

Health Care Cost Transparency Board

Annual Report

Second Substitute House Bill 2457; Section 7(2); Chapter 340; Laws of 2020

Substitute Senate Bill 5589; Section 1(3); Chapter 155; Laws of 2022

Second Engrossed Substitute House Bill 1508; Section 3; Chapter 80; Laws of 2024

December 1, 2025

Analysis of health care expenditure trends and recommendations to improve affordability

Acknowledgements

The Health Care Cost Transparency Board (Cost Board) acknowledges and thanks its committees:

- Health Care Stakeholder Advisory Committee
- Data Issues Advisory Committee
- Primary Care Advisory Committee
- Nominating Committee

Their time, recommendations, and expertise over the past year have been a tremendous gift. A special thank you to the individuals who chaired these bodies and generously gave their time and energy: Mich'l Needham, Eileen Cody, and Bianca Frogner.

We also express gratitude to the Institute for Health Metrics and Evaluation (IHME) for their partnership and excellent work on the Analytic Support Initiative (ASI). We thank the Peterson Center on Healthcare and Gates Ventures for funding the ASI grant. We also express appreciation to Onpoint, Health Management Associates, and the Peterson-Milbank Program for Sustainable Health Care Costs for their support and partnership.

Finally, we thank our fantastic administrative assistant, Audrey Rodney, for ensuring meetings run smoothly, and Rachel Oaks, our communications consultant, for making our work legible and accessible.



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Table of contents

Executive summary.....	4
Introduction.....	6
Health care expenses continue to rise in Washington.....	6
Increasing health care spending is a national problem.....	7
Health care is unaffordable for many people in Washington.....	7
Federal changes will negatively impact affordability in Washington state.....	8
Potential policy interventions to help slow health care spending growth.....	10
Strategies to improve: prioritizing policy action.....	10
Slowing spending growth.....	12
Background and current state in Washington.....	12
Analysis of spending growth.....	12
2023 performance against the benchmark highlights.....	15
Opportunities for higher value health care.....	17
2025 progress.....	18
Primary care utilization.....	19
Background and current state in Washington.....	19
More information about the primary care expenditure target and performance.....	20
2025 updated policy package.....	21
Market transparency and oversight.....	23
Background and current state in Washington.....	23
Framework for market oversight.....	25
2025 progress.....	25
2026 recommendations.....	27
Conclusion.....	29
Appendices.....	30

Executive summary

Washington's health care expenditures have grown faster than the cost growth benchmark (target for growth) as well as the state's inflation rate and wage growth for the second year since measurement began. Washington's upward growth trend aligns with those of other states tracking performance against benchmarks. Multiple market factors drive increasing growth, including:

- Health care cost increases reflected in pharmaceutical and hospital prices
- Insurance reimbursement rate increases
- Underutilization of primary care
- Consolidation of health care organizations

New federal policies are expected to negatively impact Washington's health care delivery system, adding instability to the marketplace with reductions in coverage and federal funding. Most importantly, **these changes will impact individuals seeking health care**, many of whom are already burdened by high out-of-pocket medical costs, premiums, and deductibles. For the people of Washington, affordability will continue to be a growing challenge.

The Health Care Cost Transparency Board (Cost Board) will continue to monitor these impacts and remain open to strategies to address them. The Cost Board's mission remains as important as ever, ensuring the state does not lose sight of the affordability challenges faced by Washingtonians — even as the Medicaid and individual markets draw attention with major changes resulting from new federal regulations.

Looking ahead to 2026, the Cost Board continues key data monitoring efforts. The board also focuses on three policy areas originally identified in 2024:

- Improve affordability by **slowing spending growth**
- Increase **utilization of primary care**
- Enhance **market transparency and oversight** to balance an increasingly consolidated market

The table on the following page summarizes foundational pieces of legislation aimed at improving affordability which were passed in the 2025 legislative session. The Cost Board continues to support these strategies and priorities for policy action along with several additional recommendations for 2026.

Table 1: The Cost Board’s legislative recommendations: 2025 progress and 2026 priorities

Priority area	2025 progress	2026 recommendations
Constraining cost growth and price regulation	<p>Hospital price transparency - SSB 5493: Requires hospitals to meet federal standards regarding price transparency. Also, hospitals must now submit this information to the Department of Health (DOH) annually.</p> <p>Reference-based pricing - ESSB 5083: Beginning January 1, 2027, Public Employees Benefits Board and School Employees Benefits Board programs (PEBB/SEBB) reimbursement is capped for inpatient and outpatient services at licensed hospitals with reimbursement floors at 150% of Medicare for primary care and behavioral health to encourage provider participation and increased use of these services.</p>	<p>Continue to support implementation of reference-based pricing as a tool to control cost growth. HCA is developing rules related to legislation passed in 2025, setting the stage for 2027 implementation.</p>
Primary care utilization	<p>Reference-based pricing - ESSB 5083: See description above.</p> <p>Primary care spend reporting - SB 5084: Allows the Office of the Insurance Commissioner (OIC) to require health carriers to annually report primary care expenditures from previous calendar years, or anticipated expenditures for upcoming years. OIC will determine reporting requirements considering the definitions and targets set by the Cost Board.</p>	<ul style="list-style-type: none"> • Continue public reporting of primary care expenditure ratios for all carriers (monitoring function migrating to OIC in 2026). • Revisit mechanisms to hold payers accountable to achieve target, including potential updates to OIC regulatory authority. • Increase Medicaid reimbursement for primary care services, including sustainable funding and payment mechanisms.
Market transparency and oversight	<p>Provider registry - ESSB 1686: Requires DOH, in collaboration with HCA, OIC, and the Governor’s Office, to develop a plan and recommendations for an interactive health care provider registry that will clarify business structure and funding sources of health care entities.</p> <p>State Health Plan - SSB 5568: Refreshes Washington’s State Health Plan (SHP), establishing statewide health planning policies and goals related to availability of health care facilities and services, quality of care, and cost of care. SHP helps the Certificate of Need (CN) program build the criteria to approve health care facilities in Washington and determine how many facilities the state needs.</p> <p>Primary care spend reporting - SB 5084: Allows OIC to require health carriers to annually report primary care expenditures from previous calendar years, or anticipated expenditures for upcoming years. OIC will determine reporting requirements with consideration for the definitions and targets set by the Cost Board.</p>	<p>Continue to support and develop policy recommendations and legislation regarding corporate practice of medicine to address commercialization and profit-seeking associated with corporate and private equity ownership.</p>

Introduction

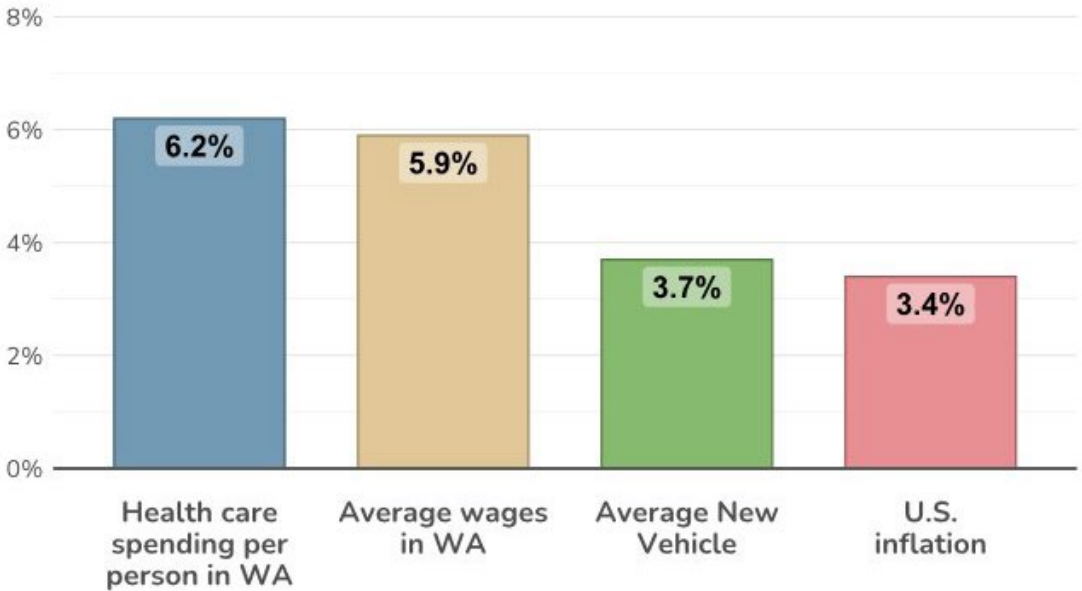
Health care expenses continue to rise in Washington

Over the last decade, Washington state has experienced double-digit growth in health care spending. In 2020, the Legislature established the [Health Care Cost Transparency Board](#) (Cost Board) to monitor how much Washington state spends on health care and make recommendations to slow the growth in health care spending.

Each year, the Cost Board measures how much Washington’s health care spending has grown since the previous year. The Cost Board’s most recent data (2023) shows that total health care expenditure grew 6.2% between 2022 and 2023. This rate of growth is:

- Higher than Washington’s 2023 average wage growth (5.9%)¹
- Higher than the 2023 rate of inflation (3.4%)²
- Higher than the 2023 price growth for a new vehicle³

Figure 1: Growth in health care spending in context, 2022–2023



Source: Cost Board 2025 data call, Employment Security Department,¹ Bureau of Labor Statistics,² Federal Reserve Bank of St. Louis ³

¹ Data source: [Employment Security Department](#), Washington State. Accessed October 14, 2025.
² Data source: [U.S. Bureau of Labor Statistics](#). The Economics Daily. Consumer Price Index: 2023 in review. January 19, 2024. Accessed October 14, 2025.
³ Data source: [Federal Reserve Bank of St. Louis](#). Consumer Price Index for All Urban Consumers: New Vehicles in U.S. City Average. Accessed November 4, 2025.

As spending has increased faster than wages and inflation for multiple years, health care has become increasingly less affordable for individuals, families, and businesses in Washington.

Increasing health care spending is a national problem

Washington's experience is part of a national trend of rising health care expenditures. Per-person U.S. health spending increased by 7% in 2023, with the average person spending \$1,514 out-of-pocket for health care.⁴ In other states that also have cost growth targets we see that health care spending is growing at an unprecedented rate with spending increasing across all service categories and markets (Commercial, Medicare, Medicaid).^{5,6} Reasons cited for this rapid growth in spending include:

- Increasing price and utilization of inpatient, outpatient, professional, and retail pharmacy services⁵
- Increases in reimbursement rates negotiated with health insurers
- Increases in utilization of medical and surgical services
- Inflation
- Fallout of an uncompetitive market⁷

The trend toward increasing year-over-year expenditures is projected to continue at an average rate of about 5% per capita through 2032.⁴

Having experienced years of rising health care spending, almost half of U.S. adults report that it is difficult to afford health care and 62% worry about being able to afford their deductible before health insurance begins to pay for care.⁴

Health care is unaffordable for many people in Washington

Like many Americans, Washingtonians are concerned about growth in health care spending because it affects both their personal finances and their health. The [2024 Washington State Health Care Affordability Survey](#) found that the cost of health care limits Washingtonian's access to needed physical, behavioral, and dental services such that 57% of those surveyed had either delayed care or skipped a recommended treatment.⁸ Twenty-four percent of those surveyed said they had cut pills in half, skipped a medication dose, or did not fill a prescription due to cost concerns.⁸ In this same survey, 75% of small business owners responding reported that they had been burdened by health care costs, noting difficulties with affording and accessing health insurance (90%), taking on medical debt (59%), and having a lower credit score because of health care costs (40%).⁸

People with lower incomes, younger adults, the uninsured, and those in fair or poor health are even more likely to report cost-related barriers to accessing health care.⁴ In 2023, 38% of Washington households were either financially insecure according to the Federal Poverty Level (10%) or experiencing financial

⁴ Cox, C., Ortaliza, J., Wager, E., Amin, K. [Health Policy 101: Care Costs and Affordability](#). KFF. 2025.

