

Health Care Cost Transparency Board meeting

October 23, 2025

Tab 1

Health Care Cost Transparency Board

Agenda

Thursday, October 23, 2025

2:00 – 5:00 PM

Hybrid Zoom and in-person

Board Members

☐ Mich'l Needham, Interim Chair	☐ Ken Gardner	☐ Ingrid Ulrey
☐ Jane Beyer	☐ Jodi Joyce	☐ Kim Wallace
☐ Eileen Cody	☐ Gregory Marchand	☐ Carol Wilmes
☐ Lois C. Cook	☐ Mark Siegel	
☐ Bianca Frogner	☐ Margaret Stanley	

Time	Agenda Items	Tab	Lead
2:00–2:05 (5 min)	Welcome and roll call Agenda overview	1	Mich'l Needham, Chief Policy Officer, HCA
2:05–2:10 (5 min)	Approval of the July meeting summary	2	Mich'l Needham, Chief Policy Officer, HCA
2:10–2:20 (10 min)	Public comment	3	Ross Valore, Director, Boards & Commissions, HCA
2:20–2:30 (10 min)	Advisory committee updates	4	Eileen Cody, Chair, Health Care Stakeholders Advisory Committee Bianca Frogner, Chair, Data Issues Advisory Committee
2:30–2:40 (10 min)	Nominating Committee updates & announcements - Committee recommendations - Volunteer requests for new Nominating Committee member - Vote	5	Carol Wilmes, Nominating Committee Member
2:40–3:15 (35 min)	Primary Care Committee updates Vote to adopt package recommendations	6	Dr. Judy Zerzan-Thul, Medical Director, HCA
3:15–3:25 (10 min)	Break		
3:25–3:45 (20 mins)	CPOM - Washington's Model: SB 5307 Overview, relationship to Oregon's model, and implementation	7	Senator June Robinson
3:45–4:15 (30 mins)	CPOM - Oregon's Model: SB 0951 Background, reporting, implementation, and lessons learned	8	Hayden Rooke-Ley, Senior Fellow in Health Services, Policy and Practice, Brown University
4:15–4:45 (30 min)	Review legislative report draft	9	Jenn Scott, Senior Health Policy Analyst, HCA Harrison Fontaine, Senior Health Policy Analyst, HCA Ross Valore, Director, Boards & Commissions, HCA
4:45–5:00 (15 min)	Wrap up, 2026 updates, and adjourn Next meeting: January 28, 2-5 PM	10	Mich'l Needham, Chief Policy Officer, HCA

Tab 2

Health Care Cost Transparency Board Meeting Minutes

July 22, 2025

Virtual meeting held electronically (Zoom) and in person at the Health Care Authority (HCA).
2–5 p.m.

Note: This meeting was video recorded in its entirety. The recording and all materials provided to and considered by the board are available on the [Health Care Cost Transparency Board webpage](#).

Members present in person

Mich'l Needham, Interim Chair
Jane Beyer
Eileen Cody

Members present via Zoom

Lois Cook
Bianca Frogner
Kenneth Gardner
Margaret Stanley
Ingrid Ulrey
Kim Wallace
Jodi Joyce

Members absent

Carol Wilmes
Greg Marchand
Mark Siegel

Call to order

Mich'l Needham, interim chair of the Health Care Cost Transparency Board (Cost Board) and chief policy officer, Health Care Authority (HCA), called the meeting of Cost Board to order at 2:03 p.m.

Agenda items

Roll call

Ross Valore, Board and Commission Director, HCA, conducted the roll call. Enough members were present to allow a quorum. Board members and the public attended either in person or virtually via Zoom.

Approval of meeting minutes

Members moved and seconded a motion, to approve the meeting minutes from the June 2, 2025 meeting. Minutes were approved by unanimous vote.

Tab 2: Health Care Cost Transparency Board Meeting Minutes, June 2, 2025 Public comment

Public comment

Ross Valore called for comments from the public. The Washington State Hospital Association (WSHA) sent written comment which is in Tab 3 of the meeting packet. A written comment from the Washington State Medical Association (WSMA) will be included in an amended version of the packet accessible from the Cost Board's website which will be published shortly after the meeting. Two members of the public provided comments during the meeting.

- **Katerina LaMarche, WSHA**
- **Jeb Shepard, WSMA**

Please see [the recording for this meeting](#) for full testimony.

Tab 3: Washington State Hospital Association letter from Katerina LaMarche, Policy Director, Government Affairs

Advisory Committee Feedback

Eileen CODY provided an overview of feedback provided by the Health Care Stakeholders and Committee on Data Issues advisory committees at their joint meeting on March 27, 2025. The discussion was focused on how the Cost Board can best utilize and engage its advisory committee members. The committees would like to be better used in an advisory capacity to the Cost Board. The committees also expressed a preference for separating the Data & Stakeholder meetings unless there was a topic that lent itself to a joint meeting.

Bianca Frogner reviewed the discussion and feedback session that occurred at the May 22, 2025 Joint Advisory Committee meeting. This included a summary of the joint advisory committee's discussion of hospital expenditures and potential policy levers to mitigate spending growth. Advisory committee members had diverging opinions about whether hospitals can mitigate cost growth due to economic and federal policy changes and whether hospital pricing is the right strategy for the Board to focus on given concerns expressed about hospital financial stability and potential negative impacts on access and quality.

Tab 4: Advisory Committee Feedback & Cost Board Work Going Forward

Cost Board's Directive

Mich'l Needham used a graphic to provide an overview of the multiple areas of focus and work that make up the Cost Board's scope and described her vision of a multi-faceted approach for addressing affordability in 2025-2026.

Tab 5: A Multi-Faceted Approach for 2025-2026

Health Benefit Exchange (HBE) Updates and Coverage Impacts

Ingrid Ulrey, Chief Executive Officer at the Health Benefit Exchange, provided an overview of federal health coverage policy changes and their estimated impact on Washington state in terms of enrollment reduction, premium increases, and ripple effects throughout the health care delivery system. Federal changes to the Affordable Care Act are expected to cause a 35%-50% enrollment reduction and up to a 15% premium increase in Washington. Federal changes to the CMS marketplace rule are estimated to cause a reduction up to 23% and premium increase up to 4.5% in Washington. Federal changes to the ACA marketplace are expected to reduce enrollment by 25%-50% in Washington and increase premiums by 5.4%.

Tab 6: Health Benefit Exchange Updates and Coverage Impacts

State Health Plan – Implementing SB 5568

Mandy Stahre, Director, Health Care Research Center at the Office of Financial Management (OFM), provided a presentation on the statewide health resources strategy, background and updates on RCW 43.370 which require development of a new State Health Plan due in 2027. Mandy provided details on the areas being updated in the new plan which are focused on definitions of facilities, access and confidentiality of data, principles of health equity, two hearings, and updates every four years. She provided a status on progress to date. A key piece of work is building a Technical Advisory Group.

Tab 7: Statewide Health Resources Strategy RCW 43.370

Impacts of Federal Budget on Apple Health (Medicaid) in Washington State

Evan Klein, Special Assistant for Policy & Legislative Affairs at HCA, provided a presentation on federal impacts on Apple Health (Medicaid), including background on the federal budget and Apple Health, Medicaid policies, impacts on enrollment, state funding, payment, frequency of eligibility redeterminations, federal work requirements, SDPS and provider taxes, cost sharing requirements, rural health funding, and other provisions. Washington is projected to lose billions in federal funding between 2025-2034. Between 200,000 and 320,000 Washingtonians are projected to lose Medicaid coverage.

Tab 8: Impacts of federal budget on Apple Health (Medicaid) in Washington State

Panel discussion: Federal Impacts

Bianca Frogner facilitated a panel discussion about anticipated federal policy impacts following presentations by:

Kenneth Gardner, Director of Growth & Administration, Health Benefits Trust

Kim Wallace, Medical Administrator, Washington State Department of Labor & Industries (L&I)

David Bonauto, Research Director of Safety and Health Assessment and Research for Prevention (SHARP) program

Panelists described the multiple impacts expected on many aspects of society, the health care delivery system, and particularly on health care staff, patients and clients, hospitals, and immigrants.

Tab 9: Panel Discussion Federal Impacts – Discussion Questions

Wrap up and adjourn

The meeting adjourned at 5:00 p.m.

The next Cost Board meeting is on October 23, 2025. The start time is 2 p.m.

Tab 3

Public comment

Washington State Medical Association statement to the nominating committee:

While RCW 70.390.040(3)(c) requires the WSMA to put forward three nominees for consideration for appointment to the advisory committee, the WSMA submitted a single candidate — John Bramhall, MD, PhD — for consideration at the nominating committee's October 2 meeting. This approach is consistent with how WSMA has filled this seat in the past. Previously, we submitted Dr. Nariman Heshmati as a lone nominee, and the Board approved that selection.

Prior to submitting Dr. Bramhall's nomination, we shared information about this opening at all of WSMA's physician leadership tables during in-person and Zoom meetings, as well as with our 13,500 members via email. Dr. Bramhall was the only member who indicated interest in the position. This was disappointing but not surprising to us given our experience over the past five years — documented in public testimony and written comments — that advisory committee feedback has not been meaningfully incorporated into the broader work of the Board.

The Board's work to address rising health care costs is critically important, and WSMA values having a seat at the table. However, we have polled our members extensively and we only have one interested nominee. Accordingly, WSMA wishes to have this role filled by our past president, Dr. Bramhall, as was the case previously with Dr. Heshmati.

Thank you for your consideration.

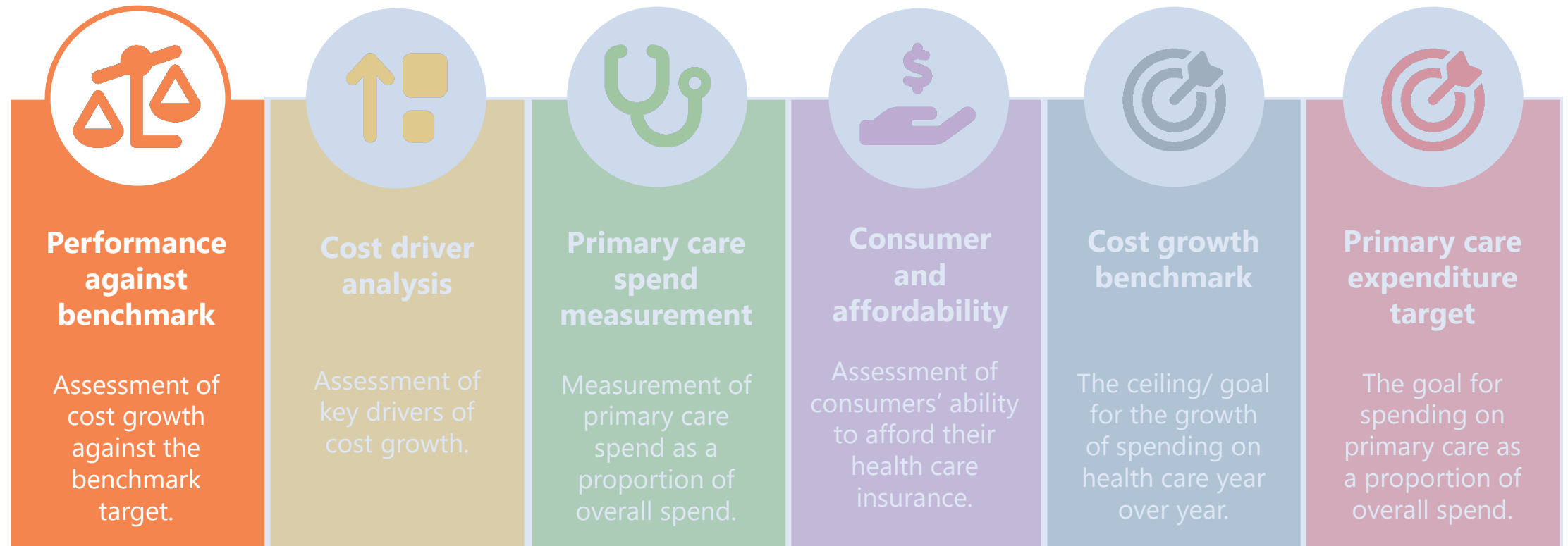
Tab 4

Update from the September 25, 2025 Joint Advisory Committee Meeting

Health Care Cost Transparency Board

October 23, 2025

Cost Board data analysis and goals



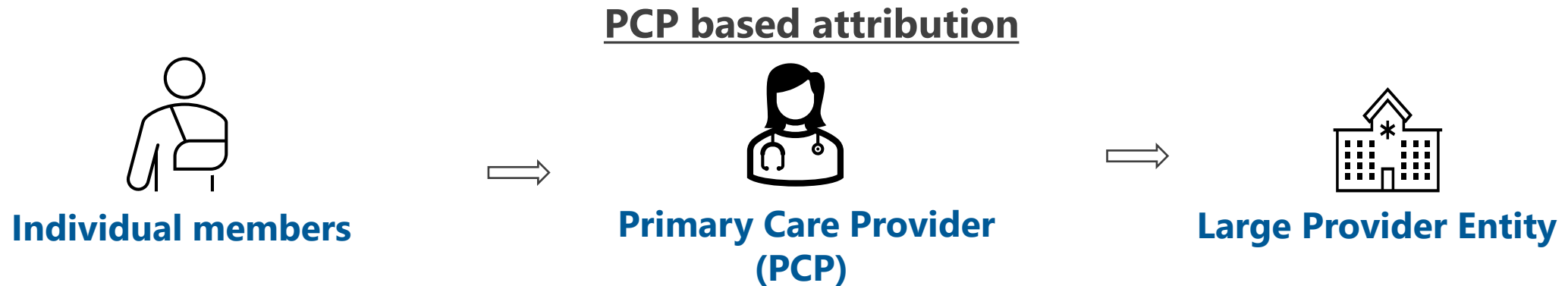
Data call and performance against the benchmark updates

- ▶ Upcoming data call changes
 - ▶ New data ingestion tool
 - ▶ Collection of non-claims primary care expenditures
- ▶ Recalculate the Health Care Cost Growth Benchmark
 - ▶ 70/30 weighting of historic median wage growth and per capita potential gross state product (PGSP) growth
 - ▶ Refresh with updated data

Calendar year	Benchmark value
2022	3.2%
2023	3.2%
2024	3.0%
2025	3.0%
2026	2.8%

Current attribution methodology

- ▶ Purpose is to improve attribution of health care spending to inform policy discussions



- ▶ **PCP attribution is based on the following order:**
 - ▶ PCP selection by member (as required by plan)
 - ▶ Contract arrangement between carrier and provider
 - ▶ Utilization history

Committee feedback

▶ Attribution

- ▶ Provider organizations find it difficult when the carrier methodologies are non-standard and not shared with the provider organizations.
- ▶ Attribution makes sense in the context of value-based payments, but not all hospitalization costs flow from those contracts.

