowerPoint presentation

Ms. Gellermann shared slides previously viewed by the Board reminding members of the cost growth benchmark logic model, and emphasizing the section related to identifying opportunities and strategies to slow cost growth. The presentation described two approaches, devising specific strategies through analysis, and advancing broad based strategies that may impact overall cost growth. The committee saw a list of strategies employed in other states, including market consolidation oversight, price growth caps, prescription drug pricing legislation and advance value-based payment models. The committee also reviewed the Board's criteria for selecting strategies, as follows:

- Implementation of the strategy is likely to have a substantive impact on cost growth benchmark attainment. Evidence supports the strategy, or if not, there is a compelling logic model for the strategy.
- The strategy is actionable for the state, payers, or provider organizations.
  Approval from federal partners is not required to implement the strategy, or there is a high likelihood of obtaining required approval.
- Relevant stakeholders have the capacity to design and execute the strategy thoughtfully and successfully.

Committee members had a vigorous discussion related to the communication process between the Board and the committee, the criteria, and potential mitigation strategies. The committee requested that the Board routinely seek advance input on decisions in critical areas rather than discussing and making comments and recommendations after the Board has acted (e.g., to adopt criteria).
The Committee strongly recommended that an additional criterion be added related to the impact on reducing access to services, or quality of services, or other unintended consequences

Considering data on state health costs

AnnaLisa Gellermann, Committee facilitator
PowerPoint presentation

Committee members reviewed portions of the Board presentation related to data on cost growth drivers, including a survey of data charts sourced from varied places. They learned about the cost driver analysis done by the Office of the Insurance Commissioner conducted by OnPoint from the WA All-Payer-Claims Database. They were introduced to the Washington Health Alliance total cost of care tool, including a chart describing commercial spending by service category. The committee heard the 3 major areas of interest for deeper dives, which were Market Oversight, hospital pricing strategy including global budgets and the impact of labor costs, and value-based payments. The committee was asked for feedback on the areas selected, including challenges that might arise in identifying or developing cost mitigation strategies in these areas, or whether there were other areas that Board should consider in addition to these three.

One committee member stated that the Board should not focus only on areas of high cost but should seek opportunities for significant cost impacts. The committee also generally requested information about strategies that were attempted but failed, to inform future strategy selection. One member emphasized that health care is not a competitive environment, but one that depends on the structure developed by policy.

Related to feedback on areas selected by the Board, one committee member identified pharmacy costs as a significant challenge but a critical impact, emphasizing that data needs would need to be very granular to

determine strategies for action. One committee member recommended that the Board collaborate with current Washington entities working in this area, including the Bree collaborative, HCCT and WHA. One committee member suggested that the Board request input from subject matter experts in health care purchasing and delivery to determine the most promising areas to explore.

Impact of Covid and inflation on the benchmark

AnnaLisa Gellermann, Committee facilitator
PowerPoint presentation

Committee members reviewed the Board's requested presentation from Bailit Health on impact of Covid-19 and rising inflation on the benchmark. The presentation reviewed the unusual spending trends in 2020 and 2021, in which utilization dropped significantly prior to rebounding to lower than the 2019 baseline level. Bailit reported that the trend for 2019-2020 will be very low, and the trend for 2020-2021 will be much higher. Hospitals and health care systems are contending with higher cost and significant workforce issues, raising concerns about near-term prospects for meeting the benchmark. The committee heard that the Board had determined not to change the benchmark, but to continue monitoring the situation and stay engaged with stakeholders.

Public Comment

There was no public comment.

Primary Care Expenditures

AnnaLisa Gellermann, Committee facilitator
PowerPoint presentation

Ms. Gellermann reported on SB 5589, passed by the legislature in the 2022 session. The bill put into a place a primary care expenditure target of 12% of total health care expenditures. The Board is required to report annually to the legislature on the following topics:

- How to define "primary care" for purposes measurement
- Current level of primary care expenditures
- Methods to incentivize achievement of the 12% target.
- Reimbursement practices supporting legislative goals

At a future meeting, the committee will be asked for recommendations to the Board to support implementation of these requirements.

Benchmark reporting discussion

Discussion of the topic was deferred due to time. The committee will discuss accountability at the next meeting and provide a recommendation to the Board on both principles and specific elements of the process.

Adjourn

Meeting adjourned at 4:00 p.m.

Next meeting

Thursday, June 2, 2022
*Meeting to be held on Zoom
3:00 p.m. – 5:00 p.m.
**Zoom meeting is dependent on public health emergency.*

Advisory Committee of Health Care Providers and Carriers

June 2, 2022

Washington State Health Care Authority

Washington State Health Care Authority

Topics we will discuss today

TAB 3

Topics we will discuss today

- Hospital Cost Analysis: The Colorado story
- Washington hospital cost story
- Update on provider reporting list
- Primary care project

Washington State Health Care Authority

Hospital cost, price, and profit analysis: The Colorado story

TAB 4

Hospital Costs, Price, and Profit Analysis: The Colorado Story

John Bartholomew, Presenting
Bartholomew-Nash & Associates

Advisory Committee of Health Care Providers and Carriers

June 2, 2022

Analysis by the Colorado Department of Health Care Policy and Financing – Kim Bimestefer Executive Director, Tom Nash, and John Bartholomew

