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Kate Harris, Chair
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NAIC Health Care Affordability and Mitigation (B) Working Group
National Association of Insurance Commissioners
1101 K Street, N.W., Suite 650 Washington, DC 20005

Submitted via Email: Joe Touschner (jtouschner@naic.org)

RE: BCBSA Comments on Drafting Group 4: Reference-Based Pricing

Dear: Ms. Harris and Mr. Beagan

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide feedback on the Reference-Based Pricing Brief developed by the Health Care Affordability and Mitigation (B) Working Group Drafting Group #4.

BCBSA is a national federation of 31 independent, community-based and locally operated Blue Cross and Blue Shield companies (Plans) that collectively cover, serve, and support 1 in 3 Americans in every ZIP code across all 50 states and Puerto Rico. BCBS Plans contract with 95% of hospitals and 91% of doctors across the country and serve individuals covered through Medicare, Medicaid, employer-sponsored coverage, and the individual market.

BCBSA believes that everyone deserves peace of mind when it comes to their health care. As health care costs continue to rise, families, employers, and public programs are facing increasing financial pressure. Consumers are experiencing higher premiums, increased cost sharing, and rising out-of-pocket expenses, underscoring the need for solutions that address the underlying drivers of health care costs. BCBS companies are focused on addressing the root causes of rising costs and advancing a [roadmap](#) that could reduce health care costs by nearly \$1 trillion over 10 years through targeted reforms designed to improve affordability and promote a more sustainable health care system.

Given this commitment to improving health care affordability, BCBSA appreciates the Working Group's efforts to develop issue briefs that serve as educational resources for regulators and policymakers. These

resources provide a valuable overview of policy approaches being considered and implemented across states and can help inform ongoing discussions regarding strategies to improve affordability and access to coverage. BCBSA believes the briefs will be a useful resource for regulators seeking to better understand the range of state policy options, as well as the opportunities and tradeoffs associated with different approaches. BCBSA looks forward to working with the Working Group as it continues its examination of policies that can support affordable, high-quality health coverage and care.

As the Working Group continues to refine these resources, BCBSA encourages the adoption and maintenance of a standardized format across the issue briefs. A consistent structure, including the presentation of state examples, discussion of policy considerations, evaluation of available evidence, and identification of legal, operational, and implementation considerations, would strengthen the briefs and make it easier for regulators and other stakeholders to compare approaches across topics. In addition, BCBSA agrees with recommendations offered by our consumer representative colleagues that each brief clearly articulate the affordability challenge it is intended to address and explain how the featured state approaches are designed to respond to that challenge. Providing this context would enhance the educational value of the briefs and help readers better understand the relationship between specific policy interventions and affordability objectives.

BCBSA also encourages the Working Group to maintain the briefs as neutral educational resources consistent with their stated purpose. The briefs are most effective when they provide an objective assessment of state approaches, including implementation experiences, operational considerations, potential benefits and drawbacks, and any available evidence regarding outcomes. Because states face differing market dynamics, regulatory frameworks, and affordability challenges, the briefs can serve as a particularly valuable resource when they present information in a balanced and non-prescriptive manner, enabling regulators and policymakers to evaluate policy options within the context of their own markets.

Finally, we recommend that the briefs consistently identify when a highlighted policy, law, or regulatory approach is subject to ongoing litigation, legal challenge, enforcement stays, or other significant legal uncertainty. Providing this context is particularly important where legal proceedings may affect implementation, enforceability, or the ultimate viability of a policy approach. Including such information would help ensure regulators receive a complete and balanced understanding of the policy landscape and avoid inadvertently presenting unsettled approaches as established best practices.

In addition to the overarching comments outlined above, BCBSA has provided attached redlines and document-specific comments for the Working Group's consideration. These recommendations are intended to improve consistency across the briefs, enhance contextual information, support the briefs' educational purpose, and ensure that relevant implementation and legal considerations are presented in a balanced manner.

Thank you for the opportunity to provide feedback. We appreciate the Working Group's continued efforts to develop these resources and look forward to continued engagement as the briefs evolve. If you have any questions or would like additional information, please contact Randi Chapman at randi.chapman@bcbsa.com.

Sincerely,

A handwritten signature in dark ink, reading "Clay S. McClure". The signature is written in a cursive, flowing style.