▶ Benchmark

- ▶ Requests for separate benchmark for high-growth subcategories and revised methodology
- ▶ High growth in separate categories may be best addressed by cost driver analysis
- ▶ The purpose of the benchmark is to ensure spending growth is reasonably related to wages. It's in no one's interest for 50k people to go uninsured because they can't afford it

Tab 5

Update from the October 2, 2025 Nominating Committee Meeting

Health Care Cost Transparency Board

October 23, 2025

Oct. 2nd Agenda

- ▶ Review nominations for vacant positions & vote on current nominees:
 - ▶ Primary Care Advisory Committee (1)
 - ▶ Stakeholder Advisory Committee (4)

Primary Care Advisory Committee

Lost 4 members from the committee in the past year:

- ▶ David DiGiuseppe
- ▶ Meg Jones
- ▶ Sarah Stokes
- ▶ Sharon Eloranta

Primary Care Advisory Committee nomination

Candidate's background

- ▶ **Elizabeth Hutchinson, MD**
 - ▶ Primary Care Physician at UWUW Ravenna Primary Care (Jan 2021 – Present)
 - Manage a panel of ~1,250 patients, three days/week
 - Focus on comprehensive primary care to improve outcomes and reduce healthcare costs
 - Special interests: women's health, pediatrics, substance use disorders, mental health, procedures, musculoskeletal medicine.
 - ▶ Physician and Surgeon, Washington State (MD00047330), 06/2004 – present
 - ▶ Diplomate, American Board of Family Medicine, 12/2007
 - ▶ Graduate of University of Washington, Seattle, School of Medicine
 - July 2000 – June 2004

Discussion points & voting

▶ **Motion to recommend**

▶ Strengths:

- ▶ Primary care & behavioral health experience
- ▶ Accolades as a teacher speaks to strong engagement

VOTING

Stakeholder Advisory Committee nominations

# Of members	Committee member position	Nominating Entity	Member resigning from this role
1	One physician, selected from nominees submitted by WSMA	Washington State Medical Association	Dr. Nariman Heshmati, President, WSMA
1	One member representing hospitals and hospital systems, selected from nominees submitted by WSHA	Washington State Hospital Association	Eric Lewis, CFO, Premera Blue Cross

Stakeholder Advisory Committee nominations

One nomination sent to Nominating Committee from **Washington State Medical Association**:

▶ **John Bramhall, MD, PhD**

- ▶ Board certified by the American Board of Anesthesiology. He specialized in the treatment of trauma patients at Harborview Medical Center, where he was also Associate Medical Director. He retired from clinical service there in 2024.
- ▶ Received his PhD in biochemistry from Birmingham in the UK. He came to United States as a Fulbright scholar at UCLA before undertaking postgraduate training at the Max Planck Institutes in Germany and Stanford University.
- ▶ He is a past delegate to the American Society of Anesthesiology and is a trustee of the Washington State Medical Association (WSMA). He is the immediate Past President of WSMA and currently Chair of the WSMA Executive Committee.

The Nominating Committee members noted Dr. Bramhall's deep background in medicine, strong engagement with WSMA and record of representing physicians and surgeons in Washington state.

WSMA Committee Member Position

- ▶ At the Oct. 2nd meeting, the Nominating Committee recommended that the Cost Board defer voting to give WSMA time to nominate the required 3 nominees.
- ▶ After the Nominating Committee meeting, Jeb Shepard, Director of Policy, WSMA, provided the statement (at right).
- ▶ While RCW 70.390.040(3)(c) requires the WSMA to put forward three nominees for consideration for appointment to the advisory committee, the WSMA submitted a single candidate — John Bramhall, MD, PhD — for consideration at the nominating committee's October 2 meeting. This approach is consistent with how WSMA has filled this seat in the past. Previously, we submitted Dr. Nariman Heshmati as a lone nominee, and the Board approved that selection.
- ▶ Prior to submitting Dr. Bramhall's nomination, we shared information about this opening at all of WSMA's physician leadership tables during in-person and Zoom meetings, as well as with our 13,500 members via email. Dr. Bramhall was the only member who indicated interest in the position. This was disappointing but not surprising to us given our experience over the past five years — documented in public testimony and written comments — that advisory committee feedback has not been meaningfully incorporated into the broader work of the Board.
- ▶ The Board's work to address rising health care costs is critically important, and WSMA values having a seat at the table. However, we have polled our members extensively and we only have one interested nominee. Accordingly, WSMA wishes to have this role filled by our past president, Dr. Bramhall, as was the case previously with Dr. Heshmati. Thank you for your consideration.

VOTING

Stakeholder Advisory Committee nominations

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1	One member representing hospitals and hospital systems, selected from a list of three nominees	Washington State Hospital Association	Eric Lewis, CFO, Premera Blue Cross

Stakeholder Advisory Committee nominations

Select *one* of three nominees from **Washington State Hospital Association**:

- ▶ Jason G. Hotchkiss, CPA
- ▶ Katerina LaMarche, JD
- ▶ Jennifer Brackeen, MHA

WSHA's recommendation was to choose Jason Hotchkiss based on his experience.

Katerina LaMarche, J.D.

- ▶ Currently serving as Policy Director for Washington State Hospital Association (May 2022 – Present)
- ▶ Former Policy Analyst at WAHA (March 2019 – May 2022)
- ▶ Experience working with state officials to improve health care
- ▶ Worked at Social Security Administration (SSA) as an Attorney Advisory (November 2017 – February 2019)
- ▶ Graduated from UW with B.A. in Psychology
- ▶ Pace University School of Law, NY

The Nominating Committee Recommends Katerina LaMarche, JD citing her broad background & proven commitment to policy work.

VOTING

Nominating Committee

- ▶ Nominating Committee members recommended process improvements regarding the information they are provided about nominees and committee needs.
- ▶ The committee has an outgoing member and an upcoming vacancy.

Appendices

Jason G. Hotchkiss, CPA

- ▶ Chief Financial Officer at Great Falls Clinic Hospital in Great Falls, MT (January 2025 – Present)
- ▶ Former Chief Financial Officer of MultiCare Health Systems, Tacoma WA (April 2019 – March 2024)
- ▶ Experience working at 388 bed tertiary hospital located in Spokane WA (April 2019 – October 2022)
- ▶ Graduated from Western Washington University, B.A. Business

*(CV in appendix)**

Jennifer Brackeen, MHA

- ▶ Currently Senior Director, Government Affairs at WSHA (April 2025 – Present)
- ▶ Former Director of Innovation at Summit Pacific Medical Center (July 2019 – April 2025) with experience directing population health, advocacy, care management, and value-based contracts
- ▶ Worked at CHOICE Regional Health Network in a manager and director role for nearly seven years
- ▶ Graduated from University of Washington with Masters in Health Administration

*(CV in appendix)**

Tab 6

Primary Care Advisory Committee Report Out

Improvements in Measuring Primary Care Spend

- ▶ In 2023, a new standard definition of primary care spending was adopted
 - ▶ Based on service type, provider type, care setting
 - ▶ Includes non-claims payments like capitation and performance incentives
- ▶ First used in 2024 reporting
- ▶ Enhances:
 - ▶ Accuracy
 - ▶ Accountability
 - ▶ Alignment with health system transformation

Claims-based Definition

▶ Services (what)

- ▶ New patient visits
- ▶ Preventive visits
- ▶ Treatment visits
- ▶ Contraceptive care
- ▶ Routine and developmental screenings



▶ Providers (by whom)

- ▶ Pediatricians
- ▶ Family medicine physicians
- ▶ Internal medicine physicians specializing in geriatric or adolescent medicine
- ▶ Physician assistants, nurse practitioners, and clinical nurse specialists specializing in pediatrics, gerontology, adult health, women's health, and more



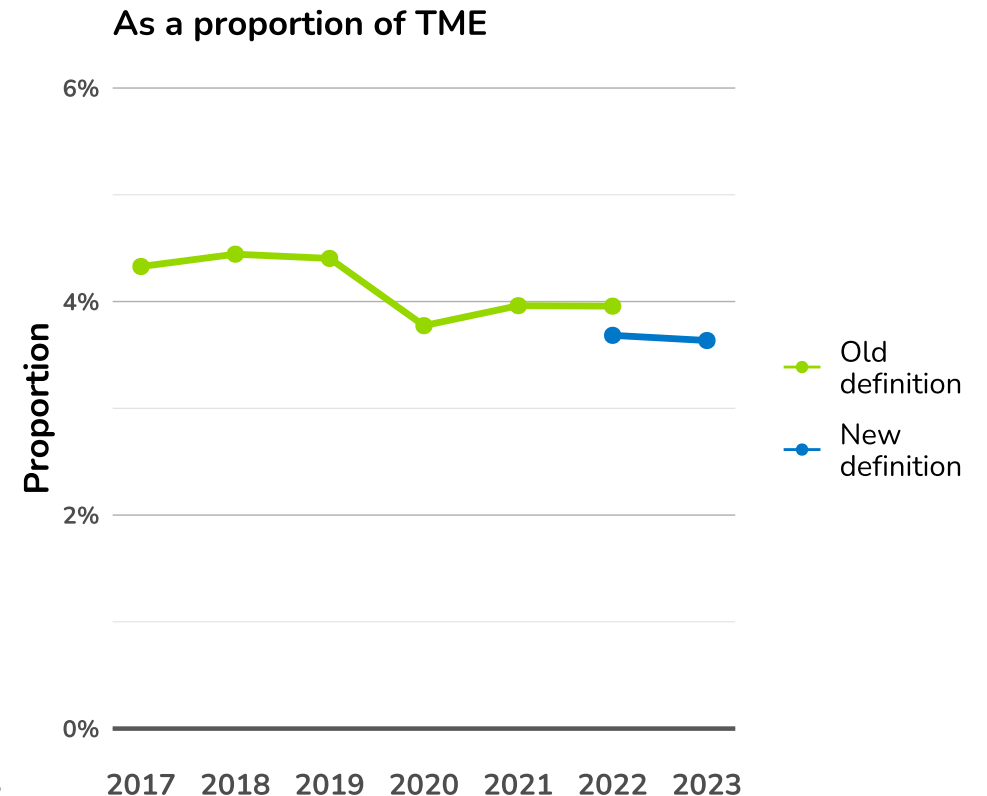
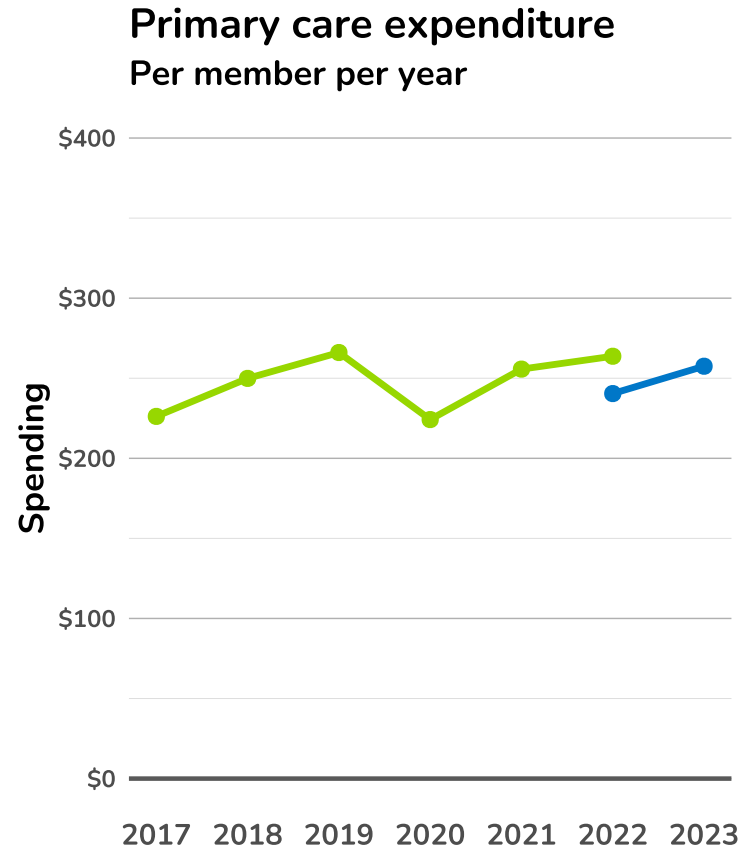
▶ Locations (where)

- ▶ Schools
- ▶ Outpatient offices
- ▶ Telehealth
- ▶ Tribal and Indian Health Service facilities
- ▶ Federally Qualified Health Centers (FQHCs)

Results

Primary care expenditures

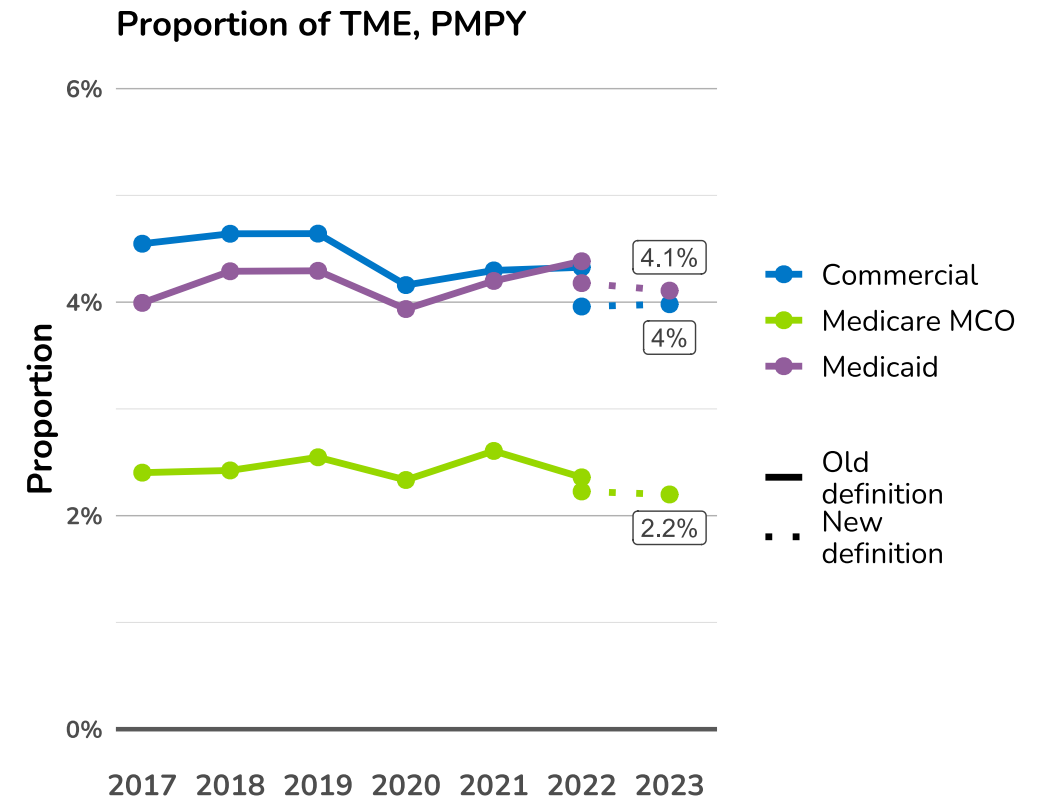
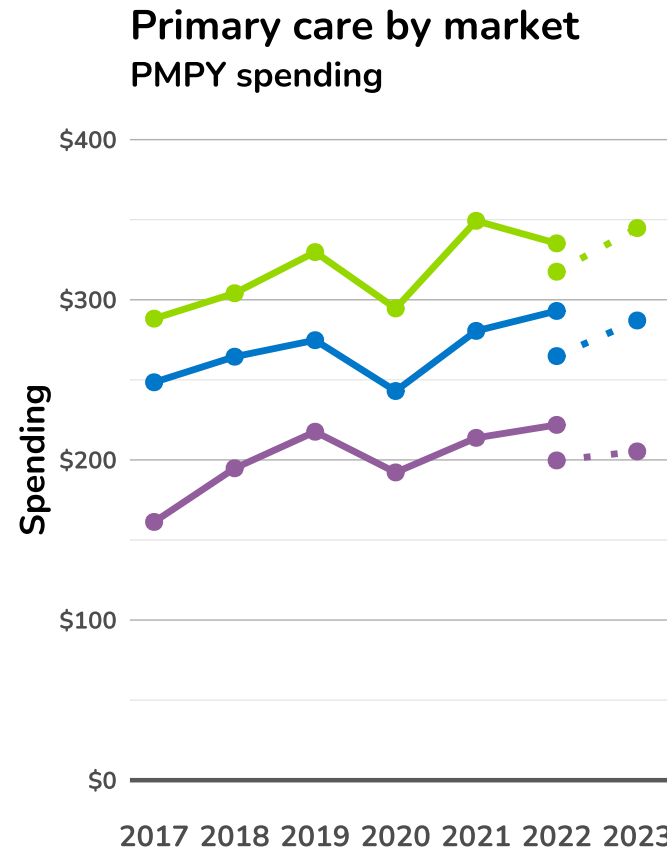
- ▶ Per capita primary care spending has rebounded in the post-pandemic period, but has stagnated as a proportion of total market expenditure (TME)
- ▶ The implementation of the new, **narrower** definition of primary care is observed as a drop in the blue line, including re-reported data from 2022



