NAIC Health Care Affordability and Mitigation Working Group: Reference-Based Pricing

The Health Care Affordability and Mitigation Working Group Briefs are intended to be short, informative briefings for regulators and policymakers on various affordability efforts states have undertaken in recent years to help make health insurance more affordable. They are intended to be high-level and not an exhaustive resource on each issue. They also do not represent policy positions of the NAIC, a given state, author, or workgroup member.

Submission Date

TBD

Contributors

Contributors	Titles of Contributors	States of Contributors
Sarah Bailey	Life and Health Supervisor	Alaska
Kate Harris	Chief Deputy Commissioner, Division of Insurance	Colorado
Maddie Davis	Colorado Option Program Administrator	Colorado
Lindsi Swartz	Senior Advisor to the Insurance Commissioner	Pennsylvania
Rachel Bowden	Director of Regulatory Initiatives for Life and Health	Texas

Executive Summary

TBD (write after rest of brief is finalized)

DRAFT

Reference-Based Pricing

Introduction

Regulators and others have looked at Reference Based Pricing (RBP) in healthcare to try to answer two complex questions: “What amount of payment is too little?” and “What amount of charge is too much?” The far ends of balance between these questions can facilitate fraud, waste, and abuse, inflating premiums, draining resources, and reducing quality of care.

Insurers and other payers often seek contracted payment rates with health care providers, but when such a payment arrangement cannot be reached, a payment amount must be determined. Payers do not typically pay the billed charge. Reference price standards may set thresholds for network contracts but also provide a minimum or maximum payment in the absence of a network contract. This may be applicable in emergency situations, where network adequacy is lacking, or where state laws require coverage for out-of-network benefits. A reference price establishes a payment threshold; it does not, by itself, establish the quality, appropriateness, or value of care.

Overview

Reference based pricing is a tool used by health plans to set healthcare reimbursement rates using a reference price, rather than a negotiated rate. The reference price could be a percentage of the Medicare rate or another publicly-available source, or a proprietary rate established by the health plan. Payments that differ from a reference amount may recognize variations within clinical outcomes, patient complexity, access, continuity of care, geography, and other factors.

Traditional major medical plans

Traditional major medical indemnity plans paid on an expenses-incurred basis up to a limit — typically the "usual and customary rate" (UCR). The UCR represented what payors felt was a fair market price, based on what health care providers in a market normally charged.

Out-of-network payment standards

When managed care plans emerged, payors negotiated in-network rates and continued using UCR as an out-of-network payment methodology. As billed charges moved further away from negotiated rates, plans looked for alternative out-of-network payment methodologies, with many plans using a percentage of the Medicare rate. For out-of-network care governed by the No Surprises

DRAFT

Act, in the absence of a state-regulated payment standard, plans must pay the qualifying payment amount (QPA), which is generally the plan's median contracted rate on January 31, 2019, increased for inflation.

ERISA plans and state employee plans

Recognizing that broad variation in in-network reimbursement rates results in unnecessary claims costs, some self-funded plans use reference pricing as a strategy to maintain broad networks, while directing enrollees towards high value care. For specific services where price variation leads to unnecessary spending and where it is feasible for enrollees to shop in advance of care, the plan sets a reference price as the maximum payment amount. If an enrollee chooses a higher cost provider, they are responsible for any cost beyond the reference price. CMS and DOL provide guidance on how a plan can maintain compliance with ACA requirements in the CMS FAQs About Affordable Care Act Implementation Part XIX and Part XXI. The guidance requires consideration of access to quality providers and an exceptions process where care quality could be compromised.

Fixed indemnity excepted benefit plans

In states that permit per-service fixed indemnity plans, some plans base the fixed payment amount on a reference price, with granular service definitions down to the CPT code level. The reference prices are designed to approximate expenses incurred, often using Medicare rates or an approximation of what providers accept as cash prices. Some states have not approved these plans as excepted benefit plans because the reference prices are not "regardless of expenses incurred."

Non-network major medical plans

Some states have approved non-network major medical plans that pay for medical expenses based on proprietary reference prices that are designed to align with what most health care providers accept as cash prices. Starting in 2027, CMS rules permit these plans to be offered as QHPs on state based exchanges and on the federal marketplaces in plan year 2028, subject to state approval. Enrollees must ask for the cash price and compare it to the plan's payment amount. They have the flexibility to use any provider, but any costs beyond the payment amount are not covered by the plan or counted towards the out-of-pocket maximum.