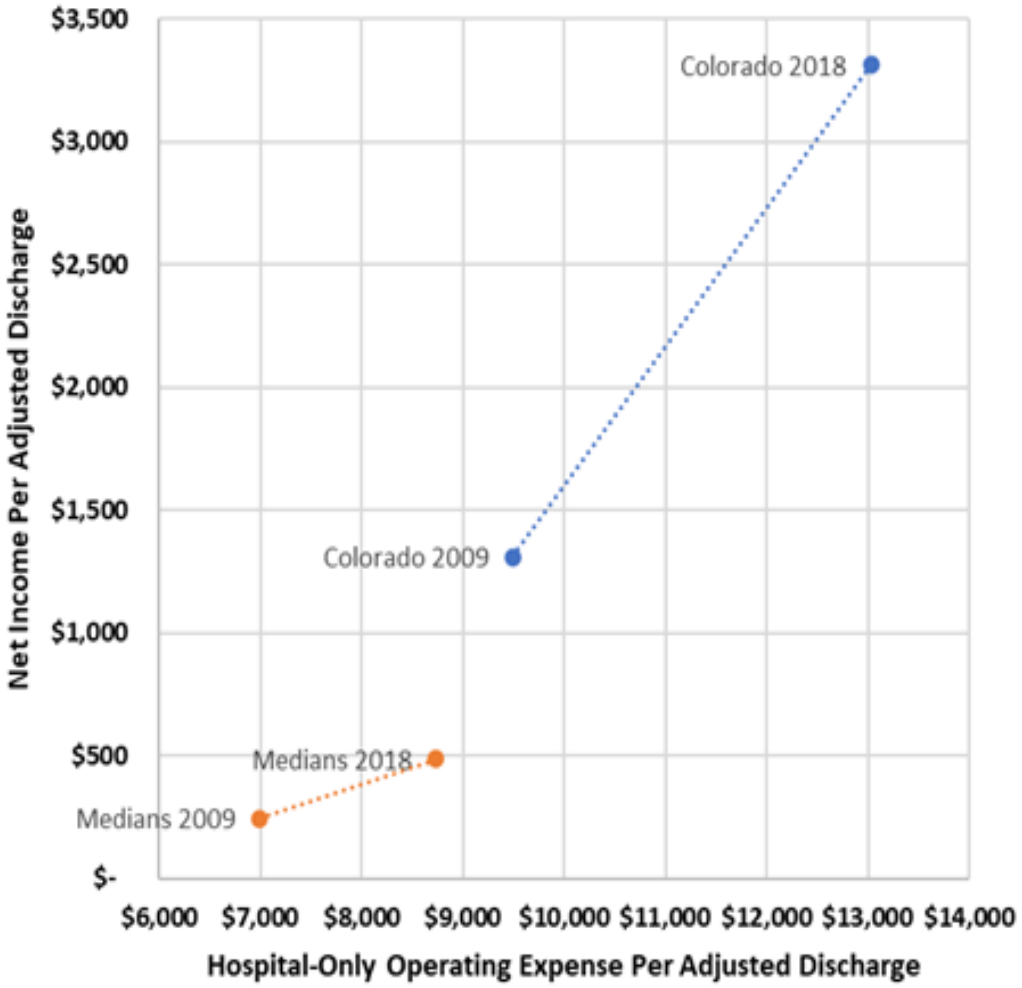
The Problem

State inititiatives to improve coverage and fund hospital care in Medicaid

- 2009: Hospital provider tax that increased hospital reimbursement for Medicaid services and created state funding source for the ACA Medicaid expansion
- 2014: ACA Medicaid expansion decreased uninsured rate and cut charity care/bad debt by 50%+

Results = Rising insurance costs and hospital costs

- 2009-2018 CO hospital costs grew 50%+ more than national average
- In 2009, CO hospital profits exceeded national median by 5 times; in 2018, profits exceeded national median by 7 times



The Approach to Identify Solutions

- In 2014, the State Legislature established the Colorado Commission on Affordable Health Care to understand why commercial health care costs were rising so fast
  - The main finding still used today: hospital financial analysis is needed at the state level.

- Using Medicare Cost Report data, create metrics on Net Patient Revenue, Hospital-Only Operating Cost, and Net Income by dividing data by adjusted discharges.
  - Net Patient Revenue divided by Adjusted Discharge = **Price per Patient**
  - Hospital Only Operating Cost divided by Adjusted Discharge = **Cost per Patient**
  - Net Income divided by Adjusted Discharges = **Profit per Patient**

- Observe trends across hospital types
  - Health systems, independents, for-profit, not-for-profit, rural, urban, by bed size

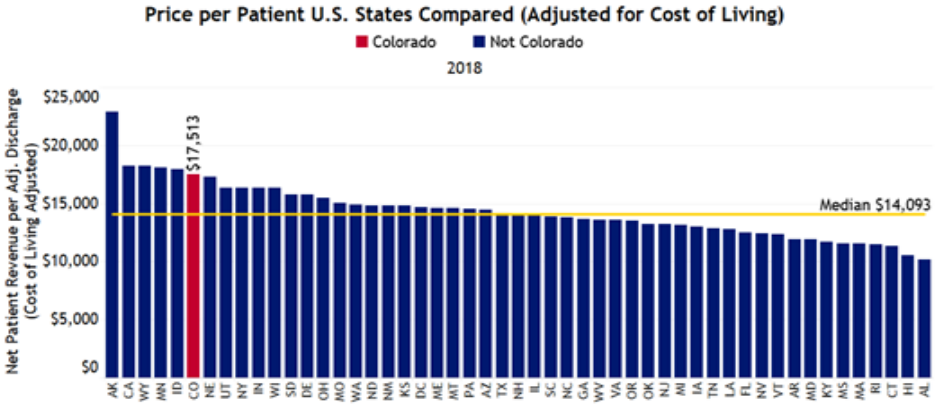
Summary of the Analysis Conducted by The Colorado Department of Health Care and Financing

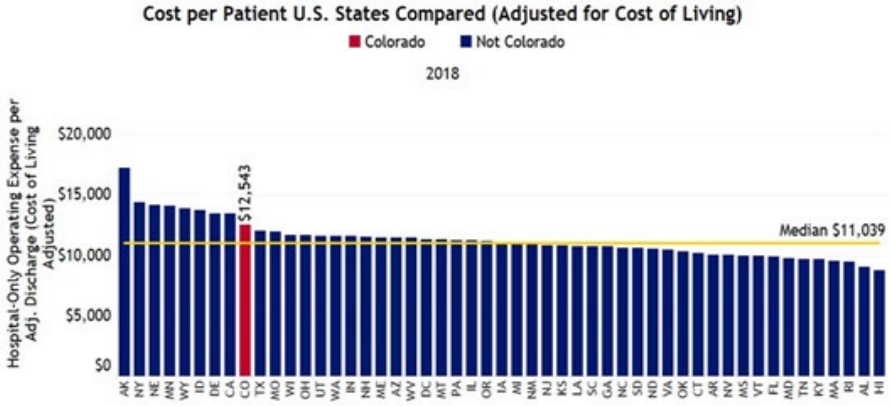
Report Published in August, 2021:
Hospital Cost, Price & Profit Review

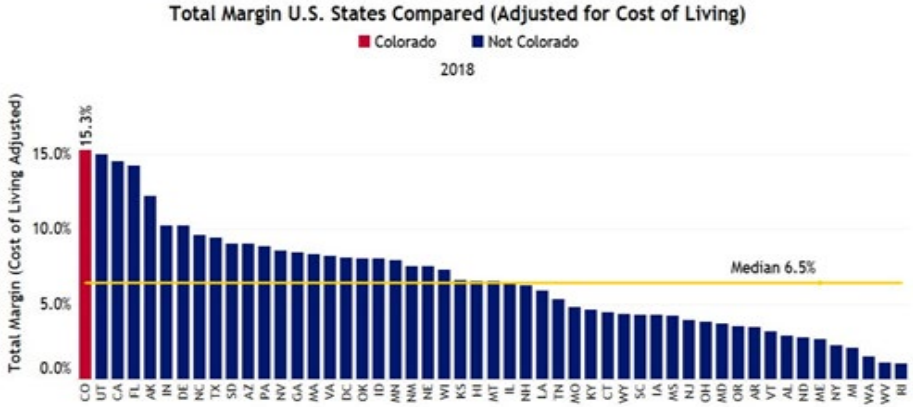
Hospital Cost, Price, Profit Analysis

- *National Rankings*
- *Data Source/Metrics*
- *Findings*
- *Community Benefit*

Transparency: Medicare Cost Reports, 2018
CO Rankings: 6th Price, 9th Cost, 1st Total Profit

