

# Health care spending growth in Washington, 2022–2023

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**Results from the Health Care  
Cost Transparency Board’s  
2025 data call**

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## Acknowledgements

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

Their time, recommendations, and expertise over the past year have been invaluable. A special thank you to the individuals who chaired these bodies and provided their expertise and guidance: Mich'l Needham, Eileen Cody, and Bianca Frogner.

## Acronym glossary

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<b>CMS</b>	<b>Centers for Medicare &amp; Medicaid Services</b> The federal agency that provides health coverage to more than 160 million people through Medicare, Medicaid, the Children’s Health Insurance Program, and the Health Insurance Marketplace.
<b>DOC</b>	<b>Department of Corrections</b> Washington State DOC manages all state-operated adult prisons and supervises individuals who live in the community and are under DOC supervision.
<b>DSHS</b>	<b>Department of Social and Health Services</b> The DSHS manages the administration of aging and long-term care, behavioral health, development disabilities, vocational rehabilitation, Medicaid pathways based on age and disability, and other public benefits in partnership with federal government agencies.
<b>FFS</b>	<b>Fee-for-service</b> A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.
<b>HCA</b>	<b>Washington State Health Care Authority</b> HCA administers a wide range of programs and initiatives, working to ensure Washington residents have access to better health, better care, and lower costs.
<b>L&amp;I</b>	<b>Department of Labor and Industries</b> L&I is the administrator of Washington’s workers’ compensation system. The department is similar to a large insurance company, providing medical and limited wage-replacement coverage to workers who suffer job-related injuries and illness.
<b>MCO</b>	<b>Managed care organization</b> An entity contracted by a state Medicaid agency that accepts a set per member per month (capitation) payment for health care services.
<b>NCPHI</b>	<b>Net cost of private health insurance</b> The difference between total premiums collected from enrollees and payments made to providers for health care delivered.
<b>PGSP</b>	<b>Potential gross state product</b> An estimate of the total economic value of goods produced and services provided if growth were steady and inflation stable.
<b>THCE</b>	<b>Total health care expenditures</b> The amount spent on health care and related activities such as private and public health insurance, government agency-provided health care, and public health activities.
<b>TME</b>	<b>Total medical expenses</b> The amount paid to providers for the delivery of health care services to the member population, including patient out-of-pocket costs and non-claims payments.
<b>VA</b>	<b>U.S. Department of Veterans Administration</b> The VA administers the largest integrated health care system in America, providing health care services for military veterans, with facilities throughout the country, the Veterans Health Administration (VHA).

## Executive summary

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In response to rising health care spending, Washington state's Legislature established the Health Care Cost Transparency Board (Cost Board) in 2020. As part of the efforts to make health care more affordable, the Cost Board set a growth rate that carriers and providers should endeavor to stay below. This growth rate is called the **health care cost growth benchmark** or the benchmark. For 2023, the benchmark was 3.2%, calculated based on indicators of wage and overall economic growth.

In 2025, the Cost Board collected spending data for 2022 and 2023 from the state's largest health care payers. With this data, the board reports on spending growth rates and compares cost growth to the benchmark. Cost Board staff presented key findings at the [November 20, 2025, Health Care Cost Transparency Board Public Hearing](#), and these findings are further discussed in this report.

Total health care costs in Washington in 2023 reached a record **\$56.9 billion** in 2023 — approximately \$8,000 per person per year. Health care spending represents approximately 7% of Washington's 2023 gross state product<sup>1</sup> and 28% of median annual income per person for a four-person household.<sup>2</sup> The rising costs detailed in this report are passed on to the consumer in the form of higher premiums, deductibles, and out-of-pocket expenses. Many Washingtonians already struggle to pay for care. Nearly six out of 10 Washington residents report at least one affordability burden in the last year, and nearly nine out of 10 worry about affording health care in the future.<sup>3</sup>

### 2023 spending growth performance against the benchmark

The data show that statewide spending growth **markedly exceeded the 3.2% benchmark**. The per-member total health care expenditure (THCE) grew year over year by 6.2% in 2023. This growth is a rapid increase from the 3.6% growth observed in 2022. Other findings from 2023 include:

- Spending growth in all markets exceeded the benchmark. Per-member total medical expenses (TME) grew 7.2% in the commercial and Medicare markets and 5.2% in the Medicaid market.
- **Nine out of 11 insurance carriers** in the commercial market exceeded the benchmark.
- **Twelve out of 19 large provider organizations** in the commercial market exceeded the benchmark.
- Washington's overall spending growth was in line with other states that report performance against a benchmark.
- Per-member total health care expenditures grew by 29.4% between 2017 and 2023.

### Contributors to growth

In previous years, contributors to spending growth were concentrated in a few categories. In contrast, growth in 2023 was more evenly distributed across several categories. Findings include:

- In the commercial market, the lead contributor to spending growth was **hospital outpatient spending**. Professional services, hospital inpatient, and prescription drug spending also made sizeable contributions.
- The lead contributor to growth in the Medicare market was **prescription drug spending**. Non-claims spending, hospital outpatient, professional services, and other claims spending made roughly equal contributions. Increases in capitation and bundled payments drove increases in non-claims spending.
- Following a period of slower growth, the Medicaid market grew substantially in 2023. The lead contributors were **prescription drug spending** and **professional services**.

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<sup>1</sup> Gross state product was approximately \$800 billion in 2023. [Gross Domestic Product](#). Federal Reserve Bank of St. Louis.

<sup>2</sup> Median annual income for a four-person household in Washington was \$113,436 in 2023. [State median income chart](#). Washington State Department of Social and Health Services.

<sup>3</sup> [2024 Washington State Health Care Affordability Survey](#). Digital Research, Inc.

This benchmark report is organized into six sections. The first section provides background on the work of the Cost Board, including the work on the cost growth benchmark and performance against the benchmark (the focus of this report). The remaining five sections present the analysis of the spending data collected by the Cost Board. The second section analyzes the overall spending in 2023 relative to previous years. The third section compares the year-over-year per member spending growth rate in 2023 against the benchmark at the market, carrier, and large provider organization levels. The fourth section discusses growth by service category and contributors to overall growth. The fifth section provides a brief look at primary care spending, and the final section provides a longer-term view by looking at 2019–2023 cumulative growth rates by service category and market.

# Introduction

## Background

In 2020, [House Bill 2457](#) established the Cost Board to support reducing health care cost growth and increasing price transparency. The goal is to help make health care affordable for individuals, families, businesses, and others in Washington state.

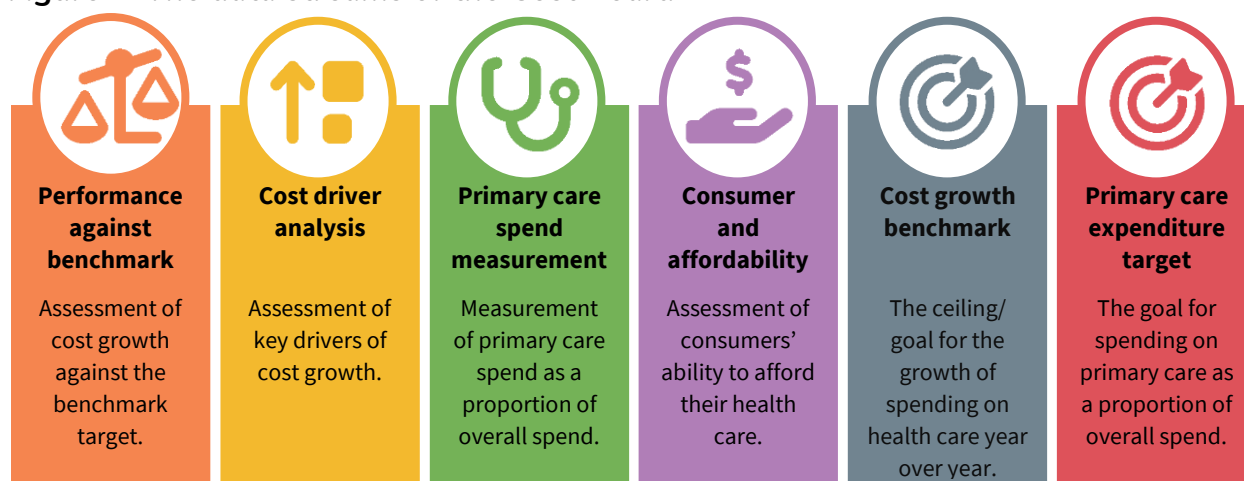
The Cost Board strives to achieve this goal by:

- Determining the state’s total health care expenditures.
- Setting a health care cost growth benchmark for providers and payers.
- Identifying spending trends and cost drivers in the health care system.
- Providing policy recommendations for lowering health care spending to the Legislature.

In 2025, the Cost Board analyzed information from multiple data streams (Figure 1) in partnership with numerous stakeholders. This work is summarized in the [Annual Report to the Legislature](#). In contrast, this report focuses specifically on the first data stream in Figure 1 — performance against the benchmark.

This benchmark performance report presents health care expenditure trends from 2017–2023 with a focus on assessing performance for 2023. This follows the [brief released in early 2025](#), which focused on performance in 2022 and across the pandemic period from 2019–2022, and [another in 2024](#), which presented analysis on health care spending data in the period 2017–2019.

**Figure 1: The data streams of the Cost Board**



## Health care spending growth benchmark

In September 2021, the Cost Board approved Washington’s spending growth benchmark for 2022–2026 (Table 1). The benchmark is a specific rate that the expenditure performance of carriers and providers has been measured against since 2022.

In establishing the benchmark, the Cost Board reviewed how other states created their benchmarks and considered many different factors that might influence their choice of benchmark. To derive the cost growth benchmark, the Cost Board adopted a methodology that uses a 70/30 weighting of the growth rates of historical nominal median wage and nominal per capita potential gross state product (PGSP).

The goal is to encourage health care industry participants to achieve a rate of health care spending growth that is the same or slower than the growth of income. Slower spending growth contributes to greater health care affordability.

**Table 1: Spending growth benchmark for Washington state**

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

Each year starting with 2022 data, the Cost Board compares the spending growth benchmark against actual health care spending per member per year (PMPY) growth rate (performance) at the following levels of aggregation: statewide, by market (i.e., commercial, Medicare, Medicaid), by carrier, and by large provider organization. Performance in these groups is specifically measured by the metrics in Table 2.

**Table 2: Performance indicators by aggregation levels**

Aggregation level	Basis for performance
Statewide	Total health care expenditure (THCE) PMPY growth rate
Markets	Total medical expenditure (TME) PMPY growth rate
Carriers	Confidence interval of age-sex adjusted truncated TME PMPY growth rate
Large provider organizations	Confidence interval of age-sex adjusted truncated TME PMPY growth rate

[Appendix A](#) explains the data sources and the formulas for calculating the various performance indicators. In summary, data was collected from carriers (insurers) at the parent company level and from other entities that have health care spending in Washington:

- Centers for Medicare & Medicaid Services (CMS)
- Health Care Authority (HCA)
- Department of Labor and Industries (L&I)
- Department of Corrections (DOC)
- U.S. Department of Veterans Affairs (VA)

Note that non-carrier data isn't broken down by large provider organization and by carriers, so carrier and large provider organization performance is based on carrier data alone. Since data on large provider organizations come from carrier data, carriers must attribute members to large provider organizations. Moreover, to ensure that a few high-cost clients don't impact carrier and large provider organization performance, the Cost Board calculates growth rates based on truncated and age-sex adjusted spending numbers. Based on these adjusted numbers, a confidence interval of the spending growth rate is calculated and compared to the benchmark.

[Appendix A](#) provides links to detailed discussion on attribution and the methodologies used to measure carrier and large provider organization performance.

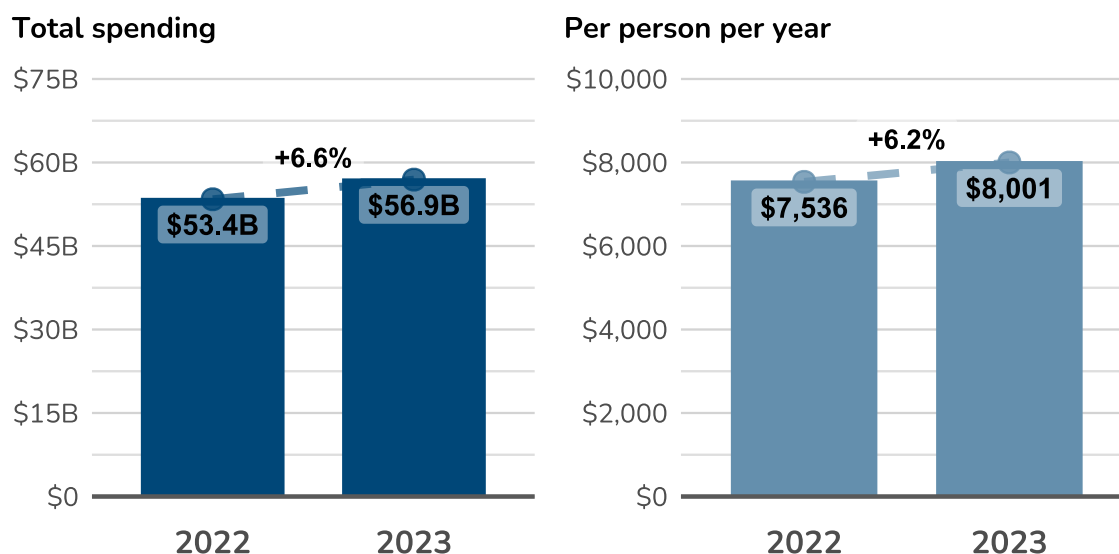
## Overall spending

This section provides an analysis of health care spending trends in Washington state. The analysis covers total health care expenditures (THCE) and its components.

### Total health care expenditures

Total health care expenditures (THCE) in Washington state grew by 6.6% (\$3.5 billion), reaching \$56.9 billion in 2023 (Figure 2, left panel). On a per-person basis, THCE surpassed \$8,000 and grew by **6.2%**, the second-highest growth rate since the Cost Board began collecting data in 2017 (Figure 2, right panel). The \$8,001 THCE PMPY in 2023 represents roughly 28% of the median annual income per person for a four-person household<sup>4</sup>.