⁵ Mar, J., Angeles, J. [For States With Cost Growth Targets, 2023 Spending Growth Was High Across The Board](#). Health Affairs Forefront. 2025.

⁶ Koller, C. [State Health Care Cost Growth Targets: Moving From Aspiration To Evidence To Action](#). Health Affairs Forefront. 2025.

⁷ [Annual Report: Health Care Spending and Quality in Rhode Island](#). 2025.

⁸ Data source: [2024 Washington State Health Care Affordability Survey](#). Fair Prices Washington. August 2024.

hardship, otherwise known as Asset Limited, Income Constrained, Employed (ALICE) (28%).⁹ ALICE households have income above the Federal Poverty Level. They generally earn too much to qualify for assistance but not enough to afford basic expenses in the counties where they live. For many of these families, health care is prohibitively expensive, meaning it costs so much that it discourages or prevents them from seeking health care.^{4,10} The decision to pay for medical care may mean that the household does not have money for other essential items like food or transportation. As a result, ALICE families are more likely to go without regular care and less likely to receive preventive care.¹⁰

According to [KFF](#),

“For those in families with incomes at 199% of federal poverty and below, the average family payments for health insurance premiums and medical care is 9.6% of family income. A substantial share (about two thirds) of that spending is for the premium contributions. Families with incomes between 200% and 399% of poverty spend an average of 6.2% of family income on insurance premiums and medical care. Meanwhile, those in families with incomes at or above 400% of the federal poverty level pay about 3.4% of their family income on premium contributions and medical expenses.”¹¹

Proposed changes at the federal level have the potential to significantly impact health care affordability in Washington and low-income households will be among those most impacted.

Federal changes will negatively impact affordability in Washington state

Federal changes include the Centers for Medicare & Medicaid Services' [Marketplace Integrity Rule](#), the reconciliation bill ([H.R.1](#)), and the expiration of Enhanced Advance Premium Tax Credits for the individual market plans. While some plans are awaiting decisions by courts and congressional votes, Washington state agencies, employers, and insurance carriers are projecting and preparing for impacts to affordability. Washington's Health Benefit Exchange projects that:

“The cumulative effect of the changes to the Affordable Care Act (ACA) marketplaces would result in an estimated one-third to one-half of all current Washington Healthplanfinder qualified health plan enrollees losing access to health insurance. These federal changes put the stability of our individual insurance market at risk.”¹²

Washington's hospitals will also be impacted by federal policies as patients previously covered by Medicaid become uninsured. According to the Washington State Hospital Association, Medicaid

⁹ Data source: [The State of Alice in Washington](#). United for Alice. Accessed October 14, 2025.

¹⁰ Impact of Alice: [What do families do if they cannot afford health care?](#) United for Alice. Accessed October 14, 2025.

¹¹ Cotter, L., Claxton, G., McGough, M., Rae, M. [How affordability of employer coverage varies by family income](#). Peterson-KFF Health System Tracker. 2025.

¹² Source: [Washington Health Benefit Exchange. Update on federal changes](#). Accessed October 14, 2025.

enrollment changes will result in an increase in uninsured patients seeking care in the emergency department and a corresponding increase in hospital charity care.¹³

Expiration of the Enhanced Advance Premium Tax Credits

Apprehension about the expiration of the Enhanced Advance Premium Tax Credits, set to expire at the end of December 2025, is a factor driving high insurance rate increases by individual market carriers along with increased use of health care services, increased health care and prescription drug costs, and concerns about health care consolidation's impact on prices.^{14,15}

Fourteen health insurance carriers submitted proposed rates to OIC for individual plans. The average approved rate increase for Washington's 2026 Individual Health Insurance Market is 21%.^{14,16} With this increase, Washington's small business owners and others who purchase their health insurance on the open market through the Health Benefit Exchange will pay more for health insurance than they did in 2025. Three-quarters of Washingtonians qualified for federal premium tax credits, which helped to reduce insurance premiums by an average of \$1,330 per person per year.¹⁴ Washington's public option plans, called Cascade Select plans, are offered by three carriers with premium rate increases ranging from 5% to 27%. Rates for PEBB and SEBB programs will increase by an average of 9.5% and 8.8%, respectively.¹⁷

¹³ Washington State Hospital Association Public Comment October 4, 2025. See Appendix.

¹⁴ Source: [Office of the Insurance Commissioner Washington State. Insurers seek 21.2% average rate change for 2026 individual health insurance market.](#) Published May 27, 2025. Accessed October 14, 2025.

¹⁵ Source: Member comment during the September 11, 2025, FTAC meeting.

¹⁶ Source: [Office of the Insurance Commissioner Washington State. Average 21% rate increase approved for Washington's 2026 Exchange health insurance market.](#) Published September 10, 2025. Accessed October 14, 2025.

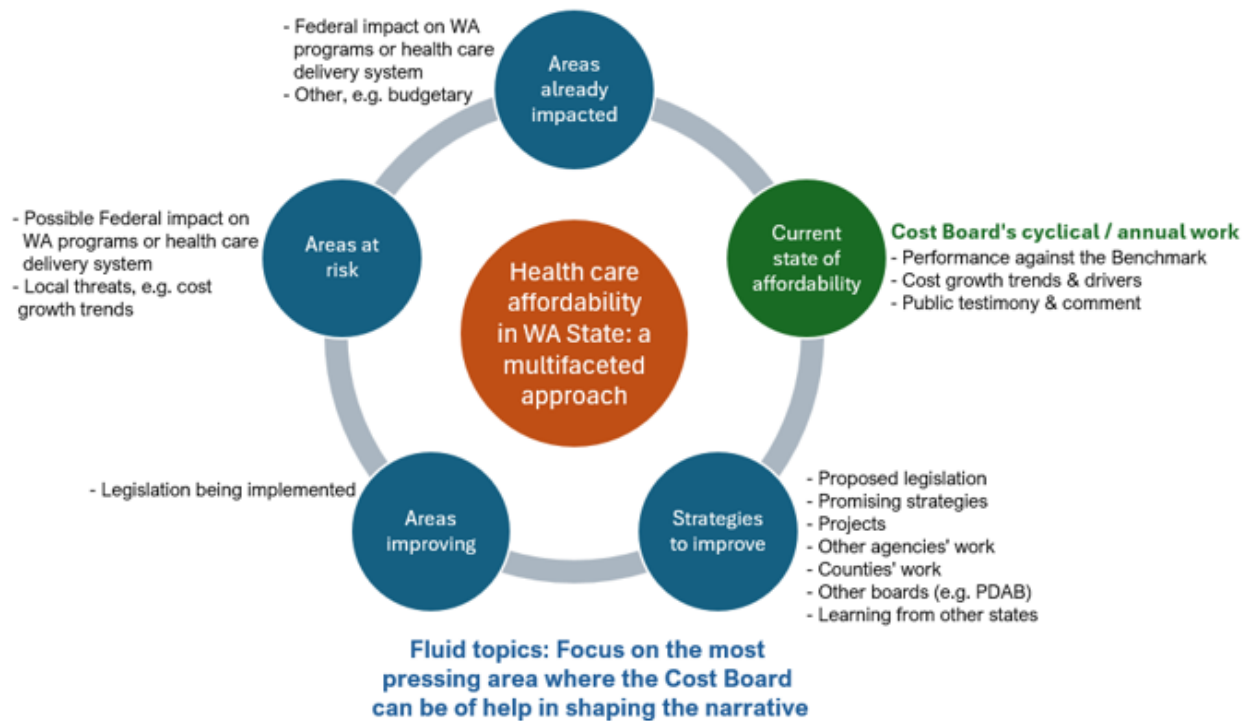
¹⁷ Source: PEBB and SEBB Programs, HCA

Potential policy interventions to help slow health care spending growth

The majority of Washingtonians who responded to the 2024 Washington State Health Care Affordability Survey — 87% — believe that Washington lawmakers should take action to address health care costs, with 41% ranking health care affordability as one of the top four issues for elected officials to address.⁸

Beyond monitoring health care spending and identifying trends and drivers, the Cost Board is charged with making policy recommendations to the Legislature intended to slow health care spending growth. To effectively curb expenditure growth in a dynamic health care market, the Cost Board acknowledges there is not one single solution that will solve the problem; we need a multifaceted approach. Figure 2 provides an overview of the work of the Cost Board. The first circle (in green) represents the cyclical annual work of monitoring spending, trends, and drivers described above. The four remaining circles reflect work that occurs concurrently, monitoring impacts on spending from local, national, and federal perspectives while identifying and recommending policy actions most likely to mitigate some of the factors that drive expenditure growth.