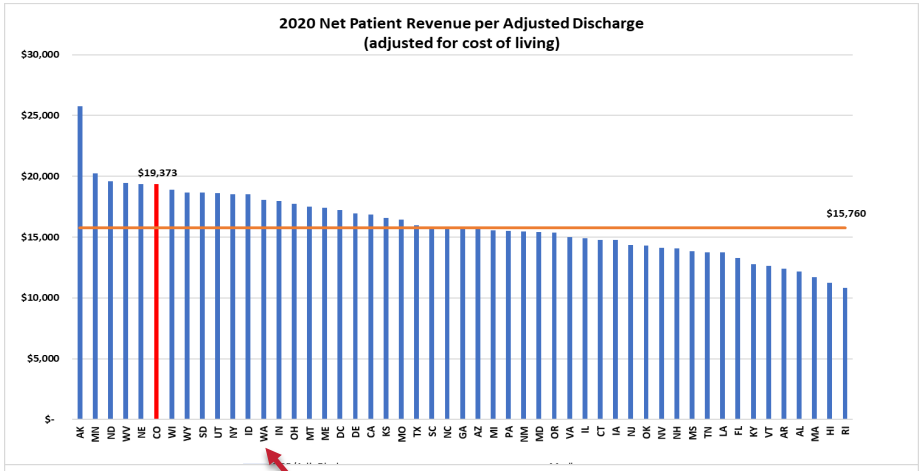


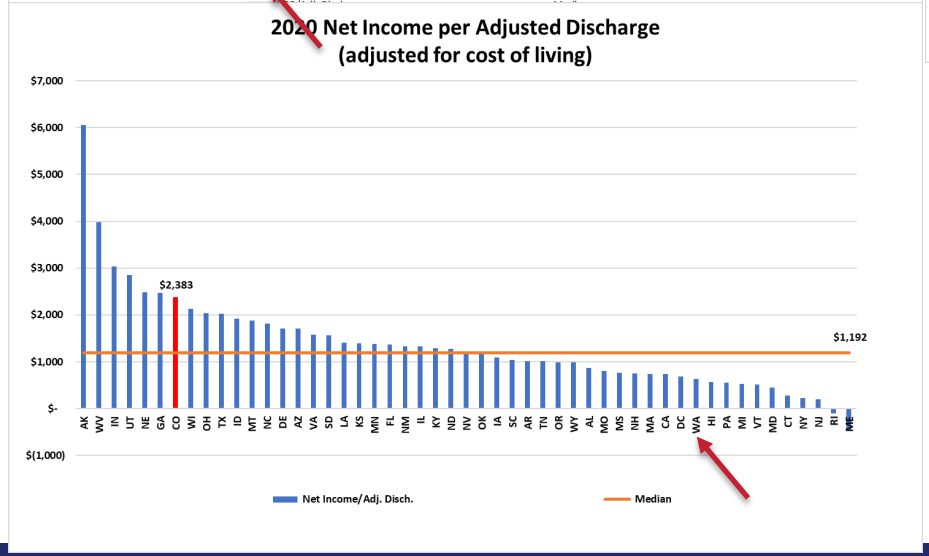


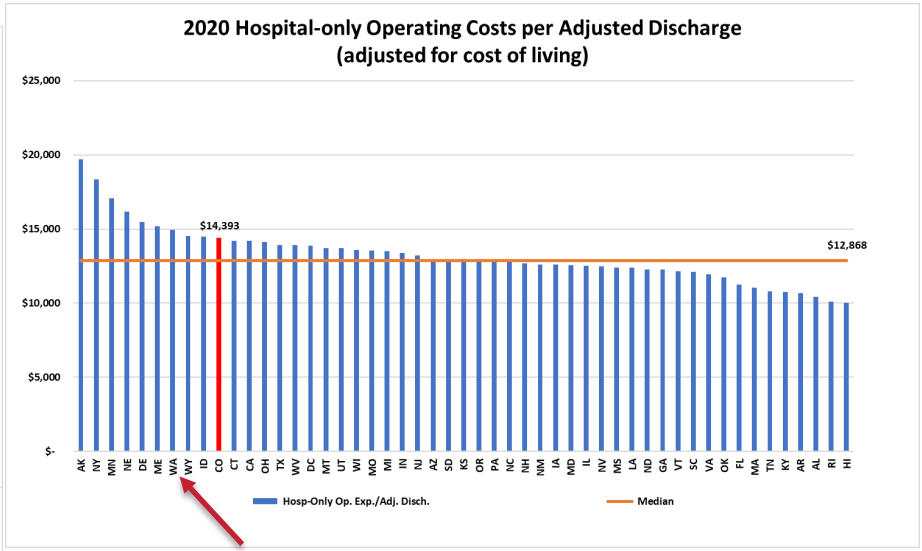


Opportunity for collaboration with hospitals to reduce prices and bring profits more in line with national median. Seeing movement: Centura, SCL, University – *but more needed!*

Transparency: Medicare Cost Reports, 2020
CO Rankings: 6th Price, ~~9th~~10th Cost, ~~1st~~7th Total Profit



