COMMITTEE FOR A RESPONSIBLE FEDERAL BUDGET



# Reference Pricing for the FEHB

**December 18, 2025**

***Health Savers Initiative***

Health care spending represents about 18% of the nation's economy and the largest area of federal spending. High and rising health care costs are driven in part by the prices for medical care, which have risen 130% since 2000, compared to 93% for overall inflation.[1] This is particularly true in commercial insurance – including large employers, the Affordable Care Act marketplaces, and public employers such as states and the federal government – where rising costs place a growing burden on workers, employers, and the federal government.[2] To manage costs, many employers attempt to work with insurance plans to reduce spending, but many lack the market power to command lower prices from providers, such as hospitals.[3]

Some public employers have looked to reference pricing to address rising employee health care costs in state plans. Under a reference pricing approach, the employer sponsoring the plan establishes a maximum price for certain services. States that have launched reference pricing programs for state employees have been able to reduce costs for state budgets as well as for enrollees.

In order to reduce health care costs more broadly, policymakers could consider adopting or encouraging reference pricing for federally-subsidized insurance. A possible place to start would be the Federal Employees Health Benefits (FEHB) program, which is the largest employer-sponsored commercial insurance program in the country and costs the federal government roughly $50 billion per year.[4]

In this brief, we discuss an option to adopt a version of reference pricing for hospital reimbursement rates in FEHB with the reference price based on Medicare rates. Doing so could save billions of dollars for enrollees and the federal government.

Over the next decade (2026-2035), reference pricing in FEHB at 200% of Medicare could:

- Reduce federal spending by **$60 billion**, producing $30 billion in mandatory savings and $30 billion in discretionary savings; and
- Reduce enrollee costs by **$30 billion**, including $20 billion from lower premiums and $10 billion from lower out-of-pocket costs.

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*The **Health Savers Initiative** is a project of the Committee for a Responsible Federal Budget, Arnold Ventures, and West Health, which works to identify bold and concrete policy options to make health care more affordable for the federal government, businesses, and households. This brief presents options meant to be just some of many, but incorporates specifications and savings estimates so policymakers can weigh costs and benefits and gain a better understanding of whatever health savings policies they choose to pursue.*

## Why Reference Pricing?

High and rising health care prices are key drivers of overall health care cost growth.[5,6] Over time, commercial hospital prices in particular have increasingly diverged from those paid by public programs such as Medicare, which are administratively determined and intended to pay efficient hospitals to cover the cost of care.[7] Commercial insurers paid hospitals similar prices as Medicare in the late 1990s but now pay prices more than 2.5 times what Medicare pays.[8,9] These rising prices drive premium increases, placing a growing burden on both workers and employers as well as taxpayers subsidizing the insurance.

A key driver of health care price increases is providers' market power, which grows stronger through mergers and acquisitions.[10,11] In contrast, health care consumers have relatively little market power or ability to bring down prices. While individuals can sometimes choose lower-cost health care providers or decline high-cost care altogether, they are often unable to see prices in advance and are mostly insulated from those prices by insurance. Furthermore, the ability to "shop" for health care goods and services – particularly emergency or unpredictable interventions – is limited, even when prices are transparent and they bear the cost.[12]

Insurers themselves have more power to drive down prices for health care services as they negotiate with providers on behalf of employers and numerous enrollees. Nonetheless, their negotiating power can be limited by their market share, the market power of various provider networks, and challenges associated with denying coverage. And the incentive for insurers to bring down costs is in part limited by lack of pressure from employers to do so.

Employers themselves also generally have weak negotiating power as they are removed from the health consumption process, lack expertise on health care pricing, and have limited bandwidth to pressure insurers to reduce prices. In addition, the premiums that employers pay on behalf of employees are excluded from income taxes, so employers have less incentive to pressure insurance companies to lower prices.

One approach to help address these challenges is reference pricing, in which the amount paid by the insurer for a given health care service is limited to a fixed-dollar amount. Prices can be set in reference to another pricing schedule (for example, a multiple of what Medicare pays for a given item or service) or relative to observed prices (for example, at the average price in a market).

Traditional reference pricing models allow enrollees to purchase care at any price while setting a dollar limit on insurance's reimbursement to drive enrollees toward lower-cost care. In this model, enrollees bear the entirety of the costs in excess of the reference price but also benefit from the discount if they use care that costs less than the reference price.

