

Data Issues Advisory Committee Meeting

October 8, 2026

Tab 1

Thursday, October 8, 2026
2–4 p.m.
Hybrid Zoom and in-person

Data Issues Advisory Committee

Agenda

Members of the Advisory Committee on Data Issues					
☐	Christa Able	☐	Jason Brown	☐	Hunter Plumer
☐	Megan Atkinson	☐	Chandra Hicks	☐	Mark Pregler
☐	Amanda Avalos	☐	Leah Allemandi	☐	Russ Shust
☐	Jonathan Bennett	☐	David Mancuso	☐	Mandy Stahre
☐	Bruce Brazier	☐	Ana Morales	☐	Julie Sylvester

Time	Agenda Items	Tab	Presenter
2:00–2:10 (10 min)	Welcome, agenda, orientation, and roll call	1	Ross Valore, Board and Commissions Director
2:10–2:15 (5 min)	Review of minutes from June Data Issues Advisory Committee Meeting	2	Rachelle Bogue, Cost Board Manager
2:15–2:25 (10 min)	Public comment	3	Ross Valore, Board and Commissions Director
2:25–2:40 (15 min)	Cost Board updates	4	Rachelle Bogue, Cost Board Manager
2:40–3:15 (35 min)	Benchmark Refresh	5	Jingping Xing, Data Science & Informatics Specialist 4 Sheryll Namingit, Data Science & Informatics Specialist 3
3:15–3:30 (15 min)	Legislative Report Overview	6	Jennifer Scott, Senior Policy Analyst
3:30–3:55 (25 min)	2027 Cost Board Planning	7	Rachelle Bogue, Cost Board Manager
3:55–4:00 (5 min)	Adjourn	8	Ross Valore, Board and Commissions Director

Tab 2

Advisory Committee on Data Issues meeting minutes

June 23, 2026

Virtual meeting held electronically (Zoom) and in person at the Health Care Authority (HCA)
2–4 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](#).

Advisory Committee on Data Issues

Members present

Jason Hotchkiss (delegate for Jonathan Bennett)
Bruce Brazier
Jason Brown
Margaret Dennis (delegate for Leah Hole-Marshall)
Hunter Plumer
Russ Shust
Julie Sylvester
Mandy Stahre

Members absent

Christa Able
Amanda Avalos
Chandra Hicks
David Mancuso
Ana Morales
Mark Pregler

Announcements

Ross Valore, Board and Commissions Director, Health Care Authority (HCA), announced that two former members have resigned their roles on this committee. Dr. Bianca Frogner, former chair of the Advisory Committee on Data Issues, has resigned as has Dr. Nnabuchi Anikpezie from the Department of Health. The Cost Board thanks them both for their work.

Call to order

Valore called the meeting of the Advisory Committee on Data Issues to order.

Agenda items

Welcoming remarks

Valore reviewed the agenda for the meeting and conducted the roll call. A quorum of members was present for the committee. Committee members and the public attended either in person or virtually via Zoom.

Tab 1: Agenda

Approval of meeting minutes

Harrison Fontaine, Senior Health Policy Analyst, HCA, asked for any comments on the minutes from the September 25, 2025, meeting. Russ Shust motioned to approve the minutes. This motion was seconded, and the minutes were approved by unanimous vote.

Tab 2: Meeting minutes from September 25, 2025

Public comment

There were no comments from the public.

Cost Board Updates

Fontaine and Valore provided updates on Cost Board discussions at the public hearing which occurred on November 20, 2025.

Fontaine reviewed information from the 2025 analysis (based on 2023 data) of health care cost growth compared to the cost growth benchmark. He also presented a summary of the panel discussions at the public hearing. Panelists represented consumer, labor, business, and payer and industry perspectives.

Valore reviewed the Cost Board's priority areas for policy action in 2026. He also shared a roadmap of upcoming discussions at the Cost Board and committees regarding health care consolidation and market oversight. These discussions will occur each month throughout 2026.

Cost Board updates begin at [meeting recording time stamp 13:46](#).

Tab 4: Cost Board Updates

State Health Plan Update

Mandy Stahre, Director, Health Care Research Center, Forecasting and Research Division, Office of Financial Management (OFM), provided an update on progress on the State Health Plan. This initiative has 5 objectives which include 1) Strategy development; 2) Inventory creation; 3) Development of a health care data resource plan; 4) Assessment of emerging trends in health care delivery and technology; 5) Creation of a rural health resource plan.

Work completed to date includes:

- Created a website to communicate progress: ofm.wa.gov/healthplan
- Compiled feedback from the public received in public hearings
- Met with partners and technical advisory committee (TAC) members to discuss feedback and edits
- Incorporated changes into a new draft
- Drafted final approach report, which is under review

Next steps include submitting a report to the legislature, updating the website, continuing partner meetings and outreach, continuing to document processes and data sources, and outlining areas where data and information gaps remain.

The State Health Plan Update begins at [meeting recording timestamp 29.41](#).

Tab 5: State Health Plan Update

Health Care Market Transparency & Oversight

Ross Valore presented information on the topic of market oversight which builds upon the Cost Board's recent discussion about health care consolidation, mergers, acquisition, and other types of transactions. He included information about the current state of health care consolidation in Washington, consolidation's impact on affordability and quality, and how Washington's market oversight and transparency requirements can be strengthened.

The Health Care Market Transparency & Oversight presentation begins at [meeting recording timestamp 46:16](#).

Tab 6: Health Care Market Transparency & Oversight

Market Oversight Panel

Valore introduced panel members Hunter Plumer who is a senior consultant with Health Trends as well as a member of the Advisory Committee on Data Issues and Margaret Dennis, Analytics Leader at the Health Benefit Exchange. Panelists responded to several questions about their experience with health care consolidation, including questions about measuring its impact and strategies they think might be helpful in addressing negative outcomes. Finally, they were asked what aspects of our health care system are important to preserve in the face of consolidation. Following the formal panel, committee members were invited to ask questions and share their own thoughts on the topic.

Suggested policies to address consolidation included: a more proactive role for the state, pre-contracting transaction review, rate setting strategies, a formal role for consumers, CPOM legislation and innovative approaches to improve affordability such as reference-based pricing employed by the state for the PEBB/SEBB groups this year. The committee emphasized the importance of preserving primary care, access for rural communities and equity and quality.

The Market Oversight Panel Discussion begins at [meeting recording timestamp 1:15:58](#).

Wrap up and adjourn

The meeting adjourned at 4:00 p.m.

The next Advisory Committee on Data Issues meeting is scheduled on October 8, 2026, from 2:00-4:00 p.m.

Tab 3

Public Comment

Data Issues Advisory Committee

Written Comments

- ▶ Public comments can be provided orally during the meeting's public comment period or in written form at any time to the Cost Board's inbox at HCCTB@hca.wa.gov.