*Excludes Medicare FFS

Primary care expenditures by market

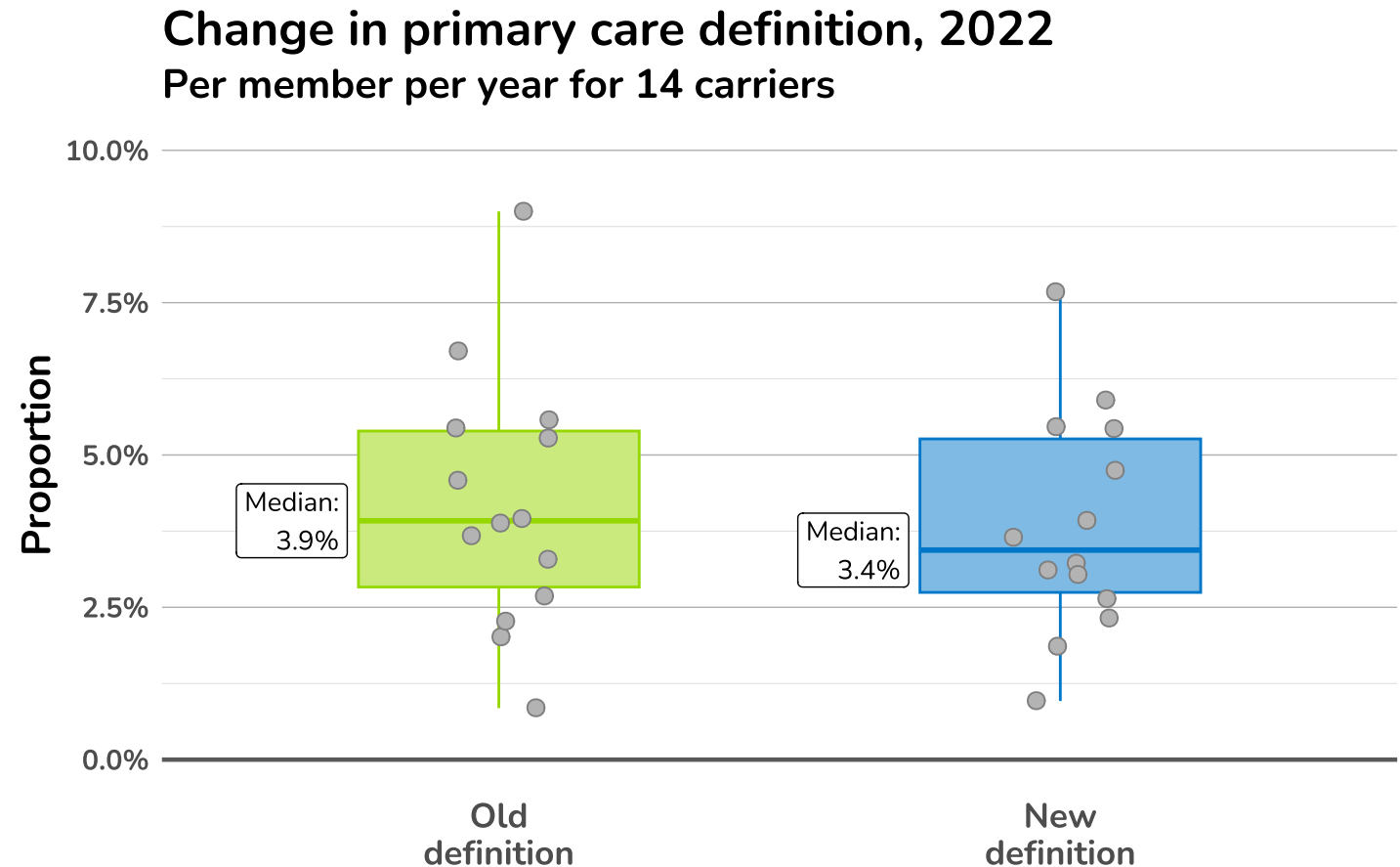
- ▶ Per capita primary care spending is highest in the Medicare managed care population across all years, followed by Commercial and Medicaid
- ▶ In 2023, primary care as a proportion of TME is highest in Medicaid
- ▶ Medicare managed care PC spending is the smallest proportion due to higher costs of care (hospital & Rx) for an older population



*Excludes Medicare FFS

Primary care expenditures by carriers

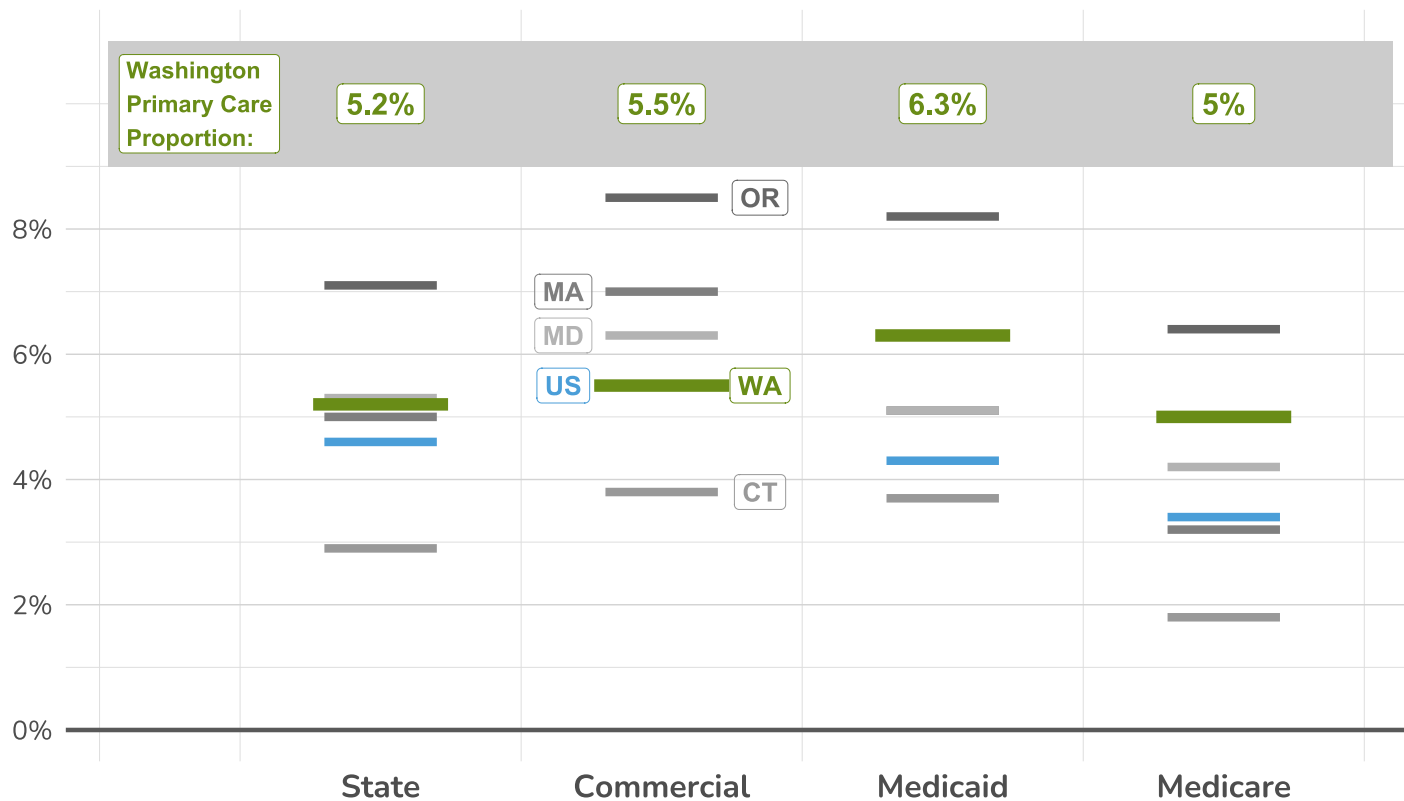
- ▶ Comparing 2022 primary care expenditure across 14 carriers (including Medicaid FFS), the new definition yields both a lower median and a tighter range of TME proportions



Primary care expenditure in other states

2022 Primary care spending, proportion of TME

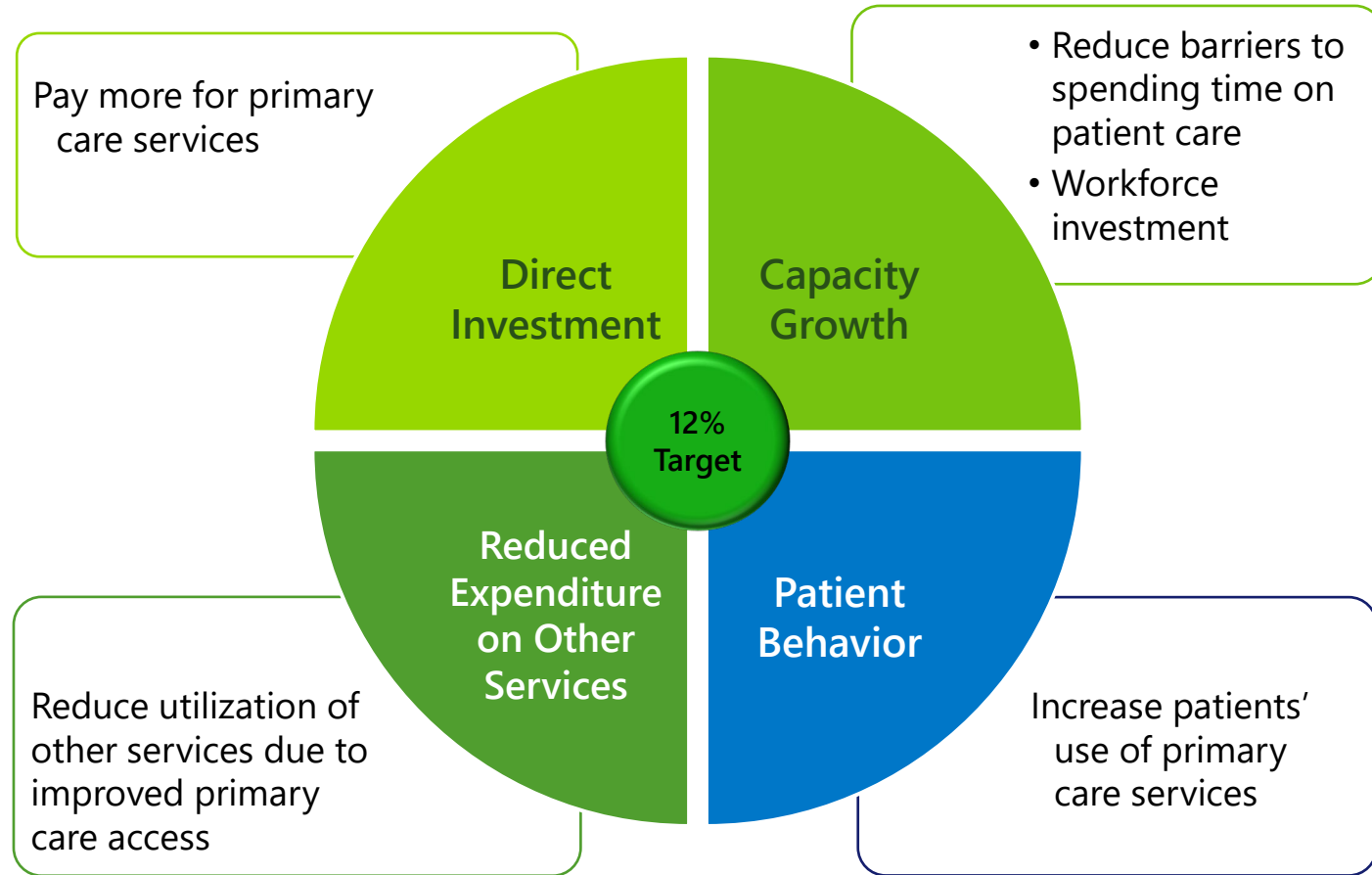
Washington with national and state data



- ▶ Based on the National Academy of Science, Engineering and Medicine (NASEM) narrow definition
- ▶ The trends across markets are directionally the same for WA

Primary Care Advisory Committee Policy Recommendations to the Cost Board

Four key areas used to evaluate primary care expenditures



Primary Care Advisory Committee Recommendations

1. Increase Primary Care Spending by 1% Annually

Cost Board consider recommendations to require public reporting of primary care expenditure ratios for all carriers.

Increasing primary care redistribution

2. Increase Medicaid Reimbursement

Committee continues to recommend the Cost Board consider recommendations to raise Medicaid primary care reimbursement to at *least* Medicare levels. Committee also recommends Cost Board consider recommendation to revise fee schedules to align with updated primary care definition.

Maintain current reimbursement levels for services already at or above Medicare rates

Primary Care Advisory Committee Strategic Endorsement of Ongoing Efforts

3. Patient Engagement (*Prioritized for 2025*)

The Committee endorses:

- 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
- Agency-led efforts to incentivize patient engagement and utilization of primary care

4. Multi-Payer Alignment

The Committee endorses:

- 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

5. Workforce Development

Endorses Health Workforce Council recommendations to expand primary care access.

6. Alternative Payment Models (APMs)

The Committee endorses:

- 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

7. Measurement Strategy

Ongoing agency and HCPLAN 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.

Vote on Primary Care Committee Recommendations for Legislative Report

Cost Board Legislative Report will reflect Primary Care Advisory Committee's recommendations and Cost Board will continue to support work of Primary Care Advisory Committee.

Questions?

Proposed changes?