Figure 2: The Cost Board’s areas of focus



Strategies to improve: prioritizing policy action

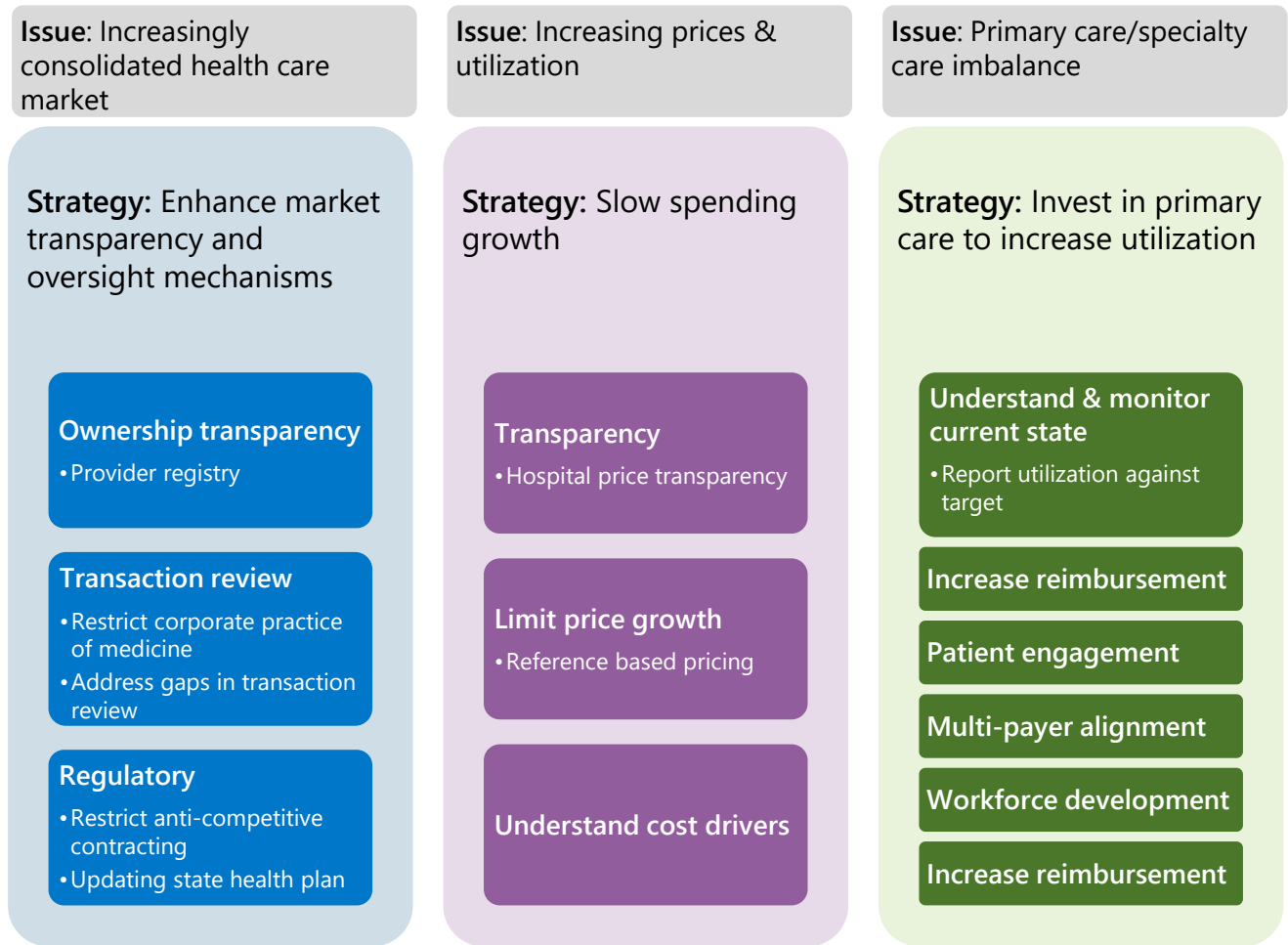
In the [2024 Annual Report](#)—informed by the work of [Washington State’s OIC](#) and the [Attorney General’s Office](#), as well as best practices from other states, and expert recommendations—the Cost Board prioritized three policy areas as its focus for legislative action addressing three of the large issues that impact health care cost growth and affordability:

- Slowing spending growth

- Increasing primary care utilization
- Enhancing market transparency and oversight

Please see the [Table 1](#) for more details. In 2025, foundational work occurred in each of these areas, and they remain the Cost Board’s priorities looking forward to 2026.

Figure 3: Health care affordability challenges and 2025–2026 Cost Board strategies to improve: priorities for policy action



Slowing spending growth

Background and current state in Washington

As health care spending continues to rise, identifying sustainable strategies to slow spending growth has been a primary focus for the Cost Board. The Cost Board's systematic analysis of health care markets, carriers, providers, and service categories provides a foundation for understanding how much spending is associated with different aspects of the health care system in Washington. This understanding can support a multi-faceted, systems approach to addressing the many components contributing to spending growth.

Analysis of the state's health care spending data submitted by commercial and public payers (e.g., insurers) shows that statewide per-member spending increased more than 29% from 2017–2023 and totaled \$8,000 in 2023.¹⁸ This represents approximately 28% of median annual income per person for a four-person household.¹⁸ Although this spending reflects payments made directly by insurers, people in Washington state ultimately foot the bill for this spending in the form of premiums, deductibles, and taxes.

The real-world impact of these figures is striking. Nearly six out of 10 Washingtonians report at least one affordability burden in the last year, and nearly nine out of 10 worry about affording health care in the future.⁸ Tracking health care spending and understanding what contributes to spending increases in Washington is a first step towards policy action to ensure all Washingtonians have access to affordable health care.

Analysis of spending growth

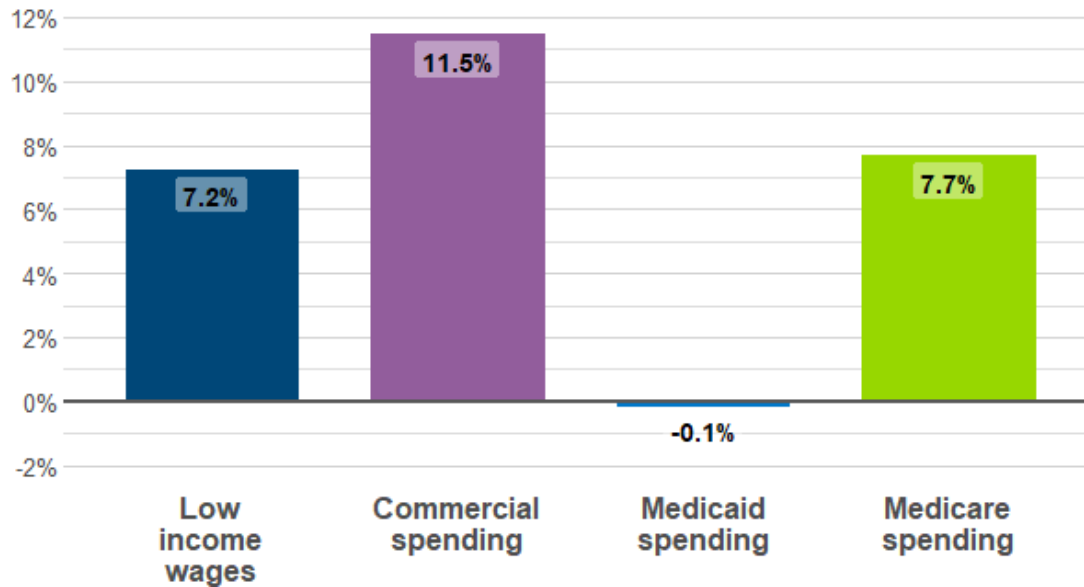
Spending growth was driven by increases across payer markets, including commercial, Medicare, and Medicaid from 2019–2022.¹⁹ Per-member Medicare spending increased nearly 8%, while Medicaid spending did not increase, and commercial market spending increased more than 11%. In the same period, income for the lowest 20% of Washingtonians increased by only 7% (Figure 4).²⁰ For these Washingtonians, already expensive health care has become less affordable.

¹⁸ Source: Performance Against the Benchmark. 2025 Executive Summary. See Appendix.

¹⁹ Source: Data Call Analysis.

²⁰ Source: [United States Census Bureau](#). Accessed October 14, 2025.

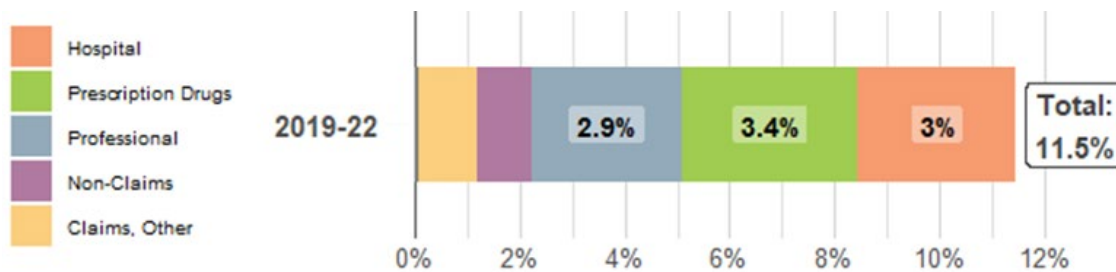
Figure 4: Medical expenditure growth by market compared to low-income wage growth, 2019–2022



Source: Cost Board data call, Census Bureau²⁰

Much of this overall spending and spending growth was due to a small number of spending categories: hospital (inpatient and outpatient), prescription drugs, and professional services (primary care and specialty care). In the commercial market, where spending growth has been fastest, these categories accounted for approximately 75% of overall spending in 2022, and more than 80% of spending growth between 2019 and 2022 (Figure 5).¹⁸ In the Medicare and Medicaid markets, non-claims expenditures also contributed to growth. This was driven by sustained increase in capitation and bundled payments in Medicaid and Medicare Advantage.

Figure 5: Spending growth in the commercial market by service category, 2019–2022



Source: Cost Board data call¹⁹

Identifying what types of health care services are contributing to overall spending and spending growth highlights where further analysis is needed and where legislative action may be needed. To determine how increases in spending for these services were driven by increasing prices or increasing use of services,

the Cost Board examined the respective contribution of price per service and service utilization. The following is a summary of changes in the same time period, between 2019 and 2022.²¹

- **Prescription drugs spending** includes retail pharmacy spending for prescription drugs, biologics, or vaccines. Analysis of spending drivers showed that across markets, an **increase in the price of prescription drugs drove the increase in prescription drug spending**. In the commercial market, prescription drug spending was driven by a 30% increase in the price of drugs, while utilization did not change from prior years. The Medicare Advantage and Medicaid markets showed similar but more dramatic price increases.
- **Hospital outpatient spending** includes payments to all hospital types, hospital-licensed satellite clinics, and emergency department visits not resulting in admission to the hospital. From 2019–2022, a **combination of increasing prices and utilization** drove the increase in outpatient hospital spending. In the commercial market, hospital outpatient service prices and utilization increased approximately 20%. Prices also increased in the Medicaid and Medicare Advantage markets, while utilization decreased for Medicaid and increased dramatically for Medicare advantage.
- **Hospital inpatient spending** is composed of all expenses related to inpatient hospital admission, including room and board. Analysis of spending drivers revealed slower growth than other top contributors, with average **prices slightly up** and utilization modestly down in the commercial market. These trends were similar in other markets, although Medicaid utilization increased modestly.
- **Professional spending** includes primary care, professional specialty, and other professional services spending. Within these subcategories, spending growth was led by professional specialty, which includes clinical areas other than family practice, geriatrics, internal medicine, or pediatrics. This growth was slower than hospital outpatient and prescription drug categories and driven by a combination of price and utilization. Price and utilization increased slightly in the commercial market, while Medicaid prices increased and Medicare Advantage prices decreased.

Taken together, this suggests that **increasing prices for prescription drugs and outpatient hospital services are central to the increase in overall health care spending between 2019 and 2022**, and policies that address these issues may improve health care affordability.²¹ While some of these trends may be attributed to specific circumstances, such as the COVID-19 pandemic, measuring over this entire period allows for the detection of broad trends that are not fully explained by specific events. It is notable that these top spending categories are sectors of the health care market where levels of consolidation are high and increasing.²²

The legislature has addressed aspects of rising prescription drug prices in recent years by strengthening regulation of Pharmacy Benefit Managers and creating the **Prescription Drug Affordability Board**

²¹ Source: Onpoint analysis of APCD data

²² [America's Health Care Consolidation Crisis: A Ledger of Harms and Framework for Advancing Economic Liberty for All](#). American Economic Liberties Project. 2024.