Tab 4

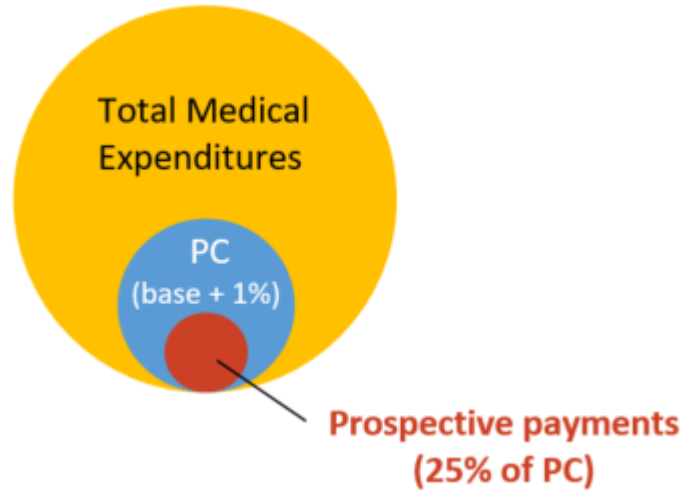
Cost Board Report Out

July 22 Cost Board meeting highlights

- ▶ Focus Area 1: Colorado Primary Care Payment Model
- ▶ Focus Area 2: California's Market Oversight Program
- ▶ Focus Area 3: Cost Board's Discussion & Vote on Market Oversight

Primary Care Investment - Regulation 4-2-72

Primary Care Investment



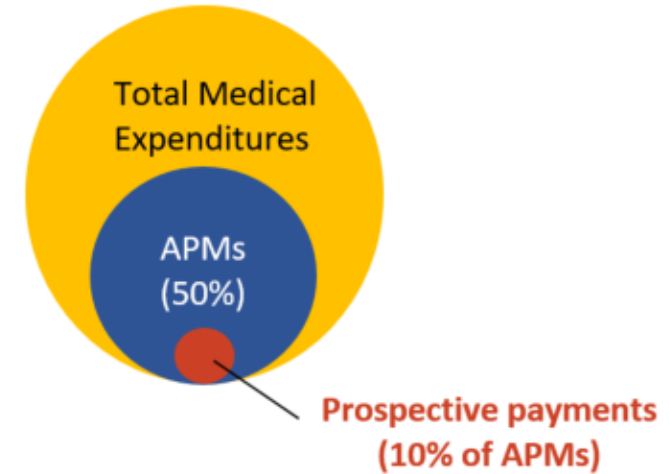
Requirement:

- One percentage point increase in 2022 and 2023

Target:

- 25% primary care expenditures through prospective payments by end of CY 2023

APM Expenditures



Target:

- 50% of total medical expenditures in APMs by end of 2022
- 10% of APM expenditures through prospective payments by end of CY 2022

Primary Care Spending in 2024

Figure 2: Share of Primary Care Spending, 2024.

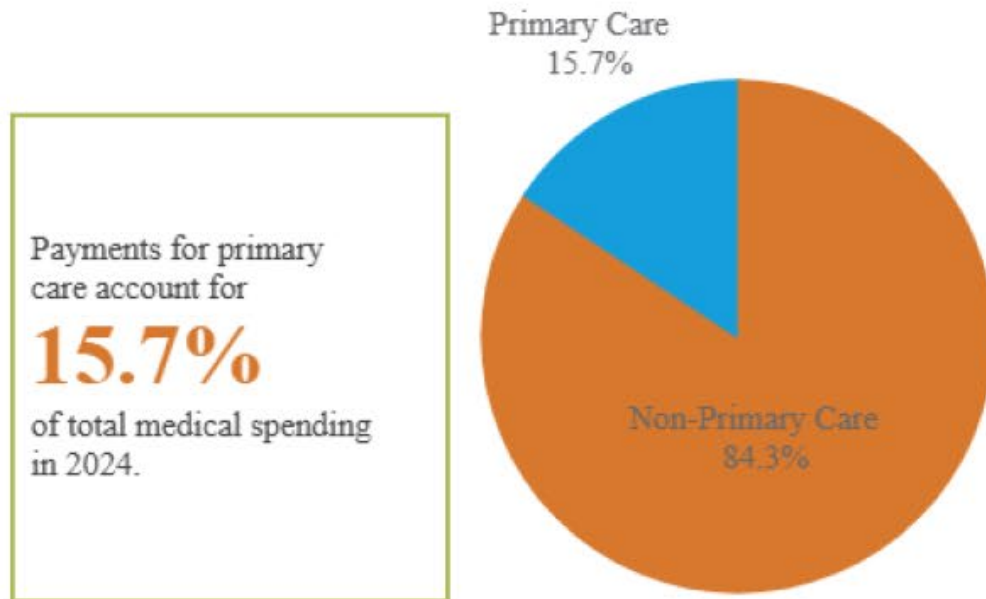
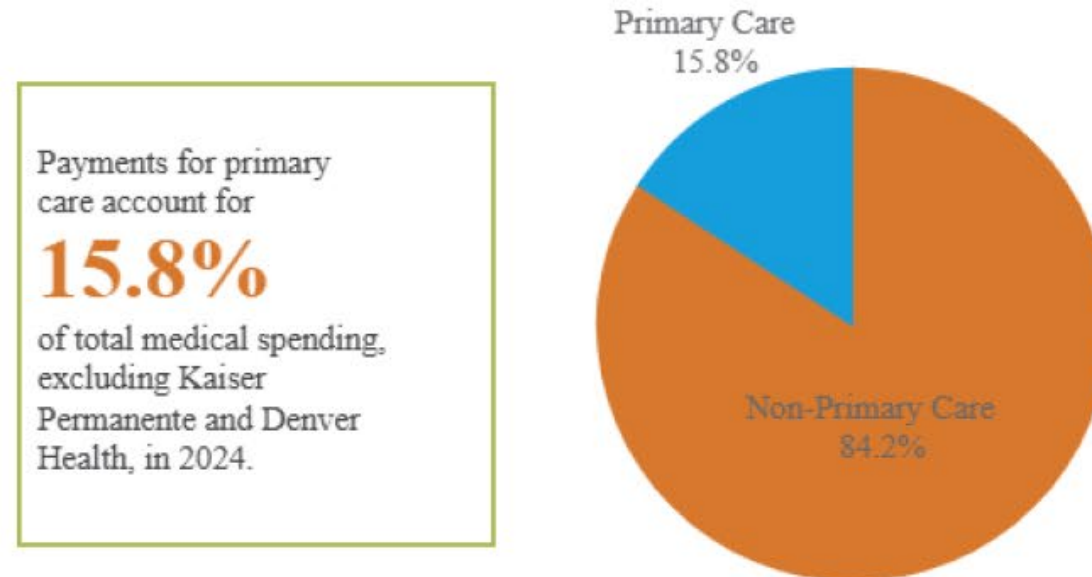


Figure 3: Share of Primary Care Spending, excluding Kaiser Permanente and Denver Health, 2024.



Moving Forward

SB25-193

Sunset Primary Care Payment Reform Collaborative



Extended PCPRC
through September
2032

Consolidation



- Private equity, vertical & horizontal mergers, insurer ownership
- Independent, rural practices

Artificial Intelligence



- Workforce impacts - reduced administrative burden, inequitable uptake
- Patient consent

H.R. 1



- Access & affordability - what is the role of primary care

Comprehensive Primary Care Strategy



- Looking across multiple domains - payment, access, workforce, outcomes - to measure state of primary care

Lessons Learned

- Legislative champions important, but build a pipeline and think broadly
- When measuring primary care spending, don't let the perfect be the enemy of the good
- Learn from peers - “enlightened larceny”
- Strike a balance between carrots and sticks

California's transaction review

- ▶ Transaction-review law requires 90 days' advance notice of material change transactions.
- ▶ Office of Health Care Affordability (OHCA) has 60 days to either issue a waiver or open a Cost and Market Impact Review.
- ▶ OHCA has transparency and reporting authority but not the power to block or condition transactions directly.
- ▶ Findings can support action by the Attorney General (AG).