**Figure 2: Growth in total health care expenditure (THCE)**

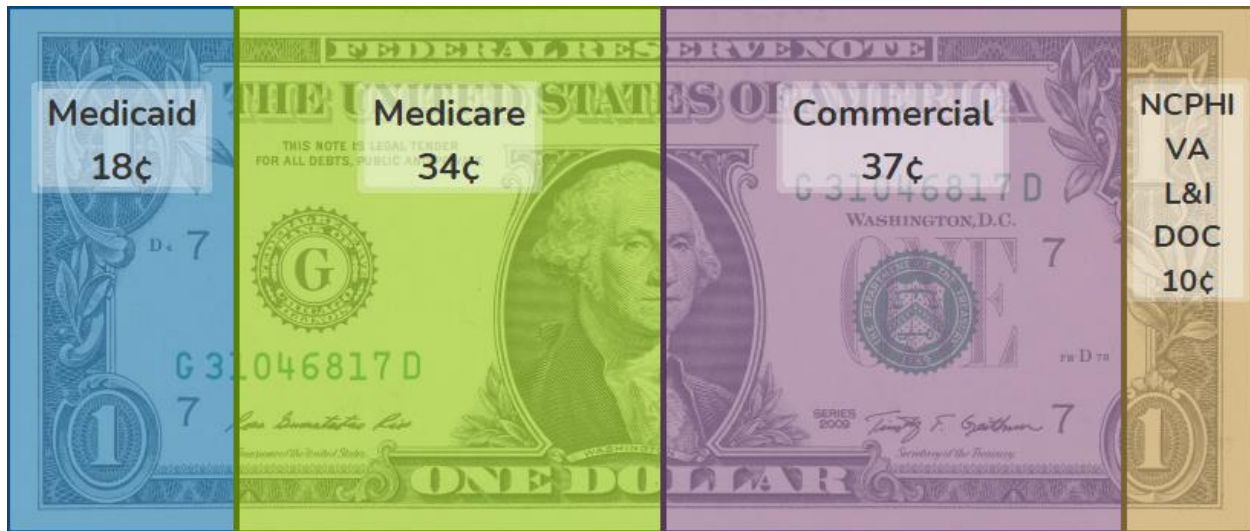


THCE is composed of seven components, collectively listed in Figure 4 and detailed in Appendix A. A large majority of THCE is total medical expense (TME), which is the total sum of claims and non-claims payments to providers in Washington in the commercial, Medicare, and Medicaid markets. Out of every dollar of health care spending, 90 cents goes to TME (Figure 3). The Medicare and commercial markets are the largest part of TME, making up 34% and 37% of THCE, respectively. The remaining 10% of THCE that is not TME includes the net cost of private health insurance (NCPHI), and government or government-administered health care spending in agencies like DOC, VA, and L&I.

The \$3.5 billion increase in 2023 expenditures is largely driven by a \$1.8 billion increase in the commercial market, followed by a \$1.5 billion increase in the Medicare market (Figure 4). This is typical of historical data in non-pandemic years, where commercial and Medicare typically drive increases in total spending. For more historical data, see [the 2024 spending growth report](#).

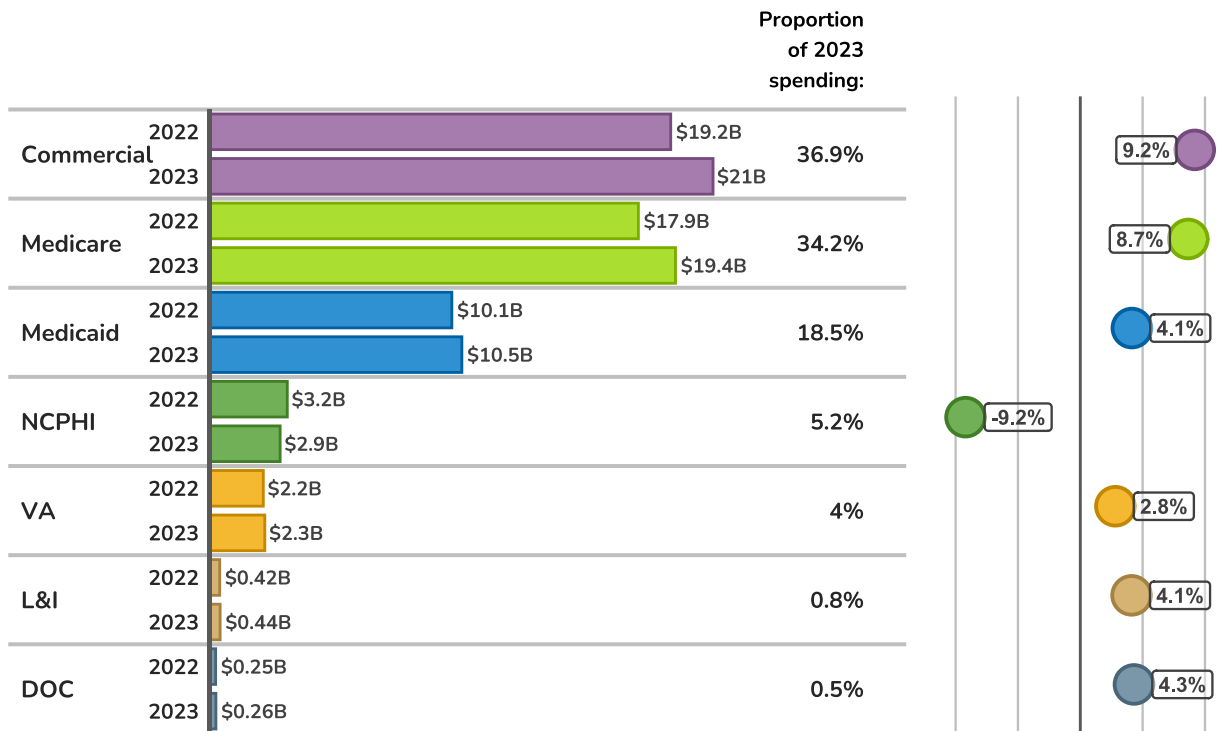
<sup>4</sup> Median annual income for a four-person household in Washington was \$113,436 in 2023. [State median income chart](#). Washington State Department of Social and Health Services.

**Figure 3: Breakdown of all health care spending**



The highest growth in 2023 was in TME for the commercial and Medicare markets (Figure 4). The Medicaid market showed more modest growth, while the non-TME components of THCE had modest growth or even decreased. NCPHI reflects the difference between premiums and claims for carriers and includes expenses, premium taxes, profits or losses, and contributions to reserves. It is typically volatile since premiums are set based on expectations of future claims. After large swings in 2020 and 2021 and a 6.7% increase in 2022, NCPHI decreased somewhat in 2023 (Figure 4).

**Figure 4: Total health care expenditure; breakdown and growth rate by component**



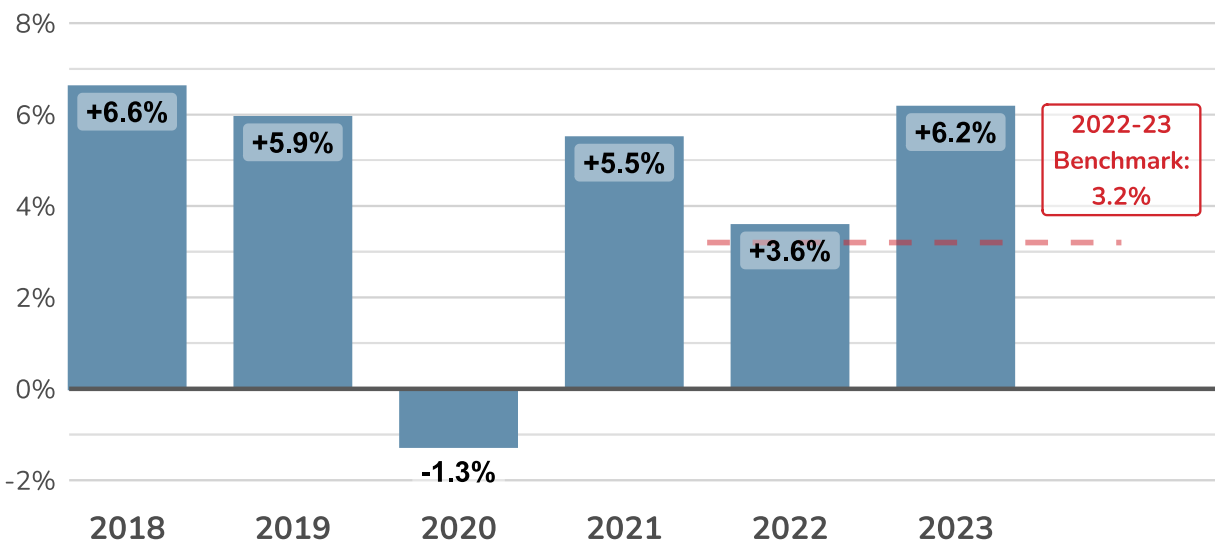
## Comparing 2023 performance against the benchmark

This section compares statewide, market, carrier, and large provider organization 2023 performance against the benchmark. In addition, there is a comparison of Washington’s performance with states employing similar analytic strategies.

### Statewide performance

As indicated in Table 2, statewide performance is measured by the growth rate in THCE per member per year (PMPY). Statewide spending growth markedly exceeded the cost growth benchmark of 3.2% with year-over-year THCE PMPY growth registering 6.2% in 2023. This is the second-highest growth rate observed since the Cost Board began collecting data (Figure 5).

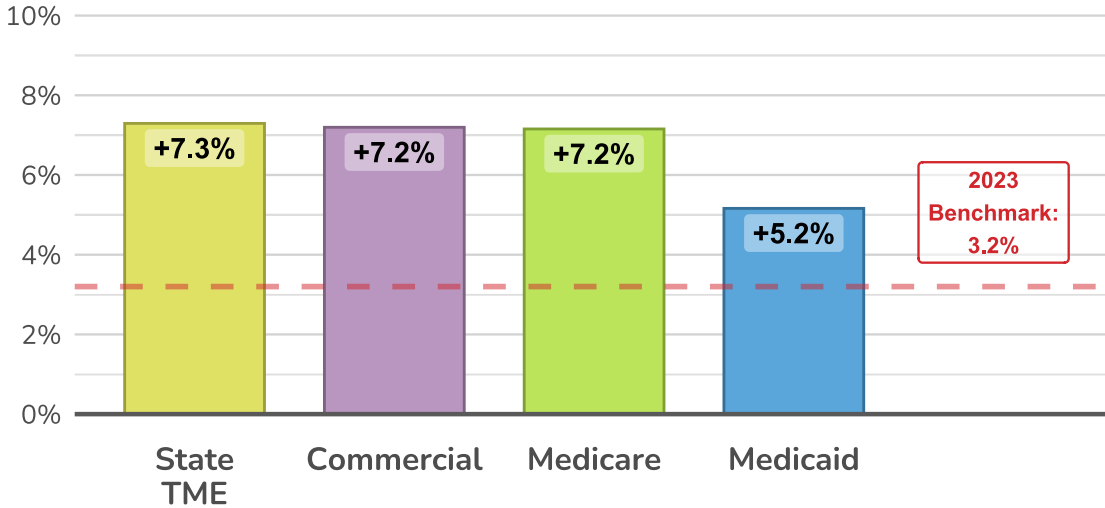
**Figure 5: Historical trend in health care spending per person**



### Market performance

To assess market performance against the benchmark, each market’s total medical expense (TME) per member per year (PMPY) growth is compared to the benchmark. TME PMPY in the Medicare market grew by 7.2%, more than double the 3.2% benchmark in 2023 (Figure 6). The TME PMPY in the commercial market also grew 7.2%, again more than double the benchmark. Growth in the Medicaid market was somewhat slower, at 5.2%, which still exceeded the benchmark.

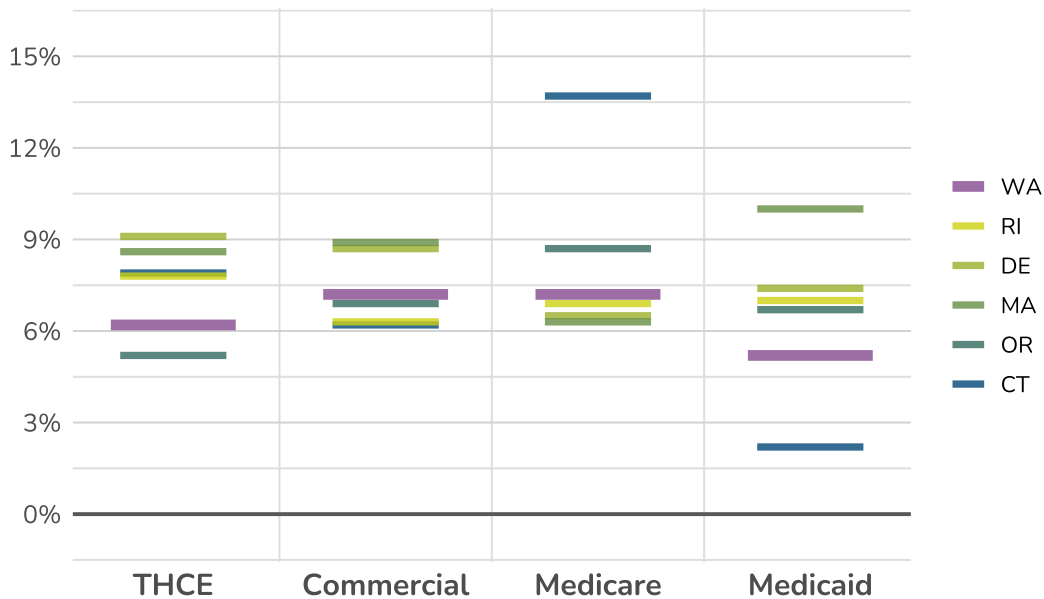
**Figure 6: Total medical expense growth in 2023 by market, PMPY**



**Washington’s statewide performance relative to other states’**

Washington state’s 2023 per-member overall THCE and market-level TME growth rates are comparable to the PMPY growth rates of most states with similar cost transparency programs (Figure 7).<sup>5</sup> Most states saw sizeable increases both overall and by market, with particular variability in Medicaid growth rates.