States with Reference-Based Pricing Policies and Reference-Based Pricing Adjacent Policies

Across the United States, states have adopted a wide range of strategies aimed at improving the affordability and transparency of health care prices. Although these initiatives vary considerably in scope, structure, and regulatory authority, many share a common objective: to slow the growth of hospital and professional service prices and reduce unwarranted variation in what

DRAFT

purchasers pay. Programs differ in the mechanisms they employ — some establish explicit benchmark-indexed reimbursement limits, while others rely on regulatory oversight, transparency tools, payment reform models, or cost-growth targets to influence prices indirectly. To organize this landscape, the following section identifies states with policies that reflect or incorporate elements of Reference-Based Pricing (RBP) or RBP-Adjacent strategies. The definitions below outline these categories, and the accompanying matrix summarizes the states, program characteristics, and key policy design features relevant to each.

Reference-Based Pricing Policies

RBP is a payment approach in which a purchaser or payer sets a fixed, transparent maximum or minimum reimbursement level ("ceilings" or "floors") for specific health care services, explicitly tied to an external reference benchmark—most commonly the Medicare fee schedule. Traditionally under RBP, the benchmark (e.g., 180% or 220% of Medicare, or a defined "reference price" for a procedure) serves as the upper limit of what the payer will reimburse. Providers may not bill above that amount when patient protections apply, and members face limited or no balance billing exposure.

RBP is defined by uniform benchmark-indexed rates, predictable pricing, and substantial reductions in unwarranted price variation across providers. However, a uniform benchmark may not fully account for differences in local labor and operating costs, patient complexity, service mix, geography, specialized capacity, or a provider's role in maintaining access for enrollees. These issues in particular, may be more pronounced in rural, underserved, or otherwise constrained markets where consumers have fewer alternative sources of care. Broad benchmark-based standards may also limit flexibility for value-based contracts, bundled payments, quality incentives, and other arrangements that do not fit neatly within a uniform fee-for-service methodology.

RBP-Adjacent Policies

RBP-Adjacent policies are cost containment or regulatory strategies that use Medicare or other external benchmarks as comparative reference points but do not establish binding reimbursement "ceilings" or "floors" tied directly to those benchmarks. These models may incorporate reference values into rate review, transparency initiatives, out-of-network payment rules, regulatory hearings, or oversight of provider contracting. They also include policies—such as site-neutral payment requirements, facility-fee restrictions, and payment-parity rules—that reduce unwarranted price variation by standardizing reimbursement across care settings or limiting add-on fees not justified by clinical complexity.

Although these approaches do not set payments at a fixed percentage of Medicare or another benchmark, they influence prices

DRAFT

indirectly through transparency, parity-based standards, or regulatory leverage, rather than through a formal reference-priced reimbursement structure.

State	Implementation Date	Type	Market Applicability	Key Variations/Notes
Rhode Island	2010	RBP-ADJACENT Inflation-indexed growth caps using benchmark comparisons	▪ Commercial fully insured (individual, small group, large group) ▪ Does not apply to self-funded, Medicare, Medicaid	▪ Caps annual hospital price growth at inflation + 1% ▪ Rate review examines trends vs. historical and national benchmarks ▪ Primary care investment mandates (33%+ increase since 2008) ▪ Alternative Payment Model (APM) adoption targets across carriers ▪ 2010–2024 program evolution: RI has gradually strengthened its affordability standards by tightening hospital price-growth caps, expanding benchmark comparisons, and increasing scrutiny of commercial insurer rate filings. RI has also integrated primary care investment requirements and introduced APM adoption targets across carriers. These updates have shifted the program from a static inflation-indexed cap into a broader, more coordinated cost-containment framework.
California	2011-2012	RBP (Sets “Ceiling”) Shoppable procedure reference pricing	▪ Self-funded: CalPERS PPO plans for state workers/retirees ▪ Not applicable to broader commercial markets	▪ Applies to high-variation procedures: joint replacement, cataract, colonoscopy, arthroscopy ▪ Reference ceilings based on high-value providers; enrollees pay difference ▪ One of the earliest large purchaser RBP models in the U.S. ▪ 2022–2023 program evolution: CalPERS strengthened its RBP strategy by integrating procedural reference pricing with