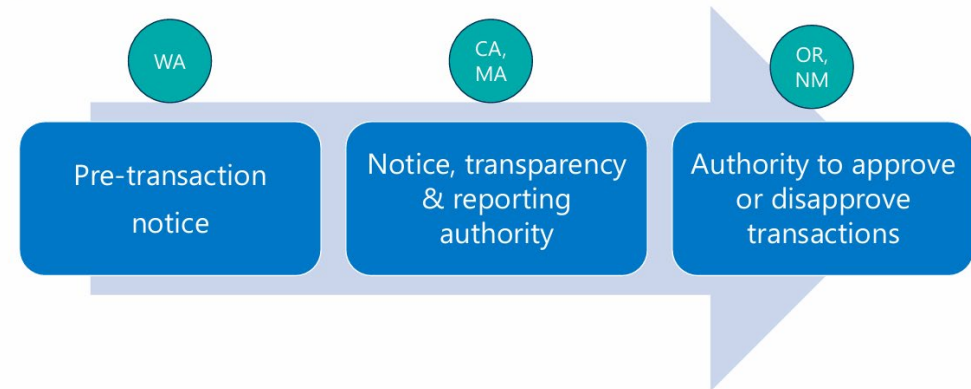
Other states

Massachusetts	New Mexico
• Transaction-review law requires 60 days' advance notice of a material change transaction for provider organizations with more than \$25 million in annual patient revenue. • The Health Policy Commission (HPC) can take up to 215 days to approve the transaction or open a Cost and Market Impact Review. • HPC cannot block or condition a transaction directly. • Findings can support actions by the AG or other regulators.	• Second state to grant a state agency binding authority over deal outcomes rather than transparency-only role • Enacted a 2024 law empowering its Health Care Authority to approve or disapprove certain health care transactions

Cost Board recommendation & vote

- ▶ Board voted **yes** for stronger oversight program that captures full range of health care entities (e.g., labs and skilled nursing facilities)

Spectrum of transaction review authority



Cost Board recommendation & vote cont.

- ▶ Board members expressed interest in understanding the broader picture of what is driving health care consolidation in Washington, how that is related to overall costs, and what alternatives to consolidation may exist which might be better aligned with public interest.
- ▶ Board members also expressed a desire to pursue multiple strategies to limit price growth, highlighting that affordability issues have worsened and the need to make progress on the Board's broader goal.

September 23 Cost Board meeting topics

- ▶ Focus Area 1: Primary Care Wrap-up and Recommendation
- ▶ Focus Area 2: Cost Board 2027 Planning and Feedback
- ▶ Focus Area 3: Consolidation's Impact on Primary Care

Cost Board recommendations on primary care

► Recommendation 1—Increase the primary care spending ratio.

Carriers and large provider organizations increase primary care spending by 1 percent annually to reach and maintain the 12 percent goal. This creates a clear path to Washington's goal of investing 12 percent of health care spending in primary care.

► Recommendation 2—Strengthen health care transaction oversight.

A growing share of primary care is delivered in hospital-affiliated settings, and integrated care is reimbursed at higher rates. Increased primary care investment alone may therefore not reduce costs if funds flow into consolidated systems. Strengthening transaction oversight would help ensure that investment reaches frontline care and that consolidation does not erode affordability or access.

***Updated market oversight recommendation:** The Legislature should pursue a health care transaction review program that allows for meaningful review of transaction's impact on **primary care**, affordability, access, and quality.

► Recommendation 3—Protect and grow the primary care training pipeline (community-based programs)

Provide stable, ongoing state funding for existing primary care residency positions (not just new positions) and additional incentives for programs to expand, particularly in communities with workforce shortages. Develop incentives to maintain/grow community based primary care programs.

► Recommendation 4 — Support exploration of the OIC's comprehensive primary care proposal.

Support exploration of the Office of the Insurance Commissioner's comprehensive primary care proposal, including study of the mechanics of a "common fund," with regular updates back to the Primary Care Advisory Committee. This explores a new payment approach that could make primary care funding more consistent across payers.

Cost Board feedback

- ▶ In the time since the Board was formed costs have only escalated. We haven't contained them. We're not doing our job right now. Chart a course for an aggressive roadmap for bending the cost curve.
- ▶ Have an in-depth discussion where members can develop more solution-oriented and specific strategies
- ▶ Make space for dialogue with industry stakeholders about how we can control costs.
- ▶ Fewer presentations – more discussion
- ▶ Less slicing and dicing of data – synthesize themes

3. Private Response

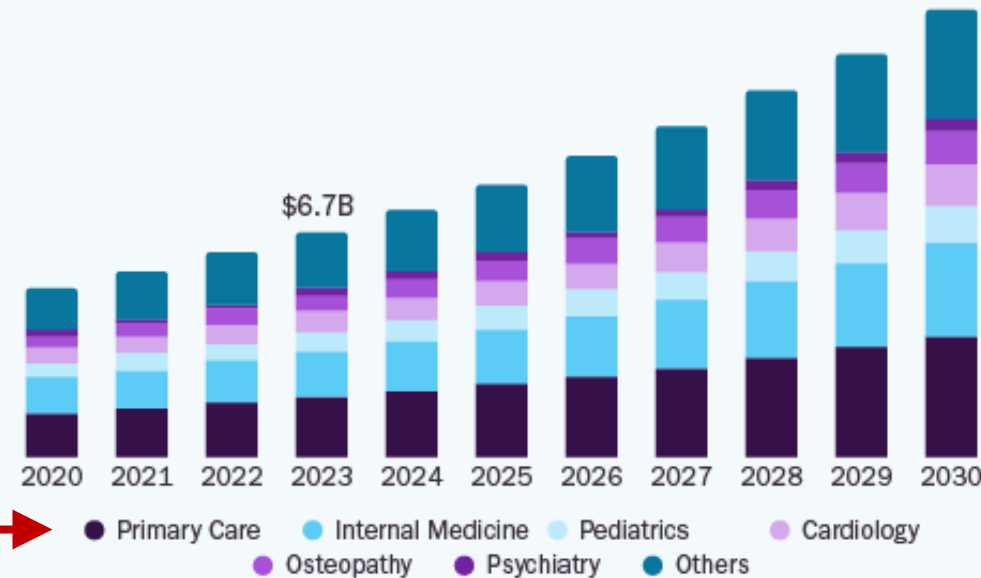
Concierge, Direct PC, Private Equity

Key U.S. Concierge Medicine Companies:

- ▶ MDVIP
- ▶ Signature MD
- ▶ Crossover Health
- ▶ Specialdocs Consultants, LLC
- ▶ PartnerMD
- ▶ Concierge Consultants & Cardiology
- ▶ Castle Connolly Private Health Partners
- ▶ Peninsula Doctor
- ▶ Campbell Family Medicine
- ▶ Destination HealthMDI
- ▶ Priority Physicians, Inc.
- ▶ U.S. San Diego Health

U.S. Concierge Medicine Market

Size, by Specialty, 2020 - 2030 (USD Billion)



10.4%

U.S. Market CAGR,
2024 - 2030

Source:
www.grandviewresearch.com



The NEW ENGLAND
JOURNAL of MEDICINE

Perspective
MAY 29, 2025

Primary Care — From Common Good to Free-Market Commodity

Zirui Song, M.D., Ph.D.,^{1,2} and Jane M. Zhu, M.D., M.P.P.³

More than 30% of U.S. adults lack a usual source of primary care.¹ As the population ages, the gap between primary care demand and supply is poised to widen. Primary care

along with willingness among many patients to pay retainer fees, health care systems have also opened their own concierge practices, often alongside traditional