**Figure 7: 2023 Growth in PMPY for THCE and three markets, comparing Washington to five other benchmark states**



Source: WA Health Care Cost Transparency Board Data Call, Bailit Health analysis

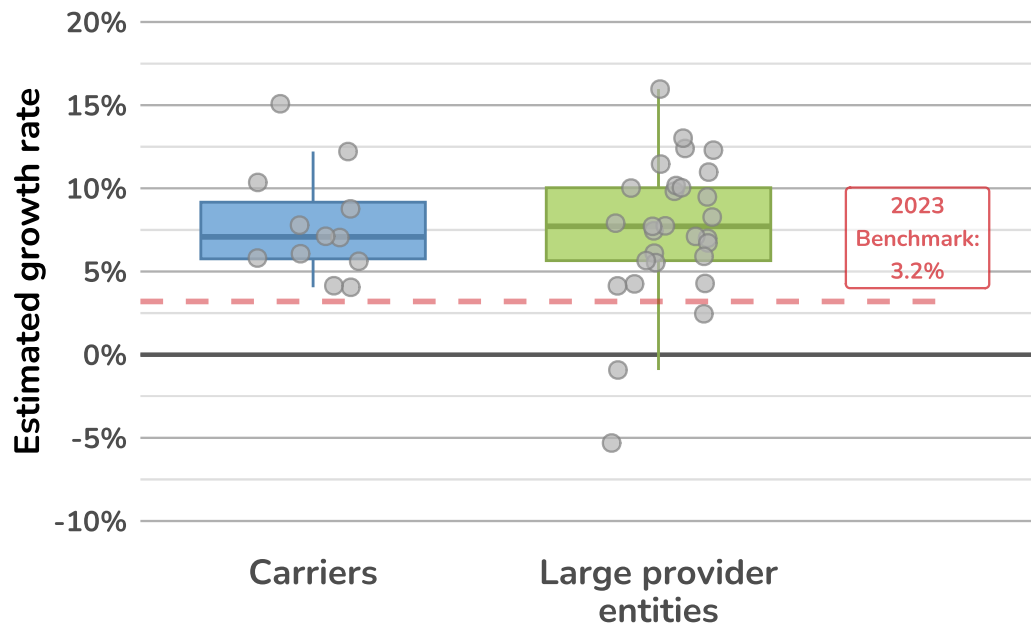
<sup>5</sup> Spending growth rates for five other benchmark states compiled in a [Health Affairs report](#) authored by Bailit Health.

## Carrier and provider performance

### Overall carrier and provider performance

There was a wide distribution of estimated growth rates across both carriers and large provider organizations in 2023 (Figure 8). However, overall growth rates (i.e., growth rate of the truncated and age-sex adjusted TME PMPY) were high relative to the 3.2% benchmark. In general, growth rates for large provider organizations varied more than growth rates for carriers.

Figure 81: Overall 2023 carrier and large provider organization performance against the benchmark, measured by the growth rate of total medical expense, PMPY

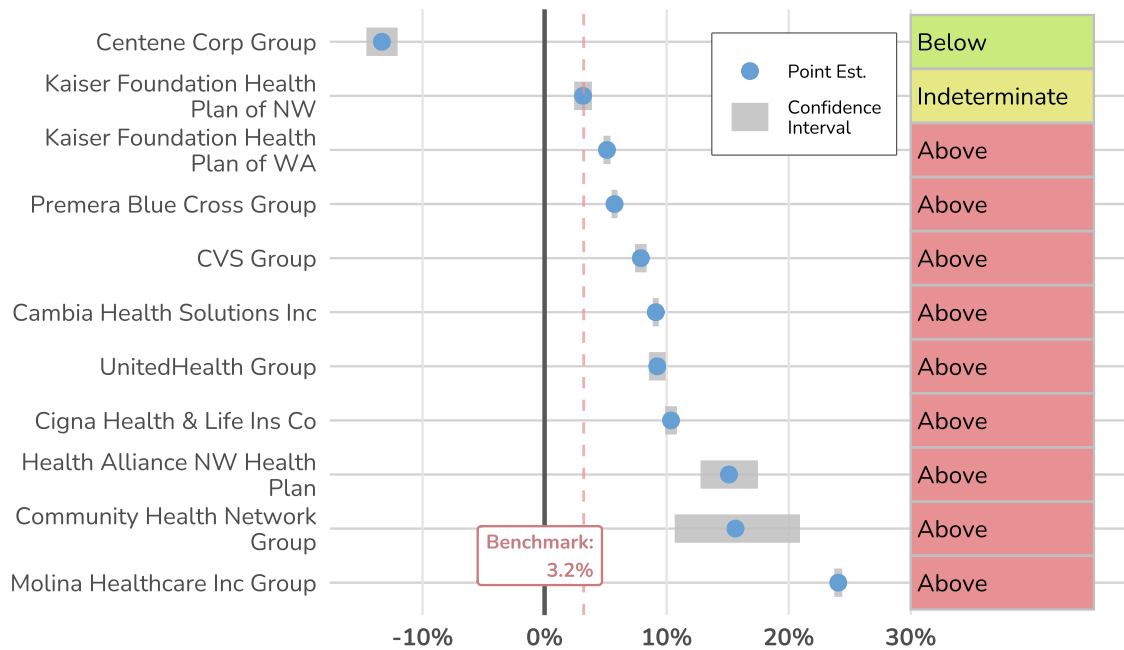


### Carrier performance by market

When broken out by market, performance against the benchmark shows a broad range of growth rates across carriers, while following the overall pattern of high growth rates in 2023 (Figure 9).<sup>6</sup> In the commercial market, nine of 11 carriers exceeded the benchmark with statistical confidence (i.e., the lower endpoint of the confidence interval was higher than the benchmark).

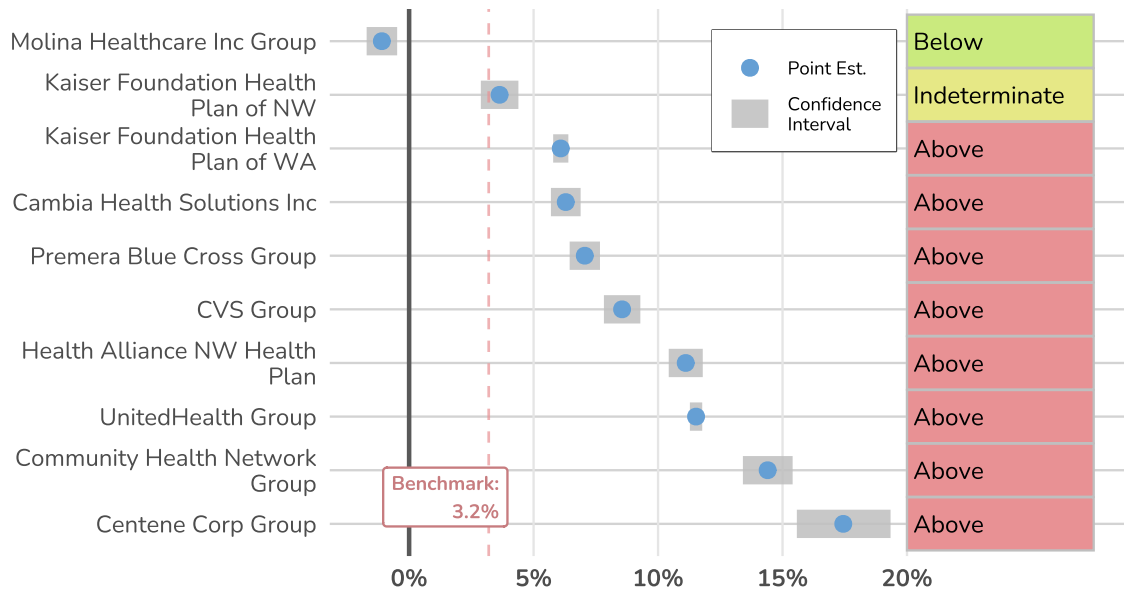
<sup>6</sup> Overall provider and carrier reporting is limited to large provider entities whose member months meet the 120,000 member months threshold. Moreover, reporting on market performance is limited to markets where a provider has at least 60,000 member months. The number of carriers and providers statewide (see Figure 8) and in each market (see Figures 9–14) may differ because not all large provider organizations or carriers meet overall and/or market thresholds.

**Figure 9: 2023 carrier performance against the benchmark in the commercial market, measured by the growth rate of TME PMPY**



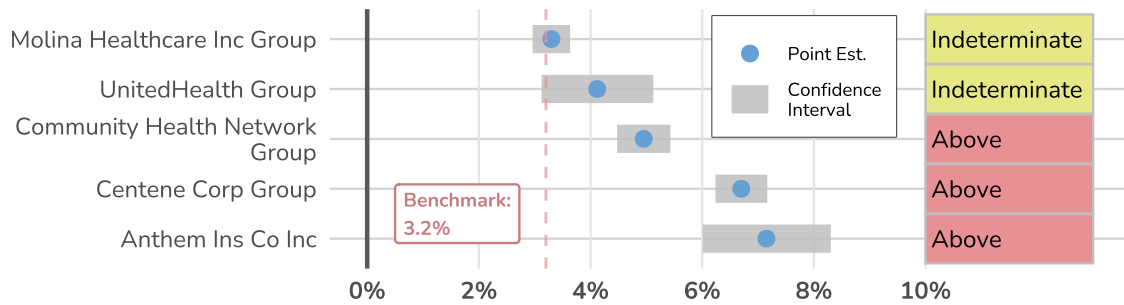
Eight of the 10 carriers operating in the Medicare market were above the benchmark in 2023, with only one carrier significantly below the benchmark (Figure 10). Most growth rates were well above the 3.2% benchmark.

**Figure 10: 2023 carrier performance against the benchmark in the Medicare market, measured by the growth rate of TME PMPY**



Three of the five carriers in the Medicaid market exceeded the benchmark with statistical confidence, while two were indeterminate (Figure 11). Although Medicaid growth rates tended to be lower than other markets, a majority of carriers still exceeded the benchmark, and no carrier was statistically below the benchmark.

**Figure 11: 2023 carrier performance against the benchmark in the Medicaid market, measured by the growth rate of TME PMPY**

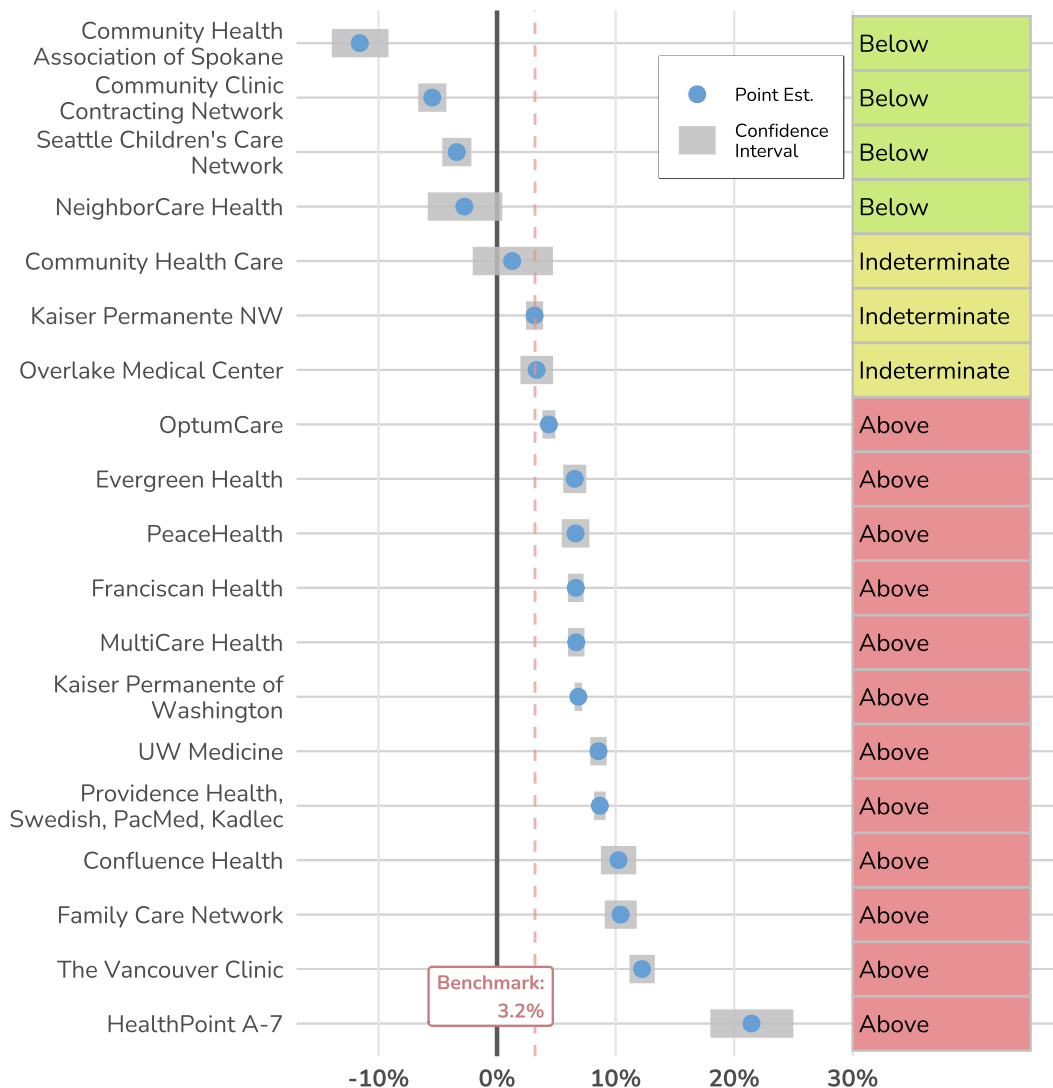


## Provider performance by market

Like the carriers', providers' performance in each market is measured by the confidence interval for the growth in the truncated, age-sex adjusted total medical expenditures per member per year (PMPY).<sup>7</sup>

In the commercial market, 12 of the 19 large provider organizations (identified by those with more than 5,000 attributed primary care lives) exceeded the 3.2% benchmark (Figure 12). Growth of TME PMPY (truncated and age-sex adjusted) for members that are unattributed to large provider organizations was 8.0%, above the growth rate for the commercial market overall. Unattributed members make up 56% of the commercial market.