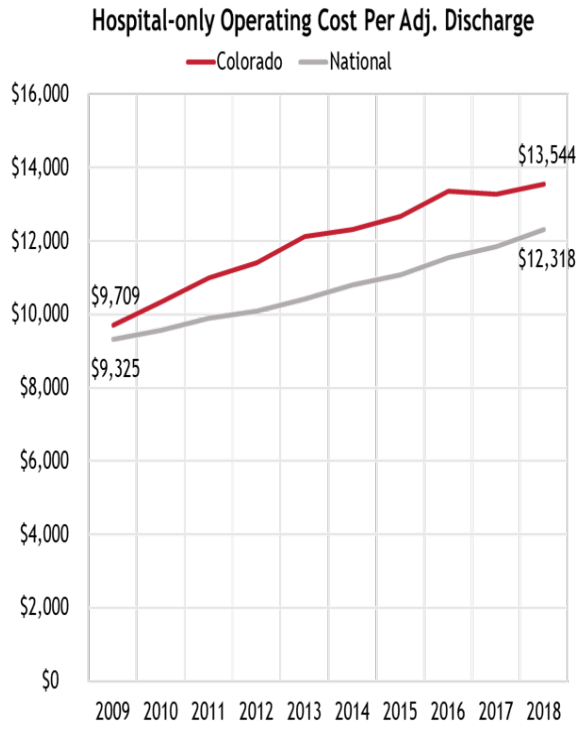


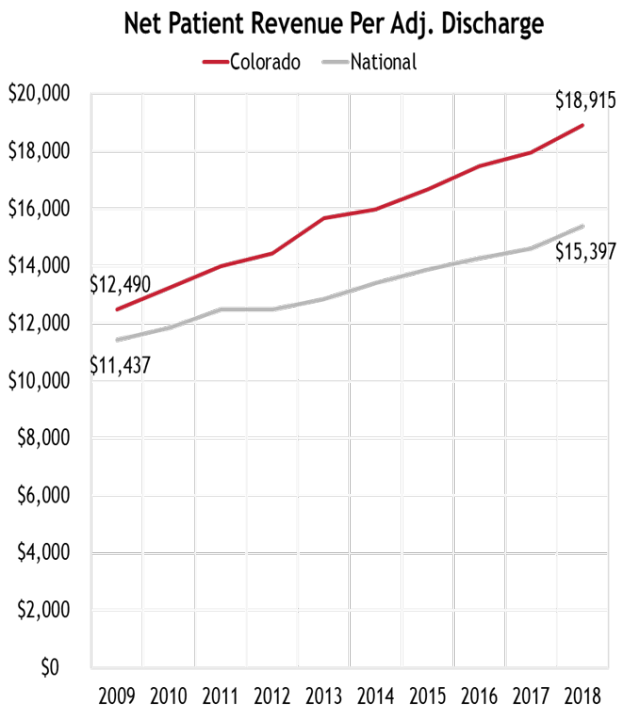


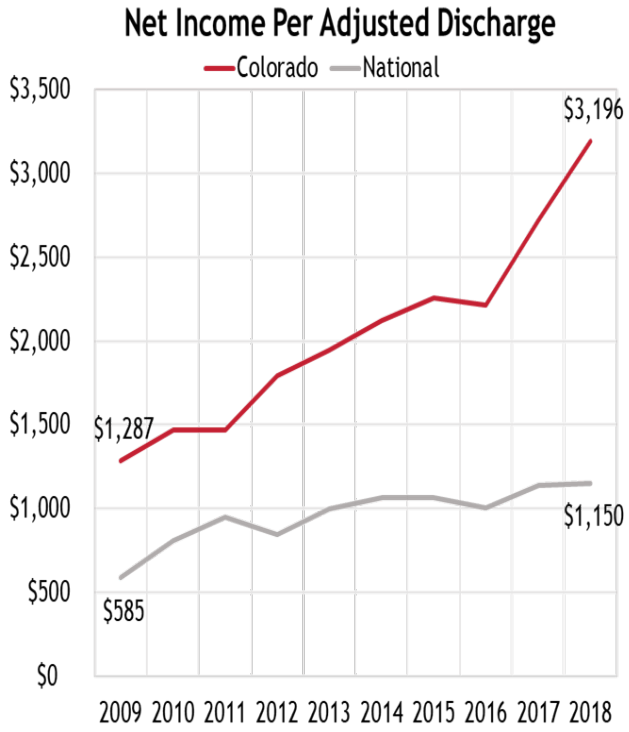
Updated data to 2020

- State of Washington identified with arrow
  - WA 14% higher than National Median on Price per patient
  - Ranked 7th highest Costs per patient

Colorado Hospital Cost, Price & Profit Trends





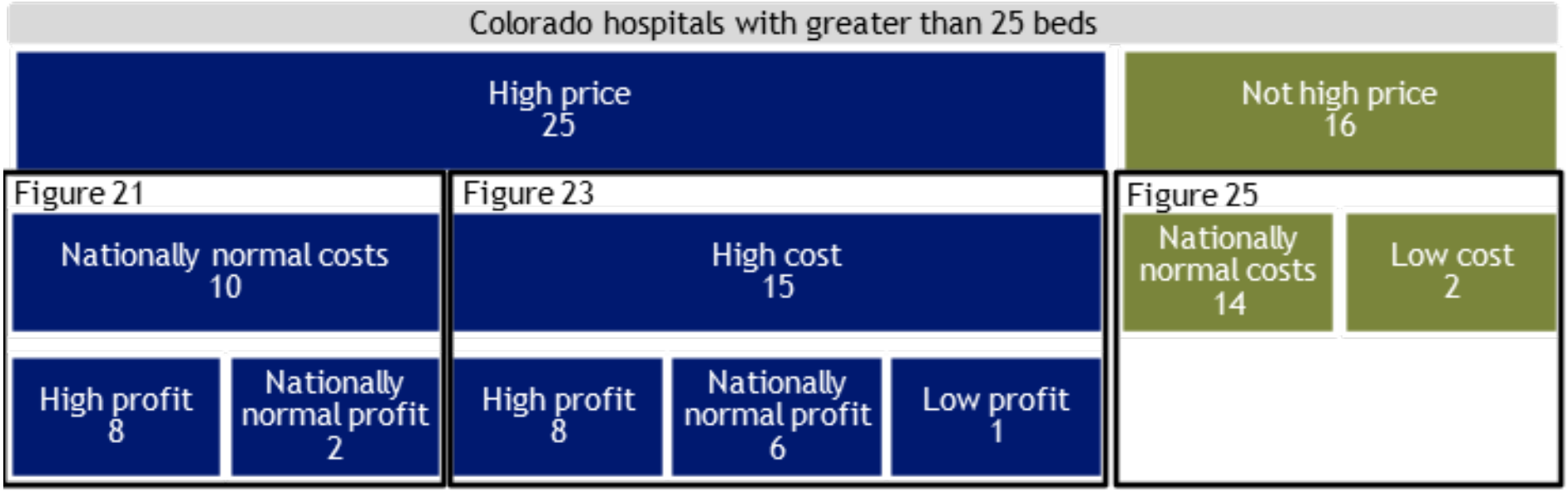


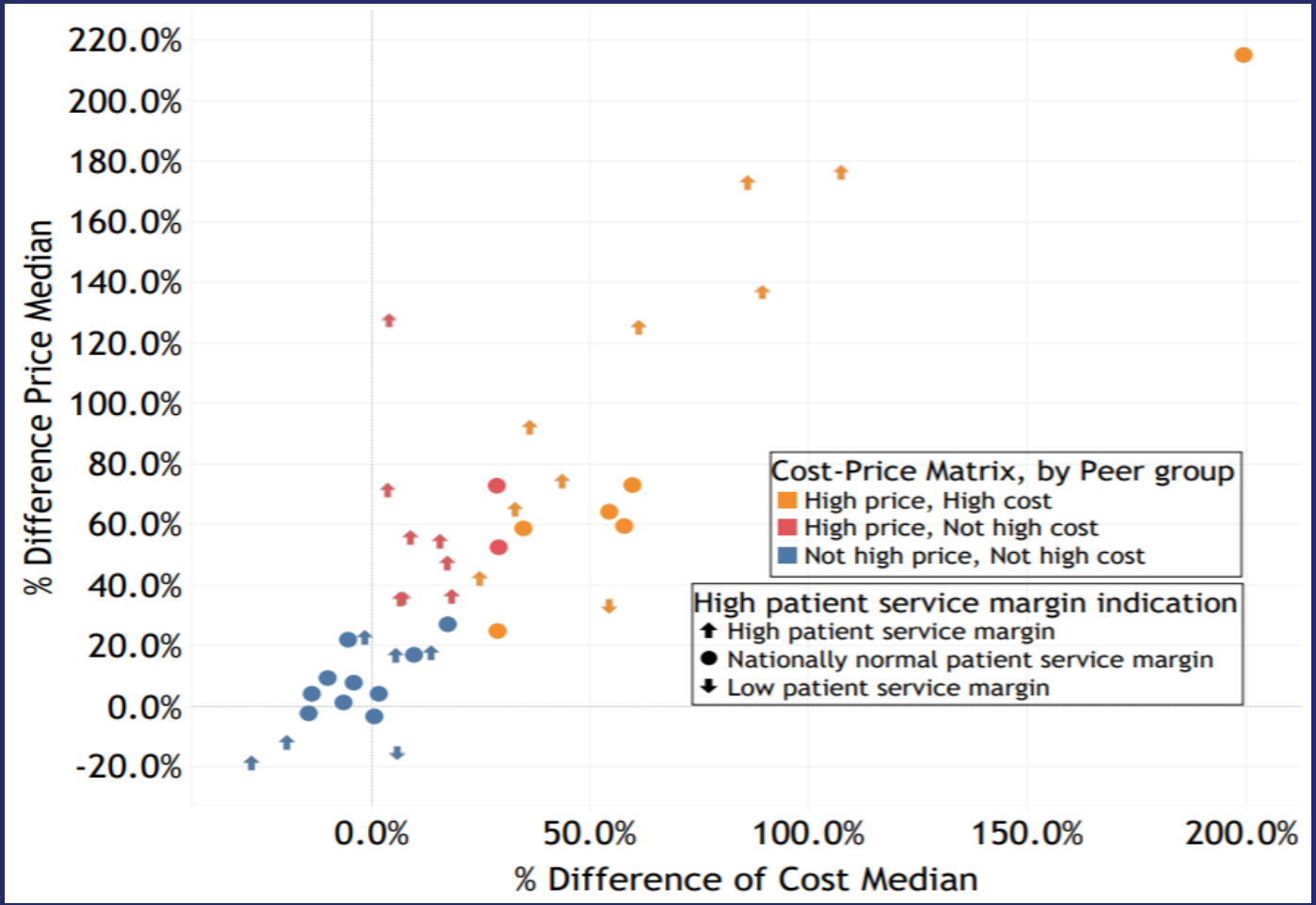
2018 Income Statement, All Colorado Hospitals; Two Types of Profit