Original Investigation

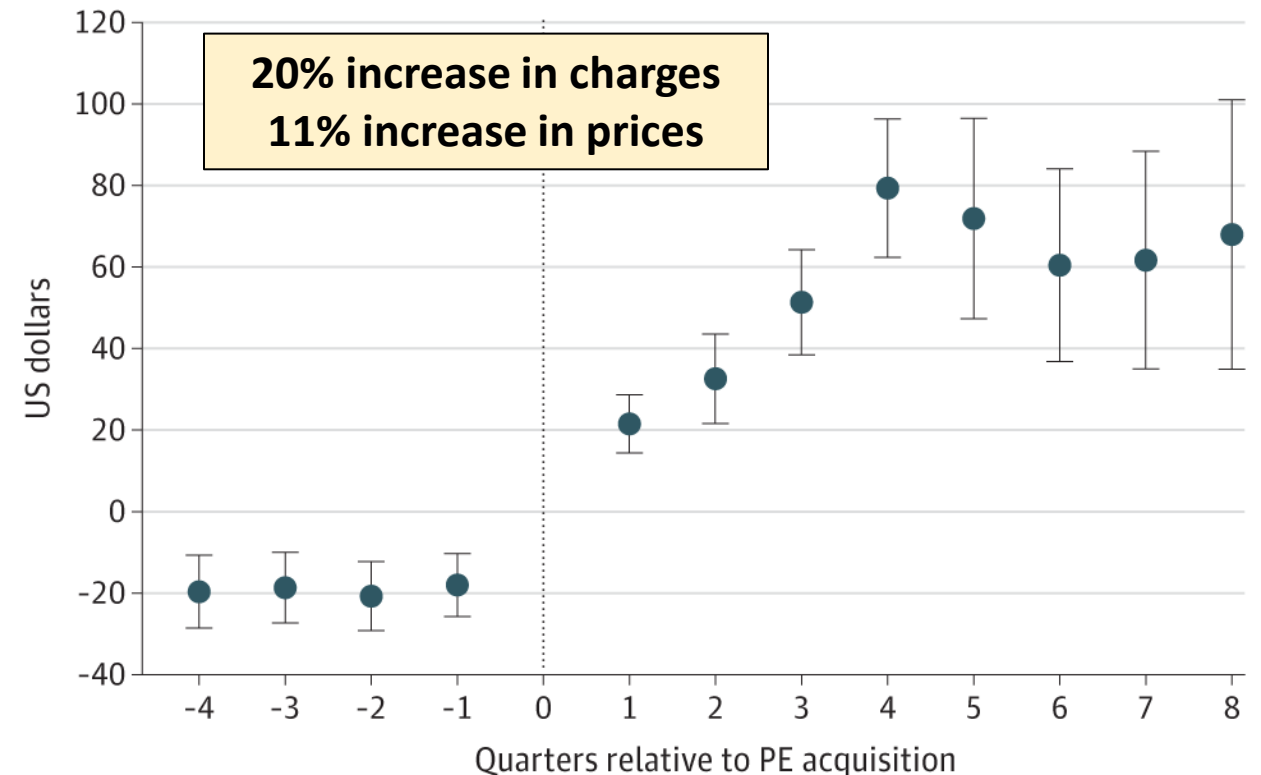
Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization

**JAMA
Health Forum**
(2022)

Yashaswini Singh, MPA; Zirui Song, MD, PhD; Daniel Polsky, PhD, MPP; Joseph D. Bruch, PhD; Jane M. Zhu, MD, MPP, MSHP

Table 1. Characteristics of PE- and Non-PE-Acquired Physician Practices at Baseline, 2015

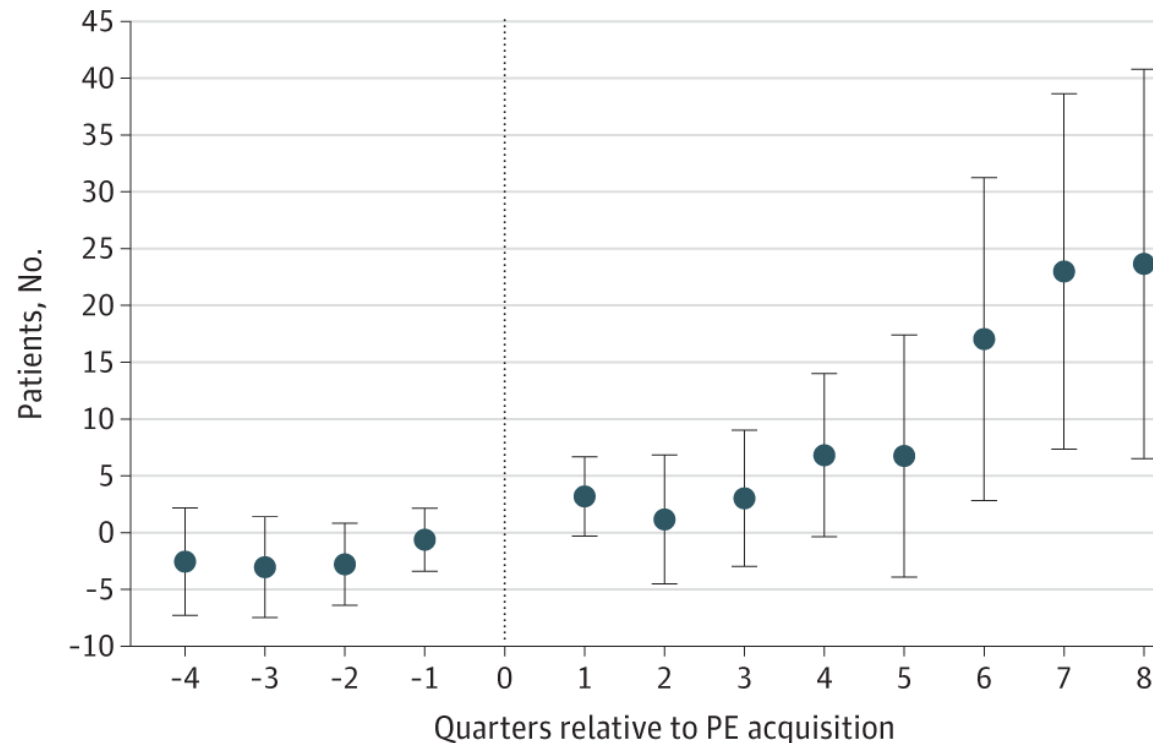
Characteristic	Mean (SD)	
	PE-acquired	Non-PE-acquired ^a
Physician practices, No.	578	2874
Charge/claim, mean \$	322 (258)	332 (326)
Allowed amount/claim, mean \$	187 (136)	178 (136)
Total No.		
Unique patients	94 (182)	88 (172)
New patients	72 (136)	67 (132)
Encounters	124 (237)	118 (224)
E&M visits	75 (188)	72 (180)
Share of E&M visits >30 min		
New patients	0.26 (0.15)	0.26 (0.21)
Established patients	0.19 (0.17)	0.18 (0.22)
Patient HCC score, median	1.21 (1.05)	1.28 (1.10)