Vote

Health Care Cost Transparency Board meeting

**We are currently on a short
break**

Tab 7

SB 5387 - Corporate Practice of Health Care

EFFORTS TO MODERNIZE CORPORATE PRACTICE OF MEDICINE LAWS
IN WASHINGTON

CPOM Landscape

- Washington's CPOM doctrine has primarily been established through decades-old case law.
- The health care market in Washington has become more consolidated and corporatized, leading to new concerns about the corporate structure of provider organizations impacting clinical decision making.
- Heard from other states about private equity investment creating disruptions in access and lowering the quality of care.
- Beginning to see more private equity entrants into the Washington market, as well as further horizontal and vertical corporate consolidation.

2025 Legislation – Primary Goals

- Codify existing CPOM case law standards.
- Modernize CPOM statute to ensure clinical decision making is free from interference within new corporate structures.
- Ensure patient care is not dictated by non-clinicians.
- Align corporate structure requirements to maintain provider autonomy.
- Rebuild trust among patients that their providers are operating without corporate interference.
- Provide agencies with the ability to investigate and enforce CPOM laws.

2025 Legislation – Bill Progress

- Started with NASHP Model Law.
- Worked with relevant agencies to align with existing state framework before introduction.
- Gathered support from agencies, consumer advocates, health care unions, and individual providers.
- Collected feedback from provider groups, hospital association, telemedicine companies, insurance carriers, and others.
- Addressed some of the concerns raised by the opponents in two subsequent substitute bills.
- Passed out of Senate policy and fiscal committees, but did not advance out of Rules Committee.

2025 Legislation - Challenges

- Identifying health care providers to include, given previous court decisions are not clearly consistent.
- Ensuring accountability for all parties involved in violating CPOM, including through corporate oversight and provider licensure.
- Applying CPOM principles to the relationship between providers and facilities, which have not previously considered themselves subject to CPOM laws.
- Navigating the realities of the current market without undermining CPOM, including the participation of private equity in the health care market and the prevalence of telemedicine companies.
- Providing agencies with appropriate resources to enforce CPOM, while facing state budget deficit.

Preparing for 2026 Session

- Planning to continue legislative efforts through SB 5387 - currently in Senate Rules Committee
- Evaluating recent successful efforts in peer states to modernize CPOM laws, especially Oregon.
- Continuing to seek feedback and suggestions from stakeholders:
 - Considering language that would focus on the practice of physicians and nurses.
 - Considering whistleblower protections for those reporting CPOM violations.
 - Considering request to ban non-competes for health care providers.
 - Considering request for more corporate structure flexibility.
 - Considering request for further enumeration of allowed corporate services.

Tab 8

The Corporate Practice of Medicine

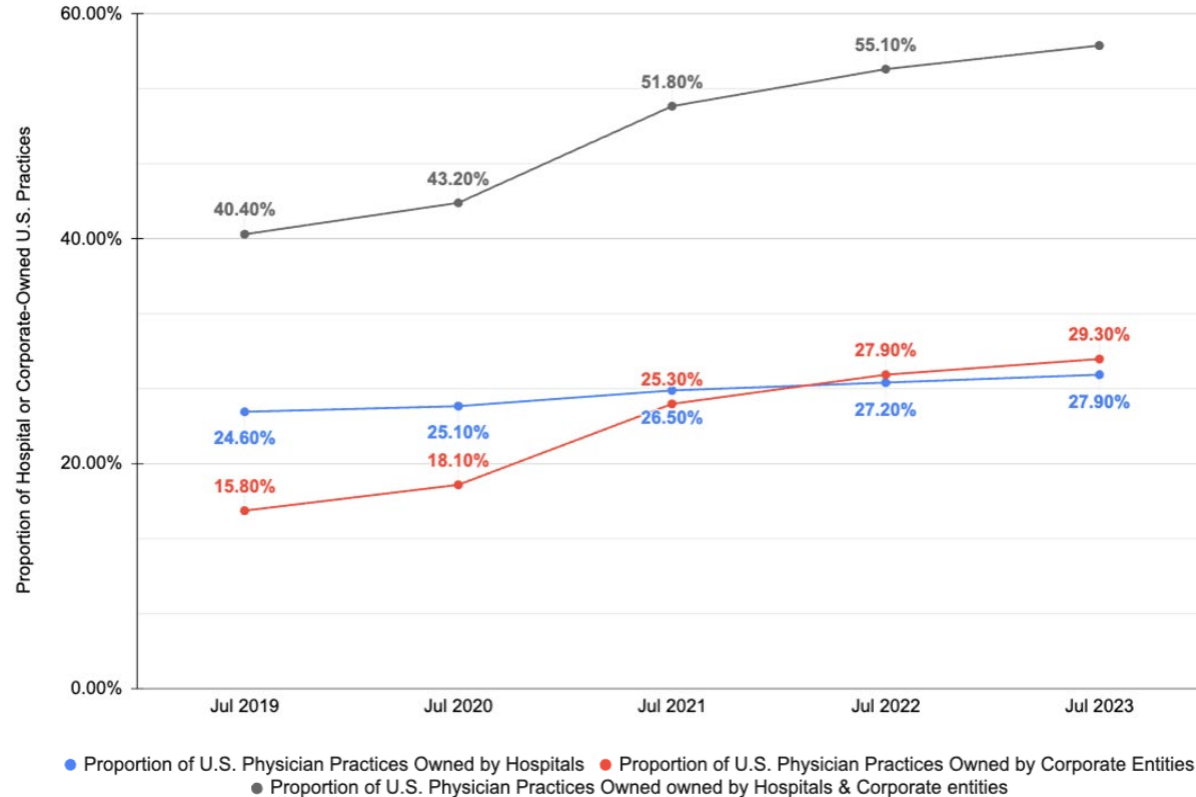
Washington State Cost Board

October 23, 2025

Hayden Rooke- Ley, JD

The opinions and conclusions expressed in this testimony are the author's alone and do not reflect those of Brown University, the Brown University School of Public Health, or any of the research sponsors.

Corporatization of Physician Practices



- The majority of physician practices are **owned** by hospitals or corporate entities (private equity, insurance companies, retailers)
- Corporate acquisition is growing
- Few physicians remain in independent practice
- 77.6% percent of physicians are **employed** by hospitals or corporate entities as of 2024

Corporate Ownership of Physician Practices in Oregon

- **UnitedHealth Group - Optum**
 - Oregon Medical Group
 - Corvallis Clinic
- **Amazon One Medical**
- **McKesson - US Oncology**
 - Willamette Valley Cancer Institute
 - Compass Oncology
- **Private Equity**
 - United Derm Partners
 - Sound Physicians
 - Summit Health

Oregon health officials give emergency OK to Corvallis Clinic's acquisition by insurance giant UnitedHealth Group

Updated: Mar. 14, 2024, 1:01 p.m. | Published: Mar. 14, 2024, 12:33 p.m.

Bend Memorial Clinic Formalizes Partnership, Takes New Name: Summit Medical Group Oregon - Bend Memorial Clinic

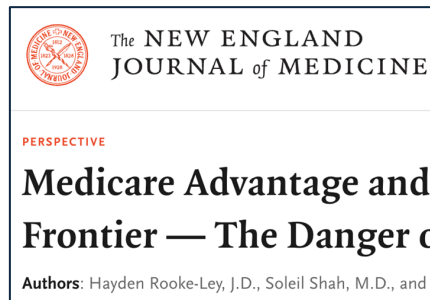
Corporatization, Policy Concerns, and CPOM

Policy Concerns

- Erosion of professional autonomy, morale, and trust
- Disruption in the physician - patient relationship
- Pressure to put profits over patients

Policy Response

State corporate practice of medicine laws (CPOM): bans unlicensed lay entities from owning, employing, or controlling medical



The Corporate Practice of Medicine Doctrine

The Corporate Practice of Medicine (CPOM) doctrine generally bans unlicensed lay entities from owning, employing, or controlling medical practices

- CPOM ban dates back to the 1800s; rooted in concerns about the commercialization of medicine and the tension between business interest and the ethical obligations of practicing medicine
- Stems from the prohibition on the unlicensed practice of medicine.
- Source of CPOM includes state statutes, common law, administrative actions (AG or Medical Board opinions)
- In Oregon - *Sisemore* case (1947) established CPOM for dentists, still “on the books”



The NEW ENGLAND JOURNAL of MEDICINE

Perspective
SEPTEMBER 14, 2023

A Doctrine in Name Only — Strengthening Prohibitions against the Corporate Practice of Medicine

Jane M. Zhu, M.D., M.P.P., M.S.H.P., Hayden Rooke-Ley, J.D., and Erin Fuse Brown, J.D., M.P.H.

In the late 1800s, corporations began hiring U.S. physicians and profiting directly from their services without being bound by professional ethics considerations. Concerned about this

commercialization of medicine, and potentially to avoid competition and tighter government regulation, the American Medical Association revised its Principles of Medical Ethics, condemning as “unprofessional” any contractual arrangement that interfered with physician practice. States soon followed by adopting the corporate-practice-of-medicine (CPOM) doctrine, which generally bars unlicensed lay entities from owning or controlling medical practices. Today, rapid corporatization of health care raises new questions about the usefulness of the CPOM doctrine: Why, despite the existence of CPOM laws in many states, has the corporate land grab

in health care continued? And how can the CPOM doctrine be strengthened to protect both the medical profession and the public interest?

Although corporate ownership of physician practices is neither new nor inherently problematic, the scope of these arrangements in health care and the recent pace of acquisitions have generated attention among medical professionals, policymakers, and the public. Almost three quarters of physicians in the United States are now salaried employees, with half of all physician practices owned by a hospital or corporate entity.¹ UnitedHealth Group is the country’s largest physician em-

ployer, with 70,000 salaried or affiliated physicians, and retailers such as Amazon, CVS, and Walgreens have spent billions of dollars expanding their primary care footprint in nearly every state. Private-equity investors have reached penetration rates of more than 30% in certain local markets.² Today’s corporate investors wield greater market power and pursue more aggressive revenue models than health maintenance organizations of the past; as a result of highly leveraged and multilayered deal structures, they also tend to be more insulated from risk. Such investors provide notable benefits for practices: in an increasingly complex clinical practice environment, corporate ownership may afford much-needed capital investments, greater financial stability, improved operational efficiency and capacity, responsiveness to the implementation of alternative

N. ENGL. J. MED. 388:11 NEJM.ORG SEPTEMBER 14, 2023

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Weakening of CPOM in Recent Decades

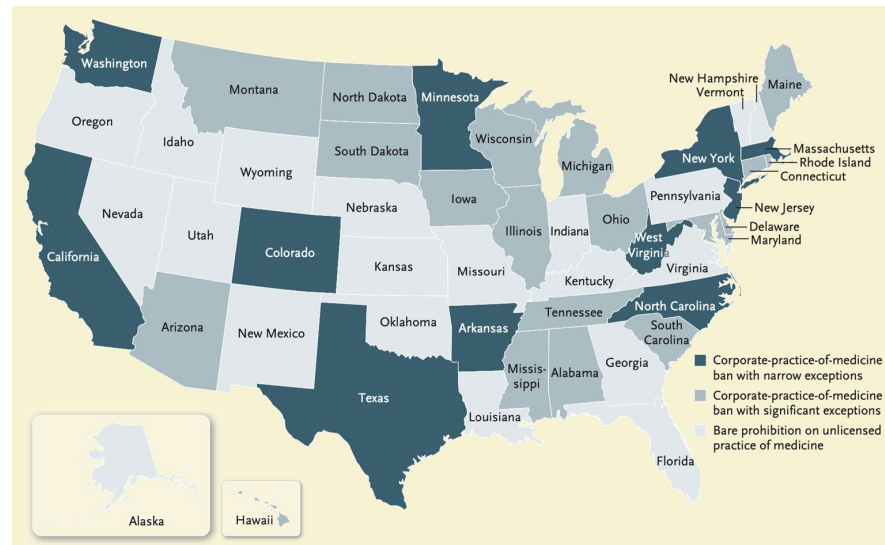
→ States began to weaken the CPOM ban beginning in the 1970s, coinciding with the “managed care” revolution

→ **Express exemptions for certain types of providers**

- E.g., health maintenance organization (HMOs) and hospitals
- **OR: hospitals and facilities exempt in AG advisory opinion (1975)**

→ **Physician ownership of corporate structures relaxed**

- ◆ Variation across Professional Corporations (PCs), Limited Liability Companies (LLCs) and Partnerships (LLPs)
- **OR: PCs required to be majority owned by clinicians**

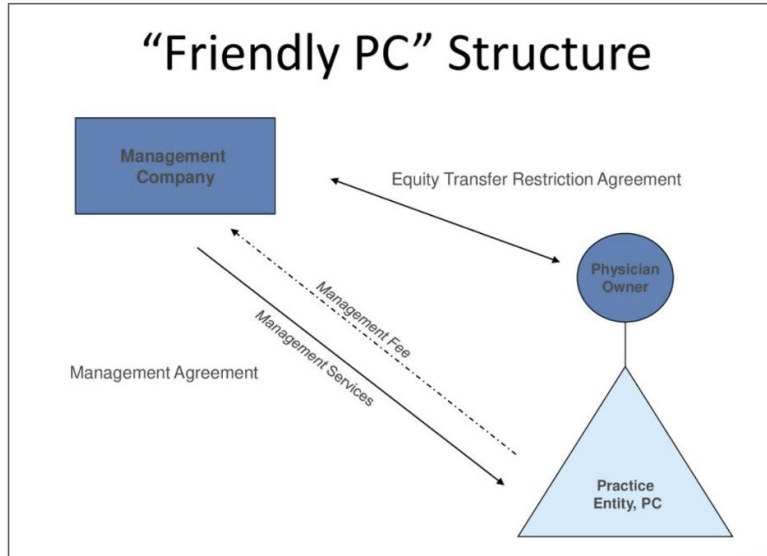


Corporations began to “contract around” CPOM bans to exert *de facto* control over a medical practice they did not formally own

Corporate Control Via Management Services Org. (MSO)

MSO Model : Corporate - owned management services organization (MSO) contracts to run the PC

Friendly PC Model : MSO installs “friendly physician” to run, and often to exclusively own, the PC



American Health Law Association Presentation (2017)

Ways in which corporate MSO exerts control

- Stock restriction agreements, non-competes, gag clauses;
- Hiring/firing physicians and clinical staff, compensation, terms of employment;
- Setting work schedules and staffing levels;
- Dictating patient volume, visit length, diagnostic codes;
- Establishing clinical standards and protocols;
- Billing and collection policies; and
- Controlling payer contracting.

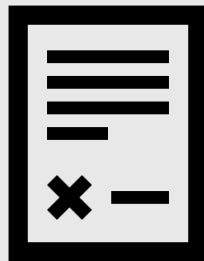
Why CPOM Legislation May Be Helpful



Codify Guidance and Case Law

Clarify the scope of CPOM

- Who does it apply to?
- Who may own or control medical practices?