(PDAB).²³ PDAB was created in 2023 and seeks to mitigate unjustified price increases of prescription drugs for people in Washington. It is tasked with:

- Identifying drugs that may be subject to an affordability review per the enabling legislation.
- Conducting affordability reviews on selected eligible drugs.
- Determining whether a prescription drug has led or will lead to excess costs for Washington consumers and if a drug is found to be unaffordable.

PDAB may set upper payment limits starting in 2027. PDAB created a list of eligible drugs for review and selected Enbrel, Xtandi, Cabometyx, and Humira as of July 2025. PDAB has begun data collection for the Enbrel and Xtandi reviews.

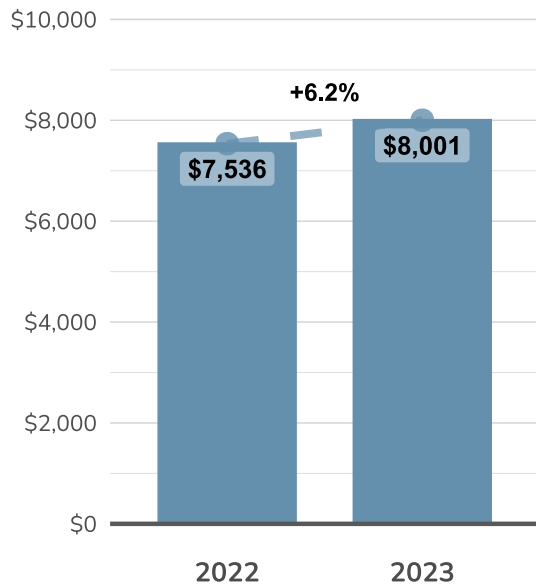
As PDAB is charged with monitoring and mitigating unsupported price increases of prescription drugs for the state, the Cost Board focused attention on policy related to addressing hospital spending. The Cost Board examined a range of options to address hospital spending. This included ways to increase transparency, as well as regulatory options focused on spending growth, prices, and price and utilization together.

2023 performance against the benchmark highlights

Analysis of the state's health care spending data shows that statewide per-member spending increased more than 29% from 2017–2023.¹⁸ In 2023 — the most recent year for which data is available — per capita total health care expenditures grew by 6.2% (Figure 6).¹⁹ This was nearly twice the benchmark rate of 3.2%. Health care spending also grew faster than the established benchmark in all other states with benchmark programs in 2023.⁵ In fact, Oregon, Rhode Island, and Connecticut reported their highest spending growth since they adopted a cost growth target. This indicates that the reasons for spending growth are not entirely unique to Washington state, and that benchmark programs alone aren't enough to improve health care affordability.

²³ [Engrossed Second Substitute Senate Bill 5213 \(2024\)](#). Signed into law March 25, 2024.

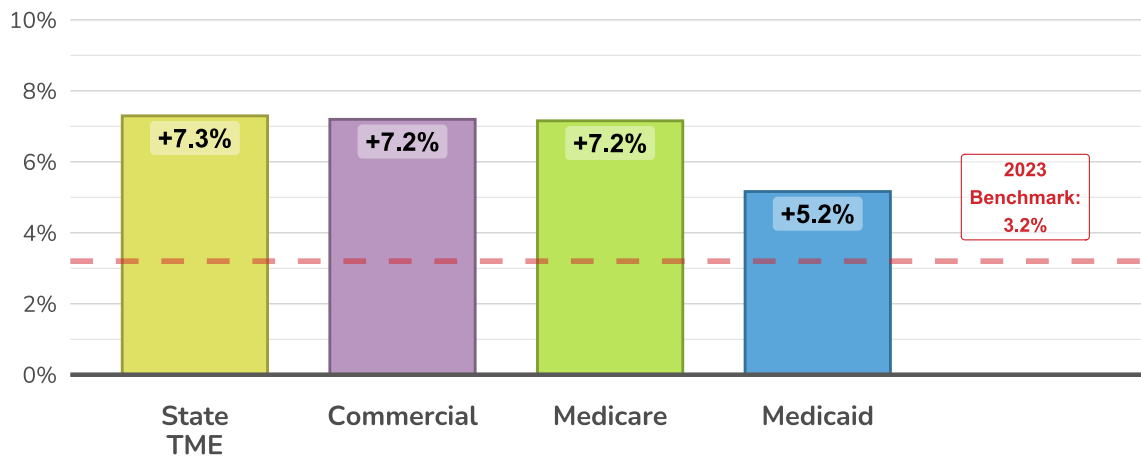
Figure 6: Total health care expenditure per person, 2022–2023



Source: Cost Board data call¹⁹

Further analysis of 2023 statewide total medical expense suggests the market-level and service category trends contributing to this rapid growth.²⁴ Commercial, Medicare, and Medicaid payers reported growth that was above the established benchmark, with spending in the commercial and Medicare markets growing faster than in Medicaid (Figure 7).¹⁹

Figure 7: Spending growth per person by market, 2022–2023



Source: Cost Board data call. TME is total medical expense.¹⁹

²⁴ Statewide Total Medical Expense accounts for 90% of Total Health Care Expenditures. State agency health care spending and other costs associated with private health insurance contribute the rest.

The spending in these markets was largely driven by growth in the same types of services identified in analysis of previous years. Statewide, growth was driven by hospital outpatient, prescription drugs, and professional services (including professional specialty services). Hospital spending accounted for more than half of the overall spending growth in the commercial market, with hospital inpatient spending up from previous years. Prescription drug spending was the leading contributor to growth in the Medicare market. Statewide, prescription drug spending accounted for 1.5% of the 7.3% increase medical expenses. Non-claims expenditures were a notable source of growth in the Medicare market but not in the commercial or Medicaid markets.

While further details of the 2023 spending trends will be available when the full Performance Against the Benchmark Report is released in early 2026, the basic picture is clear: **health care spending again grew faster than Washingtonians' ability to afford it, and spending growth was primarily driven by increased spending on hospital services, prescription drugs, and professional services.**

Opportunities for higher value health care

Improving the affordability of health care in Washington means not only slowing spending growth but also addressing where savings can be achieved through higher-value care.²⁵ In Washington state and across the nation, hospital care (inpatient and outpatient) represents the largest single component of expenditures.²⁶ Some care provided in this context could be prevented by earlier, preventive care — for example, in a primary care setting. Decreasing these potentially preventable hospitalizations is a priority shared among policymakers, public and private payers, and patient advocates.

To better understand the general and specific factors that contribute to potentially preventable hospitalizations in Washington, the Cost Board leveraged the Analytic Support Initiative (ASI). This initiative was funded by the Peterson Center for Health and the Gates Foundation and was performed in collaboration with the Institute for Health Metrics and Evaluation at the University of Washington. This analysis shows that broadly, Washington regions that are more rural or have a lower average income show higher utilization of emergency department services compared to outpatient services.²⁷ This indicates that the type of care a Washingtonian receives differs based on regional economic and demographic factors, thereby contributing to health inequities.

Additionally, condition-specific spending analysis illustrated potential savings from upstream investment. Type 2 diabetes and chronic obstructive pulmonary disease (COPD) alone drive \$400 million dollars

²⁵ The transitional solutions section of the [Universal Health Care Commission 2025 Annual Report](#) outlines additional opportunities to increase care value and decrease spending growth.

²⁶ [National Spending on Hospital Care](#). KFF. 2023

²⁷ [Health Care Cost Transparency Board Meeting](#), June 2025.

(approximately 3%) of annual inpatient hospital spending, and nearly 100 million in emergency department spending.²⁷

2025 progress

In its [recommendations for 2024](#), the Cost Board recommended the Legislature consider policies that improve hospital price transparency to help patients make informed choices.²⁸ It also recommended exploration of regulating prices for hospital services to ensure that payments for these services are fair and reasonable. The Cost Board expressed particular interest in the Health Care Authority's (HCA) agency request legislation to regulate pricing for inpatient and outpatient hospital services, primary care, and behavioral health services within the state and school employee purchasing programs. The Legislature passed bills in the last session related to each of these recommendations. These policies serve as building blocks towards the board's goal of affordability.

PEBB and SEBB together make up about 20% of Washington state's commercial market. Current spending trends for consumers and the state of Washington are unsustainable in the long term.²⁹ During the 2025 legislative session, [Engrossed Second Substitute Senate Bill 5083](#) was passed into law to address these trends and support investment in primary care and behavioral health. This law establishes PEBB/SEBB reimbursement limits for hospital services and floors for primary care and non-facility behavioral health services.³⁰ It does so by tying these reimbursements to a set reference price, a practice known as reference-based pricing. Beginning January 1, 2027, the reimbursement amount hospitals receive for these plans will be limited to 200% of Medicare for in-network hospitals and 185% of Medicare for out-of-network hospitals. To increase investment in behavioral health and primary care services, minimum reimbursement for these services is set at 150% of Medicare price. The reimbursement limits do not apply to non-system critical access hospitals, sole community hospitals, or reimbursement rates paid in the commercial market generally. Importantly, the law also requires reports of the impacts on network access, enrollee premiums and cost-sharing, and total medical expenditures. These HCA reports will be produced in consultation with OIC and delivered by December 31 of 2030 and 2034. These reports and evaluations of similar policies in other states will inform future efforts.

Also passed into law in 2025 was [Substitute Senate Bill 5493](#), which requires hospitals to comply with federal standards regarding price transparency, such as posting machine-readable files of all standard charges for hospital items or services to their website. Additionally, it requires hospitals to submit this information to the Washington State Department of Health (DOH) at least annually. This codifies federal transparency requirements into Washington state law, supporting increased transparency to the consumer and improved data access for oversight.

²⁸ [Health Care Cost Transparency Board 2024 Annual Report](#). Health Care Authority Report to the Legislature. 2024.

²⁹ [Study on consolidating the PEBB and SEBB programs](#). Health Care Authority Report to the Legislature. 2024.

³⁰ [RCW 70.41.560](#). Hospital price transparency – Publishing – Reporting. Washington State Legislature. Accessed on October 15, 2025.