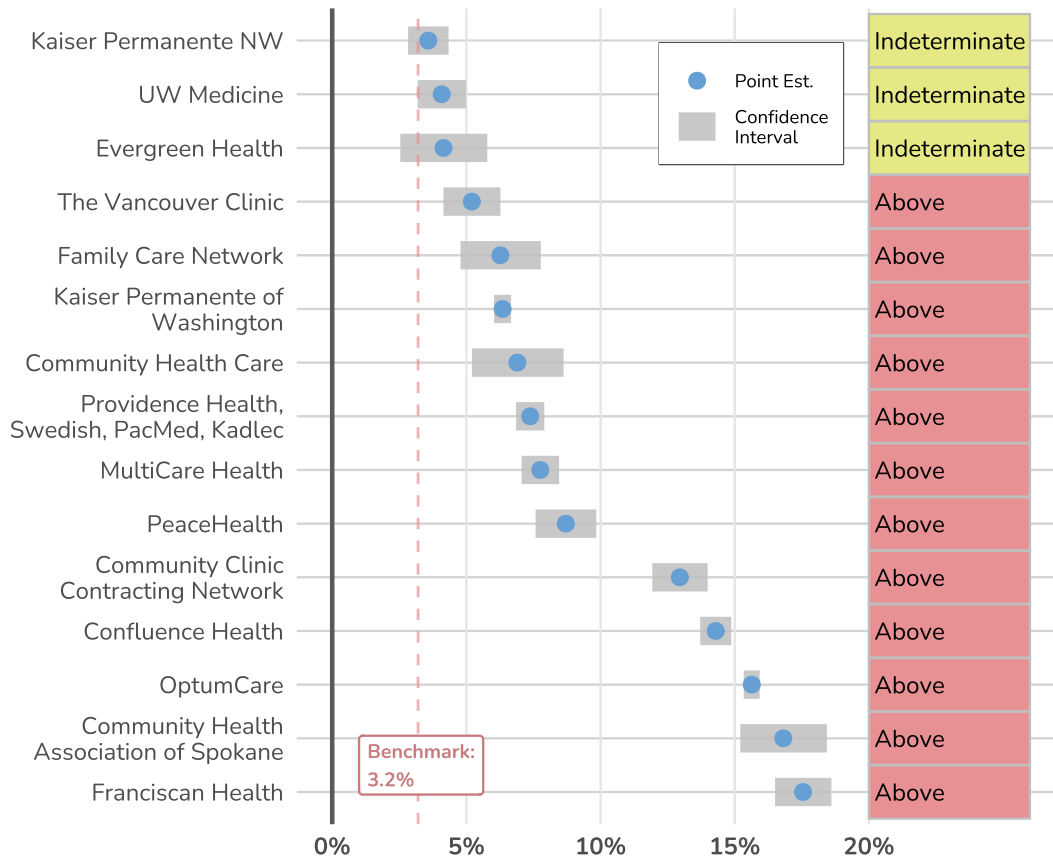
**Figure 12: 2023 provider performance against the benchmark, measured by the growth rate of total medical expense in the commercial market, PMPY**



<sup>7</sup> See footnote 6.

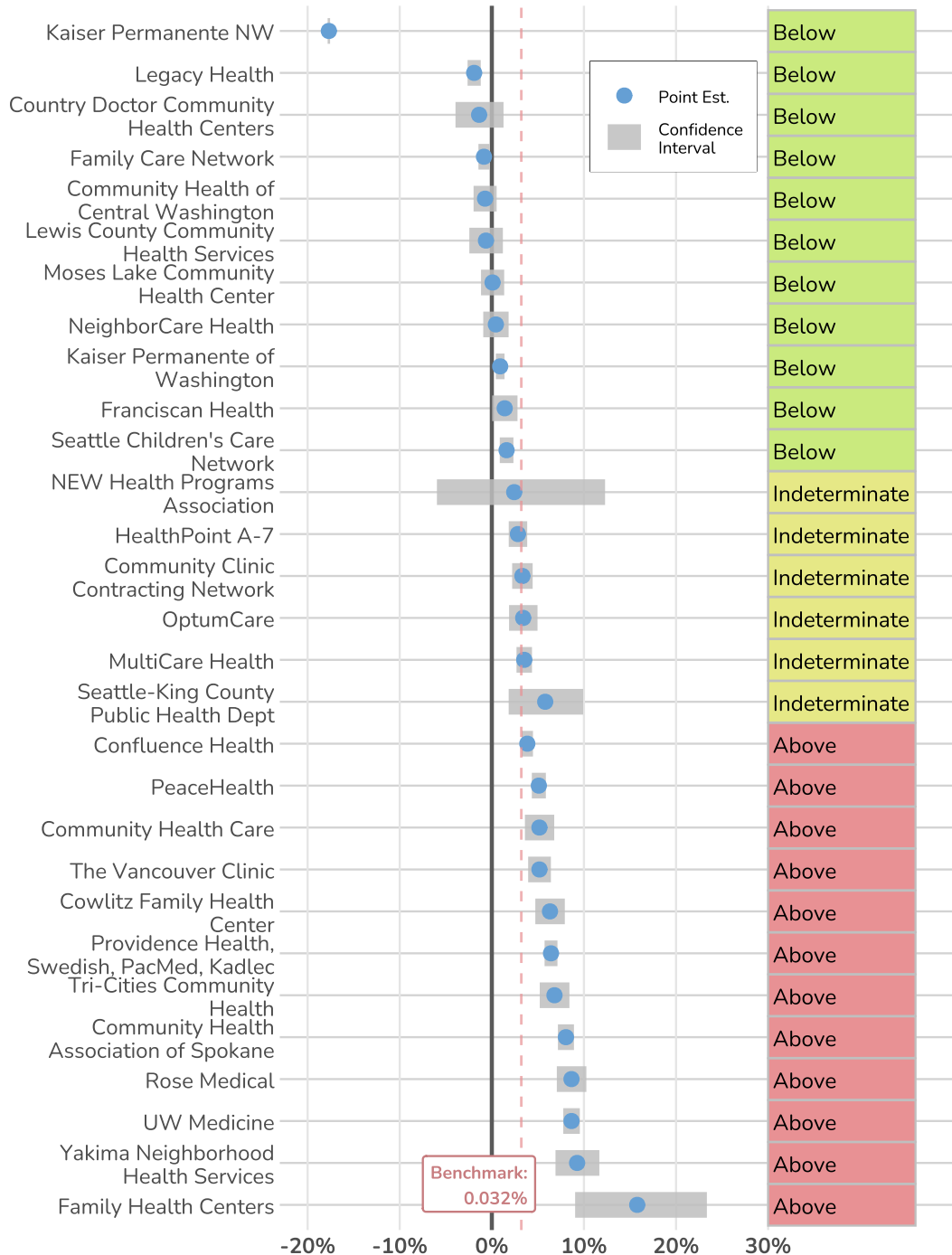
In the Medicare market, 12 of the 15 large provider organizations exceeded the benchmark (Figure 13). Growth of TME PMPY for unattributed members was 11.6 %, and unattributed members make up 23% of the Medicare Advantage population. Due to data limitations in Medicare FFS data from CMS, provider performance includes only Medicare Advantage members.

**Figure 13: 2023 provider performance against the benchmark, measured by the growth rate of total medical expense in the Medicare market, PMPY**



In the Medicaid market, 12 of the 29 large provider organizations exceeded the benchmark (Figure 14). Growth of TME PMPY for unattributed members was 5.7%, generally in line with growth for the market. Unattributed membership was about 31% of the Medicaid Managed Care membership. Due to data limitations, provider performance for Medicaid includes only Medicaid Managed Care members.

**Figure 14: 2023 provider performance against the benchmark, measured by the growth rate of total medical expense in the Medicaid market, PMPY**



## Total medical expense

### Service category breakdown

Total medical expense (TME) is divided into categories based on the type of spending and the type of service provided. Carriers pay providers for health care rendered either by a claims process or by non-claims mechanisms, such as capitation or performance-based payments. Details about the types of claims and non-claims spending can be found in the appendix. The Cost Board divides professional claims into three types of professional services:

- **Primary care:** Detailed in the [primary care section](#).
- **Specialty care:** Includes services provided by a doctor of medicine or osteopathy in clinical areas other than family practice, geriatrics, internal medicine, or pediatrics.
- **Professional, other:** Includes podiatrists, physical and occupational therapists, counselors, dieticians, and others not included in the first two categories.

CMS reports Medicare FFS data using different categories, so reporting for the Medicare market and state overall combines the three professional services categories into a single, broad professional services category. The commercial and Medicaid markets are reported using the individual professional categories.

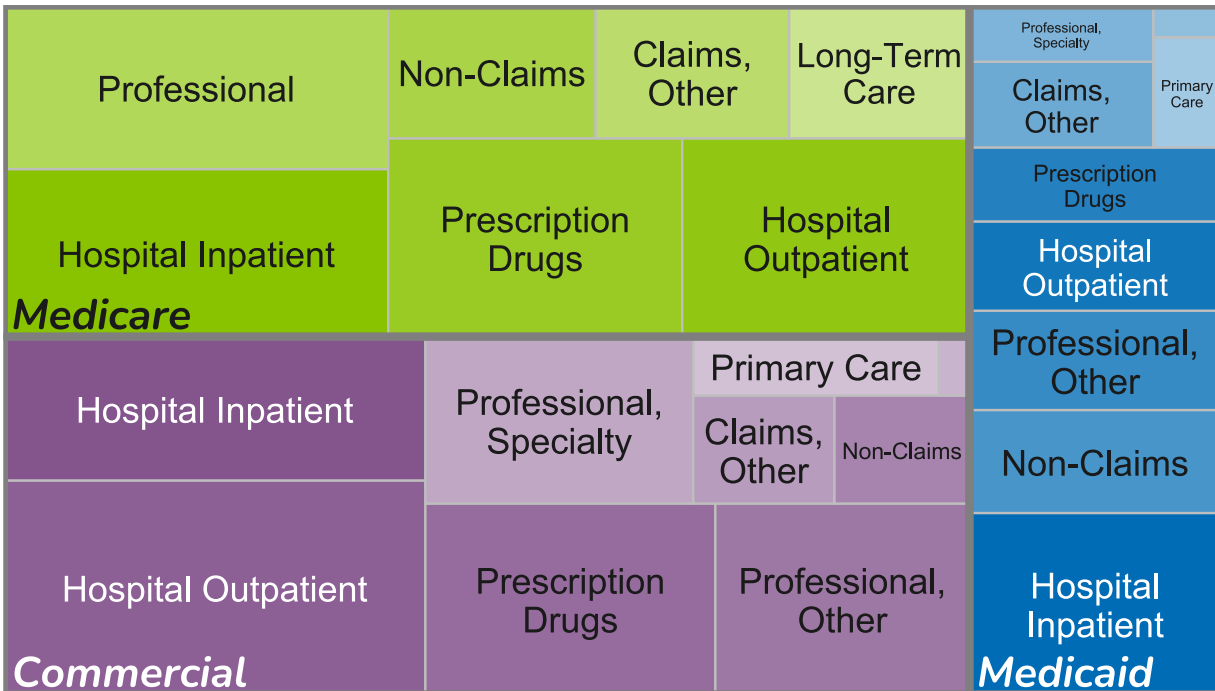
For the state overall, combined spending on hospital (inpatient and outpatient) and professional services accounted for almost two-thirds of TME (Figure 15). Retail prescription drugs accounted for another 16%, with the remainder coming from non-claims, other claims, and long-term care spending.

**Figure 15: Service category spending breakdown across three TME markets**



TME spending is dominated by the Medicare and commercial markets (Figure 16). For the commercial market, the largest categories are hospital inpatient and hospital outpatient. For the Medicare market, the largest categories are hospital inpatient and professional, although spending on prescription drugs and hospital outpatient services is also large. For Medicaid, the largest category is hospital inpatient, with non-claims a distant second.