Address Contractual Workarounds

Clarify conduct and contract terms by MSOs (e.g., friendly physicians, contractual controls) that implicate CPOM

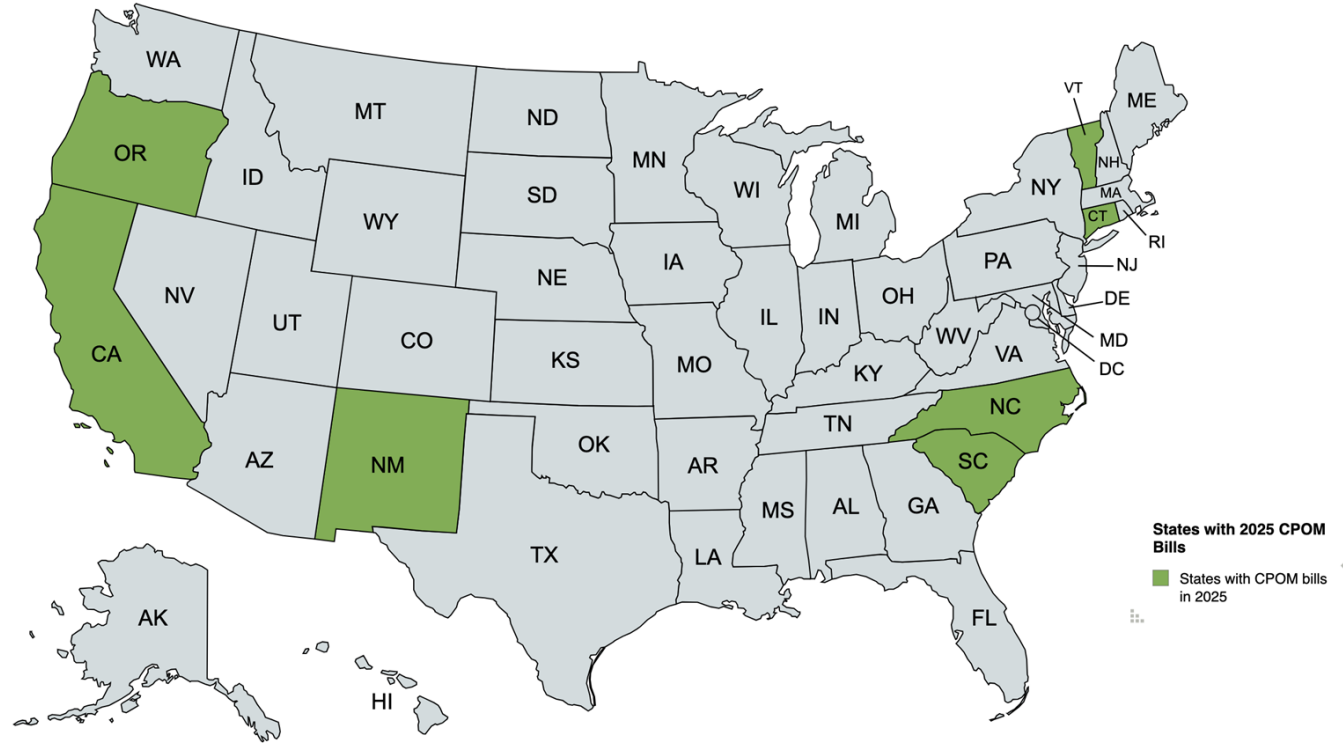


Improve Enforcement

Allow private enforcement by employees or competitors to function as private attorneys general

State CPOM bills introduced in 2025

1. CA: SB 351
2. CT: SB 261, HB 6570
3. NC: SB 570
4. NM: SB 450, HB 552
5. OR: SB 951
6. SC: S 46
7. VT: H 71



Oregon's SB 951

Regulates Friendly PC/MSO structure (does not ban MSOs)

Per se prohibitions on MSOs doing the following:

- Majority ownership in the medical practice
- Stock transfer restriction agreements
- Non-competes and gag clauses (applies to MSOs and hospitals)

De facto control: MSOs may not exercise ultimate decision making authority over activities that affect clinical decisions or care quality, including but not limited to:

- Personnel decisions, work schedules, time with patients
- Diagnostic coding decisions, clinical standards
- Billing and collection policies, price setting, payer contract negotiation

Enforcement

Private enforcement (by aggrieved employee or competitor)



School *of*
Public Health

BROWN UNIVERSITY

Tab 9

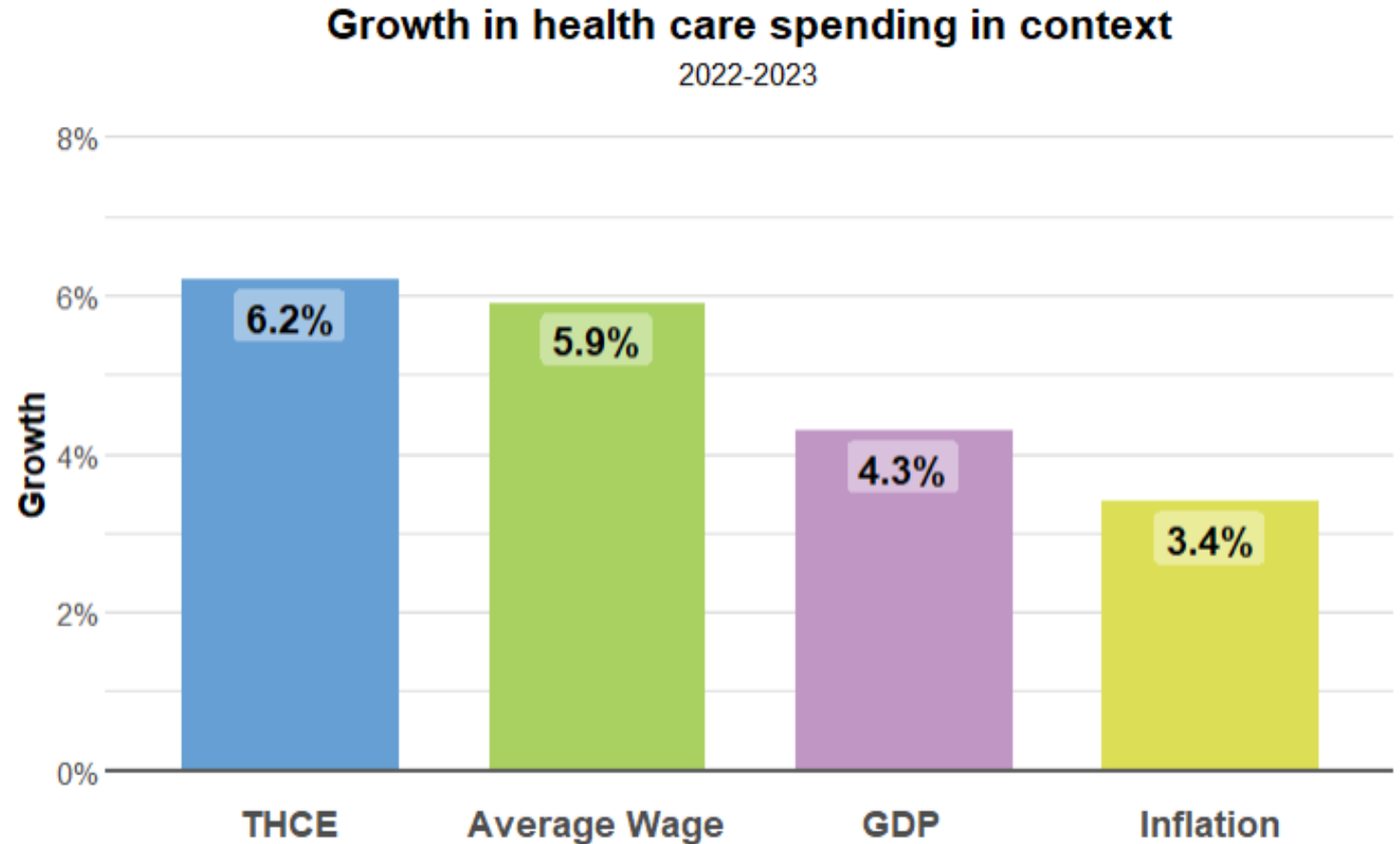
Overview of the Cost Board's 2025 Draft Legislative Report

Health Care Cost Transparency Board

October 23, 2025

Context for the report

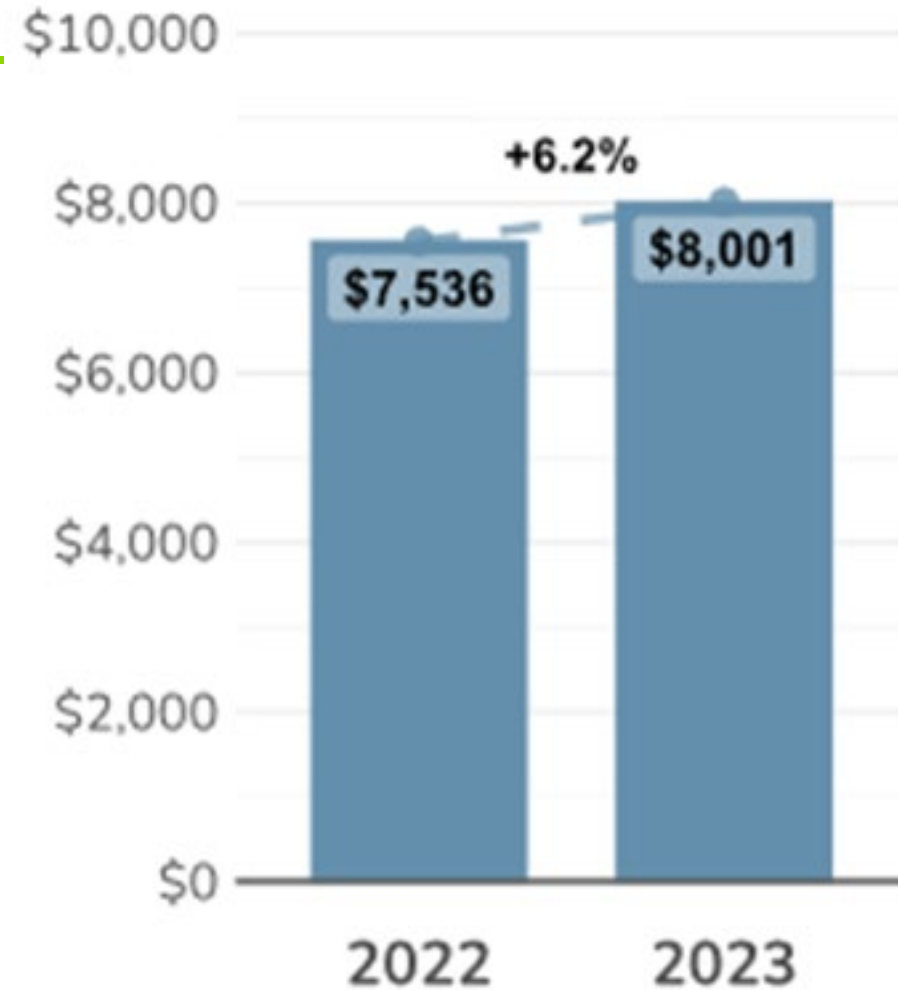
- ▶ WA's health care expenditures have grown faster than:
 - ▶ The cost growth benchmark
 - ▶ Wages
 - ▶ State's economic growth
 - ▶ Inflation



Source: 2025 data call, Employment Security Department¹, Bureau of Labor Statistics², Bureau of Economic Analysis³

For the
second
year...

Total health care expenditure
Per person per year



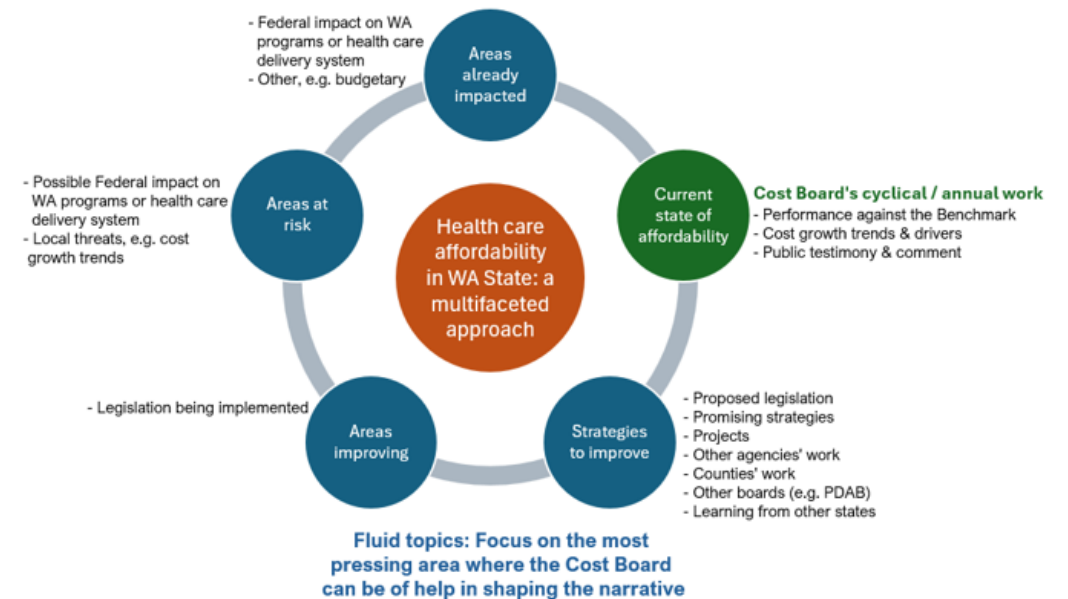
Additional Context

- ▶ Increasing health care spending is a national problem
- ▶ Health care continues to be unaffordable for many Washingtonians
- ▶ Federal policies will negatively impact affordability in WA
- ▶ Low-income households, already in a precarious financial situation, will be among the most impacted

The Cost Board's role

- ▶ Continue to monitor impacts & remain open to creative & emerging strategies to address them
- ▶ Ensure the state does not lose sight of the affordability challenges as attention is drawn to responding to major Medicaid and Individual Market changes
- ▶ **The Cost Board's mission remains as important as ever!**