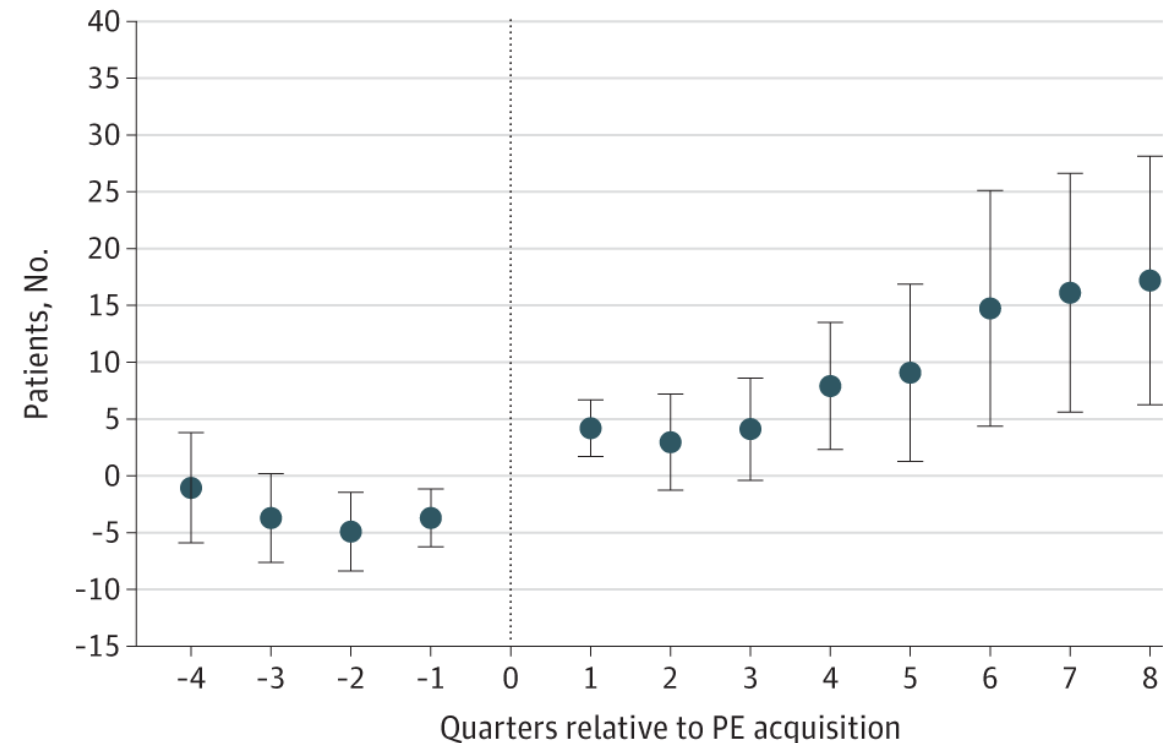
Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization

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A Unique patients per practice



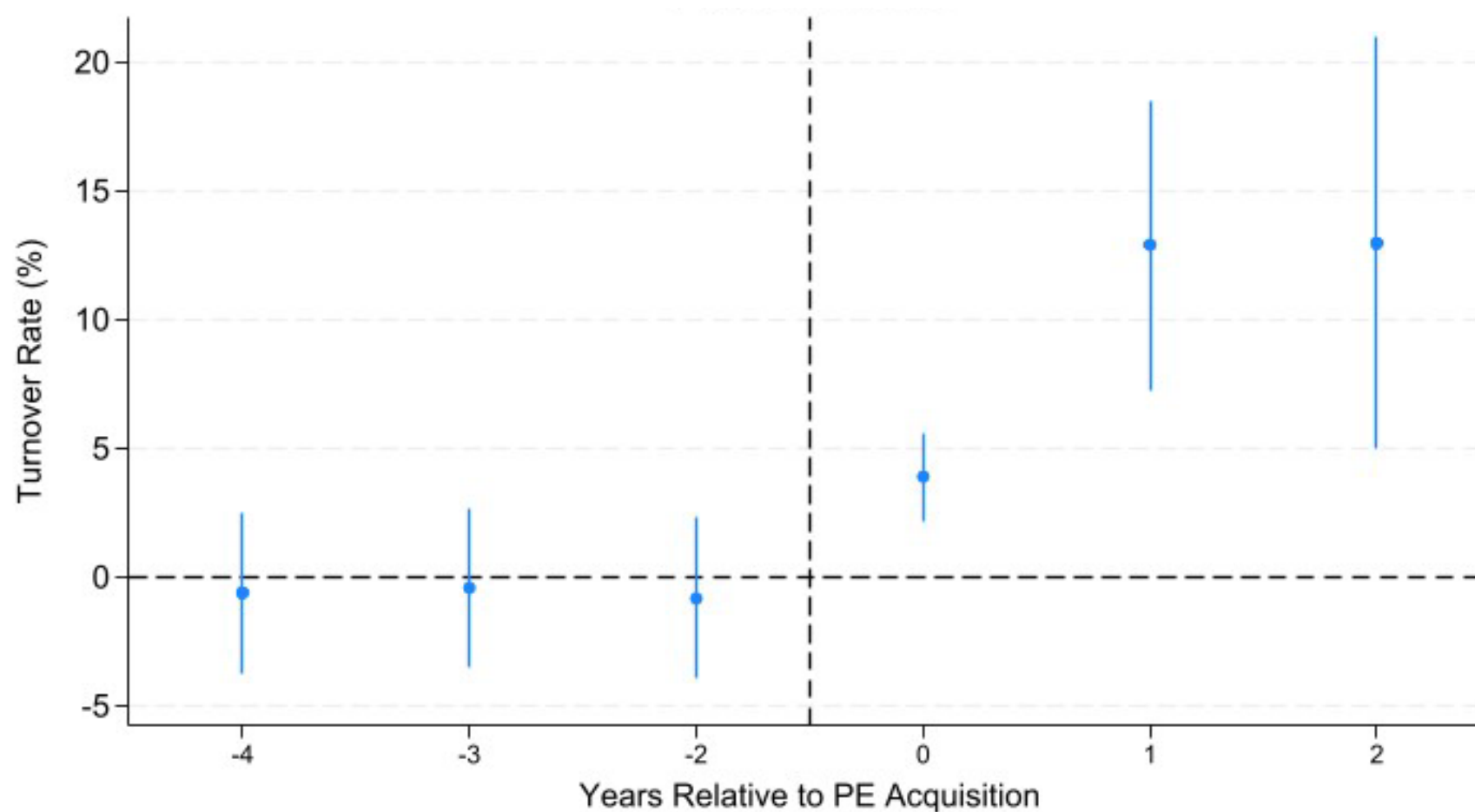
B New patients per practice



Workforce Composition In Private Equity-Acquired Versus Non-Private Equity-Acquired Physician Practices

Relative to control, PE increases APP hiring.

PE acquisitions raised physician turnover rate by 13 percentage points (265% over baseline)



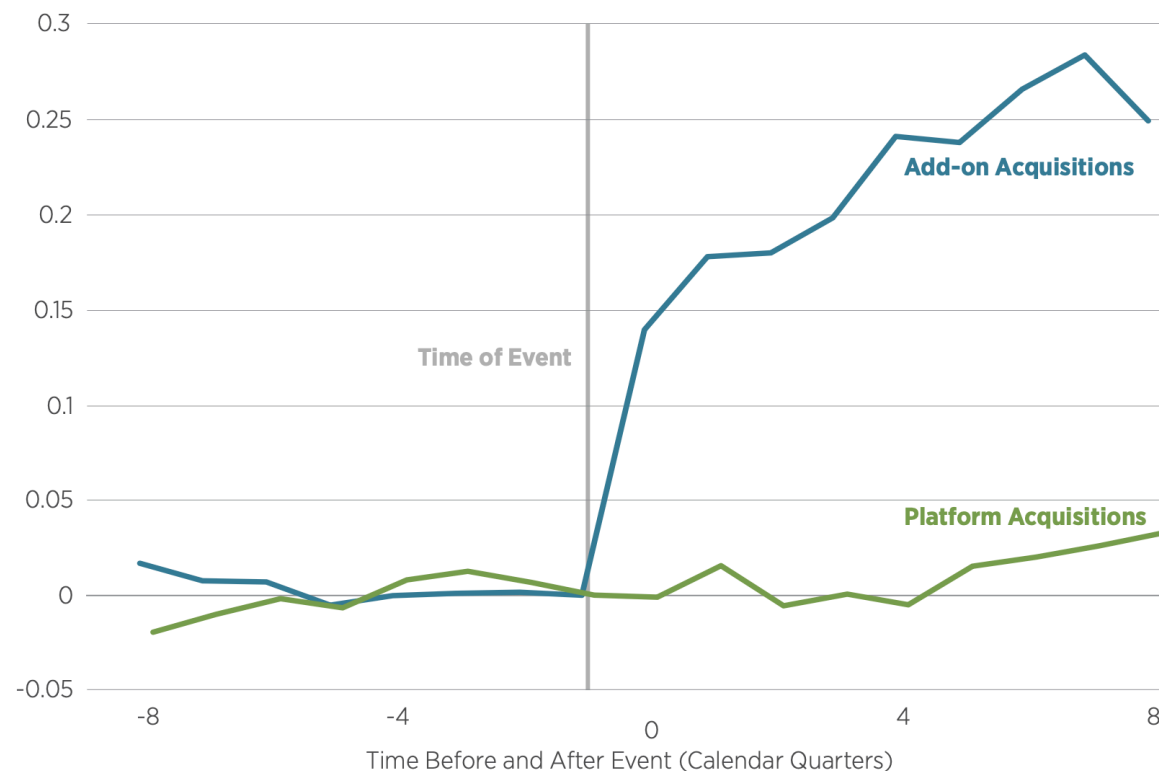
Painful Bargaining: Evidence from Anesthesia Rollups