State	Implementation Date	Type	Market Applicability	Key Variations/Notes
				site-of-service steering, specialty pharmacy contracting, and targeted bundles. It also expanded the use of analytics to identify additional shoppable service lines, reflecting a continued modernization of its RBP framework rather than a static legacy program.
Vermont	2014	RBP-ADJACENT Hospital budget caps referencing benchmarks	▪ Hospitals statewide: annual budget submission and cap ▪ Commercial fully insured: rate review aligned with budget decisions ▪ Medicare and Medicaid: integrated under the Vermont All-Payer Model ▪ Not applicable to self-funded ERISA directly	▪ Green Mountain Care Board (GMCB) sets allowable Net Patient Revenue growth (e.g., 3–4%) ▪ Unified payer oversight enhances cross-market alignment ▪ Public hearings and transparency dashboards ▪ Controls hospital financial growth but not Medicare-indexed caps ▪ One of the most comprehensive cost-regulation environments in the U.S. ▪ 2023–2025 program evolution: The GMCB refined the state's hospital budget review process by incorporating payer-specific growth targets, more granular service-line reporting, and updated all-payer cost growth benchmarks. VT also advanced a redesign of its all-payer model to strengthen alignment across Medicare, Medicaid, and commercial markets. This evolution moves VT toward a more integrated, benchmark-referenced regulatory model.
Montana	2016–2017	RBP (Sets "Ceiling")	▪ Self-funded: State Employee Health Plan	▪ State negotiated 220–250% of Medicare for hospital inpatient/outpatient services ▪ Critical Access Hospitals (CAH) exempt; rural and specialty adjustments applied

State	Implementation Date	Type	Market Applicability	Key Variations/Notes
		Medicare-indexed uniform hospital contracting	▪ No applicability to fully-insured, Medicaid, Medicare, or ACA markets	▪ Replaced variable negotiated rates with statewide uniform contracts ▪ 2023 program evolution: MT's State Employee Health Plan transitioned to a new third-party administrator (BCBSMT), introducing a hybrid payment structure that blends Medicare-indexed RBP rates with supplemental network discounts and alternative contracting tools. This shift maintains Medicare-anchored pricing but allows the administrator more flexibility in meeting savings targets and supporting provider participation. The transition signaled an evolution from strict RBP to a more mixed model, while retaining RBP as the core reference framework for facility payments.
Oregon	2019–2020	RBP (Sets "Ceiling") Medicare-indexed hospital payment caps	▪ Self-funded; Public Employees' Benefit Board and Oregon Educators Benefit Board ▪ No applicability to commercial fully insured, individual/small group, Medicare, Medicaid	▪ 200% Medicare cap (in-network), 185% (out-of-network) ▪ Rural hospital exemptions: CAH, Type A/B hospitals ▪ Hospital overpayments (i.e., exceeding the Medicare cap established) must be returned; no balance billing allowed (i.e., hospitals cannot pass any unpaid balance to patients) ▪ 2023–2024 program evolution: OR updated its PEBB/OEBB hospital cap management process to incorporate blended verification audits, improved monitoring of out-of-network claims, and alignment with broader state Cost Growth Target initiatives. While the core RBP model

State	Implementation Date	Type	Market Applicability	Key Variations/Notes
				remains intact, OR began exploring integration of RBP hospital caps with value-based purchasing contracts and incentives for ambulatory shifts, reflecting a gradual evolution from simple rate capping to a more comprehensive affordability strategy.
Washington	2020-2022	RBP-ADJACENT Site-neutral reforms + Medicare-based benchmark oversight	▪ Commercial fully insured: individual & small group (rate review) ▪ Medicaid MCOs: subject to cost-growth benchmark ▪ Large provider systems: required cost reporting ▪ Not applicable to self-funded ERISA plans	▪ Statewide cost-growth benchmark program ▪ Identifies systems exceeding allowable growth; can require corrective action plans ▪ Evaluates provider pricing against Medicare and peer benchmarks ▪ Early site-neutral policies limit add-on hospital fees in off-campus sites ▪ Cascade Care public option uses aggregate reimbursement limits
Indiana	2020-2024	RBP-ADJACENT Site-neutral payment + Medicare benchmark comparison	▪ Commercial fully insured: individual, small group, large group ▪ Regulated hospital systems: facility fee oversight ▪ Not applicable to self-funded ERISA unless voluntarily aligned	▪ Restricts off-campus hospital facility fees; promotes payment parity with independent clinics ▪ Uses RAND studies (Medicare multiples) to evaluate high commercial prices ▪ APCD launched 2024 enabling uniform benchmarking ▪ Transparency dashboards allow employers to compare hospital price positions