The Cost Board's Areas of Focus

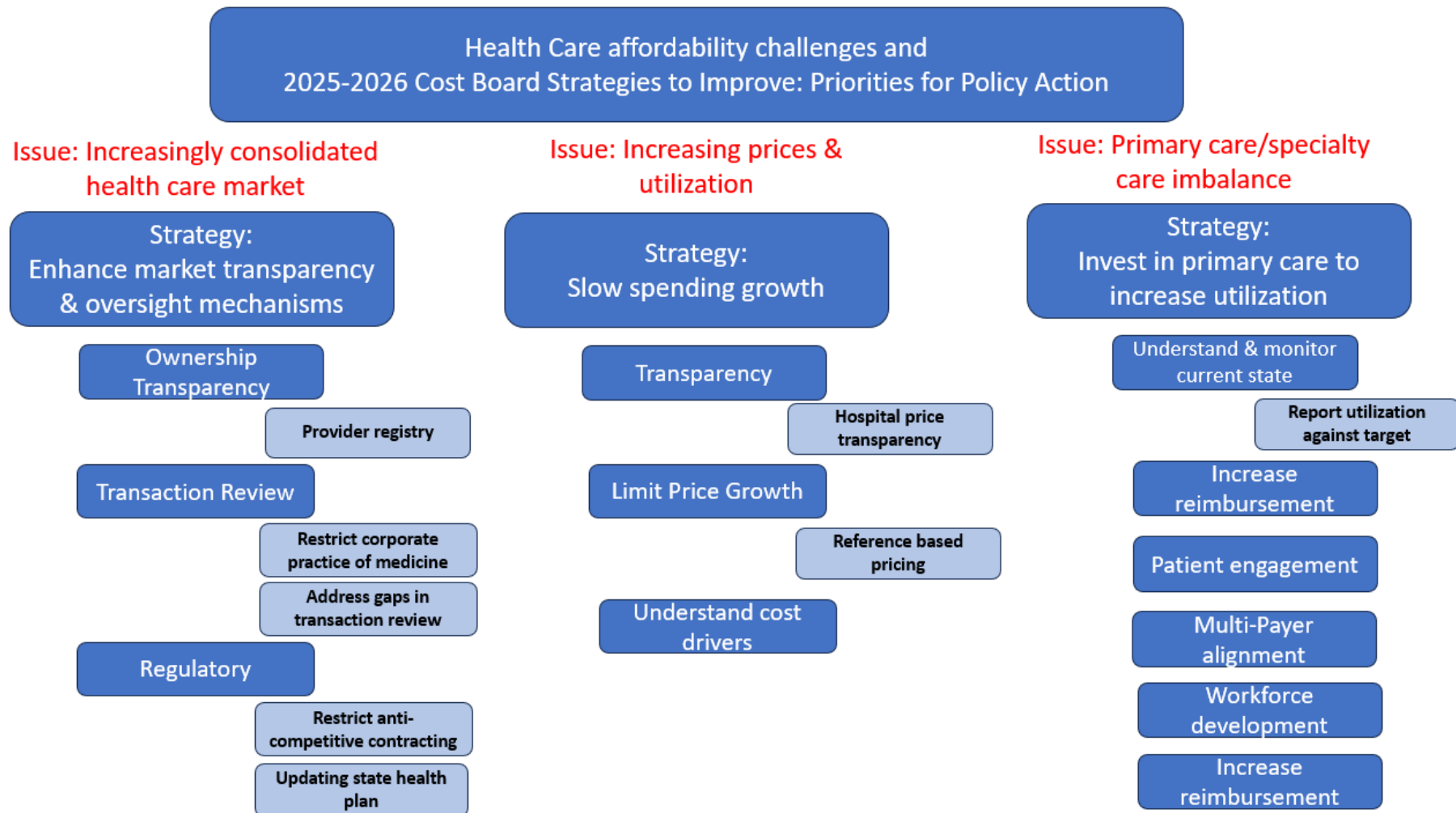


Looking ahead to 2026

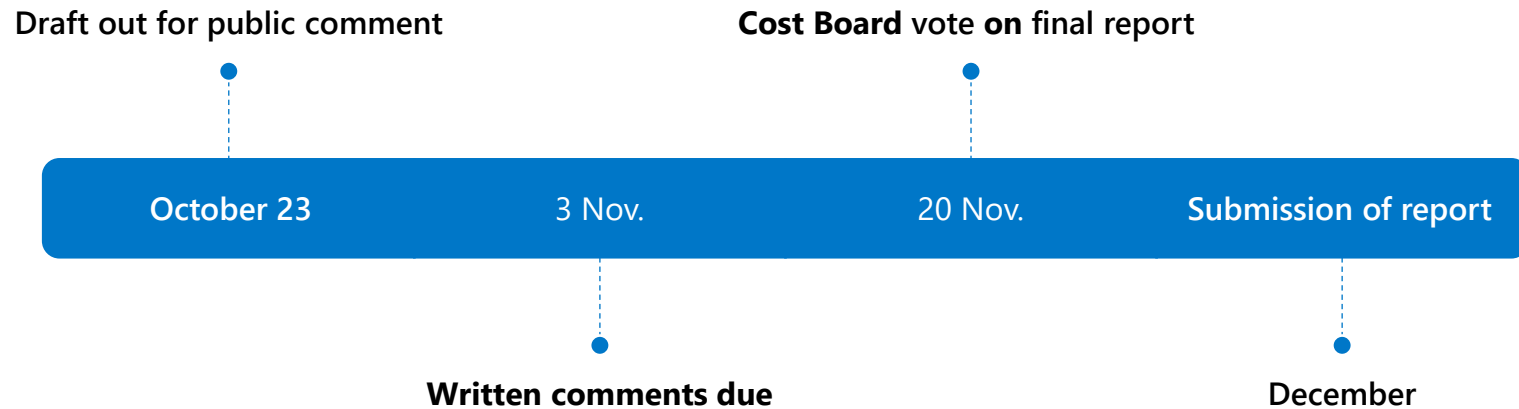
The Cost Board:

- ▶ Continues key data monitoring efforts
- ▶ Continues to support key affordability concepts to tackle priority policy areas originally identified in 2024
 - ▶ Enhancing **market transparency and oversight** to balance an increasingly consolidated market
 - ▶ Improving affordability by **slowing spending growth**
 - ▶ Increasing utilization of **primary care**

Health Care Affordability Challenges and 2025-2026 Cost Board Strategies to Improve: Priorities for Policy Action



Timeline & Next Steps



Tab 10

Calendar of Board & Advisory Committee Meetings 2026

Health Care Cost Transparency Board

Date	Time
January 28	2-5pm
March 25	2-5pm
May 28	2-5pm
July 22	2-5pm
September 23	2-5pm
October 28	2-5pm
November 18	2-5pm

Advisory Committee on Primary Care

Date	Time
August 20	2-4pm

Health Care Stakeholder Advisory Committee

Date	Time
February 19	2-4pm
April 23	2-4pm
June 25	2-4pm
August 27	2-4pm
October 8	2-4pm

Advisory Committee on Data Issues

Date	Time
February 19	2-4pm
April 23	2-4pm
June 25	2-4pm
August 27	2-4pm
October 8	2-4pm

Nominating Committee

Date	Time
April 15	TBD
October 1	TBD

Universal Health Care Commission

Date	Time
February 12	2-5pm
April 30	2-5pm
June 18	2-5pm
September 3	2-5pm
October 15	2-5pm
December 10	2-5pm

Finance Technical Advisory Committee

Date	Time
January 15	2-430pm
March 19	2-430pm
May 14	2-430pm
July 16	2-430pm
September 24	2-430pm
November 12	2-430pm

2026 Year-at-a-glance

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27	28	29	30	31		

Thank you for joining us.

Next meeting: Thursday, October 23, 2025

Appendix

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 FIRST DRAFT REPORT



Analysis of health care expenditure trends and recommendations to improve affordability

Acknowledgements

The Cost Board acknowledges and thanks the Health Care Stakeholder Advisory Committee, Data Issues Advisory Committee, Primary Care Advisory Committee, and Nominating Committee for their time, recommendations, and the gift of their expertise over the past year. 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 Oakes, our communications consultant, for making our work legible and accessible.



Washington State Health Care
Authority
626 8th Avenue
Olympia, WA 98501
Phone: [(###) ###-####]
Fax: [(###) ###-####]
<https://www.hca.wa.gov/>

[Organization]
[P.O. Box Address]
[City, State ZIP]
Phone: [(###) ###-####]
Fax: [(###) ###-####]
[www.website.com]

[Organization]
[P.O. Box Address]
[City, State ZIP]
Phone: [(###) ###-####]
Fax: [(###) ###-####]
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Federal changes will negatively impact affordability in Washington state

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Strategies to improve: Prioritizing policy action

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Executive Summary

Washington's health care expenditures have grown faster than the cost growth benchmark (target for growth) as well as the state's wage and economic growth for the second year since measurement began. Washington's upward growth trend aligns with the experience of other states tracking performance against health care cost growth benchmarks. Multiple market factors drive increasing growth including health care cost increases reflected in pharmaceutical and hospital prices, insurance reimbursement rate increases, consolidation of health care organizations, and underutilization of primary care. 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. The impact of these changes will be experienced broadly across the health system and most importantly on 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 creative and emerging 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 as attention is drawn to responding to major Medicaid and Individual Market changes being driven by new federal regulations.

Looking ahead to 2026, the Cost Board continues key data monitoring efforts and is focusing on three policy areas originally identified in 2024 – enhancing market transparency and oversight to balance an increasingly consolidated market, improving affordability by slowing spending growth, and increasing utilization of primary care. Several foundational pieces of legislation aimed at improving affordability were passed in the 2025 session, and several others will continue to be discussed in 2026. The Cost Board continues to support key concepts that tackle these priority policy concepts as described in Table 1 below.

Table 1: Cost Board 2025-2026 Legislative Priorities, Progress, Recommendations

Policy Area	2025 Progress	2026 Recommendations
Market Transparency & Oversight	Provider Registry. The Legislature passed ESSB 1686 that requires the Department of Health (DOH), in collaboration with HCA, to develop a plan and recommendations on creation of an interactive provider registry that documents the providers and facilities offering health care services in Washington. Intent is to understand the business structure and funding sources of health care entities operating in Washington. Covers licensed and unlicensed facilities, providers, provider groups, systems, carriers, and benefit managers. State Health Plan. The Legislature passed SSB 5568 that will refresh	1. Continue support and development of policy recommendations and legislation that expands the state's transaction review and oversight authority. 2. Continue support and development of policy recommendations and legislation regarding corporate practice of medicine to address commercialization and profit-seeking associated with corporate and private equity ownership.

	Washington’s State Health Plan (SHP), which was last updated in 1987. 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. 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 and provides the methodologies the CN program uses to determine the number of health care facilities that are needed throughout the state. Primary Care Spend Reporting. The Legislature passed SB 5084 that allows the Office of the Insurance Commissioner (OIC) to require health carriers to annually report primary care expenditures in previous calendar years, or anticipated expenditures for upcoming calendar years. OIC to determine reporting requirements with consideration for the definitions and targets set by the Cost Board.	
Constraining Cost Growth & Price Regulation	Hospital Price Transparency. The Legislature passed SSB 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, SSB 5493 now requires hospitals to submit this information to the Washington State Department of Health at least annually. Reference-Based Pricing. The Legislature passed ESSB 5083 establishing reimbursement limits for hospitals in Washington. Beginning January 1, 2027, this legislation caps	1. Continue to support the implementation of reference-based pricing as a tool to control cost growth. The HCA is developing rules related to legislation passed in 2025 setting the stage for 2027 implementation.

	PEBB/SEBB reimbursement for licensed hospitals in Washington. It also establishes reimbursement floors at 150% of Medicare for Primary Care and Behavioral Health Services.	
Primary Care Utilization	Reference-Based Pricing. The Legislature passed ESSB 5083 establishing reimbursement limits for hospitals in Washington. ESSB 5083 establishes reimbursement floors at 150% of Medicare for Primary Care and Behavioral Health Services to encourage utilization.	The Primary Care Advisory Committee echoed their recommendations from 2024, to achieve targeted 1% annual increase of primary care expenditure: • With ongoing public reporting of primary care expenditure ratios for all carriers (captured in SB 5084, laws of 2025, with monitoring migrating to the OIC in 2026). • The committee expressed interest in mechanisms to hold payers accountable to achieve this target, including potential updates to OIC regulatory authority. • The committee continued to recommend increases in Medicaid reimbursement for primary care services, including exploration of sustainable funding and payment mechanisms. • The committee recommended revisiting mechanisms to increase reimbursement for primary care services, including exploration of sustainable funding and payment mechanisms to support investments.

Health Care Cost Transparency Board 2025 Legislative Report

Introduction

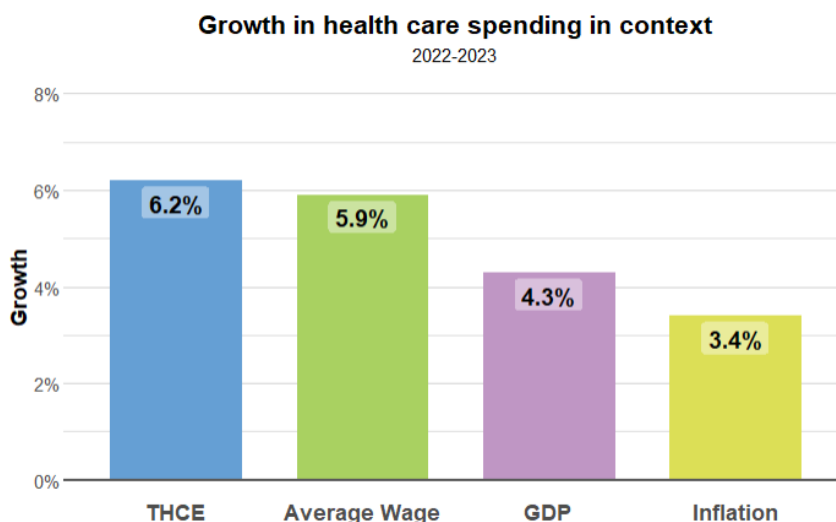
Health Care Expenses Continue to Rise in Washington

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 (THCE) grew **6.2 percent** between 2022 and 2023. This rate of growth is:

- Higher than Washington's 2023 average wage growth (5.9 percent)¹
- Higher than the 2023 rate of inflation (3.4 percent)²
- Higher than 2023 growth in the state's Gross Domestic Product (4.3 percent)³

Figure 1.



Source: 2025 data call, Employment Security Department¹, Bureau of Labor Statistics², Bureau of Economic Analysis³

As spending has increased faster than wages, inflation, and the state's economy 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 percent 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 as well as increases

in reimbursement rates negotiated with health insurers⁷, increases in utilization of medical and surgical services⁷, inflation⁷, and the fallout of an uncompetitive market. The trend toward increasing year-over-year expenditures is projected to continue at an average rate of about 5 percent 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 percent worry about being able to afford their deductible before health insurance begins to pay for care.⁴

Health Care is Unaffordable for Many Washingtonians

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 percent of those surveyed had either delayed care or skipped a recommended treatment⁸. 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 percent of small business owners responding reported that they had been burdened by health care costs, noting difficulties with affording and accessing health insurance (90 percent), taking on medical debt (59 percent), and having a lower credit score because of health care costs (40 percent).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 care⁴. In 2023, 38 percent of Washington households were either financially insecure (10 percent) according to the Federal Poverty Level or experiencing financial hardship, otherwise known as Asset Limited, Income Constrained, Employed (ALICE) (28 percent).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 and for many of these families, health care is prohibitively expensive.^{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% 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, already in a precarious financial situation, 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. In addition, these [federal] policies are likely to destabilize the individual market and fellow state-based marketplaces

including [increasing] premiums, reducing access to health insurance, increasing the number of uninsured and increasing the amount of uncompensated care provided by hospitals.”¹²

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.¹³ ¹⁴ Fourteen health insurance carriers have requested an average rate increase of 21.2 percent for Washington’s 2026 Individual Health Insurance Market and 21 percent has been approved.¹³ ¹⁵ With this increase, Washington’s small business owners and others who purchase their health insurance on the open market through the Exchange will pay more for health insurance than they did in 2025. Three-quarters of Washingtonians qualified for federal premium tax credits and that helped to reduce insurance premiums by on average, \$1,330 a year.¹³ In 2026, individuals are anticipated to pay \$1,548 a year more (calculated from the 21% rate increase) than they did in 2025.¹⁵ Washington’s public option, the Cascade Select Plan, will increase average rates by 26 percent. Rates for The Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) programs will increase by an average of 9.5% and 8.8%, respectively.¹⁶ These increases represent year-over-year changes prior to application of the state’s collectively bargained Employer Medical Contribution (EMC). ¹⁶ PEBB and SEBB employee contributions are calculated as the difference between the plan’s total rate and the EMC. ¹⁶ For this reason, the resulting PEBB and SEBB employee contributions, and the consequent annual change, shouldn’t be directly compared to premium increases in other markets. ¹⁶ The PEBB and SEBB EMC is benchmarked off the self-insured Uniform Medical Plan (UMP) Classic (PEBB) and UMP Achieve 2 (SEBB) and will increase by approximately 8% for both programs from 2025 to 2026. ¹⁶