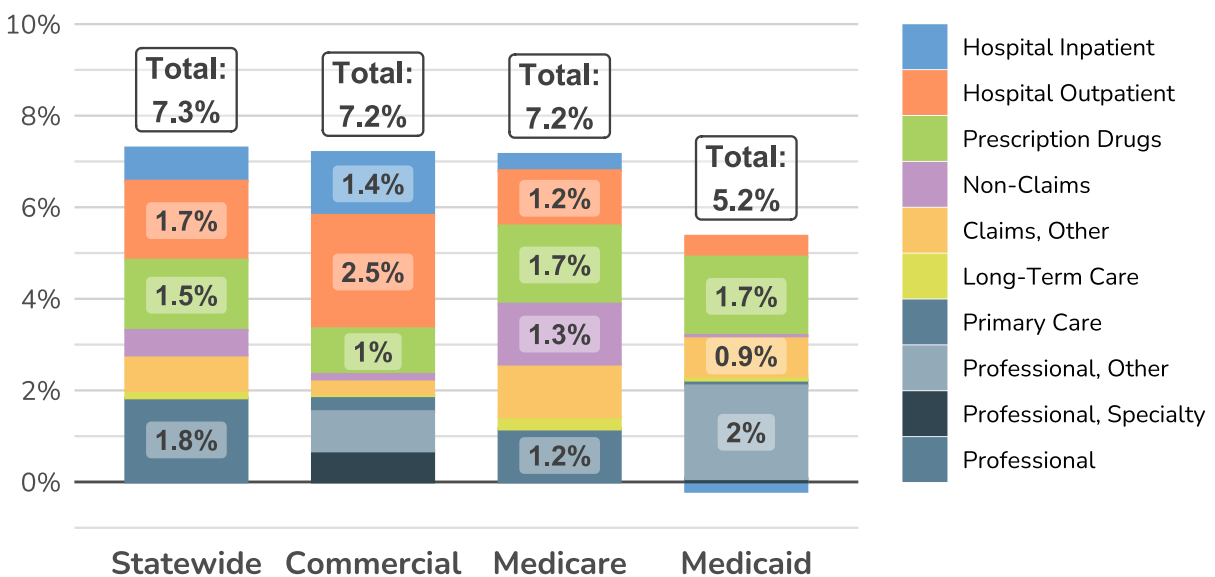
**Figure 16: Service category spending breakdown across three TME markets**



### Contributors to growth

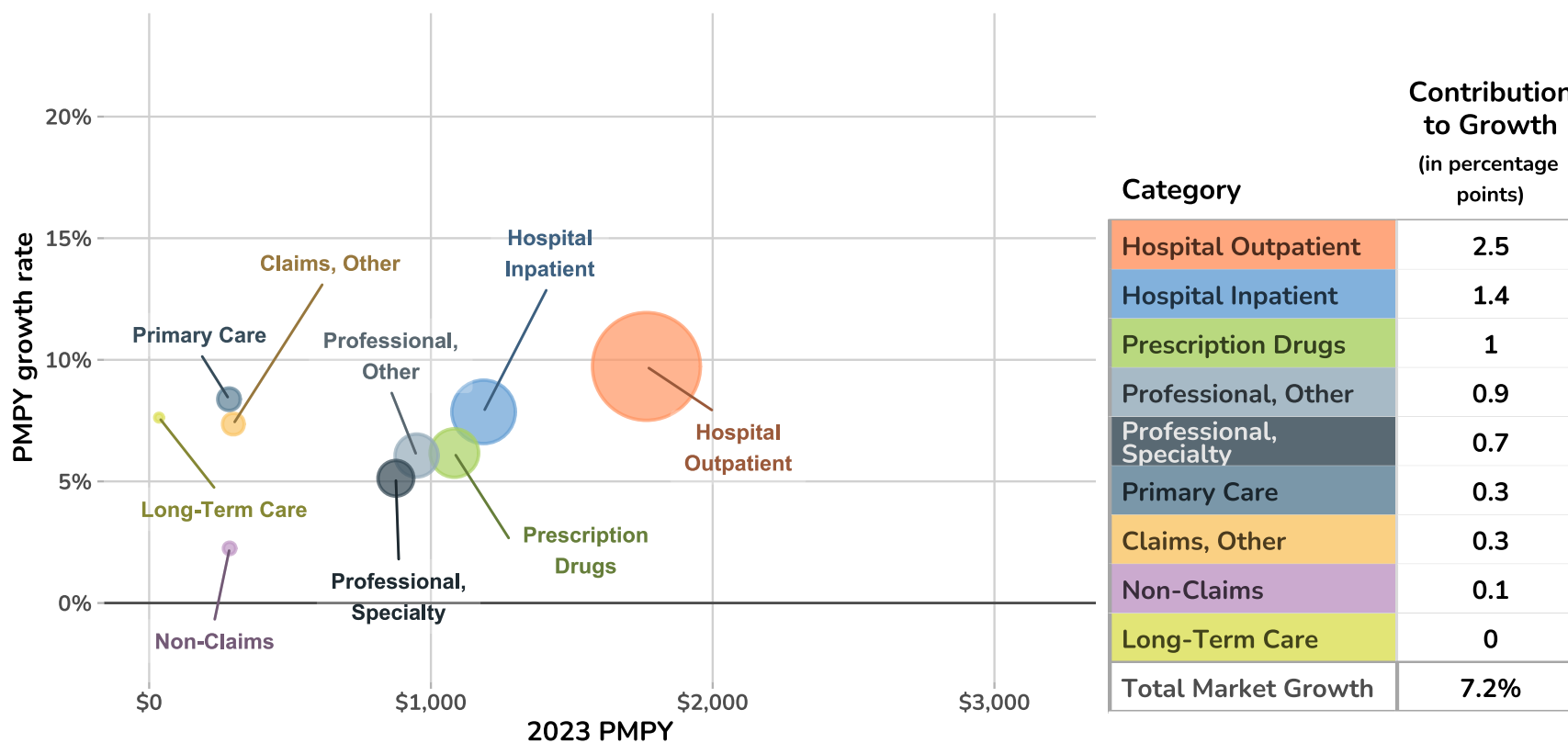
As reported above, each market grew at a rate greater than the benchmark in 2023, and contributions to growth in each market were distributed across multiple categories. For the state overall, the largest contribution to growth came from professional spending (1.8 percentage points, or ppts, of the 7.3 ppt total PMPY growth), followed closely by hospital outpatient (1.7 ppts) and prescription drugs (1.5 ppts). Together the top three categories accounted for about 2/3 of the overall growth. (Figure 17).

**Figure 17: Contribution to PMPY growth by service category spending**



In the commercial market, the largest contributor to growth was hospital outpatient spending (2.5 ppts of the 7.2 ppt total growth, or about 35% of the overall growth), as indicated by the size of the bubbles and the values in the table within Figure 18. Hospital outpatient was the largest contributor to growth by a wide margin. Unusually, the second-largest contributor to growth was hospital inpatient spending (1.4 ppts). Hospital inpatient spending PMPY in the commercial market was essentially flat between 2019 and 2022 (see the [2024 benchmark brief](#)), so this represents a departure from recent trends. Prescription drugs were the third-highest contributor to growth (1.0 ppt). Together, the top three categories accounted for about 2/3 of the total growth for the commercial market.

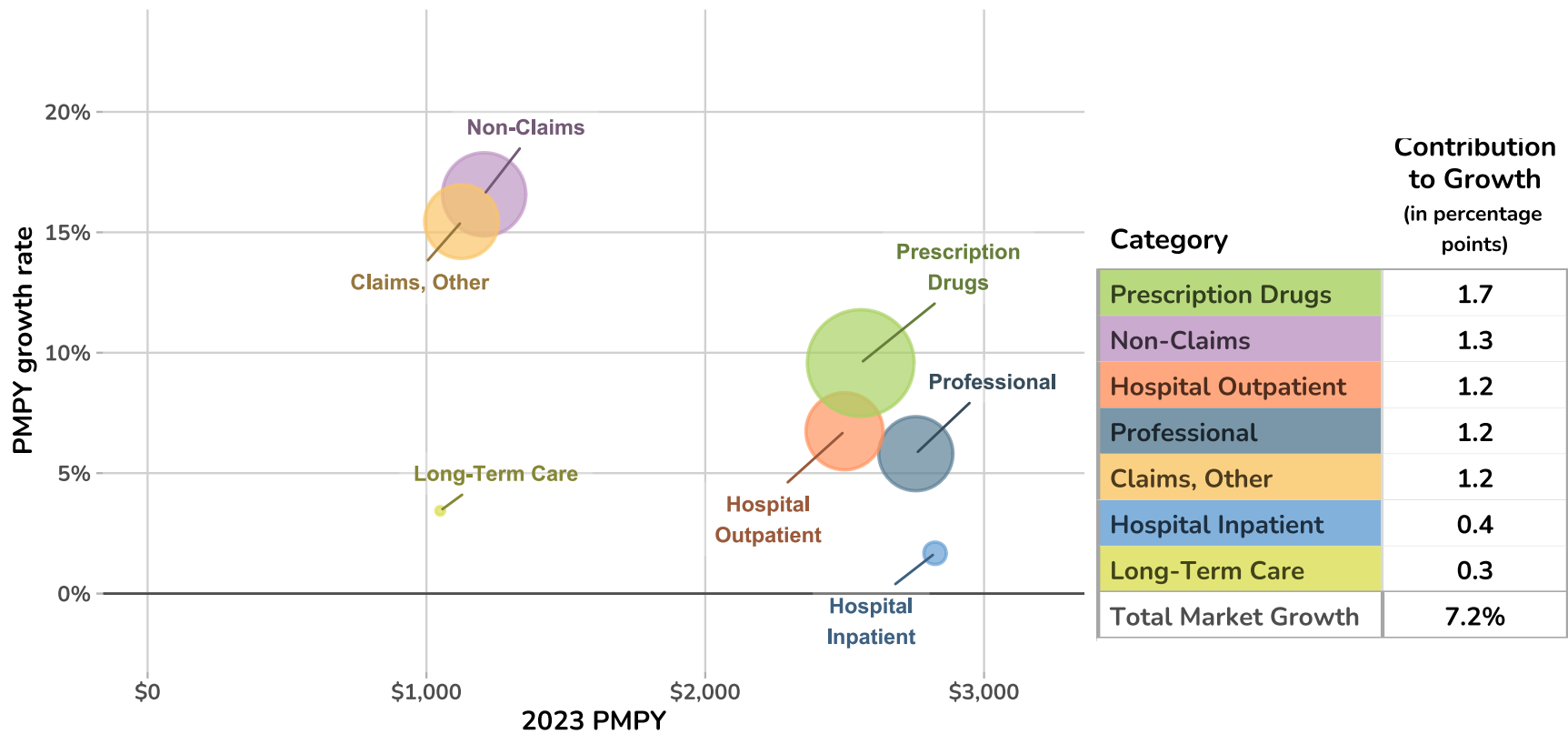
**Figure 18: Change in total medical expense by category in the commercial market between 2022 and 2023**



Note: Bubbles sized by contribution to overall market growth rate

In the Medicare market, the largest contributor to growth was retail prescription drugs (1.7 pts of the 7.2 ppt total growth; Figure 19). In addition, non-claims (1.3 pts), hospital outpatient (1.2 pts), professional (1.2 pts), and claims, other (1.2 pts) all made sizeable contributions. The non-claims growth came primarily from growth in capitation and bundled payments, with a large part of that growth coming from one carrier/provider pair, United Healthcare and Optum Care. For the Medicare population, PMPY spending is roughly double that of members in the commercial and Medicaid markets, reflecting an older population and higher chronic disease prevalence. While non-claims and claims, other both had sizeable contributions to growth, the largest categories by PMPY are professional services, hospital inpatient, prescription drugs, and hospital outpatient.

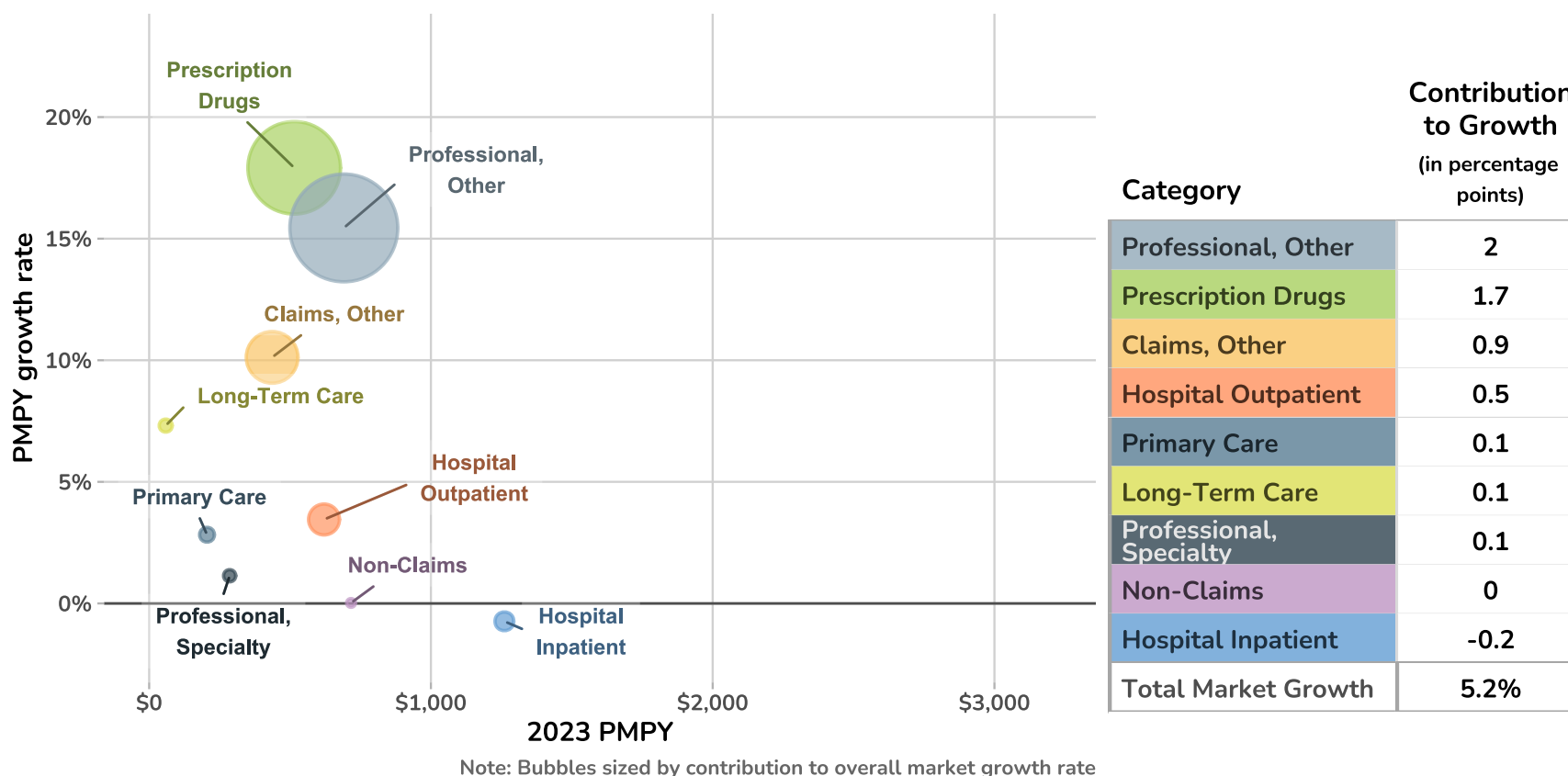
**Figure 19: Change in total medical expense by setting in the Medicare market between 2022 and 2023**



