OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

# Primary Care Expenditure Reporting Template Instructions

For Reporting Years on or after 2025
October 10, 2025

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# Instructions

## Who Must Report

Per SB 5084 (Chapter 6, Laws of 2025, codified at RCW 48.43.800), the Office of the Insurance Commissioner (OIC) may require health carriers to annually report primary care expenditures made in previous calendar years or anticipated to be made in upcoming calendar years. The statute further states that the Commissioner may determine the form and content of carrier primary care expenditure reporting. In developing the form and content for reporting, the Commissioner must consider the definition of primary care expenditures and any primary care expenditure targets established under RCW 70.390.080 as well as primary care expenditure reporting systems implemented by the Health Care Authority (HCA) for Medicaid, the Public Employees Benefits Board (PEBB), and the School Employees Benefit Board (SEBB).

The OIC, (under its authority in RCW 48.43.800) and HCA (under its authority in RCW 70.390.080), are requiring the following health carriers and Apple Health (Medicaid) issuers to submit primary care expenditure reports.

**For reporting year 2025, the following companies must submit primary care expenditure reports:**

- All issuers in the Apple Health (Medicaid) market:
    - Community Health Plan of Washington
    - Coordinated Care of Washington Inc
    - Molina Healthcare of Washington Inc
    - UnitedHealthcare of Washington Inc
    - Wellpoint Washington Inc
- All health carriers in the individual and/or small group health plan markets:
    - Asuris Northwest Health
    - BridgeSpan Health Company
    - Community Health Plan of Washington
    - Coordinated Care Corporation
    - Kaiser Foundation Health Plan of the Northwest
    - Kaiser Foundation Health Plan of Washington
    - Kaiser Foundation Health Plan of Washington Options Inc
    - LifeWise Health Plan of Washington
    - Molina Healthcare of Washington, Inc.
    - Premera Blue Cross
    - Premera Blue Cross HMO
    - Providence Health Plan
    - Regence Blue Cross Blue Shield of Oregon
    - Regence BlueShield

- UnitedHealthcare Insurance Company
- UnitedHealthcare of Oregon, Inc.
- UnitedHealthcare of Washington, Inc.

- Health carriers in the large group fully insured market with more than 2% of Washington's overall market shares based on the most recent available publication on OIC's website (Data Source: https://www.insurance.wa.gov/sites/default/files/2024-10/appendix-e-2023-annual-market-report.pdf):
  - Aetna Life Insurance Company
  - Cigna Health and Life Insurance Company

## When and How to File

The report is due to OIC by July 31, 2026.

Please use the OIC online portal (Filing and Payment Center) to upload the file. Once you have completed filling out the Primary Care Expenditure Report, save the document as a .xlsx file on your computer. Then log in to the Filing and Payment Center and upload the saved document. Please refer to these instructions on how to use the OIC online portal.

## Purpose

Washington's Primary Care Expenditure (PCE) reporting initiative serves several interrelated goals designed to advance statewide health policy, transparency, and financial accountability:

1. **Support legislative targets for primary care investment.**
   In 2022, the Washington State Legislature established a statewide target that 12 percent of all health care expenditures be dedicated to primary care services. This target is codified in RCW 70.390.080, which also requires regular measurement of progress toward that benchmark.

2. **Measure carrier-level performance and support agency collaboration.**
   The PCE report facilitates a standardized method for health carriers and Medicaid issuers to report their primary care expenditures and investments in Washington state. This information enables OIC to monitor carrier performance, track trends over time, and identify variation by line of business and market segment. It complements data collected by the Washington Health Care Authority (HCA), which uses a similar template to assess spending across state-financed health programs, including Medicaid, PEBB, SEBB, and the Cascade Care Public Option.

***Important note:*** *There are presently no financial incentives or penalties attached to PCE results. The information is collected for monitoring and transparency only.*

# How to Complete the Report

## Identifying Amounts to Report

Use the **Definitions** section of this document to determine what information should be counted and included in each report field. The definitions are broken down into key areas, consistent with the template format.

## Completing the Report

Enter data in the **Primary Care Expenditure Report** sheet using the following formatting guide:

- **Yellow-shaded cells**: Carrier input required
- **Gray-shaded cells**: Auto-calculated fields (do not modify)

Ensure all entries provided are consistent with the definitions and allocation rules described in the Definitions and Allocation by Jurisdiction Rules sections.