Primary care utilization

Background and current state in Washington

Extensive research shows that a strong high-quality primary care system leads to better health outcomes, greater equity in access and outcomes, and higher patient satisfaction with care.^{31,32} Utilization of primary care services as the foundation of the health care system leads to lower per capita health care costs as primary care is much less expensive than care provided in emergency departments and hospitals.³²

Despite its importance, research shows that the U.S. has lower utilization of primary care than other high-income countries, with U.S. adults being among the least likely to have a regular doctor or regular place they go for care.³² Patients with a long-term relationship with a primary care doctor are less likely to go to the emergency department and more likely to seek care in a less expensive setting.³²

In the U.S., there is an imbalance between primary care and specialty care. Thirty-nine percent of actively practicing physicians work in primary care compared to over 60% working in specialty areas.³³ Experts suggest that the U.S. has underinvested in primary care for many years, leading to current challenges, such as the declining number of physicians and market consolidation.^{31,32,34} In Washington, as in other states, primary care services are reimbursed at lower rates than most specialty services and primary care practices often lack the infrastructure to support population-based payment arrangements.³⁴

In Washington, primary care quality, equity, and access remain poor. Twenty-three percent of Washington's adult population does not have a usual source of care.³⁴ Inequities in care exist, with data showing that American Indian/Alaska Native, Black, and Hispanic Washingtonians use fewer preventive care visits than white Washingtonians.³⁴ Quality scores for the state are in the bottom 25% for preventive services such as access to primary well-child visits and cancer screening.³⁴ Taken together, this suggests that health inequities based on regional, demographic, and economic factors remain an issue in Washington state.

As described in last year's [legislative report](#), Washington, like other states, has adopted a comprehensive set of policy recommendations to rebalance health care utilization and to rebalance spending. The Legislature directed the Cost Board to define and measure primary care spending and recommend ways to increase it to a targeted goal of 12% of total health care expenditures ([SSB 5589](#), 2022). With current primary care performance at 3.7% of total medical expenses, the state is far from its target of 12%.¹⁹³⁵

³¹ NASHP Staff, Milbank Memorial Fund. [Implementing High-Quality Primary Care: A Policy Menu for States](#). National Academy for State Health Policy. 2025.

³² FitzGerald, M., Gunja, M., Tikkanen, R. [Primary Care in High-Income Countries: How the United States Compares](#). The Commonwealth Fund. 2022.

³³ Shi, L. [The Impact of Primary Care: A Focused Review](#). Scientifica. 2012.

³⁴ Zeran-Thul, J. [Health Care Cost Transparency Board: Primary Care Expenditure Ratio \(PCE\)](#). Senate Health & Long-Term Care Committee. January 17, 2025.

³⁵ Source: [Health Care Cost Transparency Board's Advisory Committee on Primary Care Meeting](#). August 28, 2025.

To support the legislative assignment, the Cost Board established the Primary Care Advisory Committee to develop policy recommendations and advise the Cost Board. The advisory committee has found that even modest increases in investment in primary care can lead to significant long-term savings by:

- Reducing avoidable hospital admissions and readmissions.
- Lowering emergency department use.
- Improving chronic disease management.
- Enhancing care coordination and reducing overall system utilization.

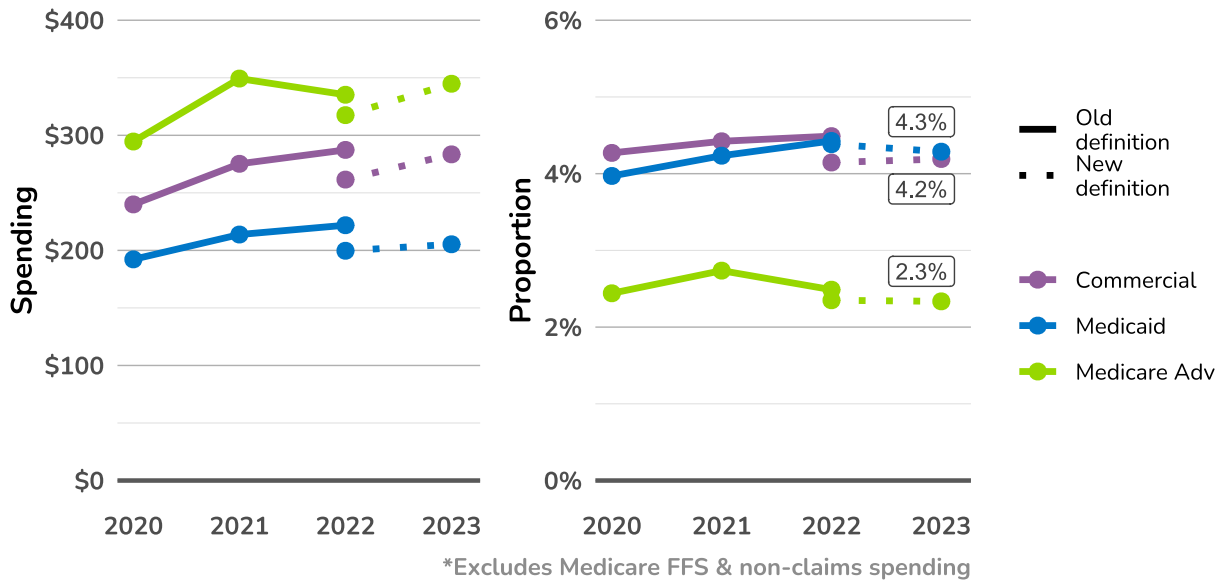
More information about the primary care expenditure target and performance

As described prior, primary care spending remains low compared to other medical expenditures. Per capita spending on primary care remains highest in Medicare managed care, followed by Commercial and Medicaid populations. However, when measured as a share of total medical expenses, Medicaid leads in 2023, while Medicare lags due to higher spending on hospital and pharmacy services tied to an older population. In October 2023, the Primary Care Advisory Committee adopted a standardized definition of primary care to improve how spending is measured and monitored in Washington, replacing the previous framework developed by the Washington State Office of Financial Management (OFM). The new definition, first applied in the 2024 reporting cycle, is based on three key criteria: **service type**, **provider type**, and **care setting**. It also includes non-claims payments, such as capitation and performance incentives, offering a more accurate and comprehensive view of primary care investment across all payers. This change enhances the state’s ability to track progress toward the 12% spending target, strengthens accountability, and better aligns with broader health care transformation goals.

An important step towards reaching the 12% primary care spending goal is understanding current levels of primary care spending. [SB 5084](#) continues to streamline reporting and monitoring advances by requiring health carriers to annually report primary care expenditures to the Washington State Office of the Insurance Commissioner (OIC). Reporting will begin in 2026 and use standards aligned with HCA’s expenditure measurement for PEBB/SEBB and Medicaid plans.³⁶ With this information, the Cost Board can better understand primary care spending trends across Medicaid, the PEBB/SEBB programs, and commercial health plans and propose strategies to increase primary care spending.

³⁶ [RCW 48.43.800](#) Primary Care Expenditures Reporting – Review. Accessed on October 20, 2025

Figure 8: Primary care per member spending (left) and proportion of per member total medical expense (right) by market



Source: Cost Board data call

2025 updated policy package

A key part of the Cost Board’s work is to recommend investments in primary care to enhance access, improve outcomes, and reduce dependence on high-cost services. Investing in primary care is a foundational strategy for creating a healthier and more financially sustainable health care system in Washington.

In 2025, the Primary Care Advisory Committee reaffirmed its policy recommendations from 2024, with suggestions to continue progress toward achieving the state’s 12% primary care spending target. Key elements of the policy package are advancing prevention, early intervention, and better care coordination. The committee endorsed seven strategic recommendations detailed on the next page of this report:

- Two that require legislative action (Recommendations 1 and 2)
- Five that are strategic endorsements of ongoing or administratively achievable efforts (Recommendations 3 through 7)

The Cost Board supports the recommendations of the Primary Care Advisory Committee to increase utilization of primary care and will work with the Primary Care Advisory Committee to advance these recommendations.

Table 2: Primary Care Advisory Committee recommendations

For legislative action	Strategic endorsement of ongoing or administratively achievable efforts
<p>1. Increase primary care spending by 1% annually</p> <ul style="list-style-type: none"> • Committee recommends Cost Board consider recommendations to require public reporting of primary care expenditure ratios for all carriers. • Increasing primary care redistribution. • Impact: Builds transparency and aligns oversight with state spending goals. <p>2. Increase Medicaid reimbursement</p> <ul style="list-style-type: none"> • Committee continues to recommend raising Medicaid primary care reimbursement to at least Medicare levels. • Committee also recommends Cost Board consider a recommendation to revise fee schedule to align with updated primary care definition. • Committee suggests Legislature should maintain current reimbursement levels for services already at or above Medicare rates. 	<p>3. Patient engagement (prioritized for 2025)</p> <p>The committee endorses:</p> <ul style="list-style-type: none"> • Eliminating cost sharing for primary care services. • HCA’s participation in the Making Care Primary and Primary Care Transformation Initiative. • Supporting whole-person care resources for providers. • HCA-led efforts to incentivize patient engagement and utilization of primary care. <p>4. Multi-payer alignment</p> <p>The committee endorses:</p> <ul style="list-style-type: none"> • The Multi-Payer Collaborative’s work to align standards, metrics, supports, and payment models. • Alignment between state initiatives and the federal Making Care Primary model. • Legislative efforts to advance and ensure state-funded plans participate in aligned models. <p>5. Workforce development</p> <p>Endorses Health Workforce Council recommendations to expand primary care access.</p> <p>6. Alternative payment models (APMs)</p> <p>The Committee endorses:</p> <ul style="list-style-type: none"> • HCA’s use of the HCP-LAN APM Framework to track and set spending targets. • Increasing the share of primary care payments tied to population-based or shared-risk models. • Annual reporting by HCA to inform future committee recommendations. <p>7. Measurement strategy</p> <ul style="list-style-type: none"> • Ongoing agency and HCP-LAN surveys are in progress, with results expected late fall/early winter • Primary care value-based payment (VBP) data is not yet reported separately this year.

Market transparency and oversight

Background and current state in Washington

Research shows that when health care organizations are acquired, merge, or are associated with private equity (PE) investments, patient prices, and health care spending go up. Price increases are driven by increased provider fees, hospital prices, drug prices, and insurance premiums.^{37,38,39,40}

Consolidation of health care resources

Most studies have found that consolidation and reduced competition lead to fewer choices for patients and decreased or unchanged quality of care.^{38,41,42,43,44,45} As it applies to the health care workforce, consolidation has been linked to slower wage growth and poorer working conditions for health care workers.⁴⁶ Recent research also indicates that market consolidation contributes to hospital closures which are in turn associated with delays in medical care, increased transport times, and increased morbidity and mortality from time-sensitive conditions.^{47,48}

Over the past thirty years, Washington's hospital and health care resources have become increasingly concentrated as hospitals have closed or become part of multi-hospital systems.^{39,49} Fifty-four percent of Washington hospitals are affiliated with a multi-hospital system.³⁹ Eight multi-hospital systems provide

³⁷ Levinson, Z., Godwin, J., Hulver, S., Neuman, T. [Ten Things to Know About Consolidation in Health Care Provider Markets](#). KFF. 2024.

³⁸ Schwartz, K., Lopez, E. Rae, M., Neuman, T. [What We Know About Provider Consolidation](#). KFF. 2020.

³⁹ Health Management Associates. [WA OIC Preliminary Report on Health Care Affordability](#). 2023.

⁴⁰ Burke, K., Chang, J. [System-Affiliated Hospitals Associated with Higher Prices](#). Health Care Cost Institute. 2025.

⁴¹ Liu, J., Levinson, Z., Zhou, A., Zhao, X., Nguyen, P., Qureshi, N. [Environmental Scan on Consolidation Trends and Impacts in Health Care Markets](#). RAND. 2022.