Statement Line	Colorado
Net Patient Revenue	$ 16,862,512,337
Hospital-Only Operating Expense	12,073,928,031
Non-Hospital Operating Expense	3,301,592,506
Total Operating Expenses	15,375,520,537
Patient Services Net Income	1,486,991,800
Plus: Other Non-Patient Income	1,371,040,633
Less: Other Non-Operating Expenses	8,546,621
Net Income	$ 2,849,485,812
Total Margin	15.6%

Non-Profit Hospitals Net Income: 58% of total	$ 1,659,344,433

Colorado Hospital Groupings
Hospital with > 25 beds

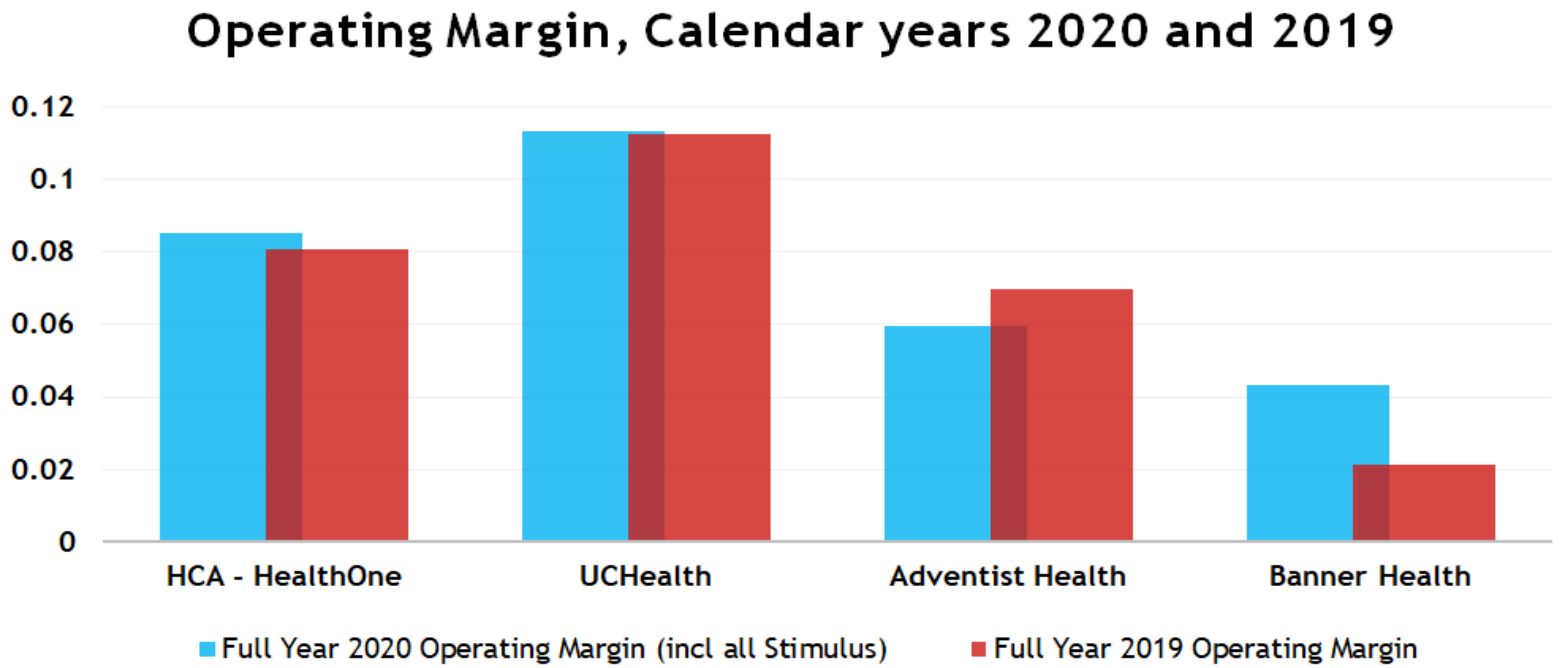




National Median Cost-Price Scatterplot of Colorado Hospitals, including Net Income/Profit