Clay S. McClure, BCBSA
Senior Director, State Affairs

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
Lindi 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)

Commented [BCBSA1]: Overarching comments:

The proposals in this brief are not what BCBSA and other industry stakeholders would consider reference-based pricing, but price setting. Reference-based pricing is a payment methodology that determines reimbursement for health care services based on a defined benchmark, rather than exclusively through negotiated provider contracts. BCBSA recommends titling this brief "reimbursement benchmarks" or another term that differentiates the topics covered from reference-based pricing. See [fact-sheet-reference-based-pricing-1118.pdf](#) from the American Hospital Association for an industry familiar definition.

BCBSA would also like the opportunity to review the finished brief as there are many sections which are not completed.

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.

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.

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 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.

Commented [BCBSA2]: The brief’s current definition may not fully reflect how reference-based pricing is used across the market. Reference-based pricing is generally understood as a payment methodology that uses a defined reimbursement benchmark, such as a percentage of Medicare or another reference amount, to determine payment. It is used in a variety of arrangements, including employer-sponsored models that rely on reimbursement benchmarks and consumer incentives. BCBSA recommends a more neutral definition centered on the use of a defined payment benchmark, while recognizing that traditional reference-based pricing models are distinct.

We recommend including a concrete example of reference-based pricing in the overview section. For example, California’s Public Employees’ Retirement System (CalPERS) implemented a reference-based pricing program for certain shoppable procedures, including joint replacements and colonoscopies. Under this approach, CalPERS established a maximum payment amount for a procedure based on a defined benchmark, and enrollees who selected providers charging more than the reference amount were responsible for the difference. This example would help illustrate how reference-based pricing functions in practice and distinguish traditional RBP models from broader affordability initiatives, public options, and hospital rate-setting policies discussed elsewhere in the brief.

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 steering 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.

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 2028, CMS rules permit these plans to be offered as QHPs, 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. **This model places the full burden of price discovery and cost calculation on the enrollee at the point of care.**

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 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

Commented [BCBSA3]: This discussion may read as a definitional disagreement, but the distinction is substantively important. Whether a product qualifies as an excepted benefit determines the applicability of ACA market reforms and consumer protections. If a state concludes that a reference-based payment design is sufficiently tied to medical expenses such that it no longer qualifies as an excepted benefit, different regulatory requirements and consumer safeguards may apply. We recommend providing additional context regarding why states have reached different conclusions on this issue and the consumer protection implications associated with those determinations.

Commented [BCBSA4]: The brief omits several important affordability policies that are directly relevant to determining appropriate prices for health care services, including Independent Dispute Resolution (IDR), site-neutral payment policies, and facility fee reforms. These approaches are frequently discussed alongside reference-based pricing because they address reimbursement levels, payment variation, and provider pricing incentives. We recommend either incorporating these topics into the brief's policy discussion or developing separate issue briefs dedicated to these subjects to provide a more complete overview of affordability strategies affecting health care prices.

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.

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 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	▪ Commercial fully insured (individual,	▪ Caps annual hospital price growth at inflation + 1%

Commented [BCBSA5]: We are concerned that the "RBP-Adjacent" category broadens the scope of the brief beyond reference-based pricing. Many of the policies included in this category, particularly cost-growth benchmark programs, hospital budget models, and state affordability initiatives, do not establish reimbursement using a defined reference benchmark and therefore do not appear directly related to traditional reference-based pricing models. Including these policies may create confusion regarding what constitutes reference-based pricing and raises questions regarding why other affordability policies are not similarly included. We recommend maintaining a narrower focus on policies that directly use a defined payment benchmark and removing cost-growth benchmark examples that are principally broader affordability initiatives.

Commented [BCBSA6]: The brief should more clearly explain that the policies summarized in this table apply to substantially different market segments, including state employee plans, self-funded employer arrangements, individual and small-group market products, and broader commercial markets. Differences in regulatory authority, purchaser leverage, benefit design, provider contracting, and enrollee population may affect both implementation and outcomes. Results observed in one market segment should not necessarily be assumed to apply to another.

