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Submitted via Email

National Association of Insurance Commissioners

Health Care Affordability and Mitigation Working Group

RE: Draft Health Care Affordability and Mitigation Working Group Brief on Reference-Based Pricing

Dear Chair and Members of the Working Group:

On behalf of Navitus Health Solutions, LLC, thank you for the opportunity to offer the following comments. By way of background, Navitus Health Solutions is a pass-through pharmacy benefit manager (PBM) that was formed more than two decades ago as an alternative to the traditional PBM model. Today, Navitus serves more than 13 million lives across all 50 states, through a range of health plan products including commercial and public payers. Our focus is on removing high costs from the prescription pharmaceutical supply chain and making medications more accessible to plan sponsors and covered lives. It is in this spirit that we offer the following comments for the National Association of Insurance Commissioners' (NAIC) draft brief regarding reference-based pricing (RBP).

We commend the Working Group for its efforts to address health care affordability and improve outcomes for patients. This is important work. As the draft is finalized, we encourage a broader affordability framework that considers not only patients' direct costs, but also the impact of reimbursement policies on the overall cost of coverage. While employers, unions, and other plan sponsors finance coverage in the first instance, higher reimbursement levels are ultimately reflected in higher premiums, increased cost-sharing, reduced wage growth, and other affordability challenges for patients and their families. A broader affordability framework would provide a more complete picture of how reimbursement policies affect both the cost of care and the long-term affordability of coverage.

Affordability Must Be Evaluated Across the Entire Health Care Financing System

Affordability should be evaluated based on a policy's impact on total health care spending and the overall cost of coverage, not solely on patient cost-sharing. While patient cost-sharing is an important measure, it captures only part of the affordability equation. Provider reimbursement is a primary driver of health care spending, and policies that reduce excessive reimbursement can lower overall costs across the health care system.

Although employers, unions, and other plan sponsors finance coverage, health care costs are ultimately borne by patients and families through higher premiums, increased cost-sharing, and less affordable coverage. As a result, reducing overall spending improves affordability for both plan sponsors and the individuals they cover.

The examples highlighted in the draft demonstrate this broader impact. Montana's Medicare-based reimbursement framework reportedly generated approximately \$47.8 million in savings for the State Employee Health Plan between 2017 and 2019, while Oregon's hospital payment cap program generated more than \$100 million in savings over 27 months. These savings reduced overall health care spending and helped make coverage more affordable.

Suggested Brief Language

While patient cost-sharing obligations are an important measure of affordability, policymakers should also consider the impact of reimbursement policies on overall health care spending and the total cost of coverage. Health care costs are ultimately borne by individuals and families through premiums, cost-sharing, wages, and benefit design. Accordingly, policies that reduce excessive provider reimbursement may improve affordability not only for plan sponsors, but also for patients and consumers by lowering overall health care spending and slowing premium growth. Evaluations of reference-based pricing and similar payment reforms should therefore consider both direct patient financial obligations and broader impacts on total health care expenditures, premiums, and coverage affordability.

Reference-Based Pricing Can Create Patient Confusion and Unexpected Financial Exposure Outside No Surprises Act Protections

While reference-based pricing (RBP) can reduce reimbursement levels and generate significant savings, it can also expose patients to unexpected financial liability in circumstances where No Surprises Act (NSA) balance billing protections do not apply. Unlike traditional network-based coverage, many RBP models establish a reimbursement benchmark, often tied to Medicare rates, without requiring providers to accept that amount as payment in full. When providers reject the reference payment, patients may face balance bills for amounts above the plan's payment limit, depending on the services provided and the applicability of NSA protections.

These risks are compounded by patient confusion. Many patients do not understand how RBP differs from traditional network-based coverage and may reasonably expect their financial responsibility to be limited to the cost-sharing amounts specified by their health plan. In practice, patients may not know when NSA protections apply or when they could be responsible for charges exceeding the plan's payment amount. Even when plans offer advocacy, negotiation, or legal support services, patients can still face uncertainty, administrative burden, and anxiety regarding their potential financial liability.