State	Implementation Date	Type	Market Applicability	Key Variations/Notes
			▪ No direct applicability to Medicaid/Medicare	
Colorado	2023	RBP-ADJACENT Rate-setting backstop referencing Medicare	▪ ACA individual & small group standardized plans (Colorado Option Plans), on & off exchange ▪ Individual & small group carriers are required to offer Colorado Option plans in all areas that they offer non-standardized plans ▪ No applicability to fully insured large group, self-funded ERISA, or Medicaid	▪ Price reduction targets: Commissioner can set hospital reimbursement rates if carriers miss premium targets (Premium rate reduction (PRR) targets: 5% (2023), 10% (2024), 15% (2025), and no greater than inflation (2026-beyond) below adjusted 2021 baseline) ▪ Medicare and independent or critical access hospital benchmarks central to "reasonable rate" determinations ▪ Network participation requirements prevent provider non-participation from undermining affordability goals
Alaska	2024	RBP (Sets "Floor") Medicare-referenced OON minimums (carrier-driven)	▪ Commercial fully insured: Premera dominant market share ▪ Self-funded Administrative Services Only (ASO) clients: adopting same out-of-network policies ▪ Not a state mandate; no	▪ Replacement of 80th percentile rule (from 2004) with out-of-network (OON) payment tied to ~125–200% of Medicare ▪ Eliminates inflationary charge-based minimum payments (which were less stable and more influenced by provider price inflation) ▪ Represents market-driven shift toward Medicare benchmarking (which is more stable and less influenced by provider price inflation) ▪ Major carrier policy decision, not a statute—creates partial RBP dynamics in OON care

State	Implementation Date	Type	Market Applicability	Key Variations/Notes
			applicability to Medicaid/Medicare	▪ Legislature continues to explore state mandated OON minimums
Nevada	2025-2026	RBP-ADJACENT Public option rate evaluation referencing Medicare	▪ Commercial fully insured: individual market (Qualified Health Plans + Battle Born State Plans) ▪ No direct applicability to small or large group markets ▪ Not applicable to self-funded ERISA	▪ 15% premium reduction target phased in over 4 years ▪ Rate hearings evaluate provider contracts against Medicare and market benchmarks ▪ Reinsurance and workforce incentives financed with 1332 passthrough ▪ Transparency mandates: 300 shoppable services, facility-fee reporting ▪ Not formal RBP but integrates benchmark-based affordability review

Policy Savings

Broad Policy Savings

The following matrix includes a description of broad policy savings resulting from reference-based pricing or reference-based pricing adjacent policies.

State	Value/Metric	Description	Source
Rhode Island	Lower hospital prices in the fully-insured and self-insured markets	Rhode Island's hospital price growth caps led to an average 9% reduction after the initiation of the policy in 2010.	**Health Affairs.** (May 2025)
California	Lower healthcare spending for the state employee health plan	After implementing a reference-based payment program, CalPERS saved $7.0 million on spending for colonoscopies in the first two years of implementation (2011-2012).	**JAMA Internal Medicine.** (November 2015)

DRAFT

State	Value/Metric	Description	Source
Montana	Lower healthcare spending for the state employee health plan	Montana's reference-based payment program is estimated to have saved $30.3 million in inpatient hospital services and $17.5 million in outpatient services for a combined total savings of $47.8 million from state fiscal year (SFY) 2017 to 2019.	**National Academy for State Health Policy.** (April 2021)
Oregon	Lower healthcare spending for the state employee health plan	Over 27 months, Oregon saved $107.5 million, equivalent to 4% of plan spending, by capping in-network payments at 200% of Medicare and out-of-network payments at 185% of Medicare.	**Brown University School of Public Health.** (December 2025)
Colorado	Lower hospital outpatient prices across the individual market	Prices at hospitals targeted for rate reductions through the Colorado Option public hearing process declined by approximately 10% in non-Colorado Option plans.	**Center for Advancing Health Policy Through Research – Brown University**. (September 2025)

Premium Impact and Out-of-Pocket Savings

The following matrix includes the impact of reference-based pricing or reference-based pricing adjacent policies on premium and/or out-of-pocket costs.