## Documenting Methodology and Supplemental Information

Use the **Reporting Methodology** sheet to explain how reported values were derived, particularly where estimates, allocations, or assumptions were applied.

**Required Documentation – When to Use:**

The Definitions section provides guidance as to when a carrier should add explanations to the Reporting Methodology sheet. Generally, carriers should provide supporting explanations in the following situations:

- **Global Capitation Allocations**: Describe how primary care expenditure estimates were derived from global expenditure amounts (methods, data sources, and assumptions).
- **"Other" Subcategories**: Clarify any entries under "Other" benefit expenditures or "Other" support/investment expenditures.
- **Classification or Allocation Conflicts**: Document any definitional ambiguity or mapping challenges and how the issue was resolved.
- **Supplemental Items**: Describe methods used to identify or estimate values for items such as urgent care, facility fees, and campus location indicators (POS codes).
- **Material Data Limitations**: Identify any gaps, suppressed fields, or limitations that could affect completeness or interpretation of the report.

**Additional Guidance:**

- Briefly describe any **internal mapping or reconciliation methods** used to align data with NAIC Health Annual Statement categories or Additional Data Statement definitions.
- Indicate whether **sample-based data**, extrapolations, or **partial systems** were used and how data reliability or credibility was evaluated.
- Avoid generic responses—documentation should include sufficient detail to allow OIC and HCA reviewers to evaluate the reasonableness and validity of reported data.

Clear and complete documentation in the *Reporting Methodology* sheet supports OIC's ability to validate submitted data, ensure consistency across carriers, and continuously improve the reporting process.

# Definitions

## Overview

This section defines key terms and reporting rules used throughout the Primary Care Expenditure (PCE) reporting template. Reporting is structured into the following subsections:

- **Annual Statement References:** Defines relationship between NAIC Health Annual Statement and NAIC Life, Accident and Health Annual Statement references.
- **Basis and Experience Period:** Defines the basis and experience period of the amounts reported.
- **Key Performance Metric:** Defines the primary care expenditure metric and how it is calculated.
- **Allocation by Jurisdiction Rules:** Explains how expenditures are attributed to Washington State using NAIC reporting standards.
- **Allocation by Line of Business and Subtypes**: Describes how reported amounts are partitioned by line of business and sub-classification.
- **Expenditures:** Provides detailed definitions of both total health care expenditures and primary care expenditures, including treatment of non-claims-based expenditures and references to applicable code sets and provider types.
- **Supplemental Data Elements:** This section defines additional data elements collected in this report to provide greater context and insight into reported primary care expenditures.

All definitions are aligned with NAIC statutory reporting where applicable and adapted to meet the requirements of RCW 70.390.080 and the Washington State Office of the Insurance Commissioner (OIC).

## Annual Statement References

This document refers to the NAIC Health Annual Statement to align the Primary Care Expenditure (PCE) report and with the annual statement framework.

For carriers that file using the NAIC Life, Accident and Health (LAH) Annual Statement:

- When this document references the NAIC Health Annual Statement – Statement of Revenue and Expenses (Page 4) or Analysis of Operations by Lines of Business (Page 7), carriers filing using the LAH Annual Statement should instead refer to the Health Supplement (Page Supp476) of the LAH Annual Statement.
- When this document references Schedule T – Allocation by State/Jurisdiction, carriers filing on the LAH basis should use the LAH Schedule T – Allocation by State/Jurisdiction.

- For all other references to the NAIC Health Annual Statement, the equivalent section in the NAIC Life, Accident and Health Annual Statement should be used.

## Basis and Experience Period

Unless specifically stated otherwise, all amounts should be reported on a paid basis.

**Experience Period:**
Report amounts paid between January 1, 2025, and March 31, 2026, for services or expenses incurred between January 1, 2025, and December 31, 2025.

## Key Performance Metric

The primary care expenditures (PCE) ratio is the key performance metric calculated at defined line-of-business level partitions and overall. This metric represents the proportion of Washington State health care spending directed toward primary care services. Specifically, the metric equals:

*Total Washington Primary Care Expenditures ÷ Total Washington Health Care Expenditures*

as defined under RCW 70.390.080.