Opportunity to rein in the outliers

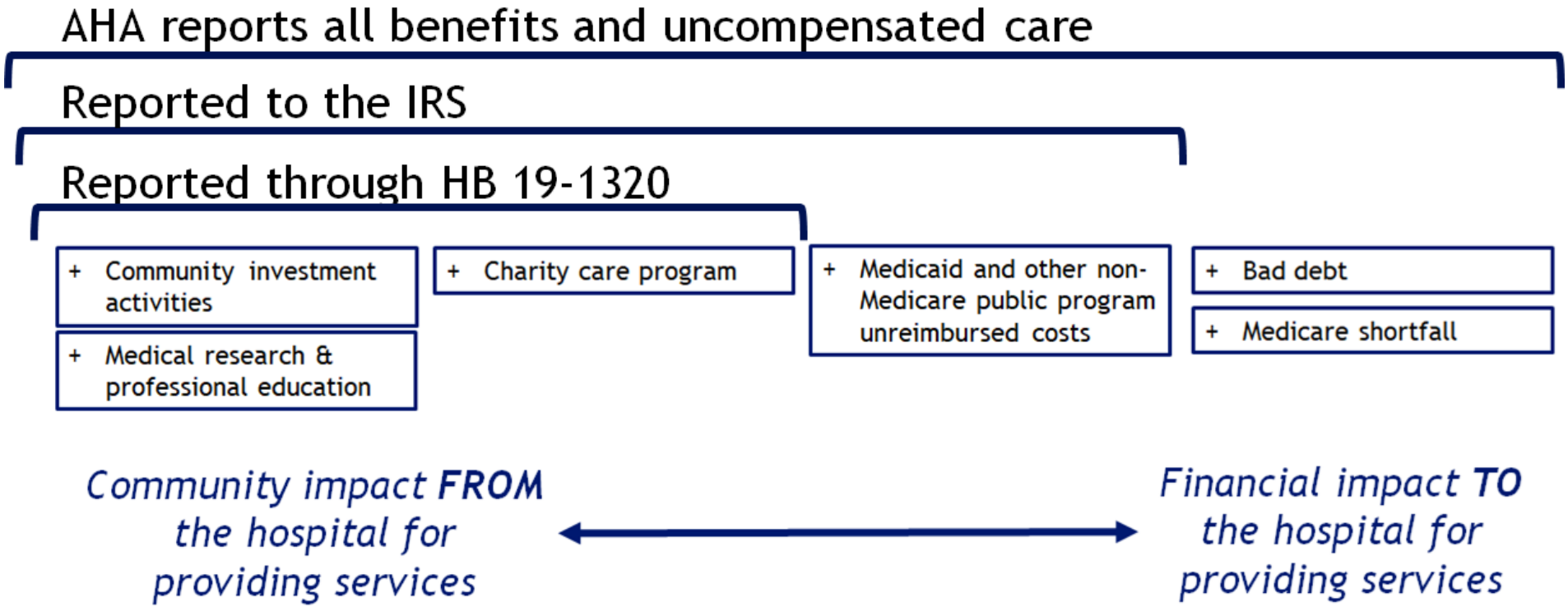
COVID-19 & Hospital Finances



- HCA-HealthOne has returned their stimulus disbursements
- SCL Health Operating margin end of 2019 was 5.8% and through Sep 2020 it was 8.3%

Community Benefit

Community Benefit can be Represented in Different Ways

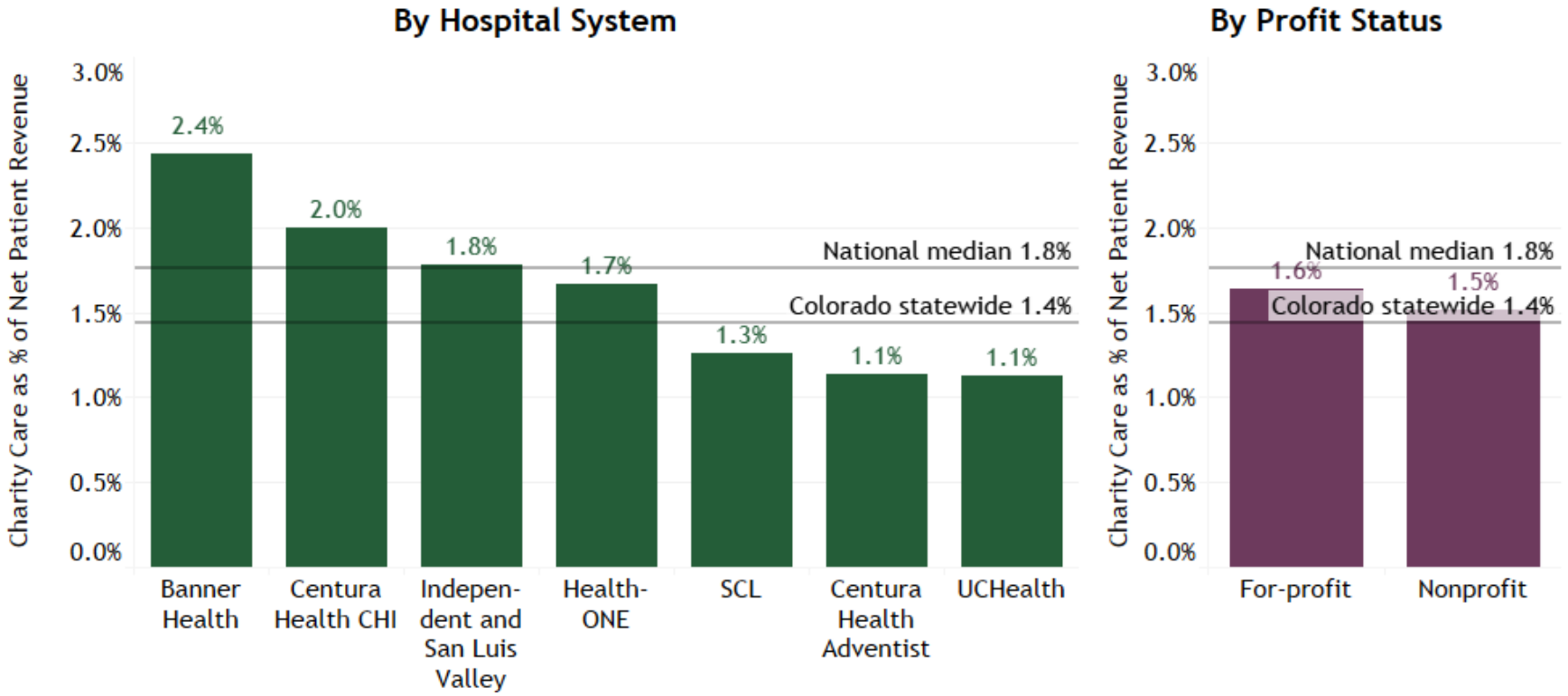


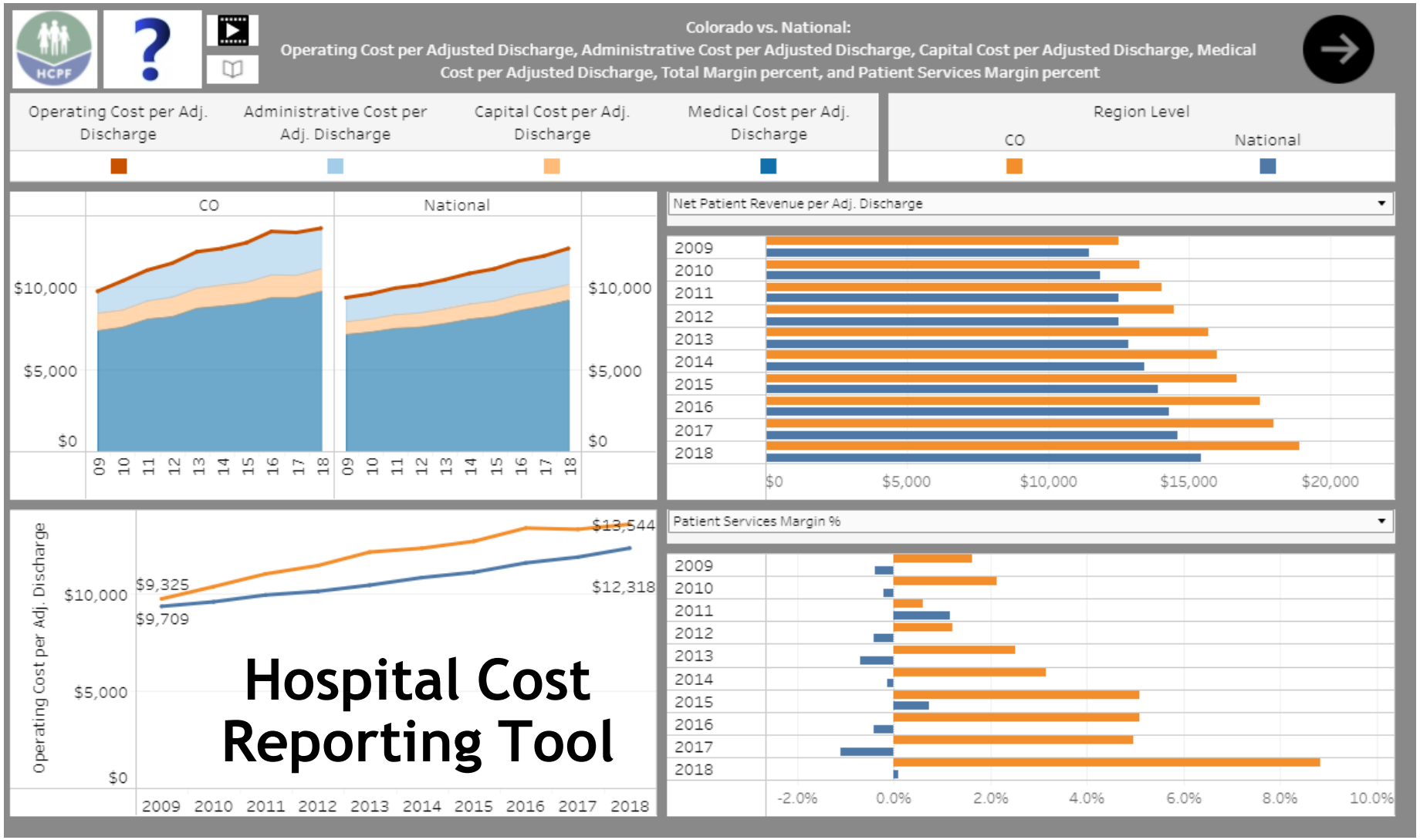
2017 Community Benefit Categories and Percent of Total Expenses