State	Premium/ Out-of-Pocket Spending Impact Description	Timeframe	Source/Citation
Rhode Island	Hospital price reductions resulted in reductions of $1,000 per member in the fully insured market per member by 2022.	2022	**Health Affairs.** (May 2025)
Oregon	Oregon's hospital price caps for the state employee health plan reduced out-of-pocket spending by 9.5%.	2019-2025	**Brown University School of Public Health.** (December 2025)

DRAFT

State	Premium/ Out-of-Pocket Spending Impact Description	Timeframe	Source/Citation
Colorado	Due to hospital reimbursement rate reductions, the Colorado Option is associated with a statistically significant $101 reduction in monthly premiums per individual market enrollee (Option and non-Option enrollees) for these plans.	2020-2024	**Center for Advancing Health Policy Through Research – Brown University.** (January 2025)
	The introduction of the Colorado Option resulted in a 15 percent decline in enrollee out-of-pocket spending per year relative to 2022.	2022-2024	**Mathematica.** (January 2026)

Other Key Data and Observations

The following matrix includes other key data and observations related to the implementation of reference-based pricing.

Data Category	Observation/Finding	Source/Context
Stakeholder Feedback		
Implementation Challenges		
Legal/Regulatory Issues		
Contact for Follow-up		

DRAFT

Reference-Based Pricing Brief

RBP and Facility Fees

Facility-fee reform is one policy lever states may consider when examining healthcare affordability and site-of-care payment differences. When a hospital or health system acquires a physician practice or designates an outpatient location as hospital-based, routine services may be billed with an additional facility charge even when the clinician, location, and care provided have not materially changed. These charges can increase health plan claims, consumer cost-sharing, and ultimately premiums without necessarily reflecting additional clinical value or hospital-level resources.

States have taken different approaches depending on their markets, regulatory authority, and affordability priorities. Available policy options include enhanced disclosure and reporting requirements, accurate identification of the site of care on claims, limits on facility fees for specified services or locations, and site-neutral payment requirements for services that can be safely and appropriately delivered in multiple settings.

Where a state chooses to pursue facility-fee reform, relevant design considerations may include:

- Whether the policy applies to particular services, locations, or both;
- Whether it regulates provider billing, insurer reimbursement, or consumer cost-sharing;
- How claims will identify the actual site where care was delivered;
- Whether prohibited amounts may be billed to the consumer;
- How emergency, trauma, rural, safety-net, or essential-access services are treated;
- How existing contracts transition; and
- What reporting, audit, repayment, and enforcement mechanisms are appropriate.

Disclosure requirements can improve transparency, but policymakers may also evaluate whether disclosure alone is sufficient when consumers have limited ability to select an alternative provider or site of care. From the payer perspective, policies that directly address unjustified facility charges may have a greater affordability impact than disclosure-only requirements, while still allowing narrowly tailored exceptions where hospital-level resources are demonstrably necessary.

DRAFT

RBP and Site Neutral Payments

To be written

Facility-fee restrictions and site-neutral payment policies address overlapping but distinct affordability issues. Facility-fee policies generally focus on whether an additional institutional charge may be billed or collected. Site-neutral payment policies focus more broadly on whether the total payment for a service should differ based on the setting in which it is furnished. Both approaches respond to circumstances in which a change in hospital ownership or billing designation may increase the cost of care even when the underlying service, location, quality of care, and resources involved have not materially changed.

Accurate identification of the location where a service was furnished is an important prerequisite for evaluating or administering facility-fee and site-neutral payment policies. When a hospital and multiple off-campus outpatient departments bill under the same National Provider Identifier, claims data may not clearly distinguish the main hospital campus from the individual locations where care was delivered. This can make it more difficult to identify facility fees, compare payments across settings, and evaluate the effects of hospital acquisitions or changes in provider-based status.