Based on BFI Working Paper No. 2024-149, "Painful Bargaining: Evidence from Anesthesia Rollups," by Aslihan Asil, Yale University; Paulo Ramos, University of Chicago; Amanda Starc, Northwestern University; and Thomas G. Wollmann, University of Chicago

Rollups in the anesthesia industry drive consolidation and significant price increases, particularly in already concentrated markets. Court-ordered divestitures and other remedies show potential for reducing these anti-competitive effects.

"Serial acquisitions of clinician practices backed by investment funds have consolidated a geographically dispersed set of markets, consistent with the... rollup as a "buy-and-build" strategy. **Prices increased by approximately 35% following add-on acquisitions.** ... the increases reflect the internalization of business-stealing effects—**less competition**—rather than other explanations, such as changes in quality, negotiating ability, or pricing tactics employed by sponsors."

Figure 1 • Prices Rise Following Add-On but not Platform Acquisitions



Note: This figure plots the average anesthesia price on the vertical axis against time on the horizontal axis. The vertical gray line corresponds to the quarter of the acquisition. Prices are normalized to zero in that quarter. The blue line corresponds to add-on acquisitions; the green line corresponds to platform acquisitions (i.e., the first acquisition by a sponsor in a market).

Questions?

Tab 5

Proposed Benchmark for 2027-2031

Outline

- ▶ Purpose of the Benchmark
- ▶ Benchmark formula
- ▶ Data used and sources
- ▶ 2022-2026 Benchmark
- ▶ Proposed 2027-2031 Benchmark
- ▶ Proposed 2027-2031 Benchmark vs Benchmark in other states

Purpose of the Benchmark

- ▶ The goal of the Cost Board is to reduce health care spending growth to make health care more affordable to consumers.
 - ▶ Set the state's target or benchmark for measuring health care spending growth and compare statewide, market, carrier and large provider healthcare spending growth against the benchmark
 - ▶ RCW 70.390.050 requires the Board to "select an appropriate economic indicator to use when establishing the health care cost growth benchmark."

Purpose of the Benchmark

- ▶ For healthcare to be affordable:
 - ▶ The cost of getting healthcare should not be a big share of an individual's income (Ideal goal)
 - ▶ The cost of getting healthcare should not grow as much as the growth of people's income (Realistic goal)
- ▶ The board decided to tie the benchmark to measures of income growth (i.e., growth of Potential Gross State Product (PGSP) and wages).
 - ▶ Expected PGSP reflects average future income (particularly, share of economic pie if distributed evenly)
 - ▶ Historical median hourly wage best reflects worker's income

Benchmark formula

$$\text{Benchmark} = .30 \times \text{Potential Gross State Product (PGSP) Growth Rate} + .70 \times \text{Median Wage Growth Rate}$$

$$\begin{aligned} \text{PGSP} = & \text{Potential labor force productivity growth} \\ & + \text{WA labor force growth} \\ & + \text{National inflation} \\ & - \text{WA population growth} \end{aligned}$$

Data used and sources

Data Used	Data Source
1. Median Wage Growth in WA, 20-Year Avg.	Washington State Employment Security Department
2. Potential Gross State Product	
a. Expected growth in national labor force productivity, 5-Year Avg.	Congressional Budget Office's Budget and Economic Outlook
b. Expected growth in the state civilian labor force, 5-year CAGR	Washington Office of Financial Management's (OFM) Long-Term Forecast
c. Expected national inflation, 5-Year Avg.	Congressional Budget Office's Budget and Economic Outlook
d. Expected state population growth, 5-Year Avg.	Washington Office of Financial Management's (OFM) State Population Forecast

Benchmark calculation, 2022-2026

	Weight	Basis of 2022-2026 Benchmark
1. Median Wage Growth in WA, 20-Year Avg.	0.7	3.0%
2. PGSP: a+b+c-d	0.3	3.8%
<i>a. Expected growth in national labor force productivity, 5-Year Avg.</i>		1.5%
<i>b. Expected growth in the state civilian labor force, 5-year CAGR</i>		1.3%
<i>c. Expected national inflation, 5-Year Avg.</i>		1.9%
<i>d. Expected state population growth, 5-Year Avg.</i>		0.8%
Benchmark		3.2%

Please see Appendix for data notes.

Benchmark for 2022-2026

- ▶ Calculated benchmark: 3.2%
- ▶ Applied a stepdown adjustment
 - ▶ To target slower health care spending growth over time and to provide relief to consumers and employers
- ▶ Benchmark for 2022-2026 (with stepdown):

Year	Benchmark
2022	3.2%
2023	3.2%
2024	3.0%
2025	3.0%
2026	2.8%

Calculation of 2027 Benchmark

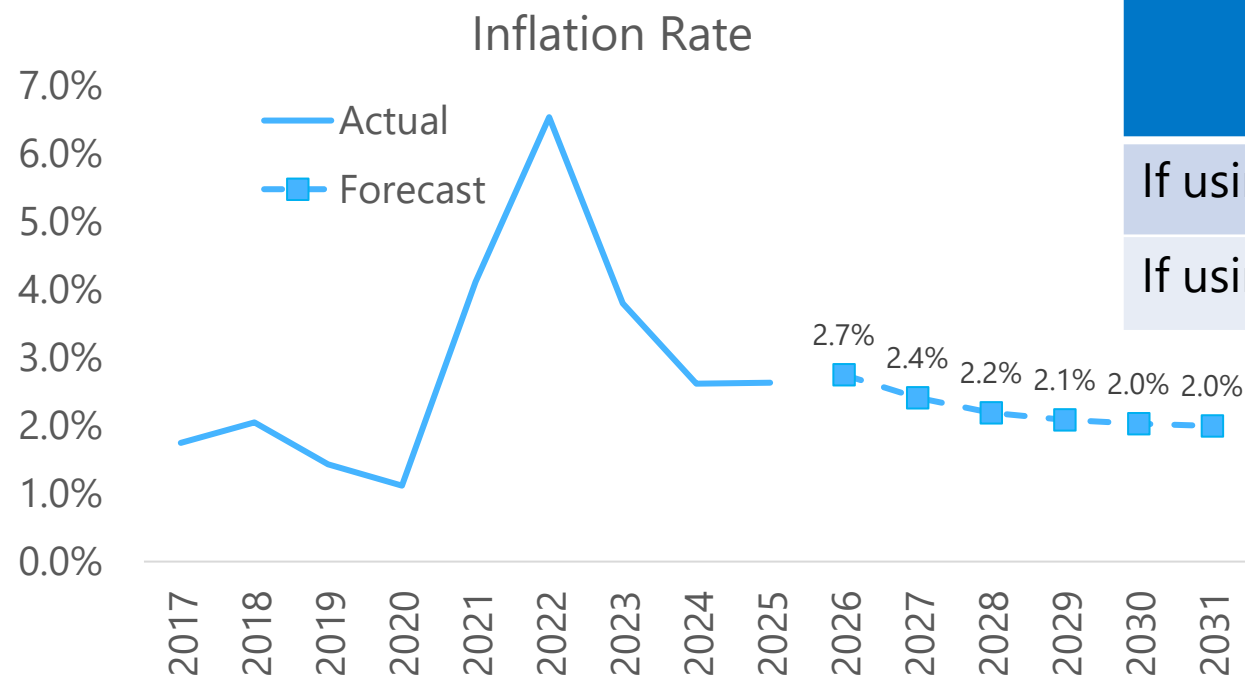
	Weight	2022 Benchmark	2027 Benchmark
1. Median Wage Growth in WA, 20-Year Avg.	0.7	3.0%	3.6%
2. PGSP ^{1/} : a + b + c – d	0.3	3.8%	3.5%
a. Expected growth in national labor force productivity, 5-Year Avg.		1.5%	1.6%
b. Expected growth in the state civilian labor force, 5-year Avg.		1.3%	0.6%
c. Expected national inflation, 5-Year Avg.		1.9%	2.1%
d. Expected state population growth, 5-Year Avg.		0.8%	0.8%
Benchmark		3.2%	3.6%