Community Benefit Category	Percent of total expense	Typical for nonprofit hospitals?	Typical for for-profit hospitals?
Financial assistance, unreimbursed Medicaid, unreimbursed costs from means-tested government programs	6.4%	✓	✓
Medicare shortfall	3.1%	✓	✓
Bad debt expense attributable to financial assistance	0.4%	✓	✓
Subtotal attributable for both nonprofit and for-profit	**9.9%**		
Health professions education	1.7%	✓	
Medical research	0.5%	✓	
Cash and in-kind contributions to community groups	0.3%	✓	
Community building activities	0.1%	✓	
Other (community health improvement, subsidized health)	1.7%	✓	
Total	**13.8%**		
Percent of total that is attributable for both nonprofit and for-profit	**71.7%**		

Total does not sum due to rounding.

2018 Charity Care as a Percent of Net Patient Revenues




Colorado vs. National:
Operating Cost per Adjusted Discharge, Administrative Cost per Adjusted Discharge, Capital Cost per Adjusted Discharge, Medical Cost per Adjusted Discharge, Total Margin percent, and Patient Services Margin percent
Operating Cost per Adj. Discharge
Administrative Cost per Adj. Discharge
Capital Cost per Adj. Discharge
Medical Cost per Adj. Discharge
Region Level
CO
National
CO
National
$10,000
$5,000
$0
09 10 11 12 13 14 15 16 17 18
Net Patient Revenue per Adj. Discharge
2009 2010 2011 2012 2013 2014 2015 2016 2017 2018
$0 $5,000 $10,000 $15,000 $20,000
Operating Cost per Adj. Discharge
$13,544
$9,325
$12,318
$9,709
Hospital Cost Reporting Tool
Patient Services Margin %
-2.0% 0.0% 2.0% 4.0% 6.0% 8.0% 10.0%

Questions?

Washington State Health Care Authority

The Washington hospital cost story

TAB 5

The Washington hospital cost story

AnnaLisa Gellermann
Board Manager
June 2, 2022

Washington State Health Care Authority

Current activity

- Washington analysis
- Rand Study
- Workforce and labor analysis
- WSHA meeting and request

What other topics should the Board consider for the WA hospital cost story?

- What does the Board need to know about hospital cost in our state?
- What recommendations do you have to ensure they have a balanced and objective understanding?
- Is there additional important information they need to learn?
- Who should be invited to present or assist with a presentation?
- What information gaps, if any, need to be filled?

Washington State Health Care Authority

Provider entities reporting for total medical expenditures

TAB 6

Provider entities that will be reported on for total medical expenditures

Ross McCool
Research Operations Specialist
June 2, 2022

Washington State Health Care Authority

Provider entities reporting for total medical expenditures

- While patients are attributed to a specific provider, the reporting for total medical expenditures (TME) falls to the large provider entity, not to the individual clinician.
- Even if a patient is not attributable to a large provider entity, their spending will still be seen in the total health care expenditure (THCE) measurement.
- TME-reportable provider entities typically include those that could (in theory) take on total cost of care (TCPC) contracts because they:
  - Include primary care providers who direct a patient's care.
  - Can exert influence over where a patient receives care.
- Provider entities do not have to be in actual TCOC contracts to be TME-reportable.

Initial draft list of provider entities

Allegro Pediatrics	Kadlec	PeaceHealth
Astria Regional Medical Center	Kaiser Permanente	Peninsula Community Health Services
Columbia Basin Health Association	Kittitas Valley Healthcare	Providence Health
Columbia Valley Community Health	Legacy Health	Sea Mar Community Health Centers
Community Health Association of Spokane	Lewis County Community Health Services (Valley View Health Center)	Seattle-King County Public Health Dept (Health Care for the Homeless Network)
Community Health Care	LifePoint Health	Skagit Regional Health
Community Health Center of Snohomish County	Mason General Hospital and Family of Clinics	Swedish Health Services
Community Health of Central Washington	Moses Lake Community Health Center	The Vancouver Clinic
Confluence Health	MultiCare Health	Tri-Cities Community Health
Country Doctor Community Health Centers	NeighborCare Health	Unity Care Northwest
Cowlitz Family Health Center	NEW Health Programs Association	UW Medicine
EvergreenHealth	North Olympic Healthcare Network PC	Virginia Mason Franciscan Health
Family Health Centers	Olympic Medical Center	Western Washington Medical Group
Harbor Regional Health	OptumCare	Whitman Medical Group
HealthPoint	Overlake Medical Center & Clinics	Yakima Neighborhood Health Services
Inland Northwest Health Services	Pacific Medical Centers	Yakima Valley Farm Workers Clinic
International Community Health Services		

Carrier survey

- To confirm the preliminary list, we created a survey.
- We queried carriers required to submit data for the benchmark about number of total care contracts.
- We asked them to tally the number of covered lives associated with the preliminary list of provider entities.
- We asked them to tell us the parent contracting entity if they do not contract with the provider entity directly.
- Additionally, we asked for provider entities we may have missed.

Carrier survey: Caveats

- Covered lives in total care contracts make up a small percentage of all covered lives.
- We approached it in this way so we can accurately associate spend with a provider entity.
- Seven of the twelve carriers submitted data in time for this committee meeting.

Carrier survey: Information learned

- We did uncover some provider entities that were not on our original list.
- Several entities have a singular parent entity they contract through.
- We want to roll up the providers to this parent entity since (in theory) the parent entity would have a larger scale of influence.
- Another reason for the roll up is we can capture many providers that use the same parent entity even if the providers would be below the cutoff.