These billing and identification gaps can have direct affordability consequences. When routine outpatient services are reimbursed at higher hospital outpatient rates or include additional facility fees primarily because of hospital ownership or site designation, medical costs can increase without a corresponding change in the care delivered. These higher allowed amounts contribute to overall medical cost trends and, over time, can be reflected in higher premiums and increased consumer cost-sharing. Clear, site-specific claims information can help regulators and market participants determine whether payment differences reflect legitimate clinical or resource needs or are driven primarily by ownership and billing status.

RBP and Industry Concerns

Affordability policies should address the underlying drivers of health care costs while preserving competition, consumer access and choice, and continued movement toward value-based care. Considerations include:

- **Preserving negotiated commercial arrangements.** Broad payment ceilings or requirements tying commercial reimbursement to a fixed percentage of Medicare may displace negotiations that account for network participation, access, service availability, quality expectations, and local market conditions.

DRAFT

- **Avoiding unintended pricing and access effects.** A ceiling that is not appropriately calibrated may affect provider participation, network stability, or the availability of particular services. A payment floor may increase costs where negotiated rates are already below the benchmark. Either may also become a negotiating anchor rather than simply an outer payment limit.
- **Maintaining flexibility to reward quality and value.** RBP methodologies generally focus on the price of individual services and may not inherently account for clinical outcomes, patient experience, care coordination, efficiency, or total cost of care. Uniform fee-for-service benchmarks may also be difficult to reconcile with bundled payments, shared savings, population-based payments, quality incentives, and other value-based arrangements unless those models are expressly accommodated.
- **Matching the policy to the identified cost driver.** Depending on the issue being addressed, more targeted tools—such as facility-fee limitations, unique site-level NPIs, accurate claims submission, honest-billing requirements, price transparency, competition policy, or consumer protections—may address specific affordability concerns without establishing a uniform commercial payment level.
- **Protecting consumers and supporting workable implementation.** Any RBP structure should clearly address balance billing, provider availability, continuity of care, clinical exceptions, appeals, treatment of amounts above the reference price, reliable claims data, and dispute resolution.
- **Evaluating broader market effects.** Assessment should extend beyond initial payment reductions to include premiums, consumer cost-sharing, access, quality, utilization, network participation, administrative burden, provider responses, and the continued development of value-based care.

RBP and 1332 Waivers

The Colorado General Assembly passed HB21-1232 in June 2021 to create the Colorado Option program, which requires issuers to lower premiums on Colorado Option plans and also allowed the state to apply for an amendment to its existing ACA Section 1332 State Innovation Waiver to capture additional federal Premium Tax Credit (PTC) savings generated from the Colorado Option. Colorado Option plans were first offered in Plan Year 2023.

Issuers are required to offer standardized Colorado Option plans at the bronze, silver, and gold metal levels in all counties where they offer non-Colorado Option plans in the individual and small group markets. These premium rate reduction (PRR) requirements are incorporated into "target premiums" each year, which are authorized by Colorado's 1332 waiver. The PRR targets are based on adjusted 2021 baseline premiums and represent a 5% reduction in 2023, 10% reduction in 2024, and 15% reduction in 2025. Starting in 2026, Colorado Option plan premiums are limited to the rate of medical inflation. Issuers must notify the Division by March 1 each year if they are able to meet the PRR targets for the upcoming plan year. Failure to meet

DRAFT

these PRR targets establishes the "trigger" by which a Colorado Option public hearing may be initiated. The public hearing process can require issuers and hospitals to reduce reimbursement rates by the maximum allowable amount, which is the greater of either a 20% reduction from the prior year's negotiated rate, or a reduction to a hospital-specific floor. The hospital floor is set in statute at 155% of Medicare with adjustments for hospital characteristics, and each hospital floor is updated by the Division each year.

The Brown University Center for Advancing Health Policy Through Research (CAHPR) found that the hospital reimbursement rate reductions achieved through the Colorado Option public hearing process are associated with a $101 statistically significant reduction in individual market premiums per enrollee. CAHPR also found that prices at hospitals targeted for rate reductions through the public hearing process declined by approximately 10% in non-Colorado Option plans, showing a broader market impact of the program's cost controls.