Notes:

1. Unlike the 2022 Benchmark calculation, Cost Board staff used data from 5 forecasted years in benchmark period (i.e., 2027-2031) instead of using one forecasted year prior to the benchmark period and 4 out of 5 benchmark years (i.e., 2026-2030).

2. Please see Appendix for data notes.

Inflation rate



	Avg. Inflation Rate	2027 PGSP	2027 Benchmark
If using 2026-2030	2.3%	3.7%	3.6%
If using 2027-2031	2.1%	3.5%	3.6%

- Changing the years used did not impact the calculated 2027 benchmark.

Source: Congressional Budget Office for forecast and Bureau of Labor Statistics for actual.

Benchmark for 2027 – 2031 cont.

- ▶ The benchmark for 2027 is calculated at 3.6%.
- ▶ For 2027-2031, the Board may use the same stepdown methodology used earlier. That stepdown adjustment would result to the following:

Year	Benchmark
2027	3.6%
2028	3.6%
2029	3.4%
2030	3.4%
2031	3.2%

Benchmark for 2027 – 2031

- ▶ The board may also choose to keep it constant for five years.

Year	Benchmark
2027	3.6%
2028	3.6%
2029	3.6%
2030	3.6%
2031	3.6%

2027 Benchmark, by state

2027 benchmarks from other cost board states
Washington and seven other benchmark states



Source: Bailit Health for other states' benchmark

	2027	2028
New Jersey	2.8%	
Connecticut*	2.8%	3.9%
California	3.2%	3.2%
Rhode Island	3.3%	
Washington**	3.6%	
Massachusetts	3.6%	
Oregon	3.8%	3.75%
Delaware	4.2%	

*Connecticut's benchmark is set to 3.9% until 2032

** Calculated in previous slide

Input for Cost Board decision: stepdown

Should the Board follow the stepdown methodology used before, or keep the Benchmark constant for 5 years?

Option 1

Year	Benchmark
2027	3.6%
2028	3.6%
2029	3.4%
2030	3.4%
2031	3.2%

Option 2

Year	Benchmark
2027	3.6%
2028	3.6%
2029	3.6%
2030	3.6%
2031	3.6%

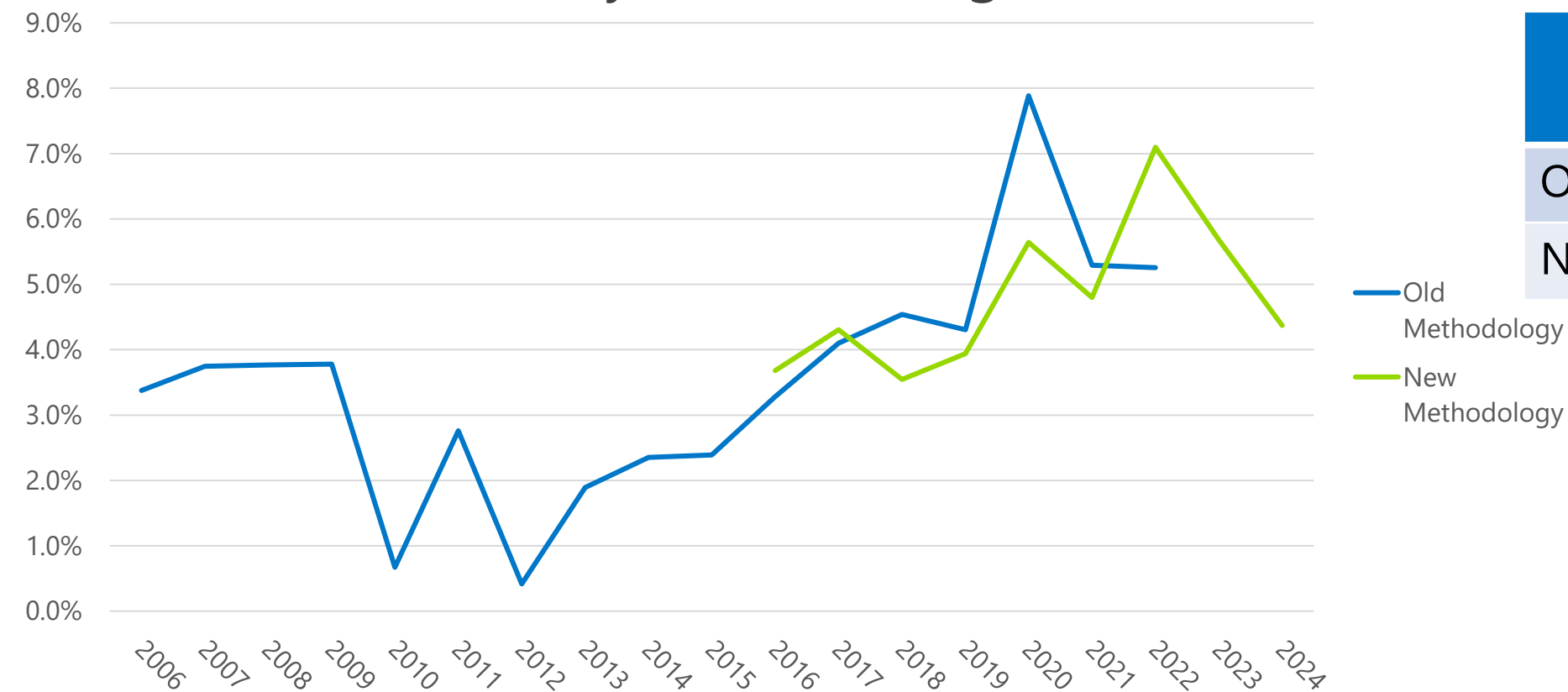
Appendix

Data Notes: Historical Hourly Median Wage Growth

1. Starting with 2015 data, the Employment Security Department (ESD) generated a [new median wage data series](#) based on a new methodology and data from a recently created database. As of August 2027, the new median wage series has data from 2015-2024. The growth rates for these two series are similar for years with overlapping data (see graph in next slide).
2. The 2022-2026 benchmark is based on the average annual growth rate of historical median wage data from 2000-2019 (based on old methodology). The 2027-2031 benchmark is based on average annual growth rate of median wage from 2005 -2015 in old series and 2016-2024 in new series.