A balanced assessment of RBP should therefore recognize both its ability to reduce health care spending and the consumer protection concerns that can arise when NSA protections are unavailable. Any discussion of RBP as an affordability strategy should account not only for savings achieved through lower reimbursement rates, but also for the importance of safeguards that protect patients from unexpected financial exposure.

Suggested Brief Language

Some reference-based pricing models establish a reimbursement benchmark without requiring providers to accept the payment amount as payment in full. In these arrangements, patients may remain exposed to balance bills if a provider does not accept the reference-based payment amount.

Policymakers evaluating reference-based pricing strategies may wish to consider safeguards designed to minimize patient confusion and unexpected financial liability, including clear enrollee disclosures, patient advocacy services, and protections against balance billing where appropriate. As a result, reference-based pricing models can present both opportunities for cost containment and consumer protection considerations that should be evaluated together.

Distinguish Between No Surprises Act Claims and Traditional Out-of-Network Reimbursement

The final brief should more clearly distinguish between No Surprises Act (NSA)-covered claims and traditional out-of-network reimbursement arrangements because they raise fundamentally different affordability concerns. For NSA-covered services, patients generally are protected from balance billing and are responsible only for applicable

in-network cost sharing. Accordingly, the primary affordability question is whether reimbursement policies increase overall health care spending, premiums, and the cost of coverage. Any payment disputes beyond the patient's cost-sharing obligation are resolved between providers and payers through the federal Independent Dispute Resolution (IDR) process.

Traditional out-of-network claims present different concerns. Because patients may be exposed to balance bills and other financial liabilities, the affordability analysis must consider both the direct financial impact on patients and the broader effects of reimbursement policies on overall health care spending. Evaluating these scenarios separately would provide a more accurate framework for assessing affordability. For NSA-covered claims, patients are largely insulated from direct financial exposure, making system-wide spending and coverage costs the central concern. Traditional out-of-network reimbursement arrangements, by contrast, implicate both overall health care costs and the risk of unexpected financial liability for patients.

Suggested Brief Language

Affordability considerations may differ depending on whether a claim is subject to the federal No Surprises Act or involves traditional out-of-network reimbursement. For services covered by the No Surprises Act, patients generally are protected from balance billing and are responsible only for applicable in-network cost-sharing amounts. In these circumstances, affordability discussions may focus primarily on the impact of reimbursement methodologies on overall health care spending, premiums, and coverage costs.

For traditional out-of-network services that are not subject to No Surprises Act protections, affordability considerations may include both the system-wide effects of reimbursement policy and the potential for direct patient financial exposure through balance billing or other out-of-pocket costs. Evaluating these scenarios separately can provide a clearer framework for understanding the affordability implications of different payment models.

Excessive IDR Awards Increase Costs Across the Health Care System

The No Surprises Act (NSA) has successfully protected patients from surprise medical bills, but patient protections alone do not ensure affordability. The current Independent Dispute Resolution (IDR) process may be increasing overall health care spending by producing payment awards that exceed negotiated in-network rates, creating incentives for providers to remain out of network and placing upward pressure on reimbursement across the market. Those higher costs are ultimately reflected in premiums, benefit costs, and other expenses borne by patients and families.

The affordability implications of the NSA therefore extend beyond direct patient liability. For NSA-covered services, patients generally are insulated from balance billing and are responsible only for applicable in-network cost sharing. The key affordability question is whether reimbursement policies increase overall health care spending and the cost of coverage.

Evidence suggests those concerns warrant consideration. The Congressional Budget Office has cautioned that arbitration outcomes exceeding market rates may encourage providers to remain out of network or seek higher reimbursement during contract negotiations, resulting in higher health care spending and premiums.¹ Recent data indicate providers prevailed in approximately 88 percent of IDR disputes during the first half of 2025 and frequently

¹ Cong. Budget Off., *A Call for New Research on the No Surprises Act* (June 15, 2026), <https://www.cbo.gov/publication/62491>.

obtained payment awards above prevailing contracted rates.² Researchers have estimated that the IDR process generated more than \$5 billion in additional health care spending between 2022 and 2024.³

Individual arbitration outcomes further illustrate these concerns. A *New York Times* investigation reported a \$50,456 arbitration award for an assistant surgeon associated with a prostatectomy, while the in-network surgeon performing the procedure received \$1,843.⁴ Other reporting has documented arbitration awards exceeding \$100,000 for services reimbursed by Medicare at approximately \$1,145. Awards of this magnitude raise concerns that the IDR process may reward out-of-network providers at levels significantly above negotiated reimbursement, weakening incentives for network participation and increasing costs for the plans that finance coverage.