## Allocation by Jurisdiction Rules

For this report all figures must represent Washington-state business, as determined under the NAIC Health Annual Statement Instructions (HASI), Schedule T, "Allocation by State/Jurisdiction" (2024 edition, pp. 312-314).

## Allocation by Line of Business and Subtypes

This template partitions experience using similar line-of-business structure found in the HASI "Analysis of Operations by Lines of Business" (page 4) and the Washington Additional Data Statement (ADS). However, additional partitions are included to meet multi-agency needs.

- Wherever a column header in this workbook matches a line caption in the HASI Analysis of Operations (e.g., *Comprehensive, Medicare Supplement, Medicaid*, etc.), use the NAIC definition verbatim.
- Sub-types that appear only in the ADS (e.g., *Individual Comprehensive*, *Small-Group Comprehensive*) inherit the ADS definitions, which are themselves direct break-outs of the corresponding NAIC lines.
- Additional line of business column definitions and instructions:
    - **Cascade Care Select Plans:** Standardized individual health plans offered on the Washington Health Benefits Exchange (WAHBE or the Exchange) (per RCW 43.71.095) that are contracted with the HCA (per RCW 41.05.410).

- **Cascade Care Plans:** Standardized individual health plans offered on the Exchange (per RCW 43.71.095), but are **not** contracted with HCA (per RCW 41.05.410).
- **Medicare Advantage Plans for Public Employees Benefits Board (PEBB):** Only Public Employees Benefits Board (PEBB) Medicare Advantage plan experience should be reported in this column.
- **Medicaid - Washington State Apple Health Plans**: Only Washington State Apple Health Plans (including Integrated Managed Care and Integrated Foster Care) experience should be reported in this column.

# Expenditures

The expenditure definitions provided in this section are intended to align with the NAIC Health Annual Statement Instructions (HASI), specifically the Statement of Revenue and Expenses (SRE) and the Analysis of Operations by Lines of Business (AOLOB), as well as the applicable guidance in the NAIC Accounting Practices and Procedures Manual (APPM).

This report requires a more granular level of reporting than what appears in the AOLOB, particularly to isolate and classify primary care expenditures in accordance with RCW 70.390.080 and the Health Care Cost Transparency Board's definitions.

**Precedence of Standards:**
Unless explicitly stated otherwise in this document, if a discrepancy exists between the expenditure definitions provided here and those found in the HASI or APPM, the NAIC standards take precedence. Reporters should default to HASI and APPM definitions for classification and treatment of financial data.

If a conflict or ambiguity is identified during reporting, please document it in the appropriate comment field or in the Reporting Methodology sheet of the workbook, including a brief explanation of how the amount was classified. This information will support review and interpretation of submitted data, and future improvement.

## Total WA Health Care Expenditures

"**Total WA Health Care Expenditures**" represents the denominator of the primary care expenditure performance metric. This amount reflects the **total cost of delivering health care services** paid by the carrier during the reporting period for Washington business, including benefit and non-benefit expenses as defined below.

### *Guidance Summary*
Follow the NAIC Health Annual Statement Instructions for Analysis of Operations by Line of Business when reporting this amount and related items.

- Definitions and classifications are in the Statement of Revenue and Expenses of the NAIC Health Annual Statement Instructions.
- Report only expenditures; do not include any revenue items.
- Include expenditures only for lines of business and subtypes listed in this template.

- Report benefit expenses net of applicable prescription drug rebates consistent with the NAIC Health Annual Statement Instructions and before reducing benefit expenses from net reinsurance recoveries.

If questions arise regarding classification or reconciliation, document the treatment in the Reporting Methodology sheet of the template.

### *Included Expenditures (General Categories)*

Total WA Health Care Expenditures should include, but are not limited to:

- **Health care benefit expenditures** for: inpatient and outpatient hospital services, primary and specialty physician services, other professional services, home health care, prescription drugs, skilled nursing care, behavioral health services, laboratory and imaging services.
- **Embedded dental and vision benefits** that are part of comprehensive health plans. *Exclude expenditures for stand-alone dental-only or vision-only coverage.*
- **All reimbursement types**, including fee-for-service, capitation, bundled/global payment models, and alternative payment arrangements.
- **Non-benefit health care expenditures**, such as administrative expenses, applicable taxes, fees, and health care-related assessments.