Note: Bubbles sized by contribution to overall market growth rate

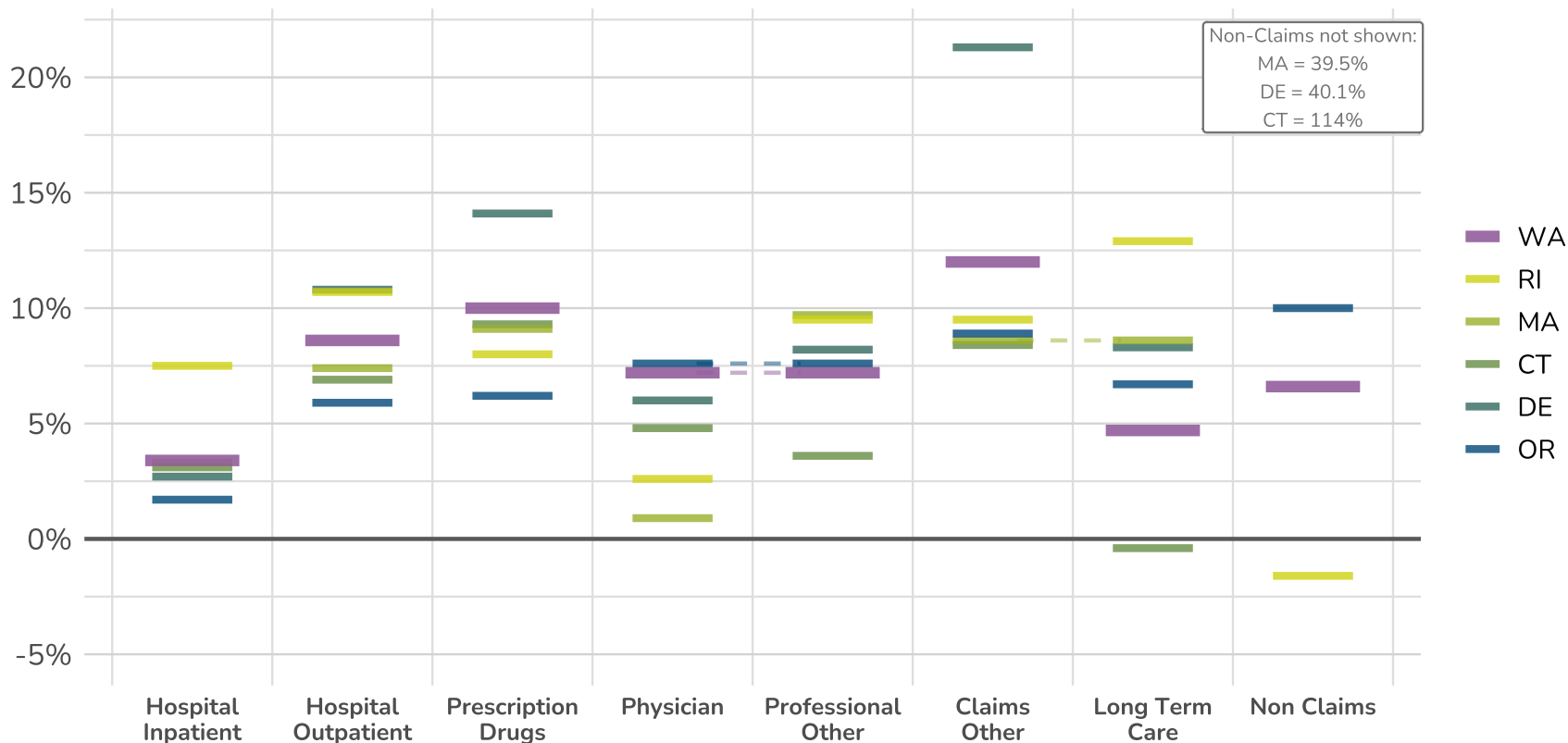
In the Medicaid market, growth in spending was led by the other professional category (2.0 pts of the 5.2 ppt total growth; Figure 20). As noted above, this includes services delivered by non-physician providers not included in primary or specialty care. Notably, many behavioral health services fall under this category. The second-largest contributor to growth was retail prescription drug spending (1.7 pts). Together, the top two categories accounted for about 70% of the overall growth in PMPY spending. Inpatient PMPY spending fell slightly, decreasing overall growth. Overall PMPMs in the Medicaid market are lower than the Medicare and Commercial markets.

Figure 20: Change in total medical expense by setting in the Medicaid market between 2022 and 2023



Growth rates in total medical expenditures per person in Washington resembled other benchmark states<sup>8</sup> across most service categories (Figure 21). The single notable exception is in non-claims, where Washington had a lower growth rate than any other benchmark state except Rhode Island.

**Figure 21: Growth in 2023 TME PMPY by service category, comparing Washington to five other benchmark states**



Note: Dotted lines denote combined service categories:  
 • Oregon & Washington report 'Physician' and 'Professional, Other' as a single category  
 • Massachusetts includes long-term care as a part of 'Claims, Other'

Source: WA Health Care Cost Transparency Board Data Call, Bailit Health analysis

<sup>8</sup> Spending growth rates for five other benchmark states compiled in a [Health Affairs report](#) authored by Bailit Health.

## Primary care spending

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In 2024, the Primary Care Advisory Committee adopted a [new standard definition of primary care](#), based on the provider taxonomy code, procedure code, and care setting for claims payments. Some examples of included services include:

- New patient visits,
- Preventative visits,
- Treatment visits, and
- Screenings.

Primary care providers include:

- Family medicine physicians,
- Internal medicine physicians specializing in geriatric or adolescent medicine,
- Pediatricians,
- Physician assistants,
- Nurse practitioners, and
- Clinical nurse specialists with a primary care focus.

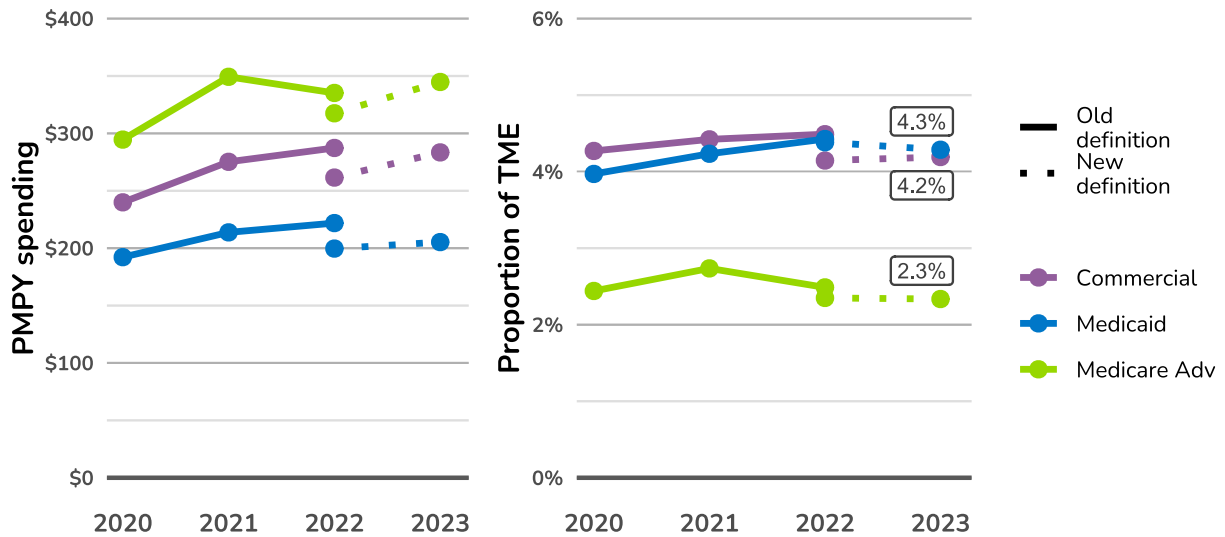
Settings include:

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

To be counted as primary care spending a listed service must be delivered by a primary care provider in a primary care setting.

The 2025 data call collected claims-based primary care spending using this updated definition for 2022 and 2023. Previous data calls collected claims-based primary care spending using the Office of Financial Management's (OFM) narrow definition, allowing for a direct comparison of results using the different definitions. The new definition is generally more restrictive than the previous standard, so as expected, reported primary care spending in the 2025 data call is somewhat lower than reported previously (Figure 22).

Figure 222: Primary care spending per person and as a proportion of TME



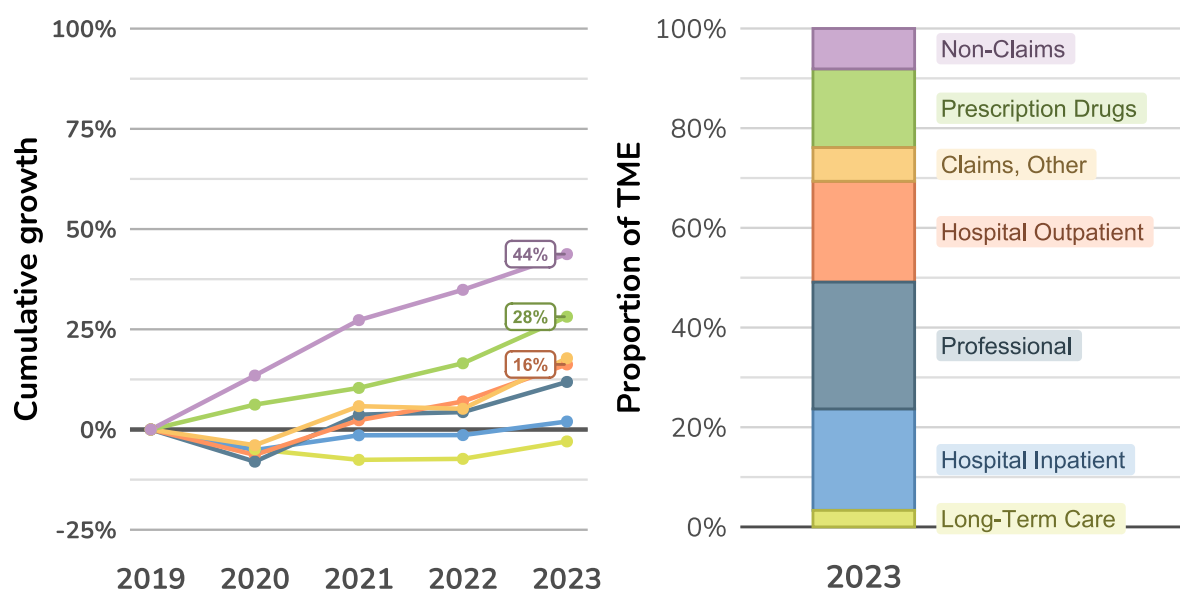
The Legislature has set a target for primary care spending of 12% of expenditures. As can be seen in Figure 22, claims-based primary care spending is substantially below this goal, at approximately 2–4% of spending depending on market. The 2025 data call did not capture non-claims primary care spending separately from other non-claims spending, but 2026 data call plans will separate this out to achieve a more complete picture of total primary care spending.

## Cumulative growth by service category, 2019–2023

This final section takes a step back to look at trends in service category spending between 2019 and 2023. The graphs below show the cumulative growth in PMPY spending for each service category on the left, while the bar graph on the right represents the proportion of 2023 TME for that category.

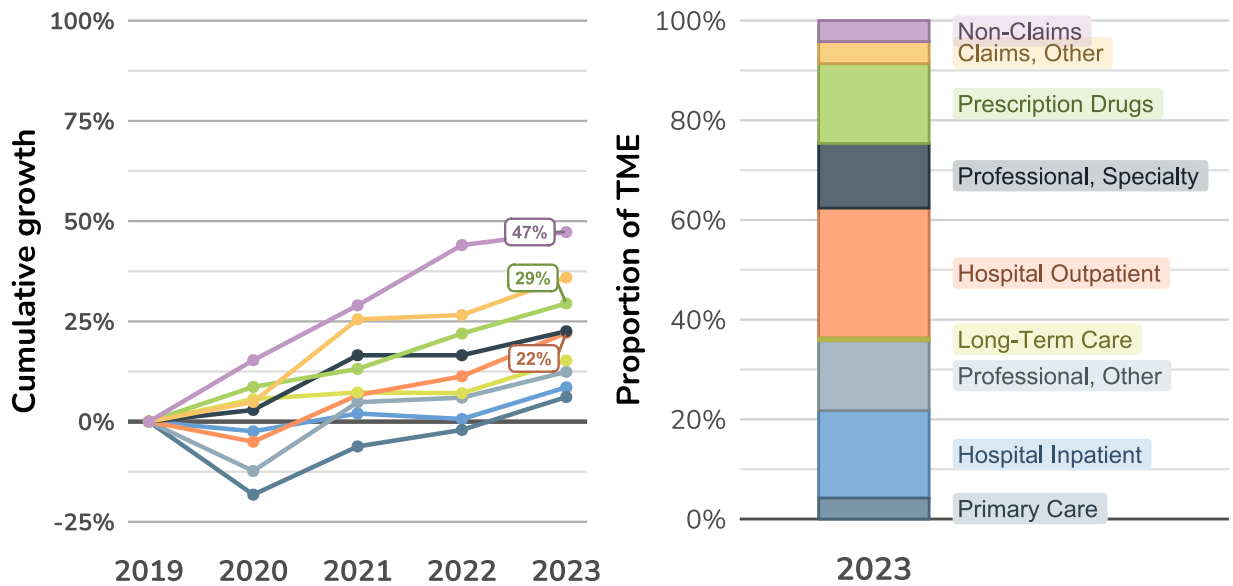
For the state as a whole, non-claims spending had the largest cumulative growth between 2019 and 2023, at about 44% (Figure 23, left panel). This growth was driven firstly by growth in Medicare Advantage non-claims spending and secondly by commercial non-claims spending. Of note, non-claims spending represents a small proportion of state TME (Figure 23, right panel). Prescription drugs had the second-highest cumulative growth rate, at about 28% over the 4-year period. Hospital outpatient spending and claims, other had similar cumulative growth rates (about 16% and about 18%, respectively) but hospital outpatient spending accounts for a much larger proportion of TME. Hospital inpatient and long-term care spending had small or negative cumulative growth rates for the full period. The left graph also shows that growth in most categories accelerated in 2022–2023 (steeper lines indicating higher growth).