Data Notes: Historical Hourly Median Wage Growth

Old vs New Hourly Median Wage Series Growth Rates



	Avg. Gr (2016-2022)
Old	5.0%
New	4.7%

Data Notes: Expected Labor force productivity

1. For the 2022-2026 benchmark, the average expected growth in national labor force productivity is based on data from 2021-2025 from the Congressional Budget Office's Budget and Economic Outlook as of February 2021. For the 2027- 2031 benchmark, this is based on data from 2027-2031 from the [Congressional Budget Office's Budget and Economic Outlook as of February 2026](#) .
2. This is based on the potential labor force productivity which is the ratio of potential GDP to potential labor force.

Data Notes: Expected Labor force growth

1. As of 2021, forecast data was only available in five-year increments. Hence, for the 2022-2026 benchmark, the average annual growth rate was calculated by using the compounded annual growth rate (CAGR) for 2020-2025. For the 2027-2031 benchmark, yearly forecast is available and hence, expected labor force used is based on the average annual growth rate for 2027-2031.

Data Notes: Expected national inflation

1. This is based on the growth rate of the Personal Consumption Expenditures (PCE) index.
2. For the 2022 - 2026 benchmark, the average expected national inflation is based on forecast for 2021-2025 from the Congressional Budget Office's Budget and Economic Outlook as of February 2021. For the 2027 to 2031 benchmark, this is based on forecast for 2027-2031 [as of February 2026](#).

Data Notes: Expected State Population Growth

1. For the 2022-2026 benchmark, the expected state population growth was based on average annual growth of population estimates (as of 2020) for 2022-2025. For the 2027 to 2031 benchmark, this is based on the average annual growth of population estimates ([as of Nov 2025](#)) for 2027-2031.

Questions?

Tab 6

Overview of the Cost Board's 2026 Draft Legislative Report

2026 Legislative Report - overview

1. Introduction

2. Measuring 2024 Health Care Spending in WA

3. Market Oversight

- a. Background
- b. Recent legislative efforts
- c. California and Oregon's transaction review programs
- d. Advisory committee input
- e. Recommendation

4. Primary Care

- a. Background
- b. Measuring primary care investment in Washington
- c. Strengthening the primary care workforce
- d. Primary care advisory committee input
- e. Recommendations

5. Slowing Pharmacy Spending

- a. Current pharmacy affordability efforts across the state
- b. Next steps for 2027

6. Conclusion

2026 Legislative Report – 2024 health care spending in WA

- 2024 health care spending information from Cost Board data call will be available October 24
- Data will be included in legislative report draft to be posted for public and Cost Board member comment in late September
- 2024 health care spending data will include:
 - Total Health Care Expenditures (THCE) for WA
 - Measuring THCE against the health care cost growth benchmark (3.2%)
 - Spending breakdown by service line
 - Spending breakdown by market

2026 Legislative Report - recommendations

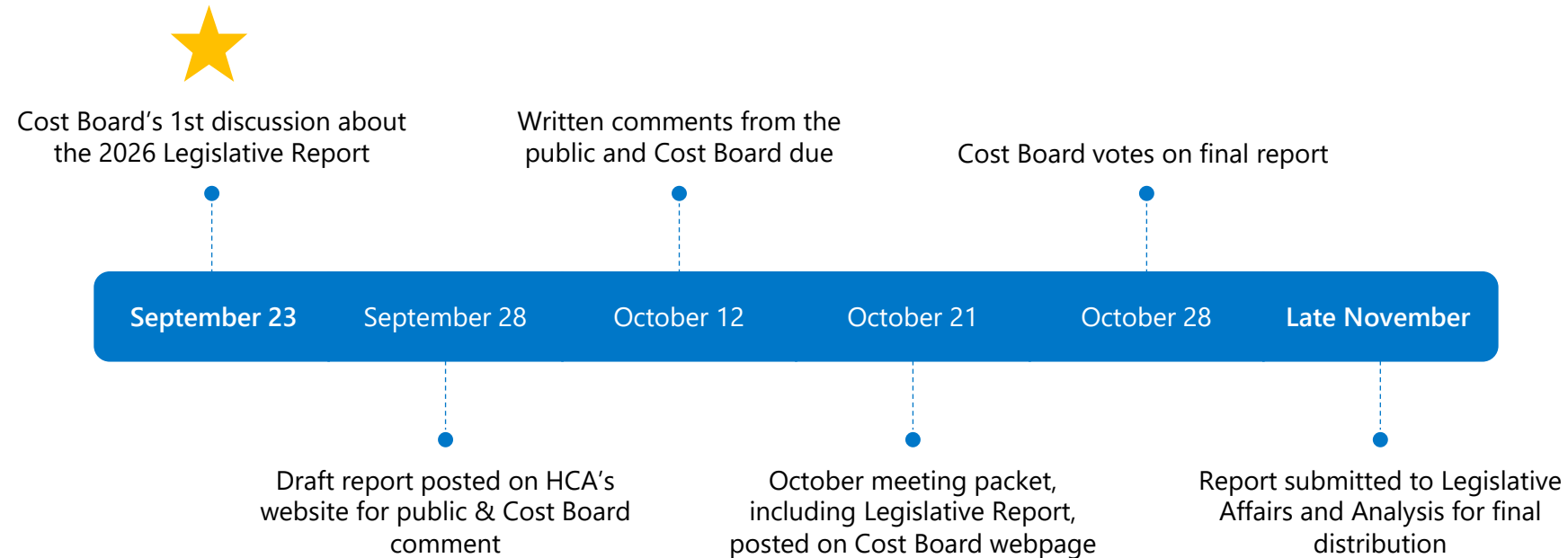
Market Oversight

- ▶ The Legislature should pursue a health care transaction review program that allows for meaningful pre, post, and ongoing review of a transaction's impact on affordability, access, and quality.

Primary Care

- ▶ Increase the primary care spending ratio.
- ▶ Strengthen health care transaction oversight.
- ▶ Protect and grow the primary care training pipeline (community-based programs)
- ▶ Support exploration of the OIC's comprehensive primary care proposal.

Legislative Report timeline



Tab 7

Cost Board Planning for 2027

2027 planning discussion - outline

- ▶ Discuss number and length of meetings
- ▶ Discuss 2027 meeting themes/topics
- ▶ Any other changes or improvements you would like to see in 2027?

Number and length of meetings

▶ Number of meetings

- ▶ In 2026, we held 7 Cost Board meetings (and 7 committee meetings)
- ▶ Our 2027 planning draft revised the meeting for 2027 to reflect the phase of work the board is in, anticipated committee engagement, and reductions in staff support

▶ Length of meetings

- ▶ In 2026, each meeting was 3 hours
- ▶ Any feedback on maintaining 3-hour meetings or reducing to 2 hours?

Cost Board feedback from 9.23.26

- ▶ In the time since the Board was formed costs have only escalated. We haven't contained them. We're not doing our job right now. Chart a course for an aggressive roadmap for bending the cost curve.
- ▶ The CB looks forward to an in-depth discussion in an in-person meeting where they can develop more solution-oriented and specific strategies and prioritize very specific actions and try things out.
- ▶ Make space for dialogue with industry stakeholders about how we can control costs.
- ▶ Looking forward to setting the next benchmark. The idea was that we would revisit enforcement another time. How to put pressure on organizations. Excited about the idea of expanding reference-based pricing.

Reviewing updated approach to attribution

- ▶ Data call collection for 2027 will be paused to allow time for review and approval of an updated provider attribution methodology
- ▶ In 2027, staff will bring a draft of an updated provider attribution methodology to advisory committees and the Cost Board for review, feedback, and discussion.
 - ▶ How to make these conversations as useful as possible?
 - ▶ What information should be included?
 - ▶ E.g., Descriptions of methodology and implementation (reporting)
 - ▶ Would you like to dedicate the whole meeting to discussing the attribution methodology?

Additional feedback

- ▶ What other changes or improvements can we make in 2027?

Questions?

Thank you for attending the
Data Issues Advisory
Committee meeting