⁴² Field, R., [Can Current Legal Tools Respond Adequately to Risks of Private Equity Investment in Health Care?](#) AMA Journal of Ethics. 2025.

⁴³ Whitehouse, S., Grassley, C. [Profits Over Patients: The Harmful Effects of Private Equity on the U.S. Health Care System](#). Senate Budget Committee Bipartisan Staff Report. 2025.

⁴⁴ [Federal Trade Commission, the Department of Justice and the Department of Health and Human Services Launch Cross-Government Inquiry on Impact of Corporate Greed in Health Care](#). Federal Trade Commission. 2024. Accessed October 15, 2025.

⁴⁵ Source: [PESP Private Equity Hospital Tracker](#). Private Equity Stakeholder Project. Accessed October 15, 2025.

⁴⁶ [Preliminary Report: Healthcare Affordability](#). Report to the Washington State Legislature. Attorney General of Washington. 2023.

⁴⁷ Tung, E., Bruch, J., Chin, M., Menconi, M., Peek, M., Huang, E. [Associations of U.S. hospital closure \(2007-2018\) with area socioeconomic disadvantage and racial/ethnic composition](#). Annals of Epidemiology. 92. 2024.

⁴⁸ Saghafian, S. [Drivers, adaptations, and public impacts of hospital closures: implications for policy](#). Frontiers in Public Health. 2024.

⁴⁹ Source: [Merger Review](#). The Source on Healthcare Price & Competition. UC College of the Law San Francisco. Accessed October 15, 2025.

more than 90% of licensed beds, more than 65% of staffed beds, and employ more than 65% of physicians and physicians' assistants who work at hospitals in the state.³⁹ Washington's insurance market has also become more concentrated; insurers are vertically integrating with physician groups and clinics in Washington.^{50,51}

Role of private equity

While PE investment is an important source of funding for many health care organizations and may promote innovation in health care delivery, there are concerns regarding PE's role in increased prices and influence over clinical care decisions. Acquisition by a PE firm can lay the groundwork for future consolidation as PE firms often acquire additional nearby practices.³⁹

Washington has seen substantial growth in PE ownership in health care over the past decade. Between 2014 and 2019, there were 97 health care acquisitions in Washington by PE firms.³⁹ According to the Private Equity Stakeholder Project's (PESP) most recent report (April 2025), 9.9% of Washington's private specialty and acute care hospitals⁵² are owned by private equity companies.⁴⁵ The available data used to track PE ownership is imperfect. Enhanced market oversight authority will enable better understanding of the data and current state of PE ownership. This will be important as the Cost Board further examines the impact of PE in Washington in 2026 and considers whether transaction review requirements are needed to ensure affordability and quality of care are maintained for Washington patients.

Market oversight

Market oversight is the regulatory framework established by statute and regulation that monitors the quality of care and financial condition of health care entities.⁵³ Market oversight also has a regulatory aspect, where the state monitors financial health and quality of care data to ensure quality and access are maintained by approved providers.^{53,54} Market oversight is intended to prevent consumer harm by detecting financial or quality of care concerns early and by identifying impacts from health care transactions for consumers. Currently, Washington has market oversight laws for insurers⁵⁵ but not for health care facilities.

To ensure health care transactions do not negatively impact consumers, states put transaction review requirements in place. Transaction reviews vary widely across states, but can include notice requirements,

⁵⁰ Source: [Large Group Insurance Market Competition 2021](#). KFF. Accessed October 15, 2025.

⁵¹ February 9, 2024, Cost Board Meeting Summary

⁵² Note: PESP identified the following facilities as having PE ownership. CHI Franciscan Rehabilitation Hospital in Tacoma; Rainier Springs psychiatric hospital in Vancouver; Lourdes Medical Center in Pasco; Kindred Hospital (long-term acute care facility) in Seattle; Trios (acute care) hospital in Kennewick; Lourdes Medical Center (rehabilitation hospital) in Pasco; Lourdes Counseling Center (psychiatric) in Richland. Appollo Global Management is listed as the PE firm with ownership interest and the parent system or company is Lifepoint Health in all cases except Kindred Hospital which is part of ScionHealth.

⁵³ [RCW 48.37.030\(5\)-\(7\)](#) Washington State Legislature. 2007.

⁵⁴ [RCW 70.38.105\(4\)\(b\)](#) Washington State Legislature. 2012.

⁵⁵ [RCW 48.37.030\(5\)-\(7\)](#) Washington State Legislature. 2007.

cost and market impact reviews, and disclosure of indirect ownership interests.⁵⁶ Transaction review laws can also apply to a variety of health care entities, including insurers, private equity, indirect owners, and physician practices.⁵⁷ Washington's transaction review laws are limited, but do include review for some types of health care transactions, such as antitrust,⁵⁸ merger and consolidation,⁵⁹ and non-profit hospital acquisition.⁶⁰

Framework for market oversight

Washington currently has transaction review laws in place that require affiliating entities⁶¹ to notify the Attorney General's Office (AGO) before any health care merger, acquisition, or other affiliation. The intent of the notification and review is to identify transactions that might do the most harm to the health care delivery system. Washington lacks the ability to consider the impact of transactions based on "affordability, access to services or quality of care and does not authorize the AGO to administratively approve, reject, or impose conditions on transactions without going to court."⁴⁶

While Washington has a transaction review structure in place, there are several areas where stronger laws would be more effective in responding to modern and innovative approaches to consolidation and mergers, such as board control and third-party contracting. In other states such as Massachusetts, California, and Oregon, regulatory agencies have more extensive powers related to transaction review.

2025 progress

The 2025 legislative session created the foundation for advancements in Washington's market oversight capabilities. Advances in market oversight allow for a better understanding of Washington's health care delivery system, insights into what factors drive health costs, and provide the state with tools to address cost growth. A foundational part of transaction review and the ability to address health care costs is understanding what health care services are being offered, by whom, and under what type of ownership or corporate structure in Washington. This is especially true as private equity continues to invest in health care and modify the health care delivery system to create efficiencies and maximize profit. State laws are often not able to keep pace with the changing landscape, and this creates a data and knowledge gap that limits the effectiveness of state policies directed at slowing health care cost growth.

To begin to address these concerns, the Legislature enacted [Engrossed Second Substitute House Bill \(E2SHB\) 1686](#) (laws of 2025) that requires DOH to develop a plan to create an interactive provider registry

⁵⁶ S. Scott Parel & Jon S. Zucker, Healthcare Transaction Review Laws, Sidney Austin LLP, available at: [Healthcare Transaction Review Laws | Sidney Austin LLP](#).

⁵⁷ S. Scott Parel & Jon S. Zucker, Healthcare Transaction Review Laws, Sidney Austin LLP, available at: [Healthcare Transaction Review Laws | Sidney Austin LLP](#).

⁵⁸ [RCW 19.86.020](#) Unfair competition, practices, declared unlawful. Washington State Legislature. 1961.

⁵⁹ [RCW 19.390.030](#) Notice of material change. Washington State Legislature. 2019.

⁶⁰ [RCW 70.45.030](#) Department approval required – Application – Fees. Washington State Legislature. 2005.

⁶¹ "Contracting affiliation" means the formation of a relationship between two or more entities that permits the entities to negotiate jointly with carriers or third-party administrators over rates for professional medical services, or for one entity to negotiate on behalf of the other entity with carriers or third-party administrators over rates for professional medical services. "Contracting affiliation" does not include arrangements among entities under common ownership. RCW 19.390020(3) (2019).

that documents ownership and location of health care providers and facilities throughout the state.⁶² DOH will work with other state agencies, the public, and affected parties to develop the plan and submit a preliminary report to the Legislature by December 31, 2027, and a final report by November 1, 2028.⁶² If future legislation is passed establishing the provider registry, it would be a tool that all Washingtonians could use to see where the providers and facilities that best meet their needs are located.

The Legislature also passed legislation ([SSB 5568](#)) (laws of 2025) that will refresh Washington’s State Health Plan (SHP), which was last updated in 1987.^{63,64} The SHP establishes statewide health planning policies and goals related to the availability of health care facilities and services, quality of care, and cost of care.⁶⁵ The SHP is used by the [Certificate of Need \(CN\) program](#) to guide the review criteria used to evaluate which health care facilities are approved to provide care in Washington.⁶⁵ The SHP also provides the methodologies the CN program uses to determine the number of health care facilities that are needed throughout the state.^{66,67,68} To ensure the refresh to the SHP is comprehensive, SSB 5568 directs OFM to work with other state agencies, the public, and regulated entities to conduct the refresh.⁶⁹ As part of the refresh, OFM will:

- Conduct a **health system assessment** that identifies trends in health status and health care needs,
- Create a **health care facilities and service plan** that reviews the utilization of health care facilities to inform planning and CN determinations.
- Create a **health care data resource plan** that identifies data needed for planning and CN review, along with an inventory of existing data sources, and any gaps in data needed to inform health planning.
- Complete an **assessment of trends in health care delivery** and recommend any changes to the scope of health care facilities regulated by CN.
- Create **rural health resource plans** to understand availability of health resources in rural communities and evaluate how reimbursement policies can be modified to meet the needs of rural communities.⁶⁹

⁶² [Engrossed Second Substitute House Bill 1686](#). Health Care Entity Registry-Report. Washington State Legislature. 2025.

⁶³ [Washington State Health Plan, Volume 1: Health Principles, Goals and Strategies](#), effective May 12, 1987.

⁶⁴ [Washington State Health Plan, Volume 2: Performance Standards for Health Facilities and Services](#), effective May 12, 1987.

⁶⁵ [RCW 43.370.030](#). Development and update of strategy-Goals and principles-Required elements-Reports-Public hearings. Washington State Legislature.

⁶⁶ [RCW 43.370.040](#) Department of health – Certificate of need review program. Washington State Legislature. 2025.

⁶⁷ [RCW 70.38.018](#) Statewide health resources strategy-Consistency-Waivers. Washington State Legislature. 2007.

⁶⁸ [WAC 246-310-210](#). Determination of need. Washington State Legislature.

⁶⁹ [Substitute Senate Bill 5568, Chapter 388, Laws of 2025. State Health Plan-Updates](#). Effective Date: July 27, 2025. Washington State Legislature.

2026 recommendations

2026 recommendations continue to focus on limiting cost growth through market transparency by expanding laws that strengthen market oversight of health care facilities. The following are some of the key market oversight strategies the Cost Board will focus on for 2026.

Corporate practice of medicine

Corporate practice of medicine (CPOM) refers to state laws that prohibit corporations and other non-licensed persons from owning and controlling medical practices and from employing or directing licensed medical professionals to engage in their profession.⁷⁰ CPOM laws are intended to prevent commercialization and profit-seeking associated with corporate and private equity ownership, and the associated downstream impacts on clinical practice and quality of care.⁷⁰

Washington state does not have a CPOM statute. Rather, requirements regarding non-medical professional ownership of medical practices come from case law.⁷¹ Generally, Washington prohibits businesses from employing medical professionals to practice their profession, although there are a few exceptions.⁷¹ The primary exception is for professional service corporations, which allow health care professionals to be owners of the professional service corporation, provided they are licensed to render medical care in Washington.

