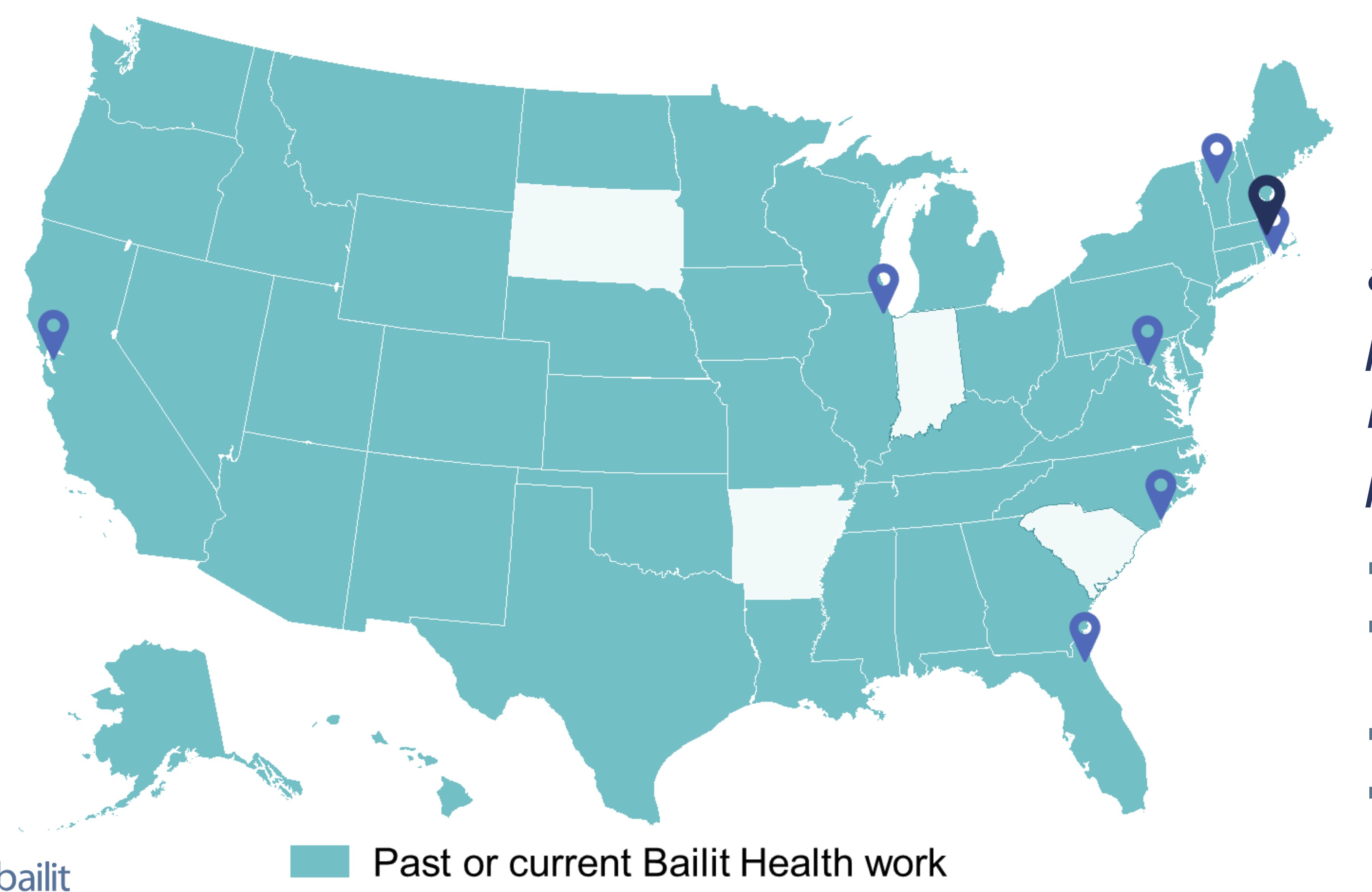
Reference-Based Pricing 101

May 11, 2026

About Bailit Health



Working with state agencies and their partners to improve health care system performance for all.

- Founded in 1997
- Have worked in 46 states and Washington, DC
- Based in Needham, MA
- Team of 15 consultants based in 8 states

bailit health

Delaware Hospitals Have Among the Highest Prices in the U.S.

- RAND periodically analyzes U.S. commercial hospital claim data.
  - Adjusting for the mix of services each hospital delivers, RAND calculates the relative price paid to each hospital.
  - This methodology allows RAND to compare dissimilar acute care hospitals, and to create decile rankings.
- RAND's most recent analysis (examining paid claims between 2020-2022) show that certain Delaware hospitals have among the highest prices relative to Medicare in the country.

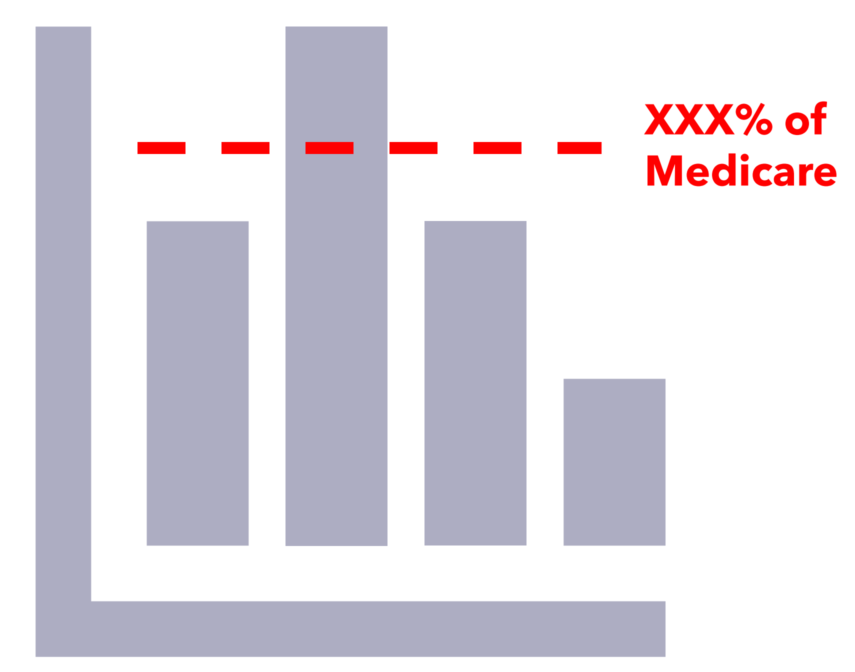
Delaware Hospital Prices by National Decile
(1 = lowest, 10 = highest)

Hospital	Outpatient Price Decile	Inpatient Price Decile
Bayhealth Medical Center	9	10
Beebe Medical Center	9	9
ChristianaCare	8	8
St. Francis Hospital	2	6
TidalHealth Nanticoke	2	1

Source: RAND (2024). Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative.

What is Reference-Based Pricing?

- Reference-based pricing (RBP) – also referred to as *payment limits*, *payment caps,* and *price caps* – limits the payment amounts for hospital services.
- Limits are established in reference to an external payment benchmark, usually a percentage of Medicare.



Reference-Based Pricing Can Be Tailored to State Goals

States considering reference-based pricing can tailor the policy in several ways:

1. Market segments subject to caps
2. Application to hospitals
3. Services subject to caps
4. Referenced benchmark and cap level
5. Implementation and enforcement

1. Market Segments

Hospital reference-based pricing can be applied to…

- Hospital charges, capturing the entire commercial market (VT)
- The fully insured commercial market
- Public employee health plans (OR, NM, WA)
- A public option (WA)
- Out-of-network payments (OR, NM, WA)

2. Application to Hospitals

States can tailor which hospitals are subject to reference-based pricing. For example, states can:

- Apply caps to all hospitals
- Exclude certain hospital types (such as financially distressed or critical access hospitals)
- Vary payment levels for certain hospital types
- Phase in certain hospital types or services

Delaware has **five general acute care hospitals and one children's hospital,** with no facilities designated as critical access hospitals. However, data shows major payment disparities between facilities.

3. Services Subject to Caps

States can determine which services are subject to reference-based pricing.

- Price caps are typically applied to inpatient and outpatient hospital services.
- Can be applied to a narrower set of services (e.g., select high-priced services, out-of-network services) or more comprehensively (e.g., including hospital-employed professionals' services) based on state policy goals.

4. Referenced Benchmark and Cap Level

Most hospital RBP policies have used a percentage of Medicare as the benchmark for the cap, applied uniformly across all inpatient and outpatient hospital services.

- Why use Medicare rates?
  - Medicare rates are already commonly in use, including as a reference for commercial insurers.
  - Administrative resources associated with using Medicare as the benchmark are low.
  - Rates are updated annually and include appropriate adjustments such as for geography.
- Financial modeling can help inform an appropriate cap level that addresses excessive prices and generates savings.

Medicare Benchmarking Options

- Existing RBP efforts in most states cap each hospital's commercial payments as a percentage of final ("fully-loaded") Medicare payments. This includes:
  - Wage index (geographic adjustment factors)
  - Hospital-specific adjustments (including Disproportionate Share Hospital and Graduate Medical Education payments)
- This means that fully loaded rates don't provide an apples-to-apples comparison.
- An alternative to using "fully loaded" Medicare rates with all adjustments is to use Medicare "base prices" with adjustments for wage index only.

5. Implementation and Enforcement

States have three main options for implementation and enforcement:

- **State purchasing authority**: The state caps prices for care purchased through public programs (e.g., the state employee health plan) through its contracts.
- **Insurance regulation**: The state regulates maximum reimbursement rates for services covered by fully insured commercial plans.
- **Provider price regulation**: The state limits the payment amounts providers can receive for services.

Existing State Reference Based Pricing Models – Pre-2025

Oregon
2019-current

Public employee and educator health plans

200% of Medicare

- Lower out-of-network cap to disincentivize leaving the plans' networks
- $107.5 million in savings for the State in first 27 months

Washington
2021-current

Public option plan

160% of Medicare

- Cap on aggregate hospital reimbursement

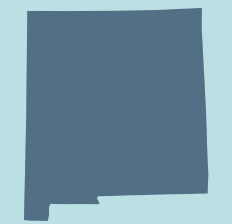
Montana
2016-2022

State employee health plan

220-250% of Medicare

- Used reference-based pricing as a tool to negotiating hospital prices.

New Legislation in 2025

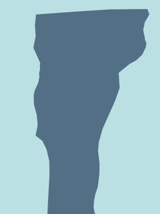


New Mexico
July 2025

State employee health plan

200% of Medicare

- Includes a lower out-of-network cap (similar to Oregon)

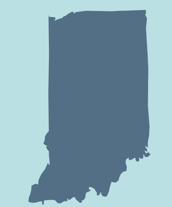


Vermont
Oct. 2026

Commercial market

Cap level TBD

- Implemented via provider rate-setting



Indiana
July 2029

Commercial market

Cap level TBD

- Prices for large nonprofit health systems must be below the state average by 2029 or face loss of nonprofit status

Washington
Jan. 2027

Public employee and educator health plans

200% of Medicare

- Includes lower out-of-network caps
- Rate floors for primary care and behavioral health

Questions?