Those costs do not remain confined to individual disputes. Higher out-of-network payments can influence future contracting expectations and place upward pressure on provider reimbursement throughout the market. As reimbursement levels rise, employers, unions, and health plans face higher claims costs that are ultimately financed through increased premiums and benefit expenditures.

The economic consequences are ultimately borne by the individuals and families who depend on health coverage. ERIC reports that the New York State Employee Health Plan identified more than \$200 million in additional claims costs associated with arbitration-related payments, while a union health plan covering approximately 20,000 workers increased premiums by 1.75 percentage points to offset arbitration costs.⁵ Over time, higher claims costs can contribute to higher employee premium contributions, increased cost sharing, reduced wage growth, scaled-back benefits, and less affordable coverage.

The success of the NSA should therefore not be measured solely by its protection against surprise medical bills. Policymakers should also evaluate whether the current IDR framework is increasing reimbursement beyond competitive market rates, weakening incentives for network participation, and contributing to avoidable growth in health care spending. While patients are appropriately protected from direct balance-billing liability, they remain vulnerable to the downstream effects of higher health care costs through rising premiums, greater cost sharing, and less affordable coverage.

Suggested Brief Language

The federal No Surprises Act protects patients from surprise medical bills and establishes an Independent Dispute Resolution process for resolving payment disputes between providers and payers. Because patients generally are insulated from direct financial liability for No Surprises Act-covered services, affordability questions often center on how dispute resolution outcomes affect overall health care spending.

Some stakeholders have expressed concern that Independent Dispute Resolution awards may exceed prevailing contracted rates in certain circumstances, potentially influencing provider contracting incentives and increasing reimbursement expectations across the market. To the extent reimbursement levels rise as a result of arbitration outcomes, higher costs may ultimately be reflected in premiums, cost-sharing obligations, and other costs associated with health coverage.

Policymakers may therefore wish to evaluate not only the consumer protection benefits of the No Surprises Act, but also the broader effects of reimbursement and dispute resolution policies on overall health care spending and coverage affordability.

² Jack Hoadley, Kennah Watts, Katie Keith & Ellie DeGarmo, *The No Surprises Act IDR Process: An Early Look At 2025 Data*, Center on Health Insurance Reforms, Georgetown University (Mar. 30, 2026).

³ Hoadley & Watts, *supra* note 2.

⁴ Reed Abelson & Sarah Kliff, "\$22,000 Per Hour: Assistants Use a Legislative Loophole to Outearn Surgeons," *N.Y. Times* (June 29, 2026).

⁵ The ERISA Indus. Comm. (ERIC), *Independent Dispute Resolution (IDR)* (2026); The ERISA Indus. Comm. (ERIC), *Independent Dispute Resolution (IDR)* (2026).

Conclusion

We appreciate the Working Group's efforts to examine reference-based pricing and other health care affordability policies. The draft appropriately focuses on excessive provider prices and payment variation. We encourage the Working Group to broaden its affordability framework to recognize that affordability affects not only patients, but also the employers, unions, governmental purchasers, and plan sponsors that finance coverage.

The examples discussed throughout the draft demonstrate that payment reforms can generate significant savings when they address excessive reimbursement levels and underlying cost drivers. At the same time, experience under the NSA shows that reimbursement systems can create substantial affordability challenges for purchasers even when patients are protected from direct financial liability.

Affordability analyses should therefore consider not only whether a policy lowers patients' immediate out-of-pocket costs, but also whether it reduces overall health care spending and improves the long-term affordability of coverage for patients and their families.

We appreciate the opportunity to provide feedback and offer these comments for your consideration.

Respectfully,

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