### *Reporting*

Total WA Health Care Expenditures must be reported in the following three components:

1. **Medical Health Care Expenditures:** All medical benefit expenditures excluding prescription drugs, as defined by NAIC categories.
2. **Prescription Drug (Rx) Health Care Expenditures:** All prescription drug benefit expenditures, whether administered directly or via a pharmacy benefit manager (PBM). This includes amounts paid through medical benefits and pharmacy benefits. Note:
    - This amount must be net of accrued prescription drug rebates, in alignment with HASI and SSAP No. 84.
    - Drug benefits paid through the medical benefit should also be included here.
3. **Non-Benefit Health Care Expenditures:** Expenditures necessary to deliver health care that are not directly tied to claims. Includes:
    - Claims adjustment and adjudication costs
    - Quality improvement and care management activities
    - General administrative expenses
    - Taxes, fees, and assessments (e.g., exchange fees, state premium taxes)

### *Report Calculation*

Total WA Health Care Expenditures =
(1) Medical Health Care Expenditures +

(2) Prescription Drug Health Care Expenditures +
(3) Non-Benefit Health Care Expenditures

## Total WA Primary Care Expenditures

"**Total WA Primary Care Expenditures**" represents the numerator of the primary care expenditure (PCE) performance metric. It captures all Washington State health care costs paid by the carrier during the experience period that meet the definition of primary care, consistent with RCW 70.390.080 and primary care expenditures as defined by the Washington Health Care Cost Transparency Board.

### *Primary Sources and Alignment Requirements*

- The core definition of primary care expenditure is governed by the Health Care Cost Transparency Board under RCW 70.390.080.
- The categories below capture the definitions needed to complete this report.
- For additional detail, see the Board's definition resources: Health Care Cost Transparency Board – Primary Care Advisory Committee

### *Annual Statement Consistency*

Primary care expenditures are a subset of the costs reported in the NAIC annual statement. While the amounts reported in this template will not directly match annual statement totals, they must be logically and proportionally related. Differences are expected due to:

- Greater granularity in this template (e.g., isolating primary care from within total medical costs),
- Differences in timing (e.g., run-out conventions or paid basis), and
- Reporting scope focused only on Washington State business as defined in the NAIC Health Annual Statement Instructions.

### *Reporting Structure and Categories*

Primary care expenditures include both direct provider payments for primary care services and supporting investments that enhance the delivery of primary care. Primary care expenditures must be reported across these two main categories, each with defined subcategories. These should be mapped, where applicable, to lines in the NAIC Health Annual Statement (page 4) to support reconciliation and ensure consistent treatment.

#### Primary Care Benefit Expenditures

Expenditures for direct delivery of primary care services (e.g., fee-for-service claims, capitated services, value-based incentives).

- The subcategories are defined in the Primary Care Expenditure Definitions and Subclassifications subsection below.
- The subcategories generally fall within Lines **9–14** ("Hospital and Medical Benefits") and should be reflected as part of the **subtotal of health care expenditures**, **Line 15**.

- Carriers should use their internal mapping to allocate reported primary care benefit expenditures to the appropriate HASI categories based on the nature of the expenditure and the service rendered (e.g., office visits, capitation, shared savings). Where estimates are used (e.g., primary care portion of global capitation), clearly explain the basis in the *Reporting Methodology* sheet.

**Primary Care Support and Investment Expenditures**

Non-claims-based expenditures that support or strengthen the primary care delivery system (e.g., HIT, workforce development, care coordination infrastructure).

- The subcategories are defined in the Primary Care Support and Investment Expenditures subsection below.
- Applicable amounts to these subcategories do **not** fall within Lines 9–15 and instead are most closely aligned to Line 19 or 20 (Claims Adjustment Expenses or General Administrative Expenses).
- These expenditures must be separately identified in the PCE report. They are excluded from incurred claims in statutory filings, but are recognized in this report as part of total primary care investment under RCW 70.390.080.

## *Primary Care Expenditure Definitions and Subclassifications*

**Total WA Primary Care Expenditures** are the sum **of 'Primary Care Benefit Expenditures' and 'Primary Care Support and Investment Expenditures'**

**Primary Care Benefit Expenditures** is the sum of 'Primary Care Fee-for-Service Based Expenditures', 'Capitated, sub-capitated, and salaried expenditures', '"Leakage" adjustments on capitated or sub-capitated primary care expenditures', 'Estimated primary care expenditures as a subset of global capitation', and 'Provider Incentives' subcategories.