**Figure 233: Cumulative growth of statewide TME PMPY by service category**



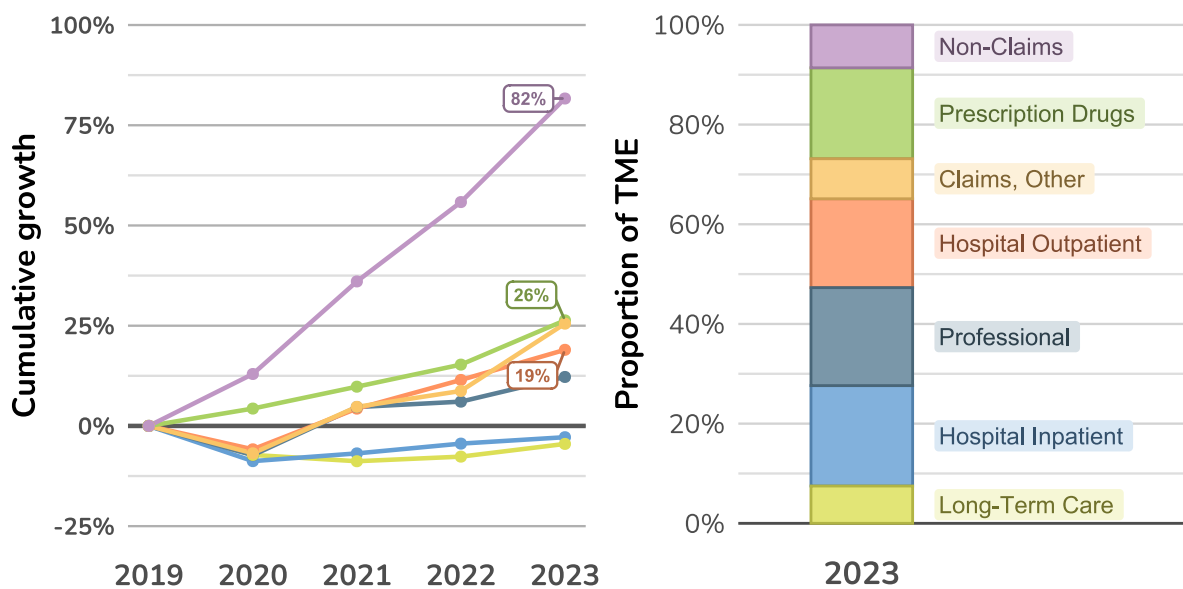
In the commercial market, the largest cumulative increases were in non-claims and claims, other spending, with non-claims having a 47% increase over the 4-year period and claims, other having a 36% increase (Figure 24, left panel). As with the state overall, these two categories also account for a relatively small proportion of overall spending (Figure 24, right panel). Prescription drugs, hospital outpatient, and specialty professional spending all had cumulative increases between 22% and 30%. They constitute a large portion of overall spending. Hospital inpatient spending was nearly flat 2019–2022 but showed a sharp uptick between 2022 and 2023. As with the statewide rates, several categories showed accelerating growth in the most recent year of reporting.

**Figure 244: Cumulative growth of commercial TME PMPY by service category**



The most striking feature of the Medicare cumulative growth rates is the 82% increase in non-claims PMPY between 2019 and 2023 (Figure 25). Although non-claims are still a small part of overall spending, this category was growing rapidly enough to be a significant contributor to growth in 2023 (see Figure 19). While the claims, other, category has grown consistently in the post-pandemic timeframe, its overall proportion of TME is modest. Hospital outpatient and prescription drugs have grown at similar rates and constitute larger amounts of spending overall. Finally, hospital inpatient and long-term care spending both showed small decreases over the 4-year period.

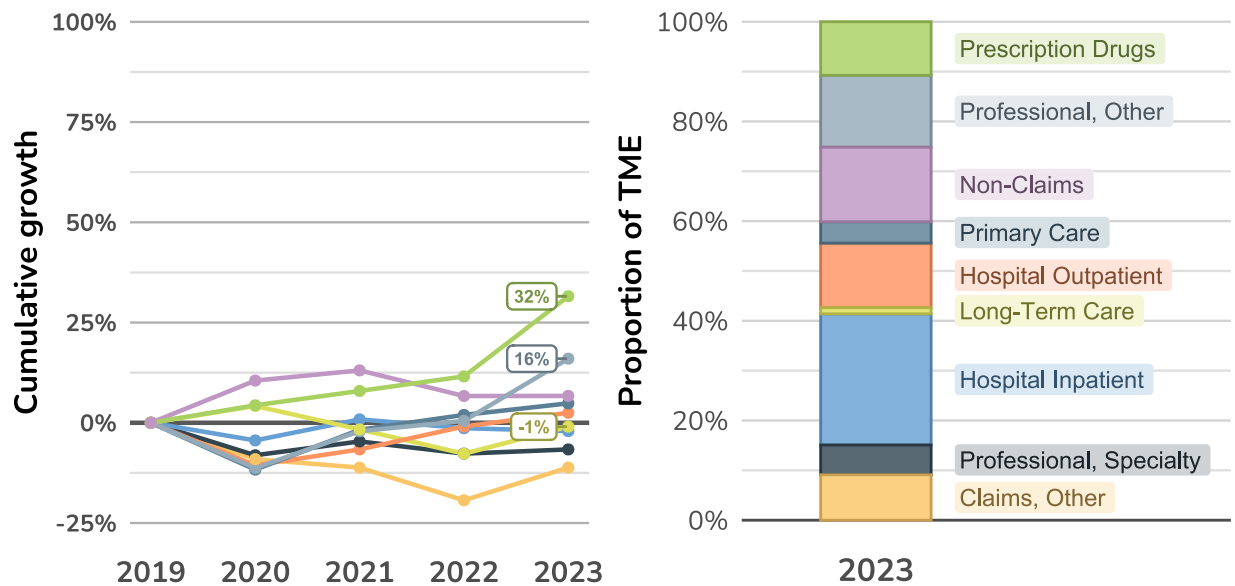
**Figure 255: Cumulative growth of Medicare TME PMPY by service category**



In the Medicaid market, the largest cumulative growth rate was for retail prescription drug spending, at about 32% (Figure 26). Overall, Medicaid has a lower proportion of spending on prescription drugs than other markets

(11% of TME in 2023, compared to 16% for commercial and 18% for Medicare), partly due to sizeable pharmacy rebates. Both retail prescription drug and other professional spending had large growth rates in 2023 (16%). Largely because of the increase in 2023, other professional services had the second-largest cumulative growth rate. Spending in several service categories decreased over this period: hospital inpatient, specialty professional, long-term care (-1%), and other claims. This may reflect the addition of the Medicaid expansion population during the pandemic, which tended to have lower costs. One important note for Medicaid spending is that this analysis does not include long-term-care spending provided through DSHS, including Aging and Long-Term Support Administration (AL TSA) spending (see the [caveats and limitations section](#) in the appendix).

**Figure 266: Cumulative growth of Medicaid TME PMPY by service category**



## Conclusion

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To address rising health care costs, Washington state has established a health care cost growth benchmark program, worked to increase transparency, conducted analysis to understand cost drivers and worked to bring about policy interventions to manage health care spending growth.

At the [November 20, 2025, Health Care Cost Transparency Board public hearing](#), the board had the opportunity to hear about the results of the 2023 performance against the benchmark and 2022–2023 spending trends. The public hearing also provided a platform for consumers, providers, carriers, businesses, and labor groups to share their reflections on the data, the impacts of health care affordability, and how they envision the work around the benchmark in the future.

### Where did spending growth occur?

Spending growth was above the benchmark across all markets, with the largest increases in the commercial and Medicare markets. Statewide, the largest contributions to growth came from **professional services, hospital outpatient services, and retail prescription drugs**. Spending growth by market from 2019–2023 shows similar trends in service category growth, though with some notable exceptions. Non-claims, hospital outpatient, and claims, other spending increased in the commercial and Medicare market but not in the Medicaid market.

Further exploring the drivers of health care spending growth will help the Cost Board consider policy interventions that can impact growth in spending. In its discussions, the Cost Board highlighted the need to better understand how service unit prices and utilization each impact spending growth. A cost driver analysis presented to the board in March of 2025 utilized the Washington all payer claims database (APCD) to address this question. Broadly, this analysis showed increasing prices is the primary driver for increased spending across many service categories from 2019–2023. This is clearest for prescription drug spending, where utilization is unchanged and prices have increased dramatically. Hospital outpatient prices also increased, although utilization of hospital outpatient services increased as well.

### What's next?

In 2023, Washington state's overall health care spending growth (6.2%) was markedly above the benchmark (3.2%). This second benchmark performance report helps Washington leaders and consumers understand the status of health care spending growth in the state and will help the Cost Board better identify trends that require further investigation. For example, the Cost Board suggested it would further study the impact of primary care spending on overall health care expenditures, as well as the relative impacts of utilization versus prices on spending growth.

In addition to understanding the separate contribution of price and utilization across service categories, the board plans to further examine these factors in context. This may include analysis of how price and utilization vary by geography, their relationship to metrics of health care quality, and how they are impacted by changes to Washington's health care landscape, such as payer and provider consolidations. Addressing these questions will build on the current work and provide a foundation for policies that further a more fair and equitable market for Washingtonians.

# Appendix A: Data sources and performance against the benchmark methodologies

## Data sources

The data used to identify health care spending trends as well as statewide, market, carrier and large provider organization performance comes from the data collected by the Cost Board in the 2022, 2024, and 2025 data calls. The 2022 data call collected data from 2017–2019, the 2024 data call collected 2020–2022 data, and the 2025 data call collected 2022–2023 data (see Table A1). The data collected includes claims, non-claims, health spending and health insurance administrative cost data from carriers and non-carriers. Claims spending refers to the allowed amounts from payers to provider organizations based on claims while non-claims spending refers to payments that health plans make to provider organizations outside of claims.

On the carrier side, the data call collected claims and non-claims data from the largest carriers (those that cover more than 10,000 covered lives in the commercial, Medicare Advantage, and Medicaid Managed Care businesses in Washington; see Table A2 for list of carriers participating in the data call)<sup>9</sup>. The data collected is broken down by large provider organizations (or provider organizations that has at least 10,000 attributed covered lives — see Table A3 for list of large provider organizations). Carriers first attributed members to a primary care provider or PCP (based on member selection of PCP, contract arrangements, and utilization). If a member is attributed to a PCP, carriers attributed this member to a large provider entity based on which large provider entity is the PCP associated with. If the member could not be attributed to a PCP or the PCP was not associated with a large provider entity, the member was categorized as unattributed. See page 17 of the Cost Board’s [data call technical manual](#) for more information on the attribution methodology.

**Table A1: Reporting schedule**

Data call	Includes data from specified years	Expenditure data reported	Cost growth target
2022	2017–2019	State and market data only*	N/A
2024	2020–2022	Large provider entities and payers	3.2%
2025	2022–2023	Large provider entities and payers	3.2%
2026	2023–2024	Large provider entities and payers	3.0%
2027	2024–2025	Large provider entities and payers	3.0%
2028	2025–2026	Large provider entities and payers	2.8%

\*The Cost Board will not publicly report insurance payer or provider cost growth for this period.

On the non-carrier side, the data call collected fee-for-service health care spending data from the Washington Health Care Authority for Medicaid FFS and from the Centers for Medicare & Medicaid Services for Medicare FFS. In addition, the data call gathered Washington state health care spending data from the U.S. Department of Veterans Affairs and two state agencies (Department of Corrections and Department of Labor and Industries). Moreover, the data call also gathered various data needed to be able to calculate the net cost of private health insurance (NCPHI). See Table A4 for a list of the data collected and their specific sources.

<sup>9</sup> Data reported by carriers was inclusive of their role as third party administrator for self-insured products.  
Health care spending growth in Washington, 2022–2023

## Table A2: List of carriers

Anthem Ins Co Inc

Cambia Health Solutions Inc

Centene Corp Group

Cigna Health and Life Ins Co

Community Health Network Group

CVS Group

Health Alliance NW Health Plan

Humana Group

Kaiser Foundation Health Plan of NW

Kaiser Foundation Health Plan of WA

Molina Healthcare Inc Group

Premera Blue Cross Group

UnitedHealth Group

## Table A3: List of provider organizations

Community Clinic Contracting Network (includes Yakima Valley, CHC Snohomish, Columbia Basin, Columbia Valley, International Community Health, Mariposa, Peninsula Community Health, Unity Care, and Sea Mar)

Community Health Association of Spokane

Community Health Care

Community Health of Central Washington

Confluence Health

Country Doctor Community Health Centers

Cowlitz Family Health Center

Evergreen Health

Family Care Network

Family Health Centers

Franciscan Health — including Virginia Mason Franciscan Health (part of Pacific NW Division of Common Spirit)

HealthPoint

Kaiser Permanente of Washington (medical centers in Western WA and Spokane)

Kaiser Permanente NW (medical centers in SW WA)

Legacy Health

Lewis County Community Health Services (Valley View Health Center)

Moses Lake Community Health Center

MultiCare Health includes Mary Bridge Children’s Hospital; Navos

Wellfound Behavioral Health Hospitals — partnership with CHI Franciscan and MultiCare

NeighborCare Health

NEW Health Programs Association

North Olympic Healthcare Network PC

Optum Care (includes Everett Clinic, Polyclinic, and Northwest Physician’s Network)

Overlake Medical Center

PeaceHealth

Providence Health/Swedish Health Services/PacMed/Kadlec

Rose Medical

Seattle Children's Care Network

Seattle-King County Public Health Dept (Health Care for the Homeless Network)

The Vancouver Clinic

Tri-Cities Community Health

UW Medicine (Valley Medical Center, Neighborhood Clinics)

Yakima Neighborhood Health Services

Community Clinic Contracting Network (CCCN) was excluded in the 2024 public reporting since CCCN negotiates contract arrangements on behalf of a handful of Federally Qualified Health Centers (FQHCs) identified in this list and does not share accountability across these FQHCs.