In 2025, Senate Bill (SB) 5387 was introduced. It would establish a corporate practice of medicine doctrine in statute including restrictions on private equity or other corporate entities' involvement in clinical decision-making or operations.⁷² SB 5387 did not pass in the 2025 legislative session but will be updated and reconsidered during the upcoming session.⁷²

Enhancing market oversight

Current Washington state anti-trust laws require reporting and review of ownership transactions, such as mergers and acquisitions that reach a certain monetary threshold. Market consolidation has increased primarily through transactions involving lower monetary amounts that do not reach the threshold, sometimes referred to as "serial acquisitions". This has particularly been the case in transactions that involve physician practice acquisitions by hospitals, insurance carriers or private equity investors.⁷³

Recent Washington legislation sought to address these gaps in transaction review. In the 2024 legislative session, [SB 5241](#), the Keep Our Care Act, proposed expanding the types of transactions requiring review, giving the Attorney General authority to approve or deny transactions and addressing certain anticompetitive contract clauses in Washington. The legislation was not enacted. In 2025, the Keep Our Care Act (HB 1881) was refined and reintroduced — including a role for HCA to conduct access,

⁷⁰ Erin C. Fuse Brown & Mark A. Hall, [Private Equity and Corporatization of Health Care](#), 76 Stan. L. Rev. 527, 562-63. 2024.

⁷¹ Luke J. Campbell, [Chapter 11 – Corporate Practice of Medicine](#), Washington Health Law Manual (4th edition). April 1, 2024.

⁷² [SB 5387-2025-26 Concerning the corporate practice of health care](#). Washington State Legislature.

⁷³ [States' Efforts to Understand and Address Health Care Consolidation](#). National Academy for State Health Policy. December 13, 2024.

affordability, quality, and equity reviews for all health care transactions subject to review — but also did not pass.⁷⁴

The Cost Board is also interested in exploring the types of notifications that the state and patients receive when health care facilities eliminate services or cease operations. In the 2024 legislative report, the Cost Board noted that “market consolidation increases prices, raises consumer costs, and jeopardizes access.” Recent research also indicates market consolidation contributes to hospital closures.⁴⁸ Hospital closures in turn have been associated with delays in medical care, increased transport times, and increased morbidity and mortality from time-sensitive conditions.⁴⁷ Hospital closures have also been linked to increases in prices at surviving hospitals with price effects concentrated among hospitals with system affiliations and hospitals operating in less competitive markets.⁷⁵ The Cost Board would like to explore what types of notifications the state and patients currently receive before a health care facility closes or eliminates services such as labor and delivery or behavioral health services, what notification requirements other states have, and if any strategies could be incorporated into patient notifications to mitigate patient harm and prevent loss of services or closure.

⁷⁴ [House Bill 1881](#). Washington State Legislature. 2025.

⁷⁵ Carroll, C., Chang, J. [Rural Hospital Closures Led to Increased Prices at Nearby ‘Surviving’ Hospitals, 2012–22](#). Health Affairs. 2025.

Conclusion

As the Cost Board wraps up the year, it looks forward to the release of the new performance against the benchmark report and the opportunity to delve more deeply into cost growth drivers during the upcoming year. The board hosted its [annual public meeting on cost growth](#) in late November. This meeting allows the board to learn from stakeholders representing many facets of the health care delivery system, including patients and employers, with a special focus on the affordability impacts felt by consumers.

The Cost Board will continue to monitor spending growth and anticipates the trend toward higher costs will continue. In the coming year, existing health care market factors that lead to cost growth will be exacerbated by new federal policies and reduced funding. These changes are expected to have negative effects on the stability of Washington's health care marketplace and the state's health care delivery system. The Cost Board will continue to monitor these impacts, employing a multifaceted approach as it studies the problem of affordability from multiple angles in coordination with its advisory committees and other state agencies.

The successes from the 2025 legislative session have created a strong foundation for future policy actions related to market oversight and slowing cost growth. Looking ahead to 2026, the Cost Board continues to prioritize the three policy areas discussed in this report, with a particular focus on strategies to strengthen the state's ability to provide market oversight.

Appendices

- Appendix A: [Health Care Cost Transparency Board and Committees Rosters for 2025](#)
- Appendix B: [Analytic Support Initiative Summary](#)
- Appendix C: [Performance against the Benchmark Executive Summary](#)
- Appendix D: [Public comment on the legislative report](#)

Appendix A: Health Care Cost Transparency Board and Committees Rosters for 2025

Health Care Cost Transparency Board roster for 2025

Member	Title, Agency	Board Member Position
Mich'l Needham, Chair	Chief Policy Officer, HCA	Representing HCA
Jane Beyer	Senior Health Policy Advisor, OIC	Representing OIC
Eileen Cody	Consumer Advocate	Representing consumers
Lois Cook	Managing Member, America's Phone Guys	Representing small businesses
Bianca Frogner	Professor and Center for Health Workforce Studies Director, University of Washington	Expert in health care financing
Kenneth Gardner	Director of Growth, SEIU 775 Benefits Group	Representing Taft-Hartley health benefit plans
Jodi Joyce	Chief Executive Office, Unity Care NW	Member of advisory committee with operational experience in health care delivery (non-voting)
Gregory Marchand	Director of Global Benefits, Boeing	Representing large employers/self-funded group health plan
Mark Siegel	Assistant Vice President, Costco Wholesale Corporation	Representing large employers
Margaret Stanley	Consumer Advocate	Representing consumers
Ingrid Ulrey	Chief Executive Officer, Washington Health Benefit Exchange	Representing the Washington Health Benefit Exchange
Kim Wallace	Medical Administrator, Department of Labor & Industries (L&I)	Representing L&I
Carol Wilmes	Director of Member Pooling Programs, Association of Washington Cities	Representing local governments that purchase health care for their employees
Outgoing member		
Carol Wilmes	Representing local governments that purchase health care for their employees	

Data Issues Advisory Committee roster for 2025

Member	Title	Agency/Organization
Megan Atkinson	Chief Financial Officer	HCA
Christa Able	Division Director, Payer Strategy and Relationships	Virginia Mason Franciscan Health
Nnabuchi Anikpezie	Senior Director of Health Systems and Workforce Intelligence	DOH
Amanda Avalos	Deputy, Enterprise Analytics, Research, and Reporting	HCA
Jonathan Bennett	Vice President, Data Analytics, and IT Services	Washington State Hospital Association
Bruce Brazier	Administrative Services Director	Peninsula Community Health Services
Jason Brown	Budget Assistant	Office of Financial Management
Chandra Hicks	Assistant Director of Delivery System Analytics	Cambria Health Solutions
Leah Hole-Marshall	General Counsel and Chief Strategist	Health Benefit Exchange
David Mancuso	Director, Research and Data Analysis Division	DSHS, Research and Data Analysis
Ana Morales	National Director, APM Program	United Healthcare
Hunter Plumer	Senior Consultant	HealthTrends
Mark Pregler	Director, Data Management and Analytics	Washington Health Alliance
Russ Shust	Senior Director of Medical Economics	OptumCare Washington
Mandy Stahre	Senior Forecast and Research Manager	Office of Financial Management
Julie Sylvester	Senior Consultant, Contracting and Payer Relations	University of Washington Medicine

Health Care Stakeholder Advisory Committee roster for 2025

Member	Title	Agency / organization	Nominating entity	Committee member position
Emily Brice	Deputy Director	Northwest Health Law Advocates (NoHLA)	Janet Varon, CEO of NoHLA	Consumer organization
Patrick Connor	Washington State Director	National Federation of Independent Business (NFIB)	NFIB	Business organizations, at least 1 small business representative
Bob Crittenden	Physician and Consultant	Empire Health Foundation	WA Academy of Family Physicians	One primary care physician, selected from a list of three nominees
Paul Fishman	Professor, Dept. of Health Services	University of Washington	Self-nominated	At least two members representing the interests of consumers
Jamie Fowler	Director of Operations	SCA Health	Ambulatory Surgery Center Association	One member representing an ambulatory surgery center selected from a list of three nominees
Justin Gill	President	Washington State Nurses Association	Washington State Nurses Association	At least two members representing the interests of labor purchasers
Jodi Joyce	Chief Executive Officer	Unity Care NW	Washington Association for Community Health	One member representing federally qualified health centers
Louise Kaplan	Associate Professor	Washington State University College of Nursing	ARNPs United of Washington State	One member representing advanced registered nurse practitioners
Stacy Kessel	Chief Finance and Strategy Officer	Community Health Plan of Washington	Association of Washington Health Care Plans	One member representing a managed care organization that contracts with HCA to serve medical assistance enrollees
Vicki Lowe	Executive Director	American Indian Health Commission	American Indian Health Commission	One member representing tribal health providers
Natalia Martinez-Kohler	Chief Financial Officer	MultiCare Behavioral Health Network and South King Region	Washington Council for Behavioral Health	One member representing behavioral health providers

Member	Title	Agency / organization	Nominating entity	Committee member position
Sulan Mlynarek	Lead Research Analyst	Service Employees International Union (SEIU), Healthcare 1199NW	Washington State Labor Council	At least two members representing the interests of labor purchasers
Paul Schultz	Executive Director, Actuarial Services	Kaiser Foundation Health Plan, Inc (WA)	Peggi Fu, ED, Association of WA Health Plans	One member representing a health maintenance organization
Dorothy Teeter	Consultant	Teeter Health Strategies	Self-nominated	At least two members representing the interests of consumers
Michele Ritala	Health Benefits Strategic Planner	King County Department of Human Resources	Purchaser Business Group on Health	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
Wes Waters	Chief Financial Officer	Molina Healthcare of Washington	Association of Washington Health Care Plans	One member representing a managed care organization that contracts with HCA to serve medical assistance enrollees

Primary Care Advisory Committee roster for 2025

Member	Title	Agency/Organization
Judy Zerzan-Thul	Chair, Chief Medical Officer	HCA
Jonathan Staloff	Co-Chair, Family Medicine Doctor, Fellow	University of Washington Medicine
Kristal Albrecht	Senior Vice President of Finance	Community Health Association of Spokane
Sharon Brown	Executive Director	Greater Health Now
Tony Butruille	Family Medicine Doctor	Cascade Medical Center
Michele Causley	Vice President of Health Plan Operations	United Healthcare
Tracy Corgiat	Vice President Primary Care	Confluence Health
Chandra Hicks	Assistant Director – Delivery System Analytics	Regence BlueShield
Gregory Marchand	Director, Global Benefits	Boeing
Lan H. Nguyen	Medical Director	Premera
Katina Rue	Family Medicine Doctor, President-Elect	Washington State Medical Association
Mandy Stahre	Managing Director, Forecasting and Research	Office of Financial Management
Ginny Weir	Chief Executive Officer	Foundation for Health Care Quality, Bree Collaborative
Shawn West	Chief Medical Officer	Embright
Staici West	Vice President	Coordinated Care
Maddy Wiley	Graduate Faculty School of Nursing	Pacific Lutheran University