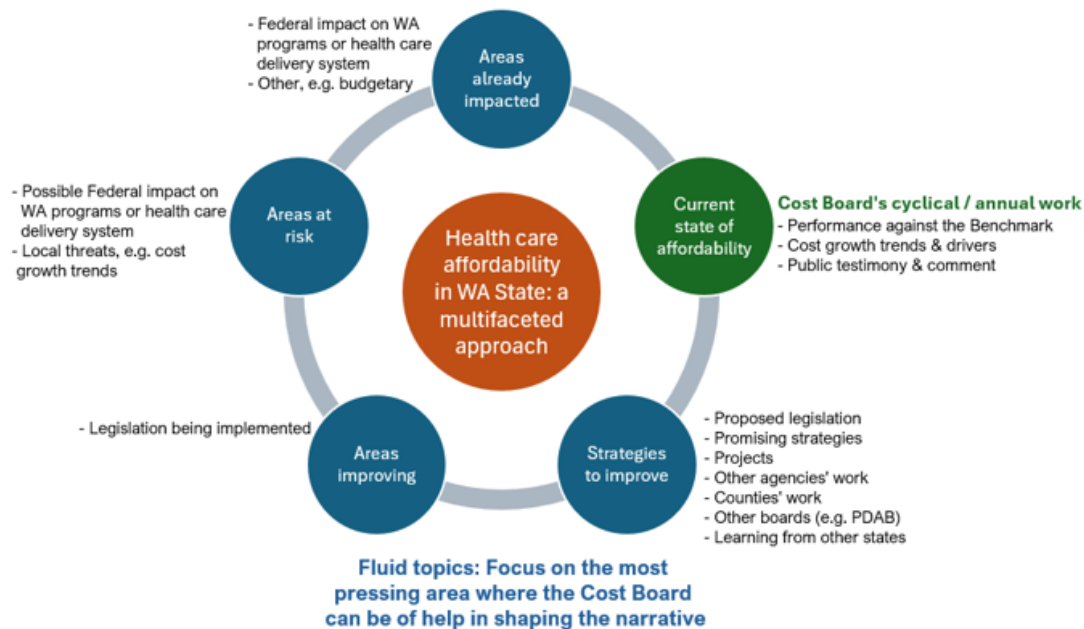
Potential Policy Interventions to Help Slow Health Care Spending Growth

Eighty-seven percent of Washingtonians who responded to the 2024 Washington State Health Care Affordability Survey believe that Washington lawmakers should take action to address health care costs with 41 percent 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. A multifaceted approach is needed. 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

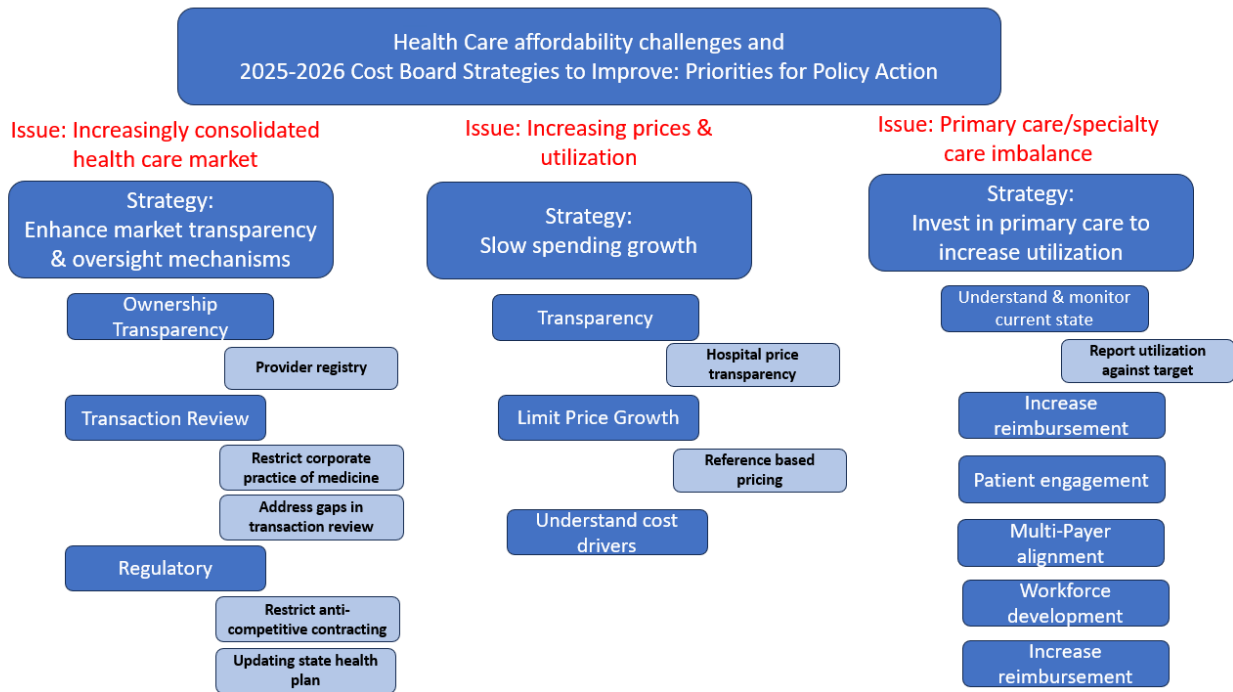


Strategies to Improve: Prioritizing Policy Action

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

1. **Slowing spending growth**
2. **Increasing primary care utilization**
3. **Enhancing market transparency & oversight**

Figure 3: Health Care Affordability Challenges and 2025-2026 Cost Board Strategies to Improve: Priorities for Policy Action



Slowing spending growth

Background & 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.

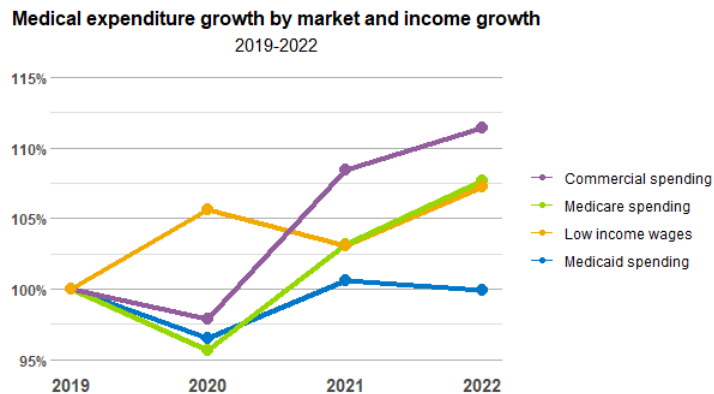
Analysis of the state's health care spending data submitted by commercial and public payers (e.g., insurers) shows that statewide per-member spending increased more than 29 percent from 2017-2023 and totaled \$8,000 in 2023.¹⁷ This represents approximately 28 percent of median annual income per person for a 4-person household.¹⁷ 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 ten Washingtonians report at least one affordability burden in the last year and nearly nine out of ten worrying about affording healthcare in the future⁸. 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 2019-2022¹⁸. 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%¹⁹ (Figure 4). For these Washingtonians, already expensive health care has become less affordable.

Figure 4:

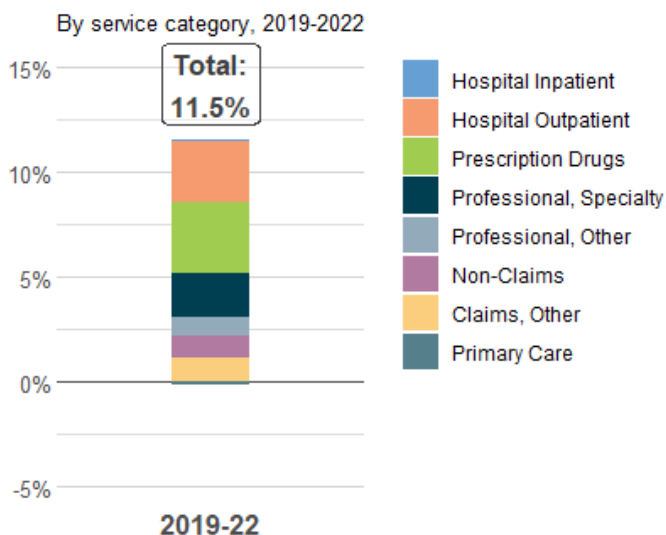


Source: HCCTB data call, Census Bureau¹⁹

Much of this overall spending and spending growth was due to a small number of spending categories: hospital outpatient, hospital inpatient, retail pharmacy, and professional specialty services. 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



Source: HCCTB data call¹⁸

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 Board examined the respective contribution of price per service and service utilization. This work is summarized below for changes in the same time period, between 2019 and 2022.²⁰

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 admittance. 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 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 specialty spending includes spending on services provided in clinical areas other than family practice, geriatrics, internal medicine, or pediatrics. Spending grew more slowly than hospital outpatient and prescription drug categories, 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 affordability²⁰. 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 increasing²¹.

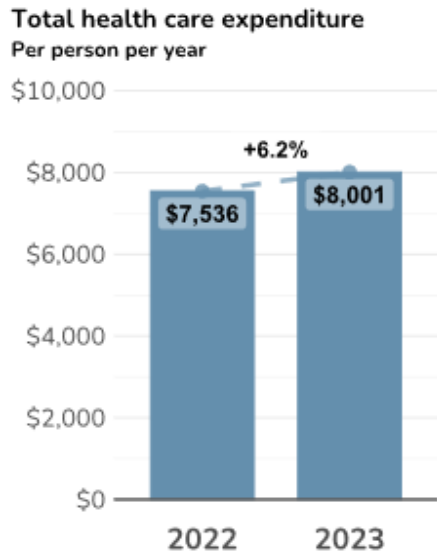
The **Prescription Drug Affordability Board** (PDAB) was created in 2023 and seeks to mitigate unjustified price increases of prescription drugs for Washingtonians. PDAB is tasked with: Identifying drugs that may be subject to an affordability review per the enabling legislation; Conducting affordability 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, the Board may set an upper payment limits starting in 2027. PDAB has created a list of eligible drugs for review and has selected Enbrel, Xtandi, Cabometyx, and Humira as of July 2025. The 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 percent from 2017-2023¹⁷. In 2023—the most recent year for which data is available—per capita total health care expenditures grew by 6.2% (Figure 6)¹⁸. 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 2023⁵. 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.

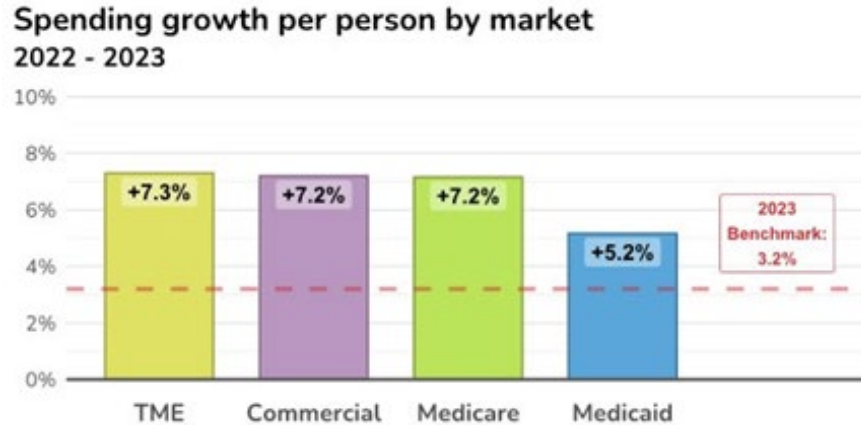
Figure 6:



Source: HCCTB data call¹⁸

Further analysis of 2023 data suggest the market-level and service category trends contributing to this rapid growth. 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 Medicaid¹⁸ (Figure 7).

Figure 7:



Source: HCCTB data call¹⁸

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, but not Commercial and Medicaid market.

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 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 single component of expenditures.²² 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. This initiative was funded by the Peterson Center for Health and the Gates Foundation and performed in collaboration with the Institute for Health Metrics and Evaluation. This analysis shows that broadly, Washington regions that are more rural or have a lower average income show higher utilization of ED services compared to outpatient services.²³ 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 (approximately 3%) of annual inpatient hospital spending, and nearly 100 million in emergency department spending.²³

2025 Progress:

In its [recommendations for 2024](#), the Board recommended the Legislature consider policies that improve hospital price transparency to help patients make informed choices²⁴. 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 agency request legislation to regulate pricing for 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/SEBB makes up about 20 percent of Washington state's commercial market and current spending trends for consumers are unsustainable in the long term²⁵. 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 health²⁶. This law establishes PEBB/SEBB reimbursement limits for hospital services and floors for primary care and non-facility behavioral health services²⁷. 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 percent of Medicare for in-network hospitals and 185 percent of Medicare for out of network hospitals. To increase investment in behavioral health and primary care services, minimum reimbursement for these services are set at 150 percent of Medicare. The reimbursement limits do not apply to non-system critical access hospitals, sole community hospitals, or reimbursement rates for other insurers in the commercial market. 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 the

Office of the Insurance Commissioner and delivered by December 31st 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 website²⁸. Additionally, it requires hospitals to submit this information to the Washington State Department of Health at least annually. This codifies federal transparency requirements into Washington state law, supporting increased transparency to the consumer and improved data access for oversight.

Primary Care Utilization

Background & 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.^{29 30} 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 settings like emergency departments and hospitals.³⁰ 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.³⁰ 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.³⁰ 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 sixty percent working in specialty areas.³¹ 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.^{29 30 32} 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.³²

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.³² Inequities in care exist, with data showing that American Indian/Alaska Native, Black and Hispanic Washingtonians use fewer preventive care visits than White Washingtonians.³² Quality scores for the state are in the bottom 25 percent for preventive services such as access to primary well-child visits and cancer screening.³² Broadly, Washington regions that are more rural or have a lower average income show higher utilization of ED services compared to outpatient services³³. This indicates that the type of care a Washingtonian receives differs based on regional economic and demographic factors—thereby contributing to health inequities.

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 percent of total health care expenditures ([SB 5589](#), 2022). With current primary care performance at 3.7 percent of total medical expenses, the state is far from its target of 12 percent^{18: 34}.

To support the legislative assignment, the Primary Care Advisory Committee was established 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

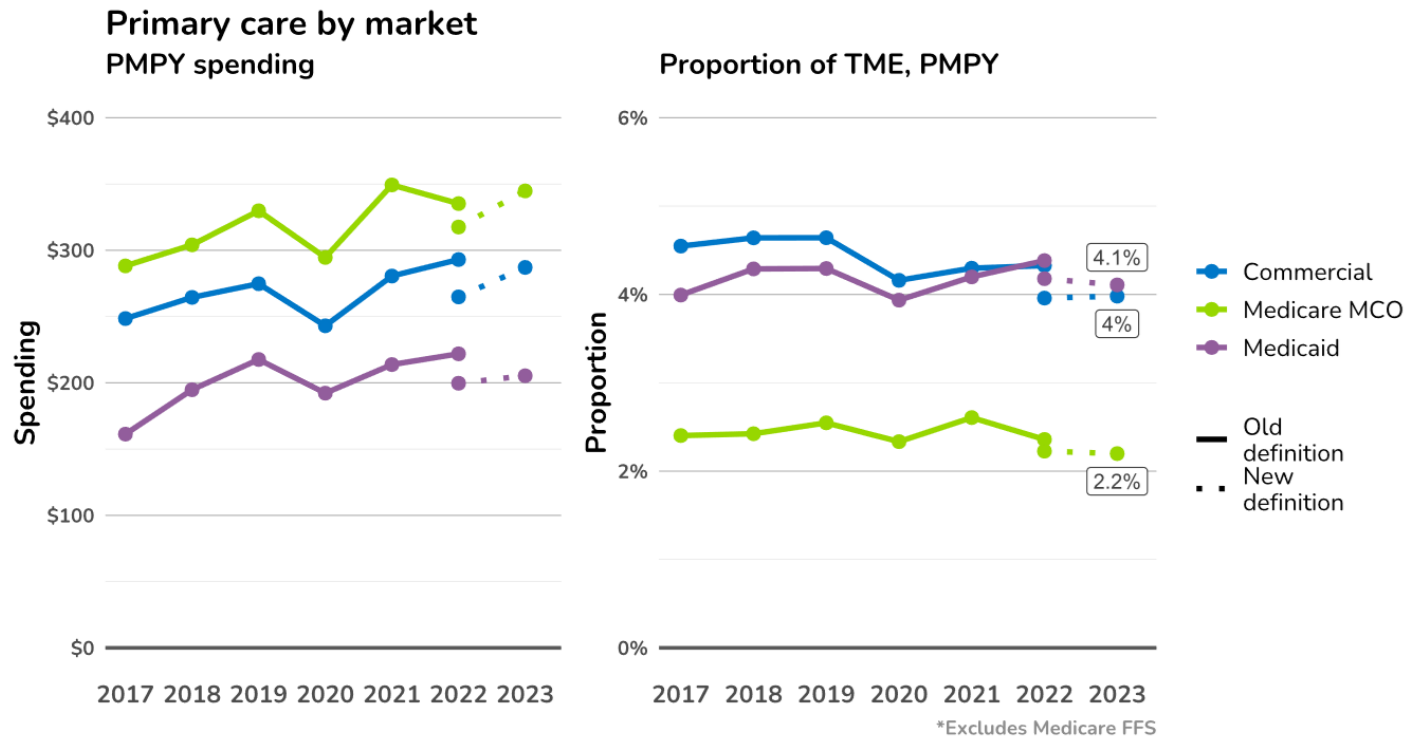
- Improving chronic disease management
- Enhancing care coordination and reducing overall system utilization

More information about the primary care expenditure target and performance

As described above, 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 (TME), 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 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 percent spending target, strengthens accountability, and better aligns with broader health care transformation goals.

An important step towards reaching the 12 percent primary care spending goal is understanding current levels of primary care spending. Senate Bill [SB 5084](#), laws of 2025, 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 beginning in 2027 using standards aligned with HCA's expenditure measurement for PEBB/SEBB and Medicaid plans.³⁵ With this information, the Cost Board can better understand primary care spending trends and propose strategies to increase primary care spending.

Figure 8:



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 percent 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:

- 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
1. Increase Primary Care Spending by 1% Annually	3. Patient Engagement (<i>Prioritized for 2025</i>) The Committee endorses:

• 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. 2. Increase Medicaid Reimbursement • Committee continues to recommend raising Medicaid primary care reimbursement to at <i>least</i> Medicare levels. • Committee also recommends Cost Board consider recommendation to revise fee schedule to align with updated primary care definition. • Committee suggests Legislature should: ○ <i>Maintain current reimbursement levels for services already at or above Medicare rates.</i>	• 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. • Agency-led efforts to incentivize patient engagement and utilization of primary care. 4. Multi-Payer Alignment The Committee endorses: • 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. 5. Workforce Development Endorses Health Workforce Council recommendations to expand primary care access. 6. Alternative Payment Models (APMs) The Committee endorses: • 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. 7. Measurement Strategy • Ongoing agency and HCPLAN 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.
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Market transparency & oversight

Background and current state in Washington:

Market oversight is the regulatory framework established by statute and regulation that monitors the quality of care and financial condition of health care facilities and providers in Washington.³⁶ Market oversight encompasses a variety of different types of transaction reviews, such as antitrust,³⁷ merger and consolidation,³⁸ and non-profit hospital acquisition.³⁹ 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.^{36 40} 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.

To ensure health care transactions do not negatively impact consumers, states put transaction review requirements in place to mitigate the impact of trends toward consolidation in health care markets, including recent trends in private equity (PE) investment. While PE investment is an important source of funding for many health care organizations and a source of innovation in health care delivery, there are concerns regarding PE's role in increased prices and influence over clinical care decisions. Research shows that when health care organizations are acquired, merge, or are associated with 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.^{41 42 43 44} Most studies have found that consolidation and reduced competition lead to fewer choices for patients and decreased or unchanged quality of care.^{45, 42 46 47 48 49} Consolidation in the labor market has been linked to slower wage growth and poorer working conditions for health care workers.⁵⁰ Acquisition by a PE firm can lay the groundwork for future consolidation as PE firms often acquire additional nearby practices.⁴³ 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.^{51 52.}

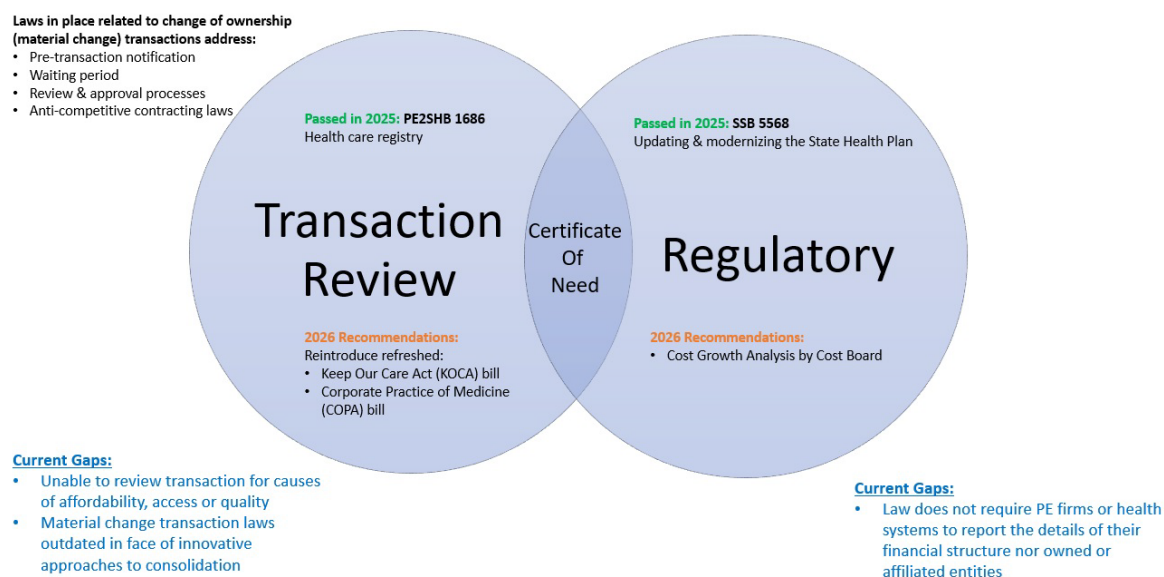
Over the past thirty years, Washington's hospital and health care resources have become increasingly concentrated as hospitals have closed or become part of multi-hospital systems.^{43 53} Fifty-four percent of Washington hospitals are affiliated with a multi-hospital system.⁴³ Eight multi-hospital systems provide more than 90 percent of licensed beds, more than 65 percent of staffed beds, and employ more than 65 percent of physicians and physicians' assistants who work at hospitals in the state.⁴³ Washington's insurance market has also become more concentrated; insurers are vertically integrating with physician groups and clinics in Washington.^{54 55} 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.⁴³ As of April 2025, 9.9% of Washington's private hospitals are owned by private equity companies.⁴⁹ Between 2012-2022 there were two hospital closures in Washington State: Walla Walla General Hospital, which closed in 2017, and Astria Regional Medical Center, which closed in 2019.

Framework for market oversight:

Washington currently has transaction review laws in place that require affiliating entities 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."⁵⁰

As identified in Figure 9 below, 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, State Attorneys General have more extensive powers related to transaction review.

Figure 9: Washington’s market consolidation oversight legislation (past, recent, and recommended)



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. An important foundational part of transaction review and the ability to address health care costs, is understanding what health care services are being offered and by whom 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 adopted Engrossed Second Substitute House Bill [ESSB 1686](#) (laws of 2025) that requires the Washington Department of Health (DOH) to develop a plan to create an interactive provider registry that documents ownership and location of health care providers and facilities throughout the state.⁵⁶ 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, 2028.⁵⁶ 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 ([SB 5568](#)) (laws of 2025) that will refresh Washington's State Health Plan (SHP), which was last updated in 1987.^{57 58} 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.⁵⁹ 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.⁵⁹ The SHP also provides the methodologies the CN program uses to determine the number of health care facilities that are needed throughout the state.^{60 61 62} To ensure the refresh to the SHP is comprehensive, SSB 5568 directs the Office of Financial Management (OFM) to work with other state agencies, the public, and regulated entities to conduct the refresh.⁶³ 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.⁶³

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. Below are some of the key market oversight strategies the Cost Board will focus on for 2026.

Corporate Practice of Medicine

The 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.⁶⁴ 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.⁶⁴ Washington state does not have a CPOM law. Rather, requirements regarding non-medical professional ownership of medical practices come from case law.⁶⁵ Generally, Washington prohibits businesses from employing medical professionals to practice their profession, although there are a few exceptions.⁶⁵ 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, the Washington state Senate introduced Senate Bill (SB) 5387, which created a formal CPOM law that included additional restrictions on private equity investment.⁶⁶ SB 5387 was not passed during the 2025 legislation session but will be updated and reintroduced again in 2026.⁶⁶

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 of lower monetary amounts that do not reach the threshold. This has

particularly been the case in transactions that involve physician practice acquisitions by hospitals, insurance carriers or private equity investors.⁶⁷

Recent Washington legislation has sought to address these gaps in transaction review. In the 2024 legislative session, [SB 5241](#), the Keep Our Care Act, sought to expand the types of transactions where review was required and address certain anticompetitive contract clauses in Washington, but did not pass. In 2025, the Keep Our Care Act (HB 1881) was refined and reintroduced, including a role for the Health Care Authority to conduct access, affordability, quality, and equity reviews for all health care transactions subject to review, but also did not pass.⁶⁸

Another market oversight topic the Cost Board is interested in exploring is the types of notifications 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.⁵² Hospital closures in turn have been associated with delays in medical care, increased transport times, and increased morbidity and mortality from time-sensitive conditions.⁵¹ 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.⁶⁹ 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, 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.

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 the drivers of cost growth in the coming year. The board will be hosting 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 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 which 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 in the areas of 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.

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Appendices (In development)

- Performance against the Benchmark Executive Summary
- Analytic Support Initiative Summary

Health Care Cost Transparency Board roster for 2025

Member	Title, Agency	Board Member Position
1 Mich'l Needham, Chair	Chief Policy Officer, Health Care Authority	Representing the Health Care Authority
2 Jane Beyer	Senior Health Policy Advisor, Office of the Insurance Commissioner	Representing the Office of the Insurance Commissioner
3 Eileen Cody	Consumer Advocate	Representing consumers
4 Lois Cook	Managing Member, America's Phone Guys	Representing small businesses
5 Bianca Frogner	Professor and Center for Health Workforce Studies Director, University of Washington	Expert in health care financing
6 Kenneth Gardner	Director of Growth, SEIU 775 Benefits Group	Representing Taft-Hartley health benefit plans
7 Jodi Joyce	Chief Executive Office, Unity Care NW	Member of advisory committee with operational experience in health care delivery (non-voting)
8 Gregory Marchand	Director of Global Benefits, Boeing	Representing large employers/self-funded group health plan
9 Mark Siegel	Assistant Vice President, Costco Wholesale Corporation	Representing large employers
10 Margaret Stanley	Consumer Advocate	Representing consumers
11 Ingrid Ulrey	Chief Executive Officer, Washington Health Benefit Exchange	Representing the Washington Health Benefit Exchange
12 Kim Wallace	Medical Administrator, Department of Labor & Industries	Representing the Department of Labor & Industries
13 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
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Data Issues Advisory Committee roster for 2025 ⁵

Member	Title	Agency/Organization
Megan Atkinson	Chief Financial Officer	Health Care Authority
Christa Able	Division Director, Payer Strategy and Relationships	Virginia Mason Franciscan Health
Nnabuchi Anikpezie	Senior Director of Health Systems and Workforce Intelligence	Washington State Department of Health
Amanda Avalos	Deputy, Enterprise Analytics, Research, and Reporting	Health Care Authority
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

Health Care Stakeholder Advisory Committee roster for 2025 ⁶

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	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	WSU 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 the Health Care Authority 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 Service Employees	Washington Council for Behavioral Health	One member representing behavioral health providers
Sulan Mlynarek	Lead Research Analyst	International Union (SEIU), Healthcare 1199NW	Washington State Labor Council	At least two members representing the interests of labor purchasers

Paul Schultz	Executive Director, Kaiser Foundation Actuarial Services	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 the Health Care Authority to serve medical assistance enrollees

Primary Care Advisory Committee roster for 2025⁷

Seat	Member	Title	Agency/Organization
1	Judy Zerzan-Thul	Chair, Chief Medical Officer	Health Care Authority
2	Jonathan Staloff	Co-Chair, Family Medicine Doctor, Fellow	University of Washington Medicine
3	Kristal Albrecht	Senior Vice President of Finance	Community Health Association of Spokane
4	Sharon Brown	Executive Director	Greater Health Now
5	Tony Butruille	Family Medicine Doctor	Cascade Medical Center
6	Michele Causley	Vice President of Health Plan Operations	United Healthcare
7	Tracy Corgiat	Vice President Primary Care	Confluence Health
8	Chandra Hicks	Assistant Director – Delivery System Analytics	Regence BlueShield
9	Gregory Marchand	Director, Global Benefits	Boeing
10	Lan H. Nguyen	Medical Director	Premera
11	Katina Rue	Family Medicine Doctor, President-Elect	Washington State Medical Association
12	Mandy Stahre	Managing Director, Forecasting and Research	Office of Financial Management
13	Ginny Weir	Chief Executive Officer	Foundation for Health Care Quality, Bree Collaborative
14	Shawn West	Chief Medical Officer	Embright

15	Staici West	Vice President	Coordinated Care
16	Maddy Wiley	Graduate Faculty School of Nursing	Pacific Lutheran University

Nominating Committee roster for 2025⁸

Seat	Member	Title, Agency	Committee Member Position
1	Kim Wallace	Medical Administrator, Department of Labor & Industries	Board member, representing the Department of Labor & Industries
2	Carol Wilmes ⁹	Director of Member Pooling Programs, Association of Washington Cities	Board member, representing local governments that purchase health care for their employees
3	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
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