**Table A4: Data categories and sources**

Category	Data source
Carrier claims payments	Carrier data submission template
Carrier non-claims payments	Carrier data submission template
Carrier enrollment	Carrier data submission template
Carrier pharmacy rebates	Carrier data submission template
Medicare fee-for-service (FFS) claims payments and enrollment, and all Part D spending	CMS
Non-managed care claims and non-claims payments and enrollment for Medicaid	HCA submission template
Veterans Health Administration medical spending and enrollment	U.S Department of Veterans Affairs
Medical spending for state workers' compensation and enrollment	L&I submission template

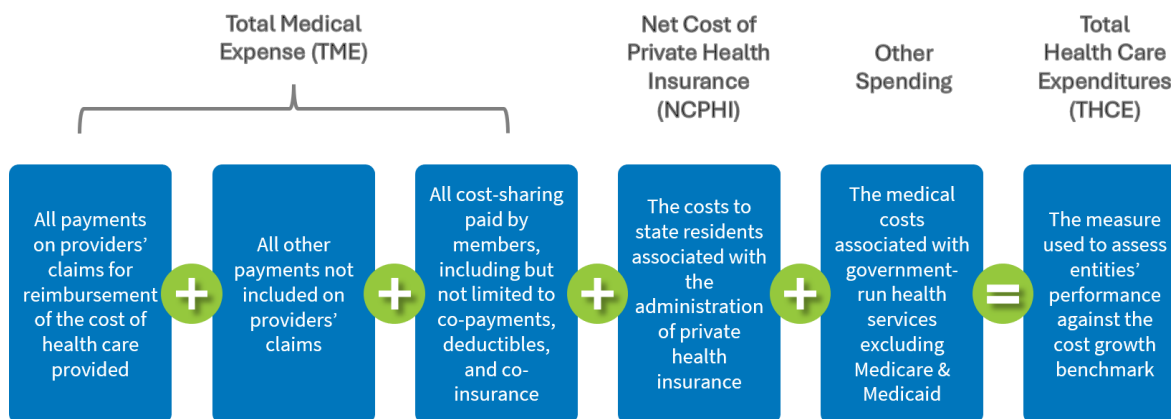
Health care spending for incarcerated individuals and enrollment	Washington DOC submission template
NCPHI for the commercially fully insured market	Federal commercial medical loss ratio (MLR) reports
NCPHI for Medicare Advantage	The Supplemental Health Care Exhibit (SHCE) from the National Association of Insurance Commissioners (NAIC)
NCPHI for Medicaid Managed Care	The Supplemental Health Care Exhibit (SHCE) from the National Association of Insurance Commissioners (NAIC)
Income from Fees of Uninsured Plans <sup>10</sup> to calculate NCPHI for the commercial self-insured market	Carrier data submission template
Number of member months in each market for calculating NCPHI	Carrier data submission template

## Data aggregation

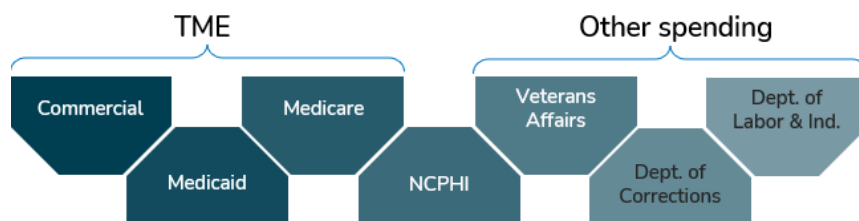
### Total health care expenditure (THCE)

The Cost Board utilized THCE to report on health care spending growth at the state level. THCE includes claims and non-claims payments between payers and provider organizations. Total medical expense (TME) is the sum of all claims and non-claims payments. Besides TME, THCE also includes other health care spending in public programs (i.e., Department of Corrections, Veterans Affairs, and the Department of Labor and Industries) as well as the net cost of private health insurance (NCPHI). The NCPHI refers to all costs associated with administering health plans. THCE is net of pharmacy rebates. Figure 18 shows the components of THCE and Figure 19 shows the various contributions to THCE.

**Figure 18: THCE formula (TME plus NCPHI plus other spending)**



**Figure 19: Components of THCE**



<sup>10</sup> 'Uninsured Plan' is synonymous with 'self-insured plan' for the purposes of this report. Uninsured is used in this instance to be consistent with the terminology in NAIC's Supplemental Health Care Exhibit (SHCE).

## Total medical expenses (TME)

The Cost Board also utilized TME to measure health care spending for market, carrier, and large provider reporting. TME, which is a subset of THCE, includes claims and non-claims spending and excludes other spending and NCPHI (see Figure 20).

- TME for market level reporting: TME is reported as net of pharmacy rebates but is not age-sex risk adjusted and not truncated (i.e., not adjusted for high-cost clients). Moreover, TME includes FFS spending from Medicaid and Medicare.
- For carrier and large provider reporting:
  - TME is age-sex risk adjusted and truncated and excludes FFS data from Medicaid and Medicare. FFS data is not broken down by carrier and large provider organization.
  - Performance is based on the confidence interval of the growth rate of the adjusted TME. If the lower bound of the confidence interval exceeds the benchmark, performance exceeds the benchmark. It is indeterminant if the confidence interval contains the growth benchmark. Performance did not exceed the growth benchmark if the upper bound of the cost growth rate is lower than the benchmark.
  - The following links provide detailed description of the methodologies used to calculate performance:
    - Truncation (pages A11–A15 of the Cost Board’s [data call technical manual](#))
    - [Cost growth calculations: demographic risk adjustment, pooled variance, and confidence interval](#) (provider organizations and carriers)

**Figure 20: Expenditures contributing to total medical expenses**



## Claims and non-claims spending by service categories

Claims and non-claims spending can be broken down into various service categories. See Table A5 for breakdown and examples.

**Table A5: Claims and non-claims spending categories**

A. Claims	
<b>Hospital inpatient</b>	<ul style="list-style-type: none"> <li>• All room and board and ancillary payments for all hospital types</li> <li>• Payments for emergency room services when the member is admitted to the hospital</li> </ul>
<b>Hospital outpatient</b>	<ul style="list-style-type: none"> <li>• All hospital types and payments made for hospital-licensed satellite clinics</li> <li>• Emergency room services not resulting in admittance</li> <li>• Observation services</li> </ul>
<b>Professional</b>	<ul style="list-style-type: none"> <li>• Primary care providers</li> <li>• Specialty providers</li> <li>• Other providers</li> </ul>
<b>Long-term care</b>	<ul style="list-style-type: none"> <li>• Skilled nursing facility services</li> <li>• Home health services</li> <li>• Custodial nursing facility services</li> </ul>

- Home- and community-based services including personal care

<b>Prescription Drugs</b>	<ul style="list-style-type: none"> <li>• Claims paid to retail pharmacies for prescription drugs, biological products or vaccines</li> </ul>
<b>Other</b>	<ul style="list-style-type: none"> <li>• Durable medical equipment</li> <li>• Freestanding diagnostic facility services</li> <li>• Hearing aid services</li> <li>• Optical services</li> </ul>
<b>B. Non-claims</b>	
<b>Non-claims</b>	<ul style="list-style-type: none"> <li>• Capitation or bundled payments</li> <li>• Performance incentive payments</li> <li>• Population health and practice infrastructure payments</li> <li>• Provider salaries</li> <li>• Recovery payments as the result of a prior review, audit, or investigation</li> <li>• Other — including, but not limited to governmental payer shortfalls, grants, other surplus payments, and Medicaid Transformation Project payments providers paid directly to carriers</li> </ul>

For more information on the data collected, see the Cost Board’s [data call technical manual](#).

## Caveats and limitations of the data

The following are excluded from the data:

- Policies offering limited benefits, such as accident, disability, Medicare supplemental insurance, vision or dental standalone policies
- Health care paid through charity care or by customer cash payment
- Certain non-claims publicly funded behavioral health services
- Anthem 2017 data
- Humana 2017 data
- Humana Medicare data
- Custodial nursing facility services, home- and community-based services, and intermediate care facilities and services for persons with developmental disabilities paid by Washington State Department of Social and Health Services (DSHS). This includes DSHS's Aging and Long-Term Support Administration (ALISA) spending.
- Federally paid tribal health data

In addition, the following caveats and limitations are important in interpreting these results:

- Statewide and market analyses are net of pharmacy rebates. These rebates include drugs covered under both the medical benefit and the pharmacy benefit. While costs for drugs covered under the medical benefit are accounted for in other types of service (inpatient, outpatient, or other claims), accurately separating the rebates on these drugs from other pharmacy rebates is difficult, so all pharmacy rebates are netted out of the prescription drug category. Carrier/provider level reporting is gross of pharmacy rebates.
- Additional Medicaid pharmacy rebates were incorporated in the 2025 data call (2022 and 2023 data) but are not captured in earlier data.
- Statewide and market analyses include Medicare FFS and Medicaid FFS data while carrier and large provider reporting excludes Medicare FFS and Medicaid FFS data.

- There were revisions for 2017–2019 data due to data resubmissions from few carriers and revisions of NCPHI data.
- There were revisions to the 2024 data call (2020–2022 data) due to data resubmissions. These revisions affected service category distributions but not total medical expenses.
- Improvements in data quality from submitters mean that data from the 2025 data call (2022–2023 data) is not directly comparable to earlier data. All 2022 growth rates are calculated using 2021 and 2022 data from the 2024 data call. All 2023 growth rates are calculated using 2022 and 2023 data from the 2025 data call.
- Member months data from DOC includes prison population and Rent-a-bed program population. The latter is limited to members with claims as existing data systems make it challenging to get information on those without claims.
- Federal Employee Health Benefit Plan (FEP) that have benefits split between two carriers are included only in the statewide and commercial market spending. Split FEP was removed from provider/carrier benchmarking.
- Member months from the Department of Labor and Industries are estimates and rounded off at the 100,000th level.

## Appendix B: Definitions of key terms

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**Allowed amount:** The amount the carrier paid a provider, plus any member cost sharing for a claim. Allowed amount is typically a dedicated data field in claims data. Allowed amount is the basis for measuring the claims component of total medical expense.

**Health care cost growth benchmark (the benchmark):** The benchmark is the value against which the Cost Board has agreed to measure THCE and total medical expense. It is the value of 70% of Washington’s nominal historic median wage growth and 30% of Washington’s nominal potential gross state product growth.

**Health insurance carrier (carrier):** A private health insurance company that offers one or more of the following: commercial insurance, Medicare Advantage and/or Medicaid managed care products.

**Large provider entity:** A term referring to provider organization that delivers health care services, employs primary care providers, and is large enough to enter into a total cost of care contract, for whom carriers must report total medical expense data.

**Market:** The highest levels of categorization of the health insurance market. For example, FFS Medicare and Medicare Advantage are collectively referred to as the “Medicare market.” FFS Medicaid and Medicaid managed care are collectively referred to as the “Medicaid market.” Individual, self-insured, small and large group products, and student health insurance are collectively referred to as the “commercial market.”

**Measurement year:** The measurement year is the calendar year for which performance is measured against the prior calendar year for purposes of calculating the growth in health care costs.

**Net cost of private health insurance (NCPHI):** Measures the costs to Washington residents associated with the administration of private health insurance (including Medicare Advantage and Medicaid Managed Care). It is defined as the difference between health premiums earned and benefits incurred, and consists of carriers’ costs of paying bills, advertising, sales commission and other administrative costs, premium taxes and profits (or contributions to reserves) or losses. NCPHI is reported as a component of THCE at the state level.

**Payer:** A term used to refer collectively to both carriers and public programs that are submitting data to HCA.

**Payer recoveries:** Funds distributed by a payer and then later recouped (either through an adjustment from current or future payments, or a cash transfer) due to a review, audit or investigation of funds distribution by the payer. Payer recoveries is a separate, reportable field in carrier total medical expense reporting.

**Pharmacy rebates:** Any rebates provided by pharmaceutical manufacturers to payers for prescription drugs, excluding manufacturer-provided fair market value bona fide service fees.<sup>11</sup> Spending at the state, market, and payer level is net of pharmacy rebates (i.e., other expenditures are reduced by the amount of the pharmacy rebates).<sup>12</sup>

**Provider:** A term referring to an individual clinician, medical group, individual provider, large provider entity or similar entities.

**Public program:** A term used to refer to payers that are not carriers. This includes Medicare Fee For-Service, Medicaid FFS and similar programs.

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<sup>11</sup> Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., carrier, pharmacy benefit manager, etc.) that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service fees, distribution service fees, patient care management programs, etc.)

<sup>12</sup> CMS is unable to report pharmaceutical rebates for traditional Medicare beneficiaries (i.e., FFS Medicare). Therefore, in the computations of THCE at the state and Medicare market levels, spending will be gross of Medicare FFS pharmaceutical rebates.

**Total health care expenditures (THCE):** The total medical expense incurred by Washington residents for all health care services for all payers reporting to HCA, plus the carriers' NCPHI. Defining specifications of THCE are included in Section II. THCE per capita: THCE (as defined above) divided by Washington's reported membership. The annual change in THCE per capita is compared to the benchmark at the state, market, and carrier levels.

**Total medical expense (TME):** The sum of the allowed amount of total claims and total non-claims spending paid to providers incurred by Washington residents for all health care services. TME is reported at multiple levels: state, market, payer, and large provider entity level. TME is reported net of pharmacy rebates at the state, market, and payer levels only.

## Appendix C: Cost Board members

	Member <sup>13</sup>	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	Kenneth Gardner	Director of Growth & Administration, SEIU 775 Benefits Group	Representing Taft-Hartley health benefit plans
6	Jodi Joyce	Chief Executive Office, Unity Care NW	Member of advisory committee with operational experience in health care delivery (non-voting)
7	Gregory Marchand	Director of Global Benefits, Boeing	Representing large employers/self-funded group health plan
8	Mark Siegel	Assistant Vice President, Costco Wholesale Corporation	Representing large employers
9	Margaret Stanley	Consumer Advocate	Representing consumers
10	Ingrid Ulrey	Chief Executive Officer, Washington Health Benefit Exchange	Representing the Washington Health Benefit Exchange
11	Kim Wallace	Medical Administrator, Department of Labor & Industries	Representing the Department of Labor & Industries

<sup>13</sup> This list is current as of November 20, 2025.