Sources

Alaska Beacon. (2025, September 11). *Alaska judge rules in state's favor on repeal of a rule intended to limit health care costs.* https://alaskabeacon.com/briefs/alaska-judge-rules-in-states-favor-on-repeal-of-a-rule-intended-to-limit-health-care-costs/

Arnold Ventures. (2023, May 25). *Indiana takes a step forward on site-neutral payments.* https://www.arnoldventures.org/stories/state-policy-win-snapshot-indiana-takes-a-step-forward-on-site-neutral-payments/

CalPERS. (2013, June). *Hips and knees reference-based pricing* [Board briefing]. https://www.calpers.ca.gov/sites/default/files/spf/docs/board-agendas/201306/pension/item-7.pdf

Brown University School of Public Health. (2025, December 2). *Oregon's first-in-the-nation hospital price cap cut costs without compromising care.* *https://sph.brown.edu/news/2025-12-02/hospital-price-caps*

Center for Advancing Health Policy Through Research – Brown University. (2025, January 7). *Estimating the Individual Market Premium Impacts of the Colorado Option.* https://cahpr.sph.brown.edu/sites/default/files/documents/Policy%20Brief_%20Colorado%20Option%20Premiums%20(1).pdf

DRAFT

Center for Advancing Health Policy Through Research – Brown University. (September 2025). *Assessing Individual Market Hospital Outpatient Prices in the Context of the Colorado Option*. https://cahpr.sph.brown.edu/sites/default/files/documents/Policy%20Briefs/2025/Policy%20Brief_%20Colorado%20Option%20Prices.pdf

Centers for Medicare & Medicaid Services. (2014, May 2). *FAQs About Affordable Care Act Implementation (Part XIX)*. *https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/aca_implementation_faqs19*

Centers for Medicare & Medicaid Services. *(2014). FAQs About Affordable Care Act Implementation (Part XXI)*. *https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/reference_pricing_faq_101014.pdf*

Colorado Division of Insurance. (2023, September 19). *Colorado Option & 1332 waiver presentation* [NAIC SCORI health workstream]. https://content.naic.org/sites/default/files/call_materials/Colorado%20Presentation.pdf

Federal Register. (2026, May 20). *Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program*. *https://www.federalregister.gov/documents/2026/05/20/2026-10050/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2027-and#page-29875*

Ginsburg, P. B., Lechner, A. E., & Gourevitch, R. (2013, December). *The potential of reference pricing to generate health care savings: Lessons from a California pioneer* (HSC Research Brief No. 30). National Institute for Health Care Reform. https://nihcr.org/wp-content/uploads/2015/03/HSC_Research_Brief_No._30.pdf

Green Mountain Care Board. (2024). *FY25 hospital budget guidance materials*. https://gmcboard.vermont.gov/FY25-HB-Guidance

Health Affairs. (May 2025). *Rhode Island's Affordability Standards Led To Hospital Price Reductions And Lower Insurance Premiums*. https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.01146

Indiana Department of Insurance. (2023). *Indiana All-Payer Claims Database 2023 annual report*. https://www.in.gov/idoi/files/2023-Annual-Report.pdf

DRAFT

Indiana Senate Republicans. (2024, August 7). *Charbonneau: Database to provide healthcare cost transparency launched*. https://www.indianasenaterepublicans.com/charbonneau-database-to-provide-health-care-cost-transparency-launched/

JAMA Internal Medicine. (November 2015). *Association of Reference Payment for Colonoscopy With Consumer Choices, Insurer Spending, and Procedural Complications*. doi: 10.1001/jamainternmed.2015.4588

Mathematica. (2026, January 16). *Analysis of the Colorado Option, pursuant to § 10-16-1304(5), C.R.S.* https://doi.colorado.gov/sites/doi/files/documents/CO-Option-10-16-1304-Report.pdf

Milbank Memorial Fund. (2024, July 10). *How payment caps can reduce hospital prices and spending: Lessons from the Oregon state employee plan* [Issue Brief]. https://www.milbank.org/publications/how-payment-caps-can-reduce-hospital-prices-and-spending-lessons-from-the-oregon-state-employee-plan/

National Academy for State Health Policy. (2021, April 5). *Independent analysis finds Montana has saved millions by moving hospital rate negotiations to reference-based pricing*. https://nashp.org/independent-analysis-finds-montana-has-saved-millions-by-moving-hospital-rate-negotiations-to-reference-based-pricing/

National Academy for State Health Policy. (2024). *Overview of states' hospital reference-based pricing to Medicare initiatives*. https://nashp.org/state-tracker/overview-of-states-hospital-reference-based-pricing-to-medicare-initiatives/?utm_source=copilot.com