Proposed list of provider entities for feedback

Community Clinic Contracting Network	HealthPoint	PeaceHealth
Community Health Association of Spokane	Kaiser Permanente	Providence Health/Swedish Health Services
Community Health Care	Legacy Health	Rose Medical
Community Health of Central Washington	Lewis County Community Health Services (Valley View Health Center)	Seattle Children's Care Network
Confluence Health	Moses Lake Community Health Center	Seattle-King County Public Health Dept (Health Care for the Homeless Network)
Country Doctor Community Health Centers	MultiCare Health	The Vancouver Clinic
Cowlitz Family Health Center	NeighborCare Health	Tri-Cities Community Health
Eastside Health Network	NEW Health Programs Association	UW Medicine
Everett Clinic	North Olympic Healthcare Network PC	Virginia Mason Franciscan Health
Family Care Network	OptumCare	Yakima Neighborhood Health Services
Family Health Centers		

Discussion

- Please share comments by email, including specific suggestions.
- Finalizing list by June 17 for inclusion in the technical manual.
- Will post both lists (provider and carrier) to our website.

Next steps

- Please share comments by email, including specific suggestions.
- Finalizing list by June 17 for inclusion in the technical manual.
- Will post both lists (provider and carrier) to our website.

Public comment

Washington State Health Care Authority

Washington State Health Care Authority

Draft provider reporting list

TAB 7

Penultimate List of Providers for Health Care Cost Growth Benchmark Measurement as of 05/26/22

Not Yet Finalized

1. Community Clinic Contracting Network
2. Community Health Association of Spokane
3. Community Health Care
4. Community Health of Central Washington
5. Confluence Health
6. Country Doctor Community Health Centers
7. Cowlitz Family Health Center
8. Eastside Health Network
9. Everett Clinic
10. Family Care Network
11. Family Health Centers
12. HealthPoint
13. Kaiser Permanente
14. Legacy Health
15. Lewis County Community Health Services (Valley View Health Center)
16. Moses Lake Community Health Center
17. MultiCare Health
18. NeighborCare Health
19. NEW Health Programs Association
20. North Olympic Healthcare Network PC
21. OptumCare
22. PeaceHealth
23. Providence Health/Swedish Health Services
24. Rose Medical
25. Seattle Children's Care Network
26. Seattle-King County Public Health Dept (Health Care for the Homeless Network)
27. The Vancouver Clinic
28. Tri-Cities Community Health
29. UW Medicine
30. Virginia Mason Franciscan Health
31. Yakima Neighborhood Health Services

Washington State Health Care Authority

Primary care bill (SSB 5589)

TAB 8

CERTIFICATION OF ENROLLMENT

SUBSTITUTE SENATE BILL 5589

Chapter 155, Laws of 2022

67th Legislature
2022 Regular Session

HEALTH CARE—PRIMARY CARE EXPENDITURES

EFFECTIVE DATE: June 9, 2022

Passed by the Senate February 8, 2022
Yeas 48 Nays 1

DENNY HECK

President of the Senate

Passed by the House March 3, 2022
Yeas 96 Nays 1

LAURIE JINKINS

Speaker of the House of Representatives

Approved March 24, 2022 9:14 AM

JAY INSLEE

Governor of the State of Washington

CERTIFICATE

I, Sarah Bannister, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **SUBSTITUTE SENATE BILL 5589** as passed by the Senate and the House of Representatives on the dates hereon set forth.

SARAH BANNISTER

Secretary

FILED

March 24, 2022

Secretary of State
State of Washington

SUBSTITUTE SENATE BILL 5589

Passed Legislature - 2022 Regular Session

State of Washington 67th Legislature 2022 Regular Session

By Senate Health & Long Term Care (originally sponsored by Senators Robinson, Cleveland, Frockt, and Randall)

READ FIRST TIME 01/27/22.

AN ACT Relating to statewide spending on primary care; adding a new section to chapter 70.390 RCW; and adding a new section to chapter 48.43 RCW.

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

NEW SECTION. **Sec. 1.** A new section is added to chapter 70.390 RCW to read as follows:

(1) The board shall measure and report on primary care expenditures in Washington and the progress towards increasing it to 12 percent of total health care expenditures.

(2) By December 1, 2022, the board shall submit a preliminary report to the governor and relevant committees of the legislature addressing primary care expenditures in Washington. The report must include:

(a) How to define "primary care" for purposes of calculating primary care expenditures as a proportion of total health care expenditures, and how the definition aligns with existing definitions already implemented in Washington, including the previous report from the office of financial management and the Bree collaborative's recommendations;

(b) Barriers to the access and use of the data needed to calculate primary care expenditures, and how to overcome them;

(c) The annual progress needed for primary care expenditures to reach 12 percent of total health care expenditures in a reasonable amount of time;

(d) How and by whom it should annually be determined whether desired levels of primary care expenditures are being achieved;

(e) Methods to incentivize the achievement of desired levels of primary care expenditures;

(f)(i) Specific practices and methods of reimbursement to achieve and sustain desired levels of primary care expenditures while achieving improvements in health outcomes, experience of health care, and value from the health care system, including but not limited to: Supporting advanced, integrated primary care involving a multidisciplinary team of health and social service professionals; addressing social determinants of health within the primary care setting; leveraging innovative uses of efficient, interoperable health information technology; increasing the primary care and behavioral health workforce; and reinforcing to patients the value of primary care, and eliminating any barriers to access.

(ii) As much as possible, the practices and methods specified must hold primary care providers accountable for improved health outcomes, not increase the administrative burden on primary care providers or overall health care expenditures in the state, strive for alignment across payers, and take into account differences in urban and rural delivery settings; and

(g) The ongoing role of the board in guiding and overseeing the development and application of primary care expenditure targets, and the implementation and evaluation of strategies to achieve them.

(3) Beginning August 1, 2023, the board shall annually submit reports to the governor and relevant committees of the legislature. To the extent possible, the reports must:

(a) Include annual primary care expenditures for the most recent year for which data is available by insurance carrier, by market or payer, in total and as a percentage of total health care expenditure;

(b) Break down annual primary care expenditures by relevant characteristics such as whether expenditures were for physical or behavioral health, by type of provider and by payment mechanism; and

(c) If necessary, identify any barriers to the reporting requirements and propose recommendations for how to overcome them.

(4) In developing the measures and reporting, the board shall consult with primary care providers and organizations representing

primary care providers and review existing work in this and other states regarding primary care, including but not limited to the December 2019 report by the office of financial management, the work of the Bree collaborative, the work of the advancing integrated mental health center and the center for health workforce studies at the University of Washington, the work of the Milbank memorial fund, the work of the national academy of sciences, engineering, and medicine, and the work of the authority to strengthen primary care within state purchased health care.

NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43 RCW to read as follows:

The commissioner may include an assessment of carriers' primary care expenditures in the previous plan year or anticipated for the upcoming plan year in its reviews of health plan form or rate filings. In conducting the review, the commissioner must consider any definition of primary care expenditures and any primary care expenditure targets established under section 1 of this act. The commissioner may determine the form and content of carrier primary care expenditure reporting.

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