This approach not only limits costs borne by insurers and built into premiums, but also harnesses consumer market power by steering patients to lower-price providers. Perhaps more importantly, it drives providers to offer services at or below the reference price.

## The Evolution of Reference Pricing

Although traditional reference pricing can reduce prices paid by insurers, it does so in significant part by shifting those costs onto consumers.

In 2019, Joe Antos and the late Alice Rivlin recommended reference pricing be used to set a price that the insurer pays for "shoppable" services – such as colonoscopies and lab tests.[13] To limit cost sharing, insurers would require in-network providers to offer a rate consistent with the reference price. Enrollees who receive care elsewhere would be responsible for the difference between the reference price and the provider's charges. However, Antos and Rivlin warned that such an approach has limits to its effectiveness on reducing costs – both because most health care services are not easily "shoppable" and because most patients rely on their health care provider's advice for referrals for further care.

Newer approaches taken by some public employers have taken a number of steps to address these shortcomings. These include widening the range of services subject to the reference price, requiring insurers to pay the reference prices, and banning "balance billing" of enrollees.

In recent years, a number of state governments have implemented forms of reference pricing on behalf of the public workforce. However, each state implemented reference pricing differently.

*California* was the first state to implement a reference pricing program, beginning in 2011 after it identified significant price variation among hospitals and between hospitals and free-standing ambulatory surgery centers.[14,15] The California Public Employees' Retirement System (CalPERS) provides health insurance coverage to 1.5 million California state, municipal, and county employees and their dependents.

CalPERS incentivized enrollees to choose providers carefully. It identified certain non-urgent procedures that patients can plan and shop for in advance and set a maximum price that CalPERS would cover.[16] For example, CalPERS limited payment to $30,000 for common joint replacement procedures and $1,500 for colonoscopies. When CalPERS enrollees received care from hospitals priced at the reference point, enrollees paid minimal out-of-pocket costs. But when enrollees received care from hospitals priced above the reference price, they were responsible for the entirety of the difference in the facility price and the reference price, a practice known as balance billing.[17]

This program reduced overall spending by $2.8 million in the first two years (at the time, spending on health benefits totaled about $14 billion over the same period) and increased enrollees' out-of-pocket costs by $0.7 million.[18,19] Over a decade later, CalPERS still runs this program but has acknowledged certain shortcomings. For example, the program is complex to administer due to the need to identify shoppable services and compare prices across different providers. In addition, enrollees need significant education to help ensure that they use in-

network providers.[20] Some enrollees are subject to significant cost sharing when they use out-of-network providers, either knowingly or unknowingly, resulting in cost shifting to employees.

Market concentration also poses challenges to the CalPERS model. When providers have significant market power, it is more likely that they will decline to join the CalPERS network and accept the lower price. This puts pressure on CalPERS to set the reference price higher than they would otherwise. In highly concentrated markets in which providers stay out of network, enrollees do not have the option to go to lower-cost providers, so steering enrollees is ineffective.

The *Montana* State Employee Health Plan implemented lessons learned from the CalPERS model. In 2016, the state implemented reference pricing in its state employee health plan for inpatient and outpatient services and physician payments. The program saved nearly $48 million on inpatient and outpatient services over the first three years, an estimated 17% decrease in spending.[21] To minimize enrollee education needs, Montana did not select shoppable services for reference pricing but rather capped payments for certain providers using Medicare rates as the reference for in-network providers.

Montana set the reference price between 220% and 225% of Medicare rates for inpatient care and 230% and 250% for outpatient services.[22] In addition, Montana wanted to maintain some financial risk for enrollees to avoid overconsumption. To do so, the state allows out-of-network providers to balance-bill enrollees if they choose to go out-of-network for non-emergency services.

The *Oregon* State Employee Health Plan (SEHP) took a broader approach to reference pricing, which has since been considered by multiple states and was enacted by Washington state in 2025. In response to budgetary pressures from health care premium growth, the Oregon state government passed legislation in 2017 to set a maximum payment for all hospital services provided to Oregon state employees and their dependents through the SEHP – which covers about 300,000 public employees and their dependents. Prices for in-network services received at large urban hospitals in the state could not exceed 200% of what Medicare would have paid for that same service. For example, if Medicare paid $19,000 for a hip or knee replacement, the state employee plan and its enrollees would not pay more than $38,000. The reference price for out-of-network services was set at 185% of Medicare.[23] Oregon's law includes protections against balance billing, so enrollees are not responsible for the difference.