Nominating Committee roster for 2025

Member	Title, agency	Committee member position
Kim Wallace	Medical Administrator, L&I	Board member, representing L&I
Carol Wilmes	Director of Member Pooling Programs, Association of Washington Cities	Board member, representing local governments that purchase health care for their employees
Ingrid Ulrey	Chief Executive Officer, Washington Health Benefit Exchange	Board member representing the Washington Health Benefit Exchange

Outgoing member

Carol Wilmes

Representing local governments that purchase health care for their employees

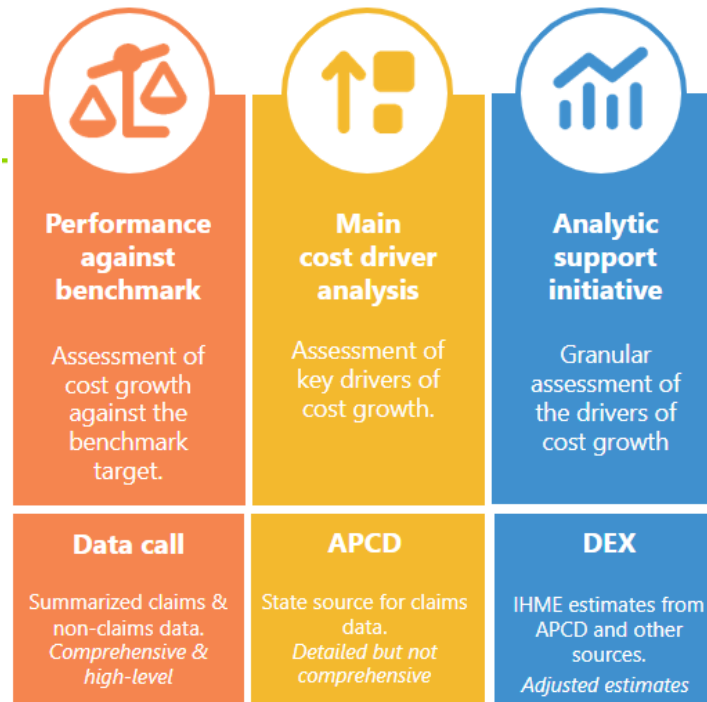
Appendix B: Analytic Support Initiative Summary

The Analytic Support Initiative (ASI) was a two-year project between HCA and the Institute for Health Metrics and Evaluation (IHME) that concluded in summer of 2025. ASI was funded by Gates Ventures and the Peterson Center on Healthcare, and it leveraged IHME's existing Disease Expenditure (DEX) effort to model granular health care spending estimates broken down by demographics, health condition, and time. The first year and a half of the project culminated in the Analytic Support Initiative Disease Expenditures report, which was included in the 2024 Cost Board report to the legislature. Key findings from this report included that increasing price/intensity was the primary driver of increased spending across services, and that demographic shifts within markets primarily impacted Medicare spending, with others much less affected. The final months of the project produced a focused analysis to examine how utilization of outpatient services and potentially preventable hospitalizations varies by regional characteristics like income and rurality. Additionally, to illustrate potential savings, we identified spending associated with conditions that contribute to potentially avoidable hospitalizations.

Background and data streams

The Cost Board collects and analyzes health care spending data to address key questions for policymakers, patients, and other stakeholders. Two primary data streams flow into the Cost Board's internal analysis of health care costs – one from large payers in the state (the annual Cost Board data call) and another from the All Payers Claims Database (APCD). These data sources have different features that make them suited for specific types of analysis, as noted in Figure 1. Currently, the board uses the aggregated information in the data call to quantify overall healthcare spending and high-level spending trends. In parallel, the APCD is used to dissect specific factors contributing to spending, including service price and utilization. From 2023-2025, the Institute for Health Metrics and Evaluation (IHME) performed supplementary analysis focused on disease-level and regional trends contributing to cost growth.

Figure 1. Primary Cost Board data streams and Analytic Support Initiative, 2025



Potentially preventable hospitalization and spending

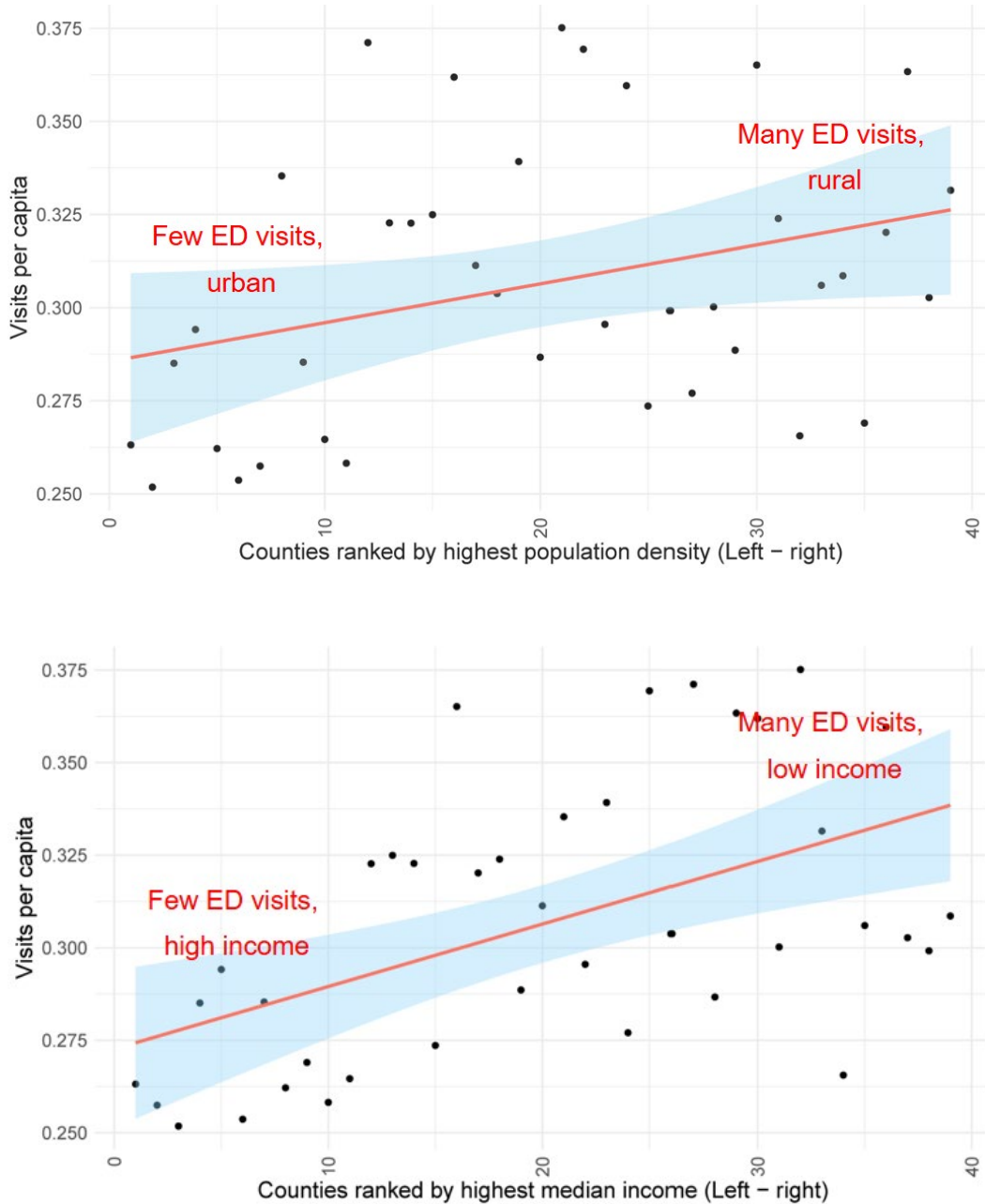
Improving the affordability of health care in Washington means not only slowing cost growth but also addressing where cost savings can be achieved through higher value care. In Washington state and across the nation, hospital care represents the largest component of expenditures⁷⁶. Some care provided in this context could be prevented by earlier, preventive care — for example in a primary care setting. Decreasing these potentially preventable hospitalizations is a priority shared among policymakers, public and private payers, and patient advocates.

To understand general factors that contribute to increased use of hospital services, we examined how outpatient and emergency department utilization varies with a region’s rurality and average income. Broadly, Washington regions that are more rural, have a lower average income, or fewer physicians per capita rely more on emergency department services and hospital inpatient care (Figure 2).⁷⁷ This indicates that the type of care a Washingtonian receives differs based on regional economic and demographic factors—thereby contributing to health inequities.

⁷⁶ Health Care Cost Institute. [2022 Health Care Cost and Utilization Report](#).

⁷⁷ [Health Care Cost Transparency Board meeting](#). June 3, 2025.

Figure 2: Emergency department utilization compared to county rurality (top), and income (bottom), 2022



Source: Disease Expenditure Database

Although these high-level comparisons show regional difference in use of services, a more granular analysis is needed to determine how conditions that are best addressed by upstream services contribute to hospital spending. From an initial set of specific conditions where inpatient admissions are potentially avoidable and data was available, the group next focused on top contributors to spending in Washington State and behavioral health conditions. These included type 2 diabetes, chronic obstructive pulmonary

disease (COPD), asthma, alcohol use disorder, and opioid use disorder.⁷⁸ These five conditions alone account for 5.6% of emergency department spending and 8% of inpatient spending. For these conditions, potentially preventable inpatient admissions were more common in counties that were more rural or had fewer physicians, reinforcing how county-level differences in access and use of upstream care have downstream impacts for patient health and hospital spending throughout the state.

Figure 3. Health expenditures for selected conditions, 2022

Health condition	WA total spending in 2022	WA total IP spending in 2022	WA total ED spending in 2022
Type 2 diabetes	\$3,000M	\$250M	\$66M
Chronic obstructive pulmonary disease (COPD)	\$600M	\$150M	\$28M
Asthma	\$510M	\$50M	\$21M
Alcohol use disorders	\$470M	\$220M	\$17M
Opioid use disorders	\$400M	\$62M	\$4.1M

Source: Disease Expenditure Database

Figure 3 provides a snapshot of how much spending was spent on these conditions statewide in 2022. From this snapshot, we can see that conditions like type 2 diabetes and chronic obstructive pulmonary disease (COPD) alone drive \$400 million dollars (approximately 3%) of annual inpatient hospital spending, and nearly 100 million in emergency department spending. Policies that address upstream factors contributing to these expenditures, including addressing social determinants of health and strengthening primary care, are addressed elsewhere in this report.

Appendix C: Performance against the Benchmark Executive Summary

View a [PDF of the Performance against the Benchmark Executive Summary](#).

Appendix D: Public comment on the legislative report

View a [PDF of the public comment letters](#).

⁷⁸ Joint meeting of the Cost Board’s Advisory Committee of Health Care Stakeholders & Advisory Committee on Data Issues. May 22, 2025.