The subcategories of Primary Care-Health Care Benefit Expenditures are defined as follows:

1. **Primary Care Fee-for-Service Based Expenditures** represent all medical payments made by the carrier to primary care providers (defined in the Provider & Sub-Specialties sheet) for specific primary care services (defined in the Procedure Codes sheet) in designated locations (defined in the Place of Services Codes sheet).
    a. For primary care expenditures exclude all vision, dental, lab, imaging services and Rx services.
2. **Capitated, sub-capitated, and salaried expenditures:** Capitation arrangements with primary care providers not billed or captured through claims (total amount, un-adjusted; see next row for how to enter "leakage" adjustments); and salaried arrangements with primary care providers not billed or captured through claims. (See Estimated primary care expenditures from global capitation to enter global capitation.)

3. **Leakage adjustments on capitated or sub-capitated primary care expenditures (report as a negative number):** Any downward adjustments to primary care capitation to reflect payments to non-capitated providers for services to patients who are attributed to a capitated provider (aka "leakage").
4. **Estimated primary care expenditures from global capitation:** This section captures the portion of global capitation expenditures that can reasonably be attributed to primary care services. Global capitation arrangements typically cover all or nearly all covered services, including but not limited to primary care.
    a. **Total Global Capitated Health Care Expenditures:** Estimate the total dollar amount of global capitation expenditures for Washington State health care during the experience period. This amount is entered under the Supplemental Health Care Data Elements.
    b. **Estimated Primary Care Portion of Global Capitated Expenditures**: Report the estimated portion of the total global capitation amount that qualifies as primary care expenditure. This estimate should be:
        i. Based on a reasonable allocation method (e.g., historical utilization, actuarial modeling, or provider financial reporting);
        ii. Expressed as a dollar amount, not just a percentage; and
        iii. Aligned with the definition of primary care under RCW 70.390.080 and HCA guidance.

        Only these estimated primary care amounts will be included in the reported Total WA Primary Care Expenditures in the template.

        Carriers must document the basis for the allocation in the *Reporting Methodology* sheet, including assumptions and data sources used. If no reasonable estimate is available, the value may be reported as zero.
5. **Provider Incentives:** Net financial incentive expenditures (bonuses minus penalties) for primary care providers or practices in a value-based payment arrangement or alternative payment model conditioned on reporting or on the quality of services provided. The incentives should be detailed by the applicable alternative payment methods - Health Care Payment Learning and Action Network Category (see Provider Incentives - LAN sheet for definitions).

    *Note: this is only the incentive (bonus and/or penalty) portion of the payment arrangement, NOT the amount of payment for services or the capitated rate.* Please be sure to report the net amount as a negative number if penalties were greater than bonuses.
6. **Other Primary Care Benefit Expenditures:** Report expenditures that are directly related to delivering primary care benefits.
    - Amounts may or may not be paid directly to primary care practices.
    - Do **not** include expenditures that are better classified under other primary care benefit expenditure subcategories.

    If you include amounts in this category, provide an explanation in the Reporting Methodology sheet, including:
    - A description of the primary care benefit expenditures reported in this category that are not captured by other subclassifications.

- A justification for why these expenditures qualify as primary care benefit expenditures and are not more appropriately categorized elsewhere.

**Primary Care Support and Investment Expenditures** equals the sum of 'Patient support fees & practice support fees', 'Expenditures for health information technology (HIT)', and 'Workforce expenditures'.

The subcategories of Primary Care Support and Investment Expenditures are defined as follows:

1. **Patient support fees & practice support fees:** Capitated, lump-sum, per-member-per-month or other forms of expenditure for a defined set of patient support activities or for a defined set of practice support activities or infrastructure.

   **Example***: Expenditures for activities that may be billable or non-billable to support patients via care coordination, case management, nurse care management, peer navigators, patient education, behavioral health integration or other patient support activities; Or, expenditures to practices/clinics for achieving NCQA Patient-Centered Medical Homes recognition, or participation in other proprietary or multi-payer medical-home initiative, or other expenditures to support practice transformation or to support capacity for improving care for a defined population of patients.*

   *If you cannot distinguish between capitation expenditures and patient support fees, please include the total in the "Capitated, sub-capitated, or salaried primary care expenditures" category and make a note in the comment box.*

2. **Expenditures for health information technology (HIT):** Expenditures that enable or reward practices' HIT infrastructure, and data analysis and/or reporting capacity.