Nevada Current. (2025, January 13). *Feds approve public option health insurance plans*. https://nevadacurrent.com/2025/01/13/feds-approve-nevada-public-option-health-insurance-plans/

Nevada Health and Human Services. (2025, February 18). *Battle Born State Plans presentation*. https://www.nevadahealthlink.com/wp-content/uploads/2025/02/10-Nevada_BBSP_Pres_FEB_2025.pdf

News-Medical. (2025, December 2). *Hospital payment caps linked to savings and stable care in Oregon*. https://www.news-medical.net/news/20251202/Hospital-payment-caps-linked-to-savings-and-stable-care-in-Oregon.aspx

Premera Blue Cross Blue Shield of Alaska. (2024, January 18). *Alaska out-of-network reimbursement update* [Press release]. https://employernewsak.premera.com/alaska-out-of-network-reimbursement-update/

DRAFT

The Source on Health Care Price and Competition. (2026). *Vermont enacts significant legislation addressing healthcare costs and hospital budgets*. https://sourceonhealthcare.org/vermont-enacts-significant-legislation-addressing-healthcare-costs-and-hospital-budgets/?print=pdf

Versán Consulting. (2022, November 1). *The undoing of success: Montana's successful RBP program*. https://www.versanconsulting.com/post/the-undoing-of-success-multipart-series-on-the-undoing-of-montana-s-successful-rbp-program

Washington State Health Care Authority. (2024, December 9). *Update on the Health Care Cost Transparency Board*. https://www.hca.wa.gov/assets/program/cost-board-leg-presentation-20241209.pdf

Further Reading

American Journal of Managed Care (Sinaiko, A. D., Alidina, S., and Mehrotra, A.). (2019) *Why Aren't More Employers Implementing Reference-Based Pricing Benefit Design?* Examines why more employers have not adopted reference-based pricing despite evidence of savings. Barriers identified include implementation complexity, employee communication challenges, provider disruption, and concern about employee dissatisfaction. https://ajmc.s3.amazonaws.com/_media/_pdf/AJMC_02_2019_Sinaiko%20final.pdf

American Journal of Health Economics (Christopher Whaley & Timothy Brown & James Robinson). (2019). *Consumer Responses to Price Transparency Alone versus Price Transparency Combined with Reference Pricing.* Price transparency alone had limited effects, but combining transparency with reference pricing led to meaningful shifts in facility choice and lower average prices paid. https://ideas.repec.org/a/ucp/amjhec/v5y2019i2p227-249.html

Center for Advancing Health Policy through Research – Brown University. *Hospital Payment Cap Simulator*. https://cahpr.sph.brown.edu/tools/simulator

Health Affairs (James C. Robinson and Timothy T. Brown). (2013). *Increases In Consumer Cost Sharing Redirect Patient Volumes And Reduce Hospital Prices For Orthopedic Surgery.* Evaluates reference pricing for knee and hip replacement among CalPERS members. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2013.0188?journalCode=hlthaff

DRAFT

Health Affairs (Robinson JC, Brown TT, Whaley C.). (2017, March 1). *Reference Pricing Changes The 'Choice Architecture' Of Health Care For Consumers.* Examines reference pricing for ambulatory surgery, advanced imaging, laboratory tests, and other shoppable services. https://pmc.ncbi.nlm.nih.gov/articles/PMC10830326/

Health Care Cost Institute. *Using Data to Lower Costs: California's Reference-Based Payment Experience and Implications for Other States.* https://bcht.berkeley.edu/sites/default/files/using_data_to_lower_costs_ca_reference-based_payment_other_states_10.18_.pdf

JAMA Internal Medicine. (Robinson JC, Brown TT, Whaley C, Finlayson E.). (November 2015). *Association of Reference Payment for Colonoscopy With Consumer Choices, Insurer Spending, and Procedural Complications.* Examines reference payment for colonoscopy. https://pubmed.ncbi.nlm.nih.gov/26348851/

New England Journal of Medicine (Robinson, J. C., Whaley, C., and Brown, T. T.). (2017). *Association of Reference Pricing With Drug Selection and Spending in the United States.* Evaluates reference pricing for 1,302 outpatient drugs grouped into therapeutic classes. https://www.nejm.org/doi/full/10.1056/NEJMsa1700087

DRAFT