State	Implementation Date	Type	Market Applicability	Key Variations/Notes
		Inflation-indexed growth caps using benchmark comparisons	small group, large group) ▪ Does not apply to self-funded, Medicare, Medicaid	▪ 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 site-of-service steering, specialty pharmacy contracting, and targeted bundles. It also expanded the

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State	Implementation Date	Type	Market Applicability	Key Variations/Notes
				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

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State	Implementation Date	Type	Market Applicability	Key Variations/Notes
		Medicare-indexed uniform hospital contracting	No applicability to fully-insured, Medicaid, Medicare, or ACA markets	- Critical Access Hospitals (CAH) exempt; rural and specialty adjustments applied - 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

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State	Implementation Date	Type	Market Applicability	Key Variations/Notes
				blended verification audits, improved monitoring of out-of-network claims, and alignment with broader state Cost Growth Target initiatives. While the core RBP model 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	- 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

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State	Implementation Date	Type	Market Applicability	Key Variations/Notes
			- Not applicable to self-funded ERISA unless voluntarily aligned - No direct applicability to Medicaid/Medicare	Transparency dashboards allow employers to compare hospital price positions
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: Premiera dominant market share - Self-funded Administrative Services Only (ASO) clients: adopting	- 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

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Commented [BCBSA7]: We are concerned that the inclusion of the Colorado Option may blur the distinction between reference-based pricing and other state affordability initiatives. The Colorado Option is principally a state-defined health plan program rather than a traditional reference-based pricing model and may be more appropriately discussed in the State-Defined Plans brief.

State	Implementation Date	Type	Market Applicability	Key Variations/Notes
			- same out-of-network policies ▪ Not a state mandate; no applicability to Medicaid/Medicare	- stable and less influenced by provider price inflation) ▪ Major carrier policy decision, not a statute—creates partial RBP dynamics in OON care ▪ 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)

Commented [BCBSA6]: The brief should more clearly explain that the policies summarized in this table apply to substantially different market segments, including state employee plans, self-funded employer arrangements, individual and small-group market products, and broader commercial markets. Differences in regulatory authority, purchaser leverage, benefit design, provider contracting, and enrollee population may affect both implementation and outcomes. Results observed in one market segment should not necessarily be assumed to apply to another.

Commented [BCBSA8]: The Policy Savings section primarily focuses on reported savings, premium reductions, and spending impacts, but does not discuss several important considerations associated with implementing reference-based pricing models. To provide a more balanced and informative overview, we recommend including discussion of provider responses to payment limitations, provider participation and network implications, potential effects on patient access, particularly in rural or underserved areas, and operational challenges purchasers may encounter when implementing and administering RBP programs.

BCBSA encourages the drafting group to acknowledge that the evidence on reference-based pricing varies across market settings and program designs. Presenting both the potential benefits and implementation challenges would better align with the stated purpose of the brief as a neutral educational resource and provide regulators with a more complete understanding of the tradeoffs associated with these approaches.

Commented [BCBSA9]: Where savings, premium reductions, or out-of-pocket impacts are presented, the brief should distinguish between observed associations and demonstrated causal effects. Market competition, provider contracting trends, enrollee characteristics, reinsurance, and other concurrent reforms may also contribute to reported outcomes. The brief should identify relevant study limitations and avoid attributing changes solely to the highlighted policy when the underlying evidence does not establish direct causation.

State	Value/Metric	Description	Source
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)
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)
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)

Commented [BCBSA10]: Colorado also has a reinsurance program which impacts savings to the CO Option program. The Center for Advancing Health Policy Through Research source notes this and recognizes their analysis is preliminary which this should note as well.

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		

Reference-Based Pricing Brief

RBP and Facility Fees

To be written

RBP and Site Neutral Payments

To be written

RBP and Industry Concerns

To be written

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 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.

Commented [BCBSA11]: The brief currently highlights potential savings and affordability impacts associated with certain reference-based pricing approaches but does not discuss several commonly cited implementation considerations. To provide a balanced overview, we recommend completing the "RBP and Industry Concerns" section with discussion of issues such as balance billing exposure, provider participation and network adequacy considerations, member education requirements, access implications in rural markets, and the administrative complexities associated with implementing and maintaining reference-based pricing arrangements.

Including both potential benefits and implementation challenges would better align with the stated purpose of the brief as a neutral educational resource and provide regulators with a more complete understanding of the tradeoffs associated with reference-based pricing models.

The section should also address how providers and health systems may respond to reimbursement benchmarks, including changes in contracting or participation, service-line decisions, consolidation incentives, appeals and dispute-resolution activity, and potential litigation.

Finally, a reference price establishes a payment threshold; it does not, by itself, establish the quality, appropriateness, or value of care. The discussion should recognize that provider quality, clinical outcomes, patient complexity, access, continuity of care, geography, and other factors may justify payment above a reference amount

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/>

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