   **Example***: Expenditures to support transition from paper to electronic health records (EHR), to upgrade an EHR system, to purchase an EHR license, to invest in a health or community information exchange platform, to invest in a population health data platform, to invest in staff to support data analysis or reporting, etc.*

3. **Workforce expenditures:** Expenditures to support workforce or worker development. *Example: Payments or expenses for supplemental staff or supplemental activities integrated into the primary care practice (i.e., practice coaches, etc.*)
4. **Other Primary Care Support and Investment Expenditures:** Report any expenditures that directly support or invest in the delivery of primary care benefits.
   - Amounts may or may not be paid directly to primary care practices.
   - Include only expenditures that substantially contribute to the delivery of primary care services.
   - Do **not** include expenditures that are better classified under other primary care support or investment expenditure subcategories.

If you report amounts in this category, provide an explanation in the Reporting Methodology sheet, including:

- A description of the expenditures reported in this category that are not included in other subcategories.
- Justification for treating the expenditures as primary care support or investment.
- Confirmation that the expenditure supports **only** primary care. If the expenditure also supports non-primary care services, estimate the proportion attributable to primary care and describe the methodology used to allocate it.

## Exposure Data Elements

This section defines exposure data elements collected in this report to provide greater context and insight into reported primary care expenditures.

1. **Member Months:** The total number of member months for Washington State business, reported in accordance with the NAIC Health Annual Statement Instructions for the Statement of Revenue and Expenses. This amount is reported in the Health Care Exposure Section of the report.
2. **Total Primary Care Encounters**: The total number of distinct primary care encounters during the experience period. Encounters must meet the primary care criteria based on the Provider Taxonomy Codes, Procedure Codes (CPT/HCPCS), and Place of Service Codes provided in the template's reference sheets. Each encounter should represent a unique face-to-face or virtual interaction as defined in those coding sets. This amount is reported in the Primary Care Exposure Section of the report.

## Supplemental Data Elements

This section defines additional data elements collected in this report to provide greater context and insight into reported primary care expenditures. These supplemental items help support interpretation, validation, and analysis.

1. **Total Global Capitated Health Care Expenditures:** Enter the total dollar amount of global capitation expenditures for Washington State health care during the experience period. This amount is reported in the Health Care Section of the report.
2. **Primary Care Spending Attributed to Facility Fees:** The total Washington State primary care expenditures attributable to facility-fee related costs, including both explicitly billed facility fees and facility cost components embedded in alternative reimbursement arrangements for primary care expenditures. This amount is reported in the Primary Care Section of the report.
    a. 'Facility fee' means any separate charge or billing in addition to a professional fee for physicians' services that is intended to cover building, electronic medical records systems, billing, and other administrative and operational expenses.
3. **Primary Care Spending Provided as Urgent Care Benefits:** The total Washington State primary care spending associated with urgent care benefits. This should only include amounts billed with urgent care cost-sharing. This amount is reported in the Primary Care Section of the report. This amount may include:

a. Services associated with Provider Taxonomy Code 261QU0200X (*Clinic/Center – Urgent Care*), as listed in the Provider & Sub-Specialties reference sheet.
b. Fee-for-service arrangements that use urgent care POS, CPT codes, or cost-sharing indicators, and
c. Reasonably estimated primary care expenditures delivered through urgent care and reimbursed through capitation, global budgets, or other non-FFS arrangements.

Use internal data to identify applicable urgent care services and allocate associated expenditures accordingly. Any estimation approach used for non-FFS expenditures should be documented in the *Reporting Methodology* sheet.

4. **Primary Care Spending Provided at a Hospitals' Off-Campus Locations:** The total Washington State primary care expenditures associated with services rendered at off-campus outpatient hospital locations, identified by Place of Service (POS) code 19: Off Campus – Outpatient Hospital, as defined in the template's POS code reference sheet. This amount is reported in the Primary Care Section of the report. This amount may include:
    a. Services billed with POS 19 under fee-for-service arrangements, and
    b. Reasonably estimated primary care expenditures delivered at off-campus hospital settings and reimbursed through capitation, global budgets, or other non-FFS arrangements.