The Oregon SEHP and its enrollees saved about $50 million per year (or 4% of plan spending). Most of the savings came from large reductions in hospital payments, where inpatient prices declined by 3% and outpatient prices declined by 25%.[24] Enrollees' outpatient out-of-pocket spending declined by 9.5%, from $70 per procedure to $63 per procedure.[25] There were also no observed changes in hospitals' financial stability, quality of care, or care operations and staffing.[26]

## How Reference Pricing Could Work in the FEHB Program

The FEHB program provides comprehensive health insurance for 8.2 million federal employees, retirees, and their families.[27] The program spent $73 billion on health care in 2025 – $49 billion paid by the federal government and $24 billion from enrollees – and operates like many employer-sponsored insurance plans.[28] The program contracts with private health insurers and third-party administrators (TPAs) to offer about 180 plans.[29]

**Table 1. FEHB Program Costs, in Millions, Plan Year 2025**

| | Costs |
|---|---|
| Mandatory Spending | $23 billion |
| Discretionary Spending | $26 billion |
| **Total Federal Costs** | **$49 billion** |
| | |
| Enrollee Premiums | $24 billion |
| Enrollee Cost-Sharing | $7 billion |
| **Total Enrollee Costs** | **$31 billion** |
| | |
| **Total Costs*** | **$73 billion** |

*Total costs exclude enrollee cost sharing.
Note: Numbers may not sum due to rounding.
Source: U.S. Office of Personnel Management, Congressional Budget Justification, Fiscal Year 2026.[30]

As with other commercial plans, providers' rates are set through negotiations with FEHB plans. Rates can vary significantly from market to market depending on a myriad of factors, such as state regulations, competition among plans, or other providers.[31] Outside of Washington, D.C., plans often lack strong market power relative to hospitals and providers with significant size, prominence, and/or lack of competitors.

Congress could use reference pricing to set lower provider rates in FEHB and improve affordability for federal workers, retirees, and their families. Following the state models in Montana, Oregon, and Washington state, a broader reference pricing model has the potential to generate substantial savings. This model could also serve as an effective pilot program for reference pricing in other federally-subsidized commercial insurance plans.

Although there are many ways to design a reference pricing program (see Appendix I for discussion), we consider a model that would:

- Apply reference pricing to most hospital services, not only shoppable services.[32]
- Set the reference price at 200% of Medicare rates for in-network hospitals.
- Set a second out-of-network reference price at 175% of Medicare in order to encourage providers to remain in network.
- Set reference prices as maximum prices, allowing insurers to negotiate below it.
- Impose standard cost sharing for enrollees at in-network providers.

This approach has the potential to reduce costs for both the federal government and enrollees without significantly compromising access to care. If successful, it could be expanded within and ultimately beyond the FEHB program.

## Estimated Fiscal and Financial Impact

Based on modelling from faculty at the Brown University Center for Advancing Health Policy Through Research,[33] a reference price set at 200% of Medicare would reduce total health care costs by $90 billion over ten years, with $60 billion of federal savings and $30 billion of enrollee savings.

The FEHB program is funded through both mandatory (direct) and discretionary (appropriated) federal funding.[34] About half of the $60 billion in federal savings would be the mandatory side and would directly result in deficit reduction; the discretionary half would lead to deficit reduction only if Congress reduces future appropriations in response.

Of the $30 billion of enrollee savings, $20 billion would come from lower premiums and $10 billion from out-of-pocket spending. The level of savings could differ if enrollees responded to reference pricing by adjusting their plan enrollment and or health service consumption.

**Table 2. Estimated Savings Over Ten Years from Reference Pricing for the FEHB Program**

| | 150% of Medicare | 200% of Medicare | 250% of Medicare |
|---|---|---|---|
| Mandatory Savings | $50 billion | $30 billion | $15 billion |
| Discretionary Savings | $60 billion | $30 billion | $15 billion |
| **Total Federal Savings** | **$110 billion** | **$60 billion** | **$30 billion** |
| | | | |
| Enrollee Premiums Savings | $35 billion | $20 billion | $10 billion |
| Enrollee Out-Of-Pocket Savings | $15 billion | $10 billion | $5 billion |
| **Total Enrollee Savings** | **$50 billion** | **$30 billion** | **$15 billion** |
| | | | |
| **Total Savings** | **$160 billion** | **$90 billion** | **$40 billion** |

Source: Brown University Center for Advancing Health Policy Through Research, research analysis using RAND, KFF, National Academy for State Health Policy Hospital Cost Tool.
Numbers rounded to the nearest $5 billion and may not sum due to rounding.

Savings would differ depending on the exact reference price levels. Lower reference prices would save more money but also increase financial risk for providers and access risk for enrollees; a higher reference price would have the opposite impact. For example, a reference price at 150% of Medicare would reduce total costs by $160 billion, including $110 billion of federal savings and $50 billion of enrollee savings. Conversely, a reference price at 250% would save $40 billion, including $30 billion of federal savings and $15 billion of enrollee savings. Policymakers could consider starting at a higher reference price and phasing down the reference price over time.

Importantly, these savings come only from reference pricing for hospitals. Additional savings could be generated by expanding reference pricing to physician services, laboratories, freestanding surgical centers, and other services.

If desired, Congress could increase savings through other plan features. For example, more cost variability could be allowed for "shoppable services" – either through traditional mechanisms or through provider "tiers" with differential cost sharing based on reimbursement rate. Policymakers would also need to decide whether to allow out-of-network providers to balance bill, which could lead to higher savings but more financial risk for enrollees.

## Conclusion

As health care spending consumes a larger portion of the federal budget and the economy, reference pricing offers a possible approach to managing health care cost growth. We find that adopting a reference pricing scheme for hospital payment in the FEHB program at 200% of Medicare prices could reduce total health costs by $90 billion over a decade, including $60 billion in federal savings and $30 billion in enrollee savings.

This approach could also serve as a pilot project of sorts, modeling reforms for other major employers and federal programs. Indeed, the 2010 National Commission on Fiscal Responsibility and Reform (the Simpson-Bowles Fiscal Commission) had proposed, on a bipartisan basis, to pilot a "premium support" model in FEHB; a similar approach could be taken here.[35]

If successful in the FEHB program, policymakers could consider expanding reference pricing to other federally-subsidized commercial insurance. For example, the federal government is projected to spend over $1 trillion over the next decade to subsidize commercial insurance purchased on the Affordable Care Act exchanges, where health care costs are expected to rise considerably.[36] And through the tax code, the federal government subsidizes employer-sponsored health insurance – which faces rapid cost growth – to the tune of $250 billion per year.[37]

The federal government is a health care payer with significant market power due to its size and status and has a responsibility to be a good steward of taxpayer funds. Where possible, Congress should use its authority to keep costs low and avoid paying for unnecessary or overly costly care or providing excessive subsidies to providers or other intermediaries.

Applying reference pricing in the FEHB program offers an opportunity to lower these costs for the federal government and enrollees alike, saving tens of billions of dollars or more over a decade. Expanding reference pricing to other programs could theoretically save hundreds of billions of dollars, significantly lower health care costs economy-wide.

## Appendix I: Key Considerations Under a Reference Pricing Model

Reference pricing has been shown to reduce spending, but employers must weigh several programmatic considerations to balance tradeoffs.

Which Services to Index to the Reference Price

Setting reference prices for all services may not be feasible, so employers need to choose which set of services or providers are suitable. One option is to set reference prices on services that are "shoppable." Shoppable services are those that can be anticipated (not emergency services) and for which providers can provide prices, such as a knee-replacement procedure. Many services are not shoppable. Outside of preventative screenings, such as a colonoscopy, often the consumer does not know what services they need when seeking out services from a physician or hospital. Significant education is also needed to ensure enrollees understand how to compare prices. To incentivize enrollees to opt for the lower-cost providers, this approach imposes higher cost sharing for higher-cost providers. In addition, in markets where providers are highly concentrated, consumers may not have enough choices to compare different options.

Identifying the drivers of health cost increases is also important. In recent years, hospital prices have been a key driver behind the increases in national health expenditures, particularly in the commercial market.[38]

What to Use as the Reference Price

*Commercial or Medicare rates.* Reference prices are generally based on commercial or Medicare payments. Using commercial payment data can be a challenge due to limited transparency and the lack of publicly available information on hospital prices. Additionally, commercial payments are influenced by provider and insurer bargaining leverage and thus do not necessarily reflect the true costs of care.

Medicare payments, on the other hand, are determined for hospitals nationwide using standardized formulas and data that consider key factors, such as patient characteristics, facility type, and geographic location. Medicare payments are also based on hospitals' self-reported charges and costs of providing care. Medicare payments are also designed to allow efficient hospitals to "break even," although one study estimated that in 2023 the median Medicare rate required for hospitals to "break even" is 124%.[39]

*Base rates or final payments.* If benchmarking to Medicare, it is important to decide whether to reference the base rate or the final payment. The base rate is the amount Medicare pays hospitals for specific patient cases before adding any hospital-specific adjustments.[40] Variation in hospitals' base rates across states mainly reflects differences in labor costs.

The final payment incorporates additional adjustments such as disproportionate share hospital (DSH) status, uncompensated care (UCC) payments, and quality adjustments (for example, penalties for excess readmissions). The final payment can also vary substantially depending on factors such as whether a hospital is a teaching institution, serves a high proportion of low-income patients, or has certain quality performance scores. One study found these add-ons can increase the base rate by 31% on average.[41]

Where to Set the Reference Price (and Potential Exemptions)

Setting the reference price is critical. Analyzing current prices relative to Medicare payments can help determine a maximum payment that balances cost containment with provider sustainability and

willingness to participate, especially when participation safeguards or requirements are absent. Oregon and Washington state employee plans set the reference price at 200% of Medicare payments.[42]

Setting the reference price too low could result in substantial revenue losses for some hospitals, which may threaten their financial viability or prompt them to leave the network. The risk may be especially concerning for small, rural hospitals, which operate on low margins. Oregon exempted critical access hospitals and some sole community hospitals that met certain criteria.[43,44] While this exemption helps protect smaller or rural hospitals, it decreases many of the benefits for enrollees in those areas, who would not benefit from lower out-of-pocket costs. However, these enrollees would still benefit from reduced premiums.

On the other hand, setting the reference price too high may result in minimal savings for the employer and enrollees and could encourage some efficient providers to increase their prices. Oregon encountered this issue after initially specifying that payment "shall not exceed" 200% of Medicare. In response to the observed price increases in the first year, the state revised the language to require that payment shall be "the lesser of" the negotiated rate, billed charges, or 200% of Medicare, effectively closing this loophole.[44] Insurers should be free to negotiate prices below the reference price.

Encouraging Providers to Remain In Network

If providers refuse to join the network, then enrollees may have limited choices. To encourage provider participation, states have relied on two main approaches:

*Out-of-network reference price*: This approach sets a reference price for care provided to enrollees at a non-contracted provider, typically at or below the in-network reference price. Oregon, for example, set its in-network reference price at 200% of Medicare and its out-of-network reference price at 185% of Medicare. The lower reference price level may encourage providers to remain in network because they could secure a higher payment rate.

*Participation requirement*: Washington state adopted a different model by linking participation in the state plan to eligibility for other government programs. Specifically, hospitals are required to contract with one state employee health plan as a condition for receiving payments from Medicaid and the exchange plans. This creates a strong incentive for hospitals to contract with the state employee health plan.

Balancing Enrollee Financial Risk with Cost-Consciousness

Copays and coinsurance steer enrollees to lower-cost providers because in-network providers accept limits on cost sharing. When providers are out of network, enrollees' cost exposure can be high, as providers can balance bill enrollees the difference between the provider's price and the insurer's reimbursement.[45]

Reference pricing programs must weigh enrollees' financial risk with the need to encourage providers to join networks through various trade-offs. For example, one state's reference pricing program (Montana) permitted out-of-network providers to balance bill enrollees. As a result, enrollees have a strong incentive to use in-network providers. Another state (Oregon) implemented a state law to prohibit out-of-network providers from balance billing state plan enrollees and offered out-of-network providers a lower reimbursement rate. This approach protects enrollees but does not encourage enrollees to use in-network providers. Furthermore, the lower reimbursement rate for out-of-network providers is an important lever to incentivize providers to participate in network.

## Appendix II: Estimating Methodology

Faculty at the Brown University Center for Advancing Health Policy Through Research performed the analysis for this report and describe their methodology below.

Data. To estimate savings from hospital-based reference-based pricing for the FEHB program, we used data from multiple sources. Hospital pricing data came from the Hospital Price Transparency Study (round 5.1), which includes commercial pricing information for about 4,000 of US general acute care and critical access hospitals. These data were collected from state all-payer claims databases, health plans, and self-funded employers to improve hospital price transparency. The primary variables included state-level data on average commercial prices per inpatient admission and outpatient service, and the average Medicare-equivalent price for an inpatient admission or outpatient service.

We used several additional data sources to approximate FEHB program service utilization. First, we pulled publicly available information on the Federal Civilian Workforce and the number of individuals with employer-sponsored and non-group insurance — from the KFF — to estimate the share of total commercial savings that would accrue to the FEHB program. Second, because the RAND Hospital Price Transparency data only account for a share of the commercial market, we used data from the Medicare Cost Reports — accessed through the National Academy for State Health Policy Hospital Cost Tool — to create an adjustment factor to scale total savings to the broader commercial market in each state. We compared the total commercial allowed amount in 2022 to the total statewide commercial net patient revenue to estimate the share of hospital commercial revenue represented in our data. We excluded Maryland and the U.S. territories from our analysis, as data for these areas were not available in the Hospital Price Transparency Study. Maryland would also need to be exempt from FEHB reference pricing as their hospitals are paid under a hospital global budget model.

Analysis. We modeled potential savings for the FEHB program and its enrollees under a reference price set at 150%, 200%, and 250% of Medicare. At the state level, we calculated the inpatient reference price by multiplying the Medicare-equivalent price per inpatient admission by the multiplier (1.5, 2, or 2.5). If the average commercial price exceeded this reference price, we estimated savings per admission as the difference between the two. We then multiplied the per-admission savings by the number of inpatient admissions in each state to calculate total inpatient savings, accounting for certain behavior effects. We adjusted savings accounting for the share of total commercial hospital spending represented by our data. Then, we calculated the share of total savings that would accrue to the FEHB program using the share of individuals with commercial insurance (minus exchange plans) that are federal employees by state. The same methodology was applied to estimate savings for outpatient services.

To estimate how total savings would be divided between out-of-pocket and premium reductions, we assumed that out-of-pocket spending accounts for 9.3% of total payments for inpatient and outpatient hospital services among commercially insured enrollees, based on Health Care Cost Institute's 2022 Health Care Cost and Utilization Report. Under this assumption, 9.3% of the total savings would reduce member coinsurance and deductible payments, while the remaining 90.7% would be passed along through premium reductions, assuming that all savings are fully passed on to the FEHB program and its enrollees by its insurers and third-party administrators.

Finally, to estimate savings over a 10-year period, we applied annual growth rates for Medicare payment updates and hospital price inflation. Over the past three years, Medicare payment updates grew at an average rate of 3.3%, while hospital prices increased by an average of 4.2%.

## Appendix Table 1. Detailed Annual Savings by State

| State | Average inpatient prices relative to Medicare | Average outpatient prices relative to Medicare | State level savings in millions under reference pricing model | | |
|---|---|---|---|---|---|
| | | | 150% of Medicare | 200% of Medicare | 250% of Medicare |
| AK | 235% | 345% | $59.8 | $31.4 | $9.9 |
| AL | 216% | 185% | $214.7 | $50.4 | $0.0 |
| AR | 182% | 144% | $53.2 | $0.0 | $0.0 |
| AZ | 302% | 262% | $264.7 | $175.3 | $86.4 |
| CA | 280% | 344% | $1033.8 | $655.9 | $280.4 |
| CO | 286% | 296% | $325.3 | $205.9 | $87.2 |
| CT | 250% | 264% | $31.6 | $15.9 | $0.5 |
| DC | 236% | 249% | $1291.9 | $540.5 | $0.0 |
| DE | 289% | 331% | $36.5 | $23.6 | $10.8 |
| FL | 321% | 401% | $1042.6 | $741.9 | $442.9 |
| GA | 312% | 332% | $902.6 | $623.8 | $347.0 |
| HI | 191% | 299% | $71.5 | $19.1 | $9.5 |
| IA | 210% | 258% | $49.4 | $10.4 | $0.4 |
| ID | 304% | 280% | $93.2 | $62.1 | $31.2 |
| IL | 213% | 300% | $238.2 | $70.5 | $16.1 |
| IN | 281% | 320% | $288.8 | $180.9 | $73.7 |
| KS | 235% | 268% | $118.2 | $50.9 | $2.4 |
| KY | 214% | 243% | $101.9 | $26.3 | $0.0 |
| LA | 221% | 276% | $162.4 | $50.9 | $1.9 |
| MA | 190% | 195% | $90.4 | $0.0 | $0.0 |
| ME | 220% | 278% | $109.2 | $39.1 | $5.5 |
| MI | 206% | 172% | $138.4 | $15.0 | $0.0 |
| MN | 228% | 247% | $130.4 | $48.6 | $0.0 |
| MO | 231% | 277% | $250.6 | $100.4 | $5.3 |
| MS | 181% | 193% | $57.9 | $0.0 | $0.0 |
| MT | 251% | 255% | $105.5 | $53.5 | $1.8 |
| NC | 221% | 328% | $239.7 | $94.3 | $24.3 |
| ND | 217% | 235% | $40.2 | $11.0 | $0.0 |
| NE | 285% | 286% | $104.6 | $65.5 | $26.9 |
| NH | 195% | 276% | $31.0 | $1.8 | $0.6 |
| NJ | 246% | 284% | $103.0 | $51.9 | $4.9 |
| NM | 194% | 280% | $78.8 | $15.9 | $5.9 |
| NV | 245% | 295% | $54.0 | $26.8 | $2.1 |
| NY | 317% | 304% | $447.6 | $311.0 | $175.1 |
| OH | 259% | 300% | $440.4 | $245.2 | $51.2 |
| OK | 214% | 278% | $308.6 | $72.6 | $3.2 |
| OR | 243% | 265% | $113.7 | $53.9 | $2.1 |
| PA | 192% | 255% | $218.0 | $32.5 | $2.7 |
| RI | 217% | 183% | $27.5 | $6.3 | $0.0 |
| SC | 286% | 394% | $217.7 | $141.0 | $64.7 |
| SD | 223% | 279% | $87.3 | $29.9 | $1.9 |
| TN | 233% | 235% | $184.6 | $ 73.0 | $0.0 |
| TX | 237% | 293% | $871.1 | $380.1 | $13.1 |
| UT | 207% | 223% | $132.9 | $18.8 | $0.0 |
| VA | 261% | 262% | $762.8 | $419.1 | $77.7 |
| VT | 227% | 311% | $22.9 | $10.7 | $3.0 |
| WA | 253% | 249% | $349.9 | $178.4 | $8.6 |
| WI | 279% | 356% | $172.6 | $109.5 | $46.9 |
| WV | 314% | 385% | $303.8 | $212.7 | $122.4 |
| WY | 217% | 361% | $49.0 | $17.2 | $4.9 |

Sources: RAND Hospital Price Transparency Study (Round 5.1), KFF, National Academy for State Health Policy Hospital Cost Tool.

Notes: Average inpatient prices relative to Medicare represent the average price per inpatient admission in the state relative to what Medicare would have paid for that case at the state level. Average outpatient prices relative to Medicare represent the average price per outpatient service in the state relative to what Medicare would have paid for that service at the state level. State level savings are for both inpatient and outpatient care combined.

[1] Federal Reserve Bank of St. Louis, "Consumer Price Index for All Urban Consumers: Medical Care in U.S. City Average, Accessed December 17, 2025, https://fred.stlouisfed.org/series/CPIMEDNS#. See also, Federal Reserve Bank of St. Louis "Consumer Price Index for All Urban Consumers: All Items in U.S. City Average, Accessed December 17, 2025, https://fred.stlouisfed.org/series/CPIAUCNS

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[33] We are grateful to Roslyn C. Murray Ph.D., MPP and Christopher M. Whaley Ph.D., from the Brown University Center for Advancing Health Policy through Research for modeling these options and patiently fielding our many questions.

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