    Use internal data to identify services performed at off-campus hospital locations and allocate associated expenditures accordingly. Any estimation approach used for non-FFS expenditures should be documented in the *Reporting Methodology* sheet.
5. **Primary Care Spending Provided at a Hospital's On-Campus Locations:** The total Washington State primary care expenditures associated with services rendered at on-campus outpatient hospital locations, identified by Place of Service (POS) code 22: On Campus – Outpatient Hospital, as defined in the template's POS code reference sheet. This amount is reported in the Primary Care Section of the report. This amount may include:
    a. Services explicitly billed with POS 22 in FFS claims, and
    b. Reasonably estimated primary care expenditures delivered at on-campus hospital settings and reimbursed through capitation, global budgets, or other non-FFS arrangements.

    Use internal data to identify services performed at on-campus hospital locations and allocate associated expenditures accordingly. Any estimation approach used for non-FFS expenditures should be documented in the *Reporting Methodology* sheet.
6. **Expenditures Not Considered:** This is a calculated amount intended to estimate the portion of total Washington State health care expenditures that are expected to be unreported in this filing due to the use of a paid-claims basis and incomplete claim run-out at the time of reporting, as well as expenses required to pay those claims. This amount is reported in the Health Care Section of the report.
    a. **Calculation:** Total Claims Unaccounted = Incurred Claims – Paid Claims as of the reporting cutoff date.
    b. **Scope Consistency:** Paid and incurred claim amounts should be consistent with the Medical Health Care Expenditures and Prescription Drug Health Care Expenditures reported elsewhere in this template.

c. **Incurred Claims Definition:** This is the amount reported by the carrier. Incurred claims should reflect obligations for services rendered during the reporting period including those not yet paid, and should be calculated consistent with the NAIC Health Annual Statement Instructions for the Analysis of Operations by Lines of Business (i.e., incurred claims = paid claims + change in claim reserves), except only considering amounts applicable to the experience period.

## Template Worksheets

This section describes the purpose of each worksheet included in the reporting template.

1. **Primary Care Expenditure Report:** The main worksheet for reporting the primary care expenditure experience.
2. **Reporting Methodology:** Used to describe the methods, data sources, and assumptions supporting the expenditure amounts reported in the Primary Care Expenditure Report.
3. **Provider & Sub-Specialties:** Lists the provider types and subspecialties included in the primary care expenditure definition, as referenced in other sections of this document.
4. **Procedure Codes:** Lists the procedure codes that define primary care expenditures, as referenced in other sections of this document.
5. **Place of Service Codes:** Lists the place of service codes applicable to primary care expenditures, as referenced in other sections of this document.
6. **Provider Incentives – LAN:** Identifies provider incentive payment models (LAN categories) that align with the primary care expenditure definition, as referenced in other sections of this document.
7. **PCE Report – DataExtract:** Designed for use in data collection, aggregation, and internal reporting processes.

# Resources

**Primary Care Expenditure Definitions**

**Washington State Health Care Cost Transparency Board** – Defines qualifying primary care services and expenditures through its Advisory Committee on Primary Care.

- *Appendix A – Primary Care Definition and Code Sets:*
  Cost Board 2024 Legislative Report (PDF)
- *Advisory Committee Website:*
  Health Care Cost Transparency Board – Primary Care Advisory Committee

**Standard Reporting References and Definitions**

All classifications of expenditures, lines of business, and membership should follow the hierarchy below when defined:

- **NAIC Recent Publications (https://content.naic.org/publications)**
  - **Health Annual Statement Instructions (HASI) and NAIC Life, Accident and Health (LAH) Annual Statement**
    Includes definitions for claims, administrative expenses, and line-of-business structure used in the Analysis of Operations.
  - **NAIC Health Annual Statement Blank and NAIC Life, Accident and Health (LAH) Annual Statement Blank**
    Used for crosswalk and reconciliation of totals and categorical data.
  - **NAIC Accounting Practices and Procedures Manual (APPM)**
    Provides statutory accounting standards including SSAP 55 (Unpaid Claims), SSAP 70 (Expense Allocation), and SSAP 84 (Pharmaceutical Rebate Receivables).
- **Washington State Additional Data Statement Instructions (IC-13A-HC / IC-14-HMO)**
  Filing Requirements for Health Care Service Contractors and HMOs
  Includes state-specific reporting instructions, allocation rules by line of business, and definitions used for